THE MORECAMBE BAY INVESTIGATION

Thursday, 4 December 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth - Expert advisor on Paediatrics

MARIE RATCLIFFE

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(At 10.17 a.m.)

DR KIRKUP: Thank you for coming. Hello.

MS RATCLIFFE: Hello.

DR KIRKUP: Thank you for coming. Please come and take a seat. Move it a little bit closer, it might help with the sound, that's it; you've got some water there for you if you'd like.

MS RATCLIFFE: Thank you.

DR KIRKUP: We'll just wait for you to -- okay, my name's Bill Kirkup, I'm chairing the Panel; I'll ask my colleague to introduce himself to you.

PROFESSOR FORSYTH: Good morning, my name is Stewart Forsyth and I'm a paediatrician and a Medical Director from Dundee.

DR KIRKUP: You'll see that we're recording proceedings; we will make an agreed record at the end. You also know that we've asked family members to be here as observers, and we do have family members present today. Others may listen to the recording subsequently. And you also know that we've asked you to hand in any mobile telephones, laptops, potential recording devices, just to emphasise we don't want anything to go outside the room until we are ready to produce the report with everything in context.

MS RATCLIFFE: Okay.

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

MS RATCLIFFE: No, I'm okay.

DR KIRKUP: Okay, I'll start with a general question then, which is can you outline when you started at the Trust, and what you have done there, and how long that lasted?

MS RATCLIFFE: I qualified as a midwife in 1990 and started working at Furness General in October of that year.

DR KIRKUP: Okay and how long did you work there?

MS RATCLIFFE: Until January of this year.

DR KIRKUP: And did you have any different roles or were you practising as a midwife throughout?

MS RATCLIFFE: No, I was - in 1997 I was promoted to what was then a G Grade Midwife, which was then a Band 7 and is now a coordinator.

DR KIRKUP: Yes, and did you stay as a coordinator until you left?

MS RATCLIFFE: Yes.

DR KIRKUP: Okay. Where did you do your training?
MS RATCLIFFE: At Lancaster.
DR KIRKUP: Okay, thank you, I'll hand you over to Stewart.
PROFESSOR FORSYTH: Sorry, I didn't quite catch the year you started at -
MS RATCLIFFE: 1990.
PROFESSOR FORSYTH: 1980?
MS RATCLIFFE: 1990.
PROFESSOR FORSYTH: Sorry 1990, so what was the unit like at that time, when you first started? How many midwives were involved in the labour suite and the midwifery department?
MS RATCLIFFE: Oh gosh, I'm not sure how many midwives would have been employed there, perhaps about 40 I suppose, on the whole.
PROFESSOR FORSYTH: And were you initially in the labour suite, or were you in other parts?
MS RATCLIFFE: We rotated from – into different departments, so I worked in the post-natal and ante-natal ward, ante-natal clinic, community, special care baby unit and labour ward.
PROFESSOR FORSYTH: And what about the numbers of deliveries changed over the years?
MS RATCLIFFE: They're fewer than they were then.
PROFESSOR FORSYTH: They're fewer?
MS RATCLIFFE: Yes.
PROFESSOR FORSYTH: So what was it, what did it peak at?
MS RATCLIFFE: I think it was probably about 1800 deliveries.
PROFESSOR FORSYTH: 1800?
MS RATCLIFFE: Yes.
PROFESSOR FORSYTH: So that would be around when?
MS RATCLIFFE: That would be sort of in the early 1990s I think.
PROFESSOR FORSYTH: Right. And in terms of practice, has practices changed over that period of time?
MS RATCLIFFE: Yes.
PROFESSOR FORSYTH: In what way?
MS RATCLIFFE: Every aspect of practice has changed in some way or another over - that's sort of 20 years isn't it.

PROFESSOR FORSYTH: And what do you - how did you – you've obviously been working in this unit throughout that period of time, so how do you manage to maintain your skills and develop your skills during that time?

MS RATDCLIFFE: Well, we would be expected to have regular training, both in house and external training. When I became a G Grade Midwife that would include managerial things as well; we had our annual in house training, appraisal, audit, supervision.

PROFESSOR FORSYTH: And do you think that that was sufficient and enabled you to provide what you thought was reasonable quality of care?

MS RATCLIFFE: Do you mean do I think we enough training after we were qualified?

PROFESSOR FORSYTH: Mmm.

MS RATCLIFFE: It's difficult to answer that really, because you might not necessarily be aware of your deficiencies unless they were pointed out to you.

PROFESSOR FORSYTH: And do you think it was a case of that? Do you feel that was there a turnover of staff coming from other centres who had worked in other units?

MS RATCLIFFE: We did have staff from other units, yes. And then we would meet staff from some of the other units as well, on for instance such as the ALSO course that we would go on and updates of that.

PROFESSOR FORSYTH: So, did midwives feel that they were familiar with what was happening elsewhere and obviously deciding whether to change their practice accordingly?

MS RATCLIFFE: Oh yes, I think so.

PROFESSOR FORSYTH: So, what was the - what did you feel about midwifery practice, as you say, there was a lot of changes to it during that time; did you agree with the changes that had taken place?

MS RATCLIFFE: I couldn't say if I really agreed or disagreed about it, it's such a wide – I'd have to know specifically.

PROFESSOR FORSYTH: Well, what you said there were changes that took place during that time.

MS RATCLIFFE: Yes.

PROFESSOR FORSYTH: So give me some examples of some of the changes that

took place and tell me about how you felt they were in keeping with your thoughts of how midwifery practice should be.

MS RATCLIFFE: Well, one example, one obvious example would be the lack of time that ladies would stay in hospital after they'd had a baby. When I started there in 1990 people who had had a caesarean section would be in hospital for a week after their delivery, and having their first baby they would stay in for five days, the second baby three days. Now, it's common practice for women to go home as soon as possible.

PROFESSOR FORSYTH: Do you think that's a good thing or a bad thing?

MS RATCLIFFE: It's got its advantages and its disadvantages.

PROFESSOR FORSYTH: Sorry?

MS RATCLIFFE: It's got its advantages and disadvantages.

PROFESSOR FORSYTH: Yes. Was there – did you feel that there was sufficient community support for that?

MS RATCLIFFE: The number of post-natal visits are fewer, and in general there's some concerns over that. I know that the Royal College of Midwives have had that women are perhaps not getting as much post-natal care as they used to.

PROFESSOR FORSYTH: Do you think that the staffing numbers on the midwifery unit were adequate during the period of time you were working there?

MS RATCLIFFE: We felt that we were short of midwifery staff, and support staff probably from about 2008 or so. We'd quite a lot of issues with being able to cover the rotas with the staff that were available and that was a situation that did get worse actually.

PROFESSOR FORSYTH: Because you said that the numbers of deliveries had been falling from the year 2000 so -

MS RATCLIFFE: Yes.

PROFESSOR FORSYTH: So were the numbers of staff on the unit reducing over time?

MS RATCLIFFE: Yes.

PROFESSOR FORSYTH: And how did you – has was that - was that getting addressed? Did the midwives discuss it with the head of midwifery, for example?

MS RATCLIFFE: Yes, but we were told that the calculations were that we did have

sufficient staff.

PROFESSOR FORSYTH: So what was your view on that?

MS RATCLIFFE: Well sometimes as the coordinator, you would spend maybe 4 or 5 hours on a shift trying to cover off duty for the following few days, so it was very time consuming. People were working a lot of extra hours, which were cumulating, because this was in the period when the Trust was applying for Foundation Trust status and I think everybody had the opinion that we had to be in a good financial position, and that meant not spending money unnecessarily. Overtime payments weren't being made, so people were just accumulating hours.

PROFESSOR FORSYTH: Right. Can I ask you about the relationship you had with the obstetricians; how did you find working relationships with them?

MS RATCLIFFE: On the whole – I can only speak – I'm only speaking personally now, but I think overall they were good.

PROFESSOR FORSYTH: And with the paediatricians?

MS RATCLIFFE: The same.

PROFESSOR FORSYTH: Were there, at times, conflicts over a high risk mother being delivered in Furness and whether she should be transferred or not?

MS RATCLIFFE: With the paediatricians do you mean?

PROFESSOR FORSYTH: Well, obviously with obstetricians, paediatricians, midwives?

MS RATCLIFFE: I'm sure there must have been on individual occasions. I cannot personally bring one to mind at the moment.

PROFESSOR FORSYTH: You can't think of any specific cases you were aware of?

MS RATCLIFFE: I – when you're working in a team different members of the team are going to have different opinions at different times, aren't they; I don't know if that's necessarily a bad thing. As far as women being transferred out to other units, our main consideration would be the woman's wishes I would say, just because sometimes long distances were involved, it can be difficult for people, with their family circumstances and so on.

PROFESSOR FORSYTH: So you don't think there were babies being delivered, and you can't give me an example of any babies you were involved in, who were being delivered in Furness, who it might have been better if the mother had been transferred for example? [*Pause*]

MS RATCLIFFE: I'm just trying to think if I can recall that; I can't think of anything that I was personally involved in, no.

PROFESSOR FORSYTH: What is the – again just to go back to the changes in practice over the period of time, and did you feel that, I know there's the idea of trying to pursue normality in terms of the unit, is this something that you felt strongly about?

MS RATCLIFFE: I did, yes.

PROFESSOR FORSYTH: And do you feel that at times this might have caused particular problems?

MS RATCLIFFE: I don't think it caused problems no, there might have been some discussion and people might have different opinions, but I don't think that's a problem necessarily.

PROFESSOR FORSYTH: Does this lead to issues of when to contact, for example, an obstetrician?

MS RATCLIFFE: No, I don't think so. Each – the decisions of whether to contact an obstetrician is one that I've made hundreds and hundreds of times, so your decisions – it's only in retrospect but with the benefit of hindsight that sometimes if you know you've made the right decision or not.

PROFESSOR FORSYTH: Do you think that maybe your decision was influenced by whether your felt that the middle grade doctor, for example, was as competent as you or did you have concerns about the competency of the first middle grade doctor who you were calling?

MS RATCLIFFE: I don't think I have concerns about doctors' competencies. Since I have been working as a midwife, since the working time directive, because of doctors working shifts, they don't necessarily have the breadth of experience they once did have, simply because that's just not available to them anymore. I don't think that's an issue of competence necessarily, it's just their breadth of experience.

PROFESSOR FORSYTH: So, do you think then that if there was a situation where you felt you were more experienced and your judgement might be better than the middle grade doctor?

MS RATCLIFFE: I don't – if I differed, if my opinion differed I would just discuss it with them.

PROFESSOR FORSYTH: And what about the consultants, where there times when

you felt that you had to go directly to the consultant?

MS RATCLIFFE: I'm sure I have done that on a few occasions, yes.

PROFESSOR FORSYTH: And so you felt confident about doing that?

MS RATCLIFFE: Yes.

PROFESSOR FORSYTH: And were the consultants content for you to do that, contact them directly?

MS RATCLIFFE: Yes.

PROFESSOR FORSYTH: Was there any examples of where you did that, can you think of any cases where you were not content with the opinion of the middle grade doctor and got a consultant?

MS RATCLIFFE: Think of an example, a lady that another midwife had delivered, that needed a perineum repair, and I went to suture it, and it was extremely unusual, complicated and I called the Registrar and he felt it was not an issue; he didn't identify a particular problem.

DR KIRKUP: You just need to be careful when talking about clinical details. I should have said it at the start of the session, we will have a portion of the interview where you can talk about, and we'll ask you about confidential clinical information, so if you could just keep that until that part of it that would be helpful.

MS RATCLIFFE: Alright.

PROFESSOR FORSYTH: Okay, well I'll just hand over to you just now.

DR KIRKUP: Okay. I want to pick up this question about the normal childbirth agenda, it's clearly been a trend in midwifery; it's a welcome trend, but it's a trend that needs checks and balances, can you just tell me how you approached the issue of where the checks and balances were in the move to normal childbirth?

MS RATCLIFFE: The main thing is to make sure you differentiate between normal risk, low risk and high risk labour.

DR KIRKUP: Yes okay, so what was your approach to differentiating the two?

MS RATCLIFFE: Well, the identification of a high risk woman starts off at booking, is re-evaluated throughout pregnancy and during her labour. So, any deviation from the normal is – alters their labour from low risk normal labour.

DR KIRKUP: And how do you practise if you're looking after somebody who was judged to have a high risk pregnancy?

MS RATCLIFFE: Their care would be obstetrician led.
DR KIRKUP: Would that include labour?
MS RATCLIFFE: Yes.
DR KIRKUP: In every instance?
MS RATCLIFFE: If – yes, it would be yes, if a woman was high risk then the person responsible overall, for her care, would be the obstetrician.
DR KIRKUP: Okay, who was responsible for making the decision about whether there is high risk situation to be managed like that, or whether it was not?
MS RATCLIFFE: Well, initially if the first person the woman saw was the midwife then it would be the midwife, ante-natal usually.
DR KIRKUP: Was there any discussions with obstetricians about that?
MS RATCLIFFE: Yes, there were guidelines to follow, so there would be a list of risk factors to be identified.
DR KIRKUP: That's not quite same though is it; did you discuss individual cases as a team, obstetricians and midwives?
MS RATCLIFFE: Yes, after the woman's been identified as high risk you mean?
DR KIRKUP: Yes.
MS RATCLIFFE: Yes.
DR KIRKUP: Okay, how would that discussion take place?
MS RATCLIFFE: Well, if it was ante-natal it would be in the ante-natal clinic; if it was when the woman was in hospital, say she was on the ante-natal ward, then there would be a multidisciplinary ward round with midwives and doctors, and discussion of the case.
DR KIRKUP: Right, and on the labour ward?
MS RATCLIFFE: On the labour ward the obstetricians would come to labour ward at least 4 hourly, and any women that were identified as high risk would be reviewed by them.
DR KIRKUP: You see I have to say, after what you're describing there it sounds like an idealised version, it sounds like what should have happened, but you're the first person that's told us that it actually did happen like that, at any of those stages.
MS RATCLIFFE: I'm sure there'd be individual examples of where that didn't happen. But that was the process that was in place.
DR KIRKUP: That was the theoretical process?

MS RATCLIFFE: Yes.
DR KIRKUP: Okay and you're saying that there were deviations from it, but only in isolated examples? Because I think again it's only fair for me to reflect to you that the general message that we've heard is that it didn't happen routinely, not just that there were isolated examples.
MS RATCLIFFE: You mean that the – you mean – I'm sorry, can you rephrase the question, because -
DR KIRKUP: Yes, you described a situation where there were discussions in the ante-natal clinic about risk identification, there were discussions on the ante-natal ward, and there were discussions in the labour ward, and people have said, not just that there were isolated cases where that didn't happen, but actually really it wasn't the norm.
MS RATCLIFFE: Because I did not work on ante-natal clinic or the ward, I couldn't really comment on that. I have seen care plans in people's notes, which reflect that so –
DR KIRKUP: Okay.
MS RATCLIFFE: But on labour ward the doctors did come and have their handover and cases were discussed.
DR KIRKUP: Would that have applied throughout your time at Furness General?
MS RATCLIFFE: No, not throughout the time, that's something that has evolved.
DR KIRKUP: Yeah, okay so can you tell me when it began evolve, when it was fully evolved? [*Pause*]
MS RATCLIFFE: I can't remember exact time; I think it would be in the sort of last four years perhaps.
DR KIRKUP: So, since about 2010?
MS RATCLIFFE: Probably, yes.
DR KIRKUP: So, tell me what the situation was like, say between 2004 and 2010? Give me a picture of how that system operated then.
MS RATCLIFFE: It would be a lot less formal.
DR KIRKUP: Right.
MS RATCLIFFE: So, the doctors wouldn't necessarily come to labour ward unless they were called.
DR KIRKUP: Okay, so how would midwifery practice have differed between midwives led and higher risk labours during that sort of time period?

MS RATCLIFFE: The higher risk labour you would call the doctor and inform them of the woman's admission and her risk factors and ask them to be involved.

DR KIRKUP: Now again, can we identify whether that's what should have happened, what routinely happened but there might have been exceptions, or what happened all the time?

MS RATCLIFFE: I am sure there are exceptions, yes.

DR KIRKUP: But you would say the majority of cases?

MS RATCLIFFE: In the majority of high risk cases the doctors would be aware of them, I would say, yes.

DR KIRKUP: And how would the doctor have been made aware?

MS RATCLIFFE: He would have been phoned by the midwife.

DR KIRKUP: At the time of admission?

MS RATCLIFFE: Yes, or when a problem was identified.

DR KIRKUP: Okay. So, what was your approach, as a midwife if the doctor had been informed and had said 'Okay you carry on and let me know if there's any problems', how would your approach differ in a high risk pregnancy and labour led specifically?

MS RATCLIFFE: There would be a difference in the decisions that you made regarding the care you were giving; you would – depending on what the problem was, made different decisions.

DR KIRKUP: Can you give me some examples? I don't mean in relation to real cases, I mean hypothetically; what would you do differently?

MS RATCLIFFE: Different levels of foetal monitoring, different frequency of vaginal examination.

DR KIRKUP: Okay.

MS RATCLIFFE: Different criteria for assessing progress.

DR KIRKUP: Okay can we talk about the foetal monitoring criteria? What would you do what would you do differently; you would do intermittent auscultation if it was somebody at low risk; what would you do if it was somebody at a high risk?

MS RATCLIFFE: It depends on what the risk factor was.

DR KIRKUP: In what sense?

MS RATCLIFFE: If they were high risk as a general rule you would do continuous monitoring.

DR KIRKUP: Okay, external or foetal scalp electrode?
MS RATCLIFFE: External initially, you can't do internal until they've had – got ruptured membranes.
DR KIRKUP: Yes, I know. So, what would prompt you to change to internal monitoring?
MS RATCLIFFE: If you weren't able to obtain a good external monitoring.
DR KIRKUP: Okay.
MS RATCLIFFE: Or if it was twins.
DR KIRKUP: And would there be some high risk labour, some women with high risk labours where you wouldn't do continuous foetal monitoring of one sort or the other?
MS RATCLIFFE: Well, over the years the guidelines for continuous monitoring have changed, so what wouldn't have been considered – at one time it wouldn't have been considered necessary to monitor a woman particularly, and then as time passes that woman then falls into a category where she does need continuous monitoring.
DR KIRKUP: So, are you saying that nobody with a high risk labour would have been continuously monitored before a certain time?
MS RATCLIFFE: They would have been yes, it's just they may not have been categorised as high risk previously.
DR KIRKUP: Okay so it's the categorisation of risk that's changed over time?
MS RATCLIFFE: Yes.
DR KIRKUP: Okay well can you give me some more examples of in what sense the risk has changed?
MS RATCLIFFE: Well for example, a woman with a high BMI.
DR KIRKUP: Okay yes.
MS RATCLIFFE: So, in I think it was the 2009 confidential enquiry that was identified that women with a BMI over 34 had double the risk of an adverse outcome of women with a healthy BMI, so but previously they hadn't specifically been identified as a high risk category and then after that they were.
DR KIRKUP: And are there any other examples in which the definition of risk has changed over that time? [*Pause*]
MS RATCLIFFE: Women with prolonged rupture of membranes? So, previously that wasn't considered such a risk factor from ruptured membranes over 24 hours

but now it is, so there is a protocol to follow if women have got ruptured membranes for more than 24 hours.

DR KIRKUP: Okay so there's been some shifts around, how can I describe it, shifts around the edges of how you define somebody as high risk.

MS RATCLIFFE: Yes.

DR KIRKUP: But hasn't the principal throughout been that somebody at high risk should be continuously monitored?

MS RATCLIFFE: Yes it probably has been the principle yes. I mean there's on the other hand there's also been some research done which shows that if you actually compare, even in high risk women, although the guidelines and NICE recommendations are continuous monitoring, so that's what you would follow; actually if you compare continuous monitoring with intermittent auscultation there isn't really very much difference in outcome, or any difference in outcome, apart from a slightly increased risk of admission to special care baby unit.

DR KIRKUP: In high risk pregnancies? I am aware that that is the case in low risk. Are you sure that applies to high risk?

MS RATCLIFFE: Well, I'm not sure what the – you wouldn't really be able to do a control with that would you, because then you'd have to not monitor high risk women, so I don't think that research has been done.

DR KIRKUP: Yes and high risk women have had continuous foetal monitoring since well, well before the time period that we are talking about.

MS RATCLIFFE: Yes they have, yes.

DR KIRKUP: Yes okay. What would you do if you were monitoring somebody intermittently and you detected any abnormalities in progress of labour or the intermittent monitoring? What was your reaction?

MS RATCLIFFE: If it was a high risk or low risk?

DR KIRKUP: A high risk.

MS RATCLIFFE: A high risk one, sorry, did you say she was having intermittent monitoring?

DR KIRKUP: You said that that happened from time to time, yes.

MS RATCLIFFE: Then you would do continuous monitoring.

DR KIRKUP: Okay and what about abnormalities in continuous monitoring trends?

MS RATCLIFFE: You'd refer that to the obstetrician.

DR KIRKUP: Usually?
MS RATCLIFFE: Always. I would.
DR KIRKUP: Okay, and again is that what would happen, routine practice with occasional exceptions or was it normal?
MS RATCLIFFE: I think everybody would say that if they found an abnormality in the CCG monitoring they would refer a woman to the obstetrician. If that hasn't happened it's because of a misinterpretation of the monitoring, not because of the person's intention not to do it.
DR KIRKUP: Okay. And how about failure to progress in labour, how would you manage that?
MS RATCLIFFE: In a high risk woman?
DR KIRKUP: Yes.
MS RATCLIFFE: I would refer her to the obstetrician.
DR KIRKUP: Every time?
MS RATCLIFFE: Yes.
DR KIRKUP: Without any exceptions?
MS RATCLIFFE: No exception comes to mind, no.
DR KIRKUP: Okay. One more general question about the normal childbirth agenda; where would you say that you fitted on the spectrum of opinion about how to increase the proportion of normal childbirth?
MS RATCLIFFE: My philosophy actually is not so much – it's not really about the normal childbirth, it's about making sure the woman gets the sort of labour and birth that she wants to. So, for some women that might actually be an elective caesarean section. That might be the best option for them, in which case I would support that. But if, on the other hand, the women are very keen for a normal birth, or as much normality as is possible in their labour and birth, then I would advocate for that.
DR KIRKUP: Okay. Would you say that you were keen to promote the natural – the normal childbirth agenda within that unit? Were you seen as somebody who was keen to promote it?
MS RATCLIFFE: Yes, I was keen to promote the advantages of it, yes.
DR KIRKUP: Okay and how did doctors fit into the normal childbirth agenda?
MS RATCLIFFE: Well, some of them are real advocates of it.
DR KIRKUP: In the Morecambe Bay unit; in the Furness unit?

MS RATCLIFFE: Yes. Yeah.
DR KIRKUP: Okay so you wouldn't recognise a situation where you might need to keep some doctors at arm's length from it, from labour I mean, otherwise it would disturb the normal childbirth?
MS RATCLIFFE: No, I don't think so, if it was a low risk woman and we're talking about?
DR KIRKUP: Well it depends on the assessments; tell me about each low risk or high risk?
MS RATCLIFFE: If it was a low risk one then that wouldn't really be an issue; because if there was no deviation from normal the doctor wouldn't be involved anyway.
DR KIRKUP: Yes.
MS RATCLIFFE: I think the most obvious example that comes to mind is probably induction of labour, where there might be some disagreement there whether the number of inductions that we were doing was maybe a bit high.
DR KIRKUP: Yes, but what about the situation where somebody had had an induction of labour; was that then – did that then become an obstetric issue or is that then something that you took over the care of and the obstetricians were at arm's length again?
MS RATCLIFFE: I wouldn't say they were at arm's length no, they would have – if it was a woman who was being induced for post maturity they wouldn't have such a level of involvement as say, a woman who was being induced for raised blood pressure, for instance.
DR KIRKUP: Okay. Do you have any more questions?
PROFESSOR FORSYTH: A couple of points actually, first of all did you have any involvement at all with the Lancaster unit?
MS RATCLIFFE: I did my training as a midwife there.
PROFESSOR FORSYTH: Yes.
MS RATCLIFFE: I did a period of supervised practice there in 2010.
PROFESSOR FORSYTH: But between 2010 – did you ever – did the midwives in Furness integrate at all with the midwives in Lancaster, did you share practice, did you share developments?
MS RATCLIFFE: Yes, we had some shared study days and so on yes.
PROFESSOR FORSYTH: So, how often would you meet up with midwives from

Lancaster?

MS RATCLIFFE: Oh well personally speaking I was a mentor for student midwives, so we would have meetings with staff from Lancaster and Holme Chase a couple of times a year to discuss issues of student training and so on.

PROFESSOR FORSYTH: And do you feel that there were differences in practice between the Lancaster unit and the Furness unit from a midwifery perspective?

MS RATCLIFFE: Possibly. I'm not sure.

PROFESSOR FORSYTH: Is there anything that stands out that you feel was a different approach to Kendal?

MS RATCLIFFE: They probably – they had a higher, well, we knew what each units rate of normal deliveries and instrumental deliveries, epidurals was and so on; they had a higher rate of epidurals at Lancaster and a higher rate of instrumental deliveries. Caesarean sections and inductions the rates were the same.

PROFESSOR FORSYTH: The second point was in terms of the care of the new born baby; I just wondered how you managed to maintain your skills in that.

MS RATCLIFFE: We had twice yearly in house study days where there would be one of the topics would involve care of the baby.

PROFESSOR FORSYTH: So, was that at the period you were working there?

MS RATCLIFFE: Yes, yeah. I actually the only time I was actually – I actually did work on special care for a period of three months in 2009, in 1997 I should say, sorry. We were – we had good relations with staff in special care; they would inform us about practice and -

PROFESSOR FORSYTH: But did you think that the midwives in the Furness unit and in the labour suite had the knowledge and skills to recognise a baby becoming unwell?

MS RATCLIFFE: I would have thought that they did yes, but again that's an issue sometimes that there might be something you don't know, but yes until it's pointed out, if you don't know you don't know.

PROFESSOR FORSYTH: So, did you think there was a risk there, did you think there was a risk?

MS RATCLIFFE: I don't – I didn't – I wouldn't have been able to identify a risk, no.

PROFESSOR FORSYTH: Okay.

DR KIRKUP: There are points that I would like to follow up, but it's going to be going into clinical detail, so before we get to that part of the interview, there is one other area that I haven't asked you about yet, and that's the response of the unit when something has gone wrong. How do you investigate and how do you learn lessons, what has been the approach over the years?

MS RATCLIFFE: The approach has changed over the years; and improved.

DR KIRKUP: So how did it start out?

MS RATCLIFFE: It was very informal I'd say really. It wasn't the standard that you would expect now.

DR KIRKUP: Okay and how has it changed?

MS RATCLIFFE: It's become more formalised; there's a much more formal risk management system way of reporting serious untoward incidents; there's been training in that.

DR KIRKUP: When was that introduced?

MS RATCLIFFE: Probably about 2010, 2011.

DR KIRKUP: Okay.

MS RATCLIFFE: I'm only guessing that, I can't remember exactly.

DR KIRKUP: So before then it remained an informal process?

MS RATCLIFFE: Yes, on the whole, yes.

DR KIRKUP: Okay, but there were still reports produced that said 'We've investigated this incident; this is what we think lies at the core of it' that was done informally; is that what you're saying?

MS RATCLIFFE: I say informal because some incidents might have been investigated and others not, so there may have been examples of good practice, but also not such good practice.

DR KIRKUP: Okay, what prompted some to be investigated then?

MS RATCLIFFE: That's very difficult to say. I can't –

DR KIRKUP: Was it not the profile of -

MS RATCLIFFE: Probably, yes.

DR KIRKUP: - the incident? Yes, so it got publicity and -

MS RATCLIFFE: Yes.

DR KIRKUP: Okay and what did you think of the root cause analysis that were done, say prior to 2010? Did you feel that they identified what the real problems were?

MS RATCLIFFE: Not necessarily, no.
DR KIRKUP: Did everybody take part in those investigations, or was it done –
MS RATCLIFFE: No.
DR KIRKUP: Was it midwives did an investigation?
MS RATCLIFFE: Yes.
DR KIRKUP: Okay, obstetricians involved in that at all?
MS RATCLIFFE: If the midwives did an investigation it would be supervised in that investigation. If there were any midwifery management investigation done then the obstetricians would be involved.
DR KIRKUP: Did you have multidisciplinary meetings where you talked about incidents and events?
MS RATCLIFFE: No.
DR KIRKUP: Not at any stage?
MS RATCLIFFE: There would be possibly once every few weeks, no less than that, probably every couple of months, an initiative led by the paediatricians to discuss adverse outcomes, and the midwives would be included, and obstetricians.
DR KIRKUP: And routinely attend?
MS RATCLIFFE: No.
DR KIRKUP: Any particularly reason why?
MS RATCLIFFE: Because of staffing; the midwives would have to go while they were on duty and sometimes that wasn't possible.
DR KIRKUP: Yes. What time were the meetings arranged for?
MS RATCLIFFE: They were usually at lunch time.
DR KIRKUP: Okay. And was that attendance occasional or was it the midwives never went to those?
MS RATCLIFFE: I would say it was occasional, occasionally went.
DR KIRKUP: Right okay. That's the sort of situation normally where you would find divisions between staff.
MS RATCLIFFE: Possibly yes.
DR KIRKUP: And probably a blame culture where each group were criticising the actions of the other. That's something you were aware of?
MS RATCLIFFE: Nobody likes to admit they've made a mistake do they, I think that's -

DR KIRKUP: Sure. So are you agreeing with what I said, I don't want to assume that you would?

MS RATCLIFFE: Yes that did happen on occasions, yes.

DR KIRKUP: Okay, anything else? I do want to pursue these other points then, so we'll have a break while we ask people if they would leave the room and we can talk about clinical, confidential matters.

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

THE MORECAMBE BAY INVESTIGATION

Monday 1 December 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – expert adviser on governance
Professor Stewart Forsyth – expert advisor on paediatrics

HUGH REEVE

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(At 10.17 a.m.)

DR KIRKUP: Good morning.

DR REEVE: Good morning.

DR KIRKUP: Take a seat.

DR REEVE: Who has this number? Oh, is that for my phone? I'd better keep it hadn't I.

DR KIRKUP: Thank you for coming

DR REEVE: That's alright.

DR KIRKUP: My name's Bill Kirkup. I'm DR KIRKUP of the Investigation Panel.

DR REEVE: Yes.

DR KIRKUP: And I'll ask my two colleagues to introduce themselves to you.

PROFESSOR FORSYTH: Good morning, my name's Stewart Forsyth, I'm a Paediatrician and Medical Director from Dundee.

DR REEVE: Hello.

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 within the Department of Health.

DR REEVE: Right.

DR KIRKUP: As you see, we are recording the proceedings.

DR REEVE: Yes.

DR KIRKUP: And we are producing an agreed record at the end. You may also know that family members have been invited to be here as observers; as it happens we don't have any this morning, but they may listen to the recording.

DR REEVE: No, that's fine, yeah.

DR KIRKUP: Subsequently; and as you know, because you've got the number five in your pocket, you have to hand in any mobile phones or potential recording devices; just to emphasise that we don't want anything to go outside the review until we're ready to produce the report in its final form.

DR REEVE: Yeah.

DR KIRKUP: Any questions for me about the process?

DR REEVE: No, no that's fine.

DR KIRKUP: Okay, I'll start with a general question, which is can you outline your involvement in Cumbria, in general practice and PCT, CCG and what you're

interested it, so if you start in 2004.

DR REEVE: So your interest starts in 2004, yeah.

DR KIRKUP: Yes.

DR REEVE: Well, I arrived in Cumbria in 2001, and that was to do the job that yes, I was still doing in 2004, yes I was. So, I came up from Manchester, where I had had a whole host of GP roles, academic roles, and also I'd been Medical Director of a health authority in the past. So I came up to become Medical Director of what was then Morecambe Bay Primary Care Trust, which was the – part of which then became Cumbria Primary Care Trust and the other half essentially became Lancashire North – well North Lancashire Primary Care Trust, it became Lancashire North CCG. So it was North Lancashire Primary Care Trust.

So I was, over that period of time, well I was Director of Clinical Governance and Medical Director for the Bay PCT and my responsibilities were standard Medical Director responsibilities for, in once sense for a hospital's Trust or a community Trust, because we actually ran mental health services. And also we had community paediatrics, so we had a number – we had about 35 to 40 consultants.

And then there was Medical Director responsibilities for general practice, which was more akin to what a standard PCT Medical Director would do around performance and such like. And Director of Clinical Governance I was – I think you're probably aware of the difference between governance and clinical governance, and so it was more about clinical standards and quality, clinical quality. And at that – obviously that lapped over into the performance stuff of practices and consultants.

DR KIRKUP: Okay.

DR REEVE: I stopped doing that, and this is where I have to get my dates right, probably around 2005 and then for a year I was PEC, Professional Executive Committee Chair, for Morecambe Bay PCT. And I did, sort of I did bits and pieces for a year, as I was trying to work out – I had some general practice; I did all the time – during that time I did some general practice, I did a day a week.

And then I went – I decided eventually to go back into general practice, almost full time. I was a bit disillusioned I have to say, with the NHS

management structures, and I think, you know, the massive changes that occurred with the formation of Cumbria PCT, which was, for Cumbria, a massive upheaval.

DR KIRKUP: Sure.

DR REEVE: And so I went into practice in 2006, April 2006, which is where I am now, in Grange-over-Sands, which sits sort of midway between Furness, Barrow and Lancaster, so our patients go in both directions.

DR KIRKUP: Right, okay. And you had a role with Cumbria PCT?

DR REEVE: Yes.

DR KIRKUP: Okay.

DR REEVE: So, Cumbria PCT was then formed in October 2006, I went back into practice in April 2006, a new Chief Executive, who had a different approach to things; well I think you've met.

DR KIRKUP: Sure.

DR REEVE: And persuaded me to come back into doing things for the PCT. So, while the PCT was in existence I was – initially I just became a member of the PEC, although it was not really ever called the PEC, eventually it was called the clinical senate. And then I became, after about 2 years I think, locality lead for South Lakes, so that the PCT worked on the basis of 6 localities. And I think you saw my colleague who hopefully I think you were trying to see us both together, Geoff Jolliffe, on Friday; so he was the locality lead for Barrow, and for Furness.

And then, in the last year of the PCT, the CCGs were being formed, I was elected by my colleagues to become Chair elect of the new CCG, so that was essentially from, I'll do the sums, 2012 so around sort of summer, autumn 2012. So we went through the approval process in September 2012 and so formally, from April 2013, when the CCG was formed I was appointed Clinical Chair. We have an accountable officer who is non-clinical.

DR KIRKUP: Okay.

DR REEVE: So since then I've not had a locality role; I've had a Cumbria wide role.

DR KIRKUP: Yes.

DR REEVE: And so that really Cumbria wide role started, as I say, during 2012, so we appointed another GP to be locality lead from 2012, who I don't think you've seen, Dr Alistair McKenzie.

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

PROFESSOR FORSYTH: Yes, so in any of the roles you had, when was the first time you were aware of some difficulties around maternity, certainly in the neonatal services?

DR REEVE: Do you mean over and above just the sorts of things when patients -

PROFESSOR FORSYTH: Well, even just from that, when did you feel yourself that there might be some issues around the maternity unit?

DR REEVE: Well, when I – I suppose when I thought there might was when really – when everything blew up, to be quite honest. Prior to that – yes, prior to that I don't think that I would have placed concerns about maternity above concerns about any other service; and that would have been through a variety of routes. Because prior to that we had got more concerns about some of the others, so we had ongoing concerns about emergency services, particularly at the RLI; we were starting to hear quite a lot of noise within the system, about outpatients, and the administration of outpatients. And I think, I have to say, it somewhat surprised me when the issues arose around maternity.

Well, as soon as they came up we then went back into our practice list, because our patients, they go to all three sites; they go to Furness, they got to Westmorland General and they go to Lancaster, depending on their choice. And so we went back into our list and one of my partners said – I can't remember the patient's name, and it wouldn't be appropriate to bring it up here; but she said, "Oh, I'm sure there was one" and when we dug it out and there was a neonatal death, which we then informed the people who were involved into sort of looking around Gold Command and all that sort of stuff at that time, so we forwarded her name and everything.

PROFESSOR FORSYTH: Just what you said, so what time are we talking about, roughly?

DR REEVE: That would have been – oh my gosh; as I say, when I came in, I hadn't done a whole load of researches to dates because it all sort of merges together. But that would have been, I think, probably in 2012, probably around then. I'm trying to remember when the first Gold Command actually was put up, but it was around that time, yes.

PROFESSOR FORSYTH: Okay.

DR REEVE: Because there was a request coming out, as if we – to practices, if we

had any information to give, and we had already given it some thought, and the only person we had identified was this particular family. But that was retrospectively, and that had occurred prior to that, it had occurred a few years previously, it wasn't a – it hadn't just occurred, it was actually one that we had dredged up from our memories really, and I think we might have done a computer search as well, yes.

PROFESSOR FORSYTH: So, in terms of what was your involvement in terms of the discussions?

DR REEVE: Well, I had limited involvement at that time; we had a Medical Director of the CCG – of the PCT, Mike Bewick, and we had a discussion about who would get involved in all the – because I was still a practising GP, at that point I was doing three days a week in general practice, whilst only doing two days for the Primary Care Trust, and Mike was full-time Medical Director.

And it seemed appropriate that Mike took the lead on sitting on all the committees, so around specific investigations into maternity issues, I had limited involvement, and also, because I wasn't in that patch, Geoff was in that Geoff Jolliffe was in that patch, so he had more day to day involvement with the local clinicians and in hospital than I did, because I actually didn't know any of them, to be quite honest. Our links were much more with the Lancaster consultants, and we knew them by name, but, as has happened in general practice in medicine, we see much less of each other than we used to.

PROFESSOR FORSYTH: And so, more recently in your current role, what involvement you had in terms of the strategic planning or other services?

DR REEVE: Well, you will be aware the major strategic planning that's now been going on for – well it's probably a good – more than two years, 2 ½ years, 3 years now, and we first started, and that was mainly to do with – well it came out of all the – not just the maternity issues, you will be aware that there are other issues that came up, which were mainly around emergency services and certainly outpatient staff.

And obviously there was, as the Trust started to try and put all of those right, then they ran into serious financial problems because they had traditionally been slicing and dicing services in order to make ends meet as we are now aware that's what was happening, because a lot of that was

happening internally and it wasn't – we weren't fully aware of that, except for our patients actually.

PROFESSOR FORSYTH: How were you not aware of that?

DR REEVE: Well we, as – in the sense that the Trust had a cost improvement plan every year and we became aware of it, I think through things like what was happening with maternity, and with out-patients. So, I think it was those sorts of things that started to show that the service was creaking in a way that it hadn't done before.

The Trust was meeting its – was financially seemed to be reasonably sound up until about 2 years ago, so when you looked at it financially, it seemed to be hitting the bottom lines. There were some wobbles, there were some concerns that were starting to come up around quality issues, which ourselves and our colleagues in North Lancashire were starting to pick up, and it was quite soft. And as I say, it was the report back from the patients about some of the issues they were having about being able to get appointments and things weren't happening when they were supposed to and it seemed to be getting worse.

PROFESSOR FORSYTH: So was this not being detected at an earlier stage through normal performance management processes, commissioners and assessment providers?

DR REEVE: Well that is what was being fed back through those issues that we were having concerns about that; but I mean, back from the year dot, ever since I've been involved in commission going back to Stockport days, when I was Medical Director; there's a perennial issue about administrative services for out-patients and such like, with letters arriving on time, or not arriving. That wasn't a unique problem to this Trust, so it didn't ring any alarm bells as to being something specific as an issue to this Trust.

And I think some of the issues about how vacancies were – as we've now discovered, around the approach to perhaps vacancy control and such like; we were not as – well I certainly wasn't aware, I don't know if the rest of the PCT was, but it wasn't specifically my responsibility that; because as I say, I was a clinical advisor to the PCT and I think you'd have to talk to the Director of Nursing and the Medical Director of the PCT for some of that in more detail, because I was slightly peripheral to a lot of that.

Because our involvement as GPs at that time was particularly around community services, so I was leading community service development and general practice development, and had some involvement on a strategic level with the Trust, and so that was in my PCT days. Obviously the last 2 to 3 years, or the last 2 years of – well, 1 ½ to 2 years had been different, because I am now Chair for the whole of Cumbria, so I actually have a slightly different role now.

You asked about my involvement around strategic issues, which is what I was in the process of talking about, was clearly we've now got a major strategic programme, under the banner of Better Care Together, which I'm sure people have talked to you about. And clearly, maternity services and children's services, particularly at Barrow, have been a key element of that, and have been a key cause of concern for the local population. Then a lot of patient engagement and public engagement, because it's not just to do with patients, with the local population about this and had some quite interesting feedback, some of which has been a little bit counter-intuitive.

Not surprisingly the public see maternity services as a local service, and it's something that just happens to everybody and should be there, to précis things, enormously, but around paediatric services actually when their view was when something was seriously wrong with their children, you didn't mind travelling. They hoped it would not happen very often, but – we hoped it never happened to any of their children, but if it did, they were prepared to travel, and this was the Barrow population who traditionally haven't really been happy to travel for a lot of things, we've had challenges just when we're trying to rationalise vascular services and such like.

But around children with serious problems they said they were prepared to travel. They wanted to be assessed and even want an emergency service there where they could be assessed. So, those – that's informed very much the current approach that we've taken around services, particularly at the Barrow end, and we've stated quite clearly that we believe we should maintain, as commissioners we've stated that we should maintain an emergency service there, which included emergency surgery, but not complex emergency surgery and that there should be a consultant led maternity unit there, along with the support services that you need for that,

and probably – and a paediatric assessment service, possibly with short stay beds.

So that's our position around what should happen at Furness, and similar things should be in place at Lancaster as well, and we are in – at the moment the service in Westmorland General has been – the maternity unit has been – the midwifery led maternity unit has been maintained, but they are going to more of an on call system rather than having it fully staffed, which brings it more into line with other units elsewhere in the country.

PROFESSOR FORSYTH: And how would you define that in consultant led obstetrics in terms of a downgraded paediatric service?

DR REEVE: Well, it would still be consultant-led paediatric service, it will still be a consultant led paediatric service with beds, but with a more of a sense – I am not the clinical lead for paediatrics, we have a – you probably know Neela Shabde, and I don't know whether she's spoken.

PROFESSOR FORSYTH: Yes.

DR REEVE: You've probably met, but Neela and [Mandy Boardman?] are the people to – I would dig holes for myself if I'm not careful on this one, because I don't profess, but clearly this had been thought through with a lot of external support and you'll be aware that recently, last week, two weeks ago in fact, or 10 days ago we had Tony Faulkner up leading a team on behalf of ourselves and Lancashire North PCT to look at the future, not what's happened in the past, and this is what we've had to keep telling everybody, we're not going over – we've got people doing it, already looking at – we've done it before and you're looking at what happened in the past, but to answer the very question that you've, in part, that you've just raised, about what is feasible and what is desirable in terms of maternity and the related support services for Lancaster and the rest, and Cumbria.

And that's – I mean, people have thought that because of the problems that we've had in North Cumbria, but actually it's not it's a commissioners request, because there's county council, for examples, can't understand why, at the moment, there seem to be too much interest in the north, and don't want to provide any maternity – consultant led maternity services in Whitehaven, whereas the Trusts in the south are saying they think it's possible to do it.

And from a dispassionate, or not dispassionate but somebody slightly outside of the system they say, well aren't the issues exactly the same, given the remoteness and geography, and in fact Furness is slightly further from Lancaster than Whitehaven is from Carlisle, but the roads aren't – they are both equally bad, so it's – so at the moment we decided that we need to get some external input into that.

To start to answer that question about – and ask Tony Faulkner and his team because I was quite involved in this, I asked Tony Faulkner and his team to be prepared to step outside of the box, and so we actually put them in a minibus and they went to the various places and we took them around, and clearly you would have done this, I understand you have some of the meetings – the panel sessions in Barrow; so you will be aware of the journey from Barrow to Lancaster, although whether you started at the Royal Lancaster Infirmary and go into Barrow you may well not have done, but that's – through Lancaster is a problem as well.

But then the journey from Barrow to Whitehaven and then the journey from Whitehaven to Carlisle– it has to be experienced, so – and we didn't plan it, but there was an accident on the A590 when they went from Lancaster to Barrow, so we hadn't planned it, it was just being clear so they didn't stop there for a 1 ½ hours but they were delayed by about 20 minutes.

So, that's what we've asked them to do and it ties in, I think, with obviously your report will be important as to that; it ties in also, because we'd commissioned that before it was we decided to have a national review because I think this actually is a national problem, I don't think it's something that we, in Cumbria, or Lancashire North, as commissioners, can solve on our own, because you should deliver in maternity services to isolated, largish populations which are more urban in nature than they are rural is not – the Royal College guidelines just don't fit places like Barrow and Whitehaven, nearly 50 miles from another small unit; it's not even as is if you're 50 miles from an all singing and dancing unit, you're 50 miles from another small unit.

PROFESSOR FORSYTH: So, do you have a solution yourself as to what -?

DR REEVE: Well, I have a solution, if the NHS would make a decision about whether it was a National Health Service or not. I think that – I just think that at the moment the market has almost been let to rip and when the Trust has is

approached, groups like this, the North West Specialty Group, for advice and help, and they've looked at the situation and said 'Yes it's very difficult, we wish you all the best' and then they've approached – they are in the process of approaching other Trusts for more than a buddying relationship, to develop more of a partnership. They've had a lot of support around the governance stuff and coming over to check that things are alright and perhaps some training support and such like. But when you talk about people physically being on rotations from a large unit, be it Preston or Liverpool I think we have particularly been talking to, the Trust in Liverpool; about your part of this deal would be that the consultants, or specialist nurses on site would rotate though like almost in a chain, the European approach of having a hospital, particularly the German approach of having a hospital change. Well they would say, 'Why would we do that?' and you have to say as a standalone Foundation Trust, why would you do that, if you try to recruit people to do that, unless you offer them a pad in the lakes which has been thought up, but how do you make it attractive to come and spend a month, or two months here on a rotation through?

Because you could put – as you know, you could put the best clinicians in Barrow but in five years' time they wouldn't be the best clinicians. So, it is not just maternity that's a problem for us, but I think it's maternity and paediatrics, it bring it to an absolute you know head, that it's something that you can focus on and I think that's clearly where the national review is going to have to – because we're not the only place in England with this, Scarborough is similar. People say 'Cornwall is', but we say 'No it's not, Cornwall has a hospital in Truro which is in the middle of Cornwall, and all roads lead to Truro.

If we didn't have mountains and we put a hospital in the middle of Cumbria we'd have it probably in Keswick, but I mean that would be the worst possible place to – so there is a historical reason why the hospitals are all around the edge of Cumbria, so we have a problem. And I think there needs to be a national decision about this, because it's not something that we can deliver on our own.

PROFESSOR FORSYTH: When the Royal College of Obstetricians is going to be reporting back to you and then -

DR REEVE: We've been told that they are reporting back in February time, so late January, February. I don't know if they'll meet that deadline or not.

PROFESSOR FORSYTH: Have you met any of the families that have been involved in some of the incidents?

DR REEVE: Not directly, Geoff has been the person that has more involvement with them because he's the local GP and such like, so no, I made a decision that, you know, you can have too much involvement really and he's known within the community, respected in the community and he's had links with several of them, yes.

PROFESSOR FORSYTH: Thank you for that.

DR KIRKUP: Thank you, Julian?

MR BROOKES: Thank you. Can I just pursue a little more about Better Care Together.

DR REEVE: Yes.

MR BROOKES: And that, it's slightly wrong chronology but just following on from the conversation we were having, there's an affordability issue here.

DR REEVE: Yes.

MR BROOKES: Where is the CCGs thinking in terms of affordability? I know the model that you have as a preferred model; there are some potential issues though, in terms of affordability. Are you aware of the costings for that particular model?

DR REEVE: Yes, we looked at, I haven't got them at the forefront of my mind, excuse me, but we did look in reasonable detail, I don't want to egg this up too much, but we were working with PricewaterhouseCoopers who you're probably aware, did a lot of work for the Trust, looking at what's been termed the structural deficit. It's a bit strange because national use that in a different way as regards the country's deficit, but the meaning really the deficit that's – the cost of running a number of sites when, if you're in Greater Manchester, or somewhere you would run one site.

So, Pricewaterhouse did an assessment of that as it stands now, or just costing the Trust now. We then did work as to if we moved the organisations to the top quartile ~~core time~~ in terms of their efficiency on a whole number of measures, what that would do. So, if you get everything it was, and you moved to that level of efficiency, how much would that save, I'm

afraid I can't give you the figures off the top of my head; I would need notes for that.

Then we looked at what the cost would be if we moved certain services, mainly moving them – we were trying to be agnostic but in reality it was moving them from Barrow, although to be fair we also said we would move them from Lancaster to Barrow, although that was – the Trust would have been unviable then, because too many patients would have gone to Preston, would have come down here from Lancaster; not because it was necessarily the wrong thing to do and why on earth would you do it, it wasn't, we looked at that, but it meant that the catchment of the Trust then became too small.

And when we looked at, particularly the one that stuck in my mind was emergency A&E, because that's the – if you move the A&E and you downgraded the A&E at Barrow to become a glorified minor accident unit, how much would you actually save, well the actual savings were not very high and in the terms of £1, £2, £3 million, it was not tens of millions that you would save to do that. But the thing that actually blew it out of the water was then the ambulance costs. So the ambulance costs, when we were doing it, was £500,000 per ambulance to run, and we knew that cost because we'd had to commission an extra ambulance when we downgraded Westmorland General in 2006, 2007 or 2008, and discussions were going on between 2006 and 2008 but it moved in 2008. We had to commission a new ambulance then, but it was nearly £500,000 then.

So, once you'd worked out how many new ambulances you needed to commission there was actually no financial benefit for emergency care. And similar costs were done around maternity, which and again, as soon as you added the ambulance costs, you might have made a saving of maybe £500,000 but then you had to do a judgement call as to – given the fact that you were then being embroiled in judicial review for the next 5 to 10 years, irrespective of whether you'd gone through the process absolutely perfectly, we knew that we were told that the MP and various other – some of the people I think you've probably met already, were quite open with us and said, 'Well, we'll just take you to judicial review whatever, because we feel that it's the wrong thing.

So, you then hit a judgement call as to well, for saving £1 million, £500,00 with potentially worse outcomes of nobody has conducted that sort of experiment in the UK, and that was the problem, you conduct an experiment as to whether it's safe to have people 50 to 60 miles, a large population of deprived people, 50 to 60 miles for a maternity unit, is that – and we don't know if it's better or not, so there's no, any sorts of trials or comparative work being done for that size population. People have done it for small populations of 5,000, 6,000, 7,000, needing obviously a maternity unit. They are a midwifery led unit that we know the number of people that transfer to an acute when in crisis.

MR BROOKES: So, what is your anticipated additional cost for having a service?

DR REEVE: I can't give you that figure off the top of my head. But clearly there are costs associated with having to run the additional rotas, and that's really what it boils down to. We've been told there aren't a lot of savings from the physically infrastructure, because once it's there unless you knock it down you can't – you have to physically knock it down to get it off the books. So, it's to do with the rota costs; but again, I don't hold that in my brain; I would have to take you through the work that's been done. In can assure you that that work's being done by Pricewaterhouse on our behalf, looking at those costs.

MR BROOKES: It's always interesting on what Pricewaterhouse makes its assumptions.

DR REEVE: Yeah.

MR BROOKES: Having been involved with this before, they sometimes have core ties nota achievable when you've got a complex footprint.

DR REEVE: Yes.

MR BROOKE: But I'm more interested in – there's always a tipping point.

DR REEVE: Yes.

MR BROOKE: About what is affordable and what isn't affordable, and I'm must interested that that's not clear in terms of where you are in the process.

DR REEVE: No, we've got to the position where, I don't know how much people have talked you about this, but we have got to the position that, at the moment we have, and it varies, but we have around a £27 million problem. It varies from week to week, by £500,000 or so, but it's around a £27 million problem across the whole system, not just for our CCG, we've got a much

bigger problem for the CCG in the north, but we're not here to discuss that. But that's relevant to what happened in the past. The issue for us -

MR BROOKES: Sorry, just to be clear, are you saying £27 million in Barrow?

DR REEVE: No, no, no, we had a £27 million system problem across Morecambe Bay alright, so we – it's quite hard to define where that lies, because it's a system problem and we've made a conscious decision to talk about the system has this problem, so that it's not just the responsibility of the hospital; that includes Lancaster General, but it includes the community services and such like as well, which -

MR BROOKES: And am I correct that's an unaffordable problem?

DR REEVE: Yes well I –

MR BROOKES: For the system; can the system afford to pay the additional £27 million?

DR REEVE: Well no, that's the amount that system is overspent by, we are spending £27 million of other people's money at the moment; now that's mainly going through the Trust and the Trust is accessing public dividend ~~demain~~ capital to actually fund that through Monitor. So that's money we don't have.

MR BROOKES: So, Better Care Together brings you to a position of balance?

DR REEVE: No, Better Care Together brings us to a position, depending on which option, final option goes to of a problem still £5, £6, £7, £8 million, depending on which of the – there is a very, very optimistic yes, which doesn't – even that doesn't bring into full balance; and that's one of the issues that we are discussing with Monitor and NHS England at the moment. And I've had to counsel people not to look at the Simon Stevens announcement that the NHS is £8 billion short; that therefore that's our share of the £8 billion. I said, "NO, that's not the way to look at it".

This is actually a discussion about delivering health care to a population spread across a geography like we've got, and that's a wider discussion than we've got. Now, if we get told that that's – that we have to sort that there will be some challenging decisions to have to make and I think it will bring some of the commissioners ~~s~~ and some of us to the point where we say, well there's a safety point and there's a quality point beyond which we are not prepared to go; and if you're insisting that we do that you then have to make a

decision based on what you're prepared to do or not. So we haven't reached that point yet, but for certain, if we got to that point personally I would have to consider my position as to whether I was prepared to oversee such decimation of services for an area of the population.

MR BROOKES: And understanding that context, as CCGs, do you have minimum specification for maternity services?

DR REEVE: We do now, we didn't. The PCT didn't, late last year or last year and I'm not sure when it quite started, but in partnership with NHS England the CCG developed a specification for local maternity services, which was included in this year's contract. I wasn't involved in the development of that; that was more Mandy Boardman and Neela Shabde and colleagues from NHS England, so I can't talk to you in detail about what's in that statement.

MR BROOKES: That's alright, I just wanted to know if there was one, because I was aware there wasn't one previously.

DR REEVE: Yes, there wasn't one.

MR BROOKES: And do you know whether or not Morecambe Bay is meeting that specification?

DR REEVE: I couldn't give you, hand on heart; I'd have to go to Neela and Mandy about that. All I can say is I haven't been told they are not. I would expect to be told if there was clear evidence that they were not. I do know that they are still having immense challenges around staffing; I know that from talking to them, and I also know if from one of my patients, who's a nurse on a special care baby unit who comes in and it's the usual things about being a local GP, the number of patients that work in the Trust.

MR BROOKES: Okay, can I go back in time now. This is to the time of the PCT and where you were leading as Head of Care of Clinical Governance.

DR REEVE: Back in Morecambe Bay times.

MR BROOKES: Yeah, back in Morecambe Bay. Just give me an indication of what that role entailed and did it cover both primary and secondary care?

DR REEVE: It didn't cover – it was a PCT provider role really. And as a provider, because at that point clearly the PCT had contracts with primary care, so it was a provider role around general practice, pharmacy, dentistry, optometry, I had clinical leads in those areas to help me, because they weren't areas I had any expertise in, and mental health and community paediatrics; essentially

there were a few other things like sexual health services and smaller services. Clearly we ran also community nursing and a number of therapy services, so I had overall responsibility for that, but there was a Director of Nursing as well.

MR BROOKES: Okay, so just to be clear, your role was very much around the provider of the services?

DR REEVE: Yes, it didn't cross over into – it only crossed over in the sense that as Medical Director I – we were also a commissioning organisation, we had a Director of Public Health at the time as well, and the Director of Public Health, because mine was a new role, and the Director of Public Health had been in the post for quite some time, the PCT hadn't had either a Director of Clinical Governance, or a Medical Director, the Director of Public Health had taken on the role for a lot of the – the commissioned services, and he retained that responsibility.

MR BROOKES: So, who took on the responsibility for clinical governance when Cumbria PCT came into existence?

DR REEVE: We had a full-time PEC Chair, who was – well he was nearly full-time, he was 4 days a week, so he took on a lot of that responsibility with a director of nursing. Fairly quickly the PCT decided that it needed a Medical Director and Mike Bewick was brought into post. There were specific leads for things like prescribing that were in place as well, so I think Sue Page felt fairly quickly she actually needed a full time medical director.

MR BROOKES: So, who oversaw, or assured the PCT board that the quality of services in secondary care was -

DR REEVE: Well, there was a dual role because we also had a Director of Public Health, and the Director of Public Health took responsibility for – this is the Cumbria PCT now, the Director of Public Health took responsibility for all the serious incidents and over saw that process and we quite frequently got feedback, it was Professor John Ashton. So I don't know if you've seen him or it would be relevant for you to see him if you haven't, very relevant. And John actually did have concerns, which I'm sure he's talked to you about around services.

Going back to your first question, I've just suddenly thought that was probably the place that I first heard about the concerns really was through John and expressing some concerns, and he actually commissioned a review

of I think it was neonatal deaths and such like, which actually I need to talk to you about, I've just suddenly remembered that. So it was John and then when Mike Bewick came into post, it was basically Mike and John, as I've described around the – Mike took the lead on the investigations and sitting on Gold Commands that seem to be running for quite some time over a number of issues.

MR BROOKES: So, was the PEC engaged at all, or aware of serious and untoward incidents?

DR REEVE: Well, we were, through John. John was the person that raised them to us in general terms. We had this ongoing discussion within the PCT about not wanting to duplicate the things that the board then also took responsibility for – I think this was a perennial challenge for PCTs, certainly it was my experience, when I was at Morecambe Bay, that you didn't want to tie up clinicians who only had a limited amount of time when we weren't – it wasn't quite clear what our formal position was, because the accountability really lay with the board so we would – my recollection is that we were informed of issues, but we didn't go into detailed discussion. John had set up a separate process for that, which one or two members of the clinicians were involved in, we had a mental health lead who was involved in that process; so people who were specific leads often were involved in that process, and then it fed more directly to the board than it did to the PEC.

MR BROOKES: Yes, so as a PEC member you were not made aware of – that there might have been a number of serious and untoward incidents around maternity services?

DR REEVE: Well yes, I mean as I said, John informed us, and he was told he was commissioning a – he was quite vocal about his good about that, yes. I wouldn't say that we went through each incident in detail though.

MR BROOKES: Sure.

DR REEVE: Yes.

MR BROOKES: Sure.

DR REEVE: It was more about the concerns were raised with us and we said "You've got our full support to commission that work John".

MR BROOKES: And from what you were saying earlier as well, there was no triangulation of what you were hearing through your GP role?

DR REEVE: Not particularly, no, I think that was a weakness and certainly that's something that we've, over the last two years, worked quite hard to change, so we've now got a formal mechanism for picking up – if you like more low level concerns that GPs can now report back through an electronic system from desktops, which are then captured. And previously I think each locality had done its own thing, when I was leading in South Leeds we had introduced a yellow card system, which I think Barrow had introduced as well. But there were some challenges about how you brought all that together, because somebody then physically had to try and pick something out of the electronic system with key words and everything, it's actually – we've improved that so – and that's now reported formally to our board about the number of issues that arise through the GP reporting system, as against come through the Trust's reporting system, so we have much better triangulation now, and I think that was one of the lessons that was learnt, I think particularly I would say, from the out-patient stuff, because once that really became the extent of the problem became apparent, then a number of people said, "Oh well, we knew about that" like people, like often we do, with retrospect.

MR BROOKES: Did you attend the board?

DR REEVE: Not – later in – latterly I did but it tended to be Mike Bewick rather than myself on a regular basis because I wasn't formally PEC Chair.

MR BROOKES: Right. So –

DR REEVE: Until I was actually CCG Chair elect and then they made me PEC Chair.

MR BROOKES: So I understand there was some general reporting of serious and untoward incidents at PEC; as PEC involved in the commissioning services, in terms of advising the commissioning services?

DR REEVE: Yes, yes. Mainly yes, it was, in terms of strategic direction I mean, there's probably some very good examples of – one particular example was the cardiac PC primary at Primary PCI Service that was commissioned for North Cumbria and the PEC was very involved in that. But it tended to be around specific changes, rather than the general review of services, it was more of strategics.

MR BROOKES: Just finishing that off then, so as a person working within the PCT, were you ever aware of reports about maternity services at Barrow, were you aware of anything other than serious untoward incidents being discussed in

terms of concerns prior to 2012?

DR REEVE: I was aware that the issues that Professor John Ashton brought to us but that would, be probably it.

MR BROOKES: Okay, just one final set of questions if I can, were you involved in any discussions as a professional member of the PCT, relating to the FT application for the Trust?

DR REEVE: Yes, I remember being present at a meeting with Sue Page and Geoff Jolliffe, I cannot remember if John Ashton was present at that meeting, or Mike Bewick, I can't remember actually, it was at Westmorland General. I can't remember the exact date of it but it was about 3 months before they were approved as a Foundation – 3 or 4 months before they were approved as a Foundation Trust, 3 to 6 months; it'll be in that time period, I'm sure you've got the date of when they were approved, so you can work it back from that.

Monitor wanted to meet with the commissioners and Sue wanted to make sure that the two locality leads were there around then. And we were the masters??? of what we thought and we were less than enthusiastic about the proposal for them to become a Foundation Trust for several reasons I think and -

MR BROOKES: And those reasons were?

DR REEVE: I can go into them if you want me to.

MR BROOKES: Briefly, just briefly.

DR REEVE: I think, on several footings, I have been involved with the Trust since 2001 when Ian Cummings had been Chief Executive and then Tony Halsall became Chief Executive after him. And I think over the whole period one of my real concerns had been engagement with the clinicians, as Medical Director and PCT, Morecambe Bay and subsequently, I had quite a lot of involvement with clinicians and I was quite concerned, particularly compared to where I had been working in Greater Manchester before; about the engagement of clinical and roles of Clinical Directors which didn't seem to be a very – it seemed to be a very important role really.

It had been highlighted, particularly by Sue Page, who had come from a Trust where that was the way she ran things, and that's what she did introduce within the CCG, so I was sat there in the PCT with, as far as I could

see, far more ability to influence the way the services that we provided, than the Clinical Directors did in the Trust, so that was one concern.

There were concerns about their engagement with us as commissioners, particularly, I think, when Tony Halsall was there. I had personal experience of being kept waiting an hour, sat on hard chairs, outside of his office on at least two occasions with no information given to me as to about why I was being kept waiting; and that was when I was lead for a population of 110,000 people that he was – so one just felt that we were not terribly important to him; that we were people that were tolerated rather than seen as true partners. I have to say things are totally different now and perhaps they have been turned around completely now. I think there was a – those, to my mind, and there was issue that the public just didn't feel terribly engaged with the Trust.

MR BROOKES: So, is it fair to say that from your view, engagement by the Trust with the public was poor, clinician to clinician was poor, management to GPs or commissioners was poor?

DR REEVE: Management and the other thing was that all the time that I had been involved with the Trust, and this is particularly important I think, the Trust has never existed really as a single organisation. It's existed as an organisation that works out of Furness and an organisation that works out of Lancaster and Westmorland, and those two tended to have gone together.

When I was Medical Director for Morecambe Bay PCT and we were trying to appoint, particularly we were trying to appoint, at that time, paediatricians who had worked both in the community and in acute care, they didn't grow on trees those sorts of individuals and I still don't think they did. They do now, but we could see that we had real problems with community paediatrics as a PCT provider and we did work with them and say, 'Can we appoint some joint posts' but they were very much – the post was just in Furness, and there was no sense of them working across.

And we also had an alternate experience of them appointing paediatricians to Lancaster, good paediatricians, but with no sense that they were expected to work into Furness at all and the argument we were given is 'Well, they won't come if they're told they have to work in Furness' and you sort of thought, you know, do you manage this as a single organisation or

not?

And that's existed a long time and I didn't see any movement during Tony Halsall's time in leading the Trust and the team he had, of making any inroads into that at all.

MR BROOKES: Okay. One final question, would you describe PCTs, both Cumbria and the previous one, as strong commissioners?

DR REEVE: Morecambe Bay, I'm not sure really, it was my first role as commissioner.

MR BROOKES: Cumbria, how was that as a commissioner?

DR REEVE: Cumbria. I think Cumbria was a strong commissioner in one sense; I don't think Cumbria was brilliant at relationships with its providers. So I said that about the PCT, the Trust, but I really don't think – Sue Page was a – this is obviously I'm being honest here, and it's not going to be published, I presume, and if it I'm not going to say it.

MR BROOKES: What you say on record is available for families.

DR REEVE: Families right, yes, well, Sue was a brilliant Chief Executive, but she's a hospital's Chief Executive, that's what she essentially was; so when you put three hospital Trust Chief Executives in a room together there was – I probably don't need to say anymore do I. And that's different from being a commissioner, when maybe you're – as I see it, my role as Chair of the CCG, and my accountable officer, is we're responsible for the system and so you know, it falls to us really to sometimes knock some heads together and get them to talk and get them to work together. And I don't think that was a strength of the previous PCT. The previous PCT, Cumbria, brought real rigour to the way we commissioned with people and brought us into conflict with the SHA, and I think we had a fairly weak SHA in the north west, and we came into challenge with them on several occasions, particularly with regards to the north of the patch. And the north of the patch did – also the other issue about commissioning for the south of the patch, is that the north of the patch took up so much of our energy because that's where the real financial role was, and that's where, you know, the problems in the north – I think the PCT was caught a bit on the blind side by the size of some of the problems that existed in the south of the patch, because the problems in the north had been going on years and years and years and over £100 million had been sunk into

the north by previous organisations with no apparent, over and above their contractual – so that's where I think there were some weakness in the CCG.

MR BROOKES: Thank you.

DR REEVE: What the CCG, PCT managed to do was when it started it had a massive financial problem, when the PCT finished the system still had a massive financial problem; it just didn't sit with the PCT. So you could say it actually sat – you could say it sat where it needed to sit, where the problems were.

MR BROOKES: Thank you, that's helpful.

DR KIRKUP: Just one point of detail that I need to pick up with you, and apologies that it is a bit of nit-picking detail.

DR REEVE: That's alright.

DR KIRKUP: It is an important point.

DR REEVE: Yes.

DR KIRKUP: It's this meeting that you had where the PCTs talked to Monitor about the application.

DR REEVE: No, I think it was – I think, I think it was just our PCT.

DR KIRKUP: Okay, your PCT. It's not a joint meeting.

DR REEVE: I don't think it was a joint meeting, I don't recall it being with the other PCT, with Lancashire, I don't – North Lancashire.

DR KIRKUP: It's the timing that concerns me. The FT application was approved in October 2010.

DR REEVE: Yes.

DR KIRKUP: And you put it 6 months or so before then.

DR REEVE: Well sometime within –

DR KIRKUP: Can I just remind you and see whether you want to think again about it, or maybe you just can't remember, that's fine.

DR REEVE: Yeah.

DR KIRKUP: But I need to clarify this; the original application was put forward in February 2009 and was suspended in May 2009 for almost a year.

DR REEVE: Right.

DR KIRKUP: It was reactivated in April 2010.

DR REEVE: Right, you're asking me whether it was before the original one?

DR KIRKUP: Is it in connection with the original one or the restarted application in

2010?

DR REEVE: I could find out for you, but I can't remember.

DR KIRKUP: I would be grateful if you would.

DR REEVE: Yes.

Additional comments – I have done some searching and although don't have access to diaries etc. around the time the date of the conversation with Monitor. I think the date was with respect to the original application not the deferred one.

DR KIRKUP: Would it be inconceivable that it was in connection with the original 2009 application?

DR REEVE: Well, it wouldn't be inconceivable no, but I can't pretend that my memory – those years sort of blurred a bit really.

DR KIRKUP: Yes, I appreciate that.

DR REEVE: But if you would like me to just confirm.

DR KIRKUP: Well, it is an important point because if it's one way and it does conflict with other information that we've got so that would be best understood.

DR REEVE: Yes, actually I had forgotten that it had been deferred. Yes, it will be the meeting that, I know Geoff and I were talking, before when we knew you wanted to see us a few weeks ago. We said, "Oh yeah there was that meeting wasn't there" so -

DR KIRKUP: I appreciate that the distance of time.

DR REEVE: We both remembered being at it, but I haven't spoken to Sue Page in the last few months so – but we will be able to – we should be able to find out when it was.

DR KIRKUP: If you would get back to us and just confirm which year it was, in 2009, 2010 that will be very helpful.

DR REEVE: Yes.

DR KIRKUP: Anything else?

MR BROOKES: No.

DR KIRKUP: Anything else you want to say to us; it's not compulsory but if there's anything you feel we've missed out on?

DR REEVE: No, I don't think so, I think the context of Cumbria over the past 7 or 8 years is, which I'm sure people have talked to you about, but is an important context in terms of – I mean Geoff and I used to get frustrated when we sat on the PEC, which was called the Clinical Senate, about the amount of time that

was spent talking about North Cumbria. And we used to, at times we just said, "Look, you know, we can't spend all this time talking about North Cumbria, because it just –" and I think Sue had a real understanding of acute hospitals, and so that was where her comfort zone was, and didn't have such a comfort – that's why, I think, she gave us such a responsibility for community services and general practice because we understood it and she didn't and once she'd checked us out that we were fairly competent and safe, she wouldn't have done with her Clinical Directors. But I do think that had an impact on the way that the PCT behaved.

DR KIRKUP: Okay. Thank you very much for coming.

DR REEVE: Good, okay.

DR KIRKUP: Thank you.

(The meeting concluded at 11.19 a.m.)

THE MORECAMBE BAY INVESTIGATION

Tuesday, 1 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Ms Jacqui Featherstone – Expert advisor on Midwifery
Professor Stewart Forsyth – Expert advisor on Paediatrics
Professor Jonathan Montgomery– Expert advisor on Ethics

GERALDINE ROBINSON

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DR KIRKUP: I'm Bill Kirkup. I'm chairing the panel in the investigation and I'll ask my other colleagues to introduce themselves.

PROF FORSYTH: Stewart Forsyth. I'm a paediatrician and, latterly, a medical director in Tayside, in Scotland.

PROF MONTGOMERY: I'm Jonathan Montgomery. I'm an academic healthcare lawyer from University College London but also chair the Health Research Authority.

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm head of midwifery and head of nursing from a district general hospital in Essex.

DR KIRKUP: As you see, we've got recording equipment around the room. We will make a recorded version of the interview, which you'll be able to see in due course. We open the proceedings to family members. As it happens, there are none here today but they will be able to listen to selected parts of the recording. I say selected parts, because that wouldn't include any confidential patient data that we might want to discuss at some point.

You also know that we haven't allowed anybody to bring any recording devices or mobile phones or anything in here. That applies to the panel as much as it does to anybody else. And we are very strict that we don't want any material, whether recorded, written or remembered, to be discussed after the event. We want the panel findings to come out as a whole, to be placed in context, not for bits of speculation to go on in the mean time. Is there anything that you would like to ask me about the process before we start?

MS ROBINSON: No. It's suddenly become extremely real as I walked through the door. I am extremely nervous but we're at the long end of a very long journey

and, as such, it's just made me extremely nervous.

DR KIRKUP: I do understand that. Thanks for sharing that with us but I do understand and I apologise that the surroundings and the microphones and so on are a bit daunting. Our objective is to have a conversation with you, where you tell us as much information as you can. It will help us to understand and will help us to put all these events into a proper framework.

Can I start out by asking you when you started working at Furness and what different things you have done there?

MS ROBINSON: Okay. I started in 1992 as a student midwife – prior to that, I was a staff nurse – and I qualified in 1993 as a midwife with a diploma. Subsequently went on to do a BA Honours degree in health studies. Staffed on the unit for a good number of years and then became the deputy ward manager. And then, in 2004, became the ward manager. And since November 2013, I've been the unit manager.

DR KIRKUP: Okay. Thank you. That's really helpful. Can I pass you over to Jacqui?

MS FEATHERSTONE: I'm just going to ask you – it's just really for you to tell the story. So, just explain: what were you ward manager of in 2004?

MS ROBINSON: Just the ward – the ward area.

MS FEATHERSTONE: Which is what?

MS ROBINSON: It is a postnatal ward, where we have antenatal patients as well.

MS FEATHERSTONE: So, you don't have separate antenatal and postnatal.

MS ROBINSON: We don't, no.

MS FEATHERSTONE: Okay. And what sort of bedded ward is it?

MS ROBINSON: 22 capacity, so a capacity for 22... Sorry, 18 postnatal, 18 babies as well, and four antenatal, but it all depends on capacity. We can use the single rooms for antenatal as well.

MS FEATHERSTONE: Okay. And just that you're now unit manager – again, what does that mean?

MS ROBINSON: That means not only do I cover the maternity ward but I manage the labour-ward environment as well.

MS FEATHERSTONE: Okay. And when you were ward manager in 2004, there was somebody else managing labour ward?

MS ROBINSON: Yes, but that was a matron. It wasn't a labour-ward manager; it was a matron.

MS FEATHERSTONE: Okay. So, going back to when you were ward manager, how was the process when incidents happened? Anything within the ward, how would you share that information and how would you... or how would the information get to you to share with your staff?

MS ROBINSON: Sorry?

MS FEATHERSTONE: Anything – anything that happened.

MS ROBINSON: Anything at all.

MS FEATHERSTONE: So, complaints – communication. Start with communication. How would communication get to you?

MS ROBINSON: Okay, communication. Okay. Well, usually, if a complaint came in, it went immediately to the head of midwifery or matrons, and then it was cascaded down to me, but it depended on the complaint and what needed to be done from that.

MS FEATHERSTONE: And would you get feedback? So, if it was particularly about something that had happened on your ward, would you get feedback?

MS ROBINSON: Yes.

MS FEATHERSTONE: And then how would you expect that information to the staff on the ward?

MS ROBINSON: To the team?

MS FEATHERSTONE: Yes.

MS ROBINSON: Via... Well, we did the PSI meeting – sorry, the risk meetings. They were done monthly. And then it was cascaded from there, from the minutes of those meetings. Prior to that, if there'd been a unit meeting or a ward meeting, it would have been passed down that way as well. Also, depending on the incident or whatever needed communicating down to the team, it came... Wherever it came from, it was cascaded from the management side down to us.

MS FEATHERSTONE: And was the communication good?

MS ROBINSON: From where?

MS FEATHERSTONE: Well, did you feel that you were well informed of what was going on?

MS ROBINSON: Within the unit?

MS FEATHERSTONE: Yes.

MS ROBINSON: It depends, really. It depends in which context. Some things, yes; other things, absolutely not.

MS FEATHERSTONE: If there was a serious incident that had happened, would you know about it?

MS ROBINSON: Yes.

MS FEATHERSTONE: And were the meetings that you had attended, were they multidisciplinary?

MS ROBINSON: The...

MS FEATHERSTONE: Anything: governance, generally. So, again, communication. It's keeping the communication loop going. So, did you feel that –

MS ROBINSON: They were multidisciplinary but then again it depended on who chose to attend.

MS FEATHERSTONE: So, people were invited.

MS ROBINSON: People were invited.

PROF MONTGOMERY: Was there a pattern to who didn't choose to attend?

MS ROBINSON: To be perfectly honest, there tended to be different patterns. There were patterns. Paediatricians weren't... didn't usually attend but, again, it depends in what context. It depends on the situation. It depends on the meeting. It depends on... But that multidisciplinary team, we attempted to have a multidisciplinary team but there was no... there was nothing to say that 'you must attend'. Although it was expected, it didn't happen. The same from sometimes consultant obstetricians or even the registrars or even the house officers, as they were then. There was nothing that compelled them to attend.

MS FEATHERSTONE: So how would you... The information came down to you. If you were concerned about something, how would you escalate it back up?

MS ROBINSON: I cascaded that up through my line manager, who was the matron, and then it went from there, but I also went straight to the head of midwifery on

a number of occasions with issues that I felt were strong enough to require an answer at that time.

MS FEATHERSTONE: Can you give an example of –

MS ROBINSON: The biggest example is staffing levels.

MS FEATHERSTONE: On a particular shift or per se?

MS ROBINSON: No, per se.

MS FEATHERSTONE: And what was the conversation?

MS ROBINSON: The conversation was I used to spend... I didn't have any management time at all, so I had to find that management time, because of staffing levels. So, I used to spend hours and hours and hours walking around with a clipboard attempting to cover the unit – safely cover the unit with the numbers that we were told we had to have, with the cuts, which meant that there were five midwives in a morning to cover the postnatal ward and the labour ward, there were four midwives on the late, which covered the postnatal ward and the ward, and then there were four midwives on nights, which covered both areas. And we had... we developed an on-call system to try and make it safer.

MS FEATHERSTONE: And this was for... What band midwives would be on-call then?

MS ROBINSON: Well, that was Band 6, Band 7. It was Band 6 and 7.

MS FEATHERSTONE: Are you a supervisor?

MS ROBINSON: No, I'm not a supervisor.

MS FEATHERSTONE: So, how did supervision and what's your experience of supervision? Did you escalate to the supervisors?

MS ROBINSON: Yes, and the supervisors took that onboard and it was taken elsewhere. But there is only so much you can do.

MS FEATHERSTONE: But you escalated it to the supervisor in the supervision route as well.

MS ROBINSON: Yes, it was escalated, yes. It was escalated. At that particular time, we didn't... it was all about funding and cuts. And we couldn't... there was no overtime payments; you had to have time owing. There was a time-owing book which disappeared with the new matrons that came in, and the time-owing book disappeared and, to this day, I still have 42 hours time owing. And that's not half of the time that I gave to the service to make it safe.

MS FEATHERSTONE: Did you have student midwives?

MS ROBINSON: We did.

MS FEATHERSTONE: And did you employ those after... were you able to take those on after they qualified then?

MS ROBINSON: It depended if there was an opening. And we did at one point develop a preceptorship programme for them, but there was no guarantee. There was no guarantee, because it was all cuts.

MS FEATHERSTONE: And so, the staffing issues that you escalated, did it ever come back through the university because the students weren't getting their mentor or...?

MS ROBINSON: No, the students... we protected the students in many, many ways, because they are our future. They were the future of the service, so we protected the students. The students always got their mentors. The students always got the experience. We wanted to keep that. The people of Furness

deserved it and, as a service, we deserved it as well from the students that we had. And we were always very proud of our programme for the students – always very proud of it. So, a preceptorship package was developed but it was just a 12-month one and, from natural wastage, I think we managed to employ those midwives.

MS FEATHERSTONE: Did the exec team ever visit regularly maternity at all?

MS ROBINSON: No. I first met our chief executive just after one of the serious incidents and I was under the impression he was visiting the ward as part of a new programme – the... I can't remember what we called it now. There was a trust programme and I'm sorry, I can't remember what it was called. But within that there was a diary, if you like, that stated who would be visiting your ward each month and at what time, so my understanding was that that was the reason for his visit. It turned out that that wasn't the reason for his visit. There was an underlying incident that he wanted to get a handle on, I think.

MS FEATHERSTONE: So, did he speak to you when he came onto the unit?

MS ROBINSON: He did. He did and I showed him all round the unit and I answered a few questions, and then it became extremely apparent that he was there for one reason and one reason alone, and he wanted to see where the incident had taken place, he wanted to know how many staff had been on, and it soon shifted to that, so I had no idea he was coming for that reason.

MS FEATHERSTONE: Can I just ask you about recordkeeping and audits? So, from your supervisor, you would do recordkeeping audits with her, or him.

MS ROBINSON: Yes.

MS FEATHERSTONE: And on the ward, as the ward manager, did you do anything

with recordkeeping with your own team?

MS ROBINSON: I can't remember. How far back are we going now?

MS FEATHERSTONE: Really round about between 2004/2008. Or what do you do now? Is it any different now what you're doing?

MS ROBINSON: It's a lot different now.

MS FEATHERSTONE: In what sense?

MS ROBINSON: Well, I think, from all the training that we've had over the years, it's become much higher profile, recordkeeping, most certainly. And there's been a lot of training gone into it and we're certainly... we're still as... The Band 7 still take three sets of notes each week and go through them, and then it's cascaded back to the individuals, if it's needed to cascade back. But equally, if it's a good record, we'll –

MS FEATHERSTONE: So, good and bad.

MS ROBINSON: Yes. That goes back. That's cascaded back as well.

MS FEATHERSTONE: Okay. That's fine. Thank you.

DR KIRKUP: Thanks. Stewart.

PROF FORSYTH: Hello, there.

MS ROBINSON: Hello.

PROF FORSYTH: I missed the date you took over as unit manager.

MS ROBINSON: As unit manager, November last year.

PROF FORSYTH: November last year. So, 2013. Had you had much involvement with the labour suite prior to that?

MS ROBINSON: Yes. Yes.

PROF FORSYTH: So, did you work in the labour suite.

MS ROBINSON: Until I became the unit manager, yes, and then I still had some experience on the labour suite as well.

PROF FORSYTH: Can you just give us a feel for how it worked around 2008, around that, before and after?

MS ROBINSON: When you say how it worked...

PROF FORSYTH: Yes, in terms of... Clearly, the midwives were very much the key professional group.

MS ROBINSON: Very much so.

PROF FORSYTH: And I'm interested in the interface between the midwives and the obstetrician, and the midwife and the paediatrician.

MS ROBINSON: Okay. How did it work? We were all under a lot of pressure and that was because of staffing levels. As I've said previously, it was sometimes an hourly struggle to ensure that you had those safe staffing levels, depending on what was happening on the unit at that time. But also we were... around about that time, we were asked to do a session at the children's centre as well, so one of our midwives would have to leave the unit and go out to a children's centre, which depleted staff as well.

PROF FORSYTH: So, how far is that away?

MS ROBINSON: Sorry?

PROF FORSYTH: How far is... how were they located?

MS ROBINSON: They were located within the town centre. Yes, it wasn't on the actual unit, no. So, that depleted staff as well and it left it at unsafe levels, most definitely.

PROF FORSYTH: You think... you feel the levels were unsafe at that time.

MS ROBINSON: Yes, I think it's apparent, from all the meetings and the minutes of the meetings that we've had over the years, that midwives were extremely concerned about the safe level of staffing for the service we were trying to provide.

PROF FORSYTH: So, these minutes of meetings, these were midwives' meetings and they were meetings that went to higher levels?

MS ROBINSON: There were certainly midwifery meetings but there were also Royal College of Midwives meetings. There were meetings that we'd had one-to-one discussions with our supervisors as well, and it went via the supervision route as well, so... And then, of course, there was the discussions that we had with the head of midwifery as well.

PROF FORSYTH: Do you want to tell us a little bit about these?

MS ROBINSON: I remember distinctly having a one-to-one with my head of midwifery. At that time, I was tasked with the off-duty, which meant I did the off-duty on a six-weekly basis. So, I knew, six weeks in advance, the gaps that we had within the units, and I worked out exactly how many staff we needed of different bands to enable us to deliver the service that were delivering at that time, and we were nine whole-time equivalent down of midwives. That was at that time, trying to deliver the service that we were delivering.

PROF FORSYTH: So, what sort of time of year would that be around?

MS ROBINSON: That was probably about 2006/2007, but I can't be accurate with that, but it was probably around about... possibly 2007/2008 but I can't remember. And the answer was we had the staff that we were going to have, and that was it. That was it. So, consequently, my clinical time, my managerial

time, my training time, my... every part of my working day was intertwined with trying to find staff from anywhere – anywhere at all – which meant we liaised with the community – the community midwives. We liaised with clinic. We liaised with everybody within the service that we could, hopefully, try and continue to run that service.

PROF FORSYTH: And of course, even if you did encourage somebody from clinic or whatever to come in –

MS ROBINSON: It would deplete their staffing.

PROF FORSYTH: They were experienced... A bit more experienced?

MS ROBINSON: Well, yes, but also the staff within those areas are all midwives, so they are all able to do the same abdominal palpation, blood pressures, temperatures, put CTG monitors on – things like that. So they were –

PROF FORSYTH: CTG readings?

MS ROBINSON: Well, it's part of their role of being a midwife. It is part of their role. Now, we have a fresh-eyes approach, so somebody would always check that. And it's different at that time. No, midwives would do the CTGs, interpret them as they were and, if they felt there was a problem, then it would then be escalated to either a senior midwife or a doctor.

PROF FORSYTH: Just moving on to the doctors, the relationship between the midwives and obstetricians, was it a good one?

MS ROBINSON: I've been asked this question so, so many times – so many times. On a working day, you have individuals that are completely at opposite poles. They're poles apart, with any individual in any walk of life. But overall and on the whole, the relationship between obstetricians – be it registrars, be it

consultants – on the whole, within the work environment, there was a professional approach but also there was... We communicated quite well but it depends on the situation.

PROF FORSYTH: Yes. So, if you suddenly needed... a woman, CTG tracing coming off, were you able to be reassured that you could get an obstetrician there quickly, if you needed one?

MS ROBINSON: Yes, yes. Yes, that wasn't a worry. There wasn't somebody on-hand on the labour suite at all times, but I knew, by bleeping somebody, I could get somebody there.

PROF FORSYTH: Yes. So, you would have someone there.

MS ROBINSON: Yes.

PROF FORSYTH: And was the obstetrics service... Obviously, they would have, presumably, doctors, whoever they might be, with variation in quality. Did you find that there was a variation in terms of –

MS ROBINSON: Yes. Yes, without a doubt. There always is – always is. And it's very difficult when you have somebody that you feel... Well, when they first come in, they need to find their feet also, and you build that trust between you, between the team. You build that trust and it would be wrong to say that you made an opinion straightaway. You need to build that trust.

PROF FORSYTH: We'll probably be asking the obstetricians about this anyway but, in terms of locums, did they have a lot of locum doctors who were just there short-term? Were you aware of that?

MS ROBINSON: I can't remember. I really can't remember. No, I can't remember.

PROF FORSYTH: What about the paediatricians? What was the relationship there

with paediatricians? Were they available when you needed them?

MS ROBINSON: Sometimes. Not all the time. It depended, really. They did what they did a grand round in the morning, so they would all get together and then hand over the patients within the children's ward, special care baby unit, any emergencies that they'd had. So, they got together –

PROF FORSYTH: So, they had a grand round every day.

MS ROBINSON: They did.

PROF FORSYTH: The medical staff.

MS ROBINSON: The paediatricians.

PROF FORSYTH: The paediatricians did that.

MS ROBINSON: Yes.

PROF FORSYTH: Sorry.

MS ROBINSON: Yes. I don't ever remember a situation where they were ever involved in any of our rounds. So, the communication, if a consultant made a decision about delivery or if we had a preterm or, depending on whether or not it was an emergency, then, obviously, we would have to emergency-bleep them, but if somebody came through the door and you had the opportunity to inform them what we had, then, really, it went between the two consultants. We informed the special care baby unit but, really, it went through the consultants. Decisions made and whether or not there was capacity on special care, that went through the consultants. Or it appeared to go through the consultants.

PROF FORSYTH: And did you feel that, if you a high-risk mother in labour and there was potentially going to be a problem with the baby, there was sufficient

planning and people were there at the time for delivery, ready? That the right people with the right skills were there to resuscitate, if necessary?

MS ROBINSON: No. No, but again it depends on the situation. Certainly, when we're talking about intubation, if you've got a very junior SHO that has only been in the post for two weeks and that SHO has to resuscitate, sometimes midwives, certainly, were in a better position to do the resuscitation as opposed to the very junior SHOs. And that was simply because they had the experience and it was the best use of that resource.

PROF FORSYTH: So, did you feel that there was not 24/7 cover from a neonate point of view with skilled resuscitation?

MS ROBINSON: No. No, we didn't have a consultant paediatrician on-site at all times. So, the consultant paediatrician would have to be either informed at home or rung at home or his house officer would ring him at home. But no, they weren't on-site.

PROF FORSYTH: So, there'd be often an SHO but there would, presumably, be also a middle-grade doctor or paediatrician?

MS ROBINSON: Yes, but they weren't... we didn't have a middle-grade doctor on-call at all times.

PROF FORSYTH: Not all the time.

MS ROBINSON: No. No, we didn't.

PROF FORSYTH: So, there were times when you'd be having a high-risk lady in labour –

MS ROBINSON: Yes, and you'd have to pre-empt that, if you could.

PROF FORSYTH: And the midwife or the SHO would be the two people initially

trying to resuscitate the baby.

MS ROBINSON: Yes.

PROF FORSYTH: From a neonatal point of view, the unit... My understanding is that that's a Level 1 unit. Did you feel that there women being delivered in Barrow who were going to produce a baby that would require more than just Level 1 care?

MS ROBINSON: It's a really difficult question to answer – a really difficult question to answer. Sometimes, yes. So, it would depend on the problem. It would depend on the problem. And if that had already been identified, she would have been going to a specialist centre, if it had already been identified, and you could plan, but you can't always plan.

PROF FORSYTH: No, I appreciate that, yes. And so, if the baby is delivered, did you have sufficient arrangements for the baby to be transferred out?

MS ROBINSON: It's a difficult question for me to answer that, because all that planning comes from the special care baby unit and the paediatricians. The midwives aren't involved in that at all. So, it is a difficult question for me to answer. I think I would be probably doing them a disservice to answer for them.

PROF FORSYTH: That's okay. I'll maybe just try another question around this. Do you have there's a relationship between the paediatricians and the obstetricians so that, actually, the situations were trying to be reduced as much as possible, or do you think the communication was not –

MS ROBINSON: Again, it's a very difficult one. We fought for a long time to get them to come together for guidelines – just for guidelines. So, it depended on

the individual as to whether or not you would get the response. It was almost like consultant pitted against consultant and who was going to win this one. 'It's my decision – I'm a consultant.' 'Well, actually, no, it's my decision – I'm a consultant.' And in the mean time, there's somebody in the middle that is very, very important and they've lost sight of it.

DR KIRKUP: Were these two consultants both paediatricians or are you talking about a paediatrician and an obstetrician?

MS ROBINSON: Paediatrician and obstetrician. But not the two same individuals. We had more and have more than one consultant paediatrician and more than one consultant obstetrician.

DR KIRKUP: Sure.

MS ROBINSON: They're not all the same. It was just individual.

DR KIRKUP: And was it the obstetricians who were hawks and the paediatricians who were doves, or the other way round?

MS ROBINSON: Both.

DR KIRKUP: Who wanted to keep the babies in Barrow and who wanted to move them?

MS ROBINSON: Both.

DR KIRKUP: It could be either.

MS ROBINSON: Again, depending on the situation, if a baby had to go out, then the baby had to go out, and that was the paediatrician's decision to make. But we're talking now after the baby was born; we're talking a transfer. But, if we had a baby that had been identified with a cardiac problem, or any specific problem, that required surgery, and we didn't have those skills, and if we could

plan for that moment of transferring and delivering those tertiary, then then that's what we did.

DR KIRKUP: Right, just checking the answer to that, so if either one wanted the woman to be transferred would that be the plan?

MS ROBINSON: Well there could have been arguments, there could be an argument.

DR KIRKUP: But was the default that arrangements were made to transfer, unless they could agree that she would stay, or would it depend?

MS ROBINSON: It would depend on the situation. And obviously our aim was for the safe delivery of mother and baby; that was our aim, but ultimately it wasn't our choice. It didn't fall to us.

DR KIRKUP: No, what you're saying is it depends on who's going to prevail in any particular situation.

MS ROBINSON: Yes.

PROF FORSYTH: Sorry, just to finish off, and this is probably not one that you can answer, because I wonder about the fact that there was potentially, how much involvement they had in these discussions. I wonder whether you actually had regular meetings.

MS ROBINSON: I can't answer that question.

PROF FORSYTH: Obviously you weren't there and you weren't in a position to answer that.

MS ROBINSON: I was never involved in meetings between the tertiary centre's consultants, never, no – and I'm not sure what took place, I really don't know.

PROF FORSYTH: Thank you.

DR KIRKUP: Really, just one question before I pass over to Jonathan; you were talking about paediatric grand rounds, and you said that decisions were made, particularly on the grand rounds, by consultants; or at least they appeared to be, I just wondered what you meant by that?

MS ROBINSON: Well, if I rang a paediatrician to say I need somebody, I needed the baby to be seen at that particular time, it was '"Oh well we're on rounds".

DR KIRKUP: Okay. It was a comment about decisions appearing to be made between consultants, I don't know if you remember?

MS ROBINSON: Yes, between the consultant obstetrician and the consultant paediatrician.

DR KIRKUP: I didn't think that was the context of the grand rounds, I was wondering what the particular context of the grand rounds was.

MS ROBINSON: Oh right. Well the grand round, which basically as far as I'm aware, because I never – I didn't ever even attend a grand round.

DR KIRKUP: Yes.

MS ROBINSON: So, as far as I am aware, it took place in a seminar of a paediatric seminar, where they would discuss what they had that day, what they'd had at that night time, what they had in the special care unit, what clinics they had, who would be sent where, and that is my understanding of their grand round in the morning. And if you interrupted them then there were problems.

DR KIRKUP: Okay. Thank you.

PROF MONTGOMERY: I've got a number of things that have come out of the things that you've said, so sorry if it's slightly out of order, but can I start with that, what you've just described, in terms of the tussles between the consultant

paediatricians and the obstetricians? Was that perceived by them, or anybody else in the Trust, as a problem? Was anything done to sort of try and find a way of getting a quick resolution?

MS ROBINSON: It was certainly an issue that had been taken to the head of midwifery on more than one occasion, yes.

PROF MONTGOMERY: And had it gone from the head of midwifery to the medical director or anything like that?

MS ROBINSON: Not that I'm aware of. However, again, I was never involved in any senior leadership meetings, never at all.

PROF MONTGOMERY: And you had no feedback whether there'd been any?

MS ROBINSON: No.

PROF MONTGOMERY: Thank you. Can I ask you a bit more about your meeting with the chief executive; and you described how it started as one thing, and then appeared to be something else, and that was the first time that you met the chief executive; was it the only time you met the chief executive or -?

MS ROBINSON: No, I called for a meeting with the chief executive following the inquest, because we had had no feedback from the team at all, the executive team; and no support, and really I wanted personally, but staff who were involved, and the whole unit really, the whole team, wanted to know how our Board felt about the midwifery team.

PROF MONTGOMERY: And what was the answer? What was the response?

MS ROBINSON: The response was, he came into a room full of very, very concerned people; he took his jacket off, he threw it over the back of a chair, sat on the chair like that, and said, "Right, what do you want?" So, because I

had specifically asked for that meeting, I said, "Well clearly we'd like to know how you and the Board feel about your midwifery team." And his response was, "Well, you've still got a job, haven't you?" and it went downhill from there. He had a lot of very, very emotional and damaged people in there, and we were just totally, totally unsupported.

PROF MONTGOMERY: What date are we talking about, which inquest?

MS ROBINSON: This is the June 2000 and - I can't remember if it was - 2011 it must have been, June 2011.

PROF MONTGOMERY: And did he come on his own?

MS ROBINSON: No, he came with HR; our head of midwifery came, others from HR came as well; and I think they were as surprised as we were, at the response.

PROF MONTGOMERY: And were people able to speak up, apart from yourself, or did you have to go it alone?

MS ROBINSON: No, people did speak up, but as you can imagine, it was extremely emotive; and it was – it was still ongoing and there'd been so much to deal with, with investigations and other issues, and NMC; and it was just – and all the change, the drastic change that came with it as well.

So, it was very emotive, so staff and the team were incredibly upset and a number of staff were crying; a number of staff were openly crying at the same time as trying to vocalise, but when somebody's put that brick wall up as soon as they walk through the door, very soon after a damning report; it has an effect on how you respond. So, we were, at that time, despondent, because we hadn't ever had any response that would support us, other than the team that

we were at that time.

PROF MONTGOMERY: So, who were the most senior people in the Trust who'd been to see you when all those investigations and reports and the preparation questions?

MS ROBINSON: The matrons and certainly our risk manager. The head of midwifery, but it wasn't going to touch them personally, I'm sorry, by then I mean the Board.

PROF MONTGOMERY: Yes.

MS ROBINSON: If I can be extremely frank, it was almost like a damage limitation exercise, simply because we'd had advice from various areas, about taking our own representatives with us. And we truly, truly believed that it was in the interests of the Board to get the best out of the midwives and that - the request; but it quickly became very apparent that we were – it was a damage limitation exercise, and we were led like lambs to the slaughter. And that is because every day, we took questions to our solicitor that needed to be asked to be able to get the true picture, and they were just ignored. They were simply ignored.

DR KIRKUP: Okay, can you give an example of a question that you wanted to be taken up?

MS ROBINSON: Well, the first question was "Are you aware that never ever have the midwives had the opportunity to say they were sorry, never". And we needed the opening to be able to say that. And we asked for that opening for us.

DR KIRKUP: Yes, thank you.

MS ROBINSON: Thank you. We asked for that opportunity; because of the nature

of the job, because of the people we are, because we wanted to be able to; and we'd been silenced, the whole time we'd been silenced by rules and regulations, by the NMC; we've been dignified in our silence. We cannot respond, but we wanted to respond, and we weren't able, and the platform was there for us to be able to say if somebody would give us that opening.

DR KIRKUP: Who was it who was stopping you?

MS ROBINSON: It wasn't that they were stopping us, but what we needed was that opening, but because it was very – a lot of animosity, there was a lot of anger, and there was – we needed that opportunity to be able to say, "We are truly sorry for your loss", and asked to be given that opening; and it never came. It never came. And that's one of the first things that the Coroner said; but we didn't ask for that, and really you can ask me now, you can say, well actually you were up there, you had that opportunity; we didn't, and nobody acknowledged the effect it had. We didn't.

DR KIRKUP: Did you ever have a chance to meet any of the families?

MS ROBINSON: No, no.

DR KIRKUP: Did you ask for the opportunity?

MS ROBINSON: There was too much anger, there was far too much anger and I don't mean on the part of the midwives. We'd seen the way that it had moved along, we'd observed, we'd had hearing after hearing, we'd had breaches of the security, and I met with the members of the family face to face, and it was not a pleasant meeting.

DR KIRKUP: Sure.

MS ROBINSON: And it - I have been asked since, and my honest, honest reply

was that if I felt it could draw a line under everything over the past or six years, then yes, I would do it. It wouldn't be easy but yes, I would do it.

DR KIRKUP: But would it not been easier if that had been done in the first place?

MS ROBINSON: We were never, ever asked that question, never asked, because -.

DR KIRKUP: Well, I'm asking your opinion now.

MS ROBINSON: My opinion was that it was dealt with in a way that we've never known; it was unprecedented, the way that it was dealt with. I've never known a chief executive go to the families' house, because it was always dealt with in the department, and I don't mean it didn't escalate up to the Board members, I mean it was always dealt with the head of midwifery, with supervision, specifically with midwives if that was how it needed to be dealt with.

And from that end, they would be the people who would go out and see, and then the families would visit, would meet with the obstetricians, they were always given that opportunity. But meeting with somebody that's lost a baby can be very – and it often it's the families that don't want to meet us, I don't know if they were given that opportunity, I've no idea. I know we weren't given that opportunity, at the beginning.

DR KIRKUP: Do you have any idea, any inkling why he took such an unprecedented approach in this particular case? You said you've never known that to be done before, why this time?

MS ROBINSON: I don't know. I think what it did was, what that particular case did was it clearly highlighted a number of problems, a number of problems that certainly needed dealing with, but they needed dealing with in the correct way, and obviously the Board felt that they were dealing with it in the correct way;

but from a front line staff point of view, you could see how can they – how can they give detailed information if they don't know where to look for that detailed information?

How can they hold - look at the issues surrounding it and make an opinion from that and report on that, when they never, ever, ever spoke to the staff that were involved in it, ever? One report, they came in on New Year's Eve, they were there for two hours, they left and then said that the information that they were looking for wasn't there.

I could have given them that information; I could have shown them where to access that information on the system. It would have been that simple, and it just escalated beyond that, escalated to something that is - you question how am I here, how has it come to this, and it's the first time I've questioned that.

I absolutely appreciate that there were missed opportunities. I absolutely appreciate that there were, in one particular – the only one that I can comment on, because I was involved in it. But, the missed opportunities from the Trust Board, when they were looking for information and said it didn't exist are numerous. It was there. That information was there, but they never asked us for it.

DR KIRKUP: What was the information? What was it?

MS ROBINSON: Well certainly, for one, just off the top of my head with one, it was information surrounding a baby check that from the first investigation they said didn't occur, but it did occur; it's just that they didn't know where to look for that information. And as a midwife, when you've done your first baby check, we

would put that, that data goes into the system and then it's recorded in the system and it remains on that database, but they didn't know where to look for it, they said it hadn't been done. It had been done. It's just that they didn't know where to look for it. It was in the Evolution system that we use specifically for maternity, for midwifery, it was there; and that is just one example.

And then, of course, finding you know, a fortnight before action plans need to be done, we've never seen reports; and yet the action plan for one incident is due in a fortnight, what has been done about this, this, this and this? Well nothing, I'd never seen the report, let alone the action plan, and yet they've asked for the reports.

PROF FORSYTH: Which report was that?

MS ROBINSON: The Fielding report.

PROF FORSYTH: Sorry?

MS ROBINSON: The Fielding report.

PROF FORSYTH: The Fielding report, yes.

MS ROBINSON: There were two instances where I had to been seen by Charles Glynn, I asked for those reports, never saw those reports. And I specifically asked for them but they never came, they never came. So, when we were asked for the action plans that are due in a fortnight, how can you comment? I'd never seen it, so how can I comment on an action plan. I don't know if it's exists because I've never seen it, and that was a fortnight before. And that's how it is.

DR KIRKUP: Thank you, I'm sorry, I interrupted you.

PROF MONTGOMERY: No, that's fine.

DR KIRKUP: You asked the question I was going to ask.

PROF MONTGOMERY: There are quite a number of points in that, and you've talked about the Board; and one of the things we're trying to understand is who knew about what; so, you've described a meeting with the chief executive that came to – and you've talked quite a lot about the Board, did you have any contact or any dealings with the Board?

MS ROBINSON: No, never. The only time I ever saw a board member was when there was a report about to be published, a report that had been published, or local press, or media, or Inquests, or that's the only time I ever saw a member of the Board.

PROF MONTGOMERY: And which member would you see? Do you remember that?

MS ROBINSON: I can't remember.

PROF MONTGOMERY: That's okay.

MS ROBINSON: I'm sorry, I can't remember.

PROF MONTGOMERY: Do you have any feel for whether the Chair and non-executives had any understanding of what was going on?

MS ROBINSON: They had no understanding. They had no understanding at all; so much so that I had a huge, huge worry after the inquest that as individual, the damage that they had done to the individuals - and they were trying to deliver that safe service whilst at the same time, going through all the changes, I don't think they had any idea at all. And it had kind of rumbled on, although we do have a supportive head of midwifery by this time, we had supportive matrons at that time; and we supported each other. And we were damned for that. We

were, we were said, "Cut one and they all bleed" that was the information that was coming back to us from -.

PROF MONTGOMERY: From the Trust?

MS ROBINSON: Yes.

PROF MONTGOMERY: Right.

MS ROBINSON: Had we not all bled they wouldn't have had a service, because we all did so much for them to enable that service to continue. We did it. We weren't in each other's pockets; we were there for a common goal. We were there because we all wanted to be midwives and we all wanted to do our best, not because you know, we all lived in each other's pockets, and we went out with each other, it wasn't like that, but that's the message that came down.

PROF MONTGOMERY: And who on the Board was responsible for maternity services?

MS ROBINSON: Who on the Board? They were all responsible for maternity services.

PROF MONTGOMERY: There was no particular portfolio, because the head of midwifery reports to the director of nursing, or -?

MS ROBINSON: Well, it did go to the director of nursing; she was the director of nursing and midwifery, yes, yes, it did.

PROF MONTGOMERY: Did you ever see her?

MS ROBINSON: Only when there was a problem, the first – I mean occasionally I saw her but until that time, no, no I didn't see her at all.

PROF MONTGOMERY: And were there any methods of contact with non-executive Chairman and members of the Board, any soft meetings or anything like that at

all?

MS ROBINSON: No.

PROF MONTGOMERY: No, so there was no -?

MS ROBINSON: No.

PROF MONTGOMERY: Thank you.

MS ROBINSON: Not that I can remember.

PROF MONTGOMERY: I think the other things are relatively minor things, just to understand a little bit, and on – you talked about how the training round records have changed since the early time. If I went and looked at records from 2004 onwards and the records today, how would they look different to me, a lay person who doesn't know, apart from the obvious?

MS ROBINSON: Well straight away they would look different, because we would be using the perinatal institute records now, so that again they were brought in very soon after because they had been identified as being the notes to use, but how they – well, I would say there would certainly be double the dialogue in it, and certainly more evidence of patients being involved in the care, down to simple things such as tea taken and showered; but yes, certainly a lot more dialogue. But again, a lot more within those notes as well, we do a lot completely different, completely different, so that would involve CTGs, that would involve the ante-natal records, that would involve the booking, that would – and a lot more now, a lot more.

PROF MONTGOMERY: Is the general feeling between you and your colleagues that that is an improvement, or is it a burden or what?

MS ROBINSON: In many ways it can be a burden, yes, because it removes you

from patient care and you are – we are spending a lot of time in-putting in data. So yes, it can be seen as a burden. And actually patients have commented on it, "You spend more time writing than you do actually speaking to us", so yes, it has been commented on. However, it's finding the balance, a safe balance and I'm not sure there is one.

PROF MONTGOMERY: Thank you, and then a couple of other areas, if I may, one is around just understanding, as an outsider, the staffing issues, you're nine full timers down, I don't quite understand how you decide what the complement ought to be, so down from what, and what counts as a safe standard?

MS ROBINSON: Right, well we used to work, and I'm going back quite a number of years now, but since the 2000s, we used to have five midwives on the delivery suites and four midwives on the ward. That is nine.

PROF MONTGOMERY: I understand that, but how do you know whether five and four are the right numbers?

MS ROBINSON: Well, they'd use both – plus but again that was flawed because the information going into Birth Rate Plus was wrong. How they captured their evidence and even when the results came from Birth Rate Plus, we knew that they were the wrong results, and we said "You must challenge this, because what Birth Rate Plus have showed us is actually we require something like 1.2 whole time equivalents across the Trust", it was flawed, and it was apparent it was flawed.

And clearly, the way they captured that data was flawed. And we asked them to challenge it but there was no challenge. Never once did the midwives sit back and say, "This is our lot, this is what we're getting" because you had to

challenge it, because we knew we weren't delivering what needed to be delivered.

PROF MONTGOMERY: Thank you, and can I ask you about occupancy levels, so you talked about 22 beds, 18 and 4?

MS ROBINSON: That's just purely maternity ward.

PROF MONTGOMERY: Yes, and how full was your sort of range of normal occupancy, how many of those would be full?

MS ROBINSON: It depends on a daily, hourly, two hourly, it depends. Sometimes it would be full to capacity, other times we can be down to four, three patients, it depends; we have our peak times, we have our times when we are quiet, but you cannot plan for the unexpected, you can't plan for the emergencies that come through the door; so to have those ten staffing levels, you must have that base line of staff.

But, in order to do that what you do is work out how many staff are required, when I talk about staff now, I'm purely talking about midwives; how many staff are required overall; how many staff are required on late, how many staff are required on the night, that's seven days a week, 52 weeks a year. When you've worked that out on how many shifts needed to be covered on a daily basis, it worked to that we were nine full time equivalent short on a weekly basis.

PROF MONTGOMERY: That's on the basis of the five and four?

MS ROBINSON: That's on the basis of the five and four and four, yes, that was just on the minimum staffing level; but I have to say that within that there was a training period, where we trained our auxiliary nurses to become Band 3

nurses, and they had a 12 month programme to enable them to undertake different roles within; and without them we couldn't have fulfilled our role at all.

PROF MONTGOMERY: Okay, thank you. I think the only other thing I wanted to ask about was safety concerns other than staffing, so you've described, very clearly, the problems that you raised about staffing and you escalated those, but what were other safety concerns, you know, other concerns, and how did you raise those with people?

MS ROBINSON: There were many issues, many issues, I mean, the night time for midwives, on the whole unit, if you had, if you were full to capacity on the ward, and you removed one midwife, which one of the midwives and one clinical support worker, and then had to remain the on-call midwife, there was always that period of time where you were down on staff and you were concerned for the safety of your staff, as well as the patients and the babies, because you just physically cannot do everything that is required, it's impossible to do. So that's the biggest concern I think, the biggest safety issue.

PROF MONTGOMERY: It was an issue that was raised in the Fielding Report, and indeed raised by the CQC this week, of access to theatre in an emergency; were you concerned about that?

MS ROBINSON: We were concerned about that. There was - when we first moved to Furness General Hospital there was a purpose built theatre, but it has never ever been used, ever, as it wasn't staffed certainly – it just was never used, so in 1984 I think we moved to Furness General, so from 1984 until three years ago, it was still an empty theatre, with all the equipment in there. And we took our routes via the corridor; so out of our main doors to the main corridor, turned

right and then turned left and down into theatre.

Now, we go through the ME which is, and can be, a bigger problem because not only have you got an area where you have to go through in a very quick timeline, depending on the emergency, or the category of section, when they initially did it, the beds didn't fit. So they didn't come to the midwives and say, "Right, okay, what do you need to take through there?" And while they were doing it we said, "The beds will not fit through there", and when it was finished the beds did not fit through there.

But not only that, once they'd done it, it had a key on it, sorry, it didn't have a key on it, it just had a lock on it where we could open it from our side, but it couldn't be opened from the other side. But unfortunately, patients who were a little bit confused were able to get to gain access to their ward. So then they put a lock on it; the lock, the key stays on the main keys that the co-ordinator has.

But if the co-ordinator isn't asked for those keys then it's just the midwife is asked, "Where are those keys kept?" We can say, "The co-ordinator has those keys" because she does, it's common practice, she holds the keys for the controlled drugs, she holds the keys for the unit, she holds the key for that door to go through there, so we all know where that key is. And my understanding is that they asked an individual who had – didn't work on the unit, and covers three hospital sites, and has no idea where the key is kept. So, that's why they came up with -

PROF MONTGOMERY: So, your assessment would be it would be unsafe because people actually need to know to do that?

MS ROBINSON: No. Yes. But of course, you've got complications with that door as well, because never, ever, ever, did we have a complaint about women going to theatre for an emergency caesarean section; they accepted that it's a hospital and if we have to go to theatre, in an emergency situation down the main corridor, in full view of the public, which – at that time they're not naked, they are covered. And then we never had a complaint about that at all, there was never a complaint.

And in many ways it's made it worse because we have to go through a door, and you have to take a direct left, and then you have to go through units where there is equipment, where there are nursing staff, where there are patients, and we have to go through there, and then we have to stop all the people coming along the corridor, and pull a curtain, and wait for that patient to go through. It's ten times worse, it is not better, it's worse.

DR KIRKUP: Thank you, I just want to go back to a couple of areas that you've touched on already. The first one, you've talked a bit about professional relationships between different groups of staff; and you've talked about the relationship between the obstetricians and the paediatricians. You haven't said much about the relationship between the midwives and the obstetricians. Can you expand?

MS ROBINSON: How can I - my understanding, I always questioned, in reports, how they asked by saying that there was a breakdown in communication between the obstetricians and the midwives. I don't know where it came from, because my working day I – occasionally you would have, but you can have, certainly not arguments, but you can certainly have an opinion, you're allowed

to have an opinion; but that doesn't mean that it's right. But you can have a good discussion and debate, and, you know, look at research and, "How have you come to that, and let's discuss it." I don't know where it came from, this breakdown between midwives and obstetricians. It wasn't always great; it never is when you're working in an environment like that.

DR KIRKUP: Sure.

MS ROBINSON: Especially when it's – you're working in a high risk environment in a major – people get - they respond differently to emergencies, and so you expect that, you accept that, but where the total breakdown came – I don't know, because it was never there.

DR KIRKUP: Okay, I am not sure that I have seen allegations there was a total breakdown, but I've certainly seen pretty consistent suggestions that the relationship wasn't as good as it could have been. I accept that there will always be tension in that situation. That's not your experience?

MS ROBINSON: No, and to me the breakdown was between paediatricians and obstetricians, and where it came to obstetricians and midwives, I don't know. I don't know how it got there.

DR KIRKUP: It's certainly a consistent perception reported that midwives, or maybe it was only some midwives, I don't know, seemed reluctant to call for obstetric help. There seemed to be a recurring pattern that, "We'd rather keep it within midwifery and we don't need the help of doctors on this". That doesn't ring any bells with you?

MS ROBINSON: I can honestly say – I can honestly say – that certainly there are midwives who work in different ways and when I say that there is normality and

at the other end there is the one that works extremely well within the emergency situation and then – but you wouldn't always strive for normality if it was going to put somebody at risk. However, how somebody works behind closed doors is very difficult to assess because the only time at that time you would be in that room is if you were called for a specific thing, be it second midwife or they required a drug or they required a monitor or ... so to comment on individual practices is very hard to do.

DR KIRKUP: Sure.

MS ROBINSON: It is very hard to do. There are midwives, and still are midwives, who like to practise normality. There are midwives who like water births. There are midwives who find more – I was going to say enjoyment; it isn't enjoyment – but who find –

DR KIRKUP: Satisfaction?

MS ROBINSON: Satisfaction in different parts of midwifery. That will always be the case.

DR KIRKUP: Okay.

MS ROBINSON: But commenting on individual midwives is very difficult because you are not behind closed doors with them.

DR KIRKUP: Okay, understood, thank you. Can I take you on to incidents and dealing with incidents?

MS ROBINSON: Mm hmm.

DR KIRKUP: You must have been involved with dealing with quite a lot over the years. Can you tell us, do you think that the right things were being reported as incidents?

MS ROBINSON: I think that is all we knew. I don't think we knew any other way of reporting incidents, so looking back now to how I report incidents or anybody reports and deals with incidents, no, it was totally inadequate, totally inadequate.

DR KIRKUP: Yes.

MS ROBINSON: But that's all we knew.

DR KIRKUP: Yes, okay.

MS ROBINSON: We didn't have any other avenue of reporting. We had a risk manager that did 25 hours a week for the whole Trust.

DR KIRKUP: Mm hmm.

MS ROBINSON: Nobody else worked with her or for her. I think after that we got a midwife, a band 6 midwife, that actually did a day with her, but that was for the whole Trust and that's all we knew. It was clearly acceptable to the Trust and the Trust Board and that is all we knew but no, looking back now it certainly wasn't enough.

DR KIRKUP: Okay. Let's have a look at a hypothetical example.

MS ROBINSON: Okay.

DR KIRKUP: I absolutely stress this is hypothetical.

MS ROBINSON: Yes.

DR KIRKUP: And I do not have a particular case in mind but let's suppose we've got somebody who appeared to be having a more complicated pregnancy and labour and then it turned into an intrapartum still birth. The baby's alive going into labour and then dies – I don't need to set the terms for you, I am sorry.

MS ROBINSON: Okay.

DR KIRKUP: How would you expect that to be dealt with? Is that an incident? Is it discussed in a clinical meeting between consultants and midwives? How is it dealt with?

MS ROBINSON: There would be a full, full – it would become a root cause analysis now. It would become that now, but prior to ---

DR KIRKUP: You say that now?

MS ROBINSON: Yes – no, I mean it could have been a root cause analysis then but it would have been looked at, and remember we are going back quite a number of years now but my understanding was that it would be dealt with via supervision, root cause analysis, the head of midwifery and matrons. That is my understanding of how it would be dealt with and depended on the circumstances. It would again depend on how it was dealt with. Now it is completely different, completely different.

DR KIRKUP: But would all of them have been even in those days, even in, say, I don't know, 2007/8 – would they all have been subject to similar scrutiny or would some of them have simply been, "Well, these things happen from time to time. Let's just move on"? I don't want to put words in your mouth but just so that I understand the distinction.

MS ROBINSON: Well, from the medical point of view, from the obstetrician's point of view, I have no idea because I was never involved with any discussions, any meetings and I have no idea, so I can't comment on that. From a paediatrician point of view, well, the paediatricians wouldn't have been involved unless there was going to be some attempted resuscitation, but again it depends on the situation. From a midwifery point of view I would have been cascaded down to

us, yes, but again it would have been the individuals that were involved with it. It would have been then a risk manager, supervisor, matrons and then it would have escalated up.

DR KIRKUP: Was there a regular clinical meeting where things like that were discussed, where cases were presented and discussed and lessons learnt?

MS ROBINSON: There were attempted, but no, it wasn't regular.

DR KIRKUP: What went wrong? They were attempted but it didn't succeed?

MS ROBINSON: I don't know. I don't know what went wrong. I really don't know what went wrong.

DR KIRKUP: Well, were midwives involved in those, the attempt I mean?

MS ROBINSON: Yes, and certainly with the risk meetings midwives were involved. They have always been invited to attend but at that time, again they were held in the working week and, you know, in the afternoon and if you didn't have the staff then you couldn't attend. I think that the staff were just completely burnt out and didn't want to come in their own time, understandably so.

DR KIRKUP: Mm. Did that apply to the medics as well, the paediatricians and obstetricians?

MS ROBINSON: Oh no, no, no. The whole team were invited to attend the IR meetings, yes, yes. So, we would have a consultant obstetrician, midwives, the risk manager, a supervisor and then anybody else that had been invited but they were open meetings for people to attend.

DR KIRKUP: And I can see what you are saying about the midwives being understaffed and therefore finding difficulty in finding the time or the energy to attend. What was the reason for the paediatricians and the obstetricians not

attending?

MS ROBINSON: I don't know. I have no idea. I can't answer that question; I am sorry.

DR KIRKUP: You can't answer that, okay. Some of the cases that have been involved in bringing Morecambe Bay to attention publicly have been pretty high profile.

MS ROBINSON: Very high profile.

DR KIRKUP: Have you been involved in any of those?

MS ROBINSON: I was involved in one, at the end of one.

DR KIRKUP: Can you tell us –

MS ROBINSON: Do you want me to elaborate?

DR KIRKUP: Yes, can you tell us what your...

MS ROBINSON: Okay. I was involved in finding and resuscitating a baby, and that was my only involvement, and because of that I have been drawn into everything, but again I am the ward manager. I feel responsible. I feel responsible for everything that happens on the unit. It is part of me and part of my professionalism and part of the team. Of course, I feel responsible.

DR KIRKUP: Okay.

MS ROBINSON: I have been drawn into it and, you know, it is what it is, but yes, I found the baby and I resuscitated the baby.

DR KIRKUP: Right. How did the process afterwards operate from your point of view?

MS ROBINSON: How did the process afterwards operate?

DR KIRKUP: Yes.

MS ROBINSON: The process afterwards was —

DR KIRKUP: What happened next? Take me through the story.

MS ROBINSON: Okay, the story. Do you want a timeline of events or a timeline of events surrounding that story?

DR KIRKUP: It is your particular involvement and how it was handled that I really want to know.

MS ROBINSON: Okay, and how it was handled?

DR KIRKUP: Yes.

MS ROBINSON: Okay, I resuscitated the baby. The paediatric nurse came. The paediatrician came. The baby was transferred to the Special Care Baby Unit. As is the norm, I took the observation chart over to the Special Care Baby Unit with me because you need a full picture to be able to form an opinion and without that and without that history they couldn't start to make any diagnosis because they needed to – so I took it over there, and from there we were asked to do statements a very short space of time after, but it would be normal to do statements. With any serious untoward incident it would be normal to do a statement, so I did my statement as everybody else did and I sent it to the Head of Midwifery and that was that for – I don't know. I can't remember the timeline. There's been so much I can't remember the timeline.

DR KIRKUP: That's okay. That's okay.

MS ROBINSON: But after that, that's when the Chief Executive came down and wanted to look round the unit and then started to ask me questions about it.

DR KIRKUP: That wasn't the subject of a clinical meeting then?

MS ROBINSON: No.

DR KIRKUP: And was it the subject of a root cause analysis?

MS ROBINSON: No.

DR KIRKUP: Did that surprise you?

MS ROBINSON: The questions he was asking me or the fact that it was out of –

DR KIRKUP: The fact that it wasn't going in the way that it would normally be going as a serious incident?

MS ROBINSON: It was very subtle and it wasn't really until sort of halfway through the discussion that I thought his agenda was different to the one I understood he was coming for, so –

DR KIRKUP: But what did you understand it –

MS ROBINSON: I understood that he was doing a visit to the ward as part of the visits that Members of the Executive Board were doing throughout the Trust, so that was my understanding of it and it soon became very clear when Sid started to ask me the questions and then he got deeper into it that there was another agenda on his part and that's when I asked him if, you know, there was another agenda to his visit and he said, "No", obviously because of the way things were going and the severe issues that we were under, which I wasn't aware of at the time. I didn't know that he'd already been out and met him. I had no idea.

DR KIRKUP: Okay, and is this when you formed the view that this was about damage limitation –

MS ROBINSON: No, the damage limitation view was at the inquest. That's when I thought – and this is a personal opinion, this is from me, this is not from anybody else; this is a personal opinion – I just felt that it was a damage

limitation exercise. I just felt that – I think there had been a call for an inquest for a long, long time and it had been turned down on many occasions.

DR KIRKUP: Yes.

MS ROBINSON: And then all of a sudden we were going to inquest and it was alarming. It was alarming because we'd had that timeline of events prior to that, so that was all the investigations, it was all the reports, it was all the changes, it was the breaches of security, it was the media, it was the television crews. We'd had all of that and now we were going to an inquest and all that time we said had they asked us for the information that was required, we possibly wouldn't have got to where we were.

DR KIRKUP: Mm. Well, why do you think we wouldn't have got to where we are?

MS ROBINSON: Because of the flawed reports, because – I am not saying all the reports were flawed. I am not saying that but some of the information within the reports was incorrect information. Information that was required was there. They just didn't ask the appropriate people for that information and when I say that, you know, it's the previous things that I have told you about.

DR KIRKUP: Yes, yes.

MS ROBINSON: But it's other things as well.

DR KIRKUP: Yes.

MS ROBINSON: It's other things as well and just down to clinical things.

DR KIRKUP: Such as?

MS ROBINSON: Well, it's very difficult to put a point on it. There has just been so much. It's so very, very, very difficult but off the top of my head I can't think now, I'm sorry.

DR KIRKUP: Okay, that's fine. Take your time.

MS ROBINSON: It's just gone ---

DR KIRKUP: There was a lot of clinical information that you thought should have been taken into account?

MS ROBINSON: Yes, there was, there was. I mean, one of the biggest things about babies coming on to the ward to be looked after on the ward was it seemed to happen through the back door.

DR KIRKUP: Mm.

MS ROBINSON: We were never given any training. We didn't have any training and that was a huge concern. Not only did we not have the training, our training, the midwifery training for our skills was purely for a healthy neonate. It's never for a poorly baby; it was for a healthy neonate, so our training for a poorly baby was six weeks in SCBU when you were doing y our initial training, and that, you know, depended on what was in SCBU, it depended on what you learnt, really. So, these babies that came, it was a fait accompli. We said we hadn't had any training, who's made the decision; we look after healthy neonates and you are asking us to do something that we have never done before, and it was a fait accompli. The decision was made and then the babies were coming through, so these babies were babies that normally would have been nursed on SCBUs so these babies were hypothermic babies, they weren't feeding well, babies with low blood glucose, things like that and of course the risk factors had changed dramatically as well with everything, you know, all the changes within midwifery and technology and everything else, so the risk factors were quite high as well and there was no training. There was

no training.

DR KIRKUP: Did you reflect that back to them?

MS ROBINSON: Absolutely. It was reflected back to our matrons, our head of midwifery, the paediatricians and we had a very good nurse on SCBU that actually came and did some training, some one-to-one training with us and that is great but clearly it wasn't what we needed. It wasn't what we needed because we had a baby with hypothermia and because we had a baby with hypothermia, we warmed that baby because we thought we were doing right, and that's it.

DR KIRKUP: Yes. Tell me about the preparation of the inquest.

MS ROBINSON: The preparation for the inquest? Oh, goodness. The preparation for the inquest. We were asked to put our statements into Trust format and so were provided with the statements that we had already made but we still had those anyway because you always keep a copy of a statement that you make.

DR KIRKUP: Yes.

MS ROBINSON: We put our statements into the Trust format and they went off again. Each and every one of us – I think there was only one, possibly two midwives that had ever been to an inquest but because of the high profile case and what had come before that, we were all extremely worried, extremely worried. So, the Trust offered to meet with the solicitor that would be attending with us and of course we said "Yes, please".

DR KIRKUP: That was the Trust's suggestion?

MS ROBINSON: Oh yes, yes.

DR KIRKUP: Okay, and what was the discussion with the solicitor?

MS ROBINSON: The discussion with the solicitor? There were a number of questions that I think had been raised that had gone to – now, I don't know where the questions came from. I have no idea. I don't know if the questions had been raised with the Coroner; I don't know if they were questions that had been raised with our legal team; I don't know if they had been questions that had been raised with – I don't know where the questions came from but there were a list of questions that apparently the family wanted answering. So, we were given the list of questions of the questions, the questions that had been asked by the family –

DR KIRKUP: Sure.

MS ROBINSON: – so that we had some idea of what was going to be asked of us at the inquest because we hadn't attended an inquest before.

DR KIRKUP: Did you have suggested answers to the questions?

MS ROBINSON: No, absolutely not.

DR KIRKUP: It was up to you to think about the questions?

MS ROBINSON: Absolutely.

DR KIRKUP: And how you responded?

MS ROBINSON: Absolutely.

DR KIRKUP: Was there any – this is a phrase I learnt in a different context – any review and alteration in your statements?

MS ROBINSON: No, absolutely not.

DR KIRKUP: They went in as you had written them and they came out as you had written them?

MS ROBINSON: The Trust format?

DR KIRKUP: Yes.

MS ROBINSON: Yes.

DR KIRKUP: I appreciate that they were put into a Trust format.

MS ROBINSON: Yes, absolutely.

DR KIRKUP: There was no change of content –

MS ROBINSON: No, and I signed that statement to say that it was my signed statement, yes.

DR KIRKUP: Okay. You mentioned one of the questions which I think relates to a missing part of the clinical record, and I think that you mentioned it yourself –

MS ROBINSON: I did.

DR KIRKUP: – when talking about taking a baby over to SCBU.

MS ROBINSON: I did.

DR KIRKUP: Is that your view of where that bit of record went missing?

MS ROBINSON: I know that that is where it went missing because I took it there.

DR KIRKUP: Yes. Where did it go to from there? What happened to it?

MS ROBINSON: I don't know because paperwork – I mean, I know SCBU have paperwork copied, photocopied so that that information can go with the baby.

DR KIRKUP: Yes.

MS ROBINSON: We keep the original copy.

DR KIRKUP: Yes.

MS ROBINSON: Where it went after that I have no idea. I wish, I truly, truly wish, that that piece of paper had never gone missing because it would have helped us.

DR KIRKUP: Yes.

MS ROBINSON: It would have helped. It would have perhaps not led to this. It would have only helped us. It wouldn't have damned us. It would have helped us and I wish I knew where that went. I know it took it. It is easy to tell the truth because it never changes, the story never changes and it rolls off the tongue. I took that piece of paper because it is what I would do because they need that full history to be able to care for and diagnose that baby.

DR KIRKUP: I can understand that. You know the conclusion that the Coroner in Newcastle came to about the missing document.

MS ROBINSON: The Coroner in Newcastle?

DR KIRKUP: Yes.

MS ROBINSON: No.

MS ROBINSON: In Newcastle?

DR KIRKUP: Yes. Are we not talking about the same case here?

MS ROBINSON: No, the Coroner in Barrow.

DR KIRKUP: The Coroner in Barrow. I am sorry, it was the one in Newcastle who said there should be an inquest, yes?

MS ROBINSON: No, the one in Newcastle said no, there shouldn't be an inquest. It was the Barrow Coroner.

DR KIRKUP: Okay, it was Barrow. My mistake then.

MS ROBINSON: Yes, I am aware. I am absolutely aware.

DR KIRKUP: You know the conclusion that he came to about –

MS ROBINSON: I do and I know the damage that that has done to individuals including myself.

DR KIRKUP: Yes.

MS ROBINSON: I know because I put my hand on a Bible and swore to tell the truth. It is an absolute insult to me and that team to actually come to that conclusion because I understand, I really understand, the collusion part of it in regard to the meeting, but it didn't happen. The eight, nine, 10, 11 people that say exactly the same thing is because it is the truth. That story has never changed. If you are telling untruths you get subtle differences. There are no subtle differences. It is easy to tell the truth. It rolls off the tongue.

DR KIRKUP: Mm, I appreciate that.

MS ROBINSON: And because of the way the inquest went I truly believe there was a bias with the Coroner and I asked the Trust Board to question that as well because the subsequent police investigation gave me that information that I was astounded, absolutely astounded because it confirms the information that midwives ruled the roost and didn't allow doctors to enter their kingdom and part of that was the question that the police asked me, which was, the Coroner remembers you being interviewed by BBC Radio some years ago and your response to the interview was, 'We don't need doctors here. I never allow doctors on to this area'. That was part of the police investigation. I have never, ever been interviewed by BBC Radio, ever, and had I been interviewed by BBC Radio that is not a statement that I would ever make, and that confirmed to me the bias that has come from that Coroner.

DR KIRKUP: Mm, okay. What is your view of where that missing record went? You clearly had a different view from the Coroner. What is your view?

MS ROBINSON: I truly believe – it could have gone in the bin. It was a piece of paper, a piece of A4 paper on its own. It could have gone in the bin. I don't

know who cleaned up after that baby had gone. I don't know who moved things. I don't know who put the pack together for that baby to go. I have no idea. My role was to put that piece of paper there, to show them where it was and to walk out.

DR KIRKUP: Yes, I understand that. I am not suggesting that –

MS ROBINSON: No, no, no.

DR KIRKUP: I am just getting your view, and I am asking what are your suggestions as to what might have happened.

MS ROBINSON: It could have gone anywhere. It could have been mixed with another baby's notes. It could have been left in the photocopier and destroyed from there. It could have gone, it could have been lost once the baby – I have no idea. I wish with all my heart it could have been found.

DR KIRKUP: I know. Did you have any experience of that happening in previous cases or subsequent cases?

MS ROBINSON: Well, no, because once we left the babies on the Special Care Baby Unit, that was our involvement finished. Unless the paediatricians needed to speak to us surrounding that case, that was our involvement ended.

DR KIRKUP: Yes, okay.

PROF FORSYTH: Just for the record on this particular interview, can you tell us exactly what the information was, just for the record, and from your interpretation of it?

MS ROBINSON: Okay. Previously I have spoken to you about these babies coming on to the ward and we weren't trained to deal with this so I developed a neonatal chart, a neonatal observation chart which had the date, the time, and

I have to think back now because I have not seen them for a long time. There would be the temperature, the rest, tone, colour, feeding pattern and comments, and possibly some more because we didn't have a record. All our records for anything with a baby went on to the feeding chart and the feeding chart then went into their hospital notes.

PROF FORSYTH: I see you've got a separate observation chart?

MS ROBINSON: Yes, and it was yellow, and specifically yellow because it acted as a reminder apart from anything else, when you saw that chart you knew that that baby was on enhanced observations.

PROF FORSYTH: And so it was the temperature, heart rate chart –

MS ROBINSON: Yes.

PROF FORSYTH: And clearly [redacted]

MS ROBINSON: Yes.

PROF FORSYTH: And [redacted] do you remember what it showed?

MS ROBINSON: [redacted]

PROF FORSYTH: That was the observation that really attracted your attention, the foreign –

MS ROBINSON: No, no, no. [redacted]

PROF FORSYTH: [redacted]

MS ROBINSON: Yes, yes. No, [redacted]

PROF FORSYTH: [redacted]

MS ROBINSON: [redacted]

PROF FORSYTH: [redacted]

[redacted]

MS ROBINSON: [redacted]

PROF FORSYTH: [redacted]

MS ROBINSON: [redacted]

DR KIRKUP: Okay?

PROF FORSYTH: Thanks.

PROF MONTGOMERY: Two very quick things. You said that you asked the Trust Board to challenge the Coroner's view.

MS ROBINSON: I did.

PROF MONTGOMERY: Can you just explain how you asked and what response you got?

MS ROBINSON: How did I ask? I think that was through – I think I did that through Jackie Holt. I think it was that way. I can't fully remember but I think it was through Jackie Holt. No, it could even have been Tony [Halsall?] as well. It could have been the night, the evening that I had requested that meeting so it could even have been then. I can't remember.

PROF MONTGOMERY: So, you don't know whether it had ever gone to the Trust Board?

MS ROBINSON: No, no.

PROF MONTGOMERY: And the other question was have you had a copy of the Fielding Report and seen that now? You said that there were various things that you weren't shown.

MS ROBINSON: I got a copy of the Fielding Report at the same time I was asking for the action plan.

PROF MONTGOMERY: Thank you.

MS FEATHERSTONE: Just one last thing. You talked about not being involved in the senior leadership meetings when you were the ward manager. Your role is different now.

MS ROBINSON: It is.

MS FEATHERSTONE: Are you now part of that?

MS ROBINSON: Yes.

MS FEATHERSTONE: That is all I ask, thank you.

PROF FORSYTH: Just so that I get everything up to date today, how are relationships between midwives[?] and the paediatricians today?

MS ROBINSON: (Laughter)

PROF FORSYTH: Any better?

MS ROBINSON: I think there is a bit of a status quo. We've got new paediatricians and they appear to be part of the team and we appear to work well together. Now, that is my perception. You may well get a different response from somebody else, I don't know, but we appear to work well together and I think there will always be a one-upmanship when it comes to the consultant paediatricians and obstetricians.

PROF FORSYTH: I won't pass any comment.

MS ROBINSON: No.

DR KIRKUP: Any final things? (*No*) Is there anything that you would like to say to us that you do not feel that you have explained adequately or want to add?

MS ROBINSON: I am sure that there is an awful, awful lot, an awful lot. I'd like to think that we are at the end of a very, very, very long road. I have no doubts whatsoever that the service is certainly a safer place to be in. I think we had huge, huge problems but I don't think – I think it was an event of so many things that highlighted the issues – for example that midwife that made the phone call, I know she made that phone call. I was there when she made that phone call. Equally, she had started work on the ward. She had come over to labour ward to take over somebody's care. She had gone out to a clinic, to

deliver a clinic, and then back on to the unit to look after patients, and that was in one shift.

DR KIRKUP: Yes.

MS ROBINSON: And how anybody thought that that was acceptable – and we challenged. We did not sit back and accept, we did challenge and we didn't get a response.

DR KIRKUP: You did not get a response. Can I just be absolutely clear what the phone call is that you are referring to?

MS ROBINSON: Oh, sorry, phone call to paediatricians that there is —

DR KIRKUP: I thought that is what you meant.

MS ROBINSON: Yes, sorry. There is an allegation within that but again I told people that I was there; I heard that. Nobody ever asked me. Nobody asked me. Nobody asked me about the statement surrounding that. Nobody asked me.

DR KIRKUP: And what was your impression of what the response was from the paediatrician?

MS ROBINSON: To me it would have been at that time a normal response. If they were busy doing something else, passed the information along, you did what they asked you and you actually documented what they had said to you.

DR KIRKUP: Okay.

MS ROBINSON: Sometimes you didn't document it.

DR KIRKUP: Okay. Anything else?

MS ROBINSON: I am sure that there's an awful lot, an awful lot, but I mean –

DR KIRKUP: Yes, I understand that and thank you for your patience. I do

appreciate it. If there is anything else that you think that you would like to tell us, please get in touch with the secretariat and we can arrange a way to do it. We could either talk to you on the phone or you could let us have something in writing. Just if there is anything else that you think, "Ah. Why didn't I tell them that" –

MS ROBINSON: I'm sure there'll be an awful lot.

DR KIRKUP: Please do feel free.

MS ROBINSON: I am sure there will be an awful lot. Thank you.

DR KIRKUP: Okay, thank you very much.

MS ROBINSON: Thank you.

(Interview concluded)

THE MORECAMBE BAY INVESTIGATION

Tuesday, 2 December 2014

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

Before:

Mr Julian Brookes - Expert advisor on Governance (In the Chair)
Dr Geraldine Walters – Expert advisor on Nursing
Professor Stewart Forsyth - Expert advisor on Paediatrics

LESLEY RYAN

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Telephone 020 7269 0370

(At 14.14)

MR BROOKES: Make yourself comfortable, there's some water there if you need it –

MS RYAN: I've got some as well. I've got a bit of a sore throat so I apologise. I've been in clinic all morning; by the end of it, my voice was beginning to go. I'm normally quite as deep as this – it's rather nice actually! – so I apologise.

MR BROOKES: That's okay, and it's a bit 'echo-y' in here. If you can't hear us –

MS RYAN: It is – I could always sing it to you. That would work!

MR BROOKES: It wouldn't be if we sung it back though! I'm Julian Brookes, I'm a panel member who's standing in as Chair for Bill today, who unfortunately can't be here. My background is, I'm currently Deputy Chief Operating Officer for Public Health England, and was previously Head of Clinical Quality at Department of Health.

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

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

MR BROOKES: I just want to go through some housekeeping arrangements first and foremost. You'll see that we're 'mic'd' up. That isn't to help us with our voices; it's more to do with the fact that families are invited to sessions. There is nobody here today; however, they have an opportunity at a later stage to listen to the transcript if they so wish. Also, it's an opportunity for us to make sure that we've got a full and accurate record of the proceedings. On the same note, we've asked you to hand in any mobile phones or anything that. That's purely on the basis so there's no opportunity to record anything. Because we are very conscious that any evidence given is taken in context, and looked at in the totality of the evidence we adduce, so it doesn't get used out of context. There's an opportunity in these sessions to have a part one and part two, where if there's anything of a clinical nature or we need to discuss confidentially, we will do that in part two. I believe that will be the case in this interview. I will indicate when we move to that session. So, we keep this to a non-confidential discussion to start with. That's the element which is open to the families. We'll then move into a closed session, which won't be available. Is that clear?

MS RYAN: That's fine, yes.

MR BROOKES: I'm just going to start with a couple of general questions and then I'll move to my colleagues. So, I'm just interested in terms of your time at Morecambe Bay, and if you could just say when you started, the roles you've done and what you're currently doing, that would be really helpful?

MS RYAN: Okay, well I've been nursing 41 years, and Morecambe Bay for 30 of that 41 years. I moved from Scotland down here, and initially started in Morecambe Bay in the coronary care unit, and then something happened to one of the Sisters in the paediatrics and I moved to paediatrics. I worked as a Sister in paediatrics for quite some time. Then we moved to a purpose-built Portakabin and the RLI from an external area – the hospital we were in was Beaumont so it was one of these satellite-type hospitals, where they had paeds and ENT and things. The purpose-built unit housed us as a medical ward. But there was problems in the surgical ward, so they transferred me to the surgical ward to sort that one out, and I worked there for quite some time, until we then moved over to the Centenary Building, where the existing paediatrics now stands. At that time, I was only working at RLI.

MR BROOKES: So where do you work now?

MS RYAN: No, I worked cross-Bay as my role as my paediatric nurse practitioner, which I reverted to, but when I was Matron, I was paediatric nurse practitioner and Matron, combined, but initially before that, was a paediatric nurse practitioner.

MR BROOKES: So when you were Matron were you cross-Bay?

MS RYAN: I was cross-Bay.

MR BROOKES: So you spent some of your time at Barrow and some of your time –

MS RYAN: Yes, I usually spent two days a week at Barrow; one day a week as a NP, and two days at RLI. But that was a very moveable feast ~~face~~, may I say, and often as an NP, I was still the Matron. You couldn't delineate where one started and one stopped I'm afraid.

MR BROOKES: So just for understanding, when did you start that role and work through – so how long had you been working part-time at Barrow? Or part of your role that included Barrow?

MS RYAN: I was a paediatric nurse practitioner across Bay before I took the combined role, and that – I can't even think what year – so about 14 years in

total as a cross-Bay paediatric nurse practitioner, which I still am, and then lifted the Matron combined role, about six years ago.

MR BROOKES: So doing my maths here: 2008-ish, you became Matron?

MS RYAN: Do you know, I was actually trying to think about that this morning. I actually can't remember, but yes, I'm sure it was, when my colleague retired.

MR BROOKES: Okay, so 2008 you –

MS RYAN: It was a period of eight months when the two Matrons – one retired and the other one retired, there was a period of about eight months when there wasn't anyone in the role, so we were picking it up.

MR BROOKES: So 2008, paediatric cross-Bay?

MS RYAN: Cross-Bay.

MR BROOKES: Potentially two days at Barrow?

MS RYAN: Potentially. It was a very moveable feast.

MR BROOKES: And you finished that Matron role in?

MS RYAN: After I'd had a bilateral knee replacement in 2013, I was off for three months, back for two weeks; off for three months, and when I came back, I dropped the Matron role, and became back to nurse practitioner.

MR BROOKES: Excellent, okay, I think I've got that.

MS RYAN: It's complicated.

PROF FORSYTH: Thanks. First of all, in your nurse practitioner role, what do you do?

MS RYAN: Specifically I have a cardiac bent and an allergy bent. So I do allergy clinics and cardiac murmur clinics on my own. I act autonomously on both of those. So I do everything that yourself would do, and all the bits the nurses would do too. I do a one-stop allergy clinic where I take the history, do everything else, do the investigations if necessary – skin prick tests, whatever – give them the diagnosis, treatment and prescribe. So I do all of that.

PROF FORSYTH: So whereabouts do you do these clinics?

MS RYAN: In paediatric outpatients at both Barrow and Lancaster. I always have done, plus when I was nurse practitioner prior to going off, I would work on the assessment unit, often, as well, on both sites.

PROF FORSYTH: In terms of your Matron role, previously, what did you understand did that include?

MS RYAN: That included the paediatric units. I was Matron for paediatrics across the Bay, but we did dovetail a little bit with Neonatal ~~A&E~~. So Angie and Kathy were originally in the Matron role, obviously when Angie went off, I was covering or if there were problems.

PROF FORSYTH: So when were you covering the neonatal units? What years?

MS RYAN: That was 2012, towards the end.

PROF FORSYTH: 2012?

MS RYAN: Yes, but in between, we would cover each other, if one was on holiday. So there was a lot of dovetailing.

PROF FORSYTH: So were you covering the neonatal or the special baby unit in Barrow?

MS RYAN: Yes, and sorting out staffing and everything else –

PROF FORSYTH: At that time.

MS RYAN: Some of it, yes.

PROF FORSYTH: And so what is your – in terms of your involvement in some of the changes that have taken place around the paediatrics and neonatal services? Let's start with Barrow?

MS RYAN: The neonatal services, the special care unit, that's now moved from its original place to the new place. I wasn't directly involved. I was on the periphery originally because I then went off to have my knee replacements done, so all the moving and everything else was done actually after I'd gone off. But obviously I was involved in some of the discussions in the lead up, and I was heavily involved in sorting staffing and things out – or not, as the case may be. I was also involved in paediatrics – paediatrics across the Bay hasn't actually changed in its entirety, apart from the staffing situation, which I don't think has got much better, personally, at the present minute, than it had when I was in place.

PROF FORSYTH: Okay, we'll come to that in a moment. In terms of the changes that were taking place in Barrow around special care, and the policy of babies being put out onto the post-natal wards and –

MS RYAN: That was beginning to happen as I was there –

PROF FORSYTH: What was the thinking behind that?

MS RYAN: The thinking behind it was a lot of the babies going into special care at the time, they were very well growing, full-term babies going into that unit,

that really did not need to be in special care. They were often many, many days, weeks, when there was no babies in there at all; and they certainly weren't high dependency. Those that were in were feeding and growing, on the whole, a lot of the time. There were times in paediatrics at Barrow that there would be two patients, six patients, as opposed to Lancaster, who had 22, 28. There is a huge difference and there certainly was a difference in – a perceived difference as well as physical. The workload was very different. Obviously the staffing, of the medical staff was hugely different and that was a massive problem at the Barrow end of the patch, because it was consultant-led, and fewer – well, no middle grades, and fewer SHOs.

PROF FORSYTH: Yes, and just in relation to – just to finish off about the changes in the special care. How were you going to be assured that, yes, babies who may look healthy but they were then going to looked after by midwives who maybe have less experience of identifying signs of a baby becoming unwell?

MS RYAN: I think one of the important things that we did discuss that we train the midwives to know the red flags and anything else that was important: was the weight within the parameters, was the TSB within the parameters, was the temperature, all of it – respiratory rate, particularly. A lot of things that had been possibly a little bit woolly in the past, these things that they were trying to make sure that the midwives had the – because that was one of the huge concerns the midwives had, that they did not feel experienced enough to look after the little babies, and that was one of their concerns.

PROF FORSYTH: Do you think that became a risk-free change? Do you think –

MS RYAN: No, I don't think it was a risk-free change: I think the whole thing wasn't risk-free. But we did – and certainly that was in place when I was there – we were trying to put in as many governance covers in place, so that every eventuality was covered, but to be fair, you can't always cover for everything, but we did try. We were going through horrendous staffing issues, which was another problem with the special care because we really did not have the staff. We were moving staff up and down the patch from Lancaster to Barrow and vice versa. It was awful.

PROF FORSYTH: Do you think that the current arrangements that you have now in relation to post-natal care are satisfactory?

MS RYAN: ~~There doesn't seem to be any~~ – I have to say, if I was being totally truthfully honest, I'm not as involved as I was back then.

PROF FORSYTH: So you do not have the same responsibilities –

MS RYAN: I do not have any responsibility whatsoever. I do keep my ears open and I am talking to staff, but I'm not actually involved either in governance or quality or any of those things that I would normally have done as Matron, even senior nurse. I have been very much side-lined, to doing what I do and that's it.

PROF FORSYTH: Hypothetically if you were still in charge, do you feel that –

MS RYAN: I still think there are some issues –

PROF FORSYTH: There still are issues?

MS RYAN: Around staffing particularly. I think we are addressing a lot of the issues regarding governance and any risk; they're far, far better at looking at and accepting that there are risks that they need to attend to.

PROF FORSYTH: These risks around staffing, is it numbers or actually –

MS RYAN: It's mostly numbers. My concern – what I am saying now is a lot of juniors are coming in and we're losing a lot of senior staff.

PROF FORSYTH: Is that – are we talking nursing here or –

MS RYAN: Nursing. Medics have changed as well, obviously.

PROF FORSYTH: In terms of nursing, you think that there's still issues of recruitment is there?

MS RYAN: There is, yes. They are trying very hard and they are getting staff in, and it is supposedly improving. But when I was off, I had visits from the interim people who were saying, 'We've got money for this number of people now' – I was off nearly eight months, albeit I was back two weeks in the middle, and I was told it was going to improve way back at the beginning of my time off, and I never saw it. In fact, I would say, it's only beginning to come to terms now, and that's a year and more – more than a year and a half since I had my knees done. So I found that a tad worrying; I would be a liar if I didn't.

PROF FORSYTH: You think therefore there's still significant risk?

MS RYAN: I think there is some risk; I don't think it's as significant as it was when I was in post, which was horrendous. I think it is still a risk, and there are situations where they're continually asking for staff to cover, and we're still

moving people up and down the patch, which I never think is a good idea. It's unsettling.

PROF FORSYTH: In terms of medical staff –

MS RYAN: There's been a lot of changes there.

PROF FORSYTH: There have been changes there?

MS RYAN: Yes.

PROF FORSYTH: What were the issues, if you were going back a few years, in terms of medical paediatric staffing?

MS RYAN: The cover at Barrow has always been poor-ish, in that they don't have the same middle grade – there's no middle grade cover at Barrow – very rare; it seemed to disappear and it never really got replaced, even though it was asked for, to be fair. There was always originally only four consultants, four paediatricians, and now they've got 10. But there isn't 10 in post; there are 10 in numbers, but there aren't 10 working in a given time, and there's been a lot of to-ing and fro-ing of staff, and there's a lot of locums in place; actually at both ends of the patch at the minute there's a load of locums in place.

PROF FORSYTH: Really? And do you get – what about the quality of the locums you get?

MS RYAN: Variable. I think that's the same everywhere you work: one or two are absolutely excellent, and one or two of them have stayed. And others have come and gone fairly quickly because they're not up to the mark. It is hard to recruit to Barrow, because of its distance, because of its geographical location, is right out on a limb. And people don't seem to like that commute.

PROF FORSYTH: Do you have an integrated child health service across the Trust?

MS RYAN: I'd like to say we had, but I don't think it's integrated enough, no. Some of us work cross-Bay, nurses – senior nurses always worked cross-Bay – that is not the same for the medics.

PROF FORSYTH: Do you have responsibility for community paediatrics?

MS RYAN: I had a community nurse who I line-managed at Barrow, who worked full-time, along with one other who worked one day. So they shared the load. That community nurse was actually within the paediatric unit, and still is, but I understand has been moved out to be with the rest of the community team in Kendal. We did – [Lynn Shannon?] put a bid in, a long, long time ago, for a

community team across Bay, and it went to Carlisle and Penrith, who got the Diana Nurses, and all the money went up there and we didn't. So all we got was the one full timer, and we had two paediatric community nurses at Lancaster, who were not part of our team, but were actually out on the community who concentrate now very much on looked-after children and chronic illness.

PROF FORSYTH: And what about paediatricians who are involved in some of the community child health –

MS RYAN: We have generic paediatricians who work both community and – our community paediatrics at Lancaster tend to work Kendal and all around our area: Morecambe and Lancaster. The community paediatricians up at the Barrow end was one of the paediatricians did community and then they had one or two in the child health department who worked community only. We tried very much, in the last two years particularly, we tried to integrate everybody and tried to get regular meetings with the community paediatricians and the rest of us, so that we all sang from the same hymn sheet, because we felt it was essential that we did. We were making in-roads there, but that all went by the by when one or two of them went off.

PROF FORSYTH: So all the paediatricians, and those who spend some time in the community and those who spend time in hospital – they're all on the night time rota are they?

MS RYAN: They were; you'll now find that that's not the case. They don't take hot weeks and they don't –

PROF FORSYTH: The community paediatricians don't do hot weeks?

MS RYAN: No.

PROF FORSYTH: So how do they therefore maintain their skills to be on-call at night? Are they on-call at night and weekends are they?

MS RYAN: Rarely.

PROF FORSYTH: Rarely?

MS RYAN: Rarely.

PROF FORSYTH: So how many paediatricians participate in the on-call rota if we're looking –

MS RYAN: At Lancaster, [Jo Fedee ~~Feddy~~?] does community and does general, and she takes part in the rota. Dr Cade ~~Kate~~, who is retiring as of January, he is

going to be a community paediatrician but he did community and on-call and hot weeks. So those two did. Dr Service and Dr Eaton tend to focus on community and do some clinics; they don't work in acute, and their reasoning for that is that they felt they had been on the periphery for so long they weren't skilled to undertake care duties.

PROF FORSYTH: Are we talking about Barrow?

MS RYAN: No, that's Lancaster.

PROF FORSYTH: That's Lancaster.

MS RYAN: Barrow – I'm not aware of any of the paediatricians in the community, which is a bit strange, but there is not that same input up at the other end, at the Barrow end of the patch –

PROF FORSYTH: Sorry, there is or isn't...?

MS RYAN: There isn't. Because of the rota system at Barrow, all the consultants on that rota have to cover – so community issues are a bit of a problem there.

PROF FORSYTH: Right.

MS RYAN: Dr Asghar and I think Dr Ghanim to a certain extent a few years back, [redacted] would have covered some of the community.

PROF FORSYTH: And how about the relationships between the paediatric staff and, for example, midwives and obstetrics? Just thinking around maternity and neonatal services?

MS RYAN: We tried to be as integrated as we can, or could. Speaking for myself, I had quite a good relationship with the maternity services and we certainly had, towards the latter years, we had meetings where all staff – where obstetricians and paediatricians, midwives, paediatric nurses if they could be spared – were at regular meetings, where the division would discuss things and they tried to integrate as far as that went. There was a good rapport, I would've said, between the special care and paediatrics in Barrow, and neonatal unit and Lancaster, and RLI – what we did was rotate the paediatric nurses through special care and neonatal unit, so that they got experience, so that if any one of them were called, they at least could go into the unit and know what they were doing. It wasn't fully reciprocated because of the staffing, but they were very good and they worked very closely.

PROF FORSYTH: But in terms of paediatric staff across Lancaster versus Barrow.

MS RYAN: It sounds like that, but it isn't like that, and we did have a lot of staff – oddly enough, we have a huge number of staff who live in Barrow and work in Lancaster, and several staff who live in Lancaster and Morecambe and work in Barrow, which never makes sense really, but obviously they were the ones we would go to first to transfer if necessary. There is a much better rapport, and I really worked hard at trying to integrate, and we tried to rotate staff into both units. In fact, three of the staff up in Barrow at the minute, one of the Sisters, has just moved from Lancaster to Barrow and is now working up there. So there is integration; it was done a bit more subtly, but it was often done under duress, which was harder. But we were trying to work together. Certainly the senior staff, at Sister, Ward Manager level, would've worked together.

PROF FORSYTH: Do you have any formal liaison in the north of Cumbria?

MS RYAN: To a certain degree, in some of the things like – a lot of the CQUINs that have been coming out – and when I went back after being off, I went off to do the respiratory CQUIN and we hugely developed links with the north of Cumbria, and in actual fact, I was part of a Matron's group in the northwest who was – inaugurally we set it up, and all the matrons in the northwest would meet regularly and were a great help and acted as a great help to each other.

PROF FORSYTH: Did you have any sub-specialties where a paediatrician is seeing children from the north and the south in Cumbria?

MS RYAN: That would be really nice to think there is. Obviously both Barrow and Lancaster see patients from Kendal which is south Cumbria, but they don't from the north-north – so Carlisle and Penrith –

PROF FORSYTH: It's a completely different world?

MS RYAN: It can be and they do come at things from a different way, but I actually have some patients who come from Penrith, which is odd for allergy, and there are one or two patients who actually come from the other end, the Blackpool squad. So it's a huge catchment area.

PROF FORSYTH: When you get down to the sub-specialities, having someone covering with that sort of expertise, especially the relatively small speciality of children requiring that care –

MS RYAN: We are part of the – we are a Tier 2(B) allergy service, so we work very hand and glove with Manchester and Alder Hey, and we are part of that team. We are one of five DGHs that feeds into the Allergy Northwest Group, and that's made huge in-roads, and that works – although the patients are not seen at Barrow, the Barrow come to Lancaster to be seen – it's a distance thing. But we have cardiologists coming from Alder Hey – originally it was Manchester and Alder Hey, now it's Alder Hey –

PROF FORSYTH: Does the cardiologist see children from the whole of Cumbria?

MS RYAN: They don't see the whole of Cumbria, because I find that Cumbria and Penrith tend to use Newcastle, as a catchment. So there is a discrepancy there. CF is always from that – cystic fibrosis – Prof David used to come up but now somebody else comes up.

PROF FORSYTH: And they see children from the whole of Cumbria?

MS RYAN: They see one or two from ~~form~~ outwith but again, Newcastle is the place that they tend to be. There is a sort of line, and it is an odd line, that is drawn in the sand. Barrow is very much on its limb, I'm afraid.

MR BROOKES: Sorry, that line is drawn on the –

MS RYAN: Well, it's historical because Carlisle and Penrith and Eden – but the borders blur as they do – they blur a tad. But you do get patients coming from an odd place. We've got two patients from Morecambe that actually travel to Newcastle. It's preference, and if the parents make that – so it can happen, but we don't routinely see patients coming in from other areas. But there are a few, but it's not fully integrated.

PROF FORSYTH: Okay, I will stop there just now.

DR WALTERS: Hi Lesley –

MS RYAN: Hi.

DR WALTERS: So when you said that the staffing levels were horrendous, just put that into terms of numbers of staff on a shift and the numbers of babies they might be looking after?

MS RYAN: In special care in Barrow, for example, at times, we had one member of staff who wasn't – we always had one level 3 – there was always one who was a higher level nurse than the other, but at times, we'd have a paediatric nurse and that would be it. There may be no babies but we still had to cover it, and we still have to man it, if there is a 28-weeker turns up, or less, for

example, that we were then able to deal with that baby properly. That was why there was huge, huge problems. I mean, I've even covered Barrow special care after doing a full-day shift; I stayed on and did a few hours just for safety's sake, so the cover was there. You could say that wasn't safe; I have done a midwifery and I have done neonates, but that was a long time ago. We found it very hard, even though we grew our own neonatal nurses, it was much more – this is going to sound very much Lancaster against Barrow and it isn't. But there is an ethos when you go through Dalton, hit that curtain, and there's a different ethos at the Barrow end, and it's taken us a long, long time for it to be an 'us', but you'll still find all three hospitals in the UHMBT work in three different ways. I've worked across all three, because I worked in Kendal as well, and they all have a different way of managing things. It took us a long time to get the idea in that you really needed to train. We would find, for example, Staff Nurses who had been in special care unit, who had been there for 8, 9, 10 years, would not take responsibility at all.

DR WALTERS: So you might just have one nurse, and a baby coming in, and if a second baby came in, you'd really only have one person –

MS RYAN: We wouldn't through choice –

DR WALTERS: But that was all that was available, yes.

MS RYAN: So then we'd have to steal them from another unit, from a children's ward, and obviously when the unit was quiet and/or no babies, there was huge problems if we tried to move the staff out to help elsewhere. There were several occasions where the staff were made to work on adult wards –

DR WALTERS: If the unit was closed?

MS RYAN: Which was outwith their area of expertise, though they could have worked as an auxiliary and they could still make a bed, but it didn't go down well and it caused huge, huge problems.

DR WALTERS: And the geography was too far to say to somebody to come over from another unit?

MS RYAN: We would do it, we would often move people up, but then you were – we were in a financial bind and if I was moving staff from Lancaster to Barrow or vice versa and they had no transport, I would have to move them, whichever way was (a) quickest and (b) cheapest. They might not pay for the taxi to get them from point A to point B. I never, ever – I personally never quibbled, and

I would argue that one with the senior management, but this was not an option. If you wanted the cover, we need the safety, therefore, a staff member comes by taxi and goes back by taxi. But we would find there would be a discrepancy by that, because one person would do it and somebody else wouldn't, and then they had to – they had to have the time within the 12-hour shift, which was not good if we had no cover either. So there were a few inherent problems, as you can understand. But we did try and we always tried to cover safely. We would never have left – but there were occasions in special care that there were two paediatric nurses one without a doubt.

DR WALTERS: So the worst-case scenario would be that a paediatric nurse would come in. It wouldn't be that you'd have one neonatal nurse looking after two or three babies?

MS RYAN: If there were two well babies, you would possibly, but you would get help – what would happen is we'd take the auxiliary from the children's ward if there was a auxiliary on, we would move that to the paediatric ward, and take a Staff Nurse off them. But then if the ward was busy and there were poorly kids in there, it was equally a problem – because there was only ever two staff on at Barrow on a paediatric unit at night, which is woefully inadequate.

DR WALTERS: Then you get to problems covering breaks –

MS RYAN: Well, breaks were a thing of the past. That was a huge problem. So much so that special care had a beautiful sitting area and a kitchen and everything, and they would not have their breaks off the unit. But technically, they should have.

DR WALTERS: So what sort of issues were there, then, with keeping these people up to date?

MS RYAN: Well, we tried our best and we introduced what we call a Panda Day – that was paediatrics and neonatal development day. We would try and put things into those days, at least once a year – it's all the mandatory training, but not the mandatory training as in manual handling, and all that kind of thing. It was BLS, PLS, all those – and anything that had changed in the system and any other things that impinged on both paeds and neonates and that was done with a combined staff. It worked very well, but it went right out the window in that year I was off, partly because nurse educators were the ones doing the matron roles, which is exceedingly sad, because that was an

excellent thing we had in place and it was a governance issue because it was safety – teaching the staff, make sure they were up to date with everything, but it went a bit awry.

DR WALTERS: Did you ever do anything like send them to other units?

MS RYAN: Yes we did; we used to send them to Preston to train on the [405?]. Unfortunately they changed the rules a tad in that year, particularly the year I went off; the rules altered as to what they could and couldn't do, and who they would take, and it became problematic, but yes, we still sent them. We always had one or two neonatal nurses doing their training elsewhere. We even thought of sending them down to Manchester and Alder Hey, whatever.

DR WALTERS: So what was the total neonatal trained staff, then?

MS RYAN: Where particular?

DR WALTERS: In Barrow?

MS RYAN: Now you're asking... it depends when you're asking about. If you go back a few years, when we first took over, there were certainly about six or seven fully neonatal trained staff, with others who had been there – so I would say probably 8-10 who had been there for a long time and were very, very experienced.

MR BROOKES: Sorry, when was that?

MS RYAN: I'm going back when I first started.

MR BROOKES: 2000?

MS RYAN: Probably from sort of 2000, then there was sort of normal drop offs and then the Sister retired and one thing and another, so the number of level 1 neonatal nurses dropped drastically, and then somebody went off on long-term sick, and then somebody else retired. There was a lot of sickness, a huge amount of sickness in the three or four years before.

DR WALTERS: And you just couldn't recruit people to fill the spaces?

MS RYAN: We tried but we equally weren't allowed to, to a degree, because of money.

MR BROOKES: So did your establishment formally change?

MS RYAN: The establishment changed several times over – to put things in perspective, we had three chief execs, three different senior nurses. We, paediatrics and neonates – and maternity – became part of four or five different divisions over a 10-year period. It was a nightmare. Paediatrics

was always a Cinderella service where, if we said anything, 'Oh, well it's just paediatrics bleating as usual'. That was a standard comment. If my head is dented it's because I hit it against a brick wall continually, and we were continually pointing out that this wasn't safe, that the levels weren't safe. But my role came about because they took the two matrons who were cross-Bay, two and a half days each end, and they amalgamated to make one Matron – i.e. me, combined with the nurse practitioner – and that was cost cutting. They were saving 46-grand at the time. They cost cut wherever they could; they dropped the establishment to bare-minimum wherever they could. But my boss was made to do that. If there was ever cost-cutting to be looked at, it was the staffing; it went off the staffing, to the end result, we ended up in a real mess.

MR BROOKES: So you said 8-10 around 2000. What was the lowest level it got to?

MS RYAN: Of neonatal?

MR BROOKES: Yes.

MS RYAN: In Barrow?

MR BROOKES: Yes.

MS RYAN: At one point I think we were down to four who were actually physically working; one was off long-term sick. I have to say, guys, this is off the top of my head.

MR BROOKES: It's just giving an indication.

MS RYAN: But roughly it certainly was low numbers. We didn't have –

PROF FORSYTH: They would be neonatal trained nurses?

MS RYAN: They would be neonatal trained nurses. There were few.

DR WALTERS: So if somebody was in the unit, there were no babies in the unit, did they go and look around maternity?

MS RYAN: We would suggest that they did and they would link to maternity. We have a nurse practitioner – a neonatal nurse practitioner – who worked. She used to go around and work on maternity if there were no babies, and the others we would send to paediatric and/or wherever they were needed. They didn't go out of the unit to adult wards very often, I have to say, because that was nipped in the buds, but they did go to paediatrics, as would paediatrics if they were quiet, they would go and assist on neonatal unit. The other thing that I didn't make clear and I should've, is that if I felt at any time, the

neonatal, special care unit in Barrow was under-cover, I would ask the paediatricians to base themselves there, especially overnight if there was a situation where it really was not up to the mark. We would ask the paediatricians to centre themselves in that unit.

DR WALTERS: And did they?

MS RYAN: Some of them, yes, on the whole, when asked. And I would always ask their opinion and I would always be informing them in advance that, 'This is the situation, this is what we're trying to do, we're trying to get staff in but in the event that we can't, and we can't move anyone up the patch, can you be...?' and then we would put another paediatrician on-call.

DR WALTERS: So how often did situations like that arise?

MS RYAN: A lot in that last 2012. It happened a lot. It felt sometimes as if all I was doing was fire-fighting staffing, especially with special care, which is why I put it on the risk register. It was a huge thing on the risk register, and Angie Whitaker and I would spend – she was a neonatal Matron – would spend time trying to do risk management packages for any eventuality: if the unit had to shut, this is what would happen; if the unit was down to one, this is what would happen.

DR WALTERS: And the concern in the Trust – we've picked up a lot of concern in the Trust about paediatrician staffing. Did that encompass this?

MS RYAN: It didn't help the situation. We only had, initially, the four consultants, and then that increased to six, and then that increased to eight. And then, as I say, there are officially 10 rota'd, but there's not 10 working, because one's on maternity leave and two were on gardening leave for quite some time after a long period of that concern. So it was very difficult. While we would ask, sometimes, for a paediatrician to go up to the other end of the patch, it wasn't always possible. I've been asked not so long ago to go and cover for paediatricians when they're off; I thought that's quite amusing, in a way. It isn't, but yes; I was asked to go and cover one night and one weekend. I didn't.

DR WALTERS: Were the staff there to be recruited or were they not there at any price?

MS RYAN: No, there wasn't a lot of staff to be recruited. It's the same problem happening up and down the country; in medical staffing and in nursing

staffing, and there certainly weren't middle grades, but you know that yourself. The number of middle grades available is dwindling hugely.

DR WALTERS: So was the lack of neonatal nurses, was that failure to recruit or was that not enough money in the budget to recruit them.

MS RYAN: I would've said not enough money in the budget, with a little bit of failure to recruit. Because we did try: when we tried to recruit to the Ward Manager role, we got one person who actually probably wasn't suitable per se. So we didn't get a huge influx – but by that time, there was a lot being said about UHMBT in the media and press, and you can understand people not wishing to come to a unit where, understandably, there are concerns.

DR WALTERS: But before that were you not getting enough neonatal nursing staff because you were advertising, they weren't there, or were you not able to advertise because you didn't have enough money?

MS RYAN: There was a bit of both.

DR WALTERS: A bit of both.

MS RYAN: So when we did advertise, we didn't always get – and sometimes one or two of the paediatric nurses would move across to the special care baby unit. We did try, frequently, to train the neonatal nurses who were not neonatal trained; we tried to get them to undertake the training but it was a huge, uphill struggle. Enormous uphill struggle, because they would say, even if they were trained, they wouldn't take charge. It was the taking charge of the unit – everybody had a huge bee in their bonnet about – but I used to say to them, 'But you're really well experienced, you've been here for years, you can do this standing on your head', but they just weren't interested.

DR WALTERS: Interested? Weren't confident?

MS RYAN: A bit of both. They were concerned about the risk because they'd put complaints in frequently but they wouldn't – they wouldn't assist us with addressing the problem by undertaking the training.

DR WALTERS: So it was on the risk register –

MS RYAN: It was –

DR WALTERS: There was a proposal –

MS RYAN: Once there was a risk register. Even before that, we had formulated a plan –

DR WALTERS: Raising concerns?

MS RYAN: We raised concerns. I have to say, this sounds like we just carried on, willy-nilly ignoring; but we didn't. Lyn Shannon, myself, Angie Whitaker, before that, Ann West and [Marjorie Borgoine ~~goyne~~?], all of us had expressed concerns that we were lowering the staffing levels, but we were under budget constraints and no matter who it was, it would come back that we had to lose more if anything else, not less.

DR WALTERS: So were there any concerns between, say, around 2008 and 2011, about the outcomes of the unit?

MS RYAN: In terms of number of baby deaths, you mean, and the things that had happened?

DR WALTERS: Poor outcomes?

MS RYAN: There wasn't anything overtly obvious jumping up, to be fair. Again, I'm the wrong person to that degree; on those years I was on – more on the periphery. I was aware of it. There one or two, obviously, issues with certain babies, and there were one or two issues with some of the treatment some of the patients had, but they were addressed at the time, and that was flagged up higher also.

DR WALTERS: So we won't go into specific cases until later, but – so where there was a poor outcome or a death, how was it looked at?

MS RYAN: It was investigated – all –

DR WALTERS: Who used to investigate?

MS RYAN: At the time, Lynn Shannon would be the one that would look into –

DR WALTERS: Who is she?

MS RYAN: She was my – she was the senior nurse for paediatrics.

DR WALTERS: And what about the paediatricians?

MS RYAN: And the paediatricians would obviously be involved as well. But it was usually done by the senior nursing team, interestingly.

DR WALTERS: Right, and did the outcomes of those reviews, did they lead to any changes in practice?

MS RYAN: Whenever they needed to, definitely.

DR WALTERS: What sort of things might they...?

MS RYAN: Things like flagging up, you know, if the baby's a certain weight, you must act on it; if the baby's temperature drops or whatever, we would flag up things to the paediatricians immediately. There were a few changes of that

nature; if there was anything specific. Some of the problems were on a more minor level; that doesn't sound right, but things like gentamicin levels and things like that, basic things. Or investigations undertaken ~~ing~~ or not undertake ~~ning~~. Those sorts of things, but they were all flagged up and discussed at a senior level and senior combined meetings with the paediatricians, senior nurses, and passed on to the staff obviously.

DR WALTERS: Did they ever get external reviews of particular cases from people who didn't work in the unit?

MS RYAN: Not so much back in 2008-2010, but it began to – there were one or two towards 2012, 2013, yes.

DR WALTERS: And was there ever any issue about the state of the babies once you received them? Was there anything, any issues around being sent too late, things not being recognised earlier?

MS RYAN: Obviously there are situations like that, but they were dealt with, with the people concerned.

DR WALTERS: So that wasn't a common thing?

MS RYAN: It wasn't, to be fair. I know it sounds like it does, from everything that's been said, but in actual fact, no it wasn't. There were situations where – one of the things that I can remember continually fighting, and Angie, and Ann West before me, was we couldn't get the obstetricians to agree to send these women out with those babies in them when they really needed to go elsewhere rather than hang onto them until the very end. Of course, you knew they would deliver, and the unit wasn't set up to take those. We struggled a lot with that.

DR WALTERS: What sort of women were they?

MS RYAN: The 28-weekers, the 26-weekers that were niggling on, niggling on; we would have preferred them to go out, in utero transfers, and instead, what they ended up doing was delivering them, then we had a lot of – we would have chaos reigning as we had to get the transfer team, the STARS team to get them transferred out.

MR BROOKES: Can I ask, was that because there was not clear protocols about how these cases should be handled or was that people making individual clinical decisions against protocol or in spite of protocol?

MS RYAN: I think sometimes it was a bit of both there as well. It seemed to vary greatly. We would jump up and down and say, 'Look, can we move this bairn out in utero, this is not a safe practice; we haven't got...' – especially when the staffing of the unit was at its lowest, and I knew that I didn't have staffing. We would point this out and say, 'Look, protocol would dictate,' but they would just sit on it a bit longer, and bingo, it just – so there were situations. Does that make sense?

MR BROOKES: Yes, thank you.

PROF FORSYTH: It was breaking, breaching protocol, presumably, because the neonatal unit at Barrow is a level one unit, so they wouldn't be able to look after the baby at all?

MS RYAN: No, and we would point that out to them, but it was still – it was more the obstetricians, but sometimes they would ask for the paediatricians. I wasn't always there.

DR WALTERS: So within clinical governance of the area, then, it sounds like you've got a unit which is a bit fragile with staffing issues, capacity issues?

MS RYAN: Yes.

DR WALTERS: And you've then got something absolutely obvious that is happening which is not best practice. Did that not sort of all come together?

MS RYAN: It did eventually.

DR WALTERS: But it was something that people were pre-empted?

MS RYAN: We tried to pre-empt it, but we got stymied by some of the more senior medics, for example, who would not back up what we were saying; and also nobody at senior, senior level – I'm not talking nursing or medic here – would not shut the unit down even though you begged them to sometimes. You'd point out that this is not safe practice, that it was unsafe practice, it was against the protocols, that problems would occur. We could see it coming and we would say to a higher level, 'Well, we won't shut them down if...' – and they wouldn't let us. Simply they would not let us.

MR BROOKES: Can I just be clear on who you're talking about? What level?

MS RYAN: Senior management.

MR BROOKES: Sorry?

MS RYAN: Senior management.

MR BROOKES: Such as...?

MS RYAN: Senior nursing, higher than Lyn Shannon's level; and the clinical director. Because we would take it as high as we could; we would go up clinical leaders, up to –

MR BROOKES: So within the directorate, not higher than that?

MS RYAN: No, higher than the directorate –

MR BROOKES: Who specifically would be very helpful?

MS RYAN: If I had a problem that I felt was unsafe practice or whatever, I would flag that up to my boss; obviously that's Lyn Shannon. In her absence – it was often me that took whatever calls – I would then inform others ~~slam it up~~ – we had a protocol this; we had an escalation policy, which we would try and follow but we would still find sometimes told that we were told to remain open even if we felt it wasn't safe.

MR BROOKES: It's by whom, I'm trying to understand?

MS RYAN: That's senior nursing?

MR BROOKES: Nurse Director?

MS RYAN: Nurse Director – it was mostly Jacqui Holt – they often would listen but they sometimes would not, and clinical director, medical clinical director. There is – there are other people like SMOCs – and I don't know if you know our system, but senior management on-call. I was part of that team, but the senior management on-call could be senior managers from HR or IT, and their capacity for knowledge – and they would bump it up to, for example, Jacqui Holt as the senior nurse, and even higher. And it would still come back, 'You will just have to make do and mend'.

MR BROOKES: Thank you, sorry.

DR WALTERS: So do you think the – why do you think they didn't want to transfer these babies in utero?

MS RYAN: The obstetricians? I honestly couldn't answer that. Because they didn't think it was necessary and because there was an ethos in Barrow, that special care was being hard done to, and they could perfectly well look after these children under any circumstance. And also, there was an awful lot of people who seemed to think that the average 22-weeker or 23-weeker won't turf up on the doorstep. It's reality; that's what happens; people turf-up on your doorstep. You can shut your unit and say, 'We're not accepting anything under 28 weeks', but what are you going to do with a 26-weeker

that drops at the door? So it's always going to happen but we need to be geared for that eventuality. But if you were faced with it in front of you, we would think the obstetrician to think about in utero transfers, especially if they were labouring.

DR WALTERS: Because there's something about closing the unit isn't there?

MS RYAN: Yes, that was the biggie. That was the big, big stumbling block: do not close this unit.

DR WALTERS: But isn't the thing you do before you close the unit, is to try and reduce the risk?

MS RYAN: Absolutely, which is what we were doing.

DR WALTERS: No, I mean try and reduce the risk but not having the -

MS RYAN: Yes, absolutely.

DR WALTERS: Thank you.

MR BROOKES: I'm not clear did they unit close?

MS RYAN: The unit closed frequently.

MR BROOKES: Frequently –

MS RYAN: Now you're going to ask me how often?

MR BROOKES: Not precise but is it once a week, once a month?

MS RYAN: At times, if there was no babies, the unit would be shut, but the neonatal nurse would be available to open it at the drop of a hat. So they weren't off-duty, they were still – they might be sitting on the children's unit or whatever, or rotating around maternity. So yes, it did close, and it closed on a fairly often basis. There was one time I am sure there was six or seven days with no babies. It can happen.

MR BROOKES: But did it ever close when there was a baby who potentially used the service – the difference between –

MS RYAN: I know what you're saying, yes.

MR BROOKES: Closing because there's no babies around and potentially babies -

MS RYAN: If there was anything in the unit that we knew of, we would bend over backwards to try and cover the unit so that it was open, but there was always a neonatal nurse – or where possible – available for any eventuality, like the 24-weekers, like the 26-weekers, and the paediatricians would be there as well. So while the unit might be physically shut, it could open at the drop of a hat.

MR BROOKES: And there was clarity amongst the different clinical professions?
MS RYAN: We had risk protocols in there, we had risk management plans in there for any eventuality.
MR BROOKES: And were they always followed?
MS RYAN: I would say on the whole, yes. The other thing I mentioned earlier about the obstetricians, they weren't part of the paediatric and neonatal protocols, per se. We would always try and send a paediatrician around to discuss, but that wasn't always feasible, so does that clear that – there were protocols in place which we did –
MR BROOKES: Which on the whole were followed but there might have been the odd occasion –
MS RYAN: Yes, there might have been for whatever reason –
MR BROOKES: Okay. You also described some of the staffing levels as unsafe?
MS RYAN: Yes.
MR BROOKES: Were there any other elements of the service not directly associated with staffing levels which were unsafe?
MS RYAN: [*After a short pause*] Expertise, perhaps in one or two people.
MR BROOKES: So down to training or competence?
MS RYAN: At more senior level, but competency levels, yes.
MR BROOKES: In any particular areas?
MS RYAN: I would've said, partly in medical staff themselves, one or two of them; and partly, obviously, one or two of the maternity staff were unsure and unhappy sometimes to look after the babes. Sometimes there was a lack of education so we had to put things in place to assist them, which is what we tried to do. So we then tried to widen the education so that it took in the midwives as well, so they'd feel less uncomfortable.
MR BROOKES: And on that point –
MS RYAN: We did try –
MR BROOKES: Would it be fair to say that the midwifery staff might have felt they weren't as well trained as they should be for some of the babies they were starting to get?
MS RYAN: We definitely felt that; there's no doubt in my mind that they did feel that. They've said it frequently. But we did try and address those issues as they arose; and in fact, we tried to pre-empt those issues when there was

discussions about some of the babies – they changed the entrance to special care, the level of – they went to 36 weeks – 32 weeks, 36 weeks – so there was a lot of moving back and forward and that altered a few of the problems.

MR BROOKES: Just one last thing from me before we move into the next session. I'm just interested: I get a sense of identified risk at ward level, etc.; clearly reporting of that risk register when you had a risk register – it's interesting that you didn't have one all the time –

MS RYAN: We didn't initially before risk registers and clinical governance took off; going back to when the clinical governance wording and things wasn't as it was. We had other things in place; we had escalation policies in place, we had –

MR BROOKES: But whatever reason, there was a reporting mechanism –

MS RYAN: There was a reporting mechanism.

MR BROOKES: Of what you see as a clinical risk for the labour

MS RYAN: Yes.

MR BROOKES: It seems to have stopped –

MS RYAN: Patient safety incidents were used a lot.

MR BROOKES: It seems to have stopped somewhere in the hierarchy in terms of being addressed.

MS RYAN: Perhaps in terms of being addressed adequately is what I would say, in our eyes.

MR BROOKES: So the risks were not necessarily being resolved?

MS RYAN: Not fully and not speedily.

MR BROOKES: Okay. Any other questions in this session?

PROF FORSYTH: Just one factual point, in terms of the comparative capacity at Lancaster, did they run into problems at time of having insufficient capacity?

MS RYAN: Absolutely, because they would be taking some of the babies from the Barrow end who were poorly or babies who were coming back from elsewhere, so it would be over the capacity.

PROF FORSYTH: So would they then pass the babies onto Preston or somewhere else?

MS RYAN: Well, we passed those that we could, if they were Barrow babies, we would try and put them back up, but we had to be careful what we put back up to Barrow, obviously, and would depend on the high dependency level.

PROF FORSYTH: I'm thinking of those times where a baby in Barrow clearly needs to be transferred out, so it needed an intensive care –

MS RYAN: They might go to Preston –

PROF FORSYTH: Lancaster may be closed or full –

MS RYAN: Yes, it has happened.

PROF FORSYTH: And so the next stop would be where? Would it be Preston?

MS RYAN: Preston. We've had a couple, I think, of situations – certainly in the last year when babies have gone out even further because there was no capacity. Neonatal cots are reduced quite markedly and it is a problem; there was a lot of discussion of whether Barrow became a level two unit, and that's been going on for a long, long time; and it was decided that it stays at level one. Lancaster's a level two; there was a lot of discussion whether that changes to level three, but then they wanted everything moved to a central unit. So there's been neonatal discussions up and down the country, hasn't there. So neonatal services have changed hugely over the last few years as to who accepts what and when, but Lancaster can quite often be over its capacity. Rarely is it down to two or three babes, ever.

MR BROOKES: We are going to formally break now, in terms of coming to the end of the open session and we are now moving to a closed, clinical session. I'm just saying that for the record so that we're clear.

(The hearing went into private session at 15.15)