THE MORECAMBE BAY INVESTIGATION

Wednesday, 17 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
Dr Geraldine Walters -- Expert adviser on Nursing

JACKIE DANIEL

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

MR BROOKES: Good afternoon. First thing. Can I apologise on behalf of Bill Kirkup, who, unfortunately, cannot be here today. He has asked me to Chair this particular Panel. We will go through and remind you who we all are in a second and for the record you can say who you are. There is a couple of housekeeping things and we will go into the questions.

(Following introductions by the Panel and housekeeping matters)

MS DANIEL: I am Jackie Daniel. I am Chief Executive at University Hospitals Morecambe Bay.

MR BROOKES: Welcome.

DR WALTERS: Jackie, just start off by telling us what was it like when you arrived at the Trust? What were your impressions?

MS DANIEL: Okay. Difficult. I had been ~~the~~ a Chief Executive for over ten years and so I had done a number of difficult -- what I thought were turnaround Chief Executive-type roles. ~~It~~ The CEO role at University Hospitals was more problematic than I think I anticipated on the lead up. I will try to explain why.

I mean, I think it is always difficult when you walk into an organisation with lots of interims, with interim Chairman -- they ~~have~~ had just started putting the NEDs in place just prior to my arrival in the summer. There was not really -- there were a couple of executive team members

remaining, but it was, you know, it took a few weeks, I think it is fair to say, at the very least to get a sense of what was really going on. There was a lot of regulatory action plans, you know there had been one inspection after another, after another, after another and so there was a lot to do. A lot of people, I think it is fair to say, regulators, commissioners, other people had been drafted in to help so it was a very crowded pitch and quite chaotic. Highly pressured. Yes, I think that pretty much sums it up.

DR WALTERS: Moving all of them aside, what about the core organisation? What were you thinking about that?

MS DANIEL: I remember feeling quite shocked that I guess, "How can this be?" is the first thing and most obvious thing to say. How can it be, given that, you know, one would assume on the lead up to being authorised as an FT there would be a lot of things taken care of; so a good governance systems and processes; a strategy; resilient financial plan. Just those things that you would anticipate underpin a good performing re-organisation. So, I think, although I knew that would not be the case, because of the regulatory action, I was quite shocked to find just how dysfunctional things were.

You know, an example is the governance systems and structures. You know, I was used to seeing a good Board assurance framework, so risks being managed up and down from

Boards through the Sub-Committees, through the divisions or, you know, management tiers. It just was not connected up.

There were many things not being placed. I don't think that was just because the organisational memory was being eroded pretty quickly, a lot of people left; I am sure it was more than that. I do not think that some of the things were there to begin with, or were very weak and fell apart at that point.

DR WALTERS: Were you getting any sort of indicators about, you know, the services, how they were delivered, what their clinical risks were? Because we can all have lots of systems in place but actually sometimes they do not work any way, do they?

MS DANIEL: Yes. It was quite tricky early on because, of course, there were so many regulatory action plans. There was a major piece around governance that had been led by PWC, who had come in and done a review and said actually you can get very limited assurance from what is there. You really do need to fundamentally rebuild.

There were various specific service-focused regulatory actions. Emergency care springs to mind. Maternity was an obvious one that had been ongoing, you know, for some time. Out patients was another area where 19,000 follow-up appointments had been missed. It was not just in one area. There was these sort of ~~elements~~ examples right across the piece.

You could see where some of that had come from. Lack of clinical leadership. Lack of, I think, good general management; the glue in the system. I think staffing levels, pretty much across the piece, were very inadequate. It was not just, you know, the usual sort of systems and processes actually some of the fundamentals, like staffing levels, is probably the best example; they were just really inadequate and had been, I think, for one to two years proceeding that.

DR WALTERS: Had they had a financial turn around before you got there, or did you have another one when you walked in?

MS DANIEL: We certainly had a financial turnaround ~~from me,~~ just following my appointment. The first thing we did was look at the quality things we needed to fix. We did not really worry too much about the financial consequences. I think in fixing some of the quality elements, they brought inevitable financial consequences. What had looked like a fairly sort of smooth, calm, cost-improvement plan looking back, when you get underneath that -- and, I mean, the work that we have done since -- actually there was an underlying deficit running for years, which is significant now.

We have learnt a lot about actually the cost of running services across three hospital sites. We have done a big piece of work around the cost of provision -- cannot be provided in

tariff, the gap is around 18 million each and every year that you need to make good, which we are dealing with at the moment. It gives you an indication of, you know, although the finances, you know, probably leading up ~~against~~ to Foundation Trust authorisation, when they would have been very heavily scrutinised, looked okay; it quite evidently was not.

I think, looking back at the cost-improvement programme, the way they had been handled there was not what I would call a "strategic approach" to financial management. You know, it seemed to me that it was "salami slicing" and, therefore, eroding things like basic staffing levels. It was always at the frontline. It was never really focused around the efficiencies that were clearly there, or thinking about very different ways of doing things.

DR WALTERS: What have been your big priorities and your big aims and objectives since you have --

MS DANIEL: Again it is two years looking back, you know, to August 2012. I mean, the early priorities were just getting a sense of what was going on, trying to clear some of the -- see some of the wood for the trees. Trying to prioritise. An organisation has got over 50 actions, together with just the everyday running, with no permanent Senior Executive staff, with press and media-hype and all the activities that was running, it is really difficult to get a sense of, okay, what do I need to focus on?

I spent the first few months, I guess, on looking at the quality failures and focus there, with the express permission of Monitor, at the time, not to worry about financial impact of things.

We put in place what we call — Recovery Part 1 & Recovery Plan Part 2 we have two recovery plans, part one and part two, to the regulators. The first one was really focused on the priorities around quality, which included maternity and neonatal services, but also included A&E, medicine, staffing, those sorts of things, and the governance review. Part two of the recovery plan, which was submitted a bit later, but a couple of months after that, focused on the financial agreement and management and the additional cash that we would need to do the things that we needed to do very quickly.

DR WALTERS: How far have you got? Where do you think you are now in moving through the path of the organisation? What has changed to your mind?

MS DANIEL: A lot has changed. It is tempting to say, you know, so much has been done in two years, but we have got such a long way to go. I mean, I think again going back to the starting point was much lower than, I think, I imagined. In my mind I talked to staff about a three-phased approach from when I get the appointment. A sort of a "transactional approach" to the things that were badly run and needed fixing, which I imagined would be six to eight months,

really trying to get to grips with those.

We then start talking about, you know, a sort of a "transitional phase", which we would put into place a longer-term strategy and try and get the plans that would really take us much further forward, where we might start thinking about some transformation. We are still very much in the transition phase. I thought that we would, after two years, be into transformation ~~-~~phase we're not. I think we are 12-months away from that still.

We have now got a full Board. We are hoping to make an announcement about the ~~another~~ Chair's appointment ~~-~~ we interviewed yesterday. I think, we should be able to announce it on Thursday. Some very good and experienced candidates, which will be important. I have now got a full team of executives. The last one -- my Deputy Finance Director -- only joined in January this year, so you can kind of get a picture of how long it took either to get people exiting the organisation from the team, that I didn't feel had the capabilities to do what they needed to do. So it has really taken until January this year to get a stable team of executive directors. So that Board is in place now.

The clinical leadership in the organisation was put in place just before I came into post. It was then made substantive, I think six months/eight months after I came. Those people have remained in post. We have done quite a

lot of development though, through different OD programmes and different leadership and development programmes with the Clinical Directors and also the speciality leads. We invested about £1.7 million in giving clinicians a time to lead. It still feels -- they still feel quite young teams really. There is a lot more development we need to continue to do with them.

We have been through a process of strengthening the general management. The new Director of Nursing -- I say "new", Sue came in December 2013, she has been here a year almost -- has done a lot of work with ward leaders, with matrons, with some of the, you know, the people -- healthcare assistants at the lower levels as well. That is really paying dividends. I am starting to feel that we have got a connective leadership effort across the Trust.

We have also, in that leadership piece, tried to connect the sites, because that has been and remains a difficult issue where we have got big distances between the two main sites. There is quite a lot of staff do work across and do travel and do rotate, but not all staff. We have now got site specific. We have got Deputy Medical Directors at each of the main sites, and Deputy Nurse Directors with an operational site management team.

They do now hold their own Trust management board meetings and communication feels much more solid. The

patient-safety focus feels much more solid through those professional routes of governance.

The governance systems and processes I have talked about. We have now had, through the external auditors, you know we have now got assurance around the Board, assurance framework in the way that is working. Again, I would say that we need to continue our efforts in terms of learning from incidents. We have now got good reporting systems. We have got evidence that we are reporting a lot and we are beginning to learn. It feels like we are probably, you know, solid performance on that probably in the last nine/ten months.

Again, would I say we have got an embedded culture of learning? Not yet.

Focus on staffing. In two years we have invested over £5 million in frontline staffing. Last month, following the NICE guidance on nurse/ward staffing, we have approved further investment of over £3 million. The main problem is not the money -- although of ~~course that~~course that is a problem. Yes, it is getting them (Staff).

We have lifted our sights, if you like thinking more strategically in terms of recruitment. We now always aim to over recruit -- not all the time, if we have got the luxury of doing that. That is paying obvious dividends in both quality and financial terms.

We are out to the European market. Last week we

recruited 29 Greek nurses. We have been to Spain. That recruitment approach takes longer because we have got to put good supervision in place for at least 3 – 6 months– there are some cultural differences, so we are finding it takes about ~~ten~~ 6 months, with staff, to feel confident and staff, as a team, to feel confident working together. We have some successes there so I have no doubt that will continue to be a feature.

We have now got a good cadet scheme. We can actually -- two years ago I think we have got 16 cadets, we have now got 150, which is really good, working with the two universities.

Things like apprenticeship schemes we have got much more success at, so with healthcare support workers actually trying to give them a career ladder.

It is starting to feel more robust. [We have got all the matrix]?. The Nurse Director now has got a good nursing dashboard. We are part of the national programmes. We have got information boards outside every ward with staffing levels as they should be and the actual staffing levels as they are on that particular shift, with details of the harms data/complaints. Those sorts of things are reported daily and are kept up-to-date, also reporting on the website and through NHS Choices.

It is trying to be much more open about where we are at with that.

DR WALTERS: I think going from the Board-level down to that level, I suppose is specific things which we would like to be able to say to give some assurance about Barrow and maternity services because Stewart will want to talk about that and small units. If you have got any specific things to do –

MS DANIEL: In terms of Furness? Yes, absolutely. Yes. The things I talked about generally there -- I am happy to come onto things like strategy, engagement, partnership working, all of those things are really important – is that my mind maps have got, you will have to stop me, if I am not hitting on relevant ~~nerves~~ issues. All of those things, of course, are relevant to the services at Barrow between the – it is just a microcosm of the bigger picture.

The same approach to staffing has been taken at FGH. Everything I said around strengthening leadership is true ~~at~~ for the team at Barrow. We have now got practice educators in place. We have got lead clinicians for patient safety and an obstetrician who is now leading that work. We have got a good new general manager coming from the voluntary sector, interestingly, but ~~he's~~ she is doing a really good job with the leadership team.

Their governance systems were the first that we have focused on, for obvious reasons. They have laid the way in terms of, you know, they were regular ward rounds and

patient reviews on the labour suite and the wards were happening far more regularly there than anywhere else to begin with.

DR WALTERS: Are you getting some variability in the clinical body?

MS DANIEL: Yes.

DR WALTERS: That is something we will be talking about, having group thinking. Have you a lot of people who are there at one time?

MS DANIEL: There have been a lot of changes. One of the things I did when I came in, I wanted to review and look back at some of the instances that have even reported and you're investigating here. I wanted to be clear that those midwives that have been subject to investigation or review were still confident that they were fit to practise. You are probably aware that there have been a number of those that have since left the organisation.

There has been quite a lot of turnover -- I think that is a good and healthy thing -- both in neonatal nurses, midwives, but obstetricians as well and consultant posts. We have managed to recruit some new blood in there. I think, again, that is really helpful. I managed to get you know the rotation that we have been trying to get networking between the two sites; I think that is really helping. Again, it is not easy to do -- the drive time and the miles

are so great. I think we have got to continue with that.

I think connection with mothers and, you know, patients again, you know, not having things like Maternity Services Liaison Committee, not having the groups to connect with, patients and families -- certainly was not in existence when I came in 2012 -- it is now. They are developing lots of different ways to work with those groups, using things like friends and family test "I Want Great Care", in maternity. You know, the usual satisfaction questionnaires. But mainly different approaches to things like complaints resolution, trying to do as much as possible face-to-face; not relying on an overly-bureaucratic system that has spat out a response; trying to connect with families right from the word go. We do that across the piece now, but, again, FGH and maternity at FHH is probably leading that.

DR WALTERS: What sort of profile does this have ~~on~~ at the Board? What sort of detail do the Board go in to about maternity specifically?

MS DANIEL: A lot of detail. I think we have handled that differently over my two years of being here. Initially we established what we call the Intensive Support Programme for Women and Children's Services, which was chaired by the Vice-Chairman, which I co-chaired. It also involved Key members of the executives and non-executives, it was intended to, you know, they were handling recommendations as a result of the

regulatory action in 118 actions, together with all of the outcomes of the various other police investigations. They were under a lot of stress and scrutiny. We took the approach to give them equal measures of support and challenge and to get as close as possible, from the Board perspective and non-executive, perspective, to those issues.

I think that worked quite well. It did not substitute what the regular Board Sub-Committees and assurance committees were looking at either. It just enabled us to have a discrete space every month where we just focused on the team and met directly with the team to talk about that progress; challenges that we were facing; risks; and issues. A lot of detail. Every month we would talk about maternity matters at the board. On a number of occasions we did have workshop time with the Board to meet with, you know, the supervisor of the midwives will join us and we will have a sort of workshop-type event on some of the development work that was going on. Also space to think more strategically about how we could make sure that services remained resilient.

Now we have got, I think, a much clearer idea from the commissioner's about what they want to see going forward and working with what we call "stability partners", which is the bigger unit, in order to get some cross-fertilisation for the governance -- fresh thinking and challenge.

DR WALTERS: Where are you with consultant hours on the labour ward and midwives to birth ratio.

MS DANIEL: We meet all the current standards, yes. Maternity dashboard, that was developed, it has been in place now two years. It has been under development. We have added things in there. We have monitored things like the staffing rations, we monitor things like Section rates, sepsis -- all the things you would expect to see on there. That is shared monthly with our regulators so it never really is not —being monitored it has been continuously scrutinised...

DR WALTERS: What's happened to the sort of case mix that goes to Furness? Has that changed at all? Do you think they become more risk aware or risk averse?

MS DANIEL: No evidence of that, which I found interesting. I am not sure what I expected. But, no, there is no evidence of that at all.

~~Activities~~ Activity has been fairly consitant– in fact activity is slightly higher than it was in 2011. Not very much, but slightly. It does seem interesting, the local population, you know, that they, as you know we have been through quite a rigorous process with the Commissioners in determining whether we should continue with obstetric-led care there and, at the moment, their view is that they would like to sustain that model of care. Not at any costs, obviously. What was really clear to me, talking with groups of local population, through the

Commissioner-lead process, was that, you know, the families at Barrow -- the public at Barrow -- really held that dear; did not want to see that service lost. In fact, we had some interesting discussions that you might imagine at that point in time about is that at any cost? Actually, access was ~~p~~ pretty high on the list; you know, ease of access to the sorts of services was really high on the priorities list.

DR WALTERS: It often is if they do not understand the clinical risks --

MS DANIEL: Absolutely, Geraldine. Absolutely. As Commissioners, you might imagine, you know, it is not my job to dictate that and Commissioners certainly did —consider access carefully we have involved the clinical senate locally, and right now Cumbria are actually working with the Royal Colleges to look again at the model we are proposing and the model that has been ~~proposing~~ proposed in North Cumbria, we have got similar issues, you might imagine -- not the same, but quite similar. I absolutely understand that.

DR WALTERS: You might want to pick up stratification more than me. I will hand over to you, thank you.

PROF FORSYTH: Are there any continuing concerns regarding the maternity services?

MS DANIEL: I think that the continuing concerns are about how we maintain that resilience. We have talked about actually managing to recruit. We think the right quality

staff, medical and ~~periphery~~ midwifery and neonatal staff; it is never easy but we are managing to recruit. Our gaps, interestingly, probably are narrower than most of the units we are working with and benchmarked against. Nevertheless, I think the challenge is that, you know, when you have got an isolated unit, which is only delivering a fraction of the births and that —another unit might if you look at, I do not know, look at the guidelines, I think that my frustration is ~~we were seen~~ they seem to shift and you know you cannot, nobody seems to want to pin it down and come off the fence and actually say, you know, outcomes are dependent on ~~activities. I do not know if — I have looked at as much evidence as I can find.~~ the level of activity through a Unit. We (The Commissioners have reviewed all the avalible evidence)

You know in the absence of that, what we have been looking at is the dashboard as indicators and watching those really carefully. I think this is a moving feast. I think nationally, you know, this is going to continuously be in our sights. I think the prospect of working with another partner or partners, it will be interesting to see what comes out of the Dalton Review nationally about sustainability of district general hospitals. We are looking at all of those emerging models. You know, we have met with David to get some early sight of the work he's doing about whether we should be -- how we should be partnering the units. At the moment we are looking -- and just about to conclude -- a piece of work on the stability partner and a

number of the units have expressed an interest of working with us. We think that, at least in the interim, gives us a prospect of making sure that we are not losing sight of any of the risks and that we are managing the risks appropriately.

PROF FORSYTH: You have got the numbers, but you say it is quality of the staff. I wondered, in terms of the number of appointments, in the consultant level --

MS DANIEL: Yes.

PROF FORSYTH: -- I wondered how you felt confident that they would be good quality appointments?

MS DANIEL: Yes.

PROF FORSYTH: Also maintaining their skills if the actual clinical service is low.

MS DANIEL: I think that is where the stability partner does come in. We have talked about not only rotating into other units and the prospect of trying to get -- we talked about joint appointments, just how practical that will be, but certainly offering clinicians time at the units, blocks of time -- that might be a two-week block or a one-week block. An opportunity to experience different skill mix and caseload.

I think the joint audit that we are doing, joint reviews -- so, for example, now, any serious incident, or any incident, is reviewed by, we work with two partner

organisations at the moment but we do get an external review on those. Our lead obstetrician (Alison Sandbrook) is a new appointment. She is a young obstetrician who, you know, is leading some of that work. Far more audit activity going on; clinical governance activity going on.

However, you know, I am not going to sit here and say I have got the magic answer. I think every small obstetric-led unit in the Country is looking continuously at making sure that, you know, you make the right appointments, you have got the right turn-over, you are not just appointing anyone who will come -- you are actually --

PROF FORSYTH: Bums on the seats.

MS DANIEL: -- you have got good external assessors and you have got people who will challenge some of that on appointments and, if necessary, not make an appointment rather than make the wrong appointment.

PROF FORSYTH: Have you had any serious incidents in the last six months?

MS DANIEL: There have been some serious incidents. We have done all the usual root cause analysis. I think there will always been serious incidents, unfortunately, in the field of obstetrics. We are satisfied that, you know, we have taken all the necessary action. We are still being very heavily scrutinised, so every incident is styced reported through the Serious Untoward Incident System. ~~(?)~~ for the system.

It has got CCG/local area team involvement; actually got a

regional NHS England involvement in the oversight as well. We feel we have got double and triple scrutiny on incidents that you would probably ~~say~~ see, well, in fact, you know we are not an outlier in terms of the incidents when we try and look at benchmark data. But, yes, we have had incidents and we have continued to have incidents, as I expect we will.

I think the confidence lies in how we respond, what we learn, and the fact that actually what we are not discovering when we do the route cause analysis is that there are fundamental issues with practice systems or processes, you know, that either have been things, you know, deterioration due to clinical condition, that was outwith anything that we were doing.

PROF FORSYTH: You are probably aware we have reviewed cases from throughout the period of the scope of the inquiry. Certainly there is very little improvement in terms of clinical skill issues --

MS DANIEL: Yes.

PROF FORSYTH: -- right through from the beginning to the most recent cases. I was wondering -- clearly that will be important to look at carefully because these are preventable -- if you actually have staff with the right skills then these can be prevented. Particularly in relation to, for example, paediatrics -- I am a paediatrician -- the neonatal unit, the Special Care Baby

Unit at Furness is just a level one unit.

MS DANIEL: Yes.

PROF FORSYTH: They should not be looking after any baby that has got any significant problem. That presents a problem with the obstetricians as they are keen to look after the slightly more complicated woman. I wondered, in terms of policy within the Trust, how you are addressing that particular issue?

MS DANIEL: Well guidelines about level one units are pretty clear. I mean, we know that babies, you know, do deteriorate. We have got clear policies and guidance in place. We are, you know, looking at each and every escalation and case.

Clearly, I have talked with Geraldine about the fact that, you know, I do not think that -- we are not a high-performing Trust. If you say to me, you know, do you think you are governance systems are watertight? Do you think you have got all of that taken care of? No, we have not. we are still learning, probably got more to learn. But, I think, that the systems for alerting us to when things are not following the course of action we would expect them to, they are stronger and they are getting stronger all the time.

PROF FORSYTH: Do you think your new clinical leadership will be more effective in ensuring that risk

assessment is done; decisions are being based on risk assessment, rather than maybe the wishes of the clinicians?

MS DANIEL: Yes. Yes. Yes, I do.

PROF FORSYTH: Thank you.

MS DANIEL: You know, talking with the Medical Director, he will probably, you know, say -- I think when you have the Board conversation, he will talk much more eloquently than I can -- I can talk about the risk and the overall governance systems. I am sure you will get into more of that.

PROF MONTGOMERY: Thank you. You have touched on a lot of things that I wanted to ask about already. I want to start about the capabilities of the leadership.

You talked about the Board. You have talked about the clinical leadership. I want to talk about the governors and members and where they sat and how they saw what has gone on, what the challenges are now?

MS DANIEL: I think the relationship with the governors, as with the staff, as with partners -- so I talked a bit about partnership and stakeholder -- the state of the relationships, from what I observed when I was appointed to the Trust, they were broken. They were broken across the piece with staff, with commissioners, with stakeholders. The same is true with the governors. It is not helped when you have got quite a lot of churn in the top team because they've not been a stable organisation. Arguably, you know,

what is stable, but I described for you that the last member of the executive team just came onboard in January and we have just appointed the second chairman two-years yesterday. I think developing the relationships with governors is making that much more difficult in the circumstances.

PROF MONTGOMERY: Can you elaborate on where they sit, because I could see a model in which the governors would deny that there was any real problem, they said, "Our job is to protect the hospital", and they could be a barrier to change. Or you can see a bit that they are saying, "Why have an executive team not sorted it already?"

MS DANIEL: Where they were when I came in was, they felt that they had been kept in the dark. They felt that they had been kept out of the picture. They felt not involved in the governance arrangements. They were not really aware so there was a lot of surprises.

Since that time I can see that, you know, the various kind of interim/permanent Chair, the Board, myself, worked really hard to develop the relationships. I think again they are much stronger but, you know, there are still times when it is really easy for that trust to be questioned again – it might be a media report, it could be a number of things that actually start to shape that –

PROF MONTGOMERY: When that happens, do they get defensive? Do they feel the Trust has been victimised –

MS DANIEL: Not at all. They are at the other end of the spectrum. They will really want to -- they ask all the rights questions, they want to get close to the detail so they know what is happening. "Can you take us through and assure us?" They are very, very clear at holding the Chairman to account.

PROF MONTGOMERY: How often do they get together?

MS DANIEL: Every about six to eight weeks, but no less frequently than that. There is a board scheduled meeting, they also have their own sub-groups. They have a strategy sub-group; they have the patient experience sub-group. They are now really actively involved in the walk abouts, 15 steps programme that we have got in place. We have encouraged them to get close so that we can show them the improvements so that they can see them, touch and feel them.

PROF MONTGOMERY: That ~~sands~~ sounds like a big shift from what we have learnt from the early days. If I was asking for -- and similarly it seems very strange that you have not got a Maternity Liaison Committee, given the things that have gone on. If it is now there, if we were asking for a couple of examples that shows this does work, and it has changed because of what has been learnt on the walk around, or because of hearing the patient voices and Monitor voices and the things, would you give us an example --

MS DANIEL: A couple of examples of that. A physical

example was the relocation of SCBU on to one of the adjacent to -- linked to the other wards. I mean, the environment, Special Care Baby Unit at Furness, was -- I do not know whether you have actually seen that, but I was again quite shocked. You know, it was a very outdated facility. Whilst it is not 100% ideal—you know we would still like to inject some capital to further improve it, and other areas at Furness; it will be better than it was. Just the environment; the provision for mums and families to stay. The general place is so much brighter and much more fit for purpose.

An example, which is not about the physical environment is, for example, we have got bereavement midwives working with families and I think better understanding the kind of support that they need at those times.

PROF MONTGOMERY: While we are close to the environment, tell us about the access to the theatre for emergency Sections, which keeps popping up over a decade. We would like to be able to say it's sorted.

MS DANIEL: Well, I think it is sorted within the current physical constraints. I think we met the requirements following the CQC inspection: We were not wheeling people through the corridors with flimsy curtains et cetera. The unit needs a different location, as with many other elements of our estates.

PROF MONTGOMERY: What is your take on what happened in terms of the finding the key? The CQC said it took them about eight minutes for the key to be located to a key door to be able to get them into the theatre. We have heard different accounts of whether that was a real problem or not. What is your take on that?

MS DANIEL: I am afraid I cannot -- I do not feel I can answer that, Jonathan, really. I am not aware that remains a problem but I cannot tell you that I physically have been, you know -- unlocked and tested that.

PROF MONTGOMERY: We are meeting the Board, maybe I can ask that question again if they can find out because it will be one of the things that we would like to nail and say --

DR WALTERS: It is all about access at night.

MS DANIEL: I am sure that Headley (?) Griffin ? The Head of Midwifery could tell you that and clarify. I am sure the Chief Nurse can tell you that and --

PROF MONTGOMERY: We have heard -- it was people like that who were asked and they could not -- the ward staff were saying that if you had asked the person who worked there, they would find it immediately. We are told things then that they are saying that it probably is all right, but it will probably be all right on the night, as the saying goes, but I do not think we can say with any confident we know that is certain. It sounds as though, today, you

cannot quite, but if you could before we get ready to report it will be great.

You talked a bit, I think again it feels very reassuring, I am trying to pin down my understanding about the improvements of the clinical leadership and the work you are doing on making it one trust and not a number of separate sites.

How many of the clinical leaders, with the Trust-wide responsibilities, spend their working time mainly in Barrow because we have got the perception you have a stronger team in Lancaster so it will be helpful to --

MS DANIEL: Certainly we are all --working across the sites I think the messages and the expectation is that everybody spends time everywhere. As you might imagine that is not always easy, but that is certainly what the leadership signed up to. We are trying to make sure that we are on all of the sites; in fact the two main sites the majority of the time --

PROF MONTGOMERY: That is not quite what I was asking you about, although I would have asked that if you had not said it.

In many places we have the problem, we have the perception of "It's a takeover". If you have that, you have people who have been based at the RLI, and now over at Barrow, that will feel a bit different if you managed to source leaders from both places and move them both ways.

There may not have been a balance, but are there people in Barrow you have been able to appoint in, or find, who then can go out to the RLI and say, "We do good things we ought to tell you about?"

MS DANIEL: Yes. Again, the job planning -- the consultant job planning is pretty complex. I am happy to give you a lot of detail around that. I cannot give it you off the top of my head, but, you know, most of the specialty leads work across —the Trust the specialities work across two sites. There are very few, I mean, you have got healthcare assistants that cannot travel 50-odd miles to work across sites; that will not make any sense whatsoever. Certainly the leadership team, senior clinical leads, work across the sites at the moment --

PROF MONTGOMERY: That is not quite what I am asking, I understand that is big progress from some of what we have heard about in the past.

I am still trying get a feel of whether we have got leadership competency in Barrow, so that you have got that balance, or whether actually what you need to do is to take the leadership skills and the people you have in the RLI and get them seen in Barrow --

MS DANIEL: Okay. I think it is improving. I talked about Alison Sandbrook being appointed. We have got Richard Lee, who is an excellent —Physician/Consultant one of the best physicians I have

ever worked with. Some of the A&E consultants we have just recruited too; some of the anaesthetists. Significantly improved --

PROF MONTGOMERY: Those are people whose main centre of gravity will be Barrow. I think that is really helpful for us to understand --

MS DANIEL: Yes.

PROF MONTGOMERY: -- we have picked up a few times what could be -- I am cautious about how tightly that is -- is there is the crises, people in the RLI take an interest, then it fades away again it slips back into Barrow being isolated.

One of the other things on that was about how you re-assure yourself that the people working in Barrow understand that it is not always done the way Barrow has done it for the last 100 years. We have heard about training patterns and there is a lot of effort and work going in to training and the availability of training packages. I still do not have the sense of how easy it is for people, whose main workplace -- I think particularly of midwifery and front-line maternity care staff -- to discover what it will be like if they work somewhere else; training courses that enable them to rub shoulders with --

MS DANIEL: We do a lot between places like Salford Royal, and Wigan, Wrightington, and Leigh. Increasingly there is

cross-fertilisation of, not just engagement programmes, but development programmes, sharing ideas there.

We are members of the improvement hubs like ~~AQA~~ AQUA, you know, so there is a lot of shared learning. We do a lot of work with the leadership academy; encourage staff to participate in those. I think things like the patient safety summit conversations that now happen every week -- it is across the Trust, so it does not quite reach the point you make about getting external, but what it does is put the microscope on all incidents right across the Trust, every week. It is usually by video conference, or conference call, but there is, you know, senior leaders, clinicians, and managers, actually, from across the Trust that all dial in. Medical Directors and Chief Nurse take it, you know, in turns to Chair that. Things like that really are really healthy.

PROF MONTGOMERY: That is helpful. You see I am trying to pin down examples so I can get some cross-checking assurance.

You also said some very constructive and positive things about loosening the policy of the complaints so it was not about processing; it was about meeting complainant's needs. I wonder whether you have examples of -- also we have to translate that into service changes. So you are meeting complaints, understanding what lay behind them, you

have got help from that to go back to the services and say, "Would it not be better to do it like this?" Because it is a separate layer, isn't there, about the method of complainant's handling service, from the bit that was also in the organisation that can make a difference.

MS DANIEL: There are probably lots and lots of examples. Some of the ones that come to my mind are things like now having a matron's bleep that is advertised at visiting times. Reference, if you want to speak to somebody in a senior position about your relative, now ring this number, or ask the nurses to ring this number. Actually I thought that they may be absolutely inundated; that has not been the case but it certainly has been well used.

MR BROOKES: That was generated by a particular issue raised by patient?

MS DANIEL: Yes. It was about coming in and not being able to see somebody in a senior position at seven o'clock in the evening. I think another example is Patient's Advice and Liaison Service we put all the posts back in. That again was through direct, a number of people telling us actually they just wanted to talk to someone. They didn't want to make a formal complaint but they did want to speak to somebody on that site.

PROF MONTGOMERY: We heard from families, actually some people had quite positive experiences of PALS and other people have not, had poor experiences. What has been your

thinking about -- I understand retrospectively and meeting the families who have prompted this inquiry -- have you met them? Have you felt unable to because of the inquiry or --

MS DANIEL: I always try to maintain an open line with all of the families. The majority of them have not wanted and expressly said, "I do not want to meet with you". I kept the offer up. I get the communication channels open, even, you know, it has felt quite difficult. Those remain. The Head of Midwifery and the Chief Nurse and myself have got meetings scheduled with the co-ordinator of the group and are really keen to, as I say, just keep channels open. But it is -- that has not been, the families have not wanted to take it up.

PROF MONTGOMERY: This is linked and, I think, it is my last question. This is a phrase that has raised a couple of times in people we have seen, or things we have read. I will need to gloss? it slightly because, I think, we also have discussed other things. It is a question that has been raised: Is the Trust yet ready to say sorry? I gloss? that by saying there are lots of letters in which the Trust has said sorry. I am not asking the question about uttering the words, it is something around how you get some closure, where the Trust can be able to say, not just that was in the past and we wish it had not happened, but also some degree of assurance of the families that we have learnt from the

process. I do not know whether you are in a position to say anything very much about that while this process is going on, but it links directly to what you just said about --

MS DANIEL: I think that we have in the past and are ready to say sorry. On occasion, as families have wanted to meet directly with some of the midwives. This has been a painful journey for everyone, I think, and it is really difficult for the Chief Executive to try and facilitate those joint and open meetings. Neither party, I do not think, have felt ready up until this point. I hope that in the future —can do this we had some of the discussions, through some of the GPs in Furness, with some of the families about, you know, we would really do anything on your terms to try to make that happen. For whatever reason we have not managed to find a way that they will find acceptable until now.

PROF MONTGOMERY: I do not think we can go further on that. Thank you.

MR BROOKES: I have got a couple of things, if I may. To go back to your arriving at the Trust, I am interested on your views. You arrive at the Trust, there are serious significant problems, this is an organisation which has relatively recently gone through the FT process; was it ready for FT?

MS DANIEL: No.

MR BROOKES: Did the FT process in any way exacerbate

problems?

MS DANIEL: I think -- well it is difficult, isn't it, because but I am happy to give my opinion of that. I think that it did exacerbate problems. I think it was not an open organisation; was very defensive. It was described to me by partners as being very defensive, very closed, quite arrogant, focused on things like financial management and takeover bids. Business acquisition and those sort of things, which really seem ludicrous -- even just reflecting a short time after that.

My impression is that an FT process, you know, encouraged those kind of behaviours and that kind of approach and certainly did not help.

MR BROOKES: Its business plan was based on expansion.

MS DANIEL: Yes.

MR BROOKES: I think we have probably all seen it somewhere in the conversation. It was not realistic.

MS DANIEL: No. No.

MR BROOKES: That is helpful to understand because, I think, that it helps us set the context of what you saw when you arrived and some of the time line of what happened.

Turning to something else. I have been very struck on a number of interviews we have had about the feeling of futility amongst some staff that they raised concerns about the quality of the service and it did not go anywhere.

There is a balance there about individual responsibility et cetera, but two parts of that. One is: Do you feel that if there was a concern being raised it would be dealt with now? Are there processes in place for individuals who feel strongly about things -- process/policies/et cetera, could not find one the previous times -- are those in place and are they being used, do you know?

MS DANIEL: Yes. To start with that. I guess now, yes, there is a whistle-blowing policy. It is used -- it is not often used when we look at -- you know it does not really matter, but it is used to raise issues, whether they are true whistle-blowing issues or not. Thankfully staff have used it.

Some time back, just after I came to the organisation -- and the contract was still holding for 24/7 independent whistle-blowing help and guidance -- that has not particularly been well used, even over a number of years, but it is still in place. Actually, an idea that came from one of the families was initiating things like patient safety -- reporting a patient safety station in a couple of locations at each of the sites. Just a place for staff to anonymously post concerns that they had. Those boxes are emptied by the Deputy Medical Director and Chief Nurse on a weekly basis and are picked up. What is done about those is posted in that location. That has been quite useful and was

quite, you know, well used at Furness in particular.

Things like Speak Out Safely nursing campaign has been -- we have promoted. I still think that there are pockets of the workforce today who, you know, may be reluctant -- I think that is part of, I still think we have got --??

MR BROOKES: It was not necessarily a reluctance. It was a feeling they had got to the stage and they needed to say something, either clinical people or professionals or, and did not feel that they had ever been listened to, or the process got lost in the middle of the organisation.

MS DANIEL: I think there was a lot of evidence of that. If you look at staffing levels alone, they were really wholly inadequate. You know, we are still a work in progress. We have got to spend in excess of £3 million. We have still got to be able to recruit the staff. But I still hear stories from staff about issues that they have raised in the past, you know. Thankfully I am hearing less and less about the issues that have not adequately been dealt with. It was definitely a culture of, I think, a lot of staff switched off and stopped raising issues and lost faith and got demotivated.

You know, part of the cultural shift that we are trying to bring about now is we are embarking on what we call Listening to Action, which is a national campaign, which is

really ambitious programme starting next week, with a cohort of other trusts. It will ignite engagement at a level we have not been able to do before. I think had we tried to do that two years ago, I think you know it has been sort of a process of putting systems that connect people together, putting systems where people can raise things anonymously actually demonstrating that we do listen and that we are picking things up. It felt like again that has taken much, much longer than I imagined it would. I still think it is, you know, it is work in progress.

MR BROOKES: One last question, not the easiest, but one last question. You never give 100 percent guarantee, but in your view, are maternity services, across the Trust, safe?

MS DANIEL: As you say, never 100 percent guarantee but, yes. Yes, I feel as confident, as I have felt in any other leadership role, our services are safe. I guess what comes with additional scrutiny is additional ~~scrutiny~~ assurance. Everybody looks at every single issue/incident still and for now, I think, that is no bad thing.

MR BROOKES: Thank you very much.

THE MORECAMBE BAY INVESTIGATION

Thursday, 4 December 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

JULIA DENHAM

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(At 2.11 p.m.)

DR KIRKUP: My name is Bill Kirkup and I am DR KIRKUP of the Investigation Panel. I will ask my colleague to introduce himself to you.

PROFESSOR FORSTYH: Good afternoon. My name is Stewart Forsyth. I am a paediatrician and medical director from Dundee.

MS DENHAM: Nice to meet you both.

DR KIRKUP: You will see that we are recording proceedings. We will produce an agreed record at the end. You may also know that family members have been invited to be present as observers of interviews, but as it happens we don't have any this afternoon. They may listen to the recordings. We have asked you to hand in any mobile telephone or record device etc. just to emphasise we don't want anything to go outside the room until we are ready to produce a report with everything we have considered in context. If it is necessary we can have a reserved session where we talk about anything which raises any confidential information. That may not be necessary in this case but we can do that if we need. Is there anything you would like to ask me about the process?

MS DENHAM: No. I'm okay. Thank you.

DR KIRKUP: Okay. Thanks. I will start off my asking you if you will just outline for us what you have done at the Care Quality Commission, when did you start, what had you done before?

MS DENHAM: Okay. During the period in question back in 2009 I was an area manager with the Care Quality Commission. And prior to that I had worked with the Commission for Social Care Inspection and its predecessor organisation, the National Care Standards Commission. My background is in social work but I have been in regulation for many years now. My position as an area manager, that positioned me so that I was reportable to the regional director, who at that time was Alan Jefferson, and I was responsible for the management of a number of – Excuse me, I was absolutely fine before I came in here.

DR KIRKUP: I know the feeling. Have a drink of water.

MS DENHAM: I was responsible for a number of local area managers, that they were called then, who in turn managed the teams of inspectors. And as we were into that period, also a period of a number of assessors – I think you

have had an explanatory note about the period of time which meant that we were – We were just in a change period.

DR KIRKUP: Okay. And how long did you carry on as an area manager?

MS DENHAM: I carried on as an area manager I think until round about May 2010. I was an area manager certainly up to and including the point of registration of Morecambe Bay.

DR KIRKUP: So you will also Sue McMillan after Alan Jefferson retired.

MS DENHAM: I did, because I also worked with Sue McMillan in the position that I then went on to have as well. So, yes.

DR KIRKUP: What did you move on to do?

MS DENHAM: That tier of management at area manager level was taken out of CQC. So the position that I then held was actually the registration manager. I am now the head of registration for north and central regions of the Commission.

DR KIRKUP: Okay. And as area manager what was the area that you covered?

MS DENHAM: At that time I covered Blackpool and Cumbria. So that involved all the social care services that were at that time registered and the inspectors would be regulating. I also covered the performance assessment at that time of councils. So my councils at that time were Blackpool and Cumbria. And just on the cusp of that the annual health check, whilst it wasn't something that previously I had been involved in I did –

DR KIRKUP: It was part of the Healthcare Commission before?

MS DENHAM: It was. But as it came over and we still had that responsibility I did have some involvement in the annual health check of the NHS Trust, because in the – if I could just call it a shake up – in the transition from those organisations coming together in the northwest we ended up fairly top heavy with social care background people rather than people from the Healthcare Commission, so I was grafted in. Drafted in even.

DR KIRKUP: Okay. The annual health check came over to CQC from the Healthcare Commission when CQC was still in shadow form in 2009, is that right?

MS DENHAM: That is my recollection.

DR KIRKUP: Yes, okay. Now, what was your involvement in the health service from 2009 onwards when CQC were in shadow form?

MS DENHAM: I had some involvement with the annual health check.

DR KIRKUP: Apart from that you weren't involved in the health sector?

MS DENHAM: I would have been managing and was managing at least one of the assessors who had come from the Healthcare Commission. It was Dawn Hodkins.

DR KIRKUP: Okay. So what was your first acquaintance with health services in Morecambe Bay?

MS DENHAM: From memory my first acquaintance with that was when the email came through from James Titcombe, which had come through to our national contact centre and was an email telling us about the death of his baby son, Joshua, and which had a presentation attached and other documentation. And that was forwarded to me by our contact centre because I was in the area covering Morecambe Bay. So it landed with me.

DR KIRKUP: Can you give us roughly when the date of that was? I know that we have it but if you could just help us.

MS DENHAM: It was around about 18 May that the email was forwarded to me.

DR KIRKUP: 2009?

MS DENHAM: 2009. Sorry, yes.

DR KIRKUP: Thank you. So what was your reaction to the email? What did you do?

MS DENHAM: I found the email very, very upsetting. It very much touched me. I was very concerned as to it content and I knew that we needed to do something with that very pertinent information in terms of that trust. What that was I didn't at that time know.

DR KIRKUP: Okay. So what steps did you take?

MS DENHAM: So just in terms of a little bit of context, so up until that point I had been working in my comfort zone in terms of the social care side of the business and so this was at a very early stage in terms of us having taken on the responsibility of the health side of the business. So I wasn't familiar with the procedures and the key people at that time. So when that did come through I would have asked other people what do we do in terms of this significant information. I can't remember specifically but I know I talked to Dawn Hodgkins, who was the assessor who was from a healthcare background and therefore knew the go-to people if you like, and I know that I

also raised it with Alan Jefferson, who was the regional director, because it was very significant information. And I know that somewhere in the mix we were advised to run it by Ian Biggs, who was another regional director but who had been in the Healthcare Commission previously so was at senior level but knew the old ropes if –

DR KIRKUP: Which region was he in?

MS DENHAM: South somewhere? It might have been southwest.

DR KIRKUP: No problem. We can find out.

MS DENHAM: So somewhere along the line that led me to believe that the direction of travel should be to refer it through to the investigations team.

DR KIRKUP: Right. Can you just explain what you think it was about referring it to the investigations team?

MS DENHAM: I think I can tell you the – I am trying to be as honest as I can here, and I am not entirely sure from memory which bits I knew at that time and which bits I know now. So in its simplest terms I was referring it to the investigations team because that at the least I knew that I had been advised that that is the place it should go. I know now and I knew very shortly afterwards that one of the criteria for the investigations team linked to systemic failure. So I knew at some point around that time that [inaudible] systemic failure was an issue and whether it was before I suggested the referral or after I am not sure. And so once I knew that was the route I had been given someone's name, I have forgotten it now. It ended with Sarah Seaholme, but it went to somebody else first. Somebody else. Setting out the – Well, actually, forwarding the email that James Titcombe had sent and the documentation.

DR KIRKUP: Can I just be clear, was the James Titcombe complaint the only basis of the referral? There weren't some other serious untoward incidents as well?

MS DENHAM: There were. The other serious untoward incidents only came to light post having the James Titcombe email. And Monitor I think was the route that we got that information. And so in the email that I sent to the person whose name fails me for the moment in that email I had indicated that there has been the serious untoward incidents as well.

DR KIRKUP: Had you taken any step to find out any further information about those untoward incidents?

DR KIRKUP: Not at that time.

MS DENHAM: It was – I think the email had come through on 18 May or was dated 18 May. And an email went to Sarah Seaholme on 20 May. Now, the other email went to someone who passed it on to Sarah Seaholme. So it was in a very short timescale. It didn't allow for kind of doing other supplementary checks.

DR KIRKUP: Okay. So what happened next?

MS DENHAM: So the email that went to the person whose name escapes me was then transferred to Sarah Seaholme and somewhere along the line it must have transpired that we needed to do kind of a referral form for the investigations team. Dawn Hodgkins, who was the assessor, filled that form and sent that through to Sarah Seaholme. At the same time or in that time scale I think that it was that Monitor had got in touch with us, which was how we knew about the serious untoward incidents. And, of course, Monitor were on the brink of deciding whether Morecambe Bay should have foundation status and therefore were keen to know what impact the serious untoward incidents may have on our thinking. They had already had that information, actually, before us but nevertheless they were keen to know that. I think that probably the email that James Titcombe so eloquently and painfully put forward would have made anyone sit up really, quite frankly.

DR KIRKUP: And did that email itself make you think there were systemic problems in Morecambe Bay or did it require the addition of the other four incidents?

MS DENHAM: At the time when I was keen that investigations picked this up it was the combination because, and this is very – I mean if we keep the chronology, so obviously the referral went through to Sarah Seaholme, Monitor were then, 'What is going to happen? What is going to happen?', the assessor (sorry, we change our titles so much) had sent a reminder email to Sarah Seaholme for the outcome and Sarah eventually – I'm not saying eventually because it was a long period of time, it wasn't – Sarah came back and advised that she didn't feel that it was applicable for the investigations team to take that on.

DR KIRKUP: Okay. Can I just pause you at that moment? I want to check one thing and then another. The one is you say it took a while to come back but was the reply from Sarah Seaholme not 27 May? Have I got that right?

MS DENHAM: I would need to check, actually.

DR KIRKUP: Okay. That may have been the decision. Maybe the email was later. I don't know.

MS DENHAM: The email to Sarah I have noted was the 20th. That went to her quickly.

DR KIRKUP: I have that, but I thought we had information that a decision had been made within 7 days. So maybe the reply didn't come straight to her but the decision was made.

MS DENHAM: Yes. Maybe.

DR KIRKUP: Okay. It's fine. The other thing I wanted to check with you was you, I think, said that you made the decision to refer for a potential investigation before you had heard about the additional SUIs from Monitor. Did I pick you up correctly there?

MS DENHAM: I don't think you did. Because in the email to the person whose name I forget I think that included reference to the serious untoward incidents as well, and I do know that in subsequent discussion with Sarah when Sarah had indicated that the investigations team weren't going to proceed with an investigation that I did have a telephone discussion with her, in part so I could try and unpick why that was and I know that I was thinking, 'Would these others mean that that would indicate?' But that was in the context of not having a great feel for, and nor did the assessor actually, and nor did Dawn at the time – is 12 an unusual number? Is five in maternity unusual? And ultimately, of course, we were trying to seek that advice from the Strategic Health Authority who monitored the serious untoward incidents and we felt would have a far better handle on that than we would. So yes, it kind of felt to me that there are other things there, maybe it does indicate that so would the investigations team take it on. I've got to be honest. I was disappointed. Yes, I was disappointed.

DR KIRKUP: Okay. I will come back to that in a second, but I do need to understand this timescale between 18 and 20 May. I'm sorry to be nit-picky about it but I think it is an important point. The email from James Titcombe, 18 May, that

you said alarmed you as well as upsetting you, very understandably. And you sought advice from Alan Jefferson and from Ian Biggs I think. That was before you knew about the other incidents. When did the other incidents come to light via Monitor?

MS DENHAM: I can't remember. I know it was in that very early period and it was definitely before we referred it through to –

DR KIRKUP: So sometime in that 48 hour period?

MS DENHAM: Yes.

DR KIRKUP: Okay. I need to phrase it as a hypothetical in that case. If they hadn't have come to light would you still have referred it for an investigation? I am trying to get at whether the James Titcombe email did itself raise systemic issues or did it take the SUIs tipping in for you to think that there were systemic problems?

MS DENHAM: And I think that is going to challenge me again in terms of trying to think myself back into it because the information about the serious untoward incidents was very quickly in the melting pot. And obviously to know over a period of years it has kind of been visited and I can't remove that from my thinking to be honest.

DR KIRKUP: That's fine. So let's go forward then to Sarah Seaholme says it doesn't meet the criteria for an investigation and that is her judgement. You had a telephone conversation to try and understand that better. Can you recall the content of the telephone conversation?

MS DENHAM: Not in any detail on that I know that I emailed when the response from Sarah had gone through to the assessor, Dawn Hodgkins, and I know that I emailed Sarah and said that 'I am disappointed that you have not come back to me in terms of this because I sent the original email, and also I am concerned about the decision and I need to understand that more.' And I know that my belief at the time was that I felt that the investigations team should pick it up. So I know that the discussion with Sarah would have been along those lines. Sarah indicated that it – I don't think it indicated systemic failure. I think that was part of the reasoning and also because the Ombudsmen had already had a referral and were therefore also looking at it, that there was nothing further to be gained from us also picking that up.

DR KIRKUP: Okay. Did she explain why she thought it wasn't evidence of systemic failure?

MS DENHAM: I can't remember. I think it would have been around the number. I can't remember to be honest. I just know we had a conversation because I wasn't happy with the decision. But it is speculation to a degree as to what actually the content of that conversation was

DR KIRKUP: Okay. If I suggest a potential line of reasoning feel free to disagree if that is not your recollection.

MS DENHAM: Okay.

DR KIRKUP: But we understand that what was quite central to that decision was the unconnectedness of the five incidents. Yes, there were five incidents. They all related to maternity or nearby to maternity but they were unrelated clinically so they were unconnected. Does that ring any bells with you or not?

MS DENHAM: I know that ultimately that was something that was concluded, but the timescale of when that conclusion was reached I am not clear. I can't remember whether it was at that time or not but it could well have been.

DR KIRKUP: Okay. What was your view about whether there were systemic failures at that point? Did you think, to put it bluntly, the investigations team had got it wrong?

MS DENHAM: Yes, I did. I did.

DR KIRKUP: Okay. Take me through what happened next.

MS DENHAM: I would have flagged the decision of the investigations team with the regional director, with Alan Jefferson, at the time. And we then went through the advice from Sarah, which was what we needed to do was find out more in terms of – I can't remember that. Let's just cut off the advice from Sarah. I know that part of the advice from Sarah was about monitoring action plans form the Trust. But what we did do was we got in touch with the Strategic Health Authority, who had the responsibility at that time for monitoring those serious untoward incidents to try to understand from them what their view was on the serious untoward incidents.

DR KIRKUP: Sure.

MS DENHAM: We did establish that the Trust itself had commission some external agencies to look at how the maternity services were operating, and I think the

Strategic Health Authority were aware of that and were monitoring the actions that the Trust were taking. I think at that time there was maybe – I don't know if there had been the LSA report. I think at that time that was already held by the Strategic Health Authority and then there were two further reports on agencies and –

DR KIRKUP: Can you recall which reports they were? There have been rather a lot.

MS DENHAM: The other two were the birth rate plus and the [Charles Flynn?] which weren't through at that point. I've got a note that we met with someone form the Strategic Health Authority on 3 June 2009. That was myself and the assessor, Dawn Hodgkins. And what the Strategic Health Authority were saying at that time was that they were satisfied with the actions the Trust were taking at that point.

DR KIRKUP: Okay. Can I mention one more report here? The Hobson-Chandler Report. Does that ring any bells? Who did you speak to at the SHA?

MS DENHAM: Not made a note of the name, it's – it is within various documentation in there but I can't remember it.

DR KIRKUP: Right okay I would think it would either have been Angela Brown or Jane Cummings one of the two.

MS DENHAM: Angela Brown.

DR KIRKUP: Angela Brown, okay. Okay that takes us to the middle of 2009 so what happened after that?

MS DENHAM: Okay, so at the various points the other reports from those other agencies came though, the birth rate plus reports and the Charles Flynn report and the strategic health authority were continuing to have dialogue with the Trust and monitor the progress and on 17 September 2009, [Dawn Hodgkins?] myself and Allan Jefferson met with the chief exec and chair of Morecambe Bay –

DR KIRKUP: Sorry I missed the date that you said there.

MS DENHAM: The 17 September.

DR KIRKUP: Okay go ahead.

MS DENHAM: In order to raise the concerns with them in terms of the actions that they did need to take, the progress that they needed to demonstrate as a result of the- you know those various external reports, and I think also there

were some outstanding issues from the annual health check.

DR KIRKUP: Yes.

MS DENHAM: I think that the actual results of the annual health check weren't in the public domain at that time and I think perhaps that they'd not been shared with the Trust at that point, but I think that Allan Jefferson, kind of, gave an indication to them that you know, they would need to take account of any findings from the annual health check and be able to demonstrate progress in terms of the external reports. Obviously the whole intent to make sure that services were safe and from memory he would have flagged the fact that the Trust would be approaching, it was leading up to the time when it would have been submitting application for registration and would have kind of given them a nudge really that you know, as part of that they needed to get the house in order really and make sure that they were taking appropriate actions in line with those of the reports.

DR KIRKUP: Okay, how would you characterise the Trust's response to all of that?

MS DENHAM: They weren't defensive, you know I can't remember, you know a lot of detail of the meeting but I do know that they weren't defensive and that the whole way that the Trust were at that time in terms of interactions with us were that they were keen to show that they had and were making progress. It's also fair to say that it was reasonably- so they would have been very clear that they you know, they did not deny things in terms of Joshua Titcombe's death, they weren't being defensive.

DR KIRKUP: They had accepted liability.

MS DENHAM: That's right. And they were- you know they did- they commissioned these external reports which kind of looks like someone is trying to actively sort out what's happening rather than just doing things internally. But there was also kind of a part of it that they were very keen to demonstrate they'd made progress because they were very aware that there was the foundation Trust status hanging in the balance and I know at some point they had indicated you know that in order to do that costs- you know, they had costs attached in terms of putting forward that bid.

DR KIRKUP: Are you suggesting they were a bit too keen to demonstrate their progress? Were you suspicious that there were overegging the pudding?

MS DENHAM: I wasn't suspicious that they were overegging the pudding, I don't

think that you know, I kind of- and I don't think at that time certainly I had a belief that what they were saying they were doing wasn't the case. But I did think that they you know they were very keen for us to know what they were doing and for us to kind of be quick to form a view that progress had been made rather than us, you know, well let's have that information, let's look at it, let's see what you're saying, let's- you know potentially test it out.

DR KIRKUP: It sounds like in hindsight you are saying that they were a bit too keen but it wasn't apparent at the time, but I don't want to put words in your mouth.

MS DENHAM: I think that they were keen definitely but I don't think that the combination of them being keen and not being honest you know, I wasn't thinking 'oh you're keen and therefore you're not being honest.' It was, you're being keen, you hold your horses, but- okay.

DR KIRKUP: No I don't think I was suggesting that, but people can be too enthusiastic and can persuade themselves sometimes that things are better than they are.

MS DENHAM: Absolutely, yes.

DR KIRKUP: Now what I'm keen- sorry, to establish is whether you thought that at time or whether that's purely with the benefit of hindsight.

MS DENHAM: In terms of the keenness?

DR KIRKUP: Mm.

MS DENHAM: I think that I did think it at the time, you know there was- I feel as if I can remember both from the Trust and to a degree from Monitor kind of a keenness in terms of the Trust status, but I also do remember thinking well never mind, never mind how- whether you're keen and whether you want the foundation status, we will nevertheless do the job to the best of our ability, that- you know, at that time. And that was certainly also the view of the regional director then, Allan Jefferson, he- you know he wasn't going to be pushed to give a change in our opinion on Morecambe Bay to Monitor or to Morecambe Bay itself without you know, having properly formed that opinion.

DR KIRKUP: Okay, so what's the next event as far as you're concerned?

MS DENHAM: The- behind the scenes and that I'm less clear of now, I guess there would have been some on-going interaction and you know kind of checking in terms of what was happening with the Trust.

DR KIRKUP: When you say 'checking what was happening' you mean from the-

from Dawn and- yes, you don't mean from the SHA or somebody else?

MS DENHAM: Yes the local- I think that- well the SHA was still very much involved because they still had responsibility around monitoring of serious untoward incidents although during this time that was changing, so the primary care-

DR KIRKUP: They were passing it to the PCT?

MS DENHAM: That's right yes and that kind of creating another level of complexity because there were two primary care Trusts that kind of were both covering that Morecambe Bay area. So the next I suppose significant- well I suppose there were two significant parts then was the ombudsman reached their decision and that decision was that they wouldn't investigate themselves into the death of James- the death of Joshua Titcombe.

DR KIRKUP: How did you hear about that?

MS DENHAM: Do you know I can't remember? I can't remember- I've refreshed my knowledge obviously ready for today so I can see that we had a letter that set out the reasoning, but I can't- I just can't remember now.

DR KIRKUP: Yes I think the letter would have been a copy of the letter to James Titcombe wouldn't it? Which is rather later and was the next February I think. I mean our information is that there was a conversation between the deputy PHSO and the regional director Alan Jefferson.

MS DENHAM: Okay.

DR KIRKUP: In fact there were several telephone conversations.

MS DENHAM: Okay and I can't remember.

DR KIRKUP: You can't recall having a conversation with Alan Jefferson where he said the PHSO –

MS DENHAM: I can't.

DR KIRKUP: Can you remember whether there were any sort of provisions around the PHSO not investigating any implications for CQC?

MS DENHAM: Only that we were to monitor the action plans, monitor the progress of the Trust, that what the PHSO was saying was that and- as I understand it they'd had clinicians involved in reviewing some of the information that James Titcombe had presented and their review of that evidence was that there wasn't a lot that they would gain by doing their own investigation in part because some of the records were missing and they were I guess unlikely to surface it at that point. And I think they also acknowledged that indications

were that the Trust was making progress in remedying the issues that were around at the time of Joshua's death and therefore suggested that CQC carried on monitoring the Trust action plans, which is what we were doing in any case.

DR KIRKUP: Can you recall there being a point around the fact that the- that particular case, the Joshua Titcombe case – raised systemic issues of concern about the Trust and that those were matters for CQC to investigate?

MS DENHAM: No.

DR KIRKUP: Okay. And that message didn't reach you?

MS DENHAM: No, it didn't and that certainly wasn't in the letter that I'd seen from the Ombudsman. And had it come to me given that I'd had a view all along that I was concerned that the investigations team hadn't picked this up I would have more than happily picked that phone up and got it through, yes.

DR KIRKUP: Okay, you said there were two significant events, one was the Ombudsman's decision not to investigate and I interrupted you on the second one.

MS DENHAM: That's fine, yes the other really was the- then they started to think about the registration of the Trust because the Trust – I can't remember the time scale for the actual submitting of the application but all the NHS Trust's obviously had to submit an application which was in effect a declaration against the new health and social care act which they were then required to comply with as from 1 April 2010, and the declaration then was in terms of the outcome areas, links to the regulations that we set out in the application form for the Trust to complete.

DR KIRKUP: Okay so what was your role in relation to the application for registration?

MS DENHAM: Okay so the application went to- I'm going to call them an inspector because I can't think what they were called, I think it was an inspector. [Elaine Brayton?] who – no sorry, Elaine Brayton was the manager, went through to an assessor then Jan Yeats who must have taken over the lead relationship for Morecambe Bay I think from Dawn Hodgkins which is why Jan would have then been involved. So the application would go to Jan, Jan would have looked at what the Trust were telling us in terms of whether it was declaring itself to be compliant or otherwise, the Trust had declared itself

to be compliant across the board. The Trust was- there wouldn't have been any significant problem had the Trust declared in any area that it wasn't compliant, but it had declared that it was. We – what the assessor would then have done is right okay, so the Trust has said that they are compliant, and let us check that against what we already know about this Trust, and so they would have taken information from the findings of the annual health check, what other agencies were telling them, strategic health authorities, PCTs, and of course information in terms of the James Titcombe and you know that body of information that we knew, that body of concerns yes.

DR KIRKUP: Yes, that bit that we've discussed. Who would they have taken a view from about that last aspect? Was that you or Alan Jefferson or both?

MS DENHAM: It would have been from a number of people, there would have been handover from Dawn Hodgkins, there was- the way that Trusts were monitored in the region and I think through to nationally as well was via a risk Panel so the – I think those risk Panels were monthly and at that risk Panel there would be consideration of a Trust and what it current risk rating was. And if – so with Morecambe Bay at one point its risk rate, I can't remember the, you know the ratings but its risk rating at one point certainly as a result of this- the untoward incidents, etc., had escalated and at a certain point in the risk Panel the actions taken by the Trust, the information that we had from strategic health authority etc., would have fed through into that risk Panel and the Panel would have taken a view, are these sufficient to downgrade the risk that this Trust has. So at a point the risk rating which had elevated as a result of concerns, the risk Panel factored in information we had, reduced that risk and all that information would have been available to Jan Yates ~~Yeats~~ as she pulled together her assessment of the Trust. And I would have been involved throughout because of course I was very conscious of you know, key information in terms of Morecambe Bay, and I was also very conscious that James Titcombe understandably was very, very concerned that something was done. And therefore I was keen that any- that our scrutiny and our analysis of Morecambe Bay that would feed through to the registration decision was as thorough as was within our power at that time to do because I knew that you know, James Titcombe would continue to be very concerned, or was likely to be. He was- I knew he was unhappy with

the Ombudsman's decision, so you know I'm not shirking from any of this, the assessor was doing the work that they were doing, that was managed by her line manager, the local line manager Elaine Brayton. Elaine's background was social care; Jan's background was health. Elaine- I would have kept an eye because I would- do you know I didn't want things slipping through and I did have that overview. I also managed the registration manager Susan Easton who ultimately the scheme of delegation positioned the decision of whether to- the decision to register with a registration manager and so I kind of had an overall responsibility. But of- but whilst Alan Jefferson was around I would have been keeping Alan Jefferson appraised and when Sue McMillan came along I would have been keeping Sue McMillan appraised.

DR KIRKUP: Okay, so when this kind of thinking about the assessment in the run-up to registration was going on, what sort of time period are we talking about? Is this the first couple of months of 2010?

MS DENHAM: The notices of decision and then ultimately the certificates needed to be issued for 1 April 2010.

DR KIRKUP: Yes.

MS DENHAM: Now can't remember the period, do you know I feel as if I should have got this for you before I've come now.

DR KIRKUP: Okay we can clarify it later if you need to refer to the records. I'm going to take it that from- based on everything else that we know that we're talking about the first couple of months of 2010.

MS DENHAM: I think it was the first couple of months.

DR KIRKUP: Can I ask what your perception was of the level of systemic problem in the Trust at that sort of period? You had had a view that there were systemic problems, was it still you view that they were there in early 2010 or had it changed?

MS DENHAM: It had changed, it had changed because we had the reports from the LSA Charles Flynn, birth rate plus and we had the information from the Trust itself in terms of what action it was taking and from the strategic health authority in terms of its view of the progress that the Trust was making. And so by the time that we were considering the actual registration decision, the assessment record that the- that Jan completed identified for me, one significant area that wasn't resolved which was falling out of the birth rate

plus report, they'd made recommendations about staffing.

DR KIRKUP: Okay, there's a couple of points I want to just test with you there. I'm not sure which is the best to start with. Let me start with the Flynn report, did you read the Flynn report yourself?

MS DENHAM: I can't remember. I can't remember because as part of trying to progress- to prepare for this I've not even been able to track it down to remind myself of it.

DR KIRKUP: Sure, it's not so much what you make of it now, I mean that is of interest but it's much more what you know, whether you were in a position to comment on it at the time. Okay let me ask a kind of parallel question. How much did you regard it as part of your role at CQC to be sceptical about Trusts telling you that they were doing the right things to make progress? Did you regard it as your role to challenge that? To test it?

MS DENHAM: I'm going to say yes. It- to me because I was getting to grips with the system that I hadn't known previously, and the analogy that- the way that I apply things was that I had been involved in - and in fact I was still – whilst Morecambe Bay's going on of course I'm doing the performance assessment of Blackpool Council and doing the rest of the business, but – so I was quite used to challenging Council's in terms of the performance. So you know- in fact I'd met Lancashire Council directors here and they would have provided things to me and you know, it wasn't a problem for me at all to kind of look at that kind of thing and say 'well you say in that but' and to challenge. But the- so yes, that challenge would have been there but I do think that Morecambe Bay my knowledge of those areas wasn't good and without some clinical expertise and probably- do you know what I mean, as it turns out we can't get away from the fact that the way that things have ultimately rolled out at Morecambe Bay and things have been found out, have been because we've gone over the threshold and actually looked at what happens on the wards, etc. And that wasn't the way that things operated at that time, it was very much in terms of analysis of information. So yes, the role was clear and I wouldn't have shirked from challenge had I kind of identified a gap and needed to challenge.

DR KIRKUP: Okay, let me take you back to the Flynn report then, it did- I don't think anybody would say that in their wildest dreams they got to the bottom of

everything that was happening at Morecambe Bay, but it certainly did identify some pretty deep cultural issues about the way the clinical unit operated. I just wonder whether a potential area of challenge is a Trust says that within six months they can turn that around.

MS DENHAM: Mm.

DR KIRKUP: Is that – does that sound feasible using your – I know you didn't have direct experience of health care, but if a social care provider had told you they'd had those kind of cultural issues and they'd sorted it out in six months I would have thought you'd be a bit sceptical.

MS DENHAM: Yes, and with benefit of hindsight do you know if you and I were now sitting down and having the discussion and you said 'Julie hang on a sec, what do you think about that, I would say, do you know you're right.' But yes, I can't say other than that, I think with the benefit of hindsight that that would have been worth pursuing.

DR KIRKUP: Okay, thanks. I won't question any further on that I appreciate exactly what you said. Alan Jefferson was on record in correspondence as late as December 2009 saying that he still had significant concerns about systemic problems. Did that – was that your view shared with him at that time, in December?

MS DENHAM: I can't remember the timescale.

DR KIRKUP: He wrote to James Titcombe in December and I may not have got the words exactly right but they're as near as- he felt there were clearly still significant systemic problems.

MS DENHAM: Okay.

DR KIRKUP: You wouldn't have differed from him at that point? From what you've said so far, I mean correct me if I've said that wrong, I'm summarising that that would have been your view too.

MS DENHAM: I think it's very unlikely that I would have differed from him at that point, yes. It would have been the same view because we were looking at the same information and having reasonably regular discussion about it, so if that was his view at that time then it was likely to have been informed by information that Dawn and I were supplying. So somewhere between then and the point of our registering the Trust, the concerns are certainly mitigated.

DR KIRKUP: From an outside perspective, it seems like a pretty dramatic change. In the autumn of 2009 – and from that letter, it doesn't seem to have changed up until the December of 2009 – people in the regional arm of CQC are expressing pretty serious concerns about systemic problems, and are saying things like they'll take registration very seriously. Within, what, three months of that, it changed to registration without condition. That seems hard to understand.

MS DENHAM: Okay. In August 2009, Alan Jefferson sent an email to Amanda Sherlock that said, 'As the most recent North-West Risk Panel concluded, many of the uncertainties have now been resolved. The seriously untoward incident reports turned out to have no common thread. The SBA inspection has revealed only minor concerns. The fact that the Trust has unequivocally accepted that it messed up with the Baby T case renders the outcome of the Ombudsman inquiry fairly irrelevant, though, for the record, we've not heard whether or not the Ombudsman intends to pursue the complaint. The recent Risk Panel decision to reduce the risk from red to amber was appropriate in the circumstances. I immediately passed this information on to Monitor. What we are left with is an external evaluation that says that communication between maternity services in the Trust's three sites is inadequate; that midwifery, obstetrics and paediatrics do not communicate properly' –

DR KIRKUP: That's the Flynn Report, yes.

MS DENHAM: 'And that there is a uni-disciplinary approach to issues that should be dealt with in a multi-disciplinary framework. The external report also says that, notwithstanding the significant screw-up in recording the events surrounding Baby T's care and the Trust's consequent decision to purchase a new recording system, insufficient priority has been given to training staff to use it. We have very recently received an action plan from the Trust that tells us what they intend to do to rectify matters, and [inaudible] review of the progress that is made with the plan and evaluate whether or not it achieves its planned aims.'

DR KIRKUP: Okay. I'm familiar with the email, but thank you.

MS DENHAM: Yeah, sorry. It's just that it helps me remember what the thinking was. So –

DR KIRKUP: Well, yeah. It's not altogether helpful to me, because on the one hand, you've got – in August 2009, you've got a relatively reassuring message, but then subsequently, the CQC is telling the PSHO that it's going to take registration 'very seriously indeed'. That's the words, and secondly is writing to James Titcombe in December that there is still a significant level of concern about systemic problems, so that – there's on the one hand, and on the other hand.

MS DENHAM: Okay. All I can say is that at the point where we were registering the Trust, all the information that we had at that time that was weighed in the balance, that was presented, led us to the conclusions that we got to. I think that we would have needed, you know, to have been able to go into the Trust and see things for ourselves – would have given the definitive.

DR KIRKUP: In the run-up to registration, Alan Jefferson left. He formally ended it on 31 March, but I think he actually left several weeks earlier, and Sue McMillan replaced him. Was that in any way involved in the change of attitudes towards the Trust?

MS DENHAM: I certainly haven't made a connection to that, no. No – I mean, Alan Jefferson would have had a handover to Sue McMillan when Sue McMillan took over from Alan. She was aware of which the risky Trusts in the North-West were, and – so, I don't know that that would have been the case.

DR KIRKUP: Did the decision to register without conditions surprise you?

MS DENHAM: No, it didn't. It didn't, on the basis of the information that we had at that point and the methodology that we employed at that time in terms of where we were going with the Trust. And what we flagged was that there were issues that needed early follow-up following registration, so Morecambe Bay was identified as needing an earlier inspection.

DR KIRKUP: This was in relation to the staffing issues, wasn't it? The birth rate, plus staffing?

MS DENHAM: I think that the – yeah, those were the issues that were the issues at this part of registration.

DR KIRKUP: That was in the letter, yeah.

MS DENHAM: And that the – certainly, before I finished doing the job that I was doing with [redacted] and my involvement with Morecambe Bay, my recollection is that an

inspection would focus on maternity, and if there were issues beyond – if you're looking at maternity, then if there are issues that are over and above, staffing, any concerns in terms of the function of the maternity would come to light. That, of course, being the light of us having the relevant skills, clinical expertise, to drill down.

DR KIRKUP: Does that imply that you had reservations about whether you had the relevant – I mean, collectively, the relevant skills and expertise?

MS DENHAM: Before I was no longer responsible – so by the time the inspection took place, I was on to other things, but I do know that I was involved in advising Jan Yates, who was going to be part of the inspection. I do know that I was very clear that we needed some specialist input, and I recall that there was an email that you could use – you know, like a generic email box –

DR KIRKUP: A template, yeah.

MS DENHAM: That you could send off that went somewhere to request specialist input, and I can remember Jan coming back to me and saying, 'Oh, Julia, I've tried this email box, and it's bouncing back or whatever.' So ahead of me finishing, we were trying to get specialist input into that inspection, and as I understand it, that – you know, it was never able to be sourced, and therefore the inspection happened without the specialist knowledge, you know.

DR KIRKUP: Okay. And did I understand you right that your involvement with Morecambe Bay came to an end when you moved in May 2010?

MS DENHAM: Around about. It was around about somewhere between April and May.

DR KIRKUP: So did you come across Morecambe Bay at all after that, or was that it, as far as you were concerned?

MS DENHAM: No, no. I mean, maybe very much in passing, picking things up on the news, or – yeah, maybe even being aware that that inspection had happened, but not in any detail at all.

DR KIRKUP: Did any of the subsequent events surprise you?

MS DENHAM: I don't think I'd say 'surprise', because – I think it was more concerning than surprising.

DR KIRKUP: Sure, yeah.

MS DENHAM: Because if we had done things differently, if the methodology had been different, if we had been able to have the investigation, if we'd been

able to have people with clinical expertise to go in and take a look at it, then perhaps there could have been more focus on improvement; that what happened eventually with the gold command that I'm not familiar with all the detail of, but – and kind of a focus on improving could have happened, and therefore improved patient care, which – see, I'm not going to say it's surprising, because I – and I'm not going to say that I wasn't surprised. I just don't think that was on my plane of thinking, but it was concerning. It was concerning.

DR KIRKUP: No, I understand how you've explained that. Thank you. Stewart?

PROFESSOR FORSYTH: Just a couple of points. Just in relation to what we've just been discussing, do you think if the registration had put a condition on maternity services, that might have prevented some of the subsequent issues? And was there – just again, I'm just wondering – was there a feeling that, well, it'd be difficult to do that because of the location of Barrow-in-Furness Hospital, the impact it'd have on maternity care in that area?

MS DENHAM: Well, it would depend what condition you were going to apply, and so you could have put a condition on that said ~~side~~: 'There should be no admissions to either Furness General or Lancaster Royal.' They would have had a significant impact, most definitely. Another condition at the time, of course, of registration of NHS Trusts – which doesn't apply to the normal state of play for registering providers, because the norm is that a provider isn't providing the activity, and therefore must be fully compliant or be able to demonstrate that they will, in the future, be fully compliant at the point of registration. But the transitional arrangements – the law allowed that we could have imposed a condition on that Trust to, in effect, comply with the regulations it was already required to be complying with anyway, so the condition would either have been 'No admissions to either of the maternity hospital locations' or 'Sort your staffing out.'

PROFESSOR FORSYTH: Sorry?

MS DENHAM: 'Sort your staffing out', or 'Sort your culture out', you know, if we'd unpicked that.

PROFESSOR FORSYTH: Would that not have been a reasonable thing to do?

MS DENHAM: They would have been difficult conditions to – I mean, certainly one about culture and –

PROFESSOR FORSYTH: Well, I mean, I think – let's go back to Alan Jefferson's letter, which you received a copy in December 2009. He sets out quite clearly to James Titcombe three big bullet points, starting off, 'I am able to confirm at the present time we have a number of concerns about the operation of UHMBT, some of which stem from information the Trust has provided us about its own investigations surrounding Joshua's death, and some of which are quite separate.' And then bullet points, all around 'Improve levels of multi-disciplinary working', 'Provide evidence[?] of effective communication, the system[?] working with maternity across UHMBT', 'Inadequate recording of care provided to patients.' I mean, these are all serious issues, and this was in December 2009. I mean, it seems to me strange that just a few months later, you can register without condition a maternity services, because these will not have been resolved by then. And therefore, the argument could be that the subsequent issues might not have happened.

MS DENHAM: Okay. If we'd imposed conditions, what we'd then have done is make sure that there was an early inspection post-registration to check on progress, and they would have been registered in April. There already was an inspection in June, the early inspection that had already identified – so then – yeah, even if other than to impose conditions, we'd actually said, 'No admissions to either of those locations', any other condition would have triggered the early inspection, which is what happened anyway.

PROFESSOR FORSYTH: It would have maintained the pressure on the Trust to sort out the problem, surely.

MS DENHAM: It would.

PROFESSOR FORSYTH: And it'd also have been made clear to the general public living in the area that there's still continuing issues about the maternity services.

MS DENHAM: It would. It would. My understanding, at the point of us reaching the decision to register, was that there was evidence that the Trust had taken seriously the issues identified; that they were making progress to put things right, and the methodology within CQC in terms of registration at that time

was that that would result in the decision that, ultimately, it was on the day[?]. It went through – you know, it wasn't just my decision. It went through a quality assurance panel in the CQC, which was around ensuring consistency in terms of the judgements reached about Trusts. The – and those decisions were, you know – obviously, the suggestion in terms of whether a Trust should be registered or not were considered then at a higher level in CQC, even the [inaudible] ~~allegation~~ not allegation – I think I was saying that the scheme of Delegation positioned that decision– position that decision with the registration manager at the time. My view is that the only way that, had we done things differently in terms of securing improvement at Morecambe Bay at an earlier stage, would have been to do exactly what we do now, which is to have –

PROFESSOR FORSYTH: So if James Titcombe's email arrived in an office in the CQC today, what would happen?

MS DENHAM: I'm not actually the best person to answer that. I can answer it in as good a way as I can, but because I don't work on the side of things that regulate and inspect – but what I would expect is that we would look at the detail of that; that, again, we would check the information that we already hold in terms of how that Trust's performing, and I would expect that we would look at actually going into the Trust and looking with a team of clinicians to see how the Trust is operating. That's how we would do it. And if we were registering a brand new provider now, a service where we didn't hold the expertise, then we would seek – so, for instance, when we're registering termination of pregnancy clinics, we would seek gynaecological input into that in that very high-risk area to make sure that our decision is informed by some clinical knowledge.

We'd do things very differently now than we did then, but in line with the methodology at that time, I don't think that anything other than us having gone in with clinicians[?] would have resulted in a different outcome. We could have put a condition on, but it would have resulted in an early inspection, unless you actually put a condition on that said that Furness General couldn't operate. And because we had not gone in, we didn't have the information to inform us doing that.

PROFESSOR FORSYTH: Wasn't the early inspection that you've been referring to focused around the content of the improvement letter, which was just about relatively limited staffing issues and nothing to do with these cultural, unit, clinical issues that have been identified in the December letter?

MS DENHAM: I don't know, because I wasn't part of that, but what I would certainly expect is that if we did an inspection of a care home and there were concerns about staffing, I would expect that that inspection would be able to pick up those issues. But you would need to have that knowledge about how things function and those inter-relationships, which I think kind of, you know, filters back to the expertise to be able to pick that up.

PROFESSOR FORSYTH: It's not immediately apparent at first sight, though, in an inspection that is based around an improvement letter that says, 'You need to up staffing levels', is going to look at cultural issues about how a unit operates. It's not apparent to me.

MS DENHAM: Okay.

DR KIRKUP: Is there anything else you would like to say to us?

MS DENHAM: I don't think so.

DR KIRKUP: You don't have to. If there's anything you'd like to add –

MS DENHAM: Sorry?

DR KIRKUP: If there's anything you'd like to add, you're very welcome. You don't have to.

MS DENHAM: No, I think that's okay. Thank you.

DR KIRKUP: That's fine. Thank you for coming.

(Meeting concluded)

THE MORECAMBE BAY INVESTIGATION

Wednesday, 8 October 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert Adviser on Ethics
Ms Jacqui Featherstone – Expert Adviser on Midwifery
Professor James Walker – Expert Adviser on Obstetrics

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(At 10.39 a.m.)

DR KIRKUP: Hello. Thank you for coming. I'm Bill Kirkup, I'm chairing the Investigation Panel. I'll ask my colleagues to introduce themselves to you. Shall we start on the –

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm the Head of Midwifery and the Head of Nursing at a Trust in Essex.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm Professor of Healthcare Law at University College London and Chair of the Health Research Authority. And in the past I've chaired provider Trusts, PCTs and an SHA.

PROF WALKER: I'm Jimmy Walker, I'm Professor of Obstetrics and Gynaecology in Leeds. I also previously worked for the National Patient Safety Agency.

DR KIRKUP: Can I apologise for the delay in starting, mostly caused by my late train. You will know that we are recording proceedings and we will produce an agreed record of the interview at the end. We'll also allow you a brief opportunity to raise anything that may be clinical and in confidence when we will clear the room of any other persons for that part of the session. You'll know that we have asked you to hand over any mobile phone, recording device etc to emphasise the fact that we don't want anything to go outside the room until we can produce findings in context and in a report. Do you have any questions for me about the process?

MS DINELEY: No I don't.

DR KIRKUP: Okay. I'll start with a very general question and then pass you over to colleagues. My general question is, can you tell us when you started, I think it was at CSCI and then CQC and what positions you've held since?

MS DINELEY: Okay. I joined the Care Quality Commission in late July 2010 and that was from an acute NHS Trust. I wasn't part of any predecessor organisation.

DR KIRKUP: You weren't part of CSCI?

MS DINELEY: No.

DR KIRKUP: All right. Thank you.

MS DINELEY: I was appointed into the role of Head of Regulatory Risk. Whilst that job title remained over the following 18 months, the role changed with additional responsibilities coming in. There was a common theme there though about managing risk and setting up systems in place, not only for the

identification of risk but internal reporting of that risk as well around providers and our regulatory activity.

In 2011, April 2011, my remit expanded further to include responsibilities for the National Pharmacy Inspection Team, Corporate Provider Compliance Team, and that was around our large corporates that were registered with us, and also then into 2012 the Foundation Trust Assurance Team.

DR KIRKUP: Okay.

MS DINELEY: What I would be clear about is that within all of those roles, other than for the pharmacy inspections, the team were largely non-decision makers within regulatory activity. They were there more in an advisory and supporting role.

DR KIRKUP: And who was in the decision making capacity?

MS DINELEY: The pharmacy inspection team. So they were pharmacy inspectors that were aligned to the regions who were going out and doing frontline inspections as part of the scheme of delegation they were obviously authorised to make those decisions.

DR KIRKUP: Okay. Thank you. Jonathan.

PROF MONTGOMERY: Thank you very much. I wonder if we could start by asking you about the system then that you put in place for managing risk Point of clarification & context. The system for managing risk largely related to the reporting of risk which is reiterated and supported by the response on page 4, line 2 (original transcript) and I would like to understand where University Hospitals Morecambe Bay registered on that in due course but to understand the system would be very helpful, in particular how intelligence gathered in the regional parts, how was that processed and evaluated in the national risk processes?

MS DINELEY: Okay, in terms of when I joined in the summer of 2010, there was a lack of structure and systematic approach to risk reporting. We at the time, within the Care Quality Commission and within the operations directorate, had seven, nine regions. Sorry, they have been through a number of iterations over the time. Each region was doing something slightly differently both in terms of how it was being recorded, how they were identifying it, their thresholds around it. So my first starting point was actually to put in a system

that gave consistency in what we were looking at, how we were recording it, how it was being assessed and actually, more importantly, what we were doing about it.

The national role that was played by myself and my team was around collating that information. So if I could start by the systems that were within the regions. Inspection – compliance managers, as they were at the time, obviously had a broad portfolio. They would manage the risks within their teams reporting up any concerns that had been identified on a moderate basis based on our judgement framework at the time or any information that was coming through that was significant enough to trigger some kind of review, whether that was about interim inspection or review across the board of information that was known about a provider

That was then reported up into their regional directors through their risk panels. Risk registers would be collated on a regional basis of all their providers and the level of concern attached to them and essentially the action that was being taken. That was used both to inform who was inspected, when they were inspected and what they were looked at but actually allowed for escalation of risk outside the region. Point of clarification & context. "Escalation of risk outside of the region" refers to the increased oversight and scrutiny that could be afforded internally as well as external reporting.

So when things and circumstances maybe beyond or require additional input, these could be reported through into a national forum, considered, rationale tested and feedback provided.

PROF MONTGOMERY: So that would relate to things that required resources that were not within the control of the region or would it relate to seriousness?

MS DINELEY: Or it could be about escalating action.

PROF MONTGOMERY: Okay.

MS DINELEY: And that could be about escalating regulatory action. It could be continued non-compliance equally. There were a number Point of clarification "there were a number (of providers)", so if I could just focus on the NHS Trusts, there were a number of Trusts that were informally being termed 'struggling Trusts' those that were in and out of compliance through inspections so they would, and this isn't just in one region, this was across the regions, they would be inspected, concerns would be identified, action would

be taken, they would address that action but actually then when it was re-inspected and followed up to see whether compliance had been achieved, new issues would come through and you were continually going in and out of this compliant, not compliant, but for different issues and they were called the 'struggling' elements. We wanted some greater scrutiny.

PROF MONTGOMERY: So the level of non-compliance as a one off wouldn't have triggered escalation but if it continues coming in and out?

MS DINELEY: If it continued, absolutely.

PROF MONTGOMERY: Okay. And who would that be escalated to?

MS DINELEY: So that would be – so on a monthly basis those regional risk registers were submitted centrally. We would pull those together, actually have an initial overview of them to see was all the information provided on them. And I say all of the information, clarity in terms of what the concerns were that were being raised and the action that was being taken and the timeliness of that action as well so we could have a comprehensive discussion at what was then the Risk and Escalation Committee within the CQC.

PROF MONTGOMERY: And did you have access to all information held by the region at that stage if you wanted it or was it just a summary of that information?

MS DINELEY: I would have access to their risk registers that were submitted and they were in the form of an Excel spreadsheet.

PROF MONTGOMERY: Right.

MS DINELEY: So in terms of the detail that sat behind it and the judgements that were there in terms of all the information was considered, that was not part of it, that was helped that part of my remit, that was part of the regional decision making.

PROF MONTGOMERY: Okay. And the risk registers, they were a number based system were they, a combination of seriousness and probability or was it some different sort of reference system?

MS DINELEY: And so we had at the time something called the judgement framework which would allow us to identify the concerns that we had based on a low, moderate and major scale and they would be weighted then accordingly. We also worked around a 5 x 5 matrix as well which is probably something you're familiar with in terms of likelihood and severity.

PROF MONTGOMERY: Yes, okay. And what sort of variation do you find between the regions on the level of risk that they – the way they rate risks? Is that one of the things that you looked at?

MS DINELEY: It certainly improved.

PROF MONTGOMERY: Okay.

MS DINELEY: I think initially we had differences and I'm now, just in terms of timescale, talking probably around the autumn of 2010 so we were six, eight weeks into me being appointed. A lot of discussions there to understand actually what was being considered and they were two way discussions so that we could work to have a system that was reflective of what was happening operationally at a regional level but actually also regionally it was ensuring that the right – that concerns were being rated in the right way as well and being escalated to take away some of that local tolerance and knowledge that built up.

PROF MONTGOMERY: And how did the assessments made in this region compare to those made elsewhere?

MS DINELEY: I think in terms of general themes that came across, across all the regions, is that there were individual providers where perhaps issues had become tolerated. I'm not saying that they had been accepted but in terms of the assurances being provided back and the progress and actions being taken, I think there was a local acceptance to that rather than challenging. Certainly from a national perspective I found that quite difficult because I would be asking more questions of the regions in terms of next steps and pushing things forward.

PROF MONTGOMERY: So are you saying that that was true across – all regions would have, what I might say is slight blind spots, that is to say they've got used to something and tolerated it or was it different between regions?

MS DINELEY: I think that it wasn't exclusive to what was at the time the north west region. I'm aware that there were other discussions that we were having with other regions whereby similar circumstances were coming up so, yes, it was across other regions. I wouldn't say across all of them but certainly across more than one.

PROF MONTGOMERY: Okay. And do you have a sense of whether there was any pattern to those Trusts where you felt that they were a little bit too tolerant of

concerns?

MS DINELEY: Pattern in –?

PROF MONTGOMERY: Were they particular types of Trusts? You know, were they big teaching Trusts? Were they Trusts with dispersed sites? I'm just wondering whether there was any pattern to that.

MS DINELEY: I think there was clearly themes that came through which were around those that were multi-site, those that may have had some longstanding service configuration issues, say perhaps there were questions that had been raised about either centralising or moving services from different sites. There were certainly some common elements there. There was equally other areas whereby these were longstanding concerns, issues that had been picked up. They weren't sort of new coming to the table in sort of the last 12 months. They may have been going on for several years prior to –

PROF MONTGOMERY: So they didn't pass the risk threshold before, why would they pass it now? Is that the sort of mind-set that you think you're describing, that people have said 'Well, we would have already addressed this if it was that serious'?

MS DINELEY: I don't know if I'm in a position to answer that. Point of clarification & context: I was unable to answer the question as I had no practical knowledge or experience of systems in predecessor organisations and pre dating my employment at CQC.

PROF MONTGOMERY: No?

MS DINELEY: Because obviously I'm not familiar with the previous systems which they operated with. I think, you know, I was dealing with the present as it was at the time –

PROF MONTGOMERY: But your sense of what it meant to deal with it must have involved you trying to think through 'What's the problem I'm dealing with?'

MS DINELEY: I think there were a number of factors within that. I think there was one about the assurances that they were receiving from third parties and inevitably a number of our staff had come from previous organisations whereby approaches had allowed them to take those assurances on face value rather than seeking further independent assurance or checking that, going and checking and having a look themselves. I think in addition to that there was elements about working within a new model, people being confident

about what they were seeing and being able to make a judgement on that. I was new to the organisation so didn't have any of that legacy of previous organisations or methodologies and having just come from the NHS Trusts I was quite clear about what was acceptable and what was not.

PROF MONTGOMERY: So I guess I'm trying to get my head round is what is acceptable, not an objective standard, and it sounds as though what you were trying to create is a system in which it would be an objective standard where the same standard would be applied across the country. Or was there an element of subjectivity about it which might include how difficult the job that the Trusts that were being rated were trying to do, how intractable the problems had been, whether the Trusts were – whether it was too difficult for local systems to let the Trusts fail. I mean were those the sorts of things that you were concerned might be happening in the assessment of risk?

MS DINELEY: So, yes, I think, you know, there were clearly in addition to us looking at the face value and the idea of what systems, and this is why I've referred earlier to it needed to be a two way conversation about how we rated risk. There were local circumstances that we needed to take into consideration. However, prior to that, we needed to make sure that we had identified the concerns, assessed them in terms of the level of risk to understand it to ensure that local conditions were elements that were considered in terms of the action that we were taking rather than it preventing us from identifying the risk in the first instance.

PROF MONTGOMERY: Okay, so you would want to see the risk classified and clarified –

MS DINELEY: Absolutely.

PROF MONTGOMERY: And then ask what was being done about it and then re-assess the risk in the light of that, on –

MS DINELEY: Yes.

PROF MONTGOMERY: Okay. And how common was it for you to think the risks had been overestimated or did you generally find that you felt they had been underestimated and tolerated too much?

MS DINELEY: I can certainly, as I sit here today, I can recall probably more incidents where they were underestimated rather than them being overestimated.

PROF MONTGOMERY: Okay, that's helpful. Can I take us to this region then and

you arrived in the summer of 2010. Was Morecambe Bay on your radar, on the National Risk Register at that stage?

MS DINELEY: Morecambe Bay as a Trust came to my attention in April 2011. That was the first time in as much as a concern being raised around non-compliance following a comprehensive inspection.

PROF MONTGOMERY: Okay, so it didn't appear on the risk profile, it wasn't being flagged up from the region as one of its risks at that stage?

MS DINELEY: No.

PROF MONTGOMERY: Okay, so I think it would be useful to go to the stock take review that you were asked to do because I think it would be helpful to see the timeline going through. So rather than start at April 2011 when you became aware of it, can you take us back to what you looked at in the stock take review, you know where the timeline started for you in terms of that and what you discovered in terms of the management of risk and the regulatory decisions that were taken? Can you take us through step by step?

MS DINELEY: Okay. So just to confirm, this is around the report I was asked to complete in October 2011, I was requested by the Director of Operations to essentially review regulatory activity that had been undertaken at the Morecambe Bay Trust to actually understand, so to put it in the context, we had inspected the Trust in the July, a warning notice had been issued in September.

By the end of September that warning notice had been breached with a serious untoward incident being reported. There was a question here around there was more noise in the system as well in terms of was it a matter that standards had deteriorated significantly over the last 12 months post registration with the CQC and as part of its authorisation or were these new concerns coming out? And I think it was a case of we were tending to, that these issues had been around and we wanted to understand through our regulation of the Trust, essentially what did we know and when? What did we do about it? What impact did that have? So in terms of completing this piece of work, for me I was independent to it. I didn't have the history or connection with the organisation and necessarily with the decision making either of CQC and its registration or in the predecessor organisations.

I put that as a marker because that then influenced who I needed to

speak to as part of the review and a large part of this was based on documents that were pulled together by the region dating back to 2009. I use that as the marker because it seemed to be at that point, it was the start of the preparations for the authorisation process for the Trust to become a Foundation Trust. There were a number of joint collaborative reviews Point of clarification & context: the joint collaborative review was a forum attended by the CQC, Monitor and the SHA. Decisions made at the forum's meetings were considered as collaborative that were held from the summer of 2009 through into early 2010 that CQC was a part and contributed to along with Monitor and the SHA in relation to the risk rating of the organisation.

The fact that early reports in the summer of 2009 were rating this Trust as a red rated organisation, obviously not being privy to the detail of the scoring system at the time, clearly it was a concern, there were real concerns there based in terms of the safety and quality of the services that were being delivered.

Over the following six months I think two further joint collaborative reviews were held and during the discussions that were held the concerns that were raised were clearly being monitored and progress against action plans being reported. I say reported. I'm not aware and nor did I find that they were independent – those assurances and the monitoring being provided as part of those joint collaborative reviews were being independently tested.

PROF MONTGOMERY: So what they had were copies of the Trust's action plans, is that what you're saying?

MS DINELEY: And from the parties that were sitting round the table in terms of progress against those.

PROF MONTGOMERY: And who was round the table apart from the CQC?

MS DINELEY: Monitor and the SHA.

PROF MONTGOMERY: Thank you. Sorry, not PCTs?

MS DINELEY: I'm not –

PROF MONTGOMERY: Is there any evidence of that?

MS DINELEY: I'm not aware of those but they were the three main parties I picked out as part of the review.

PROF MONTGOMERY: Okay.

MS DINELEY: This took us through into the new year at which point, so we're now

into January 2010, the discussions by the parties that were round the table, whether that's a virtual table or a telephone conference at the time, had actually decreased the rating down to a green rating considering that progress had been made against the action plans.

PROF MONTGOMERY: And did the documentation show you why that, was it simply progress against the action plan that was being –

MS DINELEY: That's from the notes that were provided, and the records that were available. It was purely about that it had been reduced, not necessarily the supporting rationale of evidence that had been seen or that had been considered.

PROF MONTGOMERY: And who were the CQC personnel around that table at that stage?

MS DINELEY: So, as part of the conversations I believe it was either the Regional Director at the time or their representative.

PROF MONTGOMERY: Can you remember the names? It's just helpful for us to –

MS DINELEY: I've suddenly gone blank on the – so it was Sue McMillan's predecessor.

PROF MONTGOMERY: Alan Jefferson?

MS DINELEY: Alan Jefferson. Thank you.

PROF MONTGOMERY: Because one of the things we're trying to understand is his level of concern and why it may have changed and at the moment there is a gap in our understanding between the points at which he was expressing significant concerns about the level of risk and the downgrading and we can't quite close that gap. So did your documentation give you any indication about whether he changed his mind, whether the group discussed it and it was the group decision to change the risk?

MS DINELEY: Obviously I can only take a view on what I saw as part of that time period and what I've seen subsequently so it would be just an ~~outsize~~ outsiders view looking in on this. I think the assurance was taken from the reports that were being provided by the SHA. The detail around those I'm – I wouldn't be able to provide you but every indication was it was about the monitoring and the reporting that they were providing back into that group.

PROF MONTGOMERY: Okay, and do you know who from the SHA was party to that?

MS DINELEY: Unfortunately I can't recall that detail. I can certainly go back through our records to provide that if that would be helpful. Point of clarification. Email sent to the Inquiry secretariat on 10 October 2014 to confirm the additional information that the panel would like me to provide based on the interview. No confirmation or request received.

PROF MONTGOMERY: I think that might be helpful. What we'll do is, there'll be a list of things that we might want clarification on which we will write to you about afterwards. So we've got to January 2010 –

MS DINELEY: So into January 2010 which was really going to be the marker for the start of this but having had the initial conversations with the region I realised that there had been that sort of significant three month period beforehand. The people that had necessarily been involved in that weren't around but it was clearly about the decisions and the information that was reviewed as part of our decision to register the Trust in April 2010. So during that time period there was obviously a registration and assessment process that reviewed the Trust's application and providing an opportunity to follow up on concerns. The registration process, however, as the review identified, was not designed to examine and test every part of the application process. Again, I was going on essentially what the design of the model was and what was actually done, not necessarily how it had been informed.

PROF MONTGOMERY: Can I just clarify that a bit? There's a difference between not designed to test any of the self-declarations the Trust is making and a system that might pick some to test as opposed to look at all of them so can you be a bit more precise about what degree of challenge to the Trust's self-declaration the system [inaudible] at that stage and then what you found had actually happened in this case?

MS DINELEY: So in terms of the degree, it would have been following up based on either concerns that had been identified or where our information or information from other sources didn't tally with what was being declared as part of the application process. They were the high level principles which we would then be following up.

PROF MONTGOMERY: So you do a sort of consistency check and –

MS DINELEY: Absolutely.

PROF MONTGOMERY: And if there was no reason to think there was anything

inconsistent, the self-declarations would be the basis of the decision?

MS DINELEY: Absolutely.

PROF MONTGOMERY: And what happened in relation to University Hospitals Morecambe Bay? Were there any inconsistencies identified?

MS DINELEY: I think, I'm not sure I'd term them as inconsistencies, but I think there were elements within their declaration that would have triggered, with the benefit of hindsight, further investigation and follow-up to it. An example around that was within the Board minutes Point of clarification: Inclusion of the Board minutes and its reference to the Fielding report. which I believe were from the March, the reference to the Fielding Report and to have actually requested a copy of that at the time rather than receiving it 12 months later.

DR KIRKUP: Can I just pick up one point to that answer. You said 'might have been evident with hindsight'. What exactly was the reason it wasn't evident at the time?

MS DINELEY: I wasn't the one making the decision but I think given the significance then of the contents of the Fielding Report and what it highlighted in terms of the gaps, if that had been reviewed at the time it may have thrown up some sort of further questions on the assurances that we were receiving elsewhere. So coming back to the point of actually if it was all consistent in terms of the information and the messages that were being received, it wouldn't have triggered a review. However, I think this would have brought in some inconsistency in terms of the assurances that were being provided from other areas.

DR KIRKUP: So the hindsight is the Fielding Report?

MS DINELEY: It's one element of it, yes.

DR KIRKUP: And the other elements?

MS DINELEY: Other elements are I think as we progress through the journey in terms of timeliness of follow-up so it would have been about requesting that information. Equally it would have been about testing out some of those assurances we were receiving from third parties rather than receiving them on face value and not doing the detailed full site inspection of going and having a look.

DR KIRKUP: Okay. One other point of clarity on that answer, so I think you've just said that the CQC held information that identified the Fielding Report but the

significance of the information wasn't apparent to anybody at the time?
MS DINELEY: Yes.
DR KIRKUP: Okay, thank you.
MS DINELEY: Sorry, can I just clarify that, it was we didn't hold the report at that time.
PROF MONTGOMERY: No, I understand that but what you've said was there was a Board minute available which referred to that –
MS DINELEY: It identified it.
PROF MONTGOMERY: There was such a report. It may not have said what was in it but –
MS DINELEY: Yes.
PROF MONTGOMERY: Okay, that's very helpful. What about the discussions that are going on at that period between officers in the Parliamentary and Health Services Ombudsman and officers in the CQC? Did that feature at all in any of the records that you looked at?
MS DINELEY: No it didn't.
PROF MONTGOMERY: Okay, so that meeting, that stage in January 2010 through to the registration, there is no indication there of any discussions about the Ombudsman's –
MS DINELEY: Not from the information that I saw.
PROF MONTGOMERY: And what about the various incidents that have occurred by then, and in particular maternity services, did they feature in the records?
MS DINELEY: So in terms of the incidents that were being reported, they continued to feature not only in the records there and again an action plan was evident that had been shared with the – a Trust action plan was evident that had been shared with the SHA that was being monitored there and again we had seen a copy of that, we were aware that it was being monitored and that progress was being made from it and that was being reported again back through the CQC through the regular conversations both with the Trust and with the SHA.
PROF MONTGOMERY: Okay. And what about the question which looks very obvious with hindsight and I'd be interested to know whether it seemed to be there at all about connectedness or otherwise of these incidents. Did that feature as part of the discussions that you [inaudible]?
MS DINELEY: I think, so if we continue through into April when there was an

inspection – sorry – I'm getting to the right years now – so we did the follow-up inspection in the July.

PROF MONTGOMERY: 2010 we're still in.

MS DINELEY: I think we're in 2010, sorry. It does all become quite confusing. It was again around the incidents and it was a very narrow inspection based around maternity services. So as part of that, incidents that had been reported, the follow-up to them, the progress against the action plan was key to all of that within that particular service.

PROF MONTGOMERY: But at the stage where they were discussing the registration or non-registration, and they were discussing conditions or not conditions and anything a bit less than conditions, we've seen some discussions around, some of them – it wouldn't be as strong as a condition but there might be some correspondence, was there any discussion at that stage around whether it mattered that there was a view on these incidents being connected or not connected?

MS DINELEY: I don't recall seeing any paperwork that connected, that made a connection between these incidents. Point of clarification: Provision of supplementary information in 2009 and as part of the factual accuracy check of the section 48 investigation report to support that the SHA had confirmed it was not possible to confirm any commonalities between the incidents.

PROF MONTGOMERY: Okay, that's helpful. Does that go as strong as did you see any paperwork that suggested that they were not connected? Or thought not to be connected perhaps I should say.

MS DINELEY: As part of, sorry let me just get my – as part of the review, sorry I'm trying to be clear whether this was part of the review or was part of the following work is that we – I believe that there was a report saying that there was no common theme between the incidents, that they were essentially being dealt with as isolated incidents or individual incidents rather than there being a common theme going across a group of the incidents.

PROF MONTGOMERY: And your recollection is that the report was known at the registration stage?

MS DINELEY: I think if my recollection is correct, and again I'd be very happy to confirm this point because, sorry, it is quite a lot of detail to recall, that was as part of the action planning and the independent review that was conducted by

the SHA into the serious untoward incidents that were at the Trust.

PROF MONTGOMERY: Thank you.

MS DINELEY: But because that wasn't directly a piece of work that we had done, it was relying on a – that's why I was just trying to get the timeline.

PROF MONTGOMERY: You had a document that was a product of that, I understand.

MS DINELEY: I think we had a confirmation of it rather than a full detailed document.

PROF MONTGOMERY: We've seen from various bits of correspondence and whatever that have been made available to us that there certainly were some discussions indicating that at least in Alan Jefferson's mind there was a question about conditions on registration. So what did you find in review about the discussion about conditions and there is the sort of vague question about there might not be formal conditions but there might be attention drawn to issues something of that sort. So what did you find when you reviewed about those sorts of discussions?

MS DINELEY: So in terms of the detail of what was recorded around those discussions, it was very limited. So I could not find a clear rationale as to why conditions had not been imposed and that there had been consideration to other perhaps lesser interventions being considered. That would have been normally recorded as part of CQC's processes but as part of that review there wasn't a clear account that there had been that discussion.

PROF MONTGOMERY: Okay, so I'll just make sure I've heard that correctly, are you saying that in the records there wasn't even any discussion possibly having conditions or are you saying that the rationale for not having conditions wasn't recorded?

MS DINELEY: There was, I think there is an element in between that which is that there wasn't a rationale that was recorded there in terms of the decision not to impose any conditions or that actually anything else had been considered.

PROF MONTGOMERY: But was your assessment then that they had had a discussion about that and it just wasn't very well recorded?

MS DINELEY: I think there was a conversation. Whether that went into a detailed discussion about testing the rationale, it can only be at point in time. Again, I wasn't in the Commission at the time so I'm not sure what actually was supposed to have been the right process then. I could only apply it to actually

the discussions that we had subsequently around imposing conditions, how that would have been recorded and that rationale in terms of either information evidence that would have been considered and the reasons supporting the decision, whatever that decision was.

PROF MONTGOMERY: Is a conversation something different from what you're describing about the virtual table that people were around? Is it a smaller number of people involved in that or is it a discussion at that meeting?

MS DINELEY: Again, at the time I'm not aware about what the standard process was.

PROF MONTGOMERY: Yes, okay.

MS DINELEY: And the exact number of who was involved, whether that was just around the regional team or whether it was much broader than that. My understanding from the process was that actually these were decisions that the regional teams were making as part of the registration process.

PROF MONTGOMERY: So your understanding is this was a decision that they took, informed by the SHA's view informed by the action plans that they'd seen. So your understanding then is that by the time we get to registration, the regional team is comfortable that they don't need to put conditions on. That's a decision taken at the regional level as opposed to elsewhere in the system?

MS DINELEY: That's – yes.

PROF MONTGOMERY: Okay. You've then got the July inspection which you've talked about which is narrowly on maternity.

MS DINELEY: Absolutely.

PROF MONTGOMERY: What happens next?

MS DINELEY: So in terms of the next significant date in the timeline is a letter that is drafted by the Regional Director on behalf of the Director of Operations that was to go to the monitor to inform the authorisation decision whether to authorise the Trust as a Foundation Trust. And that was in the early autumn of 2011. I think we initially drafted the letter in September. I think it may have had an October date on it although finally authorised in early October.

PROF MONTGOMERY: 2010.

MS DINELEY: 2010, sorry.

PROF MONTGOMERY: 2010, yes. So what does that letter say? Is it a very short letter or does it record some of things that you had a look at?

MS DINELEY: It is a short letter that details that the quality and risk profiles had been reviewed or had certainly informed the content of that letter and there are essentially no concerns. That's paraphrasing in the highest level but it certainly did not highlight any concerns that we had around the Trust.

PROF MONTGOMERY: And I don't know how many of those sorts of letters that you have now seen from that sort of period but I don't have a sense of whether there is a range of them, you know so is there a no concerns, a some concerns but not a barrier to authorisation – Is it a binary question you either support or don't support, or – ?

MS DINELEY: I think it was, I don't think there are necessarily a range of letters that went. I think it was something that was fairly standard but with regional variations in terms of what was known. These were being issued six months after registration so I think people were looking at the highest level where the Trust had been registered with conditions, the outcomes of any inspections that had been completed and equally what the QRP was showing and I think there was a familiarity with the QRP that actually if there weren't red dials flashing on the system that actually everything was okay.

PROF MONTGOMERY: So they've got a system where the CQC have rated it as red, it's gradually got downgraded in terms of the rating of risk –

MS DINELEY: It wasn't just CQC that rated it as red. It was part of the broader discussions, yes.

PROF MONTGOMERY: Okay, and we know that early in 2010 the regional team had significant anxieties. They then become allayed. Did Monitor have any awareness of the fact that there's a history to this or do they just get a snapshot that it's a clean bill of health at this point?

MS DINELEY: So from the letter, that's what they would have received. I think what is important to note though is that they were in similar discussions in the preceding 12 months as CQC had been so it was an assumption to say that they –

PROF MONTGOMERY: And they had suspended an application previously?

MS DINELEY: So they were aware of the concerns, the discussions where it had come from a red rating in 2009 just 12 months earlier which again had paused their authorisation process through into being downgraded so they had been party to those discussions.

PROF MONTGOMERY: Okay. Can I ask you to relate that back to the comments you made earlier about degrees of tolerance? Because I think what you described when you began to put together the risk system was that you were concerned that there were people who were just tolerating poor levels of risk because they had just been dealing with it. But this seems a rather different issue, that previously they hadn't been tolerating that level of risk, they thought it was quite high and I'm not quite clear why they thought that things get better. So did your investigations lead you to form any view on that subject? I think it's a little bit different from the problem that you identified as concerning generally.

MS DINELEY: So I think that the issue there is actually one about the information Point of clarification & context: There was an objective process to reach a judgement on a breach in regulation, tolerance and acceptance of risk varied across regions with regional decision makers influenced by the assurances provided and the relationship and involvement of the SHA that was being used as part of the downgrading and I think that was the assurance elements that were being offered by other parties either around the table or directly from the SHA with their monitoring hat on. And I think in terms of those tolerances, I think it was about – so I think there was a tolerance in relation to a relationship with an organisation that has been going on for some time. I think there is something about also a tolerance given that you're taking assurances that it's improving as well, that there is improvement to the system and I think for both of those examples, it's something that was relevant to the conversations at the time and then that happened with the history at Morecambe Bay.

PROF MONTGOMERY: Might there have been any issue about the fact that the CQC needs to register the entire NHS all at the same time? Would that have altered the tolerance of risk?

MS DINELEY: Again, not being in the organisation at the time I think I can only speak from having witnessed the subsequent registration processes that there was a pressure to clearly register at different stages, thousands of providers. So NHS was a couple of hundred or so then we'd moved into the adult social care.

PROF MONTGOMERY: And what about the conditions process? Because I mean the safety valve if you like from the fact that everybody had to be registered

was that you had the ability to register with conditions if you still had concerns and I'm still struggling to understand how that fell out of the question to the CQC and I think the only thing we've got from you've discovered is that people took assurance from the action plans –

MS DINELEY: Yes.

PROF MONTGOMERY: And I think you've said 'Everybody took assurance from the action plans' so to say the CQC was taking the same line on that as the SHA was?

MS DINELEY: Everyone was. I think that's absolutely correct.

PROF MONTGOMERY: Okay. And no indication of any differences of views within the CQC team that came out of the documentary notes?

MS DINELEY: Not that I'm aware of. I'm aware as part of completing the review I spoke to a number of members of staff and I think whilst there wasn't necessarily disagreement, there was certainly a sense of confidence that they had around some of the decisions that they were either making or were being made, purely relating to it was a new model, it may not be a sector that they were familiar with or through their own experiences and the oversight around that.

PROF MONTGOMERY: Okay. So I think we've got to the correspondence with Monitor, we've got a straightforward bland letter –

MS DINELEY: Yes.

PROF MONTGOMERY: Which reflects the levels of concern as they were at that stage. Next step?

MS DINELEY: The next significant date around this were as around the inspections that commenced in 2011. As I said previously, I became aware of the Trust following an inspection which identified concerns in round about April 2011. A decision was made at the time not to impose any further action but continue to monitor and this would then be followed up as part of the July inspection. Again, during that course of time it was about reviewing the information that was available and using that to go and independently plan what was looked at and the scope of the planned inspections and it's important to note that it was at the same time we received a copy of the Fielding Report from the Trust, so this is almost 12 months after it had originally been identified.

The July inspection obviously identified concerns which resulted in a

warning notice being issued on maternity services and that was practically issued in September. So by the end of September – sorry, I stray into the chronology of everything because it all starts to build up.

PROF MONTGOMERY: And then you are directly involved as opposed to retrospectively involved at this time?

MS DINELEY: So I wasn't actually directly involved until the December. Provision of context: In December 2011 I was identified by the Director of Operations to line manage and provide oversight to the section 48 investigation at the Trust in the absence of the Regional Director who had been appointed to a different role within the CQC. My role was required to maintain the scheme of delegation. Up to this date I had had no direct involvement in the regulation or decision making relating to the Trust.

PROF MONTGOMERY: December.

MS DINELEY: So serious untoward incident we were notified of at the end of September. Clearly we were concerned that the warning notice had only been in place three weeks and had already been breached in relation to the staffing levels that had been contributing to this incident.

There was also equally questions being raised I think more outside of the region, so certainly from Monitor, and from some internal challenge about actually had – it was only 12 months since it had been authorised, 18 months post-registration, had standards slipped considerably during that time period or actually was it something that pre-dated both of those authorisations?

We get to commissioning the review from the Director of Operations to myself. In October though, further noise gathered around the system in terms of where our focus had been around maternity services other services were starting to be identified as having some serious issues or concerns around them. I think there were particular issues highlighted around outpatients and their booking system there which obviously you are aware of which then led into a serious of independent reviews being commissioned by Monitor, the findings of which started to suggest that the concerns that were being identified were not solely limited to maternity services, that this was slightly more widespread across the organisation. But again we were looking at individual services and the shortfalls.

At the end of November we received some whistle blowing that

prompted a responsive inspection of the A&E Department in early December and, again, it was another service, another specialty where concerns were being identified both in relation to staffing levels. So over the course of three months we went from having identified concerns in a single service to actually something here that was much more widespread. So from a national perspective, we could see that actually there were further questions that needed to be asked and understood around what was happening at the Trust. Was it systemic failure? Or actually were these still just individual service issues that were falling down? During the course of this period of time, both internally and externally, there were considerable discussions being held around Morecambe Bay. So certainly within our organisation we were using the escalation routes through our risk and escalation committee, through emails that both the Director of Operations, Deputy Chief Executive and Chief Executive were being copied in on in terms of the next steps because it was a case of – Do we escalate our enforcement action that we've got there? So a warning notice potentially looking at a notice of proposals around either restrictive conditions, and that was early October, or actually could we be confident that with the implementation of close monitoring by the SHA with the establishment of gold command that actually the risk was being managed. Because obviously additional support was required.

Externally to that, and away from the Trust, clearly Monitor were asking very similar questions about their own authorisation process as much as us scrutinising our internal processes as I said about what did we know and when and how did we respond to it. And clearly there were some high level discussions going on there between Chief Executive and Chief Executive.

PROF MONTGOMERY: Just to be clear then, you were all asking the question 'Has this changed or did we miss it previously?' And what was the answer that you came to?

MS DINELEY: The answer I think that we came to is that actually a number of these issues had been longstanding issues and that became more apparent to me, particularly as we ~~prepared for the section 48~~ Point of clarification "prepared for the section 48 investigation" and some of the push back that we received directly from the SHA and other individuals.

PROF MONTGOMERY: Okay. Tell us about the push back.

MS DINELEY: So you will obviously be aware that there was a gold command structure that was set up by the SHA and when we talked, we obviously joined the conversations, I joined to support a newly appointed Head of Regional Compliance at the time at the end of November. There was I think a reluctance for any further regulatory intervention or activity. Certainly in terms of the findings that were coming out of the ~~Independent Reviews Commission~~independent reviews commissioned by Monitor and then in our subsequent discussions with them about concerns that we had identified in the A&E Department. The comments that were made, well certainly in relation when we announced we were going to take a section 48 investigation 'Why now? It's been like this for years.'

PROF MONTGOMERY: Where was the reluctance coming from?

MS DINELEY: So, I don't think there was anyone who was a member of gold command that didn't show a degree of reluctance to either the section 48 or escalating regulatory intervention at the Trust.

PROF MONTGOMERY: A couple of questions that are in my mind about that set of decisions about regulatory action, one is the discussions that you had about what to do at the end of the time period. You've given in the warning notice there's a period by which you expect the Trust to become compliant. They write to you on the last day of that claiming that they are compliant and I can't quite track what the discussion response to the Trust was and what the options that were considered at that point were?

MS DINELEY: So in terms of the warning notice that was issued, our normal process would have been to have gone and followed up the warning notice and that would have been led from within the region.

PROF MONTGOMERY: And the form of follow up?

MS DINELEY: Would have been an inspection.

PROF MONTGOMERY: Inspection.

MS DINELEY: My involvement with the Trust obviously was in the oversight of the section 48 which was managed outside of the region. So in terms of the testing of that, that warning notice and what they looked at, I'm afraid I'm not in a position to give a lot of detail around that.

PROF MONTGOMERY: Despite that you were briefing Amanda Sherlock because she was away at some crucial time?

MS DINELEY: I was briefing Amanda in relation to the section 48 and any escalating concerns that we had ~~in what~~. What I would say in relation to Morecambe Bay Point of clarification & amendment The escalating concerns would not have been exclusive to UHMB but would have applied equally to other providers I think we had moved beyond the concerns in maternity with the concerns that had been raised both through the independent reviews, through the whistle blowing, throw our own responsive inspection as well. The situation from a regulatory perspective had, I think, moved in terms of its scope. So having been solely focussed on a single service to date and having a lot of investment in that and close working with the strategic health authority around the monitoring of the action plans, actually what was being presented now was more about action and potential risk across a whole range of services and that needed to be understood. I think not least to ensure that actually whatever action was taken next brought about not only the changes and improvements but they were sustainable.

PROF MONTGOMERY: I think I understand why it's important to move elsewhere. There are two things I don't quite understand from what you've just described: one is I don't quite understand how the process works between the national decision making about the section 48 and the regional decision making about the inspection and other regulatory action. Point of clarification & context: During Autumn 2011 the Operations Directorate commenced a restructure with the aim of moving from a management model of 9 regions and 7 Regional Directors to 4 regions and 4 Deputy Director of Operations. The new model would become effective from 1 April 2012. In November 2011 the Regional Director for the North West region was appointed to a new role which left the region without a substantive Regional Director. As a result the region received management input from resources from other teams in Operations. In respect of the section 48 this resource came from the national team. In other section 48 investigations it would have been the Regional Director who would have coordinated the decision making on day to day regulatory decisions and the investigation. For completeness regulatory decisions (from November 2011 onwards) remained in region with the Head of Regional Compliance. Because you describe one would naturally sit with the region and one sits nationally and they need to be discussed together. And the other is the decision not to

include maternity in the section 48. You'd done that in Barking and Havering. So there's a messiness about this that doesn't neatly fit how you devolve down the responsibilities to things and I can understand that's difficult to deal with.

MS DINELEY: Okay, let me see if I can help with the separation of the two issues and that escalation.

So in early October I was copied into correspondence between Amanda Sherlock as Director of Operations and Sue McMillan as the Regional Director. It was clear from that email correspondence that actually from a national perspective, outside of the regions, we could see that there was a – I say 'we' as in CQC – could see that the issuing of warning notices clearly hadn't brought about the change that was needed, the improvement that was needed, given the serious untoward incident had been reported. Sue McMillan was asked at that time to consider imposing restrictive conditions or go to a notice of proposal. Her feedback was 'Actually I'd like to see what the SHA, whether their monitoring of the action plan and the situation that's being put in place in terms of managing the required changes in the systems and processes to support the warning notice will have an effect'. Her feedback to Amanda as her line manager was 'Actually, I'd like to see how the SHA route and monitoring element goes'. So we have a specific issue that is being managed at a regional level.

PROF MONTGOMERY: Yes.

MS DINELEY: In parallel to that, Monitor are commissioning the independent reviews, so we have stuff that is being done outside of the region by a third party which is highlighting concerns. Now as part of the conversation, so on a weekly basis, Amanda Sherlock would have a conversation with Monitor with the Regional Director, with UHMB on their portfolio to discuss any concerns coming through, not just about Morecambe Bay but about a number of other Foundation Trusts. As part of those conversations it was shared that actually the reviews were not positive. They were flagging up additional concerns. So whilst we continued to maintain action at a regional level being led by the regions, nationally, through the Director of Operations conversations with Monitor, the risk is escalating based on the independent reviews.

PROF MONTGOMERY: So the method for avoiding the region taking one decision

and the national bit being different is that Amanda Sherlock is appraised of what Sue McMillan's thinking is?

MS DINELEY: Absolutely.

PROF MONTGOMERY: Yes, okay.

MS DINELEY: So all that decision making is in line with a scheme of delegation which is about the actual escalation routes around the Regional Director reporting to the Director of Operations. So the region were aware equally of these escalating national concerns as much as being aware of what was happening locally and I think the broadening scope around the concerns and the risks that were being identified. And I've already mentioned there was the whistle blowing. Equally, at the end of November, which prompted the responsive inspection. The independent reviews were reported on – I believe saw or had headlines of them in the early December and, again, piecing the information together, we needed to understand what was happening, in the plainest sense what was happening at Morecambe Bay. Every stone that appeared to be being turned over that there was an issue under it. And I think, you know, as much as for the safety of patients and the services that were being delivered, we needed to understand what the risks were, where the concerns were and actually the nature of those concerns so that actually the right action could be taken.

PROF MONTGOMERY: Okay.

MS DINELEY: We had already tried the warning notice route and an incident occurred during that period.

PROF MONTGOMERY: So I think as a reasonable bystander I'd say, 'But you don't need to understand it in maternity?' Because you send in a section 48 and you exclude one of the services which is clearly of concern to you?

MS DINELEY: But we have that being managed through another route. So it's not to ignore it. The scope of the section 48, so the formal investigation, the premise for that was around actually using it as a diagnostic tool to understand actually how widespread the concerns and issues around safety and quality were within the organisation.

PROF MONTGOMERY: Can I – sorry.

MS DINELEY: In terms of maternity, we had not had identified any new or further concerns following the serious untoward incident in the end of September.

Actually what we had had identified though were new concerns that we hadn't previously addressed or looked at in the preceding 12 months and with all the inspection activity that had been undertaken there in other areas. And so there was a case of 'Do we inspect again against something that we've already inspected against where it could be about revisiting previous information?' Or 'Do we actually focus on something that's fairly broad?' And we took the emergency care pathway, to illustrate various touch points across the organisation so we could touch as many different services as we could, directing supporting services where we had concerns and we were following up or actually we just didn't know because it was a case of 'We're not going to wait now until we're told that there's a problem somewhere. We're going to actually independently go and test it.

PROF MONTGOMERY: Can I just test out an impression then which is, through a series of things, and CQC is one of a number of people who have this impression, you have a series of things and you are relying on the impression that they are not connected, you have another one emerges in September, I'm wondering what mechanism there is other than a section 48 enquiry to test out the hypothesis that they're not connected? Was that a missed opportunity to ask 'Was this a systemic issue in maternity services or a set of unconnected events?'

MS DINELEY: In terms of timing, potentially yes. I think what I would say is that there were some clear themes coming through the reports suggesting that actually there were connections between different service failures both around leadership, staffing levels. So there were clearly some common themes there. Within the section 48 terms of reference there was the opportunity, if further concerns came to light during the course of those preliminary site visits and the conversations, we could expand the remit of it. So there was always the potential to include additional clinical services in it rather than consider them to have been excluded.

DR KIRKUP: On that, was there a formal decision taken about whether the Trust had or had not complied with the terms of the warning notice on or by 21 November?

MS DINELEY: The deadline is given for the Trust to be compliant with.

DR KIRKUP: Yes.

MS DINELEY: We would follow it up either on or after that date to determine whether they had become compliant or not. That would have been as part of a decision making forum. The process for that would have been through going out inspecting and reviewing the evidence through a management review process which determines whether sufficient evidence means that it has been met or actually if it hasn't, and additional evidence has been collected, what the next stages are after that.

DR KIRKUP: But that didn't happen?

MS DINELEY: Not that I'm aware of. I can go back and double check on that but from sitting here today I cannot tell you whether a management review meeting was held that documents all of that.Point of clarification: Email sent to the Inquiry on 10 October 2014 to request if clarification of additional information to be provided post interview. No response received.

PROF MONTGOMERY: I think it would be helpful to know all of that and also what was said to the Trust because the Trust has written to you thinking it is compliant. And can I ask how the risk process handles the many, many warning notices that then emerge over this period? So you have one in September, as part of the section 48 review there's a whole series of them that come through and I'm wondering both how you bring that together in your risk profiling and also wondering how you communicate it with the Trust. I've seen lots of individual letters. I'm wondering whether there's a process of drawing the attention of the Trust to the overall risk profile that you hold.

MS DINELEY: So in terms of the coordination of the section 48 and the regional regulatory activity, the two were kept separate so that actually we could run regulatory activity alongside the section 48 rather than waiting for it to conclude and then take it. What I would say from the outset when we met the Trust in late January 2012 the Chief Executive at the time and the Medical Director did not appear to understand the seriousness of the circumstances that had led up to the section 48. The conversation with them was quite dismissive and actually it was almost as though going through another inspection for them, rather than recognising the breadth of the concerns and the risks that had been identified across either services and the potential areas that we were following up on because we hadn't had the assurances from them.

So my view is actually that information was shared both in formal letters and in direct meetings and conversations with the Trust.

PROF MONTGOMERY: But the Trust didn't connect it all together. Is that what you're saying? That from your perspective you have a whole series of things that are cause for concern but the Trust doesn't see that as a systemic problem.

MS DINELEY: I don't think they saw it as a systemic problem. I think that was reflected in their culture and actually throughout this process we were learning more about the organisation, how it thought and how it behaved in terms of concerns that were being identified and there appeared tolerance around them. They were very much focussed on their – I think their image.

PROF MONTGOMERY: And how does this compare to other Trusts around the country? I mean how many other Trusts would be on your national risk profile with the same number of warning letters and those sorts of things?

MS DINELEY: So on a monthly basis the list was updated and was shared with our internal risk and escalation committee. The numbers varied. So we would have some new entries to it which may have been one or two a month. However, they may be on there for a long period of time so that number would grow. And I think it was fair to say the number did grow and that's because we went out and inspected.

PROF MONTGOMERY: That wasn't quite what was I asking.

MS DINELEY: Sorry.

PROF MONTGOMERY: That tells me about the number of organisations you are worried about. I am wondering how many of those organisations had, whatever it was, half a dozen warning notices against them and a section 48 inspection? I'm wondering how the profile of UHMB compared to other ones that you had on the list.

MS DINELEY: So in terms of those, there would be a range on that list in terms of some would have one notice against them, some of them would have a restrictive condition. Some would be on there because they still had registration conditions. As you will be aware, we have only done a limited number of section 48s so actually if we're looking at them in terms of activity involving section 48 and enforcement activity, there was only a small number. But there were a small number that were consistently worrying so BHRT was

clearly another one in a similar situation.

PROF MONTGOMERY: So what would it take to get de-registered?

~~MR~~ MS DINELEY: I think practically it would be very difficult to de-register an NHS Trust. I think both in terms of the systems for us to be able to do that but actually more importantly the context of the broader health economy and would it be allowed to get to that stage. I think what we would do is there would a natural escalation in the action that we would take which would include looking at restrictive conditions to start off with which may limit how a service can operate. And as I've already mentioned, that was something which was proposed back in September 2011 but clearly that action wasn't taken. We would then go to a need to restrict a service maybe in terms of volumes of activity or operating. There is the opportunity then after even a restrictive condition to suspend a service as well and that may be permanently, that may be for a specific period of time. But to get to the point of de-registering, I'm not aware that we had done that at that time with any of the services we were looking at in the NHS.

PROF MONTGOMERY: And if we take one of the particular challenges of this case which is you can't tell women not to have babies, does the CQC have any ability within its framework to stop a service which has to be there or is that somebody else's job? So, you know, I'll put the hypothesis, however bad the maternity services became, could the CQC have addressed that question through its regulatory powers or, presumably this is part of the push back from the SHA, could you actually say no maternity services in Barrow?

MS DINELEY: So if I come back to one of my earlier answers which is around we have a process and a framework that we followed up until that point. In terms of determining the action that is taken, and we now start to get into the space of considering the local conditions, in terms of access to other services, here there were discussions around the distance people had to travel, overall access and practicalities around that, the type of service it was relating to and, actually, the maternity services are something that are largely – you can't necessarily control in a particular way the activity that comes through the door at times. So, you know, it was all factors. There were clearly, this is where the discussions with the SHA were key in terms of actually what were the alternatives. If it meant actually putting additional staff in there, where would

the staff come from? Was that expertise actually available? Is it something that could be supported? So we needed to work with them here in terms of making sure that actually, whilst we have concerns about a service, that actually safety could be maintained and ensured.

PROF MONTGOMERY: So is there an element of conditionality in that the CQC would be forced to take action unless the SHA took on responsibilities for making sure there were sustainable services?

MS DINELEY: They were the conversations that would have been had. So in different situations there were different conversations so within BHRT we did get to a restrictive condition element around their maternity service. Actually we didn't need to follow that all the way through because actually the Trust and the SHA stepped in and said 'Actually, we can manage this informally without having to go down a formal routes'.

PROF MONTGOMERY: Just for the transcript, Barking, Havering and Redbridge, is that what you meant by BHRT?

MS DINELEY: BHRT? Yes, apologies for that.

PROF MONTGOMERY: Yes, thank you. I think probably I should give the others a chance.

DR KIRKUP: Yes, thank you. Jimmy?

PROF WALKER: Can I just follow up on the last bit of the conversation [inaudible]. One of the things that strikes me about health services and maternity services in general is there are problems in Trusts that have an isolated unit often in an isolated area without then a central unit and so on. Is that something which you as an organisation have a register of yourself of different Trusts who would fall into that sort of category and therefore are aware of certain problems these Trusts would have over, say, a Trust in central London?

MS DINELEY: No, we don't have a separate risk register for that. I think in the learning that we took from our activity at Morecambe Bay Trust was that actually that is one of the characteristics that may lead to a high risk in terms of being geographically dispersed, actually being located on a coastal area and we saw similarities around the coast of England in other Trusts. So we recognise, actually, the geography as well as service distribution is a factor.

PROF WALKER: And will that change the model on how these Trusts are looked at and assessed with different questions asked of them or will they still go

through the one size fits all approach that has gone on before?

MS DINELEY: I think we recognise the differences between the Trusts and I think it's about Trusts in different locations then. I think it's then about asking the questions about how they make that work to being very clear about actually if you have got a 40 minute journey between two sites, how do you practically manage that in terms of some of the supporting services that may be available? So transport arrangements, whether that is for patients or staff or equipment or medical records. So, yes, it does form part of the conversation.

PROF WALKER: Okay. If I then go back to looking at how you gained information. Because it appears an awful lot of it appears to be information given by the organisation "a step down" Request for clarification on sentence and reference to "a step down". Suggest that this requires amendment as a potential typo who often depends on the information given by the organisation a step down as previous comment so therefore it's dependent on how much information comes up from the bottom really, how you then assess them. Is that a fair assessment?

MS DINELEY: Sorry I'm not quite sure I understand what you're asking.

PROF WALKER: Well it's really about how well a Trust is doing and what it's doing, whether it's achieving targets, etc., depends on whether it tells you it's doing it rather than actually finding out if it is doing it.

MS DINELEY: I think what we as an organisation took as part of that assessment process at the time was actually that the organisation told us that they were doing okay and that there were action plans and they were improving. The SHA told us that they were happy with the progress that was being made. I think actually an area we could have followed up on more was actually going and checking that for ourselves, talking with people on the shop floor, doing the direct work to say 'Actually, is this the sense that you get as well?' And I think as part of the investigation we carried out a number of interviews at all levels of the organisation so that actually we could test out the true information that was being provided and being collected as evidence there.

PROF WALKER: If I could go a step further, I mean we know from our enquiry that certain incidents that occurred were never reported as incidents or investigated as incidents and therefore their risk management system weren't aware or acted on certain things that happened and therefore you're not going

to find out about that either.

MS DINELEY: No.

PROF WALKER: Is there any way round that in your new systems of investigation, is there any way round that to try and stop that occurring again?

MS DINELEY: So I think as part of the new model that we have, and it wasn't just as part of the new model but it was actually in the changes to the model that were made after this point, so we went through an improvement programme in 2011, started in terms of doing the model, is actually about having more of those direct conversations with the people that are doing the work or through patients and what they're experiencing, with service user groups, having that conversation so actually it was less about looking at documents and more about collecting or observing that information first hand.

PROF WALKER: To take that on a bit further, I got a bit confused about what this virtual committee was that formed and were discussing Morecambe Bay in general which the SHA and various other people on it and that was the one, the committee that decided at some point that everything was green and wonderful and so on. Now that committee consisted of representations of groups who gave the information telling you it was green and wonderful so, at the end of the day, a decision of how to move forward is being influenced therefore by the organisations that gave you the information in the first place, which is a slightly biased sort of group. I mean how, in retrospect, how do you feel about that as a working model?

MS DINELEY: So I think in terms of the approach I certainly took nationally through the systems that we had in place was actually the assurances provided by the SHA and by the bodies was useful information but it was important that we triangulated that either with our own observations or through other sources of information, not continually going and – almost we were testing and proving the positive by testing information that we had received from the Trust which had been endorsed by the SHA which was then being used to inform discussions and decisions at a Panel that the SHA were a member of so inevitably going to agree with the information. There was no independent assessment around that we were taking the information. I think that was symptomatic of how previous models had worked as I could understand through the previous healthcare assessments or health checks which were pre

CQC and actually in the early days of the model was something that we really had to challenge back on. But actually just because somebody tells you something, or that there is an action plan and a piece of paper, doesn't necessarily give you the evidence that you need to say that actually everything is okay.

PROF WALKER: The particular point of that would be that you discovered a year after it existed that the Fielding Report existed and you were given that by the Trust. Now was any action taken to the Trust to say 'Why wasn't this given to us a year ago?'

MS DINELEY: Yes.

PROF WALKER: And how did they respond to that?

MS DINELEY: Their response was 'We thought we had given it to you'.

PROF WALKER: Right.

MS DINELEY: That was one of the responses.

PROF WALKER: And was that just accepted as it were or is there any way of black marking the Trust on withholding information from you? Because it is important information which if you, as you had already said, if you had known that before it would have changed your view.

MS DINELEY: So it's certainly not about black marking. What we had as part of the process there, we would talk about whether we had confidence in the provider and that was as much about the confidence of the information that was being shared as being completely accurate, it being complete and them being open and transparent with it as much as having confidence that if they say action is being taken that it is actually being taken. I think within this context of the Fielding Report it was, from my perspective, sitting outside the region, another example of where we couldn't trust the assurances that we were being provided with either by the Trust or within the local economy. I think we had too many sorts of either coincidence or a trend appearing here. Put in mind the context of the July in the following three months it was being escalated quite significantly after that and actually not necessarily taking the information that we were being provided with on face value and that extends to the SHA to monitor as well and going and sourcing that ourselves through the section 48.

PROF WALKER: So in the sort of reviewing of all this data, has the conclusion been made that this green lighting of the Trust at a certain point was false, by

whatever reason, and rather than things being bad and getting better and getting bad again that this getting better bit for whatever reason was a misinterpretation of what actually was going on?

MS DINELEY: As I said, in relation to the risk ratings that were given in 2009, there was very limited information that I could go on from that in terms of the rationale and the decision making that was made there. My personal view is that actually from the work that I did, that I saw actually and then in the conclusions and the recommendations that were made as part of the section 48, these were not issues and risks that had occurred in the last 12 months. Actually they had been growing and materialising in the Trust for a significant period prior to that.

PROF WALKER: Is that a yes to my question then?

MS DINELEY: I'm not sure I can answer it because I wasn't around at the time. I haven't got the evidence to go back and see what their decision making was so it's difficult for me to go beyond what you presented to me.

PROF WALKER: Okay. And lastly, I'm not quite sure what the purpose of the report you were writing actually was and what happened to it. Point of clarification & context to question of "what the purpose of the report you were actually writing was and what happened to it". The inquiry wasere advised prior to the interview that I would be unable to answer questions relating to the report specifically any actions pertaining to what happened to it due to legal action at the time. As a result of this and as a point of clarification my response at the time was given within the limits I was able to answer and had previously agreed with the Inquiry. I mean, was this a report to look at what the organisation had done over the last wee while and why it had got it wrong or what information was available or what was the actual reason why you then went and investigated these things in retrospect?

MS DINELEY: So I was asked, as I have already mentioned, by the Director of Operations to write that report. I think it was to give her a clear steer in terms of what had we done, had we missed opportunities to improve the regulation, what may have contributed to it. At the same time there was equally, I am aware that Monitor were doing a similar review around their authorisation process. So we wanted to know essentially, since registration had it deteriorated, had it been like this prior to registration. They were the simple

questions we were looking to ask.

PROF WALKER: And what was the conclusion?

MS DINELEY: Well I think as the report identifies, there were a number of factors there that contributed to it. I think there are two answers. One in terms of I can understand based on the information that people looked at and either had available to them why the Trust wasn't registered with conditions. I'm not necessarily saying that is the right answer, I would have – I think what the report shows is that there were opportunities where we could have followed up which may have resulted in a different outcome in terms of the Trust's registration status.

PROF WALKER: Do you think the same thing would happen again or are there mechanisms now in place to stop that?

MS DINELEY: I think we have a different model now that closes and addresses some of those gaps and shortfalls. I think there will always be a tension about taking information from other people as evidence. I think it's useful to take it as supporting information. I think you need to do something with it then in terms of testing its validity if that is informing your overall judgement of a provider.

PROF WALKER: Okay, thanks.

DR KIRKUP: Jacqui?

MS FEATHERSTONE: Okay, I've just got one question. You talked about going in to see the Chief Executive and that they didn't take it on board. Who went in? Obviously the CQC but who actually, what team went in to speak to the Chief Executive and who were you meeting?

MS DINELEY: So in terms of the meeting, it was a pre-meeting to the section 48 investigation. Essentially the scope of the meeting was about introducing the Investigation Manager to the Trust, to the Chief Executive and to the Medical Director and to take them through both the terms of reference and how it would work in practice. So it was a very practical, operational meeting. The meeting was attended by myself Point of clarification & context. The meeting was attended by myself in a supportive capacity as line manager of the Investigations Manager and Mandy ~~Musgrove~~ Musgrave as the Investigation Manager. From the Trust's attendance it was their Chief Executive, their Medical Director and Assistant Director of their Medical Directorate. And so a clinician there and a management representative of the Medical Directorate.

MS FEATHERSTONE: And you just said that you felt that they didn't take it on board. Was that your feeling or was that the group's feeling as you came away?

MS DINELEY: So in terms of the CQC representatives there, we both shared that feeling.

MS FEATHERSTONE: So how did you escalate? You know if you get that feeling when you walk away, what did you do then to – because if they're not taking it on board, how do you then go back to them to sort of reiterate it back with them then?

MS DINELEY: So it was very much setting out the detail in that conversation of the meeting, not only the seriousness of the concerns that had brought us up to a section 48 but by following it through what that also did was highlight areas that we really needed to focus on as part of the section 48 site visits, the interviews, who we needed to talk to and when. Certainly when I came back from that meeting I obviously updated and briefed Amanda Sherlock on how well it had gone or rather it hadn't, how we'd been received, and clearly that this was going to be a difficult investigation. I'm not suggesting that any investigation is not difficult but having experienced a six week period of objections to us taking the investigation, so this is from middle of December, so round about 20 December, something like that, all the way through to us commencing the site visits, there was continual challenge back both from the Trust, from the SHA, from key individuals as well as to trying to persuade us not to take an investigation at the Trust. So it was a, not to say that we had got used to the challenged, but it was clearly informing us in another way of the symptoms at the Trust in terms of its leadership, its ability to recognise and identify risks and the concerns themselves and the effectiveness of the actions that were being taken in terms of overall impact on the safety and the quality of services being provided.

MS FEATHERSTONE: Okay. All right, thank you.

DR KIRKUP: I just wanted to follow up a couple of points briefly from what you've said. The change in assessment in early 2010 is a very rapid change from being a red traffic light to being green. You've talked a bit about the processes that were involved in that and I realise you're looking back on that retrospectively but what I wanted to know is was that unusual to see a change of that magnitude and rapidity or was that sort of thing going on on a fairly

regular basis across other Trusts?

~~MS FEATHERSTONE~~MS DINELEY: If my recollection is correct it actually did go to amber, so it didn't go straight from red to green. It was a staged approach over a four month, five month period. In terms of whether that happened in other Trusts, again the only reason I looked at that period of time is because it was in relation to Morecambe Bay. As I previously said I was meant to be starting at the January but that had seemed relevant so I'm not sure I can answer that in any more detail.

DR KIRKUP: Okay. The role of the SHA has cropped up quite often in all of this. What's your understanding of the role of the SHA in relation to quality and in relation to the CQC?

MS DINELEY: So the role of the SHA was essentially there to performance manage the Trust and that would be across a range of activities, not just quality.

DR KIRKUP: But including quality?

MS DINELEY: Absolutely.

DR KIRKUP: Yes.

MS DINELEY: I think quality was clearly something that they had been and were actively involved in both in the form of incidents and the review of incidents that had been reported through to complaints as well as the overall service delivery linked in with the commissioners. I think what was interesting, and I'm afraid I don't have an answer for it, is the SHA's continued involvement with a Foundation Trust who were – because obviously as we were in that interim period actually SHA's were meant to be overseeing essentially non Foundation Trusts rather than the Foundation Trusts who were essentially independent by that stage. But they continued to have a very close involvement and I think contribution to the Trust.

DR KIRKUP: It's clear that they had a relatively strong role in relation to quality improvement. It's less to clear to us that they had a strong role in relation to quality assurance if I can make that distinction. Is that something that you became aware of?

MS DINELEY: I think – so from the information that the Care Quality Commission received, I think they were providing assurance to us on quality, not least on some very specific areas. Now whether that comes through their improvement mechanisms, they were certainly offering that to us in an

assurance basis rather than telling us and reporting on what was being done.

DR KIRKUP: And would you be aware that there was any attempt to test the SHA's processes in coming to those conclusions?

MS DINELEY: I'm not aware that any tests were made.

DR KIRKUP: I know you have spoken about triangulation with other impressions but did the CQC actually look at the functioning of the SHA at all or was that off limits?

MS DINELEY: Not that I'm aware of and I'm not sure that it was within our scope of our regulatory remit.Point of clarification: The SHA was included in the scope of the section 48 investigation. In terms of the regulatory remit whilst the CQC could make observations and recommendations as part of the investigation these could not be enforced as within the regulatory remit the SHA is not a registered provider as per the Health & Social Care Act (Regulated Activities) Regulations 2008.

DR KIRKUP: Yes, okay. Any more final points?

MS FEATHERSTONE: No.

DR KIRKUP: Is there anything else that you would like to say to me?

MS DINELEY: No, I don't think so.

DR KIRKUP: Okay. Would you like to raise anything that bears on clinical confidentiality?

MS DINELEY: No.

DR KIRKUP: Okay, in that case, thank you for coming.

(The meeting concluded at 12.19 p.m.)

THE MORECAMBE BAY INVESTIGATION

Tuesday, 11 November 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
Mr Julian Brookes - Expert adviser on Governance

MARIAN DRAZEK

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(At 2.02 p.m.)

DR KIRKUP: Hello, is that Marian Drazek?

MS DRAZEK: It is, yes.

DR KIRKUP: Hello, my name is Mr Bill Kirkup. I'm the chair of the Morecambe Bay investigation. Were you expecting a call from us now? I hope so. Okay, thank you. Can I ask my two panel member colleagues who are here as well to introduce themselves?

PROF FORSYTH: Good afternoon, my name is Stewart Forsyth, and I'm a paediatrician and a medical director from Dundee.

MR BROOKES: Hi, I'm Julian Brookes. I'm currently chief operating officer for Public Health England. I was previously head of clinical policy in the Department of Health.

DR KIRKUP: Thank you for helping us with this. I should say we're recording proceedings, and we'll make an agreed record at the end, and also that family members may listen to the recording subsequently, although we'll have a section where we discuss any clinical or confidential matters, which they won't be able to listen to, but I'll make it clear when that conversation starts.

MS DRAZEK: Okay, that's fine.

DR KIRKUP: And just to reinforce that we don't want anything going outside of the investigation until we're ready to produce the record, is that okay?

MS DRAZEK: That's fine.

DR KIRKUP: Any questions for me about the process?

MS DRAZEK: No, I think I already asked questions by email.

DR KIRKUP: Okay, sure thing. Well I'll just start out with the general question, which is if you could let us know, we're interested in your role as LSA midwifery officer, and when you started that and when you ended that?

MS DRAZEK: Right, I started in January 1996, and I worked full-time until May ~~late~~ 2010, when I retired. However, in May 2010, when I retired, the Strategic ~~chief of~~ health authority asked me to go back part-time until the new person ~~was~~ in place. ~~Since then I've~~ became competent and confident in the role, so I worked part-time until the end of 2010.

DR KIRKUP: Okay, thanks. That's very helpful. I'll pass you over the Stewart, then.

PROF FORSYTH: Okay, thank you very much. Can you just begin by describing your job for us, and your role as the LSA midwifery officer in that area?

MS DRAZEK: Yes ~~ah~~. I mean you're probably aware that there are LSA midwifery officers throughout the UK. For the ~~[~~main part that's to~~?]~~ make sure that statutory supervision of midwives and midwifery happens, and happens to a good standard, in accordance with the secondary ~~central~~ legislation, which provides rules and ~~of~~ standards. So my role was to ensure that happened for all midwives practising in the north-west; to set ~~the same~~ standards as an LSA.

PROF FORSYTH: Okay, and who did you have working with you? You're obviously not completely entirely on your own.

MS DRAZEK: [inaudible] Just myself and the LSA midwife ~~and~~ apart from the LSA services manager in an admin role, and LSA secretary. That was a very small team of the LSA. [Inaudible]However supervisors worked on behalf of LSA in their role as supervisor of midwives for the Nursing and Midwifery council, for the LSA, not for their employers, for the role as supervisor.

PROF FORSYTH: Yes. So how many midwives were in your patch, and how many supervisors were working with you?

MS DRAZEK: At the time, obviously it varies, but I would say over the many years I did the role, between 4000 and 5,000 midwives, and between 300 and 400 supervisors.

PROF FORSYTH: It seems a lot.

MS DRAZEK: It is a lot. It was a huge patch; the biggest in the country.

PROF FORSYTH: Did you feel that you were able to perform your duties effectively?

MS DRAZEK: When I began the role, I was on my own with one part-time secretary, and that was overwhelming. So over the years, I tried to develop ~~[inaudible]~~ the post and we managed to get the secretary upgraded and full-time. to~~There'd be~~ an LSA services manager.~~,~~ Sso the admin I had to do in the early days was obviously taken over, and then I developed the first in the country, the LSA midwife role, which was a massive, massive help.~~,~~ ~~and~~ Eeventually we got another part-time secretary which became Full time ~~fourth~~ ~~[inaudible]~~a As it was an inordinately huge job to do, and the supervisors and midwives probably, being so many of them, I didn't know some of them as

well as the other patches, where the LSAs ~~S~~we perhaps had assisted supervisors who did the role on a daily basis.

PROF FORSYTH: So how did you know that they were able to perform their duties effectively and competently?

MS DRAZEK: Right, well they also – all supervisors have a supervisor themselves, because they are practising midwives, so they would have been involved in the organisation and having one to ones at least annually with their own supervisors, but the main system was the audits of supervision in the units, which were annually, every year at least ~~their request~~. And also, I suppose, when any documents came in from the supervisors of a particular trust, you could tell the standards of supervision by the way the investigation has been carried out, by the way the report is written, and so on.~~e.~~

PROF FORSYTH: And those audits, each unit has to supply data, presumably, do they?

MS DRAZEK: Yes, and that develops with the Nursing and midwifery council becoming more rigorous in their requirements that they have with LSAs, and therefore we'd have ~~to two~~ provider~~s.~~, ~~S~~so a lot of data was provided before the audits. In addition, the supervisors of ~~and~~ midwives ~~fes~~ write ~~have~~ an annual report every year.

PROF FORSYTH: So what sort of other factors were assessed in these audits?

MS DRAZEK: The audits, we talked to the supervisors themselves, we talked to the midwives without the supervisors present to see what the midwives' opinions were of the standards of supervision. We'd talk to the mothers that were there about how the midwives and supervisors were supporting them. Because really, the supervisors are the role models for the midwives, and that then is passed onto the mothers really, although the mothers can access ~~have~~ supervisors themselves. But the data that they provide in advance, a lot of it was only for the midwives themselves, but also at the audit, we used to meet with anybody else in the trust that had an interest in supervision, and that could range from the director of nursing, the chief executive, to sometimes non-executives who have an interest in ~~trust their~~ supervision.

PROF FORSYTH: Okay, so if there was an issue regarding a midwife, and it was decided that a supervisor would need to undertake an investigation off that

midwife, who decided that and how did you choose an appropriate person to undertake that investigation?

MS DRAZEK: Normally, the supervisor and the group would ~~to~~ decide if a supervisory investigation was needed, and then the investigating supervisor would not be the midwife's ~~ves~~, ~~the~~ supervisor of midwives. She would be there continually as a support person, a support supervisor for the midwife investigated. So generally, the group themselves will decide who was the best person to start the investigation.

PROF FORSYTH: Do you think this worked well? I mean it does sound to be a bit incestuous, but I just wonder what your view is.

MS DRAZEK: Sorry, say that again?

MR FORSYHTE: Do you think this works well, because it does seem a bit, to use the word, incestuous, but midwives who are supervisors, have been working in the same unit, where there's been a problem with a midwife, for them to then investigate. Do you think they can remain objective in that position?

MS DRAZEK: I think 99% of the time they're very objective, because they do see their role as separate from being an employee, and a lot of time is spent when they're educated and trained as supervisors to make sure they understand. But there can be, ~~[inaudible] but~~ they need to realise that it's a separate ~~strict~~ employment and their role as supervisory midwives and clearly, any supervisor that wasn't confident with doing that, wasn't certain with the investigation, could say, 'I don't feel right to take it on' and somebody else would do the investigation.

PROF FORSYTH: So you feel confident that there is not a situation where a supervisor would be reluctant to make recommendations that might jeopardise midwives, as fellow midwives continuing employment within the unit, for example?

MS DRAZEK: No, because their main aim is to protect mothers and babies, and therefore if there's any suggestion that a midwife's practising poorly, or making mistakes, or needs some updating, or is dangerous and should be considered for removal from the register, then obviously that is there primarily for supervisors midwives to identify that and come up with a plan to address it.

PROF FORSYTH: Okay. Focusing a bit more into the Morecambe Bay trust, what are your reflections on what had happened there over the last number of years? You were obviously closely involved in a number of the investigations?

MS DRAZEK: Yes ~~ah~~, I think prior to any of us being aware of the situations that have become so public, supervision there was perhaps not as dynamic as at some of the trusts. I think some supervisors in some areas, and certainly in regards to probably half a dozen where the supervisors and midwives were very proactive, contacted the LSA a lot for either advice or to make suggestions or pass on best practise. The supervisors at ~~re~~ Morecambe Bay and particularly Barrow ~~[inaudible]~~ I think got on with it and thought they were doing a good job. And from what we saw on audits, although perhaps it was a little bit old fashioned way of doing supervision, they appeared to, in our opinion, carry out the role reasonably.

PROF FORSYTH: And from [inaudible] what happened subsequently, do you feel that the supervision had not in fact been conducted as well as it could be?

MS DRAZEK: I think that something that needs bearing in mind is that there is a huge variation in the level of resources and confidence from ~~an~~ employer's re supervision right across the country. That's not just the north-west, and some trusts put money into supervision, give the supervisors time, and are very respectful of supervision, and hold it in high esteem. In other trusts, not just Morecambe Bay at the time, but in other trusts, there are no resources, no time, and the supervisors are struggling to find the time to carry out the role, don't have any additional funding to undertake the role, and management for want of a better phrase, in the trust, don't support the supervision the way they do in other trusts.

So we were aware of those sorts of issues at Morecambe Bay, and in other trusts right the way through. There's a big difference between a trust where you know that if you went through the chief executive or the trust board and wanted to talk about the audits and supervision, that they would increase them because they have huge respect for supervision, and in other trusts, there was just no way that anybody was going to give out any funding or resources for it.

PROF FORSYTH: Had you had discussions with the chief executives of the trust about this?

MS DRAZEK: We've not had discussions ~~supervisions~~ directly with him, but we've ~~[inaudible]~~ included in the recommendations for the audits.

PROF FORSYTH: So who did – did somebody have a discussion with the chief executive regarding support for LSA?

MS DRAZEK: As far as I can remember, it was the supervisors, yes.

PROF FORSYTH: The supervisors themselves?

MS DRAZEK: Yes, so that was what happened in most trusts, that the supervisors wrote, similar to a business case, or had meetings with management. What level depended on which trust it was, and tried to gain A) resources, but B) a bigger understanding of supervision if there were problems with the liaison between management and supervisors of midwives.

PROF FORSYTH: I mean it seems to me surprising that supervisors of midwives are basically midwives working at a unit, who would then be expected to write a business case for supervision in their area.

MS DRAZEK: That's been done right across the country over the years, and I said business case, that's perhaps the wrong term. It was a, I suppose, an explanation of the role and why they need resources, a business case is one way ~~[inaudible]~~ to describe it.

PROF FORSYTH: What about the Strategic Health Authority, would they not have responsibility for providing support?

MS DRAZEK: That was discussed over the years [inaudible] or whether the ~~F~~SHA should give ~~need~~ funding, but the S~~F~~HA, again, right across the UK, felt that it was up to the trust because the safety of mother and baby and the resourcing of that should be important to each trust. So none of the S~~F~~HA as far as I can remember, gave any ~~every~~ thing to ~~was all~~ supervision. It wasn't in their budget. They saw it as part of a budget that each of the trusts had.

PROF FORSYTH: Okay, so in terms of Morecambe Bay, you felt that supervision was not as dynamic as it could have been, and was probably not adequately resourced by the trust, is that correct?

MS DRAZEK: I think that's correct, yes ~~ah~~.

PROF FORSYTH: What about the actual competence of the midwives? Clearly you have an insight into that through the investigations and contacts that were

made. What is your view on the performance of the midwives during that period of time?

MS DRAZEK: You mean before all the events –

PROF FORSYTH: Well you were involved throughout really, up to 2010 or so, and was there a change in how they performed from say 2003 up to the time you retired?

MS DRAZEK: Oh yes, the supervisors and the midwives, I think, took a long look at some of the culture and ~~of~~ the practises and worked extremely hard. The LSA midwife ~~ives~~ was ~~were~~ totally involved with trying to address any weaknesses in the systems, and any updates in the practise that the midwives and the supervisors felt necessary or that on ~~the~~ discussion needed a longer look at.

PROF FORSYTH: So what were the identified weaknesses in practise?

MS DRAZEK: I honestly, apart from it being quite a medicised model of care, and quite management led, I honestly can't remember anything individual over the years; it was so long ago. But the LSA midwife ~~[inaudible]~~ was very involved, and may well recall individual practises that were looked at and reviewed and how it changed.

PROF FORSYTH: But when you read some of the reports of the investigation, you must have got a feel for where, okay, strengths were, but also weaknesses were within the competence of individual midwives who were being investigated?

MS DRAZEK: Yes, things like not recognising the temperatures in babies that were ill.

PROF FORSYTH: Yes, could you just expand on that? What do you recall about that? Did you feel that some of the midwives in the unit who certainly knew about that, whereas there were others that didn't?

MS DRAZEK: At the time, no. Generally none of the midwives would have recognised that instantly as a sign that the baby was desperately ill, and again, having talked to other people at the time, as the head of midwifery talked to other people at the time, the low temperature ~~[inaudible]~~ ~~that~~ being a factor that sort of took [inaudible] at them.

PROF FORSYTH: You mean this is a sort of more widely a lack of knowledge in other midwives in other units?

MS DRAZEK: Yes ~~ah~~, I think so at the time, and it's not something that was at the time written about or identified as a really big red flag.

PROF FORSYTH: Right. Was there anything else that you felt was fairly characteristic of the midwives in the Morecambe Bay, particularly in Barrow?

MS DRAZEK: I think mainly it was more than many other units, more medically and management led than midwifery led, compared to units where the midwives are practising totally as midwifery care if you like, and totally not influenced by the medical model of care, or top down management. They were expected and encouraged to practise as individuals, and I don't think they were in Barrow.

PROF FORSYTH: And did that change at all during your time as the midwifery LSA supervisor?

MS DRAZEK: Yes ~~ah~~, I think the last, well, again, since the events that happened were looked at, and the supervisors and the LSA midwife ~~ves~~ supporting them, took steps to change ~~chase~~ the way they did things, as far as I understood it. I left before I suppose it was complete, but there was a lot of different people looking outside as well as inside, though clearly they helped to identify what weaknesses there were and to address them.

PROF FORSYTH: Okay, can I just return to your relationship with the trust, and the trust management team? How did you feel – you've already indicated that they seemed to be reluctant to put resources into supervisors. What about in response to your reports taking action? Did you feel they responded appropriately?

MS DRAZEK: You mean specific reports?

PROF FORSYTH: Yes. We don't need to go into detail at the moment; we're going to come back to that I think as the second part of this interview. But just generally, what did you feel were not being addressed?

MS DRAZEK: It is when you're comparing with other trusts, but that is the easiest way to demonstrate how – if a report had gone through in another trust immediately, I might have got a phone call or an email saying 'Let's all get together and look at this.' That didn't happen at Morecambe Bay. I think there was not the denial of supervision, but it certainly wasn't looked at in the same light as in some other places, where immediately somebody would

have said [inaudible] but if you find something and the LSA is worried, we'd need to do something about it.

PROF FORSYTH: Okay, that's all for me just now. I'll pass you on to Julian.

MR BROOKES: Hi. I just want to follow up on that last point, because I'm just trying to get a picture in my head. So you've described management as top-down, what does that mean exactly?

MS DRAZEK: Without going into details of individual people, I think that's difficult, but I think that management at Morecambe Bay ~~[inaudible]~~ felt that they were in charge of everything, including supervision, to put it bluntly.

MR BROOKES: So you'd be surprised if we heard that management was pretty much absent in the midwifery unit?

MS DRAZEK: Sorry, say that again?

MR BROOKES: So you'd be surprised to hear if we'd heard that management was pretty absent in the unit, that they felt isolated from the management, they didn't feel part of the organisation?

MS DRAZEK: I would have thought that was trust-board level.

MR BROOKES: Okay, so at trust-board level, they're not – they're doing what? Sorry, I'm just trying to understand.

MS DRAZEK: I would say that they were not responding in a way that would have happened in other trusts, that they were quite distant from supervision and from midwifery practise prior to the incidents happening.

MR BROOKES: I thought you just said they were controlling of supervision?

MS DRAZEK: Oh, from a distance, certainly. The message was sent that this was how things are going to happen.

MR BROOKES: Okay. Am I correct in thinking that there's sort of two main routes for you to find out about particular issues in the trust? One was through the annual audit, and the other was through issues raised through the supervisors, is that correct?

MS DRAZEK: And the Supervisors annual ~~service–general~~ report that the supervisors write for ~~[inaudible]~~ the LSA.

MR BROOKES: So who writes that – that's by every trust, is it?

MS DRAZEK: The supervisors at every trust must report on it.

MR BROOKES: So one per trust?

MS DRAZEK: Yes.

MR BROOKES: Okay. So they would have been – those three routes. Prior to these cases coming to light, had any of those routes indicated significant issues in this trust?

MS DRAZEK: Not significant issues, no, just sort of old fashioned ways of doing things, I think was the best term.

MR BROOKES: Okay, but you also said that following these cases, that there was a recognition that there needed to be a change in practice and a change in culture in the organisation?

MS DRAZEK: Yes.

MR BROOKES: So I'm just trying to work out, because I would read that as meaning there were those issues already there, which were identified through these cases, but hadn't been picked up through those three mechanisms prior to that date?

MS DRAZEK: I think that's correct, yes ~~ah~~.

MR BROOKES: And why do you think that is?

MS DRAZEK: I think partly because when you go to do an audit for example, the supervisors in ~~of~~ the organisation knows that you're going. They can, if you like, have meetings and decide which cases they could demonstrate good practise with. It wasn't that they were doing things wrong, it was just that it wasn't as dynamic as other places, and also, again, when they do an annual report, we ask certain questions, and we have to have answers to the questions. And when I asked them, the supervisor of midwives [inaudible] ~~organisations~~ with the LSA. I think they step away from the investigation because they're not confident or they need lots of support. Until this happened, supervisors appeared in our opinion to be getting on with things quietly, as I say, and none of these problems were highlighted.

MR BROOKES: But clearly in retrospect there were problems there, and I'm just trying to work out why they weren't identified by the supervisors. Or, were they identified by the supervisors, but they felt they weren't sufficiently important, or didn't wish to raise those with yourselves?

MS DRAZEK: I think if they had recognised them, I think they would have raised them with the LSA. I think it was that they, until things went wrong, that they weren't aware that there were real problems.

MR BROOKES: So doesn't that raise an issue about the competency of the supervisors?

MS DRAZEK: I think it raises an issue about how – the competence of the supervisors, yes – of how the NMC and the LSA's audits are. I think to be honest if it's a small LSA, where ~~as~~ the LSA midwifery officer might met each supervisor individually and spent more time with them than possibly in the north-west, it may have been picked up earlier.

MR BROOKES: Okay, and I do recognise the size of the patch and the number of midwives that you were dealing with. Who was responsible to ensure, or assure, that supervisors in a unit were competent to perform that role?

MS DRAZEK: Well the supervisors, like all the midwives, were accountable for themselves, you know, responsible for their own practise as supervisors as well as midwives. Once the supervisors of ~~and~~ midwives course ~~[inaudible]~~ has been ~~have~~ passed ~~that~~, they have peer – each supervisor has their own supervisor of midwives, ~~fe~~, so their supervisor would be there to look at their practise as a supervisor as well as a midwife, and then as far as the LSA is concerned, we go in and talk to them and look at their records and supervisory activity etc, so it was the supervisor and ~~on~~ the LSA and ultimately the NMC that they're responsible to.

MR BROOKES: Okay, so does that sort of imply to me that there's two levels of system there. You've got your supervisors supervising your supervisors, and then I'm not sure – is there then any accountability to the LSA for particularly those senior supervisors who are acting in that supervisory role for the local supervisors? I'm just trying to work out how you can be sure as LSA that supervision is in place?

MS DRAZEK: Well there are standards of supervision that they have to meet, and that includes the annual report that they send to us.

MR BROOKES: Are they doing that – they're self assessing, so there's no external assessment to see whether that is right or not?

MS DRAZEK: Well the audit is there to test out, by talking to the midwives, if supervision is being undertaken appropriately, but the supervisors as a group have no hierarchy ~~[inaudible]~~ the supervisors are all on the same level, and the supervisors each have a case load as midwives and supervisors that will include some supervisors and midwives.

MR BROOKES: Okay. If I can change to something else, you've had an audit or a review, and whatever route, one of the three routes, it's raised a particular issue in a trust, which is a concern. My understanding is that you would write a response to that to the chief executive, etc, of that organisation or highlight those concerns, is that correct?

MS DRAZEK: When we did the audits, there was always a full report with that audit, and copies of that including recommendations were sent to the chief executive, director of nursing for the SHA, and clearly in some organisations, you would immediately get a response of 'How can I help?' You know, the recommendations may have nothing to do with ~~this~~ the chief executive or the management team. It might be purely down to the supervisors of ~~y~~ midwives, so it depends what the recommendations were.

MR BROOKES: Sure, but you then through either an additional investigation or through your next audit find that no action has been taken on those particular issues. What recourse do you have?

MS DRAZEK: Recourse?

MR BROOKES: What can you do about that? And you can write them another letter, but it won't necessarily be any more successful than the previous one. Do you have any other options in terms of escalating concerns?

MS DRAZEK: Only to the SHA,or the Nursing and Midwifery Council – there's no way that as the LSA we can afford to take no action that we have recommended if it's purely management, or if it's purely midwifery staff.

MR BROOKES: In your experience, have you used those routes to raise concerns about organisations?

MS DRAZEK: Yes, certainly.

MR BROOKES: And did you do any of that about Morecambe Bay?

MS DRAZEK: Not until these incidents were highlighted, because there was no reason to.

MR BROOKES: Okay, so who at the SHA did you talk to about Morecambe Bay?

MS DRAZEK: Angela Brown.

MR BROOKES: Angela Brown. And what was their response?

MS DRAZEK: Her response – you mean before these incidents or after them?

MR BROOKES: If there was issues before I'd be interested in it, but also about these specific incidents.

MS DRAZEK: Right, well because Angela was part of ~~contacted~~ the SHA and was copied in all the reports, we would sit down perhaps twice a year and go through the units and what was happening, and which ones were flying high and which ones perhaps looked a bit thin [inaudible] We would talk about them, and I would get support just to continue trying to support the supervisors, support the midwives, but if necessary to write again, for example, to chief executives or directors.

MR BROOKES: Was there ever any intervention by the SHA on your behalf?

MS DRAZEK: There was after this incident happened, yes ~~ah~~.

MR BROOKES: Any other trusts? I'm just trying to work out if it was a routine escalation that the SHA would support, if you weren't getting progress made in particular organisations.

MS DRAZEK: It was unusual for it to be a formal escalation. Most trusts got a plan of action, which I would discuss with the SHA ~~and health about~~, but we didn't need the SHA to actually get involved more than probably three or four occasions.

MR BROOKES: Okay, but you felt you had recourse if it was necessary?

MS DRAZEK: I had support, but again there was limited action that the SHA could take with the trust, other than trying to encourage and persuade.

MR BROOKES: Well they could be slightly more forceful now if they wish.

MS DRAZEK: Okay.

MR BROOKES: Be that as it may. Can I just – one final thing. You ~~w~~talked about some trusts where the trust would invest in supervision, and others where there would be very little resources going into it. From what you were saying, I got the impression that Morecambe Bay was in the category of little resource, is that correct?

MS DRAZEK: That's correct, yes ~~ah~~.

MR BROOKES: So how would supervisors retain the level of knowledge they required to maintain their functions?

MS DRAZEK: It had taken a long time,

MR BROOKES: And do you know that's what was happening in Morecambe Bay?

MS DRAZEK: Yes, for example, re reports ~~key providers~~ if ~~[inaudible] and~~ I was chasing them up. Sometimes it would be 'I've got a day off in two days time, I'll finish the report then.' Because the post just didn't allow the time to do the

supervision, whereas in some trusts for example, they get a day, a fortnight to do supervision work, or they'll have funding for people to fill in for ~~lift~~ them so that they can just take time off for the investigation.

MR BROOKES: Okay, thanks very much.

DR KIRKUP: Yeah, I just want to pick up one specific point at this point in the interview. You referred a few minutes ago to developing some concerns about the capability of the supervisors at Furness General. Can you just talk me through how that concern arose and what form it took?

MS DRAZEK: Within the investigation, I think because it became clear early ~~ier~~ on that there were incidents that we at the LSA felt should have been notified to us, and hadn't been. The supervisory investigation didn't appear to have been started when ~~it~~ they should have been.

DR KIRKUP: Yeah. What about the quality of the investigations themselves?

MS DRAZEK: Prior to these incidents, or during them?

DR KIRKUP: Both.

MS DRAZEK: You mean quality by the number of midwives they spoke to or – ? I'm not sure I know what you mean.

DR KIRKUP: What did you think of the investigations and the results? Were they accurate recourse? Did they capture the essence of what had gone wrong?

MS DRAZEK: The investigation certainly described what happened. I think it took more detailed questioning to highlight exactly what happened, for example not recognising the temperatures, being that's a more widespread issue. There was some problem with carers [inaudible] There was originally a larger number of midwives to look at the practise of, and that was eventually reduced to a smaller group of midwives. But then there did not seem to be anything wrong in the way they were investigating, just very, very slow, and they needed some help to put the formal reports together because there were so many midwives involved.

DR KIRKUP: Okay, and after these incidents? You were describing before – what about after the incidents? What view did you have about the recourse they were produced as a result of?

MS DRAZEK: [inaudible] after the incident.

DR KIRKUP: You wanted to divide it up into two parts. You said, 'before the incidents happened or after?' You've answered before.

MS DRAZEK: That was during the incidents. After the incidents, again, the LSA midwifey did a lot of work with the supervisors of many trusts, because we realised that there was not always the correct communication with the LSA about incidents, so we then, as the LSA, took on re-educating the supervisors across the trusts, but Judith especially worked with several trusts, including Morecambe Bay in more detail on that.

DR KIRKUP: But again, what about the reports themselves? Were you satisfied that they were acceptable quality?

MS DRAZEK: The reports that I had from this time?

DR KIRKUP: Yeah.

MS DRAZEK: Yes ah? Well certainly the first one was up to the standard that I would expect. The second one, which I was not as involved in, was not quite as well written, but again, they'd met the requirements of the LSA.

DR KIRKUP: Okay. Anybody else –

MS DRAZEK: I could compare it to other trusts, where without any help or time, I would get some superb reports sort of the week after.

(The hearing entered private session)

THE MORECAMBE BAY INVESTIGATION

Monday, 24 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert adviser on Ethics

RUSSELL DUNKELD

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(At 3.36 p.m.)

DR KIRKUP: Hello.

MR DUNKELD: Hello.

DR KIRKUP: Please take a seat.

MR DUNKELD: [Inaudible] There's a piece of paper that I've been hanging on to.

DR KIRKUP: [Inaudible] any memory aids you want to use, that's fine. There's a glass of water on the table if you want [inaudible].

MR DUNKELD: Okay.

DR KIRKUP: [Inaudible]. Okay, thank you for coming. My name's Bill Kirkup, I'm the Chair of the investigation. I'll ask my colleague to introduce himself to you.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm Professor of Healthcare Law at University College, London, and Chair of the Health Research Authority, and in the past I've chaired PCTs, Provider Trusts and an SHA [inaudible].

DR KIRKUP: You'll see that we're recording proceedings, and we'll produce an agreed record at the end of the process. I think you'll also know that we've opened proceedings to the family members as observers, and we do have a family member present today. Others may listen to the recording subsequently. If we need, second part of the interview, where we can discuss any matters that raise issues of clinical confidentiality, then we can. You just need to signal to me, or I'll signal to you that we need to do that.

MR DUNKELD: Yes.

DR KIRKUP: You'll also know we've asked you to deposit any mobile phones, laptops or other recording devices, just because we don't want anything to go outside the room until we're ready to produce a report. Any questions from you about the process?

MR DUNKELD: No. It's fine.

DR KIRKUP: Okay. I'll start off just by asking a general question, which is can you tell me a bit about yourself, and your connections with Morecambe Bay, and we'll take it from there.

MR DUNKELD: I trained as a nurse at Lancaster District School of Nursing, from 1987 to 1990, and then was employed by the Royal Lancaster Infirmary under various titles: Lancaster Area Health Authority, then Morecambe Bay Trust, then University Hospitals Morecambe Bay Trust, until I resigned in 2009.

DR KIRKUP: Okay.
MR DUNKELD: So...
DR KIRKUP: Okay, and were you always working at the RLI or were you working...
MR DUNKELD: I worked at a satellite hospital, a sort of cottage hospital that they had up at the Lancaster Moor Hospital initially.
DR KIRKUP: Oh yes, okay.
MR DUNKELD: And then we moved down to the RLI site when all the services were sent – centralised on that one site.
DR KIRKUP: Can you remember roughly when that was?
MR DUNKELD: I guess about 1999 I think.
DR KIRKUP: Okay, and can you tell us about your experiences working as a nurse in the Trust? Or the preceding organisation maybe.
MR DUNKELD: I had a, you know, I was on a learning curve really, because I was a new nurse learning the ropes, and so you get different views of what's going on around you as you're experience increases. I do know that when we moved to the Lancaster infirmary the pace seemed to accelerate, sometimes being – or halt at times. That was my experience. But as your abilities increase you - every time the pressure comes on, you up your game to deal with it, don't you. So eventually I was – I felt quite confident and competent. But the place was always busy.
DR KIRKUP: Okay. Did you work in a variety of different clinical units, or was it always in the same type of speciality?
MR DUNKELD: I actually stayed with the same ward, because I felt like a round peg in a round hole really. I enjoyed me work and saw no reason to move. We had a – I started off as a medical rehab rheumatology ward, and then slowly gathered other hats as we went along, so we became the acquired brain injury unit, as well as the acute stroke unit. But in practice we took patients from – well, I've nursed patients from 13 years old to 103 years old, with a huge variety of things. Not always medical, really. Recovering from fractured femurs and things like that, you know, just anything and everything.
DR KIRKUP: Okay. But the theme was rehab, was it?
MR DUNKELD: Yes, rehab I think.
DR KIRKUP: What was your view of the clinical care that was given in that unit?
MR DUNKELD: I became quite proud of it actually. For a long while I was expecting

the world to come and beat the path to our door and ask us how the hell we were doing all this. Until I got involved in a couple of incidents that pulled the rug out from under me.

DR KIRKUP: I'm sorry, I didn't quite catch it what you said about the incidents?

MR DUNKELD: That pulled the rug out from under me.

DR KIRKUP: It pulled the rug out. Okay. Can you tell us about – if they're clinical details involved in this, we'll need to...

MR DUNKELD: I won't name patients and I won't name nurses or doctors or anybody. I won't name anyone, I'll just tell you what happened.

DR KIRKUP: Okay, yes.

MR DUNKELD: I was doing – I worked permanent nights at this point, 2005, and at midnight it was my job to total up the fluid balance charts for the day, the daily charts, and start a new chart for the next day. So I had to account for the intake and output of each patient that was being monitored in that way, and I began to become aware that we weren't performing very well on that basis. And I then realised that probably I was the only person on the ward that knew this, because being the only person who was totalling these things up, as soon as it's totalled it goes to the back and gets snapped on the clipboard and no-one ever sees it again.

DR KIRKUP: Sure. Yes.

MR DUNKELD: So I started making noises to the rest of the staff that we really ought to pull our socks up with the IV infusions and the sub-cut infusions. Because they were running way over time. For an example, I can tell you that I finished work one Monday morning and the last thing I did before I went into handover was to put a new litre bag infusion up for a patient, and so I accounted for that on the fluid balance chart and on the prescription chart, and then went off on my night off, and on the Thursday evening I came back to work, and when I reached that patient again I realised that the drip was just about to run through. So I got a new unit, looked on the prescription chart, selected the right unit, was signing up for it when I realised that the unit I'd just taken down was the one I'd started on the Monday.

Well they're not supposed to hang up there for three and a half days, you know. So I – using a red pen – I entered the details of the previous unit in red, with a couple of big exclamation marks to draw peoples' attention to the

fact that we were still performing really badly, and we've got more to do.

The ward sister, I remember, took me to one side a couple of days later, and said, 'Russell, I wish you wouldn't write in red on these charts because I've had – alarmed some of the relatives and I've had them on my back about it.' I said, 'Well really, it's not me that you should be blaming for that, you know, it's the staff who neglected to keep that thing running.'

She did agree at that point and subsided a little. But there were further incidents when she expressed her displeasure at me drawing attention in that way. Didn't seem any other way to draw people's attention to it, rather than – unless I was to call a special meeting and discuss the issue with all the staff. I thought it was much easier to do that, because anybody who was dealing with the infusions would, of course, have to look at the prescription chart anyway. But things are never that simple, are they.

DR KIRKUP: Can you tell me round about what year that would have been [inaudible]?

MR DUNKELD: 2004-5.

DR KIRKUP: Okay, so at that stage there would have been an incident reporting system in place?

MR DUNKELD: Oh yes.

DR KIRKUP: Did you consider the option of reporting it as an incident? Saying an IV bag had been on for three days?

MR DUNKELD: No. I felt I'd reported it to me ward sister, and I'd reported it to everybody else concerned in the administrations, so I didn't really, no, I didn't see the need for that.

DR KIRKUP: Okay. Can you give us an idea of what the other – you mentioned another couple of incidents. Were they similar, on the...

MR DUNKELD: Not as – no, they're not as memorable, I'm afraid, but I do remember having to write on two or three charts in red, and put exclamation marks, trying to highlight the fact that this was really not good enough.

PROF MONTGOMERY: Were they also examples of fluids not being [inaudible]...

MR DUNKELD: Yes, really slow infusions.

DR KIRKUP: Okay, were there any other aspects of care that concerned you, then or later? Apart from the IV infusions?

MR DUNKELD: That's a very searching question, because all aspects of the care

concerned me and, you know, it's always a constant battle to try to keep everything up to scratch, isn't it. There was nothing more important, in my mind, than the infusions, at that point. I think because I was so closely involved in them.

DR KIRKUP: Okay.

MR DUNKELD: But ...

PROF MONTGOMERY: You'd said earlier that you were proud of the care until these incidents. So did your view – did the care change around that time in other ways as well? Or was it that you – that you became more aware that if it wasn't going right on fluids, what else was wrong as well?

MR DUNKELD: There were, yes, there was probably a little bit of that. If you find one thing going seriously wrong, you're bound to think, 'What else is happening?' But there was – I don't think there was anything else I could really point a finger at. No.

PROF MONTGOMERY: Okay.

MR DUNKELD: Apart from, you know, there's always isolated incidents that you think, 'Oh that's let us down a bit' and, 'I wish that hadn't happened'. Not a general trend in any direction anyway.

DR KIRKUP: Okay, but what happened after that?

MR DUNKELD: There came a point in – it's hard for me to remember, because I didn't keep a record. In about April or May of 2005 I started noticing that a number of drips were turned off when I arrived in the ward to take duty. I'd come across dependent patients whose drips had been actually locked off at the roller lock.

It struck me straight away as really strange, because that's the sort of thing that I would expect to come across – maybe I might come across one or two in a year that had been locked off accidentally. For instance, the patient needed a change of pyjama jacket and the care assistants had just locked it off in order to get the – the unit through the pyjama sleeve and there wasn't a staff nurse available to set it at the right rate again. You wouldn't – it wouldn't happen very often. I would think once or twice a year you might come across that. But now I was finding two in a single shift, and two again the next night, and one the night after that. It was that sort of pattern.

This went on for a while. I mean I would just take the natural course of

action: I would check the chart, make sure that it was now running at the rate it should be, and so, be it a mistake or anything else, I'm putting it right as I'm going along. I didn't make any note in the notes, or any incident reports about it, because I just thought it must be a mistake. Somebody's just made, you know, had overlooked starting it again.

But as it begins to build up, you see more and more of them, you start thinking, 'I need to do – see somebody about this, I don't know what to do.' Somebody just can't – if it is accidental, it's being doing by somebody who really doesn't appreciate how important these things are. So we need – and I was trying to think, 'Have we got any new members of staff who haven't really been fully trained up? Or don't realise what we're doing?' There didn't seem to be anybody, any candidates amongst the staff really.

But eventually the – I was forced to think the unthinkable, because it dawned on me that every time I found a drip turned off, these – it was among the patients that had been cared for by one particular nurse, who handed those particular patients over to me that night.

DR KIRKUP: Okay.

MR DUNKELD: So...

DR KIRKUP: Go on.

MR DUNKELD: At the first opportunity I decided I would challenge that nurse about it, and seized the opportunity one night. Do you know, I can't for the life of me decide whether I'd just started my shift, or I was just leaving the ward. So it may have been the night or it may have been in the morning. If you work nights it's all one, you know.

But I saw that particular nurse sitting at the nurse station. So I went over. There was no one else around. So I said to her, 'Excuse me', by name, 'Are you having difficulty with the drips?' and she said, 'What do you mean?' I said, 'Well, I keep finding drips that are turned off' and at this point I fixed her gaze, meaning trying to mean more than I was saying. And I expected any of a number of possible excuses, like, 'I don't know what you're talking about', or, 'If I did that it must have been a mistake' or, 'Must have forgotten', or...but she actually said to me, 'Well what are you doing when you give those patients fluids? You're just killing them slowly aren't you?'

I was quite taken aback, and couldn't answer. I couldn't think of an

answer to that. And just at that moment, another nurse came out of the treatment room, who - I hadn't seen that there was anybody in there. She'd overheard the exchange, and agreed – so the second nurse, as she passed, said, 'Well, she's right, isn't she?'

I found that quite devastating. To me, that sounded as though the first nurse was admitting that she was turning the drips off, and the second nurse was in complete agreement with that.

So I discussed it with a junior sister on our ward. The ward manager not being on the ward at the time, and she said, 'Russell, I can't do anything about that unless you put it in writing' and that was the last thing I wanted to do. Because I'm – I'm completely uncertain about what's happening now, and to have to put it in writing, you put a thing in writing and it gets bigger than you meant, doesn't it? It always feels carved in stone if you're writing it down.

I was very unwilling to do that, but I realised I had to. So that night I wrote out a manuscript report. We didn't have keyboards and computers on the wards at that – in 2005, so I couldn't do it word processed, and I was very unwilling to use the word, 'murder' or any emotive language. I didn't want to precipitate things, when I've no evidence really.

So I made a very guarded statement about what I'd seen, trying to avoid it being an allegation at all. I wanted to share my suspicions really, to tell people what I'd found and what I'd heard. To have somebody consider it and perhaps ask their own questions, to take it off my hands really, that's what I was trying to do.

DR KIRKUP: Sure.

MR DUNKELD: Anyway, I then handed it to the junior sister, who I never saw again actually. She got a promotion to another ward, or another place, anyway. So I never saw her again. But about, I think it was – it's no good me saying I think how long later was, because I really have no idea how much later it was. It might have been a day or two, it might have been two or three weeks later. But eventually my ward manager took me on one side and said, 'Oh Russell, I've seen the letter that you wrote about Nurse A. I'm sure it was happening, but she's resigned now.' And I said, 'Well it was happening' and that was that. I never heard anything about it again after that.

I didn't know anything about whistle-blowing regulations or policies or

anything at that time. I didn't know – I wasn't even familiar with the term. I didn't know what that was. So I didn't think anything about not getting written acknowledgement or updates or feedback or, you know. I just left it like that. And I comforted myself with the idea that something would probably have been done, and that I couldn't be informed about it for reasons of confidentiality.

In actual fact, I never saw Nurse A again, the nurse that had...

DR KIRKUP: Is this the one who's said to have resigned?

MR DUNKELD: That's right.

DR KIRKUP: Yes.

MR DUNKELD: She apparently, and unknown to me, had been facing a separate – entirely separate charge of patient abuse and had resigned to avoid disciplinary proceedings in that case. But then because that was entirely unknown to me, I just assumed that she'd gone because of the report what I'd written.

For a quite a while afterwards I was expecting the police to come, to say, 'Tell us more, what happened, who did what, who said what?' But nothing happened at all, and eventually, of course, I just thought, 'Well they've obviously done something appropriate because she's left the ward. She's gone.' So in my trustful way I just thought something probably must have been done, and left it at that.

I didn't hear anything about it again until it became the subject of the second grievance that I raised in November 2008, when it transpired that nothing had been done whatsoever, and a search for my manuscript report found it un-actioned and unacknowledged in an archive file.

DR KIRKUP: Okay.

PROF MONTGOMERY: How did you discover nothing had happened?

MR DUNKELD: Because I raised a grievance about it...

PROF MONTGOMERY: Because you'd not heard anything?

MR DUNKELD: And that was acknowledged, at the grievance hearing, that...

PROF MONTGOMERY: A grievance against?

MR DUNKELD: Against the Trust. For not providing written acknowledgement of my whistle-blowing report, or feeding back etc.

DR KIRKUP: Was it about any other issues? Or just about that?

MR DUNKELD: That was just about that one.

DR KIRKUP: Yes, okay.

PROF MONTGOMERY: So what prompted you to think that was the time? Because you said to us you thought something must have been done. But had you discovered – how did you discover that actually nothing had been?

MR DUNKELD: In that intervening period I'd raised another grievance, about other issues, and I'd learned a lot about the whistle-blowing policy and the way things ought to be handled, and I'd realised that that earlier report, which I regarded as much more serious, can't have been handled properly because I'd not had any feedback or anything on it. And in the event I discovered that it hadn't been.

PROF MONTGOMERY: As a matter of interest, did you – it seems that, from the outside, you think that shouldn't have needed a grievance if you'd just brought it to their attention? That it had disappeared. You would have expected a management team to go and find out about it without needing to go through a grievance process. Did you raise it informally?

MR DUNKELD: We were not – my – the Trust and I were not the best of friends by then I'm afraid. They'd mishandled the first grievance so badly that I just shot from the hip I'm afraid.

DR KIRKUP: Okay. Can you tell us what the intervening issue was about? Was that about patient care as well or just...

MR DUNKELD: Yes. Principally about the administration of a nasogastric tube into a patient who, according to the protocol, should definitely not have had one, and who suffered aspiration pneumonia as a result.

DR KIRKUP: Okay. And what was the outcome of that?

MR DUNKELD: I raised a grievance about that and, 16 months after – after I'd reported the matter, the grievance investigation found that no investigation had been begun at all. That I'd received no written acknowledgement, no feedback, no updates and no investigation had even begun.

DR KIRKUP: Okay.

MR DUNKELD: So that grievance was upheld, and you can understand I was in no mood to be fobbed off any more by then.

DR KIRKUP: Yes, I understand that. What was the outcome of the nasogastric tube incident? Was it ever properly investigated?

MR DUNKELD: No. I reported it formally as a whistle-blowing report, and no investigation was begun. The grievance hearing admitted that the investigation should have been begun and hadn't, and yet they still did not launch an investigation and, when I re-engaged with the Trust in, well, late last year, I was eventually promised, in January this year, that they would begin an investigation into that nasogastric tube incident.

But, I heard nothing else about it until the day after I'd been invited to come to this investigation which, I have to say, smells like a very strange coincidence to me.

DR KIRKUP: They've waited a year.

MR DUNKELD: They've apparently completed an investigation in April, and hadn't thought to inform me of that for five, six months until they heard from the CQC that I was coming here.

DR KIRKUP: Okay. Did they tell you what the outcome of the investigation was?

MR DUNKELD: No. They are anxious to share the results with me, but I've been so busy preparing for this that I haven't been able to go to see them yet. It's a shame, it would have been convenient if they could have given me the results.

DR KIRKUP: Okay. You said that Nurse A had been the subject of a separate allegation of patient abuse? Are you aware of the nature of that patient abuse?

MR DUNKELD: I am. Only because I eventually prepared a tribunal case – an employment law tribunal case against the Trust, and in their bundle of papers that they submitted to the tribunal – the tribunal never actually happened, we never go that far – but in the bundle of papers that they submitted, [inaudible] there were copies of letters to Nurse A about previous patient abuse.

DR KIRKUP: One incident or several incidents?

MR DUNKELD: Two.

DR KIRKUP: Two. Okay. I think we may need to come back to that discussion. Okay. Were you aware of any other episodes of patient abuse yourself? Other than the ones that you've told us about, which are drips being switched off, the nasogastric tube that shouldn't have been used?

MR DUNKELD: No, no. I would have reported anything that I saw other than that.

DR KIRKUP: That was the impression I was getting.

MR DUNKELD: I'm very conscientious like that. If I can't get to the bottom of things

by face to face discussion, then it goes further I'm afraid.

DR KIRKUP: I see. Okay. And you mentioned – well, told us right at the outset you resigned in 2009, and you mentioned an employment tribunal that I guess was related. Can you tell us what happened there? Why did you decide to resign then?

MR DUNKELD: I decided to resign because I felt completely betrayed by the Trust. Defamed by my managers, estranged from all my colleagues, utterly treated with contempt. Reports that I'd made to them were just ignored, without investigation, and I can detect attempts to make me believe that things were being done about my reports, when actually nothing was being done at all.

For instance, I was getting letters from management saying - headed, 'Ongoing investigation', and as I told you 16 months later I found out the investigation hadn't even begun to be ongoing. No, I felt completely betrayed by them, and their invitations to me to, 'Put all this behind you, Russell, and get back to work, you'll feel a lot better' rather felt like I was being invited to join their gang, if you like. Now I'd would know what was happening, but I wasn't to tell anybody because I was in their trusted position now. I wouldn't join.

DR KIRKUP: Was that said to you explicitly? Or was that inference you drew?

MR DUNKELD: No, it's an inference.

DR KIRKUP: An inference, and you were suggesting there that you were off work I think. Were you off for a long period?

MR DUNKELD: I was off for a long time, yes.

DR KIRKUP: And can you remember when you went off?

MR DUNKELD: [Inaudible] sorry?

DR KIRKUP: Can you remember when it was you went off work?

MR DUNKELD: March, I think, of 2007.

DR KIRKUP: Okay.

MR DUNKELD: I went back briefly on a sort of phased return I think we call it. But it didn't work. The sleeplessness returned and I was unable to continue with it. I had numerous requests for me to put it all behind me and return to work, but of course I couldn't. I hadn't been dealt with. So it wasn't going to be put behind me I'm afraid.

DR KIRKUP: Okay, and the employment tribunal case was constructive dismissal?

MR DUNKELD: Yes.

DR KIRKUP: And it was settled before it went to the tribunal?

MR DUNKELD: Yes, it was.

DR KIRKUP: So you got some kind of...

MR DUNKELD: I was forced into agreeing an out of court settlement, yes. Forced.

DR KIRKUP: Right. Was there any suggestion that there should be a confidentiality clause attached to it?

MR DUNKELD: There was a confidentiality clause, yes.

DR KIRKUP: Okay, so you actually signed the confidentiality?

MR DUNKELD: I had to do it. My prospects at tribunal apparently had been reduced to nil by chicanery on the part of the trust and, having already spent £9,000 in legal fees, I'm a nurse, I'm not a rich man. I eventually had to swallow the advice that I'd paid £9,000 for, and that advice was, 'Give in now before it gets any worse.' So I signed.

DR KIRKUP: Is this the further – I need to ask this carefully, I think. Are you potentially in breach of your confidentiality clause talking to us?

MR DUNKELD: I'm sure I am. Yes.

DR KIRKUP: Is this the first time that you've been potentially in breach of it?

MR DUNKELD: No, not the first time, no.

DR KIRKUP: You've spoken to others?

MR DUNKELD: Since Sir David Nicholson's appearance between the Commons Health Site Committee I've been quite happy to speak about it, because he told the world that gagging clauses are utterly unacceptable.

DR KIRKUP: Sure.

MR DUNKELD: So I thought well I don't accept it either then.

DR KIRKUP: Sure, that's [inaudible]. Sorry, there was something else that I was going to ask you that's gone out of my head now. Just kind of [inaudible]...

PROF MONTGOMERY: [Inaudible]. Take over for a bit...We do need to try to understand how widespread your perception is of this attitude in the Trust. So was it unusual, in your ward, for them to sit on concerns being raised and not deal with anything, and how high up the Trust did you deal with people?

MR DUNKELD: I really don't know how wide I can go, because, of course, as soon as anybody makes a report there's this clampdown of information. Nobody says anything and nobody asks anything. So I can't spread it for you. I will

tell you that my senior divisional nurse, I believe, conspired with a human resource business partner to make a false statement to the employment tribunal, in a bid to deprive me of my legal rights, and I've left copies – there are copies of documents, they're being copied now, for you to read about that.

It arose from the – my first grievance hearing, my – there had been such a delay in dealing with the grievance that my sick pay had completely run out. On the day of the grievance hearing my total income, from all sources, was £0.64 a week in housing benefit. So I was already stretched out over a flame, and I'd already indicated that I wanted – my intention was to leave the Trust's employment.

Having had the grievance upheld, the chair of the hearing said, 'You've expressed the wish to leave our employment, but hopefully this successful outcome of your grievance, you may want to reconsider. Would you be prepared to give the Trust time to look for alternative employment for you in a less stressful area?'

Well, of course, that was just what I wanted to hear. On £0.64 a week you don't have many choices really. So I said, 'Yes, I would be interested to hear of any other opportunities elsewhere.' It's probably irrelevant to this investigation, but I had a union rep on each shoulder. They made no murmur, but that came to be the crux of the matter later on...

DR KIRKUP: Yes. Because you'd accepted that you could work at the Trust, yes, I know, I know.

MR DUNKELD: That's right. Yes. So I just accepted the breaches it had just taken me 16 months to prove. When it came to looking for alternative employment for me, I was sent to the senior divisional nurse who sat me down, welcomed me, and told me that he'd every sympathy for the trouble that I'd had, and that he'd read all about it in the grievance report.

I said, 'Oh, you've read the whole report have you?' and he said, 'Well, no, I've read the summary. The, you know...' I said, 'What? The first four pages?' This is a 120 page report, yes? He'd managed to read the first four pages. So I said, 'Well that's really not good enough, you know, because the other 116 pages contain an awful lot of stuff that is actually relevant to how I feel about the Trust at the moment, and if we can't even talk about that then really you've done me a disservice, because it's taken me an awful long time

to get this far, an awful lot of energy has gone to getting that 120 page report, and you've just managed to read the first four pages? Not good enough.'

'Oh well, well anyway, we'll – let's talk about alternative employment for you.' He offered me a job in a ward that we all knew – we'd all talked about it was the end of your career if you entered that ward. It was a place you'd never be heard from again. So I just said, 'I'm really not interested in that ward.' So he went away to try to find other wards to put me on, but he did admit to me that it was going to be difficult because all the wards are stressful. I said, 'So the Trust has offered me something that it doesn't have'.

Anyway, I went away and the next – I think it was only a day or two later, he wrote me a letter minuting the meeting that we just had, and he actually admitted in that letter that he'd read the summary of the report.

Now, later when these two gentlemen were asked to prepare statements for the tribunal, and there are copies there for you to read, you will find that they both agree that they insisted to me, in that meeting, that the senior divisional nurse had read the whole report not just once, but twice.

My barrister picked that out straight away. I was - I'd picked that out myself before I ever went to the meeting with the barrister, but my barrister was very keen on that point. She said she was looking forward to the day in court when she could have torn these two to pieces. They'd quite obviously conspired together, realised their mistake and conspired together to make it all look okay again. We never go that day in court, I'm afraid, but who would have dreamt that the court would be convened to listen to my evidence on that matter.

PROF MONTGOMERY: Are you aware of whether there are other people who've had similar experiences? One of the questions for us will be, 'Does this tell us something about the whole Trust or does it tell us something about a few individuals in the Trust?'

MR DUNKELD: I don't know of any other whistle-blowers, you see. You just get completely isolated. As soon as you blow the whistle you are completely shepherded away from everybody else.

DR KIRKUP: What was your employment record like between 1990 and 2004?

MR DUNKELD: Fine. I'd had the occasional bout of flu or, you know, I broke a toe in me foot once, but, you know.

DR KIRKUP: Any prolonged absences?

MR DUNKELD: I served overseas with the army for 6 months in Bosnia, attached to the Parachute Regiment as a medic. But no...

DR KIRKUP: Okay. I think that comes under a different category.

MR DUNKELD: Yes.

DR KIRKUP: Okay. I think, unless we've got any other questions, I would like to ask that we move into a confidential session, because there's a couple of clinically confidential details that I'd like to ask you about.

MR DUNKELD: Okay.

DR KIRKUP: Okay. We'll have a brief pause while we ask the observers to leave the room please.

(The hearing moved into private session)

THE MORECAMBE BAY INVESTIGATION

Thursday, 9 October 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes - Expert Advisor on Governance
Ms Jacqui Featherstone - Expert Advisor on Midwifery
Dr Geraldine Walters - Expert Advisor on Nursing

PETER DYER

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(At 3.28 p.m.)

DR KIRKUP: Okay. I'm Bill Kirkup. I'm the chair of the investigation panel. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: I'm Geraldine Walters, and I'm the Director of Nursing at Kings College Hospital.

MR BROOKES: I'm Julian Brookes, I'm currently the Chief Operating Officer for Public Health, England, but was previous head of Clinical Quality at the Department of Health.

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm the Head of Midwifery and the Head of Nursing at a district general hospital in Essex.

DR KIRKUP: Thank you for coming. You'll have seen we are recording proceedings, and we'll produce an agreed record at the end. You may also know that the proceedings are open to family members as observers; as it happens, we don't have any here this afternoon, but they can listen to the recordings subsequently, if they want to. I also know that we've asked you to hand in mobile telephone, tablets any potential recording devices, just to emphasise that what we talk about in the room, stays within the room until we're ready to produce a report with the findings in context. Do you have any questions for me about the process?

DR DYER: No thank you.

DR KIRKUP: Okay. I'll start with a very general question then hand you over to colleagues for a while and my general question is, can you tell us when you started at the Trust, and what you did, particularly with reference to clinical director and medical director positions?

DR DYER: I started in 1998 as consultant in oral and maxillofacial surgery. Within a few months, I was asked to -- became the clinical lead for head and neck, which encompassed my speciality, ENT and ophthalmology. From 2004 to 2006, I was the clinical director for surgery, and then from 2006 to 2012, I was the medical director.

DR KIRKUP: Okay. And since 2012, you've continued as a consultant but not with a medical director post?

DR DYER: That's correct, but I have carried on as the responsible officer for the organisation covering appraisal and revalidation of doctors.

DR KIRKUP: Yes, thank you for reminding us. That's great, that's really clear, thank you.

DR WALTERS: What were the big issues for the medical director position when you started?

DR DYER: Yes indeed, the big issue seemed to me, if I recollect, was the impending consultation regarding the medical services at Westmorland General Hospital. There was also other issues relating to some of the doctors which were ongoing, maybe investigations, maybe issues relating to the consultant contract, but by far the overriding issue was the one about whether medical services should be moved from the Westmorland General Hospital to the Royal Lancaster Infirmary ~~in the first~~ and Furness General Hospital.

DR WALTERS: And what did that involve you doing?

DR DYER: When I started, the pre-consultation phase was taking place, but within a few months really, within two or three months, the consultation phase took place and I was very much asked to lead the clinical part of that so it was really meeting members of staff, liaising with general practitioner colleagues, meeting members of the public, taking public meetings, council meetings, to put the case for the transfer of medical services – the acute medical services.

DR WALTERS: So did you have a big sessional commitment for that then did you? Or – were you still doing clinical work as well?

DR DYER: My sessional commitment as medical director was four days a week, but I did want to carry on a clinical commitment, so I used to carry on a day a week, and it actually worked out over a two, three week period of about a day, a day and a half a week actually, when that included clinics and operating, but I also maintained the on-call load as well, so – that was a one in four during the week, and every Tuesday night, and then every fourth weekend, so I did maintain a clinical aspect of my work, and that, for me, was really important as medical director.

DR WALTERS: So you were reporting to the Chief Executive?

DR DYER: Yes. My line manager was the Chief Executive.

DR WALTERS: And – so, in your sort of dealings with him, was his key interest the way that this consultation was going and you're impacting, trying to sort of craft things into rational direction?

DR DYER: Yes. At the time, when I was appointed, the Chief Executive was

incoming and there was no doubt that the aspect of acute medical services was really, I felt, uppermost in his mind. But it was also about how we managed the medical work force and as I say, there were some outstanding issues with individual consultants that I felt the Chief Executive wanted me to deal with.

DR WALTERS: What did you think of the Trust Board, and how that worked, at that time?

DR DYER: The first – my first impression really was that I entered a Board that was really quite established, but what I didn't realise at that point was that within a few months, a large number of the – there had been a high turnover, so I really wasn't expecting that, so – but I felt that it was a well-established Board; there was a fairly new chairperson at that stage, I can't quite recall how long she'd been in post, but I did get a sense that she was really taking the aspect of governance and taking the Board forward in that direction really very, very seriously, and certainly my meetings with her, I was left in no doubt at all that governance was high on her agenda, and in fact, when I had my interview that she chaired, the presentation that I had to give was just called, 'Governance', so – I felt that it was a Board that was well established but as it happened, was really coming to the end of its time.

MR BROOKES: So, if I could just clarify, that's 2006?

DR DYER: Yes.

MR BROOKES: So there was a significant transfer or change of non-executives at that stage?

DR DYER: The interregnum really lasted about a year, between 2006 right through to March 2007 when Mr Halsall took over. In the interim, the acting chief executive was – sorry, may I just refer to my notes – had been the Chief Operating Officer Kevin McGee ~~[inaudible]~~.

MR BROOKES: So it was the Chief Executive, when you were referring to the change on the board, it was really rather the Chief Executive's post, or was it – wider than that?

DR DYER: No. During that first few months, during that period of 2006 right through, the Chief Executive left, then – the Nursing Director certainly left during that time, the HR Director left. They were the key ones that I can remember, but the Finance Director had only recently started a few months before I did, but

really, in terms of the new executive, began to establish itself in April 2007 onwards, with just myself and the previous Finance Director.

DR WALTERS: So when the new team had – not sure – the new team was in place of sort of executives and non-executives, was there a change in the interests of the Board, or was it business as usual?

DR DYER: The thing that I really noticed when the Halsall administration came in, was I sensed a real change in how we looked at governance and risk in the organisation. Up to then, I wasn't aware of it being talked about, you did – it was talked about much more. And if I give an example, very early on, in that first year, we had a Board meeting or a Board away day, which was hosted by ~~the Board audit office, and we set a new [strap line?]~~ the Liverpool Internal Audit Office and we set a new strap line for the organisation, we looked at our risk rates, our risks, we established a new risk rating, as it were, for different risks and that was really the first time that I was aware of that happening, so I felt that that was putting a line in the sand, that this was the way things were going.

I've not doubt at all that that was, as a starter, in our bid to become a Foundation Trust, that we too had to think of governance and risk in a different way.

DR WALTERS: Did that sort of give you a sort of incentive to look how it worked down the chain a lot more, and did you make changes, or –

DR DYER: That had really started before I was medical director, because about the time I had my interview, Aiden Halligan who's the deputy chief medical officer, had produced a paper in which he said, 'It was time for Trusts to start bringing clinical governance and non-clinical governance together. And he described it as a thread running through the organisation. And I used that as my presentation to the medical ~~director~~ interview panel because our organisation had non clinical and clinical governance, operating not only separately, but in two different buildings, so although geographically, as well as emotionally apart, I suppose is the best way to describe it. And so, one of the things I discussed with – at my interview, and then subsequently, ~~with the chief – [Ian Collingham?] [inaudible]~~ with the chief executive Ian Cumming, who's – the need to think in terms of bringing the two together under one roof, amalgamating the departments. The clinical governance model was very

much based on pillars of clinical governance, audit, research, education and so on, and that was really the department at the time we inherited. So, the way forward was to bring the governance together under one roof and of course, I was cognisant of the document, 'The Intelligent Board', which was certainly something that I was encouraged to read very early on in my tenure ~~[inaudible]~~.

DR WALTERS: How did you go about sort of making that real on the shop floor, so, if you're working in a division, clinical division, how would you expect all that to come together, there as well as in the department's higher up?

DR DYER: It was really a long process. By which we had to put various building blocks in place. And it really took off during 2008, 2009, as we were moving towards Foundation status. The deputy chair, Stephen Smith, was asked to do a review of governance and at about that time, Jackie Holt was the new Director of Nursing, permanent lead, coming from a hospital in Liverpool, and she brought with her examples of how governance had been organised, the committee structure had been organised in her Trust. We, very early on in 2009, reorganised our governance structure in terms of committees, such that we had the Board, and reporting directly to the Board, was the Clinical Quality and Safety Committee, and below that was three sub-committees that were based on the Darzi principles of quality, so there was risk, that was safety, there was patient experience, and there was audit and effectiveness. So that was the template that we set up to look at governance – to manage governance.

There were other aspects going on at the same time, for example, how reporting of incidents took place. So there were a number of issues, or a number of things that were being put into place to bring it all together, to, if you like, put together a governance structure which was going to be truly in a position to be ~~[inaudible]~~ accountable.

DR WALTERS: So, given all that structures together then, what was – what were your biggest clinical quality concerns? And did you find out about them through that structure, articulating the way it should?

DR DYER: My big concerns when I first started was really how was reporting of incidents carried out and how did I know that we captured all those reports? When I took over the clinical governance aspect, reporting was done really in

a fairly, I felt, ad hoc fashion, so it might be telephone calls to the department, it might be a letter, it might be an email, it might be a corridor conversation. I became aware that we had a system called 'Safeguard' in the Trust which actually had a facility for allowing reporting to be done electronically. And so one of the things I instituted fairly early on in my tenure, was to get an electronic reporting as the sole way in which incidents were reported. This took quite a bit of time. The risk manager at the time was not happy to introduce that and I had to take the [redacted] when I was able to get the members of the department to introduce that. Secondly, it had to be rolled out to departments, and so there was a six month, maybe longer period, where we still used the old system, in parallel, or adjacent to the electronic system, but certainly by April 2008, we had a purely electronic system for recording. And I felt that at that point we were then in a position to – it certainly made me feel more comfortable that we were in a position to start getting more incidents reported.

DR WALTERS: And it go – did your incident rate go up?

DR DYER: Over a period of time, we were able – because it was electronic, we could then look at the data. At about the same time, the National Patient Safety Authority were also asking for information about incidents, so we were able to see the number of incidents increasing – the reports of incidents increasing, and that was absolutely what we expected, and hoped for, we were – I was particularly interested in seeing whether doctors were reporting, because I was aware that as a group, doctors were less comfortable about reporting than other groups. And we did see that; I wouldn't like to say it was absolutely perfect, but I could see an increase there.

DR WALTERS: So if the Board said to you, as Medical Director, can you give us some assurance that our elderly care services are safe, what would be your response to that?

DR DYER: Can I just go back a step to say that matters of safety and risk were dealt with through the integrated risk sub- committee, and it would be to that sub-committee that the divisions would report and it would be through there that I would have learnt if there were any risks or concerns from the medical side, and similarly from a nursing side, they would be coming there, so – there was an expectation that the divisions would report into those monthly meetings.

DR WALTERS: Right.

DR DYER: We also had other ways of intelligence as well, so we had CHKS data, which was a means in which we could look at data, although there was a degree that that was retrospective to a certain point. But as we developed as a Board, we introduced something called 'Guru', which was a day to day way in which we could look at certain aspects, so, for example, elderly care; well we could look at the number of bed sores, we could look at the number of falls which was an issue for the Trust.

DR WALTERS: Was it your view, that sort of the budget holders and the managers would be equal in their contribution to safety at divisional level, as the clinical people?

DR DYER: We expected divisions to be represented by certainly a manager and ~~commissioner~~ clinician. And in terms of budget holding, that would be the manager. Where I realised there was a shortfall, was that we needed to have a risk manager in each division, and so during, again, those early months and years of the new Board, we established, that each division should have a risk manager who was expected to come to those meetings. Parallel to that, there was also a need to align the risk with – the risk from a surgical division could be compared to a risk from a medial division. And so we instituted a RAG rating for that. But that, in itself, had its challenges, and not all the divisions, it didn't all happen overnight. This was something which – I think really that the organisation was on a steep learning curve in terms of getting processes in place.

DR WALTERS: Did you have any clinical safety concerns?

DR DYER: Certainly I had concerns about – some of it was things, just in terms of how data was handled, so, for example, a very big issue when I first started was notes not being available in the clinic, and that really was a very, very big issue for doctors when I first started. When I looked at – when I looked at CHKS data, I had concerns about, well, for example, the way in which patients were admitted to the Lancaster site, for example, under a physician and that data was captured, did not always – if the patient subsequently died, it may – the death may not be treated to the right consultants, so there was really real concerns there. And – my – the reason I was concerned about these sort of issues, because I felt I couldn't quite get a handle of – as to those issues such

as patients dying from stroke, for example. I needed to be sure that the information was absolutely right.

DR WALTERS: What was the response when suddenly, you had these high mortality rates, or you were informed that you had the highest mortality rates in the country, were you surprised about that, or –?

DR DYER: May I just refer to the letter? That particular episode took place – it was summer of 2011, I was alerted that we were going to be reported as having the highest mortality rate. This was extremely worrying, and really unexpected. And I took the view that I needed to inform my consultant colleagues, the medical directors of the two adjacent PCTs, and so I did write – and it was a letter that was widely leaked to the national press and to the television. But I essentially broke the embargo that Dr Foster had put in, because I was so concerned. But prior to that letter, I did look and see, was there an explanation for that? And that's detailed in the letter here, which you may or may not have seen already. But I picked out three areas which I felt were contributing. May I just read?

DR WALTERS: Hmm.

DR DYER: The first area I think linked into the fact that we'd moved from what was called the IPM system, for patient records, to the new Lorenzo system. It was actually the information manager who alerted me that she felt this had caused a problem because patients who had been admitted under one system were not being discharged in that system; they were being transferred to the other system, so there was – somehow, the data was not being properly recorded for a period of about three months. And certainly when I looked at it with the information manager we felt that that had a significant impact. I couldn't quantify the impact, but we felt that there was an issue there.

The second area, which was how we were coding palliative care – and I don't want to overstress this, because I know it is contentious, but certainly we as a trust weren't coding palliative care in quite the same way as other trusts were. And what I'd asked was for CHKS to rerun the data as if we were coding our palliative care as other trusts were doing it, and that produced a 10 point fall in our risk adjusted mortality index. So, taking account of all the concerns about indices, I felt that that was certainly a factor that we weren't properly managing our palliative care.

Then the third aspect, which was one that I had already started to address with concerned colleagues, was how we code comorbidities, and we weren't doing that well, and so what I had done there was instigate a number of workshops with CHKS, with our information team, working with our surgeons and with our physicians. And, actually, by the time I had written this letter, which was in October 2011, our mortality rate was down to 103 from 124, so I felt that the measures that we were putting in place were starting to have an impact, but I'm not saying that that was something to be complacent about, but I felt that I was able to confidently say to my consultant colleagues, and also to the two PCTs, that this was an unexpected spike and one which I felt we were managing.

DR KIRKUP: So what did you usually run at, before then?

DR DYER: It was round about 100 or just over 100.

DR KIRKUP: Right.

DR KIRKUP: Can I just pick up a point in relation to that? There is a view – and I'm not saying that I necessarily subscribe to this view, but there is a view that, if you do that, if you adjust comorbidities in the way you code palliative care and so on, you're kind of explaining it away rather than actually investigating to see whether there's a real underlying problem. Did you do any investigation to see whether there was a real underlying problem?

DR DYER: Absolutely, and I'm absolutely cognisant of that argument, and I didn't want us to get into a position where we were trying to explain it away, and so I looked at those consultants who were outliers; I instituted a weekly electronic recording of deaths, so every patient who died in the trust – the consultant under whom they were named was asked to acknowledge that the patient had died under them; was the diagnosis correct; and, if it wasn't, I asked that it was corrected through our coders, because that, for me, was the key thing: it was to get my consultant clinician colleagues on board with this whole process.

DR KIRKUP: Okay. Thank you. Sorry, Geraldine.

DR WALTERS: That's alright. So, just going back a bit further, from your point of view or your recollection, what generated the Fielding report and how was it commissioned?

DR DYER: May I go back again a step? When Halsall took over, we knew that we

were going to be moving towards foundation trust status. Throughout the autumn of 2007 and early 2008, we brought in a company called Matrix to look at the clinical strategy for the organisation, and we had four, I think five, workshops during that three/four month period where we had ~~commissioners~~ clinicians from our trust; we had nursing staff; we had managers; we had colleagues from the two PCTs and GP colleagues looking at clinical strategy.

Round about January 2008, once those workshops had finished, the chief exec asked me to pull together a clinical strategy for the organisation. He gave me a rather challenging time schedule; he said, 'I want it by the end of February'. So I pulled together weekly meetings and workshops with clinicians, and I involved local GPs and PCTs as well, and we pulled together a clinical strategy, which was delivered at the end of February 2008. The main question we were trying to look at was: how should services be delivered; could we carry on with the three hospital model or should it be looked at in a different way? The clinical strategy, in many ways, raised more questions than answers, and, out of that, it became quite clear that we needed to look at individual specialties. And so, over the course of the next year, two years, we instituted reviews of EMT, ophthalmology, cardiology and paediatrics, and those reports were ongoing and we were receiving the recommendations for them.

During that period, we had the tragic incidents in maternity and obstetrics, and that, for me, was a view that we should then be looking and having another external review. I don't know whose idea it was to have a review. I certainly was asked by the chief executive if I thought it was a good idea, and I said I thought it was. I wanted a review that was going to be top to bottom, absolutely looking at the whole of the service, but I was also wanting it to come up with a way in which we could bring things forward, get it moving again, because I was detecting from the staff, from the doctors and the nurses, midwives, real unhappiness about things. They felt under siege, I suppose, and so I wanted a report that would give us that drive and that guidance to take us forward.

DR WALTERS: So, to your mind, it wasn't about 'What are these incidents telling us?'

DR DYER: I thought that they would – that they couldn't produce a report which

didn't mention those, but it was very much about a fresh beginning, a fresh start for that specialty.

DR WALTERS: So we've read quite a lot in the papers about these five incidents being unconnected. Can you remember what was the grounds for thinking they were unconnected? Were you completely happy with the root cause analyses and the investigation that had taken place?

DR DYER: Each of those incidents was fully investigated. I've got timelines here. Two of the incidents were certainly subject to external review by a senior obstetrician, and they subsequently went to inquest as well. They were all, as far as I know, went through a mechanism called STEIS, which was the way in which incidents would be reporting up to the SHA. I was absolutely satisfied that they were properly investigated, that we took external review when necessary, and that we acted upon those.

DR WALTERS: So happy that they were not connected, and, from your point of view, the Fielding report was about the future and taking this forward.

DR DYER: Absolutely, yes.

DR WALTERS: So, when you saw the report, was it what you expected?

DR DYER: There was elements of it which I felt they'd gone into greater detail, particularly about concerns. I think I personally had been looking for a more aspirational, inspirational report, and there was also one aspect which was completely excluded, which I had specifically asked for.

DR WALTERS: What was that?

DR DYER: During these reports, I was conscious of the fact that there were patients who were from Asian background, married to English men, in an isolated community. I was conscious that the Confidential Enquiry for Maternal and Child Health quite frequently raised this as a high risk group. I was concerned enough to speak to Professor Ashton, who I met on a regular basis; he was the director of public health, and he and I met probably monthly to discuss things. And Professor Ashton suggested that I do a research project. I did actually make inquiries to Lancaster University, where I had research connections, and there was certainly somebody who would have looked at this, but, when I took the bones, if you like, of the project to the chief executive, he was not happy for me to proceed.

During preliminary discussions with Professor Fielding, I did express a

hope that she would look at socioeconomic and ethnic issues, but that didn't really come through very strongly, particularly the... There was acknowledgement that Barrow was a deprived area, but there wasn't a specific mention about possible ethnicity, and I was disappointed about that.

DR WALTERS: Who wrote the terms of reference for it?

DR DYER: They were predominantly – from what I recall, the chief nursing officer, but I certainly had sight of those.

DR WALTERS: Right. So then, with an external review like that, I suppose the normal thing would be that it goes to the board, that there are some actions derived from that. So did that follow the normal pattern?

DR DYER: From what I can recollect, it was discussed at length in the clinical quality and safety committee, and then would have gone to the board, but I have to be honest; I cannot remember precisely the mechanism of how that took place?

DR WALTERS: And did the board get any follow up reports on whether the actions were being implemented?

DR DYER: Again, I can't fully recall that. I do recall that there was a lot of discussion over the months at the clinical quality safety committee, but I can't remember if there was an action plan that was attached to that.

DR WALTERS: Right, so were you responsible for any of the recommendations of the report?

DR DYER: Yes, certainly. The area that I particularly was concerned about was the issue about clinical leadership. This was something that it raised... There had been... The clinical director had certainly been in post for a number of years. I didn't particularly have any concerns about the way in which he managed that bit of what he was expected. I met him on a regular basis, every month, and there were no concerns specifically flagged up to me by him. I was conscious of the fact that the report was – although it didn't mention him by name – was critical of the way in which leadership – medical leadership was taking place, and I was concerned that I spoke to the chief executive and also to the divisional manager as well. And, at the time, the view was that that person should stay in post, because it was felt that there probably wasn't somebody who would immediately go in to replace him. We were also aware that he was due to retire fairly soon, and it was felt that there

could be a mechanism where a transition could take place.

DR KIRKUP: I mean, I'm not a midwife; I'm clearly an obstetrician, but some of the things in the report that, when I read it, alarmed me a bit was the whole thing about people going to theatre for a section in the middle of the night, which I think you're supposed to do in 10 or 15 minutes or something like that, and finding that the doors were locked and that there was no one on call. Did that not worry the board?

DR DYER: Absolutely, and that particular aspect was dealt with very, very quickly. That was of real concern, and the issue about not having a dedicated team available, a second team – absolutely, and, to my recollection, that was dealt with very, very quickly.

DR WALTERS: Did the board take the report seriously, do you think?

DR DYER: Yes.

DR WALTERS: Because it doesn't seem to have got to the board very often or very quickly; do you know what I mean? I just wondered if there was a reason for that.

DR DYER: As far as I know, the mechanism would have been that it would go to the clinical quality and safety committee and then onto the board, and I acknowledge that there might have been a delay, but, without looking at the relevant documents, I couldn't tell you if there was a delay.

DR WALTERS: And how do you think the recommendations filtered down to the division? Was there some sort of performance management from you and the director of nursing down to make sure those things were being done?

DR DYER: Certainly the aspects of the clinical leadership – I remember very clearly discussing that with the divisional manager, and also the other aspect, which was to do with multidisciplinary working, where guidelines were perhaps different at different sites. That was something I was extremely concerned about, and I instituted cross divisional work where policies would become overarching. So we acknowledged that there was three different sites, but, in terms of governance, they had to have the same policies and procedures, and there were certainly some policies that were being operated differently at different sites, and particularly I do remember chairing one particular policy committee to make sure that that policy was overarching. But that, for me, was of concern, that there might be other policies and ways of working that

were different.

DR WALTERS: I mean, clearly, there was a lot going on in this organisation at that point in time, and there's an extent to which executives can't always personally see that the loop has been closed on all of the small aspects of every action plan. Were you assured, though, that that was being done?

DR DYER: I was certainly assured that those aspects that were flagged up from, if you like, the medical side were done. I can't answer the other part as to whether I thought it was being done. I think I would have had an expectation that it was being done.

DR WALTERS: So did it get reported, though, back to you at the quality and safety committee that it was being done? Were you assured in that way?

DR DYER: Absolutely, that's where it would have... And I had no reason to believe that it wasn't – that the actions weren't being implemented.

DR WALTERS: Okay, thank you very much.

DR KIRKUP: Thanks. Julian.

MR BROOKES: Thank you. Can I just take you back a little bit to some things which I remember fondly in my past lives, around the pillars of the governance and then the Darzi three themes, as it were? Can you just explain to me – did you say there were three subcommittees, for each of those Darzi themes?

DR DYER: Yes, there were.

MR BROOKES: Okay. Can you just give me a flavour of what they would look at routinely?

DR DYER: Yeah. The integrated risk subcommittee, which was the safety part of the Darzi quality theme, that was the one where we expected the divisions to bring their risk rating, their risks to the subcommittee. We expected to see progress, on a month by month basis, as to how they were managing those risks, and, if there was red rated risks, then they would be escalated to the clinical quality and safety committee.

But I do put a caveat round that that a lot of the work that I did at the time as the chair was to really get the divisions to a point where they were using the RAG rating in a consistent manner, and the first thing we needed to do was to make sure there was a risk manager in each division; and, once that was established, it was to get a RAG rating; and then it was to really get people to realise that they couldn't rate something red just because it

happened to be something that the division wanted, as a problem, sorting out. And I would be wrong to say we got that right, because I think it was very, very difficult, and I got the impression that divisions were on a learning process to know how they should deal with this.

MR BROOKES: Can you give me a flavour of what kind of risks came through that committee?

DR DYER: I might be to do with failing equipment; it might be to do with staffing issues. Particularly I remember the medical division had issues about nursing, which was frequently high on the list. It might be to do with even appointing a new consultant – a new surgeon might be required, so – right down to... What we tried to do was to get an understanding of what was going on in the division right from the ward right through to the board, I suppose; that was what we were trying to do. And so it might be issues such as notes being left on the table so as that people could pick them up, so that was the sort of thing that we were dealing with – the full range, really.

MR BROOKES: And then what would be reported to the board from that? What – the mechanism would be to the clinical safety...?

DR DYER: That then went to the clinical – yes.

MR BROOKES: And what was reported to the board from there?

DR DYER: If there was a red rated issue that needed to be escalated, that could be escalated right from the subcommittee straight up to the board, and that... I can remember one incident where that happened, or alternatively... What the committee was receiving was really a flavour of how many incidents – or, sorry, how many issues were red rated, how many were amber rated, how many green rated. So it was really I suppose a filtering mechanism, in a way. But the quality and safety committee was also getting information – for example, the nursing director would always give a report about maternity and about nursing issues, so that was how, if you like, the issues were going up through to the quality committee.

MR BROOKES: And what powers did the quality committee have to deal with those issues?

DR DYER: It was to escalate it directly to the board.

MR BROOKES: So they wouldn't take action themselves; they'd escalate it to the board.

DR DYER: Quite often, I'd be... One of the big issues that came back to me on a number of occasions was how information was being delivered to that committee, and so quite a bit of my time working with the integrated risk team was trying to establish a way in which information was understandable by the committee, by the non-executives, so it was to put it into a form which was easily digestible, and that... So we started off with having long lists of incidents and what their rating was, and then we started to: 'Well, let's amalgamate that down and try and make it more readable.' So, instead of having every single type of fall, we just had it under 'falls' would be an example. But there was a lot of... I was certainly often asked to go back and try and present information in a different way.

MR BROOKES: Yes, so there's information there; I can see that. What I'm not clear on is how things got sorted where there was a problem. Was that through the committee? Was it through a referral to the board and the board would then ensure that action took place? How did it actually work?

DR DYER: This mechanism was an assurance mechanism. The way in which issues were dealt with was at the divisions, so it was... The divisions – the surgical division, the medical division – they were the ones where, operationally, things got sorted, and, if they weren't being sorted, then they would go up to the committee and to the board. So the actual hands on operational work – the expectation was that was done in the divisions.

MR BROOKES: But, as you just said, it got escalated when the divisions weren't able to sort it. So who sorted it if the division couldn't sort it?

DR DYER: That would be... I'm just trying to think of an example. It would certainly be... I can't think of an example, but I think, if it was felt to be a medical problem, then I would have been given a remit to deal with it; if it was a nursing problem, a nurse would be – chief nurse – or, if it was an operational issue, then the chief operating officer would be tasked to sort it.

MR BROOKES: Okay.

DR KIRKUP: So, just to butt in, so something like poor obstetric cover because of difficulties in recruitment – where would that go?

DR DYER: Something like that would be certainly discussed at the board. Issues of recruitment were a really very important part of some of the discussions that took place at a board report, and it was always part of the integrated board

report. In terms of actually finding the funding for it and getting, if you like, the recruitment process, that would be down to the division, and the expectation would be that would come through the chief operating officer, because the operational side of the organisation was done through the chief operating officer. As medical director I would be saying, 'We need this', and that would have come up in my discussions with the clinical director for obstetrics, for example, if there was something identified.

But I didn't have an operational role as such. The clinical directors were answerable to the chief operating officer, so, if you like, the line of authority went through to there, and so that was certainly an issue which I think, as a board, we only realised quite some time – that that was an issue and that had to be dealt with.

MR BROOKES: Okay, thanks. So, if an individual clinician – I understand the system you described; I'll come onto the other bits in a sec – but, if an individual clinician had a concern and raised it with you, would that be put into the process, or would it be dealt with separately?

DR DYER: It would very much depend on what the concern was and how it was taken up, but I always took a view that, if I was approached, by whatever means, then that concern had to be taken seriously. And so it depended really at what point the concern was coming in: did it need an informal approach or a formal approach? As my experience developed, I realised that really there's no such thing as an informal process, and I learnt that the hard way, and it became quite clear that, really, concerns always have to be treated in a formal way. And so, again, depending on what the concern was, whether it required an investigation or whether it could be dealt with by bringing people together and discussing it, that's how I would have managed it. But, if it was a concern of such great concern, then I would have – and I did, on the one occasion I'm thinking of, go to the chair of the clinical quality and safety committee and say, 'This needs to be dealt with now. We need to do it.' It was certainly recorded in the committee structure, but it needed to be dealt with straight away.

MR BROOKES: You may not recall this, but there's an incidence which I've seen which I wonder if you can help me with, because we're not clear what happened, but there was a letter written to you by Sue Harding about

anaesthetic cover in the obstetrics unit and the fact that you were not meeting the CNST 1 levels. She wrote outlining these concerns and the potential breaches of CNST. Do you recall that at all, and what was done about it?

DR DYER: I certainly remember having – I can't precisely remember a letter, but I can certainly remember having a conversation about this matter, and this was something that I certainly remember discussing at executive level.

MR BROOKES: That's trust executive level.

DR DYER: Trust executive, and it was also something which I can't recall how it went through the committee, but it was – something that we were really concerned about was anaesthetic cover within Furness General Hospital. It was something that was really high on our list of priorities. Trying to get anaesthetic cover at Furness was really very difficult in terms of recruitment, and I can't recall how we managed that particular issue, but it was certainly one of great concern.

MR BROOKES: You would have expected that to go into the risk system for your committee.

DR DYER: I would have done, yes.

MR BROOKES: Because we can't find a reference other than the letter to you. We can't see any response or indication, from what we've seen so far, in terms of discussion by the executive or anything else, so it just feels like it's stopped, and we're just interested in understanding what happened.

DR DYER: My usual approach would have been to speak to Dr Harding; it would have been to speak to the clinical lead for anaesthetics at Furness; and it would have been to – I have certainly escalated it to the executive. I can't explain why there can't be any reference to that.

MR BROOKES: Thank you, that's helpful. Can I go back to the architecture you've been describing as being built within the organisation in terms of governance – clinical governance? And I remember well the need to bring together corporate and clinical governance, controls, assurance, movements etc., and you've described that. As you move through that and you move to towards FT status, which of course you reference as being one of the – not necessarily a driver, but an important factor in moving forward, do you believe the organisation had good clinical governance systems in place?

DR DYER: I was confident that, once we could establish the structure that I

described, that that was certainly going to give us that assurance, as a board, that we required, but I also acknowledged that we were really on a journey, changing how governance works in the organisation.

MR BROOKES: Okay, thank you. As part of the FT process, there's a memorandum signed off by the board in terms of its governance systems. Do you recall that?

DR DYER: I can remember a discussion around signing off a memorandum, but I can't specifically remember when it happened.

MR BROOKES: Okay, so it went to the board about 2009, prior to the FT application being approved, and the board signed off its governance systems. I'm assuming you were involved in that decision as a board member.

DR DYER: Absolutely. I do remember the signing off process, but I can't remember actually when it happened.

MR BROOKES: Okay, and were you involved in the development of the memorandum, given your role in governance?

DR DYER: I can't absolutely remember, because, up until early 2009, my remit was around clinical governance, and it was only when it came together –

MR BROOKES: But there was clinical governance elements – a significant component of the memorandum is an assurance that clinical governance is effectively managed within the organisation, so I assume – but I'm asking for confirmation – were you involved in that process?

DR DYER: I'm very sorry; I cannot recall.

MR BROOKES: Okay, but the board signed off the memorandum, and, as part of that assurance process, you move towards an FT and become an FT. What I'm struggling with is then 18 months later, 2011, Price Coopers comes in and does a governance review which finds serious failings in the governance of the organisation. I can't understand how it can't have deteriorated. Can you help me at all with this? Because there clearly were, from the investigation Price Coopers did, serious concerns with the governance of the organisation, yet you've described a process you've put in place; you've described, as a board member if not as a medical director and responsibility for that, signing off the governance process, yet, 18 months later, it is seen as being significantly weak. Can you explain that?

DR DYER: First of all, the report from PwC was really quite shocking. It did come at

a time when the board had recently lost its chair and the organisation had been put into gold command, and so it was really a board that felt under siege. I was quite shocked, because, at the end of the first six months of having been an FT, Monitor themselves had given governance – clinical governance – a green rating, and also financial governance was not the top, but it was second highest. So I was absolutely shocked that, having been – by Monitor's assessment, we as a board seemed to be achieving a satisfactory level, that actually so quickly that should deteriorate.

MR BROOKES: So you actually think it deteriorated; it wasn't that the systems were the same. What had changed in the systems?

DR DYER: I can't understand how PwC came to their conclusion, other than by speculating that they saw an organisation which had been under considerable amount of pressure for four months, and that they were picking up on, if you like, the fallout of that – of what was going on at that time.

MR BROOKES: So you believe that, when the board signed off its memorandum of assurance on governance, that the organisation's governance was robust.

DR DYER: I, at the time, although I can't remember the precise moment that it was signed off, I had no reason to believe that our structures were in any way not appropriate for going forward, for the FT application.

MR BROOKES: Okay. Just one last area for me. One of the other three areas of Darzi is around patient experience.

DR DYER: Yes.

MR BROOKES: How was complaints and patient experience brought into the governance arrangements you've described?

DR DYER: That subcommittee was chaired by the nursing director. I had had overall responsibility for complaints when I first took on the role of medical director. In fact, it was one of my areas of concern when I first took over the role, and, in fact, one of the first things I did was take the complaints team out for a discussion to try and understand where their underlying problems were. I was aware that it was a department that felt it wasn't managing with the numbers of complaints, and so, very early on in my tenure, I asked the person who – one of the senior nurses to manage the department on a day to day basis. She effectively took over as the complaint manager for a period of time, but it was still very much a department under siege. I can't comment on the

patient experience subcommittee, but that wasn't part of my remit.

MR BROOKES: So I'll just reflect what I think I've heard. So you've got a complaints department under siege, concerns being raised about that. You've got some clinical – significant clinical issues have been raised in maternity services. You've got then... What I'm saying is, you might have the structures in place, but that doesn't mean you've got good governance, and, if you look at what Price Coopers identified, it wasn't about having a committee; it was about how the organisation operated. And, in the evidence we've received from them, they would indicate that, currently, the organisation is still struggling to get to a standard on governance. So I can't see how the board could have been clear that it had good governance at the time it signed off the assurance process.

DR DYER: I felt that the structures that we put in place would assure the board at that time, and I had no previous experience of applying for a foundation trust, and I was happy with the direction that the trust was going, because I thought that we were recognising that clinical and non-clinical risk had to come together, that we had to have governance as a strong theme in the organisation, so I felt that the key thing, in that... I certainly wouldn't have said that we were perfect in governance, and, I mean, I can't comment about now, other than my observations as responsible officer, and I think, at some point, you might want to ask me. I think that there are – we're still on a journey in terms of governance and linking up these different areas of complaints and incidents and how doctors are training and continuing their development. I think these things are still coming together, and we're getting better at it but it's still not there completely.

MR BROOKES: Thank you.

DR KIRKUP: Jacqui.

MS FEATHERSTONE: What would you say the relationship was between the paediatricians and the obstetricians, as the medical director? Did you get involved with anything?

DR DYER: I met with the... Actually, if I just go back a step, because part of the structure that came in just as I was being medical director was that obstetrics and gynaecology and paediatrics was all under the surgical division. They had been individual directorates, but they came under the surgical division, so it was a very big division. But I still identified the leads for paediatrics and

obstetrics. I met with them both on a monthly basis, and so I was very aware if they had particular issues.

Now, I've already said that I wasn't responsible for the operational side of things, so the types of issues that would come to me might be about interpersonal problems, sharing offices, on call rotas, secretarial issues. [redacted] There was issues about the – particularly at Furness – the paediatric – the number of consultants and the fact their rota was really not acceptable. I don't think it was unsafe, but it was not acceptable in a modern way of working. And so these were the type of issues that I was being asked to deal with, and so I think the relationship I had with the leads in paediatrics and obstetrics was good.

MS FEATHERSTONE: So some of the things that they were coming to you or you knew about, were they getting resolved – so the rota issue and the paediatric...? They were.

DR DYER: Simple things like offices and secretarial seemed to take up a lot of time and go on for a long time, but, yes, I tackled those. Issues in terms of rotas and number of consultants and paediatrics was a difficult issue. One of the things I did was get the clinical director or the lead for paediatrics to actually leave his clinical work at Lancaster and go and work at Furness, so he spent some time there so that he could get an understanding of what was happening there, and we tried to put together a cross bay paediatric rota, but there was really quite a lot of resistance for that. But, for me, it was really quite important that the two specialties – they were interlinked. There was – absolutely, they had to be together, particularly in an isolated hospital such as Furness General Hospital. But I didn't have any doubts that I wasn't being told of incidents or of issues.

MS FEATHERSTONE: You talked about complaints and that it didn't come through you, but, if there was a complaint about a particular consultant, would you not have heard of that?

DR DYER: I still met with the complaints manager on a – actually, she was part of a weekly meeting that took place, and also I met her on a one-to-one basis on a monthly basis. And so, if she had any particular concerns about particular doctors, then they were raised with me directly, and then I was able to follow

those up.

MS FEATHERSTONE: And do you remember a particular doctor – were there any more complaints about one than another.

DR DYER: There was one particular doctor who... [redacted]

MS FEATHERSTONE: Okay. Can we ask which he's talking about?

DR KIRKUP: Yes.

MS FEATHERSTONE: Who are you actually talking about?

DR DYER: [redacted]

DR KIRKUP: What specialty's that?

DR DYER: Sorry? [redacted]

MS FEATHERSTONE: The other thing is just about when you were medical director, about the trust board. Would you say that they were engaged with staff on the shop floor?

DR DYER: We instituted walk rounds, and we had a rota for an executive and a non-executive to walk round the wards. That was cross bay, so it could be at any of the sites, and I certainly took part, going on round wards with a non-executive.

MS FEATHERSTONE: I was going to ask about the non-execs. So the same – they would come with you too to go around as well.

DR DYER: We'd go round. We tended to go round together.

MS FEATHERSTONE: Okay. That's all I want to ask, thank you.

DR DYER: Okay, thanks.

DR KIRKUP: Okay, thanks. I'll just pick up a few specific points, if I may. I think you've partially answered this, but I'm assuming your clinical practice is based at Lancaster.

DR DYER: No, I've always worked cross bay. I was one of the few specialties that did actually work cross bay, and so it was –

DR KIRKUP: And can you explain how that works? Is that – you do clinics in Barrow?

DR DYER: Yes. Ever since I've been a consultant, I've done clinics and operating at

both Lancaster and at the Kendall sites and at the Barrow site. When I first started, there was also a clinic at Westmoreland General, but I felt that that was spreading myself too thinly. In fact, at that stage, I took over from a singlehanded consultant who'd really spent 25 years covering all three sites, and he – although he retired, he actually stayed on for five years, and that enabled me to build up the department and crate a case for a second consultant. We've now got a third consultant, so we essentially cover all three sites, the three of us.

DR KIRKUP: Then do each of the three of you all work across three sites – or two sites out of the three, anyway?

DR DYER: The way we've organised it, that two of us work at Lancaster and at Furness, and one person works at Lancaster and at Kendall. But all the on call is based at Lancaster. We took – from a patient safety point of view, we could only deal with emergencies at one site, and all the major operating is done at one site.

DR KIRKUP: Okay. Why do more specialties not see the need to work across multiple sites?

DR DYER: Now, this is something that used to keep me awake at night, and it was, I feel, one of the areas where, although I might have had a little bit of success, I never really got to the bottom of this, and it was a great disappointment to me. Certainly, the reviews to which I referred before relating to ENT and ophthalmology – we did realise there were more specialties that we could centralise certainly the out of hours at one site, and that was a recommendation from the reports. But, when, actually, one tried to institute that with the consultants, there was very much a site based loyalty.

At one point, I remember totting up that we had out of hours, on call, over 20 different teams, so we'd be duplicating orthopaedics, duplicating medicine, duplicating microbiology and so on. And, really, I just felt that that was unsustainable, and this was one of the areas around the clinical strategy which I took back to the board time and time again, to say, 'We do need to try and deal with this.' But, actually, when it comes to trying to change how clinicians behave, it was extremely difficult. One of the things that I had limited success with was changing simple things like the job description and the contract. It was only very recently that we have a cross bay contract

introduced, and so it was really quite difficult to get these disparate groups to work.

DR KIRKUP: Okay. How's appraisal and revalidation going?

DR DYER: I've been responsible officer now for four years. When I stepped down as medical director, I was asked to carry on as responsible officer by the board. The first year was challenging, because I'd had no resources, but I did create a case for introduction of an appraisal and revalidation coordinator, and also to set up an electronic system for appraisal and also an electronic system for patient and colleague feedback. So, by the end of the first year, when revalidation had just started, we had a coordinator in place. At the end of the first year, our appraisal rate was 65%, which wasn't good. At the end of our second year, it was 90%, and that's actually better than the North West, which the average is 86%, so I'm pleased to say that we have now got a process which is truly embedded. And, even more importantly, the SAS doctors, which are a neglected group, were almost 100% appraised.

DR KIRKUP: Okay, and were you turning up issues of concern as part of that process?

DR DYER: At the moment, I've not had to... Well, as responsible officer, I have three duties, either to revalidate somebody, in which case I have no concerns; either to delay them, which means I might have concerns or the doctor may not have got their paperwork together; or they may be an non engager. At the moment, I've had nobody who's a non-engager. I have deferred doctors. Approximately 10% of the doctors have been deferred, and the vast majority have been because they haven't got their paperwork in order. [redacted]

DR KIRKUP: Any of them in the maternity unit at Barrow?

DR DYER: I cannot recall. As I say, the vast majority of people have been revalidated. There has not been a specific doctor highlighted through this process which is to do with maternity.

DR KIRKUP: Okay. I want to ask you a little bit more about the Fielding report, I'm afraid. I know we've had a couple of goes at this, but when you are looking at a collection of incidents – the ones that preceded the Fielding report – and you

say that they're not connected, what are the sort of factors that you're looking for to say whether they're connected or not? What would determine, in your mind, whether these were related in some way to each other?

DR DYER: What I'd have been looking for is if it was the same incident relating to each of the patients; it would have been if it was the same doctor or the same midwife; it would have been if there was a demonstrable pattern there. I've already alluded to one area that I was concerned about, and that was a national thing, and I've also alluded to how I thought it might be managed and how it might have been covered in the Fielding report.

DR KIRKUP: I'm bound to reflect back a slight concern that we have that these incidents, on the face of it, all involve a different clinical mechanism; there was something different clinically went wrong, but that they had underlying them a recurring pattern of human factors, behavioural factors, relationship factors. Was that your view or did you not think that that was the case?

DR DYER: I think it's fair to say that, clearly, in my training and my background, I would not have been exposed to many maternity units. However, I am also aware – and I used to attend some of the divisional meetings – that there are two professional groups involved in obstetrics, and that, in itself, might, in some occasions, be a cause of conflict, and I think that came out in the report which you're referring to. Another layer of that in Morecambe Bay was tension between obstetricians at the Lancaster and Furness sites. This was certainly a historical issue. My interpretation was that there was a degree of jealousy involved. The clinical director was a Barrow consultant. There was a lot of antagonism from some – I'm talking generally now, sorry – Lancaster consultants to the merger in 1998, and my observation was that that was probably a hangover from that time.

I felt, as an organisation, we hadn't really tackled this – and, again, allow me to generalise – across all the specialties. I did attempt to tackle it, and it was not a popular move from colleagues, but I felt that, in order... I felt we could respect different cultures at the three sites – and they are vastly different cultures – but what was important was that we had overarching clinical governance themes. I didn't have any concern about the clinical director in obstetrics per se. I was aware that he wasn't popular, certainly amongst one or two of the obstetricians at Lancaster.

DR KIRKUP: At Lancaster or at Barrow?

DR DYER: At Lancaster. There were also other issues amongst the obstetricians, but this is something different from the inter hospital context. There was a very – and this is the issue that I was talking to Professor Ashton about, was that the consultants at Barrow were senior individuals. There was ethnicity issues; there was gender issues, and these are kept under wraps, but I was aware – I felt I was aware of a tension there. I don't know... This was one of the things that I felt could be explored, but it didn't come out in the report.

DR KIRKUP: Okay. I need to be clear about what ethnicity and gender issues you're talking about there. Was that within the group of consultants operating in the Barrow unit?

DR DYER: Yes.

DR KIRKUP: Okay, and that reduced their effectiveness as a team.

DR DYER: It didn't feel to me that the team was exactly coherent, but I have to be very careful in that I'm not a gender or ethnicity expert, apart from equality and diversity training that I've been through, and so I would be very cautious about how I say that, really.

DR KIRKUP: Yes, I understand that, and I take entirely your warning there. But, nevertheless, the fact remains that what you're saying is that you don't think there was a coherent team functioning in Furness, regardless of the cause.

DR DYER: [redacted] That was one example of tension, and that took up an awful lot of time of the clinical director and the business manager, trying to sort that one particular issue out. There was also an issue that, again, in keeping with a lot of other specialties in Barrow, there wasn't the traditional team of junior doctors, trainees, and that's true for a lot of the specialties there, and so – it's true in my specialty – we rely on each other. So consultants may feel that they're doing work which they'd normally pass onto a senior registrar or a registrar.

Now, although I didn't pick that up in my meetings with the consultants there, there was always, in my mind, a view that aspirations were involved here, that I think when you're a consultant perhaps there is a view that you'll have a team who will do certain things and that you may not expect to be

called in in the middle of the night, and, in a small district general hospital such as Furness, those aspirations might not have been met.

DR KIRKUP: Yes. You also referred to lack of team working, I think, between obstetricians and midwives. Am I right?

DR DYER: I felt there was a cultural thing, because my observation was that the midwives perhaps were local trained, perhaps hadn't travelled far, so their view of the world might have been less than if they'd perhaps trained outside and come to Furness. And there was a certain hierarchy taking place between consultants who were used to coming from a background where they were certainly in a very important position, and possibly the relationship with midwives was uncomfortable because of that.

DR KIRKUP: I see. A staff group that you haven't mentioned there is the paediatricians. Were there also similar relationship problems involving the paediatricians?

DR DYER: I wasn't aware of relationship problems between the paediatricians and the obstetricians or between the midwives. Now, the only issue that I was made aware of was the one related to [redacted] but also the fact that there was tension between the Lancaster paediatricians and the Furness paediatricians, such that, when we tried to establish a cross bay rota, the Lancaster consultants were really resistant to having anything to do with on call at Furness, to the extent of one saying her remit was Lancaster and that was it. And so to try and change the behaviour and the culture there was extremely difficult, which is one of the reasons we got the clinical leads to go, because we thought that might set an example.

Sorry, there's just one other thing, which I think is important, to do with paediatrics, that we did, as I've said, institute a paediatric report; that was called the Mitchell report, and, as a result of that, the Cumbria PCT instituted their own Mitchell report, and, as a result of that, working in tandem with Carlisle hospitals and with Cumbria PCT and ourselves, we established what we thought was a new way of working for paediatrics, and that came out very much from the two reports. So we felt that we were entering a new era with paediatrics, where it was going to be delivered in a Cumbria wide view, which dealt with all different services under one roof.

DR KIRKUP: Has it made any difference?

DR DYER: No, it didn't, because it does seem, at some point, it was almost as if the three respective chief executives lost interest; the funding didn't seem to follow through; and, certainly, the clinical director, who was a Morecambe Bay consultant, felt that he'd been put into a position that was really untenable, very, very difficult. And so I think it was rather disappointing that that initiative didn't take fruition as we thought it might do.

DR KIRKUP: Okay. In that bit of the conversation that we've been having, you're fingering some pretty fundamental issues, which are potentially going to impact on the effectiveness and the safety of that service. How did you discuss those with your colleagues on the board and how did you try and tackle them to assure the board and yourself that you could make that service safe?

DR DYER: The first thing is that these issues were certainly discussed at length at executive level and at board level. I do recall that this was something that was of concern, but – and I've also said that I had great hoped that these issues would come out in the Fielding report and that they'd be looked at at that point there really to bring them out into the open. I think that they were part and parcel of a realisation of the board that it wasn't just obstetrics and gynaecology, but this was something that was really affecting all services; it was affecting many of the services. I think that there was a sense that... The discussions were: how can we keep the identity of Lancaster, Barrow and Kendall but have something which assured the board that those clinicians, midwives, nurses are working to the same rules, and I'm not sure that we ever really got to the bottom of that.

DR KIRKUP: The causes – the underlying causes that you're identifying aren't well highlighted in the Fielding report, but the picture of dysfunctional teams that didn't talk to each other and didn't relate to each other well is certainly set out in the Fielding report. How was that reflected in the action plan to implement Fielding?

DR DYER: I certainly felt that we had to get policies right and we... For example, one of the things we did was introduce cross bay working using video links so that policies could be discussed without having to bring people together under one roof, because travel is a big issue. So I was satisfied that we were addressing the issue of policies and making sure that safe working practices

at one site were adopted by the other sites: so, for example, recognising that not every expectant mother would need to come in under a consultant; some could come under midwife at Furness site; that there was a RAG rating of severity, which is working successfully at Lancaster site, which wasn't the case at Furness.

So we were trying to adopt a unification of those sort of issues, but I think, in terms of pulling people together in terms of clinical engagement, I certainly had evenings where we pulled clinicians together; we had experts come in to – or consultants come in – not medical consultants but people who could try and break down barriers. I'm not talking now about obstetrics and gynaecology, but across the board. But they seemed to go so far, but then, when we say, 'Well, how about having a unified ENT rota?', then it all just stopped and people went back into their own corners.

DR KIRKUP: Okay. Just thinking about maternity and the Fielding report, would the Fielding report have been more powerful if she'd been able to look at those incidents and review them as well?

DR DYER: I wasn't aware that she was asked not to.

DR KIRKUP: She was very clear she was asked not to.

DR DYER: Right. I can't explain that.

DR KIRKUP: Okay, but, in your view, would it have been powerful if she had been able to?

DR DYER: I've already said what my aspiration for the report was. If she had felt that that aspiration could have been achieved by highlighting the report, then absolutely. I don't know what to say, because I didn't know that there was, if you like, a proviso that she shouldn't be reporting specifically.

DR KIRKUP: Okay. Why did it take five months to get from the first draft of the report to the final draft? Do you have any idea?

DR DYER: I remember meeting Professor Fielding with the chief exec and nursing director at some point, but, no, I've no idea. We looked at a draft, but I have no idea.

DR KIRKUP: Okay. There's one other issue that I want to ask you about, and that's a letter that was written by one of the obstetric consultants about a particular case. This is Mr Misra writing to Mr Hussein, who's the clinical lead in O&G at the time, and he's raising some pretty serious concerns about an intrapartum

stillbirth and saying that it had happened before and, in his view, it would happen again unless some action was taken. Do you have any recollection of that letter?

DR DYER: I don't have a recollection of the letter. From what you said, I'm assuming that I was copied into it. I don't know.

DR KIRKUP: You were, yes.

DR DYER: My usual process would have been to speak to Mr Hussain and say, 'What's all this about?' But I'm afraid, without the letter, I can't comment, other than what my usual practice would have been.

DR KIRKUP: Yes, understood, and would you have expected there to have been some sort of formal response to the consultant who raised the concerns?

DR DYER: I would have done, yes.

DR KIRKUP: Yeah, because we can't find any trace of any response.

DR DYER: Right.

DR KIRKUP: It doesn't appear to have been discussed subsequently. That doesn't ring any bells with you at all.

DR DYER: No.

DR KIRKUP: Alright. Anymore?

DR KIRKUP: Yeah, just one, actually. So thank you for telling us about all these concerns you've got about shared practice and policies and the relationships. When, obviously, you were thinking a lot about those, were you also thinking, 'This is actually manifesting itself in unsafe practice here and now?', or did you not feel you'd really got any evidence to show that?

DR DYER: The sort of evidence that I relied upon was soft evidence, which would be people telling me something, or it would be hard evidence, such as looking at confidential inquiries or looking at CHKS or looking at the risk ratings that were coming through the integrated risk subcommittee. I certainly didn't get a sense that, although there were challenging relationships, that they were actually detrimental to the service. I didn't sense that at all.

DR KIRKUP: So I'm just wondering how... This is not me bring provocative; it's just because I know you're working with day to day things and different things appear over the parapet, but... So there's the five incidents and there's the Fielding report, which has a few red flags in it. There's then the CQC report and then this fairly tumultuous phase of the Joshua Titcombe inquest. Were

you thinking at the time, 'Yes, actually, the infrastructure here is actually leading to actual unsafe practice, and this is what all this noise is telling us', or did you think that the evidence you had got wasn't strong enough to demonstrate that actually patients were perhaps not being risk assessed properly or there were more intrapartum stillbirths than perhaps there should have been – those sort of things? Was that coming together anywhere?

DR DYER: I didn't get a sense that the incidents were linked in such a way as to give me concern specifically that there was an underlying trend. I was absolutely concerned about the individual cases, about the patients, about the families and the effects on the staff as well. I felt that, as a board and an executive, we were working through the problems; we were trying to address them and deal with them as they came about. I did feel there was a moment during – as medical director when I did feel there's an awful lot going on. But, again, perhaps because I was learning myself, it may well have been that I couldn't detect an underlying cause other than clearly the things we've talked about today, that I was conscious that there would be midwife obstetrician issues; there was certainly Lancaster and FGH issues, but there was nothing from the evidence that I had – particularly, for example, the confidential inquiry – which made me concerned that we were an outlier in any way.

DR KIRKUP: And, if the policies had been all the same, do you think they would have affected behaviour? Because having policies is one thing, isn't it, and having people doing anything different is another?

DR DYER: I was aware that an awful lot of work was taking place within the nursing and midwifery, which was led by the nursing director, so she was attempting to change behaviours there. I think these things take an awful long time. I would hope that policies were being adhered to, and I would hope that we had a rigorous audit system within those departments that were showing that to take place.

DR KIRKUP: Thank you.

DR KIRKUP: Julian.

MR BROOKES: I just want to check I've heard something correctly. When Bill was talking, you talked about the interpersonal and the impact that was having on services and being something that was discussed at the board. Is that correct?

DR DYER: Yes.

MR BROOKES: So we would find evidence of that through the minutes of the board etc.?

DR DYER: I would have expected that even... I would have expected so, but certainly I can certainly remember giving a presentation to the board very early on regarding clinical strategy and my concern about how we were duplicating services.

MR BROOKES: That's different from the kind of specifics we were talking about with Bill in terms of the relationships around the obstetric services at Barrow, for example.

DR DYER: Without looking back through the minutes, I really can't comment, but it was –

MR BROOKES: But your belief is that those kind of things were discussed at board level.

DR DYER: Absolutely, yes, yes.

MR BROOKES: Thank you.

DR KIRKUP: In public?

DR DYER: I don't know. I can't... We certainly had... Things changed before foundation trust and after foundation trust, and, before, it was – apart from – it was largely a public meeting. In fact, even afterwards, it was, although it was – I know arrangements changed slightly, but – I can't remember all the details, but certainly... Again, I can't remember whether these sort of issues were discussed in the public or the private part of the board.

DR KIRKUP: Some of it's a bit sensitive for public, isn't it?

DR DYER: I would have thought so, yes. I think anything related to gender and ethnicity and tensions would certainly be – would be very sensitive in public.

DR KIRKUP: Okay. Is there anything else that you would like to tell us about?

DR DYER: At the moment, I can't think of anything, no.

DR KIRKUP: Okay. You're very welcome to come back to us if there's anything that you think, 'Oh, I wish I'd said that' or 'I would have added to my answer on this.' That's absolutely fine; you can get in touch with the secretariat. Thank you for coming. I'm just going to make one observation, which is your colleague has taken very, very full notes of what we've been talking about, which is fine, and you're very welcome to use them yourself, but I'll just repeat,

please don't share them with anybody else.

DR DYER: No, absolutely, understood, yes.

DR KIRKUP: Okay, thank you.

(The interview concluded at 5.05 p.m.)