THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

THE MORECAMBE BAY MATERNITY AND NEONATAL SERVICES INVESTIGATION: STATEMENT OF METHODS

ANNOUNCED BY DR BILL KIRKUP CBE

FRIDAY 1 NOVEMBER, 2013

PARK HOTEL, EAST CLIFF, PRESTON, PR1 3EA

Today's statement

On 12 September, the Secretary of State for Health, Jeremy Hunt, explained in his written statement to Parliament that I would set out the methods to be used for the Morecambe Bay Investigation.

I am pleased to have the opportunity today to explain to you how the investigation will proceed.

Background

The Morecambe Bay Investigation was established following a high number of serious untoward incidents in the maternity and neonatal services provided by the University Hospitals of Morecambe Bay Trust (UHMBT). Many of the families of those who were harmed or died under the care of the Trust have persistently and courageously sought a full and independent investigation into the circumstances surrounding these incidents. In response to the concerns of the families the Secretary of State for Health established this investigation.

As chair of the investigation, I would like to be clear at the outset about the principles that will be adopted.

First, the investigation will be entirely independent.

Second, it will carry out a complete and thorough examination of the evidence.

And third, it will operate as transparently as is possible.

To ensure that we keep these principles at the forefront of our minds during the investigation, I intend to continue liaising with the families that have been affected directly by the events at Furness General Hospital, as has been the case since the outset. This will enable them to put their views directly to me, and I will take them into account as far as possible while remaining strictly impartial and objective.

Terms of reference

The terms of reference were also published on 12 September, and shape the way in which the investigation will undertake its duties.

In summary, the investigation has been charged with:

(1) reviewing clinical outcomes between January 2004 and June 2013;

(2) reviewing the Trust Board's actions and governance procedures, and the relationship and communication between the Trust and patients and families, and other agencies;

(3) reviewing the Trust Board's responses to previous reports, and action taken as a result;

(4) making findings as to the adequacy of actions taken by the Trust to mitigate safety concerns;

(5) assessing the Trust's ability to discharge its duties in delivering maternity services; and

(6) making recommendations on the lessons to be learned for both the Trust and the wider NHS to secure the delivery of high quality care.

These are important and complex areas to investigate. To ensure that they are addressed thoroughly and that all concerned will have confidence in the outcome, I will need a panel providing specialist expertise in the relevant areas: governance, obstetrics, midwifery, paediatrics, ethics and neonatal nursing.

We will hold the initial panel meeting later this month. I would like to start that meeting by asking all of the families affected to tell us about their experiences. I have had the opportunity to hear many families' experiences, which underlie the setting up of the investigation, and it is important that all panel members are able to share this.

The panel will then concentrate on three linked tasks: completing a full review of the existing documentation; identifying what further information we will need to obtain; and specifying who we will interview. It is important that we complete these early tasks thoroughly so that we can conduct interviews effectively.

In consultation with affected families, I have undertaken to hold all panel meetings and interviews in the presence of those family members able to attend, to ensure that the investigation process is transparent and open to their scrutiny. In addition, we will post a summary of proceedings as soon as practicable on a publicly accessible website.

I am conscious that this is an onerous investigation, and the patience and co-operation of all involved will be required in order to complete the task. The objective, however, is an important one, and I am determined that the work of the panel will contribute to improving the future management, delivery and outcomes of care provided by the maternity and neonatal services at the Trust, and the wider NHS.

Current activity

I hope you will find it helpful to hear about work that has already been undertaken to establish the Investigation.

Secretariat

I have appointed an independent secretariat to support the work of the Investigation.

The Secretary to the Investigation is Oonagh McIntosh and her Deputy is Tom Bacon. Additional staff have been recruited to assist with the management of documents and evidence, the oral hearings and the administration of the Investigation.

In addition I have engaged the services of an analyst who will assist me to review and compare the statistical evidence the Investigation must consider in conjunction with other evidence.

Expert panel members

As I referred to earlier, I have selected and appointed a team of expert advisors in the following fields:

Ethics

Nursing

Governance, including clinical governance

Midwifery

Obstetric care and

Paediatrics.

Professor Jonathan Montgomery, Chair of the Health Research Authority, Professor of Health Care Law at University College London, Chair of the Nuffield Council on Bioethics and of the Advisory Committee on Clinical Excellence Awards will provide expert advice on matters of ethics. Until March 2013 he chaired the cluster of primary care trusts that commissioned services for the residents of Southampton, Hampshire, the Isle of Wight, and Portsmouth and had previously chaired a strategic health authority and two provider trusts.

Geraldine Walters who is the Director of Nursing at Kings College Hospital in London, will provide expert advice on nursing matters.

Julian Brookes an established senior health executive with over 27 years management experience both in central government and all levels of the NHS will advise me on governance, including clinical governance.

Anne Thomas who is the Head of Midwifery and Gynaecology at Northampton General Hospitals NHS Trust will advise me on midwifery matters.

Dr Catherine Calderwood, will advise me on obstetrics. Dr Calderwood is a highly experienced senior obstetrician practicing in Scotland who also advises the Scottish Government.

Professor Stewart Forsyth, who has been closely involved in establishing neonatal standards within Scotland over the last three years as Chair of the Scottish Government Neonatal Expert Advisory Group and the former Medical Director of NHS Tayside will advise on paediatrics.

The team of expert advisors bring a wealth of both operational experience in the clinical areas the investigation will be looking into, and of senior leadership roles in the NHS including in organisations we will be reviewing the actions of.

Investigation offices

I am pleased to announce that the investigation has secured office and hearing room accommodation in Preston.

It has always been my intention to secure a base for the Investigation in the North West to enable the families to attend the oral evidence sessions without them having to travel a significant distance. This is the accommodation that we have secured; it is managed by Lancashire County Council and the part we are using is temporarily surplus to their requirements.

The postal address for the Investigation is

The Morecambe Bay Investigation,
3rd Floor,
Park Hotel,
East Cliff,
Preston,
PR1 3EA

The telephone number is 01772 536 381.

Preston is easily accessible by road and rail. This location, very near to the railway station and a large public car park will, I hope, make travel and access convenient for witnesses and family members alike.

Website\communications

To date, communication with the families and interested parties has been directly with me and, more latterly, with the Investigation Secretary and Deputy Secretary.

I am pleased to report that the Morecambe Bay Investigation now has its own website.

The website name is www.gov.uk/government/organisations/morecambe-bay-investigation and details of how to contact the investigation can be found there.

In order to establish the website as swiftly as possible, and in accordance with guidance issued by the Government Digital Service, the Investigation's website is hosted by the Department of Health.

The wording for the website's introductory page has had to be written to meet Government standards for accessibility and these are matters of technical convenience only. The management of content will be solely the responsibility of the Investigation's Secretariat and updates from the investigation will be loaded as "publications" on its website.

I would ask that, from today, all communication via e-mail is channelled through the investigation's e-mail address or, in writing, to the Investigation Secretary at the investigation office here in Preston. This will enable us to co-ordinate responses and maintain comprehensive records.

E-mails regarding the investigation have to date been sent directly to me, and I have previously given an undertaking to the families that I will be readily available to them. Asking that communication should now be directly with the investigation will not alter this, but will enable us to track all communications and ensure that they are properly taken into account. The Secretariat will work with me to ensure we maintain strong communication links with all those involved in the Investigation, particularly the families.

Progress regarding evidence gathering

I have begun to have meetings and discussions with representatives of the organisations who will be asked to provide evidence to the Investigation.

With the panel and the secretariat, I am determining what evidence I will require them to supply and the practical arrangements for the safe transfer of that material to the investigation.

The list of organisations includes:

The University Hospital Morecambe Bay Foundation Trust;

The Department of Health (also in their role as the legacy body responsible for the records of the Strategic Health Authority and Primary Care Trusts);

NHS England (as the co-ordinating body for the successor CCGs referred to in the terms of reference);

Monitor;

The Care Quality Commission;

The Health and Safety Executive;

Public Health England (as the co-ordinator for public health services referred to in the terms of reference); and

Cumbria Constabulary.

Additional organisations may need to be approached once evidence is reviewed.

Consideration of the evidence

Once evidence is submitted to the investigation it will be reviewed by the secretariat to establish which of the 6 terms of reference it relates to and it will need to be indexed appropriately to ensure that the investigation reviews all associated evidence relating to events, procedures and actions taken.

All evidence will be seen by me and by the expert advisor(s) as appropriate, and considered in light of related evidence submitted by other organisations.

Should further and\or related evidence be required this will be commissioned and assessed.

All of this evidence will inform the questions that I, and the expert advisors, will put to witnesses who will give oral evidence to the panel.

The investigation will make every effort to contact those families who have not yet come forward to talk about their experiences in the maternity unit at Furness General Hospital. They may well not have had the opportunity to participate in any of the earlier reviews that have taken place.

I consider it is important that all of the families and relatives affected are given the opportunity to express their views to an independent panel, if they wish to do so and I would like to take this opportunity to invite those families to make contact with the investigation as soon as they feel able to do so.

However, I am also mindful that some families and relatives will not wish to participate in the work of the investigation and their privacy will of course be respected.

Oral hearings

All of the oral evidence sessions will be open to family members at this venue. This process will form an important element of evidence the panel will consider to help shape the findings, recommendations, and my report to the Secretary of State.

I have written to the Chief Executives of all of the organisations listed and asked them to advise their staff of the approach the Investigation is taking to evidence gathering. I have also asked them to make contact with any member of staff who has retired or left the organisation.

The Investigation will provide the families and interested parties with progress updates via its website. These updates will provide the definitive record of progress for those who are following the work of the Investigation – setting out who has been interviewed, the role and responsibilities the individual was undertaking for the period the Investigation will cover and the areas that the panel has questioned them about – in short a summary of the proceedings.

In conclusion

I am encouraged by the assurances I have received from those included in the scope of this investigation and I am anticipating their full co-operation and support. This will assist the process of evidence gathering and make the arrangements for the oral hearings more straightforward.

A timetable for oral hearings will be placed in advance on the investigation website.

A copy of this statement will also be posted onto the investigation website.

I hope this is helpful and if you have any questions resulting from my sharing this statement of methods with you, I will take them now.