

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

Ms Una O'Brien CB  
Permanent Secretary  
Department of Health  
79 Richmond House  
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SW1A 2NS

3<sup>rd</sup> Floor  
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Telephone: 01772 536376

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6<sup>th</sup> January 2014

Dear Ms O'Brien,

## DOCUMENTS AND EVIDENCE REQUIRED BY THE MORECAMBE BAY INVESTIGATION

The Chairman of the Morecambe Bay Investigation, Dr Bill Kirkup's letter of 17<sup>th</sup> October 2013 refers.

The Investigation is now collecting evidence in respect of its terms of reference.

This letter sets out the evidence required from the Department of Health (DH) with regard to its role as the legacy body for those organisations which have ceased to exist. Further requests may be made at a later date.

The Investigation's Documents and Evidence Manager (DEM), Paul Roberts, or the Assistant Documents and Evidence Manager (ADEM) [REDACTED], will be your principle points of contact in relation to evidence management.

The Investigation would appreciate receiving evidence electronically in one of the following formats:

- Searchable PDF
- Word
- Excel

Should this not be possible, please contact Paul or [REDACTED] to discuss alternative ways in which the evidence can be made available to the Investigation.

### Management of evidence by the Investigation

The Investigation recognises that DH will be concerned to know how material it is being asked to provide to the Investigation will be managed. It will therefore be helpful for you to know that material sought by and supplied to the Morecambe Bay Investigation from interested organisations and the families of those involved will be viewed and accessed by Investigation staff and the Investigation Panel only.

All Investigation staff, including the Panel, will view the material via a secure internet based database to which access will be controlled by the Investigation's Documents and Evidence Management Team and all Investigation personnel, including Panel members, are required to sign and adhere to the terms of a confidentiality undertaking.

Material and/or documents supplied to the Investigation will be collected from, or derived from, official files that are the property of interested organisations and/or individuals and will be considered by the Investigation as "working papers".

Working papers will be either returned to the relevant interested organisation/family at the end of the Investigation or destroyed by the Investigation and a record of all document destruction will be retained.

The Investigation has applied to the Information Commissioner for Data Protection Act Registration and fully understands its responsibilities holding evidence supplied by interested organisations.

Material and/or documents supplied to and considered by the Investigation will not be provided or shown to any witness in advance of their attendance, by the Investigation. Witnesses will be advised in advance of their attendance what specific topics or areas the Panel wish to ask them about and which of the Investigations specific term(s) of reference they are being invited to provide evidence in respect of.

Should any witness wish to be reacquainted with any material and/or document(s) prior to attending the Investigation for an interview or to give evidence, they will be advised by the Investigation to liaise with their employer, or former employer, to make any necessary arrangements for them to undertake any such preparation.

I trust that being made aware at this early stage of the protocol the Investigation has adopted regarding document management, it will assist DH in providing material as swiftly as possible.

The evidence required for the Investigation from DH is set out at Annex and should be submitted to the Investigation **within 21 working days** of the date of this letter.

The evidence being sought covers the period from 1 January 2004 to 30 June 2013. During this period there have been substantial change in the healthcare system in England and many organisations that existed in 2004 no longer exist. DH has an important role in providing evidence to the Investigation as the legacy body for the now defunct Strategic Health Authorities and Primary Care Trusts, pending the transfer of information and records to successor organisations. We recognise that we are seeking archive material from you in respect of functions that were previously delivered by the Strategic Health Authority and Primary Care Trusts, which have subsequently transferred to NHS England, Clinical Commissioning Groups and Public Health England and/or Local Government in respect of functions delivered by the Regional Directors of Public Health.

Once the evidence has been examined, the Chairman will decide who oral evidence should be heard from. Can I remind you that it would be helpful, even at this early stage, if you would advise your staff accordingly and if you would also make contact with any staff member who has retired or left your organisation. To ensure the

smooth running of the Investigation it will be important to ensure we have up to date contact details for those who may be asked to give oral evidence.

If you have any further queries regarding the evidence being requested, please contact:

Paul Roberts: T: 01772 536401 E: [paul.roberts@mbinvestigation.org](mailto:paul.roberts@mbinvestigation.org)

[REDACTED] T: 01772 536390 E: [REDACTED]@mbinvestigation.org

Yours sincerely,

[REDACTED]

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

cc. STEVE VERDON – LEGACY MANAGEMENT TEAM

## Annex A

1. A list of all cases of maternal death, stillbirth (>24 weeks gestation) and neonatal death (up to 28 days) that occurred in the Trust from 1 January 2004 – 30 June 2013 that were brought to the attention of the Strategic Health Authority, or the Primary Care Trusts that were in existence during the relevant period.
2. As far as DH is able to ascertain the following information in respect of the Strategic Health Authority or Primary Care Trusts in existence during the relevant period, a list of all cases of maternal death, stillbirth or neonatal death that occurred following the transfer of a mother, baby or mother and baby from the Trust, to a specialist unit elsewhere.
3. The Strategic Health Authority and the Primary Care Trust's definitions of both an incident and a serious untoward incident (SUI) for the period 1 January 2004 to 30 June 2013.
4. The policies and procedures for responding to both incidents and serious untoward incidents and the associated governance procedures for the period 1 January 2004 to 30 June 2013 that the Strategic Health Authority and Primary Care Trusts required the Trust to comply with.
5. A list of all incidents and serious untoward incidents for the period 1 January 2004 to 30 June 2013 submitted by the Trust to the Strategic Health Authority and Primary Care Trusts.
6. A separate list of all **serious untoward incidents** that occurred at the Trust between 1 January 2004 and 30 June 2013 in **maternity and neonatal services** brought to the attention of the Strategic Health Authority and Primary Care Trusts.
7. A list of **incidents** that occurred at the Trust between 1 January 2004 and 30 June 2013 in **maternity and neonatal services** which were brought to the attention of the Strategic Health Authority and Primary Care Trusts.
8. Any record of the Trust Board's reporting and actions in response to incidents and serious untoward incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 that were brought to the attention of the Strategic Health Authority and Primary Care Trusts.
9. Any documents from the Strategic Health Authority and Primary Care Trusts, including all correspondence sent or received from the Regional Directors of Public Health, the Health Protection Unit of the Health Protection Agency and the Public Health Observatory, regarding maternity and neonatal services at the Trust in the period 1 January 2004 to 30 March 2013.
10. Any record of the Trust Board's actions in response to relevant investigations published by the Parliamentary and Health Service Ombudsman and/or others that were brought to the attention of the Strategic Health Authority and the Primary Care Trusts.
11. Any correspondence between the SHA and/or the PCTs and:
  - The Department of Health
  - The Trust

- The NHS Commissioning Board
- NHS England
- Monitor
- The Care Quality Commission (or its predecessor the Commission for Healthcare Audit and Inspection)
- The Parliamentary and Health Service Ombudsman
- Patients or their relatives
- Members of Parliament
- Cumbria Constabulary

regarding the standard of maternity and neonatal care at the Trust, the number of maternal and neonatal deaths/injuries sustained at The Trust, and complaints about care and the management at the Trust.

12. Any other information you consider may be relevant to the Investigation in fulfilling its terms of reference.

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6<sup>th</sup> January 2014

Dear Ms O'Brien,

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The Chairman of the Morecambe Bay Investigation, Dr Bill Kirkup's letter of 17<sup>th</sup> October 2013 refers.

The Investigation is now collecting evidence in respect of its terms of reference.

This letter sets out the evidence required from the Department of Health (DH) with regard to its role as the national policy maker. Further requests may be made at a later date.

The Investigation's Documents and Evidence Manager (DEM), Paul Roberts, or the Assistant Documents and Evidence Manager (ADEM) [REDACTED] will be your principle points of contact in relation to evidence management.

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I trust that being made aware at this early stage of the protocol the Investigation has adopted regarding document management, it will assist DH in providing material as swiftly as possible.

The evidence required for the Investigation from DH as national policy maker is set out at Annex A and should be submitted to the Investigation **within 21 working days** of the date of this letter.

Once the evidence has been examined, the Chairman will decide who oral evidence should be heard from. Can I remind you that it would be helpful, even at this early stage, if you would advise your staff accordingly and if you would also make contact with any staff member who has retired or left your organisation. To ensure the smooth running of the Investigation it will be important to ensure we have up to date contact details for those who may be asked to give oral evidence.

If you have any further queries regarding the evidence being requested, please contact:

Paul Roberts: T: 01772 536401 E: [paul.roberts@mbinvestigation.org](mailto:paul.roberts@mbinvestigation.org)  
[REDACTED] T: 01772 536390 E: [REDACTED]@mbinvestigation.org

Yours sincerely,

[REDACTED]  
**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

cc. WILLIAM VINEALL  
[REDACTED]



## Annex A

In the context of this evidence, reference to DH includes any Executive Agencies or Arm's Length Bodies that were in existence between 1 January 2004 and 30 June 2013, that produced policies or guidance pertinent to the terms of reference of this investigation.

1. The policies set nationally by DH in relation to the provision of maternity care in England.
2. The policies set nationally by DH in relation to the provision of neonatal care in England.
3. The definitions and policies set nationally by DH regarding an incident and a serious untoward incident and the appropriate and necessary responses required.
4. The definitions and policies set nationally by DH on never events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented)..
5. Any guidance published by DH in relation to the design and layout of maternity and neonatal units.
6. All correspondence between DH and:
  - Any member of the public who wrote to DH Ministers
  - Advice given to ministers, senior officials in DH and regulatory bodies
  - The Trust
  - Cumbria Primary Care Trust (PCT), North Lancashire PCT and its predecessor PCTs (Morecambe Bay PCT, Fylde PCT and Wyre PCT)
  - North West Strategic Health Authority
  - NHS Commissioning Board Special Health Authority
  - NHS Commissioning Board
  - NHS England
  - Monitor
  - The Care Quality Commission (or its predecessor the Commission for Healthcare Audit and Inspection)
  - The Parliamentary and Health Service Ombudsman
  - The Health and Safety Executive
  - The General Medical Council
  - The Nursing and Midwifery Council
  - Cumbria Constabulary
  - Any Member of Parliament

regarding the standard of maternity and neonatal care at the Trust, the number of maternal and neonatal deaths/injuries sustained at The Trust, complaints about care and the management at the Trust, advice given to Ministers and the senior officials in DH and regulatory bodies, and the suitability of the Trust as an applicant for foundation Trust status.

7. Any other information you consider may be relevant to the Investigation in fulfilling its terms of reference.

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Chaired by Dr Bill Kirkup CBE

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17<sup>th</sup> January 2014

Dear Ms O'Brien,

## DOCUMENTS AND EVIDENCE REQUIRED BY THE MORECAMBE BAY INVESTIGATION

Further to the Chairman's letter of 6<sup>th</sup> October 2013, the Investigation is seeking further evidence in respect to Local Improvement Networks (LINKs) for the period the Investigation is covering. The Investigation had contacted Healthwatch England directly for this evidence, however it has been advised that the legacy material is not held by them. The Investigation has subsequently liaised with [REDACTED] about this.

This letter sets out the evidence required from the Department of Health (DH) with regard to its role as the legacy body for those LINKs organisations that have ceased to exist. Further requests may be made at a later date.

The Investigation's Documents and Evidence Manager (DEM), Paul Roberts, or the Assistant Documents and Evidence Manager (ADEM) [REDACTED] will be your principle points of contact in relation to evidence management.

The Investigation would appreciate receiving evidence electronically in one of the following formats:

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### Management of evidence by the Investigation

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Investigation from interested organisations and the families of those involved will be viewed and accessed by Investigation staff and the Investigation Panel only.

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I trust that being made aware at this early stage of the protocol the Investigation has adopted regarding document management, it will assist DH in providing material as swiftly as possible.

The evidence required for the Investigation from DH is set out at Annex and should be submitted to the Investigation **within 21 working days** of the date of this letter.

The evidence being sought covers the period from 1 January 2004 to October 2012, when Healthwatch England was established. We recognise that we are seeking archive material from you in respect of functions that were previously delivered by LINKS organisations, which have subsequently transferred to Healthwatch England. We have already contacted Healthwatch England who have advised the Investigation that they believe you may hold any relevant information.

Once the evidence has been examined, the Chairman will decide who oral evidence should be heard from. Can I remind you that it would be helpful, even at this early stage, if you would advise your staff accordingly and if you would also make contact with any staff member who has retired or left your organisation. To ensure the smooth running of the Investigation it will be important to ensure we have up to date contact details for those who may be asked to give oral evidence.

If you have any further queries regarding the evidence being requested, please contact:

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[REDACTED] T: 01772 536390 E: [REDACTED]@mbinvestigation.org

Yours sincerely,

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

cc. STEVE VERDON – LEGACY MANAGEMENT TEAM

## **Annex A**

1. All correspondence received by the respective LINKs from any patient, relative or member of the public relating to maternity and neonatal service at the Trust during the period 1 January 2004 and October 2012.
2. All correspondence between the relevant LINKs and the Trust relating to concerns raised by patients, relatives or members of the public regarding maternity and neonatal services at the Trust.
3. All correspondence between the relevant LINKs and the following organisations:
  - North West Strategic Health Authority
  - Morecambe Bay Primary Care Trust
  - North Lancashire Primary Care Trust
  - Care Quality Commission (including it's predecessor the Commission for Healthcare Audit and Inspection – the Healthcare Commission)
  - Monitor
4. Any other information you consider may be relevant to the Investigation in fulfilling its terms of reference.

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

Mr S Verdon  
Director – Legacy Management Team  
Department of Health  
79 Whitehall  
London SW1A 2NS

3<sup>rd</sup> Floor  
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14 March 2014

Dear Steve,

## EVIDENCE FOR THE MORECAMBE BAY INVESTIGATION

Many thanks for the time you and [REDACTED] spent with the Investigation in Preston recently. Julie was kind enough to provide a summary of our discussions following the meeting, along with a request for the Secretariat, following discussion with the Panel, to endeavour to prioritise further the initial evidence request.

The Panel has had the opportunity to consider further the initial evidence request and is aware of the significant volume of material from the former North West SHA and North Lancashire and Cumbria Primary Care Trusts, the Legacy Management Team is holding.

Attached with this letter is a table setting out evidence the Investigation requires from the Strategic Health Authority and the Primary Care Trusts. The list of evidence has been prioritised, with the first section setting out the information the Investigation requires to receive as a priority. Notwithstanding the volume of documents contained in the 998 boxes your team needs to search, along with the 3 million+ emails, could provide an indication of when the Investigation can expect to receive the evidence. You are aware that the Chairman is working to a tight timescale to Report to the Secretary of State in the summer of this year, and it would be helpful if you arrange for evidence to be provided as soon as possible. The Investigation would appreciate receiving evidence in tranches, rather than wait for it all to become available, if that would help to speed up the process.

Yours sincerely,

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

## Guidance for DH (Legacy) in searching for evidence

Subject/Topic	Name	Time period	Role
<b>HIGHEST PRIORITY</b>			
All minutes for any Clinical Governance Committee meetings (CGC) within the [INSERT NAME OF SHA] (SHA) or [INSERT NAMES OF PCTs] (PCTs)	SHA	2004 - 2013	
All policies for the governance arrangements of the CGCs in the SHA or PCTs CGC	SHA	2004 - 2013	
All reports, or data, from the SHA in respect of the World Class Commissioning process	SHA	2004 - 2013	
All SHA Board minutes or papers referring to the Trust's FT application	SHA	2004 - 2013	
All SHA Board or briefing papers discussing and containing quality and financial assessments of the Trust – including informal papers	SHA	2004 - 2013	
All data to support the quality assurance process, including information on quality and the financial position of the Trust	SHA	2004 - 2013	
Names of attendee at all meetings between the SHA/PCTs and the Trust	SHA/PCT	2004 – 2013	
Information regarding all informal processes adopted and implemented by the SHA and PCTs to identify “hot topics” or “hot spots” and to communicate\brief Board and non-executive Directors (NEDs) about them	SHA/PCT	2004 – 2013	
Minutes of all quality and standards committees operated by the PCTs	PCT	2004 – 2013	
All reports or data from the PCTs in respect of the NHS North West Fitness for Purpose Capability Development Plan Programme	PCT	2004 – 2013	
Information on any mechanism used for Safeguarding or serious untoward incidents	PCT	2004 - 2013	
Names of all NEDs with lead or portfolio responsibility for	SHA/PCT	2004 – 2013	



Subject/Topic	Name	Time period	Role
governance and quality within the SHA and PCTs			
Names of all Executives Directors with lead or portfolio responsibility for governance and quality within the SHA/PCTs	SHA/PCT	2004 – 2013	
All correspondence between Directors (Executive and NEDs) of the SHA and PCTs regarding quality, application for FT status, maternal and neonatal deaths and\ or SUIs	SHA/PCT	2004 - 2013	
Details of any monthly “catch up” meetings/discussions for any known and on-going crisis	SHA/PCT	2004 - 2013	
<b>SECOND LEVEL PRIORITY</b>			
Anything to/from SHA or PCTs	Ian Cumming	1998 – September 2006	Trust Chief Executive
Anything to/from SHA\PCTs	Kevin McGee	October 2006 – March 2007	Trust Chief Executive
Anything to/from SHA\PCTs	Tony Halsall	April 2007 – February 2012	Trust Chief Executive
Anything between NHS Chief Executive (or staff in his private office) and	Ian Cumming Kevin McGee Tony Halsall	1998 – 2006 2006 – 2007 2007 - 2012	Trust Chief Executive Trust Chief Executive Trust Chief Executive
Anything between NHS Chief Executive (or staff in his private office) and	Mike Farrar SHA Medical Director SHA Director of Nursing		SHA Chief Executive
Anything between NHS Chief Executive (or staff in his private office) and	Cathy Lubelska Professor E Kane Ian Tomlinson David Henshaw	December 2005 – May 2008 May 2008 – December 2011 December 2011 – May 2012 May 2012 – February 2013	Trust Chairman Trust Chairman Trust Chairman Trust Chairman
All documents relating to Gold Command and meetings with multi-agency colleagues involved in the LA Overview and Scrutiny Committee			
All documents produced by the Trust concerning workforce issues			
All documents produced by the SHA\PCTs concerning the Trust’s			

Subject/Topic	Name	Time period	Role
financial position			
All documents produced by the SHA\PCTs concerning the quality of care at the Trust			
All correspondence between the SHA and the Department of Health regarding the financial position of the Trust			
All correspondence between the SHA\PCTs and the Medical Director of the NHS [Paul can you insert the names of the MDs – Sir Bruce Keogh being the most recent one.....]			
All correspondence between the SHA and any individual or organisation regarding UHMB NHS Trust applying for\being considered suitable for\obtaining foundation trust status			
Anything between the Regional Director of Public Health (or any of his staff at the SHA) and the Trust			
Any correspondence between the SHA and	Any other family who suffered a maternal or neonatal death\serious injury\stillbirth between 1\1\2004 and 30\6\2013		
		June 2009	
Any correspondence between SHA and CQC regarding Planned Collaborative Review meeting		January 2009	
Any correspondence between SHA and CQC regarding SUIs		June 2009	
Any correspondence between SHA and CQC / NMC / LSAM Officer re maternity services at the Trust		June 2011	
DH / CQC / NHS England catch up meeting		Late January 2012	
Risk summit (CQC, Monitor & SHA)		February 2012	
Any correspondence between			

Subject/Topic	Name	Time period	Role
SHA and NMC regarding Morecambe Bay NHS Trust			
Any correspondence between SHA and GMC regarding Morecambe Bay NHS Trust			
Anything regarding meeting between John Woodcock MP and PS(H) including any briefing the SHA provided to the Department of Health for such meetings		February 2013	

From the Permanent Secretary  
Una O'Brien CB



Department  
of Health

Richmond House  
79 Whitehall  
London SW1A 2NS

Oonagh McIntosh  
Secretary to the Morecambe Bay Investigation  
3rd Floor, Park Hotel  
East Cliff  
Preston  
Lancashire  
PR1 3EA

20 March 2014

Dear Oonagh,

Further to your letter of 6 January seeking a range of evidence from the Department of Health in relation to Dr Bill Kirkup's investigation into maternal and neonatal deaths at Morecambe Bay I am now in a position to hand over much of the information requested.

Attached to this letter is evidence relating to:

- Children and maternity policy. Officials have located a number of policy guidelines in relation to maternity and neonatal care, including the design of neonatal units. In addition officials have liaised with workforce colleagues in DH to provide any central guidance or recommendations in relation to staffing levels in these units. You will also be aware that they felt that the NHS Litigation Authority and NICE may hold relevant documents. I understand that the NHS LA were already on your list of organisations to contact, and that Paul Roberts has since issued a letter to NICE requesting any information they hold.
- SUI / never events. I am enclosing a nil return from the Department in relation to serious untoward incidents and never events. This policy transferred from DH to NHS England in April 2013, and I believe that organisation should be able to provide you with the evidence you are seeking. I have enclosed a brief update on the latest performance position at UHMB NHS Foundation Trust in respect of never events, for the period April –September 2013.
- Material in relation to Morecambe Bay's Foundation Trust application. The DH provider policy team have trawled for the information that the Department holds. Some of the information provided here relates to an

earlier period than specified in the investigation. Morecambe Bay was one of 32 trusts that sought the Secretary of State's support in 2003 to make an application to Monitor for foundation trust status in the first wave of authorisations. This application was not successful. The trust applied again for foundation trust status in 2009. Monitor will also have information which relates to this process which you have sought separately.

- NHS Business Unit – I have asked this team to provide any evidence relating to parliamentary and ministerial briefings and correspondence relating to maternity and neonatal services at Morecambe Bay as well as about the wider concerns about the Trust.
- Performance Insight Team (PIT) – in addition to the material provided above the PIT (previously known as the Performance Delivery Team) have reviewed their records for evidence of discussions between DH and the SHA about the wider performance of Morecambe Bay as part of annual planning rounds, regular monthly discussions as well as for any specific briefings about maternity or neonatal care.
- CQC sponsorship team – CQC was not established until 2008, half way through the period that you are interested in. The evidence provided from this team includes internal correspondence and briefings. There is also a significant volume of material related to the publication of the Grant Thornton report in 2013.
- Correspondence - Officials have conducted a search for correspondence from members of the public, MPs, peers and health professionals to Ministers and / or the wider Department relating to maternity and neonatal services and wider complaints about the management of services at Morecambe Bay between 1 January 2005 and 31 December 2013. Please note that correspondence addressed to Ministers or to "the Department of Health" is recorded on the CONTACT database. However, correspondence addressed to officials is not recorded on CONTACT and is processed separately. This return is made only from correspondence stored on the CONTACT database. Correspondence prior to 1 January 2005 has been deleted in line with the Department's retention policy and is not available. I would also like to make clear that the system can only search on key words contained in replies to letters from members of parliament or the public. If a piece of correspondence was deemed to be for information only, and not replied to, it will not have been recovered from the database.
- You will wish to be aware that following legal advice we are redacting the personal information from these letters in order to be able to share them with you. If you feel, on review, that knowing the complainant's details

From the Permanent Secretary  
Una O'Brien CB

would be beneficial to the Investigation you will need to let [REDACTED] know.

- Permanent Secretary's office – A large volume of material has been identified – much of which is general management information.

#### Legacy management

- [REDACTED] and [REDACTED] from the legacy team is leading the search of PCT and SHA archive documents. As you are aware this is an enormous task. Consequently it has not been possible to include information in this return. We will provide this documentation as soon as possible, and have noted your agreement to accept this evidence in tranches as and when it becomes available.

Further to your letter of 17<sup>th</sup> January regarding the potential collection of local data by LINKs, I can confirm that Healthwatch is in contact with the former LINK Chair to discuss whether any such information was collected and understand that they are in direct contact with your investigation leads. On that basis, I do not expect there to be any role for DH in those exchanges.

There may some further information that we are able to locate within the DH (for example Healthcare Commission records), which we will send on to you as soon as we are able to. To confirm, I do not expect this to be anything close to the volume of information which we have already identified.

I can confirm that [REDACTED] has written to a number of people who may well be of interest to you in your on-going investigation. Many of these people are now working in other organisations. Where they are now based in NHS England I am aware that they have also been contacted directly by their employer. In addition Jane Verity, Head of Maternity, Early Years and Families has contacted previous children's advisors – Jill Demilew, Suzanne Truttero, and Heather Mellows.

Those that we have contacted directly are:

#### Performance / local issues

- David Flory
- Tim Young
- Chris Garrett

#### Foundation Trust policy

- Warren Brown
- John Holden

From the Permanent Secretary  
Una O'Brien CB

SHA (legacy)

- Mike Farrar
- Jane Cummings

SUIs / never events

- Matthew Fogarty

CQC establishment / sponsorship

- Giles Wilmore
- Richard Murray
- William Vineall
- Lisa Walder
- Alison Smith (to be confirmed)

Please do not hesitate to let me know if there is anything further the Department can do to assist the Investigation. — particularly if you need our

*Yours Sincerely,*

*support to ensure you get full disclosure from DH's partner organisations.*

**UNA O'BRIEN  
PERMANENT SECRETARY**

# **THE MORECAMBE BAY INVESTIGATION**

Chaired by Dr Bill Kirkup CBE

Ms Una O'Brien CB  
Permanent Secretary  
Department of Health  
79 Richmond House  
Whitehall  
London  
SW1A 2NS

3<sup>rd</sup> Floor  
Park Hotel  
East Cliff  
Preston  
Lancashire  
PR1 3EA

14 May 2014

Dear Ms O'Brien,

## **DOCUMENTS AND EVIDENCE REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

Further to my letter of 6 January 2014 requesting evidence, I am now following up on the progress to provide the outstanding evidence from the Department in its legacy role.

The evidence identified at Annex A to this letter remains outstanding from my original letter. It would be appreciated if you could provide an indication, by Friday 23 May, of when this evidence might be available, as the delay is beginning to have a significant impact on the Investigation's ability to meet the deadline for delivering its report.

Whilst the Investigation has received some very useful material in relation to points 4, 8, 9, and 11 of the Annex, none of the evidence supplied is from the Strategic Health Authority (SHA). The Chairman has identified from the evidence the Department has provided that SHA material is crucial to the Investigation. It would be appreciated if this could be prioritised in your search.

The Investigation's Documents & Evidence Team (DET) would be happy to meet with any of your officials to discuss the process if it would result in speeding up the delivery of the evidence. If appropriate, the DET along with some members of the Panel could carry out an initial review of material at either one of the Department's London offices or at the storage site. Perhaps you could consider this option.

Telephone: 01772 536376  
Email: [correspondence@mbinvestigation.org](mailto:correspondence@mbinvestigation.org)

*Independent investigation into the management, delivery and outcomes of care provided by the Maternity and Neonatal services of University Hospitals of Morecambe Bay Trust from January 2004 – June 2013*



If you have any queries, please do not hesitate to contact me or the Documents & Evidence Manager, Paul Roberts on 01772 536401 or via email at [paul.roberts@mbinvestigation.org](mailto:paul.roberts@mbinvestigation.org)

Yours sincerely,

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

cc. Steve Verdon

## **Annex A – Outstanding evidence**

1. A list of all cases of maternal death, stillbirth (>24 weeks gestation) and neonatal death (up to 28 days) that occurred in the Trust from 1 January 2004 – 30 June 2013 that were brought to the attention of the Strategic Health Authority, or the Primary Care Trusts that were in existence during the relevant period.
2. As far as DH is able to ascertain the following information in respect of the Strategic Health Authority or Primary Care Trusts in existence during the relevant period, a list of all cases of maternal death, stillbirth or neonatal death that occurred following the transfer of a mother, baby or mother and baby from the Trust, to a specialist unit elsewhere.
3. The Strategic Health Authority and the Primary Care Trust's definitions of both an incident and a serious untoward incident (SUI) for the period 1 January 2004 to 30 June 2013.
4. The policies and procedures for responding to both incidents and serious untoward incidents and the associated governance procedures for the period 1 January 2004 to 30 June 2013 that were required by the Strategic Health Authority and Primary Care Trusts for the Trust to comply with, and that the Strategic Health Authority and Primary Care Trust should have followed.
5. A list of all incidents and serious untoward incidents for the period 1 January 2004 to 30 June 2013 submitted to the Strategic Health Authority and Primary Care Trusts.
6. A separate list of all serious untoward incidents that occurred at the Trust between 1 January 2004 and 30 June 2013 in maternity and neonatal services brought to the attention of the Strategic Health Authority and Primary Care Trusts.
7. A list of incidents that occurred at the Trust between 1 January 2004 and 30 June 2013 in maternity and neonatal services which were brought to the attention of the Strategic Health Authority and Primary Care Trusts.
8. Any record of the Trust Board's reporting and actions in response to incidents and serious untoward incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 that were brought to the attention of the Strategic Health Authority and Primary Care Trusts.
9. Any documents from the Strategic Health Authority and Primary Care Trusts, including all correspondence sent or received from the Regional Directors of Public Health, regarding maternity and neonatal services at the Trust in the period 1 January 2004 to 30 March 2013.
10. Any record of the Trust Board's actions in response to relevant investigations published by the Parliamentary and Health Service Ombudsman that were brought to the attention of the Strategic Health Authority and the Primary Care Trusts.
11. Any correspondence between the SHA and/or the PCTs and:

- The Department of Health
- The Trust
- The NHS Commissioning Board
- NHS England
- Monitor
- The Care Quality Commission (or its predecessor the Commission for Healthcare Audit and Inspection)
- The Parliamentary and Health Service Ombudsman
- Patients or their relatives
- Members of Parliament
- Cumbria Constabulary

regarding the standard of maternity and neonatal care at the Trust, the number of maternal and neonatal deaths/injuries sustained at The Trust, and complaints about care and the management at the Trust.

# **THE MORECAMBE BAY INVESTIGATION**

Chaired by Dr Bill Kirkup CBE

Ms Una O'Brien CB  
Permanent Secretary  
Department of Health  
79 Richmond House  
Whitehall  
London  
SW1A 2NS

3<sup>rd</sup> Floor  
Park Hotel  
East Cliff  
Preston  
Lancashire  
PR1 3EA

16 May 2014

Dear Ms O'Brien,

## **DOCUMENTS AND EVIDENCE REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

Further to my letter of 6 January 2014 requesting evidence, I am now following up on the progress to provide outstanding evidence from the Department in its policy role.

The evidence identified at Annex A to this letter remains outstanding from my original letter. It would be appreciated if you could provide an indication of when this evidence might be provided, as the delay is beginning to have a significant impact on the Investigation's ability to meet the deadline for delivering its Report.

In January the Morecambe Bay Investigation sought material from the Parliamentary and Health Service Ombudsman (PHSO) to assist its ability to address its terms of reference.

As a result of the statutory bar placed on the Parliamentary and Health Service Ombudsman by the Acts of Parliament under which it is established - The Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993 - the Ombudsman is unable to supply this material to the Investigation.

Mick Martin, the Ombudsman's Managing Director, has indicated to the Morecambe Bay Investigation that it (the Investigation) can nevertheless secure copies of correspondence between the PHSO and a number of interested organisations (including yours) by approaching each individual organisation.

Telephone: 01772 536376

Email: [correspondence@mbinvestigation.org](mailto:correspondence@mbinvestigation.org)

*Independent investigation into the management, delivery and outcomes of care provided by the Maternity and Neonatal services of University Hospitals of Morecambe Bay Trust from January 2004 – June 2013*

The Investigation is therefore seeking your assistance in obtaining copies of correspondence between the Parliamentary Health Service Ombudsman and the Department of Health regarding any complaints made to the Ombudsman about the standard of care and services delivered by the University of Morecambe Bay Hospitals NHS Foundation Trust between 1 January 2004 and 30 June 2013, and any advice given to Ministers and senior officials.

I appreciate that the Department has already been asked to the Investigation with correspondence between it and the Ombudsman. The PHSO's indication to the Investigation enables you to release any pertinent and relevant information, including all exchanges DH has had with PHSO on the matter.

Should you wish to confirm with the Ombudsman's office that this is an appropriate approach please do not hesitate to do so. You will however recognise that the Investigation needs to obtain this material as a matter of urgency and I would appreciate it if you would supply the outstanding material to the Morecambe Bay Investigation by 6 June 2014.

The Investigation's Documents & Evidence Team would be happy to meet with any of your officials to discuss the process if it would result in speeding up the delivery of the evidence.

If you have any queries, please do not hesitate to contact me or the Documents & Evidence Manager, Paul Roberts on 01772 536401 or via email at [paul.roberts@mbinvestigation.org](mailto:paul.roberts@mbinvestigation.org)

If the Department does not have or, having exhausted all avenues of possibility, is unable to provide the material, could you please confirm this in writing.

Yours sincerely,

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**

cc. William Vineall

## **Annex A – Outstanding evidence**

1. Any guidance published by DH in relation to the design and layout of maternity and neonatal units (item 5 in the original letter)

2. All correspondence between DH and (item 6 in the original letter):

- Any member of the public who wrote to DH Ministers
- Advice given to ministers, senior officials in DH and regulatory bodies
- The Trust
- Cumbria Primary Care Trust (PCT), North Lancashire PCT and its predecessor PCTs (Morecambe Bay PCT, Fylde PCT and Wyre PCT)
- North West Strategic Health Authority
- NHS Commissioning Board Special Health Authority
- NHS Commissioning Board
- NHS England
- Monitor
- The Care Quality Commission (or its predecessor the Commission for Healthcare Audit and Inspection)
- The Parliamentary and Health Service Ombudsman
- The Health and Safety Executive
- The General Medical Council
- The Nursing and Midwifery Council
- HM Coroner for South & East Cumbria (**not originally included**)
- Cumbria Constabulary
- Any Member of Parliament

regarding the standard of maternity and neonatal care at the Trust, the number of maternal and neonatal deaths/injuries sustained at The Trust, complaints about care and the management at the Trust, advice given to Ministers and the senior officials in DH and regulatory bodies, and the suitability of the Trust as an applicant for foundation Trust status.

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

Mr S Verdon  
Director – Legacy Management Team  
Department of Health  
79 Whitehall  
London SW1A 2NS

3<sup>rd</sup> Floor  
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East Cliff  
Preston  
Lancashire  
PR1 3EA

Telephone: 01772 536376

Email: [correspondence@mbinvestigation.org](mailto:correspondence@mbinvestigation.org)

6 October 2014

Dear Steve,

## **ADDITIONAL EVIDENCE REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

As you are aware the Department of Health (DH) as the legacy body for those organisations which have ceased to exist has provided valuable material to the Investigation to assist the Chairman and Panel address its terms of reference.

The Panel have now requested additional material in respect of the quality measures used by the North West Strategic Health Authority (NW SHA) during the period of time covered by the Investigation. The Panel have specifically asked for an example of the quality scorecard used by the SHA and/or all Trusts from January 2004 to June 2013. The Investigation understands this may be available from Jane Cummings when she held the role of Nursing Director at the NW SHA.

The Investigation would be grateful if this material could be supplied by Monday 13th October.

If you have any further queries regarding the evidence being requested, please contact me on 01772 536401 or email me at [paul.roberts@mbinvestigation.org](mailto:paul.roberts@mbinvestigation.org).

Yours sincerely,

**PAUL ROBERTS**  
**DOCUMENTS AND EVIDENCE MANAGER**

cc. [REDACTED] – LEGACY MANAGEMENT TEAM

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

[REDACTED]  
Policy Manager – Investigations  
Department of Health  
Room 507 Richmond House  
79 Whitehall  
London  
SW1A 2NS

3<sup>rd</sup> Floor  
Park Hotel  
East Cliff  
Preston  
Lancashire  
PR1 3EA

27 November 2014

Dear [REDACTED]

## ADDITIONAL MATERIAL REQUIRED FROM THE DEPARTMENT OF HEALTH

The Investigation is aware that a number of families who were affected by events at the University Hospitals of Morecambe Bay NHS Foundation Trust have requested information from the Department of Health under the Freedom of Information Act (FOIA).

The Investigation wishes to cross reference the material supplied by the Department with information that the families have obtained via the FOI route and subsequently supplied, in part or in their entirety.

In order to do this the Investigation requests that the Department supply it with copies of all information it has provided in response to requests made under the FOIA from 1 January 2004 until 30 June 2013 to the following families:

Telephone: 01772 536376

Email: [correspondence@mbinvestigation.org](mailto:correspondence@mbinvestigation.org)

*Independent investigation into the management, delivery and outcomes of care provided by the Maternity and Neonatal services of University Hospitals of Morecambe Bay Trust from January 2004 – June 2013*



If this information has already been supplied to the Investigation – or partially supplied – please simply advise the Investigation of the URNs of those documents.

The information should be supplied, in the usual format, to Paul Roberts, the Investigation's Documents and Evidence Manager.

Should you have any queries regarding these documents please do not hesitate to contact the Investigation. As you will appreciate the Investigation is working to a tight timeline and therefore the information is required by close of play on 5 December.

Yours sincerely,

**OONAGH McINTOSH**  
**SECRETARY TO THE INVESTIGATION**



## Department of Health

Oonagh McIntosh  
Secretary  
Morecambe Bay Investigation  
3<sup>rd</sup> Floor  
Park Hotel  
East Cliff  
Preston  
Lancashire  
PR1 3EA

24 March 2015

Dear Oonagh

### Investigation Evidence

We discussed today an issue that came to light late last week (Thursday 12<sup>th</sup> February) as the Department was putting in place its own arrangements for receiving Dr Bill Kirkup's report into maternal and neonatal deaths at Morecambe Bay.

As you know we have regrettably discovered a small number (six) additional SHA-related documents that had been identified by the DH's Legacy Team but withheld on the grounds of legal privilege. These documents were highlighted in red and as legally privileged on the summary spreadsheet that the investigation was sent on 2<sup>nd</sup> July 2014. Whilst privilege did apply to these documents, they should have been released at the time, in accordance with the Department's approach to be open and to release all the information that we found to the Investigation.

We are now making these documents available to you, in the electronic files attached, on the same terms as we released all other documentation. I can only apologise that this oversight was not discovered sooner.

Yours sincerely

William Vineall,

Deputy Director, Department of Health

T [REDACTED] [REDACTED]