THE MORECAMBE BAY INVESTIGATION

Wednesday, 12th November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth -- Expert advisor on Paediatrics
Mr Julian Brookes – Expert advisor on Governance
Dr Catherine Calderwood – Expert advisor on Obstetrics

SARAH SEAHOLME

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(at 2.17 p.m.)

DR KIRKUP: Right, thank you for coming. Apologies again. My name's Bill Kirkup. I'm chairing the investigation panel. I'll ask my colleagues to introduce themselves to you.

DR CALDERWOOD: I'm Catherine Calderwood. I'm an obstetrician in Edinburgh and a medical advisor for the Scottish Government, and also the national clinical director for maternity and women's health for NHS England.

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

MR BROOKES: And 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.

DR KIRKUP: You've seen that we're recording proceedings. We'll make an agreed record at the end. You may also know that family members are entitled to be present during interviews, but as it happens we don't have any here today, but they may listen to the recording subsequently. And you'll also know that we've asked you to hand in any recording devices like mobile phones. That's just to emphasise we don't want anything to go outside the room until we're ready to produce a report with everything in context. Do you have any questions for me about the process?

MS SEAHOLME: No, I think it's quite clear and hopefully I can help you with any questions.

DR KIRKUP: Yes. Thank you. I'll start off with a very general question before passing you on to colleagues. And my general question is can you tell me

when you started at the CQC, where you came from, what you did and how long you were there?

MS SEAHOLME: Okay. Well, I originally trained as a podiatrist and then I've had various roles within community and acute trusts, moving in to, kind of, like, clinical governance type roles. I joined the Healthcare Commission back in about summer 2005, and that was as an ~~investigating~~ investigation manager. And then I stayed with the regulator throughout its transitions, and I became a compliance manager in May 2010, working in the Surrey area. And then I moved on from that to be head of regional compliance in London, which covered the whole of London, looking at all sectors: hospitals, primary care and adult social care. And currently my role is interim deputy chief inspector for primary medical services in London.

DR KIRKUP: Okay. You have a role in relation to the investigations team in CQC?

MS SEAHOLME: Yes, so –

DR KIRKUP: When does that fit into the story?

MS SEAHOLME: Yes, so when I first joined the healthcare commission, that was joining the investigations team, and I was an investigation manager.

DR KIRKUP: Right.

MS SEAHOLME: And I was an investigation manager for about five years.

DR KIRKUP: Right. And what area did you cover in – when you were investigations manager for CQC? That's what I'm specifically – you mentioned Surrey, but you had a wider role than that I think.

MS SEAHOLME: Yes, sorry. The investigation team was a national role, so I covered all of England. We accepted referrals from a wide variety of sources: from the public, from the media, from our own surveillance and intelligence, in

particular our mortality outliers, but also from whistle blowers and also referrals from the regions that they could refer to the investigations team.

DR KIRKUP: Right, thank you. When did that come to an end?

MS SEAHOLME: May 2010 I transferred over to become a compliance manager.

DR KIRKUP: Okay. So you were still head of the investigations team in – until May 2010?

MS SEAHOLME: I was just an investigation manager, yeah.

DR KIRKUP: Sorry, not head of the investigation team.

MS SEAHOLME: Yeah. No, unfortunately not.

DR KIRKUP: Okay, I beg your pardon. I was slightly misinformed on that point. Julian?

MR BROOKES: Okay. If you could just – we could just carry on from that. So if we look back at your time as an investigations manager can you just give a – sort of an outline of what that meant? What were your – what was the role you were doing.

MS SEAHOLME: Yes. So when I was brought in as investigation manager they had a specific role in mind for me. And my role was to review all the new referrals that came to the investigations team. So, as I said, it was a national role, so I accepted referrals from all parts of the country, and we had an investigation criteria that we reviewed all referrals against. So when I received a referral to the investigations team I would undertake what we called was a first look, which was a look – a fairly quick look at the referral to see if it met the investigations criteria. And then at that point I would decide whether it met the criteria and we would take the case on as an initial consideration, which was a

further, more in depth look at the concerns, or that we would not accept the case.

Once we accepted it as a case, as an initial consideration, we would do a review of the concerns. We would talk to the trust, we'd quite often ask – request information from the trust too about the concerns. We'd talk to the referrer. We'd get information from our mortality, our surveillance information, talk to the region to build up a picture about the concerns. Quite often at this point it would require a visit to the trust. And when we did our visit to the trust it would be with an expert in the field. So if it was maternity we would take somebody with – either a midwife or an obstetrician with us to review the concerns. If it was mental health we would take a mental health expert with us.

And then on the basis of that visit, and we would gather all of the information to build up a picture, and then we would decide whether it – there was no case to answer with regards to the concerns and the trust was doing everything they could do, whether there was some things that needed to improve, and we would give recommendations to the trust, and sometimes there'd be more questions than answers on our findings so we would recommend that an investigation took place, and that would go to our investigation committee.

MR BROOKES: Okay. So at that stage still that was still the preparation for a potential investigation.

MS SEAHOLME: Yes. We didn't do very many full investigations. I've had a look at our numbers and we had about – around 600, kind of, like, referrals to the investigations team through that period of time that I was there, and we had about 19 full investigations.

MR BROOKES: Okay. So within that process did you receive a referral for Morecombe Bay?

MS SEAHOLME: Yes.

MR BROOKES: And could you just take us through where that got to and the consideration it was given?

MS SEAHOLME: Yes. So I received a referral from the regional team, and that – I received it on 22 May.

MR BROOKES: Is that the normal route for referrals? Is it that the majority would come through the regional team?

MS SEAHOLME: As I said, we were quite open about where we got our referrals from. We got some from the public, from whistle blowers, from our regional team as a result of our own mortality outliers. That would tend to trigger referrals as well. So it wasn't just the regional team. I'd be receiving referrals from other sources.

MR BROOKES: And in this particular case what had triggered the referral from the regional team?

MS SEAHOLME: In this case it came from the regional team.

MR BROOKES: Yeah, but what had triggered the referral from the regional team? What incidents?

MS SEAHOLME: Yes. So when they referred the case to me they referred it after receiving some information about a baby death that they had at Morecombe Bay.

DR KIRKUP: Can I just clarify when the referral was made. You mentioned a month, but I didn't get the year.

MS SEAHOLME: 22 May 2009.

DR KIRKUP: Thank you. Sorry.

MS SEAHOLME: And that was from Julia Denham, the area manager in the region.

MR BROOKES: Okay. So you received the referral. Could you just go then through what steps were taken?

MS SEAHOLME: So this is when I undertook the first look. So at this stage what I do is I look at the referral, see what information is given to me in that referral and make a decision about whether it meets the investigation criteria. So in the information that Julia sent me, she sent me the independent review of the care of Joshua Titcombe. Within that –

MR BROOKES: Sorry, the independent review, who carried that out, that particular [inaudible 0:10:34.5]?

MS SEAHOLME: I can double check. There was quite a few external reviews, so I can –

MR BROOKES: Exactly. That's why I'd like to understand what you received.

MS SEAHOLME: Yeah. So I can double check that for you, clarify which actual review.

MR BROOKES: Okay. Thank you.

MS SEAHOLME: I can picture it. Yeah, I'll need to come back to you.

MR BROOKES: Okay.

DR KIRKUP: Probably the [inaudible].

MS SEAHOLME: Yeah, can I just see the next page?

DR KIRKUP: Sure.

MS SEAHOLME: There was three people that were on the panel.

DR KIRKUP: [Hops, Chandler and Farrier?].

MS SEAHOLME: Yes, that's the one.

DR KIRKUP: Yes.

MR BROOKES: Okay, thank you. That's very helpful.

MS SEAHOLME: Thank you. So I was aware of that review. Within the referral there was also some emails from Monitor, which detailed a number of SUIs, so I knew that the trust had 12 SUIs and that there was five in particular that were connected to maternity. I was also aware that there was a letter from James Titcombe to the Parliamentary Health Ombudsman requesting a review of their case, because they weren't happy about the trust response. So I was aware of those things. Also in the email that I could see from Monitor, that I was aware that there was a number of reviews happening, that there was three reviews. I knew that there was one that was happening with the LSA into the practice of the midwife. I knew that there was the clinical case review that we mentioned just now, and also another management review that was also happening with regards to the concerns.

MR BROOKES: Was that the Fielding Report? Was that being undertaken by Dame Fielding?

MS SEAHOLME: I can double check. I think in the email it just said a management review taking place by a chief executive under another trust.

MR BROOKES: Okay.

DR KIRKUP: Is that not Charles Flynn.

MR BROOKES: That was Charles Flynn.

DR KIRKUP: I think that's the Flynn report.

MS SEAHOLME: Charles Flynn, yes. So I didn't actually see that, but I knew that it was happening. So I had this information, so I reviewed that and on review I felt that it didn't meet the criteria for investigation at this stage.

MR BROOKES: Can we just expand that slightly? I'd be interested on why, what were the criteria, and therefore why was the conclusion that?

MS SEAHOLME: Yes. So our criteria for investigation was that there'd be – there needs to be a risk to the safety of patients, and that would be a higher number of unexplained deaths, serious harm or abuse, that there'd be a pattern of adverse events, and that would be within an area, or potentially serious failures in teams that had been highlighted. And potentially within the criteria we could be requested by the Secretary of State of Health to carry out an investigation. What we didn't investigate was individual complaints. We didn't investigate individual concerns about professional misconduct. We didn't investigate service configurations and we didn't – or mergers. We also didn't look anything that was going through a legal process, and this was to avoid, kind of, like, over – kind of, like, burden and, kind of, like, duplication of work.

MR BROOKES: So the fact that there was an investigation or a complaint in with the ombudsman was not relevant to your criteria?

MS SEAHOLME: It was relevant in the sense that I knew that –

MR BROOKES: It wouldn't stop you from doing the investigation?

MS SEAHOLME: It wouldn't stop me if I felt that there was – it needed it, but also I was aware that there was – we wouldn't look into the individual case of Joshua Titcombe. We would be looking to see if there was a pattern or a trend in – or a high number of deaths, etc.

MR BROOKES: Yes, and I'll come back to that, but I just want to be clear, because there's been some confusion about the interrelationship between some of these reports, some of the different bodies getting involved, but as far as you're concerned the criteria under which you're assessing whether to do an

investigation or not, it wouldn't be a factor which would automatically stop you doing investigations like the legal action – legal case going on or criminal case being heard?

MS SEAHOLME: Yes, because if we did look at it we wouldn't be looking just at that individual case. We would be looking at the whole picture at the trust. We'd be looking at all the deaths that had happened. We'd be looking at how the whole maternity unit was working. We wouldn't necessarily concentrate and dig down into what happened in that particular case.

MR BROOKES: Okay. Were you made aware at the time that this was a – that the cluster, which I'll come back to, of cases, was also a reason for a pause in the FT application?

MS SEAHOLME: No.

MR BROOKES: Okay. That's alright.

MS SEAHOLME: I was aware that Monitor – that the trust was coming up for foundation status, and that they were asking our opinion on – of the trust, but not that it was causing a pause in the process.

MR BROOKES: Okay. If we go back then, just to those cases, because, as you've said, one of those is patterns of adverse events. You've already identified that there were 12 cases, five of which related to maternity services. Surely that is a pattern? I'm just trying to understand why that was discounted.

MS SEAHOLME: So as I remember when I was looking at the case, I was focussing on the maternity aspects of the concerns. So although I knew that there was 12 I was particularly looking at the five that were related in to maternity. At the time we also had quite a good mortality outlier programme that was being run, which was run on a monthly basis, that was looking for trends about – and

trying to highlight any outliers with regards to mortality for both mother and baby deaths. And I was aware that Morecombe Bay hadn't triggered on that surveillance programme, so I knew that it – there wasn't – according to the surveillance data there wasn't a trigger that there was an abnormally high number of deaths happening at the trust.

When I looked at the five SUIs, I – obviously all very serious incidents and very tragic, but I couldn't see – I didn't think that there was a pattern within that five. And two of them I thought were, kind of, like, unavoidable, and the maternity department wouldn't have been able to prevent those cases.

MR BROOKES: Okay. On that, a couple of things: did you take any clinical advice about those cases?

MS SEAHOLME: No, I didn't.

MR BROOKES: Okay. And was your conclusion drawn on purely your view of those cases, or was it influenced by additional information coming from other outside sources? So in other words, had others looked at those cases and provided you with an assessment of how they felt, or was it your assessment?

MS SEAHOLME: It was my assessment. I made the decision based on the referral that I received and the information that I've just gone through. I'm not an expert in maternity issues, but I had had experience of other maternity cases that we'd handled through the, kind of, like, investigation process, and I felt, on looking at the SUIs, that it wasn't – there wasn't a pattern there.

MR BROOKES: So you looked at the root cause analysis?

MS SEAHOLME: No, I just – all I had was a – the list of SUIs, about the main causes of death.

MR BROOKES: Okay. One of the reasons I'm pressing on this is just that we've come across a number of places this has – an assumption that the five cases were not related.

MS SEAHOLME: Yes.

MR BROOKES: And I'm just – we're just trying to bottom out where that's come from. And from what you're saying, that was a conclusion that you reached in terms of your assessment, because it's repeated in lots of different places.

MS SEAHOLME: Yes. So that's the – that's what my conclusion came to when I looked at the five cases. If I'd accepted it as an initial consideration then we would have asked the trust for all the five SUIs investigation, we would have asked for a bit more detail in order to, kind of, like, dig a bit deeper, but this was a first look, so it was a – we didn't go into as much detail at that stage.

MR BROOKES: Often with these kinds of cases it may not be clinical causes; it's the underlying culture and systems that lead to these cases, which might manifest in different ways.

MS SEAHOLME: Yes.

MR BROOKES: It sounds to me – I'd like you to just confirm this one way or the other, whether you had enough information to make that kind of judgment on what you saw, because it sounds to me like it was quite high level what you were looking at, in terms –

MS SEAHOLME: It was very high level. This was the – wasn't the only reason why I didn't accept it as an initial consideration into the investigations team. The other thing that I looked at was to see what the response of – of the trust, so I was aware that the trust had taken action with regards to this SUI, and that there was a number of external reviews happening with recommendations. So

I was confident, in that sense, that the trust was being responsive to the concerns and that they were looking to learn from the SUIs.

MR BROOKES: Is that a reason not to investigate?

MS SEAHOLME: That's not a reason not to investigate, and one of the things that I think is important to note is that, yes, I did say that I didn't feel like it met the investigation criteria, but that's not that I meant that we'd have no further involvement with regards to this case. And in my feedback to the region, what I advised the region was that they should follow up with the trust the outcome of the SUIs and the action plan, to make sure it was implemented, and also follow up with the parliamentary health ombudsman with regards to their findings. And as a result of that they could always come back to the investigation if they thought that the concerns weren't being – the improvements weren't being made or it wasn't being managed well. But I did feel that there was a lot of activity that was happened already with regards to the maternity that it didn't need somebody else coming in to do another, kind of, like, review.

MR BROOKES: So just so I'm clear, against your criteria what did the referral fail to meet which would have triggered the next stage? What were the factors it didn't –

MS SEAHOLME: What was the area – well, yes. So it was the – that there was action by the trust in order to address the issues, the parliamentary health ombudsman was reviewing the case, and that was being – that was in progress. It didn't appear on the mortality outlier surveillance data as a high – as an outlier, for women or the babies, and on review of the incidents I didn't feel that there was a pattern there.

MR BROOKES: If there had been a pattern, how would that have impacted on your review, on your judgment?

MS SEAHOLME: If there was a pattern I would have accepted it as initial consideration into the investigations team. And what happens then is that it's allocated to an investigation officer and we dig a little bit deeper into what the concerns are. So we would initially do a documentation request to the trust and ask for the SUIs, to ask for some key maternity documents, particularly looking at the governance arrangements at the trust and how they learn from things.

We would quite often do a visit to the trust, which would be an announced visit, which would be with a – experts with us, to the team. And within that we would look – we'd speak to key people in the maternity unit as well as having a walk around and talking to staff in the unit to, kind of, like, get a feel of how things were working in the unit. From then we would decide whether we felt that the trust was doing enough action or not. We would make a decision about whether we'd give recommendations, or if we felt that there were still lots of concerns at the trust then we would request an investigation, a full investigation.

MR BROOKES: Okay.

MS SEAHOLME: Sorry.

MR BROOKES: I understand that. That's very clear. That's very helpful. What I'm – the decision was solely down to you. What was the governance and the review of decisions being made by yourself in this role?

MS SEAHOLME: So we had an action log that we logged all our referrals that came to the investigations team. And on a monthly basis we had an investigations

committee, which was chaired by one of our non-execs and had a broad range of people. We had three non-execs on the investigations committee as well as clinical advisors as well. And every month I would go through the new referrals that had come through.

MR BROOKES: Okay. So they would basically endorse the decision or your -- so it was a recommendation from you to that committee. They were the ones that would make that decision. Is that how it worked?

MS SEAHOLME: No, I would make the decision, as the investigation manager, but it would be logged, it would be – and the, kind of, like, formal process was that the log went to the investigations committee for comment or review, and then I talked through that every month.

MR BROOKES: Okay. And just remind me, you said there was about 600 cases in a year referred to you. How many –

MS SEAHOLME: Not in a year, sorry. That was over the five years that I was –

MR BROOKES: Okay, that's why –

MS SEAHOLME: Yeah.

MR BROOKES: That's why I wanted to check.

MS SEAHOLME: That would've been busy, yes.

MR BROOKES: And how many of those went forward to investigation?

MS SEAHOLME: We had 19 full investigations.

MR BROOKES: 19. And how many went through to second stage of investigation.

MS SEAHOLME: I would have to double check that number, but it would be – I wouldn't –

MR BROOKES: I accept that. Was it a half? Was it a quarter? Just as –

MS SEAHOLME: It would be about half, half of that number.

MR BROOKES: Okay. Did you, as part of your assessment of this case, talk to the regional team that had referred this to you?

MS SEAHOLME: Yes.

MR BROOKES: And what was their view?

MS SEAHOLME: Well, I fed back my findings to the region through email, and I did have a conversation with Julia Denham, but I must admit I can't remember that conversation. I know that I had it because I've seen it in an email, but I can't remember that conversation. On reflection, what the process was not good at was having that conversation before I'd made the decision.

MR BROOKES: Well, that's what I was wondering.

MS SEAHOLME: Yeah.

MR BROOKES: Because clearly they had sufficient concerns to refer it for an investigation, which is not something they'd do lightly.

MS SEAHOLME: Yes.

MR BROOKES: And they may be sitting on information which –

MS SEAHOLME: That I didn't have.

MR BROOKES: – you're not aware of.

MS SEAHOLME: Yes.

MR BROOKES: Okay. So did you speak to the Strategic Health Authority at all?

MS SEAHOLME: No.

MR BROOKES: Okay. You mentioned that there was an opportunity to re-refer cases. Was this ever re-referred back to you?

MS SEAHOLME: No.

MR BROOKES: Okay.

MS SEAHOLME: No, never – didn't receive it back.

MR BROOKES: Okay. Did you have any further involvement with Morecombe Bay?

MS SEAHOLME: No.

MR BROOKES: Okay, thank you.

MS SEAHOLME: No, it was just that first look.

DR KIRKUP: Just before I lose the couple of thoughts, there's a couple of specific points from that that I want to follow up on before I pass you onto other colleagues. Just starting with that last one, I think you – one of your – one of the outcomes of you deciding not to investigate was that the SHA should follow up the reviews and also monitor the outcome of the PHSO case, but then you say you didn't speak to the SHA.

MS SEAHOLME: Yeah. No, not the SHA, the area team. Sorry, did I –

DR KIRKUP: CQC area team?

MS SEAHOLME: Yeah, CQC area team.

DR KIRKUP: Okay. And was that part of the email that you sent to that team?

MS SEAHOLME: Yes.

DR KIRKUP: Right. It may have been part of the conversation.

MS SEAHOLME: Yes.

DR KIRKUP: Okay.

MS SEAHOLME: I can't imagine me not saying that in the conversation, because –

DR KIRKUP: Okay. And just to clarify, you didn't speak to Julia Denham before you made the decision. Did you speak to Alan Jefferson?

MS SEAHOLME: No.

DR KIRKUP: You didn't speak to anybody before you made the decision?

MS SEAHOLME: No. The first look is quite a – it is what it is. It's a first look, so it's just looking at on the face of the information that I received did I feel that it met the criteria for further investigation.

DR KIRKUP: Yes, okay. And these five incidents in maternity that you were looking at, I think what you said is that the causes of death were unrelated to each other. How would you find out if there were any underlying human factors, like failures of team working or failures of relationships between different professionals? It wouldn't show up in causes of death.

MS SEAHOLME: No, you're absolutely right. I was going by the cause of the death. So I knew two of them were – one was a cardiac issue. I knew one was an amniotic embolism. There was two cases of infection, and – what was the last one? Then there was a stillborn. So I knew that – yes, you're right, I did know the outcomes. I didn't know the underlying team. What I – in my head at the time, if I remember rightly, I was thinking that the trust is taking this really seriously, that they had commissioned some external reviews, they were committed to – I felt that by doing that they were committed to learning, that they would do a good action plan to learn from the incidents, and therefore it didn't need somebody else to review the same information.

DR KIRKUP: Yeah, I see. The other thing, the final thing from me at this stage, is I picked up that you thought that on the basis of the preliminary look at the information that two of the five SUIs, the deaths were ~~unavoidable~~. What led you to conclude that?

MS SEAHOLME: I say unavoidable as in that as they presented to the maternity department I didn't think that – like the cardiomyopathy, for instance, the

cardiac one, was that. That would have been a very difficult one to pick up from the team.

DR KIRKUP: And the other one?

MS SEAHOLME: I think I was referring to the amniotic embolism.

DR KIRKUP: Yeah. It's rather difficult to come to a judgment about the vulnerability without reviewing the clinical details, isn't it?

MS SEAHOLME: Yeah. No, on reflection I think you are right. I'm not a maternity expert.

DR KIRKUP: Okay. Catherine?

DR CALDERWOOD: Oh, excuse me. Sorry. Sarah, thank you. It's very helpful. I think I picked up that the SUIs that you saw, you just saw the final bit, you didn't actually see the bits of paper or the process that came to that conclusion.

MS SEAHOLME: No.

DR CALDERWOOD: It's just the cause of death.

MS SEAHOLME: Yes.

DR CALDERWOOD: And I suppose it's likely related to Bill's question in that there are variations in what quality a SUI will be and what an individual hospital or even department within the hospital will – how thoroughly they will go through... There isn't a standard SUI, and is that something you would have been aware of? So your judgment is based on something that the trust has produced for you, that might be different had it been produced by somewhere else.

MS SEAHOLME: That's a good point. Obviously I am aware that SUI reporting is – can vary and you get over reporters and you can get under reporters. I think in this case I was taking the information at face value from what I saw.

DR CALDERWOOD: And might one of the difficulties, and you've been honest enough to say one of the difficulties with your process, might one of the difficulties with that, taking face value, is that if there's a trust that isn't performing, what they might produce for you mightn't be as – the best standard.

MS SEAHOLME: Yes. Yes, you're right. One of the things that I've said already, but I'll say again, just is that I didn't feel that my saying no to an investigation was that I felt that we should have no involvement with Morecombe Bay. I just felt that it didn't need an investigative review of maternity at this point, but what I did feel that we should make sure the trust follow through with regards to those external reviews and those recommendations, to make sure that they did implement their action plan and that we did follow up the Parliamentary Health Ombudsman review. And I did strongly believe that that should happen, and that we should still have an involvement, and any concerns that highlighted that there could be more of a deep rooted cultural or governance issue then of course that could always be referred back to the investigations team for further review.

DR CALDERWOOD: And what was the mechanism then for that follow up? So you've said there was an email, but did that say, 'You need to follow up and then that's the end of CQC's role'. You don't – or do you expect that loop to be closed?

MS SEAHOLME: Yes. So from my role as investigation manager, I closed this case once I referred it back to the region, in a sense, with that advice about needing to follow up the things I've mentioned. Each trust has a relationship manager and they're the people that keep the relationship of the trust. They monitor the

quality of work, they're involved in the – any inspections that we do etc, and all our assessments. So it would be up to that individual in order to follow up the concerns. So that's what I expected Julia Denham and her team to do.

DR CALDERWOOD: But then from your point of view you've done your part of the process and it's closed off.

MS SEAHOLME: Yes.

DR CALDERWOOD: You're not expecting to hear the outcome of any follow up.

MS SEAHOLME: No.

DR CALDERWOOD: That isn't within –

MS SEAHOLME: No, not in the first look, no.

DR CALDERWOOD: Okay. But somebody else, this relationship manager within CQC –

MS SEAHOLME: Within the CQC, yes.

DR CALDERWOOD: So we would be able to find what that follow up took.

MS SEAHOLME: Yes, yeah.

DR CALDERWOOD: That is an official part of this first look recommendation is a follow up, and then there's been recording of what actually –

MS SEAHOLME: Yes. No, so the first look was me closing it and then sending it to the region for follow up. The recommendations and follow up that the investigations would do is when we have actually done – we've accepted the case as initial consideration, and then we would get documentations from the trust, do our visits, decide if we need to do recommendations. If we send our letter with our findings, with recommendations, we would take – we would keep the – we'd keep that role with regards to following up, because we'd want

to make sure that we had the same team so we could see the improvement or not, if the case may be.

DR CALDERWOOD: So that's only if there's been a full –

MS SEAHOLME: If we'd accepted it.

DR CALDERWOOD: Yes.

MS SEAHOLME: Yes. So unfortunately I didn't accept it as initial consideration, so I didn't get to that – we didn't get to that point.

DR CALDERWOOD: That makes sense. And this may not be – this is a question that's your opinion, which – so I accept that. I know you don't know more about the cases or more about this, but do you see anything through your system with hindsight that would have made you make a different decision?

MS SEAHOLME: To be honest, yes, and I've reflected on my part of this case, and I wish I had spoken to the region before so I had more of the story. That may have made my decision that we'd accepted the case as initial consideration and gone into the trust to review. And I don't know what we'd have found on that visit, but I know then that I would have gone in and done a more robust review with the investigations team. And, yes, so I do worry that maybe my – if my decision was different then it could have changed things or made improvement happen quicker. Yeah. One of the things that – yeah, no. So yeah, no, I do, kind of, like, worry that I made the wrong decision at that point. At the time I was just – I was following a process that was quite strict. Yeah.

DR CALDERWOOD: Thank you.

DR KIRKUP: Stewart?

PROF FORSYTH: Just in relation to that, do think the process really doesn't – doesn't necessarily cater for really small units and incidents? I mean, I think

one of the – I think it's back to was there a pattern, you know. If you've got a small, isolated unit with a small number of births, small number of staff and you have four incidents – five incidents, the fact that you've got five incidents in a unit like that, to me, would be a pattern. And you may not see they're necessarily – immediately what the connection is, but, you know, that seems to me a pattern. And I just wondered, again if, particularly looking at your system, it's not – whether you really cater for – because you'll be getting referrals from large urban centres and small units, and just trying to distinguish what is important in one compared to the other.

MS SEAHOLME: Yes. I think it is a difficult decision and a judgment is made. We did have quite a high number of maternity cases that we did look at and we accepted as initial consideration. And I think with those there was other information that we had that, kind of, like, raised concern as well. So either we had a whistle blower from the trust that was raising concerns or there were a higher number of SUIs that we were aware of that made us think that we needed to accept that case. If I think of other cases, normally there's been, kind of, like, lots of things that have come in at once or over a short period of time that has raised our, kind of, like, intuition to say, 'Yes, we must go in here'.

So if I think of the Mid Staffordshire, which we did accept in the investigations team, which started off as initial consideration but then quickly escalated to an investigation, that was triggered by a patient group raising lots of concerns about mid-Staffordshire. Would that on its own have triggered an investigation? I'm not sure, because you could say that that was lots of issues that were happening that potentially would happen in any A&E. But with that strong evidence together – which was real cases – together with they would

keep triggering on our mortality outlier, made us really feel that there was a real concern there. So that's why – one of the reasons why we accepted it and undertook a visit.

PROF FORSYTH: And so –

MS SEAHOLME: So I don't – yeah.

PROF FORSYTH: But in relation to Morecombe Bay, there were continuing concerns being expressed by families, and I'd – and you said there was no – I think you've already indicated there was no, therefore, further loop round back to you with these continuing concerns, and therefore, 'Would you like to review your original decision?'

MS SEAHOLME: Yes. No, it didn't come back to me, but if they – if it had come back and they said, 'We've got X, Y and Z now that's also come in, we're more worried about this', then I think we probably would have accepted it.

PROF FORSYTH: And so you didn't have any further contact with Julia Denham?

MS SEAHOLME: No.

PROF FORSYTH: And her original referral to you, do you think it was comprehensive enough for you to – I mean, was there – would you have expected further information from her at that time to help you realise the potential gravity of this decision you were making?

MS SEAHOLME: Yes. I think what was missing was the context information and the history with regards to the – our interactions with the trust and the concerns with the trust, on reflection. So in hindsight, yes, I wish I'd had a good conversation with the region to really fully understand that. At the time the process didn't – that wasn't within our process, but on review I think that would have been the best thing.

PROF FORSYTH: I mean, you'll appreciate the reason why we're, sort of, focussing so much on this is because that was the message that then went to the trust, that these cases were unconnected.

MS SEAHOLME: Yes.

PROF FORSYTH: And then when they instructed a further review of the service they very much said to the reviewers, 'We've got these unconnected cases, and therefore we don't want you to review the cases, but look at how we're our practice'. So in fact it did, sort of, send the trust probably down a different path that [inaudible] taken.

DR CALDERWOOD: Although to be fair, Stewart, that wasn't Sarah's –

PROF FORSYTH: No, no, I'm just saying why we're so interested in this particular time and that particular review.

MS SEAHOLME: Yes.

PROF FORSYTH: Thank you.

MR BROOKES: No, just to, out of interest, it wasn't therefore within the process to triangulate the different sources of information, so to automatically go to, say, the commissioners or the region as well as that, to try and just make sure that what you'd got was a [inaudible]. That wasn't part of the process. Is that correct?

MS SEAHOLME: Unfortunately, it is part of the process but only when I – when you accept it as initial consideration. The problem with this case is that –

MR BROOKES: You never got there.

MS SEAHOLME: – it didn't even get past the – it didn't get past the criteria stage, because I didn't feel that at the time that it met the criteria, for the reasons I've outlined. If I'd made the decision – if we'd made the decision that it was – met

the criteria and we accepted it, exactly, Julian, we would have done all those things.

MR BROOKES: Yes, okay. It's just that stage. Thank you.

MS SEAHOLME: It was -- unfortunately we didn't accept it, yeah.

MR BROOKES: Yes, I understand. I understand.

DR KIRKUP: I'm trying to complete a little bit of information. I'm sorry to be slightly nit-picky but I just want to be absolutely clear about dates and times if I can.

MS SEAHOLME: Of course.

DR KIRKUP: You've very helpfully told us that the referral by the regional team was 22 May 2009. When did you communicate the decision that it wasn't going to be investigated?

MS SEAHOLME: 27 May 2009.

DR KIRKUP: Right, okay. And when was the investigation team formally wound up, because I think we've got a bit of conflicting information about that.

MS SEAHOLME: Yes. Well, we became the Care Quality Commission in April 2009, and then I became a compliance manager in May 2010.

DR KIRKUP: So was the investigations team in existence until May 2010?

MS SEAHOLME: Yes, but it was winding down. I knew that it wasn't going to be in existence before that Christmas, because we were going through, you know, consultations about our roles, about what we were going to go to.

MR BROOKES: Was it still accepting cases? Sorry.

MS SEAHOLME: I was still working and I was still accepting cases and reviewing work. We did have a depleted team because as people were leaving for other jobs they weren't being replaced. So we did have less resource, but --

DR KIRKUP: Did that affect any of the decisions whether to investigate or not?

MS SEAHOLME: No.

DR KIRKUP: Was that part of your thinking?

MS SEAHOLME: No. And we actually had one investigation that was – that did take place that year, that was accepted in that period. So it wouldn't have accepted – it wouldn't have changed my decision to take on a case.

DR KIRKUP: Right, okay. And when you communicated the decision, was it about the unconnected cases part of that communication? When you said, 'No, we're not going to investigate', you told the regional team, was – 'and part of the reason for that is the five cases don't – aren't linked'. Was that part of that communication?

MS SEAHOLME: If I remember rightly I think it was. I think I would have said.

DR KIRKUP: And did you tell – sorry.

MS SEAHOLME: I think I would have said that.

DR KIRKUP: Did you tell anybody else that you thought that the five cases were unlinked?

MS SEAHOLME: No.

DR KIRKUP: Just the regional team?

MS SEAHOLME: Just the regional team.

DR KIRKUP: Okay. Is there anything else that you would like to tell us?

MS SEAHOLME: Well, I hope I've answered your questions. I was only – I was part of this for a very short time, but I can see that it was quite crucial in the progression of the case. On reflection, I really do feel that if I'd accepted the case it would have – there would have been more focus on the trust and that maternity. I'm really sorry that I didn't make that decision at that time really.

DR KIRKUP: Okay. Well, thank you for saying that. We appreciate that, and there are one or two people similarly looking at things in hindsight, so please don't feel you're on your own there.

MS SEAHOLME: Thank you.

DR KIRKUP: Okay.

MR BROOKES: Thank you very much.

DR KIRKUP: Thank you everyone.

THE MORECAMBE BAY INVESTIGATION

Monday, 24 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert advisor on ethics

VEENA SHARAN

Transcript produced by Ubiqus
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(At 2.18 p.m.)

DR KIRKUP: Hello, thank you for coming. My name's Bill Kirkup, I'm chairing the investigation panel and I'll ask my colleague to introduce himself to you.

PROF MONTGOMERY: I'm Jonathan Montgomery, I'm Professor of healthcare law and University College London, and Chair of the Health Research Authority, and in the past I've chaired PCTs, Provider Trust and SHF.

DR SHARAN: Thank you for that.

DR KIRKUP: You will see that we are recording proceedings and we will produce an agreed record at the end. You may also know that family members are entitled to be here as observers, and we have a family member present today. Others may listen to the transcript subsequently. We also have a second closed part of the session, where we may ask you some confidential, clinical details about one or two cases, but I'll mark when we start that and you will see people leaving the room.

You will also know that I ask you to hand in any mobile telephone, recording device, laptop; it's just to emphasise we don't want anything to go outside the room until we are able to adduce all the findings in context. Do you have any questions for me about the process? [*Pause*] Any questions about the process?

DR KIRKUP: Are you happy with how we are going to do it?

DR SHARAN: No. I am very nervous.

DR KIRKUP: Okay, look, the objective is to have a conversation about it, as many of the relevant aspects in the Trust as we can. We're not here to try and catch you out, we just want to know your views on how the unit worked and so on, whatever you can tell us to help us. I hope that's helpful.

DR SHARAN: I will try.

DR KIRKUP: Alright, thank you. Perhaps I could start by asking you if you could tell me when you started at the Trust and what you did there, and for how long?

DR SHARAN: I started on 2 March 2002 and I worked until 16 December 2010.

DR KIRKUP: And did you retire?

DR SHARAN: Yes.

DR KIRKUP: Okay and you were a consultant obstetrician?

DR SHARAN: Yes.

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

PROF MONTGOMERY: And were you based at Furness General for the whole of that time?

DR SHARAN: Yes.

PROF MONTGOMERY: Thank you. I'm ask you about some general things, I think we may have to move into confidential session for more specific things, but I wanted to start by you helping us with how quality issues were managed in the unit. So, we've obviously heard a lot of things about clinical governance systems or lack of clinical governance systems. I just wonder if you could describe how, in the hospital, in the maternity services on the unit, try to understand how well it was doing and how it could improve services. I'm not asking for details of any individual cases, it's about that system, what information you had, what meetings were had to try and understand the quality issues.

DR SHARAN: I think there is almost set guidelines how to run the labour ward and the essential management or everything would be in place for every unit, which is almost mandatory these days. And most of the things we did, like we had a review of cases nearly per week, how many deliveries, what happened and everything. We also had feedback from the unit. There was incident reporting was a very important function for everybody and everything was, however the size was, small or big things – you used to try to report it. There was the risk management group, then there were monthly meetings for labour ward management, we had perinatal mortality meetings, we had weekly teaching sessions, we had foetal heart monitoring practice, everybody had to do so many hours on the line.

The Registrar will be encouraged on his weekly meetings to discuss anything that they wanted to discuss with what went well, what has not gone so well, or what was you know, needed improving. We did all this. We did a review of the audits, anything that was brought up added difficulty, we used to put it to clinical director, he will then possibly discuss with us and if appropriate he would put it to medical director, maybe I would review with the clinical director of the unit.

I think and we all had to have our appraisals and we all had to have our set training, you know, allocated at the meeting, at the time of it you have to complete this much of the things. So we discussed everything advised by the

Royal College of Nurses, as advised by the governance body.

PROF MONTGOMERY: Thank you, that's really helpful, there are just two or three of those I'd like to understand a bit more about if I may. The weekly review, who would attend that?

DR SHARAN: Weekly review was risk manager was definitely there, I think the one who was in charge of the labour ward, the consultant in charge of the labour ward could be anaesthetist; if they were free they used to come. I used to go to most of them because then I used to get overview of other things that happened beyond my duty time.

PROF MONTGOMERY: And was there a record of those that went round to people that worked there?

DR SHARAN: I presume they kept a record, because we used to sign our attendance and things like that. So there should be a record.

PROF MONTGOMERY: And the perinatal mortality meeting, how often would that happen and who would be at that one?

DR SHARAN: I was due to be – I think perinatal mortality meeting definitely happened, I can't remember exactly but it could be two monthly because it's a small hospital, the number of patients was not that big to discuss how they were that much time. We used to plan it, sometimes there were very few things that we could say, because the paediatrician also needed to come, everyone needed to come and join the thing. So, when there were three or four cases we would call a meeting. It was fixed by the paediatric unit and given the date and we would fix it.

PROF MONTGOMERY: So, it would be driven by having something to discuss?

DR SHARAN: Yeah, yeah.

PROF MONTGOMERY: Generally speaking maybe every other month.

DR SHARAN: Yeah.

PROF MONTGOMERY: Thank you. And the month labour ward meeting?

DR SHARAN: Monthly labour ward meeting was usually at lunchtime on the labour ward and were joined by the midwives. The risk manager, the anaesthetist, the paediatrician, junior – one of the – because everybody had their duties to do, so from one tier, one essential one would do it and things like that; one from every tier will be trying to join that meeting, yeah.

PROF MONTGOMERY: So, you'd have each of the professions represented?

DR SHARAN: Yeah, yeah.

PROF MONTGOMERY: And different tiers of medicine?

DR SHARAN: Yeah.

PROF MONTGOMERY: And what was the process for making sure that the people who couldn't be there learnt from those, so if you were there you would hear it directly, but would you be told what had gone on at those meetings?

DR SHARAN: Yes, we would find out what the discussion was, or we possibly sometime used to put something that we need to bring this thing up what has given us a bit of, you know, or concern or what has – we need urgently, and we would put this forward like we needed more syringe drivers because the anaesthetics department used to keep that so we thought that we need more to put something in driver, pain relief, or post-operative pain relief, transfer to neo-natal unit or the babies who will stay on the ward, and things like that. If they had been issues on anything like that we will know from before that we will talk about these things. And if I have missed that then I will say, "What was said? What did you do?"

PROF MONTGOMERY: And was there any formal system for follow-up; did you have minutes that you could then discuss at the next one to see whether the actions had happened? Was it formalised like that?

DR SHARAN: Yes, there was, there has been I think the risk manager used to take it up and possibly will follow and will let us know whether something has been – it was a little bit tedious to get anything moving quickly, but we did manage.

PROF MONTGOMERY: Okay, so a bit more about the tedium of getting things moving; are you saying that people didn't respond very quickly to issues that were raised? We're trying to get a sense of how easy it was for things to change, so what's your perception of it; if you had a concern; did you have concerns that you raised with management and did you feel that they were responded to?

DR SHARAN: Being operating in a ward hospital, it has its own difficulties and there are certain things which are – which had been there for pretty some time, possibly always be there, as long as the hospital is there, travel time, recruitment, good recruitment. So it's not that if we ask something now and I can get it within days, it was a little bit – also the resources maybe, I was not in with the money side management, but maybe they had problems with

allocating funding also.

PROF MONTGOMERY: And did you have any course, in the time that you were there, to raise concerns about the quality of care with the clinical director?

DR SHARAN: One thing I can tell you that I am aware that people were very competent. I don't think there was clinical incompetence especially I can speak for doctors definitely. Lack of staffing could be one thing because if somebody was absent or off sick, to replace somebody wasn't very easy. But small hospitals usually depend on good will of people for the work. If you want it bog standard, like any big teaching hospital, or any hospital if you compare that, you can't compare them, there is no comparison, because the set up that it is, so I would say that if you said what to rule, as for rule there are certain rules, especially for obstetrics, the department that we dealt with is extremely complex, and the rules are very black and white laid down, as for Royal College is concerned, this has to be done, this has to be, this has to be.

Unfortunately I think that that map won't fit into this small place. Like every 8 hour shift somebody should cover. Every unit has to be covered by one person sitting there. Obviously there aren't that many people to do that. So we have gone sideways on the rules, not knowingly, not by desire, but with where we are and how – what resources we have.

PROF MONTGOMERY: Is that something that you were discussing at the time, or is that something that you are saying on reflection?

DR SHARAN: No, I was very aware, I wasn't aware when I took job. But slowly and gradually I was aware because I worked at Leeds Teaching Hospital in Harrogate, which are very nicely set up and funded, so coming here then I realised that the set up would be different, because you know, but I was so used to of a busy schedule and busy work that it didn't affect me in any other way, because I could do all the things in the shortest time. But -

PROF MONTGOMERY: That's helpful.

DR SHARAN: Like you can't – like there was an elective Caesarean section list on Tuesday morning, and section list will have same type of patient that would be in the teaching hospital of big cities, like person that has repeat sections previously, two or three sections, premature babies, or not so well mum, things like that. Those are the things that we put on the list. But there wasn't a consultant assigned to do that list, to overview that list. The normal course

that would be the guideline that there has to be that and has to be supervised by the consultant anaesthetist and a consultant obstetrician, but in spite of me asking and insisting on that one, that never could happen. So what happened

PROF MONTGOMERY: So, who did you ask to try and get that?

DR SHARAN: The clinical director, who was the man in charge and we also spoke to, I brought it to the medical director also and I said that because so what happened, Tuesday morning used to ~~seme~~ be – most of the time, I think it changed at some stage, but it used to be my labour ward ~~system~~ session. But then the registrar called me in the theatre or the associate what we were doing, if there's anything difficult or anything that goes out of the way I will have to leave the labour ward and go to theatre. And I might be there for an hour, two hours, more; and so what will happen on the labour ward I will still be responsible for it, I will have to take the responsibility, but I'm tied up, I cannot come out.

And this worried me tremendously, tremendously, so I said that, you know, "I'm not saying give me that ~~assistant~~ session, but it should have been an ~~assistant~~ session for a consultant, but they were trying to get me to do work for one money, and yet make me responsible for both the things.

PROF MONTGOMERY: And was there any response to that?

DR SHARAN: No, nothing, ever.

PROF MONTGOMERY: No change?

DR SHARAN: No, I don't know if now there is separate cover but in my time it didn't happen.

PROF MONTGOMERY: Okay. You talked about your confidence in the competence of your medical colleagues, what about the other professions in the unit, were you similarly confident that they were competent or did you have concerns about the quality of theirs?

DR SHARAN: Well, we are responsible for training them, supervising them as a consultant, after all this whole thing is, so I can't – I must say sir that if you look at the – you must have had by now, the list of people, the midwives are so senior, most of them are very senior people there working, they have lived and they were born in the area. I felt that because they haven't had the diverse experience of going to different places and seeing how other people are working that's what their limit is. And you know, when like over confident

driver you become over confident in a place where you are well supported, because there were – there are people of this area, they know everybody, they have delivered their first baby, they have delivered their fourth baby; they don't – they have no big concern like other places, where people, if you go to a new place you will be trying to watch your back and everything. They have become a bit more confident that, but they are not incompetent, I must say. I didn't feel that they are, most of them are also instructors and things like that, they are very senior people, on a very high salary I would presume.

PROF MONTGOMERY: And do you think aware of what you just described, in terms of the – I think what you've described, and I'll check if I've got it right is that high levels of experience, but only from a relatively local context?

DR SHARAN: Yeah, yeah.

PROF MONTGOMERY: Do you think they were they aware that that was the pattern of their experience and were interested in finding out how things happened in other places or were they unaware that it might be different elsewhere?

DR SHARAN: No, no, I think these days everything goes on line, and I am sure they were quite aware of all the changes, all the new guidelines and everything, I am sure that they were – they will follow. I don't think they would ignore anything like that.

PROF MONTGOMERY: So, how did it compare to the midwives at Leeds; you worked at Leeds before you came?

DR SHARAN: They - I think because they have – they always had good experience they were not saddened like certainly there is everything hit them, maybe they became very confident, I just said that. I think they became more like, they always wanted – there was a little bit of conflict, I felt, that they wanted it to be a midwifery lead unit. They were thinking that the consultants were putting their nose into it and they wanted – so I think my feeling is that when I said to them, "Why are you trying to bite more than you could chew?" If you have any problems just say, we get the same salary, why will you take more risk?"

And they said, "We are professional in our own right, I can open up a private clinic and I can deliver a patient." Which is right, they are independent practice nurse like doctors, they can do that. But so on that point I can't say that they are incompetent, they have more training than nurses, they have

competent people, they are pretty knowledgeable, they can do that but in the present circumstances, in the climate we are in and the pressures of risk there is, I think I would say that instead of taking that route I think they should have possibly, in Leeds that will not happen, even if they are at the ~~next~~ Top point of midwifery, they will still – the word they use is "I call you because I want to cover myself" I said, "Well, are you naked?" so you know we laughed.

PROF MONTGOMERY: I want to ask you a bit more about that but I think it will need you to explain so that we could identify individuals, so I will hold that until we get to the confidential session. The last thing I wanted to ask you about was around how many of the many external reports that the Trust commissioned in the time that you were working there, there were a series of external reports commissioned for maternity services, by the Trust. And I wondered whether you had been aware, or involved, been interviewed in relation to any of them?

DR SHARAN: I think I was interviewed once, I think in 2008, 2009, or 2010. It was a Professor from Glasgow who did obstetrics at I think or ~~perimortem~~ Perinatal statics, or something like that.

PROF MONTGOMERY: Okay.

DR SHARAN: Headed by him with two other members, and I told them black and white everything that was going on. Whether they I recorded or not – I was surprised that I didn't get any response and I wasn't -

PROF MONTGOMERY: So, you were interviewed; did you ever see the report as a result?

DR SHARAN: No, it wasn't shown to me and I have not seen any report and I haven't heard anything, and I told them that if you don't change, if you don't try to change, you are going to get into a big thing.

PROF MONTGOMERY: Okay, and were you - did you see any reports done by external people, any action plans resulting from reports in the time that you were there? You said that you were only interviewed in relation to one, but did you see the consultant -

DR SHARAN: No, I just heard that everything went well; everything had given CNSD level 1, level 2 is going, this is happening and I was surprised, I said, "Who is giving you all this without coming here?" So maybe they came to Lancaster, maybe they came to Kendal I said, "I didn't see anybody but people are telling me you are getting through everything", but I said, "Well, I can't say much but

whatever I have asked I don't see much response. I don't know about you, people are getting through all the flying colours."

PROF MONTGOMERY: So, those meetings, the monthly labour ward meetings, they would never – they didn't see anything that came out of external reports into the unit, they were never discussed with you at those. I think that's probably all I need to ask in this session.

DR KIRKUP: One point of clarification that the Professor from Glasgow that you are referring to, would that have been Andrew Calder?

DR SHARAN: It could be.

DR KIRKUP: It could be, okay. The other people on the Panel would have been -?

DR SHARAN: Two ladies.

DR KIRKUP: Pauline Fielding and Yana Richards?

DR SHARAN: Yeah.

DR KIRKUP: Yes, okay that just helps us to understand which report it was that you were interviewed for.

DR SHARAN: I don't know whether they noted it or not, because I don't know, I say what anybody writes it, I don't know. I told them that not having theatre, ~~not having~~ — non-responsive clinical management, having, you know, ask for these things having to cover two systems constantly, any day I would be in news because something has gone wrong, and so I am battling with all these sorts of things and at the end I just said that, "It's better that I go off for retirement", because at the age of ~~53~~ 63 I said, "Well there's no point in going to find another new job – there were people offering me jobs, but I said "No, I'm not coming" and constantly I was phoned, "Why don't you come here? Why don't you do that" and I said, "No, I'm not going to take anything new now, if I don't take it."

DR KIRKUP: Okay. In general terms, without talking about any individual cases, were you involved in incident investigations if something had gone wrong?

DR SHARAN: I think it was done by usually the labour ward manager, the consultant who did the incident reporting, yeah, I did report it, incident reporting, but the investigation was done by the clinical director and by the labour ward manager I think.

DR KIRKUP: Okay. Would that have been Jeanette Parkinson, the labour ward manager?

DR SHARAN: Jeanette Parkinson was deeply involved with every little thing that was reported.

DR KIRKUP: Yes, okay. But did you take part in meetings where incidents were discussed?

DR SHARAN: Yes, yes, yes. I have taken part in quite a few of them.

DR KIRKUP: Okay, perhaps it's easier to get into the specific incidents I think. Is there anything you'd like to -

PROF MONTGOMERY: Yes, there are a couple of questions for private session.

DR KIRKUP: Yes, okay, then I need to say that we would like to move into a closed session, where we talk about clinical and confidential details, so we shall have a short pause while we ask people to clear the room please.

(The hearing went into private session)

THE MORECAMBE BAY INVESTIGATION

Monday, 29 September 2014

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

Before:

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

KAY SHELDON

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DR KIRKUP: Thank you for coming. My name is Bill Kirkup; I'm the Chair of the panel. I'll ask my two colleagues to introduce themselves to you.

PROF MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Health Care Law at University College London, and Chair of the Health Research Authority.

MS SHELDON: Okay.

PROF MONTGOMERY: I don't think we've met. We were at the same [inaudible] workshop on whistle-blowing last week.

MS SHELDON: Oh, were we? Oh, right.

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.

MS SHELDON: Okay. Thank you.

DR KIRKUP: You will notice that we're wired for sound. We will make a recording of proceedings and agree a record of them afterwards with you. You'll also know that we have open proceedings to family members, but, as it happens, there aren't any family members here today, and we've asked you to hand over any phones, recording devices, etc. just to emphasise the point that nothing goes outside the room until we're ready to produce a report with findings in context. Family members can listen to the transcript subsequently, but what I'm going to suggest is that, because there is clearly an element of this which is related to an individual case, that we're going to do what we've done in some other interviews, which is to say we'll have a general part of the interview and then pause, and we'll go off the public record at that stage to a closed session

where, if family members had been present, we'd ask them to leave, and that part of the transcript is not available to anybody afterwards, and we can talk about that individual case. Is that okay?

MS SHELDON: That's fine.

DR KIRKUP: Do you have any questions for me about the process?

MS SHELDON: No. I mean it would be useful, if I needed a break, to be able to say, 'Can we have a break?' Would that be okay?

DR KIRKUP: Please feel free. Yes – absolutely.

PROF MONTGOMERY: We'd probably be quite grateful.

MS SHELDON: Sorry?

PROF MONTGOMERY: I said we'll probably be quite grateful.

MS SHELDON: Yes, yes, but – no, I don't have any questions.

DR KIRKUP: Okay. Thank you. I'll start off with a very general question then, which is to ask you if you could just outline for us your involvement with CQC and indeed its predecessor, I think, and what happened subsequently.

MS SHELDON: Okay. So, I was appointed to the CQC Board from the beginning of December 2008, and I was previously on the Mental Health Act Commission Board. And one member from each board of the predecessor organisations was appointed to the CQC Board to help with the sort of handover, I think. So, I was appointed particularly to bring the sort of mental health – Mental Health Act – expertise, patient voice as well. So – and obviously I also had the governance expertise. So – I mean, I'm sure – as you know, when CQC was first set up, there was very little in place. I mean, it was really quite chaotic, frankly. So – and certainly from a board member's perspective, it was really

quite hard to discharge our governance responsibilities, because there was almost nothing in place.

But, I mean, you know, over time I was sort of expecting and hoping that that would improve, both for sort of the organisation and for regulation, but it didn't. Was there anything else you want me to say about the earlier days or – before I get on to that element of it?

DR KIRKUP: No.

MS SHELDON: Is that enough?

DR KIRKUP: I think, to be honest, that's absolutely fine for the background.

MS SHELDON: Yes. Yes – okay.

DR KIRKUP: And just to resume the kind of systemic nature of the interview, I'll ask Jonathan to carry on.

PROF MONTGOMERY: Thank you very much. I wanted to ask you how University Hospitals of Morecambe Bay got on to your radar, because we know that you used that to illustrate a number of things that were there. So, we wondered how it got on to your radar to start with.

MS SHELDON: Okay. I mean, the comment I just made is relevant, in the sense that the board was not getting good information about what risks were around both in the organisation and in services. This was something that I'd raised sort of a number of times. I knew, but only in very general terms, that Morecambe Bay was sort of on the radar, and I knew there was a police investigation there, but certainly throughout 2009 and 2010, there was no specific information given to me at board level. And my sort of focus was more perhaps on mental health and Mental Health Act, so early on there was very little sort of – you know, it wasn't on the radar. The reason that it became

more on the radar, as you probably know, I got extremely concerned with what was happening within the organisation. In about the middle of 2011, I was really concerned about the fact that we'd deviated completely from our strategy – that there were sort of repeated failings. There was a move to change the regulatory model, and sort of due process, if you like, hadn't – they hadn't gone through it. Effectively, what they wanted to do was to say that providers would be compliant unless there was evidence to prove they weren't compliant. So, everyone would be compliant unless – you know, so they were sort of turning it round, and it seemed to me that could be quite – could have quite serious ramifications for people in services, because thinking back to Mid Staffs, I thought, 'I cannot see that this is the right way to go.' And certainly when I looked into the work behind, it didn't really show that we would be able to effectively regulate within the statutory responsibilities that we were given. So, because, as you'll know, Morecambe was becoming more on the radar, and an investigation was launched by CQC in early 2012, and we were told about it in the board, and obviously I was aware that there had been sort of rumblings to do with Morecambe Bay for some time, and so I thought, 'Well, why are we suddenly doing an investigation now?' So –

PROF MONTGOMERY: Just to be clear, this is the Section 48 investigation.

MS SHELDON: It is, yes. Yes, that's right. Yes. So, I asked the director of operations, 'If we'd known about the issues at Morecambe Bay earlier,' you know – sorry – 'If we'd been fully functional, would we have picked up the issues at Morecambe Bay earlier?' And the response was that we were fully functional and we picked up the issues, and I thought – I didn't really – I was very sceptical about that. So – and because I also wanted to – because I was

also trying to show that CQC as a regulator was actually failing, but not just that it was failing – that it was going to continue to fail or fail even more – I looked at a few examples in detail, and Morecambe Bay was one of those. And I looked at all the regulatory reports, inspections that CQC had undertaken, including from the archive site, and I also looked at other bits of information that I managed to find out from the press, actually – Monitor was another one. And it seemed to me that, far from being a sort of robust piece of work, what seemed to be apparent was that there were sort of endless questions or failures – omissions. So, I put together a paper just asking about various questions: why did we register? Why didn't we follow up?

PROF MONTGOMERY: So, these were the 11 questions.

MS SHELDON: Exactly, yes. Yes. The 11 questions. So – and I also found quite a similar story with Barking, Havering and Redbridge actually.

PROF MONTGOMERY: I was going to ask about that. This comes up in one of your questions, but one of the differences between that is whether or not maternity gets investigated in the system review, and I think one of your questions draws attention to the fact maternity's mentioned quite a lot in the introductory stages, and then isn't after the Section 48 review.

MS SHELDON: That's right, yes.

PROF MONTGOMERY: So, I'd be interested in your reflections on that, but also what was said when you asked about it.

MS SHELDON: What was said when I asked about – well, as you know, nobody answered the questions; they just wouldn't do it. They – I persisted quite significantly, as you probably know, and I also, I have to say, persisted that I did inform the Department of Health and the Secretary of State, and the

reason I did that was because, as a non-exec director, I'm actually appointed by the Secretary of State, and it's my duty to tell them, so I did. So – and also the National Audit Office as a whistle-blower, but anyway – so I did all that. My sense at the time is that CQC was desperately trying to deflect attention from its earlier failures: that it hadn't picked up things or it had not – certainly when the Trust was registered, there was a very strong feeling that it should have had conditions, and certainly the local team thought that, but they were overruled by the centre. And after that, there was a brief follow-up to the maternity services by an inspector who was not particularly well qualified. So, then we have sort of 2010, 2011, where we have the Trust getting foundation status, saying it's more or less on top of its problems, and then suddenly we get the sort of information that there are some quite significant problems: SUIs have gone up and there have been some deaths in maternity. But, yes, when the actual Section 48 investigation – the response was that they were going to look at the emergency pathway, because that would give them a better idea of – sort of across the Trust of different elements of it, but I never got a satisfactory answer as to why maternity wasn't looked at in more depth. I don't know.

PROF MONTGOMERY: Because it was in Barking, Havering –

MS SHELDON: Yes, it was. It was.

PROF MONTGOMERY: So, it was clear that they could just about at the same time.

MS SHELDON: They could have done, yes.

PROF MONTGOMERY: Well, you won't be surprised to know that we've been asking many of the same questions as you were asking to see what answers we could get, and I think we've heard the system answer. We haven't quite

understood why that's the only thing that they had a look at, but you also raised a question which we've been asking around the status of the warning notices, because one of our – one of the things that we were – we've struggled to get to the bottom of, and you asked very much the same sort of question, was that given an existing warning notice, why was it excluded from the Section 48 review? One answer that's emerged is that they thought that the Trust would be found to be compliant if they reinspected, because at that stage there was a lot of external support going into the Trust. Was that an explanation that you've heard before?

MS SHELDON: No.

PROF MONTGOMERY: Okay. Thank you. So, in December 2011, there's this thing called Gold Command.

MS SHELDON: Yes.

PROF MONTGOMERY: You know. And one of the explanations that's emerged is that it wouldn't have made much sense for the CQC to inspect during Gold Command, because what they would see was the Trust plus all this external support.

MS SHELDON: Right.

PROF MONTGOMERY: Does that sound at all persuasive to you?

MS SHELDON: To be honest, I'm not quite sure what a Gold Command is, so –

PROF MONTGOMERY: No – we're not very much either. That's also a question that we've been asking. Yes.

MS SHELDON: I mean – so, I don't think I can really answer it.

MR BROOKES: The Gold Command isn't the relevant – it's about bringing together different organisations at a point in time to identify potential short-term

additional resource to go into the organisation to shore up services which were seen as being deficient. That's what was happening, irrespective of whether they used the mechanism of Gold Command or not.

MS SHELDON: Okay. Well, I mean, if they felt that they knew all the issues and there was support going in, then I guess it could make sense to inspect a bit later, I suppose.

PROF MONTGOMERY: I mean, that's helpful, that reaction; of course that assumes you do then inspect a bit later.

MS SHELDON: Yes – well, exactly. I mean –

PROF MONTGOMERY: So, that's helpful. The other thing which we found very perplexing and, again, I think you ask this in one of your questions, and it would be really helpful to hear what was said to you and then your reflections on it, is there's this oddity that there was a warning notice in September. It has a period by which compliance is expected, in December, and – no, November, I'm sorry – and the Trust writes to the CQC saying it thinks it's compliant. And then nothing seems to happen to that warning notice, and you asked a question about whether or not a warning notice stays in place until the follow-up, and is that safe for the public and fair to the provider?

MS SHELDON: Yes, that's right.

PROF MONTGOMERY: That's a rather more concise version than the one that we've been asking of them, but the essence of it is it just seems confusing – the idea that there's a warning notice with a date, and then that date just passes and we can't quite tell – a number of the people we've talked to from the CQC have said, 'Well, it just stays in place.' But we're not quite sure what message that gives to the public or, indeed, the provider. So, I think we

absolutely understand the challenge of the question that you asked, and we wondered to what extent you have any answer to that question.

MS SHELDON: Well, I mean I never actually got answers to the questions other than via the Grant Thornton report, so they didn't answer the questions at the time. But I mean I would absolutely expect that a warning – if you had a warning notice in place, you should go back and check, really. You might want an action plan, but you would need to go back and check; just to leave it there is – you don't know if it's – certainly the public don't know if it's current. It could cause unnecessary worry. On the other hand, it could be that nothing's happened and the problems are still there, so –

PROF MONTGOMERY: From a provider perspective, you might think, 'We've told them we're compliant, and they haven't told us we're not.'

MS SHELDON: Yes. And of course they were also wanting to change the regulatory model. So, if they had changed the regulatory model, which they haven't done – we haven't done, I should say – then the warning notice would go if the Trust said it was compliant, which just – it's a bit daft, to be honest. So – but you see there was a real –

PROF MONTGOMERY: Couldn't possibly at this stage. Yes.

MS SHELDON: Yes. But I think it was around the sort of middle of 2011, the summertime, when CQC suddenly decided it wanted to completely change the regulatory model, and I – my feeling is that was a sort of kneejerk response, because of all the issues that were sort of coming back to bite that we weren't able to follow up or we missed. So – I mean, it was very chaotic. I mean, people didn't really know what they were doing.

PROF MONTGOMERY: And do you have any sense of how different Morecambe Bay was from other places? I mean, for example, you've picked up that it was the police investigation that sort of brought it on your radar. Do you have any sense of how many other Trusts which would have had police investigations under way that might be in a similar sort of situation?

MS SHELDON: I wasn't aware of any other police investigations, but I was aware that there were problems at other trusts, including Barking, Havering and Redbridge, and Basildon and Thurrock was another one. Also, United Lincolnshire were I think also troublesome. I think Hull as well, up in Hull, yes. But on the board of CQC at that time, we were not getting the right information, and whilst we wouldn't get involved in the operational stuff, we should've been told what the worry trusts were, what the big issues were, what kind of risks, and we just simply didn't get that at all.

PROF MONTGOMERY: And one of your questions is about proportionality, really, so: why this investigation at this time? Are there other providers in the same position?

MS SHELDON: Mmm.

PROF MONTGOMERY: Was your sense, and the reason for asking that question, that you thought that others had been let off the hook, or that University Hospitals had been targeted?

MS SHELDON: Well, my worry is that we didn't know, frankly. I certainly didn't know, sitting on the Board, and I was also getting told things by CQC staff: that they didn't feel equipped to do the job; that they felt that they weren't being listened to when they raised concerns about particular providers. I was also getting concerns via sort of stakeholders as well. So, it was – so, I was

kind of sitting on the Board knowing that there were problems, but not knowing where they were for sure or whether they were being addressed, actually. And I – of course this – the whole sort of context was Mid Staffs in the background. There was a sense that the last thing that – well, the last thing the health environment needed was another Mid Staffs, and it was – it would often say, 'Oh no, it's not another Mid Staffs; it's not another Mid Staffs.' And I know that others have raised the fact that concerns – they felt that concerns were sort of minimised or kept quiet because they didn't want – in 2010 there was an election and there was the Mid Staffs, and I think I have some sympathy with that, actually.

PROF MONTGOMERY: And do you have any sense now whether or not – because we're obviously poring over Morecambe Bay in great detail. We have no remit in relation to the other areas, but we do have to try and understand the regulatory environment, and you obviously picked University Hospitals Morecambe Bay to track back over the available information to you.

MS SHELDON: Yes.

PROF MONTGOMERY: Have you attempted to do that for any of the other ones you've mentioned, just to dip in and see whether they're in a similar position?

MS SHELDON: Yes. I did it to Barking, Havering and Redbridge, and they were – they were similar issues, but it wasn't a foundation trust, and they were registered with conditions. But the conditions were actually removed, apart from one of them, very quickly. So, I'm also sort of thinking, 'Well, if Morecambe Bay had been registered with conditions, would they have disappeared relatively quickly anyway?' Because certainly at Barking, Havering and Redbridge, although the conditions were removed, actually the

problems stayed there, so – and, again, an investigation was launched, again, I think, because the problems were coming back to bite them, so 'we'll do an investigation and sort of project the image that we're a bit tough and we know the problems', but, as I say, I think that's what happened at Morecambe Bay with the investigation.

PROF MONTGOMERY: And at board level, were you briefed on the numbers of warning notices around particular organisations?

MS SHELDON: No.

PROF MONTGOMERY: I mean, there's a little sheaf of warning notices for Morecambe Bay by the time we get into the period where you're asking these questions.

MS SHELDON: No. No, we weren't briefed at all. We had very little.

PROF MONTGOMERY: And was there any way the CQC asked about the numbers of warning notices? Because one of the triggers included here might have been multiple notices against different bits of the regulations against the same provider, but I have no sense of how common that is.

MS SHELDON: Yes. And, as I say, the Board got very little information. There was something called the Risk and Escalation Committee, which was supposed to kind of oversee sort of emerging –

PROF MONTGOMERY: And was that a board committee?

MS SHELDON: No, it wasn't.

PROF MONTGOMERY: That's an executive team.

MS SHELDON: Yes, it was the executive team. I think it reported to the Audit and Risk Committee, which I wasn't on, but then we certainly didn't get anything from the Audit and Risk Committee to the Board.

PROF MONTGOMERY: Because I'm trying to get a sense of whether what we're seeing is happening everywhere and we're only looking at one snapshot of it, and one of those questions is the number of different warning notices, none of which refer to any previous warning notices. So, if I were incoming into the trust for the first time and picking one up, I might read one and think, 'Oh, that's the CQC's letter,' and then there might be five others all around the same position. So, I'm just trying to understand how we might sort of disentangle some of that.

MS SHELDON: Yes. They may have it centrally. Of course, we're changing our approach, and it's sort of been changing all the time, to be honest, so it would be quite difficult to sort of look at things across time. But, I mean, there is an issue about sort of enforcement: when we – do we enforce or not? Is a lot of enforcement good or bad? And, to be fair, we don't really – it's still quite early days for regulation, so we don't definitively know what works. We've got experts together and we learn as we go and we evaluate, so – but of course what we do need to know is sort of trends and have a kind of overview of the landscape, if you like, of regulation, which we didn't have at the time but which we are developing now.

PROF MONTGOMERY: There are a couple of things I want to ask about that. One is about the clarity or lack of it of responsibilities between the various people in this territory, and I appreciate that is changing and has changed over the period that we're talking about and that the new system about CQC roles and Monitor roles and the demarcation of it is slightly different, but I wondered what your sense from the – both from what the board knew and discussed but also from your sense observing, about the risk of things falling through the net.

So, it's about how do you make sure that the various players, whether it's the CQC, Monitor, the Strategic Health Authority, the Ombudsman, don't do the same thing as others or have a gap between them and things fall through.

MS SHELDON: Yes. Okay. Do you mean now or then, or –

PROF MONTGOMERY: I would be very interested in both, actually. If we could start with then, and then we could ask whether now we've solved the problem somewhat.

MS SHELDON: Both, okay. Well, I think then, it was largely reliant on individuals in senior positions, particularly, talking to each other. There was very little, if you like, formal ways of sharing information. It would be more a telephone call, some occasional meetings. They did have things like risk summits, I believe, when various stakeholders would be involved. I'm not sure exactly what would necessarily trigger them, or who owned them, but they were there as a mechanism. But certainly around sort of 2009, 2010, 2011, it – from what I understood, it was more of sort of informal senior people, and people lower down when it was needed, so... But whether things would fall through the gaps, I think – well, I think we know they did fall through the gaps.

PROF MONTGOMERY: Do you think we know how and why they fell through the gaps? And it may be at this point – I don't know, but it may be a point you want to talk about individual cases.

MS SHELDON: Yes.

DR KIRKUP: Shall I do that, in that case?

MR BROOKES: Well, I've just got some general questions.

PROF MONTGOMERY: I have one other general question. Shall we ask those and then ask that one again?

DR KIRKUP: Yes, okay. Can we put that one on hold, and we'll ask two more general questions.

PROF MONTGOMERY: My other general question was around the relationship between the centre and the field teams, and you alluded to a range of disagreements, and I just wondered what your observation was about the way in which the central decision-making sort of attempted to triangulate and test out what was coming up from the field teams, and any other observations you have on that.

MS SHELDON: Yes. So, registration was obviously at a key point, which was April 2010, and a lot of effort had to go into getting places for the NHS registered by 1 April. This was largely done centrally, and I – certainly at the time and certainly since I know that there was a lot of disquiet amongst the regional teams: that they weren't being listened to by the centre, as they called it, and felt they were being overruled. I know, for example, that there was a strong feeling that Morecambe Bay should have been registered with conditions, but that was overruled, apparently. Apparently there are other places as well. And there was a sort of culture within CQC that was kind of – I mean, it was a bullying culture, to be honest, but, to be fair, there was also the sort of pressure of getting things done. So – and what I was being told by some of our staff was that I – you know, they would raise concerns about a service or something, but it wouldn't be taken seriously. So, I would say it was pretty dysfunctional, actually.

PROF MONTGOMERY: And were you aware of any mechanisms for sort of holding that anxiety and that soft intelligence, or does it just disappear? If it's overruled, does it disappear from the CQC consciousness? I'm thinking in fact

that, if the organisation is functioning well, it ought to be able to assess whether it made a mistake in the past, and one of the things it would need from that was that there were concerns expressed which at the time whoever was responsible felt weren't significantly strong but they might want to know about that later on. Was there any sort of mechanism of holding that information that you're aware of, so that you could revisit those decisions?

MS SHELDON: You could look at emails. I think that would be quite a good thing to look at. I've certainly seen emails that people raising concerns –

PROF MONTGOMERY: I think that's a slightly different question.

MS SHELDON: It is, yes.

PROF MONTGOMERY: Because we can do that with the charge we've been given. I think the question's whether or not the system that the CQC operated would enable people to say, 'I can't quite prove this, but I'm anxious about it.'

MS SHELDON: Yes, okay.

PROF MONTGOMERY: Or, 'I raised this, and it wasn't thought to be significant enough now, but I don't want to lose that anxiety in case it gets corroborate in the future.' I mean, was that something the organisation could do?

MS SHELDON: I mean, we had something called the Quality and Risk Profile, where that was kind of populated with concerns, and some of it was qualitative, some of it was hard data, so – and it would be the individual inspectors that held that information. So, they would have – well, they should have it there. So – and if it isn't – that would be the place: the Quality and Risk Profile.

PROF MONTGOMERY: And do you have a sense of whether the organisation privileged hard data over qualitative assessments or balanced it or...

MS SHELDON: I don't know, really. I wouldn't – not necessarily.

PROF MONTGOMERY: I think I'll just put a question and then I'll hand over, which is you can see how one thing that might happen, as decisions get taken centrally, is that the hard data is more easily comparable –

MS SHELDON: Yes, I'm with you. Yes.

PROF MONTGOMERY: – and you might lose the edge of the nuances that were there. So, it could be one of the products of pulling those decisions up higher that it's more difficult to respond to those things. Do you think that's a fair question?

MS SHELDON: Yes, I think – I mean, I think certainly at the time during registration that, just thinking about the context at the time, that you probably would be looking more at hard data, I would've thought, but I mean also – when we were asking for reassurance at the board, we were told quite categorically that where there were concerns these were going to be thoroughly investigated – not formally, but, you know. So – I've forgotten what I was going to say now.

PROF MONTGOMERY: That's fine. So, we should expect to be able to find some record of those soft concerns in the system, if what you were being told is right.

MS SHELDON: Well, they should – I would have thought they'd have been on the Quality and Risk Profile, yes. Yes. Okay.

DR KIRKUP: Okay. Julian, you wanted to –

MR BROOKES: Just a couple of questions. I'm just trying to get the impression of the board, and you've described, tell me if I'm correct, a weak governance structure and perhaps lack of information coming to the board. In your view, did that mean that the board could not fulfil its functions?

MS SHELDON: Yes.

MR BROOKES: Clearly, yes.

MS SHELDON: Yes.

MR BROOKES: And particularly what issues – what were the main factors for it not being able to fulfil its functions?

MS SHELDON: Okay. I mean, I should say that I think early on there was very little in place, and I – we were doing all sorts of things. We were having to set up a new organisation and put all the governance in place. So, I would not be particularly critical of CQC say in the first year or so, but as time went on, things didn't improve, so –

MR BROOKES: Yes. There is a transition and a developmental stage where you would expect things to be rudimentary.

MS SHELDON: Yes, yes – exactly. And I think we couldn't have done anything else but be relatively tolerant, but we did question the executive quite closely, because that's the only real way we had of holding them to account. But then, as I say, over time, instead of getting better, it actually got worse.

MR BROOKES: When you say 'got worse', what do you mean?

MS SHELDON: Well, we had a strategy that was developed, and – but the board did not monitor how that was being delivered. I also found out sort of retrospectively that we hadn't delivered on any of our business plans. I wasn't getting any information from the Audit and Risk Committee that told me how well the organisation was performing, so all I could really do was either question the exec in board meetings, which were usually quite evasive, or go to talk to staff, patients, others, and then what I heard from them was that things weren't working at all, and of course – the way that the board was led, if I raised any of these kinds of issues with the board, the response was either to

sidestep them, or if I persisted, then to sort of make me feel that I was being inappropriate. So, there was no way on the board that we could have known whether we were doing – fulfilling our statutory obligations.

MR BROOKES: And just a link question: in your view was CQC unable to identify problems? The systems and processes weren't strong enough. Or was it that they could identify problems but weren't acting on them?

MS SHELDON: Do you mean within providers

MR BROOKES: Yes.

MS SHELDON: Or with itself? Yes.

MR BROOKES: Because it's very different –

MS SHELDON: It is, it is. Because I actually think it's probably a bit of both, to be honest, because if you identify a problem, you also – you've got to understand what that means: is it a systemic problem? Is it a one-off problem, for example? And at that time, the way that the model operated is an inspector would go in, might find one problem, and then maybe issue a compliance action or whatever, and then go out again, but the symptom could – that particular issue could be more of a sort of symptom and not necessarily the main issue. So – and of course was that our inspectors at that time were generic. We had a lot of social care inspectors investigating – sorry – inspecting hospitals, so they didn't have the background expertise, experience also, so – and which they repeatedly told the exec about: that they didn't feel equipped. So, it was sometimes not picking up the issues or it was the model that didn't allow to look at in a more kind of –

MR BROOKES: But that's very different from having that intelligence within the organisation and not acting on it in an appropriate way.

MS SHELDON: Yes. Yes.

MR BROOKES: I'm just wanting to be clear where you felt that balance sat.

MS SHELDON: Okay. Right. And if you're thinking of Morecambe Bay, they had quite a lot of intelligence actually, and I was quite shocked when I found out, because I had no idea, so – but from what I gather at Morecambe Bay that they did understand that there were some problems there, but they – what they perhaps didn't understand was the fact that they weren't being addressed properly, because they sort of sought assurances from various other quarters and, you know – so it's difficult to sort of explain, because they did know, but they potentially thought they were being addressed.

MR BROOKES: Okay. Thank you.

MS SHELDON: It's not clear-cut.

MR BROOKES: No – I understand. I understand.

DR KIRKUP: Okay. Can I say formally then that we're now moving to the closed part of the interview, where the material won't be available subsequently?

[*The remainder of the interview was held in private*]

THE MORECAMBE BAY INVESTIGATION

Friday, 13 June 2014

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

Before:

Mr Julian Brookes – Expert advisor on Governance
Professor Jonathan Montgomery– Expert advisor on Ethics (In the Chair)
Ms Jacqui Featherstone – Expert advisor on Midwifery

AMANDA SHERLOCK

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(At 11.25 am)

PROF MONTGOMERY: Thank you very much for coming in to see us and thank you very much everybody. We started a bit early from our point of view.

I am Jonathan Montgomery and I am one of the panel members with the brief around ethics. In my sort of other roles I am Professor of Health Care Law at University College London and I chair the Health Research Authority and in the past I've chaired PCTs in our strategic health authority in the south of England where I live. My colleagues will introduce themselves.

MR BROOKES: I am Julian Brookes and I am here on the panel as the Governance. Mainly in my background I was Head of Clinical Quality in the Department of Health, introduced clinical governance to the service and also set up [inaudible] many years ago. I am currently the Deputy Chief Operating Officer for Public Health England.

MS FEATHERSTONE: I am Jacqui Featherstone. I am the head of midwifery and neonatal nursing at District General Hospital in Essex and I am a midwifery expert.

PROF MONTGOMERY: Just a bit of housekeeping about things just to explain the context. It's just the three of us who will be asking you questions. You will see that we are recording the proceedings and also there will be a transcript so that we can make sure we've understood anything that we or you say properly but also so that the family or families are able to hear what is said and come and listen to the interviews and they are able to be here listening. There is one family represented and you are very welcome today.

So that is a really important part of us making sure that we get the

evidence right –

MS SHERLOCK: Of course.

PROF MONTGOMERY: – that we will hear from. There will be a summary note of what we heard, or who we have heard from perhaps more accurately, and it goes up on our website and we will obviously be connecting the evidence we get from you in this with all the other things that we hear about. For that reason we are asking people to keep their discussions confidential so that actually we take the totality of what we hear. So you shouldn't have a mobile phone or tablet or anything else in your possession. We don't have –

MS SHERLOCK: They're upstairs.

PROF MONTGOMERY: – a mobile phone or tablets or anything else. Ours are also upstairs and we would also be grateful if any notes that are taken are kept confidential, to the minimum and not shared around because we are really keen to get this right and not to find there are misunderstandings and partial accounts of what we heard come out. So we are really grateful everyone so far has been very helpful in terms of making sure that we can keep that.

So I think that's the main housekeeping other than the fact that if the fire alarm goes I am going to take it very seriously and we will follow our colleagues to a place of safety if that happens. And I think I have covered all opening things. So this is my first time doing this particular bit because we have apologies from Bill Kirkup who is the Chair of the investigation who is unable to be here today.

So we have got, we have sort of identified a number of areas that we'd like to ask you about, and we think you might be able to help us with. If you

can't, that's fine. Just tell us that. And perhaps you would like to start by explaining who you are and the roles that you have now and have had that might be of interest to us in the past so that's on the transcript.

MS SHERLOCK: Okay. I'm Amanda Sherlock. I was Director of Operations at the Care Quality Commission from July 2010 to May last year, so 2013. Prior to that I had worked in CSCI, Commission for Social Care Inspection and prior to that an executive director setting up the first national regulator for healthcare and social care, national care service commission. My background in primarily the NHS provide services with a relatively short stint at the Department of Health and I am currently a lay advisor to the Solicitors Regulation Authority and a non-executive director of NHS Foundation Trust.

PROF MONTGOMERY: Thank you very much. And just for the record where is the Foundation Trust you are non-exec?

MS SHERLOCK: North Essex Partnership Trust.

PROF MONTGOMERY: So it's a long way away from here. That's the main thing we need to establish. Thank you very much.

The first area we would like to discuss with you is just how the CQC works as in trying to get a picture of who does what so we get a better understanding and I think it would be most helpful for us if you could just describe what the Director of Operations does and what the portfolio is? That would be really helpful.

MS SHERLOCK: Okay. During my time as Director of Operations, the operations role changed to one to Chief Inspector of Hospitals and Adult Social Care this time last year so my role was providing executive leadership to all front line

operational functions of the Care Quality Commission. So that was four deputy directors of operations who had regional responsibility in the delivery of the review, the inspection and registration functions and the national customer service centre based in Newcastle that provided all the business systems and administrative support processes for CQC.

As part of my role during my time I was also the lead expert witness to the Statutory Inquiry for CQC primarily because I hadn't been involved in the Healthcare Commission's oversight of Mid Staffordshire and I had a lot of background and knowledge, technical expertise in regulation. I was on the executive but not a board member because until September last year CQC didn't have a unitary board and was accountable to the Chief Executive and ultimately through to the Chair and the Board. I chaired the Risk Escalation Committee for CQC, which was a panel of senior managers and the national professional advisors and we had oversight of organisations that were escalated from areas in the regions to the national risk register when problems had been identified through compliance inspections or occasionally through extensive media interests in a particular organisation that precipitated us working with, for example, the Strategic Health Authority or the Central Department of Health to review what might be happening in a particular organisation. That tended to be NHS rather than adult social care or independent healthcare but not exclusively. So Southern Cross and then parts of Southern Cross would be another example where we had national sight because of the scale of the issues.

PROF MONTGOMERY: That's really helpful and there's a few things about that

from the list to understand a bit better. Can we understand a bit more about what was held at regional level? So we understand from what we think we picked up so far there's a sort of regular contact type role, customer sort of relationship role and then there's a set of inspections and there's a trigger and we really need to understand at what point they come together.

MS SHERLOCK: Okay. I will confine my answers to the NHS for the purposes of this discussion.

PROF MONTGOMERY: And you can also confine them to how they worked in the North West. It's different from other places I think.

MS SHERLOCK: Okay.

PROF MONTGOMERY: If it's standard then that's fine.

MS SHERLOCK: It shouldn't have been different in the North West than anywhere else but obviously the regional directors had a mix of experience and backgrounds and that would advance the level of oversight they might have about a particular organisation. So from April 2010 when the NHS came into registration the scheme of delegation that the CQC board had agreed put the majority of regulatory decision making at a compliance manager or inspector role. The structure of a particular area, so for Morecambe that would have had a compliance manager who would have had line management responsibility for approximately ten ~~sectors~~ Inspectors who would have had a portfolio of services that they oversaw. Because 2010 was the first time the NHS had been a structured regulatory framework we took the decision that it would be a compliance manager who would have the relationship role or the relationship role with an NHS trust. So the day-to-day relationships, the picking up the

telephone having discussions would have been a compliance manager taking the lead.

PROF MONTGOMERY: Do you happen to know who that was?

MS SHERLOCK: I can't remember for 2010. I know for 2011/12 that was ~~Joe Wilden~~ Jo Wildman.

PROF MONTGOMERY: ~~Joe Wilden~~ Jo Wildman.

MS SHERLOCK: Yes.

PROF MONTGOMERY: Thank you. That's very helpful for us to try and understand what we are reading when we read things. So the inspectors you're talking about there, they're the ones who do the routine inspections?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Fill out the registration and the like. And if something comes in that is a cause for concern does that go through the compliance manager?

MS SHERLOCK: No, it would go to the inspector in the first instance.

PROF MONTGOMERY: Yeah.

MS SHERLOCK: The inspector had a portfolio of services of which Morecambe Bay would have been one of those services. The inspector, with the Trust on their portfolio, would receive information directly from the Trust, from the SHA, from members of the public, etc. They would then make an assessment about this information. So was it a safeguarding notification, is it a ~~suing~~ S.U.I. that's been passed from the Strategic Health Authority, etc. They would then document that on the CRM system and would review whether there had been any other information that had come in and they would also be responsible for

putting specific pieces of information on to the quality risk profile of the organisation. The quality risk profile would have been available to the inspector but oversight on a day-to-day basis would have been with a member of the intelligence team on our list who would work very closely with the inspectors and the compliance managers to understand what the data and information might be saying and would inform the risk judgments that were held on the quality risk profile.

PROF MONTGOMERY: And those judgments would be signed off by the compliance manager?

MS SHERLOCK: No. No, they were indicators of level of risk against certain parameters that the intelligence team provided.

MR BROOKES: So just, I'm just trying to understand then the relationship between the inspector which you described and I understand them and the compliance manager. So where there's a problem in an organisation which has been identified you quite rightly saying it goes through to the inspector.

MS SHERLOCK: Yes.

MR BROOKES: Where does the compliance manager come into that picture?

MS SHERLOCK: They would have oversight and line management responsibility for a particular inspector. So the inspector would discuss a particularly troublesome case or if they were seeking information from the Trust, for example, and the Trust were delaying in providing that information.

MR BROOKES: So the hierarchy is the compliance manager oversees a larger area and a number of inspectors. The inspectors are the day-to-day –

MS SHERLOCK: Yes.

MR BROOKES: – [inaudible].

PROF MONTGOMERY: In terms of relating, and I will ask you about national level in a minute as well, but in terms of how the information between organisations work so the Trust you described, primary care trusts, maybe the SHA; is that at inspector level or compliance manager level, the sort of day-to-day sharing of intelligence to say –

MS SHERLOCK: For a large NHS Trust it would tend to be at compliance manager level. So if there are quality summits or risk meetings it would tend to be specifically if there were ongoing concerns it would tend to be the compliance manager informed and often accompanied by an inspector.

PROF MONTGOMERY: And for these purposes Morecambe Bay is counted as a large trust, does it?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Thank you. Because obviously people's versions of what a large Trust is vary. So if we were trying to understand the conversations between the CQC and the SHA it would be at compliance manager level that most likely would have –

MS SHERLOCK: Most likely, although as concerns about Morecambe Bay escalated through 2011 into 2012 that was then escalated further to the regional director who then started having the interface and negotiations with the SHA and with the chair and chief executive at Morecambe Bay.

PROF MONTGOMERY: Thank you. There's a reference, predating the time that you would be involved because it's May 2009, in the Grant Thornton report to a conversation between the investigation team of the CQC and the regional team

of the CQC –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – about what should be done about a ~~suing~~ S.U.I.. Can you explain what those two terms mean? What is the regional team and what's the investigation team?

MS SHERLOCK: Okay. From April 2009 the start of the CQC through to May 2010 the organisation was basically the legacy commissions brought together. For that first year of operation we had to conclude the legacy of programmes and activity under the previous legislation so social care continued to be inspected and registered under the Care Standards Act and the annual health check took place on NHS organisations against the standards for better health. So the teams were the teams that the previous organisations had had whilst the board and myself with the director of, the chief operating officer at the time undertook the restructuring of CQC to prepare for April 2010.

PROF MONTGOMERY: So the regional team is the new structure that's emerging as the investigation team –

MS SHERLOCK: The investigation team were the legacy Healthcare Commission Investigation team. They were the central or the national team.

MR BROOKES: And they had a regional component which is what that's referring to?

MS SHERLOCK: No. The regional teams were the new inspector teams.

MR BROOKES: So that would have been old and new coming together?

MS SHERLOCK: Yes.

MR BROOKES: Okay.

PROF MONTGOMERY: So that comment would have been the new structure saying is there something that we should look at and the old structure saying within the legislation we don't think, although to some of them we are not going to pick it up –

MS SHERLOCK: It was against the terms of reference and criteria for undertaking an investigation of the Healthcare Commission and as we were going to be restructuring legislation changing in April 2010, 2009 was merely a business as usual as if CQC hadn't been set up and it was the Healthcare Commission working.

MR BROOKES: Could I just ask then, I understand what you are saying in terms of May 2010 onwards with the compliance managers and the inspectors. I understand that.

MS SHERLOCK: Yes.

MR BROOKES: If a similar incident had happened prior to that, what would have been the process for it to be looked at and who would look at that within CQC?

MS SHERLOCK: That would have been, and they were still called assessors. So if there had been a similar incident between April 2009 and April 2010 the previous assessor who had had the regional role, which was primarily a relationship role within an NHS organisation, would have had that information coming in to them. They would have discussed it with the regional director and followed the routes that had been in place previously. So would it be considered for an investigation which the information was passed for consideration for investigation, and or would it be part and parcel of the

relationship meetings and would it inform the standards for better health assessments.

MR BROOKES: So there would still potentially be risk summits?

MS SHERLOCK: Yes.

MR BROOKES: And who would have been involved in the risk? I'm aware, I think there was a risk summit in the end of 2009 between the SHA, CQC and Nursing and Midwifery Council –

MS SHERLOCK: Yes.

MR BROOKES: – on maternity services there?

PROF MONTGOMERY: 2009.

MR BROOKES: And one being in 2009 as well. So who would have been the CQC representatives at that?

MS SHERLOCK: That would have been the assessor and potentially the regional director.

PROF MONTGOMERY: Thank you. We are still on the [inaudible] at this stage and you've been really helpful in making sense of some stuff that didn't make sense to us before so we are very grateful. So if we get away from the regional level and we ask about the relationship of the organisations nationally. It's clearly a very complicated territory. You have got Monitor, you've got SHA, you've got the Department of Health. Can you say something about how you liaise? And you've also brought in the NMC. At that point no doubt some investigations of the GMC as well and others. So where do you think we will see those relationships?

MS SHERLOCK: They were at multiple levels. The strategic relationship sat with

myself.

PROF MONTGOMERY: Yes.

MS SHERLOCK: So I would have weekly telephone calls with the Department of Health as it was at the time the operation's performance team that sat in the ~~round hall~~ Whitehall and I would have weekly telephone call with both the assessment director at Monitor ~~Brian~~ Miranda Carter and the portfolio director at Monitor Adam Cayley. So they were catch up conversations; 'what's going on, what's happened at the Monitor board meeting, are there any authorisation decisions, etc?' Once a month we would have a face-to-face meeting where each organisation would bring their risk log, as it were, and we would exchange information about what was happening. So the Department of Health team, for example, would talk about where there were targets that weren't being met or where there were emerging financial problems. Monitor similarly would talk about the forms of FTs. We would have informed discussions about change of senior personnel in the organisations, etc.

PROF MONTGOMERY: And how were they minuted, recorded? You said you've got some weekly conversations and you had face monthly. Were they minuted meetings?

MS SHERLOCK: No, they weren't minuted meetings but from 2011 I was accompanied by Louise Dineley, who was my head of operation on quality and risk, and we updated the CQC's risk log, national risk log with the outcomes of those meetings.

PROF MONTGOMERY: And if there were actions that were agreed would they be logged in any way?

MS SHERLOCK: They would go on to the risk log and they would be passed to the region for the regions to put them in an individual organisation's regulatory plan.

PROF MONTGOMERY: That was the CQC side of it so there wasn't a sort of common action plan?

MS SHERLOCK: No.

MR BROOKES: So where SHA were involved in those meetings at all that was through the –

MS SHERLOCK: It was through, it was the national team, yes.

PROF MONTGOMERY: That's extremely, extremely helpful. And just to get that right then, so you've got weekly telephone calls and then you have a monthly face-to-face –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – meeting.

MS SHERLOCK: Yes.

PROF MONTGOMERY: Next one, I think.

MR BROOKES: Yes. Just in terms of relationship with the Ombudsman's Office? Nothing?

MS SHERLOCK: Nothing.

MR BROOKES: No formal relationship?

MS SHERLOCK: No formal relationship. There was an agreed memorandum of understanding that sat with the ~~secretary~~ secretariat I believe at CQC but I was certainly not involved in any regular meetings with the Ombudsman.

MR BROOKES: Were there any regular meetings with any other national bodies?

MS SHERLOCK: Not that I was involved in. One of my executive colleagues, the Director of Regulatory Development, had meetings with the professional regulators as it were; the NMC, the GMC and again we had memorandums of understanding with those organisations. We agreed again, I think it was during 2011, to information exchanges. So we would get deep root issues. They would come through to one of the policy leads in regulatory development and again that information would feed into the quality and risk profiles and would be passed to the inspectors.

PROF MONTGOMERY: That's grand. When the regulator and the joint inspector of the NMC comes up and we get into that it would be helpful to understand that. I think there was one other general issue we needed to understand and that is the Section 48 reviews.

MS SHERLOCK: Yes.

PROF MONTGOMERY: And we will obviously come to the one that was done on Morecambe Bay but it would be helpful for us to have a feeling of how common they are and what the sort of practice is for deciding whether they are needed before we understand what actually happened in relation to Morecambe Bay itself.

MS SHERLOCK: Okay. Section 48 is a strategic section, if you like, under the Health and Social Care Act in that investigations are in the same set of regulations as special reviews and studies. The intention was that registration powers, so Section 60 registration powers compliance activity would be the primary regulatory tool for the CQC to use. But whilst the legislation was passing through parliament there was significant lobbying for the CQC to retain

a power of investigation should it need to use the power of investigation. In the [inaudible] delegation that was put in place at the CQC, authorisation of an investigation under Section 48 investigation sat with the Chief Executive on the advice of either the Director of Operations or the Director of Legal Services. The process for giving that advice would be a request from the Regional Director through to the Director of Operations with the evidence and rationale for why a Section 48 was the right mechanism.

MR BROOKES: Can you just explain the Section 48 just so that we're absolutely clear on that? So under what circumstances or what qualifies for a Section 48?

MS SHERLOCK: Where there is evidence of systemic, potential systemic failings where it is helpful to look beyond the regulated activities that are registered at a particular provider, so the Commission, for example, the Commission in Practice and where the use of compliance regulatory tools hasn't levered the improvements in practice that you would want them to improve. They were relatively rare so investigations in the Healthcare Commission there were 15 over a five year period and in CQC there were six up until May 2013 when I left the organisation.

MR BROOKES: So how long, that's two years?

MS SHERLOCK: That's four years

MR BROOKES: Four years.

PROF MONTGOMERY: So they're not usual?

MS SHERLOCK: No.

PROF MONTGOMERY: Can you give us a flavour, so if we took the six from the

CQC of the flavour of the circumstances that triggered the need for that, we obviously know about the Morecambe Bay one because we have read the report. But the other five?

MS SHERLOCK: One thing to add is that in Section 48 the Secretary of State can request CQC to undertake an investigation and if he does request then the CQC is obliged to.

MR BROOKES: And were any of those requested by the Secretary of the State under CQC?

MS SHERLOCK: No.

MR BROOKES: So that's a power that wasn't used. Thank you.

MS SHERLOCK: Sorry, I forgot the question.

PROF MONTGOMERY: It was the other five, just an understanding of the sort of things they were about really.

MS SHERLOCK: Okay. So one that took place in 2009 so that was still really under the Healthcare Commission's methodology and wasn't recommended by me because I wasn't in post was an investigation into Take Care Now, an out-of-hours primary care provider where a German GP had flown in to do a shift and overdosed a gentleman. So that was an investigation that took place over approximately twelve months from start to finish and, as the investigation lines of inquiry emerged, that developed into a more systemic look into our services nationally and came up with some wide-ranging recommendations of the out-of- hours provision but also Commission practice for out-of-hours.

PROF MONTGOMERY: So that started as quite a frivolous piece of work?

MR BROOKES: Yes. That's exactly what I was going to say. And is that usual how

it would start? It would start around a specific issue?

MS SHERLOCK: Yes.

MR BROOKES: Yeah.

MS SHERLOCK: A second one that was fairly early on in CQC's time was Devon Partnership Trust, a large mental health and community services provider. And the remaining four were acute hospitals.

PROF MONTGOMERY: Can you remember what sort of triggered the acute hospitals?

MS SHERLOCK: Certainly one that I was very involved in which was unusual but because of the nature and scale of the problems was Barking, Havering and Redbridge Trust where there had been a longstanding history of concerns around some of its services, interest in maternity services and where there had been lots of turnover at senior level through lack of stability, significant financial problems and a shared recognition between NHS London, Quality Commission, [inaudible], etc. that there were some pretty ~~attractable~~ Intractable problems and it would be of benefit if the CQC were able to use their Section 48 powers of investigation to take a more strategic look.

PROF MONTGOMERY: And the triggers for that; were they quality issues, were they financial issues?

MS SHERLOCK: They were safety and quality issues from a CQC perspective but clearly for NHS London they could not be distracted or could not be separated from significant financial problems.

MR BROOKES: And that investigation looked into what exactly?

MS SHERLOCK: It looked into the emergency care pathway and maternity services.

PROF MONTGOMERY: And was that because there were particular quality concerns?

MS SHERLOCK: There had been a series of maternal and child fatalities, some substantial whistle blowing concerns from midwives primarily, and the Accident & Emergency was triggered by significant failings and performance and again whistle blowing concerns.

MR BROOKES: So [inaudible].

MS SHERLOCK: Yes.

MR BROOKES: So it was going to respond to particular issues within that organisation?

MS SHERLOCK: Yes.

PROF MONTGOMERY: And we presume we can read that report. It will be on the website?

MS SHERLOCK: Yes, [inaudible].

PROF MONTGOMERY: So I think we've got, we've got three now.

MS SHERLOCK: United Lincolnshire.

PROF MONTGOMERY: Lincolnshire. Thank you. And what triggered that one?

MS SHERLOCK: That was a series of serious untoward incidents and again whistle blowing concerns about safety, quality and staffing. That was also informed by Health and Safety Executive investigations into a series of concerns at the Trust.

PROF MONTGOMERY: Thank you.

MS SHERLOCK: I am trying to remember what the others were.

PROF MONTGOMERY: Well we know one of them was Morecambe Bay.

MS SHERLOCK: Yes, Morecambe Bay.

PROF MONTGOMERY: I don't think it matters too much but if we need to, we will be able to find those on the website, won't we?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Because they will be batched on that assessment.

MS SHERLOCK: Yes.

MR BROOKES: They are still on the website?

MS SHERLOCK: They should be or CQC would be able to forward them to you.

PROF MONTGOMERY: That's really helpful. I think those were all the things. We were just trying to understand how the general system operated. So if we could move to Morecambe Bay.

Could you just tell us how you first became involved with Morecambe Bay? I think if we just have the story of it as you were involved that would really help us out.

MS SHERLOCK: The first time I had discussions about Morecambe Bay was in May 2009. I had a telephone conversation with the then regional director who was new to post and this was about a month after Go Live at CQC.

MR BROOKES: Who was that?

MS SHERLOCK: Alan Jefferson. I was the deputy director of front line operations at the time so I covered the regional teams. Alan contacted me to see had we been made aware of a series of serious incidents in maternity services in ~~Gloucester~~ autumn 2008. Alan had had a discussion with the assessor.

PROF MONTGOMERY: So he became aware in 2008 or he became aware in May

—

MS SHERLOCK: He became aware in May 2009.

PROF MONTGOMERY: So he became aware in May '09 that the incident happened.

MS SHERLOCK: In of incident in '08 ~~'08~~, yes.

PROF MONTGOMERY: So that's quite important for us to understand.

MS SHERLOCK: Yeah. Alan and I had worked together in CSCI so we weren't in the Healthcare Commission at the time that these incidents happened. Alan spoke to the assessor to ascertain why Morecambe Bay hadn't been the risk register that the legacy organisations had been asked to compile for the start of CQC. So CSCI, the Healthcare Commission and the Mental Health Act Commission had been asked to highlight any organisations of concern so that they didn't slip through the net at a time of very significant upheaval and change in the organisation. Morecambe Bay –

MR BROOKES: Sorry, just for clarification. The assessor?

MS SHERLOCK: Yes.

MR BROOKES: Who, what is that exactly?

MS SHERLOCK: That's the equivalent of the inspector that the 2009 maintains they're previous –

PROF MONTGOMERY: And this would be in the investigation team that we are talking about at that stage?

MS SHERLOCK: This would be the regional team.

PROF MONTGOMERY: The regional team.

MS SHERLOCK: Yeah.

PROF MONTGOMERY: Thank you. So Alan Jefferson has tried to find out why —

MS SHERLOCK: Why –

PROF MONTGOMERY: – a risk as you would have expected it to be –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – from what has come to his attention?

MS SHERLOCK: Yes.

PROF MONTGOMERY: And what did he discover?

MS SHERLOCK: That there had been, from memory that there had been a risk summit with all of the parties that had taken place in early in the new year of 2009 and it had been determined that the SHA would take responsibility for the ongoing monitoring and pulling together of reviews and reports that were being instigated at Morecambe Bay. So the assessor, for whatever reason, hadn't felt it necessary to highlight it as a risk to CQC.

PROF MONTGOMERY: Okay. And was there any indication of a sort of role forward plan when the SHA would next liaise with the CQC?

MS SHERLOCK: I wouldn't be able to answer that. Certainly Alan didn't have that conversation with me but our conversation was: 'I have been made aware of this. We are going to refer it to the national investigations team because I think it should be looked at'.

MR BROOKES: Would you expect a more practice say if that agreement with the SHA at the risk summit had been made then there would be a record of that?

MS SHERLOCK: Yes.

PROF MONTGOMERY: But you didn't see one?

MS SHERLOCK: And it would have been on, well it could have been on a number

of the Healthcare Commission's systems because the investigation, the national investigation's team worked on a different system than the regional teams so there is lots of potential for it to be recorded but for one part of the organisation at that time not to know that it had been recorded.

PROF MONTGOMERY: Okay. That, I understand that in transition. So the decision you take, was it your decision or was it Alan's decision?

MS SHERLOCK: It was Alan's decision. I had no oversight of the investigations at that point so Alan referred it to the national investigations team. The referral was reviewed and the decision was taken that it didn't meet the criteria for an investigation.

PROF MONTGOMERY: And do you know who would have taken that decision?

MS SHERLOCK: That would have been Sarah Seaholme, who was the investigation manager at the time.

PROF MONTGOMERY: Sarah?

MS SHERLOCK: Seaholme.

PROF MONTGOMERY: Thank you, that's really helpful to understand. Okay, so –

MR BROOKES: Sorry. Just, I assume then there would be a set criteria which you would have to meet to instigate the investigation?

MS SHERLOCK: Yes.

MR BROOKES: And that's a matter of record as well?

MS SHERLOCK: Yes. That would have been, as I previously mentioned, the Healthcare Commission's criteria.

MR BROOKES: Yes.

PROF MONTGOMERY: So at that stage it would have been rolled over –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – pending –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – receipt of the document?

MS SHERLOCK: Yeah.

PROF MONTGOMERY: Okay. So now you're not formally part of that process, you are inviting Alan for part of that process?

MS SHERLOCK: Yes.

PROF MONTGOMERY: But you know that it's not taken forward by the investigation team?

MS SHERLOCK: Yes.

PROF MONTGOMERY: So what's your next involvement?

MS SHERLOCK: My next involvement is around late July or August when we, when I was contacted from Monitor to ask whether the CQC intended to take forward any regulatory action, whether the organisation was intending to investigate, whether CQC was intending to investigate and what our interface with the Ombudsman was around the complaint from Mr Titcombe.

PROF MONTGOMERY: And are you aware of any activity in between May and July that the CQC was involved in?

MS SHERLOCK: No, that would have been, that would have been Alan and his team region.

MR BROOKES: So can I just cross-reference that with what you were describing before because you've got this weekly and monthly set of meetings.

MS SHERLOCK: They weren't in place at that time.

MR BROOKES: They weren't in place at that time.

MS SHERLOCK: No, it was from 2000 —

MR BROOKES: And there was nothing similar to that prior to that time?

MS SHERLOCK: No, not that I'm aware of. There were case reviews around particular problem organisations but they would have been CQC case reviews rather than with external bodies.

MR BROOKES: And you would have had your risk register, national risk register at that stage as well?

MS SHERLOCK: There was a national risk register which was –

PROF MONTGOMERY: And was Morecambe Bay on that?

MS SHERLOCK: No, no, because it hadn't been placed on the risk register at the point of transition.

PROF MONTGOMERY: So it wasn't on the regional one at the point of transition?

MS SHERLOCK: No.

PROF MONTGOMERY: And it didn't go on to the national one –

MS SHERLOCK: No.

PROF MONTGOMERY: – at that stage? Thank you.

MR BROOKES: And did it ever become part of the risk register?

MS SHERLOCK: Yes.

MR BROOKES: When was that?

MS SHERLOCK: That would have been, again from memory, around April 2011 when there was the inspection of the [inaudible].

PROF MONTGOMERY: So Monitor contacted you to find out whether you were doing anything at that stage?

MS SHERLOCK: They were going to investigate it, yes.

PROF MONTGOMERY: And so presumably the answer was known at that stage, was it, because of the decision that had been taken?

MS SHERLOCK: Yes. I sent a letter across that was a standard letter saying that it hadn't met the criteria for an investigation but we reserve the right to revisit that decision should we get additional information or should the Ombudsman decide to investigate.

PROF MONTGOMERY: Okay. So that's July/August '09.

MS SHERLOCK: Yes. I then had no further conversations, to the best of my recollection, with the regional director until probably it would have been post registration, so post April 2010.

PROF MONTGOMERY: The Grant Thornton report refers to a meeting in August of '09 at the CQC offices with the Ombudsman. Was that something you were part of?

MS SHERLOCK: I had no idea that that meeting had taken place.

PROF MONTGOMERY: That's helpful. So we need to, we can find out about that from elsewhere. Would you have expected, given the role that you were in, to know that happened?

MS SHERLOCK: No, I wouldn't. The Director of Operations at the time may have been invited but, no, I wouldn't have expected to have knowledge of it.

PROF MONTGOMERY: Okay. So we're now into April 2010. The Trust gets registered and at that stage there's obviously some correspondence for registration without conditions but there was some correspondence. Would that have been handled at regional level?

MS SHERLOCK: Yes.

PROF MONTGOMERY: So nothing, given that it was resolved presumably nothing was escalated to you –

MS SHERLOCK: No.

PROF MONTGOMERY: – at that point? Okay. So then what happens next after April?

MS SHERLOCK: Okay. My contacts then are primarily with Monitor and the ~~Assistant~~ Assesment Director at Monitor who is writing, as was the protocol, between the organisations writing to me to ask whether CQC had any residual concerns considering it had been registered without conditions as they were looking to restart the authorisation process for its FT application. I would have been speaking with the regional director who by that time changed and Sue McMillan had come –

PROF MONTGOMERY: Who?

MS SHERLOCK: Sue McMillan.

PROF MONTGOMERY: Thank you.

MS SHERLOCK: Came into post in April 2010 and Sue would have been working with her regional team and would have been drafting the responses to requests from Monitor for the ongoing regulatory status of Morecambe Bay.

MR BROOKES: And the response to Monitor was there was no outstanding concerns?

MS SHERLOCK: No outstanding concerns. There was a follow up of what had been classed as a minor concern at point of registration by the regional team in June 2010 and that at that point the region judged that they were compliant

with the essential standards. That information was passed formally to Monitor for Monitor to take into account in coming to their authorisation decision.

PROF MONTGOMERY: From the documents that we have seen that the risk is the CQC published report in its introduction and also from the Grant Thornton report there's reference to NHS North West Action Plan which visit in June was partly checking whether the action plan had been implemented. Can you help us all understanding what that might refer to or is that?

MS SHERLOCK: No.

PROF MONTGOMERY: No. Okay, that's fine. So at that stage we've got a CQC visit specifically looking at maternity services and it finds that it's meeting the quality standards.

MS SHERLOCK: Yes.

PROF MONTGOMERY: That sort of confirms the assessment that you made about a month earlier that it was registration without conditions was appropriate from what you knew at that stage. Okay. Tell us how the story unfolds next?

MS SHERLOCK: That's it.

PROF MONTGOMERY: Right.

MS SHERLOCK: From my perspective it isn't raised by the regional director as being an organisation with concern until April 2011.

PROF MONTGOMERY: Okay.

MS SHERLOCK: Which is the point that it comes on the national risk register.

MR BROOKES: Can I just check around the first unannounced visit in 2010? My understanding, and I just want to check, was that there was a meeting with the Strategic Health Authority, the CQC and the Nursing and Midwifery Council and

amongst the actions that was agreed was that there would be an announced visit. Is that your understanding?

MS SHERLOCK: I don't know.

MR BROOKES: Who from CQC would have been involved in that discussion?

MS SHERLOCK: That would either have been Sue McMillan as regional director or the compliance manager.

MR BROOKES: Okay, thank you.

PROF MONTGOMERY: Thank you. And I also note the supervisor, midwives at that stage.

MR BROOKES: Yes.

PROF MONTGOMERY: Okay. So we have about, I guess we have got about five months, six months when, or a bit more than that, where it goes a bit quiet and then it heats up again, doesn't it?

MS SHERLOCK: Yes.

PROF MONTGOMERY: So tell us what happened in April?

MS SHERLOCK: Okay. So there's a planned inspection in April 2011 that finds a number of areas of non-compliance against the essential standards. At that point, as per the risk management process and operations, it is escalated by the region to the national risk register. I would review –

PROF MONTGOMERY: And that would go via you as something they would say to you 'this needs to be on the national risk register' and you would deal with the risk element?

MS SHERLOCK: No, that would be Louise Dineley.

PROF MONTGOMERY: Right. Thank you.

MS SHERLOCK: At that point I would be discussing informally with Louise her views on levels of risk that were on the national risk register. At any one time there might be around 12 or 15 NHS organisations and there could be several dozen adult social care and independent healthcare organisations on that national risk register. We would have discussed, perhaps at the monthly risk escalation committee, Morecambe Bay as it had been escalated to national level and I would –

MR BROOKES: I think that's a minuted meeting.

MS SHERLOCK: Yes, that is a minuted meeting.

PROF MONTGOMERY: And that's an internal CQC meeting?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Thank you.

MS SHERLOCK: And I would have been discussing in my line management capacity with the regional director problem cases, if I could put it in that way. So cases where the regional team were struggling to agree the regulatory plan or there is a problem with engagement with an organisation and that would tend to be four or five cases at a one-to-one meeting that we would cover.

PROF MONTGOMERY: And so you would have no direct relationship with the Trust at this point?

MS SHERLOCK: No.

PROF MONTGOMERY: You would be dealing with supporting and managing the –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – the planning committees, the region. By this time there's quite a lot of paperwork that's known around or maybe not known around the

place. So what were you aware of in terms of previous investigations and inquiries from the regional?

MS SHERLOCK: Until the summer of 2011 I didn't have a lot of awareness about the previous inquiries or reviews. When we went to do the April inspection and then followed that up in the June or July with an inspection into maternity services that was, again from memory, a joint inspection with the NMC that's when I started to have active oversight working with the divisional director of the regional team of Morecambe Bay and I asked for the background and the history.

PROF MONTGOMERY: So can you remember what you were told about the background and history?

MS SHERLOCK: I was – Sue would have provided me with the background to her conversations with Mr Titcombe and the conversations with the Trust about obtaining the Fielding report where there had been some significant delay in the Trust providing it through to the region. She would have been speaking to me about how she found the Trust and the relationship with the SHA and we would have been discussing what the next regulatory steps would be. I know that because there's an e-mail actually between myself and CQC's Head of Legal Services at that time where I asked him whether CQC still had the power of special measures because I was seriously concerned after the July inspection of maternity services that this was not just a service that had for some time had failings but appeared to be deteriorating even from a quality and safety base. I wasn't convinced that using the compliance powers was going to be effective in making short term change. And the other area of

concern that I had is that there are quite strict regulations around what you can say in the public domain when you're using your Section 60 registration powers. So I asked for advice from our Head of Legal Services. He came back to me and said no, that CQC had lost in the 2008 legislation the powers to invoke special measures but we did have the Section 48 powers.

So through August the region were preparing and issued warning notices, further warning notices under the Section 60 registration powers on the maternity unit. I was discussing with the regional director, colleagues in CQC at the Department of Health and in particular with Monitor about what and whether we would do a Section 48 investigation. The issuing of the warning notices in late August, I think it was, triggered Monitor to increase their risk rating on UHMB and to formally consider intervention using their powers. So these discussions were taking place daily.

PROF MONTGOMERY: So this is not in the weekly/monthly exchanges?

MS SHERLOCK: No.

PROF MONTGOMERY: This is a special set of discussions –

MS SHERLOCK: This is specifically around Morecambe Bay through, through late August and into September.

PROF MONTGOMERY: And this is about the maternity services issues –

MS SHERLOCK: Yes.

PROF MONTGOMERY: – that they had?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Yes.

MS SHERLOCK: Yes.

MR BROOKES: And was it specifically about maternity?

MS SHERLOCK: It was specifically about maternity.

PROF MONTGOMERY: This is, I don't think we've got the flow but would you have been trying to gather more information about the past at this stage as context or would you just be focussing on what's the current risk because you talk about the Fielding report and you were trying to sort of gather intelligence about?

MS SHERLOCK: We would have been focusing on the current risk that Cognisant and I had asked for a full chronology, received a full chronology of what had happened in the run up to the summer of 2011.

PROF MONTGOMERY: So that included the Fielding report?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Did it include the reports that happened before the Fielding report that had been done?

MS SHERLOCK: No, not to the best of my recollection.

MR BROOKES: So in terms of the reports, just to be clear, the Fielding report was the only report that you were made aware of?

MS SHERLOCK: Yes.

MR BROOKES: Okay.

MS SHERLOCK: And the CQC's history of interventions.

MR BROOKES: Yes. But not other independent internal or external report was made available to you?

MS SHERLOCK: No.

MR BROOKES: Thank you.

MS SHERLOCK: No. During September the organisation reported a ~~suing~~ S.U.I. through to the Strategic Health Authority, I believe, that concerns, that concerned out-patients services. That was brought to the regional director's attention and she was having conversations about the significance of this with Monitor and with the SHA keeping me advised and informed as it related to the broad context of Morecambe Bay, but again at that time through September my primary attention was on maternity services. There was also, I believe, another infant death during September 2011 that was reported to the regional director to Sue McMillan. Sue called me and I asked for an urgent teleconference with the regional team, myself and Louise Dineley and our Director of Communications and Engagement. That teleconference took place around, it's around 25th/26th September where I asked the region to go back in, even though the warning notices were set until November, I asked the region to go back in and check as there had been this further infant death and also to consider whether we went for urgent action and asked the region to consider whether there was evidence to suspend maternity services as a regulated activity at Morecambe Bay.

The region, I believe in discussion with the Strategic Health Authority and Monitor, did review the current status and the current evidence. Sue McMillan came back to me, and it's documented in an e-mail traffic, that they didn't feel that there was sufficient evidence to warrant a suspension of the regulated activity but in light of other emerging concerns that the Strategic Health Authority were going to set up what was called Goal Command[?] to have oversight of all of the emerging concerns which CQC and Monitor would

corroborate in fully. In light of the setting up of Goal Command the regional director advised me or recommended to me that we hold off any further regulatory interventions or, going forward, a Section 48 investigation to see how effective Goal Command could be in getting a grip on Morecambe Bay as it were.

PROF MONTGOMERY: So just to be clear in my mind. You're contemplating Section 48 at that stage?

MS SHERLOCK: Yes.

PROF MONTGOMERY: The advice is that this is not the time partly because there isn't sufficient evidence of what's going on for you to be sure that was right and partly that somebody else was picking it up through Goal Command?

MS SHERLOCK: Yes.

PROF MONTGOMERY: And what was the CQC's involvement in Goal Command?

MS SHERLOCK: They attended all of the, I think there were daily teleconferences at first and then meetings and there was CQC representation right up until the launch of the investigation.

MR BROOKES: Can I just check before I lose the thread?

There was a decision made about whether to suspend maternity services?

MS SHERLOCK: Yes. I asked the regional director —.

MR BROOKES: Yes.

MS SHERLOCK: – who would have the ultimate decision in the ~~senior~~ scheme delegation to consider suspension.

MR BROOKES: Yes. Under what circumstances would suspension happen?

MS SHERLOCK: When there was serious risk to quality or safety of services.

MR BROOKES: So the judgment was made in this case it didn't meet that criteria?

MS SHERLOCK: That the risks of suspending the regulated activity outweighed the risks of all the organisations collectively coming together to address the quality and safety concerns of the service.

MR BROOKES: Okay. So that's the ultimate sanction in a lot of ways around that particular –

MS SHERLOCK: Well cancellation is the ultimate.

MR BROOKES: Cancellation.

MS SHERLOCK: Yes. Suspension is a temporary measure.

MR BROOKES: Yes. Cancellation means like you don't do it again.

MS SHERLOCK: You don't go it again.

MR BROOKES: Suspension is for a period of time.

MS SHERLOCK: Yes.

MR BROOKES: You can't do it now.

MS SHERLOCK: Yes.

MR BROOKES: Going down the line of escalation, the next one down is Section 48?

MS SHERLOCK: Section 48 is under a set of different powers so you have no regulatory sanctions, as it were, under Section 48.

MR BROOKES: Under the suite of powers that CQC has what would be the step below suspension?

MS SHERLOCK: That would be restrictive conditions.

MR BROOKES: And was that considered?

MS SHERLOCK: That was also considered but that would have taken a considerable amount of time because of the rights of representation against the placing of a restrictive condition and also restrictive conditions are quite complicated legal tools to use on an NHS organisation because they are the NHS organisations registered to provide regulated activities at certain locations. So a restrictive condition could be, and we did use at Barking, Havering and Redbridge, could be you can only admit so many women to give birth if you've only got this number of staff on duty. So at this point you have to divert to another provider. That would have been hugely problematic at Morecambe Bay. At Barking, Havering and Redbridge you've got a dozen trusts within half an hour's drive. That's not the case at Morecambe Bay and as a regulator there is this –

MR BROOKES: And the decision is CQC's?

MS SHERLOCK: It is CQC's.

MR BROOKES: Okay.

MS SHERLOCK: Yes.

PROF MONTGOMERY: And how were they documented?

MS SHERLOCK: Sorry?

PROF MONTGOMERY: The thing you have just described to us, how would it be documented within the CQC?

MS SHERLOCK: That should be documented in the regulatory plan and the CRM.

PROF MONTGOMERY: Thank you.

MR BROOKES: Sorry, I just wanted to understand a little bit. So we moved away from most of the reasons that you've described. Section 48 was decided,

recommended to you to not be appropriate until Goal Command was given an opportunity to see whether it would resolve the issues?

MS SHERLOCK: Yes.

MR BROOKES: Thank you.

PROF MONTGOMERY: There's a reference in the Grant Thornton report to CQC declare an internal meeting to re-examining its regulatory decisions. Is that – do you think that would be a reference to what you've just described?

MS SHERLOCK: That was – I asked Louise Dineley, as my head of quality and risk, to undertake a review. We had a policy that was called Serious Internal Incidents. I requested that Louise looked at the regulatory oversight of Morecambe Bay with a view to making recommendations about what we could have or should have done differently or to say no, the decisions were appropriate.

PROF MONTGOMERY: If I understand the sequence right then, you have taken a decision, the CQC has taken a decision about the suspension issue?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Having taken that decision that you described, you then say there was a stock-take of this and look back. Is that the way you see things?

MS SHERLOCK: I think, yes, there were two separate processes, but my asking Louise was driven by my discomfort around allowing the scenario to carry on for too much longer. So, at the beginning of August I had asked for legal advice about what can we do, because this is interior to the service. We issued the warning notices in early September; there were then further incidents. I asked the region to consider suspension. It was not felt to have

the evidence to use suspension so I then say well, section 48 might be appropriate because then at least with a section 48 you can immediately get your concerns into the public domain, so you announce that you are going to do a section 48 investigation and these are the terms of reference. You are not able to do that using registration powers.

PROF MONTGOMERY: Do you remember when that was?

MS SHERLOCK: That was early October.

PROF MONTGOMERY: October, okay.

MR BROOKES: You asked for a chronology of events when you became aware of the seriousness of the issues?

MS SHERLOCK: Yes.

MR BROOKES: Was there anything in there that worried you about the fact that there was an opportunity to miss. I am linking that to what you said about the review you asked for. Was there anything that came out of those reviews that made you conclude that you think there were opportunities missed where things could have been intervened a bit earlier?

MS SHERLOCK: Yes, there were two aspects. The first aspect was the not putting conditions on the registration.

MR BROOKES: Yes.

MS SHERLOCK: I reviewed and looked at why that decision had been taken. On reviewing it, I think it was an understandable decision. It is not the decision I would have taken but that doesn't mean it was the wrong decision.

PROF MONTGOMERY: Can I just check on that. That was on the basis of the information held by the CQC at the time?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Did it have the Fielding Report at the time it took that decision?

MS SHERLOCK: Not at the point of registration.

PROF MONTGOMERY: Do you think if it had had the Fielding Report, it would have tipped the balance of a different decision?

MS SHERLOCK: I am sure it would because at registration, which I only remember looking back over documentation, the National Quality Assurance Panel that was put in place for all NHS organisations registration decisions did ask the region to consider whether the level of risk was a moderate or major risk rather than the minor risk that the region had determined it to be. Had the region said it is a moderate risk, we would have been looking at putting compliance conditions on the registration. The region determined it was a minor risk and therefore it didn't reach the criteria.

MR BROOKES: What requirements are there on organisations such as Trusts to provide information to the CQC?

MS SHERLOCK: At point of registration there was a legal requirement in making its declaration of compliance or noncompliance to provide us with all material information that would inform the CQC's decision. So, it is a self-declaration. The legal requirement is that you have to make an accurate declaration, you cannot withhold information that the regulator should have sight of. We did have a couple of organisations where subsequently we found that they had had information that would have materially impacted their declaration of compliance, so you knew you could not possibly be compliant with that

standard because you had an internal review et cetera. But proving that, that then goes into the criminal powers of CQC where the weight of evidence has to be much more significant. We couldn't prove that the Trust had knowingly withheld information on the balance of criminal....

PROF MONTGOMERY: You have read the Fielding Report, would you have formed the judgment that that should have been disclosed?

MS SHERLOCK: Absolutely should have been disclosed.

MR BROOKES: You believe that was a material report?

MS SHERLOCK: Yes, absolutely.

MR BROOKES: Was there any consideration taken when the Fielding Report became knowledge to CQC under criminal powers?

MS SHERLOCK: No.

MR BROOKES: Why was that?

MS SHERLOCK: I think the passage of time. By the time I became aware, it was over 12 months from the point of registration. Whilst I absolutely can understand that that would have been an accountability issue for the board of the organisation, I was more concerned about the quality of safety issues that were still prevalent in the organisation.

MR BROOKES: Thank you.

MS SHERLOCK: It would have been a big distraction.

MR BROOKES: I understand, thank you.

PROF MONTGOMERY: You say there were two missed opportunities; we just discussed one of them.

MS SHERLOCK: Yes. The second was in my management conversations with Sue

as the Regional Director, the amount of time she was spending in conversation with both the SHA and the Trust, that it almost felt like the Trust didn't know what to do to put things right. I was concerned that Sue was almost starting to take ownership for the problems.

PROF MONTGOMERY: Can I ask related to that then, part of the process and information that comes to CQC in terms of compliances et cetera, there are elements which belong/relate to the life of NHS Family as well. Would you have expected the SHA, if had been aware of the Fielding Report, to bring that to your attention?

MS SHERLOCK: Yes.

MR BROOKES: I think we are now still October '11, aren't we?

MS SHERLOCK: We are.

MR BROOKES: But you have been very helpful so far.

MS SHERLOCK: From October '11 we have agreed to participate in Gold Command; I am having lots of conversations and e mail traffic with the Regional Director to keep me updated; I have asked Louise Dineley to look at CQC's internal processes and make recommendations to me about those processes. I then go on a month's leave, so I was away from 26 October through to about 22 November. As part of my hand over to the deputy director who was covering for me, I asked Louise to keep the Acting Director of Operations and the Chief Executive informed of anything that might be escalating around Morecambe Bay.

Monitor at this point also determines that they would use their formal powers of intervention to require a series of reviews at Morecambe Bay. I was

expecting to be briefed on my return from holiday about the progress that Gold Command was making in addressing the problems.

PROF MONTGOMERY: As you went away, you knew that all this activity would happen in your month's leave?

MS SHERLOCK: Yes.

PROF MONTGOMERY: You had arranged for that to be briefed up while you were away?

MS SHERLOCK: Absolutely, yes.

PROF MONTGOMERY: But your expectation was that you would come back and grab the horns from there?

MS SHERLOCK: Yes. My date of return would also coincide with the date on the warning notices that had been issued, so there would be the opportunity to go back and check on the warning notices et cetera.

MR BROOKES: Just on that, when were the warning notices due to expire?

MS SHERLOCK: Around the middle of November.

PROF MONTGOMERY: So you arrive back on 22 November?

MS SHERLOCK: Yes.

PROF MONTGOMERY: What happens then?

MS SHERLOCK: Morecambe Bay wasn't on the top of my to do list. A member of the CQC Board and inspector made whistle blowing disclosures to the statutory inquiry and the inquiry basically reopened to take that evidence and information. As I was the main witness for the CQC, that completely consumed my first couple of weeks back, working with the inquiry solicitors and CQC solicitors to get additional witness statements prepared and submitted to

the inquiry.

The next point, I would have been discussing with Louise but on a more informal briefing basis what is happening at Morecambe Bay.

PROF MONTGOMERY: Louise would have been taking the lead at this point?

MS SHERLOCK: Yes.

PROF MONTGOMERY: And coming to you if she felt that she needed to?

MS SHERLOCK: Yes.

PROF MONTGOMERY: But looking after it while you were engaged in that?

MS SHERLOCK: Yes. The next point is that Louise has emailed me I was flying back from my holiday saying that there was going to be a teleconference with Sue McMillan, the Regional Director, to consider the progress or not of Gold Command, and how the region were going to respond to the expiry warning notices, so to get a plan together effectively. I emailed back and said if I was able I would ring in, but my diary was going to be full when I returned so not to hold that conversation up for my diary; I would join it if I was at all able to do so.

I didn't join the teleconference but I was briefed. That raised again my concerns that CQC were being too passive and that there were lots and lots of things emerging from the Central Manchester Review that had been commissioned at the start up that my monitoring colleagues were sharing with me confidentially that raised my anxieties that the services were not safe.

PROF MONTGOMERY: Can you remind me, the Central Manchester Review, was that the whole Trust?

MS SHERLOCK: No, that was just the

PROF MONTGOMERY: Thank you.

MR BROOKES: Just for clarification, I understand the outlooks to you, what were you doing in terms of briefing your Chief Executive and reporting to people within the organisation at a national level?

MS SHERLOCK: That would have been through the National Risk Register. We had weekly meetings with the Chief Executive and a number of other executives. That was an informal briefing meeting so it wasn't minuted. Myself and Louise attended those meetings and we would run through what were the organisations that were increasingly rising up the National Risk Register. I would also have been briefing on Gold Command and making sure that if the Chief Executive was speaking to the Chief Executive of Monitor or the Chief Executive of the SHA, that they were fully aware of what was happening regionally and operationally.

MR BROOKES: And the Department of Health?

MS SHERLOCK: We were continuing with having discussions through all this period.

MR BROOKES: So they were fully advised of all this?

MS SHERLOCK: Absolutely.

PROF MONTGOMERY: Prior to the publication of the CMR, the Central Manchester Report, which is December sometime, is it not, I think.

MS SHERLOCK: Yes.

PROF MONTGOMERY: You already know that the emerging findings were giving you considerable cause for concern?

MS SHERLOCK: Yes.

PROF MONTGOMERY: So you are thinking about the next steps.

MS SHERLOCK: Yes. Following the teleconference, Louise briefs me. She also briefs me about some of her early thinking around the review I have asked her to do in CQC's regulatory decisions. I then ask for a meeting, I think we do it by teleconference, with the regional team myself, Louise, and I can't remember what other colleagues were there but other CQC colleagues. I take advice from a couple of the couple of the national professional advisors. We discussed whether, I think I described it in an e mail as the tipping point has been reached. I no longer am confident that Gold Command oversight is going to be expedient enough to address the current safety concerns.

PROF MONTGOMERY: Can I just push you a little bit and ask what you mean by that. You had expectations that Gold Command would be sufficient?

MS SHERLOCK: Yes.

PROF MONTGOMERY: It has become apparent to you by this stage that it is not sufficient. Is that because problems have increased or because the employee

MS SHERLOCK: The scale of problems I think was broader and deeper than I believed either to be the case. I had significant concerns about maternity. The scale of problems across the wider organisation was becoming much more apparent.

MR BROOKES: So, Gold Command started on concerns about maternity and this issue around outpatient death?

MS SHERLOCK: Yes.

MR BROOKES: But it expanded once it got into it, is that it?

MS SHERLOCK: Other problems started to emerge.

MR BROOKES: Okay.

MS SHERLOCK: Also there were conversations myself, ~~Monitoring~~ Monitor, the Department of Health about the sustainability of the Gold Command putting in additional resources. Services aren't growing on trees anywhere in the country, so having to supplement and sustain a service at Morecambe Bay could clearly have had an impact across the wider north-west region. So, the questions and conversations we were having at a national level is it is not sustainable, do we think the problems are being resolved, that when those resources are pulled out Morecambe Bay would be a safe maternity service. I had absolutely no evidence that that would be the case; in fact, contrary evidence.

PROF MONTGOMERY: Thank you. What are your options at this point?

MS SHERLOCK: Options are to take further regulatory sanctions, which we did consider. We considered extending the timeframe of the warning notices or issuing more warning notices. I was not keen to do that because I felt it was giving the Trust a bit of a get out of jail free card, because you issue the warning notices and you say you must be compliant by this date. That meant that you got a further period of time when they were potentially non-compliant. I discussed with Sue McMillan, the Regional Director, who agreed that really there didn't seem to be anything to be gained by issuing further warning notices other than it was another slap on the wrist for the organisation.

MR BROOKES: So, the warning notice was due to expire end of November?

MS SHERLOCK: Yes.

MR BROOKES: They are allowed to expire?

MS SHERLOCK: Yes.

MR BROOKES: They were not replaced?

MS SHERLOCK: They were replaced. It's complicated and I will try to make it as easy as I possibly can. The warning notice says you are required by the law to be compliant, you are not compliant and we are giving you until this date to tell us how you intend to be compliant, so the expiry date

MR BROOKES: Sorry, sorry, that is the bit I was just wanting to understand. So, you have until this time to tell us how to do it or do you have to be compliant by that date?

MS SHERLOCK: You have to be compliant. You are required to be compliant all the time.

MR BROOKES: But by the end of November when the notice expired, was the Trust compliant?

MS SHERLOCK: No.

MR BROOKES: That is what I was trying to get at.

MS SHERLOCK: No.

PROF MONTGOMERY: How do you mark that assessment that they are not compliant?

MS SHERLOCK: It would normally have been a re inspection. We didn't do a re inspection because of the weight of the information and evidence that was coming out through Gold Command that clearly demonstrated the Trust were non-compliant so there was no need to do a re-inspection.

PROF MONTGOMERY: You didn't inspect?

MS SHERLOCK: No, we knew they were non-compliant.

PROF MONTGOMERY: If you know someone is non-compliant and they have had warning, what is the usual regulatory sanction?

MS SHERLOCK: Then we would be looking at either restrictive conditions.

PROF MONTGOMERY: Who makes that decision about who can impose restrictive conditions?

MS SHERLOCK: That would be the Compliance Manager in discussion with the Regional Director.

PROF MONTGOMERY: And the other ones who had had restrictive conditions as well?

MS SHERLOCK: Suspension of the regulatory activity; that would have been the Regional Director, certainly in discussion with myself because of the impact of a suspension; or going for either an urgent cancellation or a slow route cancellation.

PROF MONTGOMERY: Explain what a slow route cancellation is.

MS SHERLOCK: You would issue notice of intention to cancel registration. The Trust then has a right of appeal, 28 days to make representations. You consider the representations and then make the decision about whether you are going ahead with the cancellation. The Trust would then have the right of appeal firstly to a Tribunal. Whereas an urgent would be a Magistrates Order.

MR BROOKES: In this case none of those were put into effect?

MS SHERLOCK: They were all considered. We considered absolutely every avenue, discussed with the regional team every avenue, discussed the pros and cons. I discussed with the Chief Executive and with Monitor colleagues

the pros and cons, and we determined, CQC determined, myself, the Regional Director and Louise Dineley primarily, that Gold Command were giving assurances through to the Department of Health that the extra resources and oversight wouldn't be withdrawn any time soon because of the risk, but they would have to be withdrawn and a section 48 investigation would give us evidence on which to make recommendations, more strategic recommendations, for example around service reconfigurations. That couldn't be done through CQC using its regulatory powers.

PROF MONTGOMERY: Just help us. Is this one decision you are taking? Are you looking at the regulatory powers and you are considering section 48 or do you look at the regulatory powers first?

MS SHERLOCK: We looked at all of the regulatory powers first and didn't discount concurrently using the regulatory powers, which we did go on to do through the investigation, but to address the underlying systemic issues that were emerging over that three month period.

PROF MONTGOMERY: There is a gap between the section 48 decision then and the expiry of the warning?

MS SHERLOCK: The expiry of the warning notices is end of November, those warning notices were on maternity services. The decision, the formal decision is taken, I think it is 14 December, by the CQC Chief Executive to authorise a section 48.

PROF MONTGOMERY: What did the Trust understand then? You told us that you know they are no longer compliant.

MS SHERLOCK: Yes.

PROF MONTGOMERY: And what they know is that their warning expires.

MS SHERLOCK: Yes. The Trust were... it was almost like they learned our business. They didn't know what to do, they were being propped up by the Gold Command resources and the oversight. They were waiting for the Central Manchester Review, the outpatients review and the ~~governors~~ governance review to report. They didn't appear to me, but I was quite distanced so it is impressionistic on what I was being told by colleagues, they didn't seem to be taking of their own accord any urgent or remedial actions to address the problems.

PROF MONTGOMERY: If you extend the warning, that is not a good look.

MS SHERLOCK: It gives more time and we are saying again I can't think of a better way of phrasing it. It felt to me that we were almost saying we know you're not compliant, we are going to extend the warning notice because you can't become compliant. I wasn't prepared to let that continue.

PROF MONTGOMERY: What you have actually done is there is no regulatory action to the notice beforehand.

MS SHERLOCK: No.

PROF MONTGOMERY: When did they know that section 48 was going to happen.

MS SHERLOCK: They would have been known either the 14th or around 14 December. As soon as the decision was made, I advised David Nicholson's office who would advise the SHA, and the Trust were advised I believe by Sue McMillan.

MR BROOKES: You have considered the regulatory powers that you have had, the different options, and decided that they are not appropriate in this particular

case.

MS SHERLOCK: Or they weren't to lead to change or speed of change.

MR BROOKES: Okay. Then you are looking at section 48 as a tool to deal with the change that is required?

MS SHERLOCK: Yes.

MR BROOKES: So, this is being generated by the concerns in maternity?

MS SHERLOCK: Yes.

MR BROOKES: Thank you.

PROF MONTGOMERY: How do you set up the section 48?

MS SHERLOCK: Okay. It could read like we made the decision on 14 December and then we started applying. This had been weeks and weeks and weeks beforehand of considering the options, considering what we might want to review. We seriously considered whether we would use maternity services, do the section 48 on maternity services. I was having many discussions with Monitor colleagues, and I took the view and made the recommendation to the CQC Chief Executive that doing the section 48 on maternity services would not add value to the work that Central Manchester were doing. We would be using the same sorts of clinical expertise, we would have been looking at the same issues. Monitor had agreed and indeed were making the evidence and the findings from Central Manchester available to CQC to use as additional evidence. So, I didn't feel there was anything to be gained by focusing on maternity services when it was already subject to quite significant scrutiny.

We were concerned, the CQC and Monitor were concerned. I think it was described to me by Monitor colleagues when they had been having a

meeting with the Morecambe Bay board that they didn't know what they didn't know, that the systems and processes of risk and quality assurance within the Trust were so lacking that the board probably weren't even aware of the scale and nature of the concerns. That discussion took place around late November 2011.

I discussed, as I would with any case of this significance, with Louise Dineley what might be a good proxy for getting under the skin of the wider organisation so that we could understand was it something that was specific to Furness General, was it something specific to maternity services or was this a dysfunctional organisation. From my kind of background in the NHS, the way that an organisation manages its emergency services is a really good proxy to its quality systems, its governance and oversight systems, how it manages its capacity, balance of its elective and its emergency; all of the kinds of operational systems and processes. We also were being advised that they were missing ~~any~~ many targets, that there was considerable noise from the Ambulance Service and from GPs about the quality effectiveness of Accident & Emergency. That was the rationale behind choosing the emergency care pathway. It was then for CQC to identify a suitably qualified and experienced investigation manager to pull the team together and to develop the specific terms of reference, which we did.

PROF MONTGOMERY: I understand from that why you picked maternity services, I don't understand why you didn't also include something in terms of communicating your view on maternity because when you did bulking and covering, you did both so you could do both at the same time.

MS SHERLOCK: Yes.

PROF MONTGOMERY: If I was sitting in the Trust I would say okay, the warning has expired, they are not doing anything else, they are coming in now and looking at other things so obviously maternity is okay. Did you do anything to get that message across?

MS SHERLOCK: There would have been many conversations with the Regional Director and the Trust. I believe the Director of Nursing and the Chief Executive were the main conduits for her conversations with the organisation. There would have been no doubt that we had significant and serious concerns. The warning notice date expires but the warning notice still stands; you are required to be compliant, the law requires you to be compliant. So, not being compliant by that date did not preclude CQC using that as evidence, were it to use it later at some future point in time.

MR BROOKES: I understand that but look if I look from outside, I might think that that indicates that it has become compliant because there is no longer any regulatory action.

MS SHERLOCK: It would if we had removed the warning notices but the warning notices did remain. I can absolutely understand from the general public, you know, that must seem strange but the warning notice stands until CQC removes it.

PROF MONTGOMERY: Can I push you perhaps and ask you in a general way is there any communication with whistle blowers or families who raised issues with the CQC that would spark these inquiries as they go on or does it go quiet from there?

MS SHERLOCK: I don't believe it went quiet at all. Indeed when we were seeking to launch the public that we were going to do the section 48, that invited people who had got experiences or concerns or staff who wanted to whistle blow to contact the CQC, and that information helped to shape the terms of reference and the lines of inquiry that the investigation officer drew up.

PROF MONTGOMERY: Does that mean that there was some discussion about whether maternity should or shouldn't be incorporated with the stakeholders?

MS SHERLOCK: No with the stakeholders, no. Certainly those conversations took place with the Department of Health and SHA and Monitor about whether maternity services should be incorporated.

MR BROOKES: So, there was a reliance on Gold Command to sort out the specific issues about maternity?

MS SHERLOCK: Yes.

MR BROOKES: What has happened is that you had expanded your remit through some of the things that had come in to look at the whole of the organisation and were using many of these as proxy to get under the skin of the organisation?

MS SHERLOCK: Yes.

MR BROOKES: The only way in which they were going to become compliant on maternity services at that stage was through the actions of Gold Command?

MS SHERLOCK: Yes.

MR BROOKES: Thank you.

PROF MONTGOMERY: Just to make sure I have understood this correctly, in terms of current safety issues, you get some assurance that Gold Command is still in

place.

MS SHERLOCK: Yes.

PROF MONTGOMERY: It is putting more resources in. What you are describing here is the Trust is running the show on maternity as they fear risk issues?

MS SHERLOCK: Yes.

PROF MONTGOMERY: In terms of understanding what is at stake, you think you are getting enough information from the Central Manchester work to tell you what you need to know for any future regulatory action?

MS SHERLOCK: Yes.

PROF MONTGOMERY: That is why you don't add any value to send your people in to adjudicate?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Okay, I think that is very helpful.

MR BROOKES: On the face of it, it looks like you have put a particular issue in maternity services. Your introduction to your report talks about the all the concerns of maternity services and later on in A&E, so we need to be clear on the reasoning behind it.

MS SHERLOCK: It was a strategic manoeuvre and we were working very, very closely with Monitor about what we wanted to achieve across this whole organisation. It was absolutely mindful that maternity services had a very sad history.

PROF MONTGOMERY: I am conscious that we have taken a lot of your time already. We already know, I think, quite a lot about how the investigation itself went because we have had a lot on that. I think you answered one of the

things we have and that we didn't quite understand, which was about how the maternity reference were drawn up and agreed. Can I just check one aspect of that was that you signed them off jointly with Monitor.

MS SHERLOCK: Yes.

PROF MONTGOMERY: So, that goes with the CQC investigation.

MS SHERLOCK: Yes.

PROF MONTGOMERY: The maternity reference would have been signed off by yourself and Adam ~~Hailey~~ Cayley.

MS SHERLOCK: Yes.

PROF MONTGOMERY: Was there anybody else who would have seen the terms of reference and you would have checked them with the process, or just those two organisations?

MS SHERLOCK: I am sure the chief executives of both organisations would have seen them.

PROF MONTGOMERY: There is one bit that you were involved with we understand in relation to the ~~Coffey~~ inspection itself and it is because Louise Dineley was on leave at the time. There was an escalation in the middle of it; we were told that you were available to advise on what should happen then.

MS SHERLOCK: Yes.

PROF MONTGOMERY: Can you tell us what would happen then?

MS SHERLOCK: There were two regulatory interventions, as it were. The first was we went into an inspection of Accident & Emergency, I think on 20 December. The reason for that was I was asked by the SHA Department of Health if we could delay announcing the section 48 until after the Christmas and New Year

period. They were particularly concerned about public confidence in the services that are busy and pressured at the best of times. I said yes, I would agree to that if we went in and did an unannounced inspection to put the Trust on their toes, as it were, in Accident & Emergency.

The regional team went in, did an inspection, found some significant concerns that culminated in the issuing of warning notices on Accident & Emergency that were issued into the public domain mid-February, but the Trust would have been aware from the date of inspection that it was our intention to issue those warning notices.

The second intervention was Mandy, Amanda Musgrave, phoned me quite late one evening. It was either the first or second day of the onsite parts of the investigation. She said that she was so concerned about what she had seen in the department that she wanted to escalate it. I think her words were "this is way beyond my pay grade and I want you to know how serious things are".

I contacted Monitor, indeed emailed immediately that evening; emailed my Chief Executive and Director of Communications immediately and set up an urgent case conference meeting with Amanda, myself, Louise and the regional regulatory team for the next morning. The decision from that case conference was that there would be a further inspection. That inspection took place by the regulatory team and there were indeed very serious concerns. We then had a further discussion. I would not normally be so involved and enmeshed in the case conferences. Because of the seriousness and the investigation, I did maintain my involvement and I discussed with the now new interim regional

director, Debbie Westhead, whether we should apply restrictive conditions.

PROF MONTGOMERY: You say different people went in to do that from the people that you were

MS SHERLOCK: Yes, because we were looking at using our compliance powers rather than our investigation powers. Mandy Musgrave obviously was involved in all of these discussions but, as the Investigation Manager, couldn't make the regulatory decisions.

PROF MONTGOMERY: That is over those few days extra people are drafted in.

MS SHERLOCK: Extra people, yes. I was having conversations with Debbie Westhead, who was the Regional Director. We again went through one and other of our options, and the option that we came up with, I was surprised if I am being perfectly frank, that Accident & Emergency was in such a mess that it had Gold Command overseeing wider ambits of the organisation. We discussed what our options were, and I suggested that Debbie worked with our legal team to propose a restrictive condition but a restrictive condition on their elective services, so that there would be greater capacity created in the organisation to resolve what were very serious and immediate concerns in emergency services.

We drew up a restrictive condition that proposed restrictions on their knowledge of elective so that the Trust could move around its capacity and move around its staffing, which I ran operations in a large acute Trust it would seem a sensible thing to do; if you have got pressures, you look at your emergency.

We advised the Trust and advised NHS England by that time, it was

the New Year, that it was moving from the SHA to the new north region of NHS England, and were met with massive resistance from those organisations about going down that regulatory route.

MR BROOKES: Because of the impact on waiting times?

MS SHERLOCK: Yes. I had conversations with ~~Jay~~ Jane Cummings and Stephen Singleton, S Singleton; advised them why we were going down this route. Their view was that they weren't trying to interfere with the regulatory decisions but did we understand the impact that this would have. My response that did go back in writing is that I understood perfectly the impact, it wasn't a decision that we were seeking to take lightly; if they could come up with an alternative that would leave the same changes and have the same impact, then I was very happy to have that discussion with them.

In the event, within a couple of days the PCT and NHS England took the decision voluntarily to suspend some elements of elective admissions and create some immediate capacity to try and resolve the emergency care issues in the Trust, so we didn't have to impose the restrictive condition.

PROF MONTGOMERY: I will save for another time the definition of voluntarily in that scenario. Could I ask you whether or not that was the first conversation that you had with ~~Jay~~ Jane Cummings and Steve Singleton, had it been escalated to them on that side or were they involved in discussions earlier.

MS SHERLOCK: There had been earlier discussions with ~~Jay~~ Jane Cummings and Ian Dalton, myself and the CQC Chief Executive as we were planning to announce the section 48, so there was discussion about not frightening people with the language of press releases et cetera, keeping the whole system

advised about what we were going to be looking at and so on.

PROF MONTGOMERY: I think that is helpful. We need to know in a minute what happened after the report but I am just checking on what else we need.

MR BROOKES: I just wanted to check one thing. We have talked about the fact that originally they were fully compliant, it was seen there were no qualification on their original compliance; we then found there was some exposure in terms of maternity services not being compliant; then they come in and found that A&E is not compliant.

MS SHERLOCK: Yes.

MR BROOKES: Do you think that there were opportunities those events around the overall compliance in the organisation which should have perhaps been picked up?

MS SHERLOCK: Certainly if an investigation had taken place earlier than it did, that would have identified that there were more systemic problems. A lot of the problems emerged because of poor leadership and poor risk management. Whilst they are a component part of CQC, it is more intrinsic to Monitor's oversight than the CQC, and because of the way the essential standards were written and they were about outcomes for patients rather than the fitness of an overall organisation, it can be quite difficult to disentangle where it is poor leadership against an outcome for an individual patient.

MR BROOKES: I understand, thank you.

PROF MONTGOMERY: Can we move to after? I think other things that you have told us about the journey to inspection is really helpful, but one of the things that you have told us is that Amanda, your processes are that she stops having

involvement once that work is done and the report is delivered. It would be really helpful to have an understanding of the follow up. I am now thinking that our interests moves towards July, but it may be that there are things going on that we need to know about in between this sort of service. Keep us with your chronology but you do don't need to dwell too much if there isn't too much to be said.

MS SHERLOCK: We go in, we do the work around the ~~reserve strict I have~~ Restrictive condition, that isn't necessary, Amanda Musgrave carries with the investigation, information gathering. She is reporting to Louise Dineley so that I am completely separate from the findings and the decision making. Louise is keeping me briefed. Mandy, when she is in the office in London, again is keeping me briefed informally about how she is findings things.

New chairman, an interim chairman comes in. He is a colleague, a long standing colleague of the chair of CQC, so asks if it would be possible to have a discussion with myself and the Chief Executive about what the CQC really do think about Morecambe Bay and what is coming out of the investigation.

PROF MONTGOMERY: Just to be clear, this is Sir David Henshaw?

MS SHERLOCK: David Henshaw.

PROF MONTGOMERY: Who is Chief Executive of CQC at this point?

MS SHERLOCK: Cynthia Bower. We have that conversation. David Henshaw asks me if I was advising them on where to put his attention in this very early stage, where it would be. I talked about leadership, risk management and cross site culture. I then have no further contact until we were coming towards the end of

the investigation process.

MR BROOKES: Just to check on that then, this is around categories of things as opposed to services, so neither A&E nor maternity?

MS SHERLOCK: No, this was for his general investigation, if you were coming in as the interim chair, what would you look at. The Chief Executive has resigned around this time and I have discussions with Monitor.

MR BROOKES: Just checking, you mean the University Hospitals of Morecambe Bay, not the Chief Executive of CQC.

MS SHERLOCK: Yes, yes. No. I am having discussions with Monitor about who might be a good interim chief executive to go in there, that is completely routine. We would have that conversation about most organisations, let alone one where there have been significant concerns. Interim chief executive Eric Morton comes in, interim chair and the investigation carries on.

Mandy does advise me that the Trust are not always being as co-operative as they could be in providing information that she is requesting. On the other hand, they were drowning her with information that almost felt like a marketing campaign yes, it was really back then but look at what we are doing now.

PROF MONTGOMERY: She is being sent loads of stuff but not what she has asked for?

MS SHERLOCK: Yes, and it is not really pertinent to what she is looking in the investigation.

MR BROOKES: It is what they wanted you to know rather than...

MS SHERLOCK: Yes. She has some rather robust conversations with the Trust and

that starts to resolve itself. Mandy then starts to pull together the investigation report; I see a draft probably late April into May. The Trust then submits some additional information, I think, on the back of the new incoming chief exec and chair. That is basically a series of action plans and this is what we are going to be doing to address the historical concerns. Mandy says thank you very much but the investigation evidence will inform my recommendations, not what you aspire to do in the future that is right and proper, but it did delay by a few weeks finalising the report.

Through late May and into June we are agreeing with the Department of Health, agreeing with the Trust how you will communicate, how we will publish the investigation report. I do want to be absolutely clear there was no interference with the recommendations.

MR BROOKES: It was purely around publication?

MS SHERLOCK: It was around publication and messaging. I had a number of conversations through June with Sir David Henshaw, the Chief Executive, and the executive team. That was again about how we are going to message and press release and so on, were we going to do a press conference, if we were doing a press conference would it be ourselves and Monitor, would it be CQC, would the Trust be part of the press conference, so the logistics and tactics of publishing the report.

I also had a conversation with Sir David Henshaw about whether we would be prepared to put into the introduction to the investigation that there had been a change I think of practically all of the top team by this point, and that the Trust were committed to learn lessons et cetera. We probably

changed the tense of one sentence; apart from that nothing else changed. The report was published. CQC decided it didn't want to do a formal press conference and that it would publish the investigation report and put it out to as wide a circulation as possible, which we did in the middle of July.

PROF MONTGOMERY: If I can go back to what we were hearing before, I think at this stage I understand these discussions but if I am concerned about maternity services, that seems to have gone entirely silent on that account because you decided, for reasons we understand, that this is looking at the emergency care pathways, and we understand I guess protracted in order to do the things that you described. Are you still discussing maternity risks on your risk register or what about that side?

MS SHERLOCK: Morecambe Bay is the organisation we named on the risk register. I can't recall and I don't think it did remain on the risk register for maternity services concerns. I think that was primarily that the additional support and supervision continued this period. The Central Manchester report was published and so information of concerns was out in the public domain. We were discussing that with Monitor. Monitor, through the Director of Nursing and the Chief Executive, would have been ensuring that there was a board grip on maternity services. I am not aware that there were any serious and untoward incidents during this period.

PROF MONTGOMERY: The warning notice, I am still a bit confused about what there had been there and not in force. If I went to your website to see what it said about it.

MS SHERLOCK: It would say that there were warning notices in place.

MR BROOKES: Were the warning notices stopped on maternity services?

MS SHERLOCK: I believe from memory that they were removed in September 2012 but the regional team would be able to confirm that. I believe it was September 2012.

MR BROOKES: So, effectively for about a year they were non-compliant?

MS SHERLOCK: Yes, or they couldn't demonstrate that they were compliant.

PROF MONTGOMERY: You publish in July. In six months' time you will go back, I understand it, to see where things have gone.

MS SHERLOCK: Yes.

PROF MONTGOMERY: What happens in between July and the revisit?

MS SHERLOCK: A number of things. The investigation recommendations went back to the regional team and we ~~co-operated~~ incorporated in part and parcel of the regulatory oversight, the business as usual, so the comments would be on the quality of risk profile, for example; there would be conversations, relationship meetings, the general day to day work of the regional team. There was then a ~~licence to hold adjournment~~ Westminster Hall debate called, I think around late October/early November. That, I believe, focussed on maternity services but wasn't exclusively about maternity services. So, I, advised by Louise Dineley and the regional team, had an update in chronology, an update on any progress made against the investigation, although it was still a relatively early stage and I, along with my Monitor counterpart, briefed Dan Poulter as the Minister who would be participating in the Westminster Hall debate. That gave us another opportunity to review the progress that the Trust were making. I believe by this point it had now had its substantive chief executive appointed,

an appointment that Monitor had a great deal of confidence in the making, and there was no reason to believe that the Trust was not on, if not a spectacular trajectory, a steady trajectory of improvement from a very low base.

PROF MONTGOMERY: Can I just test your language there. There is no reason that they weren't, was there any reason to believe that they were?

MS SHERLOCK: The region's oversight of the actions and information plans that was being sent to them.

PROF MONTGOMERY: Okay.

MS SHERLOCK: Then, I believe it was early 2013 but it might have been late 2012, we were alerted that the Trust didn't feel they were able to safely staff the Furness, I think it was the special care baby unit, and were looking to temporarily transfer special care facility to consolidate on the Royal Lancaster site.

PROF MONTGOMERY: You don't happen to remember how early that was in 2013?

MS SHERLOCK: I can't but it would be documented because I was advised by both the regional office of CQC and by Monitor. That was obviously escalated through the SHA, NHS England to the Department of Health.

PROF MONTGOMERY: Can I push you a little bit because what the documentation I see shows is that they only knew after the decision had been taken to close the unit.

MS SHERLOCK: Yes.

PROF MONTGOMERY: Does that feel like that is your understanding?

MS SHERLOCK: My understanding is that the Trust took the decision.

PROF MONTGOMERY: And then told you?

MS SHERLOCK: And then told us, yes. They told the CQC on the basis that they didn't feel that they could safely staff the unit. I wasn't party to their conversations.

PROF MONTGOMERY: I was trying to understand that there were conversations going on at a slightly better pace, but the standard is that it suddenly came to a head and you, like everybody else, were suddenly briefed at the same time.

MS SHERLOCK: Yes, yes. I then said to the regional team had we picked this up, the Trust were telling us that they had concerns about staffing. The regional team, the best to my recollection, said that yes, they had been advised where there were staffing concerns that the Trust had, I think with the Royal Liverpool but again my memory not be correct, had sought additional resources through the SHA to ensure that they were compliant with the CQC registration requirements. Then the conversations were out with the CQC. Our concern was is the unit safely staffed; we were being assured that it was by these additional resources. The conversations then were the Department of Health and Monitor and the Trust, which culminated in the unit not closing, and I think additional support from across the north west region to safely staff the unit.

Because of that incident and conversations that we were having with the new chief executive and by at that point substantive new chair, we didn't go in to do the full follow up of the investigation part until I think April, so it was about eight months rather than six months.

PROF MONTGOMERY: That follow up was a follow up to the report, so that is concerned with the emergency care, not with protecting

MS SHERLOCK: Yes, yes.

PROF MONTGOMERY: Probably we don't need too much detail at this point, okay.

We are quite close to the end of our terms of reference, I think, by this point. Can you take us through sort of what the conversations are that are going on in your monthly meetings, what are they saying about Morecambe Bay, has the risk gone off the risk register by this point?

MS SHERLOCK: No, it remained on the risk register until the following had been concluded. We would have continued to discuss. We would also have been discussing lots of media attention around Morecambe Bay, not least the attention about CQC and CQC's role in Morecambe Bay. We would have been continuing to have conversations DoH, Monitor and CQC about the quality and safety of services which, had it not been for everything else going on around Morecambe Bay, on all the evidence that we had available it probably would have been deescalated from the national risk register to a regional oversight, but because of the attention and the noise and the history, it remained on the national risk register through that period.

PROF MONTGOMERY: I am trying to get my head around the management of the SHA oversight. It is complicated and you have probably already picked up some of the complication because you have got Ian Dalton coming in formally and technically the organisation has changed.

MS SHERLOCK: Yes.

PROF MONTGOMERY: They reorganised the responsibilities. I would really like just to have your take on who and how the SHA was sort of owning this problem, and what relationship it is the PCT, because the management moves

from the SHA and PCT in the middle of this process. We are trying to understand who saw themselves in charge at what point. We have a really clear picture of what you are responsible for and how you handled that, but just your engagement with the SHA and the PCTs, if you help us.

MS SHERLOCK: I had absolutely no engagement with PCTs at all, that would have been regional director and compliance manager level. My engagement with the SHA and NHS England was with Jane Cummings. I had no engagements historically with Mike Farrow as Chief Executive of the North West SHA; again that relationship would have been regional director. Clearly he could pick up the phone to the Chief Executive up to Cynthia Bower and said what is happening from CQC.

PROF MONTGOMERY: So, the key SHA relationship is with Jane Cummings?

MS SHERLOCK: Yes.

PROF MONTGOMERY: Although you talked about the Ian Dalton and Stephen Singleton, it was your main relationship with Jane Cummings (indistinguishable) way through.

MS SHERLOCK: That was a minimal relationship and that was from the start of the investigation through to the publication of the investigation. Prior to that I would have no

MR BROOKES: Most of the relationships you would have had through the regional director?

MS SHERLOCK: Yes.

MR BROOKES: Because you picked up a lot of the PCT element of this because they seemed to be absent from the conversation and clearly they are a key

player in this as well. What would be the normal relationship between the CQC and a PCT related to a troubled organisation?

MS SHERLOCK: That is really interesting because after the 2010 election, CQC's powers of assessment of NHS commissioning organisations were removed, so the relationships that we would have had historically doing the performance assessment of commissioning, that wasn't a route available. What had been set up, and all of the architecture of the regulators and the NHS was changing at this time. As inaudible were changing, organisations were changing. What had had been set up were quality surveillance groups where the commissioners, regulators and providers would meet to discuss organisations of concern. They were held monthly but they were in their very early stages at this point as it was just before the start of the Trust Development Authority et cetera. The whole system was in a state of flux; NHS England was going live in the April and systems and processes et cetera were not entirely set in stone. The quality surveillance groups which were at local level were the forum for the PCT discussions.

PROF MONTGOMERY: So, you had the quality standard.

MS SHERLOCK: Yes.

MR BROOKES: As far as you are concerned, Gold Command was being run by the SHA.

MS SHERLOCK: Yes, and chaired I believe by Jane Cummings.

MR BROOKES: That is very helpful.

PROF MONTGOMERY: I think you have been immensely helpful and it has been longer than we had hoped to keep you for but it has been really clear and very

helpful finding our way through. I think we are very grateful for your assistance.

MR BROOKES: Thank you very much.

PROF MONTGOMERY: That is all we need and thank you very much.

MS SHERLOCK: Thank you.

MR BROOKES: Thanks very much indeed.

MS SHERLOCK: Have a good weekend.

PROF MONTGOMERY: Thank you.

(End of interview)

THE MORECAMBE BAY INVESTIGATION

Wednesday, 8 October 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery– expert adviser on ethics
Ms Jacqui Featherstone – expert adviser on midwifery
Professor James Walker – expert adviser on obstetrics

AMANDA SHERLOCK
(via telephone)

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DR KIRKUP: Hello.

MS SHERLOCK: Hi, Amanda Sherlock here.

DR KIRKUP: Hello, it's Bill Kirkup here.

MS SHERLOCK: Hi there.

DR KIRKUP: Hi. I've also got Jacqui Featherstone, Jimmy Walker and Jonathan Montgomery with me. We only want to follow up on one specific area, please, because I know that you've had a full interview with us previously. Apologies that I was unable to make that. Can I just reiterate that we are going to record this and add it to the record of the interview and treat it the same way as the other information? Is that okay for you?

MS SHERLOCK: Yeah, that's absolutely fine.

DR KIRKUP: Righto, thank you. This relates to the decision by the Parliamentary and Health Service Ombudsman not to investigate Mr Titcombe's first complaint, and what we want to follow up on is: how did you learn of that decision from the PHSO?

MS SHERLOCK: Okay. I'll talk you through my recollections of the chronology of the events about that specific incident, and then, if there's anything to follow up on, I'm very happy to answer. So, in May 2009, I was advised by the CQC regional director, Alan Jefferson, that Mr Titcombe had passed on information to him about his concerns about Morecambe's response to Joshua's death and his complaint, and that he had referred that to the Ombudsman. Alan Jefferson and I discussed the CQC perspective. We referred it to the CQC investigations team, who took the decision that it didn't meet the criteria for a CQC investigation. I, as part of the protocol between CQC and Monitor at the time, wrote to Monitor and said CQC wouldn't be investigating, but we would revisit in the event – that decision in the event that the Ombudsman did an investigation or the Ombudsman, doing an investigation, had outcomes that added to the information that we had about Morecambe Bay.

At around end of August 2009, I was advised – and I believe it was either through Alan Jefferson and the conversation he had with Monitor or through a conversation I'd had directly with Monitor – that the Ombudsman were minded not to investigate and, at around the end of August, we sent a letter to Monitor, saying that, again, we would revisit the CQC decision in light of a formal Ombudsman decision. It was then about January 2010 before I

recall being formally aware that the Ombudsman had declined to investigate.

DR KIRKUP: Okay, and how did you become formally aware, in January 2010?

MS SHERLOCK: I believe I was advised, again, by Alan Jefferson, the regional director, that he had had notification that there wouldn't be an Ombudsman investigation.

DR KIRKUP: Okay. Was there any implication for the CQC in the fact that the PHSO had decided not to investigate?

MS SHERLOCK: There was. It added to our evidence base around consideration of Morecambe Bay's application for registration under the Health and Social Care Act, that the problems that had been evident in 2008, when Joshua had died, had been resolved or were actively being resolved to the satisfaction of the Strategic Health Authority, and the CQC, taking that information from the PHSO's decision, together with assurances from the trust itself and the SHA, was one of the determinants in not registering the organisation with conditions.

DR KIRKUP: Okay. You wrote an email where you referred to hearing through a roundabout route that the PHSO was not minded to investigate. Is that the Monitor/Alan Jefferson route that you described that you heard about it informally through?

MS SHERLOCK: It absolutely is, yes.

DR KIRKUP: Okay. Can you recall whether Alan Jefferson was involved in that or you heard directly?

MS SHERLOCK: I can't. It would either have been a conversation that I had with Miranda Carter at Monitor, or it would have been a conversation Alan Jefferson had had with Monitor that he and I would then have discussed.

DR KIRKUP: Okay, that's fine. I'll just ask whether anybody else has got any questions that they want to ask. Yes, Jonathan.

PROF MONTGOMERY: Can I just ask one? It's Jonathan Montgomery here. Just to check I understood correctly what you said about the formal notification in Jan 2010, you took, if I understood what you said correctly, the PHSO's decision as an indication that they thought the matter was resolved; did I hear that correctly?

MS SHERLOCK: Yes. That would have been and is my interpretation of the decision of the Ombudsman, yes.

PROF MONTGOMERY: Thank you very much. Okay.

DR KIRKUP: Is there anything else that you would like to tell us in connection with that?

MS SHERLOCK: I don't think so. I think most of it has been covered in either conversations with the inquiry – and certainly was covered in depth in the CQC/Grant Thornton review.

DR KIRKUP: Okay. That's very helpful, thanks very much for your help.

MS SHERLOCK: Okay, no problem.

THE MORECAMBE BAY INVESTIGATION

Wednesday, 15 October 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert advisor on governance
Dr Geraldine Walters – Expert advisor on nursing

ANDREW SIMPSON

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(At 10.15 a.m.)

DR KIRKUP: Thank you for coming. My name's Bill Kirkup, I'm the Chair of the investigation panel. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: I'm Geraldine Walters, and I'm director of nursing at King's College Hospital.

MR BROOKES: And 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.

DR KIRKUP: You'll see that we're recording proceedings. We'll make an agreed record. You may also know that family members have been invited to be present as observers at these sessions. We will though break the session into two parts, the first of which will be general matters, and the second of which will be a particular case where there are matters of clinical confidentiality that will arise.

MR SIMPSON: Okay.

DR KIRKUP: And the transcript will also – I keep calling it a transcript. Pardon me, the recording will be open to other families to listen to, but not the second part of the recording.

MR SIMPSON: Okay.

DR KIRKUP: You'll also know we've asked you to hand in any mobile telephones, laptops, recording devices to emphasise the point that nothing goes outside the room until we're able to produce a report with everything in context. Do you have any questions for me about the process?

MR SIMPSON: No, that's fine, thank you.

DR KIRKUP: Okay. I'll start off by asking you, you work at the Preston Hospital, I think?

MR SIMPSON: I was working at the Preston Hospital.

DR KIRKUP: You were? Right, could you confirm when you started what you did, and in that case when you finished?

MR SIMPSON: Oh, I started at Preston in June 2006, and I finished working at Preston in October 2013.

DR KIRKUP: Okay. What have you done since?

MR SIMPSON: I now work at Royal Oldham Hospital in Manchester.

DR KIRKUP: Okay. And what were you doing in Preston?

MR SIMPSON: An advanced neonatal nurse practitioner, and that's the same role that I have in Oldham now.

DR KIRKUP: Okay, same job. Okay, so your duties in particular would be around the care of neonates.

MR SIMPSON: Care of neonates, yes.

DR KIRKUP: Yes.

MR SIMPSON: I said I'm an advanced nurse practitioner, so I'm a qualified nurse that's undertaken extra training, and I work with advanced skills, advanced knowledge for the caring of babies. So a slightly different role to what I was doing as a registered nurse.

DR KIRKUP: Right, okay. So that's a pretty full range of procedures that you're able to do?

MR SIMPSON: Yes, basically it allows – as a nurse, it allows us to undertake some of those duties that historically have been medical duties, so I undertake a range of clinical procedures. We have a high degree of autonomy, more decision making.

DR KIRKUP: Yes. Presumably, though, you need to work reasonably closely with paediatricians.

MR SIMPSON: Very closely with paediatricians, yes.

DR KIRKUP: Yes, okay. And that works, in your experience, in Preston, it worked well?

MR SIMPSON: It worked extremely well.

DR KIRKUP: Okay. Now the thing that we're – the aspect of your job that we're particularly interested in is around neonatal transfers, where a baby comes in from another unit to Preston. Can you talk us through Preston's role in that, and how it worked?

MR SIMPSON: Yes. Preston was part of the neonatal transport team for Lancashire and South Cumbria. It's a joint operation between Royal Preston Hospital and Burnley Hospital. We worked – one week it would be Preston, one week it would be Burnley. The remit of the transport team was to transfer babies to appropriate hospitals for care, and to repatriate babies back to hospitals as their level of care allowed. The system worked generally that Monday to Fridays we worked with a transport nurse, and either one of the advanced

nurse practitioners or a registrar. Monday to Fridays we generally undertook intensive care transfers and special care transfers. At the weekends there was more limited scope, and the transport teams – generally we ran with one of the transport sisters, and the main remit at weekends was to transfer babies that were special care level of transfer.

DR KIRKUP: Okay, and what happened to ones at the weekend who needed more intensive care?

MR SIMPSON: Well at the weekend and even during the week we didn't offer 24-hour transfer, so outside of the hours that we were working our transfers went through – or any requests for transfers went through the cot bureau at Manchester, and were undertaken by the Greater Manchester Transport Team.

DR KIRKUP: Okay. Did that ever cause changeover issues where you were on the cusp of becoming out of hours? How did that work?

MR SIMPSON: No, it worked quite well because the hours that we had dedicated to us, we had a cut-off point for when we would accept a transfer, to try and ensure that our transport team had time to go out, do the transfer and come back in, in the hours that we worked. If it came to a point that we felt that we wouldn't be able to complete a transfer in our own transport times, then we would refer that through to Manchester for them to undertake.

DR KIRKUP: And was that generally understood by the units that you were taking transfers from?

MR SIMPSON: It was, yes.

DR KIRKUP: Okay. What kind of equipment and supplies did you take out to do a transfer?

MR SIMPSON: We had a transport incubator that was – basically is a mobile intensive care unit. It offers basic ventilation, full monitoring equipment, all the oxygen and air supplies that we need. We carried a transport bag with us that had all our specialist equipment. We had minimum amount of emergency drugs that we would need to carry with us, any equipment that we may need on the transfers.

DR KIRKUP: Right, what sort of drugs would you take with you?

MR SIMPSON: The standard drugs that were there, we had intravenous fluids that we may need. We had – I'm trying to think. We had adrenalin in the packs if we needed in an emergency. We had salines, we had waters. We would only

use that if we were actually in the ambulance, otherwise we would use supplies at the hospital that we were going to pick a baby up from.

DR KIRKUP: What sort of range of supplies were you expecting to have at the hospital that you were going to?

MR SIMPSON: You would expect them really to have any of the medication that you needed. If they were offering neonatal care then you would expect the hospital would have...

DR KIRKUP: The full range of...

MR SIMPSON: The full range.

DR KIRKUP: Even if they were undertaking level one neonatal care where they wouldn't be looking after babies less than 32 weeks?

MR SIMPSON: Yes, I think for a level one unit you would expect there to be a basic amount of drugs that you would need because you've always got the position that some [inaudible] is going to come through the door, so a level one unit doesn't mean necessarily that you're not going to get an intensive care baby.

DR KIRKUP: Yes, absolutely.

MR SIMPSON: So the expectation would be that the hospital would have enough supplies to be able to support the baby until transfer.

DR KIRKUP: Okay. What was the range of units that you accepted from?

MR SIMPSON: Within our own network there's Furness General Hospital, Lancaster, Blackpool, there's ourselves, there's Burnley, but we also crossed over borders sometimes because babies, for various reasons, need transferring outside of the network. So we could be involved with hospitals like Alder Hey, Liverpool Women's Hospital, Central Manchester, the other Manchester units. Occasionally, very occasionally we could go cross border and transfer in and out of some of the Yorkshire hospitals.

DR KIRUP: Yes. Did you get as far as Blackburn or would somebody else be taking over at that stage?

MR SIMPSON: Yes, Blackburn we did used to, but Blackburn transferred all their neonatal services to Burnley.

DR KIRKUP: But what if Burnley was – it was their week off and your week on?

MR SIMPSON: If it's Burnley's week off and our week on we would do Burnley as transfer and *vice versa*, if it was our week off they would cover us for transport.

DR KIRKUP: So you did sometimes pick up babies from Blackburn.

MR SIMPSON: Yes.

DR KIRKUP: And perhaps even further south.

MR SIMPSON: Yes.

DR KIRKUP: I'm allowed to say that; I'm from Newcastle. It's all south to me. Okay, which of those did you have personal experience of doing pick-ups from?

MR SIMPSON: Most of the hospitals I did transfer Preston for four or five years, so most of the hospitals I will have been into at some point or other.

DR KIRKUP: Right, okay. Can you give us a thumbnail sketch of the differences between the different hospitals?

MR SIMPSON: The differences really was the – the difference in what the hospitals were set up as. Obviously you'd got different transfers from a one hospital as you would from a level two as we would from a regional hospital such as Alder Hey. And the types of babies that we were transferring between each hospital was very different.

DR KIRKUP: Yes, okay.

MR SIMPSON: Places like Alder Hey we tended to use for babies that needed surgery, needed cardiac care, so that was quite specific, the babies that would be transferring in and out of there. Places like Furness General Hospital, a lot of the babies that were transferred there had been transferred because they fell outside the remit that that hospital was set up to do.

DR KIRKUP: Yes, okay. What sort of communications did you have with the hospitals before, during and after transfer?

MR SIMPSON: Our communication before transfer, we have a communication sheet that asks for pro forma, they set out the minimum amount of information that would be received as soon as the phone call came through. Now that might not be one of us that was on transport that was taking that information, so it was set so that a minimal amount of information could be gained at the first point. And that would consist of things like baby's name, condition of baby, what was happening with the baby, gestation, how old the baby was, was baby needing any respiratory support, were we using any drips on the baby, what medication was the baby on, and that gave us a basis then of planning the transport.

DR KIRKUP: How often did you need further information?

MR SIMPSON: Frequently we would ring back, and once it came through to the transport team I'd also ring back and get further information. Not necessarily because we needed more information, but things change very quickly with neonates, so we kept in quite close contact before we set off to do the transfer to make sure that things weren't changing. We would contact and talk to the units just before we set off once we had ambulance on site ready to go, to let them know that we were leaving and give them an idea of the time that we would be arriving.

Once we were at the hospital that we were going to if we were going to pick up a baby, if there was concerns for that child, if the condition had changed then we would contact back to Preston. We had an on-call consultant for transport each shift that we were working, so if we needed to get more information, needed to get extra support, if we needed to run concerns past somebody, we had a consultant that we could ring directly back to.

DR KIRKUP: Was that a pretty regular occurrence?

MR SIMPSON: No, I wouldn't say it was regular, but it was there if we needed it.

DR KIRKUP: Yes, okay. And did you feel that you had an appropriate relationship with sending clinicians of each of the units that you picked up from?

MR SIMPSON: Yes, we had a good working relationship with the units. I know probably before I started in the transport there there'd been a series of roadshows about transport where the lead nurse for transport had gone out to the different hospitals in our network and had spoke to the hospitals about how the transport would work. They were provided with a copy of the same form that we were using to get information, so what should happen is that they would complete the pro forma at that end so when they're offering us the information it comes through in a logical order of everything that we need to start off with. And because we worked frequently with other hospitals they got very used to what we wanted, how we did things, how things worked.

DR KIRKUP: Okay. And Furness was not unusual in that.

MR SIMPSON: No, it wasn't unusual, no.

DR KIRKUP: Okay. Geraldine.

DR WALTERS: So did you ever get to anywhere and find that actually you weren't able to do everything that was required if you were on your own without the doctor?

MR SIMPSON: It did happen, yes.

DR WALTERS: And what used to happen then?

MR SIMPSON: As I said, our first port of call was to contact our consultant on-call and discuss with the consultant and get advice from the consultant. Occasionally it would happen if we got to do a transfer and the baby wasn't fit for transfer, then again, we would speak to our consultant and we would leave the baby where it was because it was safer for the baby to stay where they were. So it does happen occasionally, and it's not unique to our transport team here.

DR WALTERS: Yes. So this case that you wrote the statement about, how typical was that case?

MR SIMPSON: That wasn't typical on that day.

DR WALTERS: Yes. So when you got the call to go out, and the doctor wasn't available so you were by yourself essentially...

MR SIMPSON: That was our norm.

DR WALTERS: Yes.

MR SIMPSON: It wasn't normal to take a consultant out on a transfer with you.

DR WALTERS: Right, or a registrar or anything?

MR SIMPSON: Yes, it would be a registrar or an advanced nurse practitioner because of the range of skills that we can offer. It was either/or.

DR WALTERS: Yes. So when you arrived there, was it...

DR KIRKUP: I don't want to get into the clinical details of the case.

DR WALTERS: Oh, I beg your pardon.

DR KIRKUP: We need to have a break before we do that.

DR WALTERS: Yes, okay. Sorry, I'd forgotten that. I think I haven't got any more general questions then.

DR KIRKUP: Okay. Julian.

MR BROOKES: Just a couple of things then. I'm interested in – you were talking about the roadshows going around, keeping people informed on what was expected. Was there any memorandum of understanding between the organisations about what they were expected to do, what you would be able to provide, some kind of written down agreement which was then consistent across? All level ones do this, level twos do this, so that there was a clear

understanding from sender organisations and yourselves about what you were doing.

MR SIMPSON: Yes, okay, as far as I'm aware from the origins of the transport team, that yes, there was agreed policies for transporting the babies that were updated from time to time. But yes, there was. Certainly we had a lead nurse at Preston who was quite heavily involved with ensuring that we had smooth running of the transport team and good communication pathways between referring units and ourselves.

MR BROOKES: Because I was interested and wondering whether there was ever any audit of compliance, if you see what I mean. A way of systematically looking at what was being sent, to learn any lessons about whether or not there were delays in decisions to contact you, things like that.

MR SIMPSON: I couldn't say whether there was specifically an audit or not. There was a clinical governance set up within the transport team that would look at any incidents, and I would presume that anything like delays or problems would fall within the remit of the clinical governance, and instant reports being reviewed. And that happened very regularly all the time I was at Preston.

MR BROOKES: Okay, that the colleagues would see. And just then one final question, were you personally aware of any particular concerns about transfers that you were receiving from Barrow?

MR SIMPSON: Not particularly; just the one incident.

MR BROOKES: Okay, that's fine.

DR WALTERS: I have been effectively programmed – I'm sorry, I'm a bit slow this morning.

MR SIMPSON: It's okay.

DR WALTERS: Were the units given any information about what equipment or drugs or support you would require when you got there?

MR SIMPSON: Not specifically about support. We would have a remit that we would talk and we would ask that we wanted this, this and this doing, 'Could you prepare this for us for when we get there?' So we would talk to the units and maybe ask them to change their management prior to us getting there. That was with a view to looking at how we were going to safely transfer the babies.

DR WALTERS: So – but was there anything along the lines of, 'We'd expect a range of resuscitation drugs; we'd expect point of care testing for gases, electrolytes,' that sort of thing? Did they have that sort of requirement set up?

MR SIMPSON: No, we didn't. We were aware of what each hospital had to offer. We did have point of care testing for gases within the transport team, we have a mobile analyser that we could utilise. Again, it comes within the remits of hospitals offering neonatal care would automatically have a minimal standard that would be there.

DR WALTERS: Right, so you shouldn't – you shouldn't need to have to specify them basically.

MR SIMPSON: We shouldn't need to specify anything particularly.

DR WALTERS: I see, okay. Thanks.

DR KIRKUP: All right. I'll have a brief pause now while we ask people to leave the room because we want to ask some questions that bear on clinical confidential matters.

[The interview continued in private]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 16 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert adviser on paediatrics
Professor Jonathan Montgomery – Expert adviser on ethics
Dr Geraldine Walters – Expert advisor on nursing

MS JACKIE SMITH

Transcript produced by Ubiqus
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Telephone 020 7269 0370

DR KIRKUP: Thank you. That's great. Thank you for coming. I'm Bill Kirkup. I'm chairing the Panel, and I'll ask the other Panel members to introduce themselves, starting with Geraldine.

DR WALTERS: We know each other.

MS SMITH: We do.

DR KIRKUP: Okay.

PROFESSOR FORSYTH: Stewart Forsyth, paediatrician and medical director from Dundee.

MS SMITH: Hello.

PROFESSOR MONTGOMERY: I'm Jonathan Montgomery, I'm a professor of healthcare law at University College London and also Chair of the Health Research Authority, and I have previously chaired SHAs, PCTs at a couple of other trusts.

DR KIRKUP: As you've seen, we're wired for sound and we are recording proceedings. We'll make an agreed record at the end of proceedings. We have opened the invitation to family members to come and observe these sessions. As it happens, there's nobody here this afternoon but they have the right to come and listen to the recording afterwards if they want to. Just so you're aware of that.

And as you'll know we've removed all telephones, recording devices etc. from us as well as you, and it's because it's important that when we produce a report it's got everything in context and we haven't had any drip feeding of information out of context ahead of time. I'm sure you'd be familiar with the reasons for all of that.

MS SMITH: Yes, indeed.

DR KIRKUP: Is there any question that you want to ask me about the process before we start?

MS SMITH: No, not at all, that's fine thank you.

DR KIRKUP: Okay, thank you. I'll start with a very general question then hand you over to Jonathan, if I remember to get the running order right this time. Can you tell me when you started in your present role? How long have you been doing it? When did you start?

MS SMITH: I became the acting chief executive to the NMC at the beginning of 2012, and then I became the permanent chief executive at in June of last year. I joined the NMC in 2010.

DR KIRKUP: Okay, what were you doing in 2010?

MS SMITH: I was the director, fitness to practice.

DR KIRKUP: Right, thank you. Jonathan.

PROFESSOR MONTGOMERY: Thanks very much Bill. I wonder if you can just take us through the connections between the NMC and the Trust, because we understand, I think, that a lot of work is about individual registrants, on both a lot of activity from the NMC in relation to this particular Trust. I just wonder if you can take it through how that unfolded, and sort of the chronology of the NMC's involvement?

MS SMITH: Yes, I mean I'll try and do that as helpfully as I can. The events from the NMC's perspective in relation to this Trust really culminated in 2011 when the NMC, alongside the CQC, did an extraordinary review, which resulted in a number of recommendations and an action plan. That review was followed up,

a year later in 2012, where we assessed progress against the recommendations in 2011 and concluded that the state of supervision, which is what we were primarily concerned with, was in a happier state of affairs than it had been.

There are a number of other things that the NMC's done, but I perhaps ought to say that the NMC didn't become aware of issues regarding individuals or the Trust, I don't think until about 2009. Which pre-dates me, and I don't make that comment as a way of saying, 'It has nothing to do with me', I make that comment as a way of saying some of your questions I may find difficult to answer, but I will be as helpful as I can be because we have gone back through the documents that we have available to us.

So you will know, for example, that the NMC requires the LSA to produce an annual report, and it certainly did produce annual reports going back to 2007, and I've studied the annual report for 2008 and 2009 and I see some information in that which, looking back now, I think could have indicated that there were some issues that the NMC should have followed up at that point.

PROFESSOR MONTGOMERY: Okay, I was going to come to that a bit later...

MS SMITH: That's fine.

PROFESSOR MONTGOMERY: ...But as you've raised it, can we start there because supervision is particular to midwives, isn't it?

MS SMITH: Yes, it is.

PROFESSOR MONTGOMERY: And it would be – and also it's been criticised by the Ombudsman's report, so as we go through we'd like to understand how the

NMC is picking that up. We can say a bit more then about what the flags that, you know, with hindsight, and I fully understand that you're talking about hindsight, the sort of things that might be generated by the LSA annual report that you could then think about actually...

MS SMITH: Well you may have looked at one of the annual reports. It's a very detailed document, it goes into a range of issues. From a regulator's perspective it should be focussing on, 'What are the red flags here?' So, for example, the number of investigations that were being carried out, I think in 2008, 2009 report there were 110 investigations into midwives. Which seemed, to me, to be high. But in the northwest region...

PROFESSOR MONTGOMERY: That's in the region, as oppose to the Trust...

MS SMITH: Yes. For the region. But in the northwest region there were over 4000 midwives. So the 110 needs to be put into the context of the number of midwives in the area, in the region. There's a further comment in the report about the number of serious untoward incidents, which, again, I think could have been a trigger to ask for further information. So I just use those by way of example. The report itself, as I say, is very detailed, and it talks about the number of supervisors versus midwives, and the ratio and births and home births and things like that.

But from a regulator's perspective, in terms of public protection, what we're concerned with is what are the issues that represent a risk and how we're responding to that.

PROFESSOR MONTGOMERY: If I could tease that out, because that's a strand I was going to come back to later, but in terms of us thinking about where we –

it's quite important to understand. So you have that report from the supervising authority which, at the time, was the northwest. Do you have a data set from which you could tell what's unusual and whether this is a pattern that's sufficiently – and if I can ask you to put that in the context of the current NHS system as well, because it's about ...

MS SMITH: Yes, I mean that is difficult.

PROFESSOR MONTGOMERY: It's about what the baselines would be that enable you to use that.

MS SMITH: No, I can't say that there was a data set back in 2009 that allowed us to compare that information and say that it was an outlier. That's not to say it didn't exist. I just – I'm not able to locate it. My best guess is that it didn't exist. The process at the time was that the LSA report went to the midwifery committee. The midwifery committee's a statutory committee of the NMC, and there was a recommendation at the time that that should then go to the Council.

There were no particular recommendations in relation to the number of investigations or the number of serious untoward incidents, but that, in effect, was the process.

PROFESSOR MONTGOMERY: And was that the process – was that there for all the regions or was something about the northwest that was reported to Council [inaudible]...

MS SMITH: No, the LSA reports would come once a year and would go to the midwifery committee, and then on to the Council. That was the process then. It isn't the process now.

PROFESSOR MONTGOMERY: So what's the process now?

MS SMITH: Well, we moved to quarterly quality monitoring in 2011, which enabled us to get information from the LSAs on a quarterly basis, based on outcomes rather than inputs and process, and that information now goes to the midwifery committee on a quarterly basis. So it enables the committee to identify any red flags, and suggest appropriate action. But that's – that's a process that has evolved over the last five years, and it is pretty much where we are now.

PROFESSOR MONTGOMERY: Excuse me, just ask the Panel, we don't have any red lights [inaudible]...

DR KIRKUP: I don't know which bit that connects to [inaudible] red lights on.

MS SMITH: Do you want me to put mine on?

DR KIRKUP: Yes please, yes.

PROFESSOR MONTGOMERY: So if I can then follow that up in terms of that you've evolved that process around supervision of midwives on – the Ombudsman's report is sort of critical of the system, but if that's an evolving process would you be thinking of extending it to nursing as well? Then the numbers would be pretty horrendous?

MS SMITH: No. I think that the history of midwifery's very important here. We're going back to 1902, and the system of regulating midwives was set up in 1902 because there was concern that midwives at that time were working autonomously and not within a managed framework.

I suppose the view that the NMC takes of this now is that in the post-Francis world the system for regulation has to be open and transparent. That is not to say that supervision doesn't have benefits. There are plenty of

examples where it does have benefits. The difficulty comes when a supervisor is the person who's providing the ongoing support and making decisions about investigation. And that's where we agree with the Ombudsman. There is the potential there for conflict, and that's a structural flaw, and therefore that's why we commissioned The King's Fund to look at how we might make some changes.

Of course, the other thing to say is that the LSA function and supervision is within the NMC's Order, so even if we wanted to change – and that's not our position – we're stuck with it unless the Government gives us the legislation to change it.

PROFESSOR MONTGOMERY: We're not stuck with it. If there were things you wanted to say to us that you'd like us to think about, in terms of recommendations, we could...

MS SMITH: Well I – we want to see what The King's Fund says. I think there is a case for saying, 'Is this a system now, which was designed in 1902, that works in 2014? Can the public have confidence in it? Does it actually deliver public protection?' I'm not talking now about supervision. And it is very difficult in this debate to separate the two, but I think the two are important. There is value in supervision, but we're talking about investigation, and the difficulty with the LSA setup is it sits outside the managed framework. So often directors of nursing will say, 'I don't know what's going on with my heads of midwifery, or my supervisors.' And that's – I don't think that's an acceptable position.

PROFESSOR MONTGOMERY: Okay thank you. We may come back to that later on, I'm not sure. Can I go back to the extraordinary review, and it'd be helpful

to know how extraordinary an extraordinary review is. You know, so is this the only one you've done, is it...

MS SMITH: No, no...

PROFESSOR MONTGOMERY: So can you tell us a bit about how common they are, what triggers them and then what triggers what in particular?

MS SMITH: Again, without trying – too technical about this, our quality assurance framework for midwifery was set up to assess whether the midwives' rules and standards were being complied with. They were the standards that were set in 2004. So it's about the number of supervisors, whether the supervision is effective. Many other things. But when we do an extraordinary review we do it where we feel there are particular concerns around public protection and patient safety that we need to be reassured about. So in previous years we've done 54 extraordinary reviews. So it's not – it's not a rarity. We don't expect, as a regulator, to do more than about 20 ...

PROFESSOR MONTGOMERY: 54 each year you're saying?

MS SMITH: Yes. We don't ...

DR WALTERS: Is it [inaudible].

MS SMITH: Is it with...?

DR WALTERS: The CQC?

MS SMITH: No, it's unusual for us to do it with the CQC, but in these two we did. Having said that, we are more inclined to do it with the CQC now because we don't want to have hospitals particularly being subject to inspection after inspection. So it's not uncommon for us to do this, and we are looking for particular areas which we need to test so, in relation to midwifery, it will be

around supervisors versus midwives, how supervision is working, how investigations are being carried out...

PROFESSOR MONTGOMERY: When you say versus, do you mean rates or...?

MS SMITH: The ratio.

PROFESSOR MONTGOMERY: Cases where there's a tension, for example?

MS SMITH: Both. Where the ratio and where there is a tension, and how they are complying with our rules and standards, and also the suitability of the learning environment for students.

PROFESSOR MONTGOMERY: And is there an equivalent for nursing as well? Or is it only about midwives?

MS SMITH: There is an equivalent, yes. And we did an extraordinary review at Mid-Staffordshire.

PROFESSOR MONTGOMERY: Okay. So if we ask about the particular ones for Morecambe Bay, and if [inaudible] will anticipate the question, which is how it came about that this was a joint review with the CQC?

MS SMITH: Yes, again I'm trying to piece the picture together, but I think what happened was complaints were made to us in 2009 about individual issues at Morecambe Bay, and...

PROFESSOR MONTGOMERY: Issues or ...?

MS SMITH: Events. Yes. Deaths.

PROFESSOR MONTGOMERY: Yes, [inaudible], but about the deaths, yes.

MS SMITH: And particular individuals were very concerned about the extent to which the LSA function and the midwives were being properly supervised. So looking at it, it took us a little while to respond to that, because that was in 2009

and then we did the extraordinary review in 2011 with the CQC.

So we had various conversations with the CQC, and the SHA as it was, around the most effective way of testing the system, governance, risk.

PROFESSOR MONTGOMERY: So the SHA has a risk summit I think in 2009.

MS SMITH: It did.

PROFESSOR MONTGOMERY: Was the NMC part of that process?

MS SMITH: Yes, yes.

PROFESSOR MONTGOMERY: Okay. And who in the SHA would you be mainly dealing with?

MS SMITH: Can I say the person's name?

PROFESSOR MONTGOMERY: Yes.

MS SMITH: Angela. I can't – I'm sorry, off the top of my head I cannot remember her title. Apologies.

PROFESSOR MONTGOMERY: Angela Brown? Associate Director?

MS SMITH: Yes, yes, that's it, yes.

PROFESSOR MONTGOMERY: [Inaudible] letter to her.

MS SMITH: Sorry. Yes, so it was mainly Angela and it was mainly the midwives who the NMC employed at the time. The NMC's gone through a restructure since then, and the way in which we quality assure midwives rules and standards is now different, so it's don't not in house but out house. It's outsourced now.

PROFESSOR MONTGOMERY: So from 2009 onwards you're – you've got an alert, you're talking with the SHA on – about what to do, and then by 2011 it's become apparent that what you're going to do is an extraordinary review. So

what sort of triggered the move into that type of action?

MS SMITH: I think – and this is a guess – I think continuing concerns about the robustness of the LSA function, how midwives were being supervised, and the culture. So there was plenty of noise, but all, really, the NMC had to go on – and I say, 'All' I don't mean it in that way, but all the NMC had to go on was the LSA reports and the complaints which were coming in.

PROFESSOR MONTGOMERY: But the extraordinary review is at two university hospitals, Morecambe Bay...

MS SMITH: Yes.

PROFESSOR MONTGOMERY: As oppose to the whole of the LSA? Because it covers a much bigger area, does it?

MS SMITH: Yes. It included how the LSA function was being managed.

PROFESSOR MONTGOMERY: Right.

MS SMITH: And I hope that we've submitted that information to you, yes.

PROFESSOR MONTGOMERY: And one of the things that I spotted from that is that you have an action plan on the back of that which is an NMC action plan as opposed to a UHMB or an NHS Northwest action plan. Would you expect action plans from those separate organisations as well? Or..?

MS SMITH: I think it was surprising that it was just an NMC action plan. This wasn't just an NMC issue. It was an issue for the NMC, but not just the NMC's issue.

PROFESSOR MONTGOMERY: So I think one of our questions we're trying to get to the bottom of is, 'What are the capacity and capabilities of those in the system to address these problems?'

MS SMITH: Yes.

PROFESSOR MONTGOMERY: And one interpretation of what I've just flagged up to ask you about is that the NMC might have taken the view that there wasn't sufficient capability or capacity to solve it within a satisfactory timetable and it had to take up responsibility on. Would that be a fair...?

MS SMITH: Well I think the way the NMC saw this was that the problem was an LSA function problem. And of course, extended beyond that, because it talked about governance and culture and all sorts of other things, and I think the NMC saw it as an LSA function problem, and therefore it took responsibility for it. But of course it was a joint investigation with the CQC, and I think our expectation – again I'm guessing – but our expectation at that time was that the other issues would be picked up equally by the CQC, and, interestingly enough, the recommendations that we both made were similar.

PROFESSOR MONTGOMERY: And the liaison with the CQC? The decision to make it joint? How was that approached?

MS SMITH: It's easier now than it was then. I would say. Because the two organisations would say, 'Well we have different frameworks and we're testing different things.' We came at this from the viewpoint that we need to go in as a team. If we're looking at the same things, testing the same things, that should be done in that way.

PROFESSOR MONTGOMERY: So would you sort of have sort of set up a – it's not quite an audit tool, but a schedule of things to look at, combining your standards and their standards?

MS SMITH: I don't know if it was done like that at the time, I'm afraid I don't know.

PROFESSOR MONTGOMERY: Fair enough. And the liaison on the – because

there's a difference between an inspectorate team and a decision to set it up and deal with it. So the decision to set it up, I mean it should be joint with the CQC, does that sit at your level now? Or another?

MS SMITH: No, no. It would sit beneath my level, and as I say, I think it is easier now than it was then.

PROFESSOR MONTGOMERY: Okay. So that's taken us to the 2011 investigation.

MS SMITH: Yes.

PROFESSOR MONTGOMERY: There's an action plan and it looks as though the NMC is quite active in monitoring that action plan, you know, you've just described that you'd sort of taken on that responsibility. Is that common with other extraordinary reviews as well? Or would it be different?

MS SMITH: It would depend. Extraordinary reviews, in relation to midwifery issues, are quite rare. We tend to see it more in nursing. Obviously the numbers are bigger. But if we're going to do an extraordinary review then we would expect to have an action plan against our own rules and standards.

PROFESSOR MONTGOMERY: But is it all for one of your assistant directors to chair the meetings through?

MS SMITH: That's as it was then, that is not the case now.

PROFESSOR MONTGOMERY: So what would happen now?

MS SMITH: Well we outsource QA, which is done by a firm called Mott MacDonald, which we've been using for a number of years. They use lay reviewers. They would do this. It would not be done by the NMC. So we've changed that.

PROFESSOR MONTGOMERY: Thank you. And then that takes us to the re-review, in 2012. Is that also joint with the CQC or [inaudible]...

MS SMITH: Yes.

PROFESSOR MONTGOMERY: Yes, and was that a timescale that was planned right from the beginning? It's always an annual return or is it...

MS SMITH: I think we decided that we would do a review a year later. We'd keep a very close eye on things, do a review a year later, give them an opportunity to make improvements. It was always the intention to do a joint review.

PROFESSOR MONTGOMERY: And what's the outcome of that? Is it a, 'We no longer have any concerns?' Or, 'We have sufficient assurance to take a step back and leave it to itself?'

MS SMITH: I don't think I could say the NMC's taken a step back. I think the NMC keeps a very close eye on events at Morecambe Bay. So we continue to monitor the action plan and, if we feel it's necessary to do another extraordinary review, that's what we will do.

PROFESSOR MONTGOMERY: It would be a new extraordinary review, would it?

MS SMITH: It will.

PROFESSOR MONTGOMERY: So you've done the one and the follow up...

MS SMITH: Yes.

PROFESSOR MONTGOMERY: And in that sense it's a watching brief file as oppose to an active brief file?

MS SMITH: Yes. I mean there are two other things. The quarterly quality monitoring, which I talked about, which gives us information sooner. And we've changed our midwives rules and standards to bring some clarity around the role of the supervisor providing support and advice versus investigation.

PROFESSOR MONTGOMERY: Okay. I wanted to ask questions about individual

referrals, but I don't know if we should break and see if anybody's got...

DR KIRKUP: Well I do. I apologise that the answer to the question to the question is probably in the paperwork somewhere, but if you could just help to take me through this particular aspect it would be enormously useful. Can you describe the accountability chain for midwifery supervision?

MS SMITH: Yes. For supervision the LSA unit appoints supervisors of midwives, and the supervisor of midwives will have a annual supervisory meeting with a midwife. So a midwife needs to have a supervisor, and then they have the annual meeting, and it is through the LSA function that that then reports into the NMC.

DR KIRKUP: Okay, so the supervisor is usually a colleague working in the same unit, possibly at a more senior level?

MS SMITH: Yes.

DR KIRKUP: If it was just a colleague, they'd report their findings to you? They do an assessment of each individual midwife. Where does that information then go to?

MS SMITH: Well, it varies. Depending on which country we're talking about.

DR KIRKUP: England.

MS SMITH: So in England it would report into the LSA. Now, it may do in some circumstances, there may be a link into the director of nursing. But that is not always the case.

DR KIRKUP: But usually to the LSA, which was a function of the SHA?

MS SMITH: Yes.

DR KIRKUP: And is now NHS England?

MS SMITH: Yes.

DR KIRKUP: Okay. So there's just one – they're not the LSA, it's just the supervising authority. Does that [inaudible]?

MS SMITH: No, there are a number of LSAs in England, but they all report into NHS England.

DR KIRKUP: Okay, and that would be another midwife, at regional level, who would be receiving the reports of all of the unit based supervisors, yes?

MS SMITH: Yes, yes.

DR KIRKUP: And then who does that person report to?

MS SMITH: My understanding is that that person reports to the CMO for England.

DR KIRKUP: Right.

MS SMITH: But the requirement for the LSA is to produce an annual report, which they send to the NMC.

DR KIRKUP: Yes. Who would be in a position to look at the work of an LSA and say, 'They're doing their job properly', or, 'They're not actually doing their job effectively'?

MS SMITH: That, in effect...

DR KIRKUP: Who would do that?

MS SMITH: That, in effect, is the NMC's responsibility according to the NMC's legal framework.

DR KIRKUP: Okay, and what process do you, as an organisation, undertake to discharge that responsibility?

MS SMITH: It's the quality assurance monitoring that we do. And scrutiny of the LSA annual reports.

DR KIRKUP: Right. What would you expect the role of the SHA to have been. Let's leave aside NHS England at the moment. But what would the relation of the – the relationship be to the SHA [inaudible]?

MS SMITH: Well I would have expect some connection, some reporting mechanism, from the LSA to the SHA. But, as I've described, it's – the system sits here and the LSA function sits there, and the relationship is between the LSA and the NMC and that's at arm's length, so I don't think you can see a clear line, a clear structure...

DR KIRKUP: I'm seeing lots of dotted lines. That's what's concerning me.

MS SMITH: Yes.

DR KIRKUP: Okay, I just wanted to be sure that I'd got that [inaudible]...

MS SMITH: No, no, no, you have described it – as I said at the outset, I'm not sure that that is the system that the public can necessarily look at and say, 'That makes sense.'

DR KIRKUP: Okay. This is not – despite the very complicated answer, it's a simple question as, well, [inaudible]. The comparison between that and the new responsible officer for doctors, with the GMC, I mean I think that would be a question we might need to ask ourselves that is in what ways are they different? Is there some similar degree of function with re-validation. Because, I mean, Nursing and Midwifery have had a long standing system for monitoring whether people keep up to date and those sorts of things, in the way that makes it difficult to [inaudible]. So how are the functions different [inaudible]...

MS SMITH: Well I've heard the comment about it's similar to the responsible officer role for doctors, but responsible officer is a local director, who's part of the

board. The LSA MO isn't. So there is some governance there, and I think that's slightly different.

DR KIRKUP: Do you think the governance is stronger for the supervision? Or weaker?

MS SMITH: I don't know that I can answer that. There are good examples and there are poor examples. The difficulty that we have is, as I've always described it, this is delegated regulation. It's regulation at a distance, and if it sits in the NMC's legal framework then the NMC should have control over it, and I think what's – what is clear is that there wasn't that control, and that's why we agree with the Ombudsman that is this structurally flawed? Yes, we think it probably is. But it's a bit more than that, because I'm not sure whether the director of nursing has control over it. Because it sits outside that clinical governance framework as well. So it's an odd setup. But I don't think it's the same for doctors in the role of the responsible officer. That's my view.

DR KIRKUP: Gerry.

DR WALTERS: You said the problem with the LSA function. Did you mean across the whole of the northwest?

MS SMITH: Well, in respect of Morecambe Bay, yes. I'm talking about the number of investigations that were reported in the annual report.

DR WALTERS: But just for Morecambe Bay?

MS SMITH: Well, it didn't break it down, yes.

DR WALTERS: Well that's the question. Because I've looked at the annual report and it's so non-granular...

MS SMITH: Yes.

DR WALTERS: It'd be very difficult to get anything out of it...

MS SMITH: Yes, exactly.

DR WALTERS: I can see why – I just wondered whether you thought it was the way that the function was being exercised from the LSA alone at sort of SHA level, or whether you thought it was about the way this particular trust were handling it?

MS SMITH: It – I'm guessing, and I'm looking back now, and I think it's probably a bit of both. But I'm guessing, because there is – there's nothing to indicate what the NMC's view was in 2009.

DR WALTERS: And when they did the extraordinary investigation, I was sort of looking at some of the actions, and they're quite wide ranging aren't they? So there's things like, 'The strategy for supervisors should reflect need to support medical staff and midwives to work collaboratively in order to provide safe care for new babies.' And, 'Supervisors need to consider how they identify and appropriately challenge process and practice if they don't think it's best practice guidance'.

And when they did the review, they sort of said, 'Met'. And I just wondered, you know, did the reviewers have real confidence in that? Because they are – they, to me, sort of are getting caught in the issues and I just wonder how – because obviously there are actions and ...

MS SMITH: Yes.

DR WALTERS: ...Follow ups on that, I just wonder what your take on ...

MS SMITH: Well I, like you, looked at the recommendations, thought they were quite broad and – would make it quite difficult to test whether you had met or

partially met. I don't know, is the answer to that. It is done differently now, because it is outsourced by us, so we would have a different tool and a different measurement.

DR WALTERS: But I suppose just to sort of – sort of ponder on if they did go and the review found full collaboration between midwives and obstetricians, and that people worked actually according to best practice, and these were really deep cultural issues, what could the NMC do about that?

MS SMITH: Report it to the Trust board and the SHA and ask them to do something about it. Beyond that, I suspect not much because we're obviously concerned with individuals.

DR WALTERS: Yes, okay.

DR KIRKUP: Stewart do you want to come in on this specific aspect?

PROFESSOR FORSYTH: Well, I was going to pick up this issue. It's very much a sort of uni-professional approach, and yet the quality of care very much depends on the good interaction between different professions, whether it's obstetricians, paediatricians, managers etc., and I therefore felt that you're missing something in terms of trying to detect how a unit works by focussing on sort of the one to one with the midwife and I do, just trying to visualise that in practice, and I can see how the message comes over maybe quite different to what's actually happening, you know, at a surface level?

MS SMITH: Yes. I mean, as I – if I can just follow up on my point, I mean, we are set up to deal with individuals. We're not a systems regulator. So I think, to some extent, what the action plan identifies is us straying into an area which we're not designed to do, but nonetheless felt compelled to do it because we

thought something needed to happen. So the way in which we do these reviews now is different, but fundamentally it comes down to individuals, and we can only act against individuals.

I suppose the value here was that we were doing it with the CQC, and therefore we would have expected action around culture and systems to be picked up. And I believe that is the case now, but we're talking about 2009, 2010 where not a lot went on.

PROFESSOR FORSYTH: I'm getting a sense here that you're saying the NMC was attempting to step into a bit of a void in 2009, '10. I don't want to put words in your mouth. Is that?

MS SMITH: Well I don't think the NMC did, from my reading of it, did much in 2009 and '10, and what I said at the beginning was we had an annual report, which me looking at it, suggested some red flags, and we obviously wanted to test how the supervisory bit was working, which was why we decided to do it in 2011. I do think that was the right thing to do in 2011. But the extent to which we can act, with systems issues, is beyond our capacity.

PROFESSOR FORSYTH: Okay, you were referring to 2011. My mistake. But would the same comment apply? Because you're straying into issues that were not simply about individual regulation, you were getting into systems?

MS SMITH: Yes, but what we could have done was ask ourselves some questions about the LSA function. This was a review of Morecambe Bay.

PROFESSOR FORSYTH: If I could just – I mean I think that in retrospect therefore do you feel the system did fail? I mean, evidence is that there were some difficulties of working – of attitudes, behaviours within midwifery. Now, do you

think in retrospect that that was ever not picked up in the previous approach that was taken by NMC?

MS SMITH: I would look at a report like that now and say, if there are 110 investigations and 40 serious untoward incidents, what's going on? And how is this being managed and what's the process and how can we be assured? But the design of this system doesn't lend itself to that happening very easily. Because LSA MOs are not appointed by the NMC, they're appointed by the LSA.

The NMC almost has, as the Ombudsman said herself, no control over this. And so you can see how, looking back, the NMC thought to it's, 'Well okay, we have an annual report here, it's telling us something, we'll do what we do, which is give it to our midwifery committee and then to our Council.'

I think the NMC has only really grasped the issue of midwifery regulation in the last two or three years, but even now we are still stuck with a system that looks peculiar, because it is at arm's length and you can't join the line.

DR KIRKUP: Yes, given that there were those red flags there, would you have expected the LSA to try and look to see where, within the region they were arising?

MS SMITH: Yes. I mean the commentary in the report says that there was no need to refer. I think there was a couple of cases where they referred to the NMC individuals. But yes, and that's - my sense of the annual report when you receive it is it gives you an awful lot of information, but it doesn't make it very easy to identify where the concerns are.

DR KIRKUP: Where's the hot spots.

MS SMITH: Yes.

PROFESSOR MONTGOMERY: Related question. Do you think it would have been easy for the LSA northwest to realise that there were red flags? Because they would have only seen their own report. You were able, Midwifery Committee, to look at reports of all the LSAs and so you'd be able to see whether this is out of line or what you'd expect.

MS SMITH: I don't know.

PROFESSOR MONTGOMERY: Can I sort of...

DR KIRKUP: Just one more on the same topic, then I'll hand back to you. Would the SH – would you expect the SHA to have had a role, if...

MS SMITH: Yes.

DR KIRKUP: Looking at that information and saying, 'We want to know where the hospital...'

MS SMITH: Yes.

DR KIRKUP: Okay.

PROFESSOR MONTGOMERY: I just want to – I may not quite be able to nail it down, but just to reflect back what I think I heard in that sort of pattern of that story, which is that at the level of the LSA report you can see some red flags. You might not have had the data set [inaudible] you should have that really systematically, but you can see that they're there, but in itself the report doesn't tell you it's Morecambe Bay, because it's aggregated, but you then have along side that you have, in 2009, some reports coming in in relation to the death and in '09 to '11, so the period before you actually did the extraordinary review,

you're in touch with the SHA and therefore you're part of the discussions about risks there, and it's in '11 and it becomes apparent to you that actually it's time to do an extraordinary review...

MS SMITH: Yes.

PROFESSOR MONTGOMERY: I've understood that?

MS SMITH: You have, yes.

PROFESSOR MONTGOMERY: Yes, good. Thank you. Can I go to the individual referrals?

MS SMITH: Of course, yes.

PROFESSOR MONTGOMERY: Deal with them, and it would be, we'll appreciate you can't say things necessarily about things that are live files and whatever, but I think the most important thing for us is try and understand the signals that can be picked up at a regulatory level, so can you say a bit about the referrals that came in from Morecambe Bay on how you connected them? Because you've described with the LSA process in 2009, how the NMC has handled those referrals?

MS SMITH: I'm just trying to think what I can say. So we have a number of open cases in fitness to practise. Some of those came in in 2009. Some related to events that had happened in 2008. There are a number of those which are still open and, again, tracking back the history, cases were put on hold pending other investigations, and it wasn't until last year, or the end of last year, that the NMC picked up and decided to investigate a number of fitness to practise concerns.

PROFESSOR MONTGOMERY: So can we – I appreciate you're very careful not to

talk about individual cases, but I think there's a pattern of the pictures that we're looking at that there is an overlap of agencies involved in this.

MS SMITH: Yes.

PROFESSOR MONTGOMERY: And our understanding, the degree of liaison, the non liaison, the handovers, the difference between not investigating something because it's a police investigation, or not investigating something because it's a CQC or because the SHA is dealing with it. So can you take us through those – what are the issues that lead you to say, 'We have to suspend this' if you like while you make...

MS SMITH: Again, I'm going back through the documents, but what appears to have been the case is that we received referrals in 2009. There – I think there were some investigations carried out and then some cases were put on hold pending discussions with the SHA, pending discussions with the CQC, pending discussions with the police so, as you say, various agencies.

I can't show you documents for those discussions, but my understanding is...

PROFESSOR MONTGOMERY: You can't show us or there aren't any?

MS SMITH: I don't think there are any, yes. I don't think there are. Because if there were I'm sure we would have found them and sent them to you. My sense was that information was being provided to us from a variety of quarters, which made the NMC start and then stop various things, and then eventually hold, when it became aware that there was a police investigation. So complaints were coming in, some investigation was being carried out, and then it was being reported pending other things happening. I know that's not terribly

scientific, but that's my sense of what happened.

PROFESSOR MONTGOMERY: And I guess my question then is, how managed that process was. There's a difference between being scientific and it being a sort of more forward system, or a sense that there was group of things that you had to keep sight of around the same institution. Because your systems are geared up around individuals, aren't they?

MS SMITH: Yes, yes. So there was very – there was very close and ongoing discussion between the fitness to practise directorate and the unit that had responsibility for overseeing the LSA function. So there were ongoing discussions between those two internally in the NMC.

But I don't think either one of those impacted, or there wasn't a connection necessarily made, except when it came to 2011 and the extraordinary review was done. At some point, again I can't show it because I don't think it exists, there was recognition that something broader needed to happen in the form of the extraordinary review with the CQC.

PROFESSOR MONTGOMERY: And would that be a similar pattern for a nursing case, and you've described it particularly around the LSA reports, but you've also described you do extraordinary reviews because of triggers around those same cases as well?

MS SMITH: Yes. Yes, that would be the same. The difference here, as you say, was there a number of agencies involved and clearly what happened was a decisions was taken that the fitness to practise cases need to go on hold pending the police investigation.

PROFESSOR MONTGOMERY: And what do the complainants and the registrants

know about that? [Inaudible] registrants have the right [inaudible]?

MS SMITH: Yes. About the investigations being put on hold?

PROFESSOR MONTGOMERY: Yes, I mean how – how much do they know about..?

MS SMITH: Well, I think some of them were aware that investigations had started and then stopped, and then I think at some point it was communicated well we're not going to do anything until the police conclude their investigation. That's my interpretation of looking back at it.

PROFESSOR MONTGOMERY: And that would be the same for both the person who had referred and also the registrant?

MS SMITH: That's my understanding, but I would need to check it.

PROFESSOR MONTGOMERY: I'm not sure whether it will matter in detail...

MS SMITH: No.

PROFESSOR MONTGOMERY: It's really understanding whether this goes completely quiet and looks like inactivity, or whether it feels, to the person that's referred, that it's being examined but it's a question of...

MS SMITH: Well I think there are two things. There's inactivity, as in nothing significant happening and it going quiet – this was never something that was quiet. There was always conversation and query or complaint about something or other. There was never great gaps where there was no communication, my look at it. What I would say is there is a general rule that where there is a police investigation we will always pause, and that should go first.

PROFESSOR MONTGOMERY: Thank you. And how common is a delay of that sort of length? Then you've got referrals in 2009, you described why there

have been various reasons for it taking long to get through, but they're still live cases. Is that [inaudible]...

MS SMITH: It's not that common, no.

PROFESSOR MONTGOMERY: So it's a peculiar feature particular to Morecambe Bay?

MS SMITH: It is.

PROFESSOR MONTGOMERY: Thank you. I think that's all I've got at the moment.

DR KIRKUP: Okay. Geraldine?

DR WALTERS: You said that some would be put on hold pending whatever the SHA were doing. What would they be doing that would warrant you to put them on hold?

MS SMITH: No, there wasn't a request from them. I think it was because there were discussions going on and complaints about the LSA report, about other investigations. They may be relevant to the FTP cases. So there was an internal dialogue between units in the NMC, 'Well I'm speaking to X, so maybe you'd better just hold on that for the moment', because other stuff might emerge. For example, there were enquiries going on that we weren't told about until much later, and got wind of later on, so because they will be relevant to the FTP case sometimes things started and then stopped.

DR WALTERS: Right, would it – would any of them have been referred back to the LSA?

MS SMITH: Would any of the cases?

DR WALTERS: [Inaudible], any of the referrals, or concerns that you received, would you have referred them back for supervision on the FTP action?

MS SMITH: No, I don't think so. I can check, but I'm pretty sure that didn't happen.

DR WALTERS: Would they always have been recognised as a cluster? Or could they have come in through different routes?

MS SMITH: I think they would have been recognised as a cluster, although I do think they came in through different routes. But again, I would need to check that.

DR WALTERS: So was there any internal discussion within NMC about suddenly we seem to have quite a lot of cases from Morecambe Bay?

MS SMITH: Yes.

DR WALTERS: And were there any decisions made because of that recognition?

MS SMITH: Well, apart from the extraordinary reviews...

DR WALTERS: No.

MS SMITH: Yes.

DR WALTERS: Right, okay.

DR KIRKUP: Thank you. Stewart?

PROFESSOR FORSYTH: Just go back to the original time of 2009. It's now 2014. Now listening to what you say about other agencies being involved, but I mean there's obviously some major issues for the individuals involved and, at the same time trying to run a service, trying to, if they're still working to and, at the same time trying to find a high quality service, and this is hanging over them this, in a ways, it's the duration could be having an impact on the service in Barrow today, and for – I just wondered what measures are being taken to try and bring this process to a satisfactory conclusion as quickly as possible.

MS SMITH: Well, the investigations are now ongoing. We will be at the point

shortly when we decide what the next steps are, and I don't think there will be a resolution in the very near future to some of these. I think it will, in some respects, continue to be an issue for the NMC for at least another six to nine months.

So I quite accept this is a hugely long period of time. We're talking about five years now, and that is very long and very disappointing, and it is unusual. But I think it's important that we take the time to make the right decisions, bearing in mind the parties involved here and the length of time that these cases have remained open.

PROFESSOR FORSYTH: Yes, I mean because it could be claimed that, in fact, the process of trying to resolve the problem is actually having continuing damaging effect on the quality of service.

MS SMITH: I understand that, but there are individual concerns which, on the face of it, appear very serious and therefore we need to take these cases through our process. I do understand that.

DR KIRKUP: Okay. I think we've covered everything on that, but does anybody want to come back?

DR WALTERS: Just one more question. I mean, again, it's if there are a cluster of cases, and the findings, in terms of peoples' practise is the same in each case, how would you deal with that from an NMC point of view?

MS SMITH: I think that comes back to supervision. And how those individuals are being trained and managed. So it's a local issue as well as a supervisory issue. It's probably as much as I can say.

DR WALTERS: Because if – just supposing – if there was some sort of element of

practice which actually all four cases they were all doing this wrong, then would you construe, 'Actually then, this is normal practice in this unit, it's probably still happening now amongst eight other practitioners.' I suppose that'd be a bit unusual...

MS SMITH: It would be, yes. It would be. Yes. I mean we would have to see what the outcomes are.

DR KIRKUP: Jonathan?

PROFESSOR MONTGOMERY: I just wanted to ask you to reflect a bit on some very very general issue, which is the different tensions between the individual regulator responsibilities that you have and the system issues, and what are the oddities about the LSA process [inaudible] stake in the system process as well as the individuals?

But I wondered if we could ask you to step back a bit and say from a point of view from a regulator, what are the contributions that you might be able to make to system safety, system improvement? Because you hold data sets that not necessarily everybody else has, and actually we've seen an example in this – the exhibit you've just taken us through, of where actually you had to work quite closely with people who are responsible for system regulation in one way or another. I'd be interested to know whether you think that's something that you could have a stronger, more general role in or whether you think it's stretching you too far?

MS SMITH: Well, we do have lots of data, and it's really picking up on Geraldine's point, which is if our fitness to practise cases are telling us something, then we need to use it and it needs to feed into education and training so that we get

that right.

We do share information with the CQC for example on a regular basis when they're doing their inspections now. We get requests, and we hope to see the same back, because it can't just be one way. So we do have a part to play in this, but I think we do have to be careful about ensuring that we don't stray into territory where actually we can't make an impact, or we can't deliver, because we're over promising there and not delivering.

PROFESSOR MONTGOMERY: And are there any issues that prevent you from doing that, when you feel you should be able to, that you might want us to think about in terms of that?

MS SMITH: Well I think in relation to midwifery and the LSA function we've been over that territory. I think beyond that no, the relationship we have with the CQC is pretty effective at the moment.

PROFESSOR MONTGOMERY: Thank you.

DR KIRKUP: Okay, is there anything else that you'd like to say to us?

MS SMITH: No, thank you.

DR KIRKUP: Thank you very much for coming.

MS SMITH: Thank you.

[Interview concluded]

THE MORECAMBE BAY INVESTIGATION

Monday, 29 September 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Julian Brookes – expert adviser on governance
Professor Jonathan Montgomery – expert advisor on ethics

JANET SOO-CHUNG

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DR KIRKUP: Thank you for coming. I'll just say for the record that my name's Bill Kirkup and I'm chairing the panel. We have met before. I'll ask my two colleagues to introduce themselves.

PROFESSOR MONTGOMERY: Thank you. 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 PCTs and an SHA, and I think we may have met before as well, because I think I recognise you.

MS SOO-CHUNG: How do you do? Nice to see you.

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

DR KIRKUP: You'll see that we're wired for sound. We will make a recording and then agree a record of the interview at the end. If there are any clinically confidential matters that you want to raise, we can go into a confidential session at that point, but you let us know.

We do open proceedings to family members. As it happens, there aren't any here this morning, but they may be able to listen to the transcript of the proceedings at a subsequent time. You'll also know that we've asked you to hand over any mobile phones, recording devices, etc. That's just to emphasise we don't want anything to go outside this room until we're able to produce a report with conclusions in context. Do you have any questions for us about the process?

MS SOO-CHUNG: I don't and my phone's been handed over.

DR KIRKUP: I'll start off with a very general question before handing you over to Jonathan. If you could just outline when you were first associated with the PCT, how long that lasted and what then happened.

MS SOO-CHUNG: Yes, that's fine. During July 2009, I was assessed and interviewed for the post of Chief Exec for North Lancs PCT, and I was subsequently appointed to that post. I came into post, I'm fairly sure, at 1 September 2009. I continued in that post through until the run-up to May 2011. I think you'll remember at that time PCTs were being clustered so, at that time, the Lancashire cluster with the five Primary Care Trusts and, following an interview process, I was asked to take on the Lancashire cluster. That was May 2011. I continued in that role through to when the PCTs were dissolved and, at that point, it was apparent that Lancashire would have its own area team. As the cluster Chief Exec and then the interim area team director, I appointed the team at Lancs LAT. I set up the eight CCGs and also the Commissioning Support Unit there. Subsequently, at the end of March 2013, I came out of the NHS as a full-timer.

DR KIRKUP: Okay, thanks. That's very helpful.

PROFESSOR MONTGOMERY: Thanks very much, Bill. Can we start with when you arrived, the handover and what you were told about the priorities, the quality issues and the financial issues, or whatever it was that was most significant at that stage?

MS SOO-CHUNG: At the point of taking up post, the usual things as an incoming chief executive: I started to brief myself about all manner of issues, so reading the usual documents, meeting a full range of staff and also meeting the local Trust chief executives. It was just really a normal handover. There wasn't

anything in those very early days, in the run-up to taking up post, that would cause me any particular concern. Truthfully, I was just getting the broadest spread of issues that I could, getting familiar with those, and really acclimatising. I'd not worked in Lancashire previously, so it was a new patch to me.

PROFESSOR MONTGOMERY: How many Trusts were you dealing with them

MS SOO-CHUNG: At the time in North Lancs, we were dealing with the University Hospitals Morecambe Bay. We also had a flow of patients to Blackpool Foundation Trust and to the Lancashire teaching hospitals based at Royal Preston, and a very small flow of patients to Southport and Ormskirk Trust – sorry, and the Mental Health Trust at that time, Lancashire Care Trust – so quite a few Trusts in that area – sorry, East Lancs Hospital Trust as well. Sorry about that; there are a lot of them.

PROFESSOR MONTGOMERY: That's fine. Tell us what your impressions of Morecambe Bay Trust were when you met the Chief Executive.

MS SOO-CHUNG: The first time I met Tony Halsall, the Chief Executive at that time, my very first meeting, he came to our offices. My office was on the second floor at that time, at Moor Lane Mills. I was told he'd arrived, so I came down from second floor just to bring him up to my office. I suppose I was a bit surprised when he said he hadn't been expecting that. I didn't quite know what he meant. I took that to mean that perhaps relationships between my predecessor and the Trust had not been everything that they might have been. I didn't comment. We started building our working relationship from there, and that was when I first met the Chief Exec of Morecambe Bay.

What happened then was one of the things that I wanted to do was get out and about, as you do. It's no good being in an office all day, so I met quite a lot of the GPs and the practice-based commissioning groups in the area. Almost immediately, within, I would say, four to six weeks of taking up my appointment, I was met with what I would describe as a rising tide of complaints and concerns, flagged by our GP colleagues. These were issues ranging from administrative difficulties in the communications from Morecambe Bay, issues relating to patient care, concerns about engagement and relationships; that's how I'd describe the set of concerns at that time.

PROFESSOR MONTGOMERY: Those GPs you were dealing with, were they mostly dealing with the RLI or were they dealing with the whole Trust?

MS SOO-CHUNG: They would mainly have been dealing with the RLI. You'll know Morecambe Bay Trust has three main sites; two of them were over the border at Cumbria PCT, and the one site at our side of the boundary was the RLI. Most of the concerns related to the RLI.

PROFESSOR MONTGOMERY: From the correspondence that I've seen, it doesn't sound as though they were focused on maternity services; they were mostly focused on other areas. I know maternity does emerge a bit later on but, at that stage, would I be right in thinking that maternity wasn't one of the issues?

MS SOO-CHUNG: It wasn't. There were many and varied issues, but maternity was not one of those at that time.

PROFESSOR MONTGOMERY: How did you go about raising the concerns that were being reported to you with Tony Halsall?

MS SOO-CHUNG: Initially when you come on to a patch, and particularly as an incoming chief executive, you'll understand that everybody wants to know your

opinion and they're very anxious to give you their opinion in return. Initially, I did wonder whether this was a bit of a phenomenon of new chief executive on the patch; this is our opportunity to say things that we've been saying for a long time but, actually, we've got a new person to say them to, so they're hearing it for the first time.

I'm also aware that, on many patches, a large acute Trust can sometimes be a target for comments, some of which may well be unwarranted. As the weeks went on, I did feel that those comments and concerns were probably a little bit more than the usual outburst, perhaps, when a new person arrives on the patch.

PROFESSOR MONTGOMERY: Was that because you felt that the clinical concerns had more substance that you might have guessed or because of the relationships that you picked up between the Trust and the outside?

MS SOO-CHUNG: I don't think it was either of those things. They way I would describe it was the concerns were so varied and from so many quarters, and voiced by so many people, that I felt that there was probably something underlying these difficulties at that time.

PROFESSOR MONTGOMERY: How did you decide to move that forward?

MS SOO-CHUNG: One of the other things I did very early on, probably within the first week of being in post, was I spoke quite a bit with my colleague, the Chief Executive of Cumbria PCT. At that time, I was obviously aware that we were co-commissioners of the Morecambe Bay Trust, bearing in mind the disposition and the geography of their sites. The Chief Exec of Cumbria was quite pleased to have somebody to work closely with in looking at the Trust,

bearing in mind that we looked at the sites on our site of the boundary probably in more detail than the ones on the other side.

PROFESSOR MONTGOMERY: It's helpful for us to use names so that we don't make a mistake. This is Sue Page, is it?

MS SOO-CHUNG: It is; it's Sue Page. That's right.

PROFESSOR MONTGOMERY: Were her concerns similar to yours or did you have different sets of concerns?

MS SOO-CHUNG: It's fair to say that Sue wasn't surprised at the concerns. It wasn't something that she'd heard described in that way from North Lancashire. I think the reason for that may have been that my predecessor had been a former Chief Executive of Morecambe Bay Trust, and there may well have been perhaps a conflict of interest. That may be putting it too strongly, but one of the things that I picked up very quickly was that one of the previous Chief Executives of the major provider on the patch had very quickly been appointed to be one of the commissioners. Additionally, the Director of Commissioning for the PCT had been the former Director of Operations for the Trust. This would have been Ian Cumming. After Ian Cumming came to the PCT, the Director of Operations became the acting Chief Executive for a while, and subsequently became the Director of Commissioning at the PCT.

PROFESSOR MONTGOMERY: How do you think that impacted on the ability of the DC to do his job and the relationship between the Trust and the commissioner?

MS SOO-CHUNG: If you've got people who, on one day, are working on the provider's side in a particular health economy and then, all of a sudden, become the commissioner of those same services, it perhaps wouldn't be a surprise if they were not able, at all times, to be independent and objective. I

was also informed by my team that I'd newly inherited, which included the former Director of Ops, that they had felt inhibited from working with Cumbria PCT and there had not been the close cooperative relationship between the two commissioners that there might have been.

PROFESSOR MONTGOMERY: In some parts of the country, the Trust had lead commissioners; you describe it as co-commissioning. Were there any ground rules from the SHA on how co-commissioning operated?

MS SOO-CHUNG: Yes, there were. I was told from the outset that Cumbria PCT was the lead commissioner with North Lancs PCT as their co-commissioners, their partners and their support. However, because the level of commissioning and the value of the contracts from both commissioners to that Trust were – I cannot remember the figures, but broadly of the same order – it did not seem to me that there was a massive flow from one, and a very minor, insignificant one. It was not exactly evenly balanced, but they both felt to be evenly balanced contracts. Although technically Cumbria was the lead commissioner, I'd always viewed it as a partnership and as a co-commissioning relationship.

PROFESSOR MONTGOMERY: What does that lead commissioning mean? Was there a single contract that you both signed up to or were there two separate contracts?

MS SOO-CHUNG: I think it was a single contract in two parts, if I'm not mistaken.

PROFESSOR MONTGOMERY: The formal bits of the negotiation would go through Cumbria, but obviously you would have your views on the quality concerns and the financing.

MS SOO-CHUNG: I think that's right, yes.

PROFESSOR MONTGOMERY: Faced with this obvious potential question around whether or not the history of the transfer across to Chief Executive has in some way compromised the commissioning relationship, you must have tested that out in your mind, in some way, looking for some examples to see whether or not your PCT was in the right place. Can you talk us through a bit? Knowing that people are saying that to you, how did you form a view on how that affected the work that you had to take forward?

MS SOO-CHUNG: The immediate things were pragmatic actions. The first thing that I felt we needed to do as a team was to get alongside our co-commissioners, as I viewed them, to work closely with them and to get the benefit of their knowledge. As I mentioned earlier, Sue Page was not at all surprised when I raised these issues of concern, some of the management concerns and some clinical concerns. It was very clear that, because Sue had been in post for probably three and a half, maybe four, years before I came into post in 2009, I was told by the Cumbria team that they were clearly a number of steps ahead of where North Lancashire was in picking up the concerns, addressing them with the Trust, discussing them and seeking to resolve them. I was very clear that, if we were really working with the same Trust, it would be valuable just to get the benefit of that experience. It was really from them that we got alongside our commissioners and I spoke a lot with our GPs, just to get underneath some of the concerns, to get more detail and to see if there was any substance behind those.

PROFESSOR MONTGOMERY: The Cumbria team told you that they were ahead of you. What did the SHA advise you, in terms of the environment you were going into?

MS SOO-CHUNG: In those very early stages, I didn't have in-depth meetings with the SHA. I'd understood very clearly that the SHA would be there to support me, if I needed support, but in those early months I was really busy getting my head down, getting into post and understanding the patch, partly so that I could give my view to the SHA. The SHA would clearly have known quite a lot, but I felt, as an incoming chief executive, it was important to get my take as well, and to add that to the picture.

PROFESSOR MONTGOMERY: Most SHAs would have given you a feel of what they thought the top issues were that they were expecting to sort out. Did they not do that?

MS SOO-CHUNG: Not in any systematic way that I can remember. What I was told was that the Trust had submitted their application to be a Foundation Trust. That had begun the year before I came into post. I was aware, at the point of arriving there, that that process had been paused. Because it had been paused and I hadn't been there to see the reasons why, it wasn't something that I looked at in detail. I knew at some point, because there was a desire for Trusts to become FTs at that time, and the FT pipeline was very important in national policy terms, I felt it was important to understand the Trust, in the knowledge that, at some point, it would come off that the suspension or however you would call it – off the pause. I was expecting that, as one of the commissioners, we would be asked for our view and I wanted to be able to give that in a straightforward way.

PROFESSOR MONTGOMERY: Can you give it to us in that straightforward way? What was your view when it came off pause?

MS SOO-CHUNG: By the time that came off – excuse me if I just check the dates – from the time I came into post, I've described the GP concerns; I've described checking with Cumbria. The other thing to mention was that, around about February 2010, four or five months after taking up post, we were undergoing the TCS process, which saw the community provider arms of PCTs passported across to one or other Trust.

PROFESSOR MONTGOMERY: Transforming Community Services?

MS SOO-CHUNG: Yes, it was Transforming Community Services. Morecambe Bay did make a pitch for hosting community services, and that bid triggered another wave of concern from GPs. We involved our general practitioner colleagues and primary care in some of those workshops, where we were looking at potential providers.

There were also, in the run-up to the FT application being resumed, various LMC meetings and correspondence with the Chairman and Vice Chairman of the LMC, all of which were logging and noting the various concerns that we had. In the run-up to our meeting with Monitor, the immediate period, we were quite surprised that the process had been restarted. That hadn't been notified by me, either by Monitor, nor Morecambe Bay. I think I picked it up through Cumbria PCT, and I'm not exactly sure how they got notified. I was surprised that I hadn't received a formal notification. In fact, the first notification was through colleagues in Cumbria, and then a letter from Monitor inviting us to attend a meeting, which eventually turned out to be 13 June – sorry, 15 June.

PROFESSOR MONTGOMERY: 2010, you're talking about.

MS SOO-CHUNG: 2010. That was the same day that Cumbria PCT met Monitor. We met them in the morning and Cumbria met them in the afternoon.

PROFESSOR MONTGOMERY: They came up to you to do that or did you have to go to London?

MS SOO-CHUNG: We met at the Westmoreland General in Kendal. In fact, I remember it very well, because actually the two commissioners – ourselves and Cumbria – met each other in the dining room during lunch. We just happened to be in there grabbing a sandwich on the way out and grabbing a sandwich on the way in. We just exchanged a brief word at that point.

MR BROOKES: Did you know that they were seeing Monitor on the same day?

MS SOO-CHUNG: Yes, we knew that. I'm clear about that because we were both surprised at the very short notice we were given. I think we probably had two to three weeks' notice of the meeting, and I know certainly that we were concerned to ensure that we cross-referenced our findings, so we did work together in the run-up to that.

PROFESSOR MONTGOMERY: Tell us about what you said at the meeting? What did you say at the meeting?

MS SOO-CHUNG: Several things. I said firstly that I had only received the integrated business plan from the Trust after it had been submitted to Monitor and, as one of the commissioners, I would have expected to have seen that and perhaps been party to one of the later drafts in discussion. Although it was the Trust's business plan, given the importance to it strategically to all of us, and we were in financial difficulties at that time, both of us, as commissioner and Trust. I was concerned that the business plan had been submitted without our knowledge and without our involvement. I was also

concerned that, with the plan, there had been a letter of support submitted from NHS North Lancashire, which was roughly about two years old. Given that I hadn't been in post for more than a year, I knew that that letter would not have been written by me. It would have been written, presumably, by my predecessor, so I was concerned by the lack of an up-to-date letter of support, comment or otherwise.

I explained to Monitor our concerns that the planning assumptions within the business plan did not entirely match the PCT's commissioning intentions so, just as one example, the activity assumptions seemed to be assuming an upward trajectory, whereas we were assuming standstill at best. We also raised, because I was accompanied in the meeting by two colleagues, that there were a number of clinical concerns that were ongoing and under discussion but, as yet, not resolved.

MR BROOKES: Do you know if those meetings were minuted?

MS SOO-CHUNG: Yes, they were. There were notes of the meeting.

MR BROOKES: It'd be interested to see them.

PROFESSOR MONTGOMERY: Where you asked straight out at that meeting whether you supported or didn't support the resumption of the FT application?

MS SOO-CHUNG: I don't remember being asked that question outright, but I did voice the view of the North Lancashire PCT that this may not be the right time for the Trust to be authorised as an FT. I was asked direct questions about the capacity and capability of the senior team. That was one very direct question towards the end of the meeting.

PROFESSOR MONTGOMERY: It would be very helpful to know both what you said about time and also your reflections, obviously because you know a lot more afterwards than you probably knew at the time.

MS SOO-CHUNG: I think at the time I felt the team was not engaging sufficiently with stakeholders, and I had that message loud and clear from the LMC and from the Practice Based Commissioning groups. I also felt that there could have been a better level of engagement and clinical cooperation with some of the other Trusts on the patch, the Blackpool and Royal Preston, for example. I also said that I felt that the team was very stretched and seemed to be short on capacity. I also expressed some surprise that, given the operational and clinical difficulties they were working to resolve, they should want to expand their base to include and incorporate the community services from the PCT. I was aware, at that time, that there were some aspirations to look at one of the acute trusts on the other side of the boundary, in Cumbria.

PROFESSOR MONTGOMERY: What about their capability, capacity and clinical governance?

MS SOO-CHUNG: I think the fact that they had clinical difficulties in A&E, and that there were very fundamental difficulties in the administration of patient care, seemed to indicate that they were not being entirely effective, as far as that was concerned.

PROFESSOR MONTGOMERY: Did they engage any of your clinical people in their clinical governance processes? Were any of your GPs involved in that?

MS SOO-CHUNG: There were very many meetings and a huge volume of correspondence, all seeking to resolve these issues. The LMC particularly was extremely frustrated by their attempts to engage. I've recently refreshed

my memory, and some of the correspondence seems to indicate that there was a lack of involvement from the senior team: meetings would be arranged and then stood down; there were promises of attendance from senior executives, which didn't in the end materialise.

It was really because of that that I got so closely involved with the LMC. The LMC was on the point of calling a board-to-board meeting with the Trust shortly after I came into post, and I actually dissuaded them from doing that, because I felt that there was more mileage in terms of me picking things up as an incoming chief executive, of engaging team to team with Tony and his directors.

PROFESSOR MONTGOMERY: Can I just check terminologies and understandings? In my part of the world, the LMC operates in part as the trade union for the GPs, and then we would have had a clinical executive committee within the PCT, which would have been the commissioning bit. Lots of people overlapped, in terms of membership. Is that how it worked up here?

MS SOO-CHUNG: I think the membership did overlap by a couple or three people. There were a number of bodies involved in the attempts to resolve these issues, including the PEC, the Professional Executive Committee, the normal governance and quality subcommittees of the PCT.

PROFESSOR MONTGOMERY: So you told us a bit about the LMC's view. What was coming through to you from your PEC?

MS SOO-CHUNG: A similar range of concerns. I know that one time, again just as I came into post, our medical director and our lead nurse on the board were reporting significant concerns arising from the Stroke Sentinel Audit that was carried out. They were also reflecting concerns in A&E – the difficulties with

ambulance turnaround, the delays in clinical handover of patients and the lack of ability of the Trust to sustain its four-hour A&E performance. During the time I was in post, I don't remember a sustained period when those targets were consistently met.

PROFESSOR MONTGOMERY: What was the SHA response to that? Again, SHAs differed. In some places, that was a trigger for a lot of SHA interest. Did it trigger a lot of SHA interest in this case?

MS SOO-CHUNG: We would have our normal performance management meetings and, as I recall, they took place on a quarterly basis. Performance issues were discussed at the regular monthly chief execs' meetings and we also had the normal bilateral meetings between our director of performance and the SHA's director of performance. Similarly, the finance directors would have met on their network, and I would have met with the directors and also the chief executive of the SHA, at that time.

PROFESSOR MONTGOMERY: What would you have talked about? What did you talk about, perhaps I should say?

MS SOO-CHUNG: At that time – again it was in the run-up to Foundation Trust status – I made at least three of the directors of the SHA aware of my concerns, bearing in mind that there'd been a history of concerns and I was still fairly new at that point. I knew that, at some point, the Trust would resume its Foundation Trust application, and I was concerned to ensure that the SHA was aware of our commissioning view of the operational difficulties, the discharge problems, the widespread concerns felt and, I think, by that time the various issues arising from maternity care, the neonatal deaths and maternal deaths.

At each meeting, and I had several one-to-one meetings with directors of the SHA, I made it clear that, looking at each of the individual concerns – for example, discharge letters or patients going home with the wrong medicines – I said that perhaps taking each of these on their own as an isolated event, concern or complaint, may not be significant. What was concerning me and frustrating me was the level, volume and the sustained nature of the way that those complaints were being brought to my attention. I clearly remember saying, 'If it is your view that these concerns are not significant and that you're not concerned, then you need to tell me that. If there are concerns, they do need to be tackled,' and explained what we would be doing through our normal governance processes.

PROFESSOR MONTGOMERY: Which three SHA directors are we talking about?

MS SOO-CHUNG: I met with Kirsten Major, who was the director in charge of – in her portfolio was the Monitor pipeline, at that time, so Kirsten Major. Jane Cummings was the Chief Nursing Officer and Director of Performance at that time, and Mike Farrar. I also had a shorter conversation with Mark Ogden, the Director of Finance.

PROFESSOR MONTGOMERY: Thanks. Can I pick up the maternity care things that you were raising? You described at the handover stage that hadn't appeared, so when did maternity care first reach your radar?

MS SOO-CHUNG: I was just checking for the date here. The point that triggered it was when we heard that the South Cumbria coroner had issued a Rule 43 letter. How that came to my attention was through two routes: through my medical director, who'd been briefed by Cumbria PCT's medical director; and I was also briefed on one of our regular discussions, by my colleague, the Chief

Executive of Cumbria PCT. I'm just trying to check the date when that Rule 43 letter was issued. I don't have the exact date, but it was in June 2011.

PROFESSOR MONTGOMERY: By that stage, the FT application had gone through. Did you, in the end, formally support the FT application? Were you asked for a fresher letter than one that was two years old?

MS SOO-CHUNG: Going back to the meeting with Monitor, I did point out that the letter of support from the PCT was two years old, and I do remember saying that I was not in a position to issue a new letter giving that support. In fact, I never did issue a letter.

PROFESSOR MONTGOMERY: Thank you. Shall we go back to maternity care then? In June 2011, you've moved the situation and it's on the radar. Is it on the radar as an issue for Cumbria or is it on the radar as an issue for your PCT as well?

MS SOO-CHUNG: Given our concerns, clearly this was a three-site Trust, but it was led by one single management team and one single board. That's why it was useful to cross-check with co-commissioners their concerns. On the maternity, as soon as we heard that the Rule 43 letter had been issued, clearly there was a maternity and obstetrics unit at the RLI. At that time, having had a discussion with my medical director, we decided and we knew that we just needed to work very closely with Cumbria. Although the event that triggered that Rule 43 letter had been in 2008, as I understand it, clearly there was a single Trust management. We felt that there may well be ramifications or implications for the unit at the RLI, even though, up until that point, we'd had no similar cause for concern.

PROFESSOR MONTGOMERY: How did you go about testing that obvious question, as to whether there were issues for maternity services for your people?

MS SOO-CHUNG: Well, at that time my medical director and our lead nurse would have those discussions with our opposite numbers. I kept closely in touch with the Chief Executive of Morecambe Bay. We also made sure that our quality and governance committee looked back over serious untoward incidents and incidents that had been put on the STEIS ~~stice[?]~~ system. We were really looking to see whether there may be any similar incidents or concerned that we needed independently to follow up.

PROFESSOR MONTGOMERY: What did you find?

MS SOO-CHUNG: We didn't find anything specifically of that nature. From memory, and I could check if you need it checking, there was one neonatal incident that predated my time at the PCT by some years. I think that was the only incident that seemed to be of a similar nature to the incident that triggered the Rule 43 letter.

PROFESSOR MONTGOMERY: Did those enquires throw up any of the various internal reports that the Trust had had commissioned by that stage?

MS SOO-CHUNG: No.

PROFESSOR MONTGOMERY: What about the CQC? Everybody suddenly gets interested around the time the Coroner's Rule 43 letter comes out, so how are you liaising with other organisations to try to make sure you don't all do the same things and share views of what you've found?

MS SOO-CHUNG: That was triggered in June. The CQC joint compliance visits, and I did check the date, started a month after in July. At that time, we were essentially cooperating in terms of that joint compliance visit. They certainly

visited RLI at different times of the day and they interviewed a number of our team as well. I actually don't think that I was interviewed, but I know that my medical director was interviewed and certain PEC members. I know that the Practice Based Commissioning group was interviewed. I don't think I was interviewed, but we cooperated with that visit and gave out a number of documents at their request, at that time.

PROFESSOR MONTGOMERY: Prior to that, there were various processes about the CQC, their normal insurance processes. The quality accounts system I think is in by then. What's the PCT's input into those judgments? Were you asked to comment on then?

MS SOO-CHUNG: Yes, we were. Again I can't recollect the date, but can check. The first set of quality accounts for Morecambe Bay was significantly delayed. There was a deadline date for them to be submitted to us in draft, and I do know that they did come in quite late. We reviewed the document and offered our comments, and those were incorporated into that.

THE CHAIRMAN: When you say 'it came in late', after the deadline or late but just before?

MS SOO-CHUNG: I think it was after the deadline. I'm not too sure.

PROFESSOR MONTGOMERY: Is it 2011 or 2012? I'm trying to see when it fits into the point in June 2011, when you know that maternity is on the radar and needs to be followed up, because you've got the Rule 43 letter. By that time inside the Trust, there's quite a lot of activity around this, which doesn't seem to have reached you.

MS SOO-CHUNG: I'm just looking. The draft quality accounts that I have here are dated the end of April 2010.

PROFESSOR MONTGOMERY: On those there are no particular quality flags that the PCT's identified.

MS SOO-CHUNG: None that I can recollect. I think there were various things. I'm just looking at them now. There were issues relating to the Healthcare Commission, at that time, annual check, MRSA trajectories, recent significant events, the electronic patient records and the reliability of care pathways. Yes, there was a range of things, but nothing particularly jumped out.

PROFESSOR MONTGOMERY: By this stage, we've already picked up a lot of external inquiries that have been commissioned by the Trust, both around maternity and other areas. Was that pattern of them inviting people in to give them advice and assurance apparent to you – that that was the way the team operated within the Trust?

MS SOO-CHUNG: Well, I got the impression, certainly in my discussions with the Trust executive team, that they wanted to handle the issues internally. I did feel that there was a reluctance to seek outside help. I was surprised that there was one report, I think it was referred to as the Fielding report, that was commissioned by the Trust. It was a report that was not known to me until after Gold Command had been called.

PROFESSOR MONTGOMERY: Would you have expected to know about it?

MS SOO-CHUNG: Yes, I would. Any major report that was being commissioned that was a concern ought to have been notified to the commissioner. Perhaps the commissioner could be involved in shaping that and perhaps consulted on the terms of reference.

PROFESSOR MONTGOMERY: Just help us on what makes that a major report. It's the third report following up that particular incident that the Trust

commissioned. We're trying to get a sense of whether people should have appreciated it was a major report, because you've said that a major report should have come to you. What makes something a major report?

MS SOO-CHUNG: Well, I think that's a very difficult question to answer as a technical question. What makes it major, or 'significant' might be a different word to use, was given the background of concerns. Around about that time in 2011, in the run-up to the meeting of Monitor, there was a huge background of concerns that related to ambulance turnaround, a lack of ability in A&E to sustain its targets; there were care quality issues raised by my GP colleagues and my PEC. I would have thought that any report that was looking to review the quality of services and patient care probably should have been notified to commissioners, and I would also regard that as part of normal working relationships.

PROFESSOR MONTGOMERY: Just relaying back what the Trust might be thinking, it's six months since they received that report; it's 18 months since the visits on which it was based. It's – I can't do the count – 36 months since the incidents. From their perspective, you haven't flagged maternity as a current set of issues. They're trying to address the current set of issues. Would you have expected them to draw back and give you all past reports?

MS SOO-CHUNG: I don't know about specific reports, but I just think that, as part of the normal commissioner and provider relationship, I'm not suggesting that anybody hid those reports or prevented us from seeing them, but I would have expected, in the normal course of events, to be aware of them. Bearing in mind the kind of relationships that I've had with Trusts that I've commissioned from in the past, I would expect to be notified of CQC visits, of Ofsted

arrangements, of issues with safeguarding, of any inspection that might affect our views, as the commissioner, or contribute to a picture of what was going on in the Trust at that time and would help us to jointly work together to address those.

PROFESSOR MONTGOMERY: That's helpful. If I just reflect back, what I think follows from that is that we should not be asking questions just about the Fielding report then, because that would apply to a number of other things, other than the Fielding report that you would have expected to have known about. The Fielding report looks at one chunk of it, but they've done reviews on staffing; they've done various other reviews around maternity and other services, paediatric reviews. All those are things that you would think would be open book, if you like, between yourselves and the commissioner.

MS SOO-CHUNG: I think that's right, because where they need to take place, if they are showing that there are areas of good practice or that things are generally safe, that they're reliable, that targets are being met and patients are satisfied with the care that they're receiving, I couldn't see a reason why a provider would not want their commissioner to be aware of those things. Equally, if there are issues that chime with concerns and comments being made, then I would think that that ought to trigger a constructive discussion. 'Yes, there were things that you raised with us last month or six months ago. We've picked this up and, actually, this is how we can address them and this is what we might need you to do to assist us in doing that.' I think that that relationship needs to have that open dialogue. I'm not suggesting that every single piece of paper that crosses the desk needs to be notified to the

commissioner. It's for the Trust to manage their own services and to operationally be in charge of those.

THE CHAIRMAN: Can I just be clear though? You are suggesting that should have occurred contemporaneously, in other words in the middle of 2010, when the Fielding report was finalised, not retrospectively a year later.

MS SOO-CHUNG: I'm sorry; say that again.

THE CHAIRMAN: You would have expected to have been involved in the Fielding report at the time when it was being published – not published, at the time when it was being produced for the Trust – not a year later, in retrospect.

MS SOO-CHUNG: I think that, if a report is being commissioned with a number of outside people with expertise being brought in, I would have thought it might have been good practice to say to the commissioner, 'We're thinking of looking this and these are the reasons why. These are the proposed terms of reference.' The reason I say those things is that I do see that, if commissioners are to be effective and provider trusts are to be effective, it's dependent on a close working relationship and it's a partnership. Even though provisioning and commissioning are sometimes viewed as being on opposite sides of the fence, I don't see it that way; it's a collaborative effort to make sure that services are as they should be.

PROFESSOR MONTGOMERY: Can I ask about your impression of –?

THE CHAIRMAN: Just before you do that, I know Julian wants to come in.

MR BROOKES: That's alright; don't worry. I want to come back to it again, because it's pertinent to your relationship in terms of your commissioning approach, but were you aware whether, within your contracts with the organisations, there were any clauses around open disclosure of those kinds of things, which are

not uncommon, to put that into a much more formal basis than 'I would expect them to tell me'? Do you know whether that was the case in this situation?

MS SOO-CHUNG: We would have operated the NHS standard contract at that time and, if that contract contained a clause, then I would expect a provider to abide by that. I must stress that, for effective commission of services, it is entirely dependent on, possibly wholly dependent on, having that constructive open working relationship. I would be very sorry to think that, in terms of commissioning, if you had to reach for the contract and look at a certain paragraph and a sub-clause to enable things to happen –

MR BROOKES: No, but it sets the environment and context in which you're working, where both parties are accepting that these are the kinds of rules and there's no chance at a later stage to turn around and say, 'Hmm, I wasn't aware that I needed to do that,' even if there is this open relationship. I totally accept and totally agree: I've done that job from a commissioning point of view and I know that you do totally rely on that – well, not totally, but you rely on that. There's also an environment in which you can work and I was just trying to get the feel for the environment, which I want to come back to later on in terms of the commissioning arrangements.

There was one supplementary to that: where you ever told within that timescale by the SHA that this report had been commissioned? They were aware of it when it was commissioned.

MS SOO-CHUNG: No, I haven't been aware of that report.

MR BROOKES: Again, would you have expected that to be information shared with you?

MS SOO-CHUNG: I think I would, but it's possible that the SHA assumed that I had been aware of it, but the SHA did not mention the Fielding report to mention that specific one.

MR BROOKES: Thank you.

PROFESSOR MONTGOMERY: You described what a functioning relationship between a commissioner and a Trust you're commissioning for would look like. I've seen a set of papers and correspondence from May 2010, when you clearly had a whole load of issues raised by your PEC and you'd picked them up with Tony Halsall. At this point, he has the draft of the Fielding report, although it's not been finalised, and you're having a series of discussions with him. The tone of correspondence doesn't sound as though it quite matches the ideal commissioner/provider relationship that you've just described. I'm trying to have an understanding of how the Trust responded to challenge. Obviously we've seen some correspondence but, if you could flesh that out for us, it would be helpful.

MS SOO-CHUNG: In the same way that I wouldn't invoke contract clauses first, as a first response, it would not be my first response to write formally to a chief executive colleague. It would probably be one of the later things that I would do, and only when I felt that I needed to do that. The context of that set of correspondence is really a series of discussions with Tony, a series of discussions with his team, various meetings at which we discussed and aired these issues. By the time I put pen to paper in May, it was also after chairman-to-chairman discussion. My Chairman at that time, William Bingley, had regular meetings with ~~when he became~~ the Chairman of the Trust ~~at that time~~. There was a fairly regular and constant flow of discussions, medical

director to medical director, chief exec to chief exec, and chairmen. It was really at that point in the run-up, April to May, that we felt that it was probably time to raise these concerns and put them formally into writing.

The other thing that was happening at this time were fairly regular discussions at our board, not just the formal boards, but also in between each formal meeting we had workshop discussions, so we discussed perhaps a little more freely then and also using our Part 2 board meeting. The first letter that I wrote, 5 May, came really because of the concern and the frustration that we were feeling as commissioners. We felt that we weren't able to break through to get some clear responses and clear actions and, by that time, we were also wanting very clearly to represent the views of GPs. By this time, it was clear that they would be the commissioners of the future. We were going from Practice Based Commissioning groups through to the new system.

PROFESSOR MONTGOMERY: Were you doing this in collaboration with NHS Cumbria? Were you doing a two-pronged attack, if you like, to address the culture or was this independent?

MS SOO-CHUNG: Again, all through this period, our team was in contact with the Cumbria team several times a week. My conversations with Sue Page, around about this time and in the run-up to the meeting with Monitor, we probably spoke on the phone two, three, sometimes four, times a day, just really checking and cross-checking issues and concerns. Also at that time, I remember discussing that I was going to put pen to paper. I'm imagining that that would have been the same from the Cumbria side. Some of this correspondence, if not all of it, would have been copied across.

PROFESSOR MONTGOMERY: I want to come on to Gold Command next, unless you want to pick up anything. The next big think we want to understand is the way this completely changes with Gold Command. You've described the SHA being aware, but the SHA suddenly becomes a bit more active on that. Gold Command is an unusual way of handling this type of situation, so we'd like to understand how it emerged and what it was thought it would achieve.

MS SOO-CHUNG: The thing that preceded Gold Command was that a risk summit was called by the SHA and there's a Department of Health Framework for early warnings that they invoked at that time. They called a risk summit and, in preparation for that, there was a fairly extensive – I think that was called on 7 October. Yes, 7 October the risk summit took place and the framework was the early warning framework. Essentially, we were invited to take part in the risk summit by producing a series of briefing documents. They were parallel documents to ones being produced by Cumbria. The whole set of concerns and issues was discussed about this summit, with particular reference to the maternity care, particular reference to safeguarding issues and particularly problems at the A&E and the administrative processes that I've mentioned.

The risk summit took place and then, really within a few days of that – the risk summit was 7 October 2011 and a major incident was declared by the SHA on Thursday 13 October. At that time, Gold Command was established and that responsibility was delegated to Cumbria PCT to lead on that.

PROFESSOR MONTGOMERY: At what point do you think that the major incident really emerges? Is there a specific trigger for this or is this a chronic problem that people have changed their attitude to how it can be solved?

MS SOO-CHUNG: I think the things that triggered it were a report published by... I think it was the report of... I think it was partly triggered by the CQC's compliance review that was published sometime in mid-September. It was having digested that and the continuing concerns that led to the major incident being called, the escalating concern and –

PROFESSOR MONTGOMERY: That didn't really discover anything that wasn't going on already. From the picture you've painted, nothing new happens at that point. It's a new discovery. Is that fair? There's a whole load of underlying concerns.

MS SOO-CHUNG: I think that it was probably the mounting concern. By then, there would have been a series of reports. There would have been the concerns raised in the run-up to the Foundation status being awarded. By that time, a police investigation had also been launched into the case that the Coroner had reviewed and issued the Rule 43 letter. I don't know if it was any single one of those issues; it was probably a combination of rising concern, and the recognition that the scale and depth of concern were such that the Trust would not be able to mobilise sufficient resources, of itself, to deal with these many issues.

PROFESSOR MONTGOMERY: If I can just tease out that separation. There's clear evidence of rising concern. Is that the same as the patient quality issues getting worse or have the patient quality issues actually been consistent through that, but we've only just begun to pick it up by this point? We'll pick it up fully.

MS SOO-CHUNG: Possibly because people were looking more closely, there seemed to be more and more examples of then being brought forward. It's

possible that there were more, but I think that the scrutiny, the different reports and everything else contributed to that.

PROFESSOR MONTGOMERY: Going back to Gold Command then, most Gold Commands are short-lived to deal with specific crises. This one goes on for quite a long time. In terms of the success question, as it was set up, what did people think would enable it to be stood down again? What was it aiming to change in that intensive intervention?

MS SOO-CHUNG: I'm sure you've seen the terms of reference for Gold Command but, in my words, I think it was a response that was designed to mobilise the wider health economy to enable us to draw on wider resources that may not be available to us. One specific, for example: because it was felt that maternity care in the two hospitals on the Cumbrian side was under review at that time, one of my concerns was that, if some of the staffing was taken from the RLI maternity unit to support on the other side of the boundary, that then might cause us some difficulties at the RLI site. I was quite relieved and pleased actually when Gold Command was established, because it meant that we could draw on a wider pool of support to draw on expertise, advice, support and mentoring for staff.

PROFESSOR MONTGOMERY: Does that imply that the Trust didn't have the capability and capacity to solve these problems alone?

MS SOO-CHUNG: It did imply that. I think that, given the scale of the issues, it would be very hard-pressed to ensure that those issues could all be dealt with in a way that was timely. That was one thing that I felt that Gold Command would and could achieve, and I think it did. The other thing was that –

PROFESSOR MONTGOMERY: Can I just test that? There are two different things it might have achieved. One is it might have addressed the problem on behalf of the health system, and the other is it might have addressed the problem on behalf of the Trust and created the capability within the Trust to have a sustained future, if you like, going forward. Which of those two did you mean?

MS SOO-CHUNG: I mean both of them. And again, I think that the – whatever would have been a concern for the Trust would also mean that it was immediately a concern for the commissioner. I don't distinguish between those, but where I would distinguish is where you get into the depths of fine, fine operational detail, and as I've said, it's for the Trust to manage their services and to make sure that they are fit for purpose and they are safe and sustainable. Clearly, the commissioner has a strong role in that, but, you know, there comes a point at which the operations of that Trust have to belong to them. So those concerns, and the assistance that we felt would be brought to bear to help the Trust resolve those issues, would also materially assist the overall health economy.

PROFESSOR MONTGOMERY: So they would stay in place after Gold Command?

MS SOO-CHUNG: I think that there were two real phases. I think one was to support immediately the maternity units at Furness General and Westmoreland General without meaning any loss of capacity and strength at the RLI. There were also other issues relating to A&E and the need to review those concerns, so I think that we were wanting to get to a point where the Trust was more stable, in terms of managing its services, and then there would need to be a period which they could sustain, and that, perhaps, would

have meant the recruitment of additional staff on a more permanent basis, reviewing their establishment, looking at their skill mix, looking at their profile.

PROFESSOR MONTGOMERY: And the commissioners were signed up to that being a commissioning responsibility?

MS SOO-CHUNG: I think it's a shared responsibility. Certainly, we were clear that, you know, in the longer term, more funds would be needed for the Trust. At one point, we looked potentially at the figures that may be needed, and we felt that whatever those were, we would need to do everything we could to find those, even though we ourselves were under some financial pressure at that time.

PROFESSOR MONTGOMERY: Thanks.

DR KIRKUP: Okay, thank you. Julian?

MR BROOKES: Just some brief questions, some of which we've touched on already. I'd be interested in your views of the relationship between PCTs and Strategic Health Authorities. It differs around the country; I was working in the south west, which has a very particular model. What was it like where you were, coming into North Lancashire, the relationship with the SHA?

MS SOO-CHUNG: I would describe the relationship as being supportive; I would describe the relationship as being light-touch, and in support of those comments, I think that we would meet the SHA regularly for our performance review meetings. We would flag concerns and issues with the SHA if we felt that was necessary, but I wouldn't describe it as very heavily performance management. I have worked in other SHAs where, perhaps, that approach is a little bit more to the fore, perhaps.

DR KIRKUP: Mentioning no names.

MR BROOKES: And that's why I'm – did the SHAs join you in your local performance management discussions with local organisations, or was it very separate: you did the local performance management, and then there was a session with the SHA?

MS SOO-CHUNG: No, the SHA didn't attend the local meetings. So the local – I think you mean the local contract meetings, the meetings to look at quality standards, the meetings to look at specific issues. These would have been, and were, handled by the PCT, and then there was a separate performance stream from the commissioner through to the SHA.

MR BROOKES: Okay, that's helpful. You mentioned about the discussion with three SHA directors, in terms of your concerns. Did you ever write to them outlining those concerns, or was it done purely in discussion?

MS SOO-CHUNG: The four meetings, the one-to-one meetings, were – I didn't minute them; they were one-to-one meetings. I had just my handwritten notes of the things that I was going to raise. The concerns are the ones outlined in my letters to Morecambe Bay, and those were all copied to the SHA.

MR BROOKES: So they'd be fully aware of your concerns?

MS SOO-CHUNG: Yes, definitely.

MR BROOKES: And would they be fully aware of your position in terms of the FT application?

MS SOO-CHUNG: Yes. I was very clear, particularly with Kirsten Major and Jane Cummings and Mike Farrar, that I didn't think that the Trust were perhaps ready to take on additional responsibilities at this time – sorry, take on a new status at this time, because there were unresolved issues. I was concerned at the time that, at the point that they became an FT, they would perhaps be

facing towards a different regulator, so perhaps we'd be less the SHA and more Monitor. And I made it clear to the SHA officers of the things that I would be saying to Monitor when we met. These meetings took place – I couldn't get access to diaries because we were dissolved, so I can't track the exact dates of those, but there were three or four specific meetings where I attended the SHA's offices in Manchester and described and discussed these concerns.

Dr KIRKUP: And what feedback did you get from the SHA? Did they react at all to this information you were giving them?

MS SOO-CHUNG: Well, the specific thing that I said was that I said I'm concerned about the totality of them, rather than the specifics. I said I was concerned that there may be underlying issues, and in each meeting, I said, if you think that these concerns are unwarranted or you think that I'm perhaps, you know, exaggerating them or being overly concerned about things that should not be a concern, then I needed to know. And nobody said that. Nobody said, 'You shouldn't worry about this; it's all in hand.'

DR KIRKUP: But neither, I'm picking up, and correct me if I'm wrong – neither did they say, 'Yes, you're right. We agree with you; that's been our impression.'

MS SOO-CHUNG: I think words to that effect were said. I mean, nobody disagreed with me.

DR KIRKUP: There's a difference between not disagreeing with you and agreeing with you.

MS SOO-CHUNG: I came away with – I came away feeling that I had done everything I could to flag those concerns with them, and that I had made my position very clear.

DR KIRKUP: And was your impression that they would then take that up? That that would become part of their assessment of the Trust?

MS SOO-CHUNG: I assumed that they would flag those concerns with Monitor. I did subsequently speak to one of the directors; in fact, it was Jane, and I asked – it was after the authorisation, actually, because I have to say I was really taken aback to find that the Trust had been authorised. And one of the conversations I picked up with Jane – I asked about the concerns I flagged, and she said that she'd passed those on to Monitor. I didn't see anything in writing.

DR KIRKUP: Okay. Sorry.

MR BROOKES: No, that's helpful. Just touching on this co-commissioning arrangement: I understand about what lead commissioners were and everything, and it operates in different ways. So, just for my own clarity, as Cumbria were lead commissioners, did they lead the negotiations and contract discussions, and secondly, did they lead the review meetings, or was it done jointly?

MS SOO-CHUNG: Up until the point I came into post, contract negotiations were done separately, but led by Cumbria. So they would have meetings, and then North Lancashire would – there were separate quality monitoring and performance meetings during the year, and those would have been led by the Performance Director and by the Medical Director, and Finance, as well.

MR BROOKES: So Cumbria would have had a set of meetings with the Trust, and North Lancs would have a set of meetings with the Trust.

MS SOO-CHUNG: Yes.

MR BROOKES: So how would concerns be communicated amongst the two PCTs?

MS SOO-CHUNG: Ahead of the meetings – well, part of that flow was really a constant set of communications between one team and another, and in fact, the Cumbria team and the North Lancs team met several times during the course of the year, just to triangulate and to swap notes and to talk about issues of common concern. And bearing in mind that we were really relating to different sites – so Cumbria related two sites; we related to RLI – we did have slightly differing issues to raise, because they were site-specific, but there were some issues that were in common.

MR BROOKES: Okay. And you've described a whole range of concerns that were building over a whole period of time. I think I'm correct in thinking those were concerns shared by Cumbria as well, from the conversations – from what you were saying. So what was the response of the PCTs to that? And I don't mean just in terms of a dialogue; I mean, what else happened? Was there any meaningful changes? Was there any thinking of different ways, different models of delivery, etc?

MS SOO-CHUNG: I suppose the way I would describe it is that in terms of the specific concerns, we would raise these issues with the Trust either in meetings or correspondence or emails, and we would receive responses describing the actions that had been taken.

MR BROOKES: But it doesn't sound very satisfactory, because there's the clear feeling of an escalation, you know. The conversations, quite rightly, between chief exec to chief exec or teams to teams, then chairman to chairman, then the formal writing of letters outlining your concerns; conversations by the boards – but it gets to the stage where if you're not satisfied with the reaction

that's coming out, I'm just wondering what was the next step? How did the PCT intend to help?

MS SOO-CHUNG: Well, I think that's right. I mean, the individual and specific concerns were one thing, but what I've tried to describe is a feeling that these events – that these incidents or concerns or complaints were really symptoms of, you know, something much more fundamental, which was about Trust management and Trust leadership and the ability for them to link these events across and to work out what the themes were that were driving these.

MR BROOKES: So what were the levers and tools that you had as a PCT to make those get changed?

MS SOO-CHUNG: Oh, we issued contract enforcement notices; we applied some penalties at one time; we raised things formally; we invoked chairman to chairman meetings; we ensured that that we fed into CQC meetings; we made our views clear to Monitor; we commented on the Trust's financial plans, as far as we were able. In terms of actual tools to compel Trusts to act as a commissioner, I don't know that there were those direct levers. It was not a situation where we could withdraw an entire contract and procure the whole service. There was never anything that I felt was in my toolkit –

MR BROOKES: There wasn't an alternative provider, in effect?

MS SOO-CHUNG: I think that some of the flows, we could have directed to some of the local Trusts, but not all of them.

MR BROOKES: Okay. And where was the SHA in this conversation? They were fully aware of your escalating concerns within the organisation? And, again, I'm just trying to get a feel for the relationship there, because in some places

that might have led to direct intervention by the SHA at quite an early stage in support of the commissioners. I don't get that feel here.

MS SOO-CHUNG: We were feeding into the SHA concerns at regular intervals. I think that where they got to a point where we'd started to get things into writing and much more formally was the point at which I was meeting SHA directors one-to-one, and in the run-up to Foundation Trust status.

MR BROOKES: Okay. Thank you

THE CHAIR: Okay. Is there anything else that you would like to say to us? It's not compulsory, but if you want to –

MS SOO-CHUNG: I can't think of anything.

THE CHAIR: Okay. That's been really helpful. Thanks very much for coming.

MS SOO-CHUNG: Thank you.

(The interview concluded at 11.41 a.m.)

THE MORECAMBE BAY INVESTIGATION

Tuesday, 7 October 2014

Held at:
Trinity Enterprise Centre,
Ironworks Road,
Barrow-in-Furness.

Before:

Dr. Bill Kirkup CBE - Chairman of the Investigation
Professor James Walker - Expert advisor on obstetrics
Professor Stewart Forsyth -- Expert advisor on paediatrics

SUNANDO SUR-ROY

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

DR KIRKUP: Thank you for coming. I am Bill Kirkup, I am the Chair of the Panel. I will ask my two colleagues to introduce themselves to you.

PROFESSOR FORSYTH: Good afternoon. I am Stewart Forsyth, I am a Paediatrician and a Medical Director from Dundee.

PROFESSOR WALKER: I am Professor Jimmy Walker, a Professor of Gynaecology in Leeds. I have also worked previously for the National Patient Safety Council.

DR KIRKUP: As you can see, we are recording proceedings. We produce an agreed record at the end. We also have open proceedings to family members, apart from the part of the session where we talk about the clinical details. If we could have two halves to the session, the first of which we will keep free of clinical details.

You will also know that we have asked you to hand over phones, recording devices, and so on. That is to emphasise that we don't want anything to go outside the room until we are ready to produce a report with all the findings in context.

Do you have any questions for me about the process?

DR SUR-ROY: No, that is fine.

DR KIRKUP: Can I start out with a general question

before handing you over then. My general question is: When were you working in the Trust? When did it start, when did it finish and in what capacity?

DR SUR-ROY: I started in October 2004 for one year as NFTTA training post. I went to ~~Harland~~ Preston and Hull Royal for one and a half years, came back in March 2007. Since then, I am working for the Trust.

DR KIRKUP: In what capacity?

DR SUR-ROY: A middle grade. Always middle grade.

DR KIRKUP: You are still working there now?

DR SUR-ROY: Still working.

DR KIRKUP: Thank you. Jimmy.

PROFESSOR WALKER: Good afternoon, I suppose it is now. You graduated from Calcutta University, is that right, in 1990?

DR SUR-ROY: Yes.

PROFESSOR WALKER: You came to the UK, first of all, in 1998?

DR SUR-ROY: 19~~9~~88.

PROFESSOR WALKER: You have worked since then within the UK system.

DR SUR-ROY: Yes. Continuously since 1998.

PROFESSOR WALKER: What did you do in 1998 when you first came?

DR SUR-ROY: I did the SHO post in Durham and then

Bishop Auckland and then Peterborough. Then I started in 2002 ~~2001/2~~ in Basingstoke and then moved to --

PROFESSOR WALKER: That does not particularly matter precisely, but so how many years, you remained as a first-on person for how long?

DR SUR-ROY: About three and a half years.

PROFESSOR WALKER: You then moved into second on-call.

DR SUR-ROY: Yes.

PROFESSOR WALKER: So that would be about 1996/97 or something, would it be?

DR SUR-ROY: I came in ~~2000~~ -- 1998.

PROFESSOR WALKER: Right.

DR SUR-ROY: I came in'98.

PROFESSOR WALKER: About 2002~~1~~ you will be up into second tier.

DR SUR-ROY: Yes.

PROFESSOR WALKER: When you came first to the Trust here you had been second tier for about three years?

DR SUR-ROY: First in the Trust for one year from 2004 to 2005 as an FTTA in the rotation in the Manchester Deanery. Then I went to Preston and Hull Royal. From 2007, as an -- sorry, non-training post -- and from 2007, March. Then I got into this staff grade post in October 2007. So 2007 March to October it was an LAS post ~~from October onwards.~~

PROFESSOR WALKER: I was trying to get a handle of when you first became a second tier doctor. That would be, when, in the first post in Barrow in 2004, or before that?

DR SUR-ROY: Before that I was in Basingstoke. First became a second Tier in 2002

PROFESSOR WALKER: Maybe about 2003?

DR SUR-ROY: 2002.

PROFESSOR WALKER: By the time you came here in 2007 you had been five years as a second tier --

DR SUR-ROY: At least five years.

PROFESSOR WALKER: -- when you were staff grade in 2007.

DR SUR-ROY: 2007, yes.

PROFESSOR WALKER: Have you been moved from staff grade to associate specialist?

DR SUR-ROY: ~~I moved to as~~ -- I didn't go through Ass Specialistty post ~~specialist, specialty doctor.~~ I am Speciality doctor

PROFESSOR WALKER: Specialty doctor. When was that?

DR SUR-ROY: Since it was retrospective one, so probably from 2009/10.

PROFESSOR WALKER: You also got the membership exam in 2005.

DR SUR-ROY: Yes.

PROFESSOR WALKER: That is right. Your role here, when you first came in 2007 and since then, has it developed

over the period of time, actually what you do?

DR SUR-ROY: Yes, I have been working continuously, and gaining experience both in labour ward and gynaecology.

PROFESSOR WALKER: What would be your job plan for the week; what sort of things would you do?

DR SUR-ROY: Usually clinics and labour ward cover. Theatre. With the consultant and during the on-call labour ward cover to cover all emergencies, both gynaecology and obstetrics.

PROFESSOR WALKER: Do you do any theatres or clinics on your own as a specialist?

DR SUR-ROY: Not majors. Laparoscopy, hysteroscopy, like, and minor laparoscopic operations like there are ectopic. But majors, like hysterectomies -- and I assist, I do with the procedure, but the consultant is always there.

PROFESSOR WALKER: Things like colposcopy and hysteroscopy -- are you up-to-date with training for that?

DR SUR-ROY: Hysteroscopy -- I did not have the training in colposcopy

PROFESSOR WALKER: But hysteroscopy you do. When you are in a labour ward, when do you start in the morning?

DR SUR-ROY: Nine.

PROFESSOR WALKER: What sort of handover do you have?

DR SUR-ROY: We have a detailed handover with the consultant. The outgoing registrar, SHO; the in-coming registrar and SHO; and the midwife -- head of the midwife.

PROFESSOR WALKER: The lead midwife. What do you do? Is it a whiteboard handover or do you do a ward round or what?

DR SUR-ROY: Yes. We do the handover first, and then we visit the patients and write the notes and the plan --

PROFESSOR WALKER: Is the handover initially at the white board in the ward area or do you --

DR SUR-ROY: There is a room. We close the doors for confidentiality and then there is a white board there.

PROFESSOR WALKER: You go through all the cases?

DR SUR-ROY: Yes.

PROFESSOR WALKER: Does the white board consist of just labouring patients, or for patients in the ward as well?

DR SUR-ROY: The patients in the -- labouring patients mainly, and some in triage who are coming with problems and antenatal -- how many antenatal are there, how many post-natals are there. The numbers are there. Then we discuss -- I suppose there are 20 natals, or three antenatal's and whatever there. Some are waiting for

induction and some are mild pre-eclampsia or UTI; that kind of thing.

PROFESSOR WALKER: Has this been true right through from 2007 when you came, or has this been something that has developed in the last --

DR SUR-ROY: It has developed, yes.

PROFESSOR WALKER: When did it start being this organised in the morning?

DR SUR-ROY: I think -- 2009 -2010 ~~2000~~ I can't remember the exact years, it has been for a few years now.

PROFESSOR WALKER: Two or three years. Then do you do a ward round around all the patients?

DR SUR-ROY: Yes. Well, antenatal absolutely, yes. Post-natal, the SHO sees and discusses with us if there is any problems.

PROFESSOR WALKER: What about the labouring patients --

DR SUR-ROY: Labouring patients we visit them and update the plans and tell them of the plans.

PROFESSOR WALKER: Would that be the consultant plus you plus the SHO and the midwife --

DR SUR-ROY: Yes.

PROFESSOR WALKER: -- you go round all the patients. Okay. What other duties would you have on a day when you were in the labour ward?

DR SUR-ROY: Antenatal ward round. Then gynae ward

round. Then if there are any referrals to other wards we go and see them.

PROFESSOR WALKER: Would you have a clinic?

DR SUR-ROY: Not when you're on call. If there is a clinic but that is manned by separate — middle grade doctor

PROFESSOR WALKER: Has that always been true or is that something that again has been brought in, in the last few years?

DR SUR-ROY: Most of the times. I have worked in other hospitals but over here we are not pulled from the labour ward.

PROFESSOR WALKER: Since 2007, when you are on labour ward, you cover labour ward and acute gynae?

DR SUR-ROY: Yes.

PROFESSOR WALKER: What about the consultants, what do they do?

DR SUR-ROY: The consultants are on-call when they're on-call. Most of the time they do not have any other commitments.

PROFESSOR WALKER: If they are on-call for labour ward they will have no other commitments, no clinics, or other commitments?

DR SUR-ROY: Very occasionally emergency situations but otherwise they are around.

PROFESSOR WALKER: Presumably if there was an emergency

gynae case, you would be called to that --

DR SUR-ROY: If there is an acute appendix -- sorry acute ectopic in the, A&E I have attended acute ectopic in the A&E. So if it is acute and needs intervention immediately, then we ship -- we take them to theatre straightaway.

PROFESSOR WALKER: If you are in theatre with an acute ectopic and there is a call from labour ward, how is that managed?

DR SUR-ROY: The consultant is there and if both of us are in -- in the theatre with the patient, then he lets me go and carries on with the procedure with the SHO

PROFESSOR WALKER: Let us take the management of the labour ward and people in labour. Are there some cases which are midwife led?

DR SUR-ROY: Some of them it is straightforward ones that are midwife led.

PROFESSOR WALKER: What does that mean as far as management is concerned?

DR SUR-ROY: If they find there is anything, any high-risk factor developing, they will immediately transfer to the obstetric lead.

PROFESSOR WALKER: If somebody's labour is -- do you have aTraffic Light "rag" system? Do you have a traffic light ~~treble-eight~~ system in the labour ward? If there are, I do not know if

they are green, if that is your midwife-led service, do you go and see these patients or do you only go if you are called?

DR SUR-ROY: If they are midwife led most of time we just review the cases notes, ~~we do not —~~

PROFESSOR WALKER: You review them outside the room, not in the room?

DR SUR-ROY: Yes.

PROFESSOR WALKER: How do you feel about how the communication is about when they are concerned about a case? Do they call you at the right time?

DR SUR-ROY: They will change the colour of the writing straightaway on the board.

PROFESSOR WALKER: Do they call you at that point?

DR SUR-ROY: Yes.

PROFESSOR WALKER: When you get called you feel you would like to have been called before?

DR SUR-ROY: No. I think they call us very earliest any complication is developing.

PROFESSOR WALKER: You think the communication between the midwives and yourself is very good in the labour ward?

DR SUR-ROY: Yes, I don't think there is any problem.

PROFESSOR WALKER: What about you rest of your colleagues? Do you get the impression that the

communication between the midwives and the doctors is good?

DR SUR-ROY: Yes. I think, so; if they call us we have to attend.

PROFESSOR WALKER: So if you're then called into a room and there was a disagreement between you and the midwife about how the case should be managed has that ever occurred with you?

DR SUR-ROY: Well, I have been working here for a long time and the whatever I ~~they~~ say they usually agree to it. If they have any concerns they will, of course, raise it to me but, no, it is something, no, it is agreement as such, if there is any concern they will tell us.

PROFESSOR WALKER: If you were concerned about the management a midwife is carrying out and she is not paying attention to you, about how you want to change it, how would you handle that situation? What would you do?

DR SUR-ROY: Well, yes, I see whether what is a major disagreement or not. If it is major disagreement then it is a risk to the patient then, of course, I will be inform the consultant but if it's minor I tend to negotiate with them, try to come to a term that we agree ~~to supply~~.

PROFESSOR WALKER: If an incident occurred in the labour ward, if a problem happened in delivery or a baby was admitted to a special care unit or whatever and you were involved in that incident, what would you do? How would you escalate that or report it?

DR SUR-ROY: We have a risk management thing. We can write and discuss with the consultant.

PROFESSOR WALKER: Right. There is a computer system, I think, called "Safeguarding" or something?

DR SUR-ROY: That is now come – previously we used to.

PROFESSOR WALKER: To write an incident? Did you do that?

DR SUR-ROY: Yes, sometimes we have to do that.

PROFESSOR WALKER: But would you expect a midwife to be reporting it or would you report it?

DR SUR-ROY: I report my one. If a midwife reports midwives' concerns, whether is in post or not, if there is any concern which I think may have implications in future, or in these patients then I file it myself.

PROFESSOR WALKER: Do you know about the trigger list that is used for reporting?

DR SUR-ROY: Trigger list, anything can be a trigger which is out of way. There is a list I think I have. Anything which concerns me is a trigger.

PROFESSOR WALKER: Do you know what is on the trigger

list?

DR SUR-ROY: Yes, I do, yes.

PROFESSOR WALKER: You have access to the trigger list?

DR SUR-ROY: Yes.

PROFESSOR WALKER: If you then report this and do you -- have you been called upon to make statements about the management of cases that you have had?

DR SUR-ROY: Yes.

PROFESSOR WALKER: Have you had any training in writing statements?

DR SUR-ROY: Formal training? No, they usually give you proformas how to write one --

PROFESSOR WALKER: Okay.

DR SUR-ROY: -- reports.

PROFESSOR WALKER: When you fill in the form do people interview you and discuss the case with you afterwards?

DR SUR-ROY: Yes, we have discussed cases and there has been some cases which we have discussed quite extensively.

PROFESSOR WALKER: What sort of discussions would that be? With you personally? With the consultant or in an open forum with midwives and anaesthetists or what sort of way?

DR SUR-ROY: There has been cases where we have discussed with them. Even the Chief Executive was

involved in some of the cases.

PROFESSOR WALKER: Were these discussions or are these enquiries?

DR SUR-ROY: There is initial discussions, inquiries, both I think. They wanted to take our views.

PROFESSOR WALKER: Right. So have you seen the reports that have been produced about these cases?

DR SUR-ROY: No.

PROFESSOR WALKER: When you give evidence to this reporting body, whoever it may be, do you ever see the outcome from that inquiry of what they concluded or what the recommendations are?

DR SUR-ROY: Do you mean any formal recommendations to me by --

PROFESSOR WALKER: Yes.

DR SUR-ROY: There has not been, I do not know. The reports if any were not circulated

PROFESSOR WALKER: A case you have been involved with, for instance, you must have been interested to know what people thought about it and after the inquiry. Do you remember seeing a report of a case that you have been involved with?

DR SUR-ROY: The conclusion?

PROFESSOR WALKER: Or just the report of the case with the conclusions and recommendations?

DR SUR-ROY: I can't remember. I cannot particularly

remember. It does not come to my mind.

PROFESSOR WALKER: You can't remember ever seeing a report or a recommendation or anything?

DR SUR-ROY: No.

PROFESSOR WALKER: Has anyone talked to you about a case after the report about anything about learning factors for your concern personally or learning for the doctors in general?

DR SUR-ROY: That I do myself, that I do myself. But learning, informal learning as such --

PROFESSOR WALKER: What do you do yourself? Do you reflect on the case to see how you can do better?

DR SUR-ROY: Yes.

PROFESSOR WALKER: But you have not discussed the case or seen the report of the case from your seniors?

DR SUR-ROY: Discussed informally, have discussed it with the consultant but not -- informal report, if you asked me to give a formal report I have not had a formal report.

PROFESSOR WALKER: You presumably have meetings on a regular basis in the Trust about incidents that have occurred or perinatal morbidity or things like that, do you?

DR SUR-ROY: We have a meetings, perinatal morbidity meeting, we have meetings with the department, we have

CTG meetings where we discuss the cases.

PROFESSOR WALKER: How often does the perinatal mortality and morbidity meeting occur?

DR SUR-ROY: Every two to three months.

PROFESSOR WALKER: Two to three months? Do you always manage to attend when you are nights, on calls.

DR SUR-ROY: Not if we are on nights on call.

PROFESSOR WALKER: Would you have a theatre at the time when the meetings are on or a clinic? Would you have a theatre or clinic on?

DR SUR-ROY: No.

PROFESSOR WALKER: They are cancelled, so you are free to go unless you have been on nights?

DR SUR-ROY: Yes.

PROFESSOR WALKER: What is discussed? What sort of things are discussed at the meetings?

DR SUR-ROY: In the meeting we discussed the whole case and whether it was managed properly, the CTG were discussed, I mean, the whole scenario was discussed and if there is anything that should have done differently and one did something.

PROFESSOR WALKER: Do you feel these meetings present cases in a way that are critical of the management? Or being presented in a way that you can learn from the problems that have occurred?

DR SUR-ROY: Not critical, no. If it is somebody had a different opinion I think then they express it but they don't say I should not have done that.

PROFESSOR WALKER: Okay. So do you feel these are good learning opportunities?

DR SUR-ROY: Yes, of course.

PROFESSOR WALKER: Do you feel you learned from them?

DR SUR-ROY: Yes, of course.

PROFESSOR WALKER: You say these particular weekly CTG meetings. Is that right?

DR SUR-ROY: Weekly, yes, every Monday.

PROFESSOR WALKER: How are they presented?

DR SUR-ROY: We get the case notes and we get the CTG and we discuss the case notes, we discuss ~~discover~~ CTGs along with the labour ~~department~~ and progress and management.

PROFESSOR WALKER: So who collects the cases?

DR SUR-ROY: The consultants, the consultants and SHOs, sometimes the registrars. During cases they discuss because the consultants know what is going on.

PROFESSOR WALKER: Who attends the meetings?

DR SUR-ROY: Everyone in the department.

PROFESSOR WALKER: And --

DR SUR-ROY: Every doctor, midwives.

PROFESSOR WALKER: Do most people attend, or only half the people?

DR SUR-ROY: Attendance is quite good.

PROFESSOR WALKER: Do people take attendance? Do you have to sign in?

DR SUR-ROY: Yes, we have to sign in the department meeting every day, every time that is on the list. The CTG meetings that have started recently. But it was not there.

PROFESSOR WALKER: You don't sign in for them?

DR SUR-ROY: Yes, now it is started, yes.

PROFESSOR WALKER: Okay.

DR SUR-ROY: Previously it was informal, there was no signing in people but now I have started this.

PROFESSOR WALKER: You mentioned a departmental meeting on Thursday. What are they?

DR SUR-ROY: It is a lunch time meeting. We do one to half-12 -- half-12 to half-one when we present interesting cases and we discuss any issues any cases interesting cases.

PROFESSOR WALKER: Is that again medical staff attending that?

DR SUR-ROY: Medical staff, that I do not -- midwives sometimes.

PROFESSOR WALKER: Do you have any meeting where midwives attend with doctors?

DR SUR-ROY: CTG meetings.

PROFESSOR WALKER: What about the perinatal meetings?

DR SUR-ROY: Perinatal. Midwives come.

PROFESSOR WALKER: Paediatricians; do they come to that?

DR SUR-ROY: Yes, they are present. We are the side of things.

PROFESSOR WALKER: You have been here now, what, seven years -- six/seven -- what do you think has changed over the period of time?

DR SUR-ROY: A lot of change, biggest change has been the theatre ~~and acceptable~~ because previously when we first came there was -- especially out of hours, the theatres was closed and the anaesthetic is -- there was no dedicated anaesthetist and the theatre staff had to be called from home for an emergency and that was the stress on us. In acute bradycardia especially ~~Everybody is tachycardia., i~~ It never happened but we were always stressed out and they had to be called from home and they had to open the theatre and put on the lights, get the stuff ready but that has changed.

PROFESSOR WALKER: How has it changed now? Are people on site?

DR SUR-ROY: Yes, people on site now.

PROFESSOR WALKER: Before the change did you feel that there was a delay in delivering babies sometimes because you had to call people in from home?

DR SUR-ROY: I didn't have that problem, fortunately. I didn't have that acute-crash section, which was done in 15 or 20 minutes; that situation did not arise from me.

PROFESSOR WALKER: You have worked in other hospital before you came here and did you feel that when you came to here that you felt this was a good environment, safe environment to work in?

DR SUR-ROY: Only this theatre bit I felt a bit uneasy but otherwise it was quite safe.

PROFESSOR WALKER: So you felt quite comfortable that the care was being --

DR SUR-ROY: -- was a high level. Yes. Yes doctors and midwives were quite qualified and quite experienced.

PROFESSOR WALKER: When the reports of cases came out, in the press and other things, were you surprised by them?

DR SUR-ROY: Yes, I thought there was a spate of bad results in a short period of time.

PROFESSOR WALKER: Were you surprised by them?

DR SUR-ROY: My only concern was theatre anaesthetist, otherwise there was -- I didn't have any concerns with that.

PROFESSOR WALKER: You thought that was a safe unit

apart from the problem with theatres? It was a safe unit providing safe care? All right.

DR KIRKUP: Stewart.

PROFESSOR FORSYTH: A couple of things. When doctors are on the middle grade rota, how many doctors are on middle grade rota?

DR SUR-ROY: There are seven and they took part in all. Seven middle grades taking part of the on-call rota and now it is come to six.

PROFESSOR FORSYTH: Now it is six. Four permanent and two --

PROFESSOR WALKER: Four permanent staff. Your level is what? You are?

DR SUR-ROY: I am a specialty doctor, middle grade.

PROFESSOR FORSYTH: The others?

DR SUR-ROY: There is two associate specialist and another specialty doctor and two is ST7 and one ST4, I think, but they keep on changing every six months.

PROFESSOR FORSYTH: How long have they been working in that unit? Have they been there for a number of years as well?

DR SUR-ROY: One from before I came and then the others were -- we are more or less, one or two years, around the same time.

PROFESSOR FORSYTH: What happens with ongoing training

and maintaining your skills and your knowledge as an obstetric Gynaecologist? How do you do that?

DR SUR-ROY: We go to these training sessions and emergency obstetrician.

PROFESSOR FORSYTH: By local consultants --

DR SUR-ROY: No, they are in Kendal, arrange it in Kendal and people are there.

PROFESSOR FORSYTH: How often do they happen?

DR SUR-ROY: They do it every six months.

PROFESSOR FORSYTH: What about audit? Do you do any audit in the --

DR SUR-ROY: Yes, I do audit and I do audit.

PROFESSOR FORSYTH: What was the last audit you did?

DR SUR-ROY: Out-patient laparoscopy.

PROFESSOR FORSYTH: Have you done any audit within the labour suite?

DR SUR-ROY: No, I did not. Previously I did an ectopic pregnancy, ectopic pregnancy and then I did -- out-patient ~~laparoscopy~~.Hysteroscopy

PROFESSOR FORSYTH: Do all the mid-grade doctors feel quite comfortable with the unit as far as you are aware?

DR SUR-ROY: Yes, we have been there for quite some time now.

PROFESSOR FORSYTH: How do you work with and liaise

with middle grade paediatricians and --

DR SUR-ROY: Middle Grade Paediatricians are not there anymore.

PROFESSOR FORSYTH: Not?

DR SUR-ROY: All consultants now.

PROFESSOR FORSYTH: Does that mean that you have less contact with paediatricians or more contact with paediatricians?

DR SUR-ROY: No, they are on-call. When you need them they are on call.

PROFESSOR FORSYTH: If there is a concern about a baby about to be delivered or just been delivered and you call for a Paediatrician it is a consultant?

DR SUR-ROY: They are come immediately.

PROFESSOR FORSYTH: Who comes?

DR SUR-ROY: They are resident.

PROFESSOR FORSYTH: They are resident on-call ~~now~~. Has that made a difference from your practice? Do you feel that it is good for you to know that there is consultant paediatricians there who can resuscitate a baby if required?

DR SUR-ROY: Yes, of course, the paediatricians they have been there before, also but only the grade have changed, but the service ~~procedure~~ is the same.

PROFESSOR FORSYTH: Did they find before it was a consultant was first on-call -- did you find that there

was variation in the competence of the paediatricians if they were called to resuscitate?

DR SUR-ROY: Previously used to be the second on-call used to come, and they sometimes told us they did not feel supported ~~were not specialty~~ because of the caseload and support was not that good, especially out of hours, but I do not have any firsthand knowledge about that and that is only what they have told me.

PROFESSOR FORSYTH: When did the consultant resident on-call system start in paediatrics?

DR SUR-ROY: Exactly, I cannot say but some time now.

PROFESSOR FORSYTH: Okay that is all. Thank you.

DR KIRKUP: Just a couple of brief follow-up questions from me.

You mentioned that the perinatal mortality meetings. When did they actually start? Had there been a system of perinatal --

DR SUR-ROY: Yes --

DR KIRKUP: -- all the way through? Did you discuss every perinatal death in one or other of the perinatal mortality meetings?

DR SUR-ROY: Yes. Yes. Most of the time because there was one of the cases are very small what they were.

DR KIRKUP: The system was every perinatal death was discussed.

DR SUR-ROY: Yes.

DR KIRKUP: Okay. Thank you. We have a number of questions that we want to ask you about specific clinical issues I will have a brief pause now while we ask people to leave the room.

Private session