THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Friday, 10 October 2014

Held at:
Trinity Enterprise Centre
Ironworks Road
Barrow in Furness
LA14 2PN

Before:

Dr Bill Kirkup CBE – Chairman of the Investigation
Mrs Jacqui Featherstone - Expert adviser on Midwifery

CATHERINE LUBELSKA

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(At 1.59 p.m.)

THE CHAIR: Hi, I'm Bill Kirkup, I'm the Chair of the investigation, and I'll ask my colleagues to introduce themselves.

MRS FEATHERSTONE: Hello, I'm Jacqui Featherstone, I'm the Head of Midwifery and Head of Nursing at an acute trust in Essex.

THE CHAIR: You'll see that we're recording proceedings, and we'll produce an agreed record. You're probably aware that we have invited family members to be observers at the interview sessions. As it happens, we don't have anybody here today, but I need to tell you that they can listen to the recording subsequently if they want to. You'll also know that we've asked you to hand in any mobile telephone, laptop, recording device.

MS LUBELSKA: Yes, three times.

THE CHAIR: Yes, well, I'm glad we're doing it thoroughly.

MS LUBELSKA: Just in case.

THE CHAIR: That reinforces the importance of nothing going out of the room until we're ready to produce a report with all the findings in context.

MS LUBELSKA: That's fine.

THE CHAIR: Any questions for me about the process?

MS LUBELSKA: I don't think so – I don't think so.

THE CHAIR: Okay. I'll start with a general question before handing you over to Jacqui for a few moments, and the general question is what connection you had with the trust and when it started. I know that you were Chairman from 2005. Did you have any connection with the trust before then?

MS LUBELSKA: Yes, I did. I was the Non-Executive Director.

THE CHAIR: When did that start?

MS LUBELSKA: From the formation of the trust, so I was – I don't know, you've got an inaugural Non-Exec Director, so from 98, when the trust was formed.

THE CHAIR: When the previous trust merged.

MS LUBELSKA: Yes, yes.

THE CHAIR: And did you have any connection with either of – any of the formative parts, the precursors?

MS LUBELSKA: No, I didn't. No, that's when I joined.

THE CHAIR: Okay. And you stayed as Chair until...

MS LUBELSKA: I stayed as Chair until April 2004, when I went to Morecambe Bay PCT as Chair.

THE CHAIR: April 2000 and...?

MS LUBELSKA: 4.

THE CHAIR: Sorry, that was when you were a NED?

MS LUBELSKA: I was a NED between 98 and April 2004 on the hospital trust, and then from April 2004 until December 2005 I was Chair of Morecambe Bay Primary Care and Mental Health Trust. And then I went back to the hospital trust as Chair.

THE CHAIR: Right, and stayed until May 2008.

MS LUBELSKA: That's right, yes.

THE CHAIR: Right, okay. And have you had any connection with the trust since then?

MS LUBELSKA: No, not really. I'm a member of the FT; I've been to one or two events. I see people from time to time, often in supermarkets and what-have-you because I'm in the area, so...

THE CHAIR: Yes, okay, that's helpful. Thank you.

MRS FEATHERSTONE: Okay, I just – really when you took on the Chair in 2005, just what was the trust like? You know, what sort of handover – because you hadn't been at the trust for a while. What was your handover of what was going on in the trust at the time?

MS LUBELSKA: Well, there'd been quite a substantial change because when I left the trust it was a three star trust and was financially okay. When I returned it had lost a couple of stars and had, I think, a £6.4 million deficit. So there was a definite change certainly in terms of morale around that time.

MRS FEATHERSTONE: Was that apparent to you or was that told to you?

MS LUBELSKA: It was told to me and it was apparent to me as well, because being Chair of the PCT, I was for a period looking at the trust from another angle, so to speak. So I was aware that there was concern, because that's quite a short period really for things to have changed so significantly. And I mean I don't know quite how much to say, but I was in a position as Chair of the PCT at the point where there was about to be this reorganisation which came in 2006 of primary care trusts, and it was unlikely that that PCT was to survive, which it didn't because we then went to a Cumbria-wide PCT, and a North Lancashire PCT. And I was – the existing Chair's term of office at the hospital trust was up, and I was encouraged, shall we say, to apply for that job. And so I took a sort of calculation that it would be a challenge; that I knew the trust, to

go back there rather than throw my hat into the ring in terms of what might happen for its sort of PCT come 2006. So that's really the background.

And so I'd had quite a lot of informal information from the SHA about their concern about the trust, and it was seen as being in need of a bit of a turnaround.

MRS FEATHERSTONE: Okay. And then as you joined, was there engagement with medical colleagues and the exec board?

MS LUBELSKA: What, with me, you mean?

MRS FEATHERSTONE: Well, just as Chair – yes, as a whole between the exec board and the non-execs and the medical – just generally was there engagement with staff?

MS LUBELSKA: With staff? I mean I think the engagement with – between the execs and the board became stronger. Engagement with staff, I think particularly strongly between the exec team and the consultant body at that point, yes, was good. I think probably there was more scope for engagement further down the organisation, but that came subsequently. So if you're asking me at the point at which I went back, there was work to be done, shall we say, around that.

MRS FEATHERSTONE: Okay. And then by the time you left in 2008, was it very different then?

MS LUBELSKA: It wasn't in a lot of respects. I mean by the time I left there was a really strong focus on wanting to achieve FT status. We'd resolved the financial difficulties pretty well. In fact within the first year we were able to do that, so that was a very strong focus when I first went. And a lot of my time was taken up around public consultation around service change, and particularly in terms of things like dealing with coronary care and stroke, and the appropriateness of having facilities at the smaller hospital, Westmorland General Hospital. And there was what was really very controversial issues around that, so there was a full consultation and a lot of public meetings around that, and that was very much part of the – I mean very strong clinical reasons for doing that, and a clear consensus that that needed to be done clinically, but also clearly there were substantial cost benefits from doing it as well.

So that sort of thing was going on early on, and that took a lot of time and concern under the sort of – the period before Ian Cumming left the trust, we were very strongly centred, so I kind of got thrown into that quite quickly. But I think there was good communication around all of that with staff; there were an awful lot of meetings and briefings and regular information bulletins and things like that. So that's – in a

sense it was quite useful because it actually did start to develop that aspect of culture perhaps a little bit more strongly than it had been previously.

MRS FEATHERSTONE: Okay, and what about around the governance agenda, do you think there was – or procedures essentially, was the board engaged with that, and how did it happen when you were there?

MS LUBELSKA: Well, it – it was, but it was my feeling that there needed to be more done around that. I mean one of the things – I suppose my perception of coming in as Chair was influenced by my experience as a non-exec, so even though there's kind of objective factors around the trust, it changed quite dramatically. Culturally it was very familiar, and there was some practices around the way that the board had run and operated, which I felt needed to change. I'd done quite a lot of board development work at the PCT, so I actually got us involved in one of the pilots run by the Clinical Support Agency to make sure that the board was skilled up appropriately, and that we actually had the kind of agendas and papers coming to the board in a form that were actually going to enable us to scrutinise better, and we did a sort of repeat. The Pilot had finished by the time I went to the hospital trust, but we did a repeat of that exercise, so we were – I think it was Jay Bevington that we were engaged with there.

And the chief executive was very responsive and very up for that, and very aware, I think, that the way the board needed to run needed to be sharpened up. So, for example, when I had been a NED, and I understand it hadn't changed in the interim, the drawing up of the board agenda was often about who felt they ought to have a paper on the board, and the Chair had very little involvement in setting that board agenda. There was a lot of tabling of papers, so sometimes you felt that the board was disproportionately engaged with some matters rather than others, and so that kind of, 'Have we covered the ground?' and these kind of things needed to – so actually trying to make sure that the board agenda reflected our role around assurance was a key thing for me. So we started – so I started to take a bigger role around making sure that those things, and discussing the board agenda with the chief exec, and also taking soundings from other exec directors and non-execs around, 'Have we got our eye on this? Do we need something on this? Has this got lost?' etc., just trying to make sure that we'd – in so far as you can, I'm not saying that I could guarantee that, but make sure as far as we could that we had our eyes on what we should have our eyes on.

THE CHAIR: So a general theme to the things that were over-emphasised and the things that that was at the expense of?

MS LUBELSKA: Well, again, that – those things – I was interchanging really quite quickly, but when I've been a non-exec we, for example, had a very substantial building programme, and we'd also our facilities. The Estates and Facilities Department had – I don't know quite what the arrangement was, but they'd been commissioned by other bodies, so for example, they'd got involved in the re-commissioning of the Ulverston Hospital and the building of a new provision for the elderly, mentally ill at the health centre. And often we would be talking, I felt disproportionately about things like that, which were important, but it's a question of balance really. It's not that you would say you shouldn't have those at the board, but at the same time making sure that other things – so sometimes things got – it was, 'Oh, well we haven't got time this month, it'll have to wait till…' so that kind of thing…

THE CHAIR: And what were the kind of things that got underemphasised?

MS LUBELSKA: Well, I felt that there was more that could be coming to the board – a little bit more depth certainly around the finance side because that was a major concern. And just before I went back to the hospital trust there had been a very substantial sort of due diligence job done and a lot of issues coming out of that that I really felt the board ought to be perhaps more fully informed about, and informing in terms of the implications for what then happened next. And also the papers on performance and just how far we were able if we needed to, to drill down around the sort of assurance side of things in relation to risk, etc. But we did start to move on that; we did start to move.

MRS FEATHERSTONE: So do you think they were – you said that they probably weren't there as much as – but were you hearing about sort of themes of serious incidents at the board? Were you hearing about concerns in the divisions at the board then?

MS LUBELSKA: Yes, we were hearing about serious incidents. And I mean I'd heard quite a lot, because when I'd been a non-exec I'd also for the last couple of years been the convener. Before they actually changed the complaints process I'd been convener for complaints, so I was quite close to that area, and I think serious untoward incidents were coming through. But then there's always a question of at what point the trigger goes that says, 'Yes, this needs to go to the board,' and at what point it perhaps still stays under the radar. And that is quite difficult for a board member because there is a sort of element of if you don't know enough then you don't know what questions you

should be asking or how deep you should be digging. But certainly we were regularly appraised of serious incidents, and certainly for anything that came at once, I became Chair, I was very keen that there was then an action plan that the board saw and was aware of what was being done and when it was being done, progress being made, so those reports, so that it didn't just vanish into the ether, you know, it's been reported and that's the end of it, that what action was being taken.

And eventually, I think it was about – I'm just trying to think when I – the final – it was probably about the middle of 2007 we'd developed a kind of corporate governance guide from a board perspective about what we wanted to see and when we wanted to meet, although we'd had lots of iterations of that. So from the word go, when I came in as Chair, there were various things like the format of papers, executive summaries, having action plans attached to things, and Executive Directors not assuming that if they came and said, 'I need this at the board next week,' it would be, because some things we had to make judgments about what was more important. And we did have very long board meetings as well, partly because of all this stuff we were doing around service reconfiguration as well. And so it was making sure that those issues that I suppose I would see as being identified with governance were always prioritised and didn't get lost. So if there was a paper which was on something that wasn't as pressing then that might have to wait rather than a sense of first come first served in terms of who gets papers on the board.

MRS FEATHERSTONE: So the papers came for your assurance, but did you ever – were the divisions ever coming to the board for assurance in person to tell you what – they're being done? Was it just – it was just papers, were they ever...

MS LUBELSKA: No, no, they did, they came. Yes, we did, we often had presentations or asked people to come to the board around particular issues. And one of the things that I did was encourage the board, and particularly the non-execs, if there was an issue coming up about say a staff shortage or something like that, to actually say it would be good if X division or manager or the clinical director came to tell us about the implications of that and what they're actually about doing it, etc. Because it's easy at a board level to take that as a workforce issue and just sort of say, 'Well, we need to get more people and this is where we're advertising, and we've got so and so locums and...' but the impact of that on the ground was often harder to – so actually getting a key person in to come and talk to you about it and tell you what was going in.

So a number of the NEDs would actually perhaps have more involvement with particular divisions, so they'd be shadowing them and having regular meetings with the clinical directors and directorate managers, and I was very keen if there were concerns that we felt we needed to be – so that they were saying, 'Right, I'm going to ask the Chair or talk to the Chair about having a slot on the next board meeting.' So we tried to do that, but again, you need a level of awareness of an issue before you can then start to sort of bring it out and get that kind of information.

MRS FEATHERSTONE: Do you think then there were things that, perhaps in hindsight, that you weren't aware of then?

MS LUBELSKA: Well, I'm sure that – I'm sure that would be the case. Yes, I'm sure there would always be things that we weren't necessarily aware of because it's difficult – it's almost a kind of – it's a difficult question to answer, isn't it? Because if you weren't being made aware of things and people weren't telling you, then you wouldn't know. But insofar as we were able to, we were doing – so again, encouraging non-execs to actually engage with staff as well, so not just go and have a sort of meeting with a couple of – you know, usually a clinical director and a manager, but actually to get on wards or talk to the staff or be aware where that was possible. And again, trying to send a clear message out about making sure that when there was an engagement with non-execs it wasn't just the senior people managing that situation, but there was an expectation that non-execs would be able to talk to staff and see what was going on.

MRS FEATHERSTONE: And that happened, did it? Did you go down to the shop floor to talk to the clinical staff?

MS LUBELSKA: Yes, yes. Yes, that did – and I have to say once we had a change of chief exec, that happened rather more because sometimes when you're talking about going to talk to other staff you would then find that it was consultants that you were getting access to, who all – or who were seeking access to you, which was fine. But then there were lots of other staff as well, you know, nursing staff and just right across the workforce who at times it's extremely helpful and relevant to be talking to. And certainly once Tony Halsall came in, he was very positive about encouraging that. There was a lot more, if you like, walking the walk as well as talking the talk at that point. It felt a little bit more to be a sort of part of culture, I suppose, that people should be out and about and seeing what was going on and talking to people.

MRS FEATHERSTONE: And that changed when he came into post, did it?

MS LUBELSKA: Yes, it started, partly because it was a very strong message which he gave out. I'm not saying it didn't – I mean it's not a black and white situation, but I think that was foregrounded much more strongly.

MRS FEATHERSTONE: Okay, thank you.

THE CHAIR: Thank you. You left your position as Chair in May 2008. Later on that year the first news began to break of a series of incidents and problems that had really continued pretty much up until the present time.

MS LUBELSKA: Yes.

THE CHAIR: Were you surprised?

MS LUBELSKA: I think I was surprised. Yes, I was surprised, and I was also, to be honest, quite upset and disappointed about that. And I have thought about it a lot as to kind of readings of situations and, you know, you often – it's not just that you think they're okay, but again, you see particular aspects which you think, 'Yes, that's good.' And particularly at Barrow, because again, as a non-exec I'd actually had a lot of involvement with the obs and gynae side at Barrow because I'd been the sort of non-exec attached to that directorate. And the clinical director and the directorate manager, it was sort of – they were focused at Barrow, and they also had what was at the time – I mean we're supposed to have these, and the PCT had an interest in them as well, but they had a maternity advisory group, which I thought was really quite innovative in the way in which it was running at Barrow, which had a lot of patient involvement in it and was very much linked into the sort of community midwifery thing.

So it was the period, for instance, when Sure Start was strong, and it was very prevalent in Barrow because we had a lot of wards that fell into that sort of level of deprivation, very high levels of teenage pregnancy, and we had really quite impressive engagement from teenage girls and from the agencies involved with them. And there was quite a lot of good stuff done around antenatal care, for instance. You know, making links and getting access to hydrotherapy pools and various other things that were going on, and reporting back about what was happening to patients when they went in, looking at the sort of patient experience stories about would it have been looking at the way that we evaluated the experience questionnaires, etc. And people were encouraged to bring back, so you know, people would come back who said, 'Well this happened, but it would be useful if we had this.' So it felt to be really quite responsive and grass roots, and I chaired that group for a couple of years. This was

before I went off to the PCT, and it was still functioning, although I obviously wasn't directly involved with it when I came back as Chair.

THE CHAIR: No.

MS LUBELSKA: So that was kind of disappointing because there was a definite sense also that the community valued this and had a lot of faith in it. So to see that undermined in the way that it is – so I was surprised and, yes, as I say, quite disappointed when that actually did come to the fore.

THE CHAIR: Have you had a chance to read any of the reports of the reviews and investigations?

MS LUBELSKA: Yes, I have. Yes, I have, yes.

THE CHAIR: Was there any inkling of any of those problems before 2008?

MS LUBELSKA: Well, I think there were – I mean again, my close – as I say, my close contact really came before I was Chair, so we're going back to 2004 and before. There was – if I try and put it in context, there was – essentially we had three services over three sites, and there was certainly, I felt, and all the people there, that they were very different kind of services. So at Westmorland General, up at Helme Chase, we had the beacon status midwife-led unit. At Lancaster we had a much more traditional obstetric-led unit. And at Barrow we had a kind of – a bit of a mixture of the two. So I mean one of the things that I was quite concerned about was that we had very high rates of Caesareans, for example, at Lancaster. And to some extent that felt as if it was to do with what was actually a very obstetrician dominated unit, and there were certainly obstetricians there who were quite keen on Caesareans, shall we say, and there were fewer at Barrow.

But I think the issue that often struck me was that I think the – well I don't know how you'd quite put it. Maybe the balance of power between the clinicians and the midwives at times did seem as if the midwives were perhaps, even though I kind of personally am quite committed to see midwives empowered, there were times when they seemed to perhaps have a little more power and influence, or there was – their word was being taken around things or their say was prevailing around things. Not in a kind of unpleasant or contentious kind of way, but certainly by contrast with Lancaster, the contrast was very marked, where the midwives at Lancaster seemed to be rather more subservient and doing as they were told, so to speak, and a much more sort of obvious hierarchy, if you like. I suppose you might say it's more traditional.

THE CHAIR: Neither of those might be regarded as ideal.

MS LUBELSKA: No, no. No, that's right. And of course the big issue was that this was supposed to be one trust, and so how you then – and I mean I think the modern matrons, when they came in, were very much trying to address those kinds of issues. But that issue of different practice and customs across the sites was not just particular to that directorate or area. I mean it was a major theme within the trust.

THE CHAIR: That relationship between the consultant obstetricians and the midwives that you're outlining there, and the differences between Barrow and Lancaster; how did you acquire that information? How did you get to know? How did you form that impression?

MS LUBELSKA: Through talking to people and observing what was going on, because they – later on they set up a similar advisory group in Lancaster, and the kind of issues that were coming to that were of a much lower level, and the consultants didn't involve themselves with that, it was seen as being a kind of patient care rather than necessarily – well when I say patient care – patient care and comfort rather than necessarily a pressing clinical matter there. And just talking – yes, talking to consultants as well who had views about the kind of range and limits of their role that actually I think were substantially different across the two sites.

Plus, you know, just – I mean this is just a perception. I can't kind of say because he said this or he said that, but that was my perception.

THE CHAIR: I understand. If you label it as soft intelligence then in terms of your perspective[?]...

MS LUBELSKA: Yes.

THE CHAIR: ...but I recognise exactly what you're saying.

MS LUBELSKA: Okay.

THE CHAIR: Did any of that kind of intelligence – let's call it soft intelligence, reach the board, or was all this in kind of one-to-one conversations that you had as chair?

MS LUBELSKA: It reached the board, but not in a formal way. It reached the board in that it did come up when we were discussing these areas, these issues. I certainly raised them, and other people raised them. And the medical director was aware of those differences as well, as was the – well, of course we have the Director of Nursing and Midwifery when I first went back as Chair, who then subsequently left, and so we had a kind of interim period when Kay Gilbey was taking an oversight of it. And I think from a nursing perspective it maybe looked different because there was a sense when you went to Barrow that you could talk to the midwives there and they knew exactly

what was going on, but that perhaps the ones at Lancaster needed empowering, so it's the kind of other side of the coin really. But certainly when we were discussing issues to do with that directorate, that often came – partly because at Lancaster there were two or three very dominant consultants, and so there were issues that came up about – and they would often make a call to the board, so to speak about, 'What are you doing about this or what are you doing about that?' or whatever. So yes, I think it was discussed, but how much significance was attached to it across the board I wouldn't like to say.

THE CHAIR: Yes, what you're describing there sounds like a difference of style, a difference of approach, but it doesn't necessarily sound as if it would be a result of the kind of dysfunctional relationships and breakdown of team working that was described, for example, in the Fielding Report.

MS LUBELSKA: No, no. And I didn't – I didn't see it that way, and I think I said when you first asked me that it didn't appear to be contentious. And in fact my perception was that people seemed to get along quite well. I felt that what was happening around midwifery in Barrow was quite – you know, it was quite a happy working environment. It wasn't – it didn't strike me as one which was full of all sorts of difficult issues.

I mean I think there were some – and again, this is – when you say soft you might want to say even softer for this, but there were some issues, if I remember, in terms of relationships between paediatricians and the obstetricians. I think that was tricky, but that was also a tricky bit at Lancaster as well, so it wasn't down to, if you like, the tribalism of the particular hospital, it was something that – and I think there was more concern about the dysfunctional paediatrics team then the obstetrics team.

THE CHAIR: Okay.

MS LUBELSKA: And there had been – we had recruitment issues around paediatrics which I think were resolved by the time I went, but there were some – there were definite – but a lot of that's personality stuff more than major issues of principal or priority, I suspect.

THE CHAIR: But sometimes personalities, if they clash, can have a significant impact on patient care.

MS LUBELSKA: Oh, certainly, yes. Oh, definitely, I believe.

THE CHAIR: Okay. Who were you execs in 2008?

MS LUBELSKA: In 2008. Well, there was a lot of change, so by 2008 there were only two people on the exec team who'd been there when I took up the post at the end of 2005.

THE CHAIR: And they were?

MS LUBELSKA: And they were – well in fact only one. Only one, and that was Tim Bennett. Peter Dyer – I'd appointed Peter Dyer, it was more-or-less the first job I did, I think, in terms of appointment.

THE CHAIR: Yes.

MS LUBELSKA: So David Telford was in the process of stepping down as I rejoined the trust, but there was quite a long transition after Peter was appointed. There was quite a long transition before he became fully fledged medical director. So who had we got by 2008? Because there were one or two appointments that took place just before I was – so the director of nursing modernisation was the last appointment I was involved in, but she hadn't actually taken up her post by the time I went, or she'd done it literally a week or so before, so I didn't ever work with her.

THE CHAIR: Okay.

MS LUBELSKA: We had Steve Vaughan, who is operations and performance.

THE CHAIR: Yes.

MS LUBELSKA: And we had – I'm trying to remember all the names now – Roger Wilson was HR, and Patrick – I can't pronounce his name – McGahon, who – he had a new title, service and commercial development, I think, so some of these were very much reflecting the orientation towards wishing to achieve FT. Medical director.

THE CHAIR: Yes.

MS LUBELSKA: Estates and facilities, now I can't actually remember who that was, but it had been Martin Allan[?], but we were…

THE CHAIR: Yes.

MS LUBELSKA: … had a new person coming in. So there'd been quite a substantial change in board personnel.

THE CHAIR: You haven't mentioned the chief executive.

MS LUBELSKA: Oh, yes, of course – sorry. I was thinking of the execs. Yes, the chief executive, yes.

THE CHAIR: Okay, and by then it was Tony Halsall.

MS LUBELSKA: Tony Halsall, yes, he was appointed – well he would have been – would it be 2000 – it was as Ian Cumming left. It took us a while to get through the process so we had an acting chief exec, Kevin, who had been chief operating officer before then,

yes. And then Tony came in. Yes, I hadn't forgotten him. Sorry, I was thinking executive directors.

THE CHAIR: I was tempted to ask if it was a Freudian slip, but it wasn't.

MS LUBELSKA: No, no, it wasn't a Freudian slip.

THE CHAIR: Okay, no problem. How would you raise it as an exec team?

MS LUBELSKA: Well, it was – it was quite new, and I think – I did have some concerns about the fact that – and I think it – I don't think this was peculiar to our trust. The drive to FT tended to sort of – so some of those titles and the combinations of roles and things like that were very much about getting that kind of sound business case out and...

THE CHAIR: Getting the FT stamp of approval.

MS LUBELSKA: ... getting the FT stamp of approval. And I – just at a personal level, I had some ambivalence about the whole process towards FT, and I know I wasn't the only one because talking to – you know, I had a lot to do with other Chairs in the area. And of course different trusts were at – some had already got there, some were on the way and there were concerns about the sort of just kind of keeping your eye on the core business and these sorts of things. So...

THE CHAIR: Was the – sorry to interrupt, but I don't want to lose the point.

MS LUBELSKA: No, no, that's fine.

THE CHAIR: Was there concern about the underlying model of a foundation trust or was it about the process of getting there?

MS LUBELSKA: I think both really.

THE CHAIR: Okay.

MS LUBELSKA: I think both really.

THE CHAIR: And was that because you were out of tune with the idea of an FT, or did you think it wasn't right for Barrow – for Morecambe Bay, I beg your pardon.

MS LUBELSKA: I think – I wasn't so much out of tune with it, and I could see – I could see the value of it if – if it lived up to the ideal of what is supposed to be. I could see a lot of benefits to that. I think my main concern was the way that the – that the focus on putting trusts onto such a strong business footing and focused around – so the kind of discussion of targets and where you needed to be, I – I still felt that our first priority had to be around the quality of care and patient experience, etc. And I'm not saying that that went, but the actual process required so much time and attention around the

kind of business side, the financial viability side, etc. So this new board reflected that, and probably quite appropriately in terms of the job in hand.

I didn't stay long enough to see how that actually played through, but I mean if you take, for example, the operations and performance role. So when Tony became chief executive, you can imagine it was slightly awkward at first because we had an acting chief executive who didn't get the job.

THE CHAIR: Yes.

MS LUBELSKA: And Tony was of the view that he didn't actually want a chief operating officer; he wanted somebody who is much more focused around operations and performance, although actually I think that was what Kevin was doing anyway. But once Steve was appointed there was a definite kind of – sort of rebalance towards the efficiency, value for money side of things rather than the whole kind of – the overall performance side of it, as I would see it. So the flavour was really quite different, and also I – when Kevin had been doing the job I met with him regularly, and took care to actively discuss how some of the pressures that we were under were – you know, so some of the things that were being proposed about efficiencies or cost, what kind of impact on that, I wanted to know whether how clinicians were responding. I found it much harder to access that kind of information off Steve, because one of the things I did was I met all the executive directors at least once a month just on a one-to-one to try and check out what's going, and I found him more elusive, shall I say, around that, and more difficult to pin.

So that was of some concern, and that was an ongoing concern as I left. But I do think this – and other Chairs had talked to me, I'm not sure it was peculiar to our trust at all.

THE CHAIR: No, no, I understand.

MS LUBELSKA: Other Chairs had talked to me about having similar concerns around these things, and that perhaps sometimes here and there, and not just, again, exclusively with our trust, there's a feeling that the non-execs were kind of, 'Oh, yes, that's all fine because actually you need to go over here and do this and...' so sometimes non-execs were seen as perhaps kind of – not being a spanner in the works, but sort of saying, 'Well hang on, this stuff is really important.' So you say, 'Yes, well we know it is and it's happening,' and all that kind of thing, but actually this is where we need to go. And non-exec time of course got increasingly diverted into the FT thing, and

the practice runs and all that sort of stuff that was, as I say, I know was going on, certainly throughout the whole of our SHA.

THE CHAIR: Absolutely. Did that impact on the working relationship between you and Tony Halsall? You talked about it impacting on your relationship with the chief operating officer, or whatever he was called.

MS LUBELSKA: Yes. Yes – yes, I think it did in that there was a – there was also a sense, and again, this was something I really didn't personally buy into around there. There was a kind of competitiveness around the FT thing, who was going to get there first, and particularly within our area. And I felt there was just a little bit too much preoccupation and drive around it. I would have personally, and this may not be a realistic position actually, but I would have personally liked to have seen it as a slightly more evolutionary process. It felt that we were kind of – we were perhaps pushing a little bit too hard around that, so sometimes discussions that I wanted to have about other things, there would be this, 'Well, this is important, this has to happen first.' So there was a – I mean it wasn't – it wasn't a kind of – we got on fine actually, Tony and I, but I did have to be quite assertive to say, 'Okay, I'll give you 10 minutes to talk about that,' because also another thing that I did, which might sound a bit excessive, but I was really quite concerned when I took over as Chair about the fact that I knew the previous Chair would go weeks and have no discussions with the chief exec. So I actually insisted on having that at least once a week, and if possible twice a week, so that I got a debrief from what was originally the executive team and then became the hospital management team. And I also, on occasions, was invited into that, and on other occasions I asked to go in because there were things where people's lines needed to be concentrated over particular issues or whatever.

And Tony was good at that, and so was Ian, once I made it clear that that was my style. And also it was what was increasingly expected, so I was working with a kind of – you know, there was a lot of documentation came out at the time about running effective boards and the intelligent board and things like this, and I actually thought that was good stuff, and it was really helpful to me because, like I said, 'Well, this is – here's the model and let's see how we can use that here.' So I did have a – so yes, it wasn't that there was a kind of refusal to them, but sometimes I just felt that that was becoming the only show in town at times.

THE CHAIR: It was a preoccupation.

MS LUBELSKA: Yes, it was maybe. And I just felt some discomfiture about the extent to which it was. And also the speed and the competitiveness seemed to me to be – well, I just didn't want into that, shall we say. I mean I didn't care whether North Cumbria or East Lancashire got there before us really; I just thought that we should be fit to do that in every aspect of the work of the trust rather than just what we could actually...

THE CHAIR: You remind me very much of somebody else who described the foundation trust status as a badge of honour for a chief executive.

MS LUBELSKA: Yes.

THE CHAIR: Is that a description you recognise?

MS LUBELSKA: Yes, I think so. I think it's – yes, and I – you know, and you can see that, because I mean you don't become chief executive unless you've got considerable ambition and drive.

THE CHAIR: Yes.

MS LUBELSKA: And in a way this is – it's like a kind of shot in the arm, you know, for that sort of major type A personality. But it did become quite – quite competitive, and there were also kind of other things which maybe enhanced that, because we were trying at the time to really develop – and when I say we, this wasn't just the hospital trust, but this was something that was being driven quite strongly by the FHA to operate as a kind of whole health economy, particularly after the new PCT was formed. And we actually had a group which was about bringing those elements together, and so our sister trust was the North Cumbria Trust, which had its own problems.

And I chaired that group, and relationships were really quite fractious within it, and there was a lot of competition, and there were things said there which I wouldn't want looked into this, but were very much about people thinking that they were better than they were, stuff like this which I thought was really inappropriate. And on one level it was kind of almost amusing, because it seemed to me to be just so irrelevant, but I think that kind of did influence things a little bit because there was this, 'We'll show them,' type mentality.

THE CHAIR: Yes.

MS LUBELSKA: But I wouldn't want to over-egg that, but if you're asking me the kind of things that I was feeling a little bit uncomfortable about, partly because they don't sit well with – with me and what I was there to do.

THE CHAIR: Okay. Why did you leave?

MS LUBELSKA: Why did I leave? Well I left for several reasons, and I mean principally I left for personal reasons [redacted]

As you know, as the Chair, you're not really supposed to be doing a full time job, but my job was taking up a huge amount of time. And I also decided that I didn't want to be Chair of a foundation trust.

And when I took the job on I had said to the SHA, 'What I see myself as doing is getting us to the point where we can start seriously to think about becoming an FT,' but I never sort of said, 'I want to see it all through to that.' And I did start to think – I mean I had concerns about how you as a Chair actually manage a range of different constituencies, and I'd gone into chairing as part – you know, I'd come out, I'd had an academic career, and I'd kind of finished that, and I was also interested in a bit more of a portfolio life. And that was actually impossible, and so when these things happened at a personal level, plus these kind of uneasy feelings about do I want to – and also I felt that whoever did that had to feel a lot more passionate about FT than I did because – and particularly within the culture as it was developing, and I could see problems ahead. So those three factors, they became the catalyst that – and I thought, right, well it's time to go.

THE CHAIR: [redacted]

MS LUBELSKA: [redacted]

THE CHAIR: [redacted]

MS LUBELSKA: [redacted]

THE CHAIR: I appreciate it, thank you. Anything else?

MRS FEATHERSTONE: No, I haven't got anything else to ask.

THE CHAIR: Is there anything else that you would like to tell us?

MS LUBELSKA: I don't think so. You know, as I say, I think my relationships with the – I found both chief execs really quite responsive to what I wanted to do and what they knew needed to happen. I think my unease came towards the end when I just did feel that FT was taking over. But I do recognise that some of that's personal rather than because there were objectively lots and lots of issues to do with me as Chair; they were to do with me as Cathy Lubelska really, as much as anything else.

THE CHAIR: Okay.

MS LUBELSKA: Okay.

THE CHAIR: That's really helpful, thank you very much for coming.

MS LUBELSKA: Is it? Okay.

THE CHAIR: I appreciate it.

MS LUBELSKA: Well thank you. Thank you. Okay. Nice to meet you.

MRS FEATHERSTONE: Thank you. Bye.

MS LUBELSKA: Bye.

(The interview concluded at 2.59 p.m.)

THE MORECAMBE BAY INVESTIGATION

Wednesday, 9 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert adviser on Clinical Governance
Professor Stewart Forsyth – Expert adviser on Paediatrics
Professor James Walker – Expert adviser on Obstetrics

Dr DHIA MAHMOOD

Transcript produced by Ubiqus
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DR KIRKUP: Hello, my name's Bill Kirkup. I'm chairing the investigation. I'll ask fellow members to introduce themselves to you.

PROF FORSYTH: Good afternoon, my name is Stewart Forsyth. I'm a Paediatrician and, latterly, a Medical Director from Dundee, in Scotland.

MR BROOKES: I'm Julian Brookes. I'm currently Deputy Chief Operating Officer at Public Health England, but I was Head of Clinical Quality at the Department of Health.

PROF WALKER: I'm Jimmy Walker, I'm an Obstetrician and University Professor in Leeds. I also was The Chairman of CMACE, and I was an Obstetric Advisor to the National Patient Safety Agency.

DR KIRKUP: Okay, as you can see, we're wired for sound, and the intention is that we record proceedings, and will produce an agreed record of what you say. We have had family members present as observers, but we don't any more. We will, however, make a slight break where we start to talk about one individual case with you, I think. We would ask you to respect the fact that we don't want information to go out of this room until we're ready to produce a full report of our findings in the context, so please don't release any information ahead of that. Is that okay?

DR MAHMOOD: Yes, absolutely.

DR KIRKUP: And is there anything that you want to ask us about the process?

DR MAHMOOD: No.

DR KIRKUP: Okay. I'll just ask a general question to get us started, and then hand over to Stewart. Your post is Consultant Paediatrician and Clinical Director for child health in Preston.

DR MAHMOOD: Yes, I was Clinical Director; I'm not anymore, I've been until 2012. Since then I've been just a Consultant Paediatrician.

DR KIRKUP: Okay, and when did you start in Preston?

DR MAHMOOD: 1995.

DR KIRKUP: Okay, what had you done before that?

DR MAHMOOD: I started several jobs, living in London for a couple of years, and then I moved to ~~Bolton — to~~ Manchester, to do a neonatal job in Hope Hospital. Then Bolton, to do a Senior ~~CR~~ SHO then Preston to do a Registrar, then went back to London to do Senior Registrar in Hillingdon ~~Wellington~~ Hospital, and then appointed as a Consultant in Preston.

DR KIRKUP: Okay, thank you. Stewart.

PROF FORSYTH: Thank you. Clearly we wanted to ask just ask you about one of the key cases in relation to that. But before that, can you just give us some of your experience of working both with Lancaster and also with Barrow, in terms of referral babies, the process, how effective it is and the quality of care?

DR MAHMOOD: The main obviously connection has been with the development of the Level 3 Unit at Preston, as a neonatal unit. I think before then we used to be, as any large district hospital, a unit with four intensive care cots and 21 beds. But I think around 2010, I think – I can't remember exactly when, so 2009/2010, along with Burnley, we developed the two Level 3 Units, one in Preston and one in Burnley, and increased our capacity and our connection with Lancaster and Barrow, and obviously Blackpool, as ~~a~~ referring hospitals to us in terms of neonatal intensive care have started.

I think I don't have any sort of specific problems, or haven't faced any

specific problems in terms of referrals from Lancaster or Morecombe Bay, of from – I mean Barrow Hospital. And I think generally they – since the arrangements have been made regarding Level 3, we have been getting the referrals generally, in general terms, as we expect really. Most of the time we get ante-natal ~~neutral~~ transfers, if we can, of babies who ~~that~~ are premature, and certainly from Barrow we get all babies who ~~that~~ are premature, and from Lancaster we get – babies are certainly less than 32 weeks, ~~I think, that really~~ who ~~are—that~~ would need – ~~at least would need~~ ventilation very likely.

Obviously, occasionally things happen and babies are born there that need retrieval from there, and coming to us either ~~other~~ by the Manchester team or by our team bringing them to our unit.

PROF FORSYTH: And is it co-ordinated – I mean is there a call centre, for example, if there's a premature baby or something delivered in Barrow that call in for a retrieval to you, they call a centre?

DR MAHMOOD: Yes.

PROF FORSYTH: Which is where? Is that in Manchester?

DR MAHMOOD: I think it's more for the whole North-West really, and it's just there to get the call, and then obviously we get the babies wherever there is a cot. We usually declare how many beds we have every day, and usually that is collated by the centre, and they organise the referral accordingly.

PROF FORSYTH: And so is there...

DR MAHMOOD: That seems to be working well.

PROF FORSYTH: ... some area retrieval teams or other available?

DR MAHMOOD: Our retrieval team is shared with Burnley – not shared in the sense

that it's shared in terms of the work that's done. We do it on alternate weeks. We don't have a dedicated sort of transport team to say like they're like a specifically – so it's from our staff, our main staff. But we cover nine to five, Monday to Friday, retrieval from the referral centres between us and Burnley, so one week we do it and one week they start doing it. And usually for Saturday and Sunday we usually get only back – retrievals back, sort of transfers – transfers that are special care mainly. We don't usually go on to get intensive care babies.

PROF FORSYTH: You said nine to five.

DR MAHMOOD: Nine to five. Well it's seven-to-seven, but usually nine-to-five is the main thing where there's a medical person available. Seven to seven is the thing, so by the time you get the call and get everything, nine to five is usually the time when you get a call and agree to take it and bring it.

PROF FORSYTH: So what happens the other seven to seven?

DR MAHMOOD: Yes, it's – well, we usually – I mean my understanding, it is seven to seven, but it is the medical staff that are available. After five you would not really agree because there won't be really much sort of cover in there. Although if you started a retrieval you don't stay at five, you extend it sometimes, even longer than seven, I would say.

PROF FORSYTH: So if Barrow wants to transfer a baby after five o'clock at night to the call centres, which retrieval team will...

DR MAHMOOD: Usually it will be Manchester.

PROF FORSYTH: So it's Manchester.

DR MAHMOOD: Manchester, yes.

PROF FORSYTH: So Barrow to Manchester is quite a long way, is it?

DR MAHMOOD: It is a long way.

PROF FORSYTH: So – and the retrieval team in terms of your – is staffed by who? This is people...

DR MAHMOOD: Usually there is a rota staffed by a consultant, a registrar or an ANNP, plus a nurse, so there's always somebody plus a nurse that – so a nurse or a sister, yes, for transport plus somebody. And that can be either a consultant, a registrar or an advanced nurse practitioner, a neonatal nurse practitioner.

PROF FORSYTH: And so, again to go back to the Barrow situation, if there's a baby delivered, some[?], make a call to this call centre. Do you have standards in terms of how quickly a retrieval team will get to Barrow?

DR MAHMOOD: We do get as soon as really possible, and we usually prioritise things. Obviously if, for example, we've – I mean we sometimes, let's say, we agree to bring a baby from Liverpool, where the cardiac surgery has been done, back to – but then somebody calls us to say there's a baby that needs to come in, 26-week, ventilated, and in Barrow, we definitely then prioritise and go and see – bring that baby first, and then bring the other baby.

PROF FORSYTH: And do you, as one of the retrieval teams, have discussions with staff in Barrow about the initial stability of the babies and immediate care that they should be provided while awaiting the retrieval team to arrive?

DR MAHMOOD: Yes, we usually do that anyway, yes.

PROF FORSYTH: Is this audited at all to know whether the immediate care that was provided was adequate or inadequate?

DR MAHMOOD: I must say, I haven't personally had that, and I've asked my colleagues around about anything that they have seen once I knew this was coming, and no one told me there has been any sort of issues that have arisen in that sense.

PROF FORSYTH: And is there meetings of the regional retrieval teams?

DR MAHMOOD: There is.

PROF FORSYTH: And is there a director for the whole...

DR MAHMOOD: There is a director for transport, which is, I think, from Burnley, and there is a lead in our Trust, which is [Dr Narasimhan ~~Miles-Seaman?~~], one of the Neonatologist ~~anthologists[?]~~, and obviously there are meetings and there are obviously issues, and if things happen, then usually there is issues to be discussed.

PROF FORSYTH: And so you would expect all the outlying units to have a representative attending these, would you?

DR MAHMOOD: I'm pretty sure they have. To be honest, I – myself, I'm not involved in the transport system because I'm a paediatrician and a neonatologist, and I am not really – and soon I will be getting out of neonatology towards paediatrics, and my interest is cardiology, so – but I understand that, yes, they have representatives and there is meetings, and usually they have sort of networks ~~sort-of-with~~ looking into issues, and if things happen then they will be discussed.

PROF FORSYTH: Okay. And from your experience, you were involved in the baby in Barrow.

DR MAHMOOD: Yes.

PROF FORSYTH: And you had to do a report about it. Do you have any comments to make that you would like to make to us in relation to that?

DR MAHMOOD: I think the only comment to make about – I've written my report, that's for Lancaster Hospital, it was actually. It was Barrow Hospital, I was mistaken, I apologise for that.

PROF FORSYTH: That's okay, that's no problem. So there was nothing on that particular occasion that you felt was relevant to this inquiry at all?

DR MAHMOOD: Not really, no.

PROF FORSYTH: I mean this was a baby who had been born where there was some concerns about intrapartum care, but the baby was severely asphyxiated at birth.

DR MAHMOOD: Yes.

PROF FORSYTH: [redacted] I don't know...

DR MAHMOOD: Sorry, do you want me to comment on whether the care was in this baby?

PROF FORSYTH: No, I'm just thinking. I'm just trying to – you know...

DR MAHMOOD: My role in this.

PROF FORSYTH: It relates to my initial previous questions about the advice you're giving to the call centres about...

DR MAHMOOD: Yes, I think this case was discussed, and I think there was a discussion, and I have in front of me the root cause analysis of a case that was done, and that was actually to emphasise the point about involving other units.

This root cause analysis involved a consultant coming from Barrow as well, and the matron from there and everybody else. So, yes, I mean I think these babies are really quite – really they are very difficult and critical, and I think the longer you leave them in without intervention, the worse they get, and they have become very critical and very difficult to manage, and that's what happened to this baby.

Now, it's difficult in retrospect to say whether an early intervention, but without a doubt. I think as we see now with these babies, we do tend to really interfere early and not leave them sort of really needing oxygen till 60/70/80% without intubation and without intervention and without the need for further action really. And so I think in this case I would have expected this baby to be transferred earlier. That's the only thing I can say, and it doesn't matter if it's night as well because we work 24 hours.

DR KIRKUP: Can I just ask whether that has been, in your experience of transfers from Furness and/or Lancaster, has that been a pattern?

DR MAHMOOD: No, that's what I mean. I haven't had really any more experience apart from this one, as far as I know. I mean it might be my colleagues might know anything different, but this is certainly...

DR KIRKUP: But you haven't spotted...

DR MAHMOOD: I haven't spotted any...

DR KIRKUP: ... a recurring tendency to hang on to babies for too long.

DR MAHMOOD: That's what I mean. It's not a pattern that I've noted. Certainly this case, yes, I would say. And it's – it might reflect the experience of the person looking after the baby and thinking the baby will get better and so on,

but I think it would have been obviously better if it had been discussed at least with us to say, 'This is the baby's situation, what do you think is the best way?' I think. At least then because we could have done something.

PROF FORSYTH: That's fine, thank you very much.

PROF WALKER: To follow up on that, was there any knowledge around your colleagues about transferring in? You know, and particularly, presumably the transport services have evolved over the years, and so it often would have teething problems initially and so on, but was there any feeling that there were problems with certain units referring in, or how the system works?

DR MAHMOOD: To be honest, no, not really. No, I haven't had anything relayed to me that there is a particular problem with any specific unit. Individual cases do happen, and I think it can happen anywhere. Obviously, the more experienced the unit are the less likely they are, but to my – if it was a pattern I would be very surprised if that is the case. I mean I am just talking from my own experience here, you certainly can ask my colleagues. And as I said, I try to ask many of my colleagues who do more transport, regarding this in the last few days, whether there is anything – a pattern, and they haven't mentioned anything to that extent.

PROF WALKER: The other thing I was going to ask is that you obviously have a transport team that go out during the day, you said, but not at night, and at night they would come from Manchester.

DR MAHMOOD: That's right.

PROF WALKER: Would they always take the baby back to Manchester?

DR MAHMOOD: No, no, they bring it to us. They bring it to the nearest unit, so if

there is a cot with us then they'll bring it to us, yes.

MR BROOKES: Just from interest really as much – I assume there's agreed protocols between each service centre.

DR MAHMOOD: Yes, that's right.

MR BROOKES: Okay, how are those reviewed, and how would a case like – would a case like this be automatically part of that review?

DR MAHMOOD: Definitely, yes. Yes, as I said, there's root cause analysis, and then issues regarding learning, issues regarding this, and maybe something that needs to be put in place to really avoid such a thing happening again is something that usually has been the case. But I think these are discussed in the regular meetings with the transport system.

MR BROOKES: And just for confirmation, I think you've already said this, as far as you're aware there are no concerns about those protocols not being adhered to by Furness Hospital?

DR MAHMOOD: No, I don't believe that there is any. As I said, I have asked around. I am not involved directly in the transport, but I have asked around, but nobody, especially Dr Gupta, who is the lead neonatology, and I've asked there yesterday, 'Is there any issues?' 'No,' she said, 'no, not specific, not systematic. Yes, I get an individual case, occasional ones, and that's happened, but not systematic.'

MR BROOKES: Okay, thank you. That's all.

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

DR MAHMOOD: No, not really.

DR KIRKUP: Okay, well thank you very much for coming.

DR MAHMOOD: Thank you.

[Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Dr Geraldine Walters – Expert adviser on Nursing
Professor Stewart Forsyth – Expert adviser on Paediatrics
Ms Jacqui Featherstone – Expert adviser on Midwifery
Professor James Walker – Expert adviser on Obstetrics

STELLA MCDOWELL

Transcript produced by Ubiqus
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DR KIRKUP: Thank you. Right, we're ready. My name's Bill Kirkup and I'm the Chair of the Panel. Thank you for coming. I'll ask my colleagues to introduce themselves.

PROF FORSYTH: Good morning. My name's Stewart Forsyth, and I'm Paediatrician and Medical Director from Dundee.

MS FEATHERSTONE: I'm Jacqui Feathersone and I'm Head of Midwifery and Head of Nursing at a district general hospital in Essex.

PROF WALKER: I'm Jimmy Walker and I'm an obstetrician and Professor in Leeds. I've got a background with the National Patient Safety Agency and CMACE.

DR KIRKUP: As you can see, we're recording proceedings and we will produce an agreed record later. You'll also see that there are some families who are in attendance as observers, and others will be able to listen to this part of the recording subsequently.

We will also have a break after a while, and when we reconvene we won't have any observers present, and that's the opportunity to talk about anything that raises issues of individual clinical confidentiality.

And you'll also note that we've taken away any mobile telephones, laptops, recording devices, just to underline the importance that nothing that we say in the room goes outside the room until we produce a report that's got everything considered in context. Is there anything you would like to ask me about the process?

MS MCDOWELL: No, thank you.

DR KIRKUP: Okay, can I just ask you to say, just to start with then, when you started at the hospital and what you've done there?

MS MCDOWELL: June 1990.

DR KIRKUP: And in what capacity was that?

MS MCDOWELL: A midwife.

MS FEATHERSTONE: Could you move nearer to the mic, please?

DR KIRKUP: If you could possibly speak up just a little.

MS MCDOWELL: Sorry, yes.

DR KIRKUP: It's the acoustics aren't brilliant in this room. I apologise for that.

MS MCDOWELL: Sorry, and we should move this forward.

DR KIRKUP: I don't think it makes the slightest difference actually, because I don't think we're transmitting on that.

MS FEATHERSTONE: It's probably stuck a bit. If you move your chair this way a bit, that's it, that's probably a bit better.

DR KIRKUP: Okay, we'll see if that helps. You started in 1990 as a qualified midwife?

MS MCDOWELL: Yes.

DR KIRKUP: Where did you do your training?

MS MCDOWELL: Blackpool Victoria.

DR KIRKUP: Blackpool, okay. And have you worked in Furness General since 1990?

MS MCDOWELL: Yes.

DR KIRKUP: Okay, and are you still working there now?

MS MCDOWELL: Yes.

DR KIRKUP: Okay, thank you. I'll hand over to Jacqui.

MS FEATHERSTONE: Just really starting from in 1990. So you went there straight from – as a newly qualified midwife?

MS MCDOWELL: No, I was abroad in Canada.

MS FEATHERSTONE: And then, in sort of the last ten years or so, has training – I'm just talking about mandatory training really, could you state what you've done in the last ten years?

MS MCDOWELL: Last ten years. Masters. I'm not quite finished with that yet. Certificate in Diabetes. Sorry, I can't think, yes.

MS FEATHERSTONE: And mandatory training? Do you do this on a yearly basis?

MS MCDOWELL: Oh, yes, we do. We do a mandatory obstetric study days, the – we have e-learning now that we have to, it's mandatory that we complete this. Sorry, I'm nervous so I can't think everything.

MS FEATHERSTONE: Go back, go back – tell me what you're doing now. Tell me what you're doing at work now?

MS MCDOWELL: At the moment I'm working in the antenatal clinic, and I'm lead midwife there.

MS FEATHERSTONE: And how long have you worked in the antenatal clinic?

MS MCDOWELL: About two – just over two and a – about two – not quite two and a half years now.

MS FEATHERSTONE: Okay, and that's in Furness?

MS MCDOWELL: Yes.

MS FEATHERSTONE: And so do you ever go onto the labour ward? Or do you stay in the clinic?

MS MCDOWELL: Well at the moment I haven't. It was supposed to be only temporary, but I appear to have been there since - yes.

MS FEATHERSTONE: Okay, so go back then to 2012, what have you done previous to that?

MS MCDOWELL: Yes, then I was a band 6 midwife on the ward. Well we rotated on the maternity ward, labour ward, and we also did rotational shift pattern, worked nights as well.

MS FEATHERSTONE: So prior to two years ago you'd worked everywhere...

MS MCDOWELL: Yes.

MS FEATHERSTONE: And were working everywhere were you?

MS MCDOWELL: Yes.

MS FEATHERSTONE: And did you have a set sort of so many months on each ward? Or...

MS MCDOWELL: They did start to introduce that more latterly. They tried to have a – but it didn't always work out, and certainly prior to that it didn't seem to always work out. I'm not sure whether it was holidays, sickness, whatever, but we didn't quite get the amount of time in each area.

MS FEATHERSTONE: Okay. So I'm not going to be talking about your antenatal clinic job, that is really about when you were working on the wards with labouring and antenatal – postnatal clinic. So, but did you, over a period of five years, were you working everywhere or were you only in the antenatal ward?

MS MCDOWELL: No, I was working both labour ward and the ante – both labour ward and the maternity ward.

MS FEATHERSTONE: Okay, and then during that time you were up to date with all your mandatory training, and what sort of things were you doing?

MS MCDOWELL: Like I say, like obstetrics study days, mentor update, I have an

interest in diabetes, so I try to pursue that. Neonatal resuscitation – I'm just trying to think. CTG monitoring...

MS FEATHERSTONE: On an annual basis was this?

MS MCDOWELL: Pretty much an annual basis I would say.

MS FEATHERSTONE: And you had a supervisor of midwives?

MS MCDOWELL: I did have a supervisor of midwives, yes.

MS FEATHERSTONE: Are you a supervisor?

MS MCDOWELL: I am a supervisor.

MS FEATHERSTONE: Oh you are a supervisor?

MS MCDOWELL: Yes.

MS FEATHERSTONE: How long have you been a supervisor of midwives?

MS MCDOWELL: Since the end of 2008.

MS FEATHERSTONE: So from a supervision point of view, did you feel then that all the training and when you were seeing your own supervisees, were they all up to date with their training? And were they – was there time allowed for them to do it?

MS MCDOWELL: In 2008 probably not. I – from a supervision perspective, I probably didn't think it was quite as robust as it is now.

MS FEATHERSTONE: What's the change now then?

MS MCDOWELL: There's very specific guidance, governance, with supervision that I think lacked prior to that. I'm not saying it was anybody's fault, it was just the way that that was integrated at the time.

MS FEATHERSTONE: So from a governance point of view, when as a midwife – because even prior to your – you're now a band 7?

MS MCDOWELL: I'm not, I'm a band 6.

MS FEATHERSTONE: Oh, band 6. But even as a band 6 on the ward you're the senior midwife. Did you get involved in investigations and complaints when you were on the ward?

MS MCDOWELL: From after I qualified as a supervisor I had so many months as like a preceptorship, but several months after it I did get involved in investigation, yes.

MS FEATHERSTONE: And... Sorry.

MS MCDOWELL: Yes, and at the time I was asked to do this investigation, as it was my first one I did feel that there was a lack of guidance, even from senior supervisors of how I was to implement it. During the beginning of it though they did produce some guidelines from the LSA which helped me.

MS FEATHERSTONE: Did you get support from the LSA?

MS MCDOWELL: Yes I did, I did. I think that – I don't know if I'm supposed to say this, I feel that it's – the person that is in charge of it now is much more supportive and perhaps recognises things than perhaps previously.

MS FEATHERSTONE: So you were doing a supervisory investigation for an incident that happened in the hospital.

MS MCDOWELL: Yes.

MS FEATHERSTONE: Was there a management investigation at the same time?

MS MCDOWELL: There was, and I was asked to do this afterwards.

MS FEATHERSTONE: To do the management?

MS MCDOWELL: No, I wasn't. There was a management, which subsequently meant that there had to be a supervisory – concurrent supervisory investigation.

MS FEATHERSTONE: Okay, and did you work together doing it then?

MS MCDOWELL: Well, to a certain extent everything had to be above board, in that I had to request management approval to look at certain things, and I understood that was the procedure then. Because otherwise it would be seen as not different to management, you know. I was looking at practise issues where they were looking at their agenda.

MS FEATHERSTONE: Okay, and then with regard to the management, because of the supervision obviously it was slightly different, did that investigation that you did, was that shared with the staff? The recommendations and...well if you do it more generic. Would you say that then – investigation, we were talking about complaints, how is that cascaded - the information cascaded back to the staff?

MS MCDOWELL: Yes, I think it was just mainly addressing procedures and protocols and seeing how best we may, you know, how best we may improve things if there had been issues that had been found, or individual needs, if they were, you know, seen to be lacking or...

MS FEATHERSTONE: Okay, and did you attend multi-disciplinary meetings and were you, you know, encouraged to attend multi-disciplinary meetings where governance issues were...

MS MCDOWELL: Between supervisory and management are you saying?

MS FEATHERSTONE: No, I'm talking about as a midwife now.

MS MCDOWELL: As a midwife. Probably not that much, no.

MS FEATHERSTONE: So how would you know -- you might know something through a supervision group, but how would you know things that were going on within the department on the shop floor, as a midwife, to make changes then?

MS MCDOWELL: With difficulty, I would probably say, yes.

MS FEATHERSTONE: Now, how would you know?

MS MCDOWELL: How would I know? I feel that there is a much improved communication system, very much from the intranet, from meetings, multi-disciplinary team meetings, from away days that they have for specific bandings now, so they do try to -- now definitely try to cascade the information to you.

MS FEATHERSTONE: When you were a midwife working – when you were working like clinical midwife on the labour ward, was it always apparent on every single shift who was the lead midwife in charge?

MS MCDOWELL: Yes, I would say so, yes. It was a band 7, yes.

MS FEATHERSTONE: And the relationship between the medical and the midwifery staff?

MS MCDOWELL: Generally okay, generally okay. I felt that most of the staff – that most of the medical staff I feel I could have approached. Maybe not everybody, maybe not everybody. I don't know if I'm explaining myself very well with that. But in general I felt that we could ask them.

MS FEATHERSTONE: If you had a problem with – who would you then go to if you were looking after a woman?

MS MCDOWELL: Well, I would have informed my band 7 and whoever was on call, the registrar or consultant who was on call.

MS FEATHERSTONE: And you were happy to do that?

MS MCDOWELL: I personally was yes, yes. I'm not saying everybody would have been, but I was.

MS FEATHERSTONE: And from a supervision point of view, do you do record keeping audits with the midwives?

MS MCDOWELL: Yes.

MS FEATHERSTONE: On a regular basis?

MS MCDOWELL: We do it at their annual review.

MS FEATHERSTONE: And do you do ad hoc record keeping?

MS MCDOWELL: I do – I do ad hoc, yes. I review notes, just as if – if I know it's one of my supervisees I look at their record keeping.

MS FEATHERSTONE: How do you record your clinical activity now? Do you have a computer system?

MS MCDOWELL: We have a computer system.

MS FEATHERSTONE: So is there much on paper now?

MS MCDOWELL: I use a proforma with regard to record keeping that I keep, and I have submitted them to the LSA when they've done their audits.

MS FEATHERSTONE: And how was that – does that change sort of from, you know, ten years ago?

MS MCDOWELL: It probably wasn't even there really much.

MS FEATHERSTONE: So everything was done on paper?

MS MCDOWELL: Yes.

MS FEATHERSTONE: And what would you say with regard to retrospective, you know, documentation. Because just some – lots of notes have got, you know, retrospective... Is that the norm within the hospital?

MS MCDOWELL: Lots of notes have got retrospective entries? Well I think sometimes in labour it's very hard to do – I mean I don't know how retrospective you're saying that some of the records – is it days?

MS FEATHERSTONE: When you were talking to a midwife and you were explaining she had to write something, how would you explain to her when to write something? You know, what you would expect, 'Retrospective' to be?

MS MCDOWELL: Well it's contemporaneous, so it should be at the time that you're doing, or shortly after you've done a procedure so it's fresh in your memory

and you've got the detail there. Sometimes, if an emergency's happening, then you're - obviously you have to go back until the emergency is dealt with and then you write in your entries of what's happened.

MS FEATHERSTONE: But within the shift that they're working? To write...

MS MCDOWELL: Try to write it there, yes, and that often means staying behind after you've finished your shift to complete it.

MS FEATHERSTONE: Thank you. I've no further.

DR KIRKUP: Thanks. Jimmy.

PROF WALKER: You said that you qualified in Blackpool then you went to Canada. Were you working as a midwife in Canada?

MS MCDOWELL: No.

PROF WALKER: So the – when you came back then to work in the Trust here and then you'd only – you'd had no post graduate training?

MS MCDOWELL: Yes I had had post graduate training, yes. I'd had two years post-graduate training in Blackpool.

PROF WALKER: In Blackpool, okay.

MS MCDOWELL: Yes.

PROF WALKER: So when you came into the Trust here you'd had that experience and been trained and had post grad training in Blackpool, did you find a difference in the way you practised or the atmosphere in Furness as compared to Blackpool?

MS MCDOWELL: I suppose I'd come from a fairly, at that time, high number of deliveries and it was very much you had a set pattern because you were so busy, whereas at Furness it was much more friendly, open, not quite as – how can I describe it? At Blackpool I had to do things in a certain set way and there was no deviation from that, because you had a lot of patients to deal with and you couldn't, you know, nip out and make them a cup of tea or toast or – you didn't have time to do that type of homely comfort, I would say. That I could – well what I saw at Barrow.

PROF WALKER: So did you prefer working in Furness when you came?

MS MCDOWELL: Well it was a little bit alien, because it was very medicalised at Blackpool. Very medicalised, and less so at Barrow I felt.

PROF WALKER: Okay. So if you – did you feel then that this was better overall for women or do you disagree?

MS MCDOWELL: It was probably a little bit better in some instances, and perhaps not in other. If – I say, how can I explain – whereas at Blackpool if you didn't do something within a certain time then that next procedure, then the next procedure, would happen, whereas at Barrow it was a little bit – you could wait and see a little bit and – I don't know if I'm explaining myself very well.

PROF WALKER: So you said that it's more homely – you've got more scope to give time to give...

MS MCDOWELL: Individualised care, yes.

PROF WALKER: Individualised care, but you also said that in some aspects it wasn't as good, so what was it particularly?

MS MCDOWELL: Well, I think coming from the background that I did, I was perhaps a little bit anxious that I wasn't perhaps doing how I'd been trained, you know. You were – it was a little bit more relaxed, should I say, at Barrow.

PROF WALKER: So do you think you felt comfortable because you'd been trained in something different.

MS MCDOWELL: Yes.

PROF WALKER: Did you feel that it was – did you feel it was unsafe? Or did you feel that you were...

MS MCDOWELL: I can't say I felt it was unsafe at the time, but there were certain practices and, coming from a larger unit, there was definitely designated people that did designated jobs, whereas at Barrow, because you were a smaller unit, you were a little bit – you did a bit of everything, which I wasn't quite as used to, you know.

PROF WALKER: And you say you didn't think it was unsafe at the time. Does that mean that in retrospect you do feel?

MS MCDOWELL: Well, I think that the situation with the caesarean section set up, you know, when you're on night duty, you didn't always have a doctor on call if you needed them immediately. So you had to be on the ball and predict, 20 minutes in advance, if there was going to be a problem, because you had to call somebody in.

PROF WALKER: So that's one thing which you felt –

MS MCDOWELL: So that was one thing which I didn't like, yes.

PROF WALKER: And that's something you felt at the time, right?

MS MCDOWELL: Yes.

PROF WALKER: Yes, but you – you also seem to suggest at the time you felt things were generally safe, but then in retrospect they weren't. Is there any other thing that stands out?

MS MCDOWELL: Well, because I had been brought up so – sorry, taught – so medicalised and this had to follow this pattern and this had to follow that pattern, waiting and seeing was a little bit alien to me, and then I found the relaxed process was, as I say, alien to me, and it took a while for me to adjust to that, because, you know, if you're taught a certain way you're – that's how you continue in some instances, isn't it?

PROF WALKER: When you practised, did you feel you were practising as an individual and in isolation? Or did you feel you had a team around you to support and help you if needed?

MS MCDOWELL: Yes, in general I feel I did have a team around me, yes.

PROF WALKER: So did you feel that less or more in...

MS MCDOWELL: Probably slightly less. Yes.

PROF WALKER: Sorry, less what?

MS MCDOWELL: Less team support.

PROF WALKER: Less team support than you did in Blackpool?

MS MCDOWELL: Yes.

PROF WALKER: Yes. So what would have been different in Blackpool? Would it have been someone coming in to make sure you're okay and checking that everything – that...

MS MCDOWELL: Yes, because it was so set in that this had to happen before this, this – you know, yes. So you knew where you were.

PROF WALKER: Okay. Now you hinted that, you know, because during nights you had to predict some time before when things are going wrong, and that's quiet difficult to do in a way.

MS MCDOWELL: It is.

PROF WALKER: Did you feel there were situations where you felt that problems were brewing and that you felt that the woman shouldn't be there, if she could be transferred out it might be better, or medical staff should be involved? Did you feel that you were just getting into troubled waters with people sometimes?

MS MCDOWELL: I think a lot of the staff that I trained with were very well – I was working with were very, very experienced, and so were able to predict, as it were. But sometimes, you know, it was a close shave.

PROF WALKER: Can you assess – can you think of how many deliveries you would have done a year?

MS MCDOWELL: How many I would have done a year? I don't know. Depending. 50.

PROF WALKER: 50?

MS MCDOWELL: It may have been, yes.

PROF WALKER: Okay, and did you feel that kept your skills up and that you [inaudible] for problems that arose? Or did you feel that things would go wrong relatively rarely that you were not – not able to keep up skills about emergency intervention things?

MS MCDOWELL: I think you always want more practical experience. And when I first started on there I was on labour ward quite a while. But – I don't feel as if I had a problem with experience, but I'm not saying that, you know, new procedures, new policies, new ways of doing things, and being of the age group that I am, you know, we used to do a lot of common [inaudible] practices than they do now, you know, they used to do breach deliveries and things like that, which obviously people don't now and things like that, you know. Or see them more than what we do now. So I felt as if I'd seen quite a few things that perhaps people don't now, but yes, I think that perhaps the keeping up the practical skills could have been improved. Yes.

PROF WALKER: If you had a problem in a patient looking after, say in the past, say five years ago or so, how would you escalate that?

MS MCDOWELL: I would get the registrar on call.

PROF WALKER: So you'd go directly to the registrar?

MS MCDOWELL: Yes.

PROF WALKER: You wouldn't go through the senior midwife?
MS MCDOWELL: I would tell her that I'm doing it probably, yes.
PROF WALKER: Okay, and how responsive would the doctor be?
MS MCDOWELL: That – sometimes that is a difficulty, sometimes some are better than others and, you know, especially on night duty.
PROF WALKER: So would you have – one of your concerns, would that be of how quickly the doctor would appear?
MS MCDOWELL: Sometimes, yes.
PROF WALKER: And what would happen if the doctor came and then didn't do what you thought should have been done?
MS MCDOWELL: I'd bring him back again.
PROF WALKER: Okay, and what if he came back and said, 'No, I'm not changing my view'.
MS MCDOWELL: Well, then I would escalate it to a consultant.
PROF WALKER: And have you ever done that?
MS MCDOWELL: Once.
PROF WALKER: And how did the consultant respond?
MS MCDOWELL: Well this particular time they were fine.
PROF WALKER: But did they support you? Or support the registrar?
MS MCDOWELL: Well, they came at my request. But it's not a thing I would like to do. Nobody likes to do that, and I don't think it's - happens very often, and it can cause ill feeling and you're working with these people.
PROF WALKER: But the consultant supported your – that you called him?
MS MCDOWELL: At the time, yes.
PROF WALKER: Okay. What happens if something in your practise goes wrong, and would you report that as an incident?
MS MCDOWELL: Yes, now yes.
PROF WALKER: And the – how would you go about that? Is it done on a book that you report it into or?
MS MCDOWELL: No, it's all on the intranet, you know.
PROF WALKER: So what about five years ago though? Did you have an incident book to fill in then?

MS MCDOWELL: It wasn't as robust as it is now.
PROF WALKER: Okay.
MS MCDOWELL: Yes. There's definitely improvements in incident reporting now.
PROF WALKER: So in the – following on from before then, so if a situation – if there was a good outcome despite the fact that there was a problem arose, would that come to the attention of anyone?
MS MCDOWELL: Probably not on occasions, no. But now it would, yes.
PROF WALKER: And what about things like the clinical governance meetings, of like clinical meetings or [inaudible] meetings, did you attend ever?
MS MCDOWELL: We did have them, yes. We have had them for a number of years. But they've become more robust as well.
PROF WALKER: Did you attend them regularly?
MS MCDOWELL: Yes – well, as much as I could, yes.
PROF WALKER: What does that mean though? Is it, did you...
MS MCDOWELL: Sometimes I couldn't attend because I was too busy, but I liked to attend them because they were interesting and you learned from them, but...
PROF WALKER: And would you attend them during your working hours? Or would you attend them out of your working hours?
MS MCDOWELL: Generally within my working hours.
PROF WALKER: And so that you would probably – where you could be relieved of the duties to attend.
MS MCDOWELL: Yes.
PROF WALKER: So were they held once a month?
MS MCDOWELL: I can't imagine – I think it was about once a month. I can't remember now at this time.
PROF WALKER: You can't really remember how often then you would attend. Would that be twice a year, or five times a year or?
MS MCDOWELL: Perhaps fives times a year.
PROF WALKER: Okay, and so – and they were open discussions about the cases?
MS MCDOWELL: I think somebody did a – somebody does a presentation of events and things like that, what's happened, and analyses the event.
PROF WALKER: Okay, you got sent at one point the Fielding Report. You're one

of the list of people that got sent that report. Do you remember receiving it?

MS MCDOWELL: It'll be – it came on the intranet as I remember.

PROF WALKER: And did you read it?

MS MCDOWELL: I did read some yes, yes.

PROF WALKER: And what did you think of it? Did it – did you feel that it was an accurate assessment of the unit? Or did you feel they got it wrong? Or they – or that they were over critical or they were under critical?

MS MCDOWELL: A mixture really. I just felt rather sad for the people that couldn't represent their voice.

PROF WALKER: So does that mean...

MS MCDOWELL: Well, some of the things that were accused I didn't feel that was justified.

PROF WALKER: So you felt that people weren't able to defend themselves?

MS MCDOWELL: Yes.

PROF WALKER: You weren't – you didn't – you're not saying you didn't think people were robust enough to speak up about problems that they didn't ...

MS MCDOWELL: People didn't speak up about problems, is that what you...sorry?

PROF WALKER: No, I'm asking you whether you felt that people didn't speak up about problems or you felt people weren't allowed to defend themselves?

MS MCDOWELL: Probably, probably yes, yes. That people couldn't speak up about certain issues, yes. It wasn't – it was ignored.

PROF WALKER: Okay. Thank you.

DR KIRKUP: Thanks. Stewart.

PROF FORSYTH: Yes, can you just go back to the statement made earlier on about the waiting and seeing? It was alien to you.

MS MCDOWELL: Yes.

PROF FORSYTH: Just expand upon that a little bit.

MS MCDOWELL: Well, as I say, coming from a bigger unit to – we had to meet, you know, certain things had to be done within a specific time, or – and if that hadn't reached that, then it was an induction of a labour, or – just a certain procedure would have to be done. Whereas if everything was okay – it was just a little bit more of a relaxed approach, not quite as – all I can say is

medicalised.

PROF FORSYTH: Do you think that was a good thing in hindsight?

MS MCDOWELL: It was in some ways. Because you were treating the individual patient rather than as a set of points, but then in other ways it left me, as a midwife, slightly more confused. It was just the way I had been taught, and I preferred to know exactly what was expected of me.

PROF FORSYTH: So it wasn't actually... Sorry... So it was not really a clear pathway of care?

MS MCDOWELL: Not all the time, no.

PROF FORSYTH: And do you think there was ever a time when the balance was out of equilibrium in terms of ...

MS MCDOWELL: Probably, probably...

PROF FORSYTH: In terms of midwife and medical?

MS MCDOWELL: Probably, yes. Yes.

PROF FORSYTH: So what period of time was that?

MS MCDOWELL: Well I probably noticed it more when I first went there. Because obviously that's the greatest impact on me, coming from another unit.

PROF FORSYTH: And was that just how the unit ran?

MS MCDOWELL: Yes.

PROF FORSYTH: And was that – obviously the way the leadership at that time felt it should run.

MS MCDOWELL: Yes, I guess so, yes.

PROF FORSYTH: Did you feel – did you express your views at that time? That it seemed very...

MS MCDOWELL: Well, I tried to just do it as I did – I'd been taught. I'm not saying all the things that we did at Blackpool were good, you know. If there was meconium liquor we did an episiotomy, things like that, you know, there were certain things that I didn't really want to do, but because our policy procedures stated that, whereas it didn't necessarily mean that. It wasn't the same type of that logic at Barrow.

PROF FORSYTH: Do you think at times it almost reached the stage where it was seen as a sort of – probably a weakness on the midwife's part not to achieve a

natural delivery and not have to contact medical staff?

MS MCDOWELL: Sorry, can you repeat that?

PROF FORSYTH: Well, do you think that the midwives, at that time, got into a way of therefore being reluctant to contact medical staff?

MS MCDOWELL: I don't think so. I don't think so. I'm only speaking for myself of course. And at the time we did achieve a very high rate of normal births if I recall, and whether that was from the individualised care and the fact that we could be with the woman more and knew their needs. I'm not saying either or medicalised and not medicalised is the better option, but a balance between the two is what's needed.

PROF FORSYTH: You've had 25 years at Furness.

MS MCDOWELL: Yes, nearly.

PROF FORSYTH: How has it been – how do you feel about being able to maintain your skills and knowledge working on what is really a small unit in an isolated area?

MS MCDOWELL: Well I think, as I said, coming from a larger unit with designated people for certain things, and that's not always a good thing because then you were totally sheltered from one aspect of the job and another, and I felt that you sometimes have a more rounded knowledge of everything coming into a smaller unit, because you're involved with everything that's going on.

PROF FORSYTH: Did you have an opportunity to go and visit other units and see how they're working and how they do things to see if there's new ideas and new ways of delivering care?

MS MCDOWELL: Not often, no. I have been to some study days based at the other hospitals, I can't think of where it is now, neonatal resuscitation, things like that, but...

PROF FORSYTH: You've suggested there are a number of changes in recent years, and occasional supervision etc. which have improved the service as such. Why do you think these were not introduced earlier?

MS MCDOWELL: Why do I think? I don't know really, I don't – maybe it was just a lack of insight from senior staff. I don't know. Or maybe as you say not enough awareness of what was going on other units, and how things could be

done or improved.

PROF FORSYTH: What about the morale in the unit over 25 years? How has it been? Have there been areas when there would have been difficulties and morale's low or whatever it is?

MS MCDOWELL: Yes, obviously, obviously as a result of the investigation that had been going on the morale has been at rock bottom I would say.

PROF FORSYTH: What about prior to that? And I'm talking of year 2000 to 2007?

MS MCDOWELL: I felt it was pretty good. I mean I felt that when I first started there it was a very nice friendly unit, and it is a small place and lots of people know each other, and if you're not related to them you know somebody who is. So I felt that the care was very good at the time. Sorry, I'm forgetting your morale...

PROF FORSYTH: With hindsight do you still think it is?

MS MCDOWELL: Pardon?

PROF FORSYTH: In hindsight, do you still think the quality of care at that time was good?

MS MCDOWELL: Well obviously now we have a more robust mechanism I can see that we had problems, yes.

PROF FORSYTH: What about your relationship with paediatricians, in terms of their support to you and support to the midwifery service?

MS MCDOWELL: I think probably there could be better communication between the multi-disciplinary team, or there should have been previously. Not everybody took onus...

PROF FORSYTH: Are there any examples of when you felt the communication was particularly bad?

MS MCDOWELL: I can't think at this point, but there obviously have been times when I felt that, yes, or nobody taking actual responsibility and feeling it was left to yourself.

PROF FORSYTH: And in terms of around – if resuscitation, if you're looking after mother and the baby delivering required resuscitation, was that – was there a system in place that always made that effective?

MS MCDOWELL: Well sometimes – how do I explain it? I probably think there should have been more senior guidance from everybody involved, and

including the junior – you know, for the junior doctors as well.

PROF FORSYTH: So do you think you're equipped – some aspects of resuscitation of babies wasn't – were unsatisfactory?

MS MCDOWELL: I'm not saying they were unsatisfactory. What I'm probably saying is there was a lack of leadership for the junior doctors on occasions.

PROF FORSYTH: In terms of leadership to medicalise? Or to...

MS MCDOWELL: Well possibly...

PROF FORSYTH: Poor communication generally between medical and midwives?

MS MCDOWELL: Yes.

PROF FORSYTH: Okay, thank you.

DR KIRKUP: I'll just pick up a couple of points. Do you have a clear policy on intrapartum monitoring?

MS MCDOWELL: Pardon?

DR KIRKUP: Do you have clear policy on intrapartum monitoring, foetal monitoring?

MS MCDOWELL: Yes, we have a policy, yes.

DR KIRKUP: So how long has that been in place?

MS MCDOWELL: I think it was 2012.

DR KIRKUP: Okay, what was there before 2012?

MS MCDOWELL: There were policies, yes. I'm sorry – I thought you meant the latest one.

DR KIRKUP: I did, but I want to know how it's changed.

MS MCDOWELL: Yes, we've been doing the K2 PACKAGE (CTG MONITORING RESOURCE TRAINING) ~~KSF~~ for a number of years now, I can't recall when it first came in, but I remember going to some study day and it was Gibb – Gibb who was the man who'd written the book on CTG monitoring, and I thought that was as far back as something like 1999.

DR KIRKUP: Have you seen changes in the approach to continuous monitoring in that period?

MS MCDOWELL: Oh gosh yes now. Massive changes, yes.

DR KIRKUP: And when would you date those to?

MS MCDOWELL: Probably from the advent of the ALSO[?] courses.

DR KIRKUP: Which would have been when?

MS MCDOWELL: Well I went on one in 2002, so that – I think they were the fairly first, but we didn't implement them straight away, yes, that's probably come at a later date, but they definitely discussed issues regarding – and, you know, using mnemonics to do things.

DR KIRKUP: Yes, was that part of the less medicalised approach that you detected when you first arrived at the Trust?

MS MCDOWELL: Sorry? Were the...?

DR KIRKUP: You've described this less medicalised and more relaxed approach in Barrow than the one you'd been used to in Blackpool. Was part of that less recourse to continuous foetal monitoring, yes?

MS MCDOWELL: Possibly, yes. Yes, I probably at Blackpool used a monitor an awful lot more than I did at Barrow, if I'm honest, yes.

DR KIRKUP: Did you feel that you were qualified and experienced to monitor babies on the maternity wards? Sometimes babies needed monitoring?

MS MCDOWELL: Yes, within – I knew my remit. I know my remit and if things went outside that I would ask for help.

DR KIRKUP: You would ask for help from?

MS MCDOWELL: The paediatrician.

DR KIRKUP: Did you feel that the nurses – the midwives, sorry – that you worked with were equally qualified and experienced?

MS MCDOWELL: I can't say they all were. But I would hope that none of us would meaningly compromise any babies.

DR KIRKUP: You didn't have any significant concerns about the babies who you were asked to monitor? It was appropriate as far as you were concerned?

MS MCDOWELL: No, I think sometimes – what period are we saying this from? Or just generally in the last ten years or 12 years or?

DR KIRKUP: We're particularly interested in 2004 to 2013.

MS MCDOWELL: Right yes.

DR KIRKUP: So over that period, any changes?

MS MCDOWELL: Well when I first started we did actually spend time on special care baby unit, so I did six months on special care baby unit and we rotated everywhere and that – I don't know when that stopped. So...

DR KIRKUP: Can you give us a rough impression? I think it's quite important.

MS MCDOWELL: I can't – it's a long time...

DR KIRKUP: After 2000?

MS MCDOWELL: I think it was before then, before then.

DR KIRKUP: Before 2000?

MS MCDOWELL: Yes, we stopped much before then we stopped rotating. I can't remember reason why at the time. And I'm sorry, I forget your original question now.

DR KIRKUP: It was the approach to monitoring babies on the maternity ward.

MS MCDOWELL: Oh that's definitely much – that's definitely improved as well. That's definitely improved. I think at one stage special care monitored more babies, and we - then it became the expectation that we had more babies to monitor, that would have previously been monitored on special care.

DR KIRKUP: Okay. Any follow ups from anybody? Okay. We'll have a short pause then and when we have asked the observers to leave we'll come back to issues that may raise issues of clinical confidentiality.

MS MCDOWELL: Right.

[*Observers leave*]

THE MORECAMBE BAY INVESTIGATION

Monday, 22 September 2014

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

Before:

Mr Julian Brookes – Expert advisor on Governance and Chair of the interview
Dr Catherine Calderwood – Expert advisor on Obstetrics
Dr Geraldine Walters – Expert advisor on Nursing

PATRICK MCGAHON

Transcript produced by Ubiqus
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MR BROOKES: Good morning. I'm Julian Brookes and I'm just going through some housekeeping things. First of all, can I offer you Bill Kirkup's apologies? Unfortunately, he can't be here for the session today, so he's asked me to chair this session for him. I'm going to ask the panel to introduce themselves then, for the record, ask you to introduce yourself. Then there's a few housekeeping things and then we'll get into some questions, okay?

DR CALDERWOOD: Good morning. I'm Catherine Calderwood; I'm an obstetrician working in Edinburgh and I also advise the Scottish Government.

DR WALTERS: Geraldine Walters, Director of Nursing and Midwifery at King's College Hospital.

MR BROOKES: And I'm Julian Brookes; I'm currently Deputy Chief Operating Officer for Public Health England, but previously head of clinical quality at the Department of Health.

MR MCGAHON: I'm Patrick McGahon, Director of Finance at NHS Business Services Authority.

MR BROOKES: Thank you. As you can see we are on microphone. We're recording all the sessions where we take evidence and that's for two reasons: one is to make sure we have an accurate copy of the discussions, but also these sessions are open to members of the families of those involved. As you are aware, there is nobody here today, but one of the things we've offered to the families if it's difficult for them to come to any particular session, is an opportunity under controlled conditions to hear what was said, so that's the other reason for it. You'll have been asked to remove your phone and turn it off. That's because we want to make sure that any recording of this session is limited to the official recording. That's to ensure that the evidence is taken in context of everything we hear and as part of the final consideration of reporting is not leaked in any ad hoc way. Just finally, there may be, on occasions, maybe not in this one, but occasions where we refer to particular cases and particular clinical cases. If that is something which we need to get into, we will do that in a closed session at the end of the session and if we start straying into that area I will remind people, okay? Finally, there is no expected fire alarm today, so if we do hear one, we will vacate the building. Okay, thank you.

DR WALTERS: Hi. Could you tell us about your role at the trust from when you first started?

MR MCGAHON: Yeah, I started in I think it was October 2006. I was on secondment to the ~~[inaudible]~~ Trust as a Turnaround head ~~director~~, because they'~~d~~ ~~just~~ had ~~—it was~~ an historic debt problem and they needed to get ~~it so~~ the financial ~~[inaudible]~~ position ~~the director of finance and executive~~ back on track. And then, in July 2007, I became the director of service and commercial development, which essentially covered the FT application process, the contracting process between ~~for~~ the trust, ~~so the contract between ourselves~~ and the PCTs. And finally, informatics around the informatics service, which essentially focused on IT.

DR WALTERS: What sort of commercial developments were on the cards at that point?

MR MCGAHON: Well, in terms of commercial development, the trust – although that was the title, I think if you look at ~~[inaudible]~~ the business plan we ~~have~~had, there wasn't really any great push to commercialise elements of the trust. And when we did secure some business later on, for example, the ~~[inaudible]~~ Ramsay unit in 2012/13, which was an IS unit based on the Kendal site, we took that over and brought that into the NHS. And we also developed some services for things like wet ~~A&E~~ AMD, ophthalmology services, but that was essentially bringing it back from the tertiary centres. There was no great push across the trust, you know, to secure vast amounts of private income. We didn't have a private unit and we didn't progress a private unit.

DR WALTERS: So in 2006, was that before the loan from the PCT was negotiated?

MR MCGAHON: In 2006 the trust had a deficit of about £6 million which had accumulated and so what we had to do ~~—there~~ was secure some support ~~provided~~ as part of that process and basically the trust had to repay ~~that~~ the debt that had accumulated, so that was part of the process.

DR WALTERS: And from 2006 were you a member of the board?

MR MCGAHON: I was an associate director up to authorisation and then became an executive director in 2010.

DR WALTERS: So at the time when you first got to Morecambe Bay, what were the real big issues?

MR MCGAHON: Well, the big issues ~~were~~ for the trust~~, in sort of a~~ were cultural ~~context,~~ tThe trust had been what ~~are~~ was called a three-star trust, so it was deemed to be ~~the sort of~~ top of the pile, but unfortunately, over a period it had dropped back and I think it was one-star; I think it went down to one-star on a scale of nought to three. So that made a big dent in terms of the culture of the organisation. Also, Ian Cumming had left, he'd gone to North Lancashire PCT and Kevin McGee was the acting chief exec. And also on top of that they had ~~this~~ the financial problem as well, so I think both of those things had an impact on the trust.

MR BROOKES: What were the factors that had moved it from a three-star to a one-star?

MR MCGAHON: Well, a lot of it ~~in~~ was in terms of the national mechanism for monitoring – I don't think there was a particularly robust process between three stars and one star. I mean, you could drop a couple of points on something, which dropped you quite a bit down the ratings~~, and that was the trust's~~ – tThe trust's view was that it was still a three-star trust, it was just the mechanism ~~of, you know, the mechanism~~ for actually calculating the rating that had caused the problem. I think, I would say that there was an element that the trust had ~~sort of~~ stood still and never really moved on. ~~You know, the~~ whole other trusts had ~~got [inaudible] moving~~ moved faster in terms of progress. I think that was one of the big ~~sort of~~ issues.

DR WALTERS: So, in relation to the FT process, obviously all trusts wanted to [inaudible], what was that like in this part of the world? Was it everybody was expected to get there or...?

MR MCGAHON: ~~Yeah~~ Yes, I think initially, back in ~~sort of~~ 2007, there was a national push and basically the message was if you didn't become an FT then you would be taken over ~~[inaudible]~~, so that was the ~~sort of~~ national message. But actually, as time progressed and we got to, ~~like,~~ 2009, 2010, there were so few trusts getting through FT it wasn't really recognised ~~as a – I think in early 2010 it was switched off~~ as failure not to be an FT. ~~You know,~~ tThe process had become so difficult to get through that very few were getting through and so there wasn't as big an issue with it really, ~~sort of in~~ from 2009/10, because if you didn't get it you were in quite a large pack, whereas the view was as more people get through that was going to cause real problems. So it was in that

context, we started in 2007, I think we started in about July-time, as soon as I'd been appointed we started to formulate, started to get things together, ~~sort of write~~ we wrote to the PCTs to join the steering group, we did clinical workshops to start working on the strategy, ~~something~~ they were called the Matrix workshops, which included the PCT ~~[inaudible]~~ representatives as well. So it sort of started from there really and then we followed a fairly standard process, supported by the SHA's team, which I can talk you through what that process was.

DR WALTERS: And what were the biggest hurdles for Morecambe Bay?

MR MCGAHON: The biggest hurdles, I think one was the finance issue, because I think ~~once they~~ everyone recognised that a trust like Morecambe Bay ~~where it's~~ covering 1,000 square miles spread across ~~the~~ three different sites was financially challenging~~,~~. ~~I mean, that's sort of been~~ The rurality issue is more recognised nationally now, ~~you know, it's certainly a challenge~~ as there is a scope to get paid above tariff. I think there was a general view also that in terms of ~~that~~ cash ~~side of it~~, that ~~it~~ was a challenge for everybody~~.~~ ~~and that's the main thing, I think, for sort of people getting through.~~

I think also performance reporting. You know, the trust needed to improve its performance reporting quite significantly.

MR BROOKES: The reporting or the performance?

MR MCGAHON: ~~Yeah, yeah, r~~Reporting performance, ~~well,~~ internally~~, but I did that~~.

MR BROOKES: Sorry, I'm still unclear. Was it the actual performance which was an issue or the way in which it was reported?

MR MCGAHON: No, in terms of the actual performance against the targets as they were at the time, which were statutorily robust in terms of ~~type and~~ delivery. So, generally speaking, we didn't have ~~[inaudible]~~ significant operational target issues but there was an issue about performance reporting to board~~,~~. ~~for example,~~ ~~s~~So we adopted UCL's performance reports at that time and amended it to utilise it for performance reporting. So those really were the big challenges.

I think the other thing generally was the culture of the organisation at the different sites, because there was a difference of culture~~,~~ ~~but t~~The chief executive did a lot of work in terms of Barrow, which is obviously isolated and out on a limb and he did spend a lot of time there talking to clinicians. He

basically assured them that the strategy wasn't going to be ~~they were going~~ to downgrade Barrow and patients would have to go elsewhere and that was – the strategy for ~~IVP~~ the intergrated business plan to essentially maintained the three sites ~~essentially~~ doing what they were doing~~,, so it wasn't [inaudible], but that was the general thought.~~

DR WALTERS: And was it believed that that was affordable?

MR MCGAHON: Well, in terms of CIP, in the early years, in ~~sort of~~ 2007/8-ish, we were round about £12 million, but actually the ~~fall~~ future years projections suggested we were going to be around £8,5-9 million, which was broadly in line with what the trust was doing, so there wasn't any great heroic assumptions around~~, you know~~ cost savings of say getting to, ~~we're going to have to get~~ £15 million a year. And that was probed heavily by Monitor as part of the process. So they probed heavily in terms of the CIP and they used people like PwC in the financial reporting review process.

DR WALTERS: And was the organisation good at CIP delivery?

MR MCGAHON: Well, the organisation delivered its CIP targets. Some of it was non-recurring, but that wasn't uncommon in trusts and still isn't uncommon now, but there's an element of recurring savings and on top of that there'd be some non-recurring savings as well. So things like rate rebates and we trawled the country and worked with a lot of the ~~local~~ neighbouring acute trusts. We met with about 10 local trusts where we exchanged ideas. We also met some of the trusts in the south as well, about ideas ~~about,~~ you know, that people were coming up with, utilised a lot of those ideas as well internally generated.

DR WALTERS: And were you reassured that there weren't quality deficits because of the CI~~B~~P stuff?

MR MCGAHON: ~~Yeah, w~~We had a quality review process~~ – well, before –~~ I can't remember what year it was, before probably 2008 quality ~~[inaudible]~~ assessments hadn't really been undertaken ~~in terms of~~ robustly across the NHS and we introduced them as part of the foundation trust application process. So, for each cost reduction plan there was a quality ~~[inaudible]~~ impact assessment signed off by the manager, ~~you know,~~ the lead clinician or the divisional clinician to say that in their view, ~~you know,~~ whether it was going to be detrimental or whether it wasn't. ~~I mean, I was involved at a later stage,~~

~~but t~~They were also reviewed by the chair of CQSC (Clinical Quality ~~Steering~~ and Safety Committee).

DR WALTERS: And did any get turned down on the basis of quality?

MR MCGAHON: ~~I think,~~ eOn recollection, I think they did challenge some of the ones that people had put forward. I think the Committee Chair challenged some of the things that were put forward. They were also reviewed by the director of nursing and the medical director as well and I do remember Peter ~~challenged~~ and Jackie challenged some of them and said that that they could not proceed– I can't remember which ones, but they did, from recollection, during that process.

DR WALTERS: So during the time you were there, what was going on around maternity? When did it start sort of –

MR MCGAHON: ~~Yeah, m~~Maternity, I think, from recollection, there were the five ~~studies~~ cases which took place and ~~Monitor – well,~~ we sent a briefing note to Monitor, from recollection. I can't remember exactly when, but I'm sure there was a note sent to Monitor explaining ~~what the studies were~~ each case. We'd also provided ~~with all the studies~~ all the RCAs associated with it as part of the process. We also had a maternity sustainability plan which picked up, from recollection, I think it was the CQC – or the Healthcare Commission, as they were back in ~~I think it was~~ 2007~~,~~. ~~the report. There was a sustainability plan produced then for maternity.~~ And so there was the SUI issue as well. And ~~then,~~ because of the SUI issue, the FT process was put on hold in 2009 and ~~they~~ Monitor asked for ~~[inaudible] at Monitor,~~ further. which was supplied ~~and also [inaudible]~~.

MR BROOKES: So did Monitor press the pause button?

MR MCGAHON: Yes, ~~yeah,~~ and my recollection is I think the CQC – well, the way the process worked at the time was that Monitor would ask the CQC for their view on the trust. And the CQC had a system of assessing trusts, like a green, amber, red scale, but no one really understood how that system worked. ~~You know, i~~It was a little bit more subjective than objective at the time. So that process went forward, then Monitor asked for further details, but basically relied on the CQC to say, in their view, ~~was~~ that the trust was compliant and they would then go on that basis, because essentially Monitor focused on they were ~~– their view was that was one issue, but the second thing was~~ the

viability and the strategy and ~~[inaudible]~~ of the Trust. So that then went forward and then I can't remember what happened in terms of the process. So we were authorised and then –

DR WALTERS: Oh, just rewind a bit. So there's the five SUIs.

MR MCGAHON: ~~Yeah~~Yes.

DR WALTERS: Monitor pressed the pause button and when did the CQC then sign off?

MR MCGAHON: The CQC, there were discussions – once that was paused the chief exec then led the discussion with the CQC with the director of nursing, I think, and the medical director.

DR WALTERS: So, at that point in time, various external reports were coming in, were they not? So after the SUIs there was the Fielding report.

MR MCGAHON: There was the Fielding report, ~~yeah~~yes.

DR WALTERS: Then sometime around that time there was the Central Manchester report, wasn't there?

MR MCGAHON: ~~Yeah.~~ In terms of timeframe, from recollection, the Fielding report came in 2010. I think the initial draft was March, then there was June, then there was the final one in August. ~~So that is then.~~ After that, there was a report commissioned ~~by a guy~~ by the Medical Director from an obstetrician called ~~by [Malik Muresh?]~~ Mike Moresh, which, from recollection, ~~I think it doesn't actually say, but~~ said there were issues within maternity that need to be addressed but broadly the service was not unsafe. The Central Manchester one was triggered in November 2011 and that stemmed from a request from Monitor because of the significant breach in October 2011. And in between that, in June 2010, the CQC had visited and done an inspection of the maternity and said it was compliant ~~[inaudible]~~ on six standards. Then, subsequent to that, there were CQC and NMC reports, I think in 2011, from my recollection, and then did a follow up in 2012. It's hard to remember.

MR BROOKES: It is hard to remember, yes.

MR MCGAHON: But I think it's 2012.

MR BROOKES: So which reports were before your authorisation?

MR MCGAHON: Before authorisation.

MR BROOKES: It would be the Fielding.

MR MCGAHON: Yeah, there was another one in 2009, but I can't remember what it was called. ~~There was [inaudible] review.~~

MR BROOKES: Yeah, but the Fielding particularly was before.

MR MCGAHON: Yeah, the Fielding came ~~—yeah, came~~ in August, ~~yeah,~~ 2010.

DR WALTERS: So I suppose something we've got to reflect on is there was obviously a head of steam building up around maternity and the trust wasn't authorised at that point. Monitor had pressed the pause button. There was the Fielding report, which wasn't altogether positive. So I suppose what gave the confidence back to take the finger off the pause button and to authorise the trust? So what happened in reassurance terms?

MR MCGAHON: I can't actually tell you what happened, because the discussions took place between, as I say, the chief exec, the director of nursing and the CQC directly, so I wasn't involved in ~~what exactly—~~that process.

DR WALTERS: So there were discussions rather than an objective the trust was now deemed to be –

MR MCGAHON: Yeah, I don't know what additional information was supplied to them as part of that process, but I'm also aware the chief exec was in discussions, obviously, with Monitor as well, some of their senior people about what was happening with the CQC as well~~,~~. ~~as par for the course. But I mean~~ ~~y~~You'd have to ask Tony and Jackie for the details.

MR BROOKES: And are you aware that the Fielding report wasn't shared with either CQC or Monitor?

MR MCGAHON: No.

MR BROOKES: Are you surprised by that?

MR MCGAHON: I think, on reflection, yes, I am surprised.

MR BROOKES: Okay, thank you.

DR CALDERWOOD: Thanks, that's been helpful so far. Reading through some of the minutes that we have of various meetings, I see that you were very involved in some of them more recently, in 2010/11, in the discussion about a business plan for maternity, about having extensive, in fact, and expensive changes to the unit and also there's quite a lot of detailed discussion about staffing and concerns about staffing, particularly from paediatricians. Can you just tell us about your perception and your role in that?

MR MCGAHON: In terms of the staffing side of it, I think the trust was aware of concerns around staffing and it undertook something called the Birthrate Plus review ~~and~~ that ~~notified there was a~~ confirmed we needed to increase the level of staffing in maternity services and that was subsequently actioned. We also tried to pursue funding of that through the PCTs. We were saying that because the service ~~[inaudible], but they weren't — they didn't feel, for whatever reason, they didn't want to fund the additional costs concerned~~ costs were not covered by tariff they should fund the extra costs but this was not provided. So the trust also in – the board, in September 2011, ~~following the issues — well [inaudible] significant breach,~~ authorised additional staffing at ~~in the~~ weekends for midwifery and it also linked with Liverpool Women's to get additional medical cover at weekends. Subsequent to that, the trust ~~— we went around — [inaudible] it was something, I can't remember exactly what it did. It was like~~ recruited 12, 13, 14, additional staff something like that, so we put a lot of additional staffing in. We also ~~[inaudible]~~ reviewed medical staff, particularly at Furness, ~~around the level of [inaudible] needed~~ and it concluded we needed 10 consultants, from my recollection, but the person who did that review from Preston basically concluded that that wasn't really a viable long-term solution, because ~~[inaudible]~~ there was inadequate work volume and consultants would become de-skilled.

In terms of the new unit, the restructure was led by ~~[inaudible]~~ the Operational Director from an Estates perspective. ~~t~~There was a lot of discussion about how that should look and how it should, you know, be manned and there was various iterations in the whole period, there were various iterations about what that would look like and how it was going to be done and so on. But I think my sort of reflection on it is the trust should have moved more quickly in terms of getting ~~that — getting~~ those issues resolved.

DR CALDERWOOD: There were obviously comments in the Fielding report about theatre and the accessibility of theatre from a labour ward, but my understanding is that from a recent CQC report that that hasn't changed significantly. There have been some changes, so that the labour room configuration with a £4-5 million ticket on it, has that happened?

MR MCGAHON: As I say, I'm not a the trust, I left more than 12 months ago, so I'm not sure where they're up to with that, but in terms of the issues with the CQC,

there were two issues really. One was principally obviously around the unit, ~~and~~ the second was the ~~[inaudible]~~ transfer distance across to the ~~[inaudible]~~ emergency theatre in terms of privacy and dignity and then the third issue was around theatre staffing ~~[inaudible]~~ levels at weekends and~~.~~ ~~And the trust was focused on surgical staff for~~ out of hours~~,~~ ~~and weekends, but.~~ ~~t~~The issue of ~~—I think the issue really about~~ the £4-5 million ~~was what was the~~ related to the long-term model for maternity and that debate is still ongoing as part of the work they're doing on a strategy for Morecambe Bay. So I think the view was that either we spend £5 million on a unit and then ~~[inaudible]~~ potentially a new strategy would make further change, so this caused a delay to the decision ~~and that really was part of the whole in terms of making a decision, I think.~~

DR CALDERWOOD: And I think they did do some - for privacy and dignity there were some solutions for that. So, in fact, this was, I suppose, stalled really, from what you're saying, because of a bigger picture –

MR MCGAHON: ~~Yeah~~Yes. There was working ongoing around maternity about what was ~~[inaudible]~~ the best model by the PCT ~~[inaudible]~~, so they were, you know, one to one going over a plan and I'm not quite sure now how far they got with that, whether they've actually finalised one. I'm not quite clear on how it's going to work.

DR CALDERWOOD: Okay. Did you – and I know you've alluded to say they didn't move on some of this very quickly. My clinical reading of some of the reports is there were safety issues. Did you feel that they took those seriously?

MR MCGAHON: ~~Yeah~~Yes, I think they absolutely took them seriously. There were issues, I remember – well, I don't remember the detail of it, but there was a discussion about, particularly SCBU, trying to move SCBU at Barrow into the ward and ~~that~~ there was a lot of work done by the division as to how they could somehow merge the ward and the SCBU to try and make it more clinically robust in terms of numbers and so on. So that plan was debated ~~and I don't know if actually – I can't remember whether [inaudible], but there was a plan, you know, and a safe plan to actually move SCBU from one end more into the ward to try and address that particular issue,~~ because SCBU was a real problem and the board spent a lot of time latterly discussing what to do ~~[inaudible] about~~ including whether they should be closing Furness SCBU and ~~moved or not~~ moving it. And the final decision discussion with the SHA ~~or~~ and

the PCT ~~[inaudible]~~ was that it would remain open and they would help secure staff ~~it~~ for it.

DR CALDERWOOD: And when you say it was a real problem, what was it?

MR MCGAHON: Well, it was highlighted by ~~[inaudible] and~~ the team, ~~you know, the~~ clinical lead that ~~[inaudible]~~ there was a concern about the robustness in terms of clinical safety. So we took a number of actions, ~~which were something like~~ including moving some babies to Lancaster. ~~and so on, s~~So there were some actions taken during this period of debate ~~[inaudible]~~ as to how it should be resolved, but the unit wasn't closing down.

DR CALDERWOOD: And that was when Gold Command was in.

MR MCGAHON: ~~Yeah~~Yes, Gold Command was involved.

DR CALDERWOOD: But do you feel that they then took those requirements seriously and acted on them?

MR MCGAHON: Oh absolutely, ~~yeah~~ yes, absolutely, ~~yeah~~ yes. My view was that, ~~you know, well,~~ there was a long debate, there was a long board debate, if you look at the minutes ~~now of part of the discussion and~~ plus also the hospital management team as well.

DR CALDERWOOD: Okay, thank you.

MR BROOKES: Can you just help me understand, because processes have moved over time and I'm just trying to make sure we understand the context at the time it was taken, how important was good governance to the FT application when you were involved in it?

MR MCGAHON: In terms of the process, the way the process worked, ~~I think at the time [inaudible] view of our application and I think – I think, looking back,~~ if you look backwards in time to how it was then, there was a strong focus on did you have the right corporate systems in place, so did you have risk management, ~~[inaudible]~~ strategy, did you have committee structures, did you have incident reporting and so on, ~~[inaudible]~~ risk management frameworks and all those kind of things. And I think in terms of the trust we did have those in operation. I think if you look in retrospect and certainly I think this was the case in a number of trusts ~~it's that it's the~~is about how robust~~ness~~ risk management was from the very base of the organisation up through – and if you look at the latest CQC report for the trust, they still seem to be having problems around incident reporting and risk management and so on and I think it's that~~'s~~ issue,

about the cultural issues about getting ~~those~~ incidents reported ~~done sufficiently~~ robustly which the FT of course didn't probe adequately.

MR BROOKES: So they were more interested in structures than they were in...?

MR MCGAHON: ~~Yeah~~Yes, I think they were interested in did you have the right high level systems– it was very much a sort of checklist type approach, which in terms of the quality element of the Monitor review we were the pilot, so prior to that we hadn't done anything on quality assessment – I can't remember what correct term they used, but it was like a quality assessment.

MR BROOKES: So you were the first organisation going through the FT ~~[inaudible]~~ quality assessment process.

MR MCGAHON: Yes.

MR BROOKES: Which was assessed for quality –

MR MCGAHON: For quality governance, yes.

MR BROOKES: For quality of governance.

MR MCGAHON: ~~Yeah~~Yes, we were the pilot.

MR BROOKES: And from what my understanding is now, I've seen the two notes of the meeting [inaudible] and it's very clear they are asking about board assurance and you've described the systems that you had in place. Were they content with that, did they look at minutes, did they look at content of meetings, makeup of meetings? In other words, the nuts and bolts, exactly what you're saying in terms of –

MR MCGAHON: ~~Yeah~~Yes, they did look at – to be honest, I can't remember the detail of what we sent through, but within the trust there is a full list of everything that was asked for and when it was sent and they did ask for board minutes, committee minutes. They went through all those kind of items. The way the system worked was Monitor reviewed everything that they requested and then, subsequent to that, would come back with follow up questions and ask for additional information.

MR BROOKES: Okay. So you were obviously able to satisfy Monitor about your governance arrangements before you were looked at being made into a foundation trust. What was your view of the quality of the governance arrangements of the organisation?

MR MCGAHON: I think at the time for things like incident reporting we were the highest or one of the highest ~~– I think we were the highest [inaudible]~~ in the North West in terms of reporting rates.

MR BROOKES: When you say 'the highest' you mean what?

MR MCGAHON: Number of incidents reported ~~for whatever the [inaudible] was~~ compared to volumes. Actually, ~~those kind of – you know,~~ if you looked at that kind of information we were ~~[inaudible] I think that a lot of our [inaudible] performance we were pretty robust in performance at the time~~ performing well~~,~~ we were hitting the targets. We did have ~~[inaudible]~~ systems in place. I think it's only really when you really probe down ~~– really probe down deep [inaudible]~~ that the main issue was lack of reporting and information to key committees ~~unication.~~ ~~o~~One of the reports says we've got to probe and get more assurance and I think that, fundamentally, ~~is~~ was and is less for Morecambe Bay, I think, looking more widely across the NHS, that's something ~~people have learnt subsequent to that~~ the NHS had learned in terms of probing more deeply.

MR BROOKES: Okay. You had obviously a strategic plan as part of your FT application. Was that supported by your PCTs?

MR MCGAHON: I think the PCTs were – in terms of the clinical process, we developed the plan with some PCT input plus, their clinicians, ~~so back in 2007 [inaudible]~~ attended the 2007 workshops. The PCTs took very much a view ~~that [inaudible]~~ that they could make massive reductions in activity through ~~the man~~ demand management and every year, to take Cumbria as an example, they'd come in and say, 'We're going to reduce your ~~[inaudible]~~ contract by £10~~,~~ £12 million. We're going to reduce ~~[inaudible]~~ activity dramatically.' Now, we always challenged that view, because we said there was no evidence locally or nationally that ~~that~~ demand reduction was actually going to be delivered and it did create a sort of adversarial ~~thing~~ relationship, because we were rejecting basically what they were saying in terms of contracting. And Monitor did quite a bit of work in that area ~~about what~~ – because what we did was we went through the assumptions that the PCTs were making around activity and we responded with what our view ~~of it would be [inaudible]~~ was based on what happened in terms of activity our view was ~~probably~~ more accurate than their view. But we did go and talk to the PCTs about that and

we Cumbria also [inaudible] commissioned a company called tTeamwork, we they did a review of how [inaudible] and came back with a report. The conclusion of the report was that our [inaudible] activity assumptions were higher than theirs. But that was really to the focus of their review of the IVP [inaudible] Trust's IBP into the strategy or governance or finances.

MR BROOKES: Quite often at that time foundation trust business cases would be based on acquisition, expansion. What was yours based on?

MR MCGAHON: Well No, ours wasn't based on that. Ours was based not on that at all, because Monitor took a view that they weren't keen on what they called income CIPs. So whatever case you put forward, if you said, 'I'm going to make a massive increase in income', you that element were basically ignored. They moved it to one side. [inaudible] slightly lower [inaudible], sSo Monitor did not accept large income gains and we didn't have any significant ones in development.

MR BROOKES: Okay. So if you looked three, four years into the future based on that view, would it be an organisation providing what the management was saying in the same way?

MR MCGAHON: Essentially, yeah yes. There were some [inaudible]increase income gain for example about wet A&E AMD, but nothing in at scale. [inaudible].

DR WALTERS: What are your recollections of the Gold Command process?

MR MCGAHON: I wasn't really involved with Gold Command. It was really dealt with by the chief exec and the director of nursing. I think, you know, tThe feedback we got was that – we had I think it was weekly meetings, from my recollection, and they would ask – there was a lot of information and probing on what proposals that went forward. I mean, I think it was probably a helpful process in terms of providing some assurance that – providing assurance to people that what we were doing was the right thing. But we did ask Gold Command for help, for example, trying to secure additional resources and stuff like that, but in practical terms most of that was trust based; it was fairly [inaudible] difficult getting extra nurses and stuff like that.

DR WALTERS: Okay. Because I think the clinical staff say that there was a point in time before which they didn't have many staff and the only things of interest in

the management world were finance and performance and then suddenly, at one point in time, more staff started to come in. Does that ring true to you?

MR MCGAHON: I think, to an extent, the national picture was focused on finance and performance and Monitor were very focused on that. That was their top priority. I think the ~~staff's~~ Mid-Staffs changed that picture ~~[inaudible]~~. But I think in terms of, you know, in discussions ~~[inaudible]~~ I was interested also in ~~[inaudible]~~ quality. It wasn't that ~~you~~ we ~~were~~ weren't interested in developing ~~a servicing~~ services and getting new ideas together. We weren~~'t~~ – and also improving management best practice, so we were working with – latterly on the strategy, we identified, ~~you know, say,~~ around 40-odd areas of best practice in different areas – within each service and we would encourage people to move to that model. So I think it's too much of a general statement to say that. And I think people, you know, Tony Halsall's view was, in a sense, ignoring FT; what he wanted was to provide really good hospitals for patients and I think the board had that view as well. I don't think the board started with the aim, ~~you know,~~ to provide poor services, we were really keen on supporting and providing good services ~~[inaudible]~~. I think, if you look back, some of our processes ~~[inaudible]~~ around risk management ~~something that needs~~ needed to be addressed. And in my career subsequently, I've been very keen on ~~[inaudible]~~ assurance I think we did see an improvement in clinical engagement subsequent to Tony's departure ~~[inaudible]~~.

DR WALTERS: Because I suppose a sort of recollection that we have heard is that up until a certain point most of the Deanery revisits, CQC reports in relation to maternity were fine and then there was perhaps the trigger of a high profile case and then suddenly, after that, they were all extremely negative.

MR MCGAHON: ~~Yeah~~Yes.

DR WALTERS: And I suppose did you get a feeling that actually there was a belief that we've been very unlucky here, actually we have got reasonable services, because we've got all this assurance from previously, but now we're going to have to do something because there is almost a PR action point?

MR MCGAHON: ~~[inaudible]~~My view is this is nothing to do with PR.

DR WALTERS: PR is perhaps the wrong word. There is a –

MR MCGAHON: Our idea was if there were issues that need to be resolved, we've got to resolve the issues that people have identified, so that was the focus of the work that we did.

DR WALTERS: But was this thought to be a sort of a bush fire rather than an indication that there were serious problems with the service?

MR MCGAHON: Within maternity, I think there was a view – I think our view was that maternity – there are issues in Barrow maternity, essentially because it was an isolated unit. That was one of its ~~[inaudible]~~ problems and also it had problems historically around recruitment. So there were – I don't think, from my memory, I think that was a well recognised issue and also we did try to address it. So we tried to support with additional staffing, ~~we tried to – you know,~~ we had a sustainability plan ~~[inaudible]~~ trying to address those factors. And I think we did, ~~as the [inaudible]~~ take further action in light of the significant breach and so on and moving forward. But the problem with – I think, when I look back, as you say, the problem is looking at it from a helicopter view, a lot of reports were saying it was fine, it was safe, acceptable. Others then saying no it's not and then the following month was yes it is and so the problem is there was ~~no~~ – for me, for a period of time there was no consistency ~~[inaudible]~~ of expert view about what the answer was. What was the – you know, what was fundamental? Was it good, bad or indifferent, in a sense? So it was very difficult. And the recent NHS Cumbria report in 2013 about perinatal mortality rates which, for 2004-2008, said that Cumbria was very low comparative to the national norms and also ~~[inaudible]~~ the reviews of cases in 2009-10 ~~of the unusual cases~~ was broadly in line with the rest of the country and internationally. But in Morecambe Bay there was an issue around identification of high-risk births. So what I'm saying is that in all this period of time there were, you know, good reports, bad reports and so on and I think that made it more difficult to get a definitive view. And I think, you know, in terms of with the Central Manchester review, it said there were 118 risks and there are 20-odd recommendations. I think the trust made a mistake then, because it focused on trying to address individual risks ~~through the~~ – what it should have done is address the recommendations and then the risks would have followed. ~~Now, the actual [inaudible] fine, but~~ I think that caused confusion within the unit and ~~across~~ – within the management team in that

division, because they were trying to chase almost too many things. And I became subsequently involved in terms of bringing the recommendations together in '13.

DR WALTERS: 2013?

MR MCGAHON: ~~Yeah~~Yes. Well, Jackie Daniel asked me to bring together one comprehensive report on progress – because Jackie Holt was away on holiday, so I was asked if I could ~~bring~~ – make sure all the reports' recommendations ~~that~~ were all there, that we had addressed them or were addressing them, ~~and that we had a [inaudible] service. So that was – I think that [inaudible] about 13% [inaudible] and it~~ the report on progress that went to Monitor was subsequently reviewed by MIAA who said we had now got all recommendations in one place and we were making progress in addressing them and that the monitoring was in place to resolve them. So I think the problem was there were so many reports that people were getting confused~~, you know, and~~ eOne of the criticisms of the trust was that, in terms of the action plans, that the action plans were there, but they weren't necessarily monitored, they weren't all connected together. And so what we decided to do was back in – in 2013, was to bring those together to make sure that we got them all and – and I think the programme management process [inaudible], which we implemented in about 2011/12 time~~, that~~ did help. A lot of the trusts ~~have used~~ use that method now, because it's much more ~~sort of~~ mechanistic in terms of have you done it, have you got assurance. So if you have a look at the report for the Central Manchester one, there's an assurance log, so for every action ~~the~~ there is evidence ~~is~~ supporting ~~that or, you know, there's a~~ it with the files, ~~so they've got~~ all those in one place. And I think we should have had that programme management methodology, ~~you know,~~ back when we – and that would have made things a lot tighter and a lot more ~~[inaudible]~~ robust.

DR WALTERS: So when you were saying you thought that the problem with the recommendations was there was too much focus on achieving a recommendation and not enough on why that recommendation was an issue, so was it something like, you know, you need another 110 guidelines, but the issue was the clinical engagement with the guidelines, not the fact that you needed to produce them? Is that what you mean?

MR MCGAHON: Well, ~~yeah~~ yes, it's something similar to that. I mean, what happened there were 118 risks in the report, the Central Manchester one, but there was about 25 recommendations. So a recommendation might be, ~~you know,~~ standardise your guidelines across the two parts of the trust, the two main sites and Kendal, but then there might have been five risks associated with that and what the division did, they focused on resolving the risks one at a time rather than saying, 'Well, let's step back and sort out the clinical ~~governance issue', which they did [inaudible]~~ guidelines.

DR WALTERS: Okay, thank you.

MR BROOKES: I'm trying just to understand where we were, getting back to FT, in the global position, because our experience elsewhere has shown that it was possible at that time to come up with a financially viable plan which met the targets, but didn't indicate high-quality service. Is that where you felt this organisation was?

MR MCGAHON: No, our objective was not to address a financial plan at the expense of services. It was just not. ~~[inaudible]~~.

MR BROOKES: But when you say 'at the expense of services' what do you mean?

MR MCGAHON: What I'm saying is we didn't knowingly do anything from a financial context that would have had a massive detrimental impact on services.

MR BROOKES: But that's assuming that the services you had were already of a high quality. And if you look at the history around, say, just on maternity services with the [inaudible] slightly before your time, the downgrading of midwives, reduction in numbers of midwives, etc, you could argue that actually what you were doing was putting forward a plan which was based on sub-optimal care to start with.

MR MCGAHON: In response to that, I think in terms of things like staffing levels, you know, we were involved with the Audit Commission's national staffing levels analysis by ward and by service and I don't know – you'd have to ask ~~Steven~~ Tim Bennett, who was director of finance at that time, but from my recollection we weren't overall significantly out against those benchmarks. There were ~~things like~~ areas we ~~should~~ needed to put more resources into for example acute medicine and put the rest into surgery, but there was nothing in those benchmarks, from my recollection of them, that said, you know, we were in the bottom quartile, let's say. So we were using benchmarks at that time. I

think the difference now is that people are using more sophisticated things. I'm talking about the staffing levels linked to patient activity for example ~~[inaudible]~~, Birthrate Plus. There's also ~~[inaudible]~~ the CQC, which has got safe staffing levels and the national ~~things~~ guidence, but at the time, broadly speaking, in terms of staffing levels we were around average. Now, that doesn't actually mean that, you know, nationally they were right, but that was what we were using as our benchmark and it was us against similar trusts.

MR BROOKES: So do you believe that the board at that time felt that they were providing safe services?

MR MCGAHON: Yes.

MR BROOKES: Were they right?

MR MCGAHON: Well, I suppose if you took maternity~~,~~ and you took the ~~[inaudible]~~ conclusions from a perinatal mortality review, you would have to say that, broadly speaking, there was nothing highlighted there that said it was an unsafe service.

MR BROOKES: But you're making an assumption there that the board would have looked at that kind of study and if you look at the – if you look at the papers of the board, there's not a lot of clinical discussion going on about that kind of thing. It's mainly, as you say, around finance, around performance issues. So where was that discussion happening to provide the board with the assurance that they were providing a safe quality service?

MR MCGAHON: Well, they were building - we built dashboard, for example, ~~like~~ ~~[inaudible]~~ out-patient clinics and also we were contributing CHKS clinical benchmarking service.

MR BROOKES: I don't mean just maternity services –

MR MCGAHON: No, no, ~~they were~~ CHKS are a nationally recognised clinical benchmarking services~~,~~. ~~the CHKS was.~~ Those reports were looked at by the CQSC, as far as I'm aware. I wasn't ~~there at the time~~ a member of that committee, but I believe they were. And so they highlighted benchmarks to the CQSC ~~CHKS~~ in the ~~[inaudible]~~ and ~~those~~ reports were available on an individual basis ~~for the committee~~at consultant level.

MR BROOKES: So can you briefly just describe the way the board would have received assurance about the quality of the clinical services provided?

MR MCGAHON: Well, the board essentially, in terms of it did have some dashboard information ~~[inaudible]~~ around clinical quality, which were very powerful, it had dashboards ~~and [inaudible] for~~ example ~~[inaudible]~~ around handwashing, infection rates, etc. and then we got the minutes of the CQSC into the main board. But I think, looking back again, I think there was – I don't think it was just at Morecambe Bay, but there was a lack of clear performance dashboards on quality. They weren't well developed. ~~You know, [inaudible] to be provided to the board.~~ And I think that our performance reports tended to focus on the actual performance issues, like ~~[inaudible]~~ RTT rates and so on. There were some elements of quality, but I think there should have been a bigger emphasis on quality. But on reflection again, at the time, we based our performance reporting on what UCL ~~do~~ did at the time and I don't think it was ~~only~~ until ~~the staff that~~Mid-Staffs really kicked in ~~and that was something that~~ that these issues were generally addressed I think now the board in Morecambe Bay board is different. There's much more reporting ~~[inaudible]~~ on quality.

MR BROOKES: Okay. Just one final thing from me: having seen a lot of discussions in terms of the preparation for foundation trust around the country, there is often a feeling that the kind of board members you need for an FT are different from the ones you need pre FT. What kind of assessment was made of the board's competence and looking at potential strengthening in particular areas as part of your FT process?

MR MCGAHON: ~~Yeah~~Yes, that was done. There was a review, we used Grant Thornton to do some work on governance and that also included looking at the board, but there was an assessment of where we needed to strengthen with the chief exec, from recollection, and we did implement, essentially, a new finance person, but we did have June Greenwell, who's a nurse by background ~~[inaudible]~~. And the other guys were essentially private sector people. I think if you looking at the board now, I would put more clinical governance people on the board. You do need finance people, no question about it, but you do – I would put more people ~~[inaudible]~~ with clinical experience.

MR BROOKES: Thank you very much. That's it, thank you very much. Thanks for your time.

THE MORECAMBE BAY INVESTIGATION

Monday, 15 December 2014

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

Before:

Dr Bill Kirkup – Chair of the Investigation
Professor Jonathan Montgomery - Expert Adviser on Ethics
Mr Julian Brookes - Expert Adviser on Governance
Dr Geraldine Walters - Expert Adviser on Nursing

JOYCE MCGULLION

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(At 2.15 p.m.)

THE DR KIRKUP: Thank you, my name is Bill Kirkup, I'm the DR KIRKUP of the Panel. Thank you for coming. I'll ask my colleagues to introduce themselves to you?

DR WALTERS: I'm Geraldine Walters, I'm the director of nursing and midwifery at King's College in London.

MR BROOKES: I'm Julian Brookes, I'm currently deputy chief operating officer at Public Health England, but was previously head of clinical quality at the Department of Health.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm professor of healthcare law at University College London, and DR KIRKUP of the Health Research Authority, and in the past I've DR KIRKUPed PCTs and SHAs and provider trusts.

MS MCGULLION: Could I just ask as well could you speak slightly louder? I've had a cold, and I'm just a little – but I heard everything, you don't need to do that again.

DR KIRKUP: We'll do our best, thank you. You'll see we are recording proceedings, and we will produce an agreed record at the end. You may also know that we've invited family members to be present as observers during the interviews. In fact, as it happens, we don't have any here at the moment, but they can listen to the recording subsequently. You also know that we've asked you to hand in any phones or laptops. That's just to emphasise that we don't want anything going out of the room until we're ready to produce the report with everything considered in context. Any other questions for me about the process?

MS MCGULLION: No.

DR KIRKUP: Okay, I'll start just by asking if you could outline when you started at the Trust, and what have you done there?

MS MCGULLION: ~~I was at [inaudible] in 1983, and worked at Bolton, and then applied for the matron's post in Lancaster and was successful, in May 2008. My background was a large years on a labour ward, and team leader combining labour ward and community, and sometimes within that we had [inaudible] and labour ward and the maternity unit. This was at Bolton.~~ I qualified as a midwife in 1983 and worked at Bolton Maternity Unit becoming

a matron at Lancaster in May 2005.

DR KIRKUP: Right.

MS MCGULLION: So in 2005 I applied and was successful in the post of community midwifery and antenatal clinic at Lancaster.

DR KIRKUP: Right, so you moved to Lancaster in 2005?

MS MCGULLION: Careerwise, yes, stayed living in Bolton, but –

DR KIRKUP: But then you became matron at Lancaster in 2005?

MS MCGULLION: ~~2005 I became the matron at Lancaster community. Then there was six matrons – no, there was more, there was eight matrons. There was two in [inaudible], there was three that mirrored Lancaster, one was for gynae services and the antenatal postnatal ward, the other was the labour ward, and the other one was community, and obviously I was the community element of Lancaster.~~ 2005 my responsibility as a matron was for community and antenatal clinic services at Lancaster. At this time there were 8 matrons cross Bay, three at Lancaster, three at Barrow and two at Helmchase. And then in – I'll have to look at I've got a timeline here.

DR KIRKUP: That's absolutely fine, you can refer to any notes or anything.

MS MCGULLION: I just need to – obviously I think in 2008 I was given community and gynae services at Barrow ~~Lancaster~~, so the role was expanded all the time with the pressures within the Trust. In November 2009 – can I name midwives?

DR KIRKUP: Yes please, it helps us to keep track of who's who.

MS MCGULLION: I was asked to do an investigation jointly with [Karen Wheatley?] regarding Marie Radcliffe, and then I was asked probably about 2010, although I may have statements that say different, that would by then the matrons had been reduced, the community matron at Barrow had gone and wanted to be a band 7 and didn't want to continue in post, and I was asked to go and look at how we can work differently in community in Barrow. So I didn't really, you know, I'd been to the unit about three times, and I looked at community for things like their timetable, off duty, holiday cover, how they were working. Then obviously I got to know Karen Wheatley a bit better, because by then Karen Wheatley basically had the whole of Barrow, because one of the other matrons had moved, emigrated to Spain with retirement, and she needed support. Following the inquest of Joshua I then – was the CQC

visit the unplanned one? There was a planned one in April 2011, and then the inquest, I was sort of going up there a lot more then, both to support [inaudible] to have the daily inquests, even though, you know, others didn't, I did, because I didn't know really the history, and then obviously I remember getting the call about the CQC, the NMC, unannounced, so could I go up to support Karen? I was at Lancaster then and I went up. Quite soon following that, really, I was up there quite a lot, and then when Karen was – I don't know what she was, really, no longer in that unit, it was all day, you know, where we were all up there with nobody really knew what was going to happen. I was asked would I take Barrow, the whole, like, community, gynae.

DR KIRKUP: And labour?

MS MCGULLION: Labour ward, and be the matron, because by then we had [Sharon Hayes?] as matron, [Sue Knowles?] as matron, and me.

DR KIRKUP: Okay, so can you give us the dates when you were actually formally covering Barrow as matron?

MS MCGULLION: That is a bit of a problem for me because – I know it's awful, because it just merged into you just did all the time, and I've retired, I know I've come today, you know. So –

DR KIRKUP: From some time in 2011?

MS MCGULLION: 2011, really from June 2011 following the inquest, although I wasn't as to do with the in-patients, I was up there quite a lot. But I was up there prior with the community under [Angela Oxley?], head of midwifery, and I never went up there under [Denise Fish?], apart from going up to the odd meeting. So it's that sort of thing. Then with [Sasha Wells?] I was asked to go up and be – well, you know, we had three matrons ~~then~~ cross bay.

DR KIRKUP: Right, so that's formally –

MS MCGULLION: [redacted] been dismissed, or finished her contract or whatever. You can tell how much we were all in to know what was going on, because we weren't –

DR KIRKUP: Yeah, okay. So you were effectively involved in Barrow from June 2011, formally from some time after that? How long did that go on for?

MS MCGULLION: It went – I mean, I was full time probably doing 80-100 hours a week certainly from about September, October.

DR KIRKUP: How long for?

MS MCGULLION: 10 months, until I was asked to go back to Lancaster because of a CQC crisis at the A and E and the medical, and they wanted me to look at the gynae.

DR KIRKUP: Okay. After that 10 month period did you have any more dealings with Barrow or were you in Lancaster all the time?

MS MCGULLION: I worked at Barrow all the time. There was a lot of changes within that. There was issues, because as a team we worked, you know, round Barrow and Lancaster on some of the issues, but not really, not full time.

DR KIRKUP: Okay, okay.

MS MCGULLION: Whereas there was 10 months of full time, solid, just travelling up, doing weekends on calls for the [inaudible] cover staff.

DR KIRKUP: I see, okay. Thank you, I think I've got a handle on that now.

MS MCGULLION: Is that okay?

DR KIRKUP: Yes, thank you.

MS MCGULLION: I'm sorry I'm so blurred, but it just does – you know when you do retire and finish you do put a lid on some of these things.

DR KIRKUP: Yes, no, understood. Geraldine?

DR WALTERS: So that 10 months, were you working on the labour ward?

MS MCGULLION: Well, you couldn't say you were working. What I did was I went up and I was asked to assess the unit, not the situation, and I never really, although you go up and you might meet with say Karen and chat and discuss things, and previously we were looking at a new model for Barrow, and things, obviously, you'd say 'how many staff?', and she'd say 'oh, four', and I would expect that to be on labour ward, as in qualified midwives, and I realised it was only four at night for the whole of the unit.

DR WALTERS: So just rewind a bit. So they asked you to assess the unit, so how did you set about doing that?

MS MCGULLION: Immediately I went obviously onto the labour ward, that was my priority.

DR WALTERS: And what were your first impressions?

MS MCGULLION: Extremely poor, below standard, way below any standard I've ever come across. And I remember her saying that there was a number of people that had gone to Cambodia, you know, and one of the lead

anaesthetists was seconded over there, and Angela Oxley had gone over, and I remember saying to people 'we have our own little Cambodia here, and you shouldn't have been' –

DR WALTERS: So what made it so bad?

MS MCGULLION: There was a number of things. There was – I did an action plan, and if you ask the Trust I regularly sent out an action plan and where we were up to for about 4 months, I don't know if you've had copies of that. Do you want me to start, should I just waffle on about it?

DR WALTERS: Yeah, just talk about how did you –

MS MCGULLION: There was environmental –

DR WALTER: Yeah, so the environment.

MS MCGULLION: Environmentally, it was extremely poor. It's only when you go in and you notice, even to you notice when you walked in and out of the labour ward from the very start the locks were never on the doors and the intercom were never used. When you looked, they had no office as such, I'd been saying to Angela Oxley previously, even before I walked into the unit, you know, and I went up as a community midwife, that the relationships were very odd. There was a very maternalistic role within key people, that I felt was unprofessional.

MR BROOKES: Sorry it's my hearing, did you say maternalistic or paternalistic?

MS MCGULLION: Well there was a paternalistic, by inference, I'd say definitely, around Barrow. That goes without saying, so it was a recurrent thing. But there was also a maternalistic by people like Janette Parkinson, although, you know, they'd been giving governance as one person, to create in the whole of maternity, it has to be said, but there was almost like – oh, there was this counselling thing, and her office was on the labour ward, so one of the things I wanted was I felt strongly that Janette should have her own office out of the labour ward to make any decent change, and that happened before I actually was given Barrow, is just whenever I was trying to look at differen things I had this issue to deal with, that was to me unprofessional and blocked change, blocked advancement, blocked communication, because of the strange culture that was within there. There was –

DR WALTER: Just to unpack that a little bit more, so what effect would that have on patient care?

MS MCGULLION: Well, the staff were more centred on themselves, I would say, and their issues. I think you've got to understand as well that the community of Barrow have a lot of inequality, and vulnerability, and what you had was, in Barrow, a lot of people from Barrow were the midwives and nurses in Barrow who had issues, and I have never worked in a unit, say, [redacted] I used to say that the labour ward was like a coffee show, because they'd even go in on their own days off to tell each other and support each other, instead of the priority being that this is a professional service, serving the community for maternity and midwifery.

DR WALTERS: So what did that mean that they sort of didn't do that they might have done if they hadn't had that relationship with each other? I'm just trying to work out what effect it had on patients.

MS MCGULLION: Well there was no confidentiality, definitely no confidentiality. They all knew so much about each other, and told each other things that – I mean, there was one when I really had to argue quite forcefully about suspending Marie Radcliffe with Angela, because she still wasn't sure, and we had quite a heated meeting about it, and obviously that altered the off-duty, because the band 7 cover the labour ward, you need a band 7, so we told one band 7 and said, strictly confidentially 'we are going to suspend so I need you to look at the off-duty and we need to sort out cover', and I know she rang Marie Radcliffe and told her we were suspending her.

DR WALTERS: So what were you suspending her for?

MS MCGULLION: Well it was over the report that we did. I don't know if you've got copies, have you got copies of that report?

DR KIRKUP: Yes, yes.

MS MCGULLION: Yeah, or just the cases, and you know, that was 12 months randomly pulled case notes. I felt that I'd been on a unit with 3,500-4,000 births at Bolton, and I'd never done as many manoeuvres as she had, so I did question, and while I was looking at some of those I even questioned 'has she been qualified?' I asked, 'are we sure, have we checked that she's qualified?' But when you stepped into the unit you realised that there was a number of things going on there. Poor practice, bloods taken out – I went to

the reception area, it was like it was their office, because the environmentally it was not well planned or well used for a maternity unit, and one of the things we did straight away was they said there was no shower and toilet facilities for women, but they had three rooms with showers and toilet facilities, and I obviously said 'well why aren't we using them?' and the answer was 'because there's no buzzers', so within 24 hours we just got temporary buzzers put in, but then it was to try and get that staff to alter and to use two high risk rooms and a low risk room that they didn't want to do, because they liked working on the other side. Do you know, and it was just the most peculiar experience I've ever had, because there was basic things that I think that everyone had got almost desensitised to working in that terrible environment. Everything was very dark, there was big old TVs that obviously we'd gone digital, that had not been used, in every room, and there was no resuscitaires in the rooms. The cleanliness was good but the relationship between everybody was very blurred. They would sit and have meals at the station, but it was an appalling station. They had no clarity about roles, and understanding about their specific roles and duties. Even cleanliness was done very ad hoc, even though there was no – you know, I'd go down to, say, the resuscitaire in the theatre and it wouldn't have been checked for 3 weeks, 2 weeks, 1 week, I'd write it down. We had a thing called traffic light system, where you put red, amber, green for risk of women, and I said straight away I walked in and said 'where are all the magnets, why don't we use them?', 'we don't use them because the magnets have fallen off', but they just didn't use them, you know?

DR WALTERS: Did they do any risk assessment?

MS MCGULLION: I would say that the risk assessments with their women were poor, and that they would – I remember going to one meeting, even prior to going up there and discussing a case, and what was said by somebody was 'let's change the paper with the risks on to say "pink", and I just said 'you could make it bright orange poker dot if you want, but it's still written there and they're not assessing risk'. The relationship between the paeds and the consultants, obstetricians, sometimes they'd fall out and they wouldn't speak, there was a category of the 32 week gestation should not deliver at Barrow, and there was almost like this norm of saying 'she's not in labour', the way

they discussed it with the women was biased to 'are you sure you want to go all that way to Lancaster, 50 miles, and your family will have to go down, you really shouldn't be in labour in here but I don't think you're in labour enough', it the way, it wasn't objective, 'this is the information', you know, because the neonatal unit couldn't cope with the 32 week gestation, and I think it's 34 now. So there was practice like I'd never seen before. They had no cleanliness round the back. I asked them what they would do if they had a pool~~r~~ delivery, how would they get the women out, they'd never done drills. I asked the governance person, the obstetric support person, could she do some drills and then do an action plan about what we need to do to make sure everybody's aware of how we need to work and what needs to be done and do an action plan, and she was in post a long time, and she just said 'I don't know how to do an action plan, can you show me how to do an action plan'. So I went in expecting one level, and it was all down here.

DR WALTERS: What was the relationship between the midwives and the obstetricians like?

MS MCGULLION: Poor. They said ~~So~~ it was good, if ever they were under scrutiny or being interviewed it always came out better, and when I went to a meeting, say, with Tony Halsall about, you know, post [inaudible], or about other things, they would stick together and say 'what a friendly unit', but sometimes – I remember we had a case where we couldn't transfer a lady who was 8 centimetres and about 28 weeks gestation, something like that, and obviously I asked for a regular multi-disciplinary team, and I was told that they'd never done that before, and, you know, there was always a bit of conflict. I remember one night, late, arguing and arguing with a consultant that a 20 week gestation pregnant lady ~~[inaudible] or something~~ needed to go to Lancaster, and he kept saying 'no it's too far and nothing's going to happen anyway'. So I would say their risk assessments were poor – but I do think there was a background of 'if we do not keep busy, and if we do not keep high risk they will close us or make us a midwife-led unit', so it all got confused, very confused. I think there was, I know there was difficultly recruiting, and you had a lot of husband and wife relationships. One of the registrars, for a start, who were husband and wife, when the midwives told me that they could have, say, the husband come over at 9 o'clock or 8

o'clock, but then if he's tired or if he was doing a locum ~~al~~ the wife would cover the rest of the night, and there was an investigation done by that, by Sue Knowles, which Ibrahim Hussain ~~[inaudible]~~ said was inaccurate and she'd exaggerated, and he would deal with, and it was that sort of inappropriate actions –

DR KIRKUP: Sorry, who would deal with it?

MS MCGULLION: He would deal with it.

MR BROOKES: Sorry, I missed what the occupation of the wife was, there, who was providing the cover?

MS MCGULLION: They were associates at Barrow.

MR BROOKES: Both obstetricians?

MS MCGULLION: Yeah.

MR BROOKES: Oh right, I see.

MS MCGULLION: And the midwives told me this would happen, and said they'd reported it for a long time. I knew there'd been an investigation, and I said 'are you still saying it happened?', 'yes, we did stop it'. But obviously I went up, no midwife spoke to me because one midwife was sobbing and saying 'what are you doing to our unit?' The band 6's were beginning to come to me and trust me. There was horizontal bullying, there was organisational bullying, I have never experienced anything like it in my life, and I felt sorry – you see, the meeting and greeting and the friendliness was all there, you know, with the women and the families. I'll give you an example that I did clash with a couple of people while I wasn't even working up there. [redacted]

[redacted] and that was under Angela Oxley's reign, and that's the sort of thing that I heard about and, you know, I was really pushing that we needed mental health services and training, and that's why, with the Fielding report, you know, we did keep saying 'where is the Fielding report', because we had said an awful lot of things, all of us, including – you know, I knew [Dave Birch?] had, I had, other matrons had, about what was required, at Lancaster but also the public health agenda that was almost non-existent at Barrow, in such a highly deprived area.

DR WALTERS: So were there any clinical incidents while you were there, and could you just explain how they were dealt with?

MS MCGULLION: There was –

DR WALTERS: So if you had an issue what would happen?

MS MCGULLION: There was lots of clinical issues. There was things like I went to the station and said 'what are these bloods here, why haven't they been sent, what are they?' and they said 'oh, they're from yesterday', so I said 'well what do you mean by "yesterday"?', 'well when we take bloods from a lady we always do a group and save anyway, just in case', so they took bloods, I don't know if they told the women, but it was routine for them to leave it just on the side, and they were yesterday's bloods. So obviously there was things like I was talking about still births to the lead, and this all in the first week, and I said – I don't know how it came up, but she said 'we never, ever use the coffin for the still births', the box, and I said 'well what do you use to transport the baby to mortuary?', because there's a set procedure of identification and transfer, and you've got to think that the labour ward was down, you know, open, public corridors, and she said 'none of us do', she said 'we swaddle the baby and take the baby to the mortuary, because' – and

I remember just going into the office and just doing this, thinking 'where do you touch that has got normal practice parameters', and I said 'from today onwards no one does that, you use normal procedures', I rang Sasha Wells and said, you know 'it's getting beyond, I almost feel that everything I touch and discuss there are issues'. So it was obvious ones like the theatre and the second stage, and, you know, the high risk rooms, the low risk rooms, the [not resuscitaires?], the old fashioned attitudes.

DR WALTERS: Yes, can I just interrupt you because we just want to get through a few things. So were you there when there were any still births or maternal deaths happened?

MS MCGULLION: I was not there when there was any of the maternal deaths and stillbirths ~~[inaudible]~~, because obviously I came afterwards.

DR WALTERS: So were there any incidents while you were there?

MS MCGULLION: There was no incidents of a still birth that I felt, and I remember Sasha actually saying 'we've gone a year now when there's been no still birth', that we felt could have been prevented,...

DR WALTERS: Were they identifying any incidents or near misses, and reporting them as adverse incidents through the Trust procedure?

MS MCGULLION: It was more that there wasn't, there was a lot of – when you were there and you sort of heard the buzzer and you went there was always issues from that obstetric issue that we had to resolve. Just basic things, like all the equipment wasn't together, nobody knew where the equipment was, the relationships were dominance. Things like the obstetricians, they told me that the associates hadn't done a foetal blood sample in 10 years. Well, you know, and it's things like that, that we were altering, but actual - I asked for some support, we did a recruitment, but there was very big things to alter, and I asked Sasha and I had a meeting at Kendal with Tony Halsall, [Jackie Holt ~~Hart?~~], and I asked them about if we scaled down and everyone including the medics would be re-trained at a different level than maybe you would expect on an obstetric issue, because I had great concerns for the safety of mothers and babies, and what was their response –

DR KIRKUP: Sorry, what date would that have been?

MS MCGULLION: I don't know, but it was [Teresa Chapman?] was up on the unit, she'd come to assess and we all went to Barrow and it was about 9 o'clock at

night, but I would imagine there was definitely by the time I'd finished talking to Sasha about what I'd found I'd also done a presentation previously on the action plan and everything that was needed from – the leadership was appalling, you know, and so I can't remember the exact date because these things happen –

DR KIRKUP: We need to try and put it into some kind of context of roughly when we're talking about, so if you can get to the nearest year?

MS MCGULLION: There was a written – I'm sure Sasha and co would know the date, I can't remember it now, because I know they didn't want minutes to be taken at that meeting.

DR WALTERS: So this would be in the 10 months that you were there, though, wouldn't it?

MS MCGULLION: It was in the early stages of being there, because I felt that we should have scaled down Barrow, this was within weeks of me going up there and having the unit, and Karen not being there, that we should scale down Barrow, that we should move all electives to Lancaster and we should include our neighbouring hospitals from Lancaster. Because, you know, I begged the Manchester team and said 'there will be another incident if you don't do something, there will be another incident', I was sure there would be. Luckily there wasn't, but I do think, you know, it was nothing to start at 8 and finish at 8 at Barrow, because ~~I you~~ didn't feel I could leave the unit – staff ~~you~~ used to just change their off-duty, with ~~you~~ never a thought ~~of~~ to the risks ~~or the~~ to women ~~or~~ of the service. Everything had to be re-done. (I was trying to explain here that it was more than just clinical practices that needed to change but also management practices including skill mix which needed be reviewed and changed.)

DR WALTERS: And what was their response when you said that to them?

MS MCGULLION: At first I was absolutely delighted when the Manchester team came in, because they saw and witnessed how they ignored me, really. You know, when I said anything people would do things, but there was a sluggishness, and a feeling that in the end they'd sort of see me off, which didn't happen, and the Manchester team witnessed this and witnessed me sort of asking, like, there was an obstetric issue [inaudible] and there wasn't enough midwives on the labour ward, so I went down and said 'somebody

will have to come up', and there was a reluctance, and then all the rest of the people at that obstetric issue came up to see why I'd made that decision, and I remember Karen Connolly saying 'and do you face this all the time', I said 'all the time', I said 'it's' – you know, there was real resistance to the change, because they didn't want any change.

DR WALTERS: So what was Janette Parkinson's job all about, then? How did she spend her time?

MS MCGULLION: When I arrived Janette was clinical governance lead, so she'd just been given the post, hadn't she, by Denise Fish. So that was Janette, and what you had under Denise Fish and Ibrahim Hussein was an emphasis to Barrow, you know, because that's where – and so I was actually employed and told I want Lancaster to be as good as Barrow, and Janette was – but, you know, it has to be said I came from a unit where guidelines and things like that, we would have meetings, discussions, we had guideline groups. So I'd say 'well we need guideline groups', 'yes but we're a three site Trust, and we can't do that, and we can't really meet for what we need to do', and I will say, you know, it was one person trying to do governance. But if there was any weakness it was about the fact of her – she couldn't be objective, nobody from Barrow could be objective about Barrow.

DR WALTERS: So was she doing guidelines herself, was she collecting incident reports, what was she doing?

MS MCGULLION: Yes, the incident reports were just on a paper base there, and she would collect them and then there would be a meeting probably every couple of months at Kendall where she's go through the incidents. It's only really after – I remember Angela Oxley asking me about some issue that had happened at Barrow, and straight away I sort of said 'well it would be this, this and this', but I began to think there was just this big wall between all the units. [Ibrahim Hussein?] and other people basically said 'if we don't keep busy and we don't keep doing we'll close', I think that was the thing. Helme Chase was always feeling they were going to close, everyone kept women in beds where they should be. You know, it was just – and I think this threat, almost, of this closure, and what they'll do to us, and the isolation of Barrow, and the fact that there was no rotation round that Trust. From what I can gather I still don't think the medical associates, which is what I wanted, had

gone down to Lancaster and done 3 to 6 months down there, you know.

DR WALTERS: Did the unit staff altogether look at problems together or look at how they could improve services together?

MS MCGULLION: Sorry?

DR WALTERS: Did the team of clinicians used to work together looking at how they could improve services or reduce risk?

MS MCGULLION: At Barrow? Not really, Ibrahim Hussein had the say, and people would criticise that, but then obviously when they wanted protection or shelter then they would go to him. There was an awful lot of people – it was the same when we were trying to create, you know, Ibrahim Hussein would agree at meetings, there was a time when fertility came to Lancaster and when I got [inaudible] there was no guidelines round it. There was nobody trained in infertility, and Dr Bamigboye, Mr Bamigboye, used to – Vincent Bamigboye, used to come down to Lancaster, say, on a Tuesday every other week. There was no guidance, there was nobody there for the women from Lancaster who had the expertise, and obviously as soon as it came under my umbrella I became very worried about the governance side of it, guidance, the support to the women, who's trained, we need a trained person, and I regularly had meetings with [Steve Evans?] who was our business manager then, Ibrahim Hussein, Kath Granger, myself, and somebody who was a lead up at Barrow, and we'd come to an agreement, say, in the meeting, but then the next day, the next week they'd just say 'no we never said that', you know, about training, about funding, and in the end we stopped, I think because I just kept going on about it that much that it wasn't safe, in the end we did stop it.

DR WALTERS: Okay, I'm just going to stop for a minute.

DR KIRKUP: Okay I just want to ask one thing before I lose the thought. You've mentioned the lack of multi-disciplinary team meetings. We've heard various accounts of when they started to happen and when they were fully operational. When was it that you said you had found that they had never done that, you had suggested them –

MS MCGULLION: You mean round a case? I'm talking about with the whiteboard, the whiteboard that was very poor, you know, not much history, and the woman in labour. I referred to the whiteboard but this is about a clinical four

hourly review of women by doctors and midwives on the labour ward.

DR KIRKUP: Okay, it's two different things then, so tell me about each of them?

MS MCGULLION: Yeah, there is the multi-disciplinary team meetings about the management side, and then there is the clinical side. The clinical side they weren't used to that, because often the paeds and the obstetricians would fall out, and so you wouldn't get them together.

DR KIRKUP: Yeah, so what year, again, roughly?

MS MCGULLION: But then there was the management side.

DR KIRKUP: Just hold onto the first one, what year roughly would it be that you were suggesting that they should have multi-disciplinary teams meetings and being told 'oh we don't do this'?

MS MCGULLION: Oh, as soon as I went up in September, October.

DR KIRKUP: 2011?

MS MCGULLION: 2011.

DR KIRKUP: Right, okay, thank you.

MS MCGULLION: What they interpreted as multi-disciplinary wasn't. There was very little management multi-disciplinary discussion, and, you know, I'm sure they're still having meetings about how they are going to redesign Barrow, and again it will be called multi-disciplinary, but I'm sure Ibrahim Hussein did not like me attending them and in the end I was asked not to go by Angela Oxley because he wanted so many beds, and he wanted this and he wanted that, and it wasn't feasible because we didn't have the patients.

DR KIRKUP: Okay. Julian?

MR BROOKES: Okay if I could just pick up on that that would be helpful. So we're talking about 2011, when you went over there. Clearly some of the concerns that were raised about individual cases was prior to that time. Were you aware of any changes to practice and the way in which they operated had happened from, say, 2008 through to 2011. You said you were there sometimes. Basically I'm just trying to understand had there been changes to the way they operated prior to your arrival which were obvious?

MS MCGULLION: I think there were certain things management wise that happened. Certainly I remember them saying that because we were very busy at Lancaster that we had to send 50 of our inductions a year up to Barrow, and Sharon Hayes and myself weren't very happy about that. You

see, you've got to understand that sort of Barrow, we would get an image of what Barrow was and how they did, and so if we say 'have you' – you know, they'd say that they've also started the cause for concern forms for safeguarding, but when I went up they hadn't started the new forms up at all. So whatever we heard – you know, I never heard the whole history of Titcombe until I went up to the inquest, and the consultants didn't either between the two areas.

DR KIRKUP: Yeah, so were you aware of any fundamental changes to the clinical practice in that unit?

MS MCGULLION: I mean obviously there was around the hypothermia and, you know, the guidance, and certainly there was a drive. But there was an acceptance from the Trust board right to the bottom that Barrow was different, and I remember I was in a winter crisis and the meeting stopping while they brought in a coffee trolley, making a racket. If we'd have done that at Lancaster it would have been – but it was just like 'well that's Barrow, it's a laughing point'. What I didn't realise was that that was just the tip of the iceberg, you know, in a lot of other ways. But it was starved financially, you know, I do think the matrons and the medics, when they said 'you can't have this' they agreed, whereas I wouldn't, I mean I wouldn't with Sharon Hayes at Lancaster. So they were supposed to do whatever changes we did, but whether they actually put them in practice, because what I found was very clear, clever obstruction to change at all levels, even consultants.

MR BROOKES: Ok, so there would be clinical guidelines?

MS MCGULLION: Yeah.

MR BROOKES: Were they being complied with?

MS MCGULLION: I would know before.

MR BROOKES: No, when you were there?

MS MCGULLION: No.

MR BROOKES: Okay. There would be training and statutory training requirements, mandatory training. Was that being complied with?

MS MCGULLION: I would say at Barrow, because obviously it was a quieter unit, I would say it was. But when I went to the obstetric issue you [inaudible] and it was led by the anaesthetists and the other people from Barrow. So it was at a level that maybe needed to be improved, which I'm sure it is now, but it was

at a level that maybe needed improvement.

MR BROOKES: Okay, in your estimation, given your experience on a busy unit, another busy unit at Lancaster, were they busy?

MS MCGULLION: At Barrow?

MS MCGULLION: What they had they had peaks and troughs. You were either nobody in the labour ward, and what I found was a practice of trying to keep women there on the labour ward for the numbers, you know, instead of discharging home or transferring to the ward, and you found it had a block in. I do think that it was definitely the difficulty with managing Barrow is that it's peaks and troughs, and the numbers that you have. Community, midwifery wasn't used to coming in to support the unit, so actually you only had what you had. The theatre was, you know, two corridors away, I know they knocked a hole through a wall and changed all that before I went, but that would take two midwives out of your four or five midwives that night to cover both the ward and the labour ward. So when they used to have four midwives in the past if two went to theatre that only left two for the ward and the labour ward. So I think practices such as leaving high risk women in early labour, even established labour, on the ward became the norm, even though they were high risk. There was, when you look through, there was regular arguments that people were normal when they weren't, they were high risk, and that sort of guidance wasn't applied to –

MR BROOKES: Okay, that was the point I was just going to come to. So in terms of the management of high risk cases, guidance wasn't followed or was followed?

MS MCGULLION: No it wasn't, not all – some case would have been, but no, and what they did it was out of almost – I can't explain, it was a strange feeling of being kind and leaving on the ward a bit longer, but I felt that the practices had started a long time ago, that women – once I said to one of them midwives 'can you explain something, why all the ladies ~~are so~~ have short ~~on the~~ labour? ~~ward~~?', and the reply by one of the band 7s was 'that's how ~~Moravian~~ Barrovian women labour', and my reply was 'anatomically and physiologically all women labour the same and you shouldn't just be having 2, 3, 4 hour labours whether high risk or low risk, they must be being laboured on the ward and you can't have that'. But I do feel that if you've only

got four midwives what they did was they coped with whatever came through the door, and an example of this was the first week, in the four-bedder, I walked out and saw a lady talking to a woman who'd had a baby or was about to have a baby. When I walked past again the visitor was on the next bed, and so I said 'can I have a word, what's happening there? A and E was out of the door and over there, I'm sure you've been', and the lady had started with chest pain so they'd put her in the next bed and put her on an ECG, A and E is over there, and an SHO that had just come off medicine was taking her bloods. Now that, you know, these are the sort of things that they did. Everyone who walked through the door they tried to cope with, but it was unsafe, and so obviously I said 'no you take her to A and E, she's transferred to A and E', 'ah but', 'no "ah buts"' you know, 'she's with her daughter and she's in labour', 'take her to A and E, she's a chest pain, we've only got three midwives and you've got a woman in labour'.

MR BROOKES: Okay, I just want to ask about one other thing and then we can move on. You mentioned that you went to the inquest every day?

MS MCGULLION: Every day.

MR BROOKED: Yes, every day. I'm just interested in, you then watched individuals, midwives and other members of the trust, give evidence. Was there anything that seemed unusual in terms of behaviour of those individuals or the way in which they gave evidence?

MS MCGULLION: I think what became was a desensitisation due to the history, and I think whoever you ask would say that 'I'm upset that that family lost a baby, and that baby could possibly have survived and has a high chance of survival', and the empathy for all that, it became a warring situation, really, between FGH and that family, and I felt that came across -

MR BROOKES: So I'm not sure how that comes – excuse me, sorry, sorry, okay, so that's how it happened in terms of the inquest, so I'm trying to understand, they're giving evidence, midwives are giving evidence, were they supportive of each other, how did they present themselves?

MS MCGULLION: Yes they were supportive of each other.

MR BROOKES: Did they act professionally at all times?

MS MCGULLION: I think they – I don't know how to explain it, I think they acted professionally, but I think there was a sort of body language, say, and I think

some of the things that were said could have been said differently. I think there was a definite pattern of information that was recurrent through. There was some strange things, like there was obviously different, you know, somebody had done a statement and then another statement, which you can do in cases, but obviously you keep your other statement, so there was different statements that, you know, by one or two midwives, that the coroner had one statement, she had another statement, you think 'well' – you know, that sort of thing isn't acceptable.

MR BROOKES: But there was nothing surprising in the behaviour in court, that you observed?

MS MCGULLION: I wouldn't say surprising, I felt that they were defensive and obviously they were very stressed and upset, and it was, you know, it was 2008 and this was 2011. I will say that I think, you know, the regulators as well, and other people that were dealing with these staff that were involved could have raised the mark as well, a bit. You know, because you're talking 2011, an inquest, and everybody still didn't know where they were with the NMC and all of the other things.

MR BROOKES: Yes, thank you.

DR KIRKUP: Thanks, Jonathan?

PROF MONTGOMERY: Can I stick with the inquest for the moment, I'm not quite sure why you went to the inquest?

MS MCGULLION: I was a matron, then, at FGH, and I felt that I needed to support the staff, but also I wanted to be there and hear the inquest, have an understanding what's been happening, because we'd had bits and bobs of information about this case and lots of things had happened, but I'd never really – you know, I was a matron at a level, and I was a matron at that unit, and I wanted to understand the cases that these cases were coming through an inquest, and I wanted to be fully aware of all the facts.

PROF MONTGOMERY: What did you discover?

MS MCGULLION: Pardon?

PROF MONTGOMERY: What did you learn from the inquest?

MS MCGULLION: I think I learnt obviously the history, and what had happened, and the care. I was obviously disappointed and quite ashamed at some of the aspects of midwifery care, and I found it – I mean I don't know if you've heard

the police thing, I found it quite upsetting, the standard of care that they received from our Trust, that I was a matron at. Certainly as a mother and a family they could have requested more, of the feeling they had that there was something wrong, and I did, I felt very ashamed, as well as I felt, you know, you have the media outside as well, and the other things, for staff, and I was a matron and needed to be there on all sides. But I think it was very poor management that someone at my level who was even part of the Trust, that I didn't know all the facts about this case and, you know, you talk about lessons learnt, there should have been a massive presentation, we should have looked at the facts, we should have, instead of keeping it almost hidden and isolated to Barrow.

PROF MONTGOMERY: So what did you learn from the inquest that you put into some form of action plan for the unit?

MS MCGULLION: Pardon?

PROF MONTGOMERY: What did you put into your action plans for the units that you learn from the inquest?

MS MCGULLION: Well I think certainly from the Titcombe case there's obviously a lot of changes within the guidance anyway, around hypothermia, and I think more than anything I was learning more about the staff. The record keeping of the staff was very poor, extremely poor.

PROF MONTGOMERY: So what did you do about that?

MS MCGULLION: And I'd noted that anyway, it was the same when we did safeguarding and when we did community, and it was the understanding that really the staff weren't aware of risk factors as much as they should have been.

PROF MONTGOMERY: So if we take those two things, the record keeping and the risk assessments, what did you do to address those?

MS MCGULLION: Well we were working as a team within record keeping, and there was workshops regarding record keeping. I will say, you know, this had started prior to the inquest, really, there was workshops, the guidance meetings. Obviously they were accelerated, but I will say, that certainly, even the guidance regarding ruptured membranes, I think it took about 2 years to finally get it agreed between the professionals, because the paediatrics wouldn't agree to one aspect, you know, and I just found that

really appalling. So we worked as a team towards a number of aspects, from not only that particular case but other cases.

PROF MONTGOMERY: And who's the 'we' we're talking about here?

MS MCGULLION: I'd say, obviously, it was involvement at all levels. But the matrons and Sasha Wells, who was then head of midwifery, she'd gone on holiday but was home, and I used to ring Sasha Wells and Jackie Holt ~~Hart~~ when we left the inquest, and inform them what had gone on that day, and so I did that, was like an intermediary with that. But as a team obviously we were aware that once, particularly we'd walked into the labour ward and there were all these other issues that were there all the time. They had no office, they had no equipment, they didn't have – I think they only had two iMacs that worked when I got there, there was five that didn't.

MR MONTOGMERY: And how long did it take to sort that out?

MS MCGULLION: Well even that, you see, and this was the thing, we would talk about the office for the labour ward, for confidentiality, and the Manchester team had been coming to other people and said that they needed a high presence at the head of midwifery, and Jackie Holt ~~Hart~~ with Sasha and FGH, and what happened was their offices were done up but I really had to argue for the office on the labour ward. So you found that, to me, where the Trust board and the finances got it all wrong, in a way, because they had an office, it just wasn't that nice because they didn't go there much. But actually they had no space on the labour ward for privacy, confidentiality, you know, a proper whiteboard with full history for them to work in, and I think if that is the place where you discuss your cases, that didn't happen, medics didn't discuss with midwives about cases in any depth.

PROF MONTGOMERY: So you were there for 10 months, did it get sorted within those 10 months?

MS MCGULLION: It got sorted, it was finally finished about a month after I left. But every now and then we'd hit a wall, we just hit walls all the time. There was the resuscitaires we got, but a lot of the equipment we got we had to go through charitable funds, they weren't just given straight away, you know, you had to source the money. There was a pressure, obviously, of monitoring, and other things that people were pushed, you know, and had to do, but there was basic equipment. The ward kept asking me to go over, on

about the third week I sort of said 'what's your issues', and then I asked them what do they sterilise the bottles with, and they just said 'we don't have any sterilisers', so obviously that day I just sent a support worker out to buy three sterilizers with my personal debit card ~~[inaudible]~~, because a maternity unit without sterilisers – and it's that sort of, they'd become so used to not asking and not receiving basic equipment. They didn't have – we ordered basic equipment ~~[inaudible]~~ because there wasn't enough thermometers and sphygmomanometers etc ~~[inaudible]~~ for every room, and there wasn't a large cuff and a small cuff, yet it's so important to have a large cuff for a big lady, and Barrow had one of the largest obesity problems in England, and they didn't have enough large cuffs to take an accurate BP, they didn't have the monitors, they shared them. There was this cost improvement programme that they really took to the heart no matter what, and it didn't matter, and I don't think they thought the safety was compromised. I think they were so downtrodden they didn't realise they should just say 'no this isn't right'.

PROF MONTGOMERY: But I think you said earlier on that there were 50 inductions a year sent from Lancaster to Barrow, did I hear that?

MS MCGULLION: That was the plan with Angela Oxley, yes, to try and fill the beds and to help with the pressures of Lancaster's beds, but we often tried very hard not to send them because we actually felt it was a unit under pressure, and we were just adding to the pressure.

PROF MONTGOMERY: So how often do you think people did get sent?

MS MCGULLION: Only in real times of crisis, because we weren't in – me and Sharon were the matrons at Lancaster, and although we were told, it was mainly for the Helme Chase induction so you would have to ask Sue Knowles how many actually went from Kendal to Barrow, but it did seem to me and I didn't know the enormity of the issues at Barrow then, but even what I knew that maybe it wasn't the right way to go to give them more births.

PROF MONTGOMERY: So of the 50 that were discussed are we talking five went?

MS MCGULLION: Well from Lancaster very few went but you would have to ask Sue Knowles because what they were- there were people that would normally go from Helme Chase to Lancaster that was then actually from a certain date went to Barrow. But that again was about increasing births, but we did have

a lot of capacity issues. I will say, I have to say as well because I will have to say it, but the agency, you know at one point when I took Barrow on, within a short period of time- at the meeting we were talking 40% sickness and absence of staffing of midwives, you know it was an enormous crisis and I just feel- and then we brought in the agencies and even they weren't scrutinized, you know.

PROF MONTGOMERY: Can I ask you about the Fielding report? You talked early on about things that you'd said the Fielding report, and you were constantly asking about the Fielding report. Can you-

MS MCGULLION: Yes the Fielding report was- we heard you know there was this multidisciplinary team, the Fielding report, they were going to interview us all, assess the units and we were- in Lancaster we were really pleased about that and I think generally the matrons were. And I know that I took the opportunity to discuss- particularly because I was community matron ~~[inaudible]~~ at Lancaster, the public health agenda, the need for funds, that wasn't- there didn't appear to be any public health- big public health drive up at the maternity services at Barrow ~~Lancaster~~. And I remember actually saying to the professor that the only extra unit- consultant clinic that had been put, had been put in the nicer side of- I forgot what it's called. [Inaudible]. In the nicer area of Barrow, and yet there were large- areas of deprivation

THE DR KIRKUP: Ulverston.

MS MCGULLION: Pardon?

THE DR KIRKUP: Ulverston.

MS MCGULLION: Ulverston, and yet there was large cohorts of high risk public health women in other areas, and if anything that's where the consulting unit should be in, because probably [they'd all get in the cars?] and come up to the unit, and they have- I'm not meaning, if we all had a massive bag of money we'd have them all over the place, but it's such a deprived area. But that again was something that Mr Hussein did, I gather, and I was most upset when I heard that they were- there was some funds for scan- he was trying to get a scan down there and he moved a gynae clinic down there, the women went to the hospital for the scan and you know, I was- I just thought it was crazy.

PROF MONTGOMERY: So did you- who did you speak to from the Fielding team?

MS MCGULLION: Angela Oxley, I pulled the car over on the A6, I remember it, and two hours of arguing about it and saying she has to do something about this gynae clinic coming up to Ulverston.

PROF MONTGOMERY: Sorry I was asking about the Fielding report. Who did you speak to?

MS MCGULLION: The Fielding- it was the professor and I think maybe ~~Dave~~ Dame Fielding ~~him~~ herself, but I know we were discussing it and we- and they agreed-

PROF MONTGOMERY: So which professor are we talking about?

MS MCGULLION: I don't know his name.

THE DR KIRKUP: [Andrew Colderove?]

PROF MONTGOMERY: Are we talking about the obstetrician?

MR BROOKES: The obstetrician was Andrew Colderove.

MS MCGULLION: And you know he said- but we were so- we asked and asked and asked about that Fielding report as matrons because we felt, it's like with me I say to anyone who comes to me, I say, put in a critical incident because that's evidence that I can argue with the board. We repeatedly asked for the Fielding report.

PROF MONTGOMERY: Who did you ask and when did you start?

MS MCGULLION: Anybody we could speak to. We asked- I would ask Sue regularly and she always told us that it hadn't.

MR BROOKES: Did you ever see the Fielding report?

MS MCGULLION: Never, the only time I saw the Fielding report was when Angela Oxley went to Cambodia. And she left her stuff for us as head of midwifery to ask, and then Sue Knowles rang me, or rang us or emailed us and said 'guess what I found, I found the Fielding report' and we were told it had never been published.

PROF MONTGOMERY: And when was that?

MS MCGULLION: It was about three weeks after Angela went to Cambodia, whenever that was. That would be 2010, would that be? Because Sasha came in May-

THE DR KIRKUP: 2011 wasn't it?

MS MCGULLION: Sasha came in May. So maybe it was 2009-

PROF MONTGOMERY: Where were you working at the time?

MS MCGULLION: At that time I was at Lancaster, but I was also doing community and trying to negotiate with Commissioners about sorting out mental health in maternity services up at Barrow, and I felt that the Fielding report would give me the extra bit to get there with it.

PROF MONTGOMERY: And did it when you saw it?

MS MCGULLION: When I read it we all agreed a lot with a lot of the things because quite honestly they'd just put down a lot of the things we'd said, you know there was nothing that big for us to disagree. And we also agreed about what it said about Ibrahim Hussein. So you know, but we read it and then obviously- we were asked then after Angela went, can we have your action plan following the Fielding report? But obviously we'd done action plans and worked towards the Fielding reports because a lot of what was in the Fielding report was matrons, what we'd said we needed to do. But we never actually had an action plan around the Fielding report because we were never actually shown it as matrons.

PROF MONTGOMERY: Thanks.

THE DR KIRKUP: Okay, I'd like to follow up a couple of points that will bear on things that are clinically confidential about individual cases. So I'm going to ask for a short pause while we ask other people to leave the room. And this part of the transcript from now- this part of the recording from now on won't be accessible to other people, so you can talk about anything in confidence to us.

(The Hearing went into private session at 3.21 p.m.)

THE MORECAMBE BAY INVESTIGATION

Thursday, 25 September 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Professor Jonathan Montgomery – Expert Adviser on Ethics

SUE MCMILLAN AND ANN FORD

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DR KIRKUP: I'm Bill Kirkup; I'm chairing the investigation panel. I'll ask my two colleagues to introduce themselves to you.

MR BROOKES: I'm Julian Brookes. I'm currently Deputy Chief Operating Officer for Public Health England, but was previously Head of Clinical Quality at the Department of Health.

PROFESSOR MONTGOMERY: I'm Jonathan Montgomery; I'm a professor of healthcare law at University College London and Chair of the Health Research Authority. In the past I've Chaired Provider Trusts and SHAs, when there were 28, and some PCTs.

DR KIRKUP: Perhaps you could just let us know which you are.

MS MCMILLAN: I'm Sue McMillan.

MS FORD: And I'm Ann Ford.

DR KIRKUP: By a process of elimination. Thank you very much for that. You will have spotted that we're recording proceedings. We will make an agreed record of that, which we will share with you. We also have opened the proceedings to family members, who are entitled to attend. As it happens, we don't have any family members present today, but they are entitled to listen to the recording subsequently if they want to.

You'll also know that we've asked you to hand in any mobile phones or any recording devices. The reason for that is just to underline that we don't... Thank you. I'm not going to go through all that again, because it's exactly the same thing that we say to everybody, so we don't need to, you'll be relieved to hear. That's just to underline that we don't want anything to go out of the room here until we are in a position to produce a report that considers all the findings in context. Do you have any questions for me before we start?

MS MCMILLAN: No.

MS FORD: No, thank you.

DR KIRKUP: In that case, I'll start with a very general question, if I could just ask each of you when you started with the organisation and what you've done since then.

MS FORD: Would it be helpful if we did it historically, if Sue went first?

DR KIRKUP: Okay.

MS MCMILLAN: Do you just want to know about the time I've been with CQC?

DR KIRKUP: Unless there's anything relevant before or after that, yes.

MS MCMILLAN: I suppose the only thing that is relevant is to explain which part of CQC I came into. My job immediately prior to CQC was with the Mental Health Act Commission. I was Director of Operations and Deputy Chief Exec there. The Mental Health Act Commission was one of the three organisations that joined together to become the Care Quality Commission. I was appointed Regional Director for Yorkshire and Humber as my first job with CQC, moving to that post on 1 April 2009, and I've worked with CQC continuously since that point in different roles, both regional roles and national roles.

DR KIRKUP: Which was the first point at which you had anything to do with the North West and Morecambe Bay?

MS MCMILLAN: It was the very end of February 2010, when I moved from being Regional Director ~~of~~ for Yorkshire and Humber to being Regional Director in the North West, and I left the region in November ~~2001~~2011.

DR KIRKUP: Okay, thank you.

MS FORD: I came into CQC from its inception in 2009. I'd previously been employed as the Business Relationship Manager for the Commission for

Social Care inspection, and I came into CQC, as I say, at its inception. At that time, I was a Compliance Manager for the Merseyside part of the region, and then I took a secondment for the Welsh inspectorate for about 18 months, returning to CQC in February 2012. I was then appointed Head of Regional Compliance in April 2012, and that was my first direct contact with the University Hospitals of Morecambe Bay.

DR KIRKUP: Okay, thank you. That's very helpful. I'll hand you over to Jonathan.

PROFESSOR MONTGOMERY: Thanks. I think there are probably two areas of focus, which probably split chronologically. We're trying to understand what happened around 2009, 2010, 2011, particularly through a set of processes around handover, changing assessments that CQC made of risk, the decision about registration, and then there are also the issue around Gold Command and quite what that was doing, which I think you picked up a bit of the tail end of, if I've understood correctly. Could I start – may I call you Sue; is that alright?

MS MCMILLAN: Yes, please do.

PROFESSOR MONTGOMERY: Sue, as you came in, February 2010, what was the handover you had in terms of Morecambe Bay?

MS MCMILLAN: To set the scene, the end of February 2010 was the last month before NHS Trusts were coming into registration for the first time. I had left Yorkshire and Humber with the registration assessments being completed for the Trusts in that area, and was moving to the North West at the point when they were in their final points of completion for that region. The Regional Director at the North West at that time was retiring.

PROFESSOR MONTGOMERY: It's helpful if we can have names, so we don't get confused.

MS MCMILLAN: Yes, no problem. It was Alan Jefferson, so Alan Jefferson was the Regional Director in the North West. He was retiring and he was formally retiring on 31 March, but he had a couple of weeks' leave to take, so I started at the end of February so that we had about a fortnight where our two periods of tenure, if you wish, were overlapping and could share information and do a full handover. Initially, the information I was given about all the services that we were regulating at that time – obviously the Trust but also care homes, etc. – were part of that handover with Alan Jefferson but, once I was in post, clearly then my knowledge was extended as I met, through my one-to-ones with my direct reports, the work that they were doing, in particular organisations and services, and I would have received additional information through those meetings.

PROFESSOR MONTGOMERY: Can we separate those two for our understanding? In the handover bit when you arrived, so before you had the opportunity to find out anything for yourself, where did Morecambe Bay fit into that? Was it flagged as a particular issue?

MS MCMILLAN: What I can recall, and clearly this is some time ago now, is that there were two main areas that we spoke about in relation to Morecambe Bay. One was that this was a Trust that had had some difficulties and where concerns had been raised previously. Over a period of time prior to my arrival, work had been done by the SHA and others and there was some proactive work happening at the Trust to put right the areas of concern, so there were action plans in place; there was a ~~respond~~ response and actions happening to improve where there had previously been concerns. That had led to the Trust

not being seen as ~~as~~ high a risk as it had been previously, and they were in the process of being assessed for registration.

The way that the registration worked, which was a nationally agreed process, was that when Trusts applied for registration, they provided initial information about whether or not they felt they were compliant with the regulations. The ~~regulation~~ registration assessors would check that against all the other information and intelligence we held about that Trust and, if they felt there was any conflict or mismatch between how the Trust saw themselves and how we saw them, then additional information was sought from the Trust and I knew that that had happened in relation to Morecambe Bay.

PROFESSOR MONTGOMERY: When had that happened?

MS MCMILLAN: It would have happened during that period of assessment, which was in that first quarter of 2010. The assessment would have been virtually complete by the time I arrived and the outcome of that assessment was that the evidence was that the Trust was addressing the issues of concern. The SHA was able to confirm that ~~that~~ was their understanding as well. There were still some outstanding issues. There'd been a Birthrate Plus report – I think that's the proper terminology – that identified some staffing issues, and that was the point that made it that we issued an improvement letter and ~~reserved~~ identified the intention to go back and inspect to check what progress had been made.

The other key area was that Alan briefed me as to the contact he'd had with James Titcombe, who was a parent whose son had tragically died in 2008. James had some continuing concerns about the Trust. Alan briefed me about the contact he'd had with him, and Alan's view was that our contact with

James Titcombe was probably coming to an end, because we had done what we could in relation to his concerns and that he would complete that piece of work and write a final letter to James that would complete that contact, which he did and he provided me with a copy of the letter.

PROFESSOR MONTGOMERY: Can I just pick back on a couple of bits of language to make sure whether they're deliberately – whether we should read significance in? The first, I think I'm clear from what you said, you use the tense 'had had problems'. I think from your summary the brief you got was that many of those problems had become managed, or whatever the right phrase is, and it was the staffing rate issue that was the live issue, by the time that you were picked up. Have I understood that correctly?

MS MCMILLAN: Yes. I think there are a couple of pieces there of context that may be helpful. One is that the methodology and approach that we were taking at registration – and remember this was the first time that NHS Trusts were coming into regulation – was that Trusts wouldn't be penalised for having identified issues and be addressing them. When a Trust was acknowledging that there were issues and were doing something about it, they were much more likely, on that basis, to be registered with an improvement letter, so no conditions but with an improvement letter, but on the understanding that the issue of an improvement letter meant that they would be inspected for those specific areas of concern in the first quarter and post-registration.

Where Trusts appeared to be in difficulties, hadn't got a grip of that and didn't have robust action plans in place to suggest that they were addressing them, those were the Trusts that had conditions, so the threshold was set at a particular place nationally and I was satisfied, I had the advantage, I guess, of

working across two regions. I was satisfied that the approach that was being taken in the North West was consistent with the approach we'd taken in Yorkshire and Humber, so there was that sense of the threshold being in the same place.

However, although there was that outstanding staffing issue and there was evidence that all the other issues relating to Joshua Titcombe's review, the review of his death, the previous annual health check for that Trust, there were areas where it would appear that actions were being taken, and so we noted those and planned that, when we went back in, that first inspection, we wouldn't solely look at staffing. We would also look at those others to check that what had appeared to be actions being progressing had actually been actions seen through to completion.

PROFESSOR MONTGOMERY: Thank you.

MR BROOKES: Sorry, can I just clarify a point? Was there a concept that there are issues that are so serious that, even if there is an action plan, that would lead to you not being comfortable, because I can see that about specific things? Yes, there's an action plan, etc. Was there this concept of so serious that that isn't acceptable?

MS MCMILLAN: At the point of assessment, in the sense that we wouldn't be content with a commitment to take action?

MR BROOKES: Yes. The issue is so serious that, just because they've got an action plan, it doesn't mean that that's okay; they will qualify. Was it that, if they were showing best endeavours and doing something about it...? Do you see what I mean?

MS MCMILLAN: Yes, I see what you mean.

MR BROOKES: There's a threshold, because there are some very different things that could potentially be done.

MS MCMILLAN: First of all, I would say all issues are serious, in the sense that, if a child had died, for example, clearly that is a very serious issue. I don't think that we would have taken any of the issues raised and that were included in the assessment as being anything but serious issues, because they were the ones that were red-rated.

MR BROOKES: I understand that. That's why I used the words 'so serious'. There's a degree there. I just want to understand, from your way of dealing with those inspections – sorry, the regulations of those organisations – it's normal things, you can understand that. I can see that. There is a problem here against this particular thing. Yes, there's an action plan. I'm comfortable that that's done. We'll come back and review. Was there this concept of so serious that actually that doesn't apply? You need to have that.

MS MCMILLAN: What I would say with so serious was that there was an incident or there was a sequence of events and we did not believe that the Trust themselves was equipped or are taking them seriously within their planning. The seriousness, in terms of the assessment of registration, was taking account of the nature of the response and if it was proportionate for what has been identified here. There were two elements to it: there's the seriousness of the incident and there's the robustness of the response from the Trust.

MR BROOKES: Okay, that's not quite the answer. I mean, generally, in your organisation, when you were looking at problems in an organisation, a Trust, and you came across something, you accepted that there was an action plan, fine. Was there this threshold in the way at which you looked at organisations,

where things were so serious that that didn't apply generally or did you deal with all of them at that way?

MS MCMILLAN: It wasn't listed in the criteria that these items, X, Y or Z, would be classed as so serious that we would, as a matter of course... It would have been on a case-by-case basis.

MR BROOKES: Yes, it would have been a judgment. I understand, thank you.

PROFESSOR MONTGOMERY: Perhaps I could cast that sort of question with a very concrete one on that: are you aware of any cases where actually conditions were imposed or you refused registration, because despite action planning in place you thought you couldn't be confident of the safety of services?

MS MCMILLAN: Yes, there were two Trusts that I can immediately remember and there may have been more. There were two Trusts that I can immediately remember, one in my Yorkshire and Humber patch and one in this North West patch, where we felt the issues were so serious that it did need conditions applying.

PROFESSOR MONTGOMERY: Okay, I don't think we need to know the names of the Trust, but I think we do need to know the nature of the circumstances.

MS MCMILLAN: It was issues around safety that had been ongoing and recurring. Despite repeated revisits, inspections or inspections with that Trust, they were not making any progress.

PROFESSOR MONTGOMERY: Are we saying people are dying? Are we saying that the...?

MS MCMILLAN: In one example, there was an issue about outliers, yes. Mortality outliers had been an issue for one Trust. There are a number. Obviously it's

that complete picture that you are looking at, so you are trying to get an assessment overall as to what the issues are for that Trust. In the first year of CQC, we had the annual health check methodology and the risk profiling that we'd inherited from the Healthcare Commission, so it would have been those Trusts that, consistently throughout that year, had been identified as high risk because of the nature of the concerns that were being raised at those Trusts. Actions had been identified that were required by those Trusts. Whether or not they happened, it hadn't delivered the required improvements, so it was a review, really, of everything we knew about those Trusts and their track record in tackling concerns, addressing them and making improvements that would have led to us saying, 'We have no(see letter URN 1027 SM 01) confidenc there that that is being appropriately addressed,' and that would have led to conditions.

Comment [F01]: Sue McMillan provided additional information. Th is logged as URN 1027 SM 01

PROFESSOR MONTGOMERY: That would have been publicly stated conditions.

MS MCMILLAN: Have they what, sorry?

PROFESSOR MONTGOMERY: Those conditions would be publicly stated.

MS MCMILLAN: Yes, yes.

PROFESSOR MONTGOMERY: Is there a reason why you can't tell us what they are here?

MS MCMILLAN: I can't remember offhand what the specific conditions were on each of those Trusts. I'm very happy to go away and look back and see what they were. I ~~can~~ know the names of the Trusts ~~though~~, so I can look back and see which ones.

PROFESSOR MONTGOMERY: Can I pick up a couple of things from that? It's about the process really. There's a risk-profiling process. What was the profile that was handed over to you for University Hospitals Morecambe Bay?

MS MCMILLAN: On University Hospitals Morecambe Bay, what the registration assessor did was they went through, in some detail, each of the outcome areas that were being looked at for the process of registration, i.e. against the regulations, and they would see, from our quality and risk profile that we had with that Trust, whether there were any red- or amber-rated areas of concern for that Trust.

PROFESSOR MONTGOMERY: It's a three-part scale, is it – red, amber, green?

MS MCMILLAN: Red, amber, green, yes. In the initial assessment, that's the piece of work they would have done and entered on to that documentation all the areas that were of concern to us and had been over that proceeding period. That was then compared to the submission from the Trust and then additional information would have been sought. The second part of the assessment for the registration would have been a detailed cross-reference to see whether there was evidence that either action was progressing in relation to putting something right or it had been resolved.

For example, I think there was one around MRSA in relation to Morecambe Bay, and we had evidence that the MRSA rates were improving. Similarly, there were other areas of concern where we were able to look at national data to confirm that what the Trust was telling us that they were improving in that area was borne out by the data to say that their performance in that area was improving.

PROFESSOR MONTGOMERY: I draw two inferences from what you've just described. One is that maternity didn't register in that process. Is that correct?

MS MCMILLAN: No, it did. That was one of the areas where there were concerns, because of James Titcombe's experience in the death of his child.

DR KIRKUP: Was it only James Titcombe's experience in the death of his child? Were any of the other SUIs taken into account?

MS MCMILLAN: We knew that there were five SUIs in relation to maternity. I was aware, as part of my briefing, that there had been five SUIs in maternity during that period. I also knew that initial work at the Trust, as confirmed by the SHA and ourselves, was that those five SUIs were not connected, that there were different causes.

PROFESSOR MONTGOMERY: How could you confirm that?

MS MCMILLAN: I was briefed that when I arrived and, my understanding was – well, I've seen it in black and white —~~that~~ that related to the consideration of whether or not there should be an investigation. I know that, when that was considered, all five SUIs were considered and the conclusion was reached that they were not connected.

PROFESSOR MONTGOMERY: We've been trying to track down who reached that conclusion. Can you help us with that?

MS MCMILLAN: Yes. That would have been Sarah Seaholme and possibly her manager as the team leader of the investigations team, so they had done that work and concluded that there were no common features on the five SUIs, that the circumstances were different.

DR KIRKUP: I'd just like to pursue that with you, a little bit. Sorry to interrupt.

PROFESSOR MONTGOMERY: I was expecting you to.

DR KIRKUP: What were the criteria for deciding whether these were connected or unconnected? How would you make that decision?

MS MCMILLAN: I didn't do that piece of work and it was before I came to the region. I can't tell you what was going on in somebody else's head. I would have to look and see what process was gone through for that investigation.

DR KIRKUP: If you were responsible for making that assessment though, what criteria would you use?

MS MCMILLAN: I would look at the outcomes of the SUI reviews for each of those five different SUIs to see what the analysis had been of what the factors were that led to those severe untoward incidents, and whether there's any commonality in the factors that led to that incident happening. I'm assuming that that's what happened, but I can't give evidence of that, because it wasn't me who did it. I'm assuming there would have been that analysis of the information that there was around those five different incidents.

DR KIRKUP: How relevant is the clinical nature of what happened in each case, the pathological case of what caused the death? Is that a relevant factor? Is that the only relevant factor?

MS MCMILLAN: It will be a relevant factor, yes.

DR KIRKUP: What if you had five deaths that occurred through different pathological mechanisms, but the behavioural factors, the root cause in the culture of the organisation – the training of individuals and their practice – what if that was common?

MS MCMILLAN: Exactly, and that was the key breakthrough, ~~wasn't it,~~ in relation to our thinking on this? To move back then, when I came and when we were considering this for the registration, our understanding – and it wasn't our

understanding alone; it was the common understanding at that time, both from the Trust but also in the organisations that were supporting and working with the Trust, was that there had been five severe untoward incidents. They had all been reviewed. The reasons why those incidents were all different, and there wasn't a commonality between them. That was the understanding at that time.

I think it's important to say, actually, that one of the issues for me, in speaking to the inquiry – and I think it's a very important one – is I clearly have a view now of what happened that is quite different from what the reality would have been at that time. I maybe ought to be very careful in my answers to you to make sure that I'm telling you whether either I'm relating how it was at that point, or whether I'm telling you as it was where now I am, with the benefit of hindsight. So with the benefit of hindsight to make that distinction, at that stage, in early 2010, I don't think anybody involved with the Trust or the Trust themselves had identified that there were some underlying cultural issues about leadership and how the maternity services were working, on site and across sites, that had been a factor in those severe untoward incidents. That was where things were at that point.

Clearly the Trust, as a part of their actions and their approach to ensuring they were addressing all the issues and concerns that had arisen, did commission the work from Professor Fielding to undertake a review of governance. That Fielding report was a breakthrough in that it challenged that and it determined that there had been issues in relation to culture, the way in which the department had operated across the sites and the relationships between different professionals, which did have a bearing and had something

in common across those five severe untoward incidents. That's why that report, the Fielding report, was such a crucial turning point in our view as an organisation and my view as the Regional Director, as to what the risks may be, in relation to Morecambe Bay.

DR KIRKUP: Okay, but that wasn't available until mid-2010.

MS MCMILLAN: That wasn't available and, at that time, in fact it hadn't even been started at that time.

DR KIRKUP: It certainly had been started, yes.

MS MCMILLAN: What at the beginning... I thought it was commissioned in early 2010. That was my understanding from the board papers.

DR KIRKUP: Sorry, I'll come back to you in just a moment. There was just one other thing I wanted to clarify, because I've heard and picked up two slightly different things and I want to be clear which of them reflects what you're saying. One is that maternity was signed off as part of the assessment that things were okay in Morecambe Bay, if I can put it in that way, because they'd recognised the problem and put an action plan in place that was addressing it. The other version of events that I'm picking up is that the Trust had looked and found that there were no commonalities between the incidents. Therefore, how can you have an action plan to address what's gone wrong if there were no commonalities. I don't understand.

MS MCMILLAN: Because it was the action plan following the review of the death of Joshua Titcombe.

DR KIRKUP: It was an action plan that was related just to that death.

MS MCMILLAN: Yes. There'd been a review in relation to the death of Joshua Titcombe. There'd also been a review of maternity services and there

was the Birthrate Plus review, so there was a number of activities going on in maternity, or had been during that period, and the Trust was responding to those. Those were the areas that we wanted to check when we went back in the June.

DR KIRKUP: What was the action plan to address the concerns raised by the Titcombe case?

MS MCMILLAN: There was a set-out action plan, which James Titcombe had also had access to and had agreed that he thought that those things needed doing, so he had also seen that and said that he felt, 'Yes, those actions were things that needed to be addressed.' ~~They wee~~There were a whole range of issues relating, for example, to safety matters, basic checks, the safety of patients, to do with record keeping. I'd have to refer back to the actual review to tell you because, clearly again, that had been completed before I arrived. The actions that were in place that were around a response to the concerns or the failings that had been identified in relation to Joshua Titcombe, those actions were being seen through.

When we went back in ~~the July to~~ June 2010, which was the first inspection post-registration, the areas we inspected were a combination of staffing, which was the issue that had come out of Birthrate Plus, and the remaining outcomes were all linked to the action plan that had come from the maternity services review relating to Joshua Titcombe's death.

DR KIRKUP: Okay, sorry, Jonathan.

PROFESSOR MONTGOMERY: I wanted to keep the chronology, because we absolutely take your points, but we'd like to hear both your reflections from what you know now, but also what was apparent at the time. I want you to fill

in the months between February and June, because I think you were indicating that, having had that handover, you did some of your own contacts.

I just wanted to pick up another word that you used when you were describing and make sure we understood it. You talked about part of the assessment of that handover being that there was proactive work being done by the Trust. Now what I've just heard sounds like reactive work, so I want to understand your assessment of how the Trust is addressing this.

MS MCMILLAN: It clearly was reactive, in the sense that they were taking actions in response to specific concerns that had been identified. I suppose why I used the sense of proactive was because we sought assurance from other organisations that there was a degree of... The level of commitment was such than they had some confidence that those would be seen through, so it's maybe a reflection of you're seeking that level of commitment, that level of understanding, and that, to use the vernacular, the Trust has got it; they know what needs doing and they're getting on with it.

PROFESSOR MONTGOMERY: It doesn't particularly matter what the word is, but you're capturing there an assessment that the same stage could be a deteriorating stage, a neutral stage or an improving stage, and you're saying that the assessment there is not just that they've got the action plans, but actually they were moving forward, as opposed to static.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: That's really helpful. Did Alan Jefferson give any indication of when he thought that had changed? One of the things that happens a bit before your time is that there's a referral for investigation of this Trust to the Central team, which is pushed back. It seems as though Alan

Jefferson was really quite concerned at that stage, and at some point the level of concern becomes one that this is under control and we need to give them the space to see through this action plan. I think what you've just described is, by the time you arrive, the level of concern is there have been issues; they've been scoped; they're being addressed and you can have some confidence that the Trust is moving in the right direction. That's the sense of 'proactive'.

MS MCMILLAN: But we do need to check.

PROFESSOR MONTGOMERY: Yes, of course.

MS MCMILLAN: That's why the improvement letter and why, by issuing the improvement letter, that meant that they would be inspected early in the inspection programme. It clearly was the message that the Trust knows they've got problems and they're doing something about it. That clearly was the message, but it was also the message of, 'And yes, we need to go back and check that they've done it.'

PROFESSOR MONTGOMERY: Do you remember whether that work action plan included commissioning something like the Fielding review? I know that, by name, you didn't know it until later.

MS MCMILLAN: The only reason I know – I mean, it wasn't referred to as the Fielding report then. The only reason why I particularly am aware of that is because, when I explained the registration process, and I talked about the fact that we took the initial information and then we took the application from the Trust, and then we compared the two and we asked for additional information, the registration assessor on that occasion asked for additional information from the Trust, as well as looking at the national data and everything, to see what actually had happened in relation to some of these areas. In response to

that, they ~~send~~ sent us a number of papers, and that included ~~broad~~ Board papers. It was in one of those board papers that there is a reference to the fact that they were commissioning some work to look at governance issues. I don't believe actually, in the paper, it said who was doing that piece of work, and that's hence my understanding of the date, but it might have been it was reported in the board papers at that particular time.

PROFESSOR MONTGOMERY: That's sometime early 2010.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: That's helpful. Okay, so you've had your handover. You know what Alan Jefferson thinks and then you were saying that, obviously, you'll have no doubt had lots of organisations to think about and you'll have had to prioritise which ones you looked at first or whatever. You've described where the handover is at, so you were sort of beginning to say earlier on that you would then have met people and formed your own views, because obviously you had to rely on what you'd been told to start off with. Tell us about contact with Morecambe Bay in that process.

MS MCMILLAN: That's right. Obviously once the handover's taken place, the responsibilities in relation to regulation of different Trusts would have been allocated out to teams on a geographical patch. As a Regional Director, I would have met, on a regular basis, with the inspection manager, then called compliance manager, for each of those areas and we would, as a routine part of that one-to-one, had conversations about any Trusts or indeed care homes, etc., where there were concerns.

We would have routinely talked about Morecambe Bay as a matter of course, because it was a Trust that had been issued with an improvement

letter and, therefore, we would have been immediately planning to go back there and inspect on that first occasion. It was through those conversations that the compliance manager would have shared with me the regulations that they were choosing to inspect again, so effectively what their regulation plan was.

PROFESSOR MONTGOMERY: Did that process lead you to doubt anything that you'd been told in the handover? Did it confirm your questions?

MS MCMILLAN: No, not at that time. The other thing that happened at that time was that James Titcombe came back and we, mainly through email correspondence, began to talk with each other and he was raising concerns with me. Sometimes it was directly with me, in which case obviously I'd respond to that. Sometimes he would copy me into emails that he'd sent to other organisations, like the ombudsman, Monitor or other organisations that he was writing to about the Trust at that time.

In my conversations with James, I was very mindful of the fact that, clearly, the concerns he had were very real concerns and they dated back to 2008. At handover, my understanding from others that I'd spoken to was that the Trust had held is hands up in relation to the death of Joshua Titcombe and had said categorically that they were to blame, hence the reason for the review and identifying what they needed to do to improve the service at Furness. It was quite difficult, in explaining to James, that whilst I absolutely appreciated his concerns, there was no evidence to suggest that, at that time, the Trust wasn't seeing that through. Clearly in regulatory terms I had to be taking account of what was the current evidence telling us about what the

Trust was doing. In that period, February through to June, the evidence was telling us that the Trust was doing what they said they were going to do.

PROFESSOR MONTGOMERY: Just to be clear, up until June, when you go in to inspect, that's essentially a paper exercise, is it?

MS MCMILLAN: No, there would have been contact between the inspection – sorry, I keep saying 'inspection manager', because it's current terminology. The compliance manager would have had regular meetings with the director of nursing, with the chief exec at the Trust and possibly with other key personnel, depending upon the nature of the query, but certainly the director of nursing they would have been in very regular contact with, as a significant number of these actions and pieces of work being taken forward related to nursing/midwifery services.

PROFESSOR MONTGOMERY: Was the brief you were getting that that was a constructive open relationship?

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: So there weren't any suggestions that they were anxious about whether they were hearing everything or anything of that sort.

MS MCMILLAN: No, there was no suggestion of that. Making that distinction, with the benefit of hindsight, I think the Trust was very good at telling us what we wanted to hear, but I don't think at the time we acknowledged that that was happening. They were telling us how they were making progress. That was what we wanted to hear and we were going back to see whether that progress had been made.

PROFESSOR MONTGOMERY: So we then get to June and people go in to follow up, and then the picture feels a bit different, does it?

MS MCMILLAN: Well, it doesn't. The inspector goes in, in June. It's a healthcare inspector, somebody who's come from the Healthcare Commission, so they've got experience of inspecting in hospitals. They go into the hospital and they check the – I think it was six regulations that we identified that would cover that area of activity. They checked them all and they deemed them to be compliant. There would have been a focus on ~~are~~ the actions that they're taking demonstrating that it's making a difference to how things are operating there, and the conclusion was: yes, it was at that time. So we had what would be called a positive outcome to that inspection to suggest the trust were doing what they said they were doing, and it was having an impact on the services provided.

The looking back bit, you know, about the different perspective –

PROFESSOR MONTGOMERY: But – and also knowing what you know now –

MS MCMILLAN: Knowing what I know now.

PROFESSOR MONTGOMERY: – was there anything that could have been picked up from that process that might have been missed?

MS MCMILLAN: I think that –

PROFESSOR MONTGOMERY: And that's different from sheared down.

MS MCMILLAN: Yes, the methodology at that time was very much about focusing where you had particular reason to go and look, and that's what we were doing, and it was a particular piece of work to follow on from registration assessment, and what you'd gone for.

So it raised the question: why did you not see some of the more underlying features? I think one of the reasons for that; I thought it was almost too focused. But I think another reason was we only went to Furness. We

didn't go and inspect across all maternity services at the trust because it was when we did that, and I don't want to leap ahead because my guess is you'll take me there.

PROFESSOR MONTGOMERY: It would be helpful to get through what we ask.

MS MCMILLAN: Yes, is when we went and looked later on with much more evidence as well, and ~~much~~ more concerns had come to light during that period. But when we did go back the following year we looked at maternity services across the trust, and it's when you look at that broader picture I think you get a much better appreciation of whether there are disconnections in the way that service is being provided as a whole. So looking back, we should have gone to all three.

PROFESSOR MONTGOMERY: Another hypothetical looking back question is if your inspectors had been expert in maternity they mightn't have needed to ask about the RLI, or they might have been able to say, 'What does it look like in Barrow compared to Manchester?'

MS MCMILLAN: Yes, that's right.

PROFESSOR MONTGOMERY: Would that have led to a different outcome, do you think? And I know we're speculating, but –

MS MCMILLAN: It's very difficult to speculate, isn't it?

PROFESSOR MONTGOMERY: – you'll appreciate that we're trying to understand what might have helped.

MS MCMILLAN: Yes, I don't know. I mean this was an experienced hospital inspector, but she wasn't a maternity specialist.

MR BROOKES: Could you just for my clarification give me a flavour of what the look would look like, if you see what I mean? What they would have done on the

ground? What they would have looked at? Was it paper-based evidence, was it visiting, was it interviews? It would be really helpful just to understand.

MS MCMILLAN: Yes, so in advance of the inspection, which was unannounced by the way, I should have perhaps said that, they would have looked at any evidence that we had currently about the trust, so any additional statutory notifications that had come, any complaints, any information from the public, and also would ring all key partners, so PCT, SHA, Monitor or indeed others who would have a view on the trust. So there would be some pre-inspection work that would be about checking what we knew, including of course the use of the quality and risk profile to see what was coming out of that. So that would have been a part of the preparation.

Once on site, the inspector then would have checked that in a number of ways, partly about talking to staff and talking to patients, partly about what they observed and what they looked at, partly by looking maybe at particular ~~pieces of~~ documentation. I mean in this case we ~~looked at~~ inspected for records, so they would have looked at records. I believe one of the actions was in relation to improving the way in which the pathway of the mum and baby were recorded, and so the inspector would have actually gone and looked and seen whether the intention of improving that had resulted in a different recording methodology, and then would take a sample of records to see how they were working in practice. So that you're attempting at each stage to triangulate what you're told with what you're seeing, and taking a sample to see what the outcomes are for a number of patients, and the inspector will have done that.

PROFESSOR MONTGOMERY: Can I ask about the records point, because there's a number of people who go in at this point and look at records in this hospital, and seem comfortable with the quality of recordkeeping. So this is not a criticism of your people particularly; we've seen it from a number of places. And we also have had a look at those records and have seen very different standards of recordkeeping say compared to some of the records from elsewhere in Cumbria. So what sort of training do your inspectors have on what the benchmarks are from that point of view?

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: And basically this is not a hostile question to the CQC because this isn't the only place that we've seen people looking at the same records and taking a different view of their quality.

MS MCMILLAN: Yes, that's right. So – well, for this particular inspector in this particular moment, the training that inspector would have had would have been the training they would have had when they were with the Healthcare Commission, and the approaches, because they would have brought those with them obviously, in terms of the skills and methodology they used. And any training that we would have provided at that early stage around the then new methodology and what the new regulations meant, the sorts of areas that they should be looking at; at that time that wouldn't have been huge because we were three months into a brand new approach, and how we inspect now is entirely different. So I think we were at the beginning then.

CQC was at the beginning of an entirely different approach to regulation, and the NHS was the first sector to come into that new process of regulation. We're now in a very different place for two reasons. Firstly, because now all

sectors are a part of that regulatory approach, but secondly, because we've moved fundamentally from a compliance/non-compliance approach to one that is about ratings and inspecting for good. And that's a very, ~~very~~ different ~~type of~~ approach. And the other big difference is that in 2010 the organisation had made a ~~very~~ specific decision that it would have generic inspection teams working, having mixed caseloads, and now we have the exact opposite. We have specialist teams, and we take professional specialists out on inspection with us, so if we're going to maternity we always have a maternity specialist with us.

PROFESSOR MONTGOMERY: I think we understood that, and obviously we can reflect on that. A couple of other questions about 2010 then, and I think we need to sort of move on to the next stage. Had there been issues in the minds of the local GPs in the local – had there been a maternity services liaison committee, which there wasn't, would that have fed into the preparatory work? Because you talked about the PCT and the SHA, so does that imply that as far as you're able to tell there was a noise, if I can use that phrase, in the system around maternity services?

MS MCMILLAN: Yes, at that point perhaps, yes.

PROFESSOR MONTGOMERY: So from your perspective you had the Titcombe case, and the failings had been acknowledged, an action plan was in place to address them, and that was your only real flag around maternity at that stage.

MS MCMILLAN: At that point.

PROFESSOR MONTGOMERY: At that point, okay. And then things do begin to change. So we've done 2010 now, I think. Are we doing into 2011, the next time there's a –

MS MCMILLAN: Yes, although I think it's probably important to say that over that period of – through 2010, we kept on the case because – because Morecambe Bay had been a place where there'd been concerns, and James was still very adamant that there were issues there that hadn't been addressed, and we listened to that. And I don't believe I ever stopped listening to James because I felt that his particular approach was such that he was getting involved at that point with other parents, and he wasn't only talking to me about his experience in relation to Joshua and the horrendous things that had happened to him. He was actively involving other parents and encouraging them to come and talk to us. So from my point of view it was really important to keep listening, because it's often through those contacts that you will find that people will come to you and give you other pieces of information that will be more current, you know, since 2008, and that will give you an indication of whether there has been an improvement for people using those services.

PROFESSOR MONTGOMERY: Okay, so there's enough of a niggle –

MS MCMILLAN: Yes, I was niggled. It's a good expression actually; it's a good way of saying.

PROFESSOR MONTGOMERY: But you're keeping a watching ear over.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: In the NHS organisations, so the SHA, the PCT, are any of those people having a bit of a niggle and sharing information, or does it feel separate?

MS MCMILLAN: The SHA had continued to support Morecambe Bay, and indeed other trusts – Morecambe Bay by no means alone. But trusts where there had

been concerns, SHA continued to provide support to – you know, to assist people with the improvement programmes, partly initially due to the foundation trust pipeline, but also subsequently where they had some involvement, and clearly Monitor had some involvement.

I met regularly with the SHA, about once a month.

PROFESSOR MONTGOMERY: Who did you meet with?

MS MCMILLAN: I met with – sometimes I met with Jane Cummings, because she headed up the performance team in her role as Director of Nursing or Chief Nurse, whatever the terminology was, and I met with members of her team. More regularly with members of her team, they were always there, and Jane would get involved if there were particular trusts we needed to discuss.

PROFESSOR MONTGOMERY: And what was your sense of what they thought the priorities were about Morecambe Bay?

MS MCMILLAN: I think they believed that they were – that they were continuing to make progress, that they were – they were responding to that drive for improvement.

PROFESSOR MONTGOMERY: And Monitor, what connection did you have with Monitor, if any, as part of their FT assessment?

MS MCMILLAN: Yes, I was in contact with Monitor relatively regularly not long after I came into post. I was very mindful of the fact that we were working with a number of trusts that were either in the FT pipeline or already FTs, and that we should establish working relationships with Monitor. So together with one of the ~~sort of~~ team leads at Monitor in London, we set up a joint workshop, and we brought together all the relationship holders from Monitor with all the relationship holders, i.e. compliance managers, in the region.

We had a workshop ~~together~~ where we shared methodologies, where we were both up to, talked about different trusts at a ~~sort of~~ general level, and then ~~we sort of~~ had a breakout session whereby all of the Monitor relationship holders and ours could have conversations about where trusts were up to. And the purpose of doing that wasn't because we thought that a single workshop would create the relationship, but it brought that face-to-face contact. People shared telephone numbers, contact details, talked about what their concerns were, and it created an environment where, either at ~~the monitoring~~ Monitor or our end, if you had a concern or you wanted to have a conversation, you could pick up the phone and talk.

PROFESSOR MONTGOMERY: And do you have a sense of what the concerns that were shared around Morecambe Bay were? I mean it was an odd application because it stopped and started, so it's hard to believe there weren't discussions about it in the context.

MS MCMILLAN: Yes. I couldn't tell you what had been discussed between a compliance manager and between the Monitor relationship manager, but in my conversations with Miranda Carter, who was the person I would have dealt with on a routine basis, initially it was about ensuring that those actions that had been identified in relation to Joshua Titcombe's death were seen through, and Monitor were seeking confirmation that had happened. And clearly from my point of view at that time, the June 2010 inspection had done that, and there was one other concern, which was a lingering concern that we had in relation to Morecambe Bay, which was about radiology, where prior to my arriving in the region, we had asked an independent person to look at all the evidence and take a sample of cases and check that appropriate decision

making had taken place. And the outcome of that was that it was appropriate and there had been the right decision making.

PROFESSOR MONTGOMERY: When you say radiology, do you mean specifically?

MS MCMILLAN: What, sorry, the?

MR BROOKES: Was there anything specifically within radiology? Was it particularly serious?

MS MCMILLAN: Yes, and I can't remember the detail. But again, if you want it, that could be found. We did talk about it at the time.

PROFESSOR MONTGOMERY: Do you know what triggered that?

MS MCMILLAN: It was a whistle-blower.

PROFESSOR MONTGOMERY: A whistle-blower.

MS MCMILLAN: A whistle-blower prior to my coming, and I shared that with Monitor, and said that even though we had done that test and we'd used an independent clinician to look at a sample of cases – I mean I say we, it wasn't me because it was before I came, but as an organisation we – the person concerned who'd made the complaint was not happy. They were saying that they didn't feel that that was sufficient, and I did share that information with Monitor. So those were the two. At that point, those were the two outstanding concerns.

PROFESSOR MONTGOMERY: So, we got through FT.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: Your people are going to go back in shortly, aren't they, in 2011?

MS MCMILLAN: Yes, that's right.

PROFESSOR MONTGOMERY: So the next step.

MS MCMILLAN: So early in 2011, James Titcombe emailed me one day and said, 'Has CQC seen this report?' and it was the Fielding Report.

MR BROOKES: So about when was that?

MS MCMILLAN: It was in January 2011.

MR BROOKES: Yes.

MS MCMILLAN: And I opened the report and printed it, and I think before I probably had chance to read very much of it, got a phone call from James saying, 'I'm really, really sorry, Sue, but I shouldn't have sent you that. My lawyer's just advised me I shouldn't have sent it, and can you delete it straightaway, please?' So I deleted the email, but of course I had a printed copy of the report. So you can't know – you can't un-know anything, fortunately.

So we then had the Fielding Report, and it hadn't been shared with us by the trust, and we double-checked. We went back through all our records and it hadn't been shared with us.

DR KIRKUP: Can I just ask why – what was the basis for saying that you had to delete the email, or asking you to delete the email?

MS MCMILLAN: It was papers that had been provided to James by his lawyer in relation to preparation for the inquest, because by that stage his – he'd been – Joshua – there was an inquest being arranged for Joshua, and papers had been provided by the lawyer to James and...

DR KIRKUP: It's not immediately apparent why that needed to be confidential to me.

MS MCMILLAN: James may be able to tell you.

DR KIRKUP: Okay. I just wondered whether you were clear on that one.

MS MCMILLAN: But James was really worried about it, and he rang – I mean it was literally within – probably within an hour that he rang me to say, 'I shouldn't have sent it you. My lawyer's told me that I shouldn't have sent it to you.'

DR KIRKUP: Okay.

MS MCMILLAN: So we read the report. Now at that stage in January 2011, we were already planning to go and do a full inspection, all regulations at Lancaster. And having read the report, we had quite a tough decision to make. Did we abandon that inspection and start thinking about another maternity inspection, or did we proceed with the inspection at Lancaster using the information in the Fielding Report, because fundamentally the information in the Fielding Report was about governance, and governance applies whatever service you're looking at.

And rightly or wrongly, we stuck – I stuck with the decision, having really weighed it up and thought it through, we stuck with the decision that we would do Lancaster first. We wanted to see what they were doing in another part of the trust, and how that was operating, but that we would as well do another maternity inspection afterwards, and we would go to all three sites and have a look and see how maternity services were working across the trust.

There was another reason for doing it that way round. We clearly knew by then that there was going to be an inquest into the death of Joshua Titcombe, and we were of the view that it would be probably of much more value to go into the trust and do that maternity inspection after the inquest, when the findings of that could be incorporated into our inspection. And [Jo Wildman2], who was the compliance manager who we were planning this with, attended all days of the inquest so that she could hear absolutely everything

that was said at the inquest by the staff and their managers. She debriefed me each day; we spoke about it, and we incorporated much of what came out of that into the inspection as well.

PROFESSOR MONTGOMERY: So what were the headlines in her briefing to you? What was her impression?

MS MCMILLAN: She wasn't very impressed. I think she felt that the midwives were being defensive and weren't really taking the issues as seriously as they should. In many ways I think the – what you might call the softer intelligence or evidence that you get from attending that inquest was very powerful in – as additional evidence really in relation to what Fielding was talking about. It's one thing to read it, isn't it, but then you – I think we were seeing it in action.

PROFESSOR MONTGOMERY: So if I can reflect on the difference that you're describing there from what you described at the stage of handover that has tipped the balance of you thinking this is a trust moving in the right direction to you asking a question of whether it's actually...

MS MCMILLAN: Well I was asking those questions in January because I wanted to know in January why hadn't they shared that report with us. I mean in – we wanted to see whether they would share it with us, so we asked them. What we actually did was after we'd got the Fielding Report and we read it and we incorporated it into the planning for Lancaster, Jo asked the – initially just verbally – Jo asked the trust for all their documentation and reviews in relation to maternity.

They didn't respond straightaway, but we pushed it and – we did, and eventually we got it in April, and –

PROFESSOR MONTGOMERY: You say you go it. You just got given –

MS MCMILLAN: No, no, no, they sent us everything.

PROFESSOR MONTGOMERY: Okay.

MS MCMILLAN: And the Fielding Report was in there.

PROFESSOR MONTGOMERY: And everything was?

MS MCMILLAN: Everything was there, and it included the Fielding Report.

PROFESSOR MONTGOMERY: Well I think you could help us know what everything was, because every time we turn over a stone another report seems to come up.

MS MCMILLAN: Oh, right. So they sent us – they sent us a whole range of – they sent it by email in attachments a number of documents that related to reviews of maternity services, which is what we'd asked for. I think we had them all, from memory, except the Fielding Report, which was in the list. And again, this is from memory, but I'm almost certain it said something in the email like, 'I don't think we've shared this one with you before.'

And in the meantime I had asked the SHA, and I'd said to the SHA, 'We've got a report that was done for Morecambe Bay which demonstrates significant problems in relation to governance culture and working relationships across the trust.' And the SHA said, 'Have you not got that? We thought you had that report,' but we didn't have it. So it seemed as though there were some assumptions being made about the information that we had.

MR BROOKES: Do you recall who at the SHA you had that conversation with?

MS MCMILLAN: It would have been one of the members of the performance team, but I can't remember. It would have been in one of those monthly meetings that I would have raised it, the first one probably after the –

MR BROOKES: Yes.

PROFESSOR MONTGOMERY: And do you have a sense of whether the SHA understood that report; so had the same implications for governance as you understood it?

MS MCMILLAN: I don't know how you couldn't really. Yes, I – they must have understood the significance of that in relation to the fact that – because for me, looking at that report, the issue it raised for you is if you don't get those cultural and relationship things right it doesn't matter how many times you respond to specific concerns in that reactive way. Those improvements aren't going to be sustained because they're going to be undermined by the fact that you haven't got your – you know, the way you're operating into a good place. So – and I think that's where we'd got to, and I suspect not only CQC, I suspect other organisations that were working with the trust that because on the surface they always appeared to be responsive. So there was never any lack of cooperation in the sense that they weren't fulsome, but if you asked them to do something they did it. If there was an issue or concern raised, they would say, 'Right, so we're going to do X in response.'

So on the surface they appeared to always be addressing, but it comes back to that reactive point that you made earlier, that they were reacting all the time. And that surface – the surface issues were being addressed, but I don't think they were every really addressing what lay underneath.

PROFESSOR MONTGOMERY: Can I ask you whether you think it's about superficiality, not wanting to dig in, or whether it's about managing the interface with the regulators?

MS MCMILLAN: You're asking me to speculate a bit there.

PROFESSOR MONTGOMERY: I'm asking what your impression is.

MS MCMILLAN: Yes. I've pondered on this on a number of times over the years, as you might imagine. I think if I was being really unkind I might think they've got very good at telling organisations, including regulators, what they wanted to hear, and they'd become very good at that. Another view on it, and I'm not sure, is were they fooling themselves? Did they believe themselves that they were actually addressing these things and that they were convincing themselves that that was sufficient, and that if they carried on doing that it would sort everything else out? So depending on how kind or unkind you're being, it would be one or the other.

PROFESSOR MONTGOMERY: So if someone were to say to you, 'We were confident we were okay because the Fielding Report gave us a clean bill of health; the CQC have given us a clean bill of health and we got through Monitor,' would that be a reasonable assessment of that documentation, do you think?

MS MCMILLAN: I think they thought they were okay. I think they were telling themselves they were okay.

PROFESSOR MONTGOMERY: Okay.

MS MCMILLAN: Which ~~sort of~~ makes me wonder what they thought of the Fielding Report.

PROFESSOR MONTGOMERY: Yes. This is another hindsight question, but you raised it, I think, when you were talking about the decision you had to take about whether to go ahead with the RLI or not. One possible interpretation is that this was fundamentally a governance issue, and the manifestation in maternity was tragically bad luck for some families, and there was a lot else

waiting to happen by luck rather than design, and it might not have happened. Given that reflection, and that's what I understand what you say, it makes sense still to look at the RLI, given that you're also going to be having a look at maternity later on. I mean if you look back from what you know now, does it feel more like a general governance problem, or rather aspects of maternity that are particularly difficult, and of course maybe a bit of both.

MS MCMILLAN: I think a bit of both.

PROFESSOR MONTGOMERY: So which bits of which?

MS MCMILLAN: I think there had been, and I've not had any [inaudible] of more recent contact, I haven't had any recent contact with the trust. I haven't had any contact with them since the end of 2011. But looking back, knowing what's happened since, I would say that fundamentally there are issues there about governance and the way quality and safety was managed that hadn't been bottomed out and hadn't been fully addressed, and that was probably having an impact on any area of service. And where it would have bubbled up would have been where the pressure point was.

So what we found, of course, and again this is going forward, that when we did that July 2011 inspection of maternity after the inquest, and we went back and looked and we issued a warning notice, it was like lifting a lid, because all sorts of other ~~things~~ concerns started being reported to us, to the SHA, and I think the other things that were being reported then were ~~the things~~ where they were the other pressure points. Because the Trust wasn't managing risk well, so it wasn't picking up early indications of risk, and where issues were arising they weren't being controlled, they were getting out of control, and it was having an impact. So it would have been very difficult, I

think, to predict, 'That's where the next problem's going to be,' because it was wherever that pressure point would be for whatever reason, and whatever the trigger was.

The reason maternity – it's a personal view, and with the benefit of hindsight, I think that those five SUIs were – were an indication that maternity was one of the places where there was a pressure point and where it was beginning to fall apart, and that wasn't being addressed.

PROFESSOR MONTGOMERY: So – but an explanation that just described maternity problems and wouldn't capture the context properly.

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

PROFESSOR MONTGOMERY: Okay, that's helpful. Are we getting towards the end of your time in the system?

MS MCMILLAN: Yes, probably have.

PROFESSOR MONTGOMERY: Yes.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: Were you there when the warning notice was –

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: Yes. So tell us a bit about the thinking behind the warning notice.

MS MCMILLAN: Yes, so – so we did the – the inspection that we did in July 2011 took account of the inquest as well, and looked at the three areas. It was unannounced; we went to all three sites on three consecutive days. We went to Furness first. We did it as a whole service review. We identified a number of areas, but fundamentally where we felt that there were failings we were in those areas that were about Regulation 10, which is do the monitoring of

quality and safety, and that ~~things~~ issues weren't being picked up and addressed. They were often known about at the ground level, but they were never getting to where they needed to get to be addressed, and for there to be action taken that would put them right.

So it was that regulation, we decided to issue a warning notice, so a warning notice is issued where you feel the concern is sufficiently severe that there's a risk of harm.

PROFESSOR MONTGOMERY: And warning notices are time limited?

MS MCMILLAN: They are – they're not time limited in that they don't have an expiry date. They have a deadline for compliance to be achieved.

PROFESSOR MONTGOMERY: And did you think compliance could be achieved within the next three months as in this...

MS MCMILLAN: This warning notice? The deadline we gave the trust was 21 November. When we issued that warning notice, I said it was like lifting a lid. That is truly how it felt; all sorts of other information started coming out. People who'd never contacted CQC before started phoning me and saying, 'We've got concerns about this.' People started speaking up, it was like it gave people permission to speak. And the SHA set up Gold Command, and –

MR BROOKES: Sorry, just at that stage, did the ~~SHS~~ SHA also join that queue of people raising concerns about the organisation?

MS MCMILLAN: Not initially, but they started reviewing some of the things that had been looked at previously, like the LSA Report, and reviewing that, and coming to the conclusion that it had been inadequate. So I think – it wasn't – I don't think the SHA came forward and shared information they hadn't

previously shared, it wasn't like that, but I think it did trigger them to look again at some of the things that hadn't been looked at previously.

But members of the public, I had a solicitor ring me who'd had a number of people approach them, so we began to learn a lot more about some of the levels of concern.

PROFESSOR MONTGOMERY: So the lid that is lifted is not just within the trust, it's actually within the other parts of the – so the regulator are aware, the general public.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: And so they'd go public on that which makes it possible to discover other things.

MS MCMILLAN: Yes, it made a big difference. So Gold Command was formed, and as a result of Gold Command, the actions that followed from that led by the SHA, and involving others, there was significant additional support parachuted into maternity services to ensure that the services were safe, and why a programme of work was done to achieve longer term improvement.

So in those circumstances I made a decision that it was not appropriate to go and re-inspect immediately after 21 November, because if we had gone in and inspected on say 22 November, what we would have been inspecting was an enhanced service propped up by a whole range of additional professionals both at – additional staff at the frontline and managerial support that had been provided to maternity services. We would be assessing their competence and their ability in ensuring that there was compliance with the regulations, and we would have been making the trust compliant when we know that that extra resource was only going to be temporary.

PROFESSOR MONTGOMERY: Okay, so just testing out, you used a phrase 'making safe'. So was it unsafe up until then to patients?

MS MCMILLAN: I – I think it's too strong to say it was unsafe. I think what I would say is that risks weren't being managed appropriately, and if risks aren't being managed appropriately then you are in a situation where things – you know, the service can become unsafe. So when I used the expression 'to go in and make it safe', clearly in the eyes of the public, if you issue a warning notice and say that risks aren't being properly addressed in this trust, they need to get their act together, which is what we were saying.

One of the first questions any pregnant mum in Furness, for example, would have been saying – or in Barrow – would have been saying is, 'Am I safe to go and have my baby?' So – and I was asked that on the television news at the time. And for me, when you take that step, when you come across something that you believe is a risk, then you have to be seen to be supportive of action to go in and mitigate that risk. So the making safe is about mitigating the risk, and that's what was happening, but that additional resource was in there for a considerable period of time.

The Trust weren't very happy about the fact that we didn't go back and reassess whether they'd met the requirements of the warning notice. Clearly they wanted the warning notice ~~of their, quote, of~~ off their record.

PROFESSOR MONTGOMERY: So you think that they thought that they had met the requirements and that you would – if you had gone in they thought you would have lifted it.

MS MCMILLAN: They probably did. My view was I wanted that compliance to be tested once the trust were on their own again.

MR BROOKES: You wanted it to be sustained.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: And did you have the opportunity of continuing the period? Well one, because we're trying to understand is – is from a lay person's perspective they have a warning, they have to comply by this date. They don't comply and they get away with it, and I understand –

MS MCMILLAN: No, because the warning notice is still there. It's still there. The warning notice doesn't disappear, it doesn't have a sell by date. On our website it will have still said that there had been a warning notice issued in respect of this trust, and that would have remained there until we removed it ~~because we had said that they were compliant and had met all the requirements.~~ (See WN clarification in letter RN 1027 SM 01)

Comment [FJ2]: Please refer to McMillan's letter URN 1027 SM 01

MR BROOKES: And when was it removed?

MS MCMILLAN: After I'd gone. You know, ultimately when ~~they would have gone back~~ the inspection team assessed as compliant..

DR KIRKUP: There is a pretty wide perception around, though, that it expired on that date in November. That's not me.

MS MCMILLAN: Yes.

DR KIRKUP: I'm telling you what we've had reported to us, and that that was regarded as a positive sign. 'Oh, the trust must be okay because the warning notice has been allowed to expire.'

MS MCMILLAN: Yes, yes. Well, legally that is incorrect, in my view. You know, it's – the warning notice was there and it was issued. It doesn't have an expiry date; it has a deadline on which people must be compliant.

DR KIRKUP: But you can see that from a lay person's perspective, and I include me in that group because I'm not an expert on regulation, although I'm getting better by the day. You can see that if it has a 'must comply by' date, and that date has now passed, they either complied or they didn't.

MS MCMILLAN: Yes.

DR KIRKUP: And if you haven't taken any further action then natural assumption must be they've complied.

MS MCMILLAN: Yes. Except throughout that period it was daily in the press about the fact there were all these extra services and all this extra support going into Morecambe Bay. I would have been very uncomfortable as a regulator going back to that trust, saying in, for the sake of argument, at the end of November that they were compliant because there were all these other services in, which then effectively gives the trust a clean bill of health, and then all this extra resource goes and there's no test.

DR KIRKUP: Okay, but isn't there then an option to set a new compliance date? You just left the original compliance date and it's passed, and we're into the December and January. What happens next? Shouldn't there have been a new compliance date?

MS MCMILLAN: Well – but we've set that date, that is the date. And so – and they probably were compliant at that date, but they weren't compliant off their own bat. They were compliant because of all the extra resource.

MR BROOKES: But again, exactly the same as Bill, what I see is you set up a warning notice with a compliance date. It's a black and white kind of issue. You're either compliant on that date or you're not.

MS MCMILLAN: Yes, yes.

PROFESSOR MONTGOMERY: But I think what we heard, which is different from what we've heard previously, is that you're saying your view was they were compliant on that date –

MS MCMILLAN: They probably were.

PROFESSOR MONTGOMERY: – but only because of –

MR BROOKES: But there was no test of that compliance.

PROFESSOR MONTGOMERY: No, no.

MR BROOKES: So you couldn't know for certain one way or the other.

MS MCMILLAN: And if we'd gone in, what we'd have been testing wouldn't have been the service provided by Morecambe Bay on its own. It would have been the service being provided at that site by the Morecambe Bay staff and a whole array of other people who had been parachuted into assist.

DR KIRKUP: Okay, I understand that. But surely then the logical step is to say, 'Let's wait for those staff to leave because the trust is now able to stand on its own two feet, and let's set a new compliance date.'

MS MCMILLAN: We can't change the date of the warning notice. It's a –

MR BROOKES: Then it must expire.

MS MCMILLAN: It's a single document. No, it's –

DR KIRKUP: But you said it's still live.

MS MCMILLAN: It's a – yes, but it's a document that's issued at that point.

DR KIRKUP: So what's the status of the document which is apparently still in existence, which says you must comply by day X. Past day X it doesn't have any meaning.

MS MCMILLAN: Yes, other than the fact that it was a warning notice, it was issued in relation to that area of activity.

DR KIRKUP: But it will be seen as entirely historical because the warning – the compliance date has expired.

MS MCMILLAN: Yes. I can't – I don't feel I can go any further because I'm telling you how that piece of regulation works.

DR KIRKUP: Yes, but you do see the difficulty that we have.

MS MCMILLAN: Yes, yes. But you can see the dilemma that I'm in as a regulator, that you can't extend a warning notice, there's no provision to extend a warning notice.

PROFESSOR MONTGOMERY: Well issue another one.

DR KIRKUP: You issue a new one.

PROFESSOR MONTGOMERY: Yes, issue a new one.

MS MCMILLAN: But you issue – sorry?

PROFESSOR MONTGOMERY: Issue a new one.

MS MCMILLAN: Well I can't, because when I go out to inspect to issue a warning notice there'll be compliance.

PROFESSOR MONTGOMERY: That's what I think we've heard today which is different.

MS MCMILLAN: Because you can only – you can only issue a warning notice on the basis of where things are at that date. If I'd gone out – not me – if the team had gone out on 22 November, they would have found it compliant. They wouldn't have been able to issue a warning notice.

PROFESSOR MONTGOMERY: Which means actually the proper thing to do would be to withdraw the warning notice, but that's a different question. Can I ask a question about the convention of writing letters?

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: Because I'm trying to under – I've seen letters which have mentioned maternity RLI, but not Furness, and other letters that have mentioned a list of things of concerns, and have had both sites on. Is it normal practice to segment your letters, so each concern or each set up goes in a different letter, or would you normally write to the trust on all the concerns that the CQC has at that time would be noted in each letter?

MS MCMILLAN: It would depend upon the context of the letters. Can you recall specifically the letter?

PROFESSOR MONTGOMERY: I can't immediately recall them, but they're a list of things they had to comply with.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: And we're in this crucial period when you'll say the warning notice is still in place.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: But it's gone past the expiry.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: And it lists maternity, and has RLIs in place where that relates to, and makes no mention of Furness. And then there's another letter less than a month later which has a list and has both sites.

MR BROOKES: And it's a similar list, if I recall.

PROFESSOR MONTGOMERY: Yes, a very, very similar list. So I'm just perplexed about what the convention is. If I were an organisation receiving a letter from the CQC, would I have half a dozen letters dealing with the six concerns that you have, or would I have a composite letter that says, 'These are current concerns from the CQC'?

MS MCMILLAN: Yes, it will depend upon the context, so it's quite difficult to ~~ask~~ answer that question generically. One of the things I think it probably – may help is that we register places by location. So for example, when you see the report for that inspection of the three maternity sites that have taken place in July 2011, you will see that the identical report is issued against RLI, against Furness and against Westmoreland, because we have to register and inspect and report against the location. So sometimes that might explain why letters are specific to location or not specific, it depends on the context.

PROFESSOR MONTGOMERY: So we should search and see if there's an identical letter, but with FDH...

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: ... in the index list. That's what you would expect to have happened.

MS MCMILLAN: Yes, because it will depend. If it's something there we have to write specifically for the location, it would be that. If it was something more generic...

MR BROOKES: So the anomaly is the one that has the two sites in it then with one in a different type face.

MS MCMILLAN: Yes, which is why I'm saying it depends on the context because it might have been a reason for that.

PROFESSOR MONTGOMERY: We'll search for that. I think we're moving into Gold Command, so it may be that Ann gets to take over on some of this, because you just picked up the area I wanted to ask about really, which is about what this does to the trust. So you described one of the things it does is that there's a whole degree of management capability and capacity that isn't going to be

there sustainably, which obviously alters your regulatory context. We've heard from a number of cases a sort of suggestion that Gold Command took both the responsibility and the ability to do things away from the trust, and we're trying to understand what it was thought that Gold Command would achieve, and in particular what you might describe as the exit strategy. So you can see why it's pulled together to make things safe, and I think you've described that process in your bit of it as well.

At some point it's got to go back to the trust, so I'd like to understand what the thinking was, and I appreciate it sort of falls between you a little bit in terms of thinking it through, but we can see from documents we've got that you picked up some of the back end of that, so we'd like to know what the thinking was of how we move through Gold Command, and we've been able to ask people about Gold Command itself, into a normal way of working, and therefore you can go back to the regulatory questions that you've had to, if you like postpone a little bit while you see what happens on a sustainable basis. So I don't mind who picks that up.

MS MCMILLAN: Can I just say something a little bit about the set-up of it, Anne? Would that be easier?

MS FORD: Yes, yes, please do so.

MS MCMILLAN: So when Gold Command was set up, I believe there was a terms of reference, and so presumably you've had that. It was very much, I think, the SHA wanted to take control of its responsibilities around performance. You know, we as the regulator had said, 'There are significant issues here.'

PROFESSOR MONTGOMERY: It was driven from the SHA was it?

MS MCMILLAN: Oh, yes, it was an SHA initiative. And I think that was the important thing I wanted to say. As a regulator you have to be quite careful that you don't get involved in improvement programmes, because otherwise when you go back you're inspecting your own work and you can't retain that level of distance or objectivity that you need.

So I can remember quite early on having a conversation with Jane Cummings, and also saying at the Gold Command meeting that whilst we appreciated the fact that CQC were being invited to the Gold Command meetings and being kept informed about the additional support that was being put in and what they were doing to support the process of improvement, that we would not be a part of the improvement plan or of agreeing specific details of it because that did put us potentially into a conflict. And so when those terms of reference were set out, I remember quite clearly saying that at a meeting, and positioning ourselves really so that we were in a position where we were being kept informed, but we weren't part of the solution because we needed to be able to go back and inspect the outcome. And at that point I moved to a different job, and so I did handover to people who followed on from me.

PROFESSOR MONTGOMERY: What was your impression of the PCT's involvement, because there's a lot of activity by PCT personnel –

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: – in this, and we're trying to disentangle what was the SHA, what was the PCT and where it was driven from.

MS MCMILLAN: I can't remember now in the detail of who did what. I know that we had quite a lot of contact –

PROFESSOR MONTGOMERY: I think we can trace the detail of who did what. It's the why and who was driving it, that's far more important to us.

MS MCMILLAN: Yes, yes. I mean it wouldn't have been in request to anything that we asked. I know throughout that whole period in 2011 where there were mounting concerns, Jo Wildman met regularly with representatives from the PCT, and the PCT was also an organisation where I think we got more information from them as we went on around – you know, they were looking back and seeing what some of the concerns had been. But we weren't – we weren't involved in decisions about how the responsibilities were taken forward.

PROFESSOR MONTGOMERY: And did you have a sense there were two PCTs involved?

MS MCMILLAN: Yes – oh, yes, it's complex.

PROFESSOR MONTGOMERY: Did you have a sense of which was the most heavily involved?

MS MCMILLAN: It's probably – I probably knew at the time and I can't remember now. I'm afraid that's all I can say.

PROFESSOR MONTGOMERY: No, that's absolutely fine. Thank you. Ann, do you want to pick up –

MR BROOKES: Can I just – before we go on, just remind me, I cannot remember this. I should know this. Was Monitor at the Gold Command?

MS MCMILLAN: Yes, they attended.

MR BROOKES: Do you know if they position themselves similarly?

MS MCMILLAN: Oh, goodness.

MR BROOKES: I know, it's asking you to remember. I can't recall anything saying that.

MS MCMILLAN: I can't remember, but that doesn't mean they didn't. I just can't remember.

MR BROOKES: Okay. Because I find Gold Command quite an unusual tool that was used in this particular case. And I understand entirely what you're saying about your positioning, and if Monitor was positioning itself similarly, I'm not sure why you needed a Gold Command. Do you see what I mean? So I'm just interested.

MS MCMILLAN: Yes – yes. I don't – I don't know how Monitor positions, so I just can't recall. And I – it was the SHA who took that initiative. My impression, but it's an impression, was for them it was about flagging the seriousness with which they were taking this. That they – you know, that this was – there had been a Gold Command in the preceding months on another issue at another trust at that time, which was a very different sort of incident and one where you might expect a Gold Command to be set up, right?

MR BROOKES: Absolutely. I think I'm aware of that one.

MS MCMILLAN: Yes, right.

PROFESSOR MONTGOMERY: We also understand there's been other Gold Commands in this part of the world for completely different things.

MS MCMILLAN: Yes, that's right. So I ~~sort of~~ wonder whether because that approach had been used in the relatively recent past to good effect, there was a view that in response to the seriousness of this, that it could be dealt with like that severity of incident. It would flag how serious the SHA were taking it, and it would mobilise resources.

Now – but that's me...

PROFESSOR MONTGOMERY: And we can be clear, what is the nature of the incident that's been thought to be so serious?

MS MCMILLAN: That we were saying in our report – well, that we were the first step, I suppose, that we were saying in our report that there were fundamentally issues around how the trust was being run that was impacting on the quality of what was provided in maternity, and that subsequent to that, as I say, the lid had been opened, there'd been an issue about recalls and outpatients' appointments, all sorts of other information started coming out that suggested that this was a multifaceted –

MS FORD: Systemic problem.

MS MCMILLAN: – problem.

PROFESSOR MONTGOMERY: So again, going back to the question I was asking about, is it governance or maternity; it's triggered by maternity but actually it very quickly becomes a systemic governance problem.

MS MCMILLAN: Yes.

PROFESSOR MONTGOMERY: Okay. May we call you, Ann, is that all right?

MS FORD: Yes, please do.

PROFESSOR MONTGOMERY: Yes. So there's a little bit of a gap between your dates, if I've got that right. But I think we're really keen to understand the winding down of Gold Command issues, and I think that's the point at which you really begin to see it happening and have understood the paperwork.

MS FORD: That's right, I came into post in April that year.

PROFESSOR MONTGOMERY: Okay.

MS FORD: And by then Gold Command had already started to come down and be called a special incident group. Again, we were conscious of the group meeting, although we didn't attend for the reasons Sue's stated. And we were engaging with Monitor and the strategic health authority through our own internal – we used to meet with them monthly to keep a progress on the trust, and it was felt then that the risks that we'd identified on maternity services, there'd been some new personnel obviously appointed as well in that time to strengthen the trust management team, that the trust was able to provide the service on its own now without that extra special – you know, all that additional resource.

And then we'd quickly, after about three – I'm not absolutely sure whether it was three meetings of the special incident group, where it was disbanded and then removed back in to sort of business as usual relationships because they felt there'd been increased staffing in maternity, there'd been some new managers appointed. There were some stronger – like they were still getting the regulatory support and challenge from Monitor and the support of the performance from the SHA. So that was my understanding of how it wound down.

PROFESSOR MONTGOMERY: And where does the Section 48 Review fit into your time?

MS FORD: The Section 48 Review, as part of my handover I was told about the Section 48 Review, and at the time the person, [Mandy Musgrave?], who led the Section 48 Review, was one of my direct reports, as the head of region. So pretty soon into my new post, Mandy and I met, and we discussed the Section 48 Report, because obviously the previous manager had spoken

earlier about it, and I was looking to have that direct contact with Mandy. So then Mandy met with me and told me about the findings, told me why we'd done the ~~aging~~ urgent care pathway, what the recommendations were likely to be and when the report was published. And then it would be down to me and my team to follow up after a given period of time the progress that the trust had made against the recommendations.

PROFESSOR MONTGOMERY: So how did you go about doing that?

MS FORD: The follow up?

PROFESSOR MONTGOMERY: Yes.

MS FORD: Well, it was more difficult than I anticipated.

PROFESSOR MONTGOMERY: Yes, we understand that.

MS FORD: For a number of reasons. One, we didn't have a methodology. Secondly, it was going to be quite an intensive piece of work, so we were trying to balance the needs of the regulatory response – the ongoing regulatory responsibility in the patch with the resources that we required to do the work. And also, some of the things that the trust had been – some of the recommendations, the trust needed more than six months to really turn that around. And by this time I'd already had some – I was starting to develop my own concerns about the trust. I felt they were reactive; I thought as soon as [inaudible]. They were very good when I went to meetings with them, and I challenged them about performance. They told me what I wanted to hear. I was a bit worried about the quality of the metrics they were using to support it.

And I thought I wanted to give them time enough to demonstrate three things: one they'd took the recommendations seriously, they'd made progress

and that it was sustainable. So that was the third reason that the review happened after six months rather than at the six-month point.

PROFESSOR MONTGOMERY: Okay, and where's maternity in your thinking there, because that review hasn't put maternity at the centre. So you have a maternity warning notice, you have a trust that is responsive to all the things you're asking about. What can you ask about maternity, given the Section 48 didn't cover it?

MS FORD: Well within the bit there'd already been a review, and I think Sue's covered that, and that things were improving. And in fairness, they had improved. They'd certainly improved in terms of the number of midwives that were available. And they'd certainly improved in terms of the local relationships at Barrow in particular. And I think things had also improved around the way clinicians were engaging with staff on the special care baby unit. There were still some tensions because -- you'll be aware of the proposed closure of the SCBU later on that year.

PROFESSOR MONTGOMERY: The near closure, yes.

MS FORD: But at that time things seemed to be going quite well.

MR BROOKES: Can I ask how you knew?

PROFESSOR MONTGOMERY: I was going to ask that question.

MS FORD: Well, yes. We were meeting with the trust regularly.

PROFESSOR MONTGOMERY: And who were you meeting?

MS FORD: We were meeting – Jackie Daniels, who was the chief exec, and the – sometimes the director of nursing and the head of midwifery, and sometimes the medical director. And we knew that Monitor were asking for a monthly report around the maternity dashboard, and some of the metrics there. So we

were meeting with the trust using Monitor's information, our own intelligence and the engagement meetings with the trust to keep a watching eye on the maternity.

PROFESSOR MONTGOMERY: But given that you're anxious that they're telling you what you need to know, do you have any mechanism for speaking to the obstetricians and paediatricians and midwives who you have evidence are not getting on very well in the past, so how does your system enable you to get an intelligence on that?

MS FORD: We were doing that through the inspection process, and we did follow up in – and we always made a point of speaking to women, we always made a point of speaking to nursing staff and we always made a point of speaking to clinical staff.

PROFESSOR MONTGOMERY: So that would have come at the six-month point when it was right for you to go back in again, you'd have had some triangulation of that.

MS FORD: Yes.

PROFESSOR MONTGOMERY: Okay.

MS FORD: I've lost my train of thought.

PROFESSOR MONTGOMERY: You were meeting with...

MS FORD: Oh, yes, we were meeting regularly, and we were using the maternity dashboard that we were having it from, and we knew from the recruitment and the challenge that we haven't had the regular engagement meetings. I was worried at one point about the skill mix at Barrow, because although they were getting a lot of new midwives in, they were relatively new, newly qualified, so some of the challenge that we put in at that time was about how are you

supporting and developing and mentoring the midwives, because I did think that was a risk. But in terms of –

PROFESSOR MONTGOMERY: And where are we with the warning notice at this point? Is it still in place at this point? Are you thinking about lifting it? Does that come at the six-month point?

MS FORD: That came when we went – when we did the follow up visit –

PROFESSOR MONTGOMERY: Okay.

MS FORD: – later on that year.

PROFESSOR MONTGOMERY: And Monitor, I mean you've described very clearly there's a set of issues about quality and safety and there's a whole set of governance issues.

MS FORD: Yes.

PROFESSOR MONTGOMERY: And while the governance issues have implications for the quality questions that are yours, and they have massive implications for Monitor, are they part of these conversations as well?

MS FORD: Yes, because I was starting – when we did the follow up visit to the – from the ~~H&K[?]~~Section 48 investigation, we did see improvement and we did see the trust was moving forward with some. We'd also seen that there'd been improvements in the maternity service, and we'd also seen that there'd been improvements in the A&E, particularly around waiting times and staffing and those sorts of things. But what I was still conscious, that the governance – everything that we found had its roots in robust governance. And I think the trust was reactive; I think it was very, very good. You know, your maternity services aren't right, so they put a whole load of resource in maternity, and it would improve. And then I'd go and look at medicine and we did look at

medicine, and the standards there were poor. So they seemed to be able to react and put something right and hold it there, but couldn't keep the plates spinning in the other services. That was my concern.

PROFESSOR MONTGOMERY: And was your assessment that that was a capability or a capacity problem, if I can use that phrase? Was it that there just weren't enough of them, and if they had more management capacity they could have spun all the plates, or were they not up to managing complex organisations?

MS FORD: I think it was both, if I'm honest. There's been a lot of turbulence in the management team, and a lot of change in personnel. And I think it was hard to sort of get people pinned down. I was also a bit disappointed at the Better Care Together strategy that was going to help the trust move forward in terms of the reconfiguration of services, and try to meet the needs of the population in a more robust way stalled as well. So I was concerned about that, and I think –

PROFESSOR MONTGOMERY: That's a commissioning strategy, isn't it?

MS MCMILLAN: Yes. Yes.

PROFESSOR MONTGOMERY: So, is the Trust buying into that, or are they resistant to it?

MS ~~MCMILLAN~~FORD: I think the Trust was – yes, they were, and they were pinning a lot on this strategy helping them solve their geographical problems and the service –

PROFESSOR MONTGOMERY: By giving them more money or by what?

MS ~~MCMILLAN~~FORD: Well, I think there was a recognition that things couldn't go on as they were, you know? And we don't get involved in the tariff or the finance, but –

PROFESSOR MONTGOMERY: But they say there's a recognition that things can't go on as they were, and we're expecting somebody else to solve it for us, or a recognition that we're part of the thing that has to change. Do you have an assessment –

MS ~~MCMILLAN~~FORD: No, I think they recognised that they had a part to play in it, and I think they recognised that they had to work with commissioners in doing that, and I think they recognised they had to have the public with them as well, because some of the decisions that we're going to make might be very sensitive. But it was the pace of change and the vigour that I was worried about. It seemed to be almost glacial at some points in terms securing the improvement. And, you know, when I had these discussions with them and I challenged them, they'd say, 'Well, we're responding all the time to your regulatory requirements,' you know, or, 'responding to Monitor's regulatory requirements,' and the CCGs were just finding their feet and coming into being. So – but I did think that –

PROFESSOR MONTGOMERY: So, ~~Sue~~ Ann? (see letter URN 1027 SM 01), if I can relay back –

MS MCMILLAN: Yes – sorry.

PROFESSOR MONTGOMERY: – that feels like they're managing their relationship with you, not sorting out the services that they're supposed to be running. Would that be – is that what you're saying to us?

MS ~~MCMILLAN~~FORD: No. I think they were sorting out their services in a reactive way. You know, they'd made the focused effort in maternity. They'd made the focused effort in accident and emergency, and on the ~~ageing~~ urgent care pathway. What I was concerned about was the quality of the other services

while they were doing that, and whether they could self-sustain the improvements that they'd secured.

PROFESSOR MONTGOMERY: So, I'm guess what I'm saying is: are they only doing that because they know you're looking at them, and then as soon as you step back and stop looking at them closely it'll revert, or do you think they made a sustainable change of that – their governance?

MS ~~MCMILLAN~~FORD: I still think there are issues around the Trust governance, and I think –

MR BROOKES: Because I think that's the point: it is that what we've seen it isn't maternity and ageing care were systematic of an organisation with poor governance, and yet their reactions are around particular services. Did you get a feel for how they were tackling the underlying governance issues?

MS MCMILLAN: After our inspection, and after Gold Command, there was a review, and when Jackie Daniel came into post, there was a review of the Trust governance systems. That –

MR BROOKES: By CQC?

MS ~~MCMILLAN~~FORD: No. By the Trust, supported by Monitor and their other agencies, to realign and reconfigure, so there was a better structure. They brought in the divisional structure, which did seem to help in terms of reporting and the metrics and quality assurance in terms of that being more robust. But I think, you know, the structure had changed but the people hadn't in some of those key roles, and I think that was one of the challenges for the Trust. I think when they got the new board in and the new director of nursing and the new director of finance, that gave them more capacity to be able to shift the

change. But I think you have to bring the change down to the mid-managers and further down the organisation. That's not quite embedded, yes.

PROFESSOR MONTGOMERY: That's interesting. And can I ask you a bit about the Board? Because at a number of points all the way through we've talked about the Board, but I've not heard anything about ~~DR KIRKUP~~Chair and the non-executive directors. No, I don't have anything for your sense of whether there's effective functioning of governors, for example, in this. Does it just sit at the executive director level? Are those the people who you think are really working on this, or is there a corporate board addressing that? And it's been unstable – we understand that. Lots of interim and the like.

MS ~~MCMILLAN~~FORD: I think it is a bit early for me to say, because ~~DR KIRKUP's~~ the Chair just changed and there have been some new key posts, and there have been some new non-executive directors appointed. So, I would be –

MR BROOKES: As part of your assessments, though, did you get a feel for whether or not there was full engagement from the Board?

MS ~~MCMILLAN~~FORD: I think there was full engagement, but I think there could have been more challenging their performance. I think they were accepting of the reports that they were given and didn't challenge the risk, because if they had've been, they'd have picked up some of the things that we reported in the way of inspection.

PROFESSOR MONTGOMERY: So, just to relay back, I think what you're saying there is you might have expected to say, 'If this is going on and the CQC's picked up, we need to ask what else might be going on and ask questions about our governance in other areas.

MS ~~MCMILLAN~~FORD: I think they could have been more challenging of the performance information they were given. Yes, I do.

PROFESSOR MONTGOMERY: Okay. I think we're probably where I thought we'd get to a lot later.

DR KIRKUP: Okay. Thank you. Do you want to –

MR BROOKES: Well, I've asked a set of questions, and I've just got a couple of things. Sue, if I can ask you first, I'm just trying to get a clear picture in my head. From what you were saying I got a feel for the importance of Mr Titcombe in terms of some of the discussions and dialogues, but I don't get a feel for where the other four SUIs fit – sat in your views about what's going on, because it clearly was a high profile one – someone who was very energetic and articulate in terms of putting forward the case. But there were these other cases of equal seriousness sitting there. What was the dialogue? How was that brought into your assessments and your relationship with the Trust?

MS MCMILLAN: Relationship with the Trust, our –

MR BROOKES: Well, yes – you know what I mean.

MS MCMILLAN: Yes. Well, I suppose James in some ways was becoming like a spokesperson on behalf of some families, and as well some of the parents did make contact with me and I spoke with them, and there were occasions, for example, when James would email me about someone else, and I would go through that process of saying, 'I can't talk to you, James, about this; I need to talk to the person direct,' and then there'd be an email exchange, where the other person would say, 'I'm happy for you to talk to James about this.' So, there was something going on that was about James being mobilising, I suppose, the conversation that parents were having and expressing that back

to us. The key thing I think here is that the Fielding Report changed our view that the five SUIs had no common elements, and I can't say exactly how she did this – only Jo Wildman would be able to tell you – but as part of Jo Wildman's preparation for what she then began as preparing for the maternity review, she would have looked at anything that we had that was historic information relating to those other areas of work to make those checks – and clearly there was information in the Fielding Report as well. So, we would have used the information. The turning point would have been the Fielding Report and us having access to that, because that flagged for us that, although at a superficial level if you looked at maybe clinical cause or whatever that there were – it appeared as though the five incidents were different, that there may be behavioural or other aspects to the service being provided that would be the commonality.

MR BROOKES: I just want to clarify that in my mind, because there are so many things you forget, and colleagues will... But I'm pretty certain that Dame Fielding started from the point of view that these cases were not connected.

MS MCMILLAN: They were not connected?

MR BROOKES: Were not connected.

MS MCMILLAN: Because that was the accepted view.

MR BROOKES: Yes. And I'll come back to that.

MS MCMILLAN: I was going to say 'wisdom' but I will use that term – the accepted view at the time.

MR BROOKES: So, I was trying to therefore understand how that – he your – how the Fielding Report then changed that perception in CQC's mind. Because she started – I think at the beginning of the document makes that statement –

that they're not connected, yet you're saying it was – when you saw that report it was a game-changer. It was something that –

MS MCMILLAN: Yes. Well, I would've received that report as saying that there were things that emerged from that report that said that how risk was managed, how people worked together, how the organisation was managing SUIs did come out of that report as being a connection – not a connection in the clinical circumstances but a connection in relation to the response of the Trust.

MR BROOKES: Okay. So, while there would be – so, it wasn't a clinical connection. It was – you saw symptomatic issues, which were brought out in the Fielding Report –

MS MCMILLAN: Yes.

MR BROOKES: – which related not just to one case but to the service.

MS MCMILLAN: Yes – that posed questions about what were the working practices, relationships and ways in which people were responding to incidents in maternity that were not being appropriately addressed.

MR BROOKES: Okay. And just for, again, the understanding, you've talked about Sarah Seaholme.

MS MCMILLAN: Yes.

MR BROOKES: Can you remind me who she was?

MS MCMILLAN: She was – I don't know what the formal title was, but she led the investigations team which was disbanded in March 2009. (see letter URN 1027 SM 01)

MR BROOKES: So, she's CQC.

MS MCMILLAN: Yes.

MR BROOKES: If I'm correct, you've said that she'd come to the conclusion that they were not linked.

MS MCMILLAN: Yes. I know that when the – as part of my handover and the information that I had around what had gone on before, the investigation – there'd been a request to consider investigating on the basis of Joshua Titcombe. One of the reasons I believe that was given in response to that – remember it was before my time, so it is third-party information this – was that the five SUIs had been considered. Because one of the things the investigations team would look at when they were deciding whether or not to proceed would be: was this a demonstration that there might be a theme or a systemic problem here? Because we're not – we didn't have as CQC – the Healthcare Commission had – but as CQC we did not investigate individual complaints, so the only reason we could undertake an investigation was that there was an indicator here that it was something systemic. And, so, as part of that, then the other SUIs would be examined to see whether there was an indication of that.

MR BROOKES: I understand that, because as Jonathan already mentioned, part of this has been trying to pin down where that becomes the perceived wisdom –

MS MCMILLAN: Yes.

MR BROOKES: – because it then becomes part of the debate in lots of places that these are not linked.

MS MCMILLAN: Yes, and I think –

MR BROOKES: And that's the only time so far we've found someone who actually has come to a conclusion at a particular point in time that they're not related, so that's quite useful to know.

MS MCMILLAN: Yes. Oh right. Yes.

MR BROOKES: Thank you. That's all I have.

DR KIRKUP: Yes. Sort picking up on that a bit, you mentioned being aware of the Ombudsman's involvement in Mr Titcombe's case when you were, I think, doing the double-running period with Alan Jefferson.

MS MCMILLAN: Yes. Alan would've mentioned to me that the case had been – that James had taken the case to the Ombudsman.

DR KIRKUP: Can I ask what your understanding was of the Ombudsman's position in relation to that case?

MS MCMILLAN: That the Ombudsman had decided not to investigate further.

DR KIRKUP: And that was it? Were there any riders to that?

MS MCMILLAN: I obviously do know additional things, but I didn't know at that time. In fact, some of the things that I know about that subsequently – the first time I knew about it was after the Grant Thornton report had been published. So, at that time, I didn't – there was a whole range of things that I didn't know about the Ombudsman.

DR KIRKUP: Right.

MS MCMILLAN: I only knew that it had been referred to the Ombudsman, and the Ombudsman decided not to. I think there was – and I have reflected on this, because I saw – when I was ~~sort of~~ revisiting papers in preparation for today I saw something that I'd written down at one point about the fact that the Ombudsman had chosen not to investigate and that – and there was – I'd put down a comment about the fact that the Trust had investigated, had admitted liability and had paid compensation, and therefore that would've been taken into account by the Ombudsman. But I don't know that that was from another

source or was – I just cannot remember, looking back at papers, whether that was something I was told or whether it was somebody saying, 'I think that the Ombudsman is less likely to look at something.' I can't recall what the validity of that statement is – whether it was someone's view or a reason that was given.

DR KIRKUP: The specific point that I'm getting at is not so much about that. It's about whether there was a shared understanding, both within CQC and also across – between CQC and the Ombudsman, about whether this was evidence of a systemic failure. That's the specific point that I'm trying –

MS MCMILLAN: I never personally had any contact with the Ombudsman.

DR KIRKUP: No, no – I understand that.

MS MCMILLAN: Yes. And –

DR KIRKUP: But I'm keen to know what briefing you got from Alan Jefferson about whether there was a systemic risk here – a systemic failure, I should say. I beg your pardon.

MS MCMILLAN: Yes. The – I think Alan had had concerns. I think Alan had been concerned previously that there were some systemic failings. But whatever had happened and whatever assurances had been given, by the Trust, by the SHA, by the Review and the action plan that followed, and the contacts with other people, before my arrival in the region the Trust had been de-escalated in risk terms as being of less risk. So, in that sense the message I was being given was there had been concerns; they are being addressed, and some have already been addressed. I don't know exactly what the nature of his concerns on that would have been.

PROFESSOR MONTGOMERY: Can I pin down a bit the impression? Because I'd be interested to know whether he felt that was right, or whether what he was handing on, and as you'd expect him to professionally, what that he'd raised concerns; they'd been looked at. Someone had taken a decision. He may or may not have agreed with it, but he's obviously – he's bound by that going forwards and... Did you get the feeling that he still thought there was something there: he had the niggle, as we were calling it, at that later stage, or do you think he was satisfied that actually the CQC had got to the right place?

MS MCMILLAN: I don't think he ever expressed that explicitly.

PROFESSOR MONTGOMERY: I wouldn't have expected him to.

MS MCMILLAN: I think probably I would say that – because clearly we didn't only talk about Morecambe Bay. We talked about every Trust in the region, and I think probably if we were thinking about a sort of league table of where he had concerns, I think what he did leave me with the impression was – is that Morecambe Bay was one to keep an eye on. So, it would have been in that position whereby, you know, he would've said, 'I think they're fine, and they're fine.' There were a couple where there were real concerns. Morecambe Bay was in that middle place, but it was one that was perhaps at the 'keep an eye on' –

PROFESSOR MONTGOMERY: So, just to put it back, that's the sort of: I can't quite put my finger on it and I can't prove it, but if I were staying, I'd be keeping a watchful eye on this one.

MS MCMILLAN: Keep an eye on it – yes.

PROFESSOR MONTGOMERY: Yes. Thank you.

DR KIRKUP: I am still concerned about this difference between whether you're dealing with an individual case here in maternity – and while there might have been some other SUIs, they weren't related – or whether there was accepted evidence that there were systemic failures. Can you help me out with that one?

MS MCMILLAN: I don't think at that stage there was... There are two different questions there, isn't there? So, there's the question about 'was Alan concerned that there might be systemic failures?' and there's the question about 'were the SUIs the evidence of systemic failures?'

DR KIRKUP: No – I was trying to park the SUIs. I was trying to say that actually there's a perception here, which is being put to us pretty strongly, that the Titcombe case alone, regardless of the others, was clear evidence of systemic failures in the Trust. But then it doesn't seem to have been treated as that.

MS MCMILLAN: No.

DR KIRKUP: It seems to have gone into – well, it's one case, and the Ombudsman's decided not to investigate, so we're going to –

MS MCMILLAN: Yes. I think at that time – and, you know, you always have to be careful because you can put benefit of hindsight on these things – but at that time the clear picture was there had been five SUIs; they had all been investigated. They had all raised obviously specific concerns. There wasn't a common systemic thread to them. There were some connections, like I think there was – there'd been – one of the SUIs was post-Joshua, and the baby hadn't died but there'd been an infection that hadn't been picked up, so that was the same issue twice.

DR KIRKUP: You see, if you don't mind me saying so, you're focusing on the clinical links again, not the behavioural ones. But –

MS MCMILLAN: Right. Yes, yes. So, I suppose what I'm reflecting –

DR KIRKUP: I want you to leave the five SUIs aside. Was the Titcombe case accepted within CQC as evidence of a systemic failure in the Trust? Because the Ombudsman thought it was. Did you?

MS MCMILLAN: Prior to my arriving in the region, the review – there'd been a review of the Joshua Titcombe case, and that review identified things that needed putting right. And without being able to look back, it is possible that some of those things that were identified were systemic things, because you would expect that where something had gone wrong. It's unusual for it to be entirely human error, so I would have to revisit the time when that review happened to comment on it. What I would say was it is highly likely that in the review the actions were partly in response to systemic issues and partly in response to maybe human error issues or, you know, maybe a training issue or whatever. So, a review was done which identified what those issues were. I can't tell you now this minute, but I could if I looked at it, whether there were systemic things in there. That would've formed Alan's view about what needed putting right, but it would also have informed his view in his message to me that he believed that the Trust were addressing those. So, whether they were systemic or not wasn't a huge issue when Alan was doing the handover. The big issue when Alan was doing the handover was that this was a Trust where there had been concerns. He'd raised those concerns; others had raised those concerns; Monitor had paused their foundation trust pipeline process, and the Trust was undertaking a series of pieces of work to put right those areas. Some of them may well have – some of them would've been systemic. I can't recall the detail of precisely what the action plan was; I would be able to if I could

transport myself back to that time. And, as I say, the overall view that I came away with was that we needed to keep an eye, the Trust was taking action, it was important to check that they saw through those review actions from James Titcombe, and that's why we included them when we did the inspection in June 2010.

DR KIRKUP: Okay. I'm seeking help again with understanding what the position was, but if we accept that there's a view at the back-end of 2009 that the Titcombe case is evidence of systemic failure in maternity services across the Trust, and that CQC would consider very carefully the Trust's application for registration in April 2010, can you reassure me that the action taken by CQC between the back-end of 2009 and registration in April 2010 was proportionate to that expectation? Because I'm not quite picking that up.

MS MCMILLAN: I can't reassure you in the sense that I wasn't the person who was there doing that work.

DR KIRKUP: But you had the handover from February to April.

MS MCMILLAN: I saw the end result of the work. Yes – so I saw the end result of the work, and the result of the work was the registration assessment document, which had the concerns, the evidence that had been sought, what that told us, and the outcome of the registration assessment documentation, which included references to maternity.

DR KIRKUP: And were you satisfied that the CQC had considered that very carefully, i.e. not just as a routine like any other Trust?

MS MCMILLAN: Yes. Yes.

DR KIRKUP: Yes.

MS MCMILLAN: There was nothing to indicate to me that we hadn't been as robust in the process with Morecambe Bay as we had any other Trust that we were registering. But I suppose what you're saying to me is were we more robust for Morecambe Bay because we knew there were concerns.

DR KIRKUP: Yes. Given that starting position, I want you to be more robust.

MS MCMILLAN: And I wasn't the regional director when that assessment would've been happening, so I find that quite hard to comment on. Because the assessment would've happened at the point where Alan was the regional director, and it had finished by the time I arrived.

DR KIRKUP: Okay. Thank you.

MS MCMILLAN: Sorry I can't be more helpful on that; it's just difficult to comment.

DR KIRKUP: No, no – that's fine. I understand; you've set out your position clearly. Thank you. Anyone?

PROFESSOR MONTGOMERY: Just one: you have described your reaction to reading the Fielding Report [inaudible] it wasn't sent to you officially, as it were.

MS MCMILLAN: Yes. Yes.

PROFESSOR MONTGOMERY: And it leapt out to you that there's a systemic problem here that needs to be thought about.

MS MCMILLAN: 'Oh, there's potentially a systemic problem here,' yes.

PROFESSOR MONTGOMERY: Did you discuss that interpretation of it with colleagues in the SHA or elsewhere? Because we've seen various documents which have used Fielding as an illustration that there wasn't a systemic problem.

MS MCMILLAN: Yes. Yes.

PROFESSOR MONTGOMERY: So, I'm quite that that? was your immediate impression of it.

MS MCMILLAN: Yes. I'm trying to recall precisely what I would've said to the SHA, and it's quite difficult all this time on. I can recall that when I went to the – I didn't pick up the phone and immediately call them, because we needed to have discussions within CQC about what we were going to do with this document. And those discussions had to be partly practicalities about how we were going to use a document that officially we weren't supposed to have. But also we needed to decide whether we were going to go to maternity earlier, and I've explained that to you, but at my next meeting with the SHA I can recall specifically raising the report. Did they know of its existence? And they did. Had they realised that it hadn't been shared with us? And they hadn't. There would've been a conversation that followed where I think the SHA – I think the SHA, and I can't remember the words – would have sought to reassure me that, because they were aware of the report, that they would – they'd had conversations with the Trust about that, and it had been built into the work they were doing with the Trust about improvements. But to be honest, I don't think I would have particularly taken an awful lot of notice of that at that point, because I was getting increasingly concerned – other events happened during that period. For example, there was an issue about emails, and the midwives and emails, and I got involved in that. There was a mounting level of concern, and I suppose I was listening less to what the SHA was saying, if I'm honest.

MR BROOKES: It's a slightly different thing [inaudible] to that. I am just interested – we've touched on this before, but I am just – I have to say I am surprised that

Gold Command was called. Are you aware elsewhere, for similar events, of how they've been handled?

MS MCMILLAN: Similar events. This is the only – so, a warning-notice type of arrangement following –

MR BROOKES: Yes, yes. Something – we're accepting there were serious problems at the Trust.

MS MCMILLAN: Yes.

MR BROOKES: But you might argue that the Strategic Health Authority with its management of the market responsibility could bring together the key component organisations without having to call a Gold Command, which was not really designed for these long-term interventions etc. I'm just interested in –

MS MCMILLAN: I was a bit taken aback. (see letter 1027 SM 01)

MR BROOKES: It tells you something about the organisation, and its relationship with other organisations.

MS MCMILLAN: Yes. So, the relationship between us and the SHA you mean, or in terms of –

MR BROOKES: No, no – it's about how it's managing its responsibilities as the Strategic Health Authority in terms of managing the market and performance management responsibilities – its feeling of authority and power around the delivery of its responsibilities.

MS MCMILLAN: I think – well, I was surprised that a Gold Command process was initiated. I'd been involved in the Gold Command process that had taken place ~~within~~ another Trusts in the months preceding this. Circumstances were entirely different.

MR BROOKES: Absolutely: time-limited, very specific [inaudible] issue.

MS MCMILLAN: And I was a bit stunned, I think, that that approach was taken, and I do recall telephoning Amanda Sherlock and telling her what the SHA had done, and her saying, 'Why have they done that?' And I don't know entirely why they did it, other than it was about it was saying there are lots of – they were taking control of the situation or that it was a statement about the taking control of the situation. It's – it remains a puzzle to me, I suppose.

MR BROOKES: Ann, have you got any observation?

MS FORD: I think Sue's right. I think they established Gold Command because they'd seen it work effectively in the other Trust. I've only ever seen it used once when there was, you know, very specific – a murder. You know, when – and that – I felt it was appropriate to that. In this instance, I think it was about the SHA – it was almost – and the other partners posturing, if you like, about, you know, 'We're taking – we'll get a grip of this.' And I think it was that sort of thing – that was the impression I got of it, because I really didn't see why the Gold Command could – achieved other than what good, robust performance management by the SHA would've achieved.

PROFESSOR MONTGOMERY: Who was the audience for that posturing, do you think?

MS FORD: I think the wider economy.

PROFESSOR MONTGOMERY: So, it was a local audience, in your view.

MS FORD: Yes. You know – yes.

MS MCMILLAN: Oh yes. Yes. I mean, the first meeting called, there were probably about 20 people in the room, including myself and including representatives

from the Trust, the PCTs, Monitor, etc. And the SHA were very much in charge. It was their meeting.

PROFESSOR MONTGOMERY: Okay. That sounds most interesting. Thank you very much.

DR KIRKUP: Okay. Is there anything else that you would like to say to us? It's not compulsory, but you can.

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

MS FORD: No. Thank you very much, gentlemen. Thank you.

DR KIRKUP: Okay. Thank you for coming.

PROFESSOR MONTGOMERY: Thank you – that's very helpful.

MR BROOKES: Thank you very much.
