THE MORECAMBE BAY INVESTIGATION

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)
Maternity and Neonatal Services Investigation

Wednesday, 5 March 2014

Held at:
Park Hotel (Council Building)
East Cliff, Preston, PR1 3EA

Before:

Dr Bill Kirkup CBE -- Chair
Mr Julian Brookes -- Expert Adviser, Governance
Dr Catherine Calderwood -- Expert Adviser, Obstetrics
Ms Jacqui Featherstone -- Expert Adviser, Midwifery
Professor Jonathan Montgomery -- Expert Adviser, Ethics
Professor Stewart Forsyth -- Expert Adviser, Paediatrics
Dr Geraldine Walters -- Expert Adviser, Nursing

Ms Oonagh McIntosh -- Secretary to the Investigation

Ms Hannah Knight - Analyst

PANEL MEETING

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CHAIR: Right, welcome. I think we're all here. It's slightly past 11 a.m. and we have a fair amount of business to get through today so thank you for attending. You are very welcome.

I do apologise that I was not able to be at the last meeting and thanks to Julian for more than ably standing in. I have mostly caught up with where we got to and it's clear that you had a very good and productive discussion despite the transport difficulties that everybody had. Well done to everybody for getting here.

You will have seen that the PSO, the Parliamentary Health Service Ombudsman Report, was reported last week. I hope you have all had a chance to read it. It's worth a read. If you are interested in these things it does get a mention in Medicine Balls in this week's Private Eye as well, as we do we. We should take encouragement from that.

I understand that Geraldine has agreed to lead the Trust management sub-group. Thank you for that. That's much appreciated. I

think that it would be useful to have a conversation about consistency of approach of all of the subgroups and I think to some extent we will pick that up at the appropriate time on the agenda today but, if necessary, I think will have a further discussion about that depending on how far we get to.

I think one of the most important things for today is making significant progress on the interview programme. Because my experience of these things is that the interviews and the arrangements that go with them and sorting out what's been said and all that process afterwards is the biggest regulating step that we have. It will be the key regulating step. We absolutely must come away from today with the ability to kick that process off. Starting this afternoon. I think that's what we need to do.

We need to come back to freeing up time in diaries but we will do that at the appropriate point on the agenda.

We've got not just a significant number of interviewees to look at, to interview, we also have masses of documentary evidence, quite a

lot of which still has not come through because of difficulties with successor organisations processing 39 boxes of files that have just been dumped on them and all the rest of it. It's clear that we have a challenging programme.

I have had a couple of conversations with Catherine earlier in the week because it's very clear that obstetrics is going to be a key pinch point in all this. There is a load of evidence to look at, there is lot of people to interview, there is a lot of careful consideration that we need to do and it's very clear, sparing your blushes, that you have a pretty heavy workload outside of this panel. You have a day job in Edinburgh and NHS England to cope with as well. As a result of that I'm going to recommend that we take somebody on to work alongside Catherine to give some support on the obstetric front and the person who was recommended and who would be ideally suitable, in my view, and Catherine confirms that she will be happy to work with him is Jim Walker from Leeds.

I do not know whether anybody is familiar,

apart from Stewart, which I will come back to in a second but he would be a strong recommendation, I think. If that is acceptable to you all as a way forward?

MR BROOKES: Is that as an additional member of the group or as a supporting person?

CHAIR: A supporting person. An associate Panel member, not a full Panel member. There is an important point in that. We need to keep Catherine in the lead in all these things. You have clearly formed a bond with many of the families and developed some trust there and you are clearly very familiar with all of what's gone on up to now, which he won't be.

The second point that I do need to mention is that unknown to both of us there is a family connection with another Panel member, Stewart, a relationship by marriage, I think.

PROFESSOR FORSYTH: Yes, he's my brother-in-law. He doesn't know or he didn't know - that I was on this.

PROFESSOR MONTGOMERY: He did know he was your brother-in-law.

CHAIR: How did you break it to him!!

PROFESSOR FORSYTH: So personally I have no concerns about that, there is no family feuds or anything to declare but as long as you feel that there is nothing that may be picked up as an adverse effect or impact on the Panel. I have certainly no personal concerns to declare.

CHAIR: Thank you. I mean, I think two things, it's important that we register it at this point because I do not want anybody coming along later and saying, "There is some connection that we didn't know about." Secondly, I would recommend that it doesn't alter the position on this. Most important on that is that Catherine is the lead on these things things and he will be working with you on them.

If it had been a question of full panel membership that would be different but it is not. So that would be my recommendation. Do I hear any disagreement? You are content with that? Okay. Thank you. I appreciate it.

Let's move on to the next agenda item in that case. Apologies. We don't have any apologies. Full compliment. Well done to

everybody.

Notes of the previous panel meeting and matters arising.

MS McINTOSH: Only really the one and Tom is going to lead on it and it's building on a discussion that you had the last time about the responses to the notice that went into the local paper. It's agenda item 5.1, so you have a table which is an update but Tom will talk about that.

MR BACON: The key points since we last met are there have been four more contacts made with the Investigation in response to the notice placed, bringing the number up to 45 in total. This table has eleven of those cases in and that's where we received proformas from those individuals. Those are all considered to be in scope because they refer to standards of care receive in maternity and neonate services in the Trust during the period in question.

Also in your pack is a draft letter which just picks up on the discussion that took place at the last panel meeting about making sure the people who have got in touch and have provided information are kept aware of what's

being done with that and so basically explains that the Panel, you, would be considering their information in more detail. At this stage it is not expected they will be asked to come and be interviewed or provide oral evidence and that the Trust themselves may get in touch with those people and seek their permission to supply the Investigation with medical information.

So really the question for today is does that letter cover the points that you wanted considered from the last meeting? Is there anything you want taking out or additionally including? Just to note that we have further contacts and we will probably have more information at the next one, two meetings.

CHAIR: Any comments?

PROFESSOR MONTGOMERY: Not quite sure I would be clear quite why these are alternatives. Relating to a specific incident I mean I might think my care going on was a specific incident. I am just wondering how this would be read by people because is the issue about trying to flag up whether we need to the clinical notes? Is that the reason we have

the alternatives in there?

MR BACON: In the letter?

PROFESSOR MONTGOMERY: Yes.

MR BACON: Yes. As I understand the position, because the Trust obviously own the medical information, if we want to see the medical notes because there was maternal death and in order for the Trust to supply that they may have to ask that family's permission to supply that information, so that would be relevant in some cases. So the reference is included in the letter so that if the Trust do get in touch with them it doesn't come as a surprise.

PROFESSOR MONTGOMERY: I'm wondering whether it would be better to include that in all of them? Because we may discover a bit later on, when we start we do not want to see it, we then think do we need to look at the letters. I don't think warning that that's a possibility raises hares running. I wonder whether one letter without that alternative might be a better way of doing it.

MR BROOKES: Just a point on that. I try to read this from a family's perspective. It's the question of what happens. If we're saying you

are now included there is no indication that you maybe called for if necessary, you won't necessarily be called for interview. We will look at your result. There is no indication about what the outcome for the family would be. I wonder if it's worth saying something about and if it is relevant it will be included in the report. I don't want them anticipating they will get a personalised response from the Panel about their particular case. It's about this will then be taken to evidence as part of the Investigation, rather than anything specific because it doesn't say anything about what happens. It just leaves you thinking, yes, you are going to be included at and you go well, what does that mean? We need to provide something just along those lines.

DR CALDERWOOD: Anticipating then, was going to make the same point. What if they come back and say I would like something specific to me? We would probably at this stage need to think through our process, which perhaps more appropriately then is Trust, because these people have been variously investigated or not

already, we take their information and it's in a report but with no direct face-to-face feedback or even a bit of feedback.

CHAIR: Okay. I mean, depends to a certain extent on how manageable the numbers are. I do not anticipate that everybody would want to have personalised feedback.

MR BROOKES: You are right. You are absolutely right. It is one we need to think through. I hadn't thought of it that way. We need to be clear this is about an Investigation and the report that comes out from the investigation. It may be that our recommendations are that the cases that haven't been reviewed need to be thoroughly reviewed. I hadn't thought through about personalised response from the Panel and whether that was appropriate.

DR CALDERWOOD: Or a response where we have agreed that something else will happen because certainly for families, dates and, you know, finality of a report being published, they will know the date, they will look for that as an answer and it may then not be a closure for some of them.

PROFESSOR MONTGOMERY: That's really important.

Thinking through how we would we respond. We have got an FOI request after the report is published. If we have an FOI request that said, "What was the summary the panel advisors made of my case?" We need think through do we need to manage evidence in a way that will enable us to say that here is the page that logs the evidence that the Panel identified that related to your case and if we had any particular conclusions what those conclusions were so that we can gear up to being able to respond to requests and that might be that we recommend that they discuss that with the Trust or we might send to it the Trust saying we recommend that you have some conversations but that would be independent of what would go in the report but I think we could reasonably expect the families to ask a question like that.

CHAIR: Yes, I think so.

DR CALDERWOOD: Whatever the follow up it will need to be agreed. I do not know, we would need to agree with the Trust that they are prepared to take that step forward.

MS McINTOSH: Maybe we could have a separate

conversation with Trust and say let them know now the number of responses, not detail of but the type of responses and the wishes of the Panel and actually agree that and come back to you with some proposals. We might need to engage them and they might go, "Not sure about that" and we need to have that discussion. Does that feel reasonable?

DR WALTERS: You said there were 45?

MR BACON: Yes, in total.

DR WALTERS: So do you know of those 45 which have been complaints to the Trust already?

MR BACON: Of the 45 so far we've had 24 submit further information. Of those, this is a rough estimate, I would say maybe half had made a complaint, which had either been unsatisfactorily dealt with or they have not taken any further but they still have concerns.

DR WALTERS: Because I think some of these we have to bat off down what would be the normal route. Some going from 2013 which, if they have been subject to a complaint, have they had a response? Are they not happy but

they have not gone back to the Trust? We might have to say, "Here is a letter of complaint. We would advise you to send this back to the Trust and go down the complaints process" because otherwise this is going to get out of hand.

CHAIR: What we do not want to do is trip over an ongoing Trust process.

DR WALTERS: My initial question was how many of these are the Trust looking at as serious incidents or did look at as serious incidents and how many were complaints that the Trust think are closed down that obviously the person thinks are not. So rather than send a bit of a sweeping letter which gives the impression that we're going to look at it.

MR BACON: You think a personalised letter would be more appropriate?

DR WALTERS: I think a proforma needs to pick up a bit more detail about the individual issues before we decide what to do --

CHAIR: Identifying what's already been done, what's happening.

MR BACON: This is a summary of those because the proformas are long, some are handwritten.

They would not be easy in this format to read quickly, so this is a summary of the information contained within that that the secretariat has done.

Absolutely, I think, at some stage, and actually I would welcome the Panel's thoughts about how you would like to see the proformas. Because that's something that the clinical sub-group might like to consider at one of their meetings, actually the detail of those, we can absolutely provide, we have got them all electronically, they can go on Huddle very quickly.

CHAIR: It seemed to me, just on a very quick overview of them, that there are a couple that raise questions about communication and attitudes and so on and there are maybe four or five that on the face of it raise clinical incident questions similar to the sort of things we had heard from the families. I certainly think that however we deal with the other we ought to be seen to be dealing with at least those four or five and whether it's compatible with the way we dealt with the index families.

DR WALTERS: Do we know if any of these were in their list of SUIs?

MS McINTOSH: We haven't cross-referred yet. If they are not we can look at them in random sampling.

DR WALTERS: We need information. I do not know if the Trust could help. Is this a complaint already?

CHAIR: We have to be a wee bit careful because about that though, don't we? Because we do not necessarily know whether these people would consent to us sharing what they have said with the Trust.

DR WALTERS: We can go back to the individuals and ask them what stage and some of them are telling us what stage they are up to. If the complaint is ongoing then it is very unfair of us to intervene in a process that the Trust has to complete.

CHAIR: But on the other hand it's reasonable for us, I think, under those circumstances to ask the Trust to keep us in touch with what they are doing.

PROFESSOR MONTGOMERY: Two things. One is, I do not think we should be frightened of

saying we're not going to do very much about this. If we've got a reason for doing it, be insistent and clear and if we are going to say, let's say the 2013 complaints we're not going to look further at those because our working assumption is that they will not yet have come to a conclusion.

Linked to that, I think we need to reflect back how it is going to help us address the Terms of Reference. If the bit of the Terms of Reference is about how the Trust responds to complaints I think it is unreasonable for us to try and draw much of an inference from complaints in a similar process as opposed to complaints that have had a reasonable chance to go through.

The bit about of Terms of Reference which is around the current fitness of the organisation, I think we should have a feel for how many complaints are coming through and are they all very strong. We might use this to say how does what we were told in the advert reflect the information given by the Trust. But we perhaps wouldn't need to go into following them through when we do not

believe the Trust has had a chance yet to deal with that.

So I think we need to work on the set of consistent lines, do we not, we are happy to say to the families this is what we did do with your notification and this is what we didn't do.

CHAIR: Yes.

MR BROOKES: I hesitate in some way to say this because I do not want to sound like the horrible person in the room kind of thing but I want us to be clear that are we acting with within Terms of Reference if we're going back in terms of individual cases? Is that within our scope? Because there is a difference between us making comments about the complaints processes and using the relevant cases to make recommendations about systems, processes and our assessment of whether they are and acting as a broker for individual cases back to the organisation and taking on actions as a panel on their behalf. Either way, I just want us to be clear on what we're doing.

The second bit is actually probably

morally more right but I just want to be clear, are we acting within our Terms of Reference if we do that because if we're not we just need to make sure we're not working out of scope. Do you see what I mean? I just want to raise it because I can see absolute good things to do and say in terms of the individual cases that we raise but are we using those to identify how the systems and the organisation works or are we actually going to come back and in the Report or separately to the Report say, this is what happened in your individual case and this is what we as a Panel want the organisation to do? They are different and I just want to be clear that we know what we are setting ourselves up to do at that point.

MS McINTOSH: Our Terms of Reference talk about how the Trust responded to serious untoward incidents and the management of incidents. I think you are right that we won't talk about individual cases because our report shouldn't refer to individual cases but we can say legitimately we have looked at a random sample including the cases that were brought to us in the response to the notice that we placed in local papers and this

pattern flows, or is it interesting that with people who came to us that different patterns emerged or, yes, they were or, no, they weren't handled properly. So I think they can legitimately be included in the work that the Panel are doing and the Investigation is doing. They need to be incorporated into the whole and I think that's how they are used.

MR BROOKES: From my point of view that's systematic, systemic and generic but it's not about providing that individual family necessarily with a bespoke response coming from the Panel. That's what I wanted us to be clear on.

PROFESSOR MONTGOMERY: My point earlier, Julian, we need to anticipate what we would be asked after the event. We need to know what we will have in place.

MR BROOKES: In terms of what we say to people, we're not saying that we will give you specific response to yours. It would be part of the evidence base on which we base our overall assumptions.

CHAIR: Yes.

PROFESSOR FORSYTH: I agree. I think what we have

done is, just reinforcing what Oonagh is saying, we decided at the start we were going to review a number of cases, which included the index cases, a sample from SUIs and to make sure there was no other cases out there that had not been brought to the attention of the Investigation we advertised. We have these cases now. They need to come into the pool of cases. If we're going to plan this we need to be clear what the strategy is in terms of case record reviews and how that is documented and part of that process is examining what we then feedback to the families at the end of the day.

PROFESSOR MONTGOMERY: Our first question is how confident are we that the Trust understands what incidents are in the process and the first thing the process is asking for is how many cases came through that weren't handled.

CHAIR: Okay. I can see a potential difficulty when we get to the end of the process though that families who were part of the initial group are going to get a slightly different deal from the ones who have now

joined in as part of this process. I expect somebody sooner or later to say, well, that's unfair.

DR WALTERS: That was my point because I think we talk about the information strategy, the evidence strategy, we really have to decide whether we are going to look at all these however many cases or not and I think, depending on how the conversation goes between us, I might propose that we didn't look at all of them. So it's hard to selectively say somehow we've got to address these ones. So I think it's something about sort of stratifying them, 45, because we only have the 11 and how many of them we would we want to respond back to saying thank you for your information, this will form part of our review of evidence but we do not envisage your case being looked at, singled out for special attention or maybe said a little bit better than that.

CHAIR: Got you. Or alternatively, yours raises different issues which are comparable, I'm not expressing it correctly and, therefore, we will look at it on the same sort of basis.

PROFESSOR MONTGOMERY: Could we express it in terms of cases which raise issues that we've not seen and, therefore, are not yet able to investigate or cases that are constant with others.

DR WALTERS: Yours is a new thing.

PROFESSOR MONTGOMERY: Some explanation. The key thing is we have to be able to explain consistently why we have treated them in the way that we have.

MR BROOKES: We have to tell them in these letters what we're doing with them.

DR CALDERWOOD: There should not also be, I mean, everybody who has something to query does not have a panel like us to deal with it. So there are processes for all of these that should be in place. We can have a discussion about whether they are adequate, that's why we're here, but surely I just feel if I was one of these ones parents that I have read and have given their story and they were told, thank you but we've got a case that's similar to that, that's doesn't help me about my daughter or son that died. So if they have been brave enough to come forward and give us detail, they clearly haven't had the answers

they want and so we need to see what the proper structures are, don't we? To say we suggest you this would be who to write or to the patient advocate and so on, even if they do not want to take a complaint forward. Again, I suppose that has to be cleared with the Trust.

CHAIR: I am seeing a number of different strata which we have to work through. One of them is this raises serious significant issues that we need to consider on a individual basis, i.e., they are equivalent to one of the people that came to talk us to us in the first place, or this raises issues which we will take into account in the overall report about how complaints are handled but not look at it individually and here's how we recommend you take this forward. There maybe another couple underneath that.

DR WALTERS: What would happen in similar situations, but this is probably too far down the route, if you have an incident in the Trust there is some sort of help line set up.

CHAIR: Absolutely.

DR WALTERS: Which wouldn't be us.

CHAIR: That's true.

DR WALTERS: I think some of these indicate that there still needs to be some sort of route.

CHAIR: I agree, yes. Yes. Jonathan, did you want to come back?

PROFESSOR MONTGOMERY: Reflecting on something in the latest commissioner's report which was around in a case where somebody died you would expect a more serious response. I wonder whether we need to think through should we in cases of deaths be seen to be making sure we are going to look at this a little bit closer, even though it should be dealt with elsewhere. I wonder whether that may be something we should be doing?

PROFESSOR FORSYTH: I did wonder about that myself. A few of these are obviously deaths and I think we cannot treat that lightly, oh, thank you very much but we've already got other cases.

To me I think that to me I think that any case where there has been a death and the family have got concerns about the quality of care I think it's difficult for us not to

actually use cases and to then have a response for the family if they request it.

CHAIR: The death or serious harm?

PROFESSOR FORSYTH: It is where do you draw the line for me. I think we have again this process and we need to think through this on what are our criteria at each level in terms of communicating with families.

MS FEATHERSTONE: It is their hope, isn't it? We have just opened the door for them.

DR WALTERS: Yes.

CHAIR: Can we take that away and come back with something -- probably by e-mail for the next Panel meeting -- that attempts to progress that along those lines so then we stratify the cases in there. Okay.

MS McINTOSH: By then we can actually have done some work to look at the list, because some of these should be included in the list of deaths we have got from the Trust anyway so we can cross-reference to see if any are on the list of serious incidents.

MR BROOKES: Very quickly just to check because that relates to how we describe this left-hand -- finalise this left-hand --

CHAIR: I would not propose finalising --
MR BROOKES: I just want to make sure that I am assuming these have had acknowledgements and know that we are considering it.
MR BACON: Every pro forma we receive gets an acknowledgement.
MR BROOKES: I would not want a black hole.
MR BACON: In the interim shall we ensure that the pro formas we received are uploaded to Huddle, so that you can look at them.
MS McINTOSH: And they will indicate -- we will indicate with those if they are on the list of deaths that the Trust has supplied us with neonatal deaths, long-term deaths, maternal deaths and in the list of serious incidents; we will do that spade work.
CHAIR: Thank you. I was optimistic in that we can tick off that agenda item.
MS McINTOSH: It would be really good.
MR BROOKES: It is pressing on other matters.
CHAIR: Are we finished on actions from the last Panel meeting? All right.
MS McINTOSH: The rest are substantive agenda items.
CHAIR: Thank you.
Item four is workforce data. We have

raised queries collectively and individually a number of times about staffing levels and all of that. Hannah has done some work on this. Can you help us on that? We might have to move.

MS KNIGHT: You might have to rearrange your chairs.

The workforce question, which has been raised under Terms of Reference one, was around whether there are any workforce-related issues during the period of the Investigation at the Trust. This data has been prepared by the Health and Social Care Information Centre. This is preliminary data and it is based on the electronic staff records, which began in 2008. Prior to that there was an annual survey every September of the workforce; we have not got access to that data yet, but the Information Centre has agreed to conduct an analysis and on our behalf we need to confirm with them exactly what questions we want them to answer.

You have copies of these slides in your pack as well. The first one relates to staff absence during the period, with the Trust in

blue here and the North West is shown in red. On the whole you can see that staff absence at the Trust has been below average, but then around 2011 there has been an increase.

PROFESSOR MONTGOMERY: Just to check we are comparing obstetrics and maternity in the North West; or is this all staffing in the North West?

MS KNIGHT: Obstetrics and maternity.

DR WALTERS: How are you defining "absence"?

MS KNIGHT: This has been conducted by the Information Centre, they are experts in analysing workforce data and it is very much more complicated than you might think so.

CHAIR: There are possibly questions of definition are there?

DR WALTERS: Yes.

CHAIR: That some people will classify groups of staff one way and some another.

MS KNIGHT: It might be useful to clarify with them exactly what defines it.

PROFESSOR MONTGOMERY: We are not necessarily interested in what definitions are, so much as are they genuine comparisons?

CHAIR: Yes.

PROFESSOR FORSYTH: Consistent so they show a trend, which is probably comparable.

DR WALTERS: We would be interested in definitions because is that sickness absence? Is it people suspended who are employed? Is it unpaid leave?

MS McINTOSH: Yes.

MS FEATHERSTONE: The same for each member of staff whether they are midwives/doctors/healthcare assistants, the whole.

MS KNIGHT: I will take the questions back to our contact there.

This is the stability index, which is defined as the number of staff present both at the start and the end of the period, over the number of staff present at the start of the period. Again this is between 2008 and 2013. We have in red the North West, as it is shown in the stability index. The blue is the Trust's. We can see that, on average, the Trust's workforce is much more stable than average. I suspect this maybe related to its geography.

PROFESSOR MONTGOMERY: Is this month by month? So

this is the number of staff who left each month?

MS KNIGHT: I think it is every two months.

PROFESSOR MONTGOMERY: Staff member period.

MS KNIGHT: I think it is every quarter from the dots on the line. April, June, August. Two months maybe. Every two-month period.

The slide shows how the obstetrics and maternity workforce changed beginning in 2008, again up to 2013. This top graph relates to the doctors. The bottom graph is non-medical Section 30 staff. Full-time equivalent by grade.

Between September 2010 and September 2011, there was an increase in the number of doctors from 12 to 20. You can see, I think, the number of registrars increased from 10 to 15. The number of associate specialists from one to three. The number of specialist doctors from one to two. At this stage it is the same since 2011.

CHAIR: That is a big jump, isn't it?

MS KNIGHT: Yes.

CHAIR: Do we have any explanation for that?

DR WALTERS: They were concerned --

CHAIR: Well, yes --

MS KNIGHT: Around the time the concerns were raised.

MR BROOKES: Do we know what the establishment was at the time? Was it for example the position of 10 the establishment; or they increase the establishment as they had lots of vacancies and they have filled?

MS KNIGHT: I do not know whether it was an issue of vacancies or not.

CHAIR: You can take that up with the Trust.

DR WALTERS: They look like they increased.

MR BROOKES: It looks like.

DR WALTERS: Increased registrars after September 2010. They are migrating a little bit.

DR CALDERWOOD: They may be responding to concerns. The registrars rotate in the North West and there may have been changes in the number of registrars that were being allocated to them. So there has been an increase, but they may not have been shown that that will be

sustained, which it has not been, and the number of Trusts have then taken the option of trying to employ permanent staff specialist doctors; that is often not successful so they end up getting consultants so there is a general reduction in the number of training grades doctors available. A lot of Trusts are responding to that because their doctors are relatively expensive. By saying, well, in fact, we may need to up our permanent members of the fully-qualified/fully-trained staff, by the combination of consultants and specialist doctors. Actually there has been an expansion in general in those grades over that time period because of the reduction of middle grade.

MR BROOKES: Should you ask the Trust to explain those figures because you are right that makes absolute sense, but there might be another reason.

DR CALDERWOOD: Yes, I am suppose I am talking generally that might be the case.

PROFESSOR FORSYTH: I think this is a response to other reports that have happened in the past where we have seen Manchester's clinical

review. I think they said they have not got enough staff covering 24/7 and they have thrown huge investment, in fact they continue to do so, in numbers for 2014 in paediatrics, I know, who are contributing to the neonatal care, they are almost at double their consultants in total.

DR WALTERS: When did the hours go up from 96.

DR CALDERWOOD: On the labour ward? Well the recommendation has actually been in place since 2005, or 2007. In fact, this size of unit it would only expect 40-hours a week consultant.

DR WALTERS: I assume that CNS required something in 2010; that is why they did that.

PROFESSOR FORSYTH: I think the value of this information, I think, is when we get to the interviews, where we are interviewing the previous Chief Executive and directors, medical directors and directors of nursing, and saying, "Well, you were there, in the early part of 08/09 et cetera, so since then you have actually massively increased the

medical staff, but were the problems related to the fact you were running a service, which had an insufficient medical staff to support it?"

I think that is the kind of information that will be useful. The actual how detailed and accurate it is, I mean there is a trend, which I think is important here; something has happened, why has it happened and was it done because one problem previously was inadequate medical members of staff.

DR CALDERWOOD: You have got to remember there are only three or four babies born a day in this unit, and the rota must be a 24/7 rota, or it could not be a consultant-led unit. So they were on a bit more often. They were not run off their feet.

PROFESSOR FORSYTH: I think that is what we need to get to if we are going to be also making recommendations in terms of is the unit now fit for purpose, and the fact that we have got dozens of staff there not getting a lot of experience and becoming deskilled might not be the answer. You know, these are issues as far as I am concerned, when

it comes to interviews.

CHAIR: I think that is spot on, yes. I do not think we can be as diagnostic as that. It helps us to answer that.

DR WALTERS: Yes.

MS KNIGHT: Before I move to the next slide we talked about the increase in the number of doctors. There has been a 9 percent increase in the number of non-medical staff in the maternity unit between 2012 and 2013.

Having spoken to the contact at the Information Centre, there are other types of information that his team will be able to produce for us and, for example, looking at the midwife to birth ratio during the period, looking more in depth at the skill mix available and how that compares to similar units, and looking at the staff absence and retention through the whole period of the Investigation, and using data prior to 2008 and the census.

Finally there is unpublished data available on the expenditure on bank staff and overtime during the period. We want to know whether that will be of interest to the Panel.

PROFESSOR FORSYTH: Yes.

MR BROOKES: Yes.

MS KNIGHT: Can I get your initial thoughts on the four questions then I will take you through it before we contact them again.

PROFESSOR MONTGOMERY: Can I ask about the similar unit problem? How easy it is to define acceptable comparators?

MS KNIGHT: Yes. We did some initial looking at other rural, geographically-isolated units with a similar number of babies a year and there were six or seven. I think, Bill, you have looked, but we wanted to avoid drawing direct comparisons between the units because it is such a unique situation in Morecambe. One for them would be to compare all the units and then you have trends that are available for all the units, regardless of whether they are similar or not if we want to avoid issues of selecting.

PROFESSOR MONTGOMERY: There is a whole series of figures that I do not know the answer to and one is talking about such a small number of comparators; are they ever going to be comparable, or will they all have quirks on

how they organise things and what they expect midwives to do? I mean actually we might not get very much from the comparisons, it might be that the trend analysis, that is more useful to us than the snapshot comparisons.

DR CALDERWOOD: We have three units within the Trust that are different from each other. You already have figures where they are squashed together, so then we need comparisons of each type of unit put together.

PROFESSOR MONTGOMERY: We probably cannot put much weight on the similar-unit type of comparison?

MS KNIGHT: I am understanding then that having trends at a unit level, rather than Trust level, would be what you feel is most useful rather than trying to benchmark against the group.

DR WALTERS: It will be good to see the graph focused.

MS KNIGHT: Broken down.

CHAIR: Yes.

PROFESSOR WALTERS: Also would there be community midwives in these?

MS KNIGHT: I will double check. I had assumed so because they would be on the database.

DR WALTERS: Yes. So if you could do all

the midwife to birth ratio, Jackie, you would want to know about the unit, do you think you should leave out community midwives?

MS FEATHERSTONE: No, I would include because of the whole picture. It is an integrated service so community midwives are part of the Trust community and it should be that when you do the birth rate you include community.

DR WALTERS: Would we want to know actually how many hospital-based midwives there are?

DR CALDERWOOD: Very difficult to answer.

MS FEATHERSTONE: Yes, because depends how they work. Everybody works in very different ways. You have to use it as a whole. Yes.

PROFESSOR MONTGOMERY: I would suspect we will not get much of a comparator.

MS KNIGHT: Is the midwife to birth ratio based on needing midwives to provide antenatal care?

MS FEATHERSTONE: It is the whole package. The whole thing.

DR CALDERWOOD: Certainly in the Manchester report that Stewart referred to earlier, there was comment, I remember, about there being a low

midwife ratio. In fact in response to that they recruited quite a significant number of senior midwifery staff. So clearly there has been a recognition, at some stage. I wonder if we could, could we look at the detail of that report and see what it was exactly they thought was wrong. They must have looked at something to give them that answer, that the ratio was low.

PROFESSOR FORSYTH: Yes.

DR CALDERWOOD: They then appeared to respond appropriately to that. That was from Barrow.

MS KNIGHT: Right.

DR CALDERWOOD: I think it was a significant proportion of senior -- seven new senior midwives -- I can't remember, but it was, you know, seven in addition.

MS KNIGHT: What year was it?

DR CALDERWOOD: We had it in the very first pack of documents to read.

CHAIR: Yes.

MS KNIGHT: Yes. All right.

MR BROOKES: Can I ask clarification on the last point, are we looking at that across the Trust or related to maternity staff?

MS KNIGHT: It will be looking -- focusing on maternity at the Trust level.

MR BROOKES: I think we need to look at the services we are looking at rather than the whole Trust; that might give us a different picture.

PROFESSOR FORSYTH: I think the number of substantive staff versus locum staff in particularly, in relation to medical staff. All the reviews I have done in the past -- issues have usually arisen because of the high proportion of locum staff. It is not just "bums on seats" really; it is: Who are these people? You know even if it is possible to get sort of a feel for what kind of locum staff were they employing -- whether they are people coming in and out or whether they are long-term locums.

PROFESSOR MONTGOMERY: That will also relate to the stability and the question, which is they are not just numbers.

.....[simultaneous conversation].....

PROFESSOR FORSYTH: That kind of detail is quite useful, you know. I think you cannot judge too much, but it gives the picture of whether the staff is maintained or rather just numbers.

CHAIR: Thank you. Thank you for that.

MS KNIGHT: The next section is about the staff survey results, which have now been uploaded on to Huddle. Start in 2003, feeding back to each unit, their own results to the staff survey. These are the 2013 results. The overall staff engagement score, which is a score that began in 2009, has been below average at this Trust every year since 2009. In 2012 and 13 it was in the worst 20 percent of Trusts. You can see here 2012 score, 2013 score, and the national average for 2013, which is very similar in 2004.

There is a lot of information available in these staff surveys. I am sure some of you have come across some of these before.

CHAIR: Are the overall results reasonably stable from year to year?

MS KNIGHT: Yes.

CHAIR: It is almost quintile and doesn't have

the same membership.

MS KNIGHT: It is, it is not standardised, it does change year to year, but in 2012 it was very similar. I think it has been improving actually year on year, the national average.

CHAIR: What I wonder is, do most of the Trusts tend to scatter about? So one year they maybe in the second quintile and next they are on the fifth and so on.

DR WALTERS: No. It is difficult to shift the staff survey.

MR BROOKES: It does not move a lot. It will be useful to see the trends there since 2009.

MS KNIGHT: All the information is available in giant spreadsheets on the internet so I can do that type of analysis.

PROFESSOR MONTGOMERY: When I was sitting in my PCT office I used to try to correlate the staff survey data on witnessing errors and near misses with the National Learning Service data on what Trusts were reporting. I do not know if it is worth asking that question to get a sense of how much is witnessed and then not exchanged and set anywhere else. I do not think you can correlate that.

MS KNIGHT: Yes. These results, taken from the 2013 report, these were the bottom five ranking scores for the Trust. We have got percentage of staff experiencing violence, percentage of staff reporting good communication, and interesting in 2013 it is very, very low. Staff recommending the Trust as a place to work, or to receive treatment, low score. Staff motivation, lower than average. Percentage of staffing satisfied with quality of the work and patient care they are able to deliver.

The "!" next to the each means it was in the bottom 20 percent.

On the other hand, there are a number of areas where the Trust has improved since 2012. Effective team working, despite the communication issue being raised as one of the low scores in previous category; support from immediate managers; and percentage of staff receiving health and safety training.

This is an overall summary of the results, in 2013, comparing the Trust with all other Trusts. It is time-lined, but essentially the green means it is positive findings; less than

average. If it has a tick it is one of the 20 percent best growing trusts. Likewise with the red scores it has an "!" it is amongst the bottom 20 percent of Trusts.

That is the end of the staff data that I have at the moment. Do you want to see those staff survey results? They are all available on Huddle under the Trust organisations.

MR BROOKES: The full staff survey, how was the information available?

MS KNIGHT: The full staff survey results that were given back to the Trust. They were also published.

MR BROOKES: Thank you.

CHAIR: Okay. We need a kind of easily-accessible digest of this, that may be more or less the slide when we come to do the relevant interviews. I think it will be important to have the information at our fingertips to ask people to explain this and, if necessary, challenge them.

PROFESSOR FORSYTH: It will be quite good to have a comparator from about 2000 and one if there was a survey done in 2005/6.

MS KNIGHT: It goes back to 2000.

PROFESSOR FORSYTH: It would be good to have the figures for the height of the problems. 2013 is a difficult time, it is very much the transitional period from the Trust. I am not sure how to interpret that. It will be good if there was a comparator in the middle. How often is the survey done?

MS KNIGHT: Every year.

MR BROOKES: You see the trend-through will be really useful.

PROFESSOR FORSYTH: Yes.

MS KNIGHT: Yes. If the Panel would like to suggest any another key questions they're interested in, I could do a trend over time.

The overall staffing engagement score was only developed in 2009, but the other question remained stable throughout the whole period of the Investigation.

PROFESSOR MONTGOMERY: I certainly like those questions around, "Have you seen a near-miss", they will give you a sense of their feeling of quality. Do we know about response rates? Have they changed because I think that will be interesting.

MS KNIGHT: This year the hresponse rate was about

50 percent; so of 800 staff, approximately 400 responded.

DR WALTERS: They only did 800 staff but you can opt to do all of them.

MS KNIGHT: 400 out of 800.

DR WALTERS: Right. They used a sample.

PROFESSOR MONTGOMERY: I think it will be interesting to see whether the response rate changed over the period as well. Are there more people wanting to give feedback than previously or not? It will be quite useful to see.

PROFESSOR FORSYTH: Not giving you more work to do, but it will be interesting to see the service breakdown of the different categories of staff who responded.

MS FEATHERSTONE: Did you say everybody? It was a full staff survey? Because it is only just a sample normally when we have done them, there is only a certain amount of people get them. It is all anonymous, but it is only a certain percentage of staff.

MS KNIGHT: The trusts can opt to pay more to do the full complement of staff.

PROFESSOR MONTGOMERY: Just 800 of the staff.

MS KNIGHT: It did not happen here.

PROFESSOR MONTGOMERY: Can I say, so this is 800 staff in the whole Trust, so actually there may not be very many from maternity in Furness General. I think we should be quite cautious about the coverage in maternity and that may mean the trends are very unreliable as well because actually one year they may have sampled them and the next one they may not.

DR WALTERS: It is a random sample of 800 who are externally sent the survey. Normally it picks up about the same across the Trust, but we have always found if you try to look at the results by division it is difficult. It is not picked up.

PROFESSOR MONTGOMERY: We may get a sense of the general Trust's approach to quality, but we will not get much about the midwives. Stewart, when we talked about breaking down by staff groups, do we need that by all staff groups or are you particularly interested in midwives and doctors? I mean because it may make Hannah's job more manageable.

PROFESSOR FORSYTH: Numbers are tiny; that is the problem.

DR CALDERWOOD: You need to be careful to get the work done on the staff that is going to give us answers. Maternity is a tiny proportion of Trust staff, up to 50 percent of them do not answer across the board; it maybe more or less in maternity. We are going to end up in a situation where we cannot interpret it because the numbers are too small.

PROFESSOR MONTGOMERY: If we were asked for information about midwives if that is available, that probably is in services that are relevant to us?

CHAIR: Would that be more helpful, or would it be more relevant to see whether we can get a break down between Furness and Lancaster.

MS KNIGHT: That is not there, unfortunately.

CHAIR: That is not possible? That would be more helpful as I think they will be very different.

PROFESSOR MONTGOMERY: I am minded to think and would probably say here we do not want too much work done on it because it will not tell us very much that is useful. A bit of trend analysis on two or three of the questions might be all

that is worth having.

PROFESSOR FORSYTH: I think we are going to be in for a Chief Executive and chief of nursing et cetera, it will be nice to have how the general status of the Trust is perceived by the staff.

DR CALDERWOOD: That is already here.

PROFESSOR FORSYTH: I think it is.

DR WALTERS: I think the interesting thing here is that they are lower than average, and I think the next interesting thing will be, what you said, what's happened between 2004 and 2013 are they very different.

CHAIR: Any other points on this? I think they are very well-made points. Right.

In that case can we move on. It is Hannah again and I presume that you will want us to stay on our seats here.

MS KNIGHT: Yes.

CHAIR: I will not give you any further interuptions.

MS KNIGHT: The next section from me is basically an update on what we have so far. I think the very first Panel meeting that I attended I gave an overview of the sources of data that might be

of interest to the Panel and that we know is available.

This is an update then of where we have got to so far with the various sources of data. I did some timeline for when the final data pack can be expected. The hospital episode statistics database, which I have presented a few times now, we have now got agreement from the Clinical Effectiveness Unit at the Royal College of Surgeons to provide us with data and to provide expert supervision analysis. This is a national centre of excellence for this type of analysis. David Cornwall (the director) has been very useful in advising how some of the rates should be interpreted and how the adjustment can be made.

The proposed outcomes that are now agreed with the Panel to look at from the maternal side are the mode of delivery, severe maternal morbidity and rate of maternal re-admission to the hospital within 28 days.

The neonatal side is the rate of stillbirth. That is broken down into total stillbirth rate. Sorry this should be a

separate section. Neonatal death rate broken down into areas of neonatal deaths; that is through linkage with ONS death register that we are able to calculate these rates.

It was requested that we look into the proportion of stillbirths and early neonatal deaths of term babies weighing more than 2500 grams. Severe neonatal morbidity rate. Stewart has had some correspondence looking at what is available in the data and how that rate might be conducted.

Unplanned neonatal readmission to hospital within 28 days. Then another specific readmission for sepsis. Then long-term complications associated with birth trauma. For example, hospital re-admission rates, for hypoxic brain injury. More work needs to be done on determining whether this can be reliably used from the HES data.

DR WALTERS: Is this by unit?

MS KNIGHT: Yes, by unit.

Then examination of the overall data quality from the Trust, which we saw in the previous meeting had dipped dramatically around 2007 and risen in 2008.

CHAIR: How, if at all, can we take into account transfers to other units for some of these conditions?

MS KNIGHT: Yes, we can because HES provides a unique ID which enables you to track patients longitudinally.

CHAIR: Is one of the outcomes transferred to a specialist unit?

MS KNIGHT: I will come to that in the next slide because there is a separate database which looks at admissions to neonatal care units. So what the outlook will be from hospital episodes statistics is repeated cross-sectional analysis looking at how the Trust and the units within the Trust compare to other Trusts and units within Trusts. So as I say, here all analysis will be performed at two levels, Trust and hospital. We will use funnel plots where appropriate to illustrate the amount of variation and whether the Trust was an outlier and then time series comparing the Trust against itself to changes at the time.

We anticipate this will be ready by the end of May 2014. As the different results

become available I can share them rather than waiting until the end.

I made a visit to the Trust on 10th February to try and establish once and for all what legacy data is available directly from the Trust's own maternity information system which, as we will know, captures more detailed information than that which is available in the national Hospital Episode Statistics data. So data items which might be particularly of interest available locally are Apgar scores at one and five minutes and lots of the information which was missing in HES like gestational age and birth weight, particularly in that 2007 period, it's missing in 75 per cent of delivery records. This is an alternative way of getting that information. It has now been confirmed that it does exist and we have formally requested it on 25th February. We also requested copies of the Trust maternity dashboard which it introduced two years ago, with the new head of midwifery, and we will be able to compare the Trust against other Trusts and like hospitals with other hospitals that

submit to the Perinatal Institute's peer database which covers the West Midlands and has about 250 maternity episodes recorded. They also collect Apgar scores and detailed clinical data items. So we have to wait until we receive the information from the Trust before that can progress any further.

DR CALDERWOOD: To reassure people, I was reading this before the meeting and I got to the slide before that I wondered if the Perinatal Institute would be able to give us comparative data? I thought I must give Hannah a phone. I then turned the page. [Laughter].

MS KNIGHT: Jason Gardosi has been very helpful.

DR CALDERWOOD: I know him. You were lucky I turned the page because I was just about to text him.

MS KNIGHT: Going back to Bill's point on transfer of babies. This is the National Neonatal Research Database held at Imperial College London, they have a Neonatal Data Analysis Unit. They conduct the national audit which now covers 97 per cent of neonatal units in England. They submit their data to this audit and the data is available for research and service

valuations.

There are on-going discussions with Neena Modi, who heads the unit, as to what they will be able to provide the Investigation and at her request I prepared a draft protocol, which I'm hoping to get some feedback on from Stewart maybe after this, if you do not mind, because the types of questions that I think this data will allow us to address are, A, are there any transfers out from the Trust that we're not already aware of. We have been given a list of 23 neonatal deaths that the Trust are aware of babies born in the Trust transferred elsewhere. There maybe others that we're not aware of. Not just deaths but other severe outcomes.

We should be able to ascertain how many of the babies that were admitted to neonatal care were term newborns weighing 2500g. How many were admitted with symptoms associated with substandard intra partum care. How many subsequently died. It's an issue of trying to make comparisons between other NHS Trusts. It's very difficult but Neena thinks that we might be able to do something there. I feel that's

useful.

CHAIR: That's a lot of work if you can do it.

MR BROOKES: How far back does the database go?

MS KNIGHT: I think it's 2006 that it started then very quickly reached quite high submission rates.

Their next steering meeting is on 14th March and that's when our protocol will be considered. I do not imagine it will be a negative response from them. The question will be whether they can supply the data to us for me to analyse or whether we will have to commission them to conduct the analysis in house because there are lots of restrictions on it. Any questions. Shall I move on?

Incident reporting. We now on Huddle have all of the clinical incidents that have been reported by the Trust and there are separate spreadsheets available for all clinical incidents which total almost 74,000. All maternity incidents just over 10,000. Not sure what the difference is between maternity specific incidents and maternity incidents but that brings us down to 4,000. Then SUIs 142,

maternity SUIs 142. There has been talk about getting a random sample and whether we could explore that a bit more so that this can be progressed.

MS McINTOSH: One of my concerns is that if we take a random sample, we talked about this previously, say take the first two on the first of every month, something like that, the number, the random sample would be such a small percentage of the overall, it just -- that's a risk we take, isn't it? Because a risk of ultimately someone saying you didn't look at very many, did you, even though it might take a phenomenal amount of time and we might look at a high number it will still be a small percentage but you pointed out that we need to be looking at not the paper cuts type thing.

CHAIR: No, we need to concentrate on the SUIs but we need to do some short of checking exercise to make sure that we think that all incidents that are not classified as SUIs are not going to throw up any unwelcome surprises and the only way I can see to do that is to take a random sample of them. I think there

are ways to do that that would a avoid bias. The important thing is it a big enough sample, because it doesn't have to be very big, but is it unbiased and maybe taking ones by database might not be unbiased but there are other ways of randomising which ones you look at.

DR CALDERWOOD: I was going to say that the perinatal reviews that are going on under Embrace they have used a percentage out of the whole to look at that, that's perinatal morbidity rather than mortality. It might be worth finding out how they did that or how they chose those case notes.

DR WALTERS: You also can stratify them further. You should be able to do that. The Trust have decided whether they were red, amber or green incidents. We were looking at a list this morning. You can knock a load out just because it's, you know, appointment, missed appointment.

MS FEATHERSTONE: There were a lot you could do.

DR WALTERS: Or admin issue and when you take all those out you then get to a smaller sample, you take a random sample to make it significant.

CHAIR: The difficulty is can you automate the going through 70 odd thousand to knock out the admin ones, because if not it is going to be time consuming.

DR WALTERS: You should at least get to the 4,000, depending on what the difference between the 10,000 and the 4,000 is. The 10,000 might be administrative issues, staff arguing, that sort of thing.

CHAIR: Yes, I mean, I think we're talking about coming to the same problem from slightly different approaches. I do not see any problem in producing a randomised sample that is lookable at and finding out that quite a lot of them are admin issues and missed appointments. We're not concerned with those. Of the other ones are there ones that would give us cause for concern that maybe should be reported as a more serious incidents?

MS KNIGHT: How many incidents would you consider to be manageable? 100? 1000?

CHAIR: I am suggesting a stratified process where somebody, maybe me, goes through them all and says no, no, no, no. They are interesting, they are interesting. Hang on,

we should look at that in more detail. In which case we could do a couple of 100 without a problem. He said confidently.

PROFESSOR FORSYTH: Do not minute that. I was also interested in training analysis in all of this and has this changed over the time period that we are reviewing. Also, in light of some recent discussions across national level, some of the more serious ones, breakdown in terms of days of the week, week days versus weekends.

MS FEATHERSTONE: Day and night as well.

PROFESSOR FORSYTH: Certainly, again, because, I mean, a lot of these issues, this unit is an exception, there will be a high proportion of locum doctors on the weekend. So if there was any trend there where weekend were higher.

MS KNIGHT: We have seen in previous meetings the reporting increases exponentially over time, starting around 2010 the increase. So that addresses the first and it was broken down into maternity.

The days of the week thing I haven't seen exactly how it's recorded in the database but I can look at that.

MS McINTOSH: We can have a look at that.

MR BROOKES: Days of the week are really important. Other subject areas are very clear issues relating to particular times of the day, particular days of the week, Fridays and Monday come to mind and a number of those things.

Coming back to what you were saying, Bill it's a separate issue about a statistically relevant sample size which confirms whether or not we think the others are being treated properly, which is the question ...

CHAIR: Exactly.

MR BROOKES: And what we do around SUIs and the 142.

CHAIR: Two completely different questions, yes.

MR BROOKES: We shouldn't get them confused.

CHAIR: Yes, yes.

DR WALTERS: If they are on the NRLS or STEIS system wouldn't that allow you to do more analysis by day and time that sort of thing?

MS KNIGHT: I spoke to somebody from NRLS and another expert on STEIS and she said that's

all taken from the Trust's own system anyway, so you would be better working with the Trust, what the Trust has already sent us.

DR WALTERS: You sometimes have to put more on STEIS than you would, it's more a forced reporting system. If they do the same thing at the Trust then, yes.

MS KNIGHT: Moving on. Confidentiality inquiry reports. They are now available on Huddle under CMACE from 2003 to 2009 for perinatal mortality. Then there was a local review of perinatal mortality in Cumbria between 2009 and 2010 on Huddle under NHS Cumbria CCG.

I have taken a few screen shots from the reports. This one looks at trends in perinatal mortality between 2005 and 2009 at the Trust, the overall trust level. You see quite a variation in the still birth rate over those years and the perinatal mortality rate mainly because the numbers are so small but there is that amount of variation.

This table breaks it down by the three units. This is just for 2009. The still birth rate at Furness General was 6.2 compared with 3.4 at Royal Lancaster. That's

the same with the perinatal mortality rate. There were no neonatal deaths at Furness General that year. So that's the same as their still birth. The rate is 1.5 since they have about 2,000 deliveries at the Royal Lancaster. It means there were three neonatal deaths that year.

CHAIR: Looking at the intervals you can't say there is anything wrong in the chance operating. Can you get this for the aggregate period as a whole?

MS KNIGHT: Yes, you can get it from the CMACE national report and each Trust has sent its own data confidentially.

CHAIR: I would be interested to see it for the whole period with the same kind of breakdown because, on the face of it, although it's not significant, Furness appears to be higher which it shouldn't be.

MS KNIGHT: North-west SHA and England as a whole are at the bottom here.

CHAIR: Yes, that's true but, I mean, if anything Furness you would expect to be lower than Lancaster bearing in mind there is a stratifying, a more problematic risk of

incidences than Lancaster. Okay, thank you.

MS KNIGHT: These funnel plots show the location of the Trust firstly for still birth and secondly for neonatal mortality. These are just babies that died within the Trust, so do not take into account babies that were transferred elsewhere and died which may explain why the Trust actually was lower average rate of both still birth and neonatal mortality when adjusted by excluding deaths less than 22 weeks from the sample.

Similar funnel plots are available for 2008, 2007, and on Huddle.

This snapshot taken from the Cumbria review 2009 to 10. It shows the age related weight at time of delivery for Morecambe Bay Trust and north Cumbria Trust. What is worth highlighting here is that you have a larger proportion of these babies that died were above the 50th centile, some of them even above the 97th centile for their birth weight gestational age and so these were larger and long-term babies that are dying. Having said that, the numbers are very small again. So whether you can draw robust conclusions from

this is not answered.

DR CALDERWOOD: This was where I felt that was a trend that was very different, not just in this but because we tend to have small babies at still birth and that the largest single cause of still birth, small babies are eight times more likely to be a still birth than full-term. If they are undetected it is 20 times the risk. So this is not comfortable reading if you understand the still birth data well.

This report did highlight that as something because they made the point that, as Hannah has correctly said, about the small numbers on the funnel plots but they did say they could not explain why there was the difference between Morecambe Bay Trust and north Cumbria Trust in this trend of the types of babies who were stillborn.

MS KNIGHT: HES may be useful for addressing this in more depth, so a line of the questions that we had to look at using much larger numbers and the proportion of still births that were less than a 2,500 grams and more than 37 weeks.

CHAIR: Yes.

MS KNIGHT: In terms of patient experience data, we have three surveys that were conducted by the CQC or its predecessors in 2007, 2010 and 2013. I have had a look at these and in none of them does the Trust appear as a poor performer from maternity service users. Actually in 2007 and '10 it was identified as a better performing Trust. However, the sample sizes are very small, the number of women that responded to the survey and we also can't differentiate between FGH and Royal Lancaster.

CHAIR: That's quite hard to interpret, isn't it? I mean, given that the great majority of people do not end up with a bad outcome and given that smaller units generally tend to be well thought of because they are less impersonal and friendlier, all of that. It's quite hard to interpret that.

PROFESSOR FORSYTH: That is quite a useful talking point when we get to interview representatives of the Care Quality Commission. Are their systems sensitive enough? Do they have the right information to draw conclusions.

MS KNIGHT: Now that the Friends and Family Test is available, I think it began just before the end of the period, in April 2013, so there will be a few months within the scope of the Investigation.

DR CALDERWOOD: It started in October 2013.

MS KNIGHT: That's when it was published. Work force is something we have already touched on so this is to emphasise that work is going to be carried out by the Information Centre and I will take the questions that have been raised today to make sure we get the output that would be most useful.

CHAIR: Okay.

MS KNIGHT: The staff survey results were available on Huddle.

MR BROOKES: In terms of staff survey, the information, does it tell us what staff size was?

MS KNIGHT: Yes. There are vast numbers of tables and towards the end you have overall response rates broken down by category of staff. So, yes.

CHAIR: Thank you. We picked up most of the questions as we have gone along. Are

there any other others? I think there is in that case one very important question, this is our last chance to commission fresh work, not totally last chance as we would have to do so specifically in response to something that cropped up at a later stage, perhaps as a result of the interviews. Is there anything which at the moment you can see is missing from this that we do need to commission at this stage?

MR BROOKES: Relating to clinical information or any information?

CHAIR: Relating to this lot of data set which is about clinical information. Shall we ask people to have a think about that and come back to us?

MS McINTOSH: Yes, I mean, as you have said, it's not closing everything down but I think, as Hannah pointed out, really well, it's important that you bear in mind that if you commission data it takes time to get in and for Hannah to analyse and for us to turn it in to something useful for you to use when you are interviewing. What I do not want to do is get information in very late in the day, too

late in the day for it to be relevant and then us to face criticism down the line. So I am trying to protect the integrity of the work really. If anybody has got any ideas about data that they think will be useful, and beyond terms of reference one and two, because that is what we have tended to focus on, I think you need to highlight it by the end of this week so we can just look at how we can find that and source it and fit into the timeline.

CHAIR: Particularly things that will feed into the interviews.

MR BROOKES: Because we're going to do analysis around the clinical side of things around SUIs but actually it's an analysis around their operation of SUIs that is really quite important as well. That's what was in my mind when I was asking that question. Looking at it and seeing how that compares, rather than just a clinical element of it I think would be quite helpful.

CHAIR: Okay.

DR WALTERS: The other thing for the interviews is that we will need things that are time bound. Because we can't ask people

who are around in 2007, we can't expect them to know the total picture but we would expect them to know what they looked at at the time.

MS KNIGHT: Once we have a schedule for the interviews I will make sure you will have that at your fingertips, the most relevant data.

CHAIR: It may well be that there is a relatively limited sub set of things that we need to think about but it's important that we do identify all of that as far as we can at this stage. If you can let us know of anything that you want to add in by close of play Friday that would be great. Thanks, Hannah.

Shall we rearrange the furniture? Let's have a look at item 6(a) addressing the Terms of Reference. You have a fair amount of stuff in your packs.

MS McINTOSH: We certainly have and I just want to start, Chair, by thanking a number of people in the team upstairs who have been beavering away to pull together the work that the Panel has been doing. We touched on this right at the end of the last Panel meeting when we had a sample of what the table will look like. You have now in front of you got

pages and pages and pages of A3 and, as I pointed out to some of the Panel, it's a sort of a bit of a Blue Peter activity that you can take it back home with you, Sellotape it together and put it up on the back of the door.

CHAIR: Sticky back plastic!

MS McINTOSH: How do we get the inside of a toilet roll into it. I don't know. What we have done in true style, here is one we prepared earlier, upstairs Sellotaped to the wall outside the room you are going to have your lunch in is the full table thus far. This is a document that we need your help with in particular two areas that need populating further.

What the team are doing, as you know, working from a Term of Reference to the key questions that have been identified and agreed and then looking at the sources of evidence to answer and address those questions to enable you to draw your conclusions.

What we have listed, and it's the sort of second set of blue headings that you have got, is the sort of relevant organisations. What

we have done is we have had a go at working out which organisations you need to be looking at the evidence of but that list is not complete. I really, really need to make a plea to sub-group leads, to all colleagues but particularly to sub-group leads that maybe even at lunchtime day using the strategically positioned dangling felt tip pen secured by elastic bands so that it can reach all parts of the table, that you actually populate more fully the list of relevant organisations that you consider there may well be evidence that will help you answer the question.

What that will enable Paul and his team to do is actually to identify within that the evidence from the organisation and actually provide you with sort of an indicator or pointer to where that evidence is. So you do not have to look through everything that the Trust has sent. We can actually try and funnel that work for you.

Now that's not going to be complete and the counterbalance to that is that we will be keeping a track of evidence that is not looked at and is not included in that so that we can

make sure we capture with sub-group leads material that has not been brought to your attention immediately so that we do not lose anything by the time you are making your findings and writing the report.

That's one request that we need help with.

The second one is something we will come to further on in the agenda which is about potential interviewees. Also in your pack, which we are going to get to when we look at how interviews will proceed and reach agreement on that, is actually a list of likely names of people who are likely to need to be interviewed or may need to be interviewed.

What we will need to do on an ongoing basis is for subgroups to be populating or to inform us of the names of interviewees so that Paul and his team, Hannah has done the lion's share of the work on this but she has plenty of other work to do, so you can set us off on it but actually so that the team can populate this and we know who needs to be interviewed. That will help with planning so that if two sub-groups want to interview Fred

Bloggs we can actually do the joined up work that you asked us to do at the last meeting.

It's a huge document. When you see it up on the wall I know it sort of looks like a bit daunting but it will be useful, it is important, it's necessary and as Julian pointed out it can be targeted. We can stream it so that you just get your sub-group or another sub-group or you just get one Term of Reference, it can be broken down. It's an Excel spreadsheet so we can manipulate so that it's most useful to you. But this is the point at which we need your input quite swiftly so that we can point you in the direction of the material that we have received thus far.

So that's where we're up to with that.

CHAIR: Thank you. What is it you would like us to do here and now as opposed to going away and trying to stretch the elastic band?

MS McINTOSH: It's difficult to read at the moment. Therefore, you do not necessarily need to stretch the elastic band. If it's a case of people go away, look at the table at lunch time and say actually to answer question

1.3 we actually need some information from, the SHA who will have had x, y, z and then if you just literally crayon on to the sheet or send us an e-mail by the end of this week, it will help the team to actually locate if we have received evidence. I am using as an example an organisation who have not yet submitted any evidence to the investigation but actually there are organisations that have been able to submit evidence. We just need to move on a step, really by the end of this week. It might not be complete, I know that this is something that is going to run on, but actually we need something to help us give you the material.

CHAIR: Stewart.

PROFESSOR FORSYTH: I mean, I am very supportive of this. I think it is a fix on this and I think that this is good because it helps us because we have all got bits and pieces and it is good to see where will this fit within the jigsaw, so that at the end of the day we have a full picture. I think that it is helpful. I think there is a good start and we do need to all think about what other pieces we want to fit into this; where they actually go onto

the jigsaw.

MS McINTOSH: I think the key thing in this is not just the questions that are pertinent to each Term of Reference; it is any questions that have also been raised in any Panel meeting, or when you have heard from any of the families, any questions they have asked. We have incorporated them into it as well and they are being taken as prompts for information.

CHAIR: I think that is very important because I do not want to end up, at the end of the process, with a question that somebody has raised being unanswered and us having the lame excuse; it was not included in the Terms of Reference. If a question has been raised we will find a way to include it. Hannah?

MS KNIGHT: I want to ask Oonagh whether when filling in the potential interview column, would you like the Panel to put specific names of the interviewee. As in are we able to identify them.

MS McINTOSH: Yes.

MS KNIGHT: Or general categories.

MS McINTOSH: I think at the moment you are helped enormously by the final paper in the pack,

because you are actually given names and roles. But if you are not and that table is not complete, so I think if you don't know and you want to put the role in, put the role in and we will try to find out from the evidence who the person was.

CHAIR: I think it might be quite time consuming to cross-reference who was the appropriate person at the time.

MS McINTOSH: We can find out. You will get that information from us.

CHAIR: But as far as possible, specific roles rather than categories, I think, will be good. Any other comments?

DR WALTERS: I might understand it better when I see it later.

MS FEATHERSTONE: It is hard to work out which bit goes where.

MR BROOKES: I have to say it is easier when you can see it on there. I think a couple of things -- I was just looking at it in terms of names as well, which I know is getting slightly ahead. But there will be a couple of things here, there may be some, like myself, who might have a conflict of interest when we

get to some of the names on the basis one of the names on here is my current Chief Executive, for example. You know, it seems like one that might be a conflict we need to be aware of those things so we probably need to map some of that out.

The second thing was an observation. They are about the Trusts, but there are a number of organisations that have non-executive boards with chairs responsible for the running of the organisations and you might want to consider whether they are people we want in as well.

CHAIR: Very good point. I think you are absolutely right; we need to think about what constitutes a conflict of interest. What constitutes a conflict of interest such that somebody should withdraw from that sub-group for that particular session. What might constitute a slightly-less significant conflict of interest when somebody might want to take an observer role rather than a questioning role. I cannot spot any ex-bosses of mine but I can certainly see some of the names are known to me.

MR BROOKES: I do not mind the ex ones, it is the

current ones.

CHAIR: Yes. I do not have a boss at the moment.

DR WALTERS: I think the perception of NHS families, we have all got a conflict of interest in here anyway. How do we get over that? You know.

CHAIR: That is why I was trying to get the kind of gradations. I mean some of them are there theoretically and some practically.

MS McINTOSH: I think when, sorry I am jumping the gun a bit too soon, when we get to how we handle the interviews, one of the things that the interview team are doing is drawing a speaking note, which I think by the end of it Bill will know off by heart and you will be fed up hearing, but at the start of every interview he will read out something which probably will not sink in with the interviewee as he or she might be nervous, but for the benefit of the public record it will be including those things that this is an independent Panel, working independently, just dealing on this, which actually should help some of the issues. It will not sink in for

the interviewees but for the audience it will be important for them to hear that and to know. We have to keep trying.

DR WALTERS: Yes.

CHAIR: If there is not anything else specifically on this, Geraldine, you raised a good point about the relationship between the subgroups. Shall we take that before lunch?

DR WALTERS: Well, I thought we could have a brainstorm on how we approach the data because I think what we have not got is it arranged in a way that is helpful, the evidence, we have almost got too much detail and we have not got an initial sift. So we were having a chat with Paul this morning about how we might try to rearrange the evidence.

I wondered if the groups are going to take the same approach. How the groups are going to approach it because there is something about you have got here a group of cases and if you were a member of the SHA or even a Chief Executive, you would not investigate all of those cases individually at the first sign of the problem. You would first look to see if that group of

cases were within the normal limits; if they were, you would not choose to look at each of them individually. That is going to be the situation that chief executives, or directors, or obstetricians might find themselves in at the time. If I was in charge of the unit for two or three years that was fine, but now six years down the line it all looks a bit different.

I am worried about diving into cases, diving into incidents, or do we first want to look at the wider picture. Have we looked at the incident profile, we have looked at the data, and, actually, between this period and this period, it was normal, therefore, would you be content? I just want a bit of discussion about how we were all thinking about all this information.

CHAIR: I mean, I will get the views in a minute, but just a couple of thoughts on that. I mean I think you are absolutely right about re-interpreting what looks like a trend in hindsight from the point of view of somebody there at the time.

DR WALTERS: Yes.

CHAIR: On the other hand, I am slightly concerned that one of the reasons that was given why things were not taken any notice of is that they all had different clinical end-points. Yes, they all have different clinical end-points, they have different things that actually led to the untoward outcome in pathological terms, but that ignores the fact that there are some common factors like relationships between different staff groups and professional relationships and working practises and all the rest of it.

Which I think leads on to the second point, which is that I think that a large focus of the questioning of people in executive positions and chief executive positions in the Trust is not so much about individual cases, but it is about responding to concerns that are raised at the time. Not subsequently, at the time.

DR WALTERS: I think you are right, therefore, I think, in looking at the information, you have got to look at what was happening at the time.

CHAIR: Yes.

DR WALTERS: That is great because I am really worried about looking at 142 SUIs, really worried about the ability to look at 120 cases. I think we are talking about that before we have done the initial sift and really got a road map of the whole thing since 2004, which I think the way things are organised on Huddle at the moment you will never get there. There is something about sifting things by chronology and by type of document, and then perhaps agreeing between the subgroups what our approach is going to be, which might be, in this, you know, look at the cases at the time-map, this appears to be a critical couple of years: At that point, who is in charge; what were the policies around; how were those issues looked at; was there a cause for concern? You know, I think, otherwise the task is going to be undo-able.

PROFESSOR MONTGOMERY: I am thinking there is another wall being covered opposite this one, which has got a time line on it. I am trying to run through and say this is when these reports became available. So I wonder whether the way into this, which should start from the

minutes of the Trust boards and its committees, and actually say what was examined on the time-line, including the reports and action plans to it. We then have to ask the questions in due course, which is what should that time-line have looked like? But I think we have picked up very early on that core to this whole task is going to be mapping out the time-line.

CHAIR: Absolutely, yes.

PROFESSOR MONTGOMERY: I wonder whether what we need to do is mirror the analysis of clinical data, that we have thought a lot about how we will do that, with sorting out this time-line, about plotting visually whether things came in. Starting by tracking that through minutes and documents, so that we are able to say this was how the organisation did respond.

MR BROOKES: I support that because I think if I knew in 2006, as an example, this incident happened, this was the system in place, this is processes and policies that were in place that were in the organisation, this is how they should have responded, this is how they did or did not react, that is really quite

important.

PROFESSOR MONTGOMERY: I think if we get the time-line of what they did, and ask what should they have done and find out what the prevailing policies were and guidance at that stage.

There is a sort of above-the line version. You have got what they did. Then above the line you have got things they should have looked at. We will be able to ask sequence by sequence did they respond to it. Then maybe below the line on the map you have got these incidents that are coming in and we look at them individually, and we may well reach the conclusion that with hindsight it looks very different. But somehow we need to have a picture of what will be available without the benefit of hindsight.

CHAIR: Maybe I have picked this up wrong, but I had not seen us analysing 142 SUIs so we can pick out number 38 and challenge the Chief Executive about how that was handled. That was not the intention at all. I think it was to use that analysis as a bit of overall aggregate information about how they operated

their processes and procedures. It is a sort of alternative look on the triangulation system that we will say; what did you do? How did you do it? How did you operate this process? But we have also got a look at the data, which shows how it actually operated in practice. Separately.

DR WALTERS: I think we are saying the same thing. I think that, I think that when the SUIs were being logged and how they were coming in, is the first; the trend on those is the first sort of phase one. Then you would want to see, right, this seems to be an awful lot; so how did the Trust respond to that. In that "awful lot", we might have to look at some of those to say, were they really awful? Because that is what you would expect people to do at the time.

CHAIR: That is it.

DR WALTERS: But then the other side of the coin is that the SUIs are only really what is reported. They are, I suppose, less susceptible to propensities to report the incidents. They are pretty reliable. But actually would that be the full picture, if

you have got more, were they getting more near-misses that were not SUIs, that would have indicated, I think it is sort of seeing, from the interviewing point of view, what indications had they got to be concerned. If there was cause for concern, did they do the right thing?

PROFESSOR MONTGOMERY: When we are interviewing we probably need to try to distinguish the question we are trying to get at to find out what actually happened, which will not, in itself, necessarily be able to attach blame. The question we are trying to get at, around what governance did you make on the basis of what you knew at the time, where clearly we are inviting people to implicate themselves in a judgment or misjudgment. If we can't keep that separate, we will not get the help from the people without getting to the heart of what happened. We need to be able to say it might be really obvious now, but we are not saying you should have known that at the time, but we need your help in saying what might have been done.

CHAIR: Yes. Stewart.

PROFESSOR FORSYTH: I mean I agree with Jonathan very much on how we set out the time-line, I think that that is how we should be operating. We should be starting back in 2004, in January, and taking up cases that were the first cases and looking at what the difficulties were then and how the Trust responded at that time. Then we move forward into the next period and see what the cases were, how the Trust responded, what were they meant to say, what was the governance doing et cetera. Then moving through to 2009 eventually. I think we may then need another big wall for that to be seen because it will be sizable.

CHAIR: I think it is three dimensions.

PROFESSOR FORSYTH: -- because then I think we can then triangulate a lot of things under the things that happened at various time periods, including the staff who are present at that time, and the questions that are coming up more specifically to them at that particular time.

PROFESSOR MONTGOMERY: You want to know what data came in after they received the report. That

adds a different context.

PROFESSOR FORSYTH: We have got the reports coming in, you have got different levels.

MR BROOKES: And building the environment in which they were working as well as best you can. It will not be perfect but you will have it.

PROFESSOR FORSYTH: Different levels, you have got cases, you have got the Trust's response, you have then got enquiry coming in at different times and then right through. I think you see how there is a good timescale to all of those. I think it makes more sense for those of us who are involved in this.

DR WALTERS: Then I think the links between the cases, the Trust response, are where the subgroups sort of give their own insight into that bit of the geology, if you like, and different levels of it.

CHAIR: Catherine?

DR CALDERWOOD: The clinical one, the governance one have moved on a lot in this decade that we are talking about. I feel that we need to be as objective as we can be. There are different guidelines that were not available at the start of the process, that now are, but

there are also, I suppose, some of what we have heard raises concerns that there was not an awareness that certain guidelines, if they were present, even should have been followed. I worry that they may have had a policy, but was that the appropriate policy even? I mean, yes, they followed their own, but there was one that was 10-years out of date.

PROFESSOR MONTGOMERY: Yes, yes. They were doing it but not what they should have been doing.

MR BROOKES: Exactly. That is what I was going to say. So you try, I think we try, to build the environment they were working in. We need to test that environment about whether it was best practice as well. I think that is absolutely right. It will not be perfect, we will able to do what we can with the evidence that we have got, but that says how they were operating; was that reasonable et cetera. Then these things happened; did they then apply the environment they were working in, irrespective of whether it was the best or not; or did they not? Then you have got the key things along the line that are feeding the report, other investigations, information they

should have had, and how did they respond to that. I think that will be really helpful.

DR CALDERWOOD: If we could, from the clinical point of view, again it is adding to the numbers, but there is a finite number of guidelines that have come out at different stages in the last 10 years, the NICE Quality Standard et cetera, and also the mode of feeding back to Trusts has changed over that time as well so that the CMACE we got, for example, was a simple one A4 sheet back in 2008. You know more recently it is a whole booklet. You again need to be careful that when we are interviewing that we get their response to what they were given. I would expect it to be very different more recently, given the amount of detail and lots of things have changed and the scrutiny with which we examine cases has changed as well. Almost very rapidly in that time period, so that it is a different expectation at the beginning than at the end, but quite markedly different for some cases that we have heard about. I mean one of the ones you will hear about this, it was the thing I am interested in, one of the reasons that I believe that the

stillbirth rate has been so static is that we have not had an awareness that we can do anything about it; but that has begun to change. In a way I might not think that that was an attitude that pervaded everywhere and still does, so that, you know, it is the context of the time and the inference is about the quality of the information that was available.

PROFESSOR MONTGOMERY: Yes.

DR WALTERS: I think the sort of scenario you had back in 2005 you have got a few local consultants who are coming and going, three doctors, and in two months you have a couple of stillbirths; who should have thought that was a problem? Probably not the people in the unit, maybe not the Trust because you have got somebody in place. External bodies? So it is a case of who should have known?

DR CALDERWOOD: Yes.

DR WALTERS: Yes. It is this building of a picture.

MR BROOKES: I think those are important questions. I think that we cannot answer them until we have some feel about what the environment is where these things were

happening in. What is going through my head while we are talking about this, because that has made it clearer in my mind, is how do we construct that environment because I take your point, Geraldine, it was almost by implication what you were saying, we need that in place before the sub-group actually works. There is a task here that we can perhaps nominate or identify on how we want to build environments and how much can we do with what we know, how much help will the Panel need and how much can be done from the team developing that?

CHAIR: Do we also need to know how some of the systems operated in the Trust or in the unit? It is a necessity that means that inevitably we have to have findings as we go along.

MR BROOKES: We do, but having some of the basics will help.

CHAIR: Absolutely.

DR WALTERS: I had a conversation with Paul this morning about how, just in the list of evidence by the Trust, how it could be re-vamped/re-jigged to make it easier to look at. If you do it that way, I think the timing of it, the time-line will fall out of that.

CHAIR: Yes.

PROFESSOR FORSYTH: I mean in terms of how the subgroups work, I mean some of my thoughts to begin with were it will be focussed very much on the clinical cases from 2004 and forward. Clinical members are focusing on the clinical care. But if we are then also saying we want to know how the Trust responded, so then it is the governance and the standing and the trust management, you could actually pick up a lot more. The information will be saying first case, case one, whatever one it is, we take all the clinical notes, and you then have to go through all the Trust information in relation to these cases in terms of complaints and through to whatever else happened, and from that you then begin to build up how did the Trust respond.

PROFESSOR MONTGOMERY: There are all sorts of potential complexities. The clinical governance could decide that actually the care of the case was acceptable, but a tragic and unavoidable outcome. The governance could decide that a really heavy intensive look was required in order to find out what the

clinical group has discovered about the outcome. On the one hand you can have a relatively favourable finding about how the care was managed and an unfavourable finding about the way to approach it.

PROFESSOR FORSYTH: Vice-versa.

PROFESSOR MONTGOMERY: There is also the complexity we have already had it raised and I think that some things we have identified are some questions around the relative prioritisation the Trust gives. We have had the question raised about status and we are going to have to somehow ask ourselves whether or not what was working through the governance systems and the board was interested in, was a reasonable judgment about relative priorities and what might look very unreasonable now, we know some of the history, may not have looked unreasonable in terms of prioritisation at the time. So there is something around us having to get a sense of the agenda the Trust had, which is outside our Terms of Reference but we have to pursue it.

MR BROOKES: It is relevant in terms of the

environment in which the organisation existed.

CHAIR: It is very relevant. It is very relevant. We have to come at it from two directions. In a sense that underlines the formation of the subgroups, but, you know, one is the top-down and the other is the bottom-up. The difficulty is where they meet in the middle and how it has to be a high degree of co-operation and liaison at that point .

MR BROOKES: Yes.

DR WALTERS: Maybe on one of our two-day sessions we should run it a bit like a scenario, so the clinical group are reporting X cases and what will the Trust group expect to have done and what did they do. If you have got six cases then you go back to clinicians and you say, "We would like you to look at all these in depth because this is" --

PROFESSOR MONTGOMERY: Shall we try to pick a date, say look at 18 months in terms of the reference and try to construct what the environment might have looked like at that point and begin to ask the questions.

CHAIR: Good.

DR CALDERWOOD: We maybe do that, Jonathan, about the time when families came forward in those years. The ones where we think that there were a number of incidents that were close together and then got the ground swell.

PROFESSOR MONTGOMERY: By that stage there should have been some questioning at least, is something happening here.

DR CALDERWOOD: That might not be correct but we have got to start somewhere --

PROFESSOR MONTGOMERY: We perhaps would have expected that question to have been asked.

MR BROOKES: If we use that on the basis of test construction, we take a case, or some cases at that time, we build an environment around it and we then start asking all the questions we want to ask and then we realise we do not know the answers because we have not of what is missing. Then I think that will be much more comfortable because I do not feel we have got that right at the moment, to be honest. I think we will we will only do it by knowing.

PROFESSOR MONTGOMERY: We will be role-playing.

DR CALDERWOOD: It is the objectivity that we have got to get right because this is how we prove

something. We have got to go back to what standards were available, what guidance were people following and then what actually happened.

CHAIR: I think that is absolutely right. I also think there is an element of having to start doing this for real; that we need to focus minds on it. We can do a certain amount in abstract in preparation but

DR WALTERS: I think --

CHAIR: -- we just have to do it.

DR WALTERS: Sorry, because I am passionate, we have got to have, I think we have got to have that line. We have got to have that visible line in order to know where to get started.

PROFESSOR MONTGOMERY: I mean we know they decided to commission reports about the points; we could start by trying to reconstruct what was the trigger of that decision and actually was there material all ready available that might have triggered it earlier, for example what did everyone say and did they recognise the problem.

CHAIR: Okay. Thank you. That has been really helpful. We have got grids to populate, as well as lunch to have, before we start to build the second wall, so I suggest we break at this point. Let us see how we progress. Thank you.

(The Panel adjourned for lunch)

CHAIR: Right. Are we all assembled?

Let's get under way. Thank you. Item 7 we're up to now, I think, which is the protocol for interviews. Two main substantive bits of work to get through. So, Oonagh, can you talk to us about the protocol for interviews?

MS McINTOSH: As Geraldine referred to this this morning, these are about the practical arrangements that we need to put in place and that need to be communicated to the interested organisations who are going to pass this information initially on to interviewees because obviously at the moment we don't have contact details for interviewees.

I think it's worth working through just for two reasons. One, if anybody can see that we've omitted something it would be very helpful and, equally, if you can see a

pitfall in anything, that would also be good to recognise now so that we can either explain why it is in there, or amend it as necessary.

I do not know if everybody has had a chance to have a read of it. They may not have done. I do not know if you want to have a couple of minutes just to look at it and then work through it or work through it first then have questions afterwards? What's the preferred approach?

DR WALTERS: Quick look through.

MS McINTOSH: Okay.

CHAIR: Okay (Pause) Okay. Are we about ready? Right. Views, please?

MS FEATHERSTONE: I was going to ask about the interviewees coming. If there is any outcome? If something is brought up that has not been brought up before, or if they have already been referred through the NMC like a midwife, in particular, through the NMC or they haven't or they haven't and something comes up, are they coming and thinking that they could be referred?

CHAIR: They are coming knowing that the Report at the end will be public and will be

sent to all the relevant organisations. So that would be a potential outcome. I think there might be some limited circumstances where we'd have to take action ahead of the Report being produced but they are pretty few and far between.

MS FEATHERSTONE: It just says that people are, that we're just expecting full co-operation from the staff but they do not or they do have to come?

CHAIR: They do have to come because it's written into people's duties that they have to co-operate in full with an investigation to find out where something has gone wrong and improve services for the future.

MS FEATHERSTONE: If they do not still work for the NHS?

CHAIR: I was going to ask you whether you thought I was going too far in the final sentence of paragraph 2.

"It's expected that this will extend to anyone no longer employed in the NHS and we would consider that present or future receipt of an NHS pension carries the same responsibility".

MS FEATHERSTONE: There are some people that are not employed and they are ones we definitely want to interview.

CHAIR: Yes.

PROFESSOR MONTGOMERY: I see no problem with that. Whether we can make it stick.

MR BROOKES: Is it legally enforceable. I do not think there is any harm in putting it in there.

PROFESSOR MONTGOMERY: We could add something about professional obligations, if people are still professionally regulated even if they are not working for the NHS.

DR CALDERWOOD: I wondered about putting a quotation into the documents. So in the Good Practice GMC documents there is one, I presume, I presume the NMC has one. I didn't think it was strong enough.

CHAIR: Okay.

PROFESSOR MONTGOMERY: We refer to professional duty but if we put it like the pension sentence, a reference to the good practice?

CHAIR: Sure, okay. Thank you.

MR BROOKES: Can I clarify, I notice, this is about the legal representation. I understand

that we're saying they can have legal representation at the interviews. A lot of them will have legal representation outside of that particular process. If they want to bring their legal representative as a friend are we going to stop them from doing that?

CHAIR: I do not think we can stop them doing that but you can make it clear you are not going to deal with them.

DR WALTERS: They could advise them not to answer a question. They may because it sounds all nice and friendly and then anything they say can lead to them possibly losing registration or pension or serious consequences afterwards.

CHAIR: I mean, we're not sitting as a judicial panel. We're not making judgments on those things. If somebody says something which demonstrates that they are putting their own likelihood in jeopardy they have to be responsible for that but that doesn't detract from their obligation under their terms and conditions and their professional duties to co-operate in full with a fact finding investigation.

DR WALTERS: If it was me then if I brought a legal representative and they said do not answer that question I probably wouldn't.

CHAIR: Yes, I know. You are right. There is kind of an elephant in the room here. I would love to be able to say that you cannot bring a legal representative but I do not think we have the power to ban them from bringing somebody in the capacity as a friend.

PROFESSOR MONTGOMERY: You will have to say the Panel have to draw inferences from the fact that you have chosen not to answer that question. That may result in them having a short recess and deciding I will answer it.

MR BROOKES: We do not want to get in the ridiculous situation of hand signals.

DR WALTERS: It is just being aware what might happen.

DR CALDERWOOD: Again, back to what we have set ourselves up to, which is to provide answers to the families and there are processes whereby that if there was negligence or there was something that that needs to be dealt with

by a completely separate route. That's nothing to do with us.

CHAIR: Exactly.

DR CALDERWOOD: So that it's the same as reporting back to the families or the complaints with the families, there are already mechanisms by which those facts should have been, may not have been dealt with, but they should have been dealt with for those individuals concerned. We're a secondary and completely separate process. I do not know whether we can make people answer I agree with you that might put me off answering but can we make some statement, you know, that we do not have the statutory powers but the onus is on them to provide answers.

CHAIR: We can but then you get into the territory where people are going to be saying you are indemnifying us against that and we can't do that either if something does emerge.

PROFESSOR MONTGOMERY: I guess you can sometimes ask questions in different ways and a question which is, "So help us work out what was going on?" might sound less hostile than, "Did you make a mistake?" or "In hindsight do you wish you had done something different?" We have to

try and make it easier for them.

CHAIR: That leads me on to re-rehearsing something that I rehearsed with some of you but not necessarily all of you before we started. One of the concerns that I have about this is managing expectations of families who come along to the interviews because I think they will be looking for a very inquisitorial, quasi-judicial process here and my view is that we will not get the best out of people if we adopt anything like that. We need to, as far as possible, make people want to contribute to this in the spirit of investigating and putting things right for the NHS. We have to be clear that that means that the way that we approach it is not to be hostile otherwise we will not get the reaction that we want, we will not get full cooperation. We will get people being inclined to saying I'm not answering the question, because I'm concerned it will incriminate me.

MS McINTOSH: At the end when you report to the Secretary of State and we place the records of these meetings into the public domain and the interviews, when I say into the

public domain they will be put in the departmental record office and then they will be FOI-able, in books with an index, labelled and they will then be FOI-able. They will be FOI-able. One anticipates that the families will FOI request to see them but I also anticipate that if I were the Trust or the Cumbria Constabulary I would also want to get them because actually they need to look at them if the police still have an ongoing police investigation or want to revisit anything or the Trust are concerned that they may need to check that the disciplinary proceedings that they have been taking were okay. So I imagine that they will be scrutinised by others who are in a better position to make those decisions than the Investigation is allowed to.

PROFESSOR MONTGOMERY: I do not think that comes across from the statement. We've talked about being shown the records but what's going to happen to the records later on. Probably wiser to put that in.

CHAIR: That's a fair point.

MR BROOKES: We have still have a duty, if

something comes up which we feel is criminally negligent or is of a stage we need to take action, don't we?

CHAIR: There are circumstances.

MR BROOKES: That's not us about taking the action, it is about referring.

CHAIR: I agree with that. What I am saying is that at this stage after this amount of scrutiny it's unlikely that something so urgent would emerge that we had to do that but, you are quite right, if it does then we will have to take action.

PROFESSOR MONTGOMERY: That duty doesn't come from the fact that we're a panel of investigation. I do not think we need to draw attention to this. If it was something that was created because of the Investigation then we should draw attention to it, which is why I think the fact that there are records and they may in the future become accessible, that's only because of the Investigation. Whereas if they disclose information, which if they disclosed in any other circumstances the same obligation would arise, they ought to know that already.

CHAIR: Okay.

DR WALTERS: We're not interviewing anybody who is directly involved in any care?

MS McINTOSH: We have not gone into that in the bullet points. We can amend the bullet points to put that in because there are midwives, for example. Although some of them may not work in the NHS any more. We can amend that.

DR WALTERS: If that's what you want to do? I just wondered why you left them out.

CHAIR: Yes.

DR WALTERS: And obstetricians.

PROFESSOR FORSYTH: I wondered if there were any circumstances in which we would want to conduct an interview by video or telephone conference. I think of examples if we were going to be interviewing people who were involved in care which, for example, some of the doctors were, probably overseas doctors some of them, out of the country. It may be fairly critical to get their perspective on this case and, therefore, the only way we would be able to achieve that would be to conduct some sort of telephone conference.

MS McINTOSH: I am smiling because we rehearsed

that at length in the office yesterday when we had a brain storm about this and the team upstairs can find lots of reasons why we should do things differently, we had good discussions. One of the things was around video conferencing saying, we weren't thinking of overseas. We were thinking of maybe someone, we had a lot people to interview from, for example, from the Trust and it was going to have an impact on the delivery of service to bring several people here. Might it be better to use the Trust and to do a video conference from there.

I was playing devil's advocate throughout the whole discussion saying what if, what if, we can't do that. One of the things we maintained is only the families should be able to observe what is happening, apart from the friend or colleague or the family member that the interviewees bring along. Actually if we have something off site we have no control or accountability to the families that we're doing what we said we would do. So that's the only reason Tom and I were smiling, as well as some of the logistical difficulties about the

fact that there are technical reasons why video conference systems are not compatible well beyond my capability of understanding but actually they do not all join up terribly well but I do get the point.

PROFESSOR FORSYTH: I mean, I was not thinking about it for people such as that. I did feel that maybe some individuals that we think are really important, perhaps a doctor on a specific night, and to speak with them.

PROFESSOR MONTGOMERY: There is nothing to stop us going back on this if we discover there is a crucial bit of information and there is no other way of getting to it but if we open up the possibility in the beginning lots of people will want to do it. We're going to say you can't take a laptop and they could be sitting in the room with all their friends saying, "Say this, say that" and we will have no control over what's happening.

CHAIR: From personal experience it is much harder to assess what lies behind what people are saying, even on a video conference. If it's just a phone it's even more difficult. But by exception I agree that we may need to

do that.

PROFESSOR FORSYTH: My question was: was there any circumstances where we might consider it. Just to pick up on the point about practical issues such as staff who are working, would we consider interviewing, if we're going to do two days together, interviewing in the evening, 6 until 8 o'clock or something?

CHAIR: We talked about reasonable transport times.

MS McINTOSH: If you are talking about interviewing people at the Trust, a number of the families, if we actually went to the Trust and did the interviews at the Trust then had a facility there. I am thinking off the top of my head. If we had a room there that the Investigation used and the families could come and observe. I do not know, that might be a way round it and we could then maybe do it at times that were more flexible, probably less flexible for the panel but more flexible for the individuals who we are interviewing.

PROFESSOR FORSYTH: It might be more efficient, we might get through more interviews and the last point was if somebody comes with information

in their defence or they think is relevant which we have not seen or heard of, it's not been provided, do we accept that and is there a process for that?

CHAIR: We have to take it into consideration. I do not think we can be seen to be rejecting it but then we have to assess where it fits into the scheme of things and why we have not been given it before.

MR BROOKES: What I have done before in these circumstances is you continue with questions that you have but you accept that there maybe other evidence in there which means that you might need to recall them. They should have provided it before.

MS McINTOSH: Similarly as there is an opportunity built in for the panel to show interviewee A a document and give them some time to look at that, maybe equally there should be time for the Panel to adjourn if they want to have a quick look at a document and then decide whether to continue with the interview or adjourn and reconvene so we have to just bear in mind the end product. That is the framework within which we work, we will work

and we communicate to people that this is what we're going to stick to but there will be exceptions that we have to make.

PROFESSOR MONTGOMERY: It is really important that there are exceptions to build control. You shouldn't create an expectation that somebody could delay the questioning by handing a document across that we need to read.

MS McINTOSH: So in a way not putting it in doesn't cause a problem.

CHAIR: Absolutely.

PROFESSOR MONTGOMERY: Couple of things, one is do we want them to be able to refer to notes and things or not. Because you are saying no laptops and things. We have to form a view about whether or not we want them to be able to come in with a sheet full of their notes and work through. Will that help us or hinder us? I do not know the answer to that one.

CHAIR: I think it helps. The point about laptops and mobiles is to prevent transmission out, not reception in. I do not have a problem. Again, the more we get people to

give us in the way of information the more we will get to the bottom of this.

PROFESSOR MONTGOMERY: We're going to give them a chance to come back with information. afterwards? How will we handle the families' expectations in that they may say we are here for questions. We didn't see the 75 page letter that they wrote in. I do not think it is very clear in this that the families are going to be there or might be there. I think we could make that clear. We talk about observers but not families.

MS McINTOSH: We can quote from the method statement to be absolutely clear.

CHAIR: You are absolutely right, if somebody raises something substantive that changes our appreciation of what we have been told then we need to share it.

PROFESSOR MONTGOMERY: Somewhere that shows that. Also I wondered whether early on we might be clear that it won't necessarily be the whole Panel who will be interviewing. That emerges later on but it might be helpful to set that out right at the top.

CHAIR: Yes. Okay.

DR WALTERS: Not quite the same as people bringing notes along. Do we want to put anything about interviewees who want to provide anything in advance to us?

MS McINTOSH: We need to incorporate that in the correspondence that we have with individuals when we say you are likely to be invited to interview because. When we move on to the next agenda item, we want to communicate to people singularly. Then when the time comes if there is anything they want to submit we flag that up in that, rather than this, because what we run the risk of is being inundated now with material that is general rather than what is relevant to the individual.

CHAIR: I'm dubious about the value of getting written submissions here. In my experience what you tend to get is a lot of rather irrelevant stuff which is hard to wade through and sort out and then people being prone to saying I have already, it's already in my statement so I do not need to answer any questions about it.

On a similar theme. We need to have a

sceptical filter on material that we're provided with afterwards, particularly on the records as well. Because people say they are raising substantive points but they are not. They are disagreeing with interpretations or whatever. Both of those counts. We try and keep that to a minimum.

DR WALTERS: Just two bits of housekeeping. I do not know if we might have to say we reimburse any loss of work?

MS McINTOSH: I realised that last night. Thank you.

CHAIR: Not for NHS people.

DR WALTERS: There is somebody I know on this list who has retired.

CHAIR: Fair enough.

DR WALTERS: I just wondered if we ought to say anything about the conduct of any observers during the interview?

MS McINTOSH: The Chair and I have spoken about it and it comes into what we do with this now which is, do you mind if I jump to that now?

CHAIR: Go ahead.

MS McINTOSH: I would like to get your comments on this today, then share this with the

interested parties, the nearly 20 organisations we already know about, just on the practical side so that they can come back and comment because they might be answering questions on this as well as others and we want them on side as well to maintain the quality of co-operation that we've had thus far.

Actually then there is something the Chair and I have talked about which is how this is communicated to the families before we finalise it and place it on the website as the agreed way forward. It's a conversation, more than a letter, it's a sitting round the table and explaining the background that you have summarised in the comments that you have made today about how you want it to work, you want it to work in a not threatening way because a number of organisations have already contacted the Investigation because they are concerned about everybody being in the same room and even down to physical proximity. We had a letter in yesterday from a firm of solicitors about that. So there are concerns and I think if we can reassure the organisations that the Chairman has had conversations with those

observing and members of the family to explain the Panel's approach and what the Investigation hopes to achieve.

CHAIR: What will be expected on the day. I think that is the way to handle it personally, I think rather than putting it onto the website which is subject to a misinterpretation.

MS McINTOSH: Exactly. It's a conversation first and then putting it on.

MR BROOKES: Can I raise a point? I haven't seen it in here. I may have missed it. If I was giving evidence, I know there is going to be records taken, do I have an opportunity to read the record?

CHAIR: Yes.

MR BROOKES: And amend.

CHAIR: Yes.

MR BROOKES: Should we say that?

CHAIR: Yes. It obviously needs strengthening.

MS McINTOSH: It is in here. "Interviewees will be shown a copy of the record of their interview as soon as practical after their attendance. They will be asked to edit --"

MR BROOKES: I missed that.

MS McINTOSH: That comes with a sort of understanding that, as the Chair said in a conversation when we talked about this earlier in the week, they are not the people who are going to leak it. We have to ask them to respect the confidentiality because they are seeing something that other people haven't seen.

CHAIR: Okay.

DR CALDERWOOD: That point, especially if there are people communicating, because there is concern about physical proximity of people, you are having the conversation, we have no way of enforcing any behaviour or good behaviour.

MR BROOKES: Other than adjournment.

CHAIR: Yes. Stop proceedings. Yes.

MR BROOKES: It is more some of the ones we do around deaths where there are some high emotions, making sure you have the facilities outside to keep people separate. When they are in the room it's having conversations beforehand but it is bumping into people outside.

MS McINTOSH: We're starting to work on the literally what is everyone's role and responsibility within the secretariat and there is line there that says, "The interviewees will be accompanied throughout" and we have a small room upstairs that will be the sort of waiting room and where they have a lunch if they stay or sit with their friend or colleague. You know any observers that come, any family members, that come we have a slightly different layout. You know, we will have, yes, the interviewee here, but might have seats in a semi-circle over there or something like that so they can see everyone.

CHAIR: I think we need some physical separation.

MS McINTOSH: We need some space, so we need to think about that.

CHAIR: We need to think about how people go in and out.

MS McINTOSH: Yes. Exactly, yes.

CHAIR: Okay.

MS McINTOSH: All right.

CHAIR: Any other points? Okay, thank you.

MS McINTOSH: We will proceed with that.

CHAIR: We will. That is really helpful.

Interview and timetable. This is the bit that I am particularly keen on because I do see the interview process, as a whole, as the next step; I think the sooner we embark, the sooner we will have a planned way through this. I think that it is also important that we send out a signal that we have got to that stage in the process. We have a list of potential interviewees. Do you want to run us through that?

MS McINTOSH: Yes. Again it is with thanks to colleague upstairs in the team who have done a lot of work on this and pulled it together, you know it is not comprehensive but it is quite a list already and it has been pulled together from the material that we have got thus far on people; also looking at who were the people in leadership positions. Also some of the other organisations provided us with organograms and structure charts so we were able to get some of that information.

I think it is a case of that it is to be almost looked at in tandem with the calender

you have got that I know I keep saying this, you know your PAs will be so hacked off with the Investigation because you are still holding a huge number of dates in the diary, but I think when we work through the list at 5.7 you will see that the days that we have got are not going to be enough and we are going to need more.

Also there is something about being realistic about this. Easter is, I mean Lent starts today, so Easter is only a matter of, you know, 40-days away; there is a lot of work to do before that. We have dates in the diary before Easter and Geraldine was talking earlier about, you know, you mentioned using some of the days to actually do some scenario planning and scenario work. It maybe is that we use those dates for planning sessions and actually people come together to do that, or those who are free come together to do that, then we start after Easter in earnest with a rigorous approach --

CHAIR: With the interviews. I think I would like to add to the "before Easter-bit", making a start on case reviews as well. I

think we can usefully do that as well. I will subject to availability.

MR BROOKES: Drawing time-lines.

CHAIR: Subject to your views I think that is a sensible suggestion. I am not aiming to start interviews until after Easter.

PROFESSOR FORSYTH: I was going to say, Chair, the case reviews; I was not quite sure where they fitted in. Clearly I think that they are going to be the foundation for a lot of the questions that we want to be asking. Therefore, the time of these and actually how we do them and I am still not clear how, are we going to go through the case records, they are not going to be scanned and on Huddle, we will be sitting in the room going through the case records.

MS McINTOSH: We can talk to the Trust I am pretty sure we can get hard copies if it is easier. What I was thinking was it might be useful to actually just go upstairs, sit down, get together and work your way through them using the sort of methodology that you have agreed. Also, you know, in that room if you need to look at documents on Huddle you can have a

member of the team there to pull them up for you very quickly; you can work through it like that.

DR WALTERS: What would you getting out of that? What would you be getting out of that?

CHAIR: The assessment of the case which I think we have to do. I think we have to have an independent assessment of the case.

PROFESSOR FORSYTH: Yes.

DR WALTERS: You see I think we want to thrash it out because I think that if there was not cause for concern about numbers, would you want to do all of them?

CHAIR: All of what?

DR WALTERS: The cases.

CHAIR: Yes, but it is what we are defining as "cases". The index families, plus the ones that we come up with where we think there is cause to add them, from the additional contacts that we have had, and then the question is do we look at all of the stillbirths and the neonatal deaths as well. I certainly think we can start on looking at the families and the additional cases that we have come up with.

DR WALTERS: We are only looking at them because they are drawing them to our attention, which is a random group, is it?

CHAIR: Yes.

MR BROOKES: They generated this Investigation.

PROFESSOR MONTGOMERY: Part of our job is to get them answers and ask whether or not the answers should have come up from other ways. I think our reason for looking at those cases is independent of the Report of the Panel. It may go into that as well but we have an independent reason for looking at it.

DR WALTERS: Yes. Okay.

CHAIR: Yes.

PROFESSOR FORSYTH: I mean, I think that we need to have dates in the diary for that, for those of us who are going to be most actively involved in that and have a good bash at that before we actually even get dates for the first interviews because I think we do need to be able to, it is quite difficult if we are interviewing some key individuals and we have not actually had, at that point, an insight into, we cannot even say we have been through the case notes.

CHAIR: Yes.

PROFESSOR FORSYTH: We need some of them. They are not all required though.

CHAIR: That is my point about we have to start with index cases and we have to do them early. I think we can get dates in the diary for the interviews, but I think we have to make sure that we have completed those case reviews by the time we get to the key interviews, although some of them they are clearly not going to be concerned with the individual cases.

PROFESSOR FORSYTH: I think it will be nice, from our credibility point of view, to say we have been through some of the cases and here are some examples and why we have said this.

CHAIR: Yes. Absolutely.

MS McINTOSH: There are dates in the calendar you have got at 5.8. The week after next we start with dates in the diary that, you know, you are holding. I know not everybody is available on those dates, but, we know what your availability is and you have told us what your availability is; we have some dates there.

CHAIR: There is a point that I would like to make here as well that is the rationale for establishing subgroups. I know it is difficult in that there are things that cross over between the different ones, but the rationale is the impossibility of getting people together, as an entire group often enough to be able to crack this within anything like the time scale we have got.

We have ended up with slightly larger and fewer subgroups, which I think is right, but I think as a corollary of that we have to accept that we're not going to be able to get dates when every member of every subgroup is going to be there. I think we have to accept that we will have to crack on with a reasonable core membership and people will have to communicate about what questions they would have wanted and what answers they would have heard if they had been there.

MR BROOKES: I assume members will have access to the records themselves, so they will have access to the records themselves.

MS McINTOSH: Yes.

CHAIR: Okay. Shall we start with the list

of interviewees then move on to the dates?

We start out with a bang, don't we, Permanent Secretary.

MS McINTOSH: Start at the top. We had to find a way to start with an Una.

PROFESSOR MONTGOMERY: How many Permanent Secretaries do we need?

MS McINTOSH: To change a light bulb.

CHAIR: Having said that, that raises two points in my mind. One is where is the Medical Director because I think if we have got a Permanent Secretary we should have the Medical Director.

PROFESSOR MONTGOMERY: He's at the end.

CHAIR: That will probably put me in the same position as you, with a current employer/ex-employer.

The other question is that in quite a number of these cases we are going to get answers along the lines of, I suspect, "Dunno", "Never crossed my radar, "Was dealt with by somebody else, I wasn't aware" and the whole thing will take about two weeks because there is a limit to the number of times you can ask the question, unless you have any

reason to suppose it is wrong. Is there any merit in proposing a slightly different approach to one or two of the names at the very first page?

MS McINTOSH: Certainly.

DR CALDERWOOD: I wonder if we should look at what we are going to expect this information to give us that we are going to then put in the Report.

CHAIR: Yes.

DR CALDERWOOD: Start with the end result. Because I can see exactly you know, Una O'Brien is extremely able, but she will never have been near there and maybe the ultimate responsibility is hers but does that help us? Does that help families that sat there? Does that help something to move forward on this point?

MR BROOKES: My --

DR CALDERWOOD: You have somebody at a very high level saying, "If only I had known I might have", "Yes, ultimately I accept it was my responsibility", that may be the case for some people because of their job status et cetera, should have been, they should have done something about it. But I am not

specifically responsible. I do not know whether we should go through every person, but it is the principle of: What are we aiming to get out of these?

CHAIR: I agree with that. Can I suggest that we actually invert the list?

MR BROOKES: That was exactly what I was going to say. I think you start at the bottom point, and then it may raise questions about who knew what in the next tier, or the next part of the organisation so you ask them those questions; that might lead you to another one. If it doesn't then fair enough.

CHAIR: Exactly. You draw the line.

MR BROOKES: If we started with Una, what will we ask? You know? It is only starting at the other end and raising questions about who knew what and when and where because we may not actually need to get to some of these people.

CHAIR: We have said from the start that we will follow the leads as far as they go. The corollary is that the lead comes to a stop at some point and you don't ask any more questions.

PROFESSOR MONTGOMERY: If we do not know what we are asking it will provide the questions.

DR WALTERS: I would like to know what their interest was in the quality of care and how they looked at it; how they discharged that responsibility down further tiers of the organisation. The route of some of this starts at the top. If all you want to do is get the Trust to FT-status, then they will not be very interested in things like staffing and services, that sort of thing. To be really controversial.

I mean you cannot say, it has got nothing to do with the centre, what people at Trust level are looking at, because they set the direction.

MR BROOKES: I know that but at the same time we need to be clear on what questions we are asking.

DR WALTERS: The relevant question is:
What, in their structure, have they put in place to secure the quality of services and make sure that they knew that quality of service was okay and would not lead to a Panel like this.
CHAIR: If we stand it on its head and do it from your direction, we will know what, if anything, specific comes up from this to ask people. If we are simply asking a purely generic question about quality of care and the NHS, and what the department's role is and all the rest of it, we will get a very generic answer because Una and all the other people on the list have been in front of the Health Select Committee and lots of other people asking those very same questions.
MR BROOKES: Absolutely.
DR WALTERS: What I am saying is that we can't not invite them at all, that is what I am saying. I do not care which way up it is, but you cannot have a Panel like this that seems to not address people at the top.

DR CALDERWOOD: We need also to be careful we are not trying to solve all of the ills of the NHS and the structure and all of these things you are saying. There are other structures and organisations that are set up to do that. This Panel is not set up to do that. If you take the premise of the centre-setting policy in this X, Y and Z, that may well be a fundamental problem, but that is not what this, frustrating as it may be, this Panel is not set up to fix all of the difficulties around the structure of the NHS.

DR WALTERS: No. We might not fix it, but we play a part in how things are set out in the future. You know? If David Nicholson was not on the hook about Francis, do you think any of that would have been in the press? Would we have had any change around it? No, we would not. We cannot ignore it. I know they cannot look after each individual Trust, but it is the way that the message is filtered down and if that message is filtered down the wrong way, there has got to be some messages going back up, hasn't there?

CHAIR: I do agree with you that I think

that a part of this will be a message about the system as a whole. I absolutely think you are right about that. I think if we stand it on its head and we work through it systematically we will know (a) who we want to ask these questions to in a more selective way; and (b) exactly what we want to put to them.

DR WALTERS: No problem with it being the other way up, I thought we were starting to sort of, you know, not look at them at all, in which case we may as well ask Midwife X why she said that on 12 December 1933 or whatever; they will not know either.

PROFESSOR MONTGOMERY: We will ask Midwife X that.

CHAIR: Okay. Mentally retain the fact that it is the other way up. Do we have any other comments about the potential content of it?

I also have no problem at all at keeping it as comprehensive and inclusive as we can, subject to the fact you will have to refine it as data emerges.

DR WALTERS: There seems to be some gaps at the NHS North of England, on the SHA level. We have got the Chairman, the Director of

Public Health and the Chief Executive. Were there performance people? Were there governance people?

MR BROOKES: Performance was the one I would suggest. I would assume the equivalent of what we call the Associate Directors of Performance who have the responsibility for those areas; the one in the SHA would have known what was going on in the organisation, and would have had the responsibility of ensuring the SHA did what they did.

PROFESSOR FORSYTH: Picking up on that discussion we have just had, I think it is, again, when you are refining the interviews, we are planning our way up the stream of responsibility, I think, so that you know we can see the pattern, we do go through the case records, we get the materials on that, we then start interviewing people who are involved at the time in those incidents, and put questions to the management and the Trust and then SHA.

MR BROOKES: Exactly.

PROFESSOR FORSYTH: And move up in that direction. As you say, Bill, we follow the trail as far as it goes.

CHAIR: Yes.

PROFESSOR FORSYTH: That helps to bring some logic to this process and, hopefully, we can see where we are going, I think.

CHAIR: Yes. We need to reserve the right to add people as well as subtract them at that point. I agree with that, yes. It is just whether there are any obvious omissions.

MR BROOKES: One I mentioned before, in terms of where we have statutory authorities, there were non-executive statutory authorities; non-executive chairman of the PCT.

CHAIR: I think the Chairs would have been called. The other thing is you have got Directors of Public Health and/or Medical Directors at some levels but not all of them. For instance, Cumbria PCT. I do know that John Ashton would be dismayed not to be asked to come and talk to us.

MS McINTOSH: Yes. He appears on the list somewhere else. He's here as Regional Director of Public Health.

CHAIR: He was North West first, but after 2006 he was at Cumbria PCT. You are right about that.

MS McINTOSH: Who is that?
CHAIR: James Owen Drife. He provided an independent report on one of the cases.
PROFESSOR FORSYTH: Right. There are staff without dates of when they were employed at the Trust.
MS McINTOSH: No. We will get that from the case reviews. The actual staff we will get from the case reviews.
MR BROOKES: For the PCT I suggest Director of Commissioning.
MS McINTOSH: Which? Sorry.
MR BROOKES: PCT.
MS McINTOSH: Could you tell me the page numbers please.
MR BROOKES: The PCT on page two, you need the Director of Commissioning. You might not need all of them but you need the one who had lead commissioning responsibilities for the Trust.
MS McINTOSH: Especially in light of the discussion we had at the last Panel meeting in whether the shift into quality moved or did not.
CHAIR: As the case maybe.
PROFESSOR FORSYTH: Your Medical Director on page 12.

MS McINTOSH: Page 12.

PROFESSOR FORSYTH: National Medical Director seems to have slipped in.

CHAIR: So he is.

MR BROOKES: You could not resist, could you?

PROFESSOR MONTGOMERY: Do we need to take a view on how long they need to be in interim positions before it makes sense to talk to them? Have you got to be interim for about one or two months for it to be worthwhile.

CHAIR: I agree.

MS McINTOSH: For example, we have got, at the Trust, I think, an interim Chief Executive as well.

DR WALTERS: For a month?

PROFESSOR MONTGOMERY: February, March and there are others.

MS McINTOSH: What do you consider is a reasonable period. Is three or four months just holding the fort?

CHAIR: I think anything less than three months is holding the fort. I think if you are there three months or more you need to start taking an interest.

MS McINTOSH: Yes.

CHAIR: Julie Walters.

MS McINTOSH: I know, the one and only.

MR BROOKES: Again back on page one, just thinking through who would be involved if there were issues. The Nurse Director would be clearly involved.

MS McINTOSH: PCT?

MR BROOKES: Well, all of them.

MS McINTOSH: Okay, yes. SHA et cetera. Yes.

MR BROOKES: The other thing that occurred to me was I do not have a strong view on this, but there is a number of reports whose authors might be of interest to us. I wondered whether they should be at least considered?

MS McINTOSH: Yes. Okay. We will find them out and share them with the Panel, yes. We will add them to the list.

PROFESSOR MONTGOMERY: Do we have a view on how many of the non-executive directors that we think we should see? We have got a list of all the ones identified at the Trust, we have got a long list of chairmen; do we see them together? Do we see them all individually? Do we sample them?

CHAIR: I think we have to have all of the

Chairs separately.

PROFESSOR MONTGOMERY: Yes.

CHAIR: I think one of the questions that we might ask ahead of time is did anybody have specific responsibilities, either for that unit or for quality or clinical services.

PROFESSOR MONTGOMERY: Yes. That is sensible.

DR WALTERS: What is CNTW?

MS McINTOSH: What page are you on?

DR WALTERS: 12. A whole load of people here.

CHAIR: It is in brackets after the title.

MR BROOKES: Central North?

DR WALTERS: You have got NHS England and then there.

PROFESSOR MONTGOMERY: One for each region.

DR WALTERS: I do not know.

MS McINTOSH: I do not know.

CHAIR: It is, isn't it. Yes. It is, Central North and Tyne, and yes. Cumbria Northumberland and Tyne and Wear.

PROFESSOR MONTGOMERY: We have John here. Where was he?

MS McINTOSH: He is covering an odd bit of the country at the top there.

CHAIR: Yes.

PROFESSOR FORSYTH: Are we just interviewing health-related people.

MS McINTOSH: Meaning?

PROFESSOR FORSYTH: We are not interviewing the Constabulary or Coroner for instance.

MS McINTOSH: The Coroner is a bit different in a way because the piece of work the Secretary of State has asked the Chair to look at is in addition to our Terms of Reference to look at the children. How do we collate information regarding children who are transferred, babies who are transferred out and die elsewhere. That is not actually within our Terms of Reference. It is almost a stand-alone piece of work, isn't it?

The Coroner who raised the issue and wrote to the Secretary of State about it has actually offered to give his full co-operation to the Chairman and will help in any way he can but has just raised a question.

CHAIR: He sees himself as a kind of "collaborator" rather than an interviewee.

MS McINTOSH: Yes.

PROFESSOR FORSYTH: You don't think there will be,

let us say, something missing by not seeing the police. There has been communication between yourself and the constabulary; I wondered whether, you know, if it is raised at the end of the day about whether the police were doing an investigation, the communication between this investigation and the police investigation. Or are we seen to be running in parallel but not communicating? I wonder whether there is someone --

DR WALTERS: We cannot test.

PROFESSOR FORSYTH: -- who was leading the investigation that we should be asking is there anything we should know?

MS McINTOSH: I do not know. I need to think. I suppose we could. I do not know.

DR WALTERS: No. I was going to say because it cannot be interpreted that we're testing out their processes.

CHAIR: That is definitely outside the ToR.

DR WALTERS: Unless they have got evidence to give to the Panel I think we are like, they are not an interviewee.

MS McINTOSH: We have a memorandum of understanding with the Cumbria Constabulary,

that was agreed even before the Panel was convened, and they have co-operated throughout and they have communicated what progress they are making and the time-line they are working to. I think that needs to be duly reflected that you have the co-operation, when you wrote to the Chief Constable and asked for it.

I think as far as interviewing them, we ruled that out, when we said we would look at the police investigation at the meeting that we had in Lancaster, I think it would feel unfair to go back on that now.

CHAIRMAN: Yes. Yes.

MR BROOKES: We are investigating different things, I think, or certainly different tests.

PROFESSOR FORSYTH: Yes. I appreciate that position. I am wondering if they may have information which they have decided themselves is not criminal and, therefore, is not in their remit, but may actually be an issue, as they see it, for health; and if this is appropriate to this Investigation.

MS McINTOSH: It is almost if you turn the other way around and said to the Trust, you know, for example, just said to the Trust, "At what

point would you engage with the local police if you had issues of concern?" Then we can legitimately say to the police, you know, is this a fair reflection of practice? You can do that in a way that is not interviewing the police, but actually testing with them. I do not know if the Trust did approach the police, but I am using that as a sort of hypothetical. It might be a way round it.

CHAIR: I do not think we have got any evidence at all that the police held anything back. I think they have shared everything they have with us.

PROFESSOR FORSYTH: We have got everything there is.

MS McINTOSH: Yes.

MR BROOKES: The one that crossed my mind, I thought of before, which is about the earlier Scrutiny Committee, the local authority, and what has tweaked my mind there as well was the gold command, which was multi-agency approach. It might be worth a conversation with the local authority about whether or not there were any other

multi-agency discussions about issues of this nature within the Trust. Because there could have been, there could have been the, what do they call them now, multi-agency reviews they do now.

DR CALDERWOOD: The Trust was under the gold command wasn't it for some time?

MR BROOKES: It was. You know there will have been multi-agency involvement, yes.

DR CALDERWOOD: We will have evidence from somebody that was involved at the time; they were brought in, I suppose, at the start of the gold command.

MR BROOKES: Yes.

MS McINTOSH: Okay.

CHAIR: Jonathan?

PROFESSOR MONTGOMERY: I think we have mentioned maternity services at the committee and whether they happened at the time because we were told they had just established one, haven't we? It was a bit of news. We have got the link, but we do not have any of the information going forward and all the things that preceded that with Healthwatch and Monitor. It could turn out to be the same

person, just pre-2011, or it could be one person who ran it for the last 20 years, but we should try to track that back.

MS McINTOSH: That is one thing that is almost something we are hitting a brick wall with at the moment because we have got Healthwatch saying they have got nothing to give us at the moment because they are virtually new. We are still trying to find where the archive material is in particular; we are still searching for that. The Department of Health is searching, on our behalf, probably in those boxes.

PROFESSOR MONTGOMERY: The other group that I am not sure whether or how or whether we should pick it up. The education activity that must be going on, there must be commissioning of education that would have been the workforce development federation, the PHSA of the period. Were there students going through this that might have been picking up feedback that they were giving to the organisations? I do not have a sense of what that might be in this area.

DR WALTERS: Yes. Deanery.

MR BROOKES: For medical staff, yes.

PROFESSOR MONTGOMERY: I mean [redacted] they pick up things about the quality of services from the students who come back and say this cannot be right.

MS [illegible]: There should be lecturers attached to the Trust.

PROFESSOR MONTGOMERY: Exactly. Er, yes.

MS McINTOSH: Okay.

CHAIR: Any others?

We will keep it under review and it is going to be added to as well. Can we turn then to the thorny questions of dates?

MS McINTOSH: Right. Okay. You have all got in front of you a calendar that takes in the rest of the year, but the key dates for us are from March. The key months are March, April, May, June, and July. These are the months in which we are holding dates for interviews/additional Panel meetings. I said earlier that not all of you are available on all of the dates. You have just spent a quarter of an hour looking through a very long list of people and agreed between you that that is not complete. If you look at the dates you are holding, even if you

saw two or three people a day you will still not have enough dates.

CHAIR: I think we can do better than two or three people a day for lots of them. Some of them not, but for many.

DR CALDERWOOD: It goes back to my original question. Although we have got all of these people, do we feel we need to interview them all?

CHAIR: No, probably not, but I think that is why we have to keep it under review and refine it as we go along and there may be somebody we have to add. There probably will be somebody that we will take out as irrelevant, the trail has gone cold before we get to it. Some of them we need to interview, but on a pretty limited sub-set of questions. I mean we certainly should not give equal duration. There will be some that will take a couple of hours, but there will be some that half an hour is probably too much.

MS McINTOSH: At the moment we've got these dates, I do need you to find more dates, that's not just for interviews but it's actually for the planning and getting together and doing work

together which might speed up the process and enable sub-groups to work through huge chunks of evidence.

PROFESSOR MONTGOMERY: There are not many more dates in June!

MR BROOKES: Just for clarification. When we are meeting, certainly in the planning sessions in the groups, those are not in public sessions or are they?

MS McINTOSH: No, they are not.

MR BROOKES: A number of us could get together in London.

MS McINTOSH: Exactly, exactly.

CHAIR: Or, indeed, by telephone.

MS McINTOSH: Yes, yes. Or if you want to come here and have the team helping you bring documents. May be the clinical group might find that easier. Some of it might be easier.

Yes, I need more dates in the diary.

CHAIR: I also think we need to ask the subgroups leads to take an active role in this, particularly in terms of identifying when we've got a sufficient core membership for any particular date and go with it and the other people that can't make it we will have

to manage around that and find other ways of communicating. Otherwise, it becomes an impossible task if every single member has to be there for a particular day to work, we will not get a fraction of these, I'm afraid.

PROFESSOR MONTGOMERY: Should the next step be the sub-group leads sitting down with a list of interviewees and identifying which sub-group they mainly fit with?

CHAIR: Yes, certainly for the initial tranche.

MS McINTOSH: I would like to push you to do that quite fast.

MR BROOKES: It's about lead responsibility because it may be some of the subgroups want to feed questions into that.

CHAIR: Yes.

PROFESSOR MONTGOMERY: We're only going to ask the people once initially and we have to decide which is the primary place.

CHAIR: Drawing the right topics and questions. Yes, I agree.

MS McINTOSH: Can we do that quite soon? I am looking at the leads. Can we do it as a telephone conference? Or a meeting, I do not

know.

PROFESSOR FORSYTH: The sooner the better. For the clinical group to get dates in the diary for the case review starting by next week. I think it's really important. Are we able to sort of discuss that?

MS McINTOSH: What's the chance of a telephone conference? I think you have to be part of that as well.

CHAIR: Do I? I thought I had been very smart in not being a sub-group lead.

MS McINTOSH: What about Friday of this week? If we could fit a phone call in for the sub-group leads this week. What's your diary like, Geraldine?

PROFESSOR MONTGOMERY: Friday this week. I will pull out of something else, I could pull out of that if it was after ten.

PROFESSOR FORSYTH: It won't take that long.

MS McINTOSH: Hopefully not.

CHAIR: Ten on Friday is the one time I can't do. I have another telephone conference between 10 and 10.30. Once that is done.

DR WALTERS: I can do sometime on Friday. If you let me know the rest.

PROFESSOR MONTGOMERY: I'm in an all day workshop from ten, that's the thing I can't move. I will come out of that at whatever the slot is.

PROFESSOR FORSYTH: I'm okay.

MS McINTOSH: It would be quite useful for you to listen in.

PROFESSOR FORSYTH: When are you free on Friday?

CHAIR: 10.30 until about 3.30?

DR WALTERS: I will try and do 10.30. I.

MS McINTOSH: We will send an electronic invitation with a telephone number for the dial in.

PROFESSOR FORSYTH: When we speak we will discuss what?

MS McINTOSH: We are discussing --

PROFESSOR FORSYTH: So I can think about it beforehand.

PROFESSOR MONTGOMERY: We fundamentally need to divide the list, we need to match the interviewees with the sub-groups so we can prioritise where they best fit. Then I guess we handle who we should see first.

MS McINTOSH: The Investigation is beginning to get contacted by admittedly senior people who

held senior positions in a number of the organisations saying, "I imagine you want to interview me. Have you any idea when it's going to be?" When we send out the protocol it is going to be very helpful if I can write out and say, "We're not anticipating starting the formal interview process until after Easter and as soon as possible but nevertheless as soon as possible we will notify people if they are likely to be interviewed" and we will then write because in this document that you cleared earlier, the protocol, it only gives a very short time period for notice, giving people notice to come and be interviewed. Some of those people are saying they need to read all the material that the SHA will be sending, all the material that the Trust is sending. You are not going to be doing a forensic interview and, therefore, they do not need to be knowing what they said in minute x on x, y, z date. So we do not want them to spend huge amounts of time and resources preparing unnecessarily but actually we want to give them an indication that they will be given a relatively short

period of notice to attend. If they can't attend for genuine reasons we need to be getting someone else lined up.

DR WALTERS: Are we saying the interviews are going to take place after Easter and the group work before Easter?

MS McINTOSH: Yes, if possible. We will only give them a week's notice. Your sub-group work you will say we just need to interview them for maybe an hour. Another sub-group might say we have lots of stuff we want to talk about. Before you know it we've got to just get a rough idea to enable us to have people lined up so that I'm not wasting your time and we're not being unfair to the interviewees.

CHAIR: Yes.

DR WALTERS: That does mean the timeline has to be done quite quickly, so we can do work before this?

MS McINTOSH: Yes.

PROFESSOR FORSYTH: For the clinical sub-group, how quickly can you get case notes here?

MS McINTOSH: We have case notes in 30 of the cases already.

CHAIR: So we could start with the index

cases, it includes all those.

PROFESSOR FORSYTH: You have the case notes here?

MS McINTOSH: Yes, they are on Huddle.

PROFESSOR FORSYTH: I would be happy for us to get our first date, it would be quite good if the clinical group could all somehow get together on the first day and so that we could actually discuss our process a little bit but also then start going through the case notes and then my original view is that, well, each case note should be reviewed by two people, a minimum of two people, ideally some of whom know about obstetrics, midwifery, neonatology would be helpful. It would be good if the clinical sub-group have an early date where we could all be here and get started.

MS KNIGHT: It's Jimmy Walker as well.

MS McINTOSH: I have to contact him. I need to contact Catherine afterwards.

CHAIR: How about the 19th and 20th, which we have been keeping clear?

MS McINTOSH: Upstairs I have got the availability of the sub-groups, so I can give you that afterwards.

PROFESSOR FORSYTH: It would be nice to have a two

day crack at it.

CHAIR: 19th, 20th.

PROFESSOR FORSYTH: Three days?

CHAIR: I'm not available but you can if the sub-group says it is necessary.

MS McINTOSH: You are coming here to do it?

PROFESSOR FORSYTH: If the notes are here. I thought it would be quite nice for the clinical group, looking at the clinical group members here, if we felt it would be quite good if we got together for the first day, got some common understanding of what we were doing and the process involved and then we can divvy it up and look at who is available. It just needs two people to look at certain case notes. Take it from there. It is really important to test the system out fairly quickly in case we find there are some major issues, like this is not going to work or something like that.

CHAIR: Okay. Everybody happy with that?

DR WALTERS: We were just wondering whether not getting the data until the end of May would be a big problem?

MS McINTOSH: The data that Hannah is talking

about?

MR BROOKES: I do not think it is in terms of what you have talked about.

DR WALTERS: The sub-group work and the interviews will be done before we get the data.

CHAIR: If we are starting at a relatively down the organisation level that sort of information is less relevant, isn't it? It will become more relevant as you get to the top.

DR WALTERS: In my head I suppose we ask the questions, then we see what the data shows but I suppose what we won't be able to find out is to what extent they were aware of it.

PROFESSOR MONTGOMERY: We should be able to find that out by seeing the papers that go to the Governance Committees. We ought to see what they knew. We can then ask when we see our data whether we think they should have known other things or whether we think they shouldn't have known it given the prevailing systems. That information could have been accessed if people had concerns. So I think we ought to be able to get enough to interview people by seeing what was covered in the

paperwork that went through their governance meetings.

MS KNIGHT: Was there anything you would particularly like to see before interviews? Because I will send the analysis around as soon as it becomes available rather than all at the end of May. If there is anything you would like earlier then I would ask for that to be passed on.

MS McINTOSH: What shall we do about the future dates that we need? Shall we leave it to the sub-group leads to supply me with extra dates?

CHAIR: That would be my suggestion. You can be ruthless in making sure that they do that. The sub-group leads need to be ruthless about saying we have to go with the core membership. We can't get everybody on this particular day but just go for it. Okay. Anything else on this one? Excellent. That's really spoiled the tone.

Thank you. Any other business? No. Thank you very much. The next meeting will be on 3rd April here. That's the full Panel, of course, and there will be plenty of activity in the meantime. Thank you very much. Thanks

for coming.

THE MORECAMBE BAY INVESTIGATION

MBIPM 5.1a

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Name and address

XXXX 2014

Dear

Information shared with the Investigation

Thank you for contacting the Investigation in response to the Notice placed in local newspapers. It was helpful of you to complete a proforma detailing the incident.

The Investigation's terms of reference form the guiding principles for its work and all of the evidence it receives must be considered against these to determine its pertinence. The Investigation is extremely grateful for your contribution. Having considered the information you have supplied the Investigation concludes your case is within its remit [or…it is highly probable that your case is within its remit].

The Investigation's Panel of expert advisors will now review your case in more detail. After this review is complete the Investigation may request additional information from you however it is not expected you will be asked to attend an interview with the Panel.

Additionally the Investigation may request information related to the care you received from the Trust. The Trust may therefore ask for your permission to release medical information to the Investigation.

Or

As your case relates to a specific incident, rather than the standards of care in maternity and neonatal services, the Investigation intends to include your case in its review of how the Trust responded to incidents during the period the Investigation's terms of reference cover.

The Investigation will keep you informed of when its Report has been submitted to the Secretary of State for Health. You can also follow the Investigation's progress via the Investigation's website www.gov.uk/government/organisations/morecambe-bay-investigation.

Once again, thank you for getting in touch and providing the Investigation with details of your case.

Yours sincerely,

OONAGH McINTOSH
SECRETARY TO THE INVESTIGATION

List of interested organisations

MBI URN Code	Organisation
1001	University Hospitals of Morecambe Bay NHS Foundation Trust
1002	The Department of Health (in respect of its responsibilities as the **legacy body** holding the records of Strategic Health Authorities and Primary Care Trusts
1003	NHS England
1004	Monitor
1005	The Department of Health (in respect of its **policy** responsibilities)
1006	HM Coroner for South and East Cumbria
1007	The NHS Litigation Authority
1008	The Health and Safety Executive
1009	NHS Cumbria CCG (for the period 1 April 2013 – 30 June 2013 and in respect of functions transferred to it from South Cumbria Primary Care Trust)
1010	NHS Lancashire North CCG (for the period 1 April 2013 – 30 June 2013 and in respect of functions transferred to it from North Lancashire Primary Care Trust)
1011	Public Health England
1012	The Nursing and Midwifery Council
1013	The General Medical Council (in respect of LMC matters)
1014	The Parliamentary and Health Services Ombudsman
1015	The Care Quality Commission
1016	Cumbria Constabulary (in respect of the on-going police investigation into deaths that occurred at University Hospitals of Morecambe Bay NHS Foundation trust)
1017	Family/Relatives
1018	
1019	
1020	Healthwatch England
1021	CMACE
1022	National Institute for Health & Clinical Excellence
1023	
1024	