THE MORECAMBE BAY INVESTIGATION

Wednesday, 1 October 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

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

ANN ABRAHAM and KATHRYN HUDSON

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

DR KIRKUP: Thank you for coming. We appreciate it.

And I will say for the record that I am Bill Kirkup and I am chairing the Investigation Panel; I will ask my two colleagues to introduce themselves.

MR BROOKES: I am Julian Brooks, currently the Chief Officer for Public Health England but previously head of Clinical Quality at the Department of Health.

PROFESSOR MONTGOMERY: I am Jonathan Montgomery, I'm a Professor of Care Law at University College, London and I Chair the Health Research Authority. In the past I have chaired PCTs and SHAs for the provider Trust.

DR KIRKUP: You will notice that we are wired for sound and we make a recording of the proceedings to produce an agreed record at the end of the process. You are also aware that we open the proceedings to family members, as it happens we have not at least yet got any family members present today but they may be able to access the recordings at a subsequent stage if they wish to do that.

You will also know that we have asked you to leave behind any mobile forms, tablets, other recording devices. That is to underline the fact that as far as we are concerned nothing goes outside the room until we are ready to produce a report that produces all of the findings.

Are there any questions that you would like to ask us about the process?

MS HUDSON: I do not think so.

MS ABRAHAM: That is fine.

DR KIRKUP: I want to start briefly with a very general question to ask each of you in turn if you could give is a brief account of your role and the times that you were in the role as related to this investigation and I will hand to Jonathan to do the early part of the discussion.

MS ABRAHAM: Well, I take that to mean my role as Parliamentary and Health Service Ombudsman. I was in that role from November 2002 until very early in January 2012. My responsibilities, I suppose, in that respect were to investigate complaints of injustice caused by mal-administration or service failure by the NHS in England and Government departments and agencies across the UK.

DR KIRKUP: Thank you.

MS HUDSON: Could I start on behalf of the both of us by expressing our sympathy for the families. Without going on at length we have been concerned for them and for the impact of all that has happened at Morecambe Bay and are keen to assist you in getting as far as we can.

DR KIRKUP: Thank you, that is appreciated.

MS HUDSON: I am Kathryn Hudson and joined the office in August 2008 as the Deputy Parliamentary and Health Service Ombudsman. In that role I was responsible for the case work service, the management of about 300 staff and ensuring that those staff were properly managed and that the quality of the work that we produced was good. At that particular time we were also taking on the work from the Healthcare Commission who had handed their complaints function to us.

Although I say I was responsible for case work service I have to say Ann has always taken considerable interest in the casework and, therefore, we worked very closely together on that aspect of my responsibilities.

DR KIRKUP: Yes, thank you. Jonathan.

PROFESSOR MONTGOMERY: Thank you very much. I want to pick up three categories of things. I really want understand more the general system and the roles of the Ombudsman and I will pick up where Kathryn left off, I think, in a moment. There are two particular decisions that will be helpful to have an understanding of the time-lines and how you went about them, so they are around 2009/10 in relation to the first complaint and the question on 2011 about the supervision. I would like to have a good understanding of the system first

before we get to the particular things.

I wondered if you could say more, Ann, I think, it is up to you. The best way of dividing the labour on the answer to the questions. I would like to pick out aspects of the PHSO role and one of them is this hand over from Healthcare Commission of the complaints function and a little bit more of exact timing. What the differences are from what Healthcare Commission could do and what the Ombudsman's office could do. Does that fall to you, Kathryn?

MS ABRAHAM: Shall I start?

MS HUDSON: Then I will pick up on the detail.

MS ABRAHAM: Indeed. Well, I suppose the fundamental difference after the reform of the NHS complaints system in 2009 was beforehand there were three stages, afterwards there were two. I do not think I would describe it as a hand over, I think I would describe it as a reform.

When I joined PHSO in 2002 from almost the moment I arrived I started to argue for reform of the system and in my evidence to the Francis enquiry I spoke at some length about what I considered was wrong with the system but one of the things that I thought was wrong was that the Healthcare Commission was involved in complaint handling. Two fundamental points about that.

One is that actually it meant that it was a very elongated and lengthy process, you had to have considerable stamina to actually stay with it. B.

Fundamentally I thought that regulation and complaint handling were not good bed fellows and that I cited my experience in other context, particularly with the previous job as the Legal Services Ombudsman where actually the regulator was in a very difficult position trying to run the complaint handling function as well as a regulatory function. It also distorted the relationship with the Ombudsman.

So I was very, pleased after I made a report to Parliament in 2005 and then the Department of Health also took up, I think, the impetus for reform.

What that did was have, if you like, a two stage system where the NHS looked at complaints and if people were not satisfied after the NHS had looked at complaints they came to the Ombudsman. That meant that the Ombudsman was looking at complaints onin a much more timely basis, that the independentse stage, you know, kicked in more quickly and that we were, I think, much more alert and alive to real time issues in the NHS than we had been previously. But, of course, in 2009 that was just happening. So we were in the very early stages of all of that.

What we had agreed with the Department of Health was that we would try and secure the smoothest possible transition from the old system to the new and I chaired a working group with the Health Care Commission to try to secure that. What it did mean was that we were increasing our staff members very substantially, we were increasing our complaint numbers and we were taking on the residual complaints that the Healthcare Commission had not been able to deal with before they ~~went down~~ were abolished.

That is quite a long answer but it is contextual for the timing and then, of course, Kathryn was very much responsibl~~eility~~ for the operational side of that.

DR KIRKUP: There was, if I can interject, there was a substantial backlog that the Healthcare Commission had at that stage, was there not?

MS ABRAHAM: I am not sure I would call it a backlog. We worked very hard with them so that we did not have a cliff edge on the 31st March. I always used to describe this as going from three-lane motorway to a two-lane motorway and that you had to actually start that transition a long way back in order for it to be smooth.

So there was a point from the autumn where they were looking at cases and if they took the view that

they were not going to complete them in the time they had available that they would fast track them to us and they had powers to do that and we had powers to receive them. So, in effect, we were taking some of that work early.

I have to say one of the things that I felt was very positive about that transition was that I do not recall getting a single complaint from an MP about complaints falling down the gap or getting stuck in the system. So there was a lot of work but we had a planned transition, which Kathryn was heavily involved in.

MS HUDSON: We did, indeed, a gradual transition from about December until April starting with the work that was coming in that they thought they would not be able to complete while they tried to complete work that they were already doing. Then gradually transferring other things at the appropriate time so that by 1 April the whole responsibility had transferred to us and they had nothing left and I am not aware that anything fell down the gap during the time.

PROFESSOR MONTGOMERY: There is a general theme we need to come back to about gaps in the system which we need to understand.

Before we get to that can I ask a bit more about

the scope of the your jurisdiction and the criteria for taking on the complaints and also I am quite interested in the evidential thresholds. I am aware that in the 2014 your successor talked about presumption of taking on investigating cases involving deaths. I do not have a feel for whether there was any sort of ~~eventual~~evidential threshold in place in 2009.

MS ABRAHAM: I hope that we can come on to the specifics of Mr Titcombe's case because I think that, you know, to talk about this in general terms as a backdrop is, of course, useful but, I think, that what I would certainly like to do this morning is try and get across to the investigation what was going on in my head and what my thinking was at the time.

If we can come to that?

PROFESSOR MONTGOMERY: It is understanding whether the Titcombe case was a reasonably straightforward working through the process or whether there were features of it that made it particularly difficult, so that is why I was asking the question separately but if it is easier to answer them together then answer them together.

MS ABRAHAM: I will start with general and move on.

I mean, I suppose there are a couple of contextual points that I would like to make really. I suppose

that the first one is what we have covered already but I often said to people when I was retiring from PHSO that I seemed to have spent my entire time there really first arguing for reform of the NHS complaints system both in terms of the process but mainly in terms of behaviour and that had I only spent, you know, the last couple of years really trying to manage the transition. But I never really got to the point of doing, you know, perhaps everything I would have liked to do there, although we did, I think, make some quite significant reports into issues around learning disabilities and care of elderly people.

You know, there was never a point when I thought that the NHS complaints system was in steady state and I thought it was working well. You know, I was always dissatisfied with it, if you like, but the other thing the other point I would like to make is that my approach was always to try and work with the other bodies in the system and that would be CQC, it would be Monitor, it would be the professional regulators such as General Medical Council, Nursing and Midwifery Council.

What I suppose I was the -- what I wanted to achieve there and it was certainly hard work and certainly ambitious. I wanted all those organisations to work effectively together. All the organisations

that were concerned with health care quality, that we developed strategic ~~allowances~~alliances, we shared information where we were able to do that, so that all of our efforts individually were harnessed to best effect in the improvement of healthshared services. You know, that is why I was developing ~~meme~~memorandums of understanding, with CQC, and then with Monitor. There was a consultation on information sharing in 2009/10. Which was very much around, you know, trying to make sure that information was shared across the system wherever it could be.

Again, if you look at my evidence to the Francis inquiry you will see that all of this is covered.

PROFESSOR MONTGOMERY: I can see two strands of questions, one is about getting the stuff to work, we can see from the notes of the meetings that you had with Cynthia Bower about the prime discussion in that August period was around getting the system operating. Your information sharing programmes, were they around systemic ~~or~~ issues or individual cases that you did? I would like to be able to disentangle in my mind the proactive role about constructing a good system and what you were discussing in terms of working together on individual basis.

MS ABRAHAM: Of course, the memorandum of understanding, I think, covers both and, again, if you

look at the consultation documents, which I am trying think about when this happened, the consultation document was in December 2009. The report on the consultation was in March 2010 and that was really trying to get a sense of what the PHSO policy should be within its legislative framework about sharing information across the system.

As a result of that consultation I actually subsequently talked to the then Secretary of State, Andrew Lansley, to ask for changes to our information sharing powers to make them wider, which actually did come through in the Health and Social Care Act eventually.

They were general, yes, but they were also case specific. I think, all of the dialogue with CQC and in that consultation covered all of that ground.

What I would say specifically about PHSO, this is a relatively small office, 400 or so staff, really, certainly when I was leaving, £35 million budget. Huge number of bodies in juris diction. All NHS bodies including individual doctors and dentists, all the UK Government departments and agencies that were not devolved. So massive jurisdiction but a very specific remit to investigate individual complaints. No ability to go looking for complaints. We had to respond to

what people brought came to us. The Ombudsman, as you well know, it is not a regulator, it is not an inspector, it has no monitoring role in relation to the quality of care provided by NHS Trusts. It is nNot the Ombudsman's job and it is not within the Ombudsman's powers to ensure that there is an acceptable standard of care from NHS providers. You know, it is a very, very specific role. I suppose if you want to put it another way, the Ombudsman's role is righting individual wrongs and securing remedies for those wrongs, where it is possible to do so and drawing attention to systemic failures for other bodies to remedy. For other organisations to remedy.

PROFESSOR MONTGOMERY: Can you elaborate more on your mechanisms for drawing attention to systematic -- you have mentioned the big report where you able to say how complaints show these themes across the whole of the NHS but one of the issues here is if a particular case emerges questions in your mind about the systemic failures in a particular organisation. Just outlined reasons why you are not the regulator of those things but what are your options in terms of the making sure that those observations are known on by people?

MS ABRAHAM: Absolutely. If you look at the, well, what it looks like now but the guidance at the time, if

on an individual investigation the conclusion was that there had been injustice as a result of mal-administration or service failure, then we would look to secure an appropriate remedy for that injustice. I mean, this is Ombudsman legislation language but you will understand why I use it.

What we would always ask the case workers to think about was individual remedy first, followed by systemic remedy and one of my concerns always was the NHS in particular I thought would jump to the systemic remedy before it would ever think about actually what do we need to do in relation to this individual. So the individual remedy would be perhaps an apology, it would certainly be an acknowledgement that things were not as they should have been and explanations of what had gone wrong. Sometimes they would be financial compensation, sometimes that would be entirely inappropriate. Once we had looked at the individual remedies we would then look, if we felt there were systemic issues, to make recommendations in that report for change and usually they would be around asking the body concerned, the Trust, to come up with an action plan to ensure that lessons were learnt and to make sure that this did not happen again.

So there would be lots of reports which would have

specific recommendations which stemmed from a case and then if, in the office, we identified patterns then we would possibly layer a report before Parliament to draw much wider attention to the issue.

PROFESSOR MONTGOMERY: Well, we will need to come back to the particulars about the Titcombe question but there are some general characteristics about your take on that and your later ~~letter~~ on decision but I want to understand whether they were unusual or common. One of those is an acknowledgement of fault by the organisation. A second is financial remedy already having been offered and a third is action planning already having gone on. I wondered whether that was a common experience that you had to complaints that came to you where those things were in place or whether it was quite unusual. Because you just described a series of remedies which they may not have satisfied the ~~complaint~~ complainant but they fit in those categories that you described as potential remedies.

MS HUDSON: Yes. I think that I would say the picture was mixed. I suppose it would be quite unusual for there to be an acknowledgement of fault, financial redress already secured and an action plan already in place for all of that to happen, to have been in place at the time that we were considering a case to take on

for investigation. That would have been quite unusual, I think.

PROFESSOR MONTGOMERY: Can you think of any other examples where there was part of those in place where it was still right for you to take on or did take on?

MS ABRAHAM: I mean, it is difficult in a way because, you, know, every case is different and certainly, you know, somebody might bring a case to us when none of those things were in place but by the time we had intervened with the body in jurisdiction, without taking it on for investigation, all of those things might have been in place actually. You know, we might have pushed it back for the Trust to look at again and secure those things. You know, it is quite a fluid question really. You know, I cannot say 20 percent of complaints looked like this and 15 looked like that. It was not like that. If you think about it in terms of what could the Ombudsman possibly deliver, those are the sorts of thing that we would always want to be doing, an acknowledgement of fault, you know, apologies. Wanting to know that lessons had been, were being learnt and that the body in jurisdiction was wanting to make sure that this did not happen to anybody else.

MS HUDSON: I think that is right. I'd just say that

probably this particular case was more unusual than not. The vast majority of cases that came to us did not have those things in place. This one, yes, a certain amount of work had already been done.

MR BROOKES: Can I qualify that? Did having those three things in place impact on the decision about how to proceed or are they somewhat separate to what you are saying?

MS ABRAHAM: I think I understand the distinction. I have not answered your question, have I?

PROFESSOR MONTGOMERY: Let us get to Julian's question.

MR BROOKES: We are terrible, we take each other's questions.

PROFESSOR MONTGOMERY: I think one of the questions you have to ask yourselves is how unusual the decision you had to take in relation to the Titcombe case was but also, in other words, to understand how you took it and why you took it. I think I would like Julian to stick a little bit, because I was asking about what the criteria were for taking things on. This has grown out of part of your criteria must be what might follow from investigation, so you take it through some of that but it may not be the whole of that question because I was also asking about the threshold of evidence and whether there was a presumption of taking on or not taking on.

MS ABRAHAM: I suppose, again, I am going to use the language of the office and legislation. I know there has been a lot of criticism of some of that language, but --

PROFESSOR MONTGOMERY: I would like your views retrospectively on whether the language could be crafted better for the future but I think we need to understand where you were at the time.

MS ABRAHAM: Yes, is the simple answer. I said that to Robert Francis X-years ago. I do not think I will defend it but in terms of the thought process, the thought process was; do we have here prima facie evidence of service failure, of mal-administration? Do we have evidence of injustice, you know, that can be seen to flow from that, you know?

Again, I mean, it is technical stuff and I absolutely understand that for the families concerned this may sound completely unrelated to their experiences, I do understand that, but what the legislation says is that the Ombudsman looks at the complaints of injustice as a result of, you know. So you need to have an indication that, you know, obviously there was clear injustice here. Was there service failure? Yes, there was. It was admitted. We had the Trust saying unacceptable standard of care.

So, for us, the question was around the third criteriona, which is what can the Ombudsman do that will secure this phrase "worthwhile outcome", which I know is the one that has caused offence and I absolutely accept that.

What that meant for us is what outcome can the Ombudsman secure that is worth securing for the complainant because that is what they want and maybe in the wider public interest to secure. That is the thinking.

PROFESSOR MONTGOMERY: Can I have a supplementary on that?

DR KIRKUP: Actually, we have just had notification that Mr Titcombe and his father have arrived. What I suggest is that, with apologies, we take a short break now and we reconvene because actually I think that is the point at which they would like to understand those processes and, I think, it will be very helpful.

We will draw to a pause and ask if we can briefly recap that, then you can go on to the questions.

Thank you, for your patience.

(Short break).

DR KIRKUP: Hello again. Thank you for bearing with us. Just before we resume I will just recapitulate the bit about as you know we open this to family members to

be observes at the session, are we are now attended by a family members. As I am sure you will know, this is James Titcombe and his father and I will just ask James at this point if he will confirm for the record that he is prepared to wave confidentiality for the session so that you can talk freely about matters relating to his case?

MR TITCOMBE: Absolutely, yes.

DR KIRKUP: Thank you for that. I just would like to briefly, if you would, recapitulate on the answers you were giving us about the remedies that are open to the Ombudsman and where they might and might not lead you.

MS ABRAHAM: So I am clear, do you want me to recap on our criteria or just on the remedies?

DR KIRKUP: The specific point about what remedies you can offer and where that takes you in terms of do you investigate or do not to investigate these. Not the whole of the area that we have covered.

MS ABRAHAM: Well, again, just to get my train of thought in order, if we up hold the complaint then we would always look first at individual remedies for the person who brought that complaint, which would always include an apology, would always include acknowledgement that something had gone wrong, an explanation, if it was possible, to explain, you know,

how and why things had gone wrong and we would look at financial remedy if it was appropriate to secure financial remedy. Sometimes that would be for financial loss but much more likely to be about distress in those cases.

If, when we had upheld a complaint, it was clear that there was systemic issues beyond this case then we would make recommendations to the body in jurisdiction. Occasionally to another body, for example, the regulator, yes, but usually to the body in jurisdiction.to make sure that lessons were learnt and that what had gone wrong here was not going to happen to anybody else.

We also, at that point, if we made systemic recommendations we would copy that report to the regulator --

DR KIRKUP: Thank you. That is very helpful. I will hand you back to Jonathan.

PROFESSOR MONTGOMERY: Thank you. I think that because we have had a break I thought of couple of follow on questions to that. I think that the nub of this issue for me is understanding and we were exploring before the break whether it was a common to have situation where you had a case where there was an apology, compensation agreed and some form of action planning

and, I think, I wanted to understand how closely you were in a position to scrutinise what you might describe as the adequacy of those things. I am thinking does the complainant believe that the apologies is genuine? Is the level of compensation that has been agreed sufficiently similar to you might have recommended, it is adequate and in terms of ~~allegation~~ action planning, how much would you be able to look at were they really following through on the action. Clearly we are able to take the a view now with the benefit of hindsight of where action planning led to. We need to ask what you could and would do faced with promised actions to assess whether or not you thought that those actions were really going to deliver.

They are each questions about your role in assessing the adequacy of something that fits in a category that you described as remedy but might not be sufficient.

MS ABRAHAM: I think, you know, as a precursor to that I would say that I was, in my early days in Ombudsman's office, I was quite concerned that the office had a history of making very specific recommendations for action which frankly it was not equipped to make. So, you know, we would have, usually with the help of our clinicians, in effect, ~~making~~ made the recommendations to

the Trust to take certain actions and then we go and do a follow-up visit. I was very concerned that we were blurring the boundaries between the role of the Ombudsman and the role of the regulator and, indeed, the role of the Trust and it was not our job to manage hospitals, certainly was not our job to regulate hospitals and that if we were not careful we could, in effect, give a green light where there should not be one and I had seen follow-up visits and thought, well, how on earth could we as the Ombudsman with our relatively small resource be saying everything is fine now?

So we pulled back from that to actually generally asking for action plans but we did not just, when those were available to us, look at, you know, something said that said "Action plan" on the cover and say that is fine, we have got that. We would ask our case work staff with the help of our clinical advisers to say well, you know, does this look to be relevant, appropriate, actually robust?

I think in this case, if I recall, one of the things that we did do was have a look at, I think, in relation to midwifery, Kathryn?

MS HUDSON: That is right.

MS ABRAHAM: To say, "Well, does this look robust?" So

we had the ability to look at them in general terms, yes?

PROFESSOR MONTGOMERY: There are two senses of robustness we might be interested in and one is was the plan robust the other is was the implementation for the plan robust.

MS ABRAHAM: That is a different story. I think what we were saying in general, if we were looking at an action plan, is, well, does it seem to be fit for purpose? Relevant to the subject matter? I was very clear it was not our job, you know, to step into the shoes of the Trust or the regulator in terms of the ongoing quality of care.

PROFESSOR MONTGOMERY: In terms of the Ombudsman's jurisdiction, if an action plan turned out not to be implemented that would need to be a new complaint and mal-administration would be in not implementing the agreed action plan, as opposed to just part of the original complaint?

MS ABRAHAM: Yes, I suppose it could be but the reason we sent the regulator details of our systemic recommendations because that was us saying, "Over to you."

PROFESSOR MONTGOMERY: What would the follow up be to sending a set of recommendations to the regulator?

Would you have a system where you would, in your meetings with regulators around the general system issues, would you pick up had they taken on the recommendations, the oversight of the recommendations that you have talked about, or do you close the file once you reach the conclusion that this is the set of recommendations?

MS ABRAHAM: We would close the file.

PROFESSOR MONTGOMERY: Okay. Perhaps we will come back right at the end to reflections on what you would like the systems to be.

I want to check one clarity of understanding then, I think, we should move to the particulars of Mr Titcombe's cases.

I think I have understood from that that there is a peculiar sense of injustice in the legislation that you work with which allows to get to a situation where you would say there was injustice in the sense of things were done that should not have been done or not done that should have been done. That in the absence of any response to that, along the lines of the three types of remedy that you talked about, the acknowledgement, acceptance, responsibility, compensation where appropriate, and appropriate action planning, you would say something was unjust but for

your technical jurisdiction it could be that you look at it and say, "The remedies are in place" and that stops it being within your remit. Have I understood that? Two slightly separate sets of questions what happened in the past going wrong and has it been put right sufficiently to mean your jurisdictional purposes it's ceased to be unjust in a very technical sense, albeit it clearly was unjust in the past, have I understood that?

MS ABRAHAM: I think so. Whether I would describe it in that way. I think the legislation is very broad. Therefore, the Ombudsman has huge discretion and limited powers, I suppose. You know, there is no power to make recommendations. Ombudsmen have always done it but they have no explicit powers to do it but, yes, certainly when we were looking at whether we would take a case on for a formal statutory investigation leading to a formal report with everything that that concluded, everything that that involved in relation to due process and natural justice and all of the rest of it, if we were making those decisions following what, in my time at the office, was called an assessment of the case, this question of, "Is there injustice that has not been remedied?" yes, was at the core of that. Yes. I think that is what, we are saying.

PROFESSOR MONTGOMERY: I think that is right. I think what we need to understand at the particular timeline of the case is what you assessed and to what extent was it assessment about the remedies or assessment about what had gone on.

MR BROOKES: Just turning that round slightly the other way, am I right in thinking that just because remedy was in place that would not automatically mean that you would not investigate?

MS ABRAHAM: I think, the answer to that is yes. Say it again?

MR BROOKES: If in a case there were remedies already in place that would not automatically mean that you would not investigate?

MS ABRAHAM: It would not automatically mean that, no.

MR BROOKES: Thank you.

PROFESSOR MONTGOMERY: I think we should move to Mr Titcombe's first request to you to look at it. I think it will be helpful to establish a timeline about things that they went through. There are couple of points we need to ask about in some detail but can you take us through when it first came into the Ombudsman's office, then the steps that are taken? We know there is an assessment meeting but there is obviously quite a lot before and after that; that is part of that

timeline.

MS ABRAHAM: Do you want to do that, Kathryn? In terms of, I mean, I know when I first became aware of it but in terms of steps that you would have gone through.

MS HUDSON: Yes, it first came into the office -- interesting, I am looking at the timeline, we have not got the date but I believe it first came into the office around April of 2009. It was assessed in the normal way through our processes and we were aware at that time that CQC and Monitor had an interest and that made it unusual. We did not usually have contact with them at that particular time.

The assessor brought the case to the assessment Panel in August, August the 12th.

PROFESSOR MONTGOMERY: Just explain what sort of person was the assessor?

MS HUDSON: The assessor was one of the trained case workers in our offices. If I just explain the structure, I said that I was responsible for casework services. Below me were a number of directors who took particular responsibilities, so there was a Director of Assessments that would have gone into that Directorate. Below that a number of teams and then a number of Assessors in each team. So the assessor would have been one of the team members who had the

direct contact with James and who did the assessment. I was aware of the case before it came to the assessment panel. It came to the Assessment Panel on the 12th August.

That Panel was a Panel that met weekly to consider whether we should take cases on for investigation. I said earlier that Ann has always maintained a great interest in casework and by that stage I had been in office for about a year and we alternated the chairing. In fact, if it came to a Panel she chaired I used to sit alongside Ann to make sure that I understood her sense of direction, where she wanted to go on cases but I chaired on another occasions on my own.

PROFESSOR MONTGOMERY: How many cases would come to an Assessment Panel?

MS HUDSON: Usually somewhere between 20 and 30. At that time quite a high number coming because they were dealing with the cases that had come to us from the Healthcare Commission. Of that only a number would be for discussion. They were the ones where we thought that there were particular issues that we needed to be clear on before we decided whether to take something on for investigation.

PROFESSOR MONTGOMERY: The others, were they paper reports which went to Assessment Panel and the

Assessment panel, unless it saw a reason to ask for discussion, would confirm the recommendation?

MS HUDSON: The papers used to go to the assessment Panel, the assessor would always be there. They would be divided up into ones that we thought we should be accepting and ones that we thought we should be declining. The Panel might raise questions and if so the assessor would be there to answer them. Most of those would be going forward as fairly straightforward. Usually, somewhere between six and ten that we would need to discuss in detail. This particular case was one that was there for discussion and it was usually because there was something that was difficult that the assessor wanted to bring to our attention and wanted a particular discussion on whether or not we should take it on.

PROFESSOR MONTGOMERY: How much paperwork would have supported that? What would you have seen before and what was be presented on the day?

MS HUDSON: The papers would come out before, usually probably two or three days before, there was quite a lot of paperwork but usually in time for us to have a good look and, of course, the members of the Panel would tend to concentrate on the ones where they thought there was some particular issues to discuss.

PROFESSOR MONTGOMERY: By that stage you would have the letters, or whatever came in, brought to your attention. What investigations would have been done by the assessor --

MS HUDSON: We would have a complete assessment form I do not know whether you have seen that as part of the evidence, which is quite a long form which goes through all the issues of is this case within our jurisdiction, the sorts of thing that Ann has been talking about, in order to make sure that we have covered off all the jurisdictional issues at that point. There would then be the assessor's assessment of the case. We would not necessarily have all the papers from the health Trust, nor necessarily the letter of complaint but if we had sought clinical advice the clinical advice would be attached to the pack. A very comprehensive form which put all the information that we needed in one place.

PROFESSOR MONTGOMERY: Would either of you have seen anything before those papers arrived about the Titcombe complaint or was that the first point at which you had seen the paperwork?

MS HUDSON: The first point at which we had seen it all brought together, unless something specific had been raised beforehand. I am not aware of having seen the papers before they came to the Panel.

PROFESSOR MONTGOMERY: I think you said the point which it first came to your attention. Is that this point or is it something different?

MS ABRAHAM: Certainly the Assessment Panel was the time I would have seen any paperwork and I think my shorthand really for what that these assessment paperwork was intending to do was to be -- well, answer the question of can we investigate, is it within remit? Should we? And it was the "should we" question that would be the subject of the discussion.

I think now in terms of did I have any awareness of this beforehand, I didn't have any awareness of the specific complaint, the details of the complaint. I think I recall that there had been some discussions that my case work manager had brought to my attention and it would have been, you know, very much in passing around some suggestion that Monitor were halting their consideration of an FT application pending our decision. To which my reaction was, "That is complete nonsense. They have got a job to do and actually the Ombudsman's decision on one case is a tiny speck really in terms of the totality of what Monitor was concerned with.

PROFESSOR MONTGOMERY: I need to ask you, I am sure you appreciate why I need to ask you this, about couple of

meetings with Cynthia Bower which may or may not have come up in discussions. One of those predates the date of the Panel meeting and one is in the afternoon of the same day and there is some indication in documents I have seen that it was possible that the Morecambe Bay case was discussed at both of those and nothing is very clear about what was discussed. Could you give us your recollection? There is a meeting on the 3 August, then there is a meeting on the 12th August and if my understanding is right they are both primarily meetings about the working relationship between the organisations and you were talking before we had break about the work on improving quality of the complaints handling, those sorts of things. Can you just take us through your recollection of what was and what wasn't –

MS ABRAHAM: I would rather not do that by way of oral evidence because I have sent to you the detailed witness statement document that I prepared when Grant Thornton were looking at these events and I am absolutely – I sent that to you because I thought it was a full record of what happened but, just to summarise really, there was a formal liaison meeting, with CQC then Chair Barbara Young and Cynthia Bower and some of her colleagues, Kathryn and myself and some of

our colleagues, which is a minuted meeting.

Kathryn and I had a different recollections as to whether Morecambe Bay got a mention.

MS HUDSON: Perhaps I can respond.

MS ABRAHAM: I have no recollection it did and certainly there is nothing in the minutes to suggest that it did. So my recollection of, well, you know, the documentary evidence in relation to that meeting, there are the minutes of it. There is no reference to Morecambe Bay. I have no recollection. So the 12th August is in terms of where my head was on 12 August is the bit that probably is of most relevance and interest to the investigation.

PROFESSOR MONTGOMERY: Yes.

MS ABRAHAM: I do not know whether you want to say anything about the 3 August?

MS HUDSON: About the 3 August, if I can explain, what we had was a formal meeting, as Ann said, with representatives from us and from CQC and the normal process in meetings of this type is after the meeting finished Ann would usually take the people who have been at the meeting to the lift in the building, the rest would remain in the room in case there were things she wanted to pick up with us afterwards. It was not unusual for Ann, on going to the lift, maybe to make a

comment about something else that was going on that was not part of the meeting.

When I was interviewed by Grant Thornton on this I was asked whether the question of Morecambe Bay was discussed in that meeting and what I have said is no but it may have been picked up in the margins and that has been interpreted into, "Kathryn Hudson says there was a discussion of this", whereas, in fact, I was just referring to the fact that we already knew that we would want to talk to CQC.

MR TITCOMBE: I cannot hear, I am sorry, what is being said.

PROFESSOR MONTGOMERY: I am sorry.

MS HUDSON: I will try to speak louder.

DR KIRKUP: It may be helpful to note the microphones are not for recording, unfortunately they do not amplify. Sorry.

MS HUDSON: I will try to speak a bit louder. What I had done was to explain the normal course of events which meant that there was an opportunity for Ann to have said to Cynthia, "We need to talk to you about Morecambe Bay." I had no way of knowing whether she had done so because I was not party to that conversation. That was interpreted by Grant Thornton as Ann having spoken to Cynthia about this case on that

day.

DR KIRKUP: Let me clarify, that was specifically the meeting that preceded the assessment meeting that you have described?

MS HUDSON: That is right.

DR KIRKUP: That was the 3rd?

MS HUDSON: On the 3rd.

DR KIRKUP: The assessment meeting was on the 12th?

PROFESSOR MONTGOMERY: Now we get to the 12th and the assessment meeting and we have the notes of the meeting so we have been able to read through them but I think it will be really helpful to relate to the context we were having earlier about the sorts of questions that were there. How you went through them at that meeting. Take us through.

MS ABRAHAM: I can tell you what was going through my mind, I think, when I was discussing Mr Titcombe's complaint and what was going through my mind is I could not see how an Ombudsman investigation was going to add anything significant to what was already known. The Trust had accepted the standard of care was unacceptable and it was obvious to me that the failings were systemic and I was concerned that if we took on the case for a formal investigation that could actually delay matters because what was urgently needed was for

CQC to do its job as a regulator to ensure that improvements were secured.

What I had understood from the assessor was that Mr Titcombe obviously wanted to understand what had happened here but that his primary concern was to prevent this happening to anybody else.

I thought that as long as we could be sure that CQC knew about these systemic failings that they were taking appropriate action then we did not need to carry out a formal investigation in order to prove something that was self-evident and we did not need to make formal recommendations to secure improvements in care quality at the Trust.

So I was minded not to accept the complaint for investigation but because at that point CQC's position was unclear, and that was something very specific that was in the assessment papers, we had this very vague statement that CQC had delayed taking their relevant action in relation to the Trust pending PHSO's decision. I didn't understand what that meant at all.

So I wanted to understand what CQC's position was and I needed more information about CQC's understanding of the situation at the Trust and what it planned to do about it. Without that information I could not safely make a decision on this case about what we should do.

So I asked Kathryn to obtain the information and I asked Cynthia Bower who Kathryn should talk to about in order to obtain the information.

PROFESSOR MONTGOMERY: Can I just test my understanding? You talked, as you were describing the introduction to that meeting, about could we, should we. I think you have just described an answer to the should we question. So it was within the jurisdiction.

MS ABRAHAM: We could have done.

PROFESSOR MONTGOMERY: The question is what value you would add and I think what you just described is what might be the negative impact in you taking it on rather than something else?

MS ABRAHAM: Yes. Delay.

PROFESSOR MONTGOMERY: Okay. We now have, I think, enquiries that Kathryn makes and will come back to it in due course and I think you contact both Amanda Sherlock or Alan Jefferson?

MS HUDSON: Alan Jefferson contacted me in response to a request from Amanda Sherlock that he should do so.

PROFESSOR MONTGOMERY: Can you tell us, start with Alan Jefferson about what he told you?

MS HUDSON: Yes. I rang Alan Jefferson specifically to try to identify what it was that CQC already knew about what was going on at Morecambe Bay.

Actually, he was already fully aware of the circumstances of the death of Joshua and also was more than willing to discuss with me the concerns that he had about what was happening at Morecambe Bay at that time and those are set out in my memorandum to Ann dated 10 September and I think you have a copy of that.

What you see is that he identified three principles issues which concerned him. One was about the specific treatment of Joshua and the lack of continuity of between the maternity, obstetric and paediatric services and he felt that they were more than just a particularly bad day in the hospital but were indicative of something a lot more concerning in dynamics of the relationships within the hospital.

He then felt that the problems were wider than the Barrow Hospital, I think it is the Furness Hospital, alone, and the relationships between the different sides were poor and so he had moved to a position where actually the concern was about the Morecambe Bay Trust as a whole, not just about one hospital within it.

Then there was another concern about the poor record keeping, which he addressed with me and told me about.

Overall the concerns was if this is what is happening in the maternity and children's services what

Comment [RP1]: Kathryn Hudson writes: Please check the recording I thin this has become a bit muddle?

is happening in the rest of the Trust? Mr Jefferson's view was that he was well aware that there were problems here, because those problems were, if you like, not fully explored at that time and certainly needed addressing, the risk rating for the hospital had been raised to red at that time.

PROFESSOR MONTGOMERY: It had been reduced to amber by then.

MS HUDSON: Then had been reduced again to amber because they felt some action was beginning to be taken. What he then said to me was he expected that rating to remain at that level for some time and that that would affect the registration of the hospital from April and might mean that the hospital be registered with conditions and what he said to me at that time was and it would mean that they could not at that time apply for foundation Trust status and they would need to reapply in due course.

DR KIRKUP: Did you imply there that his expectation was that they would be registered with conditions?

MS HUDSON: Yes.

DR KIRKUP: Or was he saying that was a possibility?

MS HUDSON: The implication I took from that, I can't remember the exact words at this distance in time, was that they would be registered with conditions.

DR KIRKUP: With conditions, yes.

MS HUDSON: Yes.

PROFESSOR MONTGOMERY: Can I just ask you to reflect on the possible difference between that conversation that you had with Alan Jefferson and the email you got from Amanda Sherlock on the same day which, I guess, was what put you in touch with him?

MS HUDSON: That is right.

PROFESSOR MONTGOMERY: The current status is that they are not considering investigation activity or other regulatory activity on the basis of the complaint. There seems to be a slight mismatch of level of concern between Amanda Sherlock and Alan Jefferson.

MS HUDSON: Yes, and I assumed, and it is my assumption I have not tested it with Amanda, that she was referring back to the view in CQC at the time when we began the investigation when they were waiting for us to decide on the outcome, before they decided whether they should take any action, and that Amanda might not at that stage have been fully aware of how the discussions had moved on since that time but I have not discussed that with her --

PROFESSOR MONTGOMERY: If I have understood this right, your are ~~directive~~ directed from Cynthia Bowers to Amanda Sherlock down to Alan Jefferson to get best understanding of the

CQC's position –

MS HUDSON: That is right.

PROFESSOR MONTGOMERY: – you get it from Alan and you have not then had any reason to think that the view elsewhere in the CQC had changed from the one that Alan Jefferson –

MS HUDSON: No, I assumed Alan Jefferson's was the accurate representation of CQC's understanding of what was happening at Morecambe Bay at that time.

PROFESSOR MONTGOMERY: Fundamentally, okay. When you look back the history of what happens later on, we might want to come back on that, it is a little less obvious that that is the case. You have done those inquiries.

MS HUDSON: Yes.

PROFESSOR MONTGOMERY: This is part of the follow up to the 12 August meeting, we will come back in due course. Were there any other conversations? Were there conversations directly with the Trust? Did you speak again with Mr Titcombe or –

MS HUDSON: I may well have spoken with Mr Titcombe during the interim period, I was in very frequent contact with him but I think actually that was slightly later on. So I am not sure. I spoke to Tony Halsall at the Trust at some time but again I think it was not

at this stage, I think it was later on.
PROFESSOR MONTGOMERY: You think it was later?
MS HUDSON: Yes.
PROFESSOR MONTGOMERY: Can you tell us what you asked him and what he told you?
MS HUDSON: Tony Halsall. I don't have notes of that in front of me but at the stage when I was talking to him – actually this is coming back to me, this was much latyer, this was after I had visited James and his family. I talked to Tony Halsall about an offer he had made to James to involve him in some of the work that had been going on at the hospital and one of the possibilities that I discussed with the family when I visited was that we might go back to that offer and James might then see more what the hospital were undertaking in order to try to improve services.

Whether when I spoke to Tony Halsall what he was saying to me was, yes, the work was in progress, things were improving, but, no, he did not want at that time to renew the offer that he had made. I think that is the only occasion on which I spoke to Tony Halsall.

PROFESSOR MONTGOMERY: In the letter that was sent on the 3 February, which possibly is a product of the next phase of the deliberation, all this comes back together, was also a reference to the agreement around

the action plan being shared. I think what we would like to understand is that you have set up on 12 August, you have had a preliminary assessment of what the more you needed to know in order to take a view. If I have understood what you told us is correctly, a key part of that is what the CQC was doing.

There is another assessment Panel is there or does it --

MS HUDSON: No.

PROFESSOR MONTGOMERY: No. Take us through how we move from those inquiries to the drafting of the letter reporting the decision?

MS ABRAHAM: I think there is an exchange between me and Kathryn when Kathryn writes to me on 10 September and incorporated into that memo to me is a very detailed note of her conversation with Alan Jefferson.

PROFESSOR MONTGOMERY: We have just discussed that.

MS ABRAHAM: Kathryn and I then had a conversation, so we would have met regularly, we talked about casework issues and on the following day I wrote a memo to her to say that I, in effect, agreed with her assessment and confirming my decision that we should not take the case on for investigation.

I did that because at that stage we had clear and documented assurances from CQC that they knew there was

systemic failing in maternity services at the Trust and possibly beyond maternity services; that there would be close oversight by CQC of the Trust's action plant to secure the necessary improvements and that progress by the Trust against their action plan would be taken into account in their registration and would also play out in their application to Monitor for FT status.

So I suppose I thought that we had secured what we needed to secure in order to actually deliver what needed to happen next to secure improvements in the quality of care at this Trust and, therefore, an Ombudsman investigation was not going to add anything to that.

So I then said to Kathryn, will you -- I was very concerned that this decision would not be well received by the family. I asked Kathryn to do something which was quite unusual for me to do, which was to ask her to go and visit the family to actually explain our decision before we confirmed it in writing. That took a while to arrange, I think, and, therefore, it was, I think, early February by the time to the decision letter came to me for signature.

PROFESSOR MONTGOMERY: I would like to ask you a few questions about what was in the decision letter in a moment but I want to understand a bit better what you

mean by securing. Because I understand, again, we have seen copies of the letters that you sent sharing your decisions. That is slightly different from knowing that the regulators are going to act so you know at that point what their current standing is. You have some indication of what the likely regulatory consequences are in terms of what seemed to be their position, probably registration with conditions. It seemed to be the position in terms of Monitor's actions, and I fully understand it now looks a bit different when we know the history afterwards, but that is what you have been told at the time.

Do you do more as the Ombudsman than re-assure yourselves that they are aware? Or is there some sort of feedback so? For example, do you get any acknowledgement from CQC, formal acknowledgement from CQC and Monitor that they are aware? Do you have any agreement about them informing you of what they have done in the future? Or is the end of your responsibility to make sure that they are aware of your decision and the reasons for it?

MS ABRAHAM: Well, I suppose I could say that actually I have no responsibility whatsoever in law and everything I was doing here was beyond the remit of the Ombudsman.

PROFESSOR MONTGOMERY: You could say you are entitled to assume that these organisations operate on good faith but in the real world you must have anxieties and I am just trying understand. So there is a bit about what you need to do and what might do.

MS ABRAHAM: I think in a way those questions are for my successor. At the time we had, Kathryn had very detailed telephone conversations, which I understood that you actually confirmed with Alan Jefferson that your understanding was correct?

MS HUDSON: Absolutely, yes.

MS ABRAHAM: We had a ~~are~~ documented record of a conversation which was very clear that all the ground was covered. I had no reason to think that anyone other than Alan Jefferson was the person from whom we should get those assurances. Therefore, I did not feel that I needed to do anything more than that because it was the regulator's job to do the things that they were doing or telling us they were doing and the system of registration and success of an FT stage application all that was in the regulatory system and, therefore, in terms of what was the Ombudsman's responsibility, what was our job? I thought we had done our job. I thought I could rely on those assurances. I had no reason to believe I could not.

Now, what I know about just how rapidly, whether it is the right language to use in the context given the seriousness of what has happened here, you know, that CQC would drop the ball so rapidly and ~~so drop ball and~~ lose it really. I had no reason to think that was the case because they were doing their job and that is what I thought they were going to do.

PROFESSOR MONTGOMERY: That is the exactly what I want to ask about. What reasons might you have had to doubt the fact the system would act, both at the time when CQC was just beginning to register, I am guessing you had no knowledge at that time how that would work because nobody did, but if I ask you with the benefit of hindsight, were there other examples where you similarly felt that your understanding of the regulatory action either by CQC or Monitor had turned out to be different?

MS ABRAHAM: No.

PROFESSOR MONTGOMERY: This is the only one. Where does that stop?

MS HUDSON: I think it is quite important to add to that that actually we went further in this particular situation because of our very deep concern for this family and ~~this~~ the situation they were in. We did not want just to say to them we are not going to take this

on for investigation to leave them with nothing. We felt they needed to the assurance that actually the system was going to deal with this properly and that, I think, is the reason why you have the situation where I have spent time on the phone to Alan Jefferson, which I would not normally have done, have received the assurance from him, have written to Monitor and to CQC about the outcome of our investigation and have visited the family to try to make sure that something was in place that would re-assure them that the whole thing was not going to drift into nothing.

PROFESSOR MONTGOMERY: Again, I was going to ask you about it. You would have written, would you, to the CQC and Monitor with your findings in other cases or was that also something that was unusual?

MS HUDSON: If we did not take on a case for investigation, I don't think that we would normally write.

PROFESSOR MONTGOMERY: All those things are additional?

MS HUDSON: All of those things are additional. The one that is particularly unusual was the fact that I visited.

MS ABRAHAM: Can I add one other thing which was in the Ombudsman's possession before we made the final decision and that was Alan Jefferson's letter to Mr and

Mrs Titcombe of the 16 December which I believe Mr Titcombe shared with us, Kathryn, I think, but he actually had said to Mr and Mrs Titcombe, "Morecambe ~~Bay~~ Bay's registration application will need to be submitted within the next few weeks. Between then and April we will be carefully reviewing their application and deciding what, if any, conditions we need to apply. The Ombudsman is, of course, aware of these powers and of our determination to use them to secure improvement in the operation of the Trust.

PROFESSOR MONTGOMERY: Thank you. Can we move to the letter, because --

MS ABRAHAM: The decision letter?

PROFESSOR MONTGOMERY: The decision letter. I know this was the subject of further correspondence and Mr Titcombe wrote to you about some aspects and there are just some things I would really like to understand what you are thinking about. I guess that the first thing was if you knew ~~now~~ what you know now about the CQC's actions in 2010, or if you had no assurance from the CQC about what they were doing, how would that have altered your thinking? I am trying understand what is conditional upon what. How important in your thinking was the fact that you had reasons to think that there was regulatory action underway?

MS ABRAHAM: Central and fundamental.
PROFESSOR MONTGOMERY: At the point when you are deciding it, your decision is governed by the information that you have got from the CQC. Without that you would have done an investigation?
MS ABRAHAM: Without that I would have done something different and I do not know because, you know, it is speculation and I am not sure how helpful it is to anybody and particularly to the families. But if I go back to what I said to you about what was my thinking on 12 August, I was saying that it would not have been safe for me to not take this case on without understanding the CQC's position and actions. Without that we would have been in a different place. I might have gone back to the CQC and had a further conversation with them because my concerns about delay, concerns about delay, if I felt CQC were not taking this seriously enough I might have gone back and had a further conversation with CQC at a senior level. Or on the basis of what I know now, that actually I could not rely on CQC to do the things that they had assured us they would do, then, yes, I probably would have taken it on.
PROFESSOR MONTGOMERY: The only answer you have got had been the answer from Amanda Sherlock that there was no

regulatory activity, that would have triggered a conversation with Cynthia Bower at that point?

MS ABRAHAM: Well, I think -- you know --

PROFESSOR MONTGOMERY: It is speculation.

MS ABRAHAM: It is speculation. I am not sure where it gets us. I thought the Amanda Sherlock email when I subsequently saw it was crossed wires. It is not unusual to get crossed wires between two organisations before you have get two people who need to talk to each other talking to each other. That was it really.

PROFESSOR MONTGOMERY: If you had not had that assurance from the CQC they were taking it seriously, I am still a bit unclear why that would have led you to investigate because you still would have had acknowledgement of responsibility, compensation and an action plan. Those things were in place from the Trust rather than the CQC. I am still a little bit unclear why that was such a big issue in your decision not to. I can understand why it was a very important thing to have happened but I am not quite so clear what you would have been able to and the Ombudsman -- on the criteria you have outlined that you needed to ask.

MS ABRAHAM: Well, because of the systemic issues. You know, that actually if the people who needed to act on and secure improvements in quality of care as a result

of those systemic issues were not sighted ~~cited~~ on, were not persuaded by, then I would have ~~been~~ brought, you know, the resources of the Ombudsman's office into doing a formal investigation which, you know, possibly twelve months later would have enabled me to go back to the CQC and say, "Look, we have really got all of the, evidence, you know, it is a shame you did not listen to me twelve months ago because actually it was self evident at the time." So it would have been to reinforce what I already knew and I was trying to get a short cut here, I suppose is what I was trying to do.

DR KIRKUP: You were reinforced in doing that because you believed that CQC were fully seized of the issues and were going to act on them?

MS ABRAHAM: Well, yes, because they told me that.

DR KIRKUP: Yes.

PROFESSOR MONTGOMERY: Was there any discussion of what – I do not know whether you call them terms of reference, but the scope of a potential investigation might be? I can see how important the systemic issues are. I am still slightly unclear what you could hope to gain from an Ombudsman's investigation, unless it is do we believe the hospital act in good faith when it gave its apology? Do we think the compensation is adequate? Do we think they are actually following

through on the action plan? Would those have been sorts of things the investigation was --

MS ABRAHAM: No, no, I do not think so. I think it would have been the about the quality of care at the Trust.

MS HUDSON: If I can come in here. The original complaint to us was about the reasons why Joshua had not received care that he needed and the fact that certain documents were missing from the records and, therefore, not taken account of. It was actually quite tightly confined. It was as we were doing the preliminary work, if you like, and from the contact we later had with the family that we began to get a much wider view of whatever going on. But the basic nature of the complaint was on those two things and that is what we would have accepted the investigation on.

PROFESSOR MONTGOMERY: There is an exchange of correspondence after your letter in February with Mr and Mrs Titcombe about what might hope time gained if you did that type of investigation and there seems to be a view expressed in your letter that you didn't think the Ombudsman would be any better at getting to the bottom of those factual discrepancies than existing investigations have been, which Mr Titcombe did not feel was a strong enough reason.

I would like to ask you what your assessment of how you reached that assessment, if you like, that you could not really add value in that area of getting the clear timeline or the settled story of the evidence?

MS HUDSON: At that stage there had already there had already been two investigations, and I am saying this without the relevant page in front of me but remember this fairly well. There had been two investigations already conducted which had not got to the bottom of some of the issues and had included interviewing various people and no light had been shed on the papers that had gone missing and we were now a year down line.

The chances of a further Ombudsman investigation discovering where those papers had gone to or, indeed, what had happened, specifically about the reasons why Joshua did not received antibiotics, because that was the issue.

PROFESSOR MONTGOMERY: You had copies of those reports you went through?

MS HUDSON: There were copies on the file, yes.

PROFESSOR MONTGOMERY: Did you speak to the people who produced them? There is now, with hindsight, a whole series of questions about the documents.

MS HUDSON: I cannot answer the question. It is part of the work the assessor would have done and I do not

know if she would have gone to that depth at that stage.

PROFESSOR MONTGOMERY: When Mr Titcombe comes back putting it to you that those reports were not actually robustly done, people had not actually been interviewed, what did you do faced with those questions?

MS HUDSON: I have notes of a telephone conversation with him when -- sorry, I am going to need to find the page.

PROFESSOR MONTGOMERY: I would rather get it right than...

MS HUDSON: I am sorry. Rather than keep flicking through the papers let me talk to my memory about the record of the conversation stands.

I had a conversation with James just before Ann made the final decision and that we were not going to decide not to investigate and James talked to me, this is the one that is about "The Seven Steps to of the Patient Safety", and in the course of that conversation, which was a long one, James and I came to a slightly different formulation of his complaint which moved away from just focusing on the missing papers and on the treatment that Joshua received and moved instead towards the fact that the Trust had not dealt with his

complaint properly in the first place and had not done a thorough investigation.

I felt that there was something there that at least needed consideration. It is for that reason that I have written the memorandum, which I have not managed to get in front of me but you have in your papers, which I then took to Ann for a further discussion before we finally sent the letter saying, no, we are not going to investigate. We discussed all of those circumstances again at that time and felt that that was not the right approach to take, particularly because we felt that CQC were going to fulfil their promise and there was, therefore, no necessity for us to do that work.

MS ABRAHAM: That is referenced in the 3 February letter towards the end, I think, where it says, "I will now consider the possibility of a more limited investigation as you have recently discussed with Mrs Hudson. Mrs Hudson and I have discussed the possibility of investigation of the process ..." is this what you are talking about?

MS HUDSON: That is the one.

MS ABRAHAM: "...but limited work would be unlikely to satisfy your concerns by providing the answers you seek. I do not think an investigation my by office could

arrive at a definitive view of ~~vents~~ events and I do not want to raise expectations for you and your wife which could not realistically be met." So that is that conversation and how that is reflected in the letters.

PROFESSOR MONTGOMERY: That is helpful. I mean, there is a specific issue, I think, Mr Titcombe that is raised in correspondence about no-one actually having had their accounts properly challenged. I think it emerges later on in the supervisory issue.

Do your investigators -- would they have gone and interviewed the front line staff who cared for Joshua? Is that the way your investigators operate? Or do you do it with review of papers or?

MS ABRAHAM: I suppose I am struggling a bit with your line of questioning. I am trying to think why really. I suppose, you know, I didn't think that we would come here today somehow to dissect the thought processes or indeed, you know, the administrative processes of the Ombudsman's office and I suppose I really do not understand why--

PROFESSOR MONTGOMERY: The reason I am trying to get to the bottom of my understanding is that one of the things that we are asked to look at is how the system as a whole provides a service for complainants and one version of that history is that we have lots of

processes and none of them quite get to the nub of what really happened to Joshua on the day. I think I understand the correspondence that is there that Mr Titcombe thought that your offices were to investigate, had a chance to get closer to what happened on the day by talking to the staff and testing out their recollection and your letter, I think, indicates the view that it was unlikely you would succeed in doing that. The question I am asking is: Is that something about the particulars of the Titcombe case and the delay to get to you? I understand there is a whole load of other things that you have gone through very carefully as part of the decision. Or was it that actually the way that you operated would never have got as close to the issues as that. Because I am trying to understand whether the NHS complaints system, and, Ann, you took us through a number of failings of the NHS complaint system before Mr Titcombe arrived. I am trying to understand whether it was never going to be available because you did not have that way of doing thing or whether it is--

MS ABRAHAM: I think that is a different question. Because what I would say is that as part of an assessment process that it was unlikely that somebody would have gone and talked to the people concerned. As

an investigation yes, absolutely, yes. You know, I come back to where was I coming from? Some serious problems here that the regulator needs to get stuck into?. Yes.? Actually we could have spent many hours carrying out the formal investigation and we might have got a better understanding of these events, you know, in terms of the very specifics of the tragic circumstances in which Joshua Titcombe died. I suppose, you know, what I was thinking was we might do that, we probably will not, records are missing, people's recollections are becoming entrenched and actually what is more important here is that the regulator goes and does the job the regulator is there to do in terms of if you think about the future, you have to ask my successor what processes are now, but certainly a formal investigation would have had all kinds of processes and methodologies, you know in its toolkit and that would have been one of them.

PROFESSOR MONTGOMERY: Two questions then, I think, we will move on from that unless my colleagues have got something, one give a sense of the duration of such an investigation? If you had commissioned an investigation, how long would it have been before you would have expected to have been able to -- did you say --

MS ABRAHAM: I said this one. It could have taken up to two years.

PROFESSOR MONTGOMERY: That is a really helpful understanding of the timeline. Linked with that, particularly what you have just said in terms of the answer, do you have any sense of what the CQC's response was likely to be of their being an investigation under way? Do you have any experience of what they do when there are investigations underway when they're also considering regulatory action? I suppose I should ask that in 2009 and I should ask it in --

MS ABRAHAM: Do you know, I mean, I can give you the 2009 answer and I can give you the 2014 answer because I am currently chairing a Ffoundation Trust. I don't think they would do anything at all. You know, I don't think that an Ombudsman investigation in the normal scheme of things, an investigation -- you are taking something on for investigation is really saying, well, there is something here that needs further consideration by the Ombudsman and the Ombudsman is looking at it. You know, we worked ~~work~~ very hard to try to make sure that the regulators were aware of -- upheld complaints where we had done our work and particularly if there were ~~was~~ systemic failings but the fact that we

were looking at something, you know – I would not expect, you know, CQC to be suddenly changing tack or halting action or stopping being the regulator because the Ombudsman was investigating a case.

PROFESSOR MONTGOMERY: That sits slightly uncomfortably with me with what you have explained about part of your thinking, which is that actually you might have delayed things and it might have been used as an excuse by the CQC not to use its regulatory powers if it thought the case was unresolved. Did I misunderstand you?

MS ABRAHAM: I think you misunderstood me, I really do because I think what I am saying is that the fact of an Ombudsman looking at a case for assessment, in old language, my language, or taking on a case for investigation, I would not have expected the regulator to think much about that other than, "We will be interested in the outcome when she gets there", but I would not expect them to stop doing the job they are there to do. So I think you did misunderstand me.

PROFESSOR MONTGOMERY: Thank you. I am glad we cleared it up.

One other question about the 2009 one and that is in 2011 the inquest happens and there is a Coroner's letter in other parts of the system that seems to have triggered new thinking about what the nature of the

problem was. I wondered whether the Ombudsman's office kept tabs on these things? You had a question, you have a duty. It is not scope for investigation. Is there any systematic way you would pick up further activity? Did you receive the Coroner's letter? Do you connect it together? Or do you close the file once you reached the stage that the decision is not to investigate? Is that a clear question?

MS ABRAHAM: Yes. I would say that we close the file and that if the complainant came back to us and said "Here is some new information", yes --

PROFESSOR MONTGOMERY: You would react --

MS ABRAHAM: -- and asked us to look at it again we will do that, but otherwise we would not, you know.

MS HUDSON: Can I add to that, that was not quite the case in this situation because I remained in contact with James for some considerable time and was updated by him on what was happening.

PROFESSOR MONTGOMERY: Yes, thank you.

DR KIRKUP: Do you want to press on?

PROFESSOR MONTGOMERY: Thank you. I mean, the other bit is about the request to investigate supervising authorities' work. We are in 2011. It is a different type of focus, it is not on the clinical care it is the failure to investigate it properly.

I am not sure there is quite enough detail to take you through it like we have gone around the 2009 mark, but I want to understand the nature of the decision-making on that one.

MS ABRAHAM: I am not sure I can help you hugely --

PROFESSOR MONTGOMERY: You absented yourself from the detailed discussions, having known that there was correspondence earlier, I understand.

MS ABRAHAM: Well, I suppose in terms of what I know because the PHSO records and the chronology that PHSO have done for me and Kathryn for today, say that there was a new complaint, I think, about the SHA in March 2011. That would have gone through our normal processes and we took a decision not to investigate it in June on the basis of no evidence of mal-administration at that point. That was dealt with at director-level in the office.

There was, I think, following the inquest, but I do not know whether it had anything to do with the inquest, a review of that decision was taken in July -- a request for a review came in, in July. In September 2011 the external reviewer found the decision sound, so that was through our own processes.

I was not personally, you know, close to any of that. I think that is all I can say. I think --

MS HUDSON: In the absence of any papers I cannot comment on that.

PROFESSOR MONTGOMERY: We have the papers, in which case I would like to do the sort of "what do you think we should learn from this?" There is a whole series of things that we now know, that you did not know and probably could not have known, at the time, or could not have known about the history. I think I have alluded to the general question, which I wanted to ask really, which is: Is the system as a whole -- not just the Ombudsman's part of it -- are there gaps in terms of its ability to deliver answers that the complainants want, that we could particularly learn from the material we have just been over this morning around the criteria that you had to work with under the Act about your powers?

I am particularly interested in the difficulties that seemed to emerge in terms of helping people steer their way through the system. One version of what seems to emerge from Mr Titcombe's experience is that his concerns were never quite within the remit of any body or organisation. Sometimes they are individual, sometimes there is the systemic, sometimes they are too difficult to investigate, sometimes they are already investigated. I can understand how, from

his perception, we have not got a system that is enabled to deliver a simple investigation of a tragic circumstance.

I think we would like to give you the opportunity to feedback to us what we might learn from our understanding of this as part of our recommendations. We know your general comments on the system that you gave to the Mid Staffordshire inquiry, but this is an opportunity now to reflect on what we have been exploring this morning and draw our attention to anything you think we should be thinking about?

MS ABRAHAM: Well, I think I am reluctant to say too much about this because it is some years now since I retired. My successor, you know, is dealing with these issues on a daily basis and I am not.

I do sometimes -- because I am involved in another context in the world of the NHS, and, therefore, you know, I read the journals and I keep up-to-date with things -- I am sometimes frustrated, I think, by a continuation of the same sort of issues that I observed when I was doing this job.

The fundamental one is about behaviours. It is not about systems and processes. It is about culture in the NHS. It is about lack of openness. It is about lack of a collaborative approach.

There are so many players in this system; far too many players in the system. They all do their own thing. You know, it is not the default behaviour, you know, to listen to and learn from other organisations in the system.

Then there are misunderstandings. I mean, I have been reading recently in the Health Service Journal about very, very sad and tragic story of a baby's death where, apparently, everybody is saying they cannot investigate. Well, the Ombudsman could investigate that case. There is, you know, no absolute time limit on an Ombudsman's investigation. There is a "normally" but, you know, "normally" is in legislation for good reason. Therefore, you know, from what I have seen in the journals there is absolutely no reason why the Ombudsman should not investigate that case. There ~~are is~~ editorials in NHSJ about "falling down gaps" and so on.

I think, that, you know, what I would say, before reaching for any kind of legislative change, let's work with what we have got, let us make sure everybody understands what we have got and let us really try and shift cultures and behaviours of which, you know, working in isolation is one.

In terms of could anybody have done the investigation of Mr Titcombe's complaint, which needed

to be done, the Ombudsman could have done that; had all the powers, you know. The decision that I took at the time was that to say this -- this was too important for the Ombudsman to spend, you know, one or two years, yes, doing a forensic investigation when actually there were serious risks that other people were going to encounter in some of the failings. That was my judgment call. Actually it turned out to be that I had assurances from CQC that were worth absolutely nothing and fell apart, you know, within a matter of weeks. But that was my judgment call.

I suppose what I am saying is that I would be very concerned that the learning out of this turns into recommendations for some kind of legislative reform, you know, because actually, in my experience, changing the law does not always and often does not change behaviours and it's behaviours that really need changing here. Attitudes, openness -- just, you know, absolute zero tolerance in relation to standards of care.

PROFESSOR MONTGOMERY: With hindsight would you have -- do you think that, having had a formal acceptance of responsibility from the CQC for picking up the issue and bringing it forward, might that have changed things?

MS ABRAHAM: I am not sure I understand that.

PROFESSOR MONTGOMERY: You took assurance from someone who, with the benefit of hindsight, looks as though they may not have been a key decision-maker on the regulatory activities, which you could not have known at the time because of the place you went to. I mean, would an exchange -- Chief Executive to Ombudsman, formally saying, "We believe you are taking responsibility for following this up", would that have been beneficial or would it have made no difference?

MS ABRAHAM: I don't know. I do not know. You know, with my Ombudsman's eye, looking at what happened subsequently, I would say that there was mal-administration at CQC, you know, with very serious consequences.

PROFESSOR MONTGOMERY: That is within -- the remit isn't it –

MS ABRAHAM: Yes. Absolutely, yes. You know, if I had written to Cynthia Bower saying, "Your regional director has told my deputy ombudsman this and I am going to hold you to it", I mean, you know, that just feels completely over the top. You know it is not that we just happened upon Alan Jefferson; we were directed to Alan Jefferson as a result of a conversation I had with the Chief Executive of CQC.

PROFESSOR MONTGOMERY: I fully understand what you describe at that time. I am wondering if, with hindsight, whether that would have been something that was worth doing, or whether it would have felt like an inappropriate action. I think you have answered that.

MS HUDSON: Yes, I agree with you.

MS ABRAHAM: Yes.

PROFESSOR MONTGOMERY: Thank you.

DR KIRKUP: Julian, you are --

MR BROOKES: I think we have covered quite a lot here. We are getting into speculation in some of these issues. I suppose the only one thing I would ask is that, as you have just mentioned previously, the situation with the Trust and CQC's position changed quite quickly. Was there an opportunity at that stage to rethink the approach you had taken, if it was based on the assurances you received from CQC, when it so rapidly changed in terms of their position?

MS ABRAHAM: I have, you know, the hindsight moments, I would say to you, genuinely, I did not know. I come back to -- this is not meant to be defensive, it is simply factual -- my remit extended across all of the UK Government departments and agencies and all of the NHS. I was thinking about what else was going on at this time. Actually I was in a battle royal with DEFRA

about the Rural Payments Agency and reporting to Parliament on the refusal of DEFRA to accept my recommendations on a case. So, you know, the reality was that I had moved on. In terms of the hundreds of thousands of cases that the Ombudsman sees, my head was in a very different place.

When did I know what had happened about CQC and Morecambe Bay and registration? Autumn 2012.

MR BROOKES: Right.

DR KIRKUP: What was your reaction to it at that stage?

MS ABRAHAM: I was astonished.

DR KIRKUP: Okay.

MR BROOKES: Thank you.

DR KIRKUP: I have got one, which I am bound to follow-up on because we are confronted with one discrepancy and I would like to try and do everything I can to resolve that. I am not relying on Grant Thornton, I am relying here on your notes to the present Ombudsman, I think, Kathryn, dated 30 December. It is this specific point at the end of the 3 August meeting you say that Ann mentioned to you she would like to talk to Cynthia about Morecambe Bay. You have said subsequently this morning that was not the case.

Can you help to try to resolve this because I need that for us.

MS HUDSON: Can I see --

DR KIRKUP: The note of the --

MS HUDSON: The covering note, yes.

DR KIRKUP: -- 2012. You are writing it in hindsight.

MS HUDSON: Paragraph 12.

DR KIRKUP: End of paragraph four.

MS HUDSON: Sorry. Right. Yes. Again, we are in a position where I have misremembered -- and I say at the beginning of my introduction here that my concern is that after the length of time when I was writing things I was still making mistakes. I was worried that my memory was not entirely correct. I have actually said that and I noticed last night that:

"Ann mentioned that she would like to talk to Cynthia about Morecambe Bay and said she would contact her".

That did not -- that could not have happened in the room because it was not relevant to the meeting. This is my assumption about what happened as Ann walked to the lift with people.

PROFESSOR MONTGOMERY: Can I clarify because I was trying to tease it out earlier. I am not clear that predates the papers going out for the 12 August meeting.

MS HUDSON: It is a mistake that I have continued in

here. Yes. I can only say that I am sorry, it is a mistake; I think that with hindsight that I am wrong, or that my memory is not strong enough on that to be sure.

The other thing I would say, as Ann and I have said in the letter to Grant Thornton, is that actually nothing turns on this. We know that Ann had that discussion, whether it happened briefly on that day, or on a later date, actually does not make any difference to the sequence of events.

DR KIRKUP: To follow-up from that one. I want to be absolutely clear about what -- this is, Ann, I am directing this to -- what your expectation was of the message that Cynthia Bower had picked up on 12 August. What had you intended to communicate to her about Morecambe Bay?

MS ABRAHAM: We need a contact point.

DR KIRKUP: The reason for that would be?

MS ABRAHAM: The reason for the contact -- why do we need a contact point -- again I am trying to turn up what I call my "aide-memoire", which you will have seen and appears in the middle of that witness statement. One of my ways of working was to jot things down before I went to a meeting so that, in effect, I had the facts clear in my head and what it was I was wanting to

cover.

What I have said about this is that I gave Cynthia a flavour of the case, in the sense that here was something where there were, to me it was self-evident there were systemic issues. That, in terms of, as we have discussed, you know, acknowledgement of failings, remedies, and so on, you know, a lot of the injustice in Ombudsman's language had already been remedied but there were fundamental issues in terms of quality of care.

Therefore, the question for us is: What can we do? What I am -- I am trying give her some background so she knows what I am talking about and why. Then I am saying, well, we need, as I said earlier this morning, we need to understand what CQC's position is on this; who should Kathryn talk to?

DR KIRKUP: Okay. Thank you. I realise that we have been over some of that before. I wanted to be absolutely explicit about that.

Finally, is there anything you would like to say to us that you don't think we have covered.

MS ABRAHAM: There is, Chairman, if I may. You have brought up Grant Thornton and I just wanted to say something in relation to that. Perhaps just to reinforce really what my reflections are on all of this

you know and, as you can imagine, I have thought about it a lot over the years. Particularly, I think, since the problems with CQC's regulatory oversight became apparent, I suppose, which was towards the end of 2012, I think that is when it came to my attention.

When you wrote to me, Chairman, to ask me to come and talk to the investigation Panel I was very wary about doing that. I was very wary because of my experience with the Grant Thornton investigation, which CQC commissioned and which was published last year, as you know.

You have copies of the correspondence that Kathryn and I had with Grant Thornton detailing our very serious concerns about their investigation.

There is a lot I could say about that but, I think, fundamentally what I would say is that Grant Thornton seriously exceeded their remit; they demonstrated a spectacular disregard for fairness and due process; they over-analysed the evidence; and they over-reached themselves drawing conclusions based on speculation and inference, rather than a balanced analysis of the evidence. Their work was amateur and sloppy and it was rushed to deliver to a deadline.

Publication of that report generated a media frenzy and a witch-hunt of

individuals focused on a single event on a particular day in March 2012 at of CQC, which, I think, distracted attention from the substantive and broader failings in the regulatory oversight of the Trust at a critical time in the run up to registration with CQC and their application to Monitor for Foundation Trust status. The consequences of all of that, for some individuals, were, and continue to be, very serious.

I do not know what the consequences of Grant Thornton's work were for the families who lost loved ones, but I imagine it can only have been distressing and bewildering.

Kathryn and I have a lot of experience of trying to make sense of a mountain of evidence and see the wood for the trees, as I know that you do. If I had had the opportunity I would have said to Grant Thornton: "Step away from the rhetoric, stand back from the detail, and you might then get a clear view of the substance". I would have said -- and this is not meant to be in anyway disrespectful -- "Do let the facts get in the way of a good story".

I am hopeful that this investigation will do a

better job in getting to the truth openly and fairly.

I think all I would say, in summary of what this morning has been about, the decision that I took in February 2010, not to accept Mr Titcombe's complaint, was taken in good faith and it was based on all the information available to me at the time. I believe it was lawful and it was reasonable. I know it was not well received and, possibly, not well understood, but it was well intentioned. It was made on the basis of clear and documented assurances from CQC that they knew there were systemic failings in maternity services at the Trust, that there would be close oversight by CQC of the Trust's action plans to secure the necessary improvements and that progress by the Trust against their action plan would be taken into account in the Trust's registration by CQC and their application to Monitor for Foundation Trust status.

As I said, at the time I had no reason to doubt those assurances, although I know now that they were of no value.

Finally, I think just to echo what Kathryn said earlier, we have every sympathy with the families who have been affected by the failings in care provided by this Trust. I absolutely understand and recognise the huge distress that has been caused.

I just wish you well with your investigation and hope that you are successful in providing those families with the answers that they are looking for.

DR KIRKUP: Thank you for that. Thank you for coming and helping with the investigation. We can let you go now. Thank you.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 22 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Professor Jonathan Montgomery – Expert Adviser on Ethics

MOIRA ANGEL

Transcript produced by Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

DR KIRKUP: Thank you for coming. My name is Bill Kirkup. I'm the chair of the panel and I will ask my colleagues to introduce themselves.

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

MS ANGEL: Hello.

PROF MONTGOMERY: I'm Jonathan Montgomery. I am a Professor of Health Care Law at University College London and I'm also chair of the Health Research Authority. In the past I've been Chair of a couple of provider trusts, the PCT and the SHA.

DR KIRKUP: As you can see we are recording proceedings and we will make an agreed record of what happens. We also have some family members in attendance as observers and other family members can listen to the recordings at a subsequent time if they would like to.

You'll know that we've asked you to hand in any mobile telephones, laptops, tablets, recording devices and that's just to underline the importance that nothing that we talk about in this room goes outside the room until we are ready to produce a report that's got all of its findings in context.

MS ANGEL: Yeah.

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

MS ANGEL: No, I think I understand that. You have my phone and my iPad.

DR KIRKUP: Okay. I'd just like to start out with a very general question, which is when did you start at Cumbria PCT and what did you do and for how long?

MS ANGEL: Yes. Well, I had a think about this actually because I think you might want some context.

DR KIRKUP: Please.

MS ANGEL: Perhaps further back than the period that you're asking me about.

DR KIRKUP: Okay.

MS ANGEL: Just to – which will perhaps help me as well just to get to the right place. I worked in Cumbria for many years actually before 2000, just before that I came to Cumbria and I worked in the, what was then the North Cumbria Health Authority. There have been so many different changes and so many different organisations that we've worked for. And I had a role then as a researcher ~~worker~~ing and then across with the local authority so a joint role, a role in working with particularly around older people at that time with the NSF as that time out, continuing care, commissioning roles and then worked in West Cumbria Primary Care Trust as the Director of Nursing there because we were three, in the north of the patch there were three, three PCTs. We then went to one management team and then into, into Cumbria PCT.

But perhaps the reason for telling you about those days in the past was that I did have some work that crossed the boundaries, so I worked with people in South Cumbria and came into touch with the Trust through work around continuing care, equipment services and some joint commissioner type roles.

DR KIRKUP: Okay.

MS ANGEL: Back in those days there was a role that sounds a bit odd really but we were called change agents and some of us were working on a change programme with people from the PCTs was then in the South and with the Trust. And I guess my role then evolved when I went into Cumbria PCT in a commissioning sense as a lead for emergency care. But it was established

quite early on that I would keep my nurse lead role but work primarily in the PCT provider services. So I had a dual role. One was commissioning and one was provider services. And I think in terms of this context that the, it's a theme in Cumbria that people have multiple roles partly because there's often not many of us, whether you're working in a provider organisation or a commissioning organisation so our ability to multi-task I guess is good but it does also have some issues that surround that which, you know, I can come to later on, I guess, in perhaps some of the questions.

DR KIRKUP: Okay.

MS ANGEL: The biggest role through those areas of the PCT with the Trust, with Morecambe Bay Trust was around winter ~~under~~ pressure, so as part of my emergency care role I was responsible for ensuring that we had Gold Command when that was ~~in~~ at that stage, which was nothing like what happened later that was just much more about managing pressures and managing bed capacity and issues like that. And it was always a pressure at Furness but more so at RLI, so that was a common theme throughout.

DR KIRKUP: Okay. When did you first have Cumbria wide responsibilities?

MS ANGEL: In 2006 when we began the PCT.

DR KIRKUP: 2006.

MS ANGEL: Yeah, yeah.

DR KIRKUP: Okay.

MS ANGEL: Yeah. But we tended to have themes so we would work on themes, so my theme at that time was emergency care, as I said.

DR KIRKUP: Okay.

MS ANGEL: It wasn't the only role but that was a primary role at that time. So pressures working on A&E targets, setting up the primary care assessment service at Kendal.

DR KIRKUP: Okay.

MS ANGEL: Emergency floor at Furness. So I was very aware of some of the pressures that the Trust were facing in those days, but my primary role would be more with adults than with children or maternity services.

DR KIRKUP: Okay. That's a very helpful context. Thank you. I will pass you over to Jonathan.

PROF MONTGOMERY: Thanks. I want to check that I have got the more recent data. So 2006 when Cumbria PCT was created you were Director of Nursing Quality right from that point?

MS ANGEL: No, no. I had a number of different roles.

PROF MONTGOMERY: You've told us about being lead for emergency care on the commissioning side and the provider arm.

MS ANGEL: Yes. I was the lead nurse and I had nursing responsibilities throughout which fed into commissioning and also into the provider side of the organisation.

PROF MONTGOMERY: And is that a board-level post?

MS ANGEL: No.

PROF MONTGOMERY: Okay.

MS ANGEL: No.

PROF MONTGOMERY: So who did you report to?

MS ANGEL: I reported to a number of different people through that time but again

mainly it was the Director of Market Development was essentially a commissioning role, a director of commissioning and that was Nigel Maguire. Nigel is also a nurse & was the Board Nurse.

PROF MONTGOMERY: Thank you.

MS ANGEL: Who, of course, now is in our CCG but he was market development and that was, that was I guess a posh name for a commissioner. He was primarily commissioning at that stage.

PROF MONTGOMERY: There was some assumptions about what you were trying to achieve, doesn't it?

MS ANGEL: Yes, and it was about a population based approach to the commission and that's why it was him.

PROF MONTGOMERY: And did you stay in that lead nurse role until 2013?

MS ANGEL: No. In April 2011 the provider services transferred to the partnership trust and there was plans for me to transfer to ~~with~~ the partnership trust. So I spent a lot of my time in 2010 preparing, you know, the due diligence and the work that had to be done to transfer the provider services and the plan was that I would go with them and, for various reasons, some of them personal but some of them I just preferred to stay in commissioning and I stayed with the PCT in the commissioning at that time. It was then that I was asked to take on the cluster role. So I was then the cluster nurse and that took a couple of months just too sort of firm up the arrangements but at that time Jane Cummings and Sue Page and others wanted me to pick that role up.

It might be worth just again in context because Cumbria only had one CCG and one PCT our cluster was slightly different than other clusters.

PROF MONTGOMERY: It wasn't really a cluster.

MS ANGEL: It wasn't really a cluster in that sense and, you know, it might be misleading to just think about it as a cluster. It was actually a role, it was a board-level role and the board covered the cluster and the PCT and eventually the CCG. So for me I had to just reconcile that in terms of I was a board-level nurse, I had responsibilities within that board-level post and I guess that's what you might want to talk to me about.

PROF MONTGOMERY: That's really, really helpful. Can I ask you then about how the PCT, and then moving into the cluster and the CCG, addressed monitoring of clinical quality and what were its systems to try and make sure that it was commissioning was what it wanted to commission?

MS ANGEL: Yeah. There were a range of things. I mean generally speaking obviously the PCT was like any other in terms of it would have all the things to do with contracts and quality, and my role as a commissioner prior to taking up the cluster nurse role was leading the quality groups. So I led the quality groups with the Trust so my role then was very much about developing CQUINsequin programs, working with Jackie Holt and others at the time.

PROF MONTGOMERY: Was that for the whole of the Trust or just for the --

MS ANGEL: That was for the whole of the Trust. The quality group was a sub-group of the contracts group.

PROF MONTGOMERY: Right.

MS ANGEL: So that was a good role in the sense that it gave me an opportunity to make sure that things about safety, quality, nursing were actually fed into the contract. So an example of that might be Section 11 audits for safeguarding,

you know, that was, that was -- I made sure they were in the contracts and there was a contractual agreement with the Trust, things like SUI management, serious incident management and reporting it's a requirement and as we know the Trust breached that requirement but it was actually, and I was influential in making sure it was actually written, some of those things were written properly into the contracts and into the quality agreements. And then more broadly, the PCT serious incident group was one that I attended throughout, even before I became the exec nurse and I was there to report from a PCT-provider trust point of view from that side of the organisation but also to make sure from a, you know, a corporate point of view that a nurse was on that, on that SUI panel.

PROF MONTGOMERY: So you were reporting SUIs from the provider arm and thinking about what the consequences were with the whole PCT wide?

MS ANGEL: Yeah, yeah. So I guess what I'm saying is I understood it from both kind of perspectives in that sense.

PROF MONTGOMERY: And was all the quality monitoring being done through the contract process or was there a separate quality committee?

MS ANGEL: No, there was a -- alongside the serious incident meeting there was a safeguarding meeting and I'll come back to safeguarding because that was a primary role for me. And then there was a PCT PROVIDER quality and standards meeting, and with the Trust though there was a quality meeting on a monthly basis with the Trust.

PROF MONTGOMERY: Can you give us a flavour of how those monthly meetings worked, what sort of paperwork did you have [inaudible]?

MS ANGEL: Yeah. Well I have to say for a period of time, partly because it was new and we were leading on the CQUIN (Commissioning for Quality & Innovation) ~~sequin~~ programme and the development of the CQUIN~~sequin~~ and that did major partly because it was, it was from top down in terms of the things that we had to put into the CQUIN~~sequin~~ but it was focussed more on adults and OLDER ~~other~~ people and not on children or the maternity services, which on hindsight might be, you know, something that we could have used that as a quality lever more. But that was the general trend then. I worked with Jackie Holt as the director of nursing who attended along with Kay Gilbey at that meeting and my observation at the time and now is still that it was very, it was very driven by nursing. You know, we were to encourage the medics to come along to that and we had to encourage other Trust members. So it was supposed to be quality across the board and not just a nursing focus.

PROF MONTGOMERY: What would be on the agendas?

MS ANGEL: Well, as I say, the CQUIN ~~sequin~~ programme, things to do with the care stream, so emergency care, things to do with long term conditions, I was talking quite a lot about diabetes services, various, you know, long term condition type things, like rheumatology and those kinds of service. So it did dip down into key areas. Often it had, I had to be very clear with people about it wasn't just about performance, it was about quality and that often the Trust and ourselves, to be fair, you know, could drift into 'why are we not meet A&E's targets', and those kind things, although there was a clear overlap that –

PROF MONTGOMERY: And what about signals from complaints or CQC?

MS ANGEL: Yeah.

PROF MONTGOMERY: Would they go into that group as well or would they go somewhere different?

MS ANGEL: There is a separate process for managing complaints but we did bring data to those groups that would give us a sort of wider picture. It's not as sophisticated as it is now. We didn't have the dashboards and all of the things we would have now and I guess that's quite a lot of learning for us I'll say under those in terms of understanding that data. But there was two bits for me that there was the data that we did or didn't have and probed often to get more data, but there was also a bit about what we would call our softer intelligence about what did that mean, you know, what was the experience. And through that period of our, when we were in Gold Command, a lot of my role was asking the Trust, you know, about patient experience. I went along to the newly created panel, I think that's probably in 2012, and I actually took one of our non-execs who was on the board who had quite a difficult experience in the Trust actually and I asked if we could go along to share that experience partly to get a flavour of the committee, but also to just help understand about how, understanding people's stories.

PROF MONTGOMERY: Who understand that?

MS ANGEL: Sorry?

PROF MONTGOMERY: Who were you trying to help understand that?

MS ANGEL: The Trust.

PROF MONTGOMERY: The Trust.

MS ANGEL: It was a ~~this~~ committee ~~is~~ chaired by a non-exec and it was the right idea, it was a huge step on for the trust ~~me~~ in terms of understanding how to

get the best out of – how to learn and how to, but it had a way to go.

PROF MONTGOMERY: So how had the Trust been getting patient experience fed back before?

MS ANGEL: I think that's a question that we were trying to ask. I'm not sure we were getting a lot –

PROF MONTGOMERY: So you couldn't really track that?

MS ANGEL: – of feedback. Having said that, again in the quality group, you know, they would bring some information but it was quite limited and we ran a couple of workshops with the Trust to try and focus on patient experience at that time and they did take on a lot of that and part of it was the panel.

What we also did from my team, I had a safety and quality team and I asked two of my team members to then work with that group in the Trust to help them with – patient experience & quality.

PROF MONTGOMERY: Would you have expected that to be part of your role or would you have expected the Trust to be doing that for itself?

MS ANGEL: My role is wide and varied and, you know, I do whatever is required and at that time it felt like to me they needed some support in understanding how to do good investigations, how to get the best of out once they had done investigations on learning and there was a mutual understanding that they wanted that support. So two of my team members would go along and sit in the group and help support that.

PROF MONTGOMERY: So when are we talking about now, which year?

MS ANGEL: I would say that would probably be 2011 before the Gold Command but that carried on and sort of developed.

PROF MONTGOMERY: After a number of investigation reports had already happened then. So the Fielding Report, for example, was that discussed at that meeting?

MS ANGEL: The Fielding Report wasn't discussed at any of those quality meetings at all. The first time we knew about the Fielding Report was September 2011. That report came –

PROF MONTGOMERY: Who is 'we'?

MS ANGEL: The PCT. It came into the PCT. It came into the chief exec's office. I have the date if you want that date, but it was the middle of September – the middle towards the end of September and we hadn't had sight of that report – we didn't know that that report was available.

PROF MONTGOMERY: And did you see action plans at the same time as you saw the report?

MS ANGEL: No. We just saw, we just saw the report initially. As I can recall, we did have subsequently action plans. We had numerous action plans from the Trust about that report and other reports, so obviously there had been a number of things prior to us seeing the Fielding Report. But the Fielding Report was –

PROF MONTGOMERY: Which other ones were you aware of?

MS ANGEL: There was obviously what happened with the CQC, the NMC, all of those reports. So they were all there and available. The Fielding Report wasn't available to us until that September.

PROF MONTGOMERY: All those other ones were publicly available from somebody else rather than the Trust?

MS ANGEL: No, some of them were forwarded by the Trust and I was, you know, I was given them from different sources. So some of them, eventually all of them became available on the action plans through the Gold Command work, but prior to that we did some of those reports.

PROF MONTGOMERY: So roughly how many action plans do you think were running around September 2011?

MS ANGEL: Oh, gosh, I wouldn't want to put a figure on it.

PROF MONTGOMERY: Around the maternity services?

MS ANGEL: I know, I would say at least half a dozen that I was aware of.

PROF MONTGOMERY: Okay.

MS ANGEL: Then we asked very specifically from the PCT, and I had conversations myself a number of times, to actually try and see if we could bring them into one place. They really did need coordinating.

PROF MONTGOMERY: And what was the response?

MS ANGEL: I think there was a willingness to do that. I think it was quite challenging it would seem for the Trust to do that. I don't know if there'd been, and this is just my view, but perhaps a tradition of, you know, if an action was given in one place it would stay in that kind of division or that department, whereas this to me was a corporate responsibility big style by then and needed to be, and needed to be brought into one place so everybody could understand what was required.

PROF MONTGOMERY: So is that a conversation that you would have had with Jackie Holt at these meetings?

MS ANGEL: Yeah. Not at those quality meetings but by then I mean I had lots of

individual one-to-ones with Jackie. I walked around the Trust and we had a number of times when we just talked about support to her, what else could be offered. I had a Cumbria wide director of nursing group, we called it the chief nurses group which Jackie sat on, so that was quite a support and we talked about a range of services then. We talked about things that they were worried about, we talked about things that they would need support on. So there was a number of different places where I could have that conversation. But during the Gold Command what Jackie, Jackie was asked to be the incident director, which was quite significant for me and her because it meant that actually that became part of something else which was to me the right thing in terms of raising the bar and raising, escalating events but it did mean that actually she wasn't in her director of nursing role. So that sort of in a way the conversation was slightly different, let's say.

PROF MONTGOMERY: Did all those half dozen action plans, did they all get swept up into Gold Command or did some of them get lost or did they get pursued separately?

MS ANGEL: I believe most of them probably did get swept up. I'm not sure how many versions there might have been or, you know, but remember as well that there was a PMO.

PROF MONTGOMERY: A programme management office.

MS ANGEL: A programme management office that was, what we expected was the vehicle that would be handling all of that. When we entered into the Gold period, another contextual thing which has no real bearing on this in a way, but we did have another Gold Command at the time that I was the incident

manager for in a nursing home which meant that Mike Bewick and [inaudible] leading the Gold and leading the sub-groups so my involvement was mostly at the weekly and sometimes daily calls you know around the UHMBT Gold Command at the beginning.

PROF MONTGOMERY: The other Gold Command, the nursing home one.

MS ANGEL: Yeah.

PROF MONTGOMERY: What triggered that?

MS ANGEL: That was a safeguarding incident.

PROF MONTGOMERY: And how long did that stay in place for?

MS ANGEL: That was almost the same period and I did have a manager on that case, but I was dipping in and out of that and remained the Lead Director throughout.

PROF MONTGOMERY: And that was a single nursing home?

MS ANGEL: It was a single nursing home but there was some really quite serious and disturbing events at that time that meant that we, we did consider quite strongly closing the home and moving the people.

PROF MONTGOMERY: Was it – at the time was it finding out what had happened or finding placements for the clients?

MS ANGEL: I think probably a bit of, a bit of both. I think the other thing to say though here is that actually gave me a good opportunity to talk to the two safeguarding boards. I was on both the children and the adults safeguarding board about safeguarding and in my, I suppose, I am perhaps the one that perhaps sees what happened at Morecambe Bay through that lens as well as through seeing serious incidents and a set of things that had gone wrong for

those reasons, it felt to me, and I've described it as such at the time and subsequently, that for me it was individual safeguarding issue for individual families, for the babies and for children in a paediatric service, but it was also an institutional safeguarding issue. So I saw it quite like actually what I was doing in the nursing home. So it was quite a good way of just kind of keeping, it was clearly different issues but very similar in terms of safeguarding, so at that time I was asking a lot of questions about was there a safeguarding nurse, were there named doctors in place? And it wasn't all in place. It took, you know, some years to get the real tangible outcomes I was looking for in safeguarding.

PROF MONTGOMERY: So if we look at the Gold Command, do you think that the Trust could have got on top of those half a dozen different action plans running different places without Gold Command?

MS ANGEL: I think the way I've kind of just written it in my notes was there was a lot of people on the pitch at that time. There was a lot of players. There was a lot of organisations. The Trust were clearly under a huge pressure to get it right but as we started to develop with them one action plan other events happened and we then became aware after the serious incidents that we were aware of, we then became aware of the outpatient issue. We then became aware of other incidents as we were in Gold Command so I think it was very challenging and very difficult.

PROF MONTGOMERY: Are you talking about new issues emerging or old ones that you suddenly became aware of?

MS ANGEL: I think they were new ones, new ones on top of what was happening.

It became very apparent, going back to the Fielding Report, that the Fielding Report, I was shocked at that. It was, it was there in black and white some of the real tensions and issues I had been experiencing with some of the teams and there's disconnect between medicine and nursing and across the sites. So whilst we know all of that now, you know, at the time we were kind of, it was an evolving picture really but I think the Trust could have and should have had one action plan that was comprehensive with the help of what they we had in the PMO. We offered a lot of help ourselves from the PCT but often that was, it was slightly knocked back at times.

PROF MONTGOMERY: You talked earlier on about having to probe to get information out. I mean was your experience that they didn't want to share things with you that you thought you should see?

MS ANGEL: I don't think it was – apart from perhaps the Fielding Report which again on hindsight there's, you know, lots written about that. I think I didn't get that sense. It was, it was not freely available which signalled to me if it wasn't freely available to me it wasn't going to be freely available inside the organisation either, and it was quite difficult to connect it up. So a bit like the action plans that data would, you know, be in one place and one department not always married up and Jackie did share with me very early on and asked my views about the guru system, which is a system that was beginning to think about early warning signs and share data in quite a different way and obviously that was a good development but it wasn't there early on.

PROF MONTGOMERY: Did any of those IT systems actually have time to bed down and get up and running because they moved to [inaudible], didn't they?

MS ANGEL: They did.

PROF MONTGOMERY: Later on.

MS ANGEL: I think in the NHS generally we've got, you know, huge IT issues, so I think it would be unfair to perhaps just single that Trust out over any other in general terms, but actually knowing what they knew and the things that they were dealing with, it seemed perfectly reasonable to me to actually pay attention, you know, in a big way to try to get those systems to talk to each other and it was clear that wasn't happening through the out-patient work in particular. Again there was good intent but I'm not sure it came to fruition. I believe it has changed quite a bit now.

PROF MONTGOMERY: Tell me a bit more about the other professions that you've described that this was a predominantly nursing exercise, so I'm particularly obviously interested in the maternity and neo-natal care issues. So paediatricians and obstetricians; where were they in that?

MS ANGEL: They weren't at the table around the quality group other than the big workshops that we ran, because we did invite them and they came and they came across the organisation. This was in part an attempt to put the QUALITY AT THE CENTRE it was the, it was Hugh Reeve that was * chairing them so they asked specifically for that. Peter Dyer was there as the medical director and there was a joining up on those things, and I wouldn't want you to have an impression that the relationships were poor in terms of, you know, and laterally Mike Bewick and myself and the nursing – * BY THIS STAGE THE LOCALITY GP'S WERE BEGINNING TO CHAIR QUALITY GROUPS.

PROF MONTGOMERY: Just to be clear, which relationships? Because you told us

earlier that relationships between the professional groups and the Trust were identified as being poor in the Fielding Report.

MS ANGEL: Yeah, yeah. The nurse director, medical director in the Trust with the – it wasn't, it wasn't the CCG, it was the CCG in shadow form at the time. Hughie was the lead for South Cumbria and those relationships were good in the sense of there was good representation from the Trust to think about quality, to think about the quality accounts, to make sure that they were sort of looking at some of the quality issues. But that was – that was in a workshop; that was in that way of working. I don't think it was true of relationships in particular departments in the organisation. (the Trust.)

PROF MONTGOMERY: So in 2011 you get to see the Fielding Report, you've identified about half a dozen different action plans. They're pulled together through Gold Command and you get a grip on things. What information have you got that tells that services are actually safer now as opposed to people implementing the action plans?

MS ANGEL: Well, throughout this obviously we were dependent on the regulators to give us some of that assurance, not all of that, we had a role in at that time the PCT to get our own assurance and, as I say, we did some of that through the quality groups and through the contracting process. I think we were given some assurances when the CQC went back in. We were given assurances by bringing the Trust in the sub-groups from Gold, so the paediatric, maternity and paediatric sub-group, the out-patients sub-group. I was seeking it through the safeguarding route as well, which isn't as documented but actually it was really quite important. We had a poor CQC visit into the children's services in North

Lancashire and then a subsequent one in Cumbria and they were, Cumbria was deemed inadequate at that time. So I was really quite keen to have a peer review process and chaired a peer review group. So a team of some of my staff, some of the safeguarding staff at the local authority did a peer review visit. So there was sort of multiple ways of trying to seek that assurance.

PROF MONTGOMERY: To look at what? What did that look at, that period of your visit?

MS ANGEL: That looked primarily at safeguarding. It looked at safeguarding practice and it would speak to in maternity in particular to see if the named professional individuals, there has to be a named safeguarding.

PROF MONTGOMERY: And is there an action plan out of that?

MS ANGEL: Yes, yes.

PROF MONTGOMERY: Has that been run separately from any other action plans or have you planned a way of consolidating it?

MS ANGEL: I think now a lot of these things are in place. During that period too my role was, as the cluster nurse was I was there to make sure that the transition period was carried out appropriately. I was also there to coach the CCG and the CCG nurse into ways of working and in a way, it might sound bit sort of crude to say this, but the case study of Morecambe Bay it couldn't have been a better one in terms of learning what to do in a new CCG and making sure that the right systems were in place.

PROF MONTGOMERY: You have had a quality hand over system although it would have been slightly odd here because you would have been handing over to yourselves. What did it say about the maternity services and their quality?

MS ANGEL: Do you mean from, in my new role?

PROF MONTGOMERY: The documents you had to produce as the PCT moving over into the new one.

MS ANGEL: Yeah. There was two documents which I don't know if you have, but one was a corporate hand over document which covered everything from finance to estates to quality, but there was a quality hand over document which was myself and Mike Bewick's responsibility and that document outlines our concerns and our continuing concerns about Morecambe Bay. This wasn't something that just stopped when we handed over and in the –

PROF MONTGOMERY: Had it got better?

MS ANGEL: I think there had been improvements. Absolutely without a doubt there had been some improvements. It was not a place that I would have liked it to be at at that stage but I was then appointed to the area team role in NHS England, so Cumbria is still very much in my remit and I have to keep one foot very firmly in Cumbria because whilst I know this is about Morecambe Bay Trust that actually it's a very challenged health community and we are dealing with other trusts that have huge difficulties. The finances were difficult, the range of ?~~quotations~~. So our very first QSG on 1 March – I won't forget it – in the new area team that Morecambe Bay issues, alongside others, with the hand over documents right across the patch were presented and the new team again were quite shocked that there was still so much to do and recognised the progress but immediately we called a quality surveillance group on 5th April, which was a Cumbria wide one, and the intention was to have a Cumbria wide quality surveillance group. In fact, what's happened in practice there's been a

number of –organisation specific meetings there's been a care review in the north. There's been risk summits. There's been recently for this Trust another quality summit which I attended with CQC. So it's absolutely about not taking our eye off the ball. Tomorrow we have a quality surveillance group with ~~North~~ Lancs AT, and ~~North~~ Lancs AT lead that process now with us very much involved. If I could take the opportunity to say that the quality surveillance groups at this stage –

PROF MONTGOMERY: I was just going to ask a question, which is probably the same one and it will be my last one, which is: why should we be more confident in the quality surveillance group system in getting to the bottom of sorting this than we would be able with the things you've just described?

MS ANGEL: I think for a number of reasons. One, that there's been huge learning across the NHS in all this [inaudible] and post_-Francis for me post and currently what's happening with this organisation. I have actually listed here two pages here of learning for me about taking a very, very different approach. It's the first time I've seen in the room in an open and transparent way regulators and commissioners and what we've done in Cumbria which we don't, we haven't used so much in the North East because we haven't had cause to although we have had two Trusts actually come in, we have invited the Trusts in to talk to us about issues and problems and allow them to tell their story so that gives us assurance rather than I think what was happening back prior to the Gold and in the early years of my work we were always given reassurance and we were given lots of documents and lots of, you know, we were doing all sorts of really good things that actually that wasn't the same as

assurance and, you know, for me I've, I've got quite terrior [inaudible] like with some very probing questions when I visit now and I have been down to, you know, Furness quite a number of times just in the last year. The triangulation of information, soft & hard intelligence is improved. There is a greater will to share and in a timely way at very senior level.

PROF MONTGOMERY: Thank you.

DR KIRKUP: Thanks. Stewart?

PROF FORSYTH: Thank you.

MS ANGEL: Do you mind if I take my jacket off?

PROF FORSYTH: Yes, yes.

DR KIRKUP: Of course.

PROF FORSYTH: Of course. Are you okay?

MS ANGEL: Yeah.

PROF FORSYTH: You mentioned coming out of the Gold Command work that the paediatric sub-group had given considerable assurance around paediatric services. What had happened to give that assurance? What were the sort of key factors?

MS ANGEL: I think that what they were able to do, and I wasn't part of the group, that group partly because I was on the nursing home issues and I think, you know, it was seen that [inaudible] that with the organisation but I kept very close to it obviously and had weekly updates in our directors' meeting in the PCT. I think what they managed to do was get down to a level of detail that perhaps hadn't been there before. I think they had the benefit then of expert reports from a number of sources. I think there was, and this is my words

really, my view, but I think there was a level of honesty maybe and a level of understanding of what the problem really was, or problems, and that was where again some of the bringing action plans together, really getting down to who was really accountable for some of those things. I think accountability was something that we talked a lot about in the PCT and, you know, when you, when you're working with a big trust people from PCT particularly but others as well, go into the Trust on a number of different fronts. I think that was a focussed piece of work that actually really got some, some discussions going.

What I think it probably did as well was draw on the ANDY MITCHELL ~~mutual~~ report which was the earlier review of children's services in Cumbria and again on reflection and on hindsight that that report didn't really major on maternity services and what the group? [inaudible] was able to do was join up some of the paediatric work with what was required for maternity.

PROF FORSYTH: Why didn't that happen earlier? Why did you have to wait for that insight into children's services with the Gold Command? There were so many systems already in play, why did you not pick all this up at an earlier stage, looking at it again from a quality perspective?

MS ANGEL: I'm not sure I know the answer to that, to be honest. I think, rightly or wrongly, and clearly with things that went, I think that's probably, you know, been a real omission but I think there was a view, and it wasn't, I don't think it was just in this part of the world, that maternity services in particular, perhaps not, you know, obs and gynae and those sort of services but I think maternity in its pure sense would be seen as a well woman's service. It didn't feature on anybody's radar really. We weren't getting any indications from the GPs or

anybody that there was any concerns other than clearly once we started to get the incidents. What we knew subsequently there was no reporting so had we known some of that then we would have been able to establish facts quicker, I believe.

As you are probably well aware, you know, John Ashton commissioned a number of reports, perinatal reports on reports to look at, you know, what would then inform some of the current commissioning work and there's been a number of ways of bringing key people together across the organisation and commissioners, including ourselves latterly in the area team, on the two areas teams to develop, you know, a new way of providing the services. But I think it's fair to say that, you know, as a commissioner, you know, and I was a nurse, a professional nurse in my cluster role I wasn't seen as a commissioner as such although part of a commission organisation that we would expect and I would expect as a nurse that, you know, staff adhere to the code; that they have professional guidance and guidelines to work to and that was what we expected to be happening in all the services. Clearly we shouldn't make some of those assumptions, you know. Sometimes I think we need to be perhaps more all encompassing in our commissioning role. This specialist commissioning role that we have now in terms of commissioning networks and very specialist services is an overlay as well, so it's about understanding for me the complexity of that and making sure all that knits together.

PROF FORSYTH: I notice that you were involved in a look at maternity services in 2013, is that right, for the NHS England visit?

MS ANGEL: I did a number of visits.

PROF FORSYTH: With Neill Tomlin.

MS ANGEL: Yes, yes, I did. Teresa Fenech, who is at the regional office, myself and Neill Tomlin visited the maternity services.

PROF FORSYTH: So what was the driver for that visit?

MS ANGEL: Well that was, that's part of, you know, I guess our assurance and it was to offer support again to the departments, remembering that one part of this was ? [inaudible] when the Trust ~~it~~ went into recovery actually I was much more actively hands on involved in that and, you know, things escalated more than once in terms of staffing levels, particularly maternity staff and midwives in the SCABU and I have been down a few times talking to the staff at SCABU and seeing the new arrangements but that visit was almost bringing somebody else in just to give us that added assurance.

PROF FORSYTH: Did it give assurance?

MS ANGEL: It did give us a bit of assurance. I don't think I was entirely satisfied. I think we still saw practice that was poor. We found environments that were poor. I think it's, you know, this has all been compounded as well by the environment and I can tell you about a visit I made specifically before that. But that visit was about our assurance and that's the sort of thing we would take back ~~down~~ to the quality ~~core~~ surveillance group to say we have done that. It was –

PROF FORSYTH: So what has happened to it since then?

MS ANGEL: Well, I was just going to say that, but actually that visit, and this is just being quite honest and open about this, that when we visited the Trust that time, the Trusts were quite uneasy about us doing that visit, and part of that

had a number of things to do that staff have to be really vigilant on.

PROF MONTGOMERY: Can I push a bit on that because that doesn't come across to me from the report?

MS ANGEL: Right.

PROF MONTGOMERY: Which doesn't feel very different from the Fielding Report in 2010. So it would be interesting to know what, what the improvements were?

MS ANGEL: Yeah. Well, I mean obviously we were going to look at some of the same things because that's what our, you know, overall our concern was and that was us probing, as I said, you know, in asking those questions again. Because we, because of the of the context of our visit what was said to the Trust was they asked us to do that. Due to the anxiety of the trust of us visiting Teresa and I took the decision to feed the report in for the Trust at ward/matron level. Jackie Holt, Jack Daniels rather rang me on that occasion to see why wasn't this visit known in the Trust and we had a conversation about why we were ~~we're~~ going, you know, and I've been and I would be going again. So that, that report was actually given to Sasha and to Sheila Lloyd at the time to say 'this is for you now to actually put this against what we've been doing and validate some of that'. Myself and Carole Pontelli Lancs AT We went back and we've been back since to talk to Sue Smith about the report ~~that~~, you know, we still think that there's room for improvement. And even in the best of Trusts I would say some of my Trusts in the North East have particular standards and I would always, you know, talk to them about improvements. * Please also see emails re a visit in July 2013 when myuself, Carole Pontelli & Emma Nirez

was a lack of communication. It was that we'd asked to go and in all the trusts that I've got, including Morecambe Bay, on the whole I have ~~had~~ an open, I've an open door policy * this usually means I can go when I like but in reality I nearly always make an appointment. which is, you know, how I like to work and the directors of nursing generally speaking are like that and Jackie was no expectation. So I had, I had assumed, I suppose, that that would be okay and then in actual fact, you know, I have a role to do but I would always go through the right people in that connection. There was a bit of a disconnect in that visit. So they were, they were felt they were little caught a little bit on the hop. Actually that wasn't a bad thing because it meant we saw it as it was and we did point out to them a number of things around infection, prevention, the environment. We particularly said that RLI, you know, there was issues of infection prevention ~~depravation~~ and that kind of thing that needed to be put right ASAP. We had an opportunity that day to then go and visit Furness and I spent a fair bit of time talking to the staff on that occasion, seeing quite a lot of improvements, some of the, again that environment had improved dramatically for me having visited the year before and 2011 and I found it really — just on a very personal level but I had my children in Southampton and it was a very bright, open, lovely place to have babies, but I also worked at the health authority there and had a role in maternity services assurance and setting up Forums ~~phones~~ for engaging women in their care and that was, you know, partly Mike and partly [inaudible]. I now have the benefit of seeing all the units in the North East and, you know, by comparison that Furness was poor. So I did see, I did see a number of improvements but, as the report says, they ~~you~~

visited the trust. This was one of our benchmarks for improvements between visits (Already submitted).

PROF FORSYTH: Did you speak with the medical staff; obstetricians, paediatricians?

MS ANGEL: Yes, we did. [inaudible] was there and [inaudible] was there I think there was, I can't remember who else was there but we met Patrick and we talked about safeguarding but definitely Owen ~~Eoin~~ was there that day.

PROF FORSYTH: And did they, how did they view how things were going at this particular time? Did they feel things were moving in the right direction?

MS ANGEL: They felt they were moving in the right direction but they were under huge pressure. There was a lot of staff issues and the staffing numbers.

PROF FORSYTH: Staffing issues have been there since about 2004. I mean I just wonder, you know, is this a matter that's going to get resolved or how many were refused inspection or regulation, et cetera. You don't seem to have overcome that particular issue yet.

MS ANGEL: Well, if I could just talk about what's happening now for a moment. I know that's not your prime concern but actually some of those questions are still the same for me.

PROF FORSYTH: Mm-hmm.

MS ANGEL: You know, CQC have been in and I think they've found, you know, much more improvement in the maternity sectors than other areas that there's been concerns about.

PROF FORSYTH: Did the Commissioners, for example, have a vision of a sustainable model that they're working towards?

MS ANGEL: I think that that's become much more apparent in the last few months. I don't sit on the Better Care Together group. It's Mike Prentice who is the medical director in the area team, but I'm kept close to it and I think what I've seen is much more buy in to either consider options certainly in this last year or so and understanding that geography is one consideration but quality has to be the absolute paramount consideration in whatever make up the services are in the future and, you know, they ~~he~~ won't suddenly have a shiny new service, that those things that we find and those things that we talked about and still talk about with them are still things they have to be working at all the time.

But staffing isn't solved, it's a ~~in~~significant problem in Cumbria. It's a huge work force issue right across Cumbria and the Trust have worked solidly to try and get more midwives. For example, we had that escalation around SCABU and, you know, I've spent a lot of time myself with others there trying to just resource nurses from elsewhere. I think what I would say though is that you're right, you know, that staffing is always an issue wherever you are in a Trust. It's the Trust responsibility from a commissioning point of view. It's a Trust responsibility to find the staff, not for the commission although we helped.

PROF FORSYTH: So there's funding there for the staff so you're commissioning sufficient funds for staffing?

MS ANGEL: I think that we are. I think the CCG are, you know, clearly have a finite amount of resources. They back in, you know, those earlier years and still there is the issue that those resources have to be spread out for primary care and for North Cumbria and everywhere else. And in developing services for this patch it feels really important to me that we pay attention to primary care

who felt the poor relation because more resources were going to Morecambe Bay and more resources did go in from ourselves and from other organisations. Whether that's enough or not is something that can be debated always and, in my experience, you know, providers are always asking for more resources but I think the issue was, for me wasn't as much about resources but actually getting the right staff in and making sure that that was resourced and I believe they I have just got the resources for 16 new midwives for the community because it feels to me that this isn't just about the Trust, it's about the community and a lot of the work that we need to learn from.

PROF FORSYTH: It's about midwifery services.

MS ANGEL: Midwifery, absolutely, yeah.

PROF FORSYTH: Because the community midwives, are they part of which Trust are they then?

MS ANGEL: They are part the Trust.

PROF FORSYTH: They are part of triangular? (UHMBT) trust.

MS ANGEL: But they were, in my view, just in economic terms at least, and in the attention that's been paid subsequent to the incidents, the concentration has been in the Trust in the acute services and in the building whereas I think there needs to be a focus on community services. So my conversation with the CCG in particular, and they've now got a Director of Children's Services who covers maternity, and my conversations with her and with that team is 'you've got to concentrate on the whole of the midwifery pathway'.

PROF FORSYTH: Okay. Thank you.

DR KIRKUP: Just a couple of points I want to be absolutely clear about in relation to

the Fielding review. When were you first aware that the Fielding review was being commissioned?

MS ANGEL: We got the report, as I say, in that September but I think —

DR KIRKUP: You hadn't heard anything of it before you got the report?

MS ANGEL: There was, there was some noises that There was a report. I wouldn't be able to put a time on that, maybe that summer or late summer, you know, there was a report that we should have seen.

DR KIRKUP: That would have been the summer of 2010?

MS ANGEL: No, '11. '11 before the Gold.

DR KIRKUP: Okay. Because the report itself was given to the Trust in final version in August of 2010.

MS ANGEL: I know.

DR KIRKUP: Okay. And you hadn't, between August of 2010 and 2011 you hadn't heard anything of it?

MS ANGEL: No, no, no.

DR KIRKUP: Did you have any conversations with anybody in the Trust about why that might have been?

MS ANGEL: I did talk to Jackie and others and clearly we had meetings with the Trust we had a number of discussions about why that might be. I think there was a feeling at the top of the organisation that it was their business and, you know, in many ways, you know, I don't ask every Trust about every review that they do, that they have quite within their rights to do reviews. But obviously this was highly significant and we would have expected that to be shared with us.

DR KIRKUP: Yes, yes. Did you have any conversations with Jackie Holt about what

had been happening during that year within the Trust in response to the Fielding Report?

MS ANGEL: Yes, many occasions, many discussions with Jackie. One thing I would say is that Jackie's name featured highly in all the actions nearly and that is not just doable for one person. I think that it felt like it was again perhaps seen as a nurse led action not for the whole of the Fielding because there was some, there was clearly things for other people, but that kind of little bit of a disconnect in there in terms of the rest of the responsibilities.

PROF MONTGOMERY: So when you saw the action plan eventually did you recognise the actions that Jackie had been doing in between –

MS ANGEL: Yes.

PROF MONTGOMERY: – or did it fall back on a new plan?

MS ANGEL: No, I think she was very much on trying to make a difference with some of those actions.

PROF MONTGOMERY: But she didn't relate in any conversations to the fact there was a report?

MS ANGEL: Not to that report particularly,, but then remember there was a lot of reports so for me in actual fact even though it was highly important what all those reports said, the bottom line for me was always about the key things I asked when I go into any Trust is, you know: 'What are the good things that have happened? Are you proud of the things you want to share with me that you've done in terms of improvement?' And particularly with Jackie because clearly there was a big improvement piece of work to be done, but then, 'What are your concerns and what are the things that you're worried about? What

keeps you awake at night?' And if they tell me that there's nothing that keeps them awake at night, no, I don't believe that. And Jackie was very open with me and some of it was just in terms of giving her a lot of support of what she needed to do, but it was clear to me that, as I say, it couldn't be a single person task and –

PROF MONTGOMERY: Right. Are you saying that your view was that she wasn't getting the support that she needed to implement the recommendations?

MS ANGEL: I think at times that probably was true.

PROF MONTGOMERY: And where would you think that she would have been looking for that support from?

MS ANGEL: I think there's a number of ways of sort of answering that. One is that, as I say, in any action plan it surely should be a corporate Trust wide board responsibility in actual fact. You know, the whole board; the non-execs and the chair and the execs. And it may be that I have a particular view because obviously my conversations were mainly with Jackie, not exclusively by any means and I don't want you to think that I didn't talk to anybody else in the Trust, that's not at all the case. But obviously my link with her being the nurse was with her as the nurse and she was focusing on, you know, developing a nursing strategy which she did a nursing and midwifery strategy. I was at the launch day, and that was probably maybe 2008/9, and her focus really was around some of the work at that time. It was the HARM FREE ~~Half Way~~ Care and the safety Thermometer ~~of the Monitor~~ type work that we are all familiar with from a nursing point of view. Maternity did not feature as highly.

PROF MONTGOMERY: Yeah.

MS ANGEL: But it didn't, the strategy – so the strategy was running this way so, you know, lots of things that came out of the strategy in fact had some actions to do her own improvement plan that she had reported to the board, and then obviously from the investigations and everything else, all the action plans that came out in subsequent reports. So I guess what I'm saying is that was quite big. And then she was taken ~~took~~ out, she was ~~on~~ the incident director and there was support put in behind that for nursing but it felt like perhaps that was, you know, a bit of a bubble.

PROF MONTGOMERY: Yeah. You're talking about slightly developmental things here, but most of what's in the Fielding report, not all of it; most of it is about doing some fairly basic things properly.

MS ANGEL: Yes, it is.

DR KIRKUP: And did you get the impression that that was being taken forward?

MS ANGEL: I think it was being taken forward. I think it was being taken seriously. I went down again on a couple of occasions to discuss?~~make~~ the quality? [inaudible] account and Sasha wanted to know, you know, exactly what we were doing about, you know, each of the incidents and all of the things that had gone on, the governance. But I think maybe and I think, I have no real evidence of this really, this is my impression, was that some of that was very much about that maternity department and again it needed support that department and it needed to connect up, you know, both from the professionals in the department. So there was a, I don't know what they called it, I think it was a near misses kind of meeting on a weekly basis looking at any incidents, which is good practice, that's what should be happening but not the

whole team were at that. So that was the sort of thing that I would go back and I would say to ~~exact~~ Jackie: 'Look, absolutely, you must get attention to some of these things'.

DR KIRKUP: And I wanted to ask you specifically about this, because there's a bit of a theme in the Fielding Report about lack of multi-disciplinary working.

MS ANGEL: Yeah.

DR KIRKUP: Different professional groups not trusting each other, not relating well to each other. You can't cure those problems from a single professional background, can you?

MS ANGEL: No.

DR KIRKUP: Where are the medical team in this? Where's the medical director? Is he involved?

MS ANGEL: Well that's my question really. I think there was –

DR KIRKUP: No, that's my question.

MS ANGEL: They were not. No, but I think I was questioning that at the time. A lack of prescence & joined up approach.

DR KIRKUP: Okay.

MS ANGEL: That for me.

DR KIRKUP: The answer you got was?

MS ANGEL: The answer I got was that the medical director was very much in the room. He was with that conversation. He understood that. It doesn't just take the medical director, it's the medical staff, isn't it, and there was a disconnect for me between the sites, there was a disconnect in the department itself in terms of, you know, who was owning those issues, who was leading. For me

there was a leadership problem and some of that, you know, from my opinion is it's still just not firm enough. It's getting there. It's not just firm enough and there was some professional issues. You know I talked to Jackie often about the NMC type issue and they were nursing and midwifery issues, but you would expect other in as much as medical director needs, you know HR, it's other parts of the system to support that work and whether it just wasn't possible to really focus it all I'm not sure, you know, about the answer to that, but we certainly had some of those conversations.

DR KIRKUP: Okay. Now, there's some fairly significant concerns I would have thought about the improvement programme in response to the Fielding report in the Trust there. Who did you report those back to?

MS ANGEL: Back in to the PCT. We had, you know, as I say, we throughout ~~threw out~~ the Gold and in any case we met on a weekly basis. We took a lot of that back into the serious incident committee. I think we had a pretty robust system actually, which I take some responsibility for. We did feel that we had a good committee there. One of the things that, and I guess the families are here as well, one of the things for me, and again one of the things on my long list of learning things is that for us in the PCT we would get things almost, certainly second-hand but often, third, fourth hand.

DR KIRKUP: Yeah, sure.

MS ANGEL: That was true of all the reports, it was also true of the work of SHA, the MSLA ~~NSA~~. For me there was a disconnect between my role. I was never actually involved in some of those discussions because the MSLA ~~NSA~~ and the SHA, you know, had a, they had a responsibility for that.

DR KIRKUP: Yeah. Did you report your concerns to the SHA?

MS ANGEL: I did, yes. I mean that was again Angela Brown in particular, you know, I worked very closely with her throughout all of this process.

DR KIRKUP: Okay. Thank you. Does anybody want to ask a follow up? Is there anything you would like to say to us?

MS ANGEL: I think I was just going to say perhaps if we're to round off as well is that for me when we saw incidents in the PCT, this is a horrible thing to say but it is true, we get them as a number, so we get them as a case, as an investigation, as a complaint and what I tried to do now, and what actually we did do in the PCT, but there was some difficulty because people felt that it was confidentiality that, and to understand the case itself, the person behind that, the people behind that and that's quite difficult in a distant organisation.

DR KIRKUP: Yeah.

MS ANGEL: So I think we've learned hugely from that and I certainly make it my business to ~~kind of~~ know the whole story and we run a number of learning events actually and hopefully concluding your work as well that will be taking that approach. [inaudible].

DR KIRKUP: Yeah. Okay. Thank you. Thanks for coming. That's the end of the interview.

MS ANGEL: Thank you.

[Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Thursday 11 September 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

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

MUHAMMAD ASGHAR

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

MR BROOKES: Good afternoon. Okay. Thank you and welcome. I know you have had a difficult journey so thank you very much for making yourself available.

The Chairman, Bill Kirkup, unfortunately is not able to be here today, so I am going to be chairing this process. We just -- it is very important part of the review. It provides us with a crucial insight into what is actually happening and gives us an opportunity to check our understanding from the evidence that we have been provided.

The second half, I will give you an opportunity to introduce yourself, but first of all if we can in to us the Panel.

DR CALDERWOOD: I am Catherine Calderwood. I am the obstetrician in Edinburgh and I am also a medical adviser for Scottish Government.

PROF FORSYTH: Good afternoon. I am Stewart Forsyth. I am a paediatrician from Dundee in Scotland and a Medical Director in Tayside.

MR BROOKES: I am Julian Brookes. I am on the Panel looking at clinical governance and previously Head of Clinical Quality at the Department of Health and currently Deputy Director of Operations at NHS England.

PROF MONTGOMERY: I am Jonathan Montgomery and I am Professor of Healthcare Law at University College London, and Chair of the Health Research Authority. I have the ethic's brief on the Panel. I have previously chaired NHS Trusts, PCTs and SHAs.

MS FEATHERSTONE: I am Jacqui Featherstone I am Head of Midwifery and Head of Nursing for Women Health at an Acute Trust in Essex.

MR BROOKES: So, you are?

DR ASGHAR: I am Muhammad Asghar. I am a Consultant Paediatrician in Barrow-in-Furness and the Furness General Hospital. For the last about nine years.

MR BROOKES: Thank you. Just to explain, as I said, there will be a series of questions. The microphones are here to

record the proceedings today so that we can take a record of the discussions.

These sessions are open to the family but, as you will have gathered, there are no family members here today. One of the reasons for making a record is to allow the families at a late stage to hear what or to see what has happened in a supervised way.

Part of the supervision is because one of the crucial elements of this is that it this is a small part of the overall evidence we are collecting for the review and it is really important for us that nothing is taken out of the context and that, therefore, what happens in here is kept confidential until we have had an opportunity to assess all the evidence that comes in and provide that as part of the result.

Part of that is, therefore, is as we have asked everybody to give us electronic equipment so that there is no opportunity for alternative recording of this. Therefore, that is the way in the

methodology in which we want to work.

In some cases, as I think in this case, there will be some specific discussions about cases and in those cases if there had been family members, they would have been asked to leave because of confidentiality issues.

Without further ado, there is no expectation that there will be a fire alarm et cetera today, if there is we will take either take guidance and follow it through.

We will start with Stewart and Catherine who will lead off with the questions.

PROF FORSYTH: You said that you came to Furness General nine years ago. Can you very briefly tell me where you have worked previously?

DR ASGHAR: I started in Furness General Hospital in 2005, in April 2005, as a locum consultant. Then I got substantive post in January 2006. Before that I worked in Canterbury, for about 18 months and before that I was in Northern Ireland.

PROF FORSYTH: What level was that at?

DR ASGHAR: In Canterbury I was staff grade paediatrician and this was my first consultant appointment in 2005. In Canterbury I have been also doing a locum consultant work and in Northern Ireland when I was also. I worked there for from 1995 to 2003 and until I moved to Canterbury and I used to work for part-time as locum Consultant Paediatrician, as a staff grade paediatrician as well.

PROF FORSYTH: So when you started in Furness, what was your job description or your job plan? What were your various clinical commitments?

DR ASGHAR: Well, when I started here, I was told that I will be doing general paediatrics and covering neonates as well. The neo-natal unit was level two at that time, now it is level one.

PROF FORSYTH: When did it change from level two to level one?

DR ASGHAR: I think it was about, roughly,

I would say about four years ago because -- in four or five years ago because these -- I -- I do not know. I think, it was Dr Anthony Emmerson or somebody from Burnley or this neonatal network in Burnley and that area.

There were a lot of discussions going on and we used to look after, say, everybody who was born to be ventilated for about 48 hours maximum and then transferred them out AFTER to stabilization -- so level two unit also considers stabilization and then transferred the babies out to wherever that was COT available like in Manchester or, depending on the condition, Liverpool or Alder Hey.

Now, at the moment, there were people -- only over 32 weeks are kept so even those who are C-Pap or -- they are also need to be transferred out.

PROF FORSYTH: Right, okay. So we can maybe come back to that in a moment. Just again describe your clinical commitments. Are you still doing a general paediatrics and neonatology.

DR ASGHAR: Yes, general paediatrics and neonatal. At the start I was also -- I was appointed as a generic paediatrician, basically, even though I did not have much experience in community paediatrician so my job description at that time, at the time of the interview, I was told that I will be doing general paediatrics neonatal and some bit of community. It was in the advisory -- it is 20 percent of community.

I did a little bit of community, probably that is why they accepted, but at the interview I was told that I will be trained to work as a community paediatrician -- work as a general generic paediatrician. But to cut a long story short there were a lot of failures.

For example, you talk of the "job plan". I never had a job plan for five years. In job from 2005 to 2010. My first job plan was first discussed in 2010, in August 2010. So that was only one thing.

The other thing is that I was told I should be doing two clinics, general

paediatric and two community – I mean, community paediatrics. I didn't have any training in community paediatrician -- in community paediatrics. Not much. I had never seen autism and I had never seen ADHD and all that stuff.

I thought at the start that what they are talking about is like developmental paediatrics, cerebral palsy or genetic condition that I will be looking after. We see that in general paediatrics as well. But gradually I realized that there are problems at community paediatrician, the lack of staffing and nobody is coming to do the community paediatricians and so they are pushing me more and more to do behaviour problems and ADHD which I was never.

In one of the senior be meetings with Dr Paul Gibson and David Stacey who were the clinical directors at that time, I showed them GMC look booklet. "Look, you are asking me to do to work beyond my competence and that is not right."

So that was the start of my job.

PROF FORSYTH: Right and so was your job plan subsequently changed?

DR ASGHAR: Well, gradually. To cut the long story short, I think, there were problems with community paediatrician and generic paediatricians doing work which they did not work very well and other paediatrician was also appointed alongside me as a generic paediatrician. He never did any community paediatrics. He totally refused that. Said "I am not going to do community because I don't have experience."

In October -- in October, I think, in October 2010 they -- 2011 I think. In October 2011 probably, the PCT at that time, withdrew the funding for generic paediatrician for -- because -- we, two of the paediatricians, we used to be get probably funds from Trust as well as some bit from PCT for doing community but they withdrew that funding and they said:

"No, we want to employ our own community paediatrics".

So that community brought my job came

to an end, in mid-2011. So from then onwards I was also doing general paediatrics and neonates.

PROF FORSYTH: In terms of you continuing training and maintaining your skills, what continuing professional development would you be undertaking? Are you currently --

DR ASGHAR: Well, I have always been taking part in the Royal College -- in College -- the Royal College of Paediatric Childhood Health CPD and, in fact, I started taking part in CPD when it was started in 1996 and I have record of those.

I have kept myself up-to-date attending different courses, even though sometimes the Trust funding was only -- at the start it was £800 a year, now it is £500 a year but I have spent myself to keep up-to-date and I had a appraisals every year from -- not at the start but only -- first job plan was discussed in 2010 and then every year they had appraisals things got little bit better.

PROF FORSYTH: From 2010 formalized job plans and appraisal scheme put in place at that time?

DR ASGHAR: Yes. I have appraisal from 2010, 11, 12, 13.

PROF FORSYTH: Who undertakes -- who --

DR ASGHAR: The first three appraisals which I had was with the Clinical Director Dr Gibson. Then the next two or probably three were with the present Clinical Director with -- who is Owen Gault. My last appraisal was on 7 November, 2013, because after three appraisals with the same person you are -- you should -- you are supposed to change the person.

So I had appraisal with Dr OLABI ~~Reddie~~ who is the clinical lead in FGH at the moment because he -- his was the first he -- the first time as an appraiser so Owen was present at that.

MR BROOKES: Sorry to interrupt. It would be helpful for us because we are running late if we could try to keep answers as succinct as possible and if we need

further information, we can. It is just about timing.

PROF FORSYTH: I think it is important to --

The appraisal scheme, I mean, was that something that influenced practice? Did you feel that having been appraised that that influenced the quality of practice that you were able to provide? From the feedback?

DR ASGHAR: Yes, it was good because -- I think it was helpful, yes.

PROF FORSYTH: If we were just -- in terms of working relationships and paediatrics as a paediatrician, did you feel you had good working relationships with the obstetrics service and midwifery service.

DR ASGHAR: A relationship between the paediatric department and the midwifery department?

PROF FORSYTH: Yes.

DR ASGHAR: I would say- NOT ~~not say~~ -- there had been communication problems between the departments, there have been communication

problems between the paediatricians, even the paediatricians themselves. It was not an ideal place, in my personal opinion, people might disagree but it was not an ideal place.

I will say that it was NOT a good team work. There were conflicts between the paediatricians.

PROF FORSYTH: And the midwives?

DR ASGHAR: And midwives about the guidelines, what to follow, whatnot to follow. I was the lead in guidelines as well and I found it quite difficult.

In midwifery, they have got their own guidelines and we had our paediatric guidelines, say, for example neonatal sepsis. I was the one who joined the guidelines together and as a lead in guidelines, I did a lot of work in this area.

PROF FORSYTH: Do you think that the poor relationships between the different professional groups had an impact on the quality of care that was provided for the mothers and their babies?

DR ASGHAR: Yes, of course. I mean, if team work is not good it certainly might, in my opinion, affects the patient care.

PROF FORSYTH: Thank you.

DR CALDERWOOD: As an obstetrician, I am interested to hear about what your relationships with the other staff. What the relationship between the obstetricians and the paediatricians?

DR ASGHAR: Well, we as paediatricians, we used to have weekly meetings, senior meeting every Thursday. Obstetricians were NOT really involved in our meetings. The only place where we used to have some discussions and face-to-face interaction with obstetricians was perinatal mortality meeting, which were three time a year or four times, three to four times in the year.

DR CALDERWOOD: Would you feel there was communication with, if there was a high risk mother in labour or somebody that they were concerned about, would you hear about that if you were on-call? Would you be alerted in advance to some potential

problem?

DR ASGHAR: Yes, we were alerted as I remember. We were alerted in advance. There was alert forms which we used to keep in the neonatal unit. The neonatal lead was another one of my colleagues and he used to have -- so we knew what sort of babies are going to be at risk.

DR CALDERWOOD: Okay so there was some communication.

DR ASGHAR: Yes.

DR CALDERWOOD: Obviously, you are here because there have been problems and baby deaths and maternal deaths in a hospital that you work in. What do you think about those? Do you have a solution to what or a theory as to what some of the key problems are?

DR ASGHAR: When I started working here the first thing -- I mean, you are asking me about the problems, what problems. I realised there were governance issues which, in my opinion, was a very serious issue and this issue has been bought up over and over again in the senior meetings

but no manager has listened to us.
DR CALDERWOOD: What's the issue?
DR ASGHAR: The consultants, as consultants we used to stay, I mean, I was staying in doctors RESIDENCE ~~resident~~ behind the hospital BUT OTHERS ~~about other~~ they stayed at home. So the junior doctors, at that time, they were four staff grade and four junior doctors, some GP trainees. So when THERE ~~they~~ are staff available, they are on their own. There was no middle grade tier; that is what I am trying to say.
DR CALDERWOOD: That will be common of a lot of hospitals of your size.
DR ASGHAR: Yes, but the GP trainees were, without any paediatric or neonatal experience, were being left on their own to deal with the neonates. I mean, if the baby is born flat you need to be there next minute. The consultant -- I have been -- I have experienced personally myself that if I jump out of bed in the middle OF NIGHT, it usually take me at least seven or eight minutes to be there. This governance issues that GP trainees are

being left and exposed with no training, at all, to deal with the new births, to very pre-term births, consultants running from home --

DR CALDERWOOD: Who's responsibility is that? You are on call with a GP trainee who has no experience --

DR ASGHAR: It is the consultant.

DR CALDERWOOD: -- it is your consultant's responsibility?

DR ASGHAR: Yes. That is why, as a consultant body, we tried to bring these issues to the management. If you don't mind --

DR CALDERWOOD: Hang on a second. Sorry. If it is the consultant's responsibility, you have said that, why would you go home to sleep in bed if the trainee was not competent to resuscitate a neonate? Answer that, that is my question.

DR ASGHAR: Yes.

DR CALDERWOOD: I do not --

DR ASGHAR: The consultant -- the system, the on-call rota was such that the consultants were on-call from home. There

was no resident on-call. If you don't mind if I tell you --

DR CALDERWOOD: I know --

DR ASGHAR: We can talk about the rota --

DR CALDERWOOD: I do not want to talk about the rota.

However, you were not resident on-call, in common with most of the practice across the UK. There is not, at the moment, resident on-call in anything like -- it is a tiny minority. You are the same as everywhere else.

There was a GP trainee who you did not feel was competent to resuscitate a neonate. When there were labouring women there, and you, as the consultant on-call went home to bed -- that is what you are telling me.(I was talking of unexpected deliveries here)

DR ASGHAR: As a consultant we went where?

DR CALDERWOOD: Because you were on-call, there would have been a labouring woman there, and a person that you regarded as not competent to resuscitate a neonate, but you went home to bed.

DR ASGHAR: What I am trying to say is

that during the daytime the consultants were nine to five in the hospital --

DR CALDERWOOD: I understand that.

DR ASGHAR: After five o'clock the consultants were on-call from home. If I knew, or my COLLEAGUES ~~colleague~~ knew, that there is a mother labouring, nobody will go home.

DR CALDERWOOD: Fine. That is the answer. You did not go home.

DR ASGHAR: No. No. Nobody went home but anything can happen unexpected. If I am at home, in the middle of the night, and some woman comes with a 26-weeker and they are -- THEN ~~that~~ I have to run. There was no resident on-call rota.

If you do not mind at the expense of this --

DR CALDERWOOD: Hang on. We are not -- I have a series of questions to ask you, you are about to tell me something about the rota; I want to finish what I am asking you about.

I suppose what I am getting at is that it is -- if there are, of course, issues that we cannot predict, I am an

obstetrician and things happen and, as you say, a 26-weeker comes in, in the middle of the night, but that is the responsibility of the consultant to liaise with the ward.

Was there a good communication? Were you always informed when the baby was admitted to the neonatal unit? Were you always made aware? If you were called, did you make yourself available?

DR ASGHAR: Yes. Not only me but other consultants as well they are made available. There was communication -- if there is a problem or if there is an at-risk pregnancy, or at-risk delivery, they were made aware. We were made aware and we were available whether it is day or nighttime.

DR CALDERWOOD: If I was to go to the hospital now, and I was to ask your peers -- so your consultant colleagues and the midwives and the nurses -- what would they say to me about Dr Asghar and his availability when he was asked to come to see a patient?

DR ASGHAR: If you are asking me personally, me, I was always available.
DR CALDERWOOD: I am asking what they would say about you, not you. I am asking you if I went and interviewed one of your colleagues, or one of the midwives or nurses and said, "Tell me about Dr Asghar. Is he available when you telephone him? Does he come to see"—
DR ASGHAR: I am sure they will say I have been available. However, I would like to say that there were issues, which was investigated about the rota by the Medical Director, about non-availability about the bleep problems. About –
DR CALDERWOOD: Tell me about that –
DR ASGHAR: There were issues about that.
DR CALDERWOOD: – bleep problems were what?
DR ASGHAR: That is what I would like to say. You said "bleep problems."
DR CALDERWOOD: No, you said bleep problems.
DR ASGHAR: Okay. Do you want me to explain?

DR CALDERWOOD: Yes.

DR ASGHAR: Okay. THAT ~~There~~ was a few years ago there was the switchboard from Barrow was moved to the Kendal area. That was a few years ago. I used to get wrong bleeps/STRANGE ~~stray~~ numbers. Somebody might have been looking for me but I am not getting the right bleep. There were bleep problems. I have documentary evidence where wrong person was being bleeped instead of --ME

DR CALDERWOOD: What was done about that?

DR ASGHAR: Well, I do not think there was anything done about that.

DR CALDERWOOD: Okay. Setting aside the bleep problem, if you had been bleeped and answered the telephone and were asked to come and see a baby in the middle of the night, what would the midwives and nurses say about you? He always come?

DR ASGHAR: I always came.

DR CALDERWOOD: Always came?

DR ASGHAR: Yes.

DR CALDERWOOD: I could go --

DR ASGHAR: You can go and ask them. I

always -- when I was informed, if you are asking me I personally myself, when I knew that I am being called I will always go and I will always, no matter how trivial is the problem. I have documentary evidence to show you here.

DR CALDERWOOD: You are unusual because I have to say that I would, if I was asked that question, I would say I do not always go.

DR ASGHAR: But I --

DR CALDERWOOD: You always go?

DR ASGHAR: When I was informed that there is a risk pregnancy, whether I am at home or whether I am -- I will always go no matter how trivial is the problem because I knew that there is no middle grade cover and I knew that the junior doctor is without an experience.

DR CALDERWOOD: Well, that is the answer I was hoping for. You would always examine the child or the baby?

DR ASGHAR: Yes.

DR CALDERWOOD: Completely?

DR ASGHAR: Yes.

DR CALDERWOOD: You have talked a lot about your documentary evidence.

DR ASGHAR: I can give it to you. MD Hired Mr Charles Flynn to investigate the Rota Problems and "Non Availability" issues. He identified- Bleep problem- midwives were bleeping the wrong person and then altering the notes to show that they had bleeped the right person.- No fixed on call room for the Consultant on call- sometimes with no telephone. Sometimes Consultant used Parents' room. (I have submitted documentary evidence about this to panel)

DR CALDERWOOD: I have some documentary evidence here that you were called to a baby and that you have not attended.

DR ASGHAR: Well, that is -- I will show you the documentary evidence here. If you don't --

MR BROOKES: We have not got time to go through it --

DR CALDERWOOD: I am making the point that I asked you a direct question, you answered me, but I have documentary evidence that is contrary to that.

DR ASGHAR: I have documentary evidence --

DR CALDERWOOD: Maybe we should start -- I do not want to hear about your documentary evidence. Maybe we should start with getting to -- what we are trying to do is to help this situation that we are in. Babies and mothers have died in your hospital, and the reason we have called you here is not only to talk about you personally, is to try to discover issues

that we can help to change for the future. We need to tell the truth and to answer as much as possible because, otherwise, we are not going to be able to move forward.

DR ASGHAR: Obviously.

DR CALDERWOOD: I suppose what I would ask you about what you think about the problems, and you have given very clear discussion about that. What do you think the parents would say about the unit? What do the parents say about you when you are there and when you are looking after them?

DR ASGHAR: Particularly about me?

DR CALDERWOOD: Yes, please.

DR ASGHAR: Well I didn't -- I do not think that parents were unhappy with me. However, having said that, every -- IN present atmosphere, every consultant would have complaints. I mean, there are complaints about the parents, from the parents, about the consultant paediatrician, or obstetrician, or whoever and I have some complaints as well.

DR CALDERWOOD: As we all do at times in

our careers.

Do you know the nature of those complaints? You know yourself; is there a theme that goes through, the complaints are the same about different people? What are parents complaining about?

DR ASGHAR: Well, I have some complaints say -- I mean, do you want me to explain each individual complaint?

DR CALDERWOOD: I suppose it is -- are there themes? Is there something that comes up over and over again, complaints?

DR ASGHAR: I cannot say, not that I know of IN ~~with~~ particular.

DR CALDERWOOD: What's the Trust's attitude to the complaints and how do they handle the complaints and you and the family? How do they deal with complaints from your opinion?

DR ASGHAR: Well, if I -- can I say about patient safety incidents as well, PSIs?

DR CALDERWOOD: Yes.

DR ASGHAR: Because some PSIs were -- if there are some neonatal or children issues, nurses were also putting in ~~up~~ PSIs.

Complaint issues from the parents has been in the Trust, another issue. There is documentary evidence documented that the Trust has not been dealing with PSIs in a timely fashion.

I have not brought it here now, but it has been -- I have documentary evidence for that.

I was not aware that what is PSI. I mean, if I have made a mistake, or if -- because a few years ago I was trained to do RCA (root cause analysis) myself by the Trust itself, so at that time, I say if there has been a complaint, complaints WERE ~~what~~ sent to me, and I will answer. I will look at the notes and answer the complaint and complaint or legal department they will deal with that and they've dealt with me about my complaints WHAT ~~with~~ people might have done.

PSIs was an issue which generally majority of PSIs were put in by the nursing staff. The Trust that was dealing with PSIs was not in a timely fashion. Say, for example, if somebody has put in a

PSIs for me, or some RCA has been done about me, and I particularly have a baby about whom RCA was done, the person who was involved say, for example I was involved in one of the baby here who died [redacted] RCA was done three or four months AFTER ~~age~~, but person was not involved. I was never aware of that until two years,AFTER about quite recently.

The Trust did not -- and managers and clinical directors -- they did not deal with the PSIs in a timely fashion. We were not aware what's happening about this. I mean, the main idea about RCA and PSI is to learn lessons from them so the person -- if I HAVE ~~am~~ missed something or if I have done something wrong, I should be involved and I should be told so. Something that I miss, something anybody -- I mean, you and me, so that is not repeated.

But that was not happening in this Trust. That is one major --

MR BROOKES: For clarification, you were not aware of a PSI, or you were not aware

that there was an issue, which might have caused the PSI?

DR ASGHAR: I was not aware that PSIs are being put in.

MR BROOKES: But you were aware there may have been complications surrounding a particular case.

DR ASGHAR: But when I became aware that PSIs are being put in.

MR BROOKES: PSI is a way of reporting an incident. If there had been a problem in the care provided by you, what would you do about it?

DR ASGHAR: If there has been a problem, I will look what I have done wrong, what I have -- what lesson can I learn and how I can improve myself to improve the knowledge. Improve my knowledge, to improve the ? SERVICE ~~purpose~~.

MR BROOKES: Were you doing that independent of the PSI request?

DR ASGHAR: Yes.

MR BROOKES: Thank you.

DR CALDERWOOD: Do you think that process could be improved on the way that --

DR ASGHAR: It has improved over the past, I will say about a year/two year. Now, RCAs, I am involved with RCA now myself and if there are PSIs they are discussed in the senior meetings and we know everybody tries to learn lessons from that; that was not happening few years ago.

DR CALDERWOOD: Do you see any other changes that are trying to bring improvements in the unit?

DR ASGHAR: Well, as I said, because of those governance issues that GP trainees WERE ~~are~~ being left all alone, they tried to hire more staff grades. That did not work out. Then they brought in the resident consultant on-call rota from February 2009. I have that rota here. This was the rota from February 2009 was bought in. However, this rota also HAS ~~as~~ problems in itself. Then in from 2005, IM us say from 2005 to 2008 we were HOT WEEK ~~hardly~~ consultants. I was -- if I am HOT WEEK ~~half team~~ (?) Consultant I was working seven days and seven nights. Day and night. I was

on-call for seven days and seven nights continuously.

DR CALDERWOOD: How many times on average would you be called in?

DR ASGHAR: We were four consultants at that time, so one in four rota. Every fourth weekend and week I was on-call from 2005 to 2008.

DR CALDERWOOD: How many times, on average, would you be called in any one night?

DR ASGHAR: Depends. You can be busy the whole night.

DR CALDERWOOD: That is probably be what --

DR ASGHAR: You might be called two or three times.

DR CALDERWOOD: On average? Bearing in mind I know how many deliveries there are.

DR ASGHAR: You are busy until 12 midnight any way, then you might get a few hours' sleep after that because you're doing continuous seven days/seven nights up to 100 --

DR CALDERWOOD: Have you ever audited, had to hand in a record of the bleeps and the

1 number of times you have attended

2 out-of-hours?

3 DR ASGHAR: I do not have record number of

4 times I have attended. I now recall that in 2006 we were asked by CD (Dr Gibson) to keep a diary this was a hard written record (enclosed). Then in 2008 Trust hired Ernt and Young Firm who asked all Consultants to keep the diary. I did this from 30/6/2008 to 21/9/08. This diary showed workload for all Consultants way above the usual 10 sessions (enclosed)) No action was taken by Trust about this. In fact diary was just dumped.

5 DR CALDERWOOD: Have you been asked by

6 people to fill in that number of

7 out-of-hour calls?

8 DR ASGHAR: No. I think, that was never

9 asked that we should be doing that. I do

10 not think that anybody has done that.

11 DR CALDERWOOD: When I asked how many

12 times, on average, you would be called

13 out-of-hours in any one week you cannot

14 tell me?

15 DR ASGHAR: Well, I can tell you, from my

16 own background from memory, but not -- I

17 don't have record of that.

18 DR CALDERWOOD: Sorry, no good. You have

19 never written it down anywhere?

20 DR ASGHAR: Nobody has written down how

21 many times. Not only me, but any other

22 consultant, as far as I know, did record

23 that we were that -- how many times we

24 were called at night time.

25 DR CALDERWOOD: Unfortunately we cannot --

that is where it suddenly runs into problems about how busy you are because we do not know.

You were going to tell us about how the resident on-call came in. Do you think that then has improved the quality of the care? The fact that you are saying right at the beginning it took time for people to come because there is an emergency situation and they were at home now there is resident on-call.

DR ASGHAR: I will tell you what exactly happened. 2005 to 2008 we used to work one week HOT WEEK ~~half week~~ day and night, up to 168 hours HOT WEEK. From February 2009 to mid2012, this is the rota, which I gathered, I collected myself. I do not have the rota from before that, this is from February 2009 to mid2012.

Resident on-call rota -- over the years I must say that year 2009/10/11 we used to have four -- eight junior doctors but then, gradually, their number dwindled because of the visa problems and all that. There was a difficulty.

DR CALDERWOOD: It is all over the UK, not just you.

DR ASGHAR: We were only left with sometimes with only three or four junior doctors, say two GP trainees at one staff grade. So when –

DR CALDERWOOD: You were lucky to have any.

DR ASGHAR: Sorry?

DR CALDERWOOD: You were lucky to have any junior doctors. Lots of units, like yours with small numbers, would not have any junior doctors. I suppose what I am trying to establish is what did the resident on-call consultant – how did that shape care –

DR ASGHAR: Resident on-call rota worked that the consultant – we, as a consultant, we will stay inside the hospital in a the room. Sometimes we – there was no fixed room, that was another issue about you're mentioning about non-availability. There was no fixed oncall room ~~issue because~~ this rota was investigated by ~~one of~~ Mr Charles – appointed by Mr George

Nasmyth, Medical Director, and his investigation is here. I have that. His investigation I can give it to you.

This rota, when came in, as a consultant we used to stay inside the hospitals, either room 9, 10 or 11 or whatever. We were available at the moment's note if the baby is born. So that way it was good.

However, because there were three or four junior doctors, some weekends, particularly weekends -- and I will give it to you, this rota, you can have a look yourself -- I have worked up to 64 hours all alone without a junior doctor. Day and night. Friday, Saturday, Sunday. 64 hours, ~~not~~ at a stretch.

Now, you see, you --

DR CALDERWOOD: How many times were you called in that time?

DR ASGHAR: That -- that.

DR CALDERWOOD: How many times were you called in that time?

DR ASGHAR: Again, you will say I haven't kept a record.

DR CALDERWOOD: Then I cannot -- you might have been called once so, unfortunately -- this is going into too much detail, it probably will not help us with our time constraints.

What I am trying to illustrate to you is that you can tell me how many hours you were on-call, but I have no feeling as to how busy you were, so that if you are wanting to make a point about being over-worked, or that being some mitigating circumstance, you need to prove that. You cannot tell me so I, at the moment, need to just -- we have to move away from that because we are not going to get anywhere.

What I really want to get down to is: Do you feel that that change, with the resident on-call consultants, has that improved care, the availability of the consultants, so that when the --

DR ASGHAR: It did improve availability of consultant because we were staying in the hospital. It did improve. It was better than when the consultants were staying at home and running from home to look at the

baby. This resident on-call rota, it did improve. However --

DR CALDERWOOD: There are more people, more consultants on that rota. Now --

DR ASGHAR: When the resident on-call came in there WERE ~~was~~ five people working in that rota. Only one another consultant was appointed. Now there are about eight or nine consultants. Over the past years ~~year~~ the number have been increased. Now there is also a shift system came in from July 2012. From July 2012. Shift system.

DR CALDERWOOD: Is there any concern from you and your colleagues, about the fact that there are now eight or nine of you in a relatively small unit, about deskilling, particularly when you are dealing with tiny neonate and perhaps not doing the same -- you will not be doing the same number of procedures as you would have been, even in 2009, five-years ago, because there are double the number of consultants on the rota?

DR ASGHAR: Well, you can argue that there will be because when there are eight or

nine or ten consultants, because Royal College says for shift system you have to have ten consultants. So there is an element of -- there might be an element of deskilling. There might be -- you are ~~have~~ less busy --

DR CALDERWOOD: What do you feel yourself?

DR ASGHAR: About my skills? Well, I don't know whether you are aware or not, but I was, [redacted]

DR CALDERWOOD: [redacted]

DR ASGHAR: [redacted] I will give it to you --

MR BROOKES: We will take that at the end.

DR CALDERWOOD: [redacted]

DR ASGHAR [redacted]

DR CALDERWOOD [redacted]

DR ASGHAR: [redacted]

[redacted]

This is the letter from the Medical Director.

DR CALDERWOOD: Okay. We can keep that. That is very kind of you to bring that. We will add that to our evidence that we have.

I think we are probably short of time so I will let my colleagues – can I ask you one more question? Do you enjoy your job?

DR ASGHAR: No.

DR CALDERWOOD: Can you tell us –

DR ASGHAR: Not in this Trust any more.

DR CALDERWOOD: – why?

DR ASGHAR: Because I have been subjected to so many unfair things and so many -- I was very happy when I came here and I enjoyed my job and I used to get up in the morning and I wanted to go to work and I was happy. However, for the last two or three years, I am not happy and I want to get out of this Trust, like so many other consultants who have left. I will not recommend -- if anybody, my friends, asked me to go to this Trust, I said, "Don't go".

MR BROOKES: Thank you. Anymore? Jonathan, can I turn to you?

PROF MONTGOMERY: Can I just check you mentioned. Your letter to us that you have concerns about the issues --

DR ASGHAR: Say again?

PROF MONTGOMERY: You mentioned in the letter to us you have concerns about the governance issues. You have taken us through a number of issues around staffing, and both the middle-grade tier and on-call rota issues. You have taken us through the bleep problems and you have

taken us through the patient safety incident problems.

I want to check whether there are any other governance areas that you had concerns about. We don't need to go --

DR ASGHAR: As I said, there were two major governance issues, in my opinion, WHEN ~~where~~ I started working here.

One was this -- well, there were so many, but two major things, as I mentioned. Not only me, but one of the consultant -- Dr Rifkin, he is the Clinical Director somewhere in Manchester -- this was his letter 14 years ago. This is his letter. 14 years ago he wrote to the Trust at that time. He says -- I will just read one sentence, if you allow me, please.

"At present we have to be on hand to deal with a variety of serious emergencies requiring our expertise, such as new born resuscitation, stabilisation of premature infants, severe respiratory distress, acute admission with children with meningitis, meningococcemia, diabetic

ketoacidosis and non-accidental injury. As well as being available for follow-up of children with chronic conditions, I believe that it is only a matter of time before issues of risk management become a real problem".

This was in April 2000, he wrote to Trust 14 years ago. Then this --

PROF MONTGOMERY: Just -- that is essentially a set of staffing issues and we have been over some of that with you.

DR ASGHAR: These are junior doctors who complained that we are being left all alone and unsupported. This is the letter in 2006.

There are other emails, which I personally raised with the --

PROF MONTGOMERY: Those are all issues, I think, you have taken us through. I wanted to check there were not issues independent of the staffing, the problems and patient safety incident. I think those are things you have taken us through so we can pick up the staffing issues.

DR ASGHAR: I would like to say these are issues about the on-call bleeps, about the availability, and non-availability. These are the emails --

PROF MONTGOMERY: We --

MR BROOKES: We will take evidence at the end. We will concentrate here on answering the questions, which have been raised previously. Anything like that we will take into consideration.

PROF MONTGOMERY: I think that means we have been over that, thank you.

MR BROOKES: I want to ask one question around governance.

What do you believe is your responsibility where you become aware of the governance issues? Not the organisation, you, as a professional.

DR ASGHAR: My responsibility is to raise the issue with senior management, with the Clinical Director, with the Medical Director and with the other managers. We -- not only me, but other consultants --

MR BROOKES: You raise it. Nothing

happens. What is your responsibility?
DR ASGHAR: Well, it is just we work --
that is what we did. Every senior meeting
we kept on raising issues.
MR BROOKES: What is your responsibility
if nothing happens?
DR ASGHAR: I contacted Medical Defence
Union at that time, that looked these
issues are being raised, and I took
advice. I have not Brought ~~bought~~ that letter,
but I have that letter; I can post it to
you if you need to see it. I personally
raised the issues with the Medical Defence
Union that these issues are being raised
by us with the management and nothing is
happening.
PROF MONTGOMERY: What was the
response?
DR ASGHAR: From the?
PROF MONTGOMERY: The MDU?
DR ASGHAR: I do not have it, it was a few
years ago that I particularly raised it
because these issues were a few years ago.
I will have to go and look back. They
advised, as far as I can remember, they

advised to put it in writing, that you have done your duty, you have contacted the Medical Defence Union, you have contacted the -- even the Chief, he has written to the Chief Executive at that time (who was Tony Halsall at that time) about these issues. In one of the senior meetings Ian Cumming, the previous Chief Executive, he was there with the Medical Director and we raised those issues.

PROF MONTGOMERY: Thank you.

MR BROOKES: Okay.

PROF FORSYTH: Did you have a formal response to those, from the individuals in writing?

DR ASGHAR: No, I am sorry, I do not have any response from them in writing.

MS FEATHERSTONE: I was going --

DR ASGHAR: Because there was nothing sent to us.

MS FEATHERSTONE: I was going to ask -- you discussed briefly with Catherine about the relationships with the doctors and midwives, what meetings did you have as a group where you discussed. You talked

about the perinatal mortality; did you have anything else where you discussed incidents, where you met with the other midwives and with the doctors?

DR ASGHAR: Well, the general contact point was perinatal mortality meetings every three or four months. Obstetricians will let us know if there is an at-risk pregnancy, as I said earlier on. We were available. We advised them. We will go -- and I will go and I personally gone to talk to Mum that, "Well, look, the baby is pre-term, that is what we do. If you deliver here, that is what you need to do".

We will advise, we will discuss it with obstetricians. We will discuss with the mother what needs to be done if the baby is born early. That bit of communication was there between, but there was -- what I am trying to say is that as paediatricians we used to have weekly meetings that we used to discuss. That is the meeting that we raised these issues, but there were no such meetings on a

regular basis with obstetricians department.

MS FEATHERSTONE: That is all I wanted to ask. Thank you.

MR BROOKES: One final question from me. Has anyone else got anything?

DR CALDERWOOD: The only thing we have not touched on is: You talked about transferring babies out and having them going to other places. I understand that that is -- is that a 24/7 service?

DR ASGHAR: Yes. It is 24/7, 365 days. If there is a baby -- as I said, [redacted] but when I was involved prior to July 2012, I have transferred babies any time. Whenever some baby was born, who needs transferring, that service, the unit was never closed.

DR CALDERWOOD: Which units do you transfer to most commonly?

DR ASGHAR: If there are respiratory problems the baby will go to Manchester or Burnley or Blackburn and anywhere COT is available; the neonatal network will find

a place. If there are, say, surgical problems, people like to transfer to St Mary's in Manchester. If there are cardiac problems, generally they will go to Alder Hey.

DR CALDERWOOD: Would you say that is a slick system? That is a system that works well? Do you think that your colleagues now, and when you were working clinically, would always be referring promptly and that would happen quickly?

DR ASGHAR: I cannot comment on my colleagues' performance, but I have not come across any issues that baby was not transferred promptly. Generally I will say that whenever a baby needed ~~a chance~~ to be transferred out, the baby was transferred out. I am aware of some issues and there have been some complaints that such and such baby was not transferred, and those are a few high-profile cases you might be aware of. You want me to tell you the names? The baby was not transferred at that time. There were issues that paediatricians were

not called, or things like that.

So these things have happened, but generally I have not been personally involved in any incidents where a baby needed transfer and that transfer was delayed.

I have some complaints from two or three parents regarding other issues, but not about the transfer.

PROF FORSYTH: Are you aware of babies, maybe not being directly under your care, but should have been transferred out earlier? Is a severely asphyxiated baby -- should that baby not be transferred out immediately?

DR ASGHAR: Can you repeat the question?

PROF FORSYTH: Should the severely asphyxiated baby not be transferred out immediately, rather than wait and see?

DR ASGHAR: Well, I would believe that -- I believe that if asphyxiated baby, or if the baby needs to be transferred, it should be transferred.

However, if there are high-profile cases -- one was [redacted] -- there

were problems about him; whether the paediatrician was called or not called, that was investigated.

There was another baby with MECONIUM ASPIRATION (MAS) (unintelligible) syndrome, who one of my colleagues was dealing with that, and they said that the transfer was delayed. There was a hearing, I am aware of that.

I, personally, was not -- I was never involved in any transfer issues.

Having said that, there was a baby recently, [redacted]

However, you are talking about systems that, whether you think that whether the system has -- the system, when I came here, about transferring babies, was network. I think network came in, Blackburn and Burnley was established

around 2006/7 and then it was a very good system. We were -- they will find the bed, then we transfer the baby. That was very good.

However, on the children's ward, this transfer, this transfer, before the new scheme came, it was no good at all. New system ~~scheme~~ came, North West -- North West [NORTH WEST NORTH WALES TRANSPORT SERVICE (NWTS)] Transfer Service, I think they came in 2000 -- few years ago. I do not remember the exact year ~~because~~ they came over, they introduced us. Before that I personally, as I believe other consultants as well, we used to ring this unit, that unit, and that unit trying to find beds. I used to find it extremely difficult to transfer babies. I used to talk to the Registrar, same story repeated; the consultant, same story; talk to the neurologist; talk to the neurosurgeon. It was a very bad system before the new scheme.

Now, since the new system ~~scheme~~ has been [NWTS] established, this system is extremely ~~very~~ working very well and it is very good.

DR CALDERWOOD: Good.

MR BROOKES: Do you have something --

PROF MONTGOMERY: If I could ask you about [redacted]. When did the consultant paediatricians first get together to discuss what might be learned from [redacted] case?

DR ASGHAR: I do not know. I cannot think what -- I am sorry, I cannot pinpoint when they got that because I was personally never involved with [redacted]. I cannot --

MR BROOKES: Have you ever been involved in the discussion about the lessons learnt from [redacted] case?

DR ASGHAR: No. I was never in any of the meetings, I was not involved in his care and I do not know who went to any of the meetings and what lessons were learnt. I am not aware.

PROF MONTGOMERY: Five paediatric consultants at that stage and they did not discuss what might be learnt from the death?

DR CALDERWOOD: And you were the consultant on-call the night he was

admitted to the unit.

DR ASGHAR: Sorry?

DR CALDERWOOD: You were the consultant on-call the night he was admitted to the unit.

DR ASGHAR: No, I was not.

DR CALDERWOOD: That is what we have documented.

DR ASGHAR: [redacted] -- I was never involved in his care.

DR CALDERWOOD: You were on-call. You might not have been involved because nobody was called.

DR ASGHAR: I never saw the baby.

DR CALDERWOOD: That is different. You were on-call the night he was admitted to the unit.

DR ASGHAR: I do not know. I do not know.

DR CALDERWOOD: I am telling you that. You were.

DR ASGHAR: Was I on-call?

DR CALDERWOOD: Yes.

DR ASGHAR: I do not know.

DR CALDERWOOD: Nobody called you so you may not have been involved in the care,

but you were the consultant on-call.

DR ASGHAR: If nobody called me -- I was not informed about [redacted]. I only became aware about [redacted] when, I think, it was Tuesday that I heard that one of my colleagues was called and they are resuscitating the baby.

DR CALDERWOOD: That was the next person on the next day [redacted]

DR ASGHAR: I don't have the rota; I do not really remember.

DR CALDERWOOD: I do. I am telling you.

DR ASGHAR: I don't remember who was on-call.

PROF MONTGOMERY: We don't have time to discuss it --

DR ASGHAR: If I was on-call, or if I had been called I am sure I would remember that. But there would have been my documentation in the notes.

MR BROOKES: To repeat the question, to be clear: Even though you were the consultant on-call that night, you were never involved in any discussion about

lessons learnt from the [redacted]
case?
DR ASGHAR: No, I am not personally involved, no. I am not aware if any meetings have happened or did happen again.
MR BROOKES: That is very clear, thank you.
I have got one last question, which is: You have raised a number of concerns about governance and safety. Would you describe, while you were there, in the periods where you were raising concerns, that the service being provided was safe?
DR ASGHAR: Sorry, say it again, please.
MR BROOKES: You have raised a number of concerns, which you have described how they were raised up the management line. At that period were you confident that the service that was being provided to patients was safe?
DR ASGHAR: Was safe?
MR BROOKES: Yes.
DR ASGHAR: If you look at my email I raised concerns at this --

MR BROOKES: I know you have raised concerns. I am asking you a very specific question. Did you believe that the service at that time was safe?

DR ASGHAR: At that time?

MR BROOKES:

DR ASGHAR: When we were raising the concerns? No, I did not and I have documented this to my colleagues.

MR BROOKES: It is not safe so you were working in an unsafe service?

DR ASGHAR: Yes, I was working in an unsafe environment.

MR BROOKES: Thank you. Any further questions?

Thank you very much. Thank you.

DR ASGHAR: Do you want me to say anything?

MR BROOKES: No. I think that is --

DR ASGHAR: I have got a lot of documentary evidence here.

MR BROOKES: The Secretariat will talk that through with you now and take the information. I am very grateful that you have brought the information as well.

DR ASGHAR: These are the issues about the rota and about the raised issues. I can give this to yourself.

MR BROOKES: Yes. That will be entered into the evidence. Thank you very much.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 14 October 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics

JOHN ASHTON

Transcript produced by Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

DR KIRKUP: Okay, I will say for the record that I'm Bill Kirkup, and I'm chairing the panel, although clearly we have met once or twice in the past.

DR ASHTON: This is true.

DR KIRKUP: I'll ask my colleagues to introduce themselves for me.

PROF FORSYTH: Stewart Forsyth, I'm a paediatrician medical director from Dundee in Tayside.

DR ASHTON: Good to meet you.

MR BROOKES: And I'm Julian Brookes, I am currently deputy chief operating officer for Public Health England, but was previously head of clinical quality, working for the Government.

DR ASHTON: Good to meet you.

DR KIRKUP: You know that we're recording.

DR ASHTON: Shall I say who I am?

DR KIRKUP: Yes, well go on, yes.

DR ASHTON: I'm John Ashton, retired director of public health for Cumbria. I'm currently president of the Faculty of Public Health.

DR KIRKUP: Thank you. About the process, you will have noticed that we're recording procedures. We will make an agreed record at the end. You may also know that we've invited family members to be here as observers. As it happens, there are none this afternoon, but they may listen to the recording subsequently. You'll also know that we've asked you to hand in any mobile telephones, laptops, recording devices just to emphasise that nothing goes outside the room until we're ready to release the report.. Any questions for me about the process?

DR ASHTON: No, I've read the blurb.

DR KIRKUP: Okay, that's great.

DR ASHTON: So it's okay, yes.

DR KIRKUP: I'll start off with a general question then, which if you could just outline when you started in Cumbria, and what you did then when that finished.

DR ASHTON: Yes, so I took retirement from the medical civil service, regional director of public health in the 2006 reorganisation; had three months' retirement, got taken on as a locum director of public health for that last three months of 2006 by Sue Page, and appointed director of public health for

Cumbria in January 2007. I was the director of public health then till this latest reorganisation at the end of March 2013.

DR KIRKUP: Okay, that's great, thank you. I'll ask Julian to start.

MR BROOKES: I'd be really interested with your overview first, just as a starting point, in terms of your perspectives while you were DPH of the trust and its issues around maternity. We'll get some of the detail afterwards, but your overall assessment and concerns that you might have had as commissioner.

DR ASHTON: I mean it's a big story, this, and it depends which entry point you take. I mean I could give you a narrative of my own if that would help, or I could try to focus in on chunks of it if that would help.

MR BROOKES: I think – can you start at the narrative and we'll see where we get to from there because there's some specific areas I want to ask about, but I'd quite like that sort of bigger picture stuff as well, it's really helpful.

DR ASHTON: Yes, Dr Kirkup will tell you that I always start with history, and so from a personal point of view my interest and experience in quality issues dates back to my work with the North West, with the Mersey regional health authority and the North West Regional Health Authority, and of course working closely with Liam Donaldson, Organisation with a Memory, and a desire to put things on a proper footing. So when I worked for the regional health authority, there's two or three salient things which I just mention because I think they're reference points for what followed in my experience in Cumbria.

One of them is that Sir Donald Wilson, when he was chairman, was in the habit of making unannounced visits to hospitals across the region. We referred to them as 'Don's tours', and he had a special cap which he wore when he took the whole of the top team unannounced to hospitals across the region, and we went and inspected, and it was very hands on so one was accustomed to that approach. Also, as a public health trained person and someone whose first questions are always to want to get at some intelligence, I was accustomed to doing that on various issues that cropped up. And famously, I mean I always used to convene major incident groups for all sorts of things. We had an outbreak of syphilis in gay men in Manchester, and I convened an incident group, got everybody round the table, decided – treated it like a Public Health Gold, a local Public Health Gold, and did that for various things over the years that I was there.

So I was accustomed to that way of thinking and doing. It was the case in the early years at Mersey, and then when it merged with the Manchester region to form the North-Western, that there were two parallel streams of focus on untoward things happening. I mean things like trolley waits and winter pressures and so on would be going on in one part of the building, and I would be doing public health type things in another part of the building. But we took the opportunity of the anxiety over the millennium bug thing to bring them together and create an incident room for the regional health authority where all the information was being gathered from the whole system, whether it was hospitals or community or public health incidents such as I was responsible for to create that. And actually it was because of that that we were able to – or I was personally able to front up the situation when we had the fuel protests, and some of you will remember I engaged quite vigorously at Stanlow with the fuel protesters because I was able to take the sheet of paper that showed the impact on not just the hospital sector but the community sector, the home nurses – community nurses, and on burial and things from not having petrol, and so we had it all one sheet that had come through the incident room that we'd established, and was able to use it.

So this is where I come from in my approach to public health, but also in those days, you know, 1993 onwards to 2006 really – no, not to 2006, till 2001 or something, whenever that reorganisation was, I as regional director of public health and regional medical officer engaged on a regular basis with the medical directors and clinical directors. I used to have regular meetings several times a year with them all. It was really encouraged by Liam Donaldson around that agenda of Organisation with a Memory and to get them all in the same place on reporting of incidents and things like that. Now when the regional health authority was abolished and we went into the Government Office in Manchester, and they created the other SHAs, so the three SHAs for the North West, Merseyside and Cheshire, Greater Manchester and then Cumbria and Lancashire, I was told that I didn't any longer have any role to play with the NHS; that I should keep away from the NHS as regional director of public health, and still regional medical officer, and that that was the responsibility of the new directors of public health in the SHAs.

What I did have still was dealing with doctors in trouble with the GMC, issuing the notices that he sent round the hospitals when a doctor was in trouble, so that...

DR KIRKUP: Alert letters.

DR ASHTON: The alert letters. When someone turned up on a Friday night to do a locum there was a way into it, and that was the residual part of that quality agenda. But obviously the SHA had taken over responsibility for building clinical governance and so on, so I was off the pitch for those few years until 2007 when I came into Cumbria. So that's the bit of history really.

MR BROOKES: That's helpful.

DR ASHTON: But I think it probably gives you an idea of where I'm coming from. So coming into Cumbria, and with the team that we had there, which is a really great team, and Sue Page's nostrum was, 'In God we trust, everyone else must bring data.' So we were very data driven, and what we found, or what I found was that it was a data desert; Cumbria was a data desert. The public health reports that had gone before I got there were not particularly strong and didn't particularly give you a feeling for what was going on and what the issues were. So I set about – I brought the first one. I realised, this is one I've written all over, so I don't know whether you want to have that and give it me back and I'll swap it for another one sometime, but that's the first one I did after a year in. But I also commissioned a whole series of reports from the Observatory in Liverpool, North West Public Health Observatory, Born in Cumbria, Starting well in Cumbria for Childhood, Coming of Age in Cumbria, Teenagers living well in Cumbria, Adults growing old in Cumbria, and the Mortality in Cumbria. I commissioned a whole set of decent documents to provide reference to what was going on. And there were other documents that I commissioned as well to give them a proper firm public health basis.

Now you'll see if you look at that, and some of the other stuff that I'm sure you're familiar with already from people who have been through here, that the thing about Cumbria, just quantitatively, is it's average. It just looks average. I mean it's average for the North West, it's average for the country, and the danger of average is complacency because you may not be saying, 'Well, but for somewhere like Cumbria, should it be better than that?' And so for perinatal mortality it looks as though it's lower than the country as a whole.

So the first cut is reassurance that it's okay, and that was true of a lot of data and particular clinical areas in Cumbria.

So it was only later as we sort of began to bed in, and Sue went round every GP in the county in the first 18 months, every practice she went round. And I went with her on a number of these as well; and beginning to get the feel for things. Now again, I went off and met the medical directors and clinical directors, re-establishing that part of my portfolio, if you will. I saw that as a strategic remit for me working at a new county level would be to engage with the clinical and medical directors.

So the first time I went to see Peter Dyer at – I went to see Peter at Westmorland General – I was taken aback by the fact that he was in the basement and the top team were on a different floor. And I'm a psychiatrist originally, so training phenomenology, I thought this is strange. You know, a medical director should be fully embedded and engaged with the top team, and so I thought that was strange. And I struck up a good relationship with Peter, had regular meetings with Peter, but on that first occasion he shared with me that he'd just heard about a perinatal death that had taken place. I think it was in the July that I saw him after starting in January; it had taken a while to fix up an appointment. So I think it would be in the July of 2007 or something like that. And he shared with me that he'd just heard of a perinatal death that had taken place in April or March, so it would be four months or something before anyone had told him about it, and I was a bit shocked about that. And I think the following week he phoned me up and told me about another one that they'd just told him about that happened some time before.

So the antennae were going up about what are the systems like in this place for reporting, and what's the communications, what's the relationships? So that was at that stage. And it wasn't – I mean the inquiry is about Morecambe Bay, but the county as a whole suffers from weak clinical systems we discovered later on, in the whole series of child health, real problems; mental health, real problems. Subsequently I had to suspend the breast screening service in North Cumbria because a lot of – well not a lot, but about 16 women had been told they didn't have breast cancer when they did. And we gradually were uncovering these things, but it was very much sensing it and seeing things coming across the desk and getting...

MR BROOKES: And was the data to substantiate that – would it have been possible to identify that from the data that the commissioners received?

DR ASHTON: Not quantitatively, and that was where I started – well as a result of this sort of learning curve over that first couple of years really, 2007 and 2008, I started – well, the other thing at the same time was there were three maternal deaths – three maternal deaths in two years; two in one year and one the year before or the year before that. There were three. And I'm thinking nationally there are about 60 a year, and you've got three in Barrow in a couple of years. Now this could be nothing, small numbers, statistically it could be an aberration. They were all women that were born overseas as well, and you thought is there something to be looked at further here? Are there cultural issues about access to good services? What does it mean? Does it mean anything? Does it mean nothing? We need to know more about this.

And I kept raising this, and we discussed it at top team. We also decided that we wanted – and I can't remember the year of this, you may well have the timelines from my colleagues, but we – in a sense I was very keen to try and put a public health framework around all these issues. I mean we were coming across these bits and pieces of things we were worried about. It was the same with children safeguarding in the county. It was the same with adult safeguarding in the county. The under-18 death reporting which had come in was another thing where we thought there's a data source here that could be important for prevention if it's connected up to some other things. There's the whole issue about clinical audit. Is it systematically embedded across the service or not?

So what we did, this is – when I say 'we', I mean particularly jointly Mike Bewick and myself, Mike as formally medical director, but me sharing medical director functions with the population hat on. And then Irvine Cobden coming in on the secondary and tertiary side part time with his experience in Northumberland as a – and with the ambulance service, he'd been a medical director of an ambulance service, I've forgotten where. And then Neela Shabde later on with her paediatric expertise, so we actually had four people sharing the medical director function, which was very unusual, but gave us a kind of 360° approach.

So we started having what I call weekly ward rounds of new incidents so that on a Tuesday, I think it was, that we – just for half an hour or an hour – what's new in, what have we been told about? Who's handling it? What's happening to it and so on. But then we had monthly meetings that Mike Bewick chaired, which were more strategic about where things were and where...

MR BROOKES: Those were internal meetings?

DR ASHTON: Internal meetings. But what we did over a period of two or three years, we started a process of trying to get everybody on the same page of all – each of the hospitals in the county. We ran workshops for the people who were responsible for clinical quality, usually a senior nurse and medical and clinical directors, reacquainted people with Organisation with a Memory, because a lot of people had forgotten all about it, and really tried to get people signed up to the idea that we at the PCT would prefer to know about things than not to know about things, and if it wasn't something that really required further investigation, that was fine, but we'd prefer people just to have a word with us about things.

One of the things I realised quite early on was that it seemed as though the obstetricians regarded stillbirth as an act of God. Very few stillbirths were reported, and yet – I mean I know now that the potential for further reduction ~~and~~ in perinatal mortality will come about as a result of understanding better the causes of stillbirth, because it makes up such a big proportion of the residual perinatal mortality. So nationally it's an issue; there are very few post-mortems carried on on stillbirths, and very few lessons learned and so on. But this was particularly the case. But there were other straws in the wind. I mean again, I know you're focusing on Morecambe Bay, but the issues that came around qualitatively in those meetings were things to do with consultant availability at weekends, failure of escalation, relatively junior staff being left adrift really. On one occasion, not in Morecambe Bay, but somewhere else, an infant having severe brain damage as a result of a difficult labour where the consultant never came to the delivery suite at all. It was a SPR doing it with – the consultant spoke on the phone, I think, once or something like that. So there was a general sense of weak systems.

MR BROOKES: I've got a feel for that.

DR ASHTON: Sorry?

MR BROOKES: I've got a feel for that; I think that what you've been doing, as part of that you were made aware of these five cases.

DR ASHTON: Yes, so I mean – yes, I'm sorry to digress wider, but it's just that this was...

MR BROOKES: Contextual to it.

DR ASHTON: It was contextual for the whole county. I mean the – the thing about the five cases then was I think we then get into the area where I would wish to talk a bit about the relationship between the strategic health authority and NHS Cumbria.

MR BROOKES: Yes, we'd be quite interested in that as well.

DR ASHTON: Yes, well we were very interested in it because it was so ambiguous. And we were trying to get into the driving seat. I mean we were all experienced people in the top team wanting to take responsibility, wanting to steer things, but this great ambiguity about who should be dealing with serious untoward incidents and who shouldn't. And there's a certain point in 2008/2009, whatever, a decision was made to hand over responsibility to us, but it didn't really happen. I mean some were kept with the SHAs, some were sort of with us and sort of not with us, and it was very unclear. And we were unable to get – we wanted to take them on. I mean we felt we had a system that we were developing was in place for us to deal with them, but it was – it was sort of – you can sort of have them but you sort of can't have them. It was very...

MR BROOKES: And these five originally went up to the SHA.

DR ASHTON: Yes.

MR BROOKES: Okay. And they came back down to you or...?

DR ASHTON: They – you'd have to look at the documentation to see about when they came back, I can't remember.

MR BROOKES: But they did come back is the...

DR ASHTON: I think they must have done in the end, but I don't want to be on the record as saying that because – you know.

MR BROOKES: Yes.

DR ASHTON: But I mean just another point I just want to make about – and this – again it's sort of contextual because it's about the constant reorganisations. I

mean the failure of handover from one organisation to the next organisation, and this is in a completely different domain. We had a problem of a fluoridation of borehole water supplies in West Cumbria, which in parts of West Cumbria the water supplies are from boreholes, and it's the only part of the county where there's fluoridated water. And it's gone back a long way and there'd been a contract between the health service and the United Utilities to fluoridate the water. And that contract had been between United Utilities and the strategic health authority for Cumbria and Lancashire, and when that was abolished there was no proper clear handover to the strategic -- the new strategic health authority from the old strategic health authority, and data was being sent into my intelligence unit in the PCT and just sitting in a drawer somewhere. Nobody had connected any of it up, and it turned out that for two or three years we'd been paying for the water to be fluoridated and it hadn't been being fluoridated, and that nobody was in charge of it. I mean so these weaknesses of handover at the time of reorganisation -- I think it was the same really with these serious incidents, there was confusion.

MR BROOKES: Okay, so there was confusion over the handover, but there's a fundamental issue which these five potentially highlight.

DR ASHTON: Yes.

MR BROOKES: What was the PCT's involvement in that?

DR ASHTON: Well, we were trying to get involved with them, but it was just unclear about who was in charge of doing so. When it became a police matter I was delegated to go off and sit with the police with a Chinese wall between me being with the CID and back on the clinical side so as not to contaminate any evidence trail when there was questions of potential prosecution, because I had to liaise over the police getting access to all the clinical records and so on. So that was my part in that, and Mike Bewick handled the other side of that.

MR BROOKES: Okay. So we've got to a situation where there is a potential problem with maternity services. I know that there's this, as you've described, there was a police investigation, etc., but what -- we've looked at the ~~SIRIs~~SUIs, such as they are, the quality of the ~~SIRIs~~ SUIs is not brilliant.

DR ASHTON: No.

MR BROOKES: I'm just interested what the interactions then were between the PCT and the Trust to try and get to the bottom of what actually the issue was.

DR ASHTON: Well we were having, on a monthly basis, one-to-one meetings with each of the provider units, with each of the hospitals and the mental health trust and so on, and trying to speed them up with dealing with the SUIs~~SIRIs~~ that were ours to deal with, because some of them had been going on for two or three years. There were very different thresholds for reporting, and we regarded it as being in a developmental process to get them, as I say, all up to the same speed, and also to get them to identify a non-executive director on their boards who would take responsibility for that, because that wasn't the case when we started off.

MR BROOKES: Anywhere, or just in that particular job [?]?

DR ASHTON: It was – it may well have been the case everywhere, but I can't...

MR BROOKES: Yes, but in Morecambe Bay there wasn't a...

DR ASHTON: I don't think that – I don't think that there was a non-exec who was responsible for SUIs~~SIRIs~~, I'm pretty certain that there wasn't. You know, in my experience, the way you get something taken seriously is by making sure somebody is responsible for it, and I don't think there was.

MR BROOKES: Okay. So you're now aware of the problem; you're aware that you're not, both through the SUI~~SIRI~~ system, that it's not being resolved.

DR ASHTON: Yes.

MR BROOKES: What else? What happened next?

DR ASHTON: Well the other thing that gets wound up in this is the pressure to approve Morecambe Bay as a foundation trust hospital, which we were at first, I think, we thought this may be okay, but we rapidly came to the conclusion it wasn't a good idea, and we recommended against it. I mean you'll be familiar with all this stuff about how they had the Fielding Review carried out and they didn't share it with us. They didn't share it with people who should have known about it because I think that would have affected the judgment and foundation trust status. But also, we were under pressure from the trust on two occasions, I've got – I've made a note of it – to close down incidents that were ongoing, to sign off as being completed; incidents to do with maternity and perinatal issues, and that was in June 2010 and again in early 2011.

MR BROOKES: That was pressure from the SHA?

DR ASHTON: No, from the hospital.

MR BROOKES: From the trust.

DR ASHTON: From the hospitals. They wanted them closed down, and I said, 'I won't do that because there's other stuff going on here and there may be a pattern to this, and we're not letting you take that off the table while we're still looking at these other things.'

MR BROOKES: Okay. Let's go onto the FT application as you touched on that. Our understanding is that, as you say, you were not supportive as commissioners of them becoming an FT application. What were the reasons for that?

DR ASHTON: Well I think the main leadership on that came from Sue Page and Mike Bewick. I mean they were very closely engaged with the hospitals themselves. I wasn't particularly. I mean I was there at our board meetings where it was discussed, but I think they were concerned about the governance arrangements.

MR BROOKES: Okay, but it wasn't – it was governance arrangements, it wasn't the quality of management or...

DR ASHTON: Well I think if you refer back to the documents you'll see that throughout this time that there are minutes that record my concerns about various matters that had come up, and I think certainly that is in the legacy document, is noted there. I mean when it came to the critical point in October 2010, is it – no – or 2011. When did we declare Gold? That was October 2011.

MR BROOKES: Yes.

DR ASHTON: That – I mean that really was what exercised me.

MR BROOKES: Yes, I want to come onto Gold in a second.

DR ASHTON: Oh, sorry.

MR BROOKES: That's okay. But just to be clear, because we've had slightly differing accounts of what happened around who agreed and who supported what around the FT application. I think we're reasonably clear that from a coverage point of view that there wasn't support.

DR ASHTON: I think Cumbria did not – Cumbria said it's not ready.

MR BROOKES: And we're also pretty clear that that message was given to the strategic health authority.

DR ASHTON: Yes, it was given to the strategic health authority.

MR BROOKES: And it's something which we've been pursuing just to understand how that worked...

DR ASHTON: Yes.

MR BROOKES: ...where our understanding as well is it's your colleagues who were sort of in joint commissioning leads with yourselves, and North Lancashire PCT also were not supportive of that, is that your understanding of it?

DR ASHTON: Well, there's a thing there, because it's my belief that the chief executive of North Lancashire, Janet Soo-Chung, was initially the lead person for all of that. But – I have to be careful what I say here, do I? I mean is it...

DR KIRKUP: We want you to be frank.

DR ASHTON: But I think she was out of her depth, and she handed it over to Sue Page. That's my recollection, was that she was out of her depth and she handed it over to Sue Page, because Sue is very competent at dealing with these kinds of difficult issues.

MR BROOKES: Okay, well we're pretty clear we understand that the lead commissioning responsibility was with North Lancs for that trust, so they would have naturally taken the lead in that, okay.

DR ASHTON: Yes, but for some of this, it was handed over, wasn't it?

MR BROOKES: That's unclear.

DR ASHTON: Oh, right, okay. Sorry.

MR BROOKES: Okay, so if we can then move on to Gold Command. I'm introduced you said earlier, or I gathered from what you said that the PCT had declared a Gold Command where we've been told that the SHA declared Gold Command.

DR ASHTON: Oh, right, well I can tell you what happened.

MR BROOKES: Yes, that would be helpful.

DR ASHTON: In the summer of 2011, when we were having regular meetings in the PCT about this, and each meeting I was saying, 'I think we need to declare a Gold Command,' with my head on that I described at the beginning. I said, 'This is a major incident, we should declare a major NHS incident; we should take charge of the situation.' And there was delay of three or four months before the SHA agreed to that. That's what happened. I'm quite clear about that. We kept asking for it, and the thing that I found most shocking was when Jane Cummings, one of the meetings that she'd come to, said, 'We can't have more than one major incident going on at the same time, we can't cope with it because we're having to deal with this thing in Stepping Hill,' you know, where the nurse was supposed to have killed patients. She said, 'We just can't cope

with more than one; you can't do that,' which I found quite shocking, the notion that you're only allowed to have one major incident at a time and if another one happens you can't have one.

MR BROOKES: I'm quite interested in why Gold Command as the mechanism. I'm more used to – I worked in the South West, I'm used to the kind of mechanisms that were down there, and I can't – calling a Gold Command would not have been necessary. It would have been about the leadership coming from the strategic health authority in that particular instance to lead...

DR ASHTON: Yes.

MR BROOKES: on those particular [inaudible]. And so I'm quite interested, where Gold Commands are usually around relatively discrete, time limited incidents, and yet this is – it was potentially still going on now.

DR ASHTON: I think we were trying to empower ourselves, I think that's what we were trying to do. We were trying to empower ourselves to get a grip because we were in a frustrating situation where we'd been trying to – that's a good point to mention. In the six years of the existence of Cumbria PCT NHS, I think the strategic health authority top team probably visited twice. So we were right on the edge of the known world from Manchester and Liverpool, and we were up for taking charge of our own destiny, but there was...

MR BROOKES: So can I ask you two questions about the SHA on that basis?

DR ASHTON: Yes.

MR BROOKES: One was what was their approach to managing the market, which was one of their functions? And secondly, what was their approach to performance management, which again was one of their functions?

DR ASHTON: Well, okay. Let me just gather my thoughts on this because there's several issues there. I mean when we started in 2006/2007, we were pretty clear what the agenda was closer to home, re-profiling, investing in primary and community care, particularly in the disadvantaged areas of the west coast, getting resource out of the hospitals and so on. And on the back of the kind of intelligence that I was feeding into the system we felt quite confident about what we needed to do. We had a very systematic programme of community consultation that was commended later by Dave Colin-Thomé in his review of Mid Staffs about the Cumbria approach to that. We'd really engaged systematically across the county to get sign-up to closer to home, and we got

sign-up from all the hospitals, who then didn't go along with it having signed up to it. And so each year it was the same repetition as what's gone on before in previous incarnations of the health service, is that at the end of the year the hospitals would come along with a deficit and tell the PCT we had to pay it up, so that we couldn't get on ~~investment~~ with re-investment. So I never got my public health budget; never, whatever that was called at the time. Bill might remember the name of the public health – what was it called? There was a...

DR KIRKUP: I know what you mean, yes.

DR ASHTON: So there was a – we never got it. I mean what I had to do was develop public health activity through partnerships, through wider engagement and so on, but I never really had a dedicated pot of money for public health because it always disappeared into the – and we were instructed to do that by the SHA each year. They never held the hospitals' feet to the fire and said, 'You've signed up to this; this is what you...'

MR BROOKES: So were they in the meetings? Did they come down and performance manage the trust prior to FT status, for example? Was there...

DR ASHTON: I'm sorry, I'm a bit deaf.

MR BROOKES: Sorry. One of the ways in which strategic health authorities work, certainly with organisations, trusts that were prior to becoming an FT, was that they'd have a direct performance management responsibility for that organisation, which they often did in partnership with the PCT. So did you have that kind of relationship with the SHA? Did they come down, understand the patch, work with you and talk to the...

DR ASHTON: No. I mean you have a situation where the SHA appear to be saying, 'We're in charge of dealing with the hospitals,' but then they weren't around on the ground. And we could – it's a Catch 22. I mean we couldn't assume...

MR BROOKES: Control.

DR ASHTON: control. Which was – we were very frustrated about that.

MR BROOKES: Okay. So that was – and of course the managing the market element of their responsibilities, they were not visible on the ground so they – were they able to manage the market? Did they take that function forward?

DR ASHTON: No, and I mean it depends what you're talking about exactly. I mean are you talking about the whole agenda of treatment centres and all of that?

MR BROOKES: No, I'm talking about they had a responsibility to look at the bigger picture in terms of the interrelationships between different components of services, and to work with PCTs to ensure that the services that were developed weren't compartmentalised by boundaries and things. They needed to make sure that the whole system was functioning effectively.

DR ASHTON: Right. Well my sense is that they weren't.

MR BROOKES: Okay.

DR ASHTON: I mean I really think that that's part of – I was busy trying to develop the public health agenda in the county, and those more transactional – and particularly hospital healthcare things were dealt with more by Sue and Mike.

MR BROOKES: So how do you think the PCT had been aware of concerns at Morecambe Bay before they were able to do something about it?

DR ASHTON: Well, that's a good question. I mean the suspicions began probably around 2008/2009, and then – so it's about two years, isn't it?

MR BROOKES: Mmm.

DR ASHTON: I mean I was – I was picking up on the perinatal issue and saying, 'I think we need to do a perinatal audit to get into the qualitative side of this because of the way the statistics didn't indicate a problem.' And I took it to the board in 2009/2010 to get authorisation to commission an external perinatal audit. We then had a delay because the Oxford team that always did those things in the past had been disbanded, or the funding had gone or something, and it took us I think a year or more to find the team who could do that job properly. And you must have that report.

DR KIRKUP: It's the Leicester team.

DR ASHTON: Sorry?

DR KIRKUP: Leicester.

DR ASHTON: Yes – sorry, it's called Solutions.

DR KIRKUP: Oh, right, okay.

DR ASHTON: You know that.

DR KIRKUP: Yes.

DR ASHTON: But also there was a statistical report which I commissioned from Liverpool, John Moores as well, that is the companion to that, which was a further in-depth quantitative review, so the two documents sit together.

MR BROOKES: I just want you to – I'm getting a feel for an organisation who's becoming aware that something isn't quite right, but not 100% sure whether or not it's just an aberration, whether it's real or not, but it feels unable to act.

DR ASHTON: That's right.

MR BROOKES: And I don't understand why you're unable to act.

DR ASHTON: Because we were unable, I think, to intervene directly with the hospital. It was the responsibility of the SHA. And particularly when you come to midwifery, which is the responsibility of the strategic health authority and of the nursing officer at the strategic health authority, and where there are concerns over midwifery was not – I don't think that was in our gift to intervene.

MR BROOKES: But you buy the services; you commission the services. That gives you a lever to be ensured that what you're buying is safe and a high quality.

DR ASHTON: Well that's the theory, but in practice the relationship I think, was between the SHA and the hospitals.

MR BROOKES: And that wasn't leading to any change is effectively what you're saying.

DR ASHTON: Exactly. I mean we – you know, during this period there was world class commissioning.

MR BROOKES: I know, yes.

DR ASHTON: And I think we were ranked fourth or fifth in the country for our world class commissioning work, which was based on data analysis stuff, what needed to happen. But actually then making it happen, the triangle of PCT, SHA, hospital; where were the levers for making it happen? I mean I suppose you could say – I mean when I suspended the breast screening service in Carlisle, that was greatly resented by the hospital. I had big run-ins with them over that. Fortunately I did get support on that occasion from the Breast Screening QA at the SHA on a specific clinic issue. But it wasn't the same with these more diffuse...

MR BROOKES: So you're concerned. Do you believe the SHA is concerned?

DR ASHTON: I think – you're asking me for my conjecture now.

MR BROOKES: I'm asking your view, yes.

DR ASHTON: Yes. I mean I think that the SHA was more concerned about getting places to foundation trust status. And having worked in the old-fashioned RHA and the rest of it, I think that the SHA was far too focused on Central

Government and wasn't focused outwards to the field and outwards to what was actually going on out there, and it was far more Ministerially focused and far more departmentally focused and not outwardly focused. I mean my experience of working in the old Mersey region and the North West was that it was very focused out to the field, out to the hospitals and so on, and this last incarnation of strategic health authorities didn't feel like that at all.

MR BROOKES: Okay. And did you personally raise these concerns with the SHA? I know your organisation did, but did you personally?

DR ASHTON: I didn't personally have a direct relationship with the SHA for much – my relationship was with the public health director, Ruth Hussey, and I did share concerns from time to time with Ruth, but it was for her to do that with the top team there really.

MR BROOKES: Okay, so just to make sure of that last thing, just to make sure I understand, so you're clear there is potentially an issue here. That's been communicated to the SHA. You're clear that the SHA's responsibility is to at least investigate that and find out whether that is right or not.

DR ASHTON: Yes.

MR BROOKES: But it's not the PCT's role to do that.

DR ASHTON: Well we were seeking the power through the Gold thing, and – oh, so that's the other thing. Because, you see, in getting the SHA to say, 'Yes, you can convene at Gold,' we thought that put us in the driving seat. But then they kept us telling us what we couldn't do. I mean that we couldn't – because we wanted to convene – well they'd already had – they'd had a summit that they convened, which nobody told us about. So that had happened. When was that? I've got a note of that.

MR BROOKES: It was just before that.

DR ASHTON: Yes, I mean they had a summit that they never told us about, so...

MR BROOKES: Because the risk summit would have been...

DR ASHTON: Pardon?

MR BROOKES: The risk summit would have naturally been the right mechanism to...

DR ASHTON: To bring everybody together.

MR BROOKES: bring everybody together.

DR ASHTON: Exactly.

MR BROOKES: And agree who was doing what and let them get on and do it. Rather than calling a Gold Command, I've always found it quite strange that there was a need for a Gold Command to be called. But from what you're describing, it's because certainly the local system seems to have felt disempowered to actually act.

DR ASHTON: Yes, I think your words capture it.

MR BROOKES: Okay.

DR ASHTON: And I think we were trying to empower ourselves, but we were dependent on them following through really and letting us get to grips with it. I mean we would have been happy to have taken on more responsibility with the hospital, is what I would say.

MR BROOKES: Okay, thank you.

DR KIRKUP: Thanks. Stewart

PROF FORSYTH: Yes, and it does seem to be with the hospital, [inaudible], because we were talking about – there was this grand scale of involvement at different levels, different organisations, healthcare regulators, Monitor, whatever. And at the day of we're dealing with a small hospital with a small maternity...

DR ASHTON: Barrow, are you talking about now?

PROF FORSYTH: Barrow, where the major incidents were.

DR ASHTON: Yes.

PROF FORSYTH: A small hospital, a small number of deliveries, maybe 1,000 deliveries per year, and not able to sort the problem out quickly and prevent further incidents to happen.

DR ASHTON: Exactly.

PROF FORSYTH: I mean do you think given – the systems were obviously clearly not working in the best interests of patient care.

DR ASHTON: Definitely, yes.

PROF FORSYTH: And also – so what would you suggest if we were looking at a review as to how we deal with this in the future to prevent particularly small units? I mean I think that as you mentioned earlier, larger units would show up unstatistical data, whatever. But what – the qualitative issue is that in a small unit could go unrecognised for a long period of time, as far as I can see. I just wondered how you felt the systems, if we agreed that the systems have failed

to work effectively to resolve the situation, how could it be changed, and what should be changed?

DR ASHTON: Okay, well I mean as you will be aware, I mean there are about 5,000 births a year in Cumbria, and they're divided between, I think, 2,800 at Carlisle, 1,400 or so at Whitehaven, 1,100 at Barrow and the rest in the midwife-led units. And from a Royal College point of view, we probably should have one obstetric unit for the county, which a county of this size is impossible, so you have to come to some other kind of conclusion. I think some of the issues that came to light during all of this were that the Morecambe Bay Hospitals had continued until very late in the day, until the pressure started to come on, to issue single site contracts to consultants, so consultants weren't required to work across the other sites. And Barrow isn't a popular hospital to attract consultants.

So there's something about the nature of the consultant contracts that require them to work across sites. I think there is something – if you're accepting that you can't actually close a unit and you've got to try and keep them all going somehow, and you've got to somehow maintain people's skill levels even though they might have not very much exposure. I mean if you look at the Barrow unit, I think there's seven consultants at Barrow, and then there's 1,100 deliveries a year. So if you do the arithmetic, 50 – 20 deliveries, 25 deliveries, three per consultant a week. How many of those are done by a midwife? So what are they actually doing during that time, and how do they maintain their skill levels at more complex procedures if they're doing so little deliveries and so on? So there's something there about rotation, there's something about contracts that say if you're in an outlying not very busy place that maybe one week a month you need to go and work in a different place and you swap people round so that they're getting exposure and experience of more complicated things.

There's something about consultant nurse midwives, about actually having nurses with extended roles who can be in more outlying places. It's the sort of thing that happens in other parts of the world where you've got big rural issues to deal with. There's definitely cultural issues, and I know from conversations I've had with the current President of the RCOG, who I think I know quite well anyway, that this is a national issue, is the issue of power and

communication relations between obstetricians and midwives. I mean there's a cultural issue that needs to be addressed nationally; it's not just that it was a particular problem at Barrow, and the failure to escalate. So that's part of it. I think there are other things which I've thought about in the past but I can't remember at the moment.

PROF FORSYTH: And in terms of addressing the issues at an earlier stage, listening to the families, for example, clearly at that time the families were angry and were pursuing their concerns in different routes. I just wonder whether from your perspective in your role, you were – did you meet the families at all?

DR ASHTON: In my village.

PROF FORSYTH: No, I mean professionally did you?

DR ASHTON: I'm sorry?

PROF FORSYTH: I mean did they come – I mean NHS Cumbria, were they involved in this, meeting the families and listening to them?

DR ASHTON: Yes, Peter Clarke was our person who did all the family liaison. I don't know whether you've had Peter?

PROF FORSYTH: No, the name doesn't ring a bell.

DR ASHTON: No. Peter Clarke, senior member of our team, who in a previous existence being a chief exec of a mental health trust, and has very good personal skills. And Peter was the one from the PCT who did most of that. I was approached by James Titcombe to have a meeting with me, which I was up for, but the decision was taken within the PCT that this was politically sensitive and best dealt with by – in a continuous way by – by Mike Bewick, so I didn't – I mean I got to know James Titcombe later, but in terms of having some clarity about who was dealing with that, that was the decision that was taken. I mean as public health director, my role normally wasn't very clinical unless it was a population thing, like a screening service or something.

PROF FORSYTH: Do you think that being within the system they felt that families were – they had the opportunity to speak to the right people to express their concerns and for – and also to see some action occurring to address their issues?

DR ASHTON: I think all I can say to you is – I mean I was going to say the village I live in is in the Dales, and it's served by Morecambe Bay Hospitals. And I can

tell you from the number of times I've had my ear bent in the pub that the responsiveness of the Morecambe Bay Hospitals to public and patient concerns has historically been bad. I was on the receiving end of that many times over the last few years as they knew what my job was, and I've had that. And there are all sorts of weak governances. I went with a farmer friend of mine who developed prostate cancer, and I went with him as a friend to – just to be with him so that he – to help him make sure he asked the right questions really, you know, having to make a decision about what treatment he should have, and was shocked to see piles of patient records in a corridor at Lancaster Infirmary; just piles of records. So I think the weak systems were part of the picture.

DR KIRKUP: You said historically unresponsiveness was poor. Is there any evidence it's getting better?

DR ASHTON: Well I had a conversation with a colleague, a medical colleague, at the weekend, who has had a friend who recently had been in Lancaster Royal Infirmary, in the last 18 months, who'd had an appalling experience with regard to communication.

PROF FORSYTH: Can I just – from a review that was done on perinatal care or perinatal mortality in Cumbria, that was a good review, and some clear themes came out of there, which I really welcome. Why was that not – you know, more action taken on that?

DR ASHTON: Well that was only published at the end really. That was published in 2013, wasn't it, in the end, I think?

PROF FORSYTH: Oh, right.

DR KIRKUP: January.

DR ASHTON: Yes. So...

PROF FORSYTH: So what has happened? Are you aware of what's – I know you're not with the hospital now.

DR ASHTON: I was off the pitch by March, I'm afraid, so...

PROF FORSYTH: There was also a review of children's services as well.

DR ASHTON: Yes.

PROF FORSYTH: And again, I was just wondering what action if any had been taken after that?

DR ASHTON: Well, has Dr Shabde been?

PROF FORSYTH: Mmm-hmm.

DR ASHTON: Because I mean, you know, she's very good and she's trying to implement it. I mean the problem with that, as you probably are aware, is that the recommendation from your colleague from London who did the report for us originally, on children's services, from Great Ormond Street.

PROF FORSYTH: It's either Mitchell or...

[Cross-talk]

DR ASHTON: Sorry?

PROF FORSYTH: There was a Mitchell Report.

DR ASHTON: Mitchell, Andy Mitchell. We decided we wanted to have a children's service for Cumbria, and the idea was we would actually put out for a contract for children's services for Cumbria. And so the existing chief executives at the existing hospitals all got in a room together and decided that they would carry on doing what they'd been doing but call it a new situation. So they subverted what we'd been trying to do really, which was to try and get fresh blood in, and – because again, as a paediatrician you'll know that Barrow has ridiculously high admission rates of children that should not be in hospital, children with constipation get admitted to hospital in Barrow. And there's a whole issue about the efficiency of bed use and how many beds they really need, and what's the best way to run that.

Clearly, obviously there's a concern locally and politically locally about losing their paediatric ward. And again, these are challenging questions in remote and smaller communities. The thing I didn't mention before was Sue Page and I were visiting a practice in Grange, I think, one day. And the GP told us she'd just seen a [redacted]3 weeks pregnant, and who could not get an appointment at Barrow Hospital. She was going to have to go to Manchester to be seen to be assessed for a termination because they were not providing – there was only one consultant at Barrow who was willing to provide a termination service. And nobody had got a grip on that. I mean we did then go through a comprehensive review of all our sexual health services, and have let a different contract since then which is really pretty comprehensive and which we're quite proud of, because sexual health services in relation to family planning and abortion and so on were also a mess that we'd inherited.

PROF FORSYTH: Okay.

DR KIRKUP: Just a few follow-up questions from me.

DR ASHTON: All right.

DR KIRKUP: What was your assessment of the Trust and its capability? I'm thinking particularly of the senior management team.

DR ASHTON: Okay, Peter Dyer I will start with. I think he's a very nice chap and he's very well intentioned, and he's sensitive to the issues. His father was public health director in Preston, so he grew up with a public health perspective. So he and I had a good relationship and we've had good conversations about the issues. I feel he wasn't properly respected by the senior management and he wasn't assertive enough in turn with them.

And I think Tony Halsall was out of his depth. I don't think he was up to running a complex system like that. Eddie Kane, I don't know what experience he'd had of chairing such a complex organisation, but I don't think he was up to it. So that's...

DR KIRKUP: How much opportunity did you have to see him in action? I'm interested in how much of that is based on face-to-face observation and how much of it is observing at a slight distance.

DR ASHTON: Yes. Well Peter Dyer was the one I had the closest contact with. We did have Tony Halsall in to various meetings, and again, I think it was telling that when we were having these regular meetings about serious incidents and so on, the chief executive tended to send a deputy or somebody else and didn't treat it with the importance that we were trying to treat it.

DR KIRKUP: Okay. You said Peter Dyer might have lacked a bit of assertiveness with his director colleagues. What about with his clinical colleagues?

DR ASHTON: Well I wouldn't be in a position to have seen that, but I think the reporting of serious untoward incidents and near misses and all of that was clearly weak. I mean the nursing side was much better than the medical side. The nurses are much better at reporting errors than the medics. So I mean if you cast me back 20 years to when I was meeting them regularly, these were the sort of conversations I used to have with – Alasdair Breckenridge and I used to meet them all in the days when we had 40 hospitals or 42 hospitals across the whole ~~N and West~~North West Region, and we used to have these meetings. And we used to try and get them all onto the same page so that

they knew what they should be doing with – so I don't think Peter had probably – I don't know, I'm guessing whether he'd had the experience and personal development to get him to the right place to be handling them.

DR KIRKUP: Okay, well I don't want you to speculate too much. It's helpful to get your impressions, but...

DR ASHTON: I know.

DR KIRKUP: let's not get too far off the evidence. He was replaced by George Nasmyth.

DR ASHTON: Yes.

DR KIRKUP: Do you have the same sort of relationship with George?

DR ASHTON: Not really, it was coming towards the end there. I mean I think he was probably only in post about a year before we all wrapped up, wasn't he? He's much more of a traditional doctor. On the face of it, quite a tough character, and you would have thought that he would have carried a lot of authority with his clinical colleagues. I don't know what happened next.

DR KIRKUP: He's still there.

DR ASHTON: Oh, has he gone?

DR KIRKUP: No, he's said that he will leave in – at the end of this year, I think, or next January.

DR ASHTON: Oh, okay. I thought he'd gone because what's-his-name, David Taylor's coming, isn't he?

DR KIRKUP: Dave Walker.

DR ASHTON: Dave Walker...

DR KIRKUP: Yes, that's right.

DR ASHTON: is coming, yes.

DR KIRKUP: But he hasn't got here yet. He'll be here in January.

DR ASHTON: Yes.

DR KIRKUP: Okay, and you wrote to George Nasmyth about the report we've just been discussing, the ~~Prenatal~~ Perinatal Report. And you pointed out quite rightly that 60 case notes, experts judged that a third of deaths were potentially avoidable and better care and advice and support had been...

DR ASHTON: Yes.

DR KIRKUP: Were you aware of any response to that? I realise you were only around for another couple of months, but...

DR ASHTON: I can't remember.

DR KIRKUP: No.

DR ASHTON: I can't remember, I'm sorry.

DR KIRKUP: We've got a record of the letter but we haven't got a record of the response to it.

DR ASHTON: No, I can't remember.

DR KIRKUP: And likewise, I need to ask this because we're interviewing him shortly, but you also copied the report to Bruce Keogh. Any response from Bruce?

DR ASHTON: I can't remember.

DR KIRKUP: Okay.

DR ASHTON: I'm sorry.

DR KIRKUP: Anything else?

MR BROOKES: You may not be able to answer this, but I'm just interested in your description around your work with the police.

DR ASHTON: Oh, yes.

MR BROOKES: And the Chinese wall between that.

DR ASHTON: Yes.

MR BROOKES: Did you feel at any stage that you were compromised, that there were issues that you were finding out through your work with the police which you really needed to use to initiate action within the community around the hospital? In other words, that you were looking at very specific cases there. I can just see from – because we've got access to the police cases, that there might have been things coming through there which would have caused you concern. And yet you're sort of – can park my eyes over here rather than allowing that to – how did you handle that?

DR ASHTON: I've always had great relations with the Cumbria Constabulary actually, and used to regularly go and drink coffee with the chief constable. And he's – Craig Mackey's now deputy in London to the London Commissioner. And one of the deputy chiefs, Sue – oh, God, what's her name now? Anyway, you know, tends to deal with all those issues that are to do with safeguarding and so on, but she was very much in the lead on this. The key issue that cropped up was the hospital refusing to release records, and they really dragged their feet on releasing records. And I had to come back into the PCT and put

pressure from the PCT on the hospital to let the police have the record – have the records that they needed.

And Neela was involved in that because there was this issue about the police not knowing what they were looking for in the records. So they needed a clinician to help mediate between the clinical records and the police need for knowing what had happened. So I don't know whether you had that conversation with Neela, but she did that for us. She – that's another triangle.

MR BROOKES: Yes, that's it. Okay, thank you.

DR KIRKUP: Is there anything else that you would like to say to us that you think we ought to hear?

DR ASHTON: Can I just check my notes?

DR KIRKUP: Yes – please.

DR ASHTON: This is a little thing. Because of your geographic past you would – you would be for it, but the North East Observatory used to do a very valuable periodic analysis of early neonatal deaths, and that included North Cumbria but not South Cumbria. And I mean when I discovered that I raised the issue about why South Cumbria hadn't bought into that because – you know, because North Cumbria's on the funnel charts as an outlier anyway compared with the obstetric units in the North East, which is interesting. And that was another angle on the whole thing.

DR KIRKUP: Yes. You started off talking about the history of clinical governance in the NHS organisations and all the rest of it. In the 1974 reorganisation, the whole of Cumbria was part of the northern region.

DR ASHTON: Yes.

DR KIRKUP: But the southern part of Cumbria protested that if you were south of Kirkstone Pass, if you wanted a night out you went to Manchester, and if you needed a [inaudible] referrer you went to Manchester, your television came from Manchester. If you were north of Kirkstone Pass replace Manchester with Newcastle on each occasion, and they said, 'We want to move to the North West,' and the observatory followed suit with geographical boundaries.

DR ASHTON: No, I do appreciate that. Sorry, let me just check if there's anything else. I think the midwifery issue and the – I think the weak managerial grip on midwifery from the SHA is an issue. I think we've covered pretty well everything.

DR KIRKUP: Okay, that's great.

DR ASHTON: Yes.

DR KIRKUP: Thank you very much for coming, you've been very helpful.

DR ASHTON: No – thank you. I hope that was of help.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 14 October 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

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

LISA BACON

Transcript produced by Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

(at 11.49 a.m.)

DR KIRKUP: Hello. My name is Bill Kirkup. I am Chairman of the Panel. I will ask my colleagues to introduce themselves to you.

PROF FORSYTH: My name is Stewart Forsyth. I am a paediatrician and a Medical Director for Dundee and Tayside.

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

DR KIRKUP: You will see that we are recording the proceedings and we will make an agreed record of the interview at the end. You probably also know that we have opened proceedings to family members. As it happens, we don't have any with us this morning but they may listen to the transcript – the recording, I should say.

MS BACON: Yes.

DR KIRKUP: If there are any issues that arise that touch on matters including confidentiality, we will have a second part of the session where people won't be able to access the recording so if we need to discuss individual details. You will also know that we have asked you to hand in any mobile telephones, recording devices?

MS BACON: Yes.

DR KIRKUP: That is just to emphasise that nothing goes outside the room so that we are able to proceed in context. Do you have any questions for me about the process?

MS BACON: No, I haven't.

DR KIRKUP: Okay. I normally start out with any general questions about what you have done and when but I understand that you would like to make some comments to us and I am absolutely happy for you to do that so long as you understand that we may come back and ask you for further details and further questions.

MS BACON: Yes, that's fine, thank you. Is that okay if I do that then?

DR KIRKUP: Yes, yes.

MS BACON: I just felt it might be helpful because there are some points and some information that I would like to share with you as part of the interview and I was going to ask if you think that would be appropriate if you would like me to

do that, and so you have.

I have been in post as the ~~SLA~~ LSA midwifery officer in the North West since January 2011 and I just wanted to try to get over some sort of key issues to do with the differences between supervision now, actually, in 2014 but starting in 2011, to how it was then. I will just make these brief, but obviously I am very happy for you to ask me further detail about this.

It is my view that supervision in midwifery is now much better understood and implemented now with greater clarity and greater transparency than it was back in 2008. There are many reasons for that. We have national guidance, which I am happy to talk about later, but basically it is better understood and it is clearer and more transparent. The second key issue, I think, is that we now have a national database on which we store all supervision data and we are able to track investigation progress and other supervision data that wasn't in place in 2008, and the third and key important issue for me is now the training, development and support for supervisors of midwives to undertake their role to a high standard, in particular the investigation process.

I have introduced mandatory training for all supervisors of midwives on the investigation process and that is included in the course that midwives undertake to become supervisors as well. I have ~~investigated~~ instigated quarterly meetings of all the contact supervisors in the North West where they network and they have leadership and development workshops. I provide a quarterly update to all supervisors and midwives across the region on themes, trends and lessons learned from investigations which they are expected to cascade amongst their teams and the local supervisor teams report on a quarterly basis to the directors of nursing in the trust with an update on all supervision issues, in addition to which I now report on a quarterly basis to the NMC and NHS England as well on supervision activity, which includes serious incidents and investigations and outcomes.

There is an LSA midwife in post now that wasn't in post at the time and her specific remit is to quality assure the investigation process and provide ongoing support for supervisors as they undertake investigations and I think overall probably a more hands-on and approachable LSA MO.

Those are the key differences in brief and I just wanted to share that

with you.

DR KIRKUP: Yes, thank you. That is very helpful context. You started as LSA MO in 2011, I think you said. What had you done before that?

MS BACON: I was a midwifery lecturer at the University of Manchester. I was the head of the Maternity and Child division at the University of Manchester and I was also a supervisor of midwives at Central Manchester Foundation Trust St Mary's Hospital. Prior to going into education, I practised midwifery clinically at Central Manchester.

DR KIRKUP: And you are still in the position of LSA at the moment?

MS BACON: Yes.

DR KIRKUP: Yes, okay. What are the organisational arrangements then? Is that part of NHS England?

MS BACON: Yes, currently the LSA function sits with NHS England so I am in NHS England North region, which is subdivided into North West Yorkshire and Humber and the North East.

DR KIRKUP: Okay, fine. Julian?

MR BROOKES: I want to carry on with some of the things you have just touched on, which would be really helpful. It would be just useful to understand a little bit more about what the MO role is and if you start from when you started and it has changed, we will go through that change, so you were taking up the post of midwifery officer in 2011. What was your prime functions? What were the main things you were doing?

MS BACON: The role specification for the LSA midwifery officer is outlined in the midwives' rules and standards, so it is a statutory function to oversee supervision of midwifery within a geographical patch.

MR BROOKES: And your patch was?

MS BACON: North West.

MR BROOKES: So, what did that cover?

MS BACON: At the time it covered North Cumbria at the very top. Now, very recently, only in June this year, North Cumbria has moved into the North East LSA but literally up until June this year North Cumbria at the very top of the region down to mid-Cheshire, which is Crewe, Leyton Hospital; Lancashire, Cheshire, Merseyside, Greater Manchester and the Isle of Man. It's about 21 organisations, trusts of which some of them are on two sites so it's about 30

sites.

MR BROOKES: So, 30 midwifery units?

MS BACON: Thirty, yes, and it also includes any qualified provider – One-to-One Midwifery Service, they are based in the North West. It is the largest geographical LSA in England. The geography is huge in terms of area and population and in terms of numbers there are approximately – it varies but always around 4,500 practising midwives, between 320 and 350 supervisors of midwives. We have a birth rate —

MR BROOKES: And how many midwifery officers?

MS BACON: Me, just one.

MR BROOKES: So, your role is to oversee that whole area?

MS BACON: Yes.

MR BROOKES: Okay, and what does that mean? In a practical sense, what does that mean? what do you do day to day?

MS BACON: I have a series of responsibilities, really. It is a requirement from the Nursing and Midwifery Council that I audit on an annual basis all of those units, and obviously that takes up quite a lot of time. I, with my LSA midwife colleague, provide support to the supervisors of midwives in terms of training development; oversee and sign off supervision investigations; ensure that recommendations from those investigations are completed in terms of what the midwives have to do as an action following from an investigation; liaise with the NMC, with my employers, with NHS England.

MR BROOKES: So, how many investigations would you be involved with on a yearly basis?

MS BACON: In the last practice year there were, I think, about 79 investigations in the North West. I don't personally carry out those investigations but I have to review all the reports, those investigation reports, and agree or not agree with the recommendations that the supervisors make.

MR BROOKES: So, those reports are actually conducted by the supervising midwives?

MS BACON: The investigations are carried out by the supervisors of midwives within the organisation but there is constant communication with the LSA in terms of progressing that investigation. All the reports are seen in draft by either the LSA midwife or myself and ultimately when that report is finished, I will sign

that off.

MR BROOKES: Forgive me, I suppose I feel slightly uncomfortable about what seems to an outsider as peers assessing peers within a unit. Why is it that way round? Why is it not that someone independent comes and does the review from a different unit, for example?

MS BACON: Sometimes that can happen if there is a conflict of interest. I think that the key issue is that supervisors of midwives, even though they may have or they will have a substantive post with their employer, are appointed by and accountable to the LSA and ultimately to the NMC for their role as a supervisor of midwives, so they are investigating that incident or reviewing that incident purely looking at the midwifery practice issues and, as I say, I will review that report and they work with the LSA midwife was well in undertaking that investigation and compiling the report. Neither myself nor the LSA midwife are employed by that trust, so there is that objectivity.

MR BROOKES: Are they practising in that trust or is there just a supervisory role –

MS BACON: That varies. Some of them will have a substantive job as a midwife within that trust. The majority probably do but not all. For example, when I was a supervisor of midwives, my job was as a midwifery lecturer at the University of Manchester but I had the role of supervisor of midwives at St Mary's Hospital, so to be honest most but not all supervisors of midwives would be employed by the organisation where they are undertaking the role. Sometimes if there is a conflict of interest that is recognised then an external investigation will – it will be investigated by a supervisor from outside of the trust. For example, if it is a supervisor of midwives herself who in her job as a midwife is involved in an incident or an issue, then that wouldn't be investigated by the local team and there is –

MR BROOKES: Is that always the case?

MS BACON: If there is a conflict of interest, yes, a situation like that.

MR BROOKES: So, a supervisor of midwives would never investigate another supervisor of midwives within the same organisation?

MS BACON: I don't know if the answer to that is 'never' but to my knowledge, I would consider that to be –

MR BROOKES: It wouldn't be usual practice?

MS BACON: No, no, no, it wouldn't. To my knowledge that would be a conflict of

interest. The supervisor would declare that as a conflict of interest. There is a move towards all investigations being done externally. This is being looked at across the whole of the north but there is still, I feel there is, impartiality and objectivity because of the involvement of the LSA, in particular the LSA midwife and we don't have the interest of providers or the interests of the Commissioners. We are looking purely at the midwifery practice issues within that incident.

MR BROOKES: So, I think you said about 70-odd average kinds of investigations ongoing in one year. How many of those have you been engaged with which relate to Morecambe Bay?

MS BACON: In the last practice year I think there were eight or nine Morecambe Bay investigations.

MR BROOKES: Does that feel high, low, what you would expect?

MS BACON: It has got higher. When I came into post I think there was probably one or two investigations at Morecambe Bay, which was low, that to me it felt low out of that number of midwives, and then I think there has been eight and then seven and then nine in the most recent practice years. I have looked back over the last five years, so it does feel more at a level where it should be now, I think.

MR BROOKES: So in 2011, when you say there was a couple, that does sound low considering the issues which have happened within the previous organisation.

MS BACON: Yes, the picture across the whole of the North West, I think the number of investigations was lower than I probably would have expected it to be given the amount of midwives working across the patch. Each practice year there has been a steady increase in the number of investigations and it has plateaued for the last two years, so each ~~practitioner~~ practice year in the last five practice years – it has plateaued in the last two at around 75, 79 investigations, which compared to other LSAs of a similar size – London, I think we are the best comparator to – is at a similar level now.

MR BROOKES: Okay, so the numbers were relatively low. What was the quality of the investigations when you arrived? Did you look at past investigations? Did you ever get any impression of whether or not the investigations were done to the standard you would expect?

MS BACON: I didn't look at so many past investigations but the investigations that I

started to review very early on in my appointment as the LSA MO, I think, yes, that there were issues with the quality of the reports. I am not sure about actually how the investigation was carried out, but how it was written up in the report, which is a reflection of how it was carried out.

MR BROOKES: What kind of issues were there in terms of the write-up?

MS BACON: In some respects there would be a lack of detail and the standard of how the report was put together, the issues of grammar and English and what it looked like, lack of detail, possibly a little bit of inconsistency – I felt as if I was having to give a lot of feedback to ask for clarity and what was meant here and make corrections, literally.

MR BROOKES: And why do you think that was? Was it because they hadn't been properly trained?

MS BACON: This would be before my time as the LSA MO.

MR BROOKES: Sure.

MS BACON: So, this is just an opinion but I think so, yes, and actually it is a fact that there wasn't any training in place for supervisors to undertake an investigation, not like there is now. A supervisor would be appointed following undertaking the preparation programme and once appointed in that role there wasn't any further ongoing training and development specifically around undertaking investigations. There were study days, conferences and continuing professional development opportunities, which were good, I think, because I was a supervisor of midwives at the time so I would attend those in my role as a supervisor, but what there wasn't was, if you like, ongoing training, as, 'This is how you do the job of a supervisor of midwives'.

MR BROOKES: Okay, and was that common across the whole patch or can you give me any insight into what you felt for Morecambe Bay in particular? Was it worse, better?

MS BACON: It would be the same. That was across the patch. There wasn't any training of development in that respect across the whole of the North West, which would include Morecambe Bay.

MR BROOKES: So, in effect, once you have done your preparation and training and you become a supervisor of midwives you didn't actually have to do any further training at that stage? Is that –

MS BACON: That's correct.

MR BROOKES: I am just trying to understand the situation.

MS BACON: That's correct, yes, there was nothing. There was no mandatory training.

MR BROOKES: And did that preparation to become a supervisor of midwives include how to investigate, how to look at the quality of services?

MS BACON: Yes, it did. That was on the curriculum, but it wasn't on the curriculum to the extent, to the depth, that it is now. Yes, there was a session taught by the course leaders on the supervision investigation process.

MR BROOKES: And how satisfied were you that irrespective of the grammar and the way that these reports were like that the action, which is the critical element, that was required following on from the investigations would be actually carried out?

MS BACON: Yes, I would always look at how they had benchmarked the issues against the Nursing and Midwifery Council's rules and standards and the code to ensure that the outcome was proportionate and fair.

MR BROOKES: Okay. So, we are in a situation where the trust has supervisors; they had been doing investigations – I am just trying to summarise what I think I have understood. There was a common issue in terms of continuous training and development of people in terms of their own supervisory but you are reasonably comfortable that the actions that were being required following investigations were being completed.

MS BACON: Yes, from when I came into post, yes.

MR BROOKES: Yes, okay. And previously, or can't you say, because there would have been a number of investigations with outstanding actions when you came into post which had been completed?

MS BACON: Oh yes, I mean from when I came into post I would pick up all ongoing ones to be completed, and obviously the ones that started from when I came into post.

MR BROOKES: Okay, and you also mentioned an audit panel as part of your role. Can you just explain that?

MS BACON: Yes, it's a requirement from the Nursing and Midwifery Council that an LSA has to audit on an annual basis the standards for supervision within a maternity service. There is a national audit tool that is used where we look at – there's four domains to that tool and the NMC standards for supervision sits

within those four domains. Domain one is about how supervision ensures safe and effective practice, so that is about the interface with supervision and governance. Domain two is profile and effectiveness of supervision. Domain three is team working, leadership and development, and domain four is the interface with service users.

I take the approach that I physically go to the unit. They, in advance of the audit, send me evidence to demonstrate to me how they are meeting the standards within those domains, so it is no good that they just say, 'Oh yes, we attend the governance meetings as a supervisory midwife'. They have to send me the minutes with their evidence that they were actually there, for example. I review all that evidence and then I go to the unit. The supervisors of midwives are requested to meet with me and the audit team. I take a peer supervisor with me, so a supervisor of midwives from outside of that organisation, and a service user. That is the audit team, generally. The supervisors of midwives undertake a presentation at the beginning of the day to the audit team and invited guests, such as the Chief Exec, Director of Nursing, anybody that they want to invite from within the organisation.

The presentation consists of their activity as supervisors over the year, actions and are they meeting the action plan through; last year's audit, any challenges, innovations, etc. Following the presentation I then meet with the supervisors of midwives' team. We go through all the evidence for the domain, discuss it further and I ask for some verification or clarification on some elements of the evidence. Meanwhile, while that meeting is going on, the peer supervisor goes around the unit talking to the midwives about their views of supervision, their experiences of supervision. There is no set pro forma. Similarly, the service user goes and talks to women and their families about their experiences of midwifery care in that organisation and all that information gets put into the format of a report, which is sent back to the organisation with my comments and recommendations as a result of the feedback that we have had, and the supervisors of midwives then have to write an action plan to meet those recommendations or how they are going to meet those recommendations and then I will further down the line review that action plan and that sort of closes the loop of the audit cycle.

MR BROOKES: Do you take into account anything from other regulatory bodies, any

information from CQC for example, or other organisations involved with the particular trust?

MS BACON: I am there to specifically audit the standards for supervision of midwifery.

MR BROOKES: But if those reports have criticised the quality of the midwifery service aren't they relevant?

MS BACON: Yes, if they have done, yes. If they have made specific comments about the supervision of midwifery, yes, I would take that on board. I would expect the supervisors of midwives to make me aware that CQC had visited, whether it is a routine one or a responsive visit which they do, and I think now CQC are moving towards trying to standardise how they make contact with the LSA because – I know you haven't asked me this question but that isn't always standard – sometimes a CQC reviewer will contact the LSA MO and ask them for some input and sometimes they don't and the LSA MOs across the UK have spoken to the midwifery advisor at CQC, Rona McCandlish, and we have agreed some standards whereby CQC will – the very least they will do is inform the LSA that they are on site and undertaking a review.

MR BROOKES: So, given the audit, given the information on the investigations etc., what was your assessment of Morecambe Bay midwifery services?

MS BACON: Okay. I audited Morecambe Bay, I think in June 2011. So, I had been in post just for a few months. When I arrived to do that audit and to meet with the supervisors of midwives' team, I could see that there were three quite separate groups of supervisors of midwives: Furness and Lancaster and Kendal. They didn't really seem to know each other. There wasn't a cross-Bay approach to working at all, so one of my very first key issues with Morecambe Bay was to try to get them working as a team of supervisors across the Bay because the standards for supervision are the standards and should be enacted in the same way across the whole of the UK, really, but certainly I wouldn't want to see differences within an organisation.

MR BROOKES: By implication you are saying there were differences?

MS BACON: I don't think that they were working particularly – well, I know that they weren't working as a cross-Bay team. I don't think they met with each other. I know that and I was given that impression at the audit as well. When I went in and did the audit in 2011 I came away with some recommendations that I

wanted the supervisors of midwives to do in addition – sorry, that I wanted them to do as a result of that audit. At the audit in 2011 I didn't have an opportunity to have what I would call a proper meeting with the Director of Nursing or the Head of Midwifery. The Head of Midwifery was very new in post when she came in in May.

MR BROOKES: Is that ~~Sacha~~Sascha?

MS BACON: Sacha came in in May. She had literally been there a few weeks. I am not even 100 per cent sure if the supervisors at the time – it's a different team now – had involved Sacha in that audit process. So, after the audit I remember making contact with the team again and saying that I wanted to hold an extraordinary meeting with the Head of Midwifery and with the Director of Nursing to discuss taking supervision forward, to discuss issues that had come up at the audit. However, very shortly after –

MR BROOKES: Is that the 14 June meeting feedback after the LSA audit?

MS BACON: 14 June?

MR BROOKES: 2011.

MS BACON: I don't know.

MR BROOKES: It's just there's a note of a meeting being pulled together at that date.

MS BACON: I don't think I've seen that information that you have got.

MR BROOKES: Okay.

MS BACON: But it would have probably been round about that time. However, that meeting never took place because I had a phone call from the NMC to say that the NMC and CQC were going to go in and review – well, the NMC were reviewing supervision. I think the CQC were obviously reviewing other things than supervision, so that sort of pre-empted the meeting that I was going to have. I can remember receiving a phone call from one of the midwifery advisers at the NMC and I said, 'Well, I've got a meeting booked with the Director of Nursing and Head of Midwifery' and I was advised by the NMC to cancel that meeting because I think they were literally going to go in that same week. And that was it then, really. The NMC went in and the CQC went in and that then triggered a whole chain of events from 2011 up until today.

MR BROOKES: So, what was your engagement after that trigger happened? Obviously, you've got a continuing responsibility.

MS BACON: Mm hmm.

MR BROOKES: How were you kept informed of what was going on? How were you made aware of or became aware of issues which had been raised and what actions to take?

MS BACON: The NMC did work really closely with me as the LSA in undertaking that review, and I was involved and present at the initial feedback meeting from the NMC to the supervisors of midwives and further follow-up meetings. I was involved, obviously, in the action plan, the supervisors of midwives' recommendations and actions that the supervisors were given to meet the recommendations from the NMC. I attended a lot of their supervision meetings and worked closely with them to help them to meet the recommendations from the Nursing and Midwifery Council and a year later in June 2012 when the report – when they went back for the substantive follow-up visit I was present at that visit as well. I shadowed the review team and was there for the feedback from that, which was positive in that I think virtually all the actions had been met and the NMC said that I think most of them had been met to a high standard.

The team of supervisors of midwives were absolutely very willing to do everything that the NMC had asked them to do, wanted them to do. I can remember one supervisor said to me that she viewed it as a golden opportunity now because there was somebody from outside of the organisation enabling them to take supervision forward in the way that they wanted to.

MR BROOKES: Doesn't that imply that they felt either disempowered or were unable to make change in the organisation?

MS BACON: It might imply that, but that is what was said to me.

MR BROOKES: Okay. Just one last thing. I would just be interested in your perspective on the quality of supervision at Morecambe Bay now and what's happened to get to – how it has changed.

MS BACON: Okay. I think it is much improved now. There is a robust and clear reporting mechanism now between governance and supervision. I will just talk about that side of it first. There is a supervisor of midwives present at all of the patient safety incident meetings where obviously safety incidents are discussed. There is rapid review of incidents that require midwifery practice

reviews. They always ensure that there is supervision representation and involvement with the labour ward for the divisional governance meetings, the guideline group audits and so on – much, much more robust evidence than was ever there in the first place.

One of the critical things I think that has happened is that they now are a cross-Bay team. They have in fact even stopped calling themselves a cross-Bay team. They are just a team of supervisors of midwives now. They all know each other, engage with each other. They do tend to do cross-Bay investigations as well, so for example if there is an incident that has happened at Lancaster it may well be a supervisor of midwives from outside the Lancaster unit that will investigate, so there is a lot of cross-Bay supervision going on.

MR BROOKES: And the quality of the reports?

MS BACON: Better.

MR BROOKES: Better or good quality? Better, good enough, or —

MS BACON: Good enough, yes, good enough, but I think that is largely also to do with the input from the LSA midwife, I think, and the training, development and ongoing support that they have had with the investigation process. I think, prior to 2011, it was more ~~than~~ an arm's length approach from the LSA. For example, I don't think the LSA there would have seen draft versions of the report or had the input with the investigation and the report as it progressed. Rather, she would just sort of see it at the end, I think. And I think the support that they have given to the midwives and their proactivity is better now than it was when I came into post, and they have made huge strides with working with service users as well.

They are very active in the local MSLC. There is always a supervisor that will attend MSLCs and service user groups and they are very committed to engaging with service users and making sure that their views are heard within the maternity service.

MR BROOKES: Thank you.

DR KIRKUP: Thanks. Stewart?

PROF FORSYTH: I just want to clarify in my mind – so, you took that post in 2011 and in your introductory comments you set out a number of changes that had taken place in the LSA processes.

MS BACON: Mm hmm.

PROF FORSYTH: What I am trying to work out is, has supervision been more effective because of the changes in LSA and therefore was the supervision poor prior to 2011 because there was not the same input from LSA, from a midwifery officer such as yourself?

MS BACON: I don't know if it was poor. All I can say is what I have put in place since, which I think has improved the supervisors of midwives' own understanding of exactly what their role is, which I think has led to better supervision, improvements in supervision.

PROF FORSYTH: What I am trying to get at as well, clearly the whole purpose of supervision of midwives presumably is to improve the quality of care that they provide for the clients.

MS BACON: It is. Ultimately it is about safety and protection of the public, I think, and the best way to do that is by having confident, competent midwives, yes.

PROF FORSYTH: And if there were issues about the quality of midwifery care, say, prior to 2011, I am trying to work out was part of that because of the lack of support that the supervisory process had at that time?

MS BACON: I am sorry, could you say that again?

PROF FORSYTH: Well, if the idea of the work that you are doing in trying to improve the supervision of midwives, if it was that there was less support for the supervisors of midwives prior to 2011 would that have contributed to the poor quality of care that the midwives were then providing at that time?

MS BACON: I don't know if it would contribute to poor quality midwifery care but I think that how supervision was carried out is better – I know it is better now than it was then in terms of reviewing midwifery practice incidents and issues.

PROF FORSYTH: But if that was not happening prior to 2011 —

MS BACON: Yes.

PROF FORSYTH: — and you have [policies?] to try to improve supervision then clearly there must be a link, I would have thought, to the standard of the midwifery care at that time. What was your impression not just about the supervision, actually, but what was your impression that you took from the quality of midwifery care when you first embarked on this post in 2011, and I am talking about the Morecambe Bay Trust? When you started hearing about the investigations and started seeing reports, did you get a feeling of concern

at that time?
MS BACON: I didn't. I wasn't aware of all the issues to do with Morecambe Bay when I came into post initially.
PROF FORSYTH: Why not?
MS BACON: I wasn't in a position to know in my other job.
PROF FORSYTH: But did someone have a similar job to yourself before that?
MS BACON: Yes, they did, they did and I was aware that there had been some issues at Morecambe Bay but not the depth, not the detail or the complexity. I wasn't aware of all the families that were involved at the time when I came into post, but —
PROF FORSYTH: So, the LSA would not – obviously the organisation weren't informing you when you took up the post that there had been issues in Morecambe Bay Trust that resulted in inquests, inquiries, etc.?
MS BACON: Yes. Prior to me coming into post I wasn't aware of the level of concern but when I came into post, bit by bit that started to be revealed to me by what was then the SHA.
PROF FORSYTH: I am sorry?
MS BACON: The SHA at the time. It was when SHAs existed and the LSA function sat with the SHA. So, when I came into post in January – I mean, it's a big patch. There was a lot for me to think about everywhere, not necessarily just at Morecambe Bay, but yes, when I came into post I did start to become aware of the issues going back to 2008 at Morecambe Bay.
PROF FORSYTH: So, what was your sort of initial analysis of that? Did you think that when you were obviously speaking with your local supervisors of midwives and beginning to see the investigations that were coming through that this was fairly exceptional?
MS BACON: Yes, in terms of the level of involvement of the families. There wasn't anything going on quite like that in other areas of the North West.
PROF FORSYTH: So, what were the sort of main areas of professional practice that you felt were appearing to be substandard?
MS BACON: Not so much professional practice. What I was looking at was how supervision was being carried out and, like I said before, I don't think there was clarity or I don't think there was the clarity that there is now in the processes of how you would and when you would undertake a supervision

investigation.

MR BROOKES: I am sorry, I am just trying to understand this. You may be going on to this, but so a supervisor of midwives would carry out supervision to the letter of the law and they may be supervising extremely poor practice but you wouldn't be looking at that? You would be looking at the quality of the supervision. Does that make sense? I just find that hard to equate. There isn't a natural link between the quality of —

MS BACON: Yes, a supervisor of midwives, their role is to intervene when practice is unacceptable and they do that; they would review an incident, review the practice issues and make that intervention. They would undertake an investigation. There would be recommendations as a result of that.

PROF FORSYTH: Because none of the reports, none of the supervisors of midwives' reports of incidents – investigation of midwives clearly raises some issues around the standards of clinical practice, and that is what we are trying to get at. I mean, from your impression – you were in effect in the position of seeing the reports and also, as you say, you were covering another area, a wide area as well, so you would get a feel for, 'Well, is this unusual?' in terms of the number of investigations where there has been concerns about quality of practice and I am just trying to get, with your insight into that, what you felt were the main issues regarding midwifery practice when you took up your post in 2011. We are particularly keen to look at the period prior to 2011 but also subsequently at what has happened since.

MS BACON: I think in specifically Morecambe Bay there may have been issues of some midwives not always recognising risk and escalating that appropriately.

PROF FORSYTH: Right.

MS BACON: There were themes across the whole of the North West, which is not unusual: CTG interpretation, recordkeeping and documentation issues, accountability, exercising accountability.

PROF FORSYTH: And so what might, do you think, have happened? Why were these issues there? Was this part of their managerial supervision or professional supervision? Was it part of their continuing professional education and training?

MS BACON: I couldn't say. I think there are probably a lot of issues. Certainly, in terms of the supervisors of midwives, they didn't have, like I say, the training

and the solid foundation necessarily. I couldn't really say.

PROF FORSYTH: Did you get a feel for – I notice it did come up in one of the recommendations in one of the reports that you were involved in – about relationships with medical staff. Were you aware of that being an issue in Morecambe Bay when you were getting these reports in?

MS BACON: Through other reports that I have read I have heard that there is – I think particularly at Furness General rather than the other two areas – that there had been some issues with the interface relationship between midwives and medical staff. I don't know if that impacted on the number of supervision investigations but obviously it is really important that midwives and obstetricians and paediatricians have respect for professional working relationships as part of a wider multidisciplinary team and I believe that the organisation have put some work in on that over the three years, four years since I have been in post. My remit, my specific remit, is to look at midwifery practice issues but a supervision investigation will also often bring to light system issues or governance or organisational issues and if as a result of a supervision investigation into a midwife's practice there was some element of lack of professional relationship between midwives, obstetricians, paediatricians, then that would be fed back to the head of midwifery, to the service side, really, as a finding from that investigation.

PROF FORSYTH: Well, what about – again at that time you mentioned about governance organisations within – did you feel that governance structures within, again, Morecambe Bay Trust, were deficient at that time in terms of monitoring of midwifery practice?

MS BACON: I don't know if I am the best person to answer a question about organisational governance but I can tell you that there was not a very robust interface between the supervisors of midwives who have the remit for the ?commitment of practice issues and governance and risk reporting mechanisms. I think the NMC highlighted that in their review as well, which, as I just described to your colleague, that system is improved, is much improved now.

Formatted: Underline

PROF FORSYTH: And likewise the relationships with the more senior management within the trust. I notice that in certainly the report of 14 June meeting you had it is mentioned it was regrettable that the Director of Nursing is not able to

attend.

MS BACON: What year is that? I beg your pardon. 14 June – is that 2011?

PROF FORSYTH: 2011.

MS BACON: Yes, I think that might have been me making my point that the Director of Nursing wasn't there.

PROF FORSYTH: Do you just want to expand on that at all?

MS BACON: Yes. I expect the supervisors of midwives to invite key people within the organisation to the LSA audit, least of all for me to meet them, for them to be involved in looking at the evidence and the feedback, etc. It is standard practice that a Director of Nursing or her representative, perhaps her deputy, would be present at the audit. Sometimes the Chief Exec will come and people from the CCG might come, anybody, really. For me the more the better. That would be what I was expecting. I was very disappointed that the Director of Nursing wasn't there. I think the Head of Midwifery was there but she, from what I can remember, I don't think had been formally invited. I think she just sort of knew that it was going on so came. So, yes, so that was me making my point that there was very poor representation from the executive team which is why I wanted to go back. I think I had a meeting planned with them to discuss the audit at the time but, as I've explained, that was then superseded by the NMC and CQC going in to undertake their review.

PROF FORSYTH: Thank you.

DR KIRKUP: Thank you. I just want to pick up a few specific points that have come out of what we have discussed so far. You described, I think, a system where the local supervisors of midwives were accountable for the supervisory function to the LSA MO. Can you tell me how that worked? How did you discharge that responsibility in practice?

MS BACON: It is in the midwives' rules and standards that they are accountable to the LSA, so for example it would be me overseeing the investigation work, the investigation reports. Everything that they do in their role as a supervisor I would be ultimately responsible for how they carried that out. So if, for example, a member of the public made a complaint about a supervisor of midwives, that complaint would come to the LSA for review rather than the Chief Exec of the organisation.

DR KIRKUP: Okay, and who would you be accountable to in turn for the discharge

of that option?

MS BACON: To the Nursing and Midwifery Council professionally but I also obviously have a contractual obligation, accountability to my employer, which is NHS England because the function of supervision, the LSA function, currently sits within NHS England.

DR KIRKUP: Was that SHA?

MS BACON: It was the SHA, Mm hmm.

DR KIRKUP: SHA, England, yes. Okay. I am still trying to pursue a little bit this 'how did it operate', and I am not sure that I am picking this up correctly, but did you judge the work of the supervisors and midwives on the quality of the reports that they produced or have I got that wrong?

MS BACON: That's part of it. That's part of it. Also, the audit really is the bigger part of it because supervisors of midwives have other functions other than just to undertake investigations. They have to meet. They have a caseload of midwives. They have to meet with those midwives at least annually and undertake an annual review with those midwives, which is similar to but not the same as perhaps a PDR process, so that they are sort of looking of the midwives' practice and benchmarking it against the rules and standards in the code. So, yes, they have to meet with their midwives. They have an obligation to continue with their own professional development as supervisors of midwives. They have to work with service users and families as I described. So, undertaking investigations where they feel that midwifery practice is not up to the standard required is one part.

DR KIRKUP: Yes, okay, and you can audit the other parts in the way that you described?

MS BACON: Yes.

DR KIRKUP: But I am keen to understand how you could assure the quality of the investigatory process. Was it just on the basis of the written inputs or was there anything else that you did to satisfy yourself that they were investigating properly?

MS BACON: I wrote a business case for a project midwife to work with the supervisors of midwives to quality ensure the investigation process, and that was successful and I had a project midwife for 12 months and then that was made into a substantive post. So, part of her role – and I can do this as well;

we work as a team – would be to go out and meet with the supervisors when they were undertaking an investigation. She is their constant advice and support, which can be over the telephone, looking at draft reports, interview transcripts. When the supervisor meets with the midwife the LSA midwife can also be present at those meetings as well.

DR KIRKUP: And how often does that happen?

MS BACON: Fairly often. Fairly often.

DR KIRKUP: How often did it happen in Morecambe Bay?

MS BACON: It didn't happen until I came into post. That wasn't happening anywhere until I came into post.

DR KIRKUP: And after you came into post how often did it – when did it start happening in Morecambe Bay and how often?

MS BACON: I am trying to think when she was in post – from, I would say, perhaps 2012 – I can't remember exactly when she came into post but the NMC review was at the end of 2011. 2012 – at some point in– I think it was September 2012.

DR KIRKUP: Okay. The system seems to me to quite importantly revolve around the supervisors of midwives and in position are the local supervisors. The supervisors and midwives are in the end mostly colleagues of the people who they are supervising. There is always in that kind of set-up – and I am not saying anything specific about midwives here, there just always is – a temptation in that kind of set-up for the relationship to become a bit complacent, a bit cosy, a bit too close.

MS BACON: Yes. I wasn't agreeing here by saying 'Yes' I think I was waiting for Dr Kirkup to expand.

DR KIRKUP: 'I understand the problems. Don't worry about it'.

MS BACON: Mm hmm.

DR KIRKUP: How do you guard against that?

MS BACON: Each supervisor of midwives has a caseload of midwives that she supervises, so they are her caseload and she provides ongoing support, meets, does the annual review with them. You wouldn't have a situation where the midwife's named supervisor is doing an investigation on one of her own supervisees.

DR KIRKUP: No, but it is still quite a small unit.

MS BACON: Morecambe Bay, yes, but hopefully it would be a supervisor of midwives from one of the other sites that is not always working with that midwife.

DR KIRKUP: Yes, you know I am going to pick up on the word 'hopefully' there.

MS BACON: Okay.

DR KIRKUP: Well, was it always somebody from a different site? I don't think it was.

MS BACON: At the time?

DR KIRKUP: Yes.

MS BACON: No, because they didn't have a cross-Bay philosophy of supervision which they do now.

DR KIRKUP: Sure.

MS BACON: But the supervisors of midwives are, in my view, very good at just focusing in on the midwifery practice issues and following the clear lines of accountability to the LSA and ultimately to the NMC.

DR KIRKUP: Yes, I have to say to you that I understand that that is how you would like it to look, but I think there is evidence that they did not always do it that way. Would that surprise you?

MS BACON: At the time in 2008, do you mean the evidence from them?

DR KIRKUP: Not just 2008. It was certainly up until 2011.

MS BACON: Yes, I beg your pardon, up until 2011. Yes, I mean obviously I am aware that criticisms have been made, as you have described.

DR KIRKUP: The close relationships that clouded the objectivity of the supervisor or at least potentially clouded the objectivity of the supervisor?

MS BACON: Potentially clouded it, yes, yes and I think possibly specifically at Furness General, which is a small unit, in quite a geographically not isolated but not – I suppose it is a small town isn't it, I think – probably a situation where not like a city centre hospital where you get a throughput of staff. Local people working in the local hospital, a very sort of local view of things, really, and I don't think that there was the same networking opportunities for the supervisors of midwives that there are now and I think that that has helped massively.

When I meet on a quarterly basis, and I meet more than quarterly but these are formal quarterly meetings with all the contact supervisors from each of the units, I expect representation from each of those units, so they are

getting out of their units now and networking much better with each other and I think that big lessons have been learnt across the patch from Morecambe Bay because the action plan that the NMC gave the Morecambe Bay supervisors of midwives, every supervision team in the North West, and I think beyond – I think most in the UK – benchmark themselves and have written their own actions.

DR KIRKUP: I do have a residual concern about that and I think that when people were asked whether the supervisory system was sufficiently objective and effective in 2008 to 2011 they would have said, 'Yes it looks fine', then too, so how can you assure me that you know that it doesn't suffer from those difficulties now?

MS BACON: I think because, like I said at the beginning, there is a better understanding now, much more openness, transparency and clarity, certainly post Francis, and I have made it so clear to the supervisors of midwives about the standards and the processes and the policies that must be followed, and I work more closely and my LSA midwife colleague works more closely with the local team now. Supervisors of midwives have said to me, and not just from Morecambe Bay but across the patch, things are much clearer now, that they do fully understand much more what they are doing. I am asking them to do more. The profile of supervision has raised. I am expecting a lot more in terms of how they undertake their role and the level of quality that they undertake their role.

For example, something that never happened up until fairly recently was the briefing where the contact supervisor of midwives sends a briefing paper to the Director of Nursing on a quarterly basis with basically all the supervision activity that has gone on in the organisation within that quarter and that includes a number of serious incidents and supervision investigations. Now, the Director of Nursing would know, obviously, that there had been serious incidents and so forth but she is hearing it from – he or she is hearing it now from a supervisor of midwives and the supervision perspective on that.

DR KIRKUP: If there is a potential conflict of interest in an investigation by the supervisor of midwives, whose responsibility is it to identify and to say, 'We need an external audit'?

MS BACON: I think it would be a joint responsibility between a supervisor of

midwives or a midwife recognising that there is a conflict or me recognising that there is a conflict. I had an email only two days ago – it was not at Morecambe Bay – where a supervisor of midwives emailed me and said, 'There's been an incident. It involves a supervisor of midwives. I think this is conflict of interest. This needs to go external'. I emailed her back and I said, 'Yes I agree' and I am meeting with that supervisor of midwives tomorrow morning to discuss taking that forward externally. What I will do is ask a supervisor from a neighbouring organisation to come in and do that investigation.

DR KIRKUP: Yes, I can see that where a supervisor of midwives per se is involved, but that goes back to this point I was making earlier about close relationships within quite a small unit and you are right, it is quite small and quite isolated and a lot of people have come up through the system; they have trained in Barrow, they have worked in Barrow and been promoted in Barrow.

MS BACON: Yes, I know.

DR KIRKUP: Let me give you an example that does concern us a little bit. One of the investigatory meetings had been carried out by a supervisor of midwives. A supervisor of midwives attended in her capacity as the midwife's RCM representative. That does seem to us to be a conflict of interest, but it happened and it was not picked up.

MS BACON: At Morecambe Bay?

DR KIRKUP: Yes.

MS BACON: Recently?

DR KIRKUP: Not that long ago.

MS BACON: So, the supervisor of midwives was the midwife's RCM rep?

DR KIRKUP: Yes. Not to go into the details of the specific case, because what happened happened, but what I am interested in is how the system is designed to be able to pick up that kind of conflict of interest.

MS BACON: I think there can be a potential conflict of interest if a supervisor of midwives is the midwife's RCM rep as well. I could only pick that up if that was flagged up to me. I wouldn't necessarily know who an RCM rep was unless it was flagged up to me but if it was, then a conversation would be had about potential conflict of interest.

PROF FORSYTH: Do they not understand the conflict of interest point, either on an

annual basis or actually for an individual case?

MS BACON: At the beginning of the interview now there is a sort of pro forma of questions and they would have to say if there was a conflict of interest. Generally what happens is the midwife under investigation will bring to the interview her named supervisor of midwives and the investigation will be led by a different supervisor of midwives. The midwife can bring, I guess, anybody for support to an interview for an investigation but they generally choose, and the preferred option would be that they would bring their named supervisor. It's not usual in my experience that they would bring an RCM rep to a supervision interview.

DR KIRKUP: Whose responsibility is it to pick up a pattern of incidents that require investigation but suggest that there is a deeper problem here?

MS BACON: Management and supervision? I think the organisation would probably have responsibility as would a supervisor of midwives. Yes, I think a supervisor of midwives is well placed to pick up with individual midwives where there might be a low level of concern about a midwife's practice which isn't necessarily triggering major serious incidents but there are some elements of that midwife's practice that might need some input.

DR KIRKUP: Is that something that you audit the supervisors of midwives on? Do you have a look at what patterns they are picking up on?

MS BACON: If a supervisor of midwives was picking up or noticing that there was a pattern with a midwife's practice they would discuss that with me, yes, or with my LSA midwife colleague. I have a few examples of that where a midwife may not have been involved in an incident but a supervisor of midwives has concerns that there are some elements of the practice that aren't necessarily meeting best practice standards.

DR KIRKUP: Yes, that is slightly wider than one individual's practice, though. If you have a unit, as there seems to be a certain amount of evidence suggesting that Furness General was, where there is a recurring pattern that mothers aren't monitored appropriately in labour, that ~~CDGs~~ CTGs aren't acted on appropriately in labour, there was failure to escalate concerns to obstetric staff, failure to communicate with paediatric staff, and actually these are pretty evident across quite a lot of [inaudible] ... which is not something that you would expect to keep on happening.

MS BACON: No, no, no. Yes.
DR KIRKUP: Who would have been able to pick that up and would your role have involved oversight of those things?
MS BACON: My role would have involved certainly ensuring that the midwives meet the required standards for practice, yes. It would do. It would do.
DR KIRKUP: And if you find some evidence that you think, 'Hang on, this isn't just a bit of temporary poor practice by midwife x, or even recurring poor practice by midwife x; actually, there seems to be a recurring problem in this unit here', what would you do?
MS BACON: I would escalate that, yes. If I saw a trend or a pattern developing of any element of midwifery practice, I would escalate that.
DR KIRKUP: Who would you escalate it to?
MS BACON: I would have a discussion with the Head of Midwifery and/or the Director of Nursing and I could discuss that with colleagues at the NMC as well.
MR BROOKES: Can I just ask if you ever done that?
MS BACON: Specifically to do with Morecambe Bay or —
MR BROOKES: No.
MS BACON: Yes, yes. I have had conversations with Heads of Midwifery where there have been issues with some elements of midwives' practice, with sort of system issues, governance issues, yes, I would do. I have done.
DR KIRKUP: Part of the scenario facing us here though is that there are an awful lot of organisations who have an interest in a part of it and you mentioned escalating it to the NMC but the NMC have been pretty clear with us that it is not their job to regulate our services, and I am sure they are right about that. Where does the CQC fit in? Where does the SHA fit in as was or NHS England now? How do all these different bodies find out what the heck is going on and put a complete picture together?
MS BACON: Yes, that's a big question. A lot of organisations have been reviewing Morecambe Bay and have had issues to do with Morecambe Bay. My remit was and is looking at standards of supervision and how that is effectively carried out.
DR KIRKUP: I know, but if everybody works on kind of quite rigid tramlines and says, 'That's not my job', then we don't communicate, the organisations don't

communicate. How can we have a system that is fit for purpose if we are all pursuing our own isolated part of all this?

MS BACON: Yes, but it still fits into the bigger picture. I would communicate – I do communicate – openly with other organisations. In fact —

DR KIRKUP: That is what I meant there.

MS BACON: Definitely. In fact I personally feel – I don't know what the word is – not aggrieved but I don't like to find out from somebody else that CQC have been in and done a visit to a unit. I expect CQC to inform me that they are going in to do a review or at least ask my view on supervision in that unit or ask me for my last audit report on that unit. I absolutely agree with you that we've all got to talk to each other and share the information. The annual report that I provide gets sent out to any stakeholder, all stakeholders, and it's – well, when we were the SHA we had a website, so I would put it on the SHA website, so it would be in the public domain.

DR KIRKUP: Okay.

MS BACON: So, please don't think that I think that I am just looking at this little bit and not anything else.

DR KIRKUP: No, no. I would appreciate then if I can push you on the role and responsibilities. You come back to the statutory point, but I do want to make this wider point that people have wider responsibilities than their specific duties.

MS BACON: They do.

DR KIRKUP: But I think we have covered that.

MS BACON: They do, okay.

MR BROOKES: Just to clarify that, is there any formal agreement or understanding, any memorandums of understanding between the different bodies about that or is it down – I hear a lot of, 'I', and I have no doubt you do that, but is that consistent? Is that understood? Is it formalised in any way, that sharing of information?

MS BACON: I'm not sure how formalised that is other than I do —

MR BROOKES: So if someone who is less consciousness than you or feels that way wouldn't necessarily have to do it? It's not clearly laid down to them?

MS BACON: It is clear – some elements of the reporting are clear. I have to fill in a dashboard on a quarterly basis which is shared with NHS England. I report on

a quarterly basis to the NMC. Even though you said that they don't regulate our services I still have to report, do a quarterly monitoring report, to the NMC. The reports are shared widely and I would think that my other LSA MO colleagues do do that as well.

MR BROOKES: But it is not specified? It's not written down? There's no agreement?

MS BACON: I don't know. I don't know if there is an actual specified, contractual agreement but I just share the information with whoever.

MR BROOKES: Thank you.

DR KIRKUP: I know that you weren't there at the time but I am asking for your opinion about why the supervisory system didn't pick up evidence of systemic failure prior to 2011.

MS BACON: Why it didn't pick up systemic failure?

DR KIRKUP: Mm hmm.

MS BACON: I am not sure. It is really difficult for me to – I can only sort of answer what I have tried to do since I have been in post. I think a lot of it might come down to the relationship possibly between – and this is almost conjecture – the local teams and the LSA and possibly a lack of sharing information. Perhaps the supervisors of midwives did not feel that they could approach the LSA MO in the same way with any concerns or worries. I don't know. I mean, there are other people involved in the organisation as well. Perhaps they felt that supervision wasn't valued or supported, I'm not sure. I can give one example now that I know would never happen now. I know that 'never' is a strong word but I am aware that there was an investigation into a stillbirth, an intrapartum stillbirth and I think the Chief Executive said, 'Don't do the supervision investigation', or, 'Put the supervision investigation on hold', or something like that, I think, but I have made it really clear to supervisors of midwives across the patch that nobody, absolutely nobody, has the authority to say, 'Stop a supervision investigation'. Even if it's the police or the coroner saying, 'Stop that supervision investigation', I now expect the supervisor of midwives to lift the phone and say to me, 'Lisa, our Chief Exec has told us to stop', or the police, or whatever, and I would then have that conversation with the police, with the coroner and it might be the right ~~cause~~ course of action but that would come through me now whereas I think at the time it might not have done. I am

not sure if the LSA at the time knew what was going on in respect of that particular example.

DR KIRKUP: Okay. I know that you say it is only conjecture but you clearly describe coming into post and being aware of shortcomings that you wanted to correct and you have told us that a few times —

MS BACON: Yes.

DR KIRKUP: — very convincingly, so you must have had some idea of what the shortcomings were that you were tackling.

MS BACON: The shortcomings across the patch I think were training, ongoing training, development and general support for supervisors undertaking their role. I think that – I am not saying that there wasn't any at all but I could see where that could be improved. My background is education and practice as well, obviously, but the key, I think, to safe and effective practice, one of the keys is training and development and ongoing competence and just – I say a lot to all the supervisors of midwives' teams, 'We're a team. The LSA – the local team supervisors are the LSA. We are a team.' It's not me and them doing their job miles and miles away, and I just get a lot more contacts, I get a lot more emails and phone calls. I just think it's a different way of doing it now.

DR KIRKUP: Okay, I appreciate that. The final one from me is that you suggest that post-2011 you have better systems. Are you confident that there is no residual pattern of systemic problems that persisted after 2011 and what would that be based on?

MS BACON: When I came into post in 2011 I was picking up issues from way back and the changes haven't happened overnight. It's a process.

DR KIRKUP: Yes.

MS BACON: I think that supervisors of midwives need to be continually reminded about incident reporting and so on and so forth, so it is a cycle of continuous improvement, really. I think the database is very helpful. That just simply didn't exist in 2008. I think we only really started using it in 2009/10 and it is becoming more and more sophisticated as it develops but now incidents are tracked and logged on the database and I can follow the progress as well.

DR KIRKUP: Okay, let me be a bit more specific. Do you think that there was a pattern of systemic problems in that unit that persisted after 2011?

MS BACON: I think there has been gradual improvement since 2011. I don't think

there are still systemic failings, not with how the supervisors of midwives work. What I could see from looking at previous reports from 2008 – I don't mean individual supervision reports, I mean ~~CGC~~ CQC and NMC, Ombudsman reports – is that there did not seem to be the picking up of supervision, of midwifery practice issues and investigating them in a systematic, standardised, robust way using nationally agreed policies and guidelines which were readily available to every supervisor of midwives, which is what happens now. The key thing that has improved, I think, is the interface between risk and supervision and how the supervisors work and how they liaise with governance, patient safety. It is much clearer, much more transparent now.

DR KIRKUP: Okay, thank you.

MR BROOKES: Just one question. How would you rate supervision at Morecambe Bay now?

MS BACON: I rate it well now. They are meeting the NMC standards to a fairly high standard, I think. I rate it as working well. I think they have had a number of depletions in the supervision team; I think a couple of supervisors on leave of absence. I think it has been hugely challenging for the supervisors and midwives because there are still a lot of midwives going through the NMC referral process, historic referrals, and I think the supervisors of midwives on that level have worked very hard to support the staff, to support the midwives, to try to support the organisation in moving forward, so we've done a lot of work with that, but I do rate it as much improved, definitely meeting the NMC standards.

MR BROOKES: Thank you.

DR KIRKUP: Is there anything that you want to ask about that relates to confidential issues? (*No*) Is there anything you want to tell us whether or not it relates to confidential issues?

MS BACON: That does relate to confidential issues, did you say, or doesn't?

DR KIRKUP: It doesn't have to but if it does we would [inaudible] –

MS BACON: No, it's not confidential.

DR KIRKUP: Right, fine, go on. This is me now – LBACON I think just too sort of reiterate what I said at the beginning, I have seen good evidence of processes for reviewing midwifery practice concerns that was not in place in 2008. The

evidence for me of how do you review midwifery practice concerns was not as clear and robust as it is now, and I think the way that the supervisors of midwives feedback system governance issues to the organisation, I can see clear mechanism and evidence of them doing that that was not there in 2008 or up to 200?, I beg your pardon.

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

MS BACON: Thank you.

Formatted: Underline

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Dr Geraldine Walters – Expert Adviser on Nursing
Professor Stewart Forsyth – Expert Adviser on Paediatrics

VINCENT BAMIGBOYE

Transcript produced by Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

DR KIRKUP: You realise that we are recording proceedings, and we are making an agreed record after the interview. You will also be aware that there are family members in attendance as observers of the sessions and that other family members may listen to the recording at a subsequent stage. You will also know that we have removed any other recording devices, mobile phones and all the rest of it and the reason is that it is very important that nothing leaves the room until we're ready to produce a final report with all the conclusions taking the evidence in context. I would ask you to remember that after the interview. Do you have any questions about the process?

MR BAMIGBOYE: No.

DR KIRKUP: Okay. I will ask you a very general question then and hand you over to [inaudible] and the general question is when you started at the hospital and what roles you had?

MR BAMIGBOYE: Yes. I started on 1 September 2002 as a Local Consultant and prior to that I was there as a Locum Registrar, I think it was in 1999. So I have been there at Local Consultant since September 2002, and the post became substantive in April 2004 when I applied and then got the job.

DR KIRKUP: Okay; and you have been a consultant since then?

MR BAMIGBOYE: Since then, yes.

DR KIRKUP: Okay. Have you had any other roles, Medical Director or Clinical Director, or Clinical Lead?

MR BAMIGBOYE: No.

DR KIRKUP: None at all? Okay. Thank you. I'll ask Stewart to start.

PROF FORSYTH: Good afternoon. Could you give me a brief resume of your job plan as to what you do day-by-day?

MR BAMIGBOYE: I was a [inaudible] as a consultant [inaudible]. When I started I was doing the clinic in Lancaster with a special interest in reproductive medicine; that was a clinic in Lancaster on Monday mornings, but that clinic ceased to exist two years ago. So since then I have been based primarily, only in ~~[inaudible]~~ FURNESS General Hospital. So on Monday I ran my gynae clinic in the morning, ~~[inaudible]~~ ADMINISTRATION in the afternoon. On Tuesday morning I have ~~[inaudible]~~ LABOUR WARD COVER and then Tuesday afternoon theatre. Wednesday morning gynae clinic; Wednesday afternoon just administration. Thursday morning I go on the ~~clinical~~ LABOUR ward and then Thursday afternoon I attend a ANTENATAL clinic. On Fridays I also double up as lecturer to medical students, so mostly medical students on Fridays.

PROF FORSYTH: Okay. In relation to your clinic in Lancaster, which is of interest [inaudible]

MR BAMIGBOYE: I have the clinic in ~~[inaudible]~~ RLI, Infertility Clinic

PROF FORSYTH: So it must be quite a small clinic, is it?

MR BAMIGBOYE: Well, I wouldn't say small, because I still get all my patients from everywhere, across the day.

PROF FORSYTH: And when you're on the labour ward can you tell me about how that works, do you do ward round, or do you—how do you [inaudible]

MR BAMIGBOYE: Of course first thing in the morning we have the handover, which includes those of us who are just coming in and those who are about to leave, and details problems that they have overnight and then discuss problems and then we do ward round after that, those of us who have just come in, see who has been admitted to the ward and then make a plan and follow that up.

PROF FORSYTH: And how does the system work on the ward with the midwives and obstetricians?

MR BAMIGBOYE: As the consultant I would always attend the handing over and then go on the ward round on the labour ward, and then on the ~~[inaudible],~~ ANTENATAL and then on the gynae ward, and then foetal assessment and day unit, just to see if there's any leftover.

PROF FORSYTH: Sorry, is that what has been happening back when you were appointed in 2002 was it? Have things changed over time?

MR BAMIGBOYE: It has changed significantly over the last four or five years, yes, it's changed.

PROF FORSYTH: In what way? What was it like previously?

MR BAMIGBOYE: Prior to that midwives wouldn't attend our ward rounds; predominantly they wouldn't. We would do the ward round and maybe [inaudible] and then they would go and check, but now everybody is under obligation to attend ward round.

PROF FORSYTH: So previously, so when was that, that's about four or five years ago?

MR BAMIGBOYE: I would say, yes. Yes, that was...

PROF FORSYTH: So just to be absolutely clear, so originally you would do ward round, but the midwives would not come with you?

MR BAMIGBOYE: Well, yes—I mean, no they wouldn't in most cases. We do know some of them, we would call them the 'old timers', who would come with you to join you at ward round and then make notes, and so on.

PROF FORSYTH: The older timers would come?

MR BAMIGBOYE: Yes, the only ones. A few of them, yes.

PROF FORSYTH: Right. So what about [inaudible] communication between midwives and [inaudible] generally poor at that time?

MR BAMIGBOYE: I would say yes; it wasn't as good as it should be, not as good as I was used to.

PROF FORSYTH: Do you think that had an adverse impact on quality of care?

MR BAMIGBOYE: Not with me, because I would usually...let the relevant midwives know about my plans I mean, each of the midwives know who is looking after who and I would always go to whoever was looking after a patient ~~[inaudible]~~ and inform them about plans for each patient as documented.

PROF FORSYTH: Do you now have joint meetings with the midwives?

MR BAMIGBOYE: Yes, we do.

PROF FORSYTH: Perinatal meetings?

MR BAMIGBOYE: Yes, we do.

PROF FORSYTH: How often do they take place?

MR BAMIGBOYE: Perinatal meetings—we call it morbidity mortality meetings—we have that on average I would say about once every six weeks, every four weeks. Yes, but on our own part we have this meeting on—sorry, on Monday afternoon between 12.00-1.00, to review-CTG & unusual cases ~~because our usual~~ cases ~~are~~ done the week before, and how they were ~~it was~~ managed, whether they were ~~it was~~ properly managed, and ~~[inaudible]~~ whether the Protocol/Guidelines were followed

PROF FORSYTH: How many obstetricians do you have now?

MR BAMIGBOYE: We have two very young ones who joined in the last two years. There is Mr Misra (semi-retired)~~[inaudible]~~ he is on his way out, and then myself and Ms Alcide~~[inaudible]~~, so there are five of us now.

PROF FORSYTH: So who is—do you have a Clinical Lead?

MR BAMIGBOYE: The Clinical Lead is not... Well, we have our own lead, but the Clinical Lead is Mr Burch~~[inaudible]~~ based in Lancaster, but our own recognised lead on our side is Mr Misra ~~[inaudible 8.25]~~

PROF FORSYTH: So what is the relationship between obstetricians in [inaudible 8.32] and the obstetricians in Lancaster? Do you communicate much? Do you meet together?

MR BAMIGBOYE: Yes, from the very beginning we are having these [inaudible 8.40] , which we all agree now we can abandon; it wasn't the ideal thing, we were having to [inaudible]. Then, of course, we have the departmental meetings in the evenings, I think once every month; that is [inaudible].

PROF FORSYTH: How many obstetricians are there in Lancaster?

MR BAMIGBOYE: I think there are seven or eight of them.

PROF FORSYTH: Sorry, you said there were about five, is it five?

MR BAMIGBOYE: Five in Barrow-in-Furness.

PROF FORSYTH: So do you do on call every fifth night, is that how you do it?

MR BAMIGBOYE: My on call is every Monday night.

PROF FORSYTH: You do every Monday? 1:4 Rota

MR BAMIGBOYE: Yes.

PROF FORSYTH: And then presumably weekends?

MR BAMIGBOYE: Well, I mean, this last weekend I was on call, so I was doing my on call this morning, yes. 1:4 weekends

PROF FORSYTH: And relationships with paediatricians?

MR BAMIGBOYE: Well, our relationships with paediatricians have always been good. Before we ran into difficulties ~~the [inaudible]~~ we used to take 26 week babies,

26 weeks, 28 weeks, 30 weeks, and so on and so forth. I would say the relationship was good.

PROF FORSYTH: So previously you used to take 26 weeks?

MR BAMIGBOYE: Yes, we used to take as low as 26 weeks.

PROF FORSYTH: My understanding is the neonatal unit in Barrow is just a level 1 unit, is that correct?

MR BAMIGBOYE: Well, it only became level 1 not too long ago. We were level 2 before that.

PROF FORSYTH: You're aware that level 2 staffing levels are quite different from a level 1?

MR BAMIGBOYE: Quite different, yes. We had [inaudible] –

PROF FORSYTH: Did they have a registrar on call...

MR BAMIGBOYE: Yes, we had several on call, yes. I remember quite a few of them.

PROF FORSYTH: But now they're compliant with the rules in terms of...

MR BAMIGBOYE: Yes, they have level 1, so we only take babies 32 weeks and above now.

PROF FORSYTH: Yes.

MR BAMIGBOYE: Yes.

PROF FORSYTH: So does that lead to some sort of heated discussion?

MR BAMIGBOYE: Yes, sometimes very, very heated discussion, especially when run into a situation whereby you are convinced in your mind that this patient is not likely to go into labour and then, of course, they insist on transferring, and the process of transferring patients can be quite tasking ~~[inaudible]~~. The problem with Barrow-in-Furness is mainly that of geography. We have the A590, which is at the best of times not the best road, and then, of course, we also suffer

from a lot of fog, so the helicopters don't fly when there is fog, so we transfer ~~[inaudible]~~ only when it is very necessary

PROF FORSYTH: Do you have discussions with the paediatrician and also the midwife about some risk assessment of the individual patient?

MR BAMIGBOYE: Yes, we do, yes.

PROF FORSYTH: And do you have written policies covering that?

MR BAMIGBOYE: Yes, we have written policies now, which ~~[inaudible]~~ we always try to follow

PROF FORSYTH: Are they relatively new these policies?

MR BAMIGBOYE: I wouldn't say new; I would say they have been updated to suit our current situation.

PROF FORSYTH: What about the higher level of management, do you have much contact with your Divisional Manager, Medical Director?

MR BAMIGBOYE: Just occasional contact, I think that could be better actually.

PROF FORSYTH: Right. So you don't feel there's any need for input from senior management?

MR BAMIGBOYE: Now that you ask, honestly I feel that the support was not as good as it should be from the management. When I joined the hospital, the then Chief Executive was excellent, Ian Cumming was his name, and he was always coming around to ask if there was any problem, and ones welfare ~~[inaudible]~~ and so on and so forth. After he left we had a few problems with—I wouldn't say problems, we had a few management teams that were not as committed as he was, but briefly my comment is the management structure is a lot better now than what it was.

PROF FORSYTH: Do you feel that the service change that has taken place with the level 1 unit, even if it is more formally accepted, that that has affected obstetric care?

MR BAMIGBOYE: It does, yes.

PROF FORSYTH: How would that be resolved when you don't actually have a very large number of babies, and running a full level 2 intensive care unit would be quite difficult?

MR BAMIGBOYE: It would be difficult, yes. I can't see, unless Lancaster and Barrow-in-Furness, unless they merge the two units I can't see any way this [inaudible] will change

PROF FORSYTH: Just to go back to the various incidents that have taken place in this time, have there been any changes in obstetric practice particularly relating to these? Have you responded to the learning from the incidents in any way?

MR BAMIGBOYE: Yes, we have. We now have meetings every Monday afternoon to review the cases in the past week, and we came to see if there was anything that we could have done better, if there was ~~anything~~ anyone who deserves a commendation ~~for an award~~ or a word, and so on and so forth.

PROF FORSYTH: Any aspects that are specific for local practice that have changed as a result?

MR BAMIGBOYE: Yes. We now have patient safety—we call it PSI—~~which [inaudible]~~ with record of incidents to now feel if something is amiss, regardless of whether, again, it went well, but if it went against the practice of the policy or the protocol, yes, we will fill that out and then we will see if the PSI will be changed. Sometimes we make changes to it, yes.

PROF FORSYTH: Who provides your obstetric ultrasound service?

MR BAMIGBOYE: We have Sonographers ~~[inaudible]~~. Unfortunately we don't have the consultant backup in Barrow-in-Furness.

PROF FORSYTH: You don't?

MR BAMIGBOYE: We don't.

PROF FORSYTH: So is there a radiologist who does them in Lancaster, or where [inaudible]

MR BAMIGBOYE: I don't think we have a radiologist who does any in Lancaster and in Barrow. We have Dr Granger, who is one of my colleagues in Lancaster, yes. She has special interest in Feto maternal medicine

PROF FORSYTH: In Lancaster?

MR BAMIGBOYE: In Lancaster, yes.

PROF FORSYTH: So the Sonographer ~~stenographer~~ is down in Barrow?

MR BAMIGBOYE: Yes.

PROF FORSYTH: So who is supervising their work?

MR BAMIGBOYE: I know there is a Dr Sambrook ~~Sandbrook[?]~~ who is a radiologist. We have Dr Sandbrook ~~whose~~ who is an Obstetrician -[inaudible], but if we have any problems in Barrow that need further...assessment If we have any problem that needs further looking into, we send them to Royal Victoria ~~in [inaudible]~~ Infirmary, Newcastle

PROF FORSYTH: [inaudible] to be around foetal growth being reported as normal...

MR BAMIGBOYE: Yes.

PROF FORSYTH: ... And actually the baby size was probably in some cases significantly smaller.

MR BAMIGBOYE: Smaller, yes.

PROF FORSYTH: Is that not a risk for your obstetric practice?

MR BAMIGBOYE: It is a risk, but in fairness to the girls I think they have done a good job, but if we have any growth problem, for example, during the 20 – week anomaly scans, we will usually refer them. If ~~their~~ there babies are very small (small for dates) ~~[inaudible]~~ after plotting the graph (on customised charts) we see these babies are small, then we want to find out the reason what is going on, we refer them to Royal Victoria. We also have direct access to Manchester, St Mary's, as well, where we have Dr Sarah Vause ~~[inaudible]~~ who is really good. and always helpful.

PROF FORSYTH: You are not aware of a recent audit of ultrasound findings in comparison to [inaudible]

MR BAMIGBOYE: We always know that there is, when you are talking about growth it could be 10% either way, an overestimation ~~on their estimation~~ or underestimation, but touch wood I don't think we've had significant problems.

PROF FORSYTH: Thank you.

DR WALTERS: So nowadays there are two obstetric ward rounds every day?

MR BAMIGBOYE: In fact, three.

DR WALTERS: Three.

MR BAMIGBOYE: Yes, one in the afternoon and the one in the evening I usually will come to attend, because I live about five minutes away, but that is not usual for all consultants.

DR WALTERS: But the three a day happen whoever is on call?

MR BAMIGBOYE: Yes, it should.

DR WALTERS: And when did they start?

MR BAMIGBOYE: They started when all these problems started about 4 years ago ~~[inaudible]~~. Before then we would have ward rounds in the morning. All of us still do; I start my ward round at 08.30 in the morning, but the acute cases are supposed to be seen by those on call.

DR WALTERS: Okay. So the first sort of external review that there was looking at the obstetrics was the Fielding Review, I don't know if you can remember that?

MR BAMIGBOYE: I can't remember the name.

DR WALTERS: So that was the one following the incidents in 2008?

MR BAMIGBOYE: I know we've had a few people around, but I can't remember their names.

DR WALTERS: Right, okay. So you won't remember the action plan that came out of that then?

MR BAMIGBOYE: Yes.

DR WALTERS: You do?

MR BAMIGBOYE: Sorry?

DR WALTERS: Do you remember the action plan that came out of that?

MR BAMIGBOYE: Yes. That was when we introduced all these changing over, people, those who are going and coming should always meet together and discuss situations and ~~[inaudible]~~ Formulate management plans

DR WALTERS: Right. Are you sure that wasn't the central managers' one?

MR BAMIGBOYE: I'm afraid I don't know.

DR KIRKUP: What was the timing of it? When were the handover changes introduced?

MR BAMIGBOYE: I wish I could tell you precisely the time, but I know...

DR KIRKUP: Two years ago? Ten years ago?

MR BAMIGBOYE: No, it wasn't definitely not 10 years ago.

DR KIRKUP: Two years ago?

MR BAMIGBOYE: I would say two or three years ago.

DR WALTERS: So one of the things that the Fielding Report raised was an issue about out of hours cover in theatre.

MR BAMIGBOYE: Yes.

DR WALTERS: How long has that been a problem?

MR BAMIGBOYE: From day one actually, I must confess to you it being a problem out of hours cover for theatre. I remember when I came as a Locum Registrar we have always had a theatre in the labour ward, but that never got off the ground. We had the theatre, we have everything that can be used for the theatre, but it was never used. So when my predecessor, Mr [redacted] told me he would retire, if I would like to apply for the job, he said by the time it I comes around this theatre should be functioning. It never did.

DR WALTERS: So if there is an emergency after hours, crash section.

MR BAMIGBOYE: We have to run over the ward to the theatre.

DR WALTERS: Right, so can you do that within the time required?

MR BAMIGBOYE: I think what happened over the years has been more luck than anything else, but not all the time, no.

DR WALTERS: So it sounds to me then that really it's not that much different from giving birth at home?

MR BAMIGBOYE: Well, I would disagree with you on that point, I still think it's better. If you have two midwives, a registrar and a consultant, you are still better off than at home without anybody.

DR WALTERS: But was it something that was a risk and a concern?

MR BAMIGBOYE: It was always, and we always mentioned it each time—even before we had problems we mentioned it. Of course, people would dismiss it, there's no money for...Staffing I think the big problem was staffing; staffing the theatre—that we never got going. All the things were there, the lighting, the ~~[inaudible]~~ gas points, all the electrical connections etc

DR WALTERS: So how did you raise issues of safety like that as an obstetrician?

MR BAMIGBOYE: We raised it with the Chief Medical Director, with the Chief Executive, and I remember when one of these inquiries started, I can't tell you exactly which one, and somebody asked, 'Vincent if I gave you £5 million what would you spend it on in this department?' I said, 'Number one it would be the theatre'.

DR WALTERS: Were there any other sorts of risks that you raised to senior management?

MR BAMIGBOYE: The usual theatre we raised. I'm very positive we did raise that.

DR WALTERS: Nothing else then that you were concerned about?

MR BAMIGBOYE: I remember we raised some problems, especially ~~to~~ Mr Misra ~~we~~ raised some problems about some midwives with the management, which I don't think they have done anything about.

DR WALTERS: What was that concern?

MR BAMIGBOYE: It was about...

DR KIRKUP: If it's about an individual case, which I think is what prompted it then we need to consider that later. Sorry.

DR WALTERS: No, it's all right; you need to say that. So the incidents that were occurring over time, and the outcomes you were getting, as a group of

obstetricians were you concerned about your mortality or morbidity rate from the Furness unit?

MR BAMIGBOYE: Well, figures can be very deceptive.

DR WALTERS: Yes.

MR BAMIGBOYE: If you look at our overall morbidity / mortality it was less than the national average. I think that gave everybody a false sense of security.

DR WALTERS: Okay.

MR BAMIGBOYE: Whereas, as we always say in medicine, one death is always too many.

DR WALTERS: Yes.

MR BAMIGBOYE: Nothing kills you more than when you have a death that could have been avoided; nothing destroys your confidence more than the fact that you know you could have done better for this baby [inaudible] and the fact that if I had got there five minutes earlier.

DR WALTERS: Yes. So was there anything, by looking at individual cases, that you felt you could change things in the unit to resolve those specific issues, even if they were all different each time?

MR BAMIGBOYE: Don't get me wrong, you never get a labour ward without problems.

DR WALTERS: No, I know.

MR BAMIGBOYE: It is never going to happen in any setting, but, yes, I do agree with you that some of them could have been avoided.

DR WALTERS: And what sort of things might have been avoided, do you think?

MR BAMIGBOYE: Well, if you look at some of them, maybe staffing would have been better it would have been better; some of them if theatre—I remember a

particular one that if the theatre was available it would have been avoided. That's all I can say, if the resources were available maybe we would have done better in some cases.

DR WALTERS: Do you think the process of risk assessment was sound, from first presentation right through to the perinatal period?

MR BAMIGBOYE: Well, no I don't think so, and I mentioned unfortunately the risk manager we had before has now retired; it was one of the midwives, and I think there was a bit of overprotection each time we raised issues.

DR WALTERS: And how did that overprotection play out in the clinical situation?

MR BAMIGBOYE: It sort of affected how we talk about the issues ~~[inaudible]~~ where you know that whatever you raised it was never going to be...addressed Nobody would be called to account. It's sort of just, 'Why bother?'

DR WALTERS: Okay.

DR KIRKUP: Just a couple of points that have arisen. You talked about the clinical meetings that the case reviews that you have now, can I just be clear how long that system has been in place?

MR BAMIGBOYE: The Monday afternoon case review I think started about three years ago.

DR KIRKUP: Okay. Was there anything that preceded that? Was there any discussion of cases or review?

MR BAMIGBOYE: We were having meetings on Thursday—we still have the meetings on Thursday afternoon as well, but not as good as what we have now where we have meetings twice a week. The meetings we call the departmental education ~~allocation~~ meeting is the one on Thursday, whereas

the one on Monday is predominantly to discuss cases, things that have gone wrong, things that have gone right, and how we could have done better.

DR KIRKUP: Before you started having the Monday meetings where did you discuss things that had gone wrong?

MR BAMIGBOYE: We were discussing these on Thursday as well; we will ask people, 'Do you have any unusual cases to come up', not that you must bring these cases.

DR KIRKUP: Yes, but the must bring these cases has only been there for three years.

MR BAMIGBOYE: It has only been there recently.

DR KIRKUP: Okay. Who attends the meetings now?

MR BAMIGBOYE: It is supposed to be mandatory for everybody. Unfortunately those who are on call overnight will be off.

DR KIRKUP: When you say everybody, do you mean everybody who is an obstetrician?

MR BAMIGBOYE: Well, it is supposed to be everybody including midwives as well.

DR KIRKUP: Obstetricians and midwives, okay.

MR BAMIGBOYE: Yes.

DR KIRKUP: Paediatricians?

MR BAMIGBOYE: No, the paediatricians ~~go [inaudible]~~ do not attend the Monday meeting

DR KIRKUP: Is that a lack?

MR BAMIGBOYE: Sorry?

DR KIRKUP: Is that a lack? Is that a drawback that paediatricians...

MR BAMIGBOYE: It is a drawback. We would have preferred to have paediatricians in that meeting.

DR KIRKUP: Given the comments that you made about the tensions around who should be delivering in Barrow...

MR BAMIGBOYE: Yes.

DR KIRKUP: ... And who should be transferred.

MR BAMIGBOYE: Yes. Yes, we should have the [inaudible]

DR KIRKUP: That sounds [inaudible], okay. We've heard described by a number of people a picture of—and this is not within the last couple of years, but perhaps a little longer ago—a picture that there were midwife cases and there were obstetric cases, and if you were a midwife case then the obstetricians would have nothing to do with you. Is that a picture that you recognise?

MR BAMIGBOYE: Yes. The ~~We are~~ midwives ~~and~~ are professionals, and people tend to be very territorial, which I am very much against. Even then I would usually say, 'I want to know about every person you have on the labour ward', because if I am likely to see ~~going to put~~ someone ~~into~~ any of the rooms I want to have the background knowledge on what I am getting myself into.

DR KIRKUP: And did you get that?

MR BAMIGBOYE: I got that.

DR KIRKUP: Did everybody get that?

MR BAMIGBOYE: I'm afraid I can't speak for them, but I had when I'm ~~[inaudible]~~ running the Delivery suite [inaudible]

DR KIRKUP: So from what you're saying they were particularly possessive about...

MR BAMIGBOYE: Very territorial, yes.

DR KIRKUP: Were you ever aware of any situations where they would hang on to a midwife patient past the point where she should stay with a midwife?

MR BAMIGBOYE: Yes, yes. I had—yes, we had a few patients and we disclosed some of these, and sometimes I had to actually more or less force [inaudible], because... I believe that if somebody call me the responsibility for managing from that point passes on to me, so if you call me and tell me, 'Don't worry the head is on the perineum. That head will have to come out. That was what happened; in fact, that happened in one or two of the cases where we got into trouble, when Registrars were called and Registrars came and stood around, only to be told, 'Don't worry, everything is okay', and at the end of the day it has been a disaster.

DR KIRKUP: Let's not go into the individual cases again, but I take the general point.

MR BAMIGBOYE: Sorry.

DR KIRKUP: My follow up on that is how did you seek to... Okay, you took responsibility yourself for making sure that you did get to see who you wanted to get to see, did you raise that more generally? Did you tell anybody that you thought this was...

MR BAMIGBOYE: We did discuss this, and I think Mr Misra, who generally was closer to us than the then Clinical Director—when I say 'us' I mean those of us junior to him who were much more closer to Mr Misra; whereas the then Clinical Director, Mr Hussain, wasn't very close to us. So when we mentioned it Mr Misra did write a letter; that was ~~is~~ when something went wrong I can remember him writing a letter that if care is not taken ~~given~~ what happened will happen again.

DR KIRKUP: Did that have any impact? Was there any action taken?

MR BAMIGBOYE: No. As far as I remember he told me that he was accused of destroying the relationship between the midwives and doctors.

DR KIRKUP: Did you seek to take it up with anybody on the midwifery side? The Head of Midwifery or the Director of Nursing?

MR BAMIGBOYE: No, I didn't, because whenever there is a problem... Whenever there was a problem I was called, they knew I was going to move in there and do whatever I felt was right, so I didn't see—I mean, once you have raised something I was never going to stand for it.

DR KIRKUP: Okay.

PROF FORSYTH: Dr Hussein was the clinical?

MR BAMIGBOYE: Director.

PROF FORSYTH: He was an obstetrician?

MR BAMIGBOYE: He's an obstetrician.

PROF FORSYTH: He was based in?

MR BAMIGBOYE: In Barrow-in-Furness.

PROF FORSYTH: And did you say that—what was the relationship between the obstetricians and Dr Hussein, was it a good working relationship?

MR BAMIGBOYE: Well, we used to call him 'God'. It was as bad as that. Well, I don't think it was a good relationship ~~[inaudible]~~, because I was very junior to him, we were ~~within~~ much more closer to Mr Misra.

PROF FORSYTH: Was he Clinical Director across the [inaudible]

MR BAMIGBOYE: [inaudible] Across the Bay. Yes

PROF FORSYTH: So he was responsible for the obstetricians in Lancaster as well?

MR BAMIGBOYE: As well, yes.

PROF FORSYTH: And you say now the Clinical Directors and obstetricians...

MR BAMIGBOYE: ~~[inaudible]~~ Mr Burch is much more approachable.

PROF FORSYTH: And is the system of having a Clinical Director covering the whole area not really working or is it?

MR BAMIGBOYE: It works; for example, Mr ~~Butcher~~ Burch has been the Clinical Director now for about two years or more. I can't remember a time I called him without getting a good response.

PROF FORSYTH: Does he come down to Barrow?

MR BAMIGBOYE: Yes, he does, yes.

PROF FORSYTH: How often?

MR BAMIGBOYE: Every two weeks; every other ~~two~~ Tuesdays.

PROF FORSYTH: Right, okay.

DR KIRKUP: Okay. I want to ask you a couple of questions about individual cases, so as that raises matters of patient confidentiality we will pause while we ask the observers to leave the room, please.

[*Attenders withdraw*]