The Morecambe Bay Investigation

Wednesday, 16th July 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert adviser on Paediatrics
Professor Jonathan Montgomery – Expert adviser on Ethics
Dr Geraldine Walters – Expert adviser on Nursing

PROFESSOR EDDIE KANE

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1 DR KIRKUP: I'm just going to ask you a general question to start and then I'll hand
2 you over to Geraldine. And the general question is: can you tell me when you
3 started in association with the Trust and when you finished?
4 PROF KANE: Yes, in June 2008. The original appointment was for May and I was
5 out of the country, so I didn't actually start until June 2008 and I finished in
6 December 2011.
7 DR KIRKUP: Okay. What did you move on to?
8 PROF KANE: I moved on to a more full-time job I'm doing now back at the
9 University, because I was working part-time then and I've moved back to
10 full-time running a new research unit.
11 DR KIRKUP: Okay. Thank you. Geraldine.
12 DR WALTERS: Hi, Eddie. When you got to the Trust in 2008, what were the big
13 issues then?
14 PROF KANE: There were three major issues that were presented to me by the SHA
15 and, I suppose, more generally by the board. The first was the Trust was still
16 in special measures because of its financial situation. It had a large deficit. It
17 had borrowed money from the SHA in order to stay afloat and because of that
18 it was put into special measures. They borrowed about 6.8 million, if I recall, it
19 was of that order. So getting out of that situation was a critical piece of work
20 that I had to do.
21 The other one, I think, which was probably, in some ways, more
22 problematic than that was the closure of the medical services or the transfer of
23 medical services from Westmorland General Hospital mostly to Lancaster, but
24 a few things to Furness, but principally to Lancaster as the services were seen

1 as unsafe. And, I think, for some while the doctor cover, particularly the
2 consultant level but not just the consultant level was virtually impossible to
3 secure. This had been going on for a long time before I was there, so
4 ~~[inaudible]~~ came in towards the end of it ~~[inaudible]~~ It was very problematic and
5 it had become a major election issue ~~[inaudible]~~ and the main platform of the
6 local MP and also a number of subsequent ~~[inaudible]~~ objecting campaigners
7 become governors of the Trust [inaudible]. So getting that to a point where the
8 public consultation was completed and actually getting the decision made and
9 endorsed by the Secretary of State, which happened and the changes went
10 through which resulted in, then, quite a lot of work in trying to keep
11 Westmorland General operating as a unit, which was mainly operated by the
12 PCT, as it was at the time, so the minor injuries unit, primary care, front end,
13 with relatively few Trust services. So that was a big – a major issue consuming
14 people at the time.
15 The other one was we were – it was at the time, just as I arrived, the
16 time when the edict from the DH came out that everybody had to be on the
17 foundation trust track and either be a foundation trust by 2014 or in partnership
18 with somebody to become a foundation trust by 2014. And obviously, with the
19 Trust in special measures, with all of the problems around the medical services
20 transfer there wasn't really a starting point [inaudible] at that time. They had
21 been flirting with the process earlier on. So getting a decision, getting to a
22 point where we could decide whether or not to pursue foundation trust status
23 on our own or trying to go with somebody else or, you know, whatever
24 arrangement we were going to make was another major issue.

1 And then, on top of that, we had the usual – those are no different to
2 other trusts, this was the usual financial, the austerity sort of time was
3 beginning to come in with a huge NHS deficit and finding ways of saving that
4 money was obviously a major agenda and trying to keep services safe at the
5 same time and actually distributed evenly across [inaudible] geography of the
6 Trust with almost 60 miles between the most southerly unit and the most
7 northerly unit. Trying to create some sort of clear identity was another major
8 sort of challenge. The Trust had been formed in name but not in reality. There
9 were still three hospitals that functioned very much as three separate hospitals
10 and even things like, not little things, but things like consultant contracts where
11 many of them still had contracts that were tied to a particular unit, whether it
12 was Furness or Lancaster, very few to Westmoreland General.
13 And I suppose the final thing was actually trying to look at the
14 operating systems of the Trust in terms of the board systems of the Trust were
15 pretty disparate at the time. Trying to rationalise some of the committee
16 structure and to try to get a closer link between what the Trust's objectives
17 overall were at the strategic level, delivering services at the ward level and
18 there was some tension, I think, at the time.
19 So those were the key things. I mean, there were all the usual other
20 things that go with running a trust, but those were the [inaudible].
21 DR WALTERS: So, as the new chairman, what did you think about the sort of
22 governance structures at the board level around things like quality and safety
23 and that sort of thing?
24 PROF KANE: They needed significant change and we started on that. I'm not sure

1 [inaudible], but you've probably heard from other people about things like
2 ~~[inaudible]~~ GURU the system to try to get more ~~wall~~ WARD to ~~wall~~ BOARD
3 assurance, get visits done by our executive and non executive directors more
4 frequently on the wards. And, at that stage, I think people had become
5 consumed by – I would say mainly consumed by the whole thing around the
6 transfer of medical services, which occupied an enormous amount of people's
7 time and long before I came. I mean, I really was at the very end of it, so I'm
8 not saying that occupied all my time, it didn't, but I think the chief executive and
9 other board members really were very much focused on that and
10 understandably so, because ~~[inaudible]~~ of its high profile.
11 DR WALTERS: Yeah. When did maternity sort of hit the board agenda or the
12 board's recognition?
13 PROF KANE: From my point of view, after the sad death of [inaudible]. Not
14 immediately after that, but sort of subsequent to that when we had the first
15 [inaudible] of that. Up to that point in time, I mean, certainly that's something
16 that happened just, well, two or three months after I first became chairman and
17 maternity safety wasn't an issue~~safe [inaudible]~~. So it wasn't, not at all, one of
18 the things that was pointed out before, you know, raised as an issue for the
19 Trust when I first joined there, so during that sort of period of time. I couldn't
20 give you an exact date, but in that sort of timeframe.
21 DR WALTERS: So, had the board been sort of receiving sort of positive assurance
22 about maternity until then?
23 PROF KANE: Absolutely and continued to do even through that period of time
24 afterwards.

DR WALTERS: What were the sources of that positive assurance?

PROF KANE: Sorry?

DR WALTERS: What were the sources of the positive assurance?

PROF KANE: Things like reports from the director of nursing and midwifery. We had two at the time; one was already there and a new one came in and, in some ways, her assurances were probably given a lot of credence because she was new to the place and so there was a fresh pair of eyes on it. I think the fact that visits were being done by other external sort of bodies, internal audit reviews, compliance, reports that were being done around maternity services.

DR WALTERS: That was after, wasn't it?

PROF KANE: Some of those things were looked at, you know, at an earlier stage. There were, obviously, things like the Fielding report, the internal audit review, the compliance with the action plan, but there were internal audit reviews done of services throughout that period of time.

DR WALTERS: Right. Because it seems to us that there were the five cases – cluster of cases, which were not related, which were sort of – really were the sort of starting point for the Fielding report and some intervention or some observation by the CQC, but there doesn't seem to have been much before that.

PROF KANE: I'd say up to then I'm not sure that there was – well, I say I'm not sure, there wasn't a recognition, I think, there was a cluster of cases –

DR WALTERS: Yeah, but there wasn't positive assurance either.

PROF KANE: There was positive assurance that, you know, maternity services

1 were fine, that there wasn't any particular pattern in events that had taken
2 place. I mean, that was the assurance that was given to the board. Whether
3 we should have taken that assurance or not is, you know, in hindsight, open to
4 question.

5 DR KIRKUP: Can I just pick up a point there, there wasn't recognition that there was
6 a cluster of cases, but what prompted the Fielding review in that case?

7 PROF KANE: The Fielding review was mainly related to – my recollection of it
8 anyway – was mainly related to trying to resolve the issues that were raised by
9 Mr Titcombe and his family. That was the sort of driver of it and then it became
10 apparent that there were other cases. So, if you want, that was the stimulus,
11 but then it pulled other things with it.

12 DR KIRKUP: So the Fielding review prompted recognition [inaudible].

13 PROF KANE: Yes.

14 DR KIRKUP: Okay. Sorry, Geraldine.

15 DR WALTERS: So when the Fielding review was commissioned, what was the
16 board's view of that? Was it about we need to take action because there's
17 been a problem or was it we've had an unfortunate cluster of cases, otherwise
18 we've got positive assurance, we just need this to sort of move things on?

19 PROF KANE: I think it was an honest attempt to find out if there was an issue, an
20 issue beyond a single case or beyond a cluster of cases.

21 DR WALTERS: Right. And from the Fielding report what was your answer to that
22 question?

23 PROF KANE: Well, there were various iterations and there were three versions of it
24 that we saw and the final version of it had a mixture of issues that needed to be

1 resolved and, actually, if you read the executive summary, a lot of positives in
2 it.
3 DR WALTERS: Yeah.
4 PROF KANE: So it's been interpreted consistently [inaudible] by people as being a
5 negative or completely negative review and it wasn't, certainly in my view it
6 wasn't. But it did prompt some further action.
7 DR WALTERS: Right. What sort of action?
8 PROF KANE: Well, a variety of things. Birthrate Plus, for example, looking at the
9 staffing, looking at the team working, I mean, a variety of things, but one of the
10 key ones, reporting, consistency of reporting, you know, those are some of the
11 key things that, from my recollection, came out to the board. And there was a
12 report to the board, I can't remember the exact date but round about
13 April 2011, after the first internal audit review had been taken up, asking then
14 for a further update and that was undertaken by the CQC visit in [inaudible].
15 DR WALTERS: So just give us a flavour of, if you're sitting round the board table
16 and they were reading the Fielding report, how did they view it? Did they say,
17 'From the evidence we've got to come up with an action plan?' or was it a case
18 of 'Oh this isn't too bad'?
19 PROF KANE: No, no, I think it was 'we need to follow up with an action plan. We've
20 got to put something in place that will change things', but I don't think, if you
21 weigh that against the positive assurance and things, other data, that were
22 around then, you know, the numbers of births, issues that cropped up in birth
23 patterns, you know, that sort of data presented to the board by the medical
24 staff and by the midwifery staff, but I think it was not something we thought

1 right, we've got to close the maternity service [inaudible].

2 DR WALTERS: Right. So when the Trust got a report like that in, what was the sort

3 of chain of action that took place from sort of board to ward?

4 PROF KANE: Okay. Normally, most reports like that would go, first of all, to the

5 quality and safety committee to be reviewed and that comprised everybody,

6 non-executives and executive directors plus medical staff, ~~plus~~ but not myself

7 Note I was not a member of this Committee (matter of record) I would not

8 have said this and the chief executive officer [inaudible]. So it would go there

9 first and then, basically, they would come up with the action plan. The action

10 plan would be what the board ~~[inaudible]~~ received from the quality and safety

11 committee ~~before going to us on the board~~. That would be the normal course

12 of action once a report – because we wanted a broad view of it, not just the

13 board [inaudible].

14 DR WALTERS: And were there some things in that were too difficult to do?

15 PROF KANE: There were things that were too difficult to do. There were things that

16 were certainly challenging to do, particularly around the staffing, particularly

17 around – with the resources that were available. Because, I mean, I suppose

18 the other big challenge that's worth mentioning and this is not, in any way, by

19 sort of mitigation, it's just a fact, the Furness health economy probably still is

20 but certainly was at the time, a conservative estimate was £7 million

21 underfunded and a more realistic one was probably about £10 million

22 underfunded and that was recognised by the PCT themselves and by the

23 subsequent CCG. So doing anything in Furness General in a big way, for

24 example, which is what we wanted to do was actually physically create a new

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~~[inaudible]~~ unit was not doable financially.

DR WALTERS: Yeah. So the Fielding report and its action plan happened and then there was a cascade of additional activity after that.

PROF KANE: Yeah. I mean, one of the big ones, which was trying to find a way to try and get the staffing level right and work out how we could best do it, was the Birthrate Plus information [inaudible], not just at Furness General but across the piece, including [inaudible] and Lancaster too.

DR WALTERS: Yeah. And so the board were satisfied then that all those actions had been completed to the best [inaudible].

PROF KANE: At that juncture we were and we were beginning to get assurance from people that it was, including internal audit and other, you know, folk, including our own clinical advisors. And, at some point in time ~~[inaudible]~~ external.

DR WALTERS: Yeah.

PROF KANE: It was a surprise to me, certainly, the CQC report in that it presented a series of issues, some of which [inaudible] and were to do with the physical – you know, the environment or the physical [inaudible] which, to be honest, were only going to be really addressed properly when ~~[inaudible]~~ rebuilt. There wasn't really any in between on that, although some of the things were [inaudible] slightly curious things that they requested to do which, to me, didn't seem to get to the heart of things. But some of the critique around emergency availability, for example, were, I think, fair criticisms, but very difficult to address in just the availability of staff [inaudible].

DR WALTERS: But do you think that made the service safe? Were the board

1 happy, therefore, that the service was safe?

2 PROF KANE: Yeah, not least because that's what the CQC – if you read the CQC

3 letter, which I did again the other day, that's what it says.

4 DR WALTERS: Okay.

5 PROF KANE: I mean, one of the things I found frustrating with some of the

6 [inaudible] is that a lot of the – a lot of reports summed up by saying – which is

7 what the board get – as being 'fundamentally this service is safe,

8 fundamentally this service is' – and then a series of areas of criticism. If you

9 read that as a sort of non-executive board member, not from clinical – you do

10 sort of think that might be – and, you know, I'm not being facetious, but that

11 might actually be not an unreasonable thing to take account of.

12 DR KIRKUP: Okay. Jonathan.

13 PROF MONTGOMERY: Thanks. Can I go back a bit to the Fielding report?

14 There's just some things I want understand and the first of those is who exactly

15 commissioned it, so can you tell us how it came to your attention? So not

16 about the finding of the report, just to understand the process.

17 PROF KANE: Well, at the executive team meeting they decided they wanted an

18 external review and [inaudible]. So the initiative originally came from them.

19 PROF MONTGOMERY: And so it was a proposal from them to the board, which

20 you then reproduced.

21 PROF KANE: Yeah.

22 PROF MONTGOMERY: And did it involve any of the board members meeting the

23 team?

24 PROF KANE: I didn't meet the team. They didn't ask to see me. I'm pretty sure –

1 and I'm really trying to cast my mind back a long time and I'm sure it's
2 recorded, but I would imagine they would have met Dr Greenwell, who was the
3 chair of the quality and safety committee, they would certainly have met the
4 executive members ~~[inaudible]~~ medical nursing and midwifery. So, yes, they
5 would have met at least those people, but I did not meet them.
6 PROF MONTGOMERY: And the report was then commissioned with board
7 authority in reply to the executive team. And what was the feedback into the
8 board? When was the report received? You talked about reading three
9 versions of the report; was that taken to the board meeting? Did the non-execs
10 see it?
11 PROF KANE: The non-execs saw it. It was circulated to the non-execs, the final
12 version, which I think – I think – was the August version. I couldn't be exactly
13 sure, but I think it was the August version. It went to the clinical quality and
14 safety committee for them to review and come up with an action plan to
15 respond to it.
16 PROF MONTGOMERY: But it didn't go to a full board discussion.
17 PROF KANE: Not at that stage, no. It went to the clinical – which is where – that's
18 the system – rightly or wrongly, that's the system that we had.
19 PROF MONTGOMERY: And you had no contact directly with the report authors.
20 PROF KANE: No.
21 PROF MONTGOMERY: Would you have expected to, initially?
22 PROF KANE: Not necessarily. I've had mixed experiences of those things, both on
23 – being on both sides of the equation, where – I mean, I've done – not on
24 maternity services, but I've done similar reports myself on mental health

1 services, where generally the people I would want to talk to would be the
2 people directly involved in the delivery of the service and, to some extent, the
3 senior management, obviously, but relatively infrequently would it be
4 non-executive directors. And maybe that's a change in the way in which
5 non-executive directors are expected to work these days.

6 PROF MONTGOMERY: And what's your experience been of follow up after you've
7 provided your report?

8 PROF KANE: Variable. From very comprehensive – I mean, what normally – I
9 suppose the – it would depend on what the situation was. There are some
10 obviously I can't really talk about. I mean, some which are of a very serious
11 nature, particularly in things like ~~[inaudible]~~secure services, you would expect
12 an extremely detailed response, extremely detailed follow up, because there
13 you're dealing with very infamous individuals and, you know, the sort of
14 security situation. For others, you'd expect an action plan. I would expect said
15 action plan follow through and then subsequent review of the action plan by us
16 to see whether or not it complied with the follow up points and so on.

17 PROF MONTGOMERY: But as the report author, would you expect to know
18 something about what was followed up to your report?

19 PROF KANE: Yes, I suppose I would. I think it generally would depend – there are
20 genuinely investigation reports that I've done where I have seen the action plan
21 and that's been the end of my involvement in it, because there's not been a
22 requirement for any further involvement in it. There have been others where
23 I've followed it right the way through to five years on, so the end of the final
24 plan.

PROF MONTGOMERY: But normally you haven't seen the action plan.

PROF KANE: No.

PROF MONTGOMERY: Thank you. That's helpful. We're sort of just trying to triangulate [inaudible] together.

The next thing I wanted to ask you about really was the informal bits of the non-executive governance. You described the structures and the committee and you described that you were putting in place a visiting programme or something of that sort. So if you could say a little bit about how you got your soft intelligence and contact with staff and walking the wards and that sort of thing.

PROF KANE: Well, a mixture of things. First of all, just that, actually visiting wards. We had non-executive directors doing that as well as executive directors, sometimes together but usually independent of each other. The GURU system, which was a way of reporting, which took some time to get off the ground, but the idea there was to try and get intelligence direct from wards to boards. And at each board meeting, this was probably from, I guess, I'd say probably from 2010-ish, that GURU dashboard would be reported to the board at each board meeting, where there was a – probably a meeting – a private meeting of the board. And the clinical leads for the particular areas that might have been highlighted with some problems or some ~~[inaudible]~~issues came to the meeting and explained what they'd done about things, what they were doing, how things were changing or not changing, what the issues were. So that was a critical way of getting intelligence. I think it needed improving further, because there's always a question of how good the quality of the data

1 is, but at least by people coming to the board there was both a direct
2 relationship between the people, the non-executive directors in particular on
3 the board and the, for example, the ward managers or the clinical service
4 manager or the consultants or whoever was involved.

5 So I think those were the key planks, the visits and the GURU system.
6 Then obviously there are the usual informal things, you know, you talk to
7 people in the car park and you see people when you're walking through -- you
8 know, that whole usual informal system. But, if you want, the more formal
9 informal structure was the GURU system and the –

10 PROF MONTGOMERY: So how often would a non-exec be at Furness General?
11 Because there are car parks and car parks and one of your problems is you
12 have three very different sites.

13 PROF KANE: Yeah. At Furness General, I mean, I couldn't tell you, but somebody
14 would be going at least between each board meeting. but it may happen more
15 frequently than that. I mean, I used to – because of where [inaudible] I would
16 go and spend all day there [inaudible] and I spent all day, you know, either at
17 Westmorland General [inaudible]. And again, a relatively limited amount of
18 time, but [inaudible].

19 PROF MONTGOMERY: Absolutely. And practice differs enormously. Did you have
20 portfolios for your NEDs? Did they have particular interests or –

21 PROF KANE: No, we generally tried to get people to look at everything, because it's
22 more – what I was looking for and what [inaudible] looking for was not the sort
23 of quasi-expert opinion, but the sort of 'why are we doing that?' type of
24 question or that sort of [inaudible] or whatever. You know, that sort of more

1 informal view of the world really rather than giving people structured sort of
2 [inaudible]. I think some people obviously have more of a – at least an
3 intellectual portfolio in their mind, just because of what they'd done themselves
4 in the past.
5 PROF MONTGOMERY: Was there anybody who was particularly interested in
6 maternity that we should hear from?
7 PROF KANE: I wouldn't have said so. [inaudible] speaking to the past –
8 June Greenwell, Dr Greenwell, but you may already know her [inaudible]. I
9 wouldn't say, to be fair, she had a particular interest in it, but she will have had
10 a lot of both formal and informal intelligence [inaudible] she chaired the
11 committee that was looking at the action plan, so probably her.
12 PROF MONTGOMERY: Thank you. And you described how the Fielding report
13 grew out of the concerns about Joshua Titcombe's death. Did you meet
14 directly with the Titcombes?
15 PROF KANE: I didn't, no [inaudible].
16 PROF MONTGOMERY: Was that a deliberate strategy?
17 PROF KANE: No. It seemed to – at the time, it seemed to be the right thing to do,
18 as Mr Titcombe – Joshua's father, as opposed to Mr Titcombe, the
19 grandfather, seemed to have formed a relationship with Tony that was
20 supportive and seemed to want to deal with things in that way. Now, that may
21 or may not have been the case, but –
22 PROF MONTGOMERY: [inaudible]
23 PROF KANE: – having been a chief exec, I have to say that's what I would have
24 expected to do. I wouldn't expect the chairman to –

PROF MONTGOMERY: And would that have been something that you discussed with Tony Halsall about how you managed that or would that have been something that you would have –

PROF KANE: No, I would expect him to do that. I mean, I would have been more than happy to have been involved in it, but I don't think I would [inaudible] at that period of time. Although it was very distressing for all [inaudible] obviously, they did seem to have formed a reasonable relationship and were working through that, both his concerns and our concerns.

PROF MONTGOMERY: And how high a profile did it have on the sort of board worry list, if you like? Would it be something that you'd have had an update on every time you met, just to say –

PROF KANE: Not on that particular single case, no, no, absolutely not, because for a great deal of the time that particular case wasn't – wasn't actually a high profile issue, you know, in being brought to the board [inaudible]. It became high profile. I mean, it's obviously very [inaudible] a tragic thing, but in terms of actually what was being dealt with on an operational, day to day [inaudible] it wasn't.

PROF MONTGOMERY: Thank you. Can I move to ask a bit about some of the external relationships? You've mentioned the PCT. You haven't mentioned the SHA yet; we'll perhaps come to that later on. But just in terms of how your relationship with the PCT operated –

PROF KANE: I think they operated – there's two PCT, so I'll just concentrate on South Cumbria rather than North ~~Cumbria~~ Lancs Didn't have any contact with N. Cumbria it is/was not a PCT. South Cumbria, the relationship with

South Cumbria was excellent when the chairman who was there when I first came who, sadly, then died very suddenly. I'd never met her in my life before, but we got on very well and felt that things in terms of, you know, things like the pressing funding issues and some of the other sort of issues and the poor relationships, which, without a doubt, had been there not just in Tony Halsall's time but before ~~[inaudible]~~ he was there. It's never been a happy relationship, I don't think, not least because the health economy was virtually bankrupt and it never makes for a good starting point.

I think things changed quite a bit when she left – when she died and I think the chief executive there, Sue Page, basically had a disproportionate influence on the way in which things operated and relationships I don't think were great at all. There are several things. They always seemed unwilling to address the funding issue. The health economy, of which we had probably a 30%-ish stake in these sense that's the amount of income we got and North Cumbria NHS Trust had the rest, wasn't a viable health economy for trying to run the hospitals that were there, including Carlisle, Furness and Westmorland General and it needed rationalising. It needed rationalising in an intelligent way and I don't think that was the way that it~~s~~ was being addressed, you know, it was just a very haphazard way. A lot of the money that was – there were fairly consistent disputes between the SHA and the PCT in North Cumbria, which ended in arbitration. Arbitration always seemed to mean that we ended up without any money again. So the 7-10 million, which is a constant feature and if you talk to the CCG person, you know, the GP ~~[inaudible]~~ lead I'm sure will tell you exactly the same thing, just became the

1 pawn in that game. So, not good relationships all round.

2 PROF MONTGOMERY: And so do you have a sense of what the profile of

3 maternity in that sort of discussion is?

4 PROF KANE: It was significant, because we were very keen on actually building the

5 maternity services, which would have – and this is prior to the CQC report that

6 criticised the environment as well as the service. Furness General is a very

7 tired hospital. You know, a classic 1960s unit built, you know, the old template

8 type of building. Even just to replace the flat roofs, you know, we spent

9 £1.5 million every year on just stopping water coming in a roof, you know. So it

10 was never really, by the PCT, we felt, treated as something that was a priority,

11 whether it was maternity or other things and not just maternity, because there

12 were lots of other things that needed shifting. And we had a view, which was

13 latterly supported by, I suppose, at the end when PCTs were disappearing and

14 they'd sort of lost control of a few things, of using Furness General in a

15 completely different way. So it would have its maternity unit, it would have

16 other services there, but it would also have some of the features of

17 Westmorland General with primary care being based there. So one of the

18 solutions to it, to bring money in and solve some of the financial problems, was

19 to actually move GPs who were in single practices around Barrow into a new

20 health centre that was physically part of Furness General. So there were lots

21 of things like that being addressed that they always seemed to actually fall at

22 the last hurdle when it came to the PCT.

23 PROF MONTGOMERY: That's helpful. We're quite pressed for time, so shall we

24 look at the SHA and understand what sort of oversight that was exercising?

1 PROF KANE: Well, if you stick with that one issue, the finance, the SHA were just
2 unwilling to address it, any arbitration, and I mean this is a matter of record, so
3 you can – it's there to look at. We, maybe wrongly, but we went along with
4 trying to actually play the corporate line with the SHA and tried to make the
5 health economy work. North Cumbria NHS Trust felt – and I can understand
6 why they felt this, I had lots of discussions with their chairman about it – felt
7 they couldn't do that. The PCT would constantly, every year that I was there,
8 would push things to an arbitration point with the SHA and the SHA would bend
9 over and, you know, the arbitration would always go in favour of – you know,
10 we didn't get – the arbitration would always go in that direction.
11 I think in terms of broad support it sort of just disappeared. I mean,
12 SHAs have disappeared, but the whole time, particularly in the last 18 months,
13 was a time when there were lots of people just worried about whether they had
14 a job or not rather than worrying about exactly what was going on in the
15 services.
16 PROF MONTGOMERY: And the quality interest?
17 PROF KANE: Sorry?
18 PROF MONTGOMERY: Issues around quality. So, you've described the financial
19 bit. Was there parallel oversight around quality or were they just not involved
20 in that?
21 PROF KANE: No. Finance was their main focus. You know, if you went to
22 chairmen's meetings or, you know, ~~the bigwigs,~~ the chairs and non-executives,
23 that [inaudible] not statutory, but targets like waiting times and that sort of
24 things. So that was - [inaudible] on the agenda, but finance was the key one

[inaudible].

PROF MONTGOMERY: And do you think your Trust featured on their worry list about risks –

PROF KANE: Well, not from anything that the chairman ever said to me, no, in meetings that I had with him. In fact, not at all, just the opposite. You know, and we went through the process leading up to foundation trust and whatever was discussed [inaudible] reports or anything else. I mean, going through that process we got nothing but positive feedback from people, whether that was misplaced I don't know, but that was the situation.

PROF MONTGOMERY: And I want to understand a bit about the FT process of how it was operated. Did the SHA go through a dummy run sort of process?

PROF KANE: Yes.

PROF MONTGOMERY: So they commissioned some form of external review or something.

PROF KANE: Yeah. They had a – I can't remember who it was now. I think it was Grant Thornton. Grant Thornton or Pricewaterhouse, because they were both involved at different times and I just can't remember which one actually did the first review, which was a fairly short piece of work. They gave the SHA a report. The SHA agreed that we could proceed. What proceeding meant really was to do some more work and have a mock, if you want, ~~ward~~ board to board with the SHA board, which we had and, at the end, got very positive feedback on that.

We embarked on the FT process. It was stopped because of the – well, it wasn't the CQC, it was the predecessor, the HCA view that – which was

1 really following on from the maternity – the beginning of the maternity issue.
2 We were given a period of time to actually deal with the concerns that they
3 had. We dealt with them. They revisited and there's a controversial,
4 subsequent report that said things were fine, gave us a green light to say,
5 'yeah, fine, you're back into the process'. And, from there, it went relatively
6 quickly.

7 PROF MONTGOMERY: And, from your perspective, it was just the halt around the
8 maternity issues that held up the process –

9 PROF KANE: That's what we were told and that's what they put in writing.

10 PROF MONTGOMERY: Yes, absolutely.

11 PROF KANE: I mean, in the long term and I think where the Trust is now and where
12 the North Cumbria trust is now demonstrates that this is an inaccurate
13 assessment. I don't think either trust are independently viable and that there
14 always was an environment – at least at the back of my mind if not other
15 people's minds – that at some point in time they needed some strategic
16 rationalisation. Whether it would ever be politically supported is another
17 question, but there needed to either be a Lancaster-Preston tie up or a
18 Furness-Cumbria tie up. Something needed to be done and there was one
19 piece of work that started when North Cumbria NHS Trust said they couldn't
20 become a foundation trust, therefore they had to seek a partner. And that
21 seemed, potentially, like an opportunity to rationalise that, but it was
22 rationalising from – the idea of it being an FT was to try and rationalise from a
23 basis of at least some strength, if you want, from some stated position as
24 opposed to being –

1 PROF MONTGOMERY: And tell me a bit about the Monitor ~~[inaudible]~~ interview.

2 PROF KANE: [inaudible] Well, we had two of them, because we had one which, I
3 would say, went averagely and then that's when the stop came after that, but
4 nothing to do with that, it came up – it was just coincidental, as far as I was
5 concerned. And then the second one, which went extremely well.

6 PROF MONTGOMERY: And who did you see from Monitor who you were relating
7 to?

8 PROF KANE: What, you mean – well, I think there were a lot of people, but the two
9 people who did the analysis [inaudible] but their main focus was, as all Monitor
10 processes were then ~~[inaudible]~~financial. That was the focus of Monitor. I
11 have to say, in my experience, it never changed.

12 PROF MONTGOMERY: And did you have to run to Bill Moyes himself?

13 PROF KANE: Yes. Well, I mean, the first round, if you want, was with Bill Moyes
14 and I saw Bill Moyes subsequently and, interestingly, discussed it with him. I
15 went to see him to see why it had stopped, the process, and he produced a
16 letter from the CQC that just said 'we're not clear that we can give this Trust
17 ~~[inaudible]~~ clearance until they've done some further work and we re-inspect
18 them' and his view as well. I'm not sure what the value of this letter was,
19 because it was literally a two-paragraph letter, but we ~~aren't~~ weren't going to
20 get further until that's sorted out. Bill then subsequently left or wasn't
21 reappointed and I can't remember the next person, Chris, I think, Chris Mellor
22 was the interim chair who was the person who we then were involved with.
23 And then, latterly, David then – it was right on that interregnum and change
24 that David Bennett first came and then obviously we were involved with other

1 people, like ~~[inaudible]~~Merav Dover. Sorry, I'll try and keep my answers a bit
2 more concise. Apologies.
3 PROF MONTGOMERY: The CQC, at various stages you get reports, which are fed
4 through, which give you a degree of reassurance.
5 PROF KANE: Yeah.
6 PROF MONTGOMERY: You said that you were surprised and I can understand
7 why, having just seen the public record, why the visit led to the report. What
8 contact did you have with the CQC? What's the step that you took when you
9 were surprised? So did you see them when they came round at all? Did you
10 seem at the end?
11 PROF KANE: Well, there's two lots of it. I had a visit from the guy who was, at the
12 time, the regional manager of the Health Care Commission, who then
13 transferred or did another job. So, if you want, that was the report that Monitor
14 didn't pick up. And we really – I certainly couldn't really get that at all; it didn't
15 seem to be very clear to me. Anyway, he left and the – most of our dealings
16 with the CQC then were with regional people and I have to say there was a
17 huge difference between the view that we got from the regional people, for
18 example, on the last two reports and the actual CQC report, did not chime at
19 all.
20 PROF MONTGOMERY: So –
21 PROF KANE: They were reassuring, saying basically they didn't have any major
22 concerns. There were a couple of – described as 'relatively minor' things.
23 PROF MONTGOMERY: And is that the direct contact you had as chairman or is
24 that the board?

PROF KANE: It was both. It was both, but it was mainly – I mean, some of that was through other people; that was also the director.

PROF MONTGOMERY: And when they came in to visit did you or any of the board members meet them at that stage?

PROF KANE: Well, the executives did, the non-execs and June Greenwell from the clinical quality committee did, yeah.

PROF MONTGOMERY: And the follow up, once you've got this surprising report having expected something a bit different.

PROF KANE: Well, it was then getting very close to the end of me being there, actually, so what we did was we – and we were very, very occupied then with Monitor's response to it, which went from no great concern, you know, [inaudible] 'we're going to have to talk to you about it, but we don't intend to take any Section 52 action', that was absolutely clear. Nothing particularly changed other than the police saying, one Friday afternoon, that they were investigating some further cases round the maternity unit and that completely changed Monitor's – I mean, literally from one Monday to the next Monday. I had a phone call on the Monday from Merav Dover ~~[inaudible]~~ saying, 'We ~~[inaudible]~~ are taking enforcement action'. And a lot of the work that we did afterwards was really around dealing with Monitor. We were going to Monitor it seemed to be every five minutes really, to have meetings, fairly unproductive meetings with them, in that they didn't really seem to have much interest in being supportive. They just had a lot of observations about what was or wasn't being done. So, not particularly helpful and the CQC were very, very evident by their absence from there on in.

1 PROF MONTGOMERY: And did that change the SHA's interest in your at all?

2 PROF KANE: Well, it was subsequent to that or very closely around that time when
3 the Gold Command, which was really that coupled with a couple of other
4 things, not least getting another job, that prompted me to leave, because as far
5 as I was concerned the SHA – and the SHA and Monitor couldn't understand
6 each other's position, I thought. Monitor thought it was a bizarre idea and
7 couldn't understand what the SHA thought they were doing and the SHA
8 couldn't understand Monitor's position, so it was a bit of a stand off there. And
9 effectively just took the running, the decisions about doing anything out of the
10 hands of the board or anybody else really, so there wasn't – as far as we were
11 concerned, it was somebody else who was then – as far as I was concerned,
12 somebody else had taken it on.

13 PROF MONTGOMERY: So you couldn't do the job anymore after that.

14 PROF KANE: No. And also – that was one thing and, on the other hand, Monitor's
15 view relative to me was, 'Well, you need to be an executive chairman'. I can't
16 be an executive chairman. I've not got five days a week to –

17 PROF MONTGOMERY: The last question from me is about whistle-blowing. We've
18 seen policies and other things, but we need to know whether there was any
19 experience of people actually bringing things to you or your non-executive
20 colleagues.

21 PROF KANE: Yes there were, but I don't think anything – nothing on maternity
22 services, although there was on outpatients and there was on, if I remember
23 rightly, one of the other – it was at the point of closing some of the elderly care
24 stuff at Westmorland General, but that was in its transition from a PCT, so it

1 wasn't really that. It was more about somebody, I think, being concerned about
2 the transfer from the PCT.
3 PROF MONTGOMERY: Having had those things raised with you, what was your
4 process for responding to them?
5 PROF KANE: Well, if it was raised to me directly like that, then I would approach an
6 independent – so the outpatient one, the first question was to do with
7 outpatient operations, about what exactly was the issue. Is this an issue? Can
8 you show me the figures, can you show me the data? Is this actually borne out
9 by – is it a fact or is it, you know? And there was an issue with outpatients
10 [inaudible] at Lancaster, basically. And it was a problem and it was dealt with
11 and it was, I think, at the time, was probably the significant issue in quality.
12 PROF MONTGOMERY: And did all the whistle-blowing examples that you can
13 remember come from Lancaster or did you get some from Furness as well?
14 PROF KANE: I can only remember Lancaster, if I'm being honest.
15 PROF MONTGOMERY: I understand. Just say what you remember as opposed to
16 –
17 PROF KANE: Yeah, yeah, the ones I can remember. The main one was the
18 outpatient one.
19 PROF MONTGOMERY: Thank you.
20 DR KIRKUP: Just in passing there's something I wanted to be clear about. Did you
21 understand what Gold Command was supposed to be doing –
22 PROF KANE: No.
23 DR KIRKUP: I thought that's what you said.
24 PROF KANE: Yeah. And I wasn't invited to the party or had anything to do with it at

all. I did actually ~~dive~~ dialled in to one of the Gold Command meetings to find out what the hell – sorry – what they were doing and I got a very garbled explanation of what Gold Command was. I mean, I know what the Gold Command idea is having run high security services. I know the concept of Gold Command, but not ~~[inaudible]~~ the purpose here.

PROF MONTGOMERY: And who was the lead person, from your perspective, on the Gold Command?

PROF KANE: Sorry?

PROF MONTGOMERY: Who was the leading person driving Gold Command, from your perspective?

PROF KANE: From our Trust?

PROF MONTGOMERY: No, from your perspective of who was –

PROF KANE: The ~~[inaudible]~~ SHA.

DR KIRKUP: Stewart.

PROF FORSYTH: Good morning. Can you just go back to what you just said previously about the police phoning up to say there's now going to be a wider investigation?

PROF KANE: Well, they didn't, sorry. They never contacted us at any juncture. It was on the television. At no point were we – the first I saw literally it was on my 60th birthday, I turned on the television and there it was.

PROF FORSYTH: So how did you respond to that?

PROF KANE: Well, we followed it up to find out what it was and I can't say [inaudible], I can't remember. It had the feeling of a press officer being contacted at the end of Friday afternoon and making a statement which then

became very sort of ~~viable~~viral, if you want, with lots of people picking things up and then there were some process of rationalisation by the police over it. That's my impression. To be fair, the police were probably ~~[inaudible]~~on the back foot.

PROF FORSYTH: But as chairman of this Trust you had, on the one hand, been given the green light regarding the maternity services to pursue foundation trust process and then, the next minute, you're having the police coming. So how do you think that happened?

PROF KANE: The police thing was something which was people – Mr Titcombe pursued directly with the police and that follow up was made directly between him and the police. And I can understand his concerns; he had every right to do that. That's how that occurred. The issue of the police looking at more cases, my understanding from the police subsequently, at that time, is that they weren't looking at any other cases.

PROF FORSYTH: They weren't.

PROF KANE: No, they weren't. They subsequently did, but they weren't at the time. And they subsequently, as I understand it ~~[inaudible]~~dropped the new cases.

PROF FORSYTH: Sorry, I missed that.

PROF KANE: They subsequently ~~[inaudible]~~dropped the new cases.

PROF FORSYTH: Clearly, Mr Titcombe was unhappy with the responses he'd had from the Trust, from the executive team and the board, presumably.

PROF KANE: Well, this didn't happen. I mean, the contact with the police went much further than that, as I understand it. I don't know, because I don't know

1 when he contacted the police. Obviously, the police aren't, quite rightly, going
2 to say anything, but it didn't happen then. This is – it ran for a while.
3 PROF FORSYTH: I'm getting to the point of saying do you think that this could have
4 been avoided? Do you think if the organisation had operated differently that
5 further involvement of the police and the involvement of other families and the
6 trauma that that, of course, led to could have been avoided by different actions
7 that the organisation could have taken?
8 PROF KANE: I think some of it could have been avoided by both organisations
9 doing things – well, a lot of organisations doing things differently and not least
10 the police. I wouldn't, in any way – because without a doubt the police, I think,
11 have [inaudible] a lot of the issues and caused a lot of concern. I think
12 [inaudible] why there were concerns and there has never been an – I mean, as
13 I say, this happened not long after I became chairman. There's never an
14 argument [inaudible] at all other than that the Trust did not serve James
15 properly. There has never been an argument for [inaudible]. The issue, the
16 controversial issue and the concern, as I understand it, from Mr Titcombe's
17 point of view, was the issue of the midwives and the missing notes and the
18 potential – you know, them basically working together to cover things up, which
19 I think the coroner reiterated, but I think there's – I think, but I may be wrong,
20 because obviously I'm not privy to it, that subsequently [inaudible] has said that
21 that didn't – there's no evidence that that actually happened. Could that have
22 been resolved more easily? I honestly don't know. I mean, I think,
23 understandably, I think I would be exactly the same as Mr Titcombe [inaudible]
24 lots of concerns. His son was dead and I don't think – I'm sure I would be

1 exactly the same. You know, this is not remotely a [inaudible]. It was a
2 tragedy and I think I would have done exactly what he's done. Could that have
3 been avoided? I honestly don't know. Whether that particular –
4 PROF FORSYTH: Did you see any information where you felt that the response of
5 the staff at the frontline service and the management service could have
6 responded better in this situation to give the answers?
7 PROF KANE: Honestly, you can always do things differently. I think there's no
8 doubt about that. I think, in this particular instance, I think the chief executive
9 and the other people, the medical director [inaudible] my impression was, in
10 the sense [inaudible] for a long period of time. I have the impression that that's
11 what Mr Titcombe thinks as well, but I may be wrong about that. So I think
12 could the whole subsequent controversy have been – I honestly think that if
13 you look at up to that Friday afternoon as a point in time in September of 2011,
14 the issue that was being dealt with was around Joshua's death and
15 Mr Titcombe's continued concerns and not getting a resolution. And I think
16 that being stimulated further by Ian Smith, the coroner's comments where he
17 did, if you look at the ~~[inaudible]~~record actually wrongly conflate two cases and
18 two timelines, unhelpfully. I think that, on the back of that, a reporter from, I
19 think, the *Westmoreland Gazette* or the *Evening Mail* for Barrow, rang up the
20 police saying, 'Are you investigating this?' This was very late on Friday
21 afternoon and they've got a press officer who I'm, to this day, convinced was
22 not aware of the detail, who said, 'Oh yes, we are and we've got lots of people
23 involved in it'. Because that was the thing; they said, 'We've got 35 officers
24 involved'. Well, I do a lot of work with ~~them.~~police and– ~~T~~they don't have

1 35 officers on public protection. So I think all of that created an environment,
2 quite a febrile environment, which I think was very dysfunctional and very
3 problematic and it did push people into defensive corners.
4 PROF FORSYTH: Yes, I suppose there's still an element of that today, several
5 years later. I just wondered, again from a board perspective, what you did to
6 try and support the staff during this time.
7 PROF KANE: I think there was a lot of support given to staff, the midwifery staff.
8 They were given counselling, they were given time off work, they were moved
9 from jobs, you know, at their request. Some people were given the opportunity
10 to work in Lancaster. There was a whole series of things done around
11 ~~[inaudible]~~staff.
12 PROF FORSYTH: And did some paper come to the board describing that and
13 giving feedback from the staff?
14 PROF KANE: At this juncture there was only one – yes, it did, but I was only there
15 at one of the board meetings. (before I left)
16 PROF FORSYTH: Right. So, as far as you' re aware, there was some follow up of
17 this by –
18 PROF KANE: Well, given that there was an initial follow up, I can't imagine that
19 there wasn't a subsequent follow up, but I've never seen those board minutes,
20 so I can't tell you, but I can't imagine there wasn't. I mean, there was initially,
21 so I can't imagine there wasn't – it didn't continue. In fact, I know it continued,
22 because informally I heard it did. And I think, you know, until the resolution –
23 well, very recently, as I understand it, the midwives – what the midwives said
24 has been accepted as being accurate, that they didn't alter records and they

genuinely didn't deliberately lose a piece of paper during the transfer to Newcastle. I think they suffered very badly.

PROF FORSYTH: And again, just too sort of be clear at the time, did the board actually ever express their support for the staff publicly?

PROF KANE: Yes. Well, no, there wasn't a sort of press statement or anything like that, but yes, there was, yes, through the director of nursing and through the medical director and through the chief executive. And I think if you look at the – I think it's the CQC, but I can't remember. It's one of the later CQC ~~[inaudible]~~reports it actually says in there that the staff were being strongly supported and that was the opinion of the staff. ~~[inaudible]~~It is there as a matter of record.

PROF FORSYTH: Okay. Finally, just to go back to an earlier point where you were setting out the issues when you arrived and subsequently and clearly staffing, you said, was challenging. I got the impression that it hadn't been fully addressed, the staffing issues, and therefore was probably a potential disaster waiting to happen.

PROF KANE: I wouldn't say it was a disaster waiting to happen at all, no, but staffing is a major challenge. Getting people, for example, to work in Barrow is very, very difficult. Getting senior clinical staff, in particular, is a very difficult. Getting staff to work across the Bay is difficult. And also, it's a fairly economically poor way of doing things, because if you've got, for the sake of argument, somebody who lives in Lancaster and Lancaster's their base, say it's a surgeon of some description, to do a list at Barrow takes out all day and then they may be on call. So the whole issue of trying to get the logistics right

1 is a problem and it always will be a problem with a three-site hospital – a
2 three-site Trust rather. I don't think, in any way, staffing was a disaster waiting
3 to happen. Staffing was a challenge.
4 PROF FORSYTH: It was fragile, wasn't it?
5 PROF KANE: It was fragile, as it is in many hospitals, but I would say it was no
6 more fragile than any hospital that I've worked in or managed or been around,
7 with the possible exception of some trusts in London [inaudible].
8 PROF FORSYTH: But subsequently there has been an increase in staffing in
9 nursing, I believe, is that right?
10 PROF KANE: I don't know the staffing level. I really genuinely don't know. I mean,
11 we increased the nursing staff whilst we were there, particularly on maternity,
12 after the Birthrate Plus review, so there was a subsequent increase in staff.
13 The only thing I know about the Trust at the moment is that it is now in a worse
14 financial situation than it was when I was there. That's not saying I changed it,
15 but it's effectively bankrupt. now
16 PROF FORSYTH: And just finally, therefore, did you feel, other than that the
17 staffing situation was fragile, the services were safe?
18 PROF KANE: Yes. And we were given reassurance that they were safe
19 ~~[inaudible]~~regularly. The only area where I would say – it's nothing to do with
20 maternity – where I think they were very tight continuously, but then there were
21 different opinions from different people working in it, was around accident and
22 emergency in Lancaster. Again, it's a matter of record. I think there were very
23 different views, though, from the consultants there, the senior consultants
24 there. One of them thought that basically it was very marginal and that they

1 were constantly under pressure. Another felt that that wasn't an issue at all. I
2 suppose the reality is, you know, the serious untoward incidents there didn't
3 materialise, but that did need addressing [inaudible] A&E problem, which
4 subsequently has been, but that was in train when I was still there. So that
5 would be the one I'd say was the most fragile, but others no.
6 PROF FORSYTH: Okay, thank you.
7 DR KIRKUP: Okay. I know we're relatively short of time, but I do want to pick up
8 some further issues, I'm afraid, on the Fielding review, if I can take you back to
9 this one. As you pointed out, there were three versions of the Fielding review.
10 Do you have a view on why there were three different versions of it?
11 PROF KANE: I honestly don't, no. I think the first one probably because there were
12 some factual queries; the usual sort of thing you'd expect when you see the
13 first version of something. The second one was ~~a~~ an edited review, you know,
14 so I think some of those had been ~~[inaudible]~~corrected and some of them
15 hadn't. And the third one, I think, was again a response to people not being
16 entirely, you know, happy that it reflected – perhaps maybe just the language
17 as much as anything – reflected the situation.
18 DR KIRKUP: And who was doing the pushing back on the versions and saying
19 [inaudible]? Who was leading that?
20 PROF KANE: I think it was a mixture. It was a discussion. Mostly it would be the
21 chief executive and director of nursing, but mainly that – but I don't think there
22 were major – it wasn't sort of like a massive controversy or issue over it. It was
23 about, I think, getting the feeling that it reflected the views – well, it reflected
24 both the facts and the views of the people involved in a reasonable fashion and

1 obviously it still had some critical comments in it, so it wasn't a great surprise
2 that it didn't create something that didn't have any critical comments in it at all.
3 DR KIRKUP: Yeah, okay. The terms of reference specifically excluded your
4 colleagues from looking at the cases. The terms of reference of the review
5 specifically excluded them from looking at the cluster of cases. Was there a
6 particular reason for that? Was that discussed with you and the board?
7 PROF KANE: I honestly can't remember. I'm not being evasive; I honestly can't
8 remember whether it was or not. My guess – and it is a guess – would be that
9 because particularly Joshua Titcombe's case was still under discussion with –
10 despite having been a [inaudible]. But I honestly couldn't say if I'm right. I
11 certainly didn't make any decisions to exclude those cases from them. That's
12 the only reason I could imagine, but I can't just remember.
13 DR KIRKUP: I'm not surprised and I'm not suggesting that you would have led that
14 process, but I want your perspective on how it was handled and how that came
15 to pass.
16 PROF KANE: I think because of – mainly because of the controversy and the whole
17 thing around Joshua's case, I think people were very reticent about looking at
18 things or having that review, because the ~~[inaudible]~~review looking at maternity
19 services overall rather than specific cases.
20 DR KIRKUP: Indeed, but as you said, by that stage it was apparent that there had
21 been a cluster; it wasn't just one case.
22 PROF KANE: I'm not trying to justify it. I'm just saying that's my perspective on it,
23 but I'm not saying it's the right one.
24 DR KIRKUP: Okay. Was any consideration given to inviting Fielding and

1 colleagues to come back and do an after review, to see whether their
2 recommendations had been implemented satisfactorily?
3 PROF KANE: No, not that I can remember.
4 DR KIRKUP: Would that be usual practice, in your view, or not?
5 PROF KANE: I think, as I was saying to your colleague earlier on, I have been
6 involved in reviews where that has happened and in others where it hasn't
7 happened.
8 DR KIRKUP: Yeah, okay. What was the lead given by the board to implementing
9 the Fielding report? How was that transmitted to the Trust? Did you take steps
10 to say, 'Look, this is a priority. We've got to get this right'?
11 PROF KANE: Yeah. I mean, all the things around – I've mentioned several times,
12 all the things around Birthrate Plus, around staffing, around physical changes
13 to the building, around getting the teams working more closely together. All of
14 those were –
15 DR KIRKUP: I understand that, but how was the message transmitted by the
16 board?
17 PROF KANE: Well, basically through the directors actually getting on, fulfilling the
18 action plan and – bear in mind all the board minutes were publicly available.
19 So the usual method that you would use, which is by getting the executive
20 directors to get on with delivering the action plan, transmitting what needed to
21 be done to whoever needed to do it, whether it was nurses, clinical staff,
22 midwifery staff, in the normal process. There wasn't any sort of specific
23 special, you know, separate process for this report any more than there would
24 be for any other one. But I'm maybe not answering your question.

1 DR KIRKUP: No, no, you are, but I need to get your view on those fair amounts of
2 documentary evidence that people in the unit were pretty unaware of the
3 Fielding report. Lots of them hadn't seen it, hadn't read it, didn't understand it
4 was a priority. They were subsequently told that it was an optional extra, they
5 could decide whether they wanted to implement the recommendations or not.
6 PROF KANE: I find that very, very hard to believe. Very, very, hard to believe.
7 There was a clear steer from the board and from the chief executive and the
8 director of nursing and the medical director. I don't think there's any doubt. I
9 would be very, very cynical about somebody saying that they weren't aware of
10 the Fielding report and what it contained.
11 DR KIRKUP: And being told by a board member that the recommendations were
12 optional.
13 PROF KANE: I would absolutely be shocked if that happened. And, if it did, I would
14 be very shocked and very surprised and extremely disappointed, but I can't
15 imagine for one minute that that's the case. But if you're telling me that, I'd be
16 interested to know about it, but as I say, I cannot for one minute imagine that
17 that would be said by anybody, but if it was, I'd be very – well, as I say, I'd be
18 shocked.
19 DR KIRKUP: Okay. Any follow ups?
20 DR WALTERS: Thinking about my own experience at board level and sometimes
21 the really conflicting situations that boards are in, do you think there was a
22 temptation to think this is about handling one difficult complaint or was there a
23 feeling of 'have we really got a problem in our maternity unit'?
24 PROF KANE: I think initially it focused on one complaint and, I think, latterly it

1 focused on there's an issue here for us to resolve. So I think there was a
2 change over a period of time, because initially that's basically how it was
3 presented and presented, not [inaudible].
4 DR WALTERS: Yeah. Because I suppose it was sort of in all the partners' interest
5 – you, the SHA, the PCT – to read these external reports and probably be
6 assured, reassured rather than absolutely saying –
7 PROF KANE: Well, I know what you're saying. I don't think that's true. I think what
8 you've got is – and if you take even the last two [inaudible]. If you look at the
9 letter, which is one of the few documents I still have to hand, it starts off by
10 being reassuring and then says 'we have got these concerns', some of which
11 are moderate and some of which are things about physical 'move that door
12 from there to there' and the key ones are about emergency equipment. But it
13 starts off by saying – I mean, [inaudible] it starts off by saying – reassuring of
14 the safety of the services. So, as a board, if you get that, it's – on what basis
15 would you say, 'Well, we need to deal with these issues' and very clearly there
16 are issues that we have to deal with and we've got an enforcement notice that
17 needs to be dealt with. Those things need to be changed, they do need to be
18 addressed, there is a problem, there is an issue that needs to be taken care of
19 there. But are the services safe? Yes. And not only that, just before this
20 report we commissioned a very ~~[inaudible] commissioned~~ senior consultant ~~an~~
21 obstetrician from Central Manchester to –
22 DR WALTERS: Was that Charles ~~Pym~~Flynn [?]
23 PROF KANE: No, no ~~[inaudible]~~ Prof of Obs & Gynae.
24 DR KIRKUP: It's the Central Manchester review.

1 PROF KANE: No, it wasn't. No, it wasn't the Central Manchester – sorry, it's quite
2 important to be clear – because the Central Manchester review, ironically – and
3 this is coincidental – the Central Manchester review was one thing. There was
4 a review where we asked somebody, I said to the chief exec, 'We want
5 somebody to look at the maternity services now, tonight' sort of thing and we
6 commissioned their Prof of obstetrics, I think he was, I could get his name, I
7 just can't remember, to do it. And he wrote a letter saying, 'I've looked at the
8 service, reviewed the services. As far as I'm concerned, they're safe'. So that
9 was my concern at that point and this is when the Friday night ~~[inaudible]~~ when
10 the publicity was around the services are safe, so that's not an issue. There
11 are things that I think need to be looked at more closely and that's what
12 subsequently ~~[inaudible]~~happened. But that letter is extant. I don't know
13 where you'd find it, but it's there. I could find his name, but just off the top of
14 my head I can't recall it. [inaudible].
15 DR WALTERS: So you're saying really that the board would have to absolutely try
16 and disprove all the reassurances that you got in order for it to be worried
17 about the safety of the service.
18 PROF KANE: Yes, I think that's basically that. Right throughout the process, when
19 an issue was raised it was reviewed. Either reassurance was given or actions
20 were prompted, actions were taken, reassurance was given. Now, whether
21 that reassurance should have been given and there is all the controversy
22 around the CQC stuff, you know, but basically it's – I had a conversation with
23 Monitor when they were saying, 'What we're concerned about is you take too
24 much reassurance from internal and external sources' and you sort of think

1 well who else can you take – if internally it says it's okay and externally it says
2 it's okay, you know, in this instance I'm not – if I happened to have been
3 running a mental health trust as a chairman, I might have had a different view
4 on some things, or if I'd have been an obstetrician chairing the Trust, I might
5 have done, but I'm not.

6 DR KIRKUP: Do you think there's a sense where there's a different way of
7 interpreting what you're being told in those kind of reports depending what
8 you're looking for? I mean, you know as well as I do that anybody writing a
9 report will say 'there's lots of good things here but...' and if you're looking at it
10 saying, 'I want to be reassured that everything's safe' you'll take the 'there's
11 lots of good things' as 'we're alright'. But if you say, 'Actually, these "buts" are
12 really pretty big and pretty significant", you come to a different view.

13 PROF KANE: Yeah, I think that's true, but – but – I would say that where the 'buts'
14 were there they were being addressed, there was a programme in place to
15 address them. So yes, the 'buts' were there and short of actually – which is
16 sort of where I had the thought when we got the person from Manchester to
17 come and have a look and the idea of the tie up with the Women's Hospital, to
18 get that external view on it, I think we wanted to be reassured that the 'buts'
19 were actually really being addressed. If somebody comes and says, 'Yes, we
20 think they are', I mean, it sounds like an excuse, it's not. There's only a certain
21 distance you can travel if you're not an expert in a particular field. Because the
22 next thing is then somebody else comes along and says, 'Oh yes, it really is
23 fine' and then you say, 'Well, actually, I don't believe you'. So at what point do
24 you actually accept somebody's opinions? But I do take your point. I think that

1 is always a possibility.

2 DR KIRKUP: Okay. Are you all done? Is there anything else you'd like to say to

3 us?

4 PROF KANE: No, I don't think so. I just hope this investigation actually manages to

5 resolve some of the issues raised. It has been very difficult for the families, it's

6 been difficult for everybody involved and if there was any way it could have

7 been avoided [inaudible]. I just hope it is resolved for everybody and that

8 where there are lessons that need to be learned then we learn them and if we

9 need to accept responsibility for things that should have been done that

10 weren't done, then I will accept that.

11 DR KIRKUP: Thank you. I'm sorry that we had a late start and that you were –

12 PROF KANE: No, thank you very much for inviting me.

13 [Interview concluded]

14

THE MORECAMBE BAY INVESTIGATION

Wednesday, 22 October 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes - Expert adviser on Clinical Governance
Professor Stewart Forsyth - Expert adviser on Paediatrics
Professor Jonathan Montgomery - Expert Adviser on Midwifery

PROFESSOR BRUCE KEOGH

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1 (At 3.00 p.m.)
2 PROF MONTGOMERY: So if at either end we get deafened, then that'd be great.
3 So what we've agreed with Bruce, is that I will do the main stuff at this end
4 because that will be a lot easier than Bill trying to do it. Is Bill there? So up
5 in Preston, who do we have?
6 DR KIRKUP: Yes, I'm here, Bill.
7 PROF KEOGH: Hello, Bill, it's Bruce.
8 DR KIRKUP: Hello Bruce, how are you?
9 PROF KEOGH: I'm well, thanks and you?
10 DR KIRKUP: Yes, good, thank you. I'll carry on moving around the table.
11 MR BROOKES: Hi Bruce, it's Julian Brookes here. I'm currently Deputy Chief
12 Operating Officer for Public Health England, was previously the Head of
13 Clinical Quality at the Department of Health.
14 PROF KEOGH: Hi Julian.
15 PROF FORSYTH: Hi, Stewart Forsyth. Paediatrician and Medical Director from
16 Dundee.
17 PROF KEOGH: Hello Jo, Stewart, sorry. I'm sorry got hearing problems as well as
18 dementia!
19 PROF FORSYTH: It's worth 50 quid though!
20 PROF MONTGOMERY: So I'm Jonathan Montgomery and I'm here as Adviser to
21 the Panel. I'm Professor of Healthcare law at University College, London.
22 I'm also Chair of the Health Research Authority and, for the record, should
23 declare that I was previously Chair of the Advisory Committee up in Preston
24 Board on which Bruce Keogh sat an ex – member and have also in my work
25 at the Health Research Authority I have been with Bruce in his role at NHS
26 England. That's for the record because we keep a record of this as families
27 are able to hear the recording that we take and that should be the only record
28 of this process until the end of the proceedings when clearly all our records
29 will make their way into the public domain. So we've ask everybody if they
30 will not bring mobile phones, tablets and anything else into the room. I
31 should say mine is in the room but well away and I hope that will be
32 sufficient. Are there any other conflicts of interest that need to be recorded
33 before I ask Bruce to introduce himself?

1 DR KIRKUP: Yes, I need to declare that I've worked closely with Bruce in the past as a colleague.

3 PROF MONTGOMERY: Thank you. Bruce, do you want to introduce yourself and your role?

5 PROF KEOGH: My name is Bruce Keogh. I'm a cardiac surgeon by background also previously a Professor at UCL. Since the end of 2007, NHS Medical Director, that was covering, if you like, the whole of the NHS and then since 2013, Medical Director for NHS England but still National Medical Director.

9 PROF MONTGOMERY: Thank you very much. So Bruce, what I think will be most helpful is to start with the system that flags up Trusts or other providers that may be of concern up to you and your Medical Director roles and how that developed over the – I have termed the reference from January 2004 up to June 2013. We thought it would be interesting to know what you inherited in 2007 and how that has developed and we will come back to what happened to Morecambe Bay as we go through.

16 PROF KEOGH: So the first thing I would like to say is that we've started to prepare a witness statement for you which will describe that and describe what my role was in policy and what have you and we will get that within a week.

19 PROF MONTGOMERY: Thank you.

20 PROF KEOGH: So it will be based to a large extent on the same evidence that I gave to the Mid Staffordshire inquiry. That I think is a important matter for the record. When I came into the Department of Health on the 12th November 2007, there had never been a Medical Director in the NHS before and there were two things effectively happening, I think. The first was that Liam Donaldson was the Chief Medical Officer, and Bill, I think you were Associate CMO at the time?

27 DR KIRKUP: That's right.

28 PROF KEOGH: Liam had previously had a massive portfolio. His big interest, I think, was in public health and safety so I think he was quite pleased to be relieved, if you like, of the NHS part of his portfolio which fell into my lap. The second thing that was going on was that Ara Darzi had recently been appointed Under-Secretary of State in the Lords and his role was to undertake a review of the NHS with the aim of reporting on its 60th birthday in 2008. So there was– Just prior to my appointment, David Nicholson had

1 come in as Chief Executive and the Department of Health was divided into
2 two bits at that point, there was if you like the regular Department of State
3 and then there was this new NHS component. Within the NHS component,
4 David was keen to create a sort of replica of what he was used to in the form
5 of a Trust Board, if you like. So he had a Director of Finance operations in
6 the form of David Flawley. He had a Chief Nursing Officer, in the form of
7 Christine Beasley and I am sure we will come back Christine later; myself, as
8 Medical Director; a Director of HR, who was Claire Chapman and others, but
9 not many others. My role in the Department of Health was largely related to
10 policy, if you like, and that was defined, to a large extent, by the work that
11 was beginning to emerge from Ara Darzi's review. In particular, the aim was
12 that I would try and bring to that team a sort of clinical compass. My role was
13 not, despite the title Medical Director, it was not the role of Medical Director
14 that you would expect in a Trust or an SHA or a PCT. I didn't have an
15 operational role.

16 What I was responsible for when I first arrived, and this will be from
17 memory now, but it will be documented in the written papers, written
18 evidence that I give you. I was responsible for clinical quality and strategy. I
19 was responsible for the major clinical programmes of work that were going
20 on. In particular to give you an example, the national service frameworks
21 around cancer, heart disease, renal disease and so forth and also for a
22 movement in the Department of Health called Medicines Pharmacy and
23 Industry which was responsible for all matters pharmaceutical ranging from
24 the negotiation of the pharmaceutical pricing review scheme with the
25 pharmaceutical industry through to the pricing of prescriptions and
26 tribulations with industry. I kind of shared that responsibility initially with the
27 Permanent Secretary, Sir Hugh Taylor.

28 When Ara Darzi's review reported there were, I think, there were a
29 number of recommendations, but of the order of 90 or so. My job was to
30 ensure the implementation of just over a third of those, I think. It was during
31 that time that Bill Kirkup and I worked together and that led me very much
32 into the policy arena. Because of the structures, I was not involved in
33 matters operational in the NHS. So if there were problems with a particular
34 Trust they would come up through the PCT or the SHA into the Finance and

1 Operations Director and be dealt with directly by David Flawley and his team
2 and that included clinical problems as well as financial. The Mid
3 Staffordshire inquiry looked into this in some way and I guess is that a flaw.
4 You could argue it either way so at one level you could say well, let the
5 Medical Director know but actually letting the Medical Director know would be
6 to discharge or to share some level of responsibility but it probably wouldn't
7 have resulted in the action being any different because the action had to be
8 dealt with through the Medical Director or Nursing Director limbs of the SHA
9 and the PCT and the Trusts anyway. So I don't think that was a big issue.
10 With respect to maternity, if I can just focus on that for a second. There
11 were some areas interestingly of clinical activity in the Department of Health
12 which did not come under my jurisdiction. The most obvious one was urgent
13 and emergency care. The second one was mental health and the third one
14 was maternity. Now I don't know the absolute details of maternity but it
15 seemed that maternity policy, strategy and all of that sat under David Behan,
16 who was Director of Social Services, I may have got his title wrong, Director
17 of Social Care within the department at the time and it was shared with
18 Christine Beasley as the Chief Nursing Officer. So even the national Clinical
19 Director for maternity, along with mental health, did not sit as a Medical
20 Directorate and had no direct reporting line to me. I'll probably stop there.
21 PROF MONTGOMERY: So that indicates the early state. Can you tell us a little bit
22 about the National Patient Safety Agency and how that collected data relating
23 to your work?
24 PROF KEOGH: In the Department of Health you have arrangements called
25 sponsorship arrangements. So within, for every arms-length body, or non-
26 departmental public body, such as NICE, such as the National Patient Safety
27 Agency (NPSA) or the Healthcare Commission, they have sponsors in the
28 Department of Health whose job it was to ensure that they kind of oversee
29 their work programme at a light touch level and to oversee their financial
30 performance. I was responsible for the oversight of NICE, the National
31 Patient Safety Agency and the Healthcare Commission. An issue which I am
32 sure will come up in discussion is that the Healthcare Commission changed
33 to the Care Quality Commission and at that point I lost the sponsorship of it
34 for the Healthcare Regulator, if you like, and we can discuss that at some

1 length. I retained responsibility of NICE and the NPSA until the NPSA was
2 abolished and until I moved over to NHS England.
3 PROF MONTGOMERY: So the reporting line on safety concerns runs from Trust to
4 the SHA, with the PCT involved as commissioners, then up to a different part
5 of the department. Were there any occasions when your clinical advice was
6 sought as they were handling those? It may not be in all the cases, but in the
7 cases that we would be relevant to our terms of reference where your clinical
8 advice was....
9 PROF KEOGH: ...no, not really. Sometimes there would be a corridor conversation.
10 There were only two times that I ever intervened operationally when I was
11 Medical Director. The first was when I had a phone call from a person who
12 was leading a rapid response team into a hospital who rang me, he was not
13 meant to talk to me because the contract between the rapid response team
14 at the Royal College of Surgeons and that hospital was in a contract between
15 the two of them. But he rang me out of fear one night and he said, "Bruce,
16 they're killing people, you've got to do something" and that was Mid
17 Staffordshire. I intervened in that and that's a matter of public record. The
18 only other time was a very similar conversation at the Children's heart
19 surgery in Leeds when I intervened on Maundy Thursday about 18 months
20 ago. So there have been no other incidences.
21 PROF MONTGOMERY: Tell us about the 14 Care Trusts, as they're known. I'm
22 trying to get the sequence right because you clearly do become involved in
23 quality care concerned blame of individual organisations as the story
24 unfolds?
25 PROF KEOGH: There's a bit that we need to focus on, which will become absolutely
26 germane to your investigation, when I had responsibility for signing off every
27 single Foundation Trust application.
28 PROF MONTGOMERY: So what are the dates for the signing off of the FT's? When
29 did you take on that responsibility? The key date for us is, it's over 2010.
30 PROF KEOGH: It was August 2009.
31 PROF MONTGOMERY: Okay, hang on, I've got it here.
32 PROF KEOGH: Do you want me to talk you through that before we go onto the 14
33 Trusts?

1 PROF MONTGOMERY: Let's do it in sequence, so let's start– So in 2007 you come
2 in. Quality issues are not up to you.
3 PROF KEOGH: No.
4 PROF MONTGOMERY: In August 2009, there is a responsibility that you gained as
5 part of the FT application process, for the professional, for the medical look at
6 the FT application. How would that work in general and then can you take
7 that through?
8 PROF KEOGH: Sorry, it was August 2010, my apologies.
9 PROF MONTGOMERY: Okay. So in that case – The Morecambe Bay story, the
10 application got paused but you came back in before it gets–
11 PROF KEOGH: So the Secretary of State approves the Morecambe Bay application
12 on the 5th February 2009. In that it's recognised that there were problems
13 with MRSA and A&E. Sorry?
14 PROF MONTGOMERY: But not maternity?
15 PROF KEOGH: Not maternity. I have a record here of the submission that went up
16 to the Secretary of State on that. I wasn't quite copied into any of the stuff. I
17 won't focus on Morecambe Bay just yet, but during this time Mid Staffordshire
18 begins to emerge and Alan Johnson was the Secretary of State at that time
19 and Alan Johnson said to me, he said, and this will be detailed in the written
20 statement that I gave you. Broadly speaking he said, 'Look, we've got a bit of
21 a problem here where the focus on Foundation Trust applications seems to
22 be on money and performance and actually we need some focus on quality.'
23 So he asked me personally to sign off every application for Foundation Trust
24 status before he would then authorise for it to go to the monitor. I was quite
25 anxious about that actually because that's a not insignificant responsibility,
26 but I was lucky. I had 10 pretty good SHA Medical Directors and so what I
27 thought was, we met on, I think it was a monthly basis, and what we decided
28 to do was to ask the Foundation Trust Team in the Department of Health to
29 prepare papers for us which we would then take to the meeting and have a
30 look at and the process evolved.
31 PROF MONTGOMERY: So all 10? All the applications, so they'd see their own and
32 they'd see other people's?
33 PROF KEOGH: Yes. So it started with all 10 SHA Medical Directors seeing stuff.
34 Then we thought we needed also to get nurses involved and secondly, with

1 the passage of time, the sort of indicators we looked at grew. We got to a
2 place towards the end of this where we had a good set of indicators which
3 were prepared for us by the Quality Observatory in the East Midlands. We
4 also expected a report to come to us from the Medical Director and the
5 Nursing Director of the SHA who were expected to have followed the
6 evidence that the indicators were showing and actually had visited and
7 interviewed and really gone over the Trust in some detail and then bring it
8 back to us. The bit that I want to say to you is that there is not a hope in hell
9 that Morecambe Bay would have passed that process and let me just explain
10 why. It would, even during this time, after the application had been delayed,
11 it had come back to us 2010, what we would have seen was a continually
12 rise in HSMR.
13 PROF MONTGOMERY: In 2010?
14 PROF KEOGH: Yes.
15 PROF MONTGOMERY: Because it was approved in October 2010.
16 PROF KEOGH: By the time we get to 2011, you would have seen an outrageously
17 high HSMR.
18 PROF MONTGOMERY: Okay.
19 PROF KEOGH: I'm happy to share that paper with you.
20 PROF MONTGOMERY: I think that would be helpful.
21 PROF KEOGH: I think this is really important and I think the second thing is the
22 MRSA rate was elevated. The third thing is that there was 12 serious
23 untoward incidents. The fourth thing is that the Public and Health Service
24 Ombudsman had issues with complaints handling. The fourth (sic) thing is
25 that there was a clinical leadership structure which was detached from the
26 operational structure within the Trust. The final thing is that there was clear
27 evidence, and we found this, I found this, last Friday from speaking to people
28 at the Trust that there was a significant focus on finance at the expense of
29 employment equality. There are more indicators there that would have failed
30 than we had for failing Mid Staffordshire.
31 PROF MONTGOMERY: So those would be indicators that were available at the
32 time?
33 PROF KEOGH: Yeah. I think to be fair, I think to be fair, there was still a debate
34 about what the HSMR meant at that time. That debate reached its peak, I

1 think, around about November 2009. I think it was the 26th November 2009
2 when Dr Foster published that stuff and that's what led to us providing the
3 Standardised Hospital Mortality Indicator. Again I will give you all of this.
4 PROF MONTGOMERY: But that means that at the SHA level all the information that
5 you've just described was available within the system and the SHA
6 [inaudible] with their FT, even before you pulled together the Medical
7 Directors. This is information that I would have expected would have been
8 available to key decision makers I can understand it wouldn't have reached
9 you until you were pulled in about it. Is that a reasonable expectation?
10 PROF KEOGH: I think that is a reasonable assumption but I think you have to see it
11 within the contact of the day about the HSMR. All I'm saying to you, and I
12 need to be absolutely clear and unambiguous about this, is that this would
13 not have got through if it had been delayed and had come back through the
14 circuit, it would never have become a Foundation Trust, for the reasons that
15 I've eluded to. I think you, in your inquiry, are sitting on something which is
16 equally as serious that has been addressed by other public inquiries.
17 PROF MONTGOMERY: The way that we've asked this question of other people that
18 we've talked to. There is a clear understanding is that the bar had been
19 raised since the early stages of FT, there's a clear understanding that the
20 processes for applications have become more robust, more information is
21 available. We are trying to tease out whether or not this Trust shouldn't have
22 met the bar in 2010, because it was already clear that it hadn't and therefore
23 the system at the time failed on its own terms, or whether it did meet the bar
24 but the bar was too low and that the new level of bar and the new system....
25 PROF KEOGH: ....so what you're asking is when the SHA Medical Directors and I
26 got involved, did we raise the bar?
27 PROF MONTGOMERY: There is also issues about monitors raising the bar and all
28 sorts of things. I think we are trying to understand did that scrutiny process
29 make it more difficult– Did a Trust that would have passed cease to get there
30 or was it just about better scrutiny?
31 PROF KEOGH: I think in fairness. So I was quite clear that I wanted to– First of all I
32 wanted the bar to be standardised and that was quite difficult. The second
33 thing is I wanted it to be at a level that I was comfortable with. So I think
34 when we first started the SHA Medical Directors business, the bar was a bit

1 higher. I think by the time we finished it was quite a lot higher and I think it
2 was quite a lot higher also at a time that there was considerable pressure, as
3 you know, to convert Trusts to Foundation.
4 PROF MONTGOMERY: One of the things that struck me when I was looking
5 through the papers is, for example, the submission that went up to the
6 Secretary of State said, "[inaudible] MRSA but the North West Community
7 Health Authority have assured us of their action plan."
8 PROF KEOGH: Well when that came to me as Medical Director, that didn't get any
9 further than my desk on the basis that I'm not interested in an action plan
10 because it could be the wrong action plan and action plans gather dust and
11 they don't always bear fruit. So we would delay things until the action plan
12 had demonstrably worked.
13 PROF MONTGOMERY: Did you ask for assurance of that from the SHA Medical
14 Director....
15 PROF KEOGH: ....we would just put a stop to the application and say, 'Come back
16 when the data shows that your MRSA is down.'
17 PROF MONTGOMERY: Okay.
18 PROF KEOGH: Now the question I think you're trying to tease out, if I'm right,
19 Jonathan, is if we were to wind back had I elevated the bar beyond what was
20 reasonable? I can't answer that.
21 PROF MONTGOMERY: No, I don't think I was trying to get to that. I think we now
22 know, both from a number of people, how much more rigorous the scrutiny
23 processes are for FT applications, particularly following on from Mid Staffs.
24 What we are trying to get a feel for though is whether it's only because the
25 scrutiny process has become more rigorous that people think that
26 Morecambe Bay would not have passed or whether actually they had already
27 failed. We know that the FHA can monitor, hold Boards to Boards with
28 Trusts as they go through. We have a sense of the balance between
29 enquiries into financial stability plans but we know in relation to Morecambe
30 Bay that there was an awareness of the maternity deaths and this is the first
31 five of the twelve because there were questions raised about it. So we are
32 trying to get our heads around, did we think on the ground at the time that
33 that should have been [inaudible] and it should have been stopped but it was

1 somehow overlooked or was it only as you pulled together those four
2 different things that you can see a complete picture?
3 PROF KEOGH: I think I purposely probably recalibrated things when I had to sign
4 them off so I think that's the fairest thing to say. So frankly, I don't know.
5 PROF MONTGOMERY: Okay. On the chronology we were going to get to the 14
6 Trusts, of which Morecambe Bay was not one, if I remember rightly. So how
7 were they selected and why do you think Morecambe Bay didn't make it?
8 PROF KEOGH: So I was asked by the Prime Minister to look at hospitals with the
9 highest mortality and the background to that is Mid Staffordshire. I think the
10 argument went something like this, Mid Staffordshire had been identified
11 because it had flagged high in the HSMR's. Nobody had taken much notice,
12 people had argued over the data and in the meantime bad things were going
13 on. There were several sorts of bad things that were going on, one of which
14 was that there was such poor care in terms of all the things that were
15 documented by Cure the NHS and Robert Francis. So what people need to
16 be clear on is that a high mortality rate also means that people are being left
17 without food, water, lying in their own excrement, all of that sort of thing. In
18 some people's minds that association had become quite fixed. So I was
19 asked just to go off and look at the hospitals with the highest mortality and I
20 thought, 'How do I do that in a way that is easily understandable?' So I
21 thought well why don't we just take hospitals that have had [inaudible] for two
22 years in a row on the HSMR. I made, what I'm about to say now, the
23 numbers might be wrong, but you'll get the gist, and I think that came up with
24 five hospitals. I thought that's--
25 PROF MONTGOMERY: Is this a sort of [inaudible] exercise or something where you
26 are trying to look at size or was it just the HSMR?
27 PROF KEOGH: It's just the HSMR.
28 PROF MONTGOMERY: Okay.
29 PROF KEOGH: I thought five isn't really enough so I thought we should look at the
30 SHMI, which is a similar indicator with a different construct, and we can go
31 into the details of the construct if it's of interest but again that will be in the
32 written stuff, and that created 14 Trusts. Now it may not be 5 and 9 but I
33 think it was. That seemed like a manageable number, a reasonable sample
34 size and it seemed it would help to get to the problem. At the same time,

1 there was quite a lot of speculation in the newspapers being driven mainly by
2 Brian Jarman that when you had excess deaths they were needless and they
3 were avoidable, a concept that I don't buy into on the basis that a lot of
4 people go to hospital with terminal illness and we can also discuss that. So
5 then I thought how are we going to look at these hospitals?
6 I should declare I've been on the Board of both the Healthcare
7 Commission and the Board of Commission of Health Improvement. I have
8 looked at both those inspection mechanisms and I've also been on the
9 specialist advisory Committee for Higher Surgical Training for speciality
10 which ran inspections and I've been on a inspection team for Senior House
11 Officers for the Royal College of Surgeons some years ago. What struck me
12 was there were good things that came out of all of those but none of them
13 had pulled them all together. So we were keen to make sure that these were
14 most the evidence based inspections that had ever happened, that was the
15 first thing and I'll come back to that. The second thing was that it was quite
16 clear in the early days of the CQC that they were sending the wrong sorts of
17 people in to inspection hospitals. So they were sending in social workers to
18 inspect hospitals. Now you can't expect a social worker to understand the
19 mechanics, the emotion, the dynamics of a hospital. That, in part, relates to
20 the transition from the Healthcare Commission into the Care Quality
21 Commission, again something that we can discuss, but there were some
22 complexities there.
23 PROF MONTGOMERY: We've seen various people from the Care Quality
24 Commission take us through the various phases.
25 PROF KEOGH: Yes, so you had had the wrong people and the consequence of that
26 was that some of the inspections produced ludicrous kind of commentary.
27 So having said we wanted them to be evidence based we then needed a set
28 of inspections to be conducted by people who knew what was going on.
29 Then finally I had certainly learned from the Commission of Health
30 Improvement days that if you tell people when there is an inspection, leave is
31 cancelled, walls are painted and you have created some kind of artificial
32 environment, so we needed unannounced inspections.
33 In terms of getting the data together, we put together I think the most
34 comprehensive data packs some of these hospitals in the NHS had ever

1 seen. So we took all the kind of usual head data. We brought in data from
2 junior hospital doctors surveys, from the General Medical Council, from
3 Health Education England. We included patient surveys, stuff from the
4 Picker Institute, stuff from the NHS LA, stuff from the Public and Health
5 Service Ombudsman, Parliamentary Health Service Ombudsman.

6 PROF MONTGOMERY: How much of that data was only available to your teams
7 because of this exercise and how much of it would have been available to a
8 Trust if they realised that they should look at it?

9 PROF KEOGH: I think per Trust it was available, all of them could have got it, could
10 have compiled it if they wanted to. What they would never have had was the
11 national benchmark. So I think that's what we offered and so we did that. In
12 terms of sending people that would do the visit, it was clear to us that we
13 needed senior clinicians, senior managers. I think the thing that we really did
14 differently was we also pulled in junior doctors and junior nurses. We also
15 advertised for members of the public who wanted to go, and patients, and
16 there's a difference. The other thing that we did that was different was we
17 advertised in newspapers and we ran sort of Town Hall focus groups so that
18 communities could tell us what they thought about their hospitals. Then we
19 visited the hospitals and a report was drawn up. Actually no, we visited the
20 hospitals once telling them when we were coming and then I think we did
21 either one or two, depending, that were unannounced visits. Very
22 enlightening because staffing levels in some hospitals changed dramatically
23 with the unannounced visits which were often done at night. Then a report
24 was put together for the Trust, they were given an opportunity to kind of
25 address issues of fact. Then we had a risk summit and I'll come back to what
26 all of that means because that was some new architecture we'd put in place
27 in the Department of Health.

28 PROF MONTGOMERY: That would be helpful because the language of that risk
29 summit did run through from quite early on and it's never quite clear what
30 they are. I'm not sure that we need too much detail on the process of the 14.

31 PROF KEOGH: Okay.

32 PROF MONTGOMERY: Morecambe Bay wasn't part of them. It would be helpful to
33 understand, I think, following on from that some of that learning that was
34 gone into.

1 PROF KEOGH: Well the point was what we defined was a new way of visiting which
2 is what the CQC do now.
3 PROF MONTGOMERY: I'd be interested to know what your view is about the
4 learning for the individual Trusts on their governance structures. One of the
5 things with Morecambe Bay is that clinical governance was not well
6 developed.
7 PROF KEOGH: Well I think that when we look at what we've learned from those 14
8 Trusts– I've been a consultant in three different hospitals, Hammersmith
9 Hospital, University Hospital Birmingham and UCLH, although I was both
10 sort of Head of Clinical Service and professor there. When I sat down with
11 consultants related to these hospitals, I might as well have been on a
12 different planet to any of the consultant groups that I'd encountered before
13 and that bothered me because they were good people but they were – what
14 became clear was these hospitals were not just, they weren't always
15 geographically isolated but they were always academically and professionally
16 isolated. That was the first thing. The second thing was, and this I think is
17 really important, all of these Trusts knew they had a problem, they didn't
18 need another visit to tell them they had a problem. What they needed was a
19 focused diagnostic, which we tried to provide, and then they needed help. I
20 think that's where we could have done better.
21 PROF MONTGOMERY: Can I skip some of the questions that I had and move onto
22 some of Stewart's questions because Stewart identified a number of
23 questions about help and what might be available because clearly Thirsk
24 General Hospital is geographically very isolated, there are some major issues
25 around staffing that they had, particularly getting medical staff in there. So
26 we've got a general picture of people suggesting to us that there is a whole
27 set of issues about geography, demography that make planning in that area
28 really tricky. So can you take us through how actually hospitals like that can
29 actually be supported to get to the type of quality service that you're
30 identifying? There's a number of things that I want to come back to about
31 Morecambe Bay but as you've taken us to that point and it's on the list of
32 questions, I think that would be really helpful.
33 PROF KEOGH: I think to be fair it's really difficult because by British standards the
34 distances are quite big. There's a feeling that people should have loads of

1 different types of high quality services close to home, and of course that is an
2 ambition of the NHS. I think thoughts in the NHS are kind of emerging
3 around this now. So, if you take maternity, which of course is your area of
4 interest, there are similarities with how you deal with neonatal care,
5 particularly neonatal intensive care, critical care generally, stroke, cardiac
6 services, trauma, and I think there's increasing recognition that we deal with
7 those in networks. And the idea of a network is to provide an opportunity
8 where people can get access to greater experience up the hierarchy of the
9 network, but it relies entirely on people at, if I can put it, the base of the
10 network, rather than the lower end – because this is not a pejorative place to
11 be – they have to understand how they stratify the risk of their patients, and
12 they have to call early to the next layer in the network.

13 PROF MONTGOMERY: So one of the challenges that has been put to us is about
14 the degree of recognition in somewhere like Barrow that they need to call
15 things early and be asking the questions about whether or not people are
16 recognising the need to call in assistance. You have the example of removing
17 those cultures, and –

18 PROF KEOGH: Can I just say that, in a network, the accountability for the service
19 rests with the highest organisation in the network, because that gives them
20 skin in the game for making sure that people, if you like, at remote parts of the
21 network are adequately trained, know what to do and all of that sort of stuff.

22 Now, to give you an example of that, let's take trauma services. So, in
23 trauma – this is something we did when I was in the DH – National Audit Office
24 report saying trauma could be improved, Public Accounts Committee; you'll be
25 familiar with the process. We established 22 different adult trauma networks,
26 and what that meant was we had to stop trauma going up to some A&Es,
27 because many A&Es were only seeing two cases of severe trauma a month.
28 People argued that people were dying, the ambulance – it was a bad thing.
29 What we did was we linked all A&Es through a network system into major
30 trauma centres, and we designated those major trauma centres. In the first
31 year of operation of the trauma networks, we saw a 15% increase in survival;
32 in the second year of operation, it depends on how you do the statistics, but
33 somewhere between 30% and 40%. We are about to enter our third year.

1 So this can be done. We have done a similar thing with stroke services
2 and myocardial infarction treatment throughout the country. For stroke
3 services, if you take London, there were 32 stroke units in London. In a kind
4 of unpopular move, we reduced those down to eight. We now ensure that
5 ambulances will drive past hospitals that can't offer you, effectively,
6 thrombolysis or an urgent CT scan and will take you to one of the eight
7 centres. The end result of that is that we have a lower mortality, a greater
8 return to independent living, a shorter length of stay and we're saving tens of
9 millions of pounds a year.
10 PROF MONTGOMERY: I understand that, but it's slightly different from the thing that
11 I was wanting to try and get at, which is the failure... What happens if – and
12 this is a suggestion that was made to us we need to assess – the failure is the
13 lack of recognition by clinicians at the front line, whether they are
14 paediatricians or midwives or obstetricians, that actually the woman coming
15 into them or the baby expected to be born shouldn't really be born here; they
16 should be born somewhere else in the network? So they're not coming in by
17 ambulance, so you can't get the ambulance drivers to take them somewhere
18 else. It's about shifting that recognition, and that may be one of the pictures
19 here, that the unit is so isolated, it doesn't actually know what's going on in the
20 rest of the NHS.
21 PROF KEOGH: That's why it's got to be part of a network, and that's why
22 accountability across those services should be with people who really know
23 how to deliver –
24 PROF MONTGOMERY: So what does that do to the board's accountability?
25 Because that is unlikely to sit in University Hospitals of Morecambe Bay, the
26 leadership of that network.
27 [Crosstalk]
28 PROF KEOGH: Ultimately, in a foundation trust, they still have to have responsibility
29 for the quality of care, but they need help from people.
30 PROF MONTGOMERY: So I'm looking really to understand what – in our current
31 system, where we no longer have SHAs; we now have smaller commissioning
32 groups, all the way up to NHS England – what the levers are to hold up the
33 mirror to an FT that says, 'Actually, you're not realising what you're

1 accountable for, here.' Bruce is nodding. Do you need any help from that
2 end?
3 PROF KEOGH: I think it's really difficult. I can give you... I'd rather not give you an
4 answer to that off the cuff, because I think the reality is that some of these
5 things are still finding their own level, Jonathan, and I think we, just tomorrow,
6 will be launching a five-year forward view for the NHS, which will show
7 different operating models.
8 PROF MONTGOMERY: We look forward to that, and obviously we'll have a chance
9 to look at it before you reflect. I mean, there are a couple of things that
10 complicate the issue even further, I think, in our context, which are
11 understandable. The first is that you have to work with what you've got, and
12 it's one thing to say we would like a network that makes sure that you get the
13 benefit of their experienced leadership. If you're the trust delivering the
14 service, you have the clinicians that you have and you have to work with that,
15 and that's clearly the intention with your aspirations for getting the right
16 clinician in the right place. They may not want to go and work there, so are
17 there any tools that you've identified to encourage people to want to work in
18 the places where we need them, even if they may not choose to go there?
19 PROF KEOGH: That's quite a multi-layered, complex question.
20 PROF MONTGOMERY: It's Stewart's. Now Stewart's laughing.
21 PROF KEOGH: I've almost forgotten the question.
22 PROF MONTGOMERY: I think we have to reflect on what could we –
23 PROF KEOGH: Oh, sorry, yeah, okay.
24 PROF MONTGOMERY: – that could help solve this problem, and one of the
25 elements of the problem is that we don't have – we wouldn't start from here.
26 We don't have the staff that we would like to have, if you're sitting in
27 Morecambe Bay's FT, and we wondered what was available in terms of
28 support, encouragement, examples of good practice that would shift us around
29 from not designing the service around the clinician but designing it around the
30 patients and women.
31 PROF KEOGH: So I started to think about this as a consequence of the 14 hospitals,
32 because some of them, as I've said, were geographically isolated, and they
33 were all professionally and academically isolated. So one of the ambitions
34 that we set following that was that hospitals like this should be incorporated

1 early into the academic health science networks, and the idea was that most
2 certainly – obviously for doctors, but most doctors, they qualify; they want to
3 do good things, and then circumstances may change – you know, people end
4 up in different places. But they all want to feel they're at the cutting edge; they
5 all want to feel that they're good, and so how can we do that?
6 And we thought that linking these hospitals into academic health
7 science networks would do several things, and there are still issues around
8 HR and all of that in this, but it offers the opportunity for rotation; it offers the
9 opportunity for recruitment into clinical trials; and we have the opportunity, in
10 our health service, to use places like this, to put many, many more people into
11 clinical trials than we have at the moment. But, while they remain
12 academically and professionally isolated, that's not going to helping, and we
13 know that the best care is provided by the best doctors, who provide the best
14 research, so there's an opportunity there. And I'm just going to... So we
15 haven't really worked all of that through yet. We've been quite clear about it in
16 our report on the 14 hospitals. Some of the academic health science
17 networks, quite frankly, they're immature organisations at the moment.
18 They're getting there, but they're still finding their own purpose, and not all of
19 them see the opportunities of engaging places like Morecambe Bay or some of
20 the other 14 hospital, but I think there is a big opportunity. I think there's a big
21 opportunity there, and I was going to make another point but I've completely
22 forgotten it.
23 PROF MONTGOMERY: There's a set of questions which have been raised around –
24 PROF KEOGH: Oh, sorry. I don't think Morecambe Bay get it, right?
25 PROF MONTGOMERY: You said you'd spoken to them recently.
26 PROF KEOGH: Yes, I spent a day out there the other day, because I just wanted to
27 see what the –
28 PROF MONTGOMERY: And one of the questions was: what were your impressions
29 of them? So elaborate on 'they don't get it'.
30 PROF KEOGH: So the first thing is I think they've made remarkable improvement,
31 and I can articulate that, if that's helpful, but there was one thing. When they
32 said to me midwives were linking up with Coventry, I thought... So I said,
33 'Why Coventry? What about the academic health science network? You've
34 got Manchester down the road. You've got some huge expertise nearby', and

1 I think it's silly that they're linking up with Coventry. It's miles away. There's
2 nothing particularly special about Coventry, other than they might know a few
3 people there. There's no sustainability in it, and yet they have the opportunity
4 to link up with – in their academic health science networks, build professional
5 networks as well as operational networks –
6 PROF MONTGOMERY: The most plausible example for picking Warwick and
7 Coventry is that the nurse director came from there before. Is that...?
8 PROF KEOGH: Yeah, and probably that there is some issue with Manchester, which
9 you might want to explore.
10 PROF MONTGOMERY: They've had Manchester coming in a few times.
11 PROF KEOGH: I think that's the problem, but it's also the solution.
12 PROF MONTGOMERY: So was your impression that they – did they recognise their
13 problems, but have a poor solution, or did they not get the extent of the
14 problems?
15 PROF KEOGH: So can I just say I think they've improved a lot, that they have a
16 new, experienced Chief Executive, in Jackie Daniel, who I think understands it.
17 The strength of their clinical leadership – you know, prior to that, they had no
18 clinical leadership structure that I would have recognised, but I think George
19 Nasmyth has been helpful in that. They have, in my view, fantastic leadership
20 from Sascha Wells in her midwifery role, and she is clearly a strong leader.
21 They've recruited, interestingly, quite a lot of additional staff. They're
22 doubled the number of consultant paediatricians and they have had a
23 significant increase in a number of midwives, whereas, prior to all of this,
24 during the FT process, they were losing staff and focusing on money in the
25 same way Mid Staffs did. They've been able now to increase staff and save
26 money.
27 PROF MONTGOMERY: Is your impression they've been able to keep them?
28 PROF KEOGH: I didn't probe that enough, but my sense was, from the staff that I
29 spoke to, that they were quite happy. I think there were some old school
30 there, which we'll come onto in a moment, that I think still have problems with
31 the changes. They've had changes to their clinical decision-making process,
32 in that babies now born before 32 weeks are transferred elsewhere, whereas it
33 used to be 28 weeks. I think they've had to swallow hard to take that on
34 board. They tell me that they have a lower threshold among the midwives for

1 calling for help from the obstetricians. I would like to come back to that in a
2 moment. They have the introduction of early-warning protocols, which seems
3 – and bear in mind I was only there for a day – seems to be working, and I
4 think they have weekly multi-professional risk committee meetings to consider
5 all incidents graded as a moderate or above, which I think is a significant step
6 forward. And I think they've appointed more midwife supervisors, which I think
7 has been a step forward. So my sense is their trajectory is good.
8 PROF MONTGOMERY: Can I ask you the question that you described quite early
9 on about the problem with actions plans? If it's more than, they have an action
10 plan.
11 PROF KEOGH: Yeah.
12 PROF MONTGOMERY: So what gives you confidence that it's moving?
13 PROF KEOGH: When you walk into a place, you can smell it. The notice boards are
14 covered with information. They can tell you what the family and friends test is
15 telling them. They're happy to share their feedback. They have a dashboard,
16 which I can share with you.
17 PROF MONTGOMERY: I think we have it.
18 PROF KEOGH: They've got quite a comprehensive dashboard. I think they take it
19 seriously; that's my sense. They talk about it.
20 PROF MONTGOMERY: How far down the organisation does that go?
21 [Crosstalk]
22 PROF KEOGH: I think it's a question of how far up the organisation it goes. So this
23 dashboard is owned by the people who are delivering the maternity services, if
24 I can use that term.
25 PROF MONTGOMERY: Which sites did you visit?
26 PROF KEOGH: Just Furness, so I can't speak for –
27 PROF MONTGOMERY: So your sense is that the frontline staff running services in
28 Furness signed up to that, because obviously we've seen it from the top –
29 PROF KEOGH: I think they developed it. The question really is to what extent the
30 board pays attention to this kind of stuff.
31 PROF MONTGOMERY: Okay. Well, we've recently met the board, and we will form
32 a view on the basis of what –

1 PROF KEOGH: So I can't form a view, but I can tell you I met a couple of the
2 paediatricians, and I met some of the obstetricians. I think there are still
3 problems, and I think those problems are not insignificant. I think –
4 PROF MONTGOMERY: So tell us the categories of problems, then. We obviously
5 don't, I think, need you to name individuals, I think, but it's effectively
6 understanding what the problems are and who owns them, if anybody.
7 PROF KEOGH: I won't name individuals, but I'll tell I think they have a serious
8 problem among consultant grade obstetricians, which I think will be destructive
9 and corrosive in the longer term. I'll say no more. I think... So a picture was
10 painted to me of what was described as 'the old days' of midwives calling
11 obstetricians too late, then telling obstetricians when they arrived at the door
12 that everything was okay and the obstetricians walking off. I don't think – and
13 I'm not absolutely convinced that even now the obstetricians understand that
14 that's an abrogation of their professional responsibility. I think they get it, but I
15 think that would need further probing. I think if you come into a hospital – and
16 I speak from my own personal experience of many times being called into
17 intensive care units and told everything's okay – not to check the patient, it's
18 ridiculous. So I think there are some issues there about vested interests and
19 turf wars.
20 I don't think they work well as a team. You can pick that up within a
21 couple of minutes of sitting in a room with them. I think they don't... They're a
22 group of consultants who have reached what they consider to be an elevated
23 position and they've pulled the ladder up after them. So I asked them about
24 residents on call. They said, 'Oh no'; they said, 'The new guy – he's resident
25 on call on a Thursday.' So I said, 'So does that mean in this hospital the best
26 day to have a baby is on a Thursday?' and there was a lot of shuffling around
27 and, 'No, no, no. It's safe all the other days.' So I said, 'If it's safe all the other
28 days, why does he have to be on call on a Thursday?' They couldn't answer
29 it, but the bottom line was that the old guys don't want to be resident on call,
30 but any new appointments will have to be resident on call. And I couldn't get a
31 clear feeling that they really related well with the midwives.
32 PROF MONTGOMERY: Now, that is a picture which is entirely consistent with what
33 the families have told us about what was going on in 2008, and we're six years
34 on from that, and that sounds as though you've picked it up in two minutes,

1 and I won't comment on what we've picked up because obviously we're doing
2 our best to get something –
3 [Crosstalk]
4 PROF KEOGH: Well, maybe it's slightly less bad than it was six years ago. I wasn't
5 there six years ago, but there are still problems there.
6 PROF MONTGOMERY: Okay. So that feels like a medical director's job to sort out,
7 does it, to you, or is it a chief executive's job to sort out, or a ward manager's?
8 PROF KEOGH: Well, the medical director's part of a unitary board. None of these
9 things are one person's responsibility, really, and there is a new medical
10 director coming in, so –
11 PROF MONTGOMERY: So why do we think that will make the difference? What is
12 the medical director's task?
13 PROF KEOGH: I didn't say a new medical director would make a difference. You
14 said that.
15 PROF MONTGOMERY: Okay, so let me rephrase my question, then. Would you
16 agree...? If you've gone in; you're medical director of NHS England; NHS
17 England is responsible for overseeing the commission system. It feels like a
18 commissioning failure that you haven't got the quality of service that you're
19 creating the specifications for, and you're asking yourself what sort of medical
20 director is needed to sort that job out. What are the qualities that the new
21 medical director needs?
22 PROF KEOGH: First of all, it's not just a failure of the commissioning system; it's a
23 failure of the provider system.
24 [Crosstalk]
25 PROF MONTGOMERY: There is a multiple set of failures.
26 PROF KEOGH: Yeah, and it's quite interesting. If you speak to the commissioners,
27 they say they knew they had problems in cardiology; they knew they had
28 problems with outpatients; they knew they had problems in a number of other
29 areas. What they never knew was that they had problems in this kind of
30 closed maternity unit, which is interesting in itself, and it's another similarity, if
31 you like, with the issues in the West Midlands. So is this a failure of
32 commissioning? I think you probably have a better view of that than I do, as
33 an ex-commissioner, but I'm uncertain – and this is –
34 PROF MONTGOMERY: So what qualities does a medical director need?

1 PROF KEOGH: I think he needs to recognise the importance of networks. I think he
2 needs to recognise the importance of professionalism and discipline. I think
3 he needs to have a deep understanding of long-ingrained vested interests
4 between obstetricians and midwives. And I think he also... You know, you
5 can't – it's not as though people are flocking to work there, so I think he needs
6 to inject ambition and encourage people. I think people respond to that far
7 more than to a stick.
8 PROF MONTGOMERY: Okay. My colleagues may want to come back on that, but I
9 wonder if I can go back a bit to a bit of the history and how things unfolded,
10 and you talked a bit about how in 2010, as you began to marshal the medical
11 directors into the FT process – we've asked a number of people this, and we'd
12 like to ask you as well about how this SHA operated around the quality
13 agenda, because there were 10 of them, and they all operated differently. I
14 think you would have been part of the assurance process that went in, so we'd
15 like to understand how this SHA operated, compared to the others.
16 PROF KEOGH: So have you seen the assurance report?
17 PROF MONTGOMERY: I don't think we've actually seen the whole... We've seen
18 some briefing documents. If we could have the whole report, I think that would
19 be helpful.
20 PROF KEOGH: We can get you the report. The key bit, I think, out of the report was
21 David Nicholson's letter to Mike Farrar, and so can I just say that, when I went
22 on the visit – I visited, I think, Manchester PCT and mental health trust
23 [inaudible] officer. Maternity services and Morecambe Bay never really came
24 into the conversation; I can find no record that it did, and I certainly don't
25 remember it, but it was an interesting SHA, because, in many senses, they
26 were ahead of the game, if you like, on quality, in the sense that Mike Farrar
27 had a vision and he was keen to engage clinicians, as you see in AQuA and
28 NHS Improving Quality – ventures like that. What I think came out of the
29 assurance, as a sound-bite summary, was that they were quite good on vision,
30 but they weren't that good at dealing with conflict and problems, and other
31 SHAs, of course, were completely the opposite, as you know.
32 PROF MONTGOMERY: My impression is of a very well worked, high-level quality
33 system, but I don't have much of a feeling of how successful they were at
34 addressing failures of quality. So obviously we've only learned about the

1 particular bits in Morecambe Bay, but I wonder if there were other examples
2 that you saw where they had spotted and intervened and supported solving
3 quality problems.
4 PROF KEOGH: No, I can't – I think you've articulated what I was trying to say better
5 than the way I had, and, because of where I sat in the system, those kind of
6 issues wouldn't come across my desk. So, unless of the SHA medical
7 directors came to me and said, 'I've got a real problem with such-and-such a
8 place', that wouldn't get to me.
9 PROF MONTGOMERY: Okay, and I wondered if I could just check, because that
10 may answer quite a lot of these things, but we talked about the FT application
11 process, and you've described that. And, if I've understood it correctly,
12 despite the fact that it got paused and resurrected after your new system was
13 in place, the unpaused application did not go through your 10 medical
14 directors' discussions.
15 PROF KEOGH: Absolutely not.
16 PROF MONTGOMERY: Okay, thanks. There's a whole series of things that then
17 happened, involving the CQC, involving something called gold command, and
18 it would just be helpful to know what, if any, of those ever got anywhere near
19 you. So, for example, there's a Section 48 investigation by the Care Quality
20 Commission at the end of –
21 PROF KEOGH: None of this got anywhere near me, until I was preparing for your
22 question. Can I just check? You've been through all the documents and seen
23 what I'm copied into. Is that a fair statement?
24 PARTICIPANT: Yep, that's fair.
25 PROF MONTGOMERY: Thank you, that's helpful. We haven't seen anything,
26 otherwise I would have asked you about it particularly. There's a couple of
27 issues which, on that basis, you probably would not have been at the time, but
28 you may have picked up now, which I think we'd be interested in your views
29 on. I think the most important one is the question about whether those events
30 were unconnected or connected events, because there's a series of briefings
31 that go up the system. Based on the view that the series of events in 2008
32 were unconnected – and that has been looked at, and we're still unable to pin
33 down who looked at it and said that felt they were unconnected, but one of the
34 things we're trying to tease out it: was that a sensible judgment? Is it only with

the benefit of hindsight that we're beginning to ask questions about these events being connected, or would your assessment – and so have you seen any of those briefings now that summarise the events of 2008-09 and form this view?

PROF KEOGH: I don't really know the answer to that question. So, clearly, the retrospect-o-scape makes it obvious that they're connected. The question is: at what number do you start to think things are connected? I think, if anything strikes me, it's the number of interminable reports from different people, looking at different things, almost as though people were frightened to make some kind of decision.

PROF MONTGOMERY: So, picking up the numbers bit, so there's the [inaudible] that were doing analysis on this, and we know that analysis was done in the PCT just looking at the incidence rates, the stillbirth rates, and those sorts of things, and we will need to form a view about whether that part of the analysis, which is not dissimilar from the sort of analysis that was done after the Shipman case – at what point might it have been possible to say that it's a statistical outlier? Looking at the numbers you just described, at what point do you begin to say, 'There must be some fire for all this smoke'...?

[Crosstalk]

PROF KEOGH: I don't know if the following remarks are going to be helpful. By the time you get statistical variation, it's almost – not too late, but you should have intervened before you get statistical variation. If you look at events in Bristol in the mid-1990s, the word on the street had been there for 10 years; if you look at maternity services in Northwick Park, probably at least 15 years; if you look at – and I know that because, when I was a medical student, I suggested to the dean that they should –

PROF MONTGOMERY: You just described one of the possibilities of this picture, which is that word was not on the street in the same way as that maternity ward.

PROF KEOGH: It came on the street, didn't it? It came on the street with a variety of things: with James Titcombe, the five deaths and then a whole series of different views, so turnaround time on the street was less, but there is something about –

1 PROF MONTGOMERY: But you're still saying that your conversations with the
2 commissioners were saying that this hadn't been flagged up to them as a
3 maternity –
4 PROF KEOGH: It hadn't at that time. It hadn't at that time. I mean, I understand
5 where you're trying to get to with your questioning. I think the point I'm trying
6 to make is that you can review a place to death and, at some point, you've got
7 to connect the dots, and I think CQC could have connected the dots earlier.
8 PROF MONTGOMERY: They said that to us as well, so I think that's a clear point at
9 which it could... I mean, is that the place now where you would expect those
10 dots to be connected, in the current system?
11 PROF KEOGH: Yeah, I think so; I think so.
12 PROF MONTGOMERY: Have you seen the Fielding report now? I appreciate you
13 wouldn't have seen it at the time.
14 PROF KEOGH: Yeah.
15 PROF MONTGOMERY: So can you just give us your reflection on the Fielding
16 report and you would have expected to have been done with it when it was
17 received?
18 PROF KEOGH: I would have expected it to have been harder-hitting.
19 PROF MONTGOMERY: What are the professional responsibilities of the people
20 brought in to...?
21 PROF KEOGH: Sorry – just the language of the Fielding report is protective.
22 PROF MONTGOMERY: Following on from that, one of the things we are – and
23 we've asked this of various people that we've seen, and it includes
24 professional regulators – in terms of the – you know, you have a nurse, an
25 obstetrician and a midwife involved in that report. It was never presented to
26 the trust board; it was never followed up by the team. So one thing we're
27 wondering is – and we asked the chief executive of the NMC – a former chief
28 executive of the NMC – about: was there any professional guidance on: 'If you
29 take this on as a regulated professional, what responsibilities does it bring?'
30 So we'd be interested to know whether you're aware of any guidance of that
31 sort and any suggestions that might be in that –
32 PROF KEOGH: So the first thing is the Fielding report comes out in August 2010.
33 CQC aren't made aware of it until May 2011. I'm not clear whether Monitor
34 ever got sight of it, and I'm not clear as to the role of the SHA.

1 PROF MONTGOMERY: So if I could tease out some of those, so CQC knew it had
2 been commissioned; the SHA knew it had been commissioned; Monitor knew
3 that there were five deaths, because they asked about it in the [inaudible]
4 board, so I'm trying to tease out: what were the issues about what they didn't
5 know? If they knew the issues were around, did they need to see the report
6 for them to have a responsibility to respond to it? We know it wasn't
7 disclosed, but what's the weight of that nondisclosure? What difference would
8 it actually make?
9 PROF KEOGH: So you've got to ask, 'Why do you ask for a report?' Normally, you
10 ask for a report as part of – whether you call it this or not, but it's part of a
11 root-cause analysis, trying to get to the nub of a problem. So then you would
12 expect that, when that report is published, you would see it straight away, and
13 then you would expect to have a discussion, I think, with involved parties to
14 say, 'Look, it shows this. How can we implement this, sort this problem out?'
15 That's the nature of the risk summits, which I know you want to talk about
16 later.
17 PROF MONTGOMERY: So I'm just trying to get into the thought process.
18 PROF KEOGH: Sorry, you wanted to know about professionals; what's their duty.
19 PROF MONTGOMERY: Yes.
20 PROF KEOGH: [redacted]
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33 PROF MONTGOMERY: So it seems, if I can reflect back, there must be certain
34 senses in which what you see is so damaging to patients that your

1 professional responsibilities, irrespective of what you think is going to be the
2 plan, you have to think about whistle blowing.
3 PROF KEOGH: So I think I say this with a great degree of caution, what I'm about to
4 say. I think the GMC maybe a bit inconsistent on this. So, for example, there
5 are problems at the moment with a breast surgeon in Birmingham, and
6 another doctor, who wrote to the Chief Executive twice, saying that there were
7 problems and brought it to his attention, has been summonsed by the GMC for
8 not having taking enough action. I don't know the details of it, but I know the
9 GMC have been written to about it. So, I don't think there's great clarity
10 around. Also...
11 PROF MONTGOMERY: It would be helpful for there to be more clarity, do you think?
12 PROF KEOGH: Yes, I think it would be helpful. I think this is quite difficult territory,
13 so it might be helpful. So, take me for example. I've reviewed 14 hospitals.
14 I've given a report to the Secretary of State. That report has been shared
15 widely in the public domain. Everything that we did went up on NHS Choices,
16 which gets 1.6 million visitors a day. All the risk summits were video recorded,
17 and there are – you can see it online. You can watch the discussions. The
18 report was sent to Monitor, and for the TDA, and commissioners were part of
19 the process. If some of those organisations don't get better, what - you know,
20 I'm the author of the report. Is it my job to chase the Secretary of State? But if
21 we know, and you just take it a little bit further down...
22 PROF MONTGOMERY: But if we go a long way further down, and we take a report
23 that was never presented to a [inaudible], in which the author was never told
24 what action, if any, was being taken. It feels that at that stage it should be
25 possible to say, 'There was a minimal standard about openness and
26 transparency. It was never published by the trust. It was only ever published
27 by the action group.
28 PROF KEOGH: Okay, so...
29 PROF MONTGOMERY: So [inaudible], so okay, I think there are some stated in
30 between those extremes where we might be able to appreciate that...
31 PROF KEOGH: Well let me give you another personal example in another extreme.
32 I was asked to look at a cardiac surgical unit in a major London teaching
33 hospital. By the then professor of surgery, who subsequently went on to
34 become a minister. And I spent a bit of time there, and I wrote a report which

1 the opening lines were something along the lines of, 'This is the worst cardiac
2 surgical unit I've seen anywhere in the world.' And it was very short, because
3 the evidence to back that up was overwhelming, and I thought to myself, 'I've
4 now got guilty knowledge. What do I do?' So when I submitted the report I
5 said, 'You've got 14 days to demonstrate to me that you're doing something
6 about this.' And in 14 days – I can't remember, he either said, 'I will report it to
7 the Healthcare Commission' or, 'I did'. I think, 'I did'. So I gave them a bit of a
8 heads up. So I discharged my responsibility in that way. And that must have
9 been about 2005 I suppose.
10 PROF MONTGOMERY: That's helpful, Bruce. Because I think though that shows us
11 that there are some ways of answering this question about are there
12 distinctions that control what is professional responsibilities. Can I ask you a
13 couple of other things about the Fielding Reports? And it's really what your
14 interpretation was, because we've seen how variously it's interpreted. To what
15 extent is your impression of the Fielding Report that it looked at the question I
16 raised earlier, about, 'Were these connected events or were they unconnected
17 events?'
18 PROF KEOGH: I'm quite honest, I read the Fielding Report quite quickly. So I've
19 only had the best bit of a week to go through all of this stuff so – but I don't
20 feel...
21 PROF MONTGOMERY: You didn't form an impression?
22 PROF KEOGH: So I can tell you what – we've been through all of these reports, and
23 we have summaries. They say a clustering of these episodes appeared to be
24 co-incidental, rather than evidence of serious dysfunction and, from the
25 briefing that you've been given, [inaudible]...
26 PROF MONTGOMERY: Is that presented to you as a finding that they made?
27 Because on one...
28 PROF KEOGH: I've seen the report...
29 PROF MONTGOMERY: They were told another reading of the report is something
30 [inaudible] concluded.
31 PROF KEOGH: Jonathan, I could send you a note on that. Because I remember
32 being kind of struck by that when I read it. Even though it was a twenty minute
33 [inaudible]...

1 PROF MONTGOMERY: ...That bit matters now. We're trying to track at what point it
2 got this interpretation in the system. The number of the ministerial briefings
3 that used the Fielding Report as evidence someone's asked this question, 'Are
4 they connected?' But it seems very clear from what we know about how the
5 report's put together that actually they were not asked to ask that question and
6 therefore didn't form a view on that. Okay.
7 PROF KEOGH: Okay...
8 PROF MONTGOMERY: Sorry, that was probably [inaudible]...
9 PROF KEOGH: No, no, it's fine to know what the impression was and what wasn't.
10 So I think that the remaining bit's really about function of the risk summit, and I
11 don't know how helpful this will be, because we're really trying to understand
12 the thinking done locally, and you probably were not played into any of the
13 thinking on – locally...
14 PROF KEOGH: Perhaps I could say something.
15 PROF MONTGOMERY: But tell me about what can be achieved at a risk summit,
16 and the [inaudible]...
17 PROF KEOGH: So, one of the things that came out of the Ara Darzi's Review was
18 the concept of a National Quality Board. What was clear to us at the time was
19 there was nowhere, anywhere, where the key players in the system sat down
20 together and talked about stuff. So, in fact, the idea of the National Quality
21 Board had come from Sheila Leatherman, and so we created this Board, and
22 we advertised, we appointed people to it, and in many ways it had four
23 quadrants.
24 So it had the usual suspects, from the Department of Health, and so
25 David Nicholson, myself, the Chief Nursing Officer, Chief Medical Officer, and
26 there were The Chairs of Monitor, CQC, NICE, the MPSA. TDA didn't exist at
27 the time, and then in the third corner we had experts in healthcare quality and,
28 in the fourth corner, sort of experts in – lay experts in quality. And this was the
29 first time, I think, that people had sat down in a room, and David Nicholson
30 personally chaired that and, in his absence, I chaired it.
31 And we got to quite a good place really, where some pretty thorny
32 issues were sorted out, between, in particular, the regulators, and it was a
33 pooled sovereignty in that group, where each autonomous organisation held
34 the others to account for delivering what they said they would do. And we

1 gave quite a lot of thought to how you could keep an eye on what I might call
2 the system, to see how this performed, and the concept emerged, first of all of
3 quality observatories which is now gone. But of quality surveillance groups,
4 and the idea of a quality surveillance group is that in different geographical
5 areas they'll meet every two months, and it puts people who are interested in
6 quality around the table. The TDA. Monitor. CQC. Commissioners. To look
7 at a whole variety of metrics at one level, and also to talk about soft signs of
8 problems, and the word on the street at another level, and then to help bring
9 people together to solve the problems.
10 PROF MONTGOMERY: And at what geographical area can that work at?
11 Presumably certainly big enough to get some comparisons.
12 PROF KEOGH: Yes. So we had them at a...Leah[?], you're not allowed to answer
13 questions, are you?
14 PROF MONTGOMERY: You can drop me a note afterwards.
15 PROF KEOGH: Yes, I've got the contact numbers. So we have – we certainly have
16 them, 28, 10, to 14. So clusters relating to [inaudible]...and then some.
17 PROF MONTGOMERY: Okay. So roughly following the commissions of NHS
18 England, then?
19 PROF KEOGH: Yes.
20 PROF MONTGOMERY: For the area teams. [Inaudible] what we're talking about.
21 PROF KEOGH: Yes.
22 PROF MONTGOMERY: Yes. Other ones within the...
23 PROF KEOGH: Yes. Quite where we are now is a separate issues. So we have
24 those.
25 DR KIRKUP: Excuse me. We're not clear on who's contributing there. Could we just
26 have a brief identification please?
27 PROF MONTGOMERY: Bruce was – I was asking about the geography. Bruce was
28 looking to the lady who's just sitting as his reporter but not saying anything,
29 and she was tempted to say something but didn't, so Bruce will have to find it
30 out afterwards.
31 DR KIRKUP: Okay. Thanks for the clarification.
32 PROF KEOGH: Sorry, Bill. So then it's a [inaudible] for four issues. We then
33 introduced a concept of risk summits. Which was if people in a geographical
34 area – if the quality surveillance group recognised there was a problem at

1 hospital X, and if they thought that was severe enough, they could call what's
2 called a risk summit. Or, if the commissioners thought there was a problem
3 somewhere else, in an isolated way from hospital Y, they could call a risk
4 summit.
5 The idea of a risk summit is that there is a relatively serious issue that
6 needs resolution, and that brings together the commissioners, CQC, Monitor
7 and TDAs, depending on who's appropriate and, you know, the chief executive
8 of the organisation around the table. To thrash out problems.
9 The idea of the quality surveillance groups is to pick out problems early
10 and solve them. A risk summit ...
11 PROF MONTGOMERY: Would quality surveillance groups operate at area team
12 level? Do the risk summits escalate to the four commissions of NHS England
13 or might they be at area level [inaudible]...
14 PROF KEOGH: They're mostly at area level.
15 PROF MONTGOMERY: So they would be depending on what the [inaudible]?
16 PROF KEOGH: Yes.
17 PROF MONTGOMERY: Okay. Thank you.
18 PROF KEOGH: Again, we could send you - we've got guidance on how to do these
19 from the National Quality Board, which we can send...
20 PROF MONTGOMERY: I think that would be helpful. I think I've got to the end of
21 my questions, [inaudible] questions. Are there any that you can see that I
22 missed, or are there any additional ones that you want to put in? Bill, do you
23 want to manage that from your end?
24 DR KIRKUP: Okay, thanks. That's helpful. I'll ask Julian to start with.
25 MR BROOKES: Hi, Bruce. Just – it's a dilemma, which I know is not a new
26 dilemma, but it's – you recall you were talking about your visit to the Trust, and
27 saw the additional staffing that was going in. They were now meeting the
28 quality standards in terms of staffing levels in maternity services etc.
29 At the same time this is an organisation which has an underlying deficit
30 of £18 million. It's not a sustainable picture probably, going forward, and it's,
31 you know, they're finding it very difficult to meet the standards that are
32 required for small maternity units, for example, within the tariff. And I
33 remember this being a point of contention and discussion around when we
34 were doing the Darzi Review as well, some years ago...

1 PROF KEOGH: Yes.
2 MR BROOKES: And it's a really tricky one, and I'm not saying that there's a simple
3 answer to it, because I think if there was someone would have come up with it.
4 But it's a real dilemma and it's something which does concern us in terms of
5 the future viability and the future sustainability of services there.
6 PROF KEOGH: Yes, I think you're right, Julian. So it's a dilemma because we have
7 a fixed approach to the way we deliver maternity services, which is a
8 combination of standards set by the Royal College of Obstetricians and
9 Gynaecologists, and the combination of the tariff. Which means that for a unit
10 to be viable, you know, it's got to do a load of births.
11 So we have that going on in one place. Then, in western Europe, in
12 other countries, we don't have that problem. We have much smaller units,
13 delivering babies with a complication rate as good as or better than England.
14 So tomorrow you will see a formal announcement that NHS England is going
15 to commission a review into maternity services, and that's based – the aim of
16 that is to explore the interactions of a tariff and working practices, and to see
17 whether we can get to a place that there's forward agreement on how you can
18 have much smaller maternity services, closer to peoples' homes, and that will
19 lead us into discussions on networks and that kind of thing.
20 MR BROOKES: What would be the timescale? That's clearly [inaudible] would be
21 the timescale?
22 PROF KEOGH: I think they will say the summer. So I – can you just keep this to
23 yourselves until tomorrow?
24 DR KIRKUP: Sure.
25 MR BROOKES: Sure.
26 PROF KEOGH: I think they'll say the summer. So what we have to work out is how
27 we conduct that review, and in my head I've got different ideas and one is
28 whether you do it in a way that we've done the urgent emergency care review,
29 which is you get all the people in a room and you conduct a consultation
30 process in public.
31 Or whether you say, in this particular territory there are so many
32 ingrained and vested professional and other interests that you conduct a
33 review in a similar way, for example, to the way I did the cosmetic intervention
34 review. Which is you have a panel of people who take evidence. And there's

1 also a question about to whom such a review would report and what have you.
2 But there will be review. Maybe next summer.
3 MR BROOKES: Yes, I think that's really helpful. I know there was some work done
4 around morality and its impact on tariff around the Darzi Review, which might
5 be a useful – but it's also obviously one of these things which will be very
6 useful in terms of if – I assume it will look at training levels and difficulties in
7 terms of small units in attracting, you know, workforce issues as well?
8 PROF KEOGH: I think it has to if it's going to have any credibility.
9 MR BROOKES: Yes.
10 PROF KEOGH: The other thing that we're going to be looking at is – is the tariff
11 system in general. So the tariff system is designed in such a way that,
12 essentially, big trusts can make a profit of sort of 4%, whereas smaller trusts
13 are looking at minus half a per cent...
14 MR BROOKES: Yes.
15 PROF KEOGH: And that's a perverse thing about our tariffs, so we're going to be re-
16 looking at that.
17 PROF MONTGOMERY: And that also will be public by the time we report by April.
18 PROF KEOGH: That will be in tomorrow. That will be in public by tomorrow
19 morning. Yes.
20 MR BROOKES: Excellent, thank you.
21 PROF MONTGOMERY: Because that actually addresses, you know, I think one of
22 the questions that we had been left with when we had a [inaudible]. You're
23 going to...
24 MR BROOKES: I just wanted to change tack very slightly. It's back to the
25 conversations we had about the system, Bruce, when you obviously came in
26 and looked at the quality around the FT qualifications and raised the bar. I'm
27 just trying to understand. Were you raising the bar from an unacceptably low
28 level to an acceptable level? Or did you feel that the – it was complimentary to
29 what was happening before?
30 PROF KEOGH: Well I've no idea what the level was. So we just set a level, which
31 was, you know, you needed to demonstrate that you took quality seriously.
32 You needed to demonstrate a variety of things, you know, that you didn't have
33 an excessive standard mortality rate, that you didn't have an excessive

1 infection rate. That you didn't have a load of serious untoward incidents.
2 That...
3 MR BROOKES: So if I reflected back the system before, which was a – what I would
4 look about whether or not you've got processes in place, and was done as a
5 board self assessment, that was – seems to have been the kind of process
6 which Morecambe Bay went through in terms of their FT application.
7 PROF KEOGH: Yes, I – you know, I wasn't part of the deliberations at Monitor, or I
8 wasn't part – and I also wasn't part of the deliberations from a foundation trust
9 part of the Department of Health.
10 MR BROOKES: Okay, thank you.
11 PROF KEOGH: So, you know, I'm just not sure there was a bar until then. And I
12 don't think it was looked at through a quality lens, and actually...
13 MR BROOKES: I think that's right. I think there was a perceived bar, which was in
14 the self-assessment of your processes. I think we can both see what the
15 potential weakness is in that. So – but that's where the bar was, so it wasn't a
16 comparative analysis against benchmarked information, for example, as
17 you've described. It was also very dependent on the assurance process, as
18 far as we can see, through the SHA. You know, they had a key role in
19 endorsing an application.
20 PROF KEOGH: So, interestingly, when David Flory wrote a rout of the service,
21 saying that I'd be taking this on, he also mentioned in his letter that he expects
22 PCTs and SHAs to be much more proactive in the way they kind of address
23 their nominations, as it were, to the FT process. If you haven't got a copy of
24 the letter, we have and...
25 PROF MONTGOMERY: We handed a copy to [inaudible].
26 DR KIRKUP: Yes, we have seen that, thanks.
27 MR BROOKES: Yes.
28 DR KIRKUP: Is that you?
29 MR BROOKES: Yes, that's fine, thank you.
30 DR KIRKUP: Okay, thanks. Stewart?
31 PROF FORSYTH: Yes, thank you Bruce. I've very much enjoyed listening to your
32 comments. I think we do recognise that currently the Morecambe Bay Trust is
33 in a much better place than it was and, of course, really following up Julian's
34 comments, sustainability is the real challenge. They've got some good people

in there now. But, of course, we don't know how long they will remain there, and therefore the future of the Trust, particularly around maternity services, therefore becomes uncertain.

In terms of sustainability, I think that we've got to recognise that what – and you touched upon that, that certainly the area they're providing is very different from the more urbanised areas within many other centres. And therefore, you know, in your – the review it's clearly important to look at, 'Well what are the best models of care in these more rural and isolated areas?' and then, of course, the job plans of the individuals who are providing services do need to be reviews as well.

And of course, as you touched upon I think again, that the colleges have an important role, because they need to be able to – they need to train people to serve communities, and these communities are, in many places, are very diverse, and I just – one of the problems it seems to be that, in the past, and till now still, we do take a sort of one size fits all approach to both structures and systems, and that also applies to training as well.

I just wondered, with the review picking up on some of this, and really trying to develop services in these more isolated areas which, in fact, can be cutting edge in terms of both service delivery and research – because they actually, collectively across England cover a quite large areas and, of course, where I am it's an even larger proportion of the country. So, in fact, they are potential areas where it could be exciting areas to work and to deliver services and to do research, and I think, it seems to me, that we do need to try and encourage that approach in any future development, and therefore I'd be quite interested in your comments on that.

PROF KEOGH: Stewart, I think I kind of agree with your sentiment entirely. In terms of we still have to draw up the terms of reference of the review and, of course, there will be all sorts of people who have a different view on that. But I think unless we address all, at least at some level, address all the concerns that you raise it's not going to be a credible review. So - and it won't get the kind of traction that's required.

One of the things that I find myself thinking, what's different now perhaps to ten years ago in remote rural areas? And I think there are two things: One is hard evidence of the value of networks, and the other thing is

1 the advent of mobile and other technologies that – the ability to transfer data
2 quite – very rapidly, and to share data with people in different places. And we
3 haven't been that good at exploiting that in the NHS, you know. We have in
4 neurosurgery, and we have in certain parts of – certain bits of radiology. But
5 we haven't exploited it in a way that other industries have. And I think we
6 could do that. In fact, I think it will happen irrespective of what we do. It's a
7 question about how we catalyse it.
8 PROF FORSYTH: Okay, thank you.
9 DR KIRKUP: Just a couple of follow-ups from me if I can, please. You were very
10 clear that after the pause in the FT application process, if it had gone back
11 through the circuit UHMB wouldn't have passed. And thank you for that
12 clarity. But my question is; why didn't it go through that circuit?
13 PROF KEOGH: I don't know, Bill. So first of all, when it went into the process to get
14 into Monitor, of course that was February 2009.
15 DR KIRKUP: Yes.
16 PROF KEOGH: And so it was kind of in Monitor. Our process was to filter things
17 before the Secretary of State referred them to Monitor. You might want to
18 address questions to Monitor about why they didn't think it was worthwhile to
19 send it back.
20 DR KIRKUP: Okay. That's helpful. Can I just pick up something that you said about
21 one of the reasons why it would have failed if it had got through? And that
22 was the high HSMR in 2010/2011. That was preceded by an unremarkable
23 HSMR and followed by an unremarkable HSMR. Is that the reason it didn't
24 get into your review of 14 hospitals and, if so, what's your reaction to the fact
25 that it went from unremarkable to the biggest outlier in the country and back
26 again?
27 PROF KEOGH: So, the first thing is that there are two temporally distinct issues. So
28 the 2010/11 HSMR was high. And, at that level, if it had come back into the
29 system – it depends where it comes back and what information's available to
30 you. So I don't want to be too hard and fast about it.
31 DR KIRKUP: Okay.
32 PROF KEOGH: But what we would have seen was an HSMR that had been climbing
33 since 2005/6. So we would have seen that, and some of that time, although it
34 was climbing, it would have still been below 100. And the reason – so, you

1 know, depends which – whereabouts in the cycle it had come back to us. If it
2 came during the financial year 2010/11, and if we could get up to date
3 information, that would have shown us a high HSMR, and, you know, HSMRs
4 fluctuate quite significantly.

5 DR KIRKUP: Yes.

6 PROF KEOGH: And they'd been on a pretty good downward trajectory since, well,
7 for a while.

8 DR KIRKUP: Okay.

9 PROF KEOGH: And, secondly, in terms of not getting into the 14 hospitals is just
10 that they didn't have a statistically significantly high HSMR for two years in a
11 row.

12 DR KIRKUP: Yes. That's what I was getting at really. Yes.

13 PROF KEOGH: It was as simple as that. I just wanted – I knew that I'd be grilled on
14 how the hospitals were being selected, so I just wanted something that could
15 be understood by the man on the Clapham Omnibus, you know. Two years in
16 a row people get.

17 DR KIRKUP: Okay. You mentioned pressure to make trusts foundation trusts. I just
18 wondered if you could elaborate a little bit on the nature of that pressure, and
19 how it was communicated and where it originated. We've heard different
20 accounts of it. I'm very interested in your take on that.

21 PROF KEOGH: Well, there are a couple of things. So I think the first indication that
22 this was important was the appointment of Ian Dalton, who was then the Chief
23 Executive of the Northeast of England, to be Director of Provided
24 Development in the Department of Health, along with Matthew Kershaw who
25 was Director of Provided Delivery. And the idea was that they would help to
26 get non-foundation trusts into the foundation trust pipeline and, you will recall
27 at that time, that there was an aspiration that all trusts would be foundation
28 trusts by – I've forgotten the date. I think it might have been 2017 or
29 something. But anyway, there was an end date, whatever it was.

30 DR KIRKUP: Okay.

31 PROF KEOGH: And then you will also be aware that the Secretary of State wrote
32 out, in September 2010, to all trusts asking them - for the chairs of all trusts,
33 and chief executives, asking them what their trajectory was to get into this
34 pipeline. So there was the political will that the trust should be got into some

1 kind of sustainable financial and clinical position, which would give them the
2 opportunity to benefit from the freedoms of foundation trust status.
3 DR KIRKUP: Yes. That's – that's setting a trajectory, and asking how people
4 matched up to that. Does that automatically equate with pressure to become
5 a foundation trust?
6 PROF KEOGH: Well, when you have an end date, an expectation – if you're a trust
7 chairman or chief executive, and you know that there is an end date, and a
8 political expectation of that date, and you receive a letter from the Secretary of
9 State saying, 'What's your trajectory', I think you would interpret that as
10 pressure to become a foundation trust, yes.
11 PROF MONTGOMERY: Are there any other examples of the Secretary of State
12 writing personally to chairs and chief execs in your time?
13 PROF KEOGH: I'm not sure that there are, but I can't remember.
14 PROF MONTGOMERY: Sorry, Bill. Just wanted to ask that.
15 DR KIRKUP: Okay.
16 PROF KEOGH: It's difficult to interpret it any other way. The – but maybe pressure's
17 the wrong word. Enthusiasm? Political enthusiasm? I don't know.
18 DR KIRKUP: Yes. I'm concerned about, 'Pressure' because the specific point that
19 I'm trying to get at here is whether there was an onus placed on people to cut
20 corners to become a foundation trust, which would be a very different...
21 PROF KEOGH: Ah, yes. Okay, Bill, no I – no. No. There was – and let's be
22 absolutely clear. I never heard anything along those lines. So I think, when I
23 use term, 'Pressure' I mean it in the terms of, you know, get your organisation
24 sorted out, get it tip top, and become a foundation trust – there was certainly
25 never, never any hint that people should cut corners to get there. Indeed, the
26 opposite. From where I sat, anyway.
27 DR KIRKUP: Okay. That's very helpful. Thanks. Last one from me...
28 PROF MONTGOMERY: Hang on, sorry, Bill, can I just ask a supplementary to that?
29 I wonder what the conversations with the SHA assurance process meetings
30 were about where people had got to on the FT pipeline? Do you have any
31 recollection of that, Bruce?
32 PROF KEOGH: Yes, I do. But that wasn't pressure, that was a report. Reporting
33 that, really. I – no, I don't think it was any pressure. Not pressure as defined
34 by Bill, which is a helpful clarification. Thanks, Bill.

1 DR KIRKUP: Okay. Last one from me. You referred to the notion of the word on the
2 street, which I think is a very helpful concept about a hospital that should be
3 giving rise to concern, and I fully agree with you that there was a word on the
4 street a long time before any statistical indicators would have become obvious.
5 Wouldn't you have expected that to have gone somewhere near the SHA and
6 the SHA Medical Director at the time?
7 PROF KEOGH: Yes.
8 DR KIRKUP: Okay. It – you clearly didn't get any feedback on that route yourself?
9 PROF KEOGH: No. But I wouldn't expect, you know. So the SHA Medical Directors
10 did not report to me...
11 DR KIRKUP: No, no.
12 PROF KEOGH: You know. They reported to independent strategic health
13 authorities, with their own board, executive team and chairman, and they were
14 part of that. And so I would have expected, if they had local problems, that
15 they dealt with the problems locally.
16 DR KIRKUP: Yes, was...
17 PROF KEOGH: So when I...
18 DR KIRKUP: Were similar issues... sorry, go on.
19 PROF KEOGH: When I brought the SHA Medical Directors together there were a
20 couple of things really. So it was - this wasn't a formally constituted group, if
21 you like. It was – but it was one that we all wanted. In the same way that the
22 NHS management board wasn't a formally constituted group, it was the chief
23 executives of the SHAs coming together. It was where we – we kind of
24 discussed mainly very specific issues that guys had a problem – a real
25 problem – they could bring it. Or mainly it was to support me in some of the
26 deliberations around policy in the Department of Health, and I think, Bill, you
27 may have been to one or two meetings.
28 DR KIRKUP: I was, yes, and I agree that was the nature of them. Just a thought,
29 really, that if there were issues of that size that were being talked about in the
30 northwest, it would have been a potential route for the medical director to raise
31 issues nationally?
32 PROF KEOGH: It could have been. But I would imagine, and it is imagining, that an
33 SHA medical director would probably only bring problems if he thought he
34 couldn't get them solved by his own organisation.

1 DR KIRKUP: Yes. Okay. I think we're all done here. So my usual question, at this
2 stage is, is there anything else that you would like to say to us, that you don't
3 think that we've covered?
4 PROF KEOGH: No. I'm sure the moment we hang up there'll be about five things...
5 DR KIRKUP: Do feel free to get back to us if you'd like to.
6 PROF KEOGH: So what I would like to do is just so that you can understand my
7 role, I think, and some of the things around risk summits and what was
8 happening, if you like, in the kind of quality space at that time, if I may, I'll send
9 you a kind of bespoke version of pretty much what I said to the mid-
10 Staffordshire enquiry, just so that you have it for your records.
11 DR KIRKUP: Yes, thank you. That would be helpful.
12 PROF KEOGH: If – but equally, if you, Bill, or your team have issues that you feel
13 that you would like to pursue with me again, I'd be very happy to do anything I
14 can to help.
15 DR KIRKUP: Thanks. That's appreciated. And thanks for talking to us.
16 PROF KEOGH: Thank you very much.
17 DR KIRKUP: Bye.
18 (Interview concluded)
19

THE MORECAMBE BAY INVESTIGATION

Thursday 11 September 2014

Held at:
Park Hotel,
East Cliff,
Preston,
PR1 3EA

Before:

Mr. Julian Brookes -- Expert adviser on Governance (In the Chair)
Dr Catherine Calderwood -- Expert adviser on Obstetrics
Ms. Jacqui Featherstone -- Expert adviser on Midwifery
Professor Jonathan Montgomery -- Expert adviser on Ethics
Professor Stewart Forsyth -- Expert adviser on Paediatrics

AYSHEA KITCHIN

Transcript from the Stenographic notes of Ubiqus,
Clifford's Inn, Fetter Lane, London. EC4A 1LD.

1 MR BROOKES: Hi.

2 MS KITCHIN: Hi. Hello.

3 MR BROOKES: Welcome. Are we ready?

4 Thank you.

5 I am Julian Brookes. Bill Kirkup who

6 chairs this investigation is unfortunately

7 unable to be with us today so he has asked

8 me just to chair this session. Most of

9 the questions will be coming from my

10 colleagues but I will try to bring that

11 back together again.

12 Just to let you know some of the

13 ground rules and how we operating, these

14 sessions are open to members of the family

15 but, as you can see, there is nobody here

16 today who is doing that. We have got

17 microphones in front of us, which are to

18 allow us to record sessions and provide a

19 record of discussions we have today and

20 that is partly for the overall

21 investigation but is also to do with if a

22 family members who is not able to come

23 today wants an opportunity to provide an

24 opportunity to supervise the discussion

25 about that.

1 That is the only recording equipment
2 that we allow. We have asked for phones
3 and everything to be taken away. That is
4 purely to allow this session to be taken
5 in the context of the overall
6 investigation. It would not help anybody
7 if parts of the investigation became
8 public knowledge prior so if you can treat
9 this with confidentially and then we will
10 take all of the components of the
11 investigation and the evidence we have
12 looked at as part of the final report.
13 Final thing is to say that we are not
14 expecting a fire alarm so we will proceed
15 in an orderly fashion if anything happens
16 when those arise. I will ask the Panel to
17 introduce themselves then we will start
18 with questions for you.
19 DR CALDERWOOD: I am Catherine Calderwood
20 I am an obstetrician and a medical advisor
21 for the Scottish Government.
22 PROF FORSYTH: I am Stewart Forsyth.
23 I am paediatrician, in Tayside and Dundee
24 and a Medical Director.
25 MR BROOKES: I am Julian Brookes and I was

1 previously Head of the Clinical Quality at
2 the Department of Health and I am
3 currently Deputy Chief Operating Officer
4 for Public Health England.
5 PROF MONTGOMERY: I am Jonathan
6 Montgomery, Professor for Healthcare Law
7 at University College London and Chair of
8 the Health Research Authority. In the
9 past I have chaired for Trusts and PCTs
10 and SHA.
11 MS FEATHERSTONE: I am Jacqui Featherstone
12 Head of Midwifery in Essex.
13 MR BROOKES: For the --
14 MS KITCHIN: I am Ayshea Mary Kitchin. I
15 worked at Furness General Hospital as the
16 labour ward co-ordinator.
17 MR BROOKES: Are you starting, Jacqui?
18 MS FEATHERSTONE: Okay. Thank you. I
19 understand you are a labour ward
20 co-ordinator.
21 MS KITCHIN: Yes.
22 MS FEATHERSTONE: So just go back to you
23 have worked at the Barrow since 1999.
24 MS KITCHIN: Yes.
25 MS FEATHERSTONE: Where did you qualify?

1 MS KITCHIN: I qualified in Stockport in
2 Manchester and, second, Stepping Hill
3 Hospital then went.
4 MS FEATHERSTONE: You stayed there --
5 MS KITCHIN: I qualified there and then I
6 worked at Blackpool Victoria Hospital for
7 three years before I came to Barrow.
8 MS FEATHERSTONE: And then what did you
9 start your job in 1999?
10 MS KITCHIN: As staff midwife which was
11 known as grade six now, as a band six, but
12 as C grade midwife.
13 MS FEATHERSTONE: Okay. Do you want to
14 take us through then what you did from
15 1999 then to ...
16 MS KITCHIN: During the period of 1999, I
17 worked as a staff midwife in the unit -- I
18 have always been hospital based -- and I
19 continued to work there full-time, until
20 in 2004 when I got my sister-post, to be a
21 labour ward sister and then become
22 co-ordinator. The title has changed but
23 it is basically the same. We run the
24 labour ward at Furness General Hospital
25 since 2004.

1 MS FEATHERSTONE: And as a labour ward
2 co-ordinator, are you one of the quite a
3 few co-ordinators or are you the senior
4 co-ordinator?
5 MS KITCHIN: No, I was more -- well, when
6 I started I was one of the junior
7 co-ordinators and I would probably say I
8 was middle. There are about seven of us
9 in total and sometimes we work together as
10 the shift but generally speaking these
11 days there is one co-ordinator per shift.
12 MS FEATHERSTONE: So generally you are not
13 taking the women you are coordinating or
14 do you still look after the women?
15 MS KITCHIN: Currently today, no, it is
16 mainly a co-ordinator role.
17 MS FEATHERSTONE: Are you supernumerary on
18 the rota?
19 MS KITCHIN: We are counted in the
20 numbers -- six in the morning, five in the
21 afternoon, five in the evening. So
22 counted in the numbers for the number of
23 staff but one call co-ordinator on each
24 shift and but that is for the unit, the
25 ward and the labour ward, but I would try

1 not to take any labouring patients if a
2 could.
3 MS FEATHERSTONE: Okay and the staff that
4 are coming through onto labour, are they
5 rotating through? So have you got
6 different staff every so many months or
7 how does it work?
8 MS KITCHIN: To talk about current day?
9 At present, no, there is not any formal
10 rotation. There is core band seven that
11 remain on labour ward. They will work on
12 maternity ward if there is another
13 co-ordinator on and then, generally
14 speaking, depending on the need or if
15 somebody has -- if somebody is working
16 shift, they band five it is direct, they
17 should work on the ward for a certain
18 period of time.
19 Other than that, it would depend on
20 what the case load is and then what the
21 work permits and to delegate staff where
22 is necessary.
23 MS FEATHERSTONE: Okay.
24 MS KITCHIN: Generally speaking, you keep
25 two or three midwives on the labour ward

1 which would include myself and the rest

2 would go to the ward. So if the labour

3 ward is quiet and the ward is busy, you

4 would send your staff to the ward.

5 MS FEATHERSTONE: How many available

6 delivery rooms have you got?

7 MS KITCHIN: Five, six labour rooms. We

8 have got three core rooms that we use most

9 of the time, we have got the pool room and

10 we have got what now known at the high

11 risk room.

12 MS FEATHERSTONE: And so do the women come

13 in to be in induced on labour ward or are

14 they in induced on the antenatal ward?

15 MS KITCHIN: Normal inductions would go to

16 maternity ward, they will pin Tuesday on

17 maternity ward unless they are high risk,

18 and it will be necessary for them to

19 remain in the labour ward. So for

20 occasionally ladies with previous

21 Caesarean Sections, they would come to

22 labour ward and be in induced there.

23 MS FEATHERSTONE: Do you have regular

24 meetings as labour ward co-ordinator? Do

25 you have an overall labour ward manager or

1 do you have -- who is your lead?
2 MS KITCHIN: Well, at the present, we have
3 a ward manager, which is over the labour
4 ward and the maternity ward and we also
5 have a matron that is now allocated to us
6 at Furness.
7 MS FEATHERSTONE: And now, but previously,
8 did you -- do you meet regularly as labour
9 ward co-ordinators to -- because you are
10 saying you work quite individually so to
11 meet to discuss what's happening and to
12 take things forward, how did that happen
13 few years ago?
14 MS KITCHIN: A few years ago, I think,
15 perhaps it depending which period of time
16 you are talking about. The labour ward
17 team did meet monthly and quite regularly
18 and a lot of the team members were able to
19 attend those meetings.
20 Now there are meetings being held but
21 they are not as successful, I would say,
22 at this present time but they are being
23 held and they are organised.
24 MS FEATHERSTONE: Why don't you think they
25 are being successful? What do you mean?

1 MS KITCHIN: I think to be able to
2 attend -- if there are couple of
3 co-ordinators or members of staff on the
4 unit and it has be held during that period
5 of time that the unit is busy, then they
6 will not be able to attend but it is
7 basically relying on the people's free
8 time to come and attend. So that maybe
9 one of the reasons.
10 MS FEATHERSTONE: So you would have
11 regular ward meetings. What about any
12 multi-disciplinary meetings you may have?
13 MS KITCHIN: Yes, they do have regular
14 ward meetings. Similar thing, the staff
15 are invited and agenda goes up prior to
16 for any topic of conversation.
17 The unit as a whole does have various
18 meetings to discuss interesting cases and
19 midwifery issues. On various time once a
20 week, we will meet on the labour ward to
21 discuss interesting cases. They also have
22 a forum in the parentcraft room so now
23 they do try to get together as a
24 multi-disciplinary team to discuss this
25 things.

1 MS FEATHERSTONE: We are now talking about
2 present, when you were a sister in 2004
3 did you say?
4 MS KITCHIN: Yes.
5 MS FEATHERSTONE: In that period of time,
6 were there multi-disciplinary meetings
7 then?
8 MS KITCHIN: It's hard to think back to
9 the actual period of time. I would say
10 that not as much. I would not certainly
11 be on regular basis of the weekly basis,
12 that now, that did not happen in 2004.
13 The midwifery team, the band sevens
14 and the matron as was then, did meet and
15 more discussion of how to work as a team
16 and how to build midwives experiences and
17 those kind of topics and problems for the
18 unit and problems that the co-ordinators
19 or the midwives were perceived to be
20 having, they were discussed at the
21 meetings.
22 MS FEATHERSTONE: Similarly, any
23 complaints, themes through complaints or
24 serious incidents, how would you hear
25 about those?

1 MS KITCHIN: 2004 onwards, I think, it was
2 building through the period of time there
3 were CNST major incidents would be
4 discussed and organised. For us as core
5 staff, there was not the feedback there is
6 now to the staff.
7 I think the amount of incidents that
8 were put through, it was not formalised
9 like it is now. The criteria for an
10 incident is more structured so people know
11 what is classified as an incident and they
12 should be reporting which it was not then.
13 MS FEATHERSTONE: How would you have found
14 out about something then?
15 MS KITCHIN: Probably -- in which respect?
16 In --
17 MS FEATHERSTONE: If there was a serious
18 incident and you did not happen to be on
19 duty and lessons learnt; how would know?
20 MS KITCHIN: If it had cascading effect,
21 if we needed to change practice or if we
22 needed to -- (inaudible) case of the
23 matron who was co-ordinating -- in charge
24 of the labour ward then would probably do
25 a tool box talk or would talk to us

1 individually, I would say, rather than as
2 a group or it maybe have been discussed at
3 the midwives meeting.
4 MS FEATHERSTONE: Okay and what would you
5 say the relationship is like between the
6 medical staff and the midwives and the
7 paediatricians and the midwives?
8 MS KITCHIN: I always felt -- are you
9 talking for the period of 2004 onwards? I
10 always felt that the relationship was good
11 between the obstetricians and the
12 midwives. I always felt that we had a
13 close working relationship and obviously
14 people have time to think about these
15 things in retrospect because obviously we
16 have been highly criticised for that in
17 the press and various things.
18 One of the think that I feel is that
19 there have a lot of communication and a
20 lot of referring and discussions among to
21 the team, but, I think, that the downfall
22 of that, that there was not a structured
23 policy and procedures that actually
24 indicated very clearly who conducted the,
25 say if you referred to a doctor and said

1 there was this problem or this problem and
2 they would advise and instruct, there was
3 not any clear identification of who
4 actually should conduct those things at
5 that time because of the policies and
6 procedures were not as robust as they are
7 now.
8 MS FEATHERSTONE: So from an escalation
9 point to mean if somebody was concerned,
10 how would you have done it then?
11 MS KITCHIN: If I was concerned, I would
12 have spoken to the registrar or midwife
13 involved would have spoken to the
14 registrar who was on-call.
15 MS FEATHERSTONE: And now?
16 MS KITCHIN: Similar way, but, I think,
17 the way the midwives conduct themselves
18 and the doctors is to actually ensure that
19 that registrar is brought and have
20 face-to-face contact with the patient and
21 instructed clearly in the notes so there
22 is no discrepancy between what has been
23 instructed and what has not and if it is
24 something that should be conducted by a
25 registrar, the midwives and registrar's

1 ensure that it is conducted by them and
2 not a midwife.
3 MS FEATHERSTONE: But if the midwife was
4 unhappy, would she be happy now just to
5 escalate immediately to the consultant?
6 MS KITCHIN: Oh, I would say they would
7 come to me first. Everything would be
8 discussed as a team. We try to bring them
9 together and then it will escalate to a
10 consultant if it was necessary.
11 MS FEATHERSTONE: Do you have a supervisor
12 of midwives?
13 MS KITCHIN: Just to go back to that, I
14 would have said that would have happened
15 previously as well. You know, we never
16 and from right through coordinating labour
17 ward never had a problem to escalate
18 things to a consultant if it was
19 necessary.
20 Sorry, go on. What were you going to
21 say?
22 MS FEATHERSTONE: No it is fine. I was
23 going about supervision, actually. Have
24 you a supervisor of midwives?
25 MS KITCHIN: Yes, yes.

1 MS FEATHERSTONE: And do you have regular
2 reviews with her or do you have an annual
3 review?
4 MS KITCHIN: I expect it would be annual
5 review.
6 MS FEATHERSTONE: And that is kept to up
7 to date?
8 MS KITCHIN: Yes. It has been a little
9 bit of change round because my supervisor
10 has left but yes, I have been replaced and
11 as midwives have changed circumstances
12 they are replaced with their own
13 supervisor. I think, some people have
14 found it difficult depending on where the
15 locality of that supervisor is. There are
16 few supervisors on the shop floor at
17 Furness at the moment.
18 MS FEATHERSTONE: Okay. What about
19 mandatory your training, how does that
20 happen within the Trust?
21 MS KITCHIN: It has always been there. I
22 feel it has become more robust in the last
23 couple of years.
24 MS FEATHERSTONE: What training do you
25 have?

1 MS KITCHIN: What training? Everything
2 from you are normal obstetric emergencies,
3 your interpersonal meetings that you
4 have -- I am trying to think of the actual
5 names of them. There are formal lists of
6 the actual days that we need to attend.
7 MS FEATHERSTONE: What have you done in
8 the last year?
9 MS KITCHIN: Health and safety, we have
10 twice yearly obstetric days that we have,
11 completed the three that we need to attend
12 in the year and that has just started
13 again. I have done level three safe
14 guarding, fire safety. Do you have any,
15 in particular, in mind that you want me to
16 know about?
17 MS FEATHERSTONE: No, I just wanted to
18 know about training that you have as
19 midwives and that it is regular; is it?
20 MS KITCHIN: Yes.
21 MS FEATHERSTONE: And it is annually and
22 it is ensured that everybody has their
23 training and I am not talking about just
24 now, I am talking about from the last few
25 years.

1 MS KITCHIN: From the last few years. It
2 was coming in more and more in the last
3 few years. There has been more to the
4 days and thing that people need to
5 achieve. Initially, previously, we would
6 have had a problem because they were extra
7 to the try and cover the staff, as well as
8 be able to attend.
9 At present, now, in the last couple
10 of years, we have also have the learning
11 development, we have the computerised
12 system so you have your learning
13 development page with what you need to
14 attend.
15 MS FEATHERSTONE: CTG training.
16 MS KITCHIN: Yes.
17 MS FEATHERSTONE: What do you do?
18 MS KITCHIN: It was the K2 package that
19 has just gone but we have been told that
20 there is the RCOG, there is and online on
21 the learning development page as well. I
22 think it is E learning --
23 MS FEATHERSTONE: Is it mandatory then?
24 MS KITCHIN: Yes.
25 MS FEATHERSTONE: It is?

1 MS KITCHIN: Yes. We have also had
2 somebody coming round recently to go
3 through the CTG package for what the Trust
4 would like us to document and achieve as
5 well.
6 MS FEATHERSTONE: Do you have any learning
7 on the labour ward on a monthly basis or
8 weekly basis with the doctors as well as
9 midwives?
10 MS KITCHIN: As in?
11 MS FEATHERSTONE: Anything. Do you have a
12 regular meeting?
13 MS KITCHIN: Skill drills, to do skill
14 drills. On the labour ward, as I say, on
15 a Monday, they have the lunch time meeting
16 which I was talking about before about
17 looking after interesting cases and any
18 problems that might have occurred during
19 that period of time where it is meant to
20 be multi-disciplinary and people meet. So
21 yes, that does occur.
22 MS FEATHERSTONE: I will talk about the
23 individual cases but does anybody else
24 want to ...
25 DR CALDERWOOD: Thank you very much for

1 coming to speak to us. I think you will
2 appreciate that we have been to see and
3 look through lots of notes and some of
4 them make uncomfortable reading. It is
5 really good to be able to hear -- you
6 don't get a feel for a place from just the
7 paper.
8 I am interested in your comments
9 about you feel that the relationship is
10 good with the midwives and obstetricians
11 and you are right that that has been
12 criticised in the past.
13 I suppose I am wondering as I worked
14 in the lot of different units where the
15 relationship is different where there
16 is -- in some places there is a very low
17 threshold for referring to obstetricians
18 and other places where it would be very
19 much a midwife case obstetricians do not
20 come in the door and this is a midwifery
21 case.
22 What would you say, where does the
23 unit fit in that spectrum of do not let
24 the doctor in at all to refer everything?
25 MS KITCHIN: I think at the moment we are

1 coming under the category of we need to
2 refer everything in Furness because most
3 of them meet some policy or procedure that
4 requires the referral.
5 DR CALDERWOOD: Is that something that is
6 has evolved more recently or ... ?
7 MS KITCHIN: No. It is very difficult to
8 talk over the last 10 years, isn't it,
9 because obviously a lot of individual
10 cases have been brought up into the press.
11 As a co-ordinator, I have never felt
12 it was totally my control. I am there to
13 work and ensure safety, you know, and,
14 therefore, I don't want any untoward event
15 to happen on my shift and obviously these
16 things do happen because some of them are,
17 you know, they happen in front of your
18 eyes even the ones you could predict you
19 have to control.
20 But I always felt that I could refer
21 and that they would, we would get advice
22 and that the doctors would go in and, you
23 know, I do feel that some of the
24 criticisms that to say that, you know,
25 that -- I am sorry to speak about what has

1 been put in press but things like "the
2 doctor was not invited in the room", you
3 know, I think that, personally, in my
4 opinion, it is very, very unfair to make
5 that comment because the obstetricians are
6 there in the labour ward, they are there,
7 they will have been phoned at various time
8 and they have every right as much to enter
9 the room and that is perfectly acceptable.
10 They are their case in majority of the
11 time.
12 I would not feel like I was
13 obstructing a doctor. I certainly would
14 want them to tell me if they felt that
15 way.
16 DR CALDERWOOD: So you would feel that the
17 obstetricians are there, the juniors and
18 the consultants are -- there is a presence
19 on the labour ward. If you need them that
20 they are available and --
21 MS KITCHIN: They are available, yes. I
22 mean, obviously we have a bleep system
23 that we can bleep because, as I say, they
24 are not all the on the labour ward; these
25 days they are more, much more and

1 previously we never had the structured
2 rounds that we have now. You know, it is
3 much more formalised now where the
4 opportunity to refer or even discuss is
5 there much more.
6 DR CALDERWOOD: How recently would you say
7 that changed? I know that is difficult --
8 MS KITCHIN: I think it was probably
9 coming back into, you know, when they did
10 the traffic light system where people have
11 91, 59, and probably around 2008 but I
12 would be little bit guessing of the exact
13 time, it was being introduced then.
14 You know, it has always been that
15 there has been a Registrar available to
16 labour ward. Whether they have been
17 visible there all the time, unless they
18 have been notified previously, I would say
19 that is probably the case.
20 Now, it is, you know, expected and
21 that is the case, working together as a
22 team to hand over what the cases are which
23 is much easier for us as well as a team.
24 DR CALDERWOOD: Yes, I am sure it is.
25 Just, it is interesting to hear that you

1 have said something about something in the
2 press. Are there other examples like that
3 that you would like to tell us because you
4 were there on the ground with some of
5 these cases that have appeared? Do you
6 feel they have some of them have been
7 misrepresented and --
8 MS KITCHIN: Obviously, it is very
9 difficult for us as a team and it is very
10 hurtful to the Trust and to think about
11 the women who come to see us now, to have
12 experienced that. Any particular case,
13 you know, it is a difficult one to say but
14 I am sure that other people have sat here
15 and felt they have been completely
16 misrepresented in press and ...
17 DR CALDERWOOD: I suppose you were
18 involved, although I not with all the care
19 of the Titcombe case and the Hendrickson
20 case.
21 MS KITCHIN: Not Mr. Titcombe, no.
22 DR CALDERWOOD: Not Mr. Titcombe, okay and
23 --
24 MS KITCHIN: Mr. Hendrickson, yes.
25 DR CALDERWOOD: Anything about that case

1 that you were aware was different from
2 your personal feeling or that you --
3 everybody talks about these things are
4 very distressing for staff, of course as
5 well.
6 MS KITCHIN: I think it is very hurtful to
7 be involved in something so traumatic for
8 everybody involved. You know, you feel as
9 you are working you are doing your best on
10 the day with what you are presented with,
11 that you hopefully installed some support
12 and some sort of network for the family to
13 be able to gain comfort or understand or,
14 you know, any of the things for all the
15 circumstances that were presented to them
16 on the day and to attend to in quite --
17 the inquest that we went to that was very
18 startling to be cross examined in such a
19 way and to hear the other side of how
20 Mr. Hendrickson was feeling towards the
21 members of staff.
22 You know, it is very shocking and it
23 is very hurtful and, you know, you would
24 like to have given some support to him and
25 his family and I would have liked him to

1 think that everybody did everything that
2 they absolutely could which is what I
3 witnessed on the day.
4 It was big multi-disciplinary team
5 and many people worked and tried to
6 resuscitate Mrs. Hendrickson for many
7 hours, you know, it is not something we
8 come across every day. So that is
9 upsetting.
10 DR CALDERWOOD: Yes. So you were seeing
11 that as there was a team approach in that
12 case --
13 MS KITCHIN: Absolutely, yes.
14 DR CALDERWOOD: -- and that there were --
15 people were there and responded and were
16 doing what they perceived to be they
17 should have been doing.
18 MS KITCHIN: Yes.
19 DR CALDERWOOD: And what about afterwards
20 and the reaction then within the Trust so
21 that the managers and the complaints
22 process and how did you feel that was?
23 MS KITCHIN: Obviously, we were not
24 involved in that as much. We had to write
25 our statements for the incident itself and

1 then it was some time before we heard some
2 of the things and I don't think I have
3 been privy to all of them.
4 You know, it was the year before the
5 inquest actually occurred and then there
6 was other things going on at that period
7 of time as well. I was shocked out some
8 of the things that came up at the inquest
9 that misunderstanding. There was one
10 about CTG in labour.
11 Sorry, I have lost my train of
12 thought there but ...
13 DR CALDERWOOD: I suppose I am trying
14 to -- you are coming over with feeling
15 that your perception has been different
16 than what was perhaps presented in, well,
17 that inquest but also --
18 MS KITCHIN: I mean, my understanding of
19 the outcome of the inquest was that if it
20 was in any other unit, the outcome would
21 never be any different. So in that, you
22 know, the outcome for that is fine.
23 DR CALDERWOOD: Do you feel that when you
24 called someone else and when you are
25 escalating, you have said they are there

1 and they respond and then, again, you
2 know, all units there are a variety of
3 people, some people like the labour ward,
4 some are not so keen, some are more
5 junior, et cetera.
6 Do you feel that those responses you
7 get from your middle grade staff and then
8 from your consultants are always what you
9 would want, that there is always somebody
10 who knows what they're doing or
11 appropriately escalates to their
12 consultant if they do not feel happy?
13 MS KITCHIN: We only have a junior SHO and
14 then a registrar, an experienced registrar
15 and the unit.
16 DR CALDERWOOD: They are quite
17 experienced, are they?
18 MS KITCHIN: Yes. With the rotation going
19 on now, occasionally we get a junior
20 registrar Who comes through for their
21 placement but our staff grades are very
22 experienced and we have had a lot of
23 experience over the years so ...
24 DR CALDERWOOD: The staff grade have been
25 on the middle tier rota or are they acting

1 as consultants?

2 MS KITCHIN: There is only one that would

3 really act as consultant, Mr. Said.

4 Everyone else would be acting as the

5 middle grade then we have had the

6 consultants.

7 DR CALDERWOOD: Again, I suppose I am

8 projecting some of the things that I have

9 experienced over the years.

10 Sometimes very experienced midwives

11 will disagree with a doctor and that is a

12 problem. There is often a tension and who

13 knows better than whom. Is that something

14 that there is an issue with where you

15 would feel you would -- you were not

16 getting the answer you were wanting and --

17 MS KITCHIN: No because I think, you know,

18 it often depends on how you handle these

19 situations and it is not for confrontation

20 at all, it should be for discussion. If

21 you are not confrontational and your able

22 to sit and discuss these things, then

23 often you will come to a plan of care that

24 is appropriate for that person.

25 It is a lot more structured now, as a

1 said before, and it is not just for
2 interpretation or decision on the day by
3 that particular practitioner because, as
4 we all know, midwifery and obstetrician
5 can be practised in many different ways.
6 Where people perceive as being perfect on
7 that day, somebody else in hindsight will
8 perceive it has not been.
9 It is not for -- as much now a days
10 any way, it is not as much down to "I
11 would like this for this person on this
12 day", it is must more down to "actually,
13 this is policy and this is what the Trust,
14 how they want us to do this and she
15 follows this guideline because her
16 criteria fits this."
17 So I don't think we have
18 confrontations like what you are
19 describing or I do not feel I have that
20 because of the relationship we have that
21 it is, you know, two professionals, three
22 professionals and everyone should respect
23 each other but at the end of the day, if
24 the Registrar wishes to order an
25 investigation or to do that, that is their

1 case.

2 They are, you know, they are

3 perfectly within their remit and they are

4 perfectly experienced to do that, unless

5 it was completely dangerous in somebody's

6 view then I would have the responsibility

7 to escalate it further.

8 DR CALDERWOOD: I'm sorry, I think you are

9 describing that things have become more

10 formalised. You are describing something

11 that maybe is better now than it was that

12 some of these, I suppose I am also making

13 notes from sometimes ago, and my sense was

14 that there was some of these tensions

15 perhaps that I am hinting at but you are

16 now describing situations which is much

17 more comfortable to me to listen to, but

18 is much more driven by the ...

19 MS KITCHIN: It is difficult to look, if

20 you look previously, because what we would

21 look at notes now and I would look at

22 notes now and think, who, what -- why?

23 These person did.... Those, I hope and, I

24 think, is the case, a lot of the criteria

25 that person might fall into today, they

1 didn't then.

2 So that, therefore, that would not

3 instruct in the way that their care and

4 their plonk of care would have gone

5 because those parameters and safeguards,

6 say like large body mass index for

7 instance, you know, in 2004 and earlier

8 than that the policies, the protocols were

9 just probably be coming there about

10 were -- did not fit that criteria for

11 continuous monitoring for, you know, for

12 pregnancy for the many things that are

13 done today.

14 With the help of NICE I'm sure up and

15 down the country it has be very different

16 in that respect but I can only speak from

17 where I come from for the last 10 years.

18 So, yes, I am sure I could look back

19 and like at previous cases and think

20 grasped from today's standards but whether

21 they met any criteria that means they

22 should have been more formally -- their

23 care should have gone a different route, I

24 do not know. I can only -- you know, I

25 think for myself if there is any notes you

1 can show me.

2 DR CALDERWOOD: I suppose there is -- you

3 have no sense that there is a push for

4 normal delivery or nonintervention to

5 the -- with just one focus --

6 MS KITCHIN: I think it has been discussed

7 highly that it is to the detriment of the

8 patient and I would very much hope in all

9 my years that I would not push for that if

10 it meant that, you know, some harm would

11 come to somebody.

12 I have always trained and looked at

13 look at the normality first. So somebody

14 comes in and it is obvious that they are

15 dehydrated, can they drink? It is not the

16 IV fluid route straightaway.

17 You know, if there is the opportunity

18 to normalise something then, I think, that

19 people would have done that previously. I

20 do not know whether there is a sure as now

21 but they would probably get the doctor to

22 see them even though they know it is they

23 need to drink or they need to sleep or

24 rest.

25 But it should not and should never be

1 and I don't believe any of my colleagues
2 would have done that knowingly or thought
3 that it was going to be to the detriment
4 of any patient or woman.
5 Obstetricians is a very difficult
6 thing because what you perceive as
7 wonderful care for that woman, that woman
8 might absolutely hate and at the end the
9 day, it is their experience and they have
10 to achieve what they want to achieve.
11 That is the important thing and normal
12 delivery means nothing, does it, if that
13 person feels it is not what they wanted.
14 DR CALDERWOOD: It is not the your fault
15 if something.
16 MS KITCHIN: Today.
17 DR CALDERWOOD: The outcome, yes.
18 Thank you very much. I do not know
19 whether Jacqui has more questions.
20 MS FEATHERSTONE: I was just going to ask
21 a little about staffing. Generally, are
22 you well staffed?
23 MS KITCHIN: Now?
24 MS FEATHERSTONE: No, going back to what
25 you have been like.

1 MS KITCHIN: No. No. Previously, as I
2 many years.
3 Initially when I first started at the
4 Trust, yes, I think, we were well staffed
5 or rightly staffed for the caseload that
6 the unit had. I think we went through a
7 lot of years of cut backs of staff, that
8 unfortunately people perceive the unit as
9 a quiet unit therefore we do not need
10 regular staff. It appears they do not
11 want to staff the unit for the potential
12 caseload.
13 As we know, labour ward is a
14 unpredictable place so you need a core and
15 a foundation number to support I do not
16 think that has always been the case. I
17 think it is getting better but we do still
18 have days and times when the work load is
19 far more than what the midwives numbers
20 can facilitate.
21 MS FEATHERSTONE: What do you do about
22 that?
23 MS KITCHIN: We still have a shortage of
24 bank. We rely heavily still on agency
25 which is very important and core to us

1 covering the shifts at the moment.

2 Goodwill, ringing round the unit.

3 Escalate now to the matrons discussions

4 with Lancaster to see our sister for the

5 Trust to see what we can achieve. Many

6 different things but it is rarer now to be

7 short staffed but it is not ...

8 MS FEATHERSTONE: Would you say that you

9 have worked a shift where it has been

10 unsafe staffing?

11 MS KITCHIN: I would say that I have

12 worked shifts where I would have would

13 have liked more staff. I would say it is

14 difficult sometimes to -- as the

15 co-ordinator of labour ward we are staffed

16 on numbers for, as I said, maternity ward

17 and the labour ward and they are slightly

18 separate, not very far but separate.

19 So your if your colleagues are

20 ringing you and telling you that they are

21 short staffed and they cannot cope, your

22 reaction to that is to try to send them

23 staff make it safe for them there which,

24 you know, if you don't -- if you don't do

25 it the right way, it could leave you short

1 where you are.

2 It is a difficult one to manage and

3 review and it is communicating, isn't it?

4 MS FEATHERSTONE: So escalate it so --

5 what about do you have and on call manager

6 at night?

7 MS KITCHIN: We have a supervisor who is

8 on-call and there will be a matron that we

9 could get hold of now to discuss.

10 Just for instance, a couple of days

11 ago I was working shift and we were -- the

12 caseload was going to be too much and the

13 ward would have been unsafe if we would

14 have taken the midwives from there so we

15 escalated it and brought in another

16 midwife and luckily we managed to get a

17 another midwife which is sometimes

18 difficult to do.

19 It carried on and we went to divert

20 which meant that any of our ladies that

21 came we were trying to divert them to

22 Lancaster. Unfortunately sometimes those

23 ladies cannot travel, they cannot go, they

24 need to come or our own clinics are

25 sending us ladies which was happening on

1 that day as well.

2 So then for the night staff coming

3 on, again, their numbers would have been

4 too little so we spoke to the supervisor

5 to ask if we could bring the community who

6 were on-call for home confinement which we

7 did.

8 MS FEATHERSTONE: That is what I was going

9 to ask, do you have community. So

10 generally, although you have got core

11 staff on labour, the other midwife

12 generally if need to call, should come and

13 sort of hit the ground running on labour

14 ward. They can all do -- their skills are

15 all up-to-date?

16 MS KITCHIN: Who, the midwives in the

17 unit?

18 MS FEATHERSTONE: Yes.

19 MS KITCHIN: Yes and the thing is we would

20 renegotiate where they are and where they

21 are working for the safety of -- to make

22 sure that the level of support and the

23 level of experience was even to be able to

24 cope as much as we possibly can.

25 There has been a lot of -- about five

1 midwives -- junior midwives coming in
2 recently so that has sometimes been
3 difficult to give them their experience
4 and make sure that they are also supported
5 because you are talking about a unit with
6 much less staff, much less ability to
7 change around and a lot of support to each
8 other.
9 But again, a little bonus in that, in
10 that you know what the people's
11 experiences are, you know, and in a big
12 unit you may not because you may not have
13 worked with them an awful lot.
14 MS FEATHERSTONE: You talked about the
15 when Catherine was asking you some
16 questions just generally about how you
17 would escalate and how things have changed
18 but any time during the last 10 years,
19 have you felt the unit was unsafe and have
20 has that been escalated -- I do not just
21 mean staff, I mean things have happened on
22 the unit. Have you ever felt that?
23 MS KITCHIN: It is a difficult question to
24 answer, is it not, because you are
25 constantly, reorganising, and rejigging

1 what is happening and what is going on
2 and, you know, there will have times when
3 we will have been short staffed or we will
4 have been stretched in the amount of care
5 that we are trying to give to ensure the
6 safety of all the patients that we are
7 involved with.
8 There has been an unfortunate event;
9 I can speak about the main one that I have
10 probably been involved in, the escalation
11 of that was, you know, the people who I
12 could inform were informed up to the head
13 of midwifery and the obstetricians to come
14 in and they all came on that particular
15 occasion and they were all available to me
16 and I did call them and they came in. The
17 night staff, I called them and they came
18 early.
19 So there was a system to go down and
20 that system went we went there and it was
21 met, if that makes sense.
22 MS FEATHERSTONE: Yes, and over a period
23 of time, do you think that the unit had an
24 increased amount, more stillbirths than
25 any other unit, or anything else that you

1 felt that it was happening more at the
2 unit than it happened anywhere else? You
3 never got that sense?
4 MS KITCHIN: No.
5 MS FEATHERSTONE: All right, thank you.
6 MR BROOKES: Thank you. Stewart?
7 PROF FORSYTH: There is a lot of
8 changing in recent years. I wondered
9 whether that apparently that was due to
10 willingness now to introduce change into
11 the labour ward; or has it just happened?
12 Do you think there was in early days a
13 reluctance to introduce change?
14 MS KITCHIN: It depends in which respect.
15 I think the thing that I have noticed most
16 in the unit, or the Trust, is the
17 CNST-side of things, the system of, you
18 know, reviewing incidents is acknowledging
19 untoward events and those things.
20 From a shop floor point of view -- I
21 think whenever there is change, there is
22 unrest and there is unsettled and
23 people -- there is always varied opinions
24 on that. But I would certainly say that
25 if it has been if it is beneficial, if

1 people can see that it is beneficial then
2 no.
3 I think one of the biggest things we
4 have had is more equipment and updated
5 courses and, you know, those sorts of
6 things to help us on the shop floor and
7 the structure is much better because, you
8 know, you do not want to be a practitioner
9 on the day when something happens. You
10 want to be supported in that somebody
11 saying:
12 "Actually, look, I can prove they did
13 the right thing on the day, they did what
14 was asked of them."
15 And unfortunately, I do not think
16 that all the time it is down to
17 interpretation whether that person did or
18 somebody's viewpoint because that system
19 was not there previously.
20 You know, people try their very best,
21 they try their very hardest because they
22 want to install in the families that come
23 to us that they are safe where they are
24 and --
25 PROF FORSYTH: Do you --

1 MS KITCHIN: -- have a good birth
2 experience.
3 PROF FORSYTH: Sorry. Have you
4 worked in other units recently?
5 MS KITCHIN: Recently, over the last
6 couple of years, no. Obviously I trained
7 at a bigger unit than where I work now,
8 and I worked at the another unit -- 3,500
9 deliveries -- before I came to Furness
10 about not in the last couple of years, no.
11 PROF FORSYTH: Do you visit other
12 units to see or do your colleagues visit
13 other units that are similar to yourself
14 to get ideas?
15 MS KITCHIN: I think if you have been to
16 cases like also courses and things like
17 that, you will have met other people and
18 obviously you build friendships over the
19 years if you have moved around and going
20 to discuss things.
21 You know, when I left Blackpool where
22 I work previously, you think it kind of
23 stands at that point and then you very
24 quickly realise that it has moved on a lot
25 in the time that has passed as well.

1 PROF FORSYTH: Do you feel isolated
2 in Furness in terms of the getting that
3 experience? You have got other similar
4 units next door to you; there is
5 Lancaster. Do you -- it is a case of
6 trying find out what other units are doing
7 to see whether you were actually employed
8 doing the best.
9 MS KITCHIN: I think that would always be
10 interesting to any unit, would it not, to
11 see if anything was a particular success
12 story for that unit.
13 It is a little bit change locality
14 where Furness is and the number of
15 deliveries we have and, you know, also we
16 were an obstetric unit so it should not be
17 under the misconception that it is a
18 low-risk unit, low-risk pregnancies.
19 Absolutely not. We have our fair share of
20 those so it will be useful to share those
21 thoughts with the units.
22 PROF FORSYTH: In relation --
23 MS KITCHIN: I do not know if that answers
24 your question.
25 PROF FORSYTH: Okay. Just in

1 relation to you saying it is an obstetric
2 unit, it is level one neo-natal unit; does
3 that present difficulties?
4 MS KITCHIN: Yes, it does and it was not
5 previously.
6 PROF FORSYTH: Was it level two
7 previously, or can you not remember?
8 MS KITCHIN: I think it was level two or
9 even previously level three but I would
10 have to look back in the books for that.
11 PROF FORSYTH: But basically it is
12 what we call a level one unit now, so not
13 providing any high dependency care or
14 intensive care. Does that present
15 difficulties in managing patients or
16 managing obstetricians or paediatricians?
17 MS KITCHIN: The thing -- the relationship
18 between the obstetric team and midwifery
19 team and the paediatricians has got better
20 over the last couple of years and
21 certainly the neonatal nurses.
22 I think it is very frustrating to the
23 unit because we, at times, would benefit
24 from providing that higher level of care,
25 or the staff would be involved in that

1 more often.

2 I cannot really talk for the

3 paediatric team in a way because it is

4 obviously a different skill and training.

5 PROF FORSYTH: Do you find that there

6 is a bit of conflict sometimes with

7 obstetricians who are maybe wanting to

8 deliver a lady who has got high risk

9 babies and presents problems for

10 paediatricians, say "We don't have any

11 neonatal"--

12 MS KITCHIN: I think we are certainly

13 aware of, as co-ordinators, the need to

14 draw the team together if in these

15 situations that, you know, obviously there

16 is no use delivering a high risk lady if

17 there is no bed for the baby, you know, it

18 is much -- then in that to transfer

19 somebody if they meet that level of care

20 of need and transfer to -- below 34

21 weeks -- to another unit. Obviously that

22 is a difficult thing to organise with the

23 structure and to gain the referral

24 sometimes.

25 But it is more -- it is higher than

1 what I am at but I am more involved in the
2 discussion of bringing the team together
3 and highlighting early to the paediatric
4 team that we may have, you know, a
5 potential case that they many need input
6 on.
7 PROF FORSYTH: If the lady is
8 required to be transferred, does that
9 normally go efficiently with no
10 difficulties or are there delays in
11 transferring the baby?
12 MS KITCHIN: You would have to speak to
13 the paediatric team because if they are
14 requiring that they are on the SCBU.
15 PROF FORSYTH: In the meantime the
16 baby will be transferring into the --
17 MS KITCHIN: Special care baby unit, yes.
18 If they are requiring those kind of input,
19 they will not be on the labour ward.
20 PROF FORSYTH: What about
21 resuscitation? Do you feel that the steps
22 of resuscitation are -- midwives,
23 paediatricians are able to maintain the
24 skills in resuscitation?
25 MS KITCHIN: I would hope very much that

1 is the case because that is essential. We
2 do have periodic updates twice yearly; for
3 neonatal resus we are going on the NLS
4 course.
5 Paediatric-wise, again you would have
6 to ask the special care unit and the
7 nurses there and the paediatricians.
8 PROF FORSYTH: Do you think -- I
9 mean, if you are around the labour suite
10 and resuscitation, do you feel that
11 standards of resuscitation in Furness are
12 adequate?
13 MS KITCHIN: Again, that is a difficult
14 question for me to answer, is it not,
15 because as we ascertained before, I don't
16 have experience of other units.
17 PROF FORSYTH: But often the midwife
18 would be first there.
19 MS KITCHIN: Yes, first line, yes. I
20 would say that they are trained and
21 capable of initiating resuscitation and
22 are trained and it provides us with the
23 other paediatricians.
24 PROF FORSYTH: Are there times of
25 delay with the paediatricians arising?

1 MS KITCHIN: The only time, if there is a
2 delay, is if they are obviously treating
3 other another emergency case on children's
4 ward or in A&E. If that ever has
5 happened, we have had good back up from
6 special care. They come, they often
7 attend at our deliveries if necessary and
8 come with the skills and the -- there is,
9 you know, they could call another
10 consultant in, if need be, and they have
11 done and we have done.
12 PROF FORSYTH: Thank you.
13 MR BROOKES: Jonathan?
14 PROF MONTGOMERY: Thank you. There
15 are a number of things that you touched on
16 that I'm not quite sure that I understood
17 quite what I have been you were saying. I
18 might have a supplementary.
19 Can I start with -- you talked in the
20 discussion about there would, of course,
21 be occurrences/shared experiences with
22 other units. I didn't quite get the feel
23 for whether you thought it did happen and
24 that you got the benefit of people's
25 awareness of what goes on in other units

1 or whether it would be nice to have but
2 you do not get as much as you would like.
3 MS KITCHIN: I think, any way of bringing
4 units forward and change that is, you
5 know, beneficial is always -- obviously
6 you cannot refuse that. That has got to
7 be what we want. It is what we want.
8 I do not know whether it happens too
9 much, I know in the last few recent years
10 they have, you know, had communications
11 with Liverpool and some midwives have gone
12 to Lancaster, but again that is the same
13 Trust, so it would be more beneficial to
14 go to another Trust.
15 PROF MONTGOMERY: Has anything, you
16 think, changed because of those visits?
17 MS KITCHIN: Yes. A few things have
18 changed. They have put in the rooms on
19 the wall like they have at Liverpool with
20 like protocols and like PPH and PH in the
21 room? There will be one or two things
22 that has been brought from there.
23 I think that the biggest thing for me
24 and the most interesting thing for me is
25 speaking to the agency midwives because

1 obviously they have a wealth of experience
2 of work up and down the country in various
3 places and that is very interesting.
4 PROF MONTGOMERY: That is great
5 because we were unclear what the geography
6 is. It is quite hard to... A couple of
7 questions about that.
8 When you have to call the agency, do
9 you get the same midwives back locally?
10 MS KITCHIN: There are occasions when we
11 do, yes. Yes.
12 PROF MONTGOMERY: Are they local
13 midwives who just don't want to work
14 locally or ...
15 MS KITCHIN: No, they are not local
16 midwives. They come from London most of
17 them so they have to travel up.
18 PROF MONTGOMERY: Okay. So
19 presumably you have to do that quite a
20 long way in advance?
21 MS KITCHIN: Yes which can make a
22 difficult if you need somebody very
23 quickly.
24 PROF MONTGOMERY: This is come up
25 elsewhere and you may not be able to help

1 us but we were trying understand the bank.
2 Whether it was that all of you doing over
3 time or whether there is a separate group
4 of midwives living in the area who could
5 be called in, but do not work full-time.
6 Who is on the bank, such as there is a
7 bank?
8 MS KITCHIN: I would say there is not
9 really a bank the moment. Previous years
10 there were, there was -- sorry, English.
11 There certainly was a bank of core
12 midwives that you could call. They would
13 probably be working in the unit and you
14 would call them in as they would be staff,
15 but they would do bank work.
16 PROF MONTGOMERY: So they would be
17 the same midwives not a --
18 MS KITCHIN: Yes, with one or two that
19 actually have other roles and other jobs
20 elsewhere, but generally speaking, yes.
21 We don't have a bank at the moment of
22 midwives. We are calling our staff to see
23 if they can come and do shifts.
24 PROF MONTGOMERY: I think it has come
25 down to the questions that Jacqui asked.

1 So the normal thing is that midwives move
2 around from community or from maternity
3 ward depending on where the pressures are
4 as opposed to coming from outside unless
5 you know in advance that you need an
6 agency midwife.
7 MS KITCHIN: Yes.
8 PROF MONTGOMERY: Thank you. You
9 talked about the staffing getting better.
10 Is it that -- is the fact that you are on
11 the way, as opposed to having been there,
12 having got to where you need to be, is it
13 difficult to recruit, or do you have
14 vacancies you are trying to recruit to, or
15 are there not enough posts to meet staff?
16 MS KITCHIN: I have not been involved too
17 much in the recruitment but my personal
18 perception is that it is the called a sack
19 area. It is difficult to get -- we are
20 getting a lot of band five midwives, newly
21 qualified midwives, recently in the last
22 three or four years as they tried to
23 recruit. It just does not feel like their
24 sustaining and staying. They are gaining
25 the two years they need or the year they

1 need and then they are ...
2 PROF MONTGOMERY: So they tend to
3 come and not stay?
4 MS KITCHIN: Yes.
5 PROF MONTGOMERY: Thank you. There
6 is a couple of things about training. You
7 described the range of training and I do
8 not know how much of that is done in the
9 Trust, on either parts, and how much you
10 do in other places on --
11 MS KITCHIN: In other units?
12 PROF MONTGOMERY: Yes.
13 MS KITCHIN: It is not generally done in
14 other units; it is within the Trust. It
15 probably -- I will be guessing, but
16 probably about 50/50 e-learning online and
17 physically attending.
18 PROF MONTGOMERY: It is not --
19 MS KITCHIN: I have not reviewed it to get
20 statistics --
21 PROF MONTGOMERY: -- at the training,
22 is it not very common when you do the
23 training you get the benefit of meeting
24 people from other units because mostly --
25 MS KITCHIN: Not with the core in-house,

1 no, unless you were attending somewhere
2 you have probably put yourself forward and
3 organised yourself.
4 PROF MONTGOMERY: Does the Trust
5 support you in going to those training
6 courses.
7 MS KITCHIN: Financially or time or --
8 PROF MONTGOMERY: Both. Do you have
9 finance and backfill --
10 MS KITCHIN: It is probably more that you
11 could ask for funding and putting the
12 rates, I think that has been funded. I
13 could not speak personally. Recently I
14 think people have.
15 How much is in the pot to be able to
16 do that and how much leeway there is --
17 but, I mean to say we don't -- I was
18 speaking about the NLS course. Most of
19 the band sevens recently have gone on
20 there and so they are talking to the
21 midwives from Liverpool where it has been
22 held, or Newcastle, so that it does happen
23 for some things.
24 PROF MONTGOMERY: I am trying to get
25 an understanding of what the opportunities

1 are.

2 You talked about the NLS course. Do

3 you have also instructors amongst your

4 colleagues?

5 MS KITCHIN: Yes.

6 PROF MONTGOMERY: And--

7 MS KITCHIN: Moving more towards Prompt

8 now and they --

9 PROF MONTGOMERY: Thank you. There

10 is a couple of other things about the

11 context in which you are working. You

12 talked about the fact that you have now

13 got, although you have said that you have

14 not always had this, the object is to have

15 regular discussion and develop meetings.

16 Can you tell us about what support in

17 terms of the what -- this might not be the

18 right term -- clinical governance data the

19 Trust makes available. So it is how does

20 it tell you what the training results are

21 and other things you might want to think

22 about. Do you get any data like that from

23 the Trust?

24 MS KITCHIN: If somebody has filled in an

25 incident and it has gone forward, they are

1 kept up to date and e-mailed back that it
2 has been reviewed, or if there is any
3 outcomes. There is also general e-mails
4 that has been sent out if there are
5 lessons learnt or key points that people
6 need to be aware of and do and ensure
7 happens. That will come out for people as
8 a result of these incidents being
9 reviewed.
10 PROF MONTGOMERY: Is there a clinical
11 risk committee or something that you hear
12 about regularly, what their perception --
13 MS KITCHIN: Yes, sorry, there is.
14 Actually I am trying to think of the
15 terminology in this pressure.
16 PROF MONTGOMERY: It is about -- how
17 useful it is --
18 MS KITCHIN: They have a -- is it a
19 monthly review where it comes out with
20 lessons learnt and they give a brief
21 scenario of what has happened within the
22 Trust. It is not just at Furness, it is
23 the whole Trust and the review and the
24 outcome and it is listed so, you know.
25 PROF MONTGOMERY: It comes to

1 everybody?

2 MS KITCHIN: Yes, I believe so.

3 PROF MONTGOMERY: Thank you and you

4 talked about putting stuff up and

5 sometimes having to bring things to the

6 notice of the head of midwifery. Do you

7 have ever have any contact with members of

8 the Trust board? Have they shown any

9 interest in services? Do they come and

10 visit you?

11 MS KITCHIN: We will have had people from

12 the Trust Board coming through. Various

13 times for various reasons on a general

14 basis, not a lot. It is usually when

15 there is something going on that we would

16 see.

17 PROF MONTGOMERY: Have you met any of

18 the non-executive directors?

19 MS KITCHIN: I will have met a few at the

20 days that we have had recently with new

21 board members, Sue Smith and various

22 people, you know, had contact with her. I

23 have not had contact with them previous in

24 the years, no.

25 PROF MONTGOMERY: So this will be

1 first time that you have?

2 MS KITCHIN: The last couple of years, two

3 or three years, yes.

4 PROF MONTGOMERY: Okay. What about

5 the Director of Nursing, Medical Director;

6 have they seen you --

7 MS KITCHIN: Yes, they will have -- yes.

8 They have. They will have come through.

9 It is not an everyday occurrence. It is

10 a good question to answer; it depends

11 whether you are on duty as well, does it

12 not?

13 PROF MONTGOMERY: So your sense is

14 that they would know what was going on in

15 the unit or that they would not know? Do

16 they come when something seems to have

17 gone wrong, do you suddenly see them --

18 MS KITCHIN: I think there is a lot more

19 meeting that go on. A lot more things

20 held at Kendal and various places where

21 the matrons go to when they feedback

22 regularly. There is a lot of managerial

23 meetings as core band seven.

24 We are not always involved in those

25 but, I think, that it is sometimes

1 surprises me about the head of midwifery
2 does know and she actually is quite well
3 informed and then is passing it on to the
4 other directors. But that is kind of --
5 always on the shop floor.
6 PROF MONTGOMERY: So while you expect
7 the Head of Midwifery to have a pretty
8 good idea of what is going on, you would
9 not know whether the other directors,
10 board directors knew about it.
11 MS KITCHIN: No, but I haven't --
12 PROF MONTGOMERY: I would not expect
13 you to.
14 Can I ask about the sort of support
15 that you have. For example, you had to
16 give evidence at the inquest and things.
17 Did you get some training in giving
18 evidence? Did you get some support in
19 preparing the statements?
20 MS KITCHIN: There was a format for doing
21 statements that we have as part of the
22 Trust and there was a meeting before we
23 went to the in inquest, we method Trust
24 barrister on one particular one.
25 I haven't been to it. I didn't

1 feel -- I didn't feel I knew what I was
2 walking into. I didn't know what was
3 going to be presented or discussed on the
4 day. Having been to three now, I kind of
5 understanding how they work and what it is
6 about more. So ...
7 PROF MONTGOMERY: Just to tease out a
8 little more of that. Beforehand when you
9 have had the meeting with the barrister,
10 was that a group of you being explained
11 how the inquest --
12 MS KITCHIN: It was just a general
13 discussion of you would go in and you
14 would be introduced and you would swear an
15 oath, you will sit at the front and that
16 is it.
17 PROF MONTGOMERY: So no tips on how
18 to keep calm when barristers are trying to
19 trip you up, or anything of that sort?
20 MS KITCHIN: No, I would have liked the
21 key about asking the same question in five
22 different forms; might have been useful.
23 PROF MONTGOMERY: When you were
24 drawing up your statement and things, what
25 support did you have to make sure that you

1 did that well and did not get yourself
2 into difficulties?
3 MS KITCHIN: Well, the format of how to
4 write factual information, sign it off. I
5 have not had coaching.
6 PROF MONTGOMERY: Sorry, you did or
7 did not have coaching?
8 MS KITCHIN: I have not had coaching.
9 PROF MONTGOMERY: Did anybody want to
10 see statements in draft before they went
11 in?
12 MS KITCHIN: They would go to the CNST and
13 they would go and the only thing I might
14 have that is that something back saying,
15 "Can you clarify this point?" In my
16 experience.
17 PROF MONTGOMERY: Did you get any
18 sort of debriefing and support afterwards?
19 MS KITCHIN: After?
20 PROF MONTGOMERY: After giving
21 evidence at the inquest?
22 MS KITCHIN: No.
23 PROF MONTGOMERY: So they just left
24 you to do it and did not --
25 MS KITCHIN: Yes.

1 PROF MONTGOMERY: That is pretty
2 tough. Did you get support from your
3 colleagues or that is --
4 MS KITCHIN: It is a close unit everyone
5 knows what yours going true system some
6 support -- you support each other where
7 you can. It is very stressful situation
8 and, you know, I sometimes wonder how they
9 expect people to conduct themselves on the
10 shop floor after such experiences but ...
11 DR CALDERWOOD: Can I ask you what about
12 at the time of the adverse events, the
13 ones that led to the inquests. Did you
14 have support or were offered counselling
15 or someone to speak to within the Trust or
16 outside it?
17 MS KITCHIN: Mrs. Hendrickson's one, we had
18 a letter from the Head of Midwifery to say
19 to us, "Thank you for the actions that you
20 did on the day", and there was support
21 through, you know ...
22 DR CALDERWOOD: Did--
23 MS KITCHIN: You could have counselling,
24 you could have it, yes.
25 DR CALDERWOOD: That was offered?

1 MS KITCHIN: On that occasion, yes.
2 DR CALDERWOOD: The other one --
3 MS KITCHIN: Nothing was booked and
4 nothing was organised, but it was
5 mentioned in this letter that you could
6 have support if you wished.
7 DR CALDERWOOD: It gave you a way to
8 access that?
9 MS KITCHIN: It will be through the
10 occupational health. That is what I was
11 thinking about.
12 DR CALDERWOOD: Not the other inquests
13 that you were involved in? There was --
14 after those incidents?
15 MS KITCHIN: No.
16 DR CALDERWOOD: Sorry to interrupt.
17 PROF MONTGOMERY: That is fine. On
18 that do you know whether anybody else used
19 that? If they found it was effective
20 or --
21 MS KITCHIN: I think one of my colleagues
22 may have used it. I certainly did not,
23 no.
24 PROF MONTGOMERY: Thank you and there
25 is a lot of things that have happened in

1 this unit and there has been all sorts of
2 people coming in we are the last of a long
3 line of people trying to find things out.
4 I wondered what it felt like and how
5 much you were involved as individual
6 members of staff, you personally saying
7 you had a Fielding team coming in, you
8 have had the Midwifery Council, the CQC.
9 Were you involved in those visits and
10 processes?
11 MS KITCHIN: No. Some of them I would not
12 have been because I would have been off
13 work for personal circumstances. It was
14 very difficult. It is very stressful. It
15 is very hard, a lot of preparation, but
16 that is what needs to be done and then
17 that is what we need to achieve and, you
18 know, we need to restore the damage that
19 has already been done.
20 PROF MONTGOMERY: So can I ask you
21 about -- so the Fielding Report, do you
22 remember team coming round? Did they talk
23 to you? Were you there?
24 MS KITCHIN: No, I do not think -- do you
25 know what year that was?

1 PROF MONTGOMERY: 2010.

2 MS KITCHIN: I think I would have been

3 off.

4 PROF MONTGOMERY: Have you seen

5 Fielding Report?

6 MS KITCHIN: No, not that recall. I may

7 have done, but the actual formal title of

8 it, no.

9 PROF MONTGOMERY: Do you remember

10 anything being discussed about it.

11 MS KITCHIN: No.

12 PROF MONTGOMERY: There was not an

13 action plan or anything?

14 MS KITCHIN: No. I was off on maternity

15 leave for that time; I may have missed it.

16 PROF MONTGOMERY: Okay. We are

17 trying to track where it went. Were you

18 around for the CQC visits; 2012 it would

19 have been?

20 MS KITCHIN: I would have been around for

21 some of those, yes.

22 PROF MONTGOMERY: Do you have a

23 memory of them coming --

24 MS KITCHIN: I think I may have been off

25 on that particular day.

1 PROF MONTGOMERY: You did well on
2 that basis.
3 MS KITCHIN: They have been around on a
4 few times; on numerous occasions so.
5 PROF MONTGOMERY: Did you have a
6 memory of what the Trust told you about
7 them and whether they were helpful in
8 telling you what the CQC might need to
9 know and -- did you learn anything about
10 what the CQC have identified, referring to
11 the discussions about how to improve
12 services --
13 MS KITCHIN: Feedback from the CQC would
14 recommend and would have liked to have
15 seen, yes, and obviously the strives to
16 rectify anything that is possibly to be
17 able to rectify that is within our
18 control, yes.
19 PROF MONTGOMERY: I think the last
20 one --
21 MR BROOKES: Good.
22 PROF MONTGOMERY: -- you talked about
23 supervision and you talked about the sort
24 of normal bit of supervision about having
25 a supervisor. What about the role of

1 supervisors when there has been something
2 untoward that has happened and you have
3 took statements and things? Can you tell
4 us about how that has worked?
5 MS KITCHIN: The review of the case that
6 has been conducted? Then we went to see
7 if there is anything that, you know,
8 personally or anything that needed to be
9 reviewed.
10 There is a lot of "behind the scenes"
11 investigations into these events, isn't
12 there, and outcomes have been brought and
13 then they cascaded down in various ways.
14 I do think that some people do not realise
15 that has been done and that actually
16 formalise it; that is part of that
17 process.
18 PROF MONTGOMERY: Would you say that
19 has helped you improve practice in the
20 unit or has it been incidental to
21 anything?
22 MS KITCHIN: Supervision? I think
23 supervision is very important to anybody's
24 practice because it is (inaudible) and it
25 is down on the level that we work at,

1 isn't it? It is midwifery supervision, it
2 is practice, in the way that we practise
3 so it can be very beneficial.
4 PROF MONTGOMERY: Thank you.
5 MR BROOKES: I have got a couple of very
6 brief questions for clarification. I am
7 pretty clear in terms of the kinds of
8 things and mechanisms that are in place
9 now. I just want to go back a little bit
10 to the previous time.
11 Was there ever a time where you felt
12 that there had been a serious issue,
13 clinical issue, within the unit that you
14 were not able to escalate that and if you
15 were able to escalate it, were they always
16 acted on?
17 MS KITCHIN: I think from my position, if
18 there was anything else I was involved
19 then I would escalate it and there would
20 be a point of person to go, as in a
21 matron, to escalate it to. It would be
22 difficult to say where it went from there.
23 MR BROOKES: The reason I am asking you is
24 because on couple of occasions we have had
25 people explaining that they had raised

1 issues but felt that they had not been
2 listened to, the seniority of the
3 organisation. Is that something you have
4 experienced, or is that -- I am trying
5 to --
6 MS KITCHIN: I think sometimes it does
7 feel like it stop s at a certain point.
8 MR BROOKES: Where is that?
9 MS KITCHIN: That is a difficult one to
10 answer, isn't it? It depends on what you
11 are escalating and what your concerns are.
12 I think that something that we would
13 escalate up would possibly be a difficult
14 thing for people solve but where they took
15 them, it is not always clear and sometimes
16 the feedback from that would not always be
17 there over the last couple of years.
18 I do not know whether I am answering
19 your question. It is a difficult one.
20 From the shop-floor point of view, if
21 there was untoward, right to escalate,
22 there would be a point for us to go for
23 the powers of us to take it any further.
24 MR BROOKES: I understand.
25 MS KITCHIN: It is limited, isn't it?

1 MR BROOKES: That is part of the issue,
2 isn't it? Where you felt that whether you
3 controlled it, and whether you are
4 supporting the rest of the organisation to
5 take it through.
6 A difficult question and you may not
7 be able to answer it but has there been
8 anytime over the last few years where you
9 have felt that service safety was
10 compromised because of lack of staffing
11 and anything else relating to the unit
12 or --
13 MS KITCHIN: I think we were heading down
14 a road where we would have been
15 compromised. At one point -- I am trying
16 to think when it was -- we were being
17 pushed from more and more to a remit that
18 a lot of us felt was going to be dangerous
19 and in the way that they wanted to run the
20 unit --
21 MR BROOKES: The skills --
22 MS KITCHIN: -- staffing where the staff
23 were based -- yes, they wanted to like
24 core people on the labour ward and people
25 based in the community and if something

1 happened or a lady came in, then you would
2 call the people back and so we were
3 running to minute numbers, which would
4 have -- I cannot see it would have worked
5 at all because they would need for some of
6 the women that were there but that was the
7 way it was going. As much as you are not
8 being to be obstructive to --
9 MR BROOKES: How are you engaged in the
10 debate, in the consultation engagement
11 process around --
12 MS KITCHIN: I think the level of that was
13 just at matron-point. It was being
14 brought forward and pushed forward at that
15 point. Then, you know, feedback was to
16 them, to different strives to try to move
17 it forward... It is limited where it
18 could go because it was being pushed
19 forward from that point forward.
20 MR BROOKES: Thank you.
21 MS KITCHIN: It would have been dangerous
22 at that point.
23 MR BROOKES: Just one last question. You
24 have talked about the constructive
25 relationship between the obstetricians and

1 midwives. Was that the same for other
2 staff groups as well? Was there any
3 issues into professional issues in the
4 unit at all?
5 MS KITCHIN: In which staff groups?
6 MR BROOKES: I am not specifically
7 pointing to any, but there is -- was there
8 any inter-professional conflicts or
9 problems that you saw with them?
10 MS KITCHIN: No, I would hope not. It is
11 a difficult question, is it not, because,
12 you know, on the day-to-day running of the
13 shop floor and how you communicate
14 together and work together as a team, I
15 always felt that was good whether it was
16 of a higher difference, you know.
17 MR BROOKES: Thank you.
18 MS KITCHIN: You would have to talk about
19 particular cases or instance.
20 MR BROOKES: Any questions?
21 DR CALDERWOOD: Just following that
22 briefly because I am conscious very much
23 of the time. You have been very helpful
24 but you have not touched on any
25 relationship with theatre teams or with in

1 the event of needing an emergency theatre
2 or whatever.
3 Any concerns about that, or was that
4 something -- a new process, nighttime,
5 daytime/weekend et cetera.
6 MS KITCHIN: I think everybody has always
7 been very mindful of the theatre as a
8 separate -- it is a general theatre, and
9 so that communication is always key, isn't
10 it, to get the early communication in to
11 make sure that it is available for us.
12 Previously, there was not an on call
13 team, you would have to call them in and
14 so earlier detection of a problem and
15 cascading was very important.
16 It has always been slightly separate,
17 I have to say, and but just as important
18 to have that team there when you need
19 them. Again, it is better now because
20 they have the on-call style, and a slight
21 removed place; it is not that far away
22 locality-wise, but it is far enough for
23 people to say it is separate.
24 DR CALDERWOOD: Any ever instances where
25 the theatre was not available because

1 there were a lot of cases or there were
2 not staff to staff it? I am thinking
3 about --
4 MS KITCHIN: There can be and you would
5 speak to them and they would get the
6 second team in. So that can happen and
7 that will have happened over, you know,
8 previous years.
9 DR CALDERWOOD: Okay, but there was a
10 plan, that was the second team, and they
11 would be there; they would be available
12 and they would come?
13 MS KITCHIN: Again, I suppose you would
14 have to speak to the theatre teams on how
15 they negotiated that but once they knew we
16 had a need, then they would try to
17 facilitate that for us.
18 DR CALDERWOOD: Thank you.
19 MR BROOKES: Okay, thank you. Unless
20 there is anything else?
21 Thank you very much for your time.
22 It has been extremely helpful and we will
23 finish it at that stage. Thank you very
24 much.
25 ---------------------------

THE MORECAMBE BAY INVESTIGATION

Thursday, 18 September 2014

Held at:
Park Hotel,
East Cliff,
Preston,
PR1 3EA

Before:

Mr. Julian Brookes – Expert Adviser on Governance (In the Chair)
Professor Jonathan Montgomery – Expert adviser on Ethics
Professor Stewart Forsyth – Expert adviser on Paediatrics
Professor Geraldine Walters – Expert Adviser on Nursing

SANGEETHA KOLPATTIL

Transcript from the Stenographic notes of Ubiqus,
Clifford's Inn, Fetter Lane, London. EC4A 1LD.

2 MR BROOKES: Hello and welcome. Thank you for coming this
3 afternoon. I am just going to explain what we can and what
4 we cannot deal with today and then we will do some general
5 introductions and general housekeeping, if that is okay.
6 We have had to consider whether or not your case fits
7 within the terms of reference to what we are looking at
8 within this inquiry. This is predominantly around maternity
9 services and that is the remit we have been set out from the
10 Secretary of State. However, within the second of our terms
11 of references there is an opportunity to look at the
12 governance arrangements and how things are handled within
13 the Trust. We feel that your case maybe relevant to that
14 particular part of the inquiry and, therefore, we are happy
15 to listen to you and discuss, with you, your evidence today.
16 However. Our remit is not to look at breast screening,
17 or radiology services; there are other mechanisms for
18 discussing the specifics around that. Really what we want
19 to understand is how you were treated, the issues that were
20 raised, and I will ask some questions around those lines, if
21 that is okay?
22
23 (Following introductions from the Panel
24 and housekeeping matters)
25

1 MR BROOKES: I am very happy to have your husband here, you
2 can introduce yourselves in a second. I will just warn you
3 that this is for your evidence, and you are here to help
4 with any misunderstandings, but not to answer the questions
5 for your wife. If you can say who you are.
6 DR KOLPATTIL: That is what I requested to Nick over there,
7 so he can maybe guide me through -- my English cannot be
8 that fluent and I may not be able to express clearly for
9 that, you to understand it. Sometimes I may need his help
10 MR BROOKES: That is absolutely fine. I will say here do
11 not worry if you don't understand the question, ask us to
12 repeat it and we will rephrase it. Similarly, if we do not
13 understand your response, we may ask you just to repeat it,
14 or to do it in a different way.
15 We want to know what concerns you raised. What was the
16 issue that you raised with the Trust?
17 DR KOLPATTIL: I am a breast radiologist and I started my
18 job in this Trust in January 2011 in breast screening. ~~and~~
19 breast screening is different and-- I need to give you some background so that you
20 understand where I am coming from. That is all, I am not
21 going into details of how we work.
22 In breast screening what we do is screen a population
23 of ladies, two of the specialists read the mammograms and
24 consider whether we can say that this is normal, or ignore
25 any innocent finding, or whether we need to bring the lady

1 back to further tests. Once that is decided, in our unit,
2 we sit again as a group to decide whether we really want
3 this lady or whether we can avoid unnecessary anxiety and
4 worry to the lady. We filter a small group of ladies to
5 undergo further tests. Maybe biopsies to either exclude, or
6 confirm, the presence of cancer. That is basic the way
7 breast screening works.
8 Basically, our intention is to catch the cancers at the
9 earliest so it makes a difference to the patient experience
10 and their prognosis.
11 We know ~~As we do~~ that we cannot catch all the cancers for sure;
12 there will be cancers which we cannot see on the mammogram.
13 Mammograms will not show up anything for us to suspect that
14 there could be a cancer. So there are mammograms which we
15 think is normal, still the lady will come with the cancer,
16 with a lump palpable~~, and that~~. That is unfortunate, it is an occasional
17 scenario.
18 That is also acceptable in breast screening, if you
19 cannot see, you cannot act. That is okay. Whilst majority
20 of cancers, which develop in between screening cycles, fall
21 into this category, the category in which you cannot
22 convincingly see an abnormality, which raises a suspicion of
23 a cancer. So from our point of view ~~mammogram occurred for~~
24 that cancer is occult on mammogram~~.~~
25 Then the ladies come back with cancer in between

1 screening. We call that "interval cancer". Interval
2 cancer -- vast majority is not much of evidence on the
3 mammogram. Hope That much is clear.
4 Now, there is a small proportion of interval cancer in
5 which that cohort of ladies were assessed in their screening
6 episode. That means that some of us had suspected something
7 and we brought the lady back, did further tests, and we
8 thought that there is no evidence of cancer at that time and
9 we discharged the ladies back to the normal screening in
10 three years.
11 These cases ~~other ladies~~ are the ones I looked at very
12 closely because I thought if we can find some evidence, or
13 to learn from it so that we can avoid future mistakes. I
14 think that if someone has seen something in their
15 mammograms, why we did not see that there is evidence of
16 cancer at that time? Where did we go wrong? Was it with
17 ultrasound? Was it with ~~for~~ the further mammogram views? Or was
18 it that we did not do biopsy? Sub-optimal assessment, in
19 its whole.
20 MR BROOKES: You were auditing?
21 DR KOLPATTIL: That is the topic I chose to audit. This is
22 a topic, which is recommended by QA team as well. So maybe
23 you can count it as a performance indicator also. This is
24 false negative assessment cancers. We will not expect huge
25 numbers, in that it should be very, very minimum because we

1 brought that lady on the basis of something and we failed to
2 detect cancer at their assessment. When they present with
3 cancer, more often the cancer is more advanced, they will
4 have to undergo mastectomy rather than lumpectomy, they will
5 have to have axillaryancillary surgery -- the lymph node removal --
6 MR BROOKES: We understand that. What was the issue that
7 caused you concern?
8 DR KOLPATTIL: Yes. Now, as I told you, I joined in January
9 2011 and we do have review of interval of cancer, as a
10 practice, within the team. In that review what we look at
11 is all the interval cancers collected and we review to see
12 whether we could have avoided it. In that review it is not
13 everybody's opinion that matters, it is the opinion of the
14 Clinical Director that matters. We just stand there, just
15 see the pictures and if we learn something for ourselves it
16 is up to you whether you want to learn or not. But the
17 decision-maker is the Clinical Director.
18 I thought that practice is not very robust. That
19 should be a learning exercise. We harm those ladies -- we
20 could not get that back any way, you cannot go back in time
21 and detect that cancer earlier. But we need to see whether
22 we can avoid it in the future. So it is a learning
23 exercise, that opportunity was not there.
24 I discussed within the team and the consultants, who
25 joined before me, the senior colleagues, and One consultant I said "Oh,

1 this is how we do that. We know it is not appropriate but
2 this is how it is done. There is no point in raising voice
3 or anything, just go with the flow".
4 I did not feel that appropriate either.
5 MR BROOKES: Who did you tell?
6 DR KOLPATTIL: This was a [redacted]
7 MR BROOKES: But you raised your concerns with somebody?
8 DR KOLPATTIL: Because I was new -- I was the most
9 recently-appointed consultant at that time, so I enquired
10 within the team, two other colleagues, how it is done. Are
11 you happy with that? They said they are not acting upon it
12 because there is no point.
13 Then I heard from other colleagues, also within the
14 breast unit, that [redacted]
15 but no-one will challenge [redacted] decisions. No-one dare to
16 discuss with [redacted] these things. I didn't have any evidence
17 at that time.
18 Still, I met Medical Director in October 2012 and
19 raised my concerns, what I hear, what I observe; I discussed
20 everything with him. That was in 2012.
21 MR BROOKES: You met with the Medical Director?
22 DR KOLPATTIL: Yes.
23 MR BROOKES: You said that you were concerned that they were
24 not taking the opportunities, arising by the audit, to learn
25 how to improve for future?

1 DR KOLPATTIL: Yes. I said interval cancer review is not
2 done appropriately. Everybody should have their views and
3 then we need to see whether anybody could have prevented
4 these things. That is --
5 MR BROOKES: What was the response to the Medical Director?
6 DR KOLPATTIL: Medical Director said to me, at that time,
7 "That is a serious allegation that you are bringing up. If
8 you say so I will have to act upon it, that is my concern".
9 I genuinely expected him to look into the data, if he did
10 not know already. I said, "It is my duty to alert you
11 because the person that I am talking about is the [redacted]
12 [redacted] and [redacted] is known to influence people so
13 fiercefully. I didn't talk to [redacted] about this issue".
14 PROF MONTGOMERY: Just to clarify. There is two
15 separate concerns. There is a concern that the process is
16 not sound. There is a concern that even though you had not
17 got the detailed processes, there is enough evidence to make
18 you suspicious --
19 DR KOLPATTIL: Yes. Yes.
20 PROF MONTGOMERY: -- you need to raise that suspicion?
21 DR KOLPATTIL: That is what he asked, if there is evidence
22 he can look at, but I am just observing the culture in the
23 department; I didn't know what is exact mechanisms are; how
24 they run these things.
25 PROF MONTGOMERY: Did he suggest that he would take any

1 steps to get evidence or not?

2 DR KOLPATTIL: He did not assure me, but he said, "It is a

3 serious allegation". He said, "[redacted] style of management is

4 kind of firm management", and he is happy with that. Things

5 like that. He was favouring [redacted]

6 MR BROOKES: Did he take any action? Did he do anything

7 from that –

8 DR KOLPATTIL: I do not know. He did not come back to me

9 and I am not aware that he did any action at all.

10 MR BROOKES: What did you do then?

11 DR KOLPATTIL: Yes. This is nearly end of 2012. I started

12 recording my performance – by the time I am also one year into the job,

13 I will look into my cases, to do that I need to go through

14 everybody else's as well because you don't get the feedback

15 or information about your own, whether you are involved in

16 the reading part of it, or whether you are involved in the

17 assessment part of it. You don't know unless you check

18 through the entire list. I started doing that ~~them. It was~~ and

19 takes a lot of time.

20 Then I started thinking of a short ~~NICE~~ audit topic and

21 that is what I come up with. We never did that audit in our

22 unit since it started somewhere in late 1990s –

23 MR BROOKES: I will come to the audit in a second. I want

24 to go back to the conversation with the Medical Director.

25 Did he write to you or put anything in writing confirming

1 your conversation --

2 DR KOLPATTIL: No.

3 MR BROOKES: -- and issues you raised?

4 DR KOLPATTIL: No.

5 MR BROOKES: Nothing. You have seen nothing since from the

6 individual in terms --

7 DR KOLPATTIL: No.

8 MR BROOKES: Thank you. You have come to the audit. Carry

9 on from there.

10 DR KOLPATTIL: Audit, as such, it is taken up with other

11 PHEs looking at it and regional QA, so it is not what

12 findings of the audit that are done... I am -- I would like

13 to explain -- yes.

14 It was in January that I started working on this

15 particular audit. By that time I need to see which data I

16 can grab to gather ~~finish~~ information. Fortunately, in interval

17 cancer review, we fill in forms, 4 ~~three~~ forms to fill in, in

18 interval cancer, and the last form is whether this patient

19 has had assessment from screening. That is the last pages

20 about that. In that page there will be details of what

21 abnormalities was that, and what did we do; whether we did

22 ultrasound; whether we did further views/biopsies/whether it

23 is discussed in MDT. Lot of things we need to tick in that.

24 You need to form an opinion, as well as a team, whether we

25 think that it is sub-optimal assessment, or optimal

1 assessment. So we fill that form so I thought I will grab
2 those forms as a start.
3 I took all the 4 forms available in the department at
4 that time, which gave me 65 forms altogether. As I filtered
5 it through I could dismiss a lot of them because it was on
6 the other side, or some other abnormality came up as an
7 interval cancer. So I could ignore all those things.
8 I was interested in 24 cases at that time, which, I
9 think, the cancer developed at the site of the previous
10 assessment. So that really alarmed me.
11 Then I looked at when was it done and who was the
12 person who did it. Again, that corresponded to this
13 particular person.
14 MR BROOKES: From your investigations you have identified
15 some significant concerns, in your mind?
16 DR KOLPATTIL: Yes.
17 MR BROOKES: What did you do about that?
18 DR KOLPATTIL: Even before finishing my data collection I
19 met Medical Director again now that I got something to show.
20 MR BROOKES: For the record, the name of the Medical
21 Director?
22 DR KOLPATTIL: George Nasmyth.
23 MR BROOKES: You met with him again?
24 DR KOLPATTIL: Yes. I met him again. I said, "I have not
25 finished data collection, but this is really worrying to me.

1 I do not know whether
2 but that at is young age -- maybe
3 mid-sixties -- whether we could have avoided that". Few
4 patients had definitive extensive surgery, whether we could
5 have avoided that. I asked him, "Whether you are aware of
6 this data?" And he said no. That, again, I was worried
7 about that. He should be knowing if there is a concern in
8 his own Trust. He said, "No, I am not aware".
9 Then I knew that it is all different layers of covers
10 so nothing will go beyond our director; everything will be
11 under. There is a ~~layer~~ way of just covering up everything with
12
13 MR BROOKES: Specifically about that, what did he say he
14 would do about the information that you brought to his
15 attention?
16 DR KOLPATTIL: Yes. He said -- I didn't give him the
17 radiologist's name. I said, I am naming A, B, C, D and E.
18 He asked me whether you know them who. I said definitely I
19 do. I took every details from the form, which we filled as
20 a group, so it is not me saying; it is the group saying to
21 you, but nobody did the audit before this time, I do not
22 think.
23 MR BROOKES: No-one had seen the total picture?
24 DR KOLPATTIL: No. At the same time I said Director of
25 Breast Screening, I would imagine that person has a

1 responsibility to look into these things and inform the

2 regional QA all these things. So that is --

3 MR BROOKES: What did the Medical Director --

4 DR KOLPATTIL: Medical Director, at that time he said it

5 maybe that the person who is missing more will be doing more

6 cases and maybe the proportion, that is what you are seeing

7 there. I said I have not looked at it, but I can look at

8 it, whatever is available data on the system and I can COME

9 back to you. He wanted me to give him yearly breakdown of

10 the data as well as number per-radiologist data.

11 I did that. ~~Then he said, "Okay at this point" -- the~~

~~12 finding -- sorry.~~ The finding is again, worrying because the radiologist in question has done least numbers of assessment and at the same time it is noting one

13 ~~radiologist is~~ missing 60 percent of the total. The others

14 are comparable, one or two cases for the others. There were

15 four radiologists.

16 MR BROOKES: By looking at the data you identified one

17 individual where there was reason for questions to be asked.

18 You took that back to the Medical Director --

19 DR KOLPATTIL: That fits in with all the information that I

20 already had from the team.

21 MR BROOKES: What did the Medical Director do about it?

22 DR KOLPATTIL: Medical Director, at that time, he said,

23 "Okay, I think this has to be raised to the QA attention".

24 I said, "I have read QA report", which we had in 2012. They

25 highlighted that our interval cancer rate is high and they

1 highlighted that our small cancer detection rate is low. ~~So~~

2 ~~these should either -- so~~ He said, "No, they said it's all

3 okay at that time". So he is not at all concerned about

4 these findings. Again he said, "Okay. I will let the QA

5 know".

6 Then I suggested I may be given the opportunity

7 explaining my audit findings to whoever QA team you are

8 commissioning for this. I gave him a little suggestion,

9 saying that it will be appropriate if you pick a QA team

10 outside our region because [redacted] was a QA radiologist

11 until a few months ago when I raised this to Medical

12 Director in March.

13 PROF MONTGOMERY: Have you identified [redacted] of

14 as the consultant who is missing the most at this stage?

15 DR KOLPATTIL: Yes, it is all written on the form. You can

16 see who did the assessment and who missed.

17 PROF MONTGOMERY: You could. Did the Medical Director

18 know that?

19 DR KOLPATTIL: He knew it later, but at that stage I didn't

20 tell him. I didn't tell him. who was the radiologist

21 PROF WALTERS: Have the QA done their own assessment of

22 why the interval cancer rate is as high and the small cancer

23 rate is low?

24 DR KOLPATTIL: As far as I know, no.

25 PROF WALTERS: Would they normally, with that finding?

1 DR KOLPATTIL: All the information should be from proper
2 audits. In our department audit culture is very poor. Very
3 poor indeed. Not at all, in fact. It is coming up now but
4 when I --
5 MR BROOKES: The Medical Director referred it to QA, or did
6 he? What happened there?
7 DR KOLPATTIL: Medical Director gave me the name of the QA
8 radiologist he is intending to give it and he said it is
9 okay for me ~~you~~ to forward the data to him. I did as he said.
10 I anonymised the patient details and sent it to the QA
11 radiologist. He gave me his telephone number to talk it
12 through also. He wanted to identify again who is A, B, C, D
13 in my ~~your~~ audit. I said, "I cannot write it to you", but as
14 he insisted, because he can look, from remotely, the
15 statistics from National Breast Screening Database when I
16 gave him the names. Then he said, "Okay, I will be planning
17 a review of everything and I will come to your unit and I will
18 ~~can I~~ interview all the film readers in the unit".
19 I had to mention to him that the culture in the unit
20 is not very helpful, or not healthy at all. He said, "I
21 already know that". I was waiting for him to make contact
22 for the review date and time. I didn't hear from him. It
23 was --
24 MR BROOKES: Was this? When did you have that conversation
25 with him approximately?

1 DR KOLPATTIL: I gave the information to them in April.
2 11 April.
3 MR BROOKES: 2013?
4 DR KOLPATTIL: '14. Yes. Couple of days after Medical
5 Director wrote to me saying that you do not need to contact
6 QA directly, because I did that on his guidance then he
7 said, no, you do not need to contact; every communication
8 should go through him. I agreed to that also.
9 MR BROOKES: Did you tell him you had already spoken --
10 DR KOLPATTIL: Yes. He knows because he was also copied to
11 everything; all the communications I e-mailed them.
12 Then the email also says another QA radiologist also is
13 involved now, so they will be doing that together. This
14 second QA radiologist is the QA radiologist came to visit
15 our unit in 2012 for the three-yearly QA appraisal. It is
16 his decision. I will go along with whatever he decides is
17 the best. Still I said it may not be right.
18 MR BROOKES: I understand what has happened. I understand
19 your concerns, that you raised them with the Medical
20 Director. You then came back with further information.
21 Raised them again. That led to contact with the QA. Are
22 you worried that that was not appropriate? I am trying to
23 understand.
24 DR KOLPATTIL: I am worried that it was not appropriate.
25 One reason, that [redacted] is a very strong personality,

1 ~~one thing~~. In my experience [redacted] will do whatever in [redacted]
2 power to cover up if it is [redacted] mistake. [redacted] want everybody
3 to know breast screening is a very good service in our
4 Trust, there is no problem. [redacted] told me that there is not
5 even a single complaint in the unit – again strange. Not
6 even a complaint in tens of years –
7 MR BROOKES: You have acted appropriately. You have raised
8 concerns. I am trying to understand what you think should
9 have happened that did not.
10 DR KOLPATTIL: Yes. I think it should have been an
11 independent review into this issue to get to the truth of
12 the matter. I know ~~I knew~~ this data exists and whether –
13 we are seeking an explanation to this data.
14 MR BROOKES: Has a QA assessment review been undertaken?
15 DR KOLPATTIL: Yes. ~~There is~~ two QA radiologists came, on 2
16 May, to our unit. They spent a whole day. Again, that day
17 we were not there. None of the breast radiologists were
18 there apart from the Director. It was a Friday.
19 MR BROOKES: What was the outcome of their assessment?
20 DR KOLPATTIL: Their assessment says that there is no
21 concerns –
22 MR BROOKES: Right.
23 DR KOLPATTIL: – for them it is comparable to the units in
24 the North West, other units in the North West. I requested
25 how did they come to that conclusion? Because I, myself,

1 know I have reviewed these films, I know that many of them
2 were preventable. All down to sub-optimal assessment. Do
3 these ladies need an explanation? Do they already have --
4 MR BROOKES: What did you do then?
5 DR KOLPATTIL: Yes. They generated a report and Medical
6 Director gave it to me, but that did not contain any details
7 what they found in these cases. Nothing. It was just a
8 number game from 24, they were concerned, now to 12.
9 MR BROOKES: You remained concerned. You were not satisfied
10 with the QA report. What did you do next?
11 DR KOLPATTIL: Medical Director reassured me that there will
12 be a meeting in which we will give you feedback and that
13 will be detailed and you will get all the details. That job
14 was given to the Assistant Medical Director.
15 In that meeting there were HR people, there were
16 divisional managers, and all the breast radiologists. I
17 felt that that meeting was for me to agree to that report,
18 for me to agree -- I said "Without knowing what it
19 involved, I do not know. I cannot -- it is our group
20 decision that reflects on this audit. None of the ladies, I
21 had put as my own inference, we should have an explanation
22 on that". Still the Director was not willing to amend the
23 minutes. They conveniently disregard this conversation that
24 I insisted on for further —clarification.
25 MR BROOKES: Did you raise your concerns with anyone else

1 after that meeting?
2 DR KOLPATTIL: I had raised it to Trust Board Chair
3 detailing what I think.
4 MR BROOKES: What happened when you raised it with the Trust
5 Board Chair?
6 DR KOLPATTIL: Trust Board Chair. At this time the review
7 report was not available from the regional QA, so he waited.
8 He responded to me reassuring that he will do everything to
9 explore this once the report is available. Later He said, "Okay,
10 this is what the report says". So it is okay. Regarding
11 the culture in the department, they are planning some
12 external team to look into whether we can make good
13 team-building inside.
14 Still, my questions are unanswered. For me, I look at
15 historical data, which is again interval cancer -- anywhere
16 will be historical; you cannot prospectively audit interval
17 cancers.
18 When I looked at the data I felt sorry for those ladies-- ~~sorry~~. I cannot go back in time line --
19 MR BROOKES: Yes. I understand -- I think I understand what
20 you are saying. I think that what I am trying to understand
21 of your case, we are not here to look at breast screening
22 and cancers, is whether or not the Trust, in your view, took
23 your concerns seriously, took appropriate action, and you
24 may not agree with the outcome, but did they take
25 appropriate action at the right time?

1 DR KOLPATTIL: They took action, I have to say, but it was
2 not appropriate.
3 MR BROOKES: Why was it not appropriate?
4 DR KOLPATTIL: Everybody is aware of the regional play in
5 breast screening. If a person raises concern, instead of
6 supporting the person, or coming to know the truth, what the
7 unit prefer to do is just ostracise that person so nothing
8 will come out. That is not only ~~new~~ in our unit, it has
9 happened in many other units, in which patients are at risk.
10 You can call it personal conflict/inter-personal or
11 team, anything, but there is a group of patients in the
12 centre --
13 PROF MONTGOMERY: Can I test I have understood what you
14 mean by "other units". Are you saying that this is common
15 in breast screenings programmes in other places; or are you
16 saying that other parts of this Trust?
17 DR KOLPATTIL: I cannot generalise it, but I know that at
18 least a couple of units had similar problems.
19 PROF MONTGOMERY: A couple of breast units or a --
20 DR KOLPATTIL: Couple of breast units.
21 PROF MONTGOMERY: Because our terms of reference enable
22 us to ask questions about the culture of this Trust, and its
23 response to people raising concerns. They would not enable
24 us to raise questions about the quality assurance process
25 for radiology. It's more for us to understand what is

1 particular about the Trust management.

2 DR KOLPATTIL: I am just getting the information. I raised concerns with

3 the Public Health England also because I thought Trust is

4 not managing this properly.

5 MR BROOKES: Again, for a number of reasons we cannot go

6 into that, but in terms of processes within the Trust, you

7 have raised your concerns with the Medical Director on two

8 occasions. On the basis of the evidence that you have

9 presented to him, he has involved the QA service. The QA

10 service has reviewed the practice within the unit. You

11 don't agree with the outcome of that review, but they have

12 reviewed that. When you felt that they were still missing

13 the point you have taken it to the Chair of the

14 organisation, of the Trust, who has waited for the regional

15 QA report. What did you do on the receipt of that? Have

16 you received that report? Has the Chairman come back to you

17 now? Has he received the report from the regional QA?

18 DR KOLPATTIL: Yes.

19 MR BROOKES: What did he say in response to the report?

20 DR KOLPATTIL: He said that there is no concerns according

21 to the QA report so we should not be worrying too much about

22 that. That is what he said.

23 Now, if you take out all the QA part of it, and audit

24 findings, I can tell you what I experienced after I raised

25 these concerns.

1 PROF MONTGOMERY: Before we get to that, in the letter
2 that the Chair writes back to you, he makes reference to the
3 fact that you were also meeting with the Chief Executive.
4 It will be helpful -- that is part of the picture of people
5 you informed, before we get to the other things.
6 DR KOLPATTIL: Yes. Chief Executive also I tried to make
7 contact in early 2013. For some reason I didn't get an
8 opportunity to talk to her in person. I met David
9 Wilkinson, who is her HR Director, delegated by Chief
10 Executive and --
11 PROF MONTGOMERY: In the letter, which is dated 20
12 May 2014, it indicated that there was a meeting you were
13 soon to have with Jackie Daniel.
14 DR KOLPATTIL: Before also I had tried to contact Jackie,
15 but I could not, but this time Jackie was willing to meet
16 with me. By this time, all this audit was given a picture -out of
17 proportion and dimension, about conflict in the department,
18 rather than the patients' safety. Patient safety was set
19 aside and people projected it as an inter-personal conflict,
20 rather than anything. Whereas my view, and I always came
21 from patient concerns -- and so Jackie met with me.
22 PROF MONTGOMERY: Did she meet with you about the
23 inter-personal questions?
24 DR KOLPATTIL: She covered a lot. She covered major topics.
25 One was my job plan dispute and one was this audit, one was

1 this inter-personal conflict. She made some reassurance.
2 Also she said that if you are not happy with this, she
3 herself will talk to NHS England about that to come to --
4 you know.
5 PROF MONTGOMERY: If I relay back what, I think, I have
6 understood about that: You have a series of concerns that
7 you are not happy have been properly addressed; at each
8 stage it does seem that someone has been prepared to arrange
9 for a further look at it. It has been a very long journey
10 but Jackie Daniel has indicated that, in order to make sure
11 she has not misunderstood, Public Health England can have a
12 look at it.
13 DR KOLPATTIL: I know you are aware of the time --
14 MR BROOKES: It is not that. It is not that at all. I am
15 just conscious of staying within the remit of what we can
16 ask about because we cannot ask about what is happening in
17 Public Health England around screening programmes. We want
18 to understand whether or not you were treated appropriately
19 within the organisation, given the concerns around patient
20 safety, and other concerns you had in the service.
21 I was concerned to read about you felt you were
22 harassed.
23 DR KOLPATTIL: I was.
24 MR BROOKES: I want to touch on that in a second, but, as
25 Jonathan has said, I think we have now got a clear picture

1 of the steps you took and the responses that the Trust took
2 in terms of how they handled this internally. That is
3 pretty much within the narrow confines of our remit; is what
4 we can ask about.
5 We are interested though in terms of you felt
6 victimised and harassed. how was that dealt with by the
7 organisation when you raised this because that is pertinent
8 to what we are looking into.
9 DR KOLPATTIL: In October, when I raised this to Medical
10 Director for the first time –
11 MR BROOKES: 2000 and?
12 DR KOLPATTIL: 12. I expected, as I told you, some actions
13 out of that, at least a proper audit. Nothing happened.
14 But our [redacted] and our [redacted]
15 [redacted] their approach to me became more and more
16 hostile: Approving my annual leave; study leave; appraisal
17 role; everything was blocked – [redacted]
18 [redacted] even that
19 was criticised and they tried to obstruct all those things.
20 That is one state. Once it has gone to a proper audit, a
21 lot more to come.
22 MR BROOKES: Did you raise the formal complaint about
23 harassment and victimisation?
24 DR KOLPATTIL: I did.
25 MR BROOKES: With whom?

1 DR KOLPATTIL: I tried to get inside the Trust. Whenever a
2 person raises concerns they will do, or at least appear to
3 do,investigation quoting the correct policies. They did an investigation with a
4 pre-determined outcome, with people –
5 MR BROOKES: We cannot tell that. I know you feel that.
6 There was an investigation –
7 DR KOLPATTIL: There was an investigation, inappropriate I
8 would say, regarding the case management –
9 MR BROOKES: What did the investigation conclude?
10 DR KOLPATTIL: Investigation concluded –
11 MR BROOKES: (To Mr. Kolpattil) I am sorry, you are there to
12 help with the English, she cannot understand the question.
13 We need to focus on your wife's views.
14 DR KOLPATTIL: Initially the investigation was inappropriate
15 and then the external investigator put up terms of
16 reference. In that, one point I wanted him to look into is
17 the patient safety in that grievance because, I think, that
18 because of this poor team working, and people just work on
19 tick boxes on paper, rather than looking into the patient, I
20 really felt that we could have given better patient care if
21 we can work in a different way, or in a better way. I
22 wanted him to look into that as well as the investigation.
23 He did not go into any detail of that, with that
24 outcome, saying that he did not see anything to corroborate
25 that patients have been harmed. Whereas from that –

1 MR BROOKES: You went through the formal grievance process.

2 DR KOLPATTIL: Yes, I did.

3 MR BROOKES: That was looked into. There was a conclusion

4 on the grievance. Did you appeal the outcome of that?

5 DR KOLPATTIL: Yes.

6 MR BROOKES: What was the outcome of the appeal?

7 DR KOLPATTIL: Outcome of the appeal also is not upheld

8 because people are -- I have evidence to whatever I tell in

9 the grievance, as well as on here also, so that maybe I

10 cannot express it everything to your satisfaction, but

11 whatever I raised is on the basis of evidence only. If

12 people cannot see the evidence, I do not know whom to blame.

13 To me, I felt governance in the Trust is not robust.

14 For the same reasons the services, I do not think, are

15 really safe. We could have had a safer service if we had a

16 proper audit and governance culture.

17 MR BROOKES: My understanding is that there is now a review

18 being undertaken by Public Health England.

19 DR KOLPATTIL: Yes, but they are not looking into individual practices but -- they

20 are looking into the breast screening statistics, and some

21 of the cases that we assess. I requested a comprehensive review -- it is all down

22 to a particular culture in the department. If people are

23 free to raise concerns, if people are free to challenge

24 people, I do not think that patients would have been harmed

25 in the past.

1 I do not know from that point how many are harmed,
2 unless we wait for their cancer to develop. To me, it is
3 tip of the iceberg. ~~Unless -- as~~ As soon as I raise concerns,
4 the next step was ~~will be~~ blocking my access to any data to get
5 more information. I challenged that, but they are all a
6 team. If I raise concerns within the [redacted]
7 will be blocked by [redacted] or [redacted]
8 [redacted] they will be blocked. So it is a step-by-step
9 block and I do not know -- why.
10 MR BROOKES: The last thing I need to ask you is: Are you
11 aware of the whistle-blowing policy within the Trust? If
12 you are aware of it, have you considered using it?
13 DR KOLPATTIL: I am aware of that. When I produced this
14 audit I wanted some protection-- I expressed to Medical Director also this
15 is under whistle-blowing policy. For some reason they are
16 trying to ignore that, application of that policy to this.
17 Again I do not know --
18 MR BROOKES: Have you formally raised these concerns as a
19 whistle-blower because that is an option open to you, or
20 anyone within an organisation. There is a --
21 DR KOLPATTIL: After going through so many of these events I
22 do not have any trust, any confidence -- in trust procedures.
23 MR BROOKES: So you have not formally --
24 DR KOLPATTIL: -- or protocols.
25 MR BROOKES: I understand that, but you have not -- I want

1 to be clear you have not gone through the whistle-blowing
2 process?
3 DR KOLPATTIL: I know about that.
4 PROF MONTGOMERY: One question, I think. The appeal
5 process, in relation to the grievance, does that involve the
6 Board Member sitting on the Appeal Panel?
7 DR KOLPATTIL: There was one Board Member. Non-executive
8 member of the Board. The governance lead was the Chair.
9 PROF MONTGOMERY: Second, related question, I am trying
10 to make sure that the issue is not blocked. We cannot get
11 involved in trying to make a judgment about whether the
12 answer was right, but it did reach the right level of the
13 organisation --
14 DR KOLPATTIL: It reached the right --
15 PROF MONTGOMERY: -- the Chief Executive spoke to you
16 about the outcome?
17 DR KOLPATTIL: It reached the right level. I tried to
18 express in the meeting also because the governance lead is
19 the Chair, I tried to but I was blocked by everybody. The
20 [redacted] -- you cannot discuss that in this forum,
21 that is what they said. I do not have a forum to discuss
22 now. Every level they are trying to, you know, suppress me.
23 They do not want to know the problem fearing that they will
24 have to take action. That is not for a proper patient care.
25 I do not think that is the right attitude. I have put up

1 with so long, trying to see someone will see that and
2 someone will take care of this. But people are just
3 shifting responsibility from one platform to the other with
4 no –
5 PROF WALTERS: When you identified the patients who
6 went on to have cancer, because their signs might have been
7 missed, did you consider whether they should have been
8 looked into a serious untoward incident?
9 DR KOLPATTIL: I considered. I asked about this in my
10 letter to the Chair, but I did not know that I should have
11 done that. It is historic data, I have to say. I am
12 looking at the cancer missed in 2011. Now, whether that
13 would have changed anything, I do not know.
14 PROF WALTERS: Well, I suppose technically, if you had
15 a missed cancer it is an untoward incident, isn't it? I
16 think probably what might be happening with the QA is that
17 there is not enough cases to pick up a trend and this is why
18 they are finding that they are not seeing, in detail, what
19 you are seeing. So, I think, it might be difficult for the
20 Trust to take action if the QA are saying it is fine.
21 DR KOLPATTIL: Again, I challenge QA – I requested, I can
22 explain what I saw, what I looked at, but they don't want
23 that from me. They will not give me explanation on why they
24 disagree with my findings. Then [redacted]
25 [redacted] initially wrote that there is no

1 concern and everything was on the basis of his letter
2 originally. But now, after it has gone to Public Health, [redacted]
3 changed [redacted] words saying that there could be some concerns
4 and that is changing.
5 Initially, when I approached Medical Director, I
6 explained to him, like I explained to you, my audit thing,
7 and I registered that and I took all the proper channels,
8 registered it first, discussed within the team to approve
9 that as a topic; then only I started working on it.
10 However, the input that Medical Director given to the
11 regional QAs that I am doing this to assess my colleagues'
12 practice, it was not the registered audit. So all the bad
13 words about me. The report came back as no concerns.
14 Then Medical Director had apologised to me. "Now I
15 understand that you did everything properly, but someone
16 told me that you did not register. I said, "You could have
17 asked me". So these are the things -- they are all
18 supporting each other so that this issue will not come out.
19 But, for me, these patients are there, on record, they
20 suffered and they will still be there as sufferers of this
21 service. How many more to add? Time will tell. But we
22 have a responsibility to at least explain to <u>them</u> ~~the~~ -- I do not
23 know whether anybody explained to these people. They are a
24 very vulnerable group of people; these are elderly people
25 who comes through the breast screening. You can guide them

1 in any way. You can tell them, "Oh, that was okay. We were
2 right at that time. Unfortunately you developed cancer".
3 MR BROOKES: Okay. This is a very difficult one for us
4 because we are constrained in our terms of reference about
5 what we can investigate and what we cannot investigate.
6 I think that we fully understand your concerns. I
7 absolutely understand that. We understand the steps that
8 you have taken with the organisation and we will consider
9 that as part of the evidence for the review.
10 What we cannot make comment on is the appropriateness
11 of the quality assurance process et cetera and what comes
12 out of that. That is, unfortunately, not within our remit.
13 We understand the efforts you went to, to raise this
14 appropriately with the Medical Director, and through to the
15 Trust Board. We now understand, from what you said, the
16 responses by the Trust. We will take that into
17 consideration.
18 DR KOLPATTIL: I will be happy if you understood my issues
19 as a whistle-blower at least, I would appreciate it,
20 because, on paper, you see all the report numbers and case
21 discussions. What one really should understand, I think, is
22 how much difficulty this person will have had raising
23 concerns, in a team where bullying and harassment is the
24 culture and it is still continuing and how long to go for
25 this person.

1 MR BROOKES: That has come through very clearly; that has
2 been really helpful for us.
3 PROF MONTGOMERY: I don't think there is anything we
4 can add today. We have read through the materials you have
5 submitted --
6 DR KOLPATTIL: Since that -- can I have your attention on
7 two more incidents? I will not take long. I have submitted
8 this to you now. In the department, Breast Screening
9 Department, false incidents -- unnecessary incidents -- are
10 put in my name and people, whom I cleared from assessment,
11 they are brought back saying, "That was not appropriate,
12 that assessment; we need to do it again". One lady having
13 been subjected for unnecessary biopsy, just to get normal
14 breast tissue for the sake of doing it. Patients are really
15 harmed~~ing~~. They are really harming patients just to prove a
16 point that I am always wrong. It is not a direct attack;
17 they are attacking patients in that way.
18 MR BROOKES: Okay.
19 DR KOLPATTIL: That is one thing.
20 MDTs should be for the patients' benefit. Here MDTs
21 are conflict; who is getting over that other person. This
22 is not good culture at all. Someone needs to intervene. I
23 have approached so many people, but nobody is willing to
24 come to the core of this and take some action. It is
25 nothing personal, but I know that this should not have

1 continued. It is not good.

2 PROF MONTGOMERY: I think we should just say then that

3 we can note those two extra things you have told us, and we

4 can think about this and see what other evidence we have

5 about the culture in the Trust. But you still need to

6 pursue those patient safety issues independently because we

7 will not be able to comment on the patient-safety aspects of

8 this as part of our investigation --

9 MR BROOKES: Yes. That is why I say it is a difficult

10 position for us. We are here for a particular reason, and

11 we are not here to advise you on what is the right way

12 forward, but you need to consider what your options are

13 around patient safety within the organisation. That is all

14 we can really say. I know that will not sound very

15 satisfactory.

16 We will take into consideration what you have just

17 said, as it pertains to our terms of reference. All I can

18 say other than that is: Thank you for coming to see us; and

19 taking the time to raise these concerns with us, which is

20 never easy.

21 DR KOLPATTIL: Thank you for listening to me. Final word, I

22 think, that, yes, we are trying to cut down expense and

23 everywhere concerning that patient care is very much

24 compromised in a culture of bullying and harassment, that

25 you will kill the patient unnecessarily. Really. Someone

1 should take some action. I am thinking I have almost

2 reached the top. I do not have any more platform to express

3 my concern. I hope that --

4 MR BROOKES: Okay. Thank you. Thank you very much.

5 ________________________________

THE MORECAMBE BAY INVESTIGATION

Thursday 11 September 2014

Held at:
Park Hotel,
East Cliff,
Preston
PR1 3EA

Before:

Mr. Julian Brookes -- Expert adviser on Governance (In the Chair)
Dr Catherine Calderwood -- Expert adviser on Obstetrics
Ms Jacqui Featherstone -- Expert adviser on Midwifery
Professor Jonathan Montgomery -- Expert adviser on Ethics
Professor Stewart Forsyth -- Expert adviser on Paediatrics

KARNAD KRISHNAPRASAD

Transcript from the Stenographic notes of Ubiqus,
Clifford's Inn, Fetter Lane, London. EC4A 1LD.

1

2 MR BROOKES: Welcome. I am Julian

3 Brookes. Bill Kirkup, who normally is

4 Chairing the investigation, unfortunately

5 cannot be here today so he's asked me to

6 chair the session for him. In a second we

7 will go round and say who we are then I

8 will give some introductory remarks about

9 how we will operate. Catherine.

10 DR CALDERWOOD: I am Catherine Calderwood,

11 I am an obstetrician and I am also a

12 Medical Advisor for the Scottish

13 Government.

14 PROF FORSYTH: Stewart Forsyth, a

15 Paediatrician in Dundee and a Medical

16 Director there.

17 MR BROOKES: I am Julian Brookes,

18 previously Head of Clinical Quality at the

19 Department of Health. I am currently

20 Deputy Chief Operating Officer at Public

21 Health England.

22 PROF MONTGOMERY: Jonathan

23 Montgomery, I am Professor of Healthcare

24 Law at University College, London. Chair

25 of the Health Research Authority. In the

1 past I have chaired PCTs and SHOs.
2 MS FEATHERSTONE: Jacqui Featherstone. I
3 am Head of Midwifery and Head of Nursing
4 at an Acute Trust.
5 DR KRISHNAPRASAD: I am Dr Krishnaprasad,
6 a Consultant Anaesthetist in Morecambe Bay
7 as well as Clinical Lead since July 2012.
8 MR BROOKES: Welcome.
9 DR KRISHNAPRASAD: Initially as interim
10 for eight months and took the post
11 permanently on 1st April in 2013.
12 MR BROOKES: Thank you. Just some
13 introductory remarks. As you are aware we
14 are recording this session. These
15 sessions are open to the families of
16 relatives relating to the cases we are
17 considering. As you are aware, there is
18 nobody here today so there is two purposes
19 for the recordings. One of them is so
20 that we have a correct record of the
21 discussions we had today. It is also to
22 give an opportunity, if any family members
23 wishes to become aware of what has been
24 discussed today in their absence, in an
25 supervised situation we can provide that

1 for them. This has two roles.
2 It is the only recording equipment
3 which we allow because we want to ensure
4 the confidentiality of the discussion, but
5 also to make sure that parts of the
6 investigation do not become public out of
7 context. It is really important for us
8 that we take all the evidence, both in
9 terms of written but also oral evidence
10 given in this way. Then we make a
11 considered opinion of that at the end.
12 That is the purpose of being asked not to
13 have a mobile telephone et cetera. We
14 want to make sure that that is secure.
15 We will start with Catherine.
16 DR CALDERWOOD: Thank you very much for
17 coming. We wanted to speak to somebody
18 from your department. I wonder if you can
19 just give me a little bit of context of
20 how many anaesthetists have you got? If
21 there is a formal obstetric anaesthesia
22 group, is there a rota? So that I
23 understand how the thing works.
24 DR KRISHNAPRASAD: As you know, Morecambe
25 Bay has got three main hospitals. One is

1 actually at the elective site in Kendal.
2 Two acute sites operating in Lancaster and
3 another in Barrow.
4 Both acute sites has got maternity
5 units. Lancaster has got its own
6 department, but you have got cross-bay
7 relations, but it has got two departments
8 with me as the Clinical Lead and overall
9 in charge.
10 We have got a site at Furness. That
11 is looking after day-to-day work there.
12 So Lancaster we have got about 29
13 permanent medical anaesthetics. Out of
14 that seven ICU consultants; four chronic
15 pain consultants; about 16 general
16 consultants and two SA doctors so who
17 actually anaesthetise but they are SAS
18 grade.
19 Obstetric-wise, in Lancaster we have
20 got the obstetric lead, who leads the
21 service who is a general consultant
22 anaesthetist. We have got five other
23 general anaesthetists who have got an
24 interest in obstetrics. Because of
25 Lancaster Obstetric Maternity Unit has got

1 2200 deliveries, roughly, so we do not
2 have a separate rota, so we always -- 16
3 consultants who is on the rota cover
4 out-of-hours, maternity and general
5 together.
6 Do you want to tell me how you cover
7 the maternity as well?
8 DR CALDERWOOD: I suppose similarly then
9 for Furness --
10 DR KRISHNAPRASAD: Furness is different.
11 We have got 15 trainees in Lancaster.
12 Rota-wise how it works is that we have got
13 trainees covering out-of-hours. We have
14 got two resident trainees in Lancaster,
15 who actually -- one trainee covers
16 theatres alone and another trainee covers
17 ICU and maternity together. We have got
18 two nonresident consultants on-call,
19 separate for ICU and separate for child
20 care.
21 In Furness. Again, as I told, the
22 maternity unit has got 1,000 deliveries.
23 We have got nine consultants there, about
24 seven SAS Anaesthetic doctors. We have got -- mainly ICU
25 is covered by consultants. We have got

1 two tiers of cover, mainly the theatre
2 covered by SAS doctors, but we are trying
3 to recruit consultants as well. Recently
4 we appointed one.
5 The general theatre call is run by
6 the residents. They are -- it is one in
7 seven, so we have got six SA doctors and
8 one consultant. They are the only people
9 residing in the hospital in the night.
10 They cover mainly maternity, general, as
11 well as helping ICU. We have got
12 nonresident consultants who mainly covers
13 ICU and oversees the SAS ~~CSA~~ doctors. They
14 are very senior doctors, who actually are
15 quite capable of doing most of the work.
16 We don't have any trainees in Furness.
17 DR CALDERWOOD: There will be a 24-hour
18 epidural service offered in Furness?
19 DR KRISHNAPRASAD: We offer 24-hour
20 epidural service, but take up is around 10
21 to 12 percent. Maybe a few reasons for
22 that because the nature of the work, but I
23 think that there is no clear-cut. We do
24 audits, but never showed actually -- not
25 able to provide that service. I think it

1 is both a mixture of people knowing that
2 it may not be -- anaesthetic will not be
3 available, that may not be offered, but we
4 are not got into the record of that,
5 whether that reason or the cultural
6 reasons.
7 DR CALDERWOOD: Very low. Very low
8 up-take. For a consultant obstetric unit
9 it is a very low rate of epidural.
10 DR KRISHNAPRASAD: You talk about -- I am
11 talking about Furness. It is actually not
12 a consultant unit but actually it is
13 covered by SAS doctors in the night. We
14 don't have a specific cover for maternity
15 as such.
16 DR CALDERWOOD: I mean, in a consultant
17 obstetric unit, which then has high-risk
18 women et cetera. Yes.
19 DR KRISHNAPRASAD: Yes, sorry.
20 DR CALDERWOOD: I suppose one of the
21 reasons for seeing somebody from your
22 department, particular somebody with a
23 lead role, is that there were several
24 things that have concerned me about some
25 of the services, particularly at Furness,

1 with reading some of the case notes, as we
2 have been doing over some months now.
3 We have also had a series of reports
4 and inspections over the years into the
5 Trust in general. I just wondered that
6 the Fielding Report, which was produced in
7 2010, which talked -- and I appreciate
8 that is before your role -- talked about
9 the theatre at Furness and difficulty in
10 accessing that and difficulty with an
11 on-call rota. Also the fact that the
12 theatre was not open and available. For
13 somebody, where I am expecting a decision
14 to delivery time for a crash Caesarean
15 Section of 30 minutes, I would not have
16 thought that, reading that set up, that
17 that would have been possible, as a
18 decision to delivery time, with having to
19 call people from home. I understand that
20 has changed?
21 DR KRISHNAPRASAD: Yes. Yes.
22 DR CALDERWOOD: Go on.
23 DR KRISHNAPRASAD: That has -- I know it
24 is before my time because I only joined
25 around 2005. Yes, I agree with your

1 comments but, I think, that is all changed
2 now. They've got a dedicated theatre team
3 resident, as well as they have got an
4 on-call team that can come and do
5 obstetric cases if it is needed and the
6 other team is busy.
7 They have got two teams currently.
8 One is resident and the other on-call.
9 DR CALDERWOOD: Do you know about audits
10 as -- the result outcomes of audits where
11 they have looked at decision to delivery
12 time and have there been any issues with
13 delay?
14 DR KRISHNAPRASAD: Recently, in the past
15 two years I have looked into -- I think
16 there are one audit done. There is no
17 major issues in the delay. Only one
18 incident where there they had to call
19 someone from home. That is why we had --
20 I will come to that, I think. They
21 changed the practice currently after we
22 put a business case to put obstetric
23 cover. Shall I discuss --
24 DR CALDERWOOD: Yes, please.
25 DR KRISHNAPRASAD: Sorry. After I took

1 over I actually looked into the staffing
2 levels across the Bay regarding
3 anaesthetic services, not only maternity
4 across the -- I had concerns about the
5 whole process of whether we can be able to
6 cover. We looked into staffing levels,
7 both in Lancaster and as well in Furness,
8 which actually showed these maternity
9 issues at that time. We put a business
10 case, actually to them and it went into
11 the directors group, which actually is
12 chaired by the Chief Executive and by
13 Medical Director and Chief Operating
14 Officer, which actually is in line with
15 the safe childbirth as well as our AAGDI AGI
16 guidelines.
17 So we put that one in place to make
18 sure that we are compliant with it, but it
19 is financially a very expensive
20 proposition. Actually both sides actually
21 costs about 1.5 million. What has come
22 back from our EDG (Executive Director Group) EBG is they will look into
23 that. They have actually gone through the
24 whole process and they accept the risk,
25 but they just are waiting for the Better

1 Care Together Group, the results. We are
2 currently the Better Care Together Group
3 coming and discussing what is the
4 provision of the services across the whole
5 of the Bay.
6 In the meantime, to mitigate certain
7 issues, especially in Furness, they
8 actually asked us to put a third on-call
9 rota in Furness, which actually, out of
10 the existing 15 anaesthetists, we are
11 putting a third on-call rota because
12 previously before my time there used to be
13 an ad hoc basis, when there is urgency
14 people used to go there and do the cases,
15 which is practically not satisfactory.
16 But now we have got an official rota so
17 one person will be nonresident and as a
18 second pair of hands, if there is anything
19 we call that person.
20 DR CALDERWOOD: I think we had established
21 that there had been a change after the
22 Fielding Report in 2010. The recent CQC
23 inspection, just in July of this year,
24 when the Inspector was actually there was
25 a need for an emergency Caesarean Section

1 and the theatre door was blocked and the
2 person with the key took eight minutes to
3 be located. That is not a practice that I
4 would recognise as being amenable to a
5 safe situation for an emergency Caesarean
6 Section. That does not seem to fit with
7 what you are saying is things have been
8 taken seriously and changed. That was
9 from the CQC inspection of this year.
10 DR KRISHNAPRASAD: Okay. Definitely there
11 is a resident. I am not aware of that, I
12 am sorry. Definitely there is a resident
13 theatre team, and on-call theatre team.
14 DR CALDERWOOD: Could the door be locked?
15 DR KRISHNAPRASAD: It is not locked
16 exactly, it is a swipe door in the main
17 theatre. I am not sure.
18 DR CALDERWOOD: This is in Furness.
19 DR KRISHNAPRASAD: It is in Furness, yes.
20 DR CALDERWOOD: Well, I suppose there
21 is --
22 DR KRISHNAPRASAD: It is actually
23 intercom. You can press and talk to
24 people inside.
25 DR CALDERWOOD: There seemed to be -- I

1 mean, this is public record, it is on the
2 CQC website -- but they report that. I
3 suppose it will be very helpful if you
4 could look into that and perhaps re-assure
5 me that there has been some misreporting
6 or something that. I think you will be
7 telling me, agreeing with me that would
8 not be acceptable to have a situation
9 where --
10 DR KRISHNAPRASAD: It's not definitely
11 acceptable, that sort of thing, yes.
12 DR CALDERWOOD: I would expect a theatre
13 to be ready with people in with the drugs
14 drawn up and the, you know, ability rather
15 than a locked door. It surprised me, I
16 suppose, and you are telling me that is
17 not the system so --
18 DR KRISHNAPRASAD: That is not the system.
19 DR CALDERWOOD: I would be grateful for
20 communication with us afterwards, if you
21 do not mind investigating that for me; it
22 is much better.
23 PROF MONTGOMERY: From memory there
24 is more than one door that is talked
25 about. It may not be the theatre door

1 that was the issue, it was not --

2 DR KRISHNAPRASAD: Because --

3 PROF MONTGOMERY: -- access.

4 DR KRISHNAPRASAD: The maternity labour

5 ward, I think, that has been identified in

6 the past, there are not major changes for

7 that because, I think, there are two doors

8 actually from the labour ward, quite far

9 off, I think, which actually -- if you

10 actually want to go across, I think, there

11 is a corridor and we have to come across.

12 Actually they've done negotiating with --

13 there is an acute medical unit that

14 actually has got a door, which actually

15 will be open straight into the corridor

16 actually, so that you can easily access

17 it. I am not sure where that door is

18 still.

19 PROF MONTGOMERY: I think that is the

20 door that the key could not be located

21 for. I do not think it was the theatre

22 door.

23 DR KRISHNAPRASAD: I am happy to

24 investigate and get back to you.

25 DR CALDERWOOD: That will be -- because

1 even if it is not the theatre door, it is
2 still a problem. It will be very helpful
3 to have reassurance that that has been
4 tackled, I suppose.
5 What I am getting at is the whole,
6 having tackled the on-call rota, that you
7 are continuing to do, the whole process of
8 transferring people from the labour ward,
9 which is distant from the theatre, is
10 smooth.
11 I think the other thing I am
12 reassured to hear about, this third
13 on-call rota, as a measure, because again
14 I was going to go ahead and ask about what
15 if there was a theatre that was already
16 being used; of course, the maternity cases
17 cannot wait --
18 The level of competency then. You
19 are saying that the resident on-call
20 consultant, they are SAS doctors.
21 DR KRISHNAPRASAD: -- and consultants
22 yes --
23 DR CALDERWOOD: With the number of
24 deliveries and the number, therefore, of
25 women who are requiring epidural or

1 emergency Caesarean Section, how do you
2 ensure that there will be quite few
3 procedures that any one consultant is
4 doing in the course of six months to a
5 year; how do you ensure they are kept
6 competent at these very technical
7 procedures?
8 DR KRISHNAPRASAD: Basically, I mean, by
9 audits and they get some sort of
10 assimilation training. We currently --
11 only in the audit, we get some sort of
12 training, but we are actually trying to
13 put the Prompt course in Furness as well.
14 That is the plan, I think. I proposed
15 people coming across to our site. I
16 think, that is one of the proposals done.
17 I think it was slightly delayed because of
18 the financial reasons because it is quite
19 a distance and people has to come across
20 and there is lots of -- in terms of other
21 things.
22 DR CALDERWOOD: Come across for training?
23 DR KRISHNAPRASAD: Yes. Training as well
24 as -- because as you must be aware from
25 some of the reports over the cultural

1 difference between the two sites, so my
2 main intention, when I took over, is to
3 bring two teams together, not only in
4 obstetric, but in all aspects, so they can
5 come and work in our site and we can work
6 across there.
7 To mind it has not happened yet, but
8 I am still trying that. You will know
9 there is financial reasons because if I
10 tell people to come across to our site,
11 the travel costs and other things are
12 there. I think, personally, I feel that
13 is very important in that terms, to get
14 together to -- especially we have got
15 trainees that their practice, they can
16 learn in a sense, not new practises but
17 they can get more education. All
18 consultants get more educated by our
19 trainees, very different techniques. That
20 is my plan; it has not happened yet.
21 DR CALDERWOOD: The use of the early
22 warning scores, the system like that.
23 Maternity services and a modified one for
24 maternity.
25 DR KRISHNAPRASAD: There is a maternity.

1 I am not completely -- I am not obstetric

2 anaesthetist but I don't regularly do it,

3 but there is a modified version of early

4 warning scores, yes.

5 DR CALDERWOOD: In Furness and Lancaster?

6 DR KRISHNAPRASAD: Furness and Lancaster.

7 I know that ~~because this~~because this was presented in the audit meeting by one of my obstetric anaesthetic colleague.~~I~~ presented an audit

8 meeting, yes.

9 DR CALDERWOOD: What about outside the

10 maternity unit then in Furness? So in the

11 HDU and in ICU; there is an early warning

12 score used?

13 DR KRISHNAPRASAD: Yes. They've got early

14 warning, that is slightly different

15 compared to the obstetric --

16 DR CALDERWOOD: But there is one.

17 DR KRISHNAPRASAD: There is one.

18 DR CALDERWOOD: I suppose I am thinking

19 specifically of a case of peri-cart (?)

20 and cardiomyopathy, which was within your

21 time as lead, I think.

22 DR KRISHNAPRASAD: Just before, yes. I

23 know well, I am aware of it; it has been

24 presented in the audit meeting and

25 discussed.

1 DR CALDERWOOD: Where I certainly would,
2 looking at the case notes, would appear to
3 have been, if there was an early warning
4 score it certainly was not acted on. Can
5 you -- you think. I actually interpreted
6 there possibly was not one in use?
7 DR KRISHNAPRASAD: That specific case I
8 actually not dealt with but, I think, that
9 I can look into it but I personally, I
10 think, it might be my predecessor actually
11 dealt with that case, yes.
12 CAROLA: Okay, again I think I would want
13 to be reassured that perhaps if that was
14 not the case, in that case that there was
15 a robust use of both early warning score
16 in high dependency and intensive care, but
17 also the modified one for maternity care.
18 I have not seen them in the notes but --
19 DR KRISHNAPRASAD: I can provide you.
20 DR CALDERWOOD: -- maybe they are not
21 filed, but again it is wishing reassurance
22 for the future that these things were in
23 place. I would appreciate if you would
24 check that for me. Thank you.
25 DR KRISHNAPRASAD: Yes.

1 DR CALDERWOOD: Thank you. I have taken
2 quite a lot of questions so that I will
3 let others have a chance.
4 PROF FORSYTH: In terms of the
5 epidural service are all the consultants
6 fully trained and competent to provide
7 epidurals?
8 DR KRISHNAPRASAD: In both sites?
9 PROF FORSYTH: Talking about Furness.
10 DR KRISHNAPRASAD: Furness. Yes, I think,
11 most of them are trained in putting --
12 PROF FORSYTH: The difference between
13 being trained and competent.
14 DR KRISHNAPRASAD: Okay. Because they use
15 epidurals for their other practises as
16 well for.
17 PROF FORSYTH: Yes. I am thinking if
18 there is only 10 percent take up.
19 DR KRISHNAPRASAD: It is quite variable
20 but on even on average around 12 to 15
21 percent a year. Looking at the recent
22 data it is up to 20 percent, but is quite
23 variable but --
24 PROF FORSYTH: We have 100 to 150
25 epidurals a year, and you have got nine

1 consultants and trainees --

2 DR CALDERWOOD: No trainees.

3 DR KRISHNAPRASAD: No. Obstetric mainly

4 done by six SA and one anaesthetist. One

5 consultant.

6 PROF FORSYTH: 12/15 a year. Not

7 very many, is there?

8 DR KRISHNAPRASAD: Along with that they do

9 the lower GI work; we use epidurals. Yes.

10 PROF FORSYTH: What about in the

11 labour suite because a anaesthetist who is

12 on that day, lady is having an epidural;

13 who is supervising the midwives when they

14 are administering the epidural?

15 DR KRISHNAPRASAD: The initial dose will

16 be given by the anaesthetist and the

17 subsequent dose will be given by the

18 midwives.

19 PROF FORSYTH: What is the protocol

20 for that in terms of checking that it has

21 been given appropriately? Is there a

22 protocol you have?

23 DR KRISHNAPRASAD: There is a protocol for

24 ~~administering and~~administering and ~~the thing, so~~ checking will

25 be only by auditing or any incidental

1 reporting if there is anything. Incidents are reported in Trust Critical Incident System.

2 PROF FORSYTH: There was an incident

3 where they gave it intravenously; how did

4 that happen?

5 DR KRISHNAPRASAD: Yes. I think -- I

6 think one of the incidents in that

7 actually the anaesthetist put the

8 epidural, actually left to do something

9 else because the --

10 PROF FORSYTH: It had been connected

11 the wrong way. Is there a process for --

12 DR KRISHNAPRASAD: That has been reviewed

13 in the department meetings.

14 PROF FORSYTH: Does the midwife who

15 is looking after that particular patient

16 have to get someone else to come and check

17 them while they're doing it so that there

18 is two people checking?

19 DR KRISHNAPRASAD: I think that has been

20 robust introduction again after that

21 incident.

22 PROF FORSYTH: Something quite

23 different. In terms of the neonatal

24 resuscitation, clearly quite often the

25 anaesthetist becomes involved in the

1 resuscitation, in the cases that we have
2 read. Primarily y because either the
3 midwife or paediatrician have had
4 difficulty in intubating the patient. Are
5 you aware -- is that something which is
6 commented on much particularly?
7 DR KRISHNAPRASAD: I am not quite aware of
8 that because I do not usual work in
9 Furness but, I mean, in our set up we do
10 not usually involve in resuscitation, I am
11 not actually told by any of my colleagues
12 in Furness that they usually. Most of
13 them are quite capable. I suppose that is
14 what their day-to-day things to intubate
15 people. The units maybe different, but on
16 the normal practice it will be possible if
17 others are struggling ~~studying~~.
18 PROF FORSYTH: Is there much
19 communication between the anaesthetists at
20 Furness and the anaesthetists in
21 Lancaster?
22 DR KRISHNAPRASAD: Not on a regular basis,
23 which what I want to be like, but it is
24 happening in the combined audits.
25 Sometimes they do some additional

1 activities across the site, in Lancaster
2 site. Not us much what I want to, like to
3 see more communication.
4 PROF FORSYTH: Do the anaesthetists
5 go to the perinatal meetings?
6 DR KRISHNAPRASAD: No. In the sense that
7 you are talking about the labour ward, the
8 discussions or --
9 PROF FORSYTH: Yes. Perinatal cases
10 that have been discussed and maternal
11 cases.
12 DR KRISHNAPRASAD: We have got a combined
13 paediatric and anaesthetic audit where the
14 cases are discussed so, I think, that is
15 only a yearly event.
16 PROF FORSYTH: Yearly event.
17 DR KRISHNAPRASAD: The regional transfer
18 service comes and gives their feedback as
19 well at that time.
20 PROF FORSYTH: Thank you.
21 MR BROOKES: Okay.
22 DR KRISHNAPRASAD: And yearly basis will
23 have few combined audits with the
24 paediatricians discussing things but not
25 on regular basis.

1 MR BROOKES: Thank you.
2 MS FEATHERSTONE: I want to -- it is just
3 more about the training. As midwives they
4 can do the top-up, so do the anaesthetists
5 teach the midwives? How does the midwife
6 become competent to do a top-up for the
7 epidural?
8 DR KRISHNAPRASAD: There is a training
9 programme, just the Prompt course, and
10 other assimilation course they do.
11 Currently it runs at once a month, every
12 month once --
13 MS FEATHERSTONE: That is led by the
14 anaesthetist, is it?
15 DR KRISHNAPRASAD: Led by anaesthetists,
16 obstetricians, different people.
17 MS FEATHERSTONE: It is a
18 multi-disciplinary thing?
19 DR KRISHNAPRASAD: Yes.
20 MS FEATHERSTONE: That is good for the
21 skills, drills and deteriorating patient.
22 DR KRISHNAPRASAD: Yes.
23 MS FEATHERSTONE: What are sort of
24 epidurals are women having? Are they
25 mobile epidurals, are they?

1 DR KRISHNAPRASAD: Top ups.
2 MS FEATHERSTONE: Do the anaesthetists
3 teach -- that will not be in the Prompt --
4 do the anaesthetists teach midwives about
5 doing that competency?
6 DR KRISHNAPRASAD: The teaching usually
7 happens in a different set up for the
8 epidural top-ups. I think it is either
9 between the midwives itself. If they want
10 help actually one of the SAS doctors goes
11 and teaches them as we do not have
12 currently any labour ward sessions in
13 Furness. We have got four labour ward
14 sessions in Lancaster, but don't have any
15 specific sessions in Furness.
16 DR CALDERWOOD: What do you mean by that
17 then?
18 DR KRISHNAPRASAD: Ideally they should
19 have labour ward sessions at the
20 consultant or anaesthetic-led labour ward
21 sessions; we don't have that in Furness.
22 DR CALDERWOOD: Four a week in --
23 DR KRISHNAPRASAD: Four a week in --
24 national standards is 12 sessions. We
25 have four sessions.

1 MS FEATHERSTONE: This is my ignorance.
2 That is meaning if you only have that
3 session, if a woman wants an epidural in
4 that time there is nobody available then?
5 DR KRISHNAPRASAD: Other -- I am talking
6 about labour ward, exclusively for labour
7 ward. There are people who actually
8 holding the bleep who can be called in.
9 MS FEATHERSTONE: Then the person that
10 is -- if it is not actually a labour
11 session, and the other person is in
12 theatre doing something else --
13 DR KRISHNAPRASAD: They will not be
14 doing -- in Furness they have got first on
15 bleep, that actually they are floating
16 anaesthetists.
17 MS FEATHERSTONE: Okay. The other thing I
18 want --
19 DR KRISHNAPRASAD: They are not only --
20 they are not dedicated to maternity.
21 MS FEATHERSTONE: There is a delay then
22 sometimes then, there could be?
23 DR KRISHNAPRASAD: Possibly, yes.
24 MS FEATHERSTONE: What about for an
25 emergency Caesarean Section then?

1 DR KRISHNAPRASAD: In the morning again
2 depend upon -- we may have some time call
3 in the people in the department who is
4 doing SP activities.
5 MS FEATHERSTONE: That goes back to the
6 point about, you know, depending what
7 category section it is, and the decision
8 to knife to skin. Okay.
9 The other thing I want to ask about
10 was patient safety and quality meetings.
11 Are the anaesthetists involved in those?
12 Do they have governance meetings at
13 Furness that the anaesthetists are
14 involved in as well?
15 DR KRISHNAPRASAD: Governance. Surgical ~~of~~& Critical Care division ~~We have~~
16 got the usual governance meeting. The
17 lead from Furness anaesthetic comes in
18 along with me. They have got the women's
19 division ~~institution~~ have got their governance
20 meetings and Furness has got a
21 governance -- or obstetrician Anaesthetic lead who is
22 actually this month she left and went to a
23 different hospital. Until that time she
24 used to attend those meetings.
25 MS FEATHERSTONE: Thank you. That is all

1 I need to ask.

2 PROF MONTGOMERY: Thank you. I may

3 not need to ask anything, you may have

4 said this. You told about starting as

5 clinical lead in July 2012. I was not

6 quite sure what you were doing before

7 that. When did you start working in the

8 Trust?

9 DR KRISHNAPRASAD: 2005. I joined as a

10 consultant in the Trust. As general

11 consultant I only work in RLI and the

12 Kendal elective site. I am primarily

13 vascular anaesthetist and paediatric

14 anaesthetist, so I do not usually do

15 obstetrics, but I have done advance obstetric anaesthesia in training ~~do core obstetricians~~,

16 done a lot of training in this.

17 PROF MONTGOMERY: You did not have

18 any particular involvement with Furness

19 until the clinical responsibility came

20 along. I think that means I have no

21 questions.

22 MR BROOKES: Thank you. That answers my

23 questions as well, thank you.

24 Is there anything else anyone wants

25 to raise?

1 DR CALDERWOOD: I suppose it is almost a
2 question you have touched on and you have
3 had a good look and over view, having been
4 relatively new here in the post. Do you
5 have -- there is a balance always between
6 what the national standard is and what is
7 achievable within the financial envelope
8 and between staffing levels.
9 Do you feel that there are national
10 standards in -- I will separate off
11 obstetric anaesthesia and also in the
12 HDU/ICU -- that there are standards that
13 is separate the two sites, in either site
14 or in both sites, that you are not meeting
15 that might compromise safety?
16 DR KRISHNAPRASAD: In obstetrician or ICU?
17 DR CALDERWOOD: Well, both I suppose.
18 DR KRISHNAPRASAD: ICU standards we are --
19 you know, the national ICU standards are
20 coming, new Service Specification ~~certification~~ is coming. If
21 that is the case actually Furness ICU may
22 not be able to function.
23 DR CALDERWOOD: May not?
24 DR KRISHNAPRASAD: Be able to function in
25 the sense that to give you the background

1 in actually Furness most of the
2 anaesthetics are actually not from trained
3 in the UK. Most of them are trained --
4 because there are issues, to be frank,
5 issues with the recruitment in Furness.
6 After I joined as a clinical lead in any
7 of the advertised posts there is no UK
8 graduate applying for the post. How to
9 change it? We do not know because people
10 do not want to go and work in Furness.
11 That is the major issue.
12 Regarding your Service Specification ~~certification~~ of ICUs,
13 that comes most probably in the next year
14 and none of the ICU consultants will be
15 actually ICU consultants. Their training will not be recognised to call them or recognise as ICU Consultant ~~They~~ will not
16 be recognised nationally. I do not know,
17 I do not have the answer for that, but
18 that is the truth. None of the ICU
19 consultants will be recognised as ICU
20 consultants.
21 DR CALDERWOOD: You are at least
22 recognising that and --
23 DR KRISHNAPRASAD: Yes. I think, that --
24 currently we do not have a solution
25 because it is a financial thing.

1 DR CALDERWOOD: What about the maternity
2 side then in Furness. The same
3 consultants are covering both?
4 DR KRISHNAPRASAD: It is, but overall, in
5 charge, when you are on-call, the
6 consultants, yes.
7 DR CALDERWOOD: The same people.
8 DR KRISHNAPRASAD: Yes.
9 DR CALDERWOOD: With your knowledge now of
10 the audits you have done and you have
11 touched a bit on the decision to delivery
12 time, do you feel that some of these
13 are -- that there are some compromises of
14 safety with perhaps delays in getting
15 anaesthetic promptly?
16 DR KRISHNAPRASAD: From incident report I
17 have not seen any of those.
18 DR CALDERWOOD: You haven't? Anything
19 then with I suppose the infrequency, with
20 the small obstetric unit, of very unwell
21 women, who have, perhaps, unusual
22 conditions, or perhaps just very unwell
23 women; I have had some concerns reading
24 the notes about, I suppose, the fact that
25 these things are not happening commonly,

1 as to whether there is full competency of
2 everybody that is dealing with these
3 unusual situations. Do you come across --
4 DR KRISHNAPRASAD: I have not come across,
5 but that is a concern. When you have 1000
6 deliveries, any obstetric or paediatrician
7 or anaesthetist, that will be a concern.
8 I do not have evidence for the concerns,
9 but that really worries me in terms of
10 leading service. That is why I have a lot
11 of few meetings with things what we --
12 because I know there are, I will tell the
13 truth, I think that publicly there are
14 outrage when you actually have talk of
15 maternity moving anywhere because. I mean
16 I am a vascular anaesthetist and when
17 centralisation happened, no voice raised
18 for vascular patient when they move to
19 Preston.
20 But maternity, they try to move, and
21 when I took over there is some problem
22 with that time, they want to move
23 maternity from Furness to RLI, but does
24 not. There is an outcry and it was
25 reversed in 24 hours. That questions

1 about whether the safety are undermined by
2 political gains; I do not know because I
3 am very small to decide those things. I
4 think that is public to decide.
5 DR CALDERWOOD: Thank you for your
6 honesty. The site where you are working
7 and more familiar, do you feel confident
8 about the staff there and the competency
9 and the safety? It is a larger unit et
10 cetera.
11 DR KRISHNAPRASAD: Yes, yes, because we
12 have got -- as we told -- slightly larger
13 unit and most of them environment that
14 they are trained in the environment, you
15 know, what is safety and things there.
16 Well-tuned.
17 DR CALDERWOOD: That is a different group
18 of anaesthetists.
19 DR KRISHNAPRASAD: Different group of
20 anaesthetists.
21 DR CALDERWOOD: Not the problem --
22 DR KRISHNAPRASAD: There is no problem of
23 recruitment in RLI.
24 DR CALDERWOOD: You feel that the issues
25 that I am referring to that --

1 DR KRISHNAPRASAD: Even though we do not
2 meet the national standards of staff
3 because of the nature of only one aspect
4 of that is one labour ward sessions -- we
5 do not have seven labour ward sessions, or
6 ten labour ward sessions. I will not
7 think personally that is required in our
8 set up of things because we have got
9 trainees, we actually carrying the bleep
10 holders immediately available to do
11 things. We don't have dedicated trainee in the
12 night. That is one of the proposals we
13 put in the case to separate the on-call,
14 the general on-call, from 16 to one in
15 eight covering maternity.
16 DR CALDERWOOD: You're trying to make a
17 dedicated -- for maternity.
18 DR KRISHNAPRASAD: Yes.
19 DR CALDERWOOD: It would be very helpful,
20 I think, for us if we could have you to
21 find out the things I have asked about,
22 the news chart, and also this theatre
23 access. I think I would also quite like --
24 it is not fair to ask you, you are --
25 MS McINTOSH: I will write a letter to

1 you.

2 DR CALDERWOOD: It is not fair to ask you

3 this, you are an anaesthetist, you are not

4 a theatre manager, but again I would be

5 quite interested in your take on --

6 probably do not have time today -- on just

7 that system at Furness. I appreciate you

8 may not know it because you do not work

9 there, but perhaps some communication with

10 the SITE ANAESTHETIC LEAD ~~clinical lead~~ that you say is on-site.

11 DR KRISHNAPRASAD: Yes.

12 DR CALDERWOOD: How that --

13 DR KRISHNAPRASAD: Personally I am

14 responsible there but yes, I think that I

15 am responsible there. I will find out

16 what is the issue there.

17 DR CALDERWOOD: Yes. That would be very

18 helpful. It is for reassurance for us

19 sitting here are things better than they

20 were when there was some problems flagged.

21 That will be very helpful, thank you.

22 MR BROOKES: Okay. Just for clarification

23 in my mind. You have raised a number of

24 things at Lancaster where there needs to

25 be some improvement. Do you feel that you

1 have got the support of the leadership in
2 the organisation to make those changes?
3 Are there possible changes?
4 DR KRISHNAPRASAD: That is the reason the
5 case has been presented to the group. We
6 are -- we work in different divisions
7 because I work in the surgical and
8 critical care division, we have got full
9 backing from that division. I am not very
10 sure about ~~what is people such as SCBU and~~ and-Executives
11 medical directors, what their views
12 because ~~personally~~ they've not asked me to
13 come and present it even though ~~because~~ I personally
14 wanted to present, but I think they took
15 the paper and given back the feedbacks to
16 us. That is an issue with engagement.
17 MR BROOKES: Thank you. Unless there is
18 anything else. Thank you very much for
19 your time, it has been extremely helpful.
20 Thank you.
21 ------------------
22
23
24
25

THE MORECAMBE BAY INVESTIGATION

Monday, 3 November 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes - Expert adviser on Clinical Governance
Professor Stewart Forsyth - Expert adviser on Paediatrics
Professor Jonathan Montgomery - Expert adviser on Ethics

JUDITH KURUTAC

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1 (At 11.33 am)
2 DR KIRKUP: Thank you for coming, my name's Bill Kirkup, I'm The Chair of the
3 investigation panel. I'll ask my colleagues to introduce themselves to you.
4 PROF FORSYTH: My name's Stewart Forsyth, I'm a paediatrician and Medical
5 Director from Dundee.
6 MR BROOKES: I'm Julian Brookes, I'm currently Deputy Chief Operating Officer
7 for Public Health England, previously Head of Clinical Quality in the
8 Department of Health.
9 MS KURUTAC: Okay, thank you.
10 PROF MONTGOMERY: I'm Jonathan Montgomery, I'm a Professor of Healthcare
11 Law at University College London, and Chair of the Health Research
12 Authority. In the past, I've chaired PCTs –
13 MS KURUTAC: Oh right, okay –
14 DR KIRKUP: You'll see that we're recording proceedings, and we'll produce an
15 agreed record at the end. You may also note that we've asked family
16 members, if they wish to be present as observers. As it happens, we don't
17 have any here this morning, but they may listen to the recordings
18 subsequently. You'll also note that we've asked you to hand in any mobile
19 phone or laptop that could act as a recording device. That's just to
20 emphasise that we don't want anything to go outside the room, until we
21 release the report with all the findings in context.
22 MS KURUTAC: Mmm, okay.
23 DR KIRKUP: Do you have any questions for me about the process?
24 MS KURUTAC: It's that I'm a bit buzzing, and I'm like – my head's going like this,
25 and I'm thinking, I'm going to be like this, saying to you, I can't hear you or
26 something, because I'm feeling a bit – I'm just feeling a bit buzzy at the
27 moment.
28 DR KIRKUP: Okay, well that's alright. If you need to take a few moments at any
29 stage, that's absolutely fine. Just let us know. If you can't, please just do
30 your best.
31 MS KURUTAC: Thank you.
32 DR KIRKUP: I'd like to start with a general question which is, you were involved
33 with the local supervisory authority. Could you tell me when that started
34 and how long you –

1 MS KURUTAC: Yes, I've been a midwife for a long time; this is my 41st year now.
2 And in the late – in the mid-90s, I was involved with case-loading of women
3 as a midwife, and I'd often contact the LSA for advice about clinical
4 practice, and it got so that I was offered a job. So I started part-time with
5 the LSA in 1999, and that became full-time by about 2000. My remit really
6 at the time in the context of development of maternity care was to focus on
7 clinical practice, and so that meant supporting midwives to look at – I don't
8 like the word 'normality' because it's something that grates as a title, but to
9 facilitate more individualised care, I should say. And also take that on
10 board with the ethos at the time, you know, reduction of caesarean
11 sections, increase in midwifery led-care. Those things that were operating
12 at the time.
13 DR KIRKUP: Yes, okay. And how long did you carry on with that role for?
14 MS KURUTAC: Pardon?
15 DR KIRKUP: How long did you carry on with the role for?
16 MS KURUTAC: Until 2013, October 2013.
17 DR KIRKUP: Okay, what happened then?
18 MS KURUTAC: What, to me?
19 DR KIRKUP: Yes.
20 MS KURUTAC: I left, I didn't feel comfortable with the way the supervision at LSA
21 – I'd done it for a long time and I didn't feel comfortable with the way things
22 were developing, I guess. And I went to Ghana to work.
23 DR KIRKUP: Could you just expand a bit? In what sense didn't you feel
24 comfortable with the way it was developing?
25 MS KURUTAC: Well, I think if you understand the historical context of midwifery
26 and I'm very conscious – I don't want to sound as if I'm divide and rule – but
27 if you uphold a midwifery profession, then the commitment to midwifery as a
28 profession is what it should be, not trying to be a mini doctor here, or an
29 expert in something over here. And I think we also find that there is a
30 tendency – because I'm quite passionate about it really. I'm very conscious
31 of retaining our professional remit as midwives and being committed to that
32 rather than to dilute that role. I think some of the issues that have gone
33 awry are because we are not – I have to be critical of my own profession I
34 think, in a way, that we've forgotten where our remit lies. It's very easy to

1 do that when the pressures on an organisation, or the pressures on: 'Do
2 this, take on a bit more, take on that', but what we do is forget the basics.
3 It's sexy to do a ventouse or it's sexy to be able to put a drip up or
4 something, but it's not so sexy to stay with the woman and do basic
5 observations and make decisions about that. I think, you know, I've lived
6 and worked abroad in several countries now, and the key to me seems to
7 be that engagement with, 'Don't forget the basics' is what I would say.
8 DR KIRKUP: Okay, that's very helpful. Jonathan?
9 PROF MONTGOMERY: Thank you very much. I wonder if I could get you to
10 elaborate a little bit on the remit of the midwife, that you've just picked up,
11 and your work about supporting midwives, looking at individualised care
12 and all-care, and how that actually worked?
13 MS KURUTAC: Well, within the LSA, midwifery supervision is about the clinical
14 practice of midwifery and upholding safety for mothers and babies. That's
15 the premise. So, on a day-to-day basis, we had the development and the
16 drivers of women being encouraged to – I'm really struggling with the right
17 words here, because it's – I repeat – it's not a question of encouraging all
18 women to have a home birth or all women to do this. It's about maintaining
19 what is appropriate for that particular individual mother and baby, and within
20 midwifery – or within maternity care I should say – that it's possible to
21 uphold you know a lot – uphold less intervention than we currently are
22 experiencing. But at the same time, you have to keep your antennae up
23 and know the difference between when things are straightforward and when
24 they're not. So my work often would be about visiting with a midwife or a
25 group of midwives or supervisors, whatever the remit was, and we've got
26 this lady who wants to have a home birth. Let's keep it simple. She's a
27 previous section and she's got this and she's got that. So it was actually
28 working, very often, with the midwives to provide appropriate care that
29 would keep safety margins for mother and baby, but not isolate the midwife
30 from all the other disciplines that are potentially involved with that remit that,
31 you know – sometimes midwives will, 'This women's having a home birth,
32 so that's normal'. What they forget is that you cannot guarantee normality
33 will be upheld forever. There's no guarantee about anything. So in
34 midwifery practice, you also have to maintain relationships with your more

1 experienced midwifery colleagues, perhaps, with your paediatricians, with
2 your anaesthetists, your psychiatrists, your obstetricians. There could be a
3 whole gambit of people that you might touch-base with, they come back,
4 have had – you've sought opinion, the women does end up with a home
5 birth and everything's alright. But you've actually – when I say, 'Covered all
6 bases', you've taken a wider remit within your role as midwife in the centre,
7 to ensure safety of mother and baby.
8 PROF MONTGOMERY: I understand that, I was trying to understand your role in
9 supporting that. So where does your role –
10 MS KURUTAC: Well, I mean, I just spent –
11 PROF MONTGOMERY: You're covering the whole of the northwest –
12 MS KURUTAC: Oh I did, that's what I did; I would go around the units, and I
13 would do a lot of workshops and I – perhaps those early years I was
14 working with the LSA, it was pretty full-on.
15 PROF MONTGOMERY: So what was your contact with University Hospitals
16 Morecambe Bay?
17 MS KURUTAC: Pardon?
18 PROF MONTGOMERY: Your contact with University Hospitals Morecambe Bay,
19 the Trust we're concerned with?
20 MS KURUTAC: Well, you've got – at the time we had 32 units, and so historically,
21 you know, I would get the LSA would be contacted if they felt they had an
22 issue. And I remember way back, one issue was the contact with the
23 midwives who were dealing with a very obese lady and they were struggling
24 because nobody around them was helping them out. So, that situation was
25 one that they had spent quite a bit of time reassuring the midwives that they
26 had everything in place, and we actually did sit down and made some
27 guidelines about the care of – as has come to fruition now – the obese – it
28 was the obese pregnant women at the time.
29 PROF MONTGOMERY: This is a lady from Morecambe Bay?
30 MS KURUTAC: Yes. [redacted]
31 PROF MONTGOMERY: And are you the supervisor for these midwives or were
32 you supporting –
33 MS KURUTAC: No, no, no. Supervision, which is something that I don't feel is
34 particularly very well understood. The ratio – in order for a midwife to

1 practice in this country, she not only has her professional qualifications, but
2 you know, she will beholden to make sure she is up to date on an annual
3 basis, and that means that she will have a supervisor of midwives. Forgive
4 me, because I don't quite know if, you know, as a panel, you're individually,
5 you know, you understand the supervisors – our senior midwives have
6 undergone more training and nowadays, it's academic level, and their
7 responsibility within a unit, is one supervisor to 15 midwives. As the LSA
8 midwife, I would be giving advice on top of that, if you know what I mean.
9 PROF MONTGOMERY: Were you advising the supervisor or the midwife directly?
10 MS KURUTAC: Both.
11 PROF MONTGOMERY: Okay.
12 MS KURUTAC: Both. It depends, because any midwife has got the right, if you
13 like, to contact the LSA at any time. They don't have to go through a
14 hierarchical step of contact.
15 PROF MONTGOMERY: So are there any examples of midwives from Morecambe
16 Bay contacting you directly?
17 MS KURUTAC: Usually – I mean – this is where I'll be struggling because it's
18 historically – I mean, I brought the last three years, I think, of audits that I
19 was involved with. But before that, I haven't got any records or anything.
20 But I believe, in all honesty, it would be mostly supervisors and the
21 occasional midwife who might be worried about – for example, you'll get the
22 occasional midwife who might be worried about the attitude or the way they
23 were being treated by – perceived to be treated by the supervisor within
24 their practice. That kind of thing, you know.
25 PROF MONTGOMERY: And you talked about seminars and workshops and
26 things. Did you do any of those in Morecambe Bay in your time?
27 MS KURUTAC: Didn't do any directly at Morecambe Bay because the three units
28 there – you've got Kendal, which is a midwifery-led unit. Highly, highly
29 skilled in terms of many midwifery practice areas that fed into – that could
30 feed into Lancaster and Barrow, and vice versa. So, mostly I can
31 remember going to Kendal to discuss midwifery issues there, rather than a
32 request to go into Barrow.
33 PROF MONTGOMERY: How do you know they were highly skilled?
34 MS KURUTAC: Sorry?

1 PROF MONTGOMERY: How did you know they were highly skilled?
2 MS KURUTAC: Statistically, you know, statistically one thing: their outcomes at
3 Kendal for – in inverted commas – normal outcomes; the request for the
4 women themselves to maintain that unit to provide care for women; the fact
5 that when it was threatened, when services were diluted and you no longer
6 had obstetricians, you – for example, you – they centred their caesarean
7 sections on Lancaster, that was one thing that shifted from Kendal; the care
8 of women with previous sections was something that obstetricians had faith
9 in the midwives to carry out, and the midwives were saying, 'Please, this is
10 beyond our remit, can we just keep things normal', and so the balance of
11 keeping – of keeping things safe again, and appropriate, were very much a
12 discipline – a cross-discipline discussion. And also, you've got a lot of
13 request from the country, around the country from midwives students, who
14 not only work there, but also to do their electives and, you know, apply for
15 jobs there.
16 PROF MONTGOMERY: So they were all indirect indicators of quality?
17 MS KURUTAC: Yes.
18 PROF MONTGOMERY: Did you have in your audits any way of getting direct
19 data on the skills of midwives?
20 MS KURUTAC: I'm sorry?
21 PROF MONTGOMERY: You've given me a number of indirect indications about
22 the fact the midwives were skilled. So, you've got outcomes that may or
23 may not be connected to skills: they might be connected to the women who
24 chose to have birth – I wonder whether your audits gave you anything
25 directly about the midwives themselves?
26 MS KURUTAC: Yes, I mean I'm not – I'm sort of – I think the other thing you got
27 in Kendal, for example, was the communication. You've got midwives close
28 to their population of women. So there's – I'm not saying you don't in the
29 other units. You've got to remember that's a rural setting, and women have
30 got quite strong views about – all women have got strong views about
31 things. But there's a tolerance and an expectation that is different. I think
32 the relationship between mothers and midwives is something that you might
33 not see in other practice areas, you know.

1 PROF MONTGOMERY: So you've given us a really helpful, sort of, picture of
2 Kendal; give us the equivalent for Barrow. What was Barrow like?
3 MS KURUTAC: Well, I'm not – I haven't been directly involved there but, you
4 know, you've got to look at the background at Barrow. That, historically,
5 you've got shipbuilding; you've got all that context of where people live and
6 how people work: unemployment and close-knit communities. Slightly
7 different approach altogether, and midwives were – I don't know. What I do
8 remember, several years ago, was the midwives struggling with that in-
9 between stage of – we do caesarean sections; we have that medical cover,
10 we do this, we do that; but they're in a sort of, 'out of the limb' kind of unit.
11 So they kind of – it's not quite a mainstream unit. It's not saying there aren't
12 skills, but there's a slightly different context. One of the things I do
13 remember: caesarean sections in one audit, I remember being a bit
14 unhappy that in order for a women to go for a caesarean section, they have
15 to go and get the keys from the general site to unlock the doors. So that
16 would imply that there was a potential delay. And I'm just giving you that as
17 an example, not because it's directly answering your question, but because
18 there's a context of practice that is almost – it's slightly different. That's not
19 – you could argue that's not acceptable, and the communication then is
20 imbalanced.
21 PROF MONTGOMERY: So [inaudible] you knew about that, it might not be
22 unacceptable to have the key to the access to the theatre on a different part
23 of the site. So what's the responsibility of the LSA to address that?
24 MS KURUTAC: Yes, so you write in the report and you make that note, and then
25 that's left within the unit to –
26 PROF MONTGOMERY: Who does that go to, that report?
27 MS KURUTAC: Well the reports are circulated and they always have been to –
28 they're open to the public, they're circulated to the midwives, the
29 supervising midwives, chief execs, and at the time, we had 17 health
30 authorities, so each person within that health authority would have it. What
31 I would illustrate to you is that those reports were widely circulated.
32 PROF MONTGOMERY: If you look at the fact that that's still a problem now,
33 doesn't sound as though circulating them helps safeguarding then? There's
34 still problems with access to that theatre?

1 MS KURUTAC: Sorry?

2 PROF MONTGOMERY: You identified that there wasn't access to theatre, and it's
3 still a problem, because it was identified by the Care Quality Commission in
4 the last few months. So I'm trying to understand how this system of
5 safeguarding...?

6 MS KURUTAC: Yes, well, from a LSA point of view, I think that's one of the issues
7 that you can – that comes out in these later reports. It's not just about
8 Morecambe Bay, it's across the board, that you have a remit of practice;
9 you have a remit of recommendations. You do not have the authority, the
10 LSA Midwifery Officer does not have the authority to demand – to dictate, I
11 should say – managerial, sort of, priorities or what have you. All we can do
12 is say, 'This does jeopardise safety of mothers and babies', and over the
13 years, you can see that it sometimes takes several goes before you actually
14 reach where you really wanted to be two years ago, whatever.

15 PROF MONTGOMERY: And would you include the safety of access to theatre for
16 emergency sections as something you could wait several years for?

17 MS KURUTAC: Sorry?

18 PROF MONTGOMERY: Would you include the safety of access to emergency
19 theatre –

20 MS KURUTAC: Yes.

21 PROF MONTGOMERY: That you would wait several years for, to attempt?

22 MS KURUTAC: I'm thinking about – I'm just trying to think about that particular
23 problem and the way the supervisors – I can remember, and I can only
24 remember, I've not got it in fact – I can only surmise and remember that led
25 to – you know when you get custom and practice and people sort of accept
26 a situation: 'Oh, well, nothing bad has happened so we'll carry on in the
27 same...' – but the potential for something to go wrong. So the supervisors
28 then have to go – I remember them going back and discussing it with the
29 theatre staff and everybody else again. And it goes around and they reach
30 a resolution. But from a LSA point of view, we just had to make sure that
31 had been taken on board internally. That was our remit: to make sure that
32 was taken on board.

33 PROF MONTGOMERY: So do you think you fulfilled that remit? Did you make
34 sure it was taken on internally?

1 MS KURUTAC: Well, it wasn't me personally: you follow that up, hopefully, on a
2 six-monthly, year-on-year basis, because these audits are done on a year-
3 on-year basis, but something as pressing, you would follow-up three
4 monthly, whatever, give somebody time to resolve it and go back, yes.
5 PROF MONTGOMERY: Okay, so I'd like to go back to the [inaudible] of the
6 Barrow bit of the Trust. So you obviously know a reasonable amount about
7 Kendal, but you've identified reasons to have some concern about Barrow.
8 I'm a bit perplexed why the support activity goes into Kendal, where things
9 seem to be working well, and you don't seem to have gone into Barrow to
10 help them sort out the deficit in Barrow?
11 MS KURUTAC: Well, it's only – I think what you're talking about, in a broader
12 sense, is the quality of the people practicing. You know, whatever your
13 discipline, if you have strong – and again, I'm using my words very – I'm
14 struggling with using the words because I might be in danger of implying
15 that people in one unit aren't strong. That's not necessarily true. It's the
16 whole structure on many layers. So if the midwives – let's just start with
17 midwives. If the midwives feel well-supported, confident in their practice,
18 then they feel strong to engage with the women in a different level; they feel
19 confident to move on and engage and challenge other practices. So within
20 Kendal, you've got arguably, a limited context, because it's a small unit, its
21 maternity based. You go to Barrow and then the remit of the midwives
22 supervisors to challenge becomes wider. And therefore, how do those
23 communications follow against a bigger – yes, a wider number of other
24 professionals. Let's put it that way. You know, in a tertiary referral centre,
25 the likes of Liverpool or Manchester, St Mary's, you know, getting everyone
26 together gets even more difficult. So, I'm trying to say that at Barrow, it's
27 one of the things that you noticed, was that the communication issue was
28 more difficult to ascertain. That was something that the supervisors and the
29 midwives would bring up more than once.
30 PROF MONTGOMERY: We've heard from families, that they think that midwives
31 in Barrow [inaudible] poor practice, competent in not sharing, is that
32 something your experience would corroborate?
33 MS KURUTAC: No. [*After a short pause*] Could you just say that again, please?

1 PROF MONTGOMERY: The families – some of the families have told us that their
2 perception of midwives in Barrow, was that they were set in their ways, that
3 they didn't communicate with paediatricians or obstetricians. If they're
4 confident in that; you've told me there were other things as you get
5 confident midwives. If you're confident in doing the wrong thing, that's
6 much worse than being tentative about what you're doing and seeking
7 advice –
8 MS KURUTAC: Yes.
9 PROF MONTGOMERY: So, I wondered whether you could share some light on
10 that?
11 MS KURUTAC: I think, because I'm not engaged – I wasn't engaged on the shop
12 floor in Barrow, so you can't – I didn't meet directly with individual
13 personalities, apart from supervisors and some of the midwives, then – I
14 think – gosh, what do I think? I think it's a question of – it's interesting
15 about perseverance, you know? Supervisors – if a supervisor is unhappy
16 with something and they were difficulties with communication with whoever,
17 paediatricians, obstetricians, whatever, then – at the risk of sounding
18 critical, because I've done it myself, as a labour ward manager, you have to
19 bite the bullet and eat humble pie, because in the interests of the mother
20 and baby, you can't let personalities – I need your opinion as an
21 anaesthetist, I need your opinion as a paediatrician –
22 PROF MONTGOMERY: I can see that's what supposed to happen; I'm trying to
23 test out whether we know whether it was happening? So you weren't
24 involved in –
25 MS KURUTAC: Yes, we do. I do know there was difficulties; I do remember
26 difficulties, and all I'm trying to say to you is that some of the – some of the
27 quality or the perceived difficulties might be perceived as the individual or
28 the collective – because at the LSA –
29 PROF MONTGOMERY: I completely understand that, but I'm trying to
30 understand, given that that might be the case, what did the Local
31 Supervising Authority do about finding out whether it was the case? So you
32 weren't involved in the shop floor? Who was involved in the shop floor, for
33 the Supervising Authority?

1 MS KURUTAC: Well, it was supervising midwives, and from the LSA point of view, you would advise and the Midwifery Officer would always advise it's not one supervisor's issues; it's collectively, and you have the legal – sorry, the professional responsibility to – if you're having problems to take it through to the Chief Exec, to bring it through to the LSA, NMC –

6 PROF MONTGOMERY: Am I right in thinking that all the supervisors of midwives in that unit worked in that unit?

8 MS KURUTAC: All the supervisors...?

9 PROF MONTGOMERY: People who were supervisors of midwives for the midwives working Barrow, did they all come from Barrow?

11 MS KURUTAC: I would – yes, I believe so at the time. Now, you have a more of a cross-base supervision system, so supervisors across units –

13 PROF MONTGOMERY: So how could you be confident whether or not supervisors were themselves part of the problem? If they're part of this unit the families have concerns over, and the only people on the shop floor from the Supervising Authority have been people working in that unit, is that not a flaw in the system?

18 MS KURUTAC: Hmm – I'm – again, I'm – there's so many – there's too many arms to this. When you – and I'm not sure how to respond to you at the minute. I mean, to ensure that... [*After a short pause*] From an LSA point of view, you understand there's a problem. You will advise supervisors what to do. Therefore, the remit then is that they need to tackle the problem internally themselves. If – and we would then go back and – I mean, audit, review, that's been tackled. If we are not therefore – if supervisors – equally, if supervisors don't tell us that they have a problem, then we can't do anything about it. So it's a two way –

27 PROF MONTGOMERY: But I'm asking, what if the supervisors are the problem?

28 MS KURUTAC: Pardon?

29 PROF MONTGOMERY: What if it's the supervisors who are the problem?

30 MS KURUTAC: If it's the supervisors are the problem, it depends what you mean by, if the supervisor is a problem. This is, where, again, I'm hesitating because I wouldn't say that the supervisors particularly – it's about a character – the characteristics of individuals again. It – there's two arms to that. If you find that people are complaining about a supervisor, whether it's

1 the midwives or the public, or this, that or the other, then the LSA would
2 investigate that supervisor; would advise that she step down from that role,
3 for example. But again, unless you – unless there is a complaint or an
4 obvious error – not an error, an obvious issue comes to light – then you
5 won't necessarily know. It's the same in any discipline – you'd –

6 PROF MONTGOMERY: Were there any complaints about supervisors from
7 Morecambe Bay?

8 MS KURUTAC: Well, in the latter years, before I left, yes. But in the early days,
9 no. Because as with many, many units at that time, one of the remits of the
10 LSA – when I say early years, I mean 2000, 2004, 2006, that sort of era,
11 that first half – we were struggling very, very hard to get the ratios of
12 supervisors to midwives up to speed in relation to Nursing and Midwifery
13 Council recommendations.

14 PROF MONTGOMERY: Can I just – clarify what counts as early and later years?
15 So what point were there complaints about supervisors?

16 MS KURUTAC: I wouldn't say – I can't answer that, exactly. I really can't. But it's
17 a drift, perhaps a gradual awareness that things aren't quite so right, as
18 perhaps the LSA were led to believe, or we assessed to believe, or
19 midwives told us. Because we then had a couple of supervisors who were
20 investigated and I do remember one supervisor of midwives who was
21 basically working so hard to keep everything – keep the supervisory role
22 going, you know – it's like somebody going off sick and somebody else has
23 to pick up the slack. Then the LSA has the problem of thinking how do we
24 make sure that function is upheld, and you end up with cross-base
25 supervision.

26 PROF MONTGOMERY: It sounds as though you are describing the supervisors
27 as the victims of something there. Is that what you're telling us?

28 MS KURUTAC: Well, I think – I keep saying, I'm being very careful here. But, you
29 know, one of the things that we had with supervision was that whilst we
30 were very – recommendations from all sorts of papers, etc., increasing
31 normality, you find that not just midwives but supervisors will take that on to
32 the nth-degree – and one of the things that – 'Oh, results look good, that's
33 grand. When we ask the questions in the audit, figures come out really,
34 really well'. But actually, with one of the supervisors, we found that her own

1 practice was questionable and she's actually – she was investigated and
2 put on supervised practice. But that took – that took a series – as things do,
3 it takes time and it takes a series of –
4 PROF MONTGOMERY: So how did you identify that?
5 MS KURUTAC: Because of – I believe it was record keeping. You know,
6 supervisors, over the years, we've got very, very – much better at
7 scrutinising notes. So you look at somebody's notes, either randomly or
8 recommend to look at, at least 10 sets of notes over a space of time. It
9 could be anybody's, and, 'Oh, that's interesting, there's no recordings of the
10 foetal heart, for example'. And, from small things unravels a bigger thing,
11 and that's how that –
12 PROF MONTGOMERY: So you're saying that there was a look at this midwife's
13 record keeping?
14 MS KURUTAC: Yes.
15 PROF MONTGOMERY: I think we need to know who this do we Bill? Do we
16 need to know who this is, or...
17 DR KIRKUP: Yes, I think we do.
18 PROF MONTGOMERY: I think we do need to know who that is?
19 MS KURUTAC: Pardon?
20 PROF MONTGOMERY: We need to know who that midwife was?
21 MS KURUTAC: Well, she has been referred, it's Jennifer Bowns.
22 PROF MONTGOMERY: Thank you. Were you involved in any of the audits
23 around record keeping?
24 MS KURUTAC: Not directly, no. Because that's a template that all units would –
25 the units would follow. If my records were looked at, a supervisor would
26 follow a template and –
27 PROF MONTGOMERY: And would that be fed into your northwest audits in some
28 way?
29 MS KURUTAC: Yes, because it's the questions that every – the template for the
30 audit documents, I don't know if you've seen them at all?
31 PROF MONTGOMERY: I think I have – I'm just trying to tease out what you –
32 what was reported up? So was there any difference in pattern on the
33 record keeping in Morecambe Bay, particularly in Barrow, compared to
34 elsewhere?

1 MS KURUTAC: No, because I think – well, what's grown up over the years, as
2 you are fully aware, is that we're talking about practice of midwifery, how
3 the efficacy of notes from the LSA, but that will actually conjoin with Trust
4 templates of record keeping. So to a certain degree, they overlap.
5 PROF MONTGOMERY: And that audit was done by the local supervisors, was it?
6 MS KURUTAC: Pardon?
7 PROF MONTGOMERY: That audit was done by the local supervisors of the
8 midwives?
9 MS KURUTAC: Yes, that's right. And sometimes, places like Oldham, in the
10 Northwest, they would do multidisciplinary, so you'd get an obstetrician or
11 another with the midwives looking at notes as well.
12 PROF MONTGOMERY: The impression that our clinicians have got, looking at
13 notes, is that the quality of notes in Barrow is very much poorer than the
14 quality of notes elsewhere in the Trust and elsewhere in Cumbria. Did that
15 every get picked up by the audits?
16 MS KURUTAC: It just – all I can think of, it's such hard work to keep, you know, to
17 keep... [*After a short pause*] You go back to a fundamental issue, and the
18 stage at which any unit is – it could be in the northwest, from my
19 experience, or nationwide, it's quite interesting why and how a variation in a
20 standard occurs. And so, from an LSA point of view, you kind of end up
21 challenging that more strongly in one unit to another. That's the only way I
22 can put it –
23 PROF MONTGOMERY: I can understand that, and I think what I'm trying to
24 understand is what triggers that challenge because what I'm hearing is that
25 it's a system very strongly based on trust, because you have supervisors in
26 the local unit, and you're relying on what you're telling you, and they're
27 telling you that they've done an audit of notes, and that they're satisfied, but
28 we look at it, and we say, 'The wool's been pulled over your eyes because
29 actually, if you'd gone in and done it yourself, it would have looked
30 different'. I'm trying to understand –
31 MS KURUTAC: That's exactly it.
32 PROF MONTGOMERY: Where the checks and balances in the system were?
33 MS KURUTAC: Yes, and I think it relates to the bigger, bigger issues; you know,
34 how one rubbish one unit's storage system is, and how units – I mean, in

1 Barrow, supervisors' notes were just chucked in the cupboard, you know.
2 Whereas, you know, you go to other units and there's a very – you've got
3 clerical staff, it's very ordered. There's a trail of where notes are and how
4 you find them. Therefore that – from those basic premises you then already
5 have established a higher standard which filters up to what is actually
6 produced on the paper.
7 PROF MONTGOMERY: I guess one of the questions, and reflecting criticisms
8 that the Ombudsman has made of the supervision system, is that those are
9 things you would expect local management to be responsible for sorting
10 out?
11 MS KURUTAC: Yes.
12 PROF MONTGOMERY: And Ombudsman's suggestion is that the separation of
13 responsibility that's created by the supervision being on a slightly different
14 professional accountability track than the line management, has actually
15 created a gap and that units like Barrow have fallen between that, and
16 nobody sorts out what were really quite fundamental problems of record
17 keeping. Is that a view that you think is fair?
18 MS KURUTAC: Yes and no. Yes and no. Because again, what you've reiterated
19 yourself already, from an LSA point of view – it's chicken and egg, a little
20 isn't it – well, I'm not asking you to agree. There's issues on both sides.
21 We, from an LSA point of view, 'How's your record keeping?' The
22 supervisor will tell you it's 80% or whatever it is, and, 'We've made
23 improvements on this and that', so you don't go around and check every
24 other bit and pieces, but also again, I think it goes back to a fundamental
25 issue of how supervision is accepted and operates across management and
26 how management operates with supervision. How do those two disciplines
27 work together, because supervision is a statutory function, you know, but if
28 a management structure – and I use that term widely and loosely – isn't
29 particularly communicative or accepting, whatever the LSA does – and I'm
30 not excusing that either – but it's easy to get a bigger rift. Whereas you go
31 to – we've got other units where the experience was that communication
32 and understanding of each of those functions was much better, and
33 therefore everything, including record keeping, you would find – let's just
34 say, runs much more smoothly. And people understand each others' remit.

1 PROF MONTGOMERY: At the moment the issue painted at Morecambe Bay is
2 that the Local Supervising Authority didn't really have much impact on the
3 problems of Morecambe Bay because it was the Local Supervisors – I'm
4 trying to understand whether that's a fundamental problem of how the
5 supervision system works or whether it was particular to Morecambe Bay.
6 So I wonder if you had examples elsewhere in the northwest, where
7 actually, the LSA have been able to play a big role in improving practice?
8 MS KURUTAC: Well –
9 PROF MONTGOMERY: Because it may be an accident that things have not gone
10 smoothly in Morecambe Bay and we need to think about what's different
11 about Morecambe Bay; or it may be that it's about the system.
12 MS KURUTAC: Well, I think, again, one of the issues – and it's an historical one is
13 that you've got three units that are very, very, very different. One of the first
14 things that I remember very early on, that Midwifery Officer did was
15 encourage cross-Bay communication as far as supervision was concerned,
16 because – I feel as if I'm repeating myself a bit now – the discipline – sorry,
17 the expertise, the discipline, the communication issues were slightly less or
18 more efficient within each individual unit. So, you want to get some equity
19 across there. So that's one thing that the LSA try to do, over a period of
20 time. The will to do that, given the day-to-day practice and demands on
21 services, means that sometimes perhaps those meetings or that intention
22 doesn't run as smoothly as – doesn't go ahead as intended. Then you're
23 trying very hard to get equity of policy, across the units as well. You know,
24 how do you deal with anything, from ruptured membranes to undiagnosed
25 breech to – well, babies, elective sections and women's request to have
26 induction or not. All those kind of practice policies. That's what I think
27 those two areas in which the LSA did try very hard and which the
28 supervisors did try very hard to improve, and I know in the latter years, the
29 quality of post-natal notes was one thing that was pertinent to Morecambe
30 Bay. It was also pertinent in other units that we did tackle.
31 PROF MONTGOMERY: Thank you, I'd like to move to specific investigation
32 question and answer. You've told us a lot about how the system worked
33 and the audit, and I know that supervisor midwives are involved in

1 investigating particular concerns at the time – you've indicated one that you
2 weren't directly involved with already?
3 MS KURUTAC: Mmm.
4 PROF MONTGOMERY: If we're going to talk about individual cases involving
5 families to move into a slightly separate part of our discussions which will be
6 confidential, but I wonder if, before we do that, we could just check what
7 investigations you were involved with, even slightly tangentially, related to
8 our Trust, that we're concerned with, and then perhaps, we'll move into the
9 particular things. So, were you involved in any of the investigations that
10 were raised out of family's concerns into the practice of midwives?
11 MS KURUTAC: Not directly, no. The only – with the Titcombe case, when –
12 PROF MONTGOMERY: I think at this stage, we should just identify that the
13 Titcombe is one that we want to talk about in a moment –
14 DR KIRKUP: We'll come onto that.
15 MS KURUTAC: What I was going to say then, I just attended a meeting with the
16 family, with the LSA Midwifery Officer and met with supervisors in the early
17 days of their concerns about that. But that's –
18 PROF MONTGOMERY: I hear – [inaudible] but I think we should check whether
19 there were any more general discussions with the first part?
20 MR BROOKES: Just a couple, just one specific one first: you mentioned about
21 medical notes being chucked into a cupboard, was I think your phrase, in
22 terms of Barrow. Is that something you actually saw or was that something
23 that was reported to you? Or was it just a turn of phrase, because I'd quite
24 like to just pin down exactly what you meant?
25 MS KURUTAC: I'm sorry, I'm – could you just say that again, please?
26 MR BROOKES: Yes, sure. When you were talking earlier, you mentioned about,
27 an example you gave, about different kinds of quality of record keeping –
28 MS KURUTAC: Yes.
29 MR BROOKES: And the phrase you used in terms of Barrow is that they were just
30 chucked into a cupboard. Is that something you actually saw or was that
31 something that was reported to you?
32 MS KURUTAC: Was it 'important'?
33 MR BROOKES: Was it reported to you?
34 DR KIRKUP: Was it reported to you?

1 MR BROOKES: Did you see it for yourself?
2 MS KURUTAC: I mean, was it reported – I'm trying to think how it came, because
3 it was – I remember being shown a door once, you know, 'Just look at this,
4 we're trying to get this organised'. I remember that as a physical thing and
5 the supervisors struggling with addressing it through the general – you
6 know, like the clerical staff. That's one thing I do remember.
7 MR BROOKES: Was it something you were sufficiently concerned about that you
8 wrote to the Trust about or report it in one of your Reports?
9 MS KURUTAC: With that storage, with that kind of issue, again, we come back to
10 the supervisors were aware of that, they were passing it through channels
11 that, locally, within their unit. From an LSA point of view, it had been taken
12 up. Therefore, that needs – that's for them to follow that through. And for
13 us to question, on another occasion, whether – as I repeat – it was an extra
14 audit <u>visit</u> ~~visible~~ or whatever.
15 MR BROOKES: Different question: I'm just trying to get in my head, and it's not
16 meant to be a pejorative question, but the added value of the LSA to the
17 system, that's – I'm struggling with that a bit. Because you can advise, you
18 can make recommendations, but you have no authority. So I'm just trying
19 to understand the added value of the LSA.
20 MS KURUTAC: Again, historically, in 1999, 2000, when I began – when I worked
21 with the – started working with the LSA, with the Midwifery Officer, we had
22 regular contacts with chief exec, which represented the 17 Health
23 Authorities for who – sorry, for whom the LSA were responsible for
24 upholding the remit, statutory function. So that particular chief exec –
25 MR BROOKES: Sorry, who was that?
26 MS KURUTAC: Do you know, I knew you were going to ask me that and I've
27 forgotten.
28 MR BROOKES: Don't worry.
29 MS KURUTAC: It was a woman, she was very dynamic and very interested.
30 There was, between the LSA Midwifery Officer and this chief exec, there
31 was regular meetings –
32 MR BROOKES: That was the old Strategic Health Authority before they were –
33 MS KURUTAC: Yes, and it would be circulated and passed on to the 17 Health
34 Authorities. Then you had 17 Health Authorities coming down to three.

1 And you know, the LSA when we – we had great difficulty and if Marian
2 Drazek[?] was sat here, she would tell you, she had great difficulty getting
3 meetings with the chief exec, then within a very short space of time, we
4 were down to one. And then, things became a little – that communication
5 became less – I won't – again, less facilitative, less easy, let's put it, than
6 just being able to bob up and – Lewis – I can't think of her ~~his~~ surname –
7 MR BROOKES: [Inaudible].
8 MS KURUTAC: The chief exec, yes. And, so the value of the LSA and its
9 understanding of it as a statutory function – and therefore its efficacy –
10 again comes down to how it can be related with the bigger, the wider
11 organisation, and how well it's understood. So arguably, it became a little
12 bit diluted over the years as much as therefore – it's going to sound as if I'm
13 shooting myself in the foot, you know, it becomes dependent on the
14 individuals and the human people who are responsible on both sides, really,
15 I guess, and the understanding that, whilst great management changes with
16 the way maternity services are being made, you know, centralising services,
17 you know, whether it's surgery, paediatrics, maternity disciplines, whatever,
18 the core elements of midwifery practice, responsibility, kind of slips away a
19 bit.
20 MR BROOKES: So what was the – this is my confusion, I just want to be clear –
21 your management relationship to the Strategic Health Authority was what?
22 MS KURUTAC: The relationship to...?
23 MR BROOKES: The Strategic Health Authority.
24 MS KURUTAC: Yes?
25 MR BROOKES: What was it, the relationship?
26 MS KURUTAC: Well, we still had an office in – what was it – we had a
27 geographical; our offices were based in Kendal, where everybody else had
28 moved to Manchester. We had a common link with the chief – with the
29 nurse, Angela Brown, at the time, so that was our common link. And we
30 were fortunate there that that was a common thread for several years.
31 MR BROOKES: Because the reason I'm asking is, if you're not getting action on
32 concerns through local management, did you have another route to
33 influence the management?

1 MS KURUTAC: Yes, well – again, the LSA, Marian Drazek specifically as the
2 Midwifery Officer – and I was present on at least an annual basis, you
3 would have a review of your concerns about the units; you know, it might be
4 that 16 or of the 32 units; or 20 of the 32 units were absolutely fine, no
5 concerns but *x*, *y* and *z* here and maybe this one unit – you know, I'm just
6 giving you an example off the top of my head, 'We've got this, and this, and
7 this issue, and we've had...' – that would be the conversation with the LSA
8 and the Health Authority, that sort of thing.
9 MR BROOKES: And that would be with the Strategic Health Authority?
10 MS KURUTAC: Yes.
11 MR BROOKES: Because, take your example, one in fact we've already used,
12 there was a concern about caesareans and locked theatres. It's not being
13 resolved. Is that the kind of thing you would expect, if it was brought to the
14 attention of the Strategic Health Authority, for them to help you with?
15 MS KURUTAC: Yes, I think the other comment I would have to make is that
16 generally maternity services within the wider remit of any Health Authority
17 was not necessarily a priority. They had bigger issues to deal with. So as
18 long as there weren't any – you know – I don't want to – there's always
19 priorities. There's always priorities, and as far as – if maternity care was
20 running along fairly 'tickety-boo', smoothly, then – my language is not the
21 best on that, in explaining that, but you know, I don't mean to dismiss it, but
22 I think even a Strategic Health Authority has got priorities is what I'm trying
23 to say, and maternity services generally were a discipline that were okay for
24 most of those years that I was working with.
25 MR BROOKES: Final question: during the latter years, when there were known to
26 be serious concerns about midwifery services at Barrow, were there any
27 discussions that you were aware of between the LSA and the Strategic
28 Health Authority?
29 MS KURUTAC: Were there any...?
30 MR BROOKES: Discussions?
31 MS KURUTAC: [*After a short pause*] I'm hesitating because I don't specifically
32 remember but I'm sure that if I looked in the records – if we looked in
33 records, there would have been, you know. Because I know – I do
34 remember Marian as the MO – Midwifery Officer – meeting with – you

1 know, I do know there were meetings ongoing but within the context here, I
2 can't be more specific than that. And I do know that, you know, as
3 situations, there were a number of clinical situations that occurred, like with
4 the supervisory midwives that we mentioned, and a couple of other things,
5 clinical issues, you know – when you start – when one thing happens, so
6 often, in any discipline, you start to sort of question and unfold other things
7 and I think that's when perhaps – again arguably – you don't want to lay
8 blame, but there's a whole domino effect; you know, perhaps we've missed
9 this 10 years ago; five years ago, everyone been keeping it going; and then
10 suddenly, something happens here, and then you look back and you can
11 see it so easily, to see how things have unravelled, and the impact then on
12 the care.
13 MR BROOKES: Yes.
14 MS KURUTAC: You know, maybe the rotation – one thing I do remember was the
15 rotation of – we had it at Lancaster as well – the rotation of agency staff,
16 you know, medical staff for example. And I do remember that being a bit of
17 an issue as much as midwives and being perhaps a little bit over – I was
18 going to say overenthusiastic, but I don't mean overenthusiastic. I mean
19 less aware of when things can go wrong and sometimes it's a very fine
20 balance.
21 MR BROOKES: Yes, thank you.
22 DR KIRKUP: Just on that last comment. You started out by saying,
23 'Overenthusiastic', and then you backed off that, and I understand that. But
24 are you saying that they were over-keen on non-intervention as opposed to
25 –
26 MS KURUTAC: Well, you find that –
27 DR KIRKUP: Not [inaudible] intervention better –
28 MS KURUTAC: Well, I've got to be a bit careful here, because as a labour ward
29 manager and a midwife that's worked over several decades, you learn a lot
30 of lessons; you walk the walk and you take nothing for granted. I'm sorry,
31 because – I'm sorry if I sound a bit – but, you know, people can drift into this
32 idea, 'Oh, the women's at home, oh, the women's in a pool of water,
33 everything's fine'. No it isn't. You need even more focus in those
34 circumstances in my view, because somebody's attached to a monitor.

1 Well, you can also be lulled into a false sense of security on occasion too.
2 But what – you know, that enthusiasm to, 'Oh yeah, we'll do this, and we'll
3 caseload and we'll midwifery-led care...' – that's great, but if you've lost the
4 experience and the insight into basic functions, whether it's physiology or a
5 clinical situation. Then you can get a little bit over-lulled into a false sense
6 of security again, I guess.
7 DR KIRKUP: And was that the vibe you picked up from Barrow?
8 MS KURUTAC: In some instances, yes. And it's not just Morecambe Bay, or
9 Furness. It's a thing – people who know me in practice, across the board –
10 you know, I find that generally within midwifery.
11 DR KIRKUP: So it's been a trend generally, but are you saying that it was more
12 noticeable in Barrow or was it just the same there as everywhere else?
13 MS KURUTAC: Well, what I think I would say about Barrow is, as has come to
14 light, you probably – you could say that there are – there've been one or
15 two influential figures who've perpetrated that kind of – perpetrated that sort
16 of approach and if you're in a group of professionals or if you're in a unit or
17 – it becomes a bit of a culture. You know what I mean? There's nobody
18 challenging that. Whereas, if you are surrounded – well, I don't know. You
19 know, if I walked – I used St Mary's. If I walked into St Mary's and I said,
20 'Oh, I'm worried about *x*, *y* and *z*', and I might get challenged by an
21 obstetrician saying, 'Judith, what are you worrying about, leave it alone', as
22 much as I might be challenged by a midwifery colleague, saying, 'What are
23 you doing that for? Aren't you going to do *x*, *y* and *z*?' So, the culture –
24 what I'm trying to say is that, perhaps it's because there's more people
25 around, perhaps it's because – whereas at a place like Barrow or smaller
26 environment, where people don't change –
27 DR KIRKUP: It's isolated, yes.
28 MS KURUTAC: People don't change, people don't rotate, again, you get lulled
29 into a particular way of operating. That's the best way I can put it.
30 DR KIRKUP: Sure, and I understand that perfectly. Would you be able to identify
31 who you think the key individuals were who were the opinion-formers in the
32 unit?
33 MS KURUTAC: Well, as in every unit, the labour ward is always a – if it was in a
34 maternity unit, it's like – it's got a reputation for being the centre of the

1 universe if you like, and it isn't necessarily. But within midwifery, I can
2 speak for midwifery, it certainly is a place where you will get clusters of
3 midwives, perhaps, one or two, that will override the culture on the unit.
4 And it's called bullying. You can – it's something that – again, in midwifery,
5 it's not something specific to any one unit; it's a problem that we've dealt
6 with, so – you know, a more junior midwife would be over – perhaps
7 overridden by a more senior opinion, and forgetting that individual midwives
8 are responsible for their own practice. That's easier said than done.
9 DR KIRKUP: Yes, again, are you saying that that was a particular risk at Barrow
10 compared with other units? You're saying it can happen anywhere or –
11 MS KURUTAC: All I would say to you is that I believe it was an issue. Whether
12 it's more at Barrow than anywhere else, I wouldn't –
13 DR KIRKUP: Right.
14 MS KURUTAC: I wouldn't go that far because there are examples elsewhere.
15 DR KIRKUP: Yes. And what was the basis upon which you believed that was the
16 case in Barrow? What was it [inaudible]?
17 MS KURUTAC: Because the drive – you know, the – [*After a short pause*] I don't
18 – I'm struggling, because I don't want it to be misunderstood really. You get
19 that sense of, 'Oh, it's marvellous, this woman's normal, everything looks
20 fine'. And keep other people away from that situation and when I say keep
21 other people away, 'Well, we don't need to tell the doctors, we don't need to
22 tell our colleagues, we don't need to tell anybody else that this woman is in
23 the unit, because she's normal', when in actual fact, I would both personally
24 and professionally work from a premise that, yes, okay, other disciplines
25 don't need necessarily to come in to see a woman, you know that's on the
26 labour ward. But you need to have the information that this is who and what
27 you have on the labour ward, just in the instance, because we all know
28 things can go awry as much as the complicated can be very straightforward
29 in the end. So, I just get that sense of – I mean, all I can do is illustrate it.
30 I've been a labour ward manager at St Mary's myself, and my premise with
31 my colleagues would be, exactly as I've just said, really. You know, 'This,
32 this and this', and I think this is going to be straightforward, but everybody,
33 colleagues, medical staff, anybody that's around, responsible for the care,

1 will be – whereas in Barrow, I just get the sense of, 'Well, nobody knows
2 unless something's gone awry', kind of thing, you know.
3 DR KIRKUP: You're painting a really vivid picture and it's really helpful. I'm trying
4 to get, slightly, a handle of how you were able to form the view that that was
5 how Barrow was operating?
6 MS KURUTAC: Yes, because this is where it gets difficult, because it's intangible.
7 Some of it is down to personality, and some of it is down to whoever's on
8 the shift at the time, you know. And then that becomes – you get a
9 development of a creeping – maybe a bit of a creeping culture within a unit,
10 you know. Then you suddenly become aware of it when you talk outside or,
11 in this case, perhaps – okay, let me rewind. You only become aware when
12 something goes awry. If everything's okay, from an LSA point of view, or
13 from an individual of it, because there is nothing to say: everything is okay,
14 actually. But you need – you only become aware when you're there and
15 you start talking to people and you start getting a sense of where people are
16 coming from. Sorry.
17 DR KIRKUP: No, no, that's really helpful and what – let me just play back to you
18 what I think I've heard there.
19 MS KURUTAC: Yes, yes, yes.
20 DR KIRKUP: Just to make sure that we are agreeing with each other here.
21 MS KURUTAC: Saying the same thing, hmm.
22 DR KIRKUP: What happens is that you get a culture that builds up in a particular labour
23 ward, in a particular unit.
24 MS KURUTAC: Yes.
25 DR KIRKUP: And if it's a bit isolated, and it's not subject to challenge from outside; and
26 new people, it drifts; but you don't get the chance to find out about that until
27 something goes wrong.
28 MS KURUTAC: Yes.
29 DR KIRKUP: Something does go wrong and you are then involved in going in and
30 looking and then your antennae pick up, you base your opinions on what you are
31 told when you go and talk to people in those circumstances, is that right?
32 MS KURUTAC: And a lot of this is, you know, and thank you so much, that's absolutely
33 fine, you know, you see, intangibility and I think in the health service, or any
34 organisation, whether it's teaching, banking, whatever you know, we're focussed

1 on what we can see and prove, the black and white so to speak. But actually the
2 situations are about all these other things that are influential.
3 DR KIRKUP: Okay. Now, I do think it's important that you've given us that vivid picture
4 and you said that there were a couple of opinion formers who were on the unit.
5 Now, I do want to know who you think the opinion formers were on the unit. I'm not
6 asking for any assessment directly of them; I just think it would be important, in the
7 scheme of things, for you to tell us. I think I would have a fair stab at it, but I would
8 like you to do that.
9 MS KURUTAC: Well I mean, the – unfortunately I've already mentioned Jennifer Bowns,
10 and I'm not – I don't want to point fingers here.
11 DR KIRKUP: No, no, that's not what I'm about -.
12 MS KURUTAC: But what you've got is, at the time, a couple of senior people who
13 believed that in all sincerity they were processing the agenda as dictated at the
14 time.
15 DR KIRKUP: I understand that.
16 MS KURUTAC: To uphold normality.
17 DR KIRKUP: I understand that.
18 MS KURUTAC: And so you've got to be very careful it's not – yes, it's done in all good
19 intention basically.
20 DR KIRKUP: I am absolutely not denying and I'm not trying to challenge that, but I do
21 think that for us to get a complete picture we need to understand who the
22 influential people were, so Jennifer Bowns was one.
23 MS KURUTAC: And I can't think of the other names at the moment, to be honest. I
24 mean, there's a midwife that I can think of who was absolutely so fantastic in
25 challenging and oh – I just can't think, I honestly can't think of names at the
26 moment; because I could give you the opposite. I have to look it up. I have to look
27 them up.
28 DR KIRKUP: I think that would be helpful, yes and I am sorry I am just pausing there
29 because I was debating whether I could suggest a name to you and see if you
30 agree with me, but it probably would be more helpful if you would look that up and
31 give it some thought and come back to us.
32 MS KURUTAC: Yes, fine.
33 DR KIRKUP: Because I think the independent corroboration would be very useful.
34 MS KURUTAC: I mean I think that -.

1 DR KIRKUP: This not something that is new to us, we have heard it before, and we have
2 heard other people saying it, but you're perspective on it is very useful.
3 MS KURUTAC: Oh right, well thank you and I think – well, the only additional thing, well
4 the supervisory midwives I'm thinking of what you then find is that you sometimes
5 have that conflict within the group of supervisors you know, so like anything else,
6 it's in danger of sometimes, sometimes, it should never be, but you get that
7 professional kind of conflict, professional power games, you know people aren't
8 necessarily consciously thinking; it become, it develops into that on a minor level.
9 DR KIRKUP: Sure.
10 MS KURUTAC: And that sensitivity to then come back and be brought up into 'I focus on
11 the mother and baby, not on your personality issues', you know, is something that
12 we all need to be reminded of sometimes.
13 DR KIRKUP: Okay, one last thing from me for the moment, there's something I want to
14 come back on but I will have to give the others a chance, but I have to come back
15 to one word that you used in the middle of your very helpful picture, which is almost
16 a throwaway, and I need to come back to you on it, you said "bullying."
17 MS KURUTAC: Oh yes. Well, you see the LSA does not have jurisdiction, well, our remit
18 is about practice. If anything impacts on practices or – are of concern.
19 DR KIRKUP: Sure.
20 MS KURUTAC: Where we have differentiated between bullying and issues directly with
21 practice, then the LSA would definitely support midwives to usually go through a
22 management route to challenge those concerns.
23 DR KIRKUP: Understood, understood. Were you suggesting, again I want to test this out
24 with you because if I've got it wrong you need to tell me, were you suggesting that
25 it was the senior opinion forming midwives who were the bullies here, or was it
26 somebody else?
27 MS KURUTAC: Well, when you – I suppose I'm going to repeat what I was saying, but
28 it's very easy for one opinion to become overriding and other midwives therefore to
29 – 'Well, I can't challenge that, I'm going to give up' and therefore they are finding
30 themselves following a route that they possibly wouldn't necessarily follow in
31 practice. When in actual fact every midwife needs to understand they are
32 individually responsible for their own practice.
33 DR KIRKUP: Yes, sure.
34 MS KURUTAC: But that's not how it works in practice sometimes.

1 DR KIRKUP: Sure.
2 MS KURUTAC: The opinions of one or two people do override, you get powerful – again
3 it's not – it's not confined to midwifery.
4 DR KIRKUP: No.
5 MS KURUTAC: But I think it's not something to be ignored either, you know.
6 DR KIRKUP: No, I understand what you're saying.
7 MS KURUTAC: And I do – and I could be challenged on using the word 'bully', because
8 you could say it's just, you know, I remember a labour ward midwife who always
9 said, "What are you doing?" you know, "What do you think you're doing?" you know
10 "Well, it's none of your business actually, I'm looking after the woman here" but that
11 influenced a lesser assertive practitioner or somebody who's in a learning capacity,
12 or not so experienced perhaps; to follow a route that they wouldn't wish to, or stop
13 them from contacting us. It stops them, they think, 'Well, I don't think it's right, I
14 need to contact such and such a person'. I'm sorry; it's so difficult to just portray
15 the right – the right level without it sounding too extreme one way or the other.
16 DR KIRKUP: Yes.
17 MS KURUTAC: But it's insidious; I think it's insidious sometimes.
18 DR KIRKUP: Yes, no I think I understand exactly what you're saying. I will have a little
19 break now.
20 MS KURUTAC: I'm sorry.
21 DR KIRKUP: No that's alright. I will come back – no.
22 PROF FORSYTH: Just in relation to that specific point, I am just trying to work out really
23 the responsibility of the LSA in that situation. You've got midwives, a small unit,
24 midwives, some of whom may be expanding, developing in areas they should be
25 doing, or maybe leading the unit in a direction it shouldn't be going. You are the
26 supervisory authority; surely it's your responsibility to detect that at an early stage
27 and manage it before incidents develop. I'm sure that would be the response of
28 the families who are in this investigation.
29 MS KURUTAC: Well again, all I can say is the structure of the Nursing and Midwifery
30 Council appoint their midwifery officers for each area, the north west happens to be
31 the biggest in the UK and therefore, as you go down, you try to uphold that ratio
32 within each unit and one, ask anybody in the NMC, one supervisor to 15 midwives.
33 And the steps to ensure that take time and so, from the LSA point of view, you
34 can't be in each unit every day watching everything that's going on.

1 PROF FORSYTH: Well, perhaps I understand the capacity issue and it is important for us
2 to be made fully aware of that so if you're saying that if the LSA was able to
3 operate as it should have done at that time, could that have picked up practices
4 and behaviours, particularly in Barrow, that might have been able to have been
5 controlled earlier, and therefore improve the practice and possibly have prevented
6 some of the incidents?
7 MS KURUTAC: I think, in retrospect, you know, it's not an admission; it's actually
8 everything in retrospect, 'you could have done this, you could have done that'
9 perhaps, but -.
10 PROF FORSYTH: Well I think what we want to do is get a particular perspective as well.
11 MS KURUTAC: I think one of the issues it highlights, as in everywhere, is perhaps there's
12 only so much – there was only one midwifery officer for 32 units.
13 PROF FORSYTH: So, is the structure of the LSA flawed?
14 MS KURUTAC: Yes. You can also it's actually historical; that's historical. It's the same
15 thing with the health authorities or any GP surgeries or anything, how are those
16 boundaries laid down. And is I's also about the way supervision has actually
17 changed, and indeed it has been challenged nationally, is to where it started in
18 1902, as a safety net for midwifery practice, and certainly in the late seventies, at
19 that time my bags were being inspected at home by supervisory midwives, you
20 opened your uniform and everything else. And to bring that into the modern 2014,
21 there is an argument that supervision is out – it's gone from where it was, perhaps
22 a little bit – perhaps it's not a function that is needed anymore, but it is still a
23 statutory function. And the understanding and the characteristic of that perhaps
24 needs to change.
25 PROF FORSYTH: Okay, thank you.
26 MS KURUTAC: And I am sorry if I'm not answering your question.
27 PROF FORSYTH: No, no, that's fine, thank you.
28 MS KURUTAC: Properly, I am sorry but that's –
29 PROF FORSYTH: No, no.
30 DR KIRKUP: Please don't, it is very useful. I have a sort of related question really, which
31 I was going to come back to, which is about the LSA role and is it primarily
32 facilitatory or it is regulatory or is it both? Are you there to try and encourage and
33 assist practitioners to get better?
34 MS KURUTAC: Yes.

1 DR KIRKUP: Or are you there to make sure that they meet a given standard?

2 MS KURUTAC: Well, the practice of midwifery is laid down in this country by the
3 professional remit, by statute, so we, as the LSA do a bit of both actually. My role is
4 to facilitate practice and improving as a clinical assistance to the midwifery officer.
5 The midwifery officer is actually there to ensure, through audit, through what's
6 going down with the NMC; that each unit is actually adhering to that template,
7 whatever that is.

8 DR KIRKUP: Yes, is there a conflict of roles there? Is it always possible to distinguish
9 between the encouraging and assisting and helping and educating on the one
10 hand, and regulating on the other?

11 MS KURUTAC: Yes, because I think of it's a bit of – we're in a Catch 22 because
12 maternity care, like health care, is part of the individual human being, and every,
13 you know, you could have a NICE template and say 'This woman's 39 weeks, we'll
14 leave her to 41 weeks and beyond that we'll induce it' you know, you could be
15 black and white like that and that's all well and good. But people, women don't
16 behave in that way, they have rights, they have – it's not right, etc, you know, you
17 get my drift? So, the facilitation – I suppose what I'm trying to get at is we're not
18 going to reach the NICE neat answers, and the LSA can facilitate safe practice,
19 based on the individual. However, what comes in to play very often is individual
20 Trust guidelines, you know, evidence all the rest of it, and what's right for one won't
21 be right for the next person. And we make a decision to do this with this person,
22 and it goes right, with somebody else it doesn't go quite so right, you know and I
23 think we have that perpetual problem. But we can still lay down the rules and
24 cause people to do X, Y and Z in a sort of a constructive way, but that wouldn't
25 change, that wouldn't necessarily, in a human function, make outcomes better.

26 DR KIRKUP: Yes, I understand. One specific element though if, as a regulator, you say,
27 'Person X or midwife X's practice is not meeting the standard in a particular respect
28 so we will work with her to improve. And then you come along six months later and
29 you re-regulate, you have a vested interest in saying, 'She's now meeting the
30 standard' because otherwise you're marking your own homework, you're saying
31 'Well, we didn't do a very good job there because she still doesn't meet the
32 standard.' Is that not a potential conflict; that's really what I'm driving at?

1 MS KURUTAC: Yes, I understand that and I think that the judgements on that are very
2 variable; but it's almost like in that sense you need to have two strikes and you're
3 out, you know.
4 DR KIRKUP: Okay, one last thing from me before we move into the second part of the
5 interview, I think one of the recurring themes around all this seems to be poor
6 record keeping in Barrow.
7 MS KURUTAC: In what sorry?
8 DR KIRKUP: Poor record keeping; there seems to have been, to me, to have been a lot
9 of reports into incidents and into where things have gone awry which conclude that
10 record keeping's been poor. Why is it such a recurring problem? Surely it isn't so
11 difficult to sort out. It's pretty obvious what needs to be done and it isn't, if you'll
12 forgive for saying so, by keeping records in cupboards; it's just about this is one of
13 your professional duties; that you need to keep decent records. Why has it been
14 so persistent?
15 MS KURUTAC: Well, I can't—I think that as I said earlier on, it might be that it's just not
16 simply about midwifery; it's about a whole attitude towards record keeping you
17 know, where I repeat I know several years ago I mentioned Oldham Hospital, they
18 long shared multi-disciplinary record keeping in maternity services with fantastic
19 outcomes and you know, risk management and excellence and all that, you know
20 all that sort of thing. And is it that there's just not the same engagement across the
21 board within Barrow, I don't know. All I know is that from a midwifery point of view,
22 when as far as record keeping is concerned, we could chase that up for an eternity,
23 sorry, from a midwifery perspective and keep chasing it, but the issues are bigger,
24 perhaps.
25 DR KIRKUP: When it is so persistent, when it's so persistent and so – you know, it does
26 not require investment, it doesn't require a new system; it just requires people to do
27 the things that they are supposed to do. You can understand, can you not that
28 somebody is going to say, "Actually this is so because it's convenient; it's actually
29 very helpful when something has gone wrong, that we don't have any good records
30 of where it all went wrong", you could understand that that would be a criticism that
31 somebody would make?
32 MS KURUTAC: Absolutely but it is something that supervision – I am struggling now
33 because I haven't got any evidence in front of me as to what, where and how.
34 DR KIRKUP: I know.

1 MS KURUTAC: Supervisors will be looking at records, they will deem that they've met
2 the standards; that would be reported to the LSA, the LSA again you know, we
3 don't know exactly because we're not actually keeping the records ourselves.
4 DR KIRKUP: No, I understand.
5 MS KURUTAC: And that's not a cop-out that's I just don't know how else to answer your
6 question.
7 DR KIRKUP: No, I understand and I'm thinking again though, a bit like when you're
8 picking up the impression about how opinions are formed within the unit, that when
9 you do go and look when any specific incident has happened, and you go back,
10 you know, three years in a row and you're getting the same conclusion, the record
11 keepings – it just seems a concern to me that opens up a whole lot of criticisms
12 and it wouldn't seem, on the face of it, to be something that was so difficult to
13 address.
14 MS KURUTAC: No, and you would, if you look at again – yes, if you look at
15 recommendations if there was an issue you would put that in and hopefully that
16 would be followed through, but I'm losing the context a little bit because I can't -.
17 DR KIRKUP: Yes, okay.
18 MS KURUTAC: I haven't got – I agree with it, I do agree with you; I just haven't got any
19 meat on which to substantiate that further.
20 DR KIRKUP: Okay, understood, thank you.
21 MS KURUTAC: I'm sorry.
22 DR KIRKUP: No, no, that's fine. Okay, can I formally record now that we are moving into
23 the part – no, I'm not.
24 PROF MONTGOMERY: Can I just get two points of clarification.
25 DR KIRKUP: You crack on.
26 PROF MONTGOMERY: From something that you've just said, which is really helpful
27 before we go to the – there were two things that you said in answer to Bill, which it
28 would be really helpful just to get some clarity in my mind; and they are both issues
29 about the benefits of hindsight so that we all understand that hindsight is a
30 wonderful thing, and there's a completely different set of questions about what it
31 was reasonable to do knowing what you knew at the time; from what things look
32 like now. But we are in the position that we have to think about recommendations,
33 and it is often very helpful to have people's reflections looking back. And there
34 were two things that you mentioned, which I would really like to understand better.

1 One was that you talked about as things came to light you got a picture of the
2 culture which was different from what was available earlier on. I would really like to
3 understand what brought those things to light, because that might be something
4 that we could focus on in a recommendation to encourage things to become
5 apparent earlier. So, do you remember what it was that brought to light these
6 questions about the culture of the unit?
7 MS KURUTAC: The culture of the unit, things come to light, you begin to notice that one
8 person's name appears on everything, you know that kind of -.
9 PROF MONTGOMERY: Yes but what gives you the opportunity to notice that is that is
10 what I am interested in, because you describe very nicely what it is that you
11 noticed then, but could we find ways in which it would be more likely that you got
12 the opportunity to notice that so was it the scrutiny of records, was it going into
13 workshops?
14 MS KURUTAC: It is just how, when you go into a unit, how you yourself talk to people,
15 how you yourself ask questions, how you yourself observe what's around you. And
16 you know, you can walk through a unit and just say, 'Oh okay, this looks very nice'
17 or you can actually 'Oh, what's that on the noticeboard?' and you delve a little bit
18 deeper and maybe that's about experience, maybe that's about instinct, maybe
19 that's about simple curiosity. But I guess some of it is about not just ticking a box
20 again.
21 PROF MONTGOMERY: So, that's about being there.
22 MS KURUTAC: Yes.
23 PROF MONTGOMERY: You talked about the names coming up; where would you have
24 seen those names to get the pattern then of –
25 MS KURUTAC: Well, you are flicking through – you might be flicking through policies and
26 guidelines, it might be changes in practice that have been made, you know,
27 information that's been put together for the public or for the midwives; that sort of
28 thing, or you know, workshops for midwives, training, that sort of thing.
29 PROF MONTGOMERY: The other thing you said was that when you look back you see
30 what you could have done here, or there, and I wondered if you had any particular
31 suggestions to us that, with benefit of hindsight, you look and you say – and we've
32 asked this a lot of the people that we have seen, that 'with the benefit of hindsight if
33 I knew what I know now I might have taken this opportunity, or taken that
34 opportunity', are there any things like that here?

1 MS KURUTAC: Well, from an LSA midwife point of view I wish we could have just been a
2 bit more proactive inside the individual units, you know. I was saying to your
3 colleague here, you've got one midwifery officer and then 32 units and there's
4 3,000 – 4,000 midwives you know. It's – the number game is always a problem
5 wherever, but you only just wish you – I think I wish, I personally do wish I could
6 have gone and spent more time with midwives perhaps, personally; that's my
7 personal view. Because when we spend more time than just a few hours here or a
8 couple of hours there, you see the – well you just get – you're exposed aren't you,
9 to what's really going on.
10 PROF MONTGOMERY: Thank you. Now.
11 MR BROOKES: Are you sure?
12 DR KIRKUP: Subject to my colleagues' views, can I record formally that we are going
13 into the closed part of the interview, where we may ask you some questions that
14 might impact on matters of patient confidentiality, and Jonathan, I think you wanted
15 to lead.
16
17 *[The remainder of the meeting was heard in private session]*
18