THE MORECAMBE BAY INVESTIGATION

Wednesday, 17 September 2014

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

Before:

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

SUE PAGE

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

1 MR BROOKES: Good morning, everybody. I am Brookes,

2 and welcome, Sue, to this session of evidence-giving to the

3 Morecambe Bay Inquiry. First of all, can I start by an

4 apology from Bill Kirkup, Chair of the Investigation.

5 Unfortunately he cannot be here today. He has asked me to

6 Chair this session. We will go through and tell you who we

7 are, then if you can introduce yourself.

8

9 (Following introductions by the Panel
and housekeeping matters)

10

11 MS PAGE: I am Sue Page. I am retired officially from the

12 NHS 15-months ago, but I have been currently asked by the

13 TDA to help out in a failing organisation in Liverpool; a

14 community service organisation, which is extremely

15 challenged on all fronts at the moment as it tries to head

16 towards FT status. So I am there for probably another six

17 months when I will retreat to retirement back to the Lake

18 District after 36 years in the NHS. 26 of those as a Chief

19 Executive.

20 MR BROOKES: Thank you.

21 I am going to start by asking Jonathan to begin

22 questioning.

23 PROF MONTGOMERY: Thank you, Julian. I will be very

24 interested if you take us through the time line later on but

25 I thought it will be helpful to start by asking a couple of

1 questions about how the PCT saw its role and went about
2 doing it.
3 The first one of those is just your approach to
4 commissioning strategy. We are trying to get our heads
5 around was there a commissioning strategy for maternity
6 services. We pick up some very significant challenges about
7 maintaining sustainable services in the area. So I wonder
8 if we could ask about the PCT's approach to commissioning
9 strategies and particularly about maternity services.
10 MS PAGE: Would it be helpful if I gave a little bit of
11 context about Cumbria and why I ended up there? Because, I
12 think, that actually, that you will begin to see the route
13 we tried to go through and perhaps the reasons why maternity
14 was not tackled as well as why, you know, when we planned to
15 do it. I think --
16 PROF MONTGOMERY: That will be helpful.
17 MS PAGE: I was running Northumbria Trust in the North-east,
18 which was a over a period of -- I suppose I was there for
19 about 17 years as the Chief Executive. I went through a big
20 clinical merger across three sites, from the North East end
21 of it -- at the end of the time right across to Hexham up to
22 the Borders in the north, all the community hospitals in the
23 middle. So it was a big merger of three or four
24 organisations including community services.
25 Why I say that is because that took me 17 years to

1 clinically merge. Where we had to have specialities across
2 sites, you know, the fights with orthopaedic surgeon to come
3 together from three different groups to one group serving a
4 wide population. We had to have them -- you know, chronic
5 disease management changes across vast landscapes of miles.
6 We could not keep bringing patients in hospital. So I spent
7 17 years and actually pulling that together and it was very
8 hard work.
9 Across other side of the Pennies, which was then part
10 of the North of England, was Cumbria. It was clearly
11 struggling to the point at which in 2006 when there was some
12 major organisation changes that happened. Cumbria PCT was
13 formed out of four or five different bits that were serving
14 the district council boundaries. I was asked, with my
15 experience from running a provider organisation for all my
16 career, would I transfer into commissioning world and start
17 laying out a plan for Cumbria.
18 So I entered in November 2006 to a fairly hostile
19 environment where the population were walking and marching
20 on the streets every weekend to save their local hospital.
21 It was quite traumatic actually what we had walked into. I
22 didn't have a team, and there was no hand over from one
23 organisation to another, so I was completely blind. I had
24 to go in and amass a team to actually try and see if we
25 could begin to sort out the services.

1 The reason I reflect to you on my period in Northumbria
2 was because it became really apparent to me very early on
3 that the hospitals, which had been merged both north of the
4 Cumbria and in South Cumbria, had not gone through that
5 provider clinical merger. So they had merged managerially,
6 but they had not merged clinically.
7 I think they were trying to tackle some financial
8 problems in a very inexperienced way. By trying to chop
9 bits off of hospitals rather than actually have a
10 conversation with the population about what they were trying
11 to achieve, engage the population in that conversation, and
12 then engage the clinicians with the population around what
13 was possible like we had done in the North-east.
14 Therefore, in that you could see hospitals like
15 Whitehaven and Carlisle and Barrow and Lancaster, and
16 Westmoreland General particularly struggling.
17 So we had to try and put down a priority order of how
18 to tackle it. So we set about preparing a strategy which
19 became known as closer to home because the population wanted
20 their care in Cumbria closer to home. If you have ever
21 lived there or been there on holiday, you will realise that
22 it is not like London where you have got hospitals on every
23 street corner. The hospitals are far away and if you are
24 elderly actually you want to die at home. You want to be
25 cared for as long as possible at home and only really go to

1 a hospital for safe care when you need to.
2 So we started engaging the GPs in Cumbria who had never
3 been involved in any decisions. They were very angry, just
4 like the population, a very angry bunch of clinicians who
5 had been excluded from decisions about closing hospitals
6 that led to the marching on the streets of the population.
7 They felt that the consultants in the hospital had not
8 engaged with them in conversations about the future.
9 So we went about putting into priority order where the
10 biggest fires were. So they were in the north of the
11 county, with all the community hospitals which my
12 predecessor had said that needed to close. It was Kendal
13 hospital where the maternity unit, the neonatal/maternity
14 unit there was under a threat of closure along with the
15 medical assessment services there. It was an acute medical
16 admitting unit at that point.
17 So we started with the big re-organisation plan for all
18 the community services, community hospitals and, in
19 particular, reorganising Westmoreland General Hospital into
20 a GP-led unit, rather than a hospital
21 consultant/physician-led admitting unit.
22 So we were trying to sort of engage with population,
23 and put structures in place to enable us to engage with the
24 population, rather than them marching on the streets. We
25 had a big plan in place to engage the GPs and the clinicians

1 in that conversation about the order and the priority that
2 we tackle things.
3 In the north the county with hospitals because of
4 Whitehaven, was under severe threat because the Northern
5 Deanery and their allocation of junior doctors, particularly
6 the Deanery were withdrawing recognition for several
7 specialities at the time and it was almost going to tip
8 over.
9 So we also concentrated on a big consultation in that
10 first two years to reorganise the two hospitals and
11 clinically merge them so that all the main surgical
12 admitting unit, the high level medical admitting unit the
13 paediatric admitting unit, would all be in Carlisle with a
14 GP led service in Whitehaven and, you know, so a smaller,
15 like Hexham really. We had re-organised Hexham as well. So
16 a low level admitting unit then transferred to Newcastle for
17 anything major.
18 So that reorganisation was the next priority to get out
19 there, harsh consultation, very harsh. To actually get that
20 in place. Alongside that, we were doing re-organisation of
21 the community services to engage those GPs in each of the
22 localities to step up to the mark as providers because they
23 were exceptionally good GPs in Cumbria.
24 A lot of them were dual qualified, they were not just
25 GP qualified, they really had either paediatrics surgery,

1 medicine. So these guys were really exceptional
2 individuals. To engage them in taking over some of the
3 community hospitals for step up facilities, reorganising out
4 of hours GP services to make that safer so that they could
5 support higher level of care into the into the community
6 hospitals. And the reorganisation of Westmoreland General
7 in the south for the GPs to take over and run that. The
8 next phase of that consultation would be Barrow and the RLI
9 so that was the next phase.
10 PROF MONTGOMERY: Dates -- when you anticipated you had
11 moved to that phase when was that?
12 MS PAGE: Right.
13 PROF MONTGOMERY: On your time line.
14 MS PAGE: Glasses.
15 PROF MONTGOMERY: You started in November -- I presume.
16 MS PAGE: Yes, November 2006/7 we were sort of gathering
17 people and pace. By the time we got to about April 2006 we
18 were preparing the big.
19 PROF MONTGOMERY: 6 --
20 MS PAGE: Sorry, 7. April 2000 -- sorry April 2007 we had
21 gauged as the clinical body what needed to happen in the
22 north and we started the consultation in the north for the
23 hospitals in September 2007. That finished in
24 February 2008. So it was a long consultation for obvious
25 reasons.

1 We were also consulting at the same time over
2 Westmorland general. So that was running in parallel and we
3 were consulting over the major changes to all the community
4 services to have a much higher level of care in the
5 community with all the integrated nursing teams, we called
6 them intensive nurses on wheels, who could really go right
7 out into the people's homes to prevent admission. With the
8 GPs, you know, virtual wards, we had all that sort of stuff
9 was going in during that time.
10 So then we were from 2009 onwards we were implementing
11 that process in the north. Running parallel to that, in 8
12 and 9 we were consulting over the major changes on mental
13 health in the county as a whole because that was a another
14 major priority that was bubbling up through then, the
15 beginnings of the GP world 's of commissioning, which was --
16 we were organising way ahead of the nation that GPs were in
17 leadership roles in the county, in localities.
18 They worked together as a clinical senate across the
19 county to make these major decisions with the consultants.
20 That was the structure. We were -- there is a process of
21 training and educating and developing them as leaders and
22 giving them the confidence to take these big decisions.
23 Then alongside that, we were putting in processes
24 across the county to get information fed into commissioning,
25 intelligence. So we were organising our patient

1 intelligence into that system. We had people on the ground
2 in each locality, you know, contacting the links people,
3 gathering soft intelligence. We had all that with the GP
4 world as well.
5 We had a process where Mike Bewick and I would visit
6 every practice every year, without exception. With an
7 agenda, that collected intelligence on them as a practice,
8 their problems, their solutions their strengths and
9 weaknesses, what they felt about the GP-world in their
10 locality, strengths and weaknesses, building up the provider
11 arm of GP world and also we went through systematically a
12 conversation about every speciality in their local hospital.
13 The good, the bad, the soft intelligence, the harder
14 intelligence and we took data with us. So we were also
15 building up data during that two year period as well.
16 PROF MONTGOMERY: I want to come back to the data later
17 on because that is one of the areas of question we needed to
18 understand, about how you brought that together.
19 Can I ask you, first, more about the patient
20 intelligence? We found it really difficult to identify what
21 the processes around the Trust were for engagement with the
22 public. You are one of the first people who have actually
23 mentioned the links as if they were functional. We have
24 found it very hard to find evidence of that.
25 If you can say more about whether that was even across

1 the county and whether it is surprising that we find a bit
2 of trace that around Morecambe Bay.
3 MS PAGE: I guess my approach with the -- I should also say
4 I recruited around me because of the nature of what I
5 could -- coming from a provider background over so many
6 years, I did not just recruit -- I had a public health
7 director, who I have to say was exceptional. I had a GP
8 Medical Director who was also exceptional.
9 PROF MONTGOMERY: Just for the record, we have not had
10 names because then we can cross-check them much more easily.
11 MS PAGE: The Public Health Director at the time was a
12 newly-retired guy called John Ashton. My Medical Director I
13 found in West Cumbria, in a practice out there, called Mike
14 Bewick. I also had a Medical Director called Irving Cobden,
15 who was a physician by background, who I brought in from
16 Northumbria Trust, in the North East, who was a national
17 leader on re-organising emergency care systems.
18 I also had latterly, because I had to wait for her for
19 a bit longer because she was not retired, Dr Neela Shabde,
20 who was an eminent paediatrician in the North-East, because
21 we had problems in paediatrics as well in the county.
22 PROF MONTGOMERY: Yes.
23 MS PAGE: I had four exceptional medical directors. They
24 were also backed by an associate-type of Medical Director
25 called Sue Roberts who was a also from my time in the

1 North-East, who was the National Czar on diabetes care.
2 She helped us with the development of a primary care
3 provider world with the trying to get the GPs up a level of
4 care so that they could put in sort of a systematic chronic
5 disease management across the county, which was a big
6 platform for their own personal development.
7 PROF MONTGOMERY: We want to understand how you brought
8 that together a bit later on. Can I --
9 MS PAGE: You want to be linked, you asked me --
10 PROF MONTGOMERY: I was trying understand how the
11 patient intelligence worked because we have found it hard to
12 trace how the system, particularly in the Trust, has
13 gathered feedback from patients. So you were talking about
14 doing that quite systematically which we want to
15 understanding.
16 MS PAGE: I suppose, on a personal level, because of what I
17 had bought from the north east and the first wave trust in
18 Northumbria, and because it was over such a large area --
19 you cannot run a healthcare system across two and a half
20 thousand square miles without having that intelligence from
21 the people who live there. Particularly in somewhere like
22 Cumbria.
23 Because they were so angry at the early days, we tried
24 to turn the anger in the different groups that were
25 operating in different parts of the county, into positive

1 contributers and we used the links -- well, they were called
2 different things but essentially the links system, and we
3 connected that eventually to each of the localities.
4 So you ended up with a lead GP in each locality, with
5 several other GPs around them in that locality as the
6 leadership team. They employed, we employed, an individual
7 who would whose job it was to link with the links, and
8 gather intelligence in many different ways in that locality.
9 Whether that be if we were changing paediatrics care, as we
10 were at one point, we would gather children and when we were
11 putting the paediatric services out to tender, in the
12 decision making body, we had a bank of children that day
13 actually giving their view about what paediatric services
14 would be for them. So that was connected into the
15 localities. That was the main focus of our --
16 PROF MONTGOMERY: One of the things that has been
17 raised in conversations with us was the challenges around
18 Furness, particularly between those who felt they need to
19 defend the hospital.
20 MS PAGE: Those?
21 PROF MONTGOMERY: Those who felt they need to defend
22 the hospital and families, who had poor experiences and
23 tragedies, what you have described grows that system of
24 feedback out of harnessing anxiety about the system. Is
25 there a risk that that could get divorced from the

1 individual quality concerns?

2 MS PAGE: I guess it could.

3 PROF MONTGOMERY: Because we have met John Woodcock the

4 MP and there did not seem to be a big role for links in his

5 in the briefing he received about the --

6 MS PAGE: That is interesting.

7 PROF MONTGOMERY: I will be very interested to

8 understand how you held -- because I can understanding what

9 you are saying about the importance of bringing the

10 community into planning, and you have described how in the

11 prioritisation, when the fires in the north so our

12 particular bit of interest is in the south and we can see --

13 MS PAGE: We did have fires in the south as well. Yes.

14 That was in that first two years that I have described those

15 fires, yes.

16 PROF MONTGOMERY: There is something about the how good

17 was the system at picking up particular quality concerns as

18 opposed to engaging the public in the broader discussions

19 because you can see how the local people might be anxious

20 about raising quality concerns if they thought the costs of

21 doing that would be losing their services?

22 MS PAGE: I see where you are getting to. Because moving

23 down to the south of the county, the next step should have

24 been, you know, a major consultation within the south. But

25 I would quite like to come back to that at some point. But

1 you asked me the question -- as well as information from
2 public engagement, we also had a very good system through S
3 the medical directors of managing the individual quality
4 incidents.
5 You probably heard about that already, but also a
6 complaint system where the individual localities would look
7 at those complaints. Plus Mike Bewick and I going out
8 absolutely to every practice getting that individual data
9 and the interesting observation I would make across the
10 county, really in that first two years there was a
11 differential feeling of, you know, I mean, if you went to
12 Eden Valley and Keswick and Cockermouth where there was a
13 proposal to close their hospitals and everybody was out on
14 the streets. They were not in Barrow, actually, but they
15 were in Whitehaven as well. The big "Save Our Hospital"
16 campaign was there.
17 In Barrow, even through all the individual year on year
18 meetings we had with the GPs, Mike and I never heard from
19 the GPs and issues around maternity. And if you, I do not
20 know if you are going to interview the two clinical, GP
21 clinical leads from the south, that is Hugh Reeve, who is
22 now the Chair of the CCG and Geoff Jolliffe, who is still the
23 GP clinical lead in Barrow. Even, you know, he and I had
24 the conversation, none of the intelligence came back from
25 the GP world about what any problems around maternity.

1 But also, I think if I were being completely honest,
2 the GPs in Barrow in those early days, raised fewer issues
3 about their local hospital than GPs in South Lakes or Eden
4 Valley where they were vociferous – much more vociferous
5 about the standards and quality of care in their main
6 hospitals.
7 I would say there was an imbalance.
8 MR BROOKES: Can I ask why do you think that was? Why do
9 you think there was, given what we know now, less kind from
10 the GPs in Barrow and nothing around maternity services?
11 MS PAGE: Would it -- I do not know the exact numbers but I
12 am going in terms of the Mike and I's journey through the
13 eight year period. Mike and I actually were passionate
14 about rooting out poor practice in GP world which had not
15 been done before.
16 Disproportionately, in my head at the moment, more GPs
17 left Barrow during Mike and I's reign than any other parts
18 of Cumbria. Some of it was quite difficult stuff to handle
19 which is why I recall it. Some days it was incredibly
20 difficult but he and I did it and, I think, over all my head
21 tells me that there were about 15 or 16 GPs we had to deal
22 with in terms of the quality of care and removing them in
23 various ways.
24 So in the early days, this is a view, it is a personal
25 view, but I would say there was "collusion" between some of

1 the poorer practice GPs in Barrow and the hospital because
2 some of practises we went to in Barrow -- and I have
3 probably still got the notes -- when you went to the really
4 good practises, they did raise issues about different
5 specialities in that hospital and I remember paediatrics
6 being one of them. I remember the high level of
7 hysterectomies being another. The fact that we could not
8 get terminations to people, to women, in Barrow and they had
9 to go to Manchester.
10 All that stuff was fed back to the Trust and we began
11 to deal with it in an order but there was -- I just felt
12 that some of.
13 MR BROOKES: Can you say what you mean by collusion?
14 Collusion of silence or?
15 MS PAGE: They did not want to lose the hospital and they
16 were not prepared to stand and say that this was bad
17 practice. Whereas if you went to Carlisle the GPs there
18 knew the things that were going wrong, they were documenting
19 it, they were feeding this information into commissioning,
20 and prioritising it for change.
21 That was a little more -- Geoff had a hard job actually
22 corralling those GPs to getting them to a position -- now,
23 five or six years on, that is in a much better position and
24 the young new GPs in Barrow may have much higher expectations
25 and I think, have much more confidence in their own ability.

1 Less patients are referred to hospital in Barrow than
2 they were in early 2006/7 and actually the admissions
3 started to go down, the general practice started to improve,
4 and the dialogue changed. But even when the dialogue
5 changed, certainly up to when I left, not one single GP
6 raised an issue about maternity in Barrow. I have to be
7 honest with you about that.
8 PROF MONTGOMERY: That is really helpful makes quite a
9 lot of sense. Some of the things that we will come back to.
10 MS PAGE: All the conversations were being had every year
11 and it was, you know, latterly very formal actually, feeding
12 into the senate across Cumbria to make an informed
13 commissioning because I didn't know what commissioning was
14 when I first went in, you know?
15 PROF MONTGOMERY: 2006 I am not sure anybody did.
16 MS PAGE: I thought that was the practical way of starting
17 to go about reorganising the county and, you know, getting
18 outcomes for patients better because the clinical data was
19 telling us that our outcomes were poor.
20 PROF MONTGOMERY: That is something we need to come
21 back to and understand because we have seen quite a lot of
22 evidence collected clinical data which is -- can I test I
23 have understood right what you just said about the GPs?
24 Because one of my questions has been did people know that
25 the standards were different in Barrow from elsewhere or did

1 they not know? There are some questions around the rotation
2 of staff, people only working there --
3 MR BROOKES: Graphical isolation.
4 PROF MONTGOMERY: Which might mean actually they were
5 not aware of the differences. Or it might have been they
6 were aware of it but felt either unwilling or unable to
7 raise it. I think I heard you say they were aware of the
8 differences and didn't want to raise it.
9 MS PAGE: I think we were aware but it is that what sort of
10 order do you put it all in?
11 PROF MONTGOMERY: I understanding that.
12 MS PAGE: If we come back to the south, I think, it was
13 probably the -- again, it is difficult for me. The
14 relationships around Chief Executives is quite difficult
15 sometimes, isn't it?
16 I think I have enough insight to know that when I
17 arrived in Cumbria, I was sent. Everyone knew I was sent,
18 and they have known that I came from the North-east, which I
19 have to say is incredibly high standards of care.
20 That was under the direction of Liam Donaldson for what
21 seemed like hundreds of years. An amazing guy who really
22 challenged us to have a learning environment, and I realise
23 transferring to the North West that it was a completely
24 different place. So they knew I was sent. I had been a
25 Chief Executive in an acute setting for a long period of

1 time.

2 The people that I was with in the north and the south
3 were new, they were young. I mean, this was Tony Halsall's
4 first big appointment. They had never handled the
5 re-organisation of acute services either in the north or the
6 south. But the other dynamic in it was that the person who
7 had run the Trust before Tony had been moved into a
8 commissioning job in North Lancashire, and that gave a funny
9 dynamic to the situation -- you are going to have to stop me
10 if I am going to -- at risk of losing my house, but I need
11 to be honest with you about how it felt to me, okay?
12 PROF MONTGOMERY: We would have asked you about this
13 any way.
14 MS PAGE: Okay. It was difficult because he had been
15 running that Trust for an awful long time, as long as I had
16 run Northumbria, and it had not clinically merged. It had
17 merged managerially but not clinically.
18 Some of the clinicians, that I found who had done it
19 despite the system, the urologists who were running a
20 fantastic service right across the bay, fabulous Clinical
21 Director, had done it of his own, you know, under the radar.
22 So you had the sort of culture in the organisation that if
23 you had a good idea, you just get on and two it but it was
24 not systematically organised like we had done in
25 Northumbria, speciality by speciality by speciality.

1 Everyone knew their turn was coming for the re-organisation.
2 I really wanted to tackle that south integration just
3 like we had done in the north. The time was right, but
4 unfortunately, the strategy for north Lancashire PCT at the
5 time was to maintain a district General Hospital in
6 Lancaster. That was, you know, whenever we got all the
7 non-executive directors together, and the Chief Executives
8 together in South Cumbria, it always came back to we are
9 going to a keep a District General Hospital in Lancaster.
10 PROF MONTGOMERY: They were lead commissioner rather
11 than you; is that right?
12 MS PAGE: I raised myself up and put myself in an equal
13 partnership in managing that contract. I made that very
14 clear.
15 MR BROOKES: They were formally the lead --
16 MS PAGE: They were but I didn't abdicate my responsibility
17 for that in any way shape or form. They were my patients,
18 my population, you know, my head, my --
19 PROF MONTGOMERY: I think I have seen in correspondence
20 that establishes that.
21 MS PAGE: Yes, absolutely. I would not give that up because
22 I knew what needed to be done and -- but it was difficult
23 because, of course, I was commenting on somebody's past
24 performance. So -- so I tried to engage with the GPs across
25 with these clinical directors, in the Trust, to get the

1 change and at no point was Barrow ever going to be without
2 an admitting medical assessment unit, trauma centre, or
3 maternity unit. It had to have one.
4 PROF MONTGOMERY: I am being nudged to move us on. Can
5 I ask how --
6 MS PAGE: Lancaster had to move and change because it was
7 only 15 minutes from Preston but people did not want to go
8 up in the helicopter that far. You know, we had performance
9 management in the system above us which was not like the
10 North-east, so in the North-east you would have a plan, you
11 would be held to account for it, the performance management
12 was far better. In the north west, that performance
13 management did not exist.
14 PROF MONTGOMERY: And a lot of was evolved down. We
15 understanding that. Can I --
16 MS PAGE: I do not think it was devolved, I do not think it
17 existed.
18 MR BROOKES: We may want to come back to that.
19 MS PAGE: It just did not exist.
20 PROF MONTGOMERY: I have got a really good sense of the
21 strategy of picking on things. You have explained starting
22 in with the north, you have explained what was going to come
23 in the south and some of the challenges. I want to link
24 that with the quality clinical governance systems
25 surveillance because a question arises about whether there

1 is cluster of cases in Morecambe Bay that cuts across that
2 strategy. Do you need to do something different?
3 We have seen that -- what we have seen is quite
4 fragmented because of the way that the archiving of the
5 records has happened but we have seen quite a lot of
6 activity within the PCT trying to ask itself the question
7 about quality of maternity services in Morecambe Bay and
8 trying to do some analysis of whether this was --
9 MS PAGE: Is there a problem or not?
10 PROF MONTGOMERY: Yes.
11 MS PAGE: Yes.
12 PROF MONTGOMERY: Can you take us through how you
13 handled that question? Being quite similar to the question
14 --
15 MS PAGE: I think, probably I need to go back to the time
16 line again. It was in 2009 when we had, I think, it was
17 Mike Bewick -- no, it was not Mike, it was John Ashton and
18 I. We had both had notified to the PCT and maternal death
19 and I remember going home that night and really searching
20 because I had never come, in my whole career, I had never
21 had on my watch a maternal death. So I had never come
22 across it before and that is why I remember it so clearly.
23 I came into work the next day and John and I had a
24 conversation which was:
25 "John, what does this mean? I have never handled a

1 maternal death before, is this normal? How many do we have
2 in the country?"
3 We had this sort of conversation and that was the very
4 first conversation we had about maternity services in that
5 way, you know from an individual incident.
6 In the north the county, the north the county was still
7 attached to the North-east's perinatal mortality review
8 system. So the medics would have had that fed into the
9 system that we had in the PCT. But this was the first in
10 the south and it was a maternal death.
11 So that was the first conversation, but then within a
12 few weeks it seemed to me -- I am trying not to use
13 hindsight here as well -- within a few weeks we seemed to
14 have a second maternal death and I said to John, "what on
15 earth is going on?" But then we found out that the second
16 maternal death was actually before the one that we were
17 talking about that day.
18 PROF MONTGOMERY: You had not been notified of it --
19 MS PAGE: No and John immediately, you know, his immediate
20 reaction was, "what's going on here?"
21 So we then began to realise that the systems in
22 processes in the Trust were perhaps not -- I think that was
23 probably the first real indication I had on a personal level
24 that, "why have they not got you know -- systems like we had
25 in the North-East for notifying everyday?"

1 Those sort of incidents in the culture in the
2 north-east were that, you know, a Chief Executive would know
3 about it immediately, it would go up the line, it was
4 notified. You know, Liam had a system very early on to
5 teach us how to do this stuff.
6 So, I think, it was from that, that John began then his
7 journey which I am sure he will tell you about, of asking
8 questions about whether or not there was a process problem
9 in the Trust, but also, you know, was it coincidence or
10 whatever.
11 We had a system in the PCT, we were beginning to take
12 handover of the control of the serious untoward incident
13 system during that period as well. I can't remember the
14 exact dates. John, with all his experience, was put in
15 charge of that and he loved doing that stuff any way.
16 He was put in charge of that with the other medical
17 directors. They had a very good robust system, which
18 challenged the Trust eventually in many ways, because, you
19 know, that team would not close cases down, without, you
20 know, all the learning being done and actually everything
21 being put to bed correctly.
22 So that was, I think, the first inkling that was
23 this -- it is easy.
24 PROF MONTGOMERY: Which had did you reach a conclusion
25 that there were connections between the cases or ...

1 MS PAGE: I think, again, you see, you cannot use hind
2 sight. I think, at the time it was, I think John and the
3 medics at that point put it down to this was just
4 unfortunate happening. I do not think that we -- I know
5 then John started to put processes in place. He was looking
6 at the perinatal mortality rates across the county, he was
7 beginning to ask those questions, he was publishing actually
8 books that were like "born in Cumbria, dying in Cumbria",
9 where the statistics were beginning, you know, to be
10 published.
11 It all looked to us at that point, if I have recalled
12 it correctly, that we were within the national norms. But
13 with -- you know, we still have the conversation around,
14 "John, you know, same hospital, what's is going on in
15 there?" We were asking ourselves the questions.
16 PROF MONTGOMERY: It sounds as though the conclusion
17 that you came to when looking at this statistics for
18 assessment was that this was not so clearly out of line with
19 the pattern that that told you anything in itself. You have
20 identified process failure and concentrate on --
21 MS PAGE: Yes.
22 PROF MONTGOMERY: -- as opposed to thinking that what
23 is told you was that there was a major clinical problem --
24 MS PAGE: Yes.
25 PROF MONTGOMERY: -- death.

1 MS PAGE: I think the four medical directors, it was not
2 just John, these were four medical directors who worked
3 together closely trying to make those assessments. I cannot
4 tell you how fantastic they were at run in that process, as
5 a bunch of eventually four of them.
6 PROF MONTGOMERY: Can I ask you what your involvement,
7 knowledge awareness was of what the Trust was doing? So the
8 Trust commissioned a number of external views on this period
9 including the Fielding Report. Were you aware of those
10 activities the Trust was doing?
11 MS PAGE: No. We were not aware of the Fielding Report at
12 all. In fact, I think, it was, if I have remembered
13 correctly, it was in the -- it was Mike Bewick and I got to
14 know about it, we were sat in an overview in scrutiny
15 Committee meeting during the Gold command process and I just
16 cannot believe it actually when I -- because Tony was
17 apologising to the Committee for not publishing the report.
18 I was sat there with Mike saying, "what report? Mike,
19 Mike -- what is that about?"
20 MR BROOKES: At no stage were you notified they had
21 commissioned a report, what the outcome of the report was?
22 MS PAGE: No, no and actually -- it is just sent shivers
23 down my spine again because, having read that report, our
24 approach to the whole damn thing would have been completely
25 different.

1 PROF MONTGOMERY: Just say a bit how that would have
2 been?
3 MS PAGE: Well, I mean, having run the hospitals for years
4 and years and years and merged departments and re-organised
5 maternity services, it is a catalogue of poor relationships,
6 poor practises, not looking across your organisation and
7 improving standards in a -- like a recipe book where
8 everyone is working to the same across the maternity units.
9 I was unfortunate in my early days in Northumbria to have a
10 baby death up in Berwick and having to re-organise the whole
11 system to ensure that that never happened again, it was --
12 we.
13 It would have jettisoned Barrow maternity services up
14 to a level where, particularly the GPs in our system and are
15 medical directors and myself, would have been doing very
16 similar to taking that priority in the north and actually
17 making the changes in the south. But we would never have
18 shut the --
19 PROF MONTGOMERY: It would have been in the South. Had
20 you seen that report? You have described the fire in the
21 North being the first --
22 MS PAGE: Yes, it was a lightning bolt but the key thing is
23 that we would never have shut Barrow maternity unit because
24 our commissioning intentions were that it should always
25 remain there. But it was the re-organisation of the RLI

1 maternity unit that would have had to enabled the rotas to
2 be changed in Barrow to support that in a sustainable way
3 along with the paediatric services.
4 Now, we did actually commission a report into
5 paediatrics because that came up very early on, through the
6 GP world, particularly in Barrow, of standards of practice,
7 where if, you know, right across the county, not just in a
8 hospital. This was the whole old-fashioned way in which
9 paediatrics services was run and organised in the county.
10 PROF MONTGOMERY: I think Stuart will want to come back
11 to that. I am interested in trying understanding if you
12 think that the failure to share the Fielding Report was
13 representative of the general attitude of the Trust
14 releasing information or whether it would have been
15 unexpected that you did not see that. Some Trusts are very
16 keen to share information with commissioners, others keep
17 information very close to their chest.
18 MS PAGE: We were on a journey with South Cumbria Trust,
19 Morecambe Bay Trust. It started with that management of the
20 SUI system, trying to get the Medical Directors to share and
21 be with others across the Trust because they were very
22 closed in the early days.
23 Even in that hand over of the SUI system between the
24 SHA and ourselves, I saw glimmers of hope and progress that
25 they were beginning to become more open and the medical

1 director particularly with our group of medical directors,
2 and, I think, I reflected that whenever I attended the SUI
3 meetings in Barrow which I did actually.
4 You know, when we had to review particularly whether we
5 were going to close cases or not because John Ashton always
6 wanted my support there because he felt sometimes he would
7 come under pressure to close something that he really did
8 not want to and so we actually stood firm together. But I
9 did see progress. But they were very closed.
10 PROF MONTGOMERY: You had a sense of moving in the
11 right direction but needing to move faster?
12 MS PAGE: You saw glimmers of hope there that actually we
13 were moving. But I think you probably go on into the
14 history a bit further that, actually, we actually advised
15 Monitor not to approve them as and FT, and one of the
16 reasons was because their clinical systems were not good
17 enough, their clinical leadership was not good enough, the
18 way they changed their organisation in the services reviews
19 across their foot print was not good enough, they were quite
20 in ward looking still and not out ward looking.
21 PROF MONTGOMERY: So tell us about the response from
22 Monitor and from the SHA from the Trust, to the fact you had
23 recommended that they were not approved.
24 MS PAGE: When we met Monitor for the second time, as we had
25 already asked for a postponement for the first time when

1 they wanted to go to FT status, but when we met for the
2 second time, we met with the GP leads and myself, and we had
3 quite a gang of us, I had my finance director with me and we
4 approached it very systematically.
5 PROF MONTGOMERY: Who did a meet in Monitor?
6 MS PAGE: They were the people who were from the
7 authorisation of FT team. This was after CQC had given the
8 Trust a clean Bill of health which to say that I was angry
9 was an understatement, okay?
10 PROF MONTGOMERY: Who did you express that to?
11 MS PAGE: I expressed that in a letter to Monitor. I think,
12 it started, very unusually for me:
13 "How very disappointed I am for you to be asking me to
14 a meeting within next two to four weeks to sign off an FT
15 application. I now need three or four months to reassess
16 their long term financial plan, is it in line with our
17 commissioning intentions?"
18 So I put off about three months until we had re-looked
19 at their new five year plan, it did not align with ours, we
20 did an assessment of the clinical learning engagement
21 because we had fantastic GP commissioning by that time. It
22 was leading the country. It was really led from the bottom
23 up. I was very proud of it.
24 They had not got the traction in the Trust, with the
25 clinical leadership and the changes to the services that

1 they now had a very good quality list based on evidence of
2 things that needed to be changed clinically.
3 So we were giving Monitor -- I thought we will hit
4 Monitor with what they like which is all the basic business
5 evidence that their business plan is not lined up to ours.
6 So financially we are going to be doing that because we were
7 on a track to closer to home and the Trust were on a track
8 to get more money in a more patients into hospital.
9 We backed that up with all the clinical leadership
10 evidence, and the evidence around all the service reviews
11 that we wanted to implement and the changes to clinical
12 practice, and I actually said to Monitor at the end, "the
13 leadership is not strong enough yet to take an FT through."
14 And I said -- I remember saying, "I am telling you that from
15 personal --" you know, I had taken Northumbria through a
16 really hard time to get to FT, and we did it with the
17 clinical services delivering high quality care, not through
18 adding numbers up and focusing on finance but the team in
19 the Trust were solely focused on FT application.
20 Now, I am in Liverpool picking up the pieces from
21 another team who, you know, who were taking the Trust to FT
22 status, despite the quality of care they were delivering.
23 So I am in exactly the same position now as I was with
24 Morecambe Bay but from a different angle. It is exactly the
25 same.

1 PROF MONTGOMERY: So that --

2 MS PAGE: I said all that.

3 PROF MONTGOMERY: And so how did Monitor respond?

4 MS PAGE: They said, "thank you very much." I remember her

5 saying that they had not had a commissioner ever put

6 evidence down -- the data -- we knew precisely how many

7 operations we needed. We had data that was really based on

8 absolute speciality by speciality detailed of what we wanted

9 and the quality we wanted. They had never seen anything

10 like that before, she told me, and that they wanted to use

11 that in other applications as good practice.

12 We walked out of that room and both Hugh Reeve, who is

13 the GP in the south, and Geoff Jolliffe, the GP in Barrow

14 Geoff said to me:

15 "Well, that has put a lid on that then. They are not

16 going anywhere. We can now get back to changing the

17 service."

18 PROF MONTGOMERY: What changed in the --

19 MS PAGE: We thought it was dead in the water. I could not

20 believe it when they went through.

21 MR BROOKES: Can I clarify, did the PCT, at any stage,

22 support the FT, formally support the FT application?

23 MS PAGE: No and we did not in the north either, North Cumbria ~~umbria~~

24 acute hospitals, because of the nature of what happened we

25 were dealing with. I have to explain to you as well that in

1 those -- that in today's world it is very easy for a PCT or
2 a CCG to say, "no, they are not supporting and FT
3 application."
4 We have to go back to that point where Mike Bewick,
5 myself, and John Ashton were standing in a field on our own
6 saying, "no". It was a very lonely place. And obviously
7 the SHA wanted them to go through as well.
8 PROF MONTGOMERY: That is the next question really. So
9 you have put all this out to Monitor, you leave the room
10 thinking that the Monitor team you have dealt with the sees
11 it essentially as a something that pulls down the shutters
12 on it and then it all changes.
13 So, I mean, did the SHA contact you about the process
14 did Tony Halsall come back to you?
15 MS PAGE: Because of the nature of what we were dealing with
16 in Cumbria which I have explained to you --
17 MR BROOKES: Yes.
18 MS PAGE: -- I think I decided at the outset that I was
19 going to make sure that I saw my boss in the SHA every four
20 weeks or so. I was probably, probably got fed up with
21 seeing me but I made sure I was in his room every four weeks
22 to actually layout -- I have still got all my notebooks of
23 everything I said at every meeting. I would layout north,
24 south, the totality, what I needed to be done.
25 Because, I have to say to you now, I came from the

1 North-east where the commissioners would hold Trust to
2 account and I was a trust, but the SHA would also hold to
3 account -- it is a joint partnership. I can only -- you
4 know, through a commissioning intention contract manage
5 contracts but I need that system in place to performance
6 manage an organisation from above.
7 That happened in the North-east. It was systematic.
8 It was every so many weeks we would all get into a room. If
9 we had said we had signed up something, a deal is a deal, we
10 would have to deliver it or explain why. It was incredibly
11 systematic.
12 PROF MONTGOMERY: You would have told Mike that what
13 you just told us?
14 MS PAGE: Absolutely but there was none of the process in
15 the place in the North West throughout my tenure with
16 exception of the final bit when it was the North-east that
17 took over totally. Then it changed. It changed markedly.
18 There was no systematic performance management in the
19 north west. So it was not that it was devolved. I already
20 had devolution as a PCT to contract manage an organisation.
21 You needed that triangulation that they had over at the
22 Pennines to actually make things happen.
23 PROF MONTGOMERY: I just have two other things, Julian.
24 I need to ask you about Gold Command and about risk
25 summits. There are series of risk summits that we see

1 referred to involving area players where they assess what
2 challenges are. I think the perception is that the
3 challenges are not perceived to be about maternity for most
4 of that. That time they are about financial sustainability
5 and about various other clinical services.
6 I would like you to talk us through the -- I don't
7 think your timeline, but there are two or three examples --
8 the summits, sometimes in involving the CQC, sometimes the
9 SHA, where there seemed to be a discussion about what the
10 most pressing issues were about Morecambe Bay. I am trying
11 get the picture of that.
12 MS PAGE: Yes. I think it is interesting there was one risk
13 summit that we did not even know about. So I do not know
14 what it was about other than hearsay really which was about
15 radiology and the culture in the organisation of Morecambe
16 Bay and I was trying to recall when that was but I cannot --
17 I cannot remember when it was.
18 PROF MONTGOMERY: That is fine. If I comes back to
19 you.
20 MS PAGE: I cannot remember. There were clearly things that
21 the SHA were notified of by the Trust but certainly I was
22 not party to any of those conversations. In terms of the
23 risk summits that were called I think because of the
24 structure that we had in the PCT, the Medical Directors
25 particularly, when they could see trends in things, when

1 they -- when they came to a point where they had groups of
2 issues, they went backward in saying we need a risk summit
3 to discuss this sort of thing.
4 I don't think that I was ever invited to any of the
5 main risk summits. I think, Mike Bewick was the one who led
6 all those but it seemed to me that it was more us being, you
7 know, agitating the system I suppose.
8 I mean, I backed my Medical Directors absolutely
9 100 percent. I would never say that they were doing thing
10 that -- but, I think, it never really came to a conclusion.
11 I watched the fall of my Medical Directors and, I think, the
12 word frustration comes to mind sometimes where they knew
13 things were not right but it was -- it was a bit of an
14 action plan then, you know -- but what we were worried was
15 that the performance management was not in place and,
16 therefore, we were coming back to the table again with the
17 next service and this went on with cardiac out patients and
18 a whole load of issues.
19 PROF MONTGOMERY: That takes us into the Gold Command
20 and we would like to understand where that came from and
21 what it was thought to achieve because, from outside, it is
22 a very long Gold Command. Are you aware of shorter in
23 intensive Gold Command activities?
24 MR BROOKES: It is an unusual mechanism we might say.
25 MS PAGE: It is but, I think, again, it is putting the

1 context into it, isn't it, because what we were building up
2 to is you can see with very -- I thought, very systematic
3 commissioning based on the data and the clinical involvement
4 and the patient evidence being gathered across the county,
5 we were sort of towards that end in a fairly decent place
6 about what needed to be done. Whether it was being
7 implemented or not was another matter but we understood the
8 county.
9 We had dealt with service failure in other parts of the
10 county. So we had had a breast screening failure in the
11 north of the county that we had to deal with. And because
12 of the resistance of the medical staff in up there at the
13 time, it eventually got into a Gold Command situation to
14 control it because of this resistance to change.
15 John Ashton would be a better one to tell you how he
16 felt about all that but to grip it and to get the clinicians
17 to accept that actually we have got bad practice going on
18 here and to handle it in a different way, was a tough
19 journey for these medical directors. So north Cumbria fell
20 into a Gold Command because it had to be, more or less,
21 command and controlled eventually because we had harmed
22 women.
23 We had also dealt with floods and shootings and things
24 like that. So -- but this one I think was like a rising
25 tide and, I think, gradually as we got into more detail

1 whether it be with maternity or all the other services, we
2 began to realise that they had got to FT. During that
3 period that they had achieved FT status, they really were
4 not in our opinion focusing on the changes to clinical
5 practice that needed to happen.
6 It was probably, I mean, if you were in their shoes
7 between to hang on to the FT kite, you know, and trying to
8 actually deliver to Monitor and all this stuff that happens
9 to you in your first year of being and FT. It is not an
10 easy place to be. Even when you have got a well run
11 maintenance organisation, that is not easy. So our
12 observation was that things were beginning to get worse or
13 not being dealt with even as quick as they were beforehand.
14 It got to a point, I think, particularly with the out
15 patients. The north Lancashire PCT, was then run by a very
16 new style lady and she was then engaging with her GPs in
17 very similar way to we were so she was beginning to uncover
18 things. We were beginning then to put pieces of jigsaws
19 together as well around maternity, and, I think, it was John
20 Ashton.
21 We were trying to get risk summits and calls organised
22 you know, to try to solve some of these problems between the
23 two PCTs and the Trust. I don't think we were getting
24 traction at all and it got to a stage where we realised that
25 this really was a rising tide of clinical failure.

1 It was John Ashton who said who said, "soon we will
2 need some form of Gold Command here because nobody is
3 listening." I think it came out of -- it probably -- it
4 would be unusual but I do not think we knew where else to
5 go.
6 PROF MONTGOMERY: But if you have described a situation
7 where the management is not having a grip, where the there
8 is a rising tide of problems, would that really be the
9 (inaudible) responsibility? You have got a big governance
10 failure there; haven't you?
11 MS PAGE: Well, again without hindsight, and I can tell you
12 how it felt but because we sort of -- we carry the -- as a
13 commissioner, we are The Guardian of quality of care for the
14 people we serve. We are responsible for making sure that we
15 have the right care in place for them to receive, it is the
16 right quality, and we are responsible for our part in the
17 performance management of that and we could see failings
18 here that were --
19 PROF MONTGOMERY: So it is Gold Command makes that safe
20 --
21 MS PAGE: It does not make it safe, I think is --
22 PROF MONTGOMERY: It takes it out of their control?
23 MS PAGE: No. I think, it got to a point where we knew we
24 needed help from outside the county to sort this out and it
25 was more than the resources we had to hand. So, I think, it

1 got to a stage where we were trying in fairness to sort it
2 but we just needed extra manpower, extra help, both in
3 maternity and in outpatients but, of course, the R L I A&E
4 department was not exactly functioning well either during
5 that period and we knew there were --
6 PROF MONTGOMERY: I mean, I think sorry -- I have to
7 curtail it because I need to hand on. I mean, we can see
8 quite a protracted intense process and a lot of things get
9 drawn into gold command and looked at. What was the sort of
10 exit strategy? As you set it up, what did you hope you then
11 be able to either hand back to the Trust or change -- what
12 would success have looked like from gold command and do you
13 think it achieved that?
14 MS PAGE: Gold Command was focused around where -- I think,
15 we got to the point where once you have got a -- what we
16 felt to be unsafe service in out-patient where we didn't
17 know what we did not know and who was out there having not
18 been followed up and treated, we were harming patients and
19 we were also, you know, the concerns around maternity care.
20 I think the outcome for us for Gold was getting that
21 safe. We knew that the Trust would have taken the normal
22 reaction, "well, let us shut the maternity unit." We were
23 worried that they were going to come with the proposal "let
24 us just shut it" because it was all too difficult.
25 PROF MONTGOMERY: They did try; didn't they?

1 MS PAGE: John Ashton and Mike Bewick and myself had a
2 conversation about -- I said:
3 "We cannot shut it because where will the women go? We
4 are transferring risk from an organisation to the
5 population. The women who will then be in Barrow in a very
6 deprived area, having to travel two hour to Royal Lancaster
7 infirmary. What we need here is external help to say no.
8 What can I the NHS do to bring clinicians into Barrow to
9 make that safe so that women who are going to give birth
10 tomorrow can give birth safely?"
11 So that was the outcome of Gold. Of course, it went
12 further than that but that was not the outcome. The outcome
13 was getting out-patients safe, you know, getting that harm
14 free care and getting women safely delivered in Barrow was
15 the outcome. I think we actually almost achieved that.
16 MR BROOKES: Stewart.
17 PROF FORSYTH: When do you think you achieved it? When
18 did you think you achieved that? Do you think it has been
19 achieved now?
20 MS PAGE: No, no, no.
21 PROF FORSYTH: Can I go back to --
22 MS PAGE: No. I mean, I am 18 months away from it. At the
23 point at which I left, we had dealt with another difficult
24 time with the Trust wanting to shut the maternity unit
25 there. So until they tackle the maternity service changes

1 across that geography, you know, that is when, I think, we
2 will have our sustainable service for the future. Which, I
3 think, will include a consultant-led maternity unit at
4 Barrow.
5 It has to because of the geography because Whitehaven
6 Hospital maternity unit we are trying to consult on that.
7 That was the one bit of close to home that we were not able
8 to consult on because the SHA would not let us because we
9 were heading to the election. So we could not include it in
10 close to home at all. We were not allowed to. The time it
11 came around to the second time it was close to the election,
12 we were not allowed to do it but I do think they are just
13 about to do it now.
14 But I think in the south the county, you know, all the
15 evidence that we amassed over the six or seven year period
16 led us to believe that we needed a consultant-led maternity
17 unit in that town but that would have to be backed up by
18 changes elsewhere.
19 PROF FORSYTH: Yes, I mean, I am keen to know because
20 we talked about the Fielding Report, which was very much
21 addressing fairly basic practice issues. It seems to me
22 that difficult to understand why this could not have been
23 addressed then and whereas the problems seem to be
24 escalating into very high levels, including Gold Command.
25 It has never really -- in fact, we will probably begin

1 to now -- address some of the real practical issues such as
2 communication, standards of clinical care, and, I mean, this
3 is not rocket science.
4 MS PAGE: No. I mean, well, it was not until we got into
5 Gold Command that we knew the Fielding Report existed.
6 PROF FORSYTH: I know. Having then been made aware of
7 the Fielding Report, the response of the commissioning group
8 would be specifically what to address that?
9 MS PAGE: Yes, absolutely, yes. But also, we knew we needed
10 to address the level of cover of the obstetric unit, you
11 know, the level of obstetrician consultant cover in the
12 unit, the extended hours. They were still work working the
13 old system up until that point, you know, the consultant
14 on-call. That needed to, we know, we had moved on in the
15 North-east from that years before that.
16 Until we had that total re-organisation of the
17 obstetric services, I do not think we could have tackled
18 that. Within the resources that we had at the time to run
19 that the whole hospital.
20 PROF FORSYTH: Did the commissioning group come up with
21 a model of care, of obstetrician care, for Barrow and the
22 southern Cumbria?
23 MS PAGE: It would have been similar to north Cumbria. It
24 was -- the same blue print that we developed in the north
25 would have fitted the south. We knew that, but we were not

1 allowed to consult on that at that time.

2 PROF FORSYTH: So that the consequence of that was that

3 we had a unit which clearly known to be unsafe continuing to

4 be unsafe during the period of time?

5 MS PAGE: Yes, I guess, had we seen that Fielding Report

6 there was, as you say, it is not rocket science. A lot

7 could have been done without any change to make that safer

8 for the day-to-day operational management of that unit.

9 What I am saying is that if we would have -- if we could

10 have been implemented the sort of higher level change, we

11 could have made it even better.

12 PROF FORSYTH: Yes, I appreciate that. That is a

13 longer term plan really and funding issue. I am worried

14 about -- trying to work out why or what action was taken, at

15 least on a temporary basis, to try to ensure, you mentioned

16 earlier, the commissioning group have got to provide

17 assurances to the local population that services that were

18 provided were safe. Therefore, I am wondering what issues,

19 what actions were taken at that time to try to sure up the

20 clinical standards within that.

21 MS PAGE: Right. It was, well, through the Gold Command

22 process, we were able to bring in midwives and obstetric

23 from outside of Cumbria and the within region as a whole.

24 So that enabled us to not only make sure that the rotas were

25 safe and the basics were done, but actually we were able to

1 bring in leadership from outside to show them what good
2 looked like around the basics of communication and all those
3 things were acted on during Gold Command.
4 I felt that we -- you know, we did as reasonable job as
5 we could and even working with the Trust then to focus on
6 those issues in a much better way than we had done
7 previously because we had -- it had never come up as an
8 issue. So had -- if we had seen that Fielding Report the
9 year before as they were heading for Trust status -- I
10 think, it came out round about when they were granted FT
11 status; was not it -- then we would have used that in the
12 our meeting with Monitor and everyone else.
13 I mean, we just didn't know about it. But once we did
14 know about it, through that Gold Command, we worked together
15 with everyone in the region to make sure that those
16 standards were raised as quickly as possible.
17 PROF FORSYTH: So what evidence did you get that the
18 standards were raised?
19 MS PAGE: Sorry?
20 PROF FORSYTH: What evidence were you given to
21 demonstrate that the standards were raised and did that
22 provide you with reassurance that the service was now at
23 satisfactory level?
24 MS PAGE: Well -- I mean, we were satisfied that all the
25 actions that we were -- so, if you -- what you go into at

1 that point was Monitor, CQC, and SHA, PCT, and a Trust,
2 right, all working together to try and organise resources.
3 And also Monitor were taking action to have more reviews
4 done into practice, they decided they were going to take
5 responsibility for that at that point. So there were all
6 sorts of reviews going on but my team, if you are asking
7 what we were doing, my team my director of nursing and the
8 then Neela Shabde and others were actually working right up
9 with the teams fulfilling our bit of responsibility, giving
10 our skills and expertise.
11 PROF FORSYTH: The team in the Trust?
12 MS PAGE: Team in the Trust, yes, to make sure that we could
13 do as much as we were doing or be as much help as we could
14 be practically to them. That included being part of
15 bringing in resources from elsewhere.
16 The medical staff through Gold had, you know, their own
17 lists of outcome measures that they were expecting to make
18 sure that they could give assurance to the population that
19 care was safer than it was. But it was on a journey.
20 I suppose Gold Command was about putting in that
21 emergency safety net, was not it, so it was not going to be
22 the perfect outcomes of epidurals being able to be given 24
23 hours a day, it was about can we assure ourselves that
24 anyone giving birth there tomorrow would be safe.
25 Change -- I know it sounds daft but we were in the

1 middle of conversations of women going from the ward to the
2 theatre as emergency sections, which, you know, so there
3 was -- I was doing things like can we find them some money
4 to actually get those doors changed because they were -- and
5 trying to help them financially, get the changes in place.
6 I remember visiting the ward to meet the midwives at the
7 time with Tony, just to sit down with them and say, you
8 know, "how does it feel? What can we do?" Trying to engage
9 them just to put some leadership into the place, you know to
10 say this matters.
11 But I do know Neela and Mike and others were actually
12 on the shop floor in Barrow Hospital with the clinical
13 leaders, with the Medical Director, actually helping and
14 supporting as much as they could. But we had an awful lot
15 of staff shipped in from outside of Cumbria, particularly
16 midwives who had the remit to get up a alongside the
17 midwives were a working there and improve practice and there
18 was the whole issue of the supervision of midwives as well
19 that was being tackled at that time. We were not sure that
20 was right. In fact, with hindsight we will say we were
21 right to probe that, but, that is how it felt.
22 We were not sitting in room saying, "we want these
23 outcomes tomorrow or next week", it was very much very
24 practically based and trying to give them really high
25 quality people from outside to help raise the day-to-day

1 practises and to show people that actually, certain practice
2 were not right, and they had to change.
3 We had people in rooms facilitating conversations
4 between midwives and consultants to actually redress the
5 balance of the relationship between obstetric and midwives.
6 So it was not rocket science, it was about doing that stuff
7 in a an attempt to try to improve the safety of the service.
8 PROF FORSYTH: Again, were you the getting feedback
9 that this was having an impact, that some of these aspects
10 of the clinical care were improving?
11 MS PAGE: From the patients?
12 PROF FORSYTH: From any sources? From patients or
13 users of the service, from the people providing the service.
14 Did it feel that it was all beneficial to them as well?
15 MS PAGE: I think, when you are in the middle of that Gold
16 Command, you don't often stop to reflect everyday about that
17 but what we did have in Barrow -- and that is through Geoff
18 Joliffe, the GP lead there -- he held the ring on collecting
19 the information from the GPs during that Gold Command
20 process to make sure that a) we were communicating correctly
21 with, you know, the women who were coming in asking
22 questions about it, but also feeding back into the system if
23 there were any particular issues that had gone wrong or had
24 failed or women that not perhaps been dealt with properly.
25 So, I think, we were in that mode rather than

1 collecting information about did people have -- it was not a
2 sort of -- the patient survey type stuff. It was more
3 clinical information about how clinical cases were developed
4 and whether GPs could be on a heightened alert really to
5 women. Because do not forget, none of the GPs had raised
6 anything about maternity services. It was more at that end
7 of it, I am afraid, rather than very organised sort of
8 systematic collection of feedback.
9 PROF FORSYTH: One of the, again, in relation to the
10 commissioning, I suppose, is that the neonatal component of
11 maternity services. The neonatal unit at Barrow is a level
12 one unit which really should not look after any baby that
13 has got anything specifically wrong with it and should be
14 transferred out. Whereas you have got a consultant-led
15 obstetrician service.
16 I wondered whether you felt that this was an issue of
17 whether some of the issues that were presented in that
18 service room were related to not having a high level of
19 neonatal service and that leads to decisions about which
20 mothers or which babies should be transferred out?
21 MS PAGE: I think it was through some of the incidents going
22 back in time. One of the reasons we brought Neela Shabde in
23 was because we were getting information in those early days
24 about paediatric services across the county. And although,
25 you know, there were a probably more issues outside hospital

1 for children and the safe guarding issues and children
2 falling through the net in Cumbria, it was not a completely
3 integrated paediatric service in the county which is where
4 we wanted to take it.
5 In answer to your question, the -- when Neela,
6 particularly after she arrived and we had gone into really
7 looking at the neonatal aspects of care across the county --
8 I do not want to put words -- I am trying to recall what
9 she -- the conversations we would have had about that. We
10 knew and I had formed a view based on what I was told, that
11 the way in which children were transferred out of Barrow
12 hospital when they needed to be transferred out, was not
13 systematic. Either throughout the 24 hours cycle, or the
14 seven day cycle depending on who was on duty, there did not
15 seem to be a systematic assessment; that is the view I came
16 to.
17 Now, I am not a clinician, right, so I am -- in one or
18 two of the incidents -- I remember one baby being
19 transferred to Manchester and then on to Newcastle and I am
20 doing this without hindsight, right, so at the time -- and
21 there were one or two other incidents around like that.
22 That was not the only reason why we got into a big review of
23 paediatric services, but it was certainly one of the reasons
24 because, I guess, again because I came from an acute
25 hospital background -- we had very systematic methods in

1 Northumbria of what we kept in-house, what transferred to
2 Newcastle, neonatology unit up there run purely by nursing
3 staff very, very well and it was very systematic.
4 I didn't see that in Cumbria anywhere. So part of the
5 paediatric review was to actually bring more systematic, a
6 much more systematic approach to that and to have more cover
7 during the course of the week of the children's unit by
8 senior clinicians making these decisions and it not being
9 left to junior doctors as it seemed to us to be.
10 That was the precursor of the Andy Mitchell report in
11 how we would in Cumbria completely change the whole
12 paediatric service and, you know, I must admit, I bought
13 Neela in because she had done it for me in the North-east,
14 she had, you know, she had really completely re-organised
15 paediatrics to be an out of hospital service, only admitted
16 if you really needed to be admitted. So she was going to be
17 instrumental in helping not just systemise the neonatal unit
18 area but also children being admitted to Barrow hospital.
19 We looked at the data on just the admissions of
20 constipation and, you know, I remember Neela and I saying,
21 "what we need here is education programmes, not admissions."
22 And so it was trying to actually get a grip of that data to
23 see what it was showing us so we were tracking babies around
24 with that data.
25 Particularly in north Cumbria, the paediatric unit

1 there on a Monday morning, suddenly there would be an army
2 of children being sent across the A69 to Newcastle because
3 of the way the place was organised over a weekend. We could
4 begin to see through just looking at that data what was
5 happening.
6 That was pre-cursor to the Andy Mitchell review and our
7 attempt then after that to commission paediatrics for one
8 Trust to run it all for the entire county. Unfortunately
9 that did not come off because the three Trusts decided to
10 work together and, anyway, it did not work out. They were
11 not held to account for it so it just fell by the way side.
12 PROF FORSYTH: Do you think that contributed to the
13 continuing difficulties of providing both maternity and
14 paediatric services in Cumbria?
15 MS PAGE: I mean, up until the time I left, yes, if I am
16 honest.
17 PROF FORSYTH: Okay. Thank you.
18 MS PAGE: It actually does not take long to re-organise
19 that. It only took me about 18 months in Northumbria to do
20 the whole lot and we could have done that back in --
21 whenever it was, 18 months back. But when you have got
22 total resistance and you are trying to commission that and
23 we went to arbitration with these Trusts, which is a very
24 high level of dispute, at points when we wanted these
25 changes to happen, and we were not supported because the

1 performance management did not exist.

2 PROF MONTGOMERY: The arbitration was at the strategic

3 Health Authority?

4 MS PAGE: So we lost the case and on we went.

5 DR WALTERS: One of your colleagues said there was

6 need to preserve the maternity services in Barrow even

7 though they were not (inaudible) and could not meet The

8 Royal College guidelines. How did that knowledge feed into

9 conversations about the incidents that you started to see?

10 MS PAGE: You would need to go back to the data but I am

11 doing this from memory now. You know, I would need to go

12 and check my facts again, I think, if I could get access to

13 them. That is when you look at Lancaster and Barrow, and

14 Helme Chase, if you look at the total number of births

15 across the footprint, when we did changes to A&E and the

16 changes to -- we did some changes to RLI which basically

17 sent this South Cumbria population base towards Barrow for

18 admission for emergency medicine, emergency surgery, which

19 increased the numbers of their emergency rotas that made the

20 rotas more sustainable so we had actually made those

21 changes, not by consultation, just by sitting down with

22 Ambulance Service and the with clinicians, and trying to

23 just redirect populations bases.

24 When we looked at the number of births, what we felt at

25 the time and again, relying on the Medical Directors to

1 analyse this data with the GPs, we felt that if you could
2 drop the R L I unit to a midwife-led unit and have the main
3 admitting unit for that population base of South Cumbria
4 into Barrow, we would have enough to actually sustain the
5 service.
6 We had to -- as commissioners, sometimes you make
7 decisions about hospital care that have unintended
8 consequences and people often -- because the nation is
9 focused on elective care sometimes, you change the elective
10 care volumes and you change your rotas in a place like
11 Barrow because you need enough volume of patients for the
12 emergency rotas to deal with and the elective rotas to deal
13 with, so it is a fine balance.
14 We used to work out the numbers from, well, if we have
15 got to have a team of six obstetricians or six surgeons,
16 what volume do we need and have we got enough volume in the
17 south the county to fulfil that? If we move the just the
18 catchment area of the population of the hospital slightly,
19 you can sustain it.
20 We felt at the time that actually if we could have made
21 those changes in the R L I, downgraded that unit slightly,
22 yes, there are some women from Lancaster who will go to
23 Preston which was 15 minutes away, but actually that
24 southern part of the Cumbria would look towards Barrow which
25 it, actually, when we looked at the data, when we moved the

1 emergency care boundaries slightly, that worked.
2 DR WALTERS: But as that was not happening, and then
3 you are now seeing maternal deaths and incidents, what was
4 the response then? You have actually got something you have
5 got a service where it is not financially viable, and you
6 are not meeting guidelines about members of staff.
7 MS PAGE: Sorry, I didn't --
8 DR WALTERS: So you have got rising -- you seem to
9 have a problem there in, for instance, you have not got that
10 change in population. So you have got numbers which are low
11 and an infrastructure which is not meeting professional
12 guidelines. I am wondering how you managed to rationalise
13 that?
14 MS PAGE: At the time, of course, we did not have that
15 picture that you have described. So with hindsight we have.
16 DR WALTERS: But you must have known that they were
17 not, that the structure of the unit was not meeting national
18 guidelines as part of your quality and commissioning?
19 MS PAGE: Yes, you do but you cannot -- even though you know
20 that, you cannot go about shutting units just because they
21 do not meet -- you will have a plan to work that through.
22 DR WALTERS: Yes, I appreciate that. I just wondered
23 what sort of conversations had gone along, "yes, we can put
24 Gold Command in place, we can have lots of action plans, but
25 actually we still here have got what is an objective

1 infrastructure problem"?

2 MS PAGE: Right. So you are wanting to know what – after

3 the Gold process, how we felt about it at that point?

4 DR WALTERS: Yes or even before that point. I mean,

5 because, I think, the Trust had written to say that unit was

6 not financially viable.

7 MS PAGE: I do not – that did not happen. I do not

8 think – I cannot remember the Trust ever writing to me –

9 DR WALTERS: Right.

10 MS PAGE: -- saying it was not financially viable. I would

11 have to go.

12 DR WALTERS: That was the first in the tariffs sort

13 of matched against you needed to provide to be --

14 MS PAGE: I do not think the Trust ever -- I do not -- it

15 might have -- if they did, it would have been very, very

16 late on when they –

17 DR WALTERS: Pre-Tony Halsall's days, I think.

18 MS PAGE: That is before my time then. I am sorry.

19 Certainly in my time, as Commissioner in Cumbria, and Tony

20 was there foremost of that, the Trust never wrote saying it

21 was not financially viable. My view of it was that having

22 run maternity units in Wansbeck, North Tyneside and Hexham,

23 which was a similar thing, Hexham was a midwife-led unit,

24 Wansbeck was destined to be the main obstetrician

25 consultant-led unit and North Tyneside a midwife-led unit,

1 that was the longer-term plan for it but that was viable
2 under an FT.
3 So I came at the maternity issues in north Cumbria and
4 South Cumbria with that the same practical hat on but no-one
5 ever wrote to me saying it was not financially viable. I
6 think that could have been on the back of someone being
7 inexperienced about running and FT and understanding how,
8 across sites, you can actually make it viable which I
9 suppose I brought with me because I just happened to have
10 it.
11 Certainly with the -- certainly at the put it of which
12 Neela arrived and we started really to look out this on the
13 journey, you know, of the PCT, we felt that it could be
14 re-organised in a different way. If it required a subsidy,
15 we would have talked about that. We talked about that in
16 north Cumbria because that -- you know, because you cannot
17 shut Carlisle maternity unit. You have to have an
18 obstetrician service, you know, covering that sort of
19 population when the next nearest hospital is Newcastle.
20 So we would have had those conversations but we felt,
21 in terms of the volume, that we could actually manoeuvre the
22 volume. It might have meant changes to Helme Chase and if
23 that had to happen, that had to happen. But we thought we
24 could come up with a viable reconfiguration if north
25 Lancashire was part of that re-organisation.

1 DR WALTERS: With hindsight, do you think anything
2 could have terminated the situation sooner? Any action on
3 behalf of the PCT?
4 MS PAGE: Gosh.... Million dollar question. You often sit
5 there, don't you, and think, of all the -- that those two
6 maternal deaths -- how we approached the process of managing
7 those serious untoward incidents, we were -- I think, to the
8 best of our ability, we probably managed that quite toughly.
9 We did not shut the cases down. I say that was not easy to
10 do, that was standing against the tide because I knew at
11 that point, having been there, that Monitor could not
12 possibly let them through if these cases were not closed. I
13 mean, you know they certainly would not have let me through
14 in Northumbria.
15 You know, we knew that so we were standing really firm
16 when we really felt we had evidence to say this should not
17 happen. John Ashton particularly was putting the pieces
18 together and acting to try and see whether this was out of
19 the norm and everything. He must have done three or four
20 different levels of investigation which was probably again,
21 more above the norm than many commissioners would have done.
22 Including a confidential inquiry because at the end he said
23 "we are just going to do a root cause analysis on every
24 single one."
25 I mean, that was, that took ages to negotiate with

1 medical directors and you know, put that together to enable
2 us to have access to all the notes and do that and all we
3 were searching for is there an issue here? Even though we
4 were searching through the data, we were searching through
5 the GPs at that point, we were -- you know, if only.
6 Perhaps we could have done more. We tried our best.
7 DR WALTERS: I think what we have to remember is that
8 actually commissioning in 2009 was not quite the same as it
9 is now. The relationships are different.
10 MS PAGE: No.
11 MR BROOKES: Thank you. Just couple of things then. I know
12 Jonathan has got one last question. I think you have
13 just -- we touched on one of the things I wanted double
14 check on because -- I want to make sure that I have got my
15 understanding right in my mind. I believe you said that if
16 you had known about the Fielding Report earlier, that would
17 have been a key trigger in earlier intervention from the
18 PCT. I think that is right?
19 The question really was: was there anything else that
20 could have been triggered it and, I think, there was
21 potentially the SUIs and you have just described the process
22 you were going through. I have seen quality of the
23 responses of the SUIs which varies dramatically from the
24 north and the south of Cumbria in terms of their responses
25 and the way in which they have dealt with those. I can

1 understanding that. But looking at it now, was there
2 anything that you think could have triggered, other than the
3 Fielding Report, earlier intervention?
4 MS PAGE: I think, again, it is with hindsight, isn't it --
5 I think had the PCT not had -- if it had been a normal
6 health economy and all the other fires had not been burning
7 I think that we would have got to maternity services across
8 the county in 2008.
9 I believe that because we were ready to consult on the
10 north and my view at the time and, I think, my team's view,
11 was that it is far better to tackle maternity right across
12 the county and have the conversation with all the women
13 about having safe births and what is safe birth and that is
14 what we wanted to do. That is what John wanted to do and we
15 would have got there earlier.
16 But, I think, you know, we would not have got there
17 because of the triggers of the SUIs or anything like that,
18 we would have got there because it was the right thing to
19 do. That we -- maternity and paediatrics, get that right,
20 because that is certainly the way I have been trained.
21 Whether it be in London on the north east, we were taught to
22 start with children and maternity. Get that safe, then move
23 on to your A&E departments and all your surgical rotas,
24 medical rotas, but go in through the eyes of safe birth and
25 safe children.

1 We tried to do that but, unfortunately, again you see
2 in the north we were knocked off because, even though we
3 wanted to put it in the consultation, we were told not to
4 because the election was looming.
5 MR BROOKES: That was advice from the strategic Heath
6 authority?
7 MS PAGE: That was -- Mike Farrar (CEO NHS North West) ~~Bewick~~ told me I should not do
8 that and the second time we got there, we were in
9 arbitration with north Cumbria over we wanted to consult on
10 maternity, and Mike gave them the money to keep it open. I
11 said, "no, we have got to tackle this" so he said, "no, we
12 cannot tackle it now. There is another election looming" so
13 it was -- we should have done it and I should have pushed
14 that harder in 2008. We should have done it for the entire
15 county, paediatrics and maternity together. But we did not
16 and that was a mistake, I think.
17 MR BROOKES: Thank you, that is really helpful and it sounds
18 like at no stage were you supported by the SHA to move that
19 up the agenda in terms of looking at maternity services.
20 MS PAGE: No.
21 MR BROOKES: Thank you.
22 PROF MONTGOMERY: Thank you. Just want to check I have
23 heard correctly what you have said us to on one point. It
24 is about the nature of the issues around management
25 capability and grip in the Trust.

1 I think I have heard you described that the problems
2 that you saw and tackled through the Gold Command were the
3 same problems as the one you identified at the time of the
4 FT application and had raised to Monitor and, you have not
5 said this, but it would seem also to be the same problems as
6 the Monitor review of management capability that was
7 commissioned in 2012. I want to check that --
8 MS PAGE: Yes.
9 PROF MONTGOMERY: -- my understanding of what you said
10 was that those were problems that both could have been
11 identified were identified at the time of the Monitor
12 application.
13 MS PAGE: Yes, they were. Yes.
14 PROF MONTGOMERY: Yes.
15 MS PAGE: You have to put that against the context of the
16 fact that the organisation, you know, when it was inherited
17 by that quite in experienced team in 2006, in my opinion,
18 you would not put a rookie Chief Executive in a place like
19 that. I was having a hard job and I was fairly experienced
20 in the county. I still, as you see, I am still made
21 mistakes.
22 PROF MONTGOMERY: I think, I'm trying to put my head
23 round was this a deteriorating situation or was it a problem
24 that had been there all the way through. I think, it was --
25 MS PAGE: It was there in 2006. It had not been tackled so

1 it was badly run from the outset. In my technical
2 experience, right, in the way I have been trained and I
3 think that team tried. We saw we saw the shoots. You know,
4 the Medical Director was responding. We saw the shoots;
5 they just were not ready.
6 Now, I actually had a really good relationship with
7 Tony Halsall. It was very professional and I think he would
8 say we got on okay. You know, we got on really well but
9 they were not experienced enough to take this through with
10 all the problems that existed in that organisation. They
11 just were not there.
12 When and FT takes you over I suppose I knew probably
13 more than even anyone in the SHA because I was operational,
14 I knew they would have trouble immediately they hit FT. It
15 was a car crash waiting to happen but, you know, you can
16 only tell the system. It felt a lonely place is all I would
17 say.
18 MR BROOKES: I can understand that. Again, this is not
19 meaning to put words in your mouth, I get a sense that
20 pre-FT, you would expect a very strong performance
21 management from the SHA, in partnership with the PCT
22 commissioning responsibilities. I have a sense from what
23 you said that that was never the culture of the SHA, never
24 its approach compared with what you were used to.
25 MS PAGE: Yes, I probably am able to say that because I came

1 from 17 years in the North-east, and you could see the
2 comparison was just -- in fact, I used to go home at night
3 saying, "God, you know, how can the NHS be so different in
4 two different bits?" I was expecting it to be the same.
5 I know when we have talked about, you know, mistakes
6 and errors, I have assumed they had backed me over maternity
7 and paediatricians because if you went to the North-east, as
8 I did, with a plan to reorganise maternity services in
9 Northumbria, we did it. And we were held to account for it
10 and we implemented it. And I was expecting that in the
11 North West and it was not there. It took me 18 months to
12 two years to realise that, actually, you know, why would you
13 not you hold people to account for implementing service
14 change and they did not even do it in the north and the
15 north is still not sorted because they were not held to
16 account for the change. So it was very different.
17 MR BROOKES: Thank you. Any further questions? No. That
18 has been very, very helpful thank you very much for your
19 time.
20
21 ______________________

THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Wednesday, 14 January 2015

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

Before:

Dr Bill Kirkup CBE – (Chair)
Mr Julian Brookes, Expert Advisor, Governance
Professor Jonathan Montgomery, Expert Advisor, Ethics

KIRK PANTER

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(At 2.11 p.m.)

THE CHAIR: Okay, thank you for coming. My name is Bill Kirkup. I'm chairing the Panel. I'll ask my colleagues to introduce themselves to you.

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

PROF MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Healthcare Law at University College London and chair of the Health Research Authority, but in the past I've chaired on a couple of provider trusts, PCT and SHA.

THE CHAIR: You'll see that we're recording proceedings; we'll produce an agreed record at the end. You may also know that we have opened proceedings to family members as observers. As it happens we don't have any here for this session, but they may listen to the recording subsequently.

You also know that we've asked you to hand in any –

MR PANTER: Mobile phones?

THE CHAIR: ...mobile phones and recording devices. Just to emphasise that we don't want anything to go outside the room until we produce the report with everything considered in context.

If you have any... I've said this so many times that I've lost my way there. Do you have any questions for me about the process?

MR PANTER: No, no.

THE CHAIR: Okay. Can you just start off by explaining for me what your position is and how long you've held that?

MR PANTER: I'm currently a nurse at the University Hospitals of Morecambe Bay. I started as a Student Nurse in 1989, qualified in 1992. For over 25 years, I have been an accredited staff representative with the Royal College of Nursing, but I'm not here in that capacity. For most of that time, I've had sort of a staff-side role just above an accredited representative, so probably from the early 1990s I think I was a staff-side secretary and probably for the last 4-5 years I've been staff-side chair.

THE CHAIR: Okay. Do you work in Lancaster?

MR PANTER: I work as a theatre nurse two days a week at the Royal Lancaster Infirmary.

THE CHAIR: Right.

MR PANTER: And then the other three days of the week – it can be a bit flexible – I work as an accredited representative and in the staff—side chair role, for which I do have a

1 job description.

2 THE CHAIR: And do you get round the three main sites doing that job?

3 MR PANTER: Quite a lot at Kendall, because a lot of meetings tend to be at Kendall,
4 certainly a lot at the RLI. I have an office at the RLI, and I do, a number of times a
5 year, get up to Barrow, but I don't tend to get a lot of meetings up there.

6 THE CHAIR: Okay.

7 MR PANTER: So that's the least frequent site for me, Barrow. Given that it's a three-hour
8 round trip I do try and avoid it, because you're spending three hours of your time
9 travelling.

10 THE CHAIR: Yes, okay. I think you got in touch with us. So, could you just explain the
11 background to that? What led you do that?

12 MR PANTER: I think I'd taken an interest in it and sort of looked on the website. And I
13 think it was a few weeks ago you interviewed a former colleague of mine,
14 Russ Dunkeld, about –

15 THE CHAIR: Sure.

16 MR PANTER: …whistleblowing and, clearly, as a nurse technically I have nothing to add in
17 terms of midwifery, because I don't know anything about it, but I felt given the time
18 I'd been at the University Hospital I may be able to add something about the culture
19 of whistleblowing, having raised… I don't like the word 'whistleblowing'; I tend to
20 think of it as raising concerns. So, you know, you haven't always got the evidence
21 and it's something I have done – you know, raised concerns when I thought it
22 appropriate – over the last 25 years.

23 Primarily, I think, as a nurse, but perhaps using my skills that I've learnt as an
24 accredited staff representative and, also, as sort of staff-side chair you feel as well…
25 You know, you look at – if something's wrong, you do want to raise issues, so it
26 might be in terms of, you know, proposals about cost improvement that might have
27 an impact on patient care, might have an impact on staff – so, again, I would respond
28 to those, so I've had that sort of role now for the best part of 15 years.

29 THE CHAIR: Okay, so what's your observation on how this Trust does respond?

30 MR PANTER: I suppose one of the things is it is very difficult being a whistleblower. And,
31 you know, I've had some difficult times with the Trust. And it goes back a long way.

32 I think it was back in the early 1990s. We had problems with the behaviour of
33 a senior member of the medical team, so I met with the chief exec and they did a big
34 investigation. And the worry was that sometimes things aren't dealt with. It was

1 another eight years before sort of that – and that's how it sort of resolved, that the
2 person sort of left, so…
3 So, you do worry that just because you raise something it can be a number of
4 years before, sadly, something gets done.
5 THE CHAIR: Is it because something else happens eight years down the line?
6 MR PANTER: I'm not sure. I think it's – in that particular case, because it was used as a
7 case study by Public Concern at Work. It was a big investigation. You know, the
8 person was spoken to. 'You need to sort your behaviour out.' And then the problem
9 is that there was another incident a couple of years later, and I don't think that was
10 dealt with particularly well. And, as well, I think some of the things I've done – and
11 I do worry there's a sort of attitude, 'Well, you need to witness it.' And I do
12 sometimes worry that…
13 One example – it was about four years ago – was there'd been an altercation
14 between two members of staff and I sat in the staff room and heard about it.
15 Someone had been verbally abusive, so I felt that was unacceptable behaviour. I sort
16 of raised it and one of the problems is that I was told, well, it had been dealt with.
17 And you're not convinced about that, and when I said, 'Well, you know, can
18 you tell me what it was like?' 'Well, it's none of your business.' One of the worries
19 is that for people raising concerns – you know, you get into that confidentiality. And
20 are you convinced that the thing has been dealt with?
21 I remember once, I think… If I go back, I'd sort of done a timeline. So, back
22 in 1994 I did raise a concern about behavioural problems with a senior member of
23 the medical team, and it went on for a number of years. I remember once going in
24 just to follow up a few issues, and I remember it was the chief exec of a good few
25 years – you know, and you realised how difficult… And the [comment was – and I'd
26 saved this one up?] 'I'm not interested it's you again.'
27 And I do worry… And there was an article in *The Times* about – in praise of
28 whistleblowers. And it said we can be difficult people, because I'm often going off
29 what people… Because people themselves are reluctant to raise the issue, so you
30 have to be quite persistent.
31 Again, in background – a bit like Russ, I have some issues with the way the
32 Trust have treated me
33
34

1 And I think one of the other issues, because you are looking at sort of, as well,
2 when the investigation went back to 2004 – because there are two big areas, aren't
3 there? There's 2004 and 2008.
4 THE CHAIR: We're looking at the period from 2004-2012.
5 MR PANTER: One of the reasons that I was considering – and I did mention this a while
6 ago, and it was only when I saw Russ in the paper had been – was that sometimes
7 you see small things. And one of the things – I'd been seconded to Improving
8 Working Lives. I remember it was a project from the government, and back in 2002
9 we were assed for practice and because I wasn't working as a nurse I got a
10 secondment to do with Practice Plus.
11 And I found a report as part of the practice assessment – and this perhaps
12 illustrates one of the problems – was that people had come in to do this practice…
13 So, it's not to do with patient care; it was to do with the working lives of the staff,
14 and then I had taken over. So, the report had been done in 2002 and then about 2005
15 I took over as the project lead for the staff side.
16 So, we had a report that we'd been shown at the time, and stuff had been added
17 about how the assessors had got it wrong and things like that. So, when I took over I
18 actually found a copy of the original report without all the additions – I've got copies
19 here – and I just happened to be looking through a particular section. And it was to
20 do with the consultants' dining room, a fairly trivial matter, but what worried me was
21 a sentence had been removed. There was a sentence in the original report, but the
22 report we'd been shown a few years earlier…
23 And it does worry me, although that was quite… And I made a non-exec
24 aware that that happened.
25 THE CHAIR: What was the sentence that had been removed?
26 MR PANTER: It was… I've got it back here. Just to give you an example, so in the original
27 report it said, 'The Medical Director indicated a commitment to deal with this
28 iniquity', and the previous sentence was, 'The Trust operates a consultants' dining
29 room that was noted by many as a significant symbol of inequality.'
30 But when the original report I'd seen that had the additional comments was that
31 sentence was missing about that he agreed to deal with the problem, so it worried me
32 that, given that that was an SHA report, who actually did that? Because people had
33 left that'd been involved in that originally, they couldn't get to the bottom of it.
34 MR BROOKES: Can I just clarify when that was, sorry?

MR PANTER: This was in 2002, but I didn't discover it until 2005.

MR BROOKES: Okay.

MR PANTER: And my worry was, if that was the culture in the run-up to 2004, that even something like an SHA report… I also followed –

THE CHAIR: Can I – I'm sorry to interrupt you, but it is slightly outside the period of reference, but I'm actually pretty surprised that they still had a consultants' dining room in 2002.

MR PANTER: Yeah, it was –

THE CHAIR: That's pretty unusual.

MR PANTER: Yeah, so what worried me was I'd discovered that, which was fairly trivial, but was that happening in other areas?

THE CHAIR: No, I understand the point about removing the sentence from the report. I understand that. I was just – it made me raise my eyebrows to still have a consultants' dining room. I thought they'd all gone a long time before 2002. Was that at RLI or…?

MR PANTER: That was at the RLI, yeah. And also I did follow things up. And, again, if we're talking about the culture, in the same way as Monitor come in, which we've talked about, CQC have come in. Again, in that period, there was, I think, five people came in and they actually spoke to them, the people who'd come in. Because, obviously, there was a bit of a gap from 2002-2005.

And, again, what they wanted was, for continuity, to bring other people in who'd been in in 2002 to come back in 2006, I think it was. And they actually said, 'I'm not prepared to come back, because of the way we were treated.' And I did speak to one of the people as well. There was a lady, [Zara[redacted]?], who was the SHA lead. And I said, 'What was it like?' because I hadn't been heavily involved.

And she said, 'The way we behaved was highly unusual in terms of the way we…' So, it worried me not only was I picking up that somebody had decided it was a good idea to remove a sentence, but somebody said, 'Well, I'm not prepared to go back and assess.'

And it's like the CQC recently, you know? They came in in – what was it? – back end of 2013 and then came back in 2014. If one of the CQC said, 'Well, I'm not prepared to go back in there because of the way I was treated'… So, I worry that in that 2004 period things were quite difficult.

THE CHAIR: Treated by who, though?

1 MR PANTER: I'm assuming the people who were involved in the... You know, when they
2 were coming in you obviously have people –
3 THE CHAIR: The interview people?
4 MR PANTER: The interview people – I think it was more the people who were managing the
5 process at the time, because I only came in for the Practice Plus.
6 THE CHAIR: Right, okay.
7 MR PANTER: There were things – I remember one...
8 PROF MONTGOMERY: Could I ask... Before I lose track of it, you said you raised it with
9 a non-executive director.
10 MR PANTER: Yeah, yeah.
11 PROF MONTGOMERY: Tell us about how that person responded.
12 MR PANTER: It was somebody – June Greenwell – that was on the list, and I think the first
13 response was, 'What do you expect me to do about it?' and I thought, 'Well, it's not
14 my remit.' And I think the problem they had was that... The answer I got was,
15 'Yes, it shouldn't have happened,' but given that the people had left it wasn't
16 something they could take outside the organisation.
17 PROF MONTGOMERY: And did you hear any more after that conversation?
18 MR PANTER: No, but I think when the new chief exec came it was actually removed as a...
19 Because it was seen as a bit of an embarrassment that they'd agreed to deal with it
20 and then it was a good 4-5 years before they actually did it. It caused a bit of bad
21 feeling, but sometimes small things do.
22 PROF MONTGOMERY: Thank you.
23 MR PANTER: And then I was... I mean, sometimes people used to get annoyed. One of the
24 earlier examples – it must have been around that period.
25 I remember I'd done a press release about a problem, and I was working as a
26 nurse at the time and I remember getting a phone call from one of the directors, who
27 thanked me for 'being fucking helpful' and slammed the phone down on me. And,
28 again, you think, if that's the culture you really need to be quite strong to challenge
29 things. And that...
30 THE CHAIR: Can you just talk me through what the incident was?
31 MR PANTER: On that one, it was... It might have been about staffing levels or something,
32 but the press had asked for a comment and I'd said what I thought was true. And we
33 didn't really get into discussions; it was just, 'We're very unhappy' – that I'd made a
34 comment to press.

1 And sometimes – you know, as a more recent example, bringing it right up to
2 date to show... Was it back in...? You've picked up the problems when the CQC to
3 do an unannounced inspection on Ward 39, which came about as an anonymous
4 whistleblowing, so we're talking about whistleblowing.
5 And in discussions – because I was working in theatres at the time and when
6 they came in... Because the theatres are next door to 39, they asked me to be pulled
7 out of theatre and, in my role as a union rep, the CQC interviewed me. And we kept
8 up a bit of an email correspondence, and one of the comments he said was...
9 And when I looked at the report, which is in the public domain, was that
10 internally there was a trail of emails where people had... Because it was primarily to
11 do with staffing levels on 39 and Ward 39 didn't exist until – was it November 2012?
12 So, it was a very new ward, so staff had been raising concerns about staffing
13 levels on there. There was a trail of emails, but what seemed to have happened is it
14 was only when somebody anonymously raised the concern with the CQC that the
15 CQC came in, and then they were actively recruiting more staff.
16 It's certainly a lot better now, but the worry was even as late as 2012 staff –
17 you know, there was evidence that staff were raising concerns internally, but the
18 worry was for me that it was only when the CQC came in, made the report that staff
19 were going home in tears and stuff like that.
20 And I think from the staff's point of view I think it was a positive report,
21 because it said how hard they were working; there just wasn't enough of them.
22 THE CHAIR: Sure.
23 MR PANTER: But, for me, if you pick up one lesson, it was the fact that they tried to say
24 there were problems for a year and then it required somebody to write an anonymous
25 letter to the CQC and the CQC came in, and then things really started to improve. I
26 mean it took a while, because they came back and there were still a few problems.
27 THE CHAIR: What was the nature of the staffing issue that caused the pressure? I didn't
28 quite get what...
29 MR PANTER: Right, in terms of 39?
30 THE CHAIR: I don't know. You said there had been an incident –
31 MR PANTER: Right, so, in terms of 39 –
32 THE CHAIR: ...where somebody picked up the phone and said there was a –
33 MR PANTER: No, this was a... What I'm saying is this was... Again, I'm sorry. I'm
34 jumping about a bit. This was back in that run-up to the 2004 bit.

1 THE CHAIR: Okay, okay.

2 MR PANTER: And what I'm saying is there's still…

3 THE CHAIR: And what was the staffing issue then?

4 MR PANTER: In terms of 39?

5 THE CHAIR: No, in the run-up to 2004. You didn't say where it was or what the nature of
6 the problem was.

7 MR PANTER: I have to be honest on that. It was so long ago – you know, you're going back
8 a long way. All I remember is that – I've probably got the press cuttings somewhere,
9 but when you're working looking after patients and somebody rings you up and
10 swears at you down the phone –

11 THE CHAIR: Yeah, sure.

12 MR PANTER: I have to say I can't remember what it was about. I knew it was to do with a
13 press release; I can't remember the exact details, but I do remember that when
14 somebody… It comes as a bit of a shock when you're in the middle of a clinical shift.
15 In terms of… It was the same sort of thing where, you know, we'd opened a new
16 ward; we'd got a new team in. And we still, clearly – when you're assessing how
17 many people you need and stuff like that…

18 THE CHAIR: Yeah, sure.

19 MR PANTER: And what I'm still a bit unclear of is to say from that 39 experience – you
20 know, where staff had raised concerns for 12 months and it seemed to be only when
21 the CQC were brought in – is what lessons can you learn even quite recently to say,
22 what went wrong when the staff were…

23 PROF MONTGOMERY: Do you think the culture of the Trust in relation to raising concerns
24 has changed since that period in 2004?

25 MR PANTER: I think we're better; we're far better. But I do think we're not there. We've
26 still got work to do in terms of responding internally.

27 PROF MONTGOMERY: So, if I can just a bit clearer in my mind, I understand it will be
28 true of lots of places – you're never perfect.

29 MR PANTER: No, no.

30 PROF MONTGOMERY: But can you illustrate for us something that you think would be
31 handled better now than it was when it was handled, say, in the early 2000s?

32 MR PANTER: I'll give you one small example. Again, it was not a clinical issue; it was to
33 do with one of our policies. And because of staffing problems at a senior level, we'd
34 had to – we'd agreed to suspend the policy and do things in a slightly different was

1 to help the Trust out.

2 And what happened was we carried on not doing what we'd agreed to do, but
3 on a lot longer basis. So, I asked a question in a meeting, for example, 'How many
4 times have you not done what we'd agreed to do?' and the answer was, 'No, we've
5 always done it,' which I didn't think was true.

6 And I raised that concern at director level and within a very short period of
7 time I actually got an apology, somebody saying, 'I'm sorry. I did mislead you over
8 that.' And I think for me that was only a small thing, but it was quite significant.

9 PROF MONTGOMERY: Would you say that's the norm now? It won't be perfect every
10 time, but normally you'd expect to get a response like that now.

11 MR PANTER: Yeah. And I think they are a lot quicker, and I think we were still having
12 significant problems up to the Ward 39, but I think Ward 39 – because it happened
13 on... It wasn't something you could blame on people who'd left; it was still there.

14 So, I think it came as a wake-up call to say, 'Things still aren't right.' And the
15 fact the CQC came back twice and gave a report saying, 'You've still got problems,'
16 you know, I think we are facing up to those issues a lot better now.

17 PROF MONTGOMERY: The other thing I wanted to ask was whether or not there were any
18 particular issues around maternity care that you were aware of having been raised?

19 MR PANTER: The only – I think one came up at a meeting I was mentioning before. I think
20 in the early days there was a... I think Tony Halsall had done some house calls and
21 you sometimes think, 'If you're going to do that you need to be very, very well
22 prepared' – and I'm not perhaps sure that was the case.

23 PROF MONTGOMERY: House calls to staff at homes?

24 MR PANTER: No, he was meeting the families, I think. So, I think that was commented on
25 at the time, but the only other one – because most of what I saw, because I'm not a
26 midwife so I wasn't involved in the... And particularly given that it was at the
27 Barrow end of the patch, and given my experience, I think it was when the coroner
28 made the comment about the temperature chart going missing.

29 My experience said that could probably trigger something happening and
30 going far wider, and I think that was when you followed the chain of events and they
31 started looking into what the CQC said previously, what Monitor had said.

32 And I think, again, going back to why I'm here, I suspect that – you know, my
33 gut feeling is that when recommendations are made and why I thought as a nurse,
34 rather than a midwife, I could contribute – and as a staff rep – about whistleblowing

1 was that I suspect the recommendations that come out of this will go far beyond the
2 midwives, and that's why I felt I wanted to just sort of make a small contribution.
3 PROF MONTGOMERY: So, are you aware of any specific recommendations that came out
4 of reports into maternity services that were discussed about having broader
5 significance?
6 MR PANTER: Not in the [inaudible]... No, I know a lot has been done in midwives and I'd
7 sort of, I think... [inaudible], you know, the midwifery full-time [inaudible] – they're
8 sort of heavily involved in that side of it, because at the moment I think it's been very
9 technical in terms of the governance arrangements and bringing new people in,
10 because midwifes work in a different way, don't they?
11 It's a specific role, isn't it? It's midwifes – they've been supervised as
12 midwives, which I don't fully understand as a nurse, but clearly that's been as a very
13 significant step forward from the early recommendations.
14 PROF MONTGOMERY: Thank you.
15 THE CHAIR: Okay, Julian?
16 MR BROOKES: For my knowledge as much as anything, a very brief description of how
17 you interact as staff-side rep with the Trust and what areas you get involved with...
18 MR PANTER: In my role as staff-side chair, my main role is we have probably at least
19 monthly meetings either with senior managers or directors. It's probably more related
20 to sort of employment relations rather than the clinical issues. You know, we do get
21 an update in terms of how the investigation – the timescales and things like that.
22 Bimonthly, one of the meetings we have sort of every other month tends to
23 focus on policies, disciplinaries, grievances and things like that – but clearly the
24 whistleblowing policy which was revamped a year or so ago. Something like that
25 would come through us.
26 When we meet with the directors on the second month, they're focusing on sort
27 of strategies and things like that. We had a difficult time back in 2013, because of our
28 financial difficulties. There was a proposal for a reduction of 270 frontline staff, and
29 this morning when I was coming in the *Lancaster Guardian* rung me up, because
30 they've been looking into staffing levels.
31 And, obviously, our concern was if you take out 270 frontline staff it will have
32 an impact on patient care. It was difficult for us to argue that, and again I think it was
33 the CQC coming in and saying, 'No, you need more staff on the frontline.' And for
34 me that probably one of the most significant things in the recent improvements.

1 An example I give is, as staff—side chair, I'm involved in the staff induction.
2 And if I was there – I was there 3-4 years ago or at least three years. The room, every
3 month, would be half empty. In the last 12-18 months, perhaps longer, when I go into
4 an induction meeting where all the new staff are, the room is quite often full and there
5 might not be a spare seat, so it tells me there's a lot more people coming into the
6 organisation, and for me – we are reviewing policies, but for me that's probably the
7 biggest…
8 PROF MONTGOMERY: And why do these inductions happen?
9 MR PANTER: Once a month at Lancaster, once a month at Barrow. My colleague does the
10 ones at Barrow. So, it's all the new staff. They try and get them in as nearest to the
11 start date, and I do say… When they talk about staffing levels, which crops up – we
12 have a bit of an open session, and what concerns them…
13 And, certainly, you know, given what had been in the press they were worried
14 about staffing levels. And I say, 'If I'm coming in to a meeting once a month and
15 there are significantly more people starting in the organisation, it makes you think…'
16 MR BROOKES: So, as a staff-side rep and then as chair, again you're involved in policies. I
17 understand that and I understand where the main focus would be, which would be
18 around HR issues. However, were you ever engaged, discussed in terms of the
19 approach the Trust was taking in terms of the governance of the organisation?
20 MR PANTER: Probably not in those meetings. I do have a seat on the board – and, again,
21 you know, there was…
22 MR BROOKES: So, you attend all the board meetings.
23 MR PANTER: Yeah. And I think one of the steps they took – there was a period where they
24 were going to change from a Director of HR to a Director of Governance. And they
25 decided – we did tell them, 'You need a Director of HR,' so I think what they did…
26 The Director of HR was made redundant; they brought in a Director of Governance
27 and then said, 'We actually need both.'
28 MR BROOKES: Yeah. So, just to be clear, those wouldn't come across the staff-side…
29 Governance issues etc wouldn't come across the staff-side.
30 MR PANTER: No.
31 MR BROOKES: Okay. But then you have a seat on the board.
32 MR PANTER: Yeah.
33 MR BROOKES: I assume as an observer.
34 MR PANTER: Just as – yeah, in the public part of the meeting.

1 MR BROOKES: How long have you been doing that?
2 MR PANTER: Probably… I took over probably about four years ago, so prior to that… I
3 think historically it goes back quite a way that the staff-side chair had a seat on the
4 board.
5 MR BROOKES: So, you've been there since 2010-ish, 2011.
6 MR PANTER: Probably, something like that, yeah.
7 MR BROOKES: In that period of time, can you give me a flavour of the kinds of discussions
8 the board had on governance?
9 MR PANTER: I'd probably give… One recent example is there's been the issue of breast
10 screening that you've probably picked up on. So, the report went into the public
11 domain and in the public meeting there was a discussion on what the report
12 recommendations were, and obviously they were reassured – I think they said they
13 didn't feel there'd been anything detrimental to patients, but there were some quite
14 serious behavioural issues and if those weren't sorted out there'd be an impact on care.
15 And, again, I think it was one of those things that was an important – that in
16 the past they'd been reluctant to say about behavioural issues… 'That should be dealt
17 with privately.' And I think I was very impressed that when that issue came up about
18 the behaviours, because it was in the report in the public domain, they said, 'No, we
19 need to discuss that because that's the problem. If we don't sort that out, then there
20 may be an impact on patient care.'
21 So, yeah, there was a discussion then. Unfortunately, the agenda's very big, so
22 they were saying, 'Well, we're putting these…' I can't remember off the top of my
23 head, but, 'We're putting things in place to sort out the…' So, that would be one
24 example.
25 MR BROOKES: So, that's one example.
26 MR PANTER: And a very recent one.
27 MR BROOKES: Is it something you feel was routinely in the agenda? Was governance
28 routinely on the agenda? Was it a topic of discussion?
29 MR PANTER: Yeah, I think the minutes from the governance committee and various
30 committees are at the back of the report. I know any key findings are… I think they
31 sort the report by exception, so, yeah, it is an item on the board, which perhaps it
32 wasn't, you know, if we're going back. Because I sometimes used to – although I
33 didn't have a place, I used to support the previous chair. And to that level I don't think
34 it was featured in the public part of the meeting. I think that's…

1 MR BROOKES: That's what changed.
2 MR PANTER: That's what changed, because there is probably more going into the public
3 part of the meeting than they had previously.
4 MR BROOKES: Okay. If I can just ask you one final area of – which is more about your
5 role as an employee in the Trust, as a nurse working in theatres etc. Can you just
6 describe to me your understanding of the governance of the organisation? How it
7 operates, how would you report an issue? How would you get concerns – not as a
8 staff-side member, but as a member of – as an independent person?
9 MR PANTER: If I was operating as a nurse, then electronically there's a clinical-incident
10 report, so at a level as a Staff Nurse it would be putting that incident in and saying
11 whatever it was, a medication error or something like that, so you would put that
12 report in.
13 And I think there was one – I don't want to go into detail, but there was one
14 where I a present and then they obviously do the rapid reviews, so somebody's
15 allocated to do it, so I'm fairly sure that I was given a copy of the comments that were
16 made and how to prevent that.
17 MR BROOKES: And what happens to them then?
18 MR PANTER: In terms of… I think there was –
19 MR BROOKES: The rapid review is being done. What happens to it? Do you understand
20 how it flows through the system?
21 MR PANTER: Yeah, so, I think in another incident – it depends what's appropriate in the
22 case. So, there was another incident, again, where there was a practice that had
23 developed that wasn't particularly proper. I think it was the CQC had picked up on it,
24 so it was reviewed; they followed it through; and then the standard operating
25 procedure was modified to fit in with the findings.
26 So, that's quite often the way. If it is a clinical issue, they'd review what's
27 happening and then amend the standard operating procedure. I mean, it's quite a
28 difficult one, because one of the questions I ask that you sort of pick up on is there's so
29 many standard operating procedures because there's so many things going on.
30 That's one of the difficulties of working clinically – actually how many
31 standard operating procedures… You need to know where they are.
32 MR BROOKES: And how well embedded do you think the governance system is in the Trust?
33 And how well educated, exactly as what you were just saying there, do you think our
34 individual frontline staff, in knowing what to do in particular circumstances?

1 MR PANTER: For clinical frontline staff, about – now, I think that has made significant
2 strides forward, but I think the governance arrangements are still... The changes are
3 still fairly new, so I still think there's quite a way to go in making sure that the
4 frontline...
5 MR BROOKES: Can you give me an example of what still needs to be done?
6 MR PANTER: I think it's probably – one example would be that, particularly, you know, in
7 the area where perhaps something happened, they'd be aware of the standard operating
8 procedures, but again one thing that would be difficult – if you're saying, 'Well, it
9 might happen somewhere else' – is making sure that the people in those other areas
10 are aware, I think. And it is a challenge, that, when you're talking about so many of
11 them.
12 MR BROOKES: Thank you.
13 PROF MONTGOMERY: I just have one quick area, I think.
14 THE CHAIR: Sure.
15 PROF MONTGOMERY: Just going back to the observing of the board and your observer
16 status on that, I wonder whether you've observed or been part of any discussions of
17 quality of maternity services while you've been an observer on the board.
18 MR PANTER: I'm trying to think, in the public part of the... I'd struggle to actually recall a
19 specific... Yeah, I'm sorry about that.
20 PROF MONTGOMERY: Thank you. And just very quickly, just in case, one of the things
21 we've been trying to understand is how the board dealt with the Pauline Fielding report.
22 Did you ever see that report as part of the meeting you were part of?
23 MR PANTER: I'm sorry, no.
24 PROF MONTGOMERY: No, that's fine.
25 MR BROOKES: Does that report mean anything to you?
26 MR PANTER: I'm sorry, no.
27 MR BROOKES: That's fine.
28 MR PANTER: No.
29 THE CHAIR: Okay, fair enough.
30 MR BROOKES: Thank you. That's very helpful.
31 THE CHAIR: Is there anything else that you would like to tell us?
32 MR PANTER: No, I think I've sort of... Hopefully I've just given you a bit of a flavour –
33 THE CHAIR: You have.
34 MR PANTER: ...of somebody who's been around a long time and been involved in those

1 sort of…

2 THE CHAIR: Okay, thank you very much. Thanks for coming.

3 MR PANTER: Thanks for your time. Thank you.

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THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert advisor on Paediatrics
Ms Jacqui Featherstone – Expert advisor on Midwifery
Professor James Walker – Expert Advisor on Obstetrics

HOLLY PARKINSON

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7th Floor, 61 Southwark Street, London, SE1 0HL
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1 DR KIRKUP: Thank you for coming. My name's Bill Kirkup and I'm chairing the
2 Panel. I'll ask my colleagues to introduce themselves to you.
3 PROF FORSYTH: Hi, I'm Stewart Forsyth and I'm a paediatrician and medical
4 director from Dundee.
5 MS FEATHERSTONE: I'm Jacqui Featherstone. I'm head of midwifery and head of
6 nursing at a district general hospital in Essex.
7 PROF WALKER: Jimmy Walker. I'm an obstetrician and professor in Leeds. I've
8 got a background working with the National Patient Safety Agency and clinical
9 governance in general.
10 DR KIRKUP: As you'll see, we're recording proceedings, and we'll make an agreed
11 record at the end. We also have family members in attendance as observers.
12 They won't be taking part in anything other than observing, and they may also
13 listen to the recording subsequently. Do you have any questions for us about
14 the process or can we start the interview?
15 MS PARKINSON: No, I've read the information that we've been sent, and it seemed
16 quite clear.
17 DR KIRKUP: Okay. I should say that we don't want to discuss individual cases in
18 the first part of the interview. We'll have a short break and ask if the observers
19 can leave and we can talk about anything that is clinically confidential and
20 refers to individuals, okay, so first part not confidential information. I'll start off
21 by asking you if you would tell us when you started at the hospital and what
22 you've done in the hospital subsequently.
23 MS PARKINSON: My first point was a student nurse in 1997, which was three years.
24 I worked as a qualified nurse for roughly a year before training as a midwife. I
25 did an 18-month course. My practice was based at Furness General, and my
26 theory was at Carlisle, at St Martin's College, it was then. And then, since
27 qualifying in 2003, I've remained at Barrow Hospital.
28 DR KIRKUP: And worked as a midwife there since 2003?
29 MS PARKINSON: Yeah. The first – if my memory serves me right, I think probably
30 the first year took little while to obtain full-time hours. It was bank work and we
31 got a short contract at Westmorland General, Helme Chase, worked at
32 maternity unit there, approximately four weeks, then, yeah, back to Barrow.
33 DR KIRKUP: And are you still working at the hospital?
34 MS PARKINSON: Yes, I am.

1 DR KIRKUP: Okay, thank you. Jacqui?

2 MS FEATHERSTONE: I just want to start. From your qualifying, just tell me what
3 sort of the process was. Did you have a preceptorship and how did it work
4 and did you rotate them? How did you – as soon as you qualified, what
5 happened?

6 MS PARKINSON: As a –

7 MS FEATHERSTONE: Midwife.

8 MS PARKINSON: It did take a little while for us to obtain full hours, so the bank
9 hours that we had, we weren't under a preceptorship programme, but then we
10 did – at some point in that year; I'm not too sure when – we did have a
11 preceptorship programme, but, from memory – I can't remember what was
12 involved.

13 MS FEATHERSTONE: Okay. Was it for a particular amount of time or just – did you
14 have competencies to get?

15 MS PARKINSON: I'm sorry, I can't remember. I can't remember.

16 MS FEATHERSTONE: Okay. Where did you first work when you first qualified?
17 How did that work? Were there other students, newly qualified midwives with
18 you?

19 MS PARKINSON: There was two based at Barrow. Do you mean in the same shift?

20 MS FEATHERSTONE: No, as in you all started together, so did you then go to
21 labour ward first and then go somewhere else, or what happened? When you
22 first qualified, where did you go within the unit?

23 MS PARKINSON: I think it was both areas, labour ward and the maternity ward.

24 MS FEATHERSTONE: Okay, and then how did it work? Did you rotate round or did
25 you...?

26 MS PARKINSON: Yeah, well, as part of the ward – labour ward practice, we used to
27 go on a three-monthly basis to labour ward for a month before returning back
28 to the ward.

29 MS FEATHERSTONE: Okay, so, over the last 10 years, where have you worked
30 within the hospital?

31 MS PARKINSON: I've worked in maternity ward. I've worked on labour ward. I did
32 roughly about six months with community.

33 MS FEATHERSTONE: So you've been everywhere, really.

34 MS PARKINSON: Pardon?

1 MS FEATHERSTONE: You've been everywhere. You've been all round.
2 MS PARKINSON: Yes.
3 MS FEATHERSTONE: And does that continue? Are you still rotating round?
4 MS PARKINSON: There's no specific rotation at the moment. We attend for the shift,
5 and then you're allocated where you work. Community have their own base,
6 but, for labour ward and maternity, we arrive and the coordinator then
7 coordinates where the staff go, but there's no specific rotation.
8 MS FEATHERSTONE: Okay, but generally you work everywhere so everybody goes
9 to each of these places.
10 MS PARKINSON: Yep.
11 MS FEATHERSTONE: Okay, and, when you first started, did you have a supervisor
12 of midwives?
13 MS PARKINSON: Yep.
14 MS FEATHERSTONE: Have you still got the same supervisor?
15 MS PARKINSON: No, because my supervisor's left now, so that's changed.
16 MS FEATHERSTONE: And you have regular meetings with your supervisor.
17 MS PARKINSON: Yep.
18 MS FEATHERSTONE: Annual reviews?
19 MS PARKINSON: Yep.
20 MS FEATHERSTONE: Okay, and record keeping audits with them?
21 MS PARKINSON: Yes. Yeah, we take our notes along and they review your notes,
22 yeah.
23 MS FEATHERSTONE: Okay, and mandatory training, did you do everything on a
24 yearly basis?
25 MS PARKINSON: We did do, or we still do obstetric days. I'm unsure when they
26 started.
27 MS FEATHERSTONE: Okay, so do you have maternity mandatory days, as well as
28 trust mandatory days, now?
29 MS PARKINSON: Yes, we do.
30 MS FEATHERSTONE: Okay, and that still attends and everybody does their yearly
31 update; that's already sorted for you.
32 MS PARKINSON: Yeah.

1 MS FEATHERSTONE: So, just generally, when you're working on the ward, would
2 you say the relationship with the medical and the nursing and midwifery staff is
3 good?
4 MS PARKINSON: Today?
5 MS FEATHERSTONE: Then, when you started, and –
6 MS PARKINSON: Yes, I thought it was good at the time. If I'm to look back in
7 comparison to how we work now –
8 MS FEATHERSTONE: It's good?
9 MS PARKINSON: I can see the difference from previously to today's practice.
10 MS FEATHERSTONE: Okay, just explain what you mean by that.
11 MS PARKINSON: I think the medical staff and the paediatric staff have a stronger
12 presence now on the maternity unit. I think they're more visible. I think we
13 see them a lot more. They seem more readily available to us.
14 MS FEATHERSTONE: On every shift, is there always a lead midwife?
15 MS PARKINSON: Yes, there's a labour ward coordinator who mainly coordinates
16 labour ward, but is responsible for maternity too, and the maternity ward is
17 allocated a shift leader.
18 MS FEATHERSTONE: And that's obvious when you walk onto the ward that you
19 know who that person is.
20 MS PARKINSON: It's highlighted on the off-duty, yeah.
21 MS FEATHERSTONE: Fine, okay. If there's a complaint or an incident happens,
22 how do you know about it? How do you find out...? If you're working on a
23 shift, how is it cascaded to you, communicated to you, that something has
24 happened so that information is shared?
25 MS PARKINSON: On that particular day, if there was a complaint that particular day?
26 MS FEATHERSTONE: Yes, do a particular day, first, yeah.
27 MS PARKINSON: I think it would probably come via the shift leader or the
28 coordinator who'd inform you.
29 MS FEATHERSTONE: And what would you say generally the way of dealing with
30 that on a day-to-day basis is, if something happens like that?
31 MS PARKINSON: I think they would maybe put an incident report in.
32 MS FEATHERSTONE: Yeah, I just meant to deal with it on a day-to-day basis, as
33 opposed to... Then something happening within the unit that you may not

1 have been on shift, how is it cascaded? How is it communicated? What sort
2 of communication channels do you have?
3 MS PARKINSON: Sorry, I'm not sure –
4 MS FEATHERSTONE: If something happened, anything, how is things
5 communicated within the unit?
6 MS PARKINSON: Verbal, written. Quite a chunk is done by email.
7 MS FEATHERSTONE: Do you have any monthly meetings that are multidisciplinary?
8 MS PARKINSON: Yeah. We have a ward meeting monthly that I assumed
9 everybody's invited to.
10 MS FEATHERSTONE: And is there a set agenda?
11 MS PARKINSON: The agenda is posted on our noticeboard, where people can add
12 in what they want to discuss.
13 MS FEATHERSTONE: So is there a set agenda where you would have governance
14 issues discussed at that meeting?
15 MS PARKINSON: No, not at that meeting. I know that there are governance
16 meetings within –
17 MS FEATHERSTONE: Have you ever attended?
18 MS PARKINSON: No.
19 MS FEATHERSTONE: No, okay, and what do you understand happens at the
20 governance meetings?
21 MS PARKINSON: I think they look at incidents, and perhaps discuss them and find
22 out what we've learnt and then they disseminate that information through a – I
23 think it's monthly – we have a newsletter, monthly newsletter.
24 MS FEATHERSTONE: So that's how you would find out and lessons learnt through
25 a newsletter.
26 MS PARKINSON: Yeah. I think it is titled 'lessons learnt'.
27 MS FEATHERSTONE: Okay, and is there any other meetings that you would attend
28 to, that you're invited to, as a multidisciplinary with other meetings within the
29 unit? Anything – nothing else that you attend? So the ward meeting is your
30 main communication for you that is fed down, so you would get everything
31 through that type of meeting.
32 MS PARKINSON: Yeah.
33 MS FEATHERSTONE: Okay, and so, with regard to the process of a formal
34 complaint, do you know how that would normally work? If a complaint comes

1 in, do you know what the process is of what happens to...? Would you write a
2 statement; would you get involved with it? Again, would you find anything out
3 from what lessons learnt from that as well?
4 MS PARKINSON: I think, if a complaint goes in, then we are asked to write a
5 statement on that, and then I would be guessing to say that an individual
6 would receive individual feedback. That's a guess.
7 MS FEATHERSTONE: Okay, but, again, you don't recall seeing a response letter,
8 so, again, to look at what the learning was from that.
9 MS PARKINSON: No, I don't.
10 MS FEATHERSTONE: Okay. What about recruitment? On a daily basis, was the
11 staffing good?
12 MS PARKINSON: Are you talking in recent years or...?
13 MS FEATHERSTONE: Yes.
14 MS PARKINSON: Initially, I thought, when I was first qualified, the staffing was good.
15 I couldn't get hours. It took me a little while to become full time, so the staffing
16 was good. And then there was a period – I'm not too sure when it changed,
17 but staffing was cut.
18 MS FEATHERSTONE: And, if you came on and there was a shortage, how was the
19 process if there was a shortage of staff or what happened?
20 MS PARKINSON: I think whoever was in charge that day tried to find more staff.
21 MS FEATHERSTONE: Okay, so generally you weren't involved with –
22 MS PARKINSON: No.
23 MS FEATHERSTONE: No, okay, but would you be called to another area? If labour
24 ward was busy and a ward was quieter, did everybody go where the work was?
25 MS PARKINSON: Yes.
26 MS FEATHERSTONE: Okay, and, because you're used to doing it in different areas,
27 that wasn't a problem.
28 MS PARKINSON: Yeah.
29 MS FEATHERSTONE: Okay.
30 MS PARKINSON: In my opinion, I don't even think it mattered if the ward was quiet.
31 If labour ward needed staff, they were taken from maternity ward.
32 MS FEATHERSTONE: So you could have been very full –
33 MS PARKINSON: Yeah.

1 MS FEATHERSTONE: And so, therefore – but, if it left you on your own and the
2 other members of staff had gone, but what did you do about then if you were
3 left, so would you be on your own on the ward?
4 MS PARKINSON: Yeah, there's been times, with a support staff included.
5 MS FEATHERSTONE: Yes, but did you need to escalate that ever to anybody? Did
6 you feel confident to escalate it to anybody, or did it not need escalating?
7 MS PARKINSON: Probably not the confidence.
8 MS FEATHERSTONE: Okay. If you did, who would you immediately go to?
9 MS PARKINSON: The ward manager.
10 MS FEATHERSTONE: Okay. Is there anybody else, then, you would be able to go
11 to, anybody else that you could...?
12 MS PARKINSON: You would maybe look to one of the senior midwives on the
13 labour ward.
14 MS FEATHERSTONE: Did you ever contact your supervisor with regard to your
15 concerns?
16 MS PARKINSON: I can't remember.
17 MS FEATHERSTONE: Okay, but you know that –
18 MS PARKINSON: Absolutely.
19 MS FEATHERSTONE: – that you could contact somebody.
20 MS PARKINSON: Yes, yeah.
21 MS FEATHERSTONE: Okay. Have you ever been aware of any inpatient surveys?
22 Again, has that sort of information or feedback been fed back down to you?
23 MS PARKINSON: No.
24 MS FEATHERSTONE: If they've ever done surveys with women that have delivered
25 and the feedback, have you ever seen any feedback from...?
26 MS PARKINSON: We have very recently – very recently, yeah.
27 MS FEATHERSTONE: Alright, okay, and do you have a maternity service liaison
28 committee within the hospital?
29 MS PARKINSON: I'm not sure.
30 MS FEATHERSTONE: Okay, that's fine, thank you. I think that's most of my
31 questions, but I'll pass over to somebody else. Thank you.
32 DR KIRKUP: Okay, thank you. Jimmy.
33 PROF WALKER: Can I go back to how the system worked? And really I'm also
34 interested in how things have changed over the last 10 years, because there's

1 been various changes – how that happened. You said, when you were fully
2 employed, and once you got the hours, that you came to the hospital and you
3 didn't necessarily know where you were going to be working, so you could be
4 working antenatal or the labour ward, but sometimes you did community as
5 well, but usually the ward – labour ward or the antenatal ward. Is that right?
6 MS PARKINSON: Most recently, now... In previous years, we were on an allocation,
7 so we were either allocated maternity ward or labour ward. That was set
8 throughout the year – on exceptions, where the staff needed to be moved
9 around, but you could maybe guarantee, January, February, March, you would
10 be allocated to the ward, and April would be your labour ward placement.
11 PROF WALKER: And that's changed more recently.
12 MS PARKINSON: Yes, it has. Maybe over the last year or two years, the allocation
13 has gone, so we arrive for your shift, and the labour ward coordinator allocates
14 where you will work for that day between labour ward and maternity. The
15 community staff have their own core staff that remain there all the time, and
16 then the antenatal clinic have their core staff too.
17 PROF WALKER: Were you more comfortable working in the labour ward or the
18 antenatal ward or did it not really matter?
19 MS PARKINSON: Anywhere.
20 PROF WALKER: You were quite happy. Now, you said that the coordinator would
21 allocate these things. I think you also said earlier that, although there was a
22 coordinator, that you would be on the staffing list or something like that. Does
23 that mean you wouldn't meet the coordinator when you first came on duty?
24 MS PARKINSON: Yes, you would, yeah. We all meet in an office.
25 PROF WALKER: So you knew that the person who was coordinating for the day
26 would be known to you from the moment you arrived.
27 MS PARKINSON: Yeah.
28 PROF WALKER: Okay. Now, when you arrived, what sort of handover did you get
29 from the staff going off about the women you're going to be caring for?
30 MS PARKINSON: It would be the name, the parity, the clinical reason for admission,
31 whether that be antenatal or postnatal.
32 PROF WALKER: Okay, so would you get an individual handover from the midwife
33 you were taking over from, or would there be a common handover –
34 MS PARKINSON: Yeah, a group handover.

1 PROF WALKER: Sorry?
2 MS PARKINSON: A group handover.
3 PROF WALKER: Okay, so you heard about all the cases that were there, but
4 specifically you'd be allocated a patient in labour or on the ward or whatever.
5 MS PARKINSON: Yeah.
6 PROF WALKER: Okay. In the –
7 MS PARKINSON: Sorry, you wouldn't... You would only receive the handover of the
8 allocated ward. You wouldn't receive both labour ward and maternity.
9 PROF WALKER: Okay, so the handover would be in the antenatal ward or the
10 handover would be in the labour ward.
11 MS PARKINSON: Yes.
12 PROF WALKER: Is that true today as well?
13 MS PARKINSON: Yes.
14 PROF WALKER: So, once you'd been allocated where you'd go, you'd get the
15 handover, okay. Now, did you feel that you practised – throughout the 10
16 years, did you feel that you were practising as an individual midwife or did you
17 feel you were part of a team?
18 MS PARKINSON: Both, I think. I think there was areas of both.
19 PROF WALKER: So what aspects would make you feel that you were working
20 independently and what aspects were you working as a team?
21 MS PARKINSON: I think the multidisciplinary approach, so you would get updates
22 from community staff of women that maybe you were expecting in or they
23 would obviously give you updates of ladies that had gone home too that you'd
24 had dealings with.
25 PROF WALKER: So you'd get other people feeding in, giving information and so on.
26 MS PARKINSON: Yes, absolutely.
27 PROF WALKER: If you were being allocated to a woman in labour when you first
28 arrived, now, did you feel that was you – for the day that you were with this
29 individual, did you feel there was people support you round about it, or did you
30 feel that you were in an isolated area, looking after the woman, or did you feel
31 you...?
32 MS PARKINSON: I think it was quite isolated at times, and the role of a labour ward
33 coordinator has been quite a recent role. It's been allocated.

1 PROF WALKER: So, when you were first appointed, were you a band 5 or 6, and
2 things have changed in the course of that time?
3 MS PARKINSON: Yeah, it was E and F grades.
4 PROF WALKER: So were you relatively on your own at that time, or did you have
5 someone supervising your care?
6 MS PARKINSON: I think there was always people there to go to, always people
7 there to go to, but quite on our own as well. I think it was maybe a mixture.
8 PROF WALKER: Okay, so you knew there were people there to go to. Were you
9 encouraged to go to them, or did you feel that you could only go to them when
10 you really needed help?
11 MS PARKINSON: I think maybe both, again. I think some people were more
12 approachable, and some people gave more encouragement than others.
13 PROF WALKER: Okay. Do you feel the system now, with the coordinator, which is
14 more established, is that person more visible now?
15 MS PARKINSON: Absolutely, yeah. If there's any concerns, they want to know. I
16 absolutely know who to go to.
17 PROF WALKER: Okay, but do they come into the room? Do they check up, make
18 sure you're okay?
19 MS PARKINSON: Yeah.
20 PROF WALKER: Okay, so, if you have a problem – say, when you first started work,
21 if you had a problem you were concerned about – someone's temperature,
22 blood pressure or foetal heart, whatever it was – what would be the sequence
23 that you would do? Who would you call on, first of all?
24 MS PARKINSON: I would probably go to the labour ward sister.
25 PROF WALKER: Okay, and what would they do? Would they come and review the
26 situation and tell you whether it's okay or whether it should be escalated
27 further?
28 MS PARKINSON: Yeah, they would.
29 PROF WALKER: Okay. Would you ever go to the doctor directly, or would you
30 always go through the sister or the coordinator.
31 MS PARKINSON: No, I would go to the doctor directly as well.
32 PROF WALKER: And what sort of response did you get from doctors when you
33 called them?

1 MS PARKINSON: It's hard to remember specifically. I think they would attend, yeah.
2 I think they would.
3 PROF WALKER: Okay. Did you feel they were supportive? Did you feel reassured
4 when they came? Did you feel there was a certain sort of conflict of you
5 having justify calling them or what?
6 MS PARKINSON: I think sometimes there was an element of needing to justify
7 yourself, but I think, when they came, they were supportive, yeah.
8 PROF WALKER: Okay. If you felt that the doctor, when they came, didn't do what
9 you thought was right, or you weren't comfortable with the decision they made,
10 what would you do?
11 MS PARKINSON: I would escalate it to the band 7 on shift.
12 PROF WALKER: Okay, and were they quite supportive of that if you had to do that?
13 MS PARKINSON: Yeah, they were.
14 PROF WALKER: Okay. Can you remember approximately how many deliveries you
15 do in a year?
16 MS PARKINSON: Personally?
17 PROF WALKER: Mm-hmm.
18 MS PARKINSON: I've no idea, I'm sorry.
19 PROF WALKER: So, I mean, on a given week shift, for instance, that you were on
20 labour ward, how many would you deliver in a week?
21 MS PARKINSON: It could be two, three.
22 PROF WALKER: So are you talking about two or three a week – with holidays, are
23 you talking about, what, about 80 deliveries a year or less than that, more than
24 that?
25 MS PARKINSON: Maybe 40.
26 PROF WALKER: Okay, alright, so did you feel that, when people came to – you
27 were looking after people in labour, did you ever feel that you maybe didn't
28 have the skills, either yourself or the hospital, to cope with the potential
29 problems this person might have?
30 MS PARKINSON: No.
31 PROF WALKER: So you were always quite confident that the facilities were there if
32 need be.

1 MS PARKINSON: Yeah, apart... I think our theatre was a problem, our theatre
2 being allocated away from our labour ward, and the fact that we didn't have a
3 theatre team on call – they were on call; they weren't in the building.
4 PROF WALKER: Okay, so can you remember any situation where there was
5 something happening, that you knew that there was an emergency required
6 and you felt things were not happening as fast as you felt they should do, and
7 you were getting anxious because of time to get a decision, time to get to
8 theatre, time to transfer?
9 MS PARKINSON: No, I'm sorry, I can't.
10 PROF WALKER: So that's more of a potential fear rather than an actual one.
11 MS PARKINSON: Yes.
12 PROF WALKER: Okay, and did you have any feeling from people you talked to or
13 your colleagues talked to that they had experienced that sort of actuality, or
14 was it – again, did they also have the same fear – potential fear?
15 MS PARKINSON: I can't remember, I'm sorry.
16 PROF WALKER: Okay, no, that's fine. You said earlier that you hadn't attended any
17 of the governance meetings where they discussed cases and things. Why
18 was that? I mean, were you not allocated time or were you not...? Because,
19 surely... Were you not expected to attend?
20 MS PARKINSON: No, I think we're more than welcome to attend. I think it's the time
21 factor, really.
22 PROF WALKER: So did you ask to attend but then told that there wasn't enough
23 midwives so you had to stay with your patient or what?
24 MS PARKINSON: No.
25 PROF WALKER: So did you not...?
26 MS PARKINSON: I think, if we were going to go, we would be expected to go in our
27 own time, rather than in a work shift.
28 PROF WALKER: So you weren't being encouraged to go. Even if the labour ward
29 was quiet, you wouldn't be encouraged to go to the meeting.
30 MS PARKINSON: If it was quiet, then, yes, you would be. You would be.
31 PROF WALKER: Okay. What about other things like...? You say you had
32 mandatory days, or obstetric days, mandatory days in the Trust. Were you
33 given time allocated to go to them, or was that in your own time?

1 MS PARKINSON: A mixture of both. I think it depended on how the staffing would
2 be on a particular day.
3 PROF WALKER: And were there days when you were booked in for mandatory
4 training but you couldn't go because you were put onto the ward?
5 MS PARKINSON: I remember one specific day being taken off to work clinically.
6 PROF WALKER: Okay. What about things like K2 training? Did you have access to
7 that?
8 MS PARKINSON: We did.
9 PROF WALKER: And were you up to date with that?
10 MS PARKINSON: I'm not quite too sure. We don't do it anymore. We don't do...
11 That's gone in the last couple of years.
12 PROF WALKER: Do you do any CTG training now?
13 MS PARKINSON: We do. We have a mini-lecture and a CTG, yeah.
14 PROF WALKER: Okay. How often do you get that?
15 MS PARKINSON: I think it's supposed to be done yearly, if not six-monthly
16 PROF WALKER: Right, and so have you ever gone over CTGs with people, cases
17 you've had or other people have had so you can learn from actual cases?
18 MS PARKINSON: Yeah, we do. There is a Monday meeting that's done midday,
19 and they try to look at a case from the previous week. That includes one of
20 our consultants and other medical staff that wish to attend, and obviously
21 anybody can go, and they do a presentation of a particular case study, and we
22 have a projector on the wall and we look at CTGs and things of particular
23 cases.
24 PROF WALKER: And have you attended them?
25 MS PARKINSON: Yep.
26 PROF WALKER: So you get the opportunity, quite regularly, to get these meetings?
27 MS PARKINSON: I wouldn't say regularly. I think that depends whether you're at
28 work on a Monday or what other things are going on at that time, you know.
29 PROF WALKER: Do you have a register in the hospital of what sort of training that
30 all the staff have done, and are you notified what you're required to do to
31 maintain standards?
32 MS PARKINSON: We do to recent date, yeah. Within the last two years, we have a
33 training matrix. It's on our computer, so it gives you what you'd done, and if
34 it's completed and if it's due to be redone.

1 PROF WALKER: Okay, and were staff – can they manage to keep up to date with
2 that allocated training?
3 MS PARKINSON: It can be hard sometimes to keep up to date with your training.
4 PROF WALKER: Okay. Just to finish off, then, to go back to the sort of partly
5 team-working, if you or a colleague ran into problems with a case in the room,
6 you'd obviously escalate that to the coordinator or whoever it was at the time.
7 What about the other midwives around? Can you come and support by – if
8 you need – you know, for shoulder dystocia, can someone else come in the
9 room? How easy is it to pull in support and help?
10 MS PARKINSON: Are we talking currently?
11 PROF WALKER: What it was before and what it is now.
12 MS PARKINSON: I think we can, yeah. You can get extra staff, or the staff that are
13 in the unit at the time. If you were in a shoulder dystocia, yeah. Once the
14 emergency bell's called or – people would come.
15 PROF WALKER: If you were involved in a particular incident that you were unhappy
16 about, would you – are you encouraged to fill in an incident form about that?
17 MS PARKINSON: Today, yeah.
18 PROF WALKER: And what about four years ago or five years ago?
19 MS PARKINSON: I can't recall. I can't recall whether we were encouraged or not.
20 PROF WALKER: So, if something in practice made you uncomfortable or there was
21 a problem or equipment wasn't working or something, but everything worked
22 out okay, would there be any way of that being reported or notified to senior
23 staff in the past?
24 MS PARKINSON: I'm not sure.
25 PROF WALKER: Okay, right.
26 DR KIRKUP: Okay, thank you. Stewart.
27 PROF FORSYTH: Have you worked in another maternity unit as a trained midwife?
28 MS PARKINSON: No.
29 PROF FORSYTH: So your entire working as a trained midwife has been in Furness
30 General.
31 MS PARKINSON: Yeah.
32 PROF FORSYTH: How have you tried to...? Have you tried to find out how other
33 units work, how they operate, what systems they have in place?
34 MS PARKINSON: More recently, yeah.

1 PROF FORSYTH: How have you done that?
2 MS PARKINSON: I think, well, we've been able to do that by discussing with new
3 people that come into the unit. They've shared their experiences, and we
4 have a lot of agency staff that have worked elsewhere, in London, and so
5 they've shared their experiences too.
6 PROF FORSYTH: So, before that time, your experience of how to run a unit was
7 entirely based on what you saw in Furness. Were there any other midwives
8 similarly – who'd had their whole training – their whole midwifery experience in
9 Furness?
10 MS PARKINSON: No, I think there've been quite a few that have moved to the area
11 and have trained elsewhere, or people have been brought up in the area and
12 then gone away to train and then moved back for family reasons.
13 PROF FORSYTH: So did they come back and try to introduce new ideas of doing
14 things within a unit?
15 MS PARKINSON: Yeah, I think they did.
16 PROF FORSYTH: And how was that received? Were these implemented?
17 MS PARKINSON: Not that I'm aware, no.
18 PROF FORSYTH: Sorry?
19 MS PARKINSON: Not that I'm aware. I don't know.
20 PROF FORSYTH: So they may have come back with ideas, but you didn't feel they
21 were implemented. Why not?
22 MS PARKINSON: I don't know. I'm not too sure. I think there must have been some
23 resistance there.
24 PROF FORSYTH: You mean there was some resistant to change in the unit.
25 MS PARKINSON: Yeah.
26 PROF FORSYTH: So where did that resistance to change come from?
27 MS PARKINSON: I think maybe higher up than my level, certainly.
28 PROF FORSYTH: Whereabouts higher up?
29 MS PARKINSON: I think from a management side, probably.
30 PROF FORSYTH: You mean beyond the matron for the labour ward, beyond the
31 head of midwifery, or around the head of midwifery.
32 MS PARKINSON: Around about the head of midwifery, yeah.
33 PROF FORSYTH: Did this concern staff that there was no change taking place?
34 Was there a feeling that the unit was not going forward?

1 MS PARKINSON: I don't think so.
2 PROF FORSYTH: You don't think so.
3 MS PARKINSON: No.
4 PROF FORSYTH: So you were comfortable with working in that environment.
5 MS PARKINSON: I think, at the time, we didn't see it. I think, now, to have
6 witnessed the changes that we've seen, it does make you look back and think
7 how differently we did work at the time.
8 PROF FORSYTH: Do you think the practices are now safer?
9 MS PARKINSON: Yes.
10 PROF FORSYTH: What are the sort of key aspects that you feel that make it safer?
11 MS PARKINSON: I think we have better support systems. We have better
12 encouragement. I think we have better training.
13 PROF FORSYTH: What about morale in the unit? What was it like in the past?
14 MS PARKINSON: I think it went through flurries of being fine, and then being
15 short-staffed obviously tends to impact on morale. People were working
16 longer, and you're seeing sickness to cover, so you're working more. I think
17 that did impact morale.
18 PROF FORSYTH: And what's the morale like today on the unit?
19 MS PARKINSON: It's okay.
20 PROF FORSYTH: Again, from your own personal practice – I don't want you to
21 specify particular cases at this stage, but were there times when you felt that
22 patients were at risk on the unit?
23 MS PARKINSON: Currently?
24 PROF FORSYTH: In the past, around 2008, around then.
25 MS PARKINSON: No, I can't remember thinking that.
26 PROF FORSYTH: So you weren't actually directly involved in a case you felt, in
27 hindsight, 'That was a very high-risk situation.'
28 MS PARKINSON: In hindsight, yes. I think even just the way we worked. If you
29 could be allocated to labour, you could be going to see two antenatal patients
30 in an admission area, so, in hindsight, yes.
31 PROF FORSYTH: Do you think that – or were there issues around the types of
32 patients you were looking after at Furness in terms of the relatively high risk?
33 Did you feel that they should be transferred to a larger centre?
34 MS PARKINSON: I think on occasion, perhaps, yeah.

1 PROF FORSYTH: I mean, were you in a situation where that happened, and did you
2 suggest that it was inappropriate for this patient to be here?
3 MS PARKINSON: I can't quite remember.
4 PROF FORSYTH: What about from a neonatal perspective? What was your
5 relationship like with the paediatricians in terms of providing neonatal care?
6 MS PARKINSON: At the time, I thought it was fine. It was good.
7 PROF FORSYTH: You say at the time you thought it was good. What about, again,
8 in hindsight?
9 MS PARKINSON: In hindsight, again, I think, as I said earlier, our paediatric staff are
10 currently more visible on the ward. Our SCBU unit is at the end of the
11 maternity ward, so it's all very accessible. We don't have to leave our unit to
12 get to our special care. Daily, they're there, with no phone call to ask them to
13 come there.
14 PROF FORSYTH: What about resuscitation skills of midwives, and particularly when
15 were was quite high-risk women delivering in Furness? Did the staff feel
16 confident they could deal with the initial resuscitation?
17 MS PARKINSON: Yeah, I think so.
18 PROF FORSYTH: How often do you resuscitate small babies?
19 MS PARKINSON: Small, premature, I don't think we would. Well, it would be very
20 rare. I don't think I personally have. I think there would always be a
21 paediatrician in attendance in anticipation –
22 PROF FORSYTH: But, if a lady came in in the middle of the night and suddenly
23 delivered, how quick would the paediatrician be? Would the paediatrician be
24 at home?
25 MS PARKINSON: Maybe, yeah, or there was an on-call room, if my memory serves
26 me right.
27 PROF FORSYTH: What about – do you think attitudes and behaviours have
28 changed around the unit?
29 MS PARKINSON: Yes.
30 PROF FORSYTH: In what way?
31 MS PARKINSON: I think there's certainly more team-working. I think that's a big
32 change.
33 PROF FORSYTH: So what's made that happen? I mean, if this wasn't happening
34 before, why did it not happen before?

1 MS PARKINSON: I don't know. I don't know.
2 PROF FORSYTH: So you don't really have a view, from your experience of living
3 through this, why it didn't happen. I think that's one of the questions that we're
4 keen to try and find the answer to.
5 MS PARKINSON: I can only relate it... In my opinion, I've seen new faces coming to
6 the maternity unit. That's how I can relate these changes to.
7 PROF FORSYTH: So you think that new people came in and introduced a new way
8 of thinking about how we do things.
9 MS PARKINSON: Perhaps, yeah. Perhaps.
10 PROF FORSYTH: In terms of the staffing issues, there was an issue around
11 re-grading and reorganising staff. Were you involved in that?
12 MS PARKINSON: No.
13 PROF FORSYTH: No. Did you feel that that process has subsequently proved to be
14 helpful, or do you think it was, in retrospect, a bad thing? You've no real
15 comment.
16 MS PARKINSON: No, no.
17 PROF FORSYTH: Okay, thank you very much.
18 DR KIRKUP: Okay, just a couple of points to pick up from me before we move onto
19 the second part. Are you aware of the Fielding report?
20 MS PARKINSON: Yeah, I have heard the name. I'm not too sure that I've read it or
21 been given it to read. I'm not too sure.
22 DR KIRKUP: Would you have expected to have seen a report that related to how
23 your unit operated?
24 MS PARKINSON: It would be nice to have seen it, but I can't recall having seen it.
25 DR KIRKUP: Were there any meetings where it was discussed?
26 MS PARKINSON: Not that I was invited to or not that I'm aware of, no.
27 DR KIRKUP: What was the policy in the unit for intrapartum monitoring?
28 MS PARKINSON: Today?
29 DR KIRKUP: Okay, tell me about today.
30 MS PARKINSON: Yeah, there's an intrapartum monitoring. It highlights who needs
31 to be monitored, if it's intermittent listening, auscultation or if it's a continuous
32 CTG. The protocol gives you advice on when to change from one to the other
33 or back to intermittent auscultation. It kind of gives you a list of the cases that
34 you need to continuously monitor.

1 DR KIRKUP: Now go back a few years. Was the situation the same then, or has it
2 changed?
3 MS PARKINSON: I couldn't honestly say. I couldn't remember. I'm sure that there
4 would have been a protocol.
5 DR KIRKUP: You see, it's interesting that, when I asked you, you said 'today'. You
6 didn't say, 'This is the system that's been around for donkey's years.' It really
7 suggests that there's been a change.
8 MS PARKINSON: Yeah, although I'm sure there was a protocol back then. I feel,
9 now, we have doubled, tripled protocols, from what I can remember.
10 DR KIRKUP: Does that mean more people are monitored now, in labour –
11 continuously monitored?
12 MS PARKINSON: Yeah, I think so.
13 DR KIRKUP: Okay. Do you feel suitably qualified and experienced to look after
14 babies who are being monitored on the maternity ward?
15 MS PARKINSON: Today, yes.
16 DR KIRKUP: And, again, a few years ago.
17 MS PARKINSON: I think incidents have highlighted where there was a shortfall,
18 certainly, or where there was a lack, yeah.
19 DR KIRKUP: But that wasn't evident before some things went wrong.
20 MS PARKINSON: No.
21 DR KIRKUP: No, okay. Unless my colleagues have got anything they're desperate
22 to follow up at this stage –
23 MS FEATHERSTONE: I've got one thing, just about agency staff. You talked about
24 agency staff. Do you have them on a regular basis?
25 MS PARKINSON: Yes.
26 MS FEATHERSTONE: Now?
27 MS PARKINSON: Yes.
28 MS FEATHERSTONE: Before?
29 MS PARKINSON: No.
30 MS FEATHERSTONE: And how many agency staff would you have per shift.
31 MS PARKINSON: It does differ. Sometimes we can work with two a shift.
32 MS FEATHERSTONE: Regularly?
33 MS PARKINSON: Yeah. Sometimes it's one. It's quite often one of the night shift,
34 and two.

1 MS FEATHERSTONE: Okay, that's all.

2 DR KIRKUP: Okay, thanks. We'll have a short pause, because we want to ask you

3 some questions that raise issues of clinical confidentiality, so we need to ask

4 the observers to leave.

5 [*Observers leave*]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 7 October 2014

Held at:
Trinity Enterprise Centre,
Ironworks Road,
Barrow-in-Furness

Before:

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

JEANETTE PARKINSON

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

1 DR KIRKUP: Good morning. I am Bill Kirkup, I am the
2 chair of the interview Panel. I will ask my colleagues
3 to introduce themselves to you.
4 PROF FORSYTH: Stewart Forsyth, a Consultant
5 Paediatrician, Medical Director from Dundee.
6 PROF WALKER: I am Jimmy Walker, a Professor of
7 gynaecology in Leeds and used to work for the National
8 Patient Safety Agency.
9 DR KIRKUP: You will notice that we're recording
10 proceedings. We will make an agreed record, which we
11 will share with you at a later stage in the process.
12 You also know that we have opened proceedings to family
13 members and we have family members in attendance today.
14 We will also allow people to access the recording if
15 they want to at a subsequent time.
16 During the first part of the interview with the
17 majority of the interview we will talk about non
18 clinical specific issues, we will then have a short
19 break while we go into a private session and we talk
20 about clinical details but that will be a subsequent
21 part of the interview.
22 You will also know we have asked you to leave
23 behind any recording devices and mobile phones, et
24 cetera, that is to emphasise that we don't want
25 anything to go outside the room until we are ready

1 produce a report with all the findings in context.

2 Do you have any questions for me about the

3 process?

4 MS PARKINSON: No, I don't think so. It is quite clear

5 thank you.

6 DR KIRKUP: I will start with a very general question

7 before handing to colleagues and that is can you tell

8 me when you started at the Trust what you have done

9 there over that period of time?

10 MS PARKINSON: I was first employed by the Trust in

11 1977, when I had qualified as a nurse, I did my nurse

12 training in Liverpool and I came back to Barrow, which

13 is my home town, and I was employed in theatre as a

14 Staff Nurse and then general medical and surgical

15 wards.

16 We then moved from that particular hospital, which

17 was North Lonsdale up to Furness General, where I did

18 ~~thumb~~ some paediatrics and then I had the opportunity to do

19 my midwifery training with the Lakeland School of

20 Midwifery, which I did in 1989, qualifying in 1990.

21 Then I worked as a staff midwife on Special Care

22 Maternity Ward, labour ward and the community during

23 that time gaining experience in all areas and then 1996

24 was when I applied and was successful with a G grade

25 post on labour ward as labour ward co-ordinator ...

1 DR KIRKUP: Yes.
2 MS PARKINSON: ... where I stayed until 2004. In 2003
3 I was offered a secondment to do the CNST assessments
4 with the head of midwifery. I did that part time for a
5 year and then the post became substantive in 2004,
6 which was full-time then, and I continued to be the
7 lead for CNST and also to took on responsibilities for
8 risk management.
9 DR KIRKUP: Okay. That carried on until?
10 MS PARKINSON: That carried it on until 2012.
11 DR KIRKUP: What have you done since then?
12 MS PARKINSON: I have retired.
13 DR KIRKUP: Thank you. I will hand you over to Jim.
14 PROF WALKER: Can I just clarify something, in
15 2003 you joined up with head of midwifery to prepare
16 the hospital for CNST?
17 MS PARKINSON: That is right.
18 PROF WALKER: 2004 you took over that role as a
19 full-time thing?
20 MS PARKINSON: That is right.
21 PROF WALKER: At that point your are commitment
22 was about making sure you achieve the standards?
23 MS PARKINSON: That is right.
24 PROF WALKER: What level was the hospital at that
25 point?

1 MS PARKINSON: Level one.
2 PROF WALKER: Did you attempt to go for level
3 two?
4 MS PARKINSON: Yes. In 2008, I am sure that is right,
5 2008, we undertook assessment at level two, in the old
6 standards, and we were successful at achieving that.
7 PROF WALKER: You were level two in 2008?
8 MS PARKINSON: Yes.
9 PROF WALKER: Did you attempt to go to level three
10 after that or is that when new standards came in?
11 MS PARKINSON: New standards came in.
12 PROF WALKER: Were you reassessed under the new
13 standards?
14 MS PARKINSON: Yes, but after I no longer worked for
15 the Trust. We were preparing to maintain level two but
16 the standards, the new standards, the evidence was
17 mainly from health records, I think it was about 80 to
18 90 per cent of the evidence would be from the health
19 records and our health records would not have met
20 standards at that time and we took the advice of the
21 assessor that a lot of Trusts who were level two had
22 undertaken level one in new standards to get the
23 guidelines in place to match the records. So we were
24 going for level one at the time I left.
25 PROF WALKER: Were you left at level two up until

1 -- then be re-assessed as level one.

2 MS PARKINSON: Yes.

3 PROF WALKER: Do you know what happened when that

4 reassessment was done?

5 MS PARKINSON: I know it was postponed and then they

6 were re-assessed at level one but I am not sure when.

7 PROF WALKER: They were successfully reassessed at

8 level one?

9 MS PARKINSON: Yes.

10 PROF WALKER: Under the new rules?

11 MS PARKINSON: Yes.

12 PROF WALKER: Now, you said that you were in this

13 position preparing for CNST and then you took on the

14 risk management title and role. When did that occur?

15 MS PARKINSON: With the substantive post in 2004.

16 PROF WALKER: You then, de facto, were called the

17 risk manager, were you?

18 MS PARKINSON: Yes, I think, I have been trying to

19 remember what my title was at that time but I think it

20 was risk manager.

21 PROF WALKER: Because we have a document, it is

22 dated 2008/2009, after that, about risk strategy. Now,

23 was that something that you came in after that or is

24 that something that you were involved in development of

25 or what?

1 MS PARKINSON: I was involved in the development of
2 that with the risk adviser for the Trust. We developed
3 the Maternity Risk Management Strategy.
4 PROF WALKER: You said at one point that to be
5 reviewed under the new rules that you did not think
6 that your case records were up to standards. What was
7 wrong with them?
8 MS PARKINSON: When you looked at the evidence that was
9 required to achieve level two, a lot of specifics
10 needed to be recorded and the records we were using at
11 the time did not enable staff to record these things in
12 a robust and consistent manner. The health records
13 were not -- would not meet them standards because of
14 that.
15 PROF WALKER: Were you using a personalised local
16 records?
17 MS PARKINSON: Yes.
18 PROF WALKER: You were not on the national record?
19 MS PARKINSON: No.
20 PROF WALKER: What things were missing? Things
21 like the patient risk assessment or--
22 MS PARKINSON: Yes, some of the risk assessments. I
23 can only explain it when we went on to the perinatal
24 notes because we had used the antenatal perinatal notes
25 for quite a lot of years. When we looked at the

1 perinatal institute birth notes and post-natal records
2 all the things that we needed to make sure that were
3 recorded, there was a place for them to be recorded.
4 The risk assessments were in place and these things
5 were missing from our notes. It relied upon people to
6 actually write them, so there was no consistent way of
7 documenting them in those records.
8 PROF WALKER: When did you change over to the new
9 perinatal notes?
10 MS PARKINSON: 2010/11.
11 PROF WALKER: Just leading up to just before your
12 retirement?
13 MS PARKINSON: Yes. We had them in place for about--
14 NEW SPEAKER: Excuse me, Chairman, I am sorry to
15 interrupt. There is a lead not plugged in there. That
16 is okay, is it?
17 PROF WALKER: You said new records were bought in
18 about 2011, 2010?
19 MS PARKINSON: 2010, I think. If I think back to when
20 they finished September 2011. Yes. Probably late 2010
21 some of the staff were trained on them.
22 PROF WALKER: Was it mostly that sort of thing
23 that were missing from the notes? The structure of the
24 notes did not lend itself to the recording of the data?
25 MS PARKINSON: Yes.

1 PROF WALKER: Do you feel that that affected the
2 care that was being given to the women at the time,
3 that the data was not being collected or thought about
4 or reported?
5 MS PARKINSON: I would not say it affected the care as
6 such, but it did not make it easy to check some things
7 had been done or had not been done. Again, it relied
8 on the specific individual to record it, hand record
9 the things and some people were better at record
10 keeping than others.
11 PROF WALKER: You mean by definition if you felt
12 that the data was not available in the notes then there
13 might be possibility that it had not been done or had
14 not been noted?
15 MS PARKINSON: Yes, I would say so, yes.
16 PROF WALKER: You were involved in reviewing of
17 cases over period of time, so did you get a feel that
18 there was sometimes a lack of risk assessment or
19 documentation of important information which,
20 therefore, was not passed on for care?
21 MS PARKINSON: There were areas within the notes that
22 health professionals could document certain things.
23 The antenatal records, because we used the perinatal
24 institute records, they were quite comprehensive. I'm
25 not saying they were always filled in 100 per cent but

1 there was opportunity there to write them.
2 The general health notes that we used for labour
3 and post-natal they relied upon the health professional
4 to record them in certain areas, so there will be small
5 prompts for people to write things in certain areas but
6 not the same sort of prompts as there would be in the
7 new records.
8 PROF WALKER: Okay. If we look at what your role
9 is, because in this document, which you were involved
10 in preparing, your role really had a wide remit, from
11 both look at risk right down to meant to be responsible
12 for training people in new equipment and various things
13 like that. Is that the range of work that you were
14 expected to do?
15 MS PARKINSON: Yes. It did expand. It seemed anything
16 to do with the risk, anything that needed overseeing,
17 collection of records, seemed to be under my remit,
18 along with the matrons as well, because the matrons
19 were responsible for training and records as well, so I
20 was not on my own with that but, yes, it seemed to
21 gather really momentum that the role over the years
22 that I did it; I seemed to be responsible for more and
23 more things.
24 PROF WALKER: Do you think that was reasonable or
25 do you feel that there could have been more people

1 employed to -- or allocated to some of these roles?
2 MS PARKINSON: We did expand the risk management team,
3 especially when I became involved in the acute
4 assessment, we did expand the team and part of that was
5 looking at the midwives who were employed, looking at
6 the incident reporting and follow up on incidents. So
7 we did employ more people in the end, but that took a
8 little bit of time to get the them in post.
9 PROF WALKER: The people brought in to help on the
10 committee, what sort of training did they have on
11 safety aspects and risk assessments?
12 MS PARKINSON: I do not think I can answer that. I do
13 not think I remember that.
14 PROF WALKER: Does that mean they didn't have any
15 training or much training or there was no organised
16 training?
17 MS PARKINSON: Not specifically on risk management, no.
18 They would have had training on the incident reporting
19 system in process and the risk advisers in the Trust
20 gave training on the system and safeguard.
21 PROF WALKER: In your situation, you had some
22 initial training on CNST standards and so on. What
23 about the risk assessment and root cause analysis?
24 Were you trained in that?
25 MS PARKINSON: There were couple of courses that I went

1 on to do with the root cause analysis, there was one on
2 that and there was another one, just two days courses,
3 on the risk assessments but we tended to learn on the
4 job really and it was up to us to sort of make sure
5 that we knew what we were doing.
6 PROF WALKER: If you were in a situation when you
7 reviewing a case and there was a problem of trying to
8 work out how to handle a certain type of problem or
9 approach it, would there be someone in the Trust to go
10 to at risk management level that you could go to for
11 advice or were you very much left to work it yourself?
12 MS PARKINSON: No, initially my first point of contact
13 would be the head of the midwifery, if there was any
14 issue around a case that I was looking at. There was
15 also the Risk Manager for the Trust, he was very
16 experienced, more in non-clinical risk but he gained a
17 lot of experience and the Risk Adviser in the Trust as
18 well. She was very helpful, she was the one that
19 managed the system. There was the risk team to go to,
20 to discuss things if I was not happy or I didn't know
21 which direction to go in.
22 PROF WALKER: When you started on this job were
23 the Trusts merged at that time or were you involved
24 throughout the Trust or was it just single site?
25 MS PARKINSON: No, it was definitely merged when I took

1 the secondment in 2003 because it was the three sites.
2 The Trust merged while I was a G grade on the labour
3 ward and I remember I was involved in that little bit
4 because I was Royal College of Midwives steward for
5 Furness, so I did attend meetings to do with the
6 merger.
7 PROF WALKER: You were Risk Manager then for the
8 all three maternity sites?
9 MS PARKINSON: Yes.
10 PROF WALKER: How did you split your time in doing
11 that?
12 MS PARKINSON: I ensured that I was on each site at
13 least one day a week and then sometimes to do with the
14 risk office as well. So I tended to divide my time.
15 Certain days I would go to the certain sites. That is
16 how I managed it.
17 PROF WALKER: If an incident occurred would you
18 call to the site at that point or would it be the head
19 of midwifery or when would you get involved in an
20 incident?
21 MS PARKINSON: Well, I was automatically involved,
22 sorry, alerted to all incidents via the Safeguard
23 System, so I would receive an email of every single
24 incident in maternity services and gynae. If there was
25 any sort of serious incident or an incident where staff

1 needed support or I needed to start an investigation I
2 would go to that site as soon as possible.
3 PROF WALKER: You talked about the -- I can't
4 remember what you said, alert system.
5 MS PARKINSON: Safeguard System.
6 PROF WALKER: What is that? Explain that?
7 MS PARKINSON: Safeguard is the system that the Trust
8 purchased to manage incidents. So the staff, once we
9 went from paper copies, which was paper when I first
10 started in 2003, I can't remember at what point we went
11 to online reporting, I have tried to think back but I
12 am not specific on that. But eventually all staff were
13 trained, had access to the system. They would go
14 online, they would put their incident in, as they would
15 do on paper, and then it would go straight to the
16 Safeguard System online and then automatically send
17 outs would go to different people required to receive
18 the incident.
19 PROF WALKER: You will be one of the people?
20 MS PARKINSON: Yes.
21 PROF WALKER: So an incident happened in labour
22 ward, it was put on to the Safeguard System, you get an
23 email for it. What would you do that at point?
24 MS PARKINSON: Depending on the seriousness of the
25 incident, I would start an investigation or I would log

1 it for follow up. It just depends on what it was.
2 Then I would contact the staff involved if I needed
3 more investigation, maybe more information and then
4 face-to-face interviews with staff if I needed further
5 information again.
6 PROF WALKER: So would these reports have enough
7 information on them online to tell you how serious the
8 incident was? I mean, the outcome may give you
9 information but there are also meant to be near miss
10 events as well. Would you have enough information
11 online?
12 MS PARKINSON: Again, the incident reporting online
13 would give you a clue as to what had happened but every
14 single incident we would review the records prior to
15 the incident meeting and we used to have incident
16 review meetings every month, so myself or, later on,
17 one of the team would review the records to see what
18 had happened and whether there was any near miss,
19 whether there was any lessons to share, any practice
20 issues involved.
21 PROF WALKER: Who would be people that would do
22 that? Who would review the cases?
23 MS PARKINSON: The Clinical Incident Review Team.
24 There was an allocated consultant for the two obstetric
25 sites and then head of midwifery, sorry -- the matron

1 for the midwife led unit, myself and then an allocated
2 member of the risk team if there was further, you know,
3 information required.
4 PROF WALKER: Would all these people be involved
5 every time? You said that there was an allocated
6 consultant. Would the consultant be present?
7 MS PARKINSON: The consultant, allocated consultant for
8 the site would be present at the review meeting.
9 PROF WALKER: That is once a month?
10 MS PARKINSON: Yes, but, of course, if the incident
11 required it it would be done sooner than that, it would
12 just reported at the meeting.
13 PROF WALKER: An event which was more serious and
14 you wanted to act sooner than waiting for a month, what
15 process would you would go through to achieve a review?
16 MS PARKINSON: I would review that incident with the
17 matron or the head of midwifery and/or the consultant
18 as soon as possible after the event.
19 PROF WALKER: Would you at that point have
20 statements from staff or would you have face-to-face
21 interviews with staff?
22 MS PARKINSON: Either or both. Whatever it required.
23 PROF WALKER: So that if you were going to review
24 would you automatically ask all staff involved to
25 produce a statement?

1 MS PARKINSON: Not every incident would require a
2 statement, no. Only those that needed follow up.
3 PROF WALKER: Did you grade your risks on the
4 standard grade risk matrix -- 13?
5 MS PARKINSON: Yes, yes.
6 PROF FORSYTH: Which ones did you take to a full
7 review?
8 MS PARKINSON: The red incidents would. We did use the
9 RAG rating system.
10 PROF WALKER: If you had a red incident what
11 process would you have gone through for that?
12 MS PARKINSON: The Clinical Director and head of
13 midwifery would also be notified of the red incident
14 and then we would start the investigation as soon as
15 possible.
16 PROF WALKER: Who would be involved in the
17 investigation?
18 MS PARKINSON: Myself, possibly another matron or an
19 obstetrician, depending on what the incident was and
20 who was required to look at it.
21 PROF WALKER: Basically you will be involved in
22 all the reporting of all incidents or reviewing all
23 incidents?
24 MS PARKINSON: Yes.
25 PROF WALKER: You will be the core person?

1 MS PARKINSON: Yes.
2 PROF WALKER: How many incidents would be
3 escalated that level across the Trust on average per
4 month, for instance?
5 MS PARKINSON: I can't remember, I am sorry.
6 PROF WALKER: Would you have a sort of a red
7 incident once a month to review or would that be less
8 than once a month?
9 MS PARKINSON: Probably more than that a month. Very
10 often when we had done the investigations the Risk
11 Adviser would down grade the risk once we had done the
12 investigation. So it may well start off as a red
13 incident but following the investigation it may be down
14 graded to a medium risk to it, you know.
15 PROF WALKER: Once an investigation has been done
16 and recommendations are produced, who's responsibility
17 was it for recommendations to be implemented?
18 MS PARKINSON: Again, depending on what the incident
19 was, but we would share the outcomes and
20 recommendations with all the staff, initially with the
21 staff involved, with the obstetrician, they would
22 disseminate it to their staff as well. We used the
23 obstetric emergency days. I had a risk management slot
24 on that, they were done twice a year so any lessons
25 learnt would be shared there as well and then we had a

1 Lessons Learned Board where it would be displayed for
2 staff to read and any changes in practice. Then we
3 also used the email to notify staff of any outcomes but
4 we did not just rely on that because not all clinical
5 staff have chance to read their emails every day.
6 PROF WALKER: You said that the midwives would be
7 told by one person and the medics will be told by
8 another person. Was there no joint meetings to discuss
9 incident and learning objectives from them?
10 MS PARKINSON: We had started to do those more
11 frequently. It was not easy with the three sites but
12 we had started to expand. We were always look at
13 different ways of sharing the lessons learnt. It was
14 still a work in progress.
15 PROF WALKER: How did they feed into, for
16 instance, changes in guidelines? Was there a system
17 for that to work?
18 MS PARKINSON: Yes, if the recommendation was that a
19 guidelines needed to be changed that would be taken to
20 the Maternity Risk Management Group and people would be
21 allocated to review that guideline and then, once that
22 had been agreed, that would be sent to all the senior
23 midwives and the obstetricians, once the guideline was
24 agreed at the Maternity Risk Management Group it then
25 would be disseminated to all staff.

1 PROF WALKER: Was there any sort of closure of the
2 loop that -- if an incident occurred, something had
3 happened, you then highlighted that happening, you then
4 were -- education or guideline was to try to be brought
5 into place to stop it happening again. Was there any
6 follow up to actually see if that all had happened?
7 MS PARKINSON: Again, that was work in progress. The
8 audits had started to be done more rigorously but it
9 was an area that we felt we were not doing very well.
10 PROF WALKER: When you say it was work in
11 progress, is that the time when you were retiring, it
12 was still in progress then?
13 MS PARKINSON: Yes, yes.
14 PROF WALKER: It had not really been brought into
15 place?
16 MS PARKINSON: Not properly. Again, we were always
17 looking at ways of trying to get that feedback and
18 trying to look at closing the loop.
19 We would do audit of records as well to have a
20 look and see if that would help but I have to say that,
21 in all honesty, we were not very good at that.
22 PROF WALKER: A specific thing like the K2 Fetal
23 Training Programmes, you seem to be responsible for
24 making sure that staff went through that as well. What
25 sort of success rate did you achieve in getting people

1 through K2?
2 MS PARKINSON: K2 was a very useful tool for the staff
3 to utilise because they could do it when they had a
4 spare half hour on the unit or even stay behind and do
5 it. So it was a good tool that we used and we
6 monitored it quite closely. Generally the midwifery
7 staff were very good at doing it. The medical staff
8 needed a little bit more persuasion, you know, we had
9 to prompt them a lot more. The success rate was quite
10 good.
11 PROF WALKER: So what sort of percentage of the
12 midwives, for instance, were trained in K2?
13 MS PARKINSON: 90 to 100 per cent of staff, of midwives
14 would utilise it.
15 PROF WALKER: And for medics?
16 MS PARKINSON: I can't remember what the percentage
17 was. I just know that we, you know, we had to persuade
18 them to do it.
19 PROF WALKER: Okay. When did you bring in K2
20 training?
21 MS PARKINSON: I cannot remember.
22 PROF WALKER: Was it there at the beginning when
23 you were first appointed?
24 MS PARKINSON: No, it was some time after that but we
25 seemed to have been doing it for a long time.

1 PROF WALKER: Did you notice any change in, say,
2 incidents concerning fetal heart rate interpretation
3 before and after?
4 MS PARKINSON: I always felt that the staff were more
5 confident in fetal monitoring having utilise that
6 tool. We used to have a slot on the obstetrician
7 emergency days as well where we would use traces as
8 examples and staff always seemed more confident in what
9 they were saying were the CTGs.
10 PROF WALKER: Okay. That does not quite answer my
11 question but did you feel that there was less problems
12 or incidents involving CTGs once K2 training had come
13 in, or did you think it did not make much difference?
14 MS PARKINSON: I don't think I can answer that really
15 because I have never really -- I cannot remember.
16 PROF WALKER: Okay. Over the time when you were,
17 what, eight years, seven years in position, what do you
18 feel that you achieved over that period of time of
19 improvement?
20 MS PARKINSON: I thought a lot of about this and
21 specifically for coming here. I think, the CNST
22 assessments gave us a tool to improve practice. We
23 introduced the ~~obstetrician~~ obstetric emergency days where skill
24 drills were undertaken, where we could capture all
25 staff, midwifery staff and some medical staff, to

1 change in practice, to current topics and the staff fed
2 back to me that having done these obstetrician
3 emergencies days twice a year they felt more confident
4 in skill drills, they felt more confident in neonatal
5 resuscitation.
6 I think just generally overseeing risk, its
7 profile had been raised by us sharing all the CNST
8 standards and the risks and helping the midwives to
9 understand that every time they met a pregnant woman
10 they were risk assessing her. It was not an add-on; it
11 was not something that they did extra to what they were
12 already doing. The risks were assessed for each lady
13 and at all times, so it was not something new to them.
14 I think that was very important for the staff. It
15 certainly was important for me because I felt like we
16 were moving forward with change.
17 PROF WALKER: In the skill training days that you
18 had, who actually ran them?
19 MS PARKINSON: At the Furness site it tended to be --
20 there was two midwives who were ~~also~~ ALSO [Advanced Life Support in Obstetrics] trained and ~~also~~ALSO
21 trainers, so they took on the role of trainers for the
22 obstetrician days.
23 For the things like neonatal resuscitation, the
24 Neonatal Nurse Practice Educator would do those
25 sessions.

1 The ~~obstetrics~~ obstetricians on the RLI site were much more
2 involved with the obstetric days than the obstetricians
3 at Barrow. They were all invited to attend and they
4 were all invited to take sessions but the uptake there
5 was not as good as what it was at RLI.
6 PROF WALKER: In as far as the trigger list and so
7 on that were produced in the document we have, the
8 trigger lists appeared to be for general hospital
9 trigger lists; did you have specific obstetrician
10 trigger lists as well.
11 MS PARKINSON: Yes.
12 PROF WALKER: Where did you get them from?
13 MS PARKINSON: They were based – the CNST for
14 maternity standards had a trigger list and then we
15 expanded upon that; we added things to it we felt
16 should be trigger list that was always evolving. There
17 was always things being added to the trigger list. If,
18 you know, if an ~~indent~~ incident occurred that we had not
19 realised, you know, we would add that to the trigger
20 list so the staff could -- were much more informed
21 about what they should be reporting.
22 The general mantra was: If in doubt report it,
23 put an incident report in and we will follow it up.
24 PROF WALKER: Lastly, when you retired what were
25 the still the bits to be done, do you think, to get the

1 hospital to the state of risk management that it should
2 be?
3 MS PARKINSON: I think one of the biggest things was
4 the record keeping. The introduction of the new
5 records needed to embed and be audited. Other than
6 that I cannot really remember.
7 PROF WALKER: All right. Thank you.
8 DR KIRKUP: Thank you. Stewart.
9 PROF FORSYTH: Thank you. So you're appointed as
10 Risk Manager in 2004, you retired in 2012. So you
11 almost covered the period of which this inquiry is
12 concentrating. You also said that you were really
13 informed of every incident in the maternity services
14 that occurred during that time.
15 Can you tell me what, in your opinion, were the
16 risks to maternity services during that period?
17 MS PARKINSON: They did vary on the three sites. I
18 think the biggest risk was communication and that is
19 always something that will be reflected in incident
20 reports. I think that --
21 PROF FORSYTH: Can you elaborate on that for me?
22 MS PARKINSON: I think that the communication between
23 the paediatricians and the obstetricians and the
24 paediatricians and the midwives was not always as it
25 should have been. It was quite difficult at times to

1 engage the paediatricians when we needed to review
2 guidelines or we needed to implement change in
3 practice. It was very difficult to get the
4 obstetricians and paediatricians in the same room at
5 times.
6 PROF FORSYTH: What period of time is that over?
7 The whole 2004 to '12 or is there --
8 MS PARKINSON: It did not seem as bad to me at first.
9 Whether that was because I had come from the clinical
10 area and I was still viewing it from a clinician point
11 of view but, again, one of the biggest risks for me as
12 a G grade on labour ward was getting the paediatricians
13 to understand what criteria we should be following when
14 we needed a paediatrician in attendance.
15 There seemed to be things going on in the
16 background that we were not aware of. The inclusion
17 criteria for a paediatrician to attend labour ward,
18 that was changed but without any discussion with us, of
19 course, the midwife would bleep to say, "We have got a
20 forceps delivery. Can you attend?", "No, we do not
21 come to them anymore." Well then they would be
22 conflict between them.
23 When we wanted to review a guideline it took a
24 long time for them to engage with us. There was also
25 changes to practice that we felt needed reviewing.

1 There was the issue of, it is going back a little
2 bit now, but it was very relevant, that with a
3 prolonged rupture of membranes we used to take an ear
4 swab and a placenta swab and that practice was found to
5 be not evidence based and a lot of babies were having a
6 positive ear swab and being put on antibiotics and
7 having to stay in hospital and that would just be a
8 localised collection of staph aureus, it would not be
9 systemic. So then by the time you got the blood
10 cultures back, which the baby had to have done, the
11 result would come back negative, the baby then stopped
12 the antibiotics and go home. To the midwives, you know
13 and, the mothers and the parents, you know, this is
14 putting the baby through unnecessary trauma and
15 unnecessary antibiotics. But it was very difficult to
16 get the paediatricians to agree to that and that was a
17 guideline, one of the guidelines that we struggled to
18 get reviewed and looked at.
19 PROF FORSYTH: Sticking with communication. What
20 about communication between the midwives and
21 obstetricians? Were there issues there?
22 MS PARKINSON: I do not feel that the communication for
23 them was as difficult but some of the staff had worked
24 together for a long time. The rotating SpRs were
25 always very on the ball more often than not and were

1 used to doing things in a very structured way.
2 The staff grades and the consultants had been
3 there for quite some time and did not always understand
4 the need for doing things differently and having the
5 evidence to show that you were doing it differently as
6 well. It was much harder to get them to engage in
7 changes.
8 Just things, I mean, one of the examples was the
9 introduction of the traffic light system to labour
10 ward. That was resisted quite strongly by some of the
11 clinicians and not adhered to. There was supposed to
12 be four-hourly ward rounds. Now the SpRs coming from
13 bigger hospitals would be used to that but trying to
14 get the staff grades to adhere to that was quite
15 challenging for the midwives, for the labour ward
16 co-ordinators and they were the ones having to push it
17 all the time.
18 PROF FORSYTH: Did that come up in some of the
19 incidents that --
20 MS PARKINSON: It did, yes.
21 PROF FORSYTH: You felt there was adverse
22 incidents as a result of failure to comply
23 with routine?
24 MS PARKINSON: Yes, I mean, it did in the sense that the
25 midwives started to, and quite rightly, utilise the

1 incident reporting system to say when a high risk
2 patient had not been reviewed or when it had difficulty
3 getting the patient reviewed and quite rightly they
4 were put an incident about that.
5 PROF FORSYTH: Again, trying to follow that
6 through more in terms of trying to bring about change,
7 you said that earlier on your first point of contact
8 was head of midwifery. Did you feel that was an
9 effective port of call?
10 MS PARKINSON: Yes. The head of midwifery was, you
11 know, would take on board what we were saying and she
12 would liaise with me with the Clinician Director and if
13 I ever struggled to get the Clinical Director to accept
14 what I was saying or to move on what I was saying, to
15 act upon it, head of midwifery was always good support.
16 PROF FORSYTH: Did you find the Clinical Director
17 quite difficult to move on some of the points?
18 MS PARKINSON: He was not difficult to communicate
19 with, he was very approachable, he just had his own
20 version of what risk management should be. He did not
21 always see the need for documentary evidence that we
22 were doing something and the follow up on incidents, if
23 it was a consultant involved, could be quite difficult
24 at times.
25 PROF FORSYTH: So communication was a key area.

1 What other aspects of midwifery care or obstetric care,
2 paediatric care kept you awake at night? Being aware
3 of all of the information, what other areas would
4 really concern you over that period of time?
5 MS PARKINSON: My mind has gone blank. I think, just
6 generally, in the last few years it seemed to change.
7 We did have a process that we were following initially
8 and I took the post and we had access to the Chief
9 Executive via the Clinician Governance Groups and the
10 then Directory of Nursing through the Nursing Midwifery
11 Forum but later, when the new Trust board came in, the
12 structure changed and it was not as easy to raise and
13 escalate issues as it had, or as I thought it had been
14 and that was one of the things that concerned me; that
15 we were raising issues, we were saying what the risks
16 were and they were not being dealt with in a way that I
17 would have been happier with.
18 PROF FORSYTH: Can you give me an example without
19 mentioning patients' names?
20 MS PARKINSON: One that comes to mind very easily is
21 the equipment. The equipment, we were getting
22 ridiculously low on equipment and I cannot think what
23 the word is, the renewal of the equipment. Again,
24 there used to be a procedure for capital bids for
25 getting new fetal monitors. The specific things with

1 the fetal monitors, the Dopplers and infusion devices.
2 Now, the infusion devices was Trust wide, it was
3 ridiculous. They were trying to work towards a library
4 and have a standard piece of equipment but that never
5 came to fruition; it did not happen and it got to the
6 point where we were really struggling for equipment
7 within the maternity services and the matron on the RLI
8 site was particularly good at persuading companies
9 maybe she would trial their equipment and then I
10 remember she got some infusion devices but had to use
11 their products, their, you know, the IV lines and things
12 like that, she had to go into that.
13 They always seemed to be trying to go through the
14 back door to get the equipment that we needed rather
15 than normal processes that we used to follow.
16 DR KIRKUP: You said that came in with new Trust Board.
17 Can I be clear which new Trust board we're talking
18 about here?
19 MS PARKINSON: Sorry. The one that came in 2007/'8.
20 DR KIRKUP: Right.
21 MS PARKINSON: I had very little dealings with the next
22 Trust Board. By the time they came in I had gone.
23 PROF FORSYTH: Were there incidents related to the
24 equipment?
25 MS PARKINSON: Yes.

1 PROF FORSYTH: Are there issues that you felt were
2 quite common coming across your desk in terms of
3 incidents which never really felt reflected risk,
4 significant risk in the maternity services?
5 MS PARKINSON: I know there are, I cannot think at the
6 moment. It has been so long and I have not had access
7 to any documentation. Can I come back to that one?
8 PROF FORSYTH: Yes, of course. Can I ask, you do
9 you feel over the period of going from 2004 to 2012,
10 that the risks were changing or were the same risks
11 coming up repeatedly and, therefore, learning was not
12 happening?
13 MS PARKINSON: I think both really. Some risks we were
14 dealing with and were not being repeated but other
15 risks probably we never got to the bottom of.
16 PROF FORSYTH: Can you give me an example there?
17 MS PARKINSON: I think one of the ones that goes back
18 in the beginning when I took the post of Risk Manager,
19 I'd just come from the labour ward at Furness and we
20 had always managed emergency sections in the main
21 theatres, the theatre that was on the labour ward had
22 never been utilised, it was never functional and we had
23 always managed with and on call system in theatre. Now
24 that was quite a big issue when I first took that post.
25 It did not seem to matter what we said to who, it did

1 not change anything for a long, long time.

2 We had, I am sure if I could look back on the

3 system, we had some near misses. One particular

4 incident occurred when – initially we could not get

5 into theatre because it was locked and the staff had

6 not arrived and the registrar and the anaesthetist and

7 the midwifery staff were there and they started the

8 procedure and it was ~~called~~ cord prolapse and the clinician

9 saved the baby. Now he went against a lot of protocols

10 doing that because the anaesthetist didn't have her

11 assistant with her and there was no scrub nurse, the

12 midwife scrubbed. They arrived just after the baby was

13 born.

14 We would raise this with the Trust that we needed

15 people on site. Now that was implemented but only

16 latterly. Again, I cannot remember what year but I

17 think it was 2009/10 and it was on our risk registrar

18 or it was one of our risks when I first took over but

19 we were asked why it was not on the risk register sort

20 of latterly and, I think, that, again, it is because we

21 just did not get anywhere with it. That was one that

22 we worried me, that eventually, you know, something

23 would happen.

24 PROF FORSYTH: Any other risks or issues, again,

25 during that period of time from the insight you have,

1 clearly you have an important insight into what
2 happened within the organisation during that period?
3 Are there other particular risks or aspects of care
4 that concerned you?
5 MS PARKINSON: Record keeping. Yes. Record keeping.
6 It was such a big thing that you can even forget about
7 it because it came into everything -- the record
8 keeping at times.
9 PROF FORSYTH: Why was that not able to be soluble
10 problem? Where did you see the difficulties?
11 MS PARKINSON: I think you have got some people who are
12 better at record keeping than others. I think, that is
13 a given. But no matter how we seemed to deal with
14 it -- I do feel it had improved. We did regular
15 sessions on record keeping as, you know, Trust
16 maternity matrons and supervisors, records were
17 reviewed annually. We had implemented band 7, what we
18 call band 7 review where they just select so many sets
19 of records, I think it was 10 sets of records every
20 month randomly, against a template. So we were always
21 striving to improve record keeping.
22 PROF FORSYTH: Was the clinician leadership doing
23 all it could to try to make improvements?
24 MS PARKINSON: I don't feel it was ever really taken as
25 seriously as what it should have been. I did record

1 keeping sessions with the medics and one of the
2 consistent things that was not happening was the time
3 that they reviewed patient and they just did not seem
4 to see why that was relevant. It would be there, they
5 would sign it and have the clinical, you know,
6 assessment there but they never – even when challenged
7 they did not understand why and the thoroughness of the
8 some of the record keeping. Explanations that should
9 be given to the patients that may well be given
10 verbally but were not written down.
11 PROF FORSYTH: What about in risks around
12 antenatal care? We have talked about pallia-tive care.
13 Were there incidents that came up, repeatedly came up
14 there that caused you concern that were not being
15 addressed effectively?
16 MS PARKINSON: Again, the record keeping for the
17 community midwives, some are better than others. They
18 did use perinatal notes, there was a place to write
19 things. So I always found that very disappointing when
20 people did not write something when there was somewhere
21 to write it, there was even a prompt there.
22 PROF FORSYTH: What about incidents when mothers
23 presented themselves to hospital and were triaged and
24 reading the case notes there seems to be a number of
25 incidents around there. Query loss of fetal movements

1 and matters of initial management?
2 MS PARKINSON: I never found that to be an issue. If a
3 lady rang up and said she was not feeling baby move she
4 was brought up, she was monitored, she was checked over
5 and she would be given a full assessment. I mean, a
6 member of the medical team would be brought in if the
7 findings -- that was not an area that I was
8 particularly concerned about.
9 PROF FORSYTH: When these incidents, the high
10 profile incidents began to emerge, how did you feel
11 your position was in relation to regulatory bodies
12 started to become involved? Did you feel that you had
13 the support you needed at that time? Particularly from
14 the Trust management?
15 MS PARKINSON: No I think they supported each other
16 because it was all -- can I have a drink? It was quite
17 overwhelming at the time but we supported each other.
18 Not particularly from the senior staff really.
19 PROF FORSYTH: Not particularly from senior staff?
20 MS PARKINSON: Not from senior management, no, Head of
21 Midwifery and the head of midwifery that was in post
22 when the incidents occurred was very supportive and
23 would keep us aware of what was going on.
24 PROF FORSYTH: Did you feel vulnerable at that
25 time?

1 MS PARKINSON: I think we all did but, yes, on a
2 personal level, yes, I think we did feel vulnerable.
3 All we could do was tell the truth and give the
4 information that was asked of us when we were
5 interviewed by the different people that came. We have
6 just, you know, tried to tell the truth really but it
7 was very stressful.
8 PROF FORSYTH: Reflecting on the various reviews
9 and reports that have come out, how do you feel in
10 relation to the Trust management of risk management
11 within the maternity services? Do you feel that in
12 hindsight things could have been done differently?
13 MS PARKINSON: Yes. I think hindsight is a wonderful
14 thing and I absolutely accept that things could have
15 been done differently. If they had been done
16 differently, maybe, you know, we would have learnt from
17 some of the things that happened quicker but generally,
18 you know -- I do feel that we did things as best we
19 could at the time.
20 PROF FORSYTH: Yes so is there anything, in
21 particular, you feel, I mean, you have suggested that
22 some things would have been done differently during
23 your time but learning from the report is there
24 anything you felt that either at your level or Trust
25 level things could have, should have been done?

1 MS PARKINSON: I think that the avenues for escalating
2 issues and them being acted on at a senior level, could
3 have been done better and could have been done
4 differently. I think when you look aback you think:
5 Why didn't I do that at that time? Why didn't I make
6 more of an issue of it? You can only think, well, you
7 thought you were doing the right thing at the time.
8 Yes, the reports that have come out and the
9 recommendations that have been made generally I would
10 agree with what they were saying.
11 If I had still be in post I would have been
12 working to implement them recommendations.
13 PROF FORSYTH: Thank you.
14 DR KIRKUP: Thank you. You have had a reasonably a long
15 association with the hospital. You started as a
16 midwife in 1990. We have heard quite a lot about the
17 professional relationships between different staff
18 groups. How did you find it when you started in 1990?
19 What was it like for a midwife in the unit?
20 MS PARKINSON: When I started as a student midwife we
21 were the first midwifery school for Barrow and staff
22 were very, very keen to make it work. I think, the head
23 of midwifery at the time was very proactive and she
24 also was the business manager side of things as well,
25 which probably, at the time, I did not realise but

1 later I did that, you know, we had a good training
2 budget for staff to go on external study days, the
3 staffing levels were different.
4 Then over time things seemed to change; more and
5 more responsibilities and extended roles were given and
6 taken up by the midwives and also the working
7 relationships between the medical staff I always found
8 as a practising midwife I had good working
9 relationships with the obstetricians and the registrars
10 and staff grades and a lot of us had worked together
11 for a lot of years I think that they trusted us to do
12 what we had to do.
13 DR KIRKUP: When did that change?
14 MS PARKINSON: I still felt that when I took the post
15 in 2003 that we still had reasonable working patterns
16 and working systems but it maybe it was my awareness
17 changing, maybe it was because I worked at, you know,
18 RLI then as well, saw a different system in place. The
19 staffing levels changed during that few years as well.
20 The Cost Improvement Programme did impact upon the
21 renewing staff, so that made it difficult. That always
22 challenges people, does it not, when the staffing
23 levels are not what they were used to. The working
24 relationships seemed to change more after I had left
25 the ~~clinician~~ clinical areas as such and I would listen to staff

1 and they would be saying what difficulties they had
2 with some of the medical staff then.
3 Of course, you know, the lead clinician, our lead
4 clinician at the time became the Clinician Director and
5 that removed him from the ~~clinician~~ clinical area to a certain
6 degree. There was no real change of medical staff at
7 that time. Our consultants had been in post for quite
8 some time.
9 DR KIRKUP: It is a pretty major change from what you
10 are describing to what is, for example, in the Fielding
11 Report and had been amply backed up by a number of
12 other people. How on earth could that have happened
13 within five years, six years?
14 MS PARKINSON: How do I think it happened? I am not
15 really sure. I think it is only when we looked back
16 that you realise how much things had changed. I do not
17 really think I can answer that.
18 DR KIRKUP: When did you read the Fielding Report?
19 MS PARKINSON: I didn't see the Fielding Report until
20 quite some time after it had come and the acting head
21 of midwifery, and I am relying on my memory here, but
22 the acting head of midwifery, because the head of
23 midwifery had gone secondment or sabbatical, the acting
24 head sent an email, myself and the matrons, saying,
25 "Has anybody got the action plan for the Fielding

1 Report?" Now at the time there was so many things
2 going on, I generally felt, "God, I have missed it. It
3 has been sent out and I haven't seen it." So I waited
4 to see what everybody else said because I thought I
5 cannot have missed that because we were waiting for it
6 and then we all said, "We have not seen report." So
7 that was some time in the middle of 2010, so that is
8 when we actually got sight of it and we very quickly
9 had to, you know, read it and come up with an action
10 plan from the recommendations. Which we did.
11 DR KIRKUP: You were aware that the Fielding
12 investigation, if I call it that, was taking place, the
13 Fielding review? You would have presumably been
14 interviewed by Dame Pauline?
15 MS PARKINSON: Well, I was interviewed. Yes, I was
16 very aware it was being undertaken. I was interviewed
17 but only for about 15 or 20 minutes. They asked if I
18 would mind being interviewed again because Mr. Hussain
19 was going to Lancaster and he needed to be seen by
20 them, so they said they would call me back but in
21 actual fact I never got called back by them but I was
22 interviewed for a brief period of time by them.
23 DR KIRKUP: Okay. How did that process strike you,
24 that you did not get sight of the Fielding Report until
25 people were starting to talk about action plans?

1 MS PARKINSON: A bit puzzled. We didn't know what had
2 happened to it and, to be honest, we thought that maybe
3 the head of midwifery, because the head of midwifery
4 had gone and there was different ones acting up that
5 somehow it had slipped through the net. It is only
6 fairly recently that I found out that it actually was
7 in the Trust but had not been shared with us.
8 DR KIRKUP: Okay. It must have made life difficult for
9 you, if you were the Risk Manager at that time. Would
10 not the Risk Manager have been central to the action
11 plan and the implementation of the action plan?
12 MS PARKINSON: You would have thought so, yes.
13 PHIL: Were you shocked when you read the Fielding
14 Report?
15 MS PARKINSON: Yes and in some respects disappointed.
16 I felt it was a true reflection of what was going on.
17 Obviously you don't agree with everything in a report.
18 To be honest I cannot think of any specifics at the
19 moment. It talked about, one of the major things was
20 around multi-disciplinary working was central to this.
21 It saddened me but it was not incorrect.
22 DR KIRKUP: So you were aware of how much things had
23 deteriorated from 2003 when you left the ~~clinician~~ clinical
24 position?
25 MS PARKINSON: I don't think I was aware of it as I am

1 now. I think, it was a very gradual thing. I do not
2 really know what else to say.
3 DR KIRKUP: I am interested to know how you think it
4 can have changed that rapidly and at what point you
5 became aware that it was changing? Were you perhaps --
6 let me see if I can help you a bit. Were you perhaps
7 given a rosy view of how things were in 2003? It was
8 not really quite all sweetness and light then?
9 MS PARKINSON: Well, it probably was not but I was not
10 involved in management then, so I was purely a
11 clinician at that time.
12 DR KIRKUP: Which gave you an opportunity to see it at
13 first hand and experience it?
14 MS PARKINSON: Yes, and as I have said, you know, we
15 felt that we had fairly good working relationships and
16 there was always areas and always certain doctors that
17 you knew you had to pull by a hook and get them there
18 and things like that but from what the staff told me
19 things had changed. Things were different.
20 DR KIRKUP: I want to pick up something about incident
21 reporting. I know we have discussed that briefly but
22 what was your impression of where the unit, the
23 maternity unit in Furness stood in terms of the
24 reporting indents that happened?
25 MS PARKINSON: Well, we were one of the first to roll

1 out the incident reporting systems and also first to go
2 live on the on line. At the time in them first two or
3 three years we were trying to move things forward. We
4 encouraged people to report. We tried to foster a no
5 blame culture.
6 DR KIRKUP: Did you think they responded to that?
7 MS PARKINSON: Yes, I did, because the incident reports
8 increased. Staff were utilising the system to report
9 things that they were not comfortable with or, you
10 know, incidents where things maybe were not managed as
11 appropriately as they should, plus they did the trigger
12 list as well, which was your general things.
13 DR KIRKUP: There were some that clearly should have
14 been reported as incidents that weren't, at least until
15 very much later and some probably never reported at
16 all. You must have been aware of those coming through
17 the system?
18 MS PARKINSON: I am sorry, I do not -- can you explain
19 that? I do not know what you mean?
20 DR KIRKUP: You must have seen things being reported
21 years later as incidents that should have been reported
22 at the time. You must have been aware of that. Did
23 you not think, "Gosh, why are we reporting something
24 now in 2010" or whenever it is, "that happened in
25 2004?", for example?

1 MS PARKINSON: I do not remember incidents being

2 reported several years later. Are you thinking of a

3 type of incident or a specific incident?

4 DR KIRKUP: I will go in to the details of a specific

5 incident when we are in second part of the session but

6 I thought perhaps we can talk about it in general

7 terms. Sticking to generalities then, you were

8 confident that everything that should have been

9 reported as an incident was?

10 MS PARKINSON: No, you can never say that, no.

11 DR KIRKUP: How far short were you?

12 MS PARKINSON: I do not know how far short.

13 DR KIRKUP: Did you try and assess that?

14 MS PARKINSON: I do not know whether this answers your

15 question but when we first took over the online

16 incident report, the risk adviser and myself would do

17 quarterly analysis of the incidents, look at what they

18 were the previous month and highlight any increases or

19 any decreases or anything that was being reported more

20 that what it had been before and we looked at trends.

21 So we did all that in the early part of when I took

22 that post. That was a regular thing that went to the

23 ~~Clinician~~ Clinical Governance Group and the Board were aware and

24 that template that we used at that time was held up as

25 a good example of how to analyse your risks and your

1 incidents and other divisions and departments were
2 encouraged to do it in a similar situation to develop
3 their own way.
4 DR KIRKUP: Okay. I want to ask you in general terms
5 about how the Trust managed preparations for inquests.
6 Can you take us through what the process was?
7 MS PARKINSON: Well, I was first involved in an inquest
8 in 2009, that will be right, 2009. Myself included and
9 the other staff had never been to an inquest before.
10 DR KIRKUP: Sure.
11 MS PARKINSON: So the head of Legal Services, who was
12 in the Trust headquarters at Westmoreland --
13 DR KIRKUP: Can I be clear who that would have been?
14 MS PARKINSON: Ranu Rowan. I met with her to discuss
15 what do we do? How do we prepare the staff? The they
16 are concerned. They do not know the process, we had
17 never been. So she agreed to meet with them and go
18 through the process with them and with staff working
19 shifts we cannot just do one meeting, you have got to
20 do at least couple. So she met with the staff and
21 prepared them for the inquest and went through what
22 would be expected of them for this particular inquest
23 that was going ahead and then the next inquest face
24 after that she did the same.
25 DR KIRKUP: When you say prepared them, give me a bit

1 more detail about what you went through?
2 MS PARKINSON: It would be, well, where it would be
3 held. Who would be there. How the room would be set
4 out. How the interview process would go. Who would be
5 in the room and what would be expected of them.
6 DR KIRKUP: When you say what would be expected of
7 them, can you unpack a little bit? The Coroner would
8 question them individually. That they could have the
9 statement with them if they had written a statement.
10 Yes.
11 MS PARKINSON: And they could refer to that statement.
12 Generally Ranu, because Ranu had been at many inquests
13 for the Trust, just maternity had never been at one
14 before, she was able to explain how Mr. Smith would, you
15 know, conduct himself and how they should not feel
16 threatened, just tell the truth and then where we would
17 meet on the day of the inquest and how it would go
18 forward. Whether the staff who were giving evidence
19 could be in the room while that was happening and, you
20 know, she explained all that to everybody. That was
21 generally what was said.
22 DR KIRKUP: Were there any other preparations apart
23 from those meetings that you describing with the head
24 of Legal Services?
25 MS PARKINSON: No.

1 DR KIRKUP: Did staff have their own meetings?
2 MS PARKINSON: Not that I am aware of, no. No. That
3 inquest was to do with a case that had happened, you
4 know, within a few months, so the staff were -- they
5 had their statements and they were aware of the case
6 and it had been fairly recent in their minds.
7 DR KIRKUP: Was that process that you have described
8 there the same for all the inquests that you were
9 associated with or were there any exceptions?
10 MS PARKINSON: They were all the same except because, I
11 think Ranu was on leave, I think she initially saw some
12 of the staff and then the solicitor from Hill Dickinson
13 came instead of Ranu.
14 DR KIRKUP: Who would that have been?
15 MS PARKINSON: Emma Giacamo. She met with the staff.
16 DR KIRKUP: Did she go through exactly the same process
17 that you described?
18 MS PARKINSON: Yes, except, as you are aware, she did
19 come up with some issues that she felt the staff might
20 want to consider because of questions that the family
21 had.
22 DR KIRKUP: Are we talking about -- I do not want you
23 to talk about clinical issues here but are we talking
24 about the Joshua Titcombe inquest at this point?
25 MS PARKINSON: Yes.

1 DR KIRKUP: So why were there issues that she wanted to
2 raise with the staff?
3 MS PARKINSON: I think because it had been such a long
4 time since the incident had occurred, since Joshua died
5 and a lot of things had happened. So I think she just
6 wanted to be aware.
7 As far as I was concerned that document came so
8 that we could answer them for her so that she had all
9 the information, that was my understanding of what that
10 document was.
11 DR KIRKUP: Right. The document you talking about is
12 the question and answer?
13 MS PARKINSON: No, it is the issues document. Not the
14 question and answer.
15 DR KIRKUP: Which is the question and answer document
16 then?
17 MS PARKINSON: That is from the communication
18 department that was used by them, the communication
19 team. It is based on the issues document but it is not
20 the same one.
21 DR KIRKUP: "Inquest Joshua Titcombe Q and As"?
22 MS PARKINSON: No, that is not ours. That was not
23 prepared by us.
24 DR KIRKUP: Who prepared that?
25 MS PARKINSON: The communication team.

1 DR KIRKUP: It is described in the email, again not
2 talking about clinical issues, but it is described in
3 the email as, "The responses to the questions that we
4 discussed at the pre-inquest meeting".
5 MS PARKINSON: No, it is not. That is not -- that is
6 not the document that I sent back to Emma Giacamo.
7 DR KIRKUP: Why is it attached to the email that you
8 sent?
9 MS PARKINSON: It was -- it was re-titled by the
10 communications team. There is two separate documents.
11 DR KIRKUP: I am talking about an email that you wrote
12 to and Angela Peel and lots of other staff, copied to
13 lots of other staff including midwives that had an
14 attachment to it that is --
15 MS PARKINSON: Yes, it did, yes, it did. It had the
16 questions that Ms Giacamo had asked, it had the answers
17 to the questions for her on that but the title of that
18 document was not the question and answers that come
19 from the communications team.
20 DR KIRKUP: "Inquest Joshua Titcombe Q and As", that is
21 the attachment taken from the email?
22 MS PARKINSON: Well, I know there was two different
23 documents.
24 DR KIRKUP: Okay. Sticking with the one that was
25 attached to the document. If you prepare a set of

1 answers to questions raised by a lawyer and circulate
2 it to anybody that sounds to me like coaching staff in
3 answers to questions.
4 MS PARKINSON: No, it certainly was not intentional to
5 do that.
6 DR KIRKUP: What was it intended to do?
7 MS PARKINSON: The intent was that Emma sent them list
8 of questions to me and we gave the responses that we
9 felt were accurate. I circulated them to the staff to
10 say, "Have I done this correctly? Is this the response
11 that we should give?"
12 DR KIRKUP: When you say, "We prepared the answers that
13 we thought ..." who is we?
14 MS PARKINSON: I did. I did and a matron as well, she
15 was involved.
16 DR KIRKUP: Okay.
17 MS PARKINSON: We answered the questions and then sent
18 them back to Emma because my understanding was that it
19 was Emma that needed them questions answering.
20 DR KIRKUP: You had also copied in all of the staff
21 including those who would be giving evidence to the
22 inquest?
23 MS PARKINSON: Yes, I did to make sure that what I had
24 put was accurate in case they wanted to add anything or
25 that I had not answered something correctly.

1 DR KIRKUP: You do understand that it is sounds from
2 where I am sitting as if you are preparing model
3 answers that all staff have access to? You do
4 understand that that is what it looks like?
5 MS PARKINSON: I can see now that that is how it might
6 look but it certainly was not my intention. It was
7 never the intention to coach staff to do anything, we
8 never did that. We just told them to tell the truth.
9 That they would have the statements in front of them,
10 and they would answer the questions that the Coroner
11 gave them. That certainly was not my intention when
12 that document was completed and sent back to the
13 solicitor.
14 DR KIRKUP: Excuse me for saying so, that is the effect
15 it has had. If you were doing it again how would do it
16 differently to stop if having that effect?
17 MS PARKINSON: Well, we learn from things, do we not?
18 I never thought that that was, you know, that would be
19 perceive in that way. It was certainly was not my
20 intention but I think I would be little more careful
21 next time before I did anything like that because of
22 the way it has been perceived.
23 DR KIRKUP: I am not sure it is just a question of
24 perception. I think it is a question that staff had
25 access to the same set of answers that in some senses

1 were model answer; they were the best answers we can
2 come up with to the questions. I don't think it is
3 just a question of perception that lies with at the
4 difficulty that I have with that.
5 MS PARKINSON: Well, again, I can only say, as I have
6 said before, said to the police, said to the Ombudsman,
7 it was not my intention, it was never my intention to
8 coach staff. It was just to get the answers for the
9 solicitor. That is why we did it.
10 DR KIRKUP: I think I have pushed the point as far as I
11 need to. I will ask my colleagues if they have any
12 follow up questions?
13 PROF FORSYTH: No.
14 PROF WALKER: No.
15 DR KIRKUP: I am going to have a brief pause now and
16 then move into the second clinical related part of the
17 interview. I will ask people to withdraw at this
18 point.
19 In private session
20

THE MORECAMBE BAY INVESTIGATION

Tuesday, 1 July 2014

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

Before:

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

JAYNE PINKNEY

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1

1 (At 11.00 am)

2 DR KIRKUP: Can I say for the record thank you for coming? My name's Bill Kirkup.

3 I'll ask the other members of the panel to introduce themselves.

4 PROF FORSYTH: Hello. My name's Stewart Forsyth; I'm a paediatrician and I'm

5 also a medical director from Teesside in Scotland.

6 PROF MONTGOMERY: I'm Jonathan Montgomery and I'm Professor of Health

7 Care Law at University College London, and chair the Health Research

8 Authority and in the past I've chaired PCTs and SHAs in Hampshire.

9 MS FEATHERSTONE: Hello, I'm Jacqui Featherstone and I'm Head of Midwifery

10 and Head of Nursing at a district general hospital in Essex.

11 DR KIRKUP: I appreciate it's a somewhat daunting setup and I apologise for that,

12 but the intention is for us to have a conversation with you where we find out as

13 much as you can tell us about some general points and some specific points

14 that we want to pick up with you. We have made these sessions open to

15 family members. In fact, we're not attended by any family members today.

16 That means that unless somebody comes in at a later stage, I won't need to

17 differentiate between the first part of the session and the second part where we

18 pick up any specific clinical points related to any individuals that we might want

19 to talk about, so feel free to treat it all the same. The reason for the electronic

20 paraphernalia is that we are recording you and it and we will make a record of

21 the proceedings, which other people will then be able to listen to subject to

22 there not being any confidential clinical details in there.

23 MS PINKNEY: Okay.

24 DR KIRKUP: We want to make sure –

1 PROF MONTGOMERY: Actually, I'm just going to ask those people to be quiet.

2 DR KIRKUP: Okay. As you know, we've asked everybody, including members of

3 the panel to hand in all electronic recording devices other than these and we

4 have placed a strict requirement on everybody present that they don't talk

5 about what's been the subject of today or put things on electronic media apart

6 from our summary, which will just say who you are and in very general terms

7 what we've talked about. That's because we want to be able to consider all of

8 the evidence to be able to come to a view about all of the context and not to

9 have people commenting on individual bits as we go along the way.

10 Is there anything else that I can tell you that you would like to ask

11 about at this stage?

12 MS PINKNEY: No, I don't think so.

13 DR KIRKUP: Thank you. Can I start off then by asking you if you could just tell us

14 when you first started at the Trust and what different things you've done?

15 Because I know that it hasn't always been the same job.

16 MS PINKNEY: Do you mean in midwifery or in total?

17 DR KIRKUP: If you had an association with the Trust before then, just tell us about

18 it briefly.

19 MS PINKNEY: Well, I trained in the Trust in 1977 as a general nurse, I was then a

20 staff nurse, then went on, in 1981, applied to train as a midwife, completed that

21 training in 1982, worked in the consultant unit until 1983, the end of 1983. I

22 then took up a role as a temporary community midwife and, in 1984, took on

23 that role in a permanent capacity. In 1999, I was appointed a clinical midwife

24 specialist for community midwifery, which is a fancy title really for community

manager. In 2003, my job title was changed to modern matron, so it was not a role that I applied for, it's just that the title was changed and I also had responsibility then for antenatal clinical as well.

In 2007, there was a reorganisation of the modern matron role and in my role as a modern matron, I had one day a week that was my allotted time for that role; for the rest of the time I had a full-time community caseload and I was a supervisor of midwives as well. In 2007, when the modern matron role was reorganised, the role was to be expanded and that was going to become a full-time managerial role with no clinical responsibility. My heart's always been as a clinician. I've always cherished my role as a community midwife, so I made the decision not to apply to become a modern matron and asked if I could step back to be a band 7 community midwife and that's what happened.

In, let me get this straight, 2008, we had a new Head of Midwifery or I think it might have been back end of 2007, but anyway, in 2008, the band 7 midwives were summoned to a meeting with the new Head of Midwifery. I obviously knew this person, because she had been a modern matron and I had worked with her in that role, but many of my colleagues hadn't met her and it was a very, very difficult meeting. It was a very challenging meeting, because we were advised that we were going to be re-banded, that there were financial constraints within the Trust, that the jobs – we had previously gone through the agenda for change job-matching process and we'd been matched as band 7s as community midwives, but we were told then that the matching was incorrect, that we didn't meet the job profiles for a band 7 and that we were going to be restructured. That had an absolutely devastating impact on the midwives who

1 were there.

2 DR KIRKUP: Did that apply to all midwives?

3 MS PINKNEY: All band 7 midwives across the whole Trust.

4 DR KIRKUP: Okay.

5 MS PINKNEY: So people were extremely upset. I think it was probably an
6 inappropriate time, bearing in mind that many midwives hadn't actually met the
7 Head of Midwifery before, this was our first contact. The meeting was not
8 minuted, HR weren't represented, so it was a very difficult meeting and that
9 had a significant impact, I think, on morale for all the band 7 midwives across
10 the Trust. We were – I think we felt devalued, demoralised.

11 We arranged to meet with HR. We arranged to meet with the Royal
12 College of Midwives. We met with our local MP. We felt aggrieved because
13 we had been matched only, I think, maybe two years before and told, you
14 know, we had matched the job description that, actually, the Head of Midwifery
15 was involved in writing as a modern matron at that time. So, anyway, the
16 process went on. I think it was actually in 2010 that we got notification that,
17 yes, this was happening, that we were to apply for the specific band 7 roles
18 that had been created.

19 DR KIRKUP: So what had happened in the intervening two years then?

20 MS PINKNEY: I think they were just going through the process, like, you know,
21 looking at, I suppose, what natural wastage there would be, looking at what
22 roles they were going to develop, you know, because they did develop actually
23 quite a lot of specialist band 7 roles. So people were – had informal interviews
24 and then formal interviews depending on what they chose to apply for. People

1 who chose not to apply for the roles were down-banded to a band 6 post. It
2 caused massive upset.
3 DR KIRKUP: How many did that apply to?
4 MS PINKNEY: In the end, it didn't actually apply to too – in fact, I think it really only
5 applied to community midwives. The labour ward midwives – I think there were
6 maybe half a dozen people who ended up being down-banded, but another
7 issue that people felt aggrieved about at that time was the Trust had just
8 changed its pay protection policy the month or two months before. Whereas
9 previously people would have had five years pay protection that was
10 down-banded, the Trust reduced it to two years. So, where people would have
11 previously – it almost felt like they – I know it probably wasn't the case, but it
12 almost felt like they'd waited until, you know, everything was ripe for them and
13 then they did what they did. And certainly within our team, as community
14 midwives, it caused massive upset, because all of a sudden you had
15 colleagues who had worked together for 20 years in some situations and then,
16 all of a sudden, some were 7, some were 6 and, actually, lots of them were
17 doing very similar clinical work. So it was a very difficult time.
18 DR KIRKUP: Sure. You started to say something about the labour ward midwives
19 there. Did this policy apply to them as well?
20 MS PINKNEY: I don't think any of the labour ward midwives were down-banded,
21 because they needed band 7 – I think they all slotted in to band 7 labour ward
22 coordinator roles.
23 DR KIRKUP: Okay.
24 MS PINKNEY: Yeah.

1 DR KIRKUP: Okay. Thank you. I'll hand you over to Jacqui.

2 MS FEATHERSTONE: Okay, thank you. You were just saying about the
3 community, so were there some band 7s out in the community then or...?

4 MS PINKNEY: We were all band 7s apart from the rotational midwives who came
5 out of the unit to work with us. So they developed some specialist community
6 roles – mental health, drug and alcohol, although the drug and alcohol post
7 was actually in place already. So people were invited to apply for specialist
8 roles and there were two community lead posts established as well, which I
9 was appointed to and a colleague. But the midwives who were downgraded, a
10 colleague in particular – well, several colleagues I don't think ever got over it
11 really and left in very difficult circumstances.

12 MS FEATHERSTONE: And is that your present post now then?

13 MS PINKNEY: No, because I was restructured again in 2012. They decided – I
14 mean, really I felt that the opportunity to get the post right was there in 2010
15 and I don't think they did. We didn't need two lead community midwives. We
16 were a team of 14; at that time it should have been one, but anyway, I was
17 invited to apply again for my post and again, because I was approaching a
18 certain age, I declined and I undertook flexible retirement and now work
19 part-time as a band 6 midwife.

20 MS FEATHERSTONE: You said you were a supervisor of midwives.

21 MS PINKNEY: Yes.

22 MS FEATHERSTONE: Are you still?

23 MS PINKNEY: No, I resigned in 2008, because of how I felt really. I was very
24 disillusioned.

1 MS FEATHERSTONE: With management or with what?

2 MS PINKNEY: I was disillusioned with everything that was happening around that
3 time, they were reducing staffing within the maternity unit, particularly on the
4 labour ward and that caused, again, massive upset, particularly to the labour
5 ward midwives and there were a number of very, very heated meetings at
6 which I was present at some of them. I think the staff felt it was unsafe to
7 reduce staffing, but the drive at that time was financial, absolutely. My belief is
8 that the finances were driving everything. That's how it felt, at the expense,
9 possibly, of safety. I know that's quite a strong statement, but that's how it felt
10 to me.

11 I was becoming disillusioned with supervision. I felt the LSA were not
12 particularly supportive. I had been involved in several situations, which was
13 nothing to do with any of the families concerned, more to do with – well, I had a
14 particular situation with an independent midwife whose practice I felt was not
15 safe and I felt very unsupported when I contacted the LSA. It felt very reactive.
16 I felt that we weren't supported as supervisors. You know, we literally had the
17 guidance, the LSA guidance and that's – that was our bible really and it felt
18 whenever you needed additional support it didn't really feel as if it was there.
19 You know, I could go on the phone and ask for advice and then I'd get off the
20 phone and think, 'Well, she's very nice but what did she actually say? What
21 did she say?' You know, so – also, because of the staffing being reduced, as a
22 supervisor or as a group of supervisors, we were being called into the unit on a
23 regular basis to fill the gaps in staffing and I was doing 2-3 on calls a week as a
24 community midwife, I was doing seven night blocks on call for supervision and I

1 had just had enough. So I resigned as a supervisor in 2008.

2 MS FEATHERSTONE: Was there a manager on call at the same time?

3 MS PINKNEY: No.

4 MS FEATHERSTONE: So just –

5 MS PINKNEY: There may have been – when you say 'a manager', I mean,
6 obviously within the Trust there would have been somebody, but there weren't
7 midwifery managers that I'm aware on call.

8 MS FEATHERSTONE: So if there were staffing issues –

9 MS PINKNEY: They called the supervisors.

10 MS FEATHERSTONE: They always called the supervisor, which actually isn't what
11 –

12 MS PINKNEY: No, it isn't and we knew that, but the bottom line is if there's not
13 enough staff safety's going to be compromised, so we went.

14 MS FEATHERSTONE: Were the community ever called in?

15 MS PINKNEY: Occasionally community would be called in. They did actually –
16 when there was all the discussion when they were talking about reducing
17 staffing on nights, they decided they would do an on-call rota for hospital
18 midwives, so that if, you know, if there was a problem overnight they would
19 have somebody to call and that continued for quite a while. I think that's only
20 just sort of stopped in the last year or two.

21 MS FEATHERSTONE: So, as a supervisor, were you involved in investigations
22 doing, you know, part of the LSA investigations when you were supervisors,
23 were you involved as a team doing those?

24 MS PINKNEY: The incidents that I was involved with really were – they were

1 discussed as a team, but two supervisors actually did the investigation.

2 MS FEATHERSTONE: And did they run alongside the management investigations

3 or how did it fit in with the governance?

4 MS PINKNEY: I'm just thinking about a particular incident where, I think, it really

5 was the supervisor investigation came first and then there was a management

6 investigation.

7 MS FEATHERSTONE: And how was either from a supervisory sort of

8 recommendation and the recommendation of management, how was that

9 shared within the multidisciplinary team?

10 MS PINKNEY: I don't think that I was involved in discussions at that level. I think it

11 came to the Head of Midwifery then and she took that role on and she was a

12 supervisor as well. I'm not very clear about that.

13 MS FEATHERSTONE: Okay. Sometimes when you were out in the community did

14 you come in to the hospital or did you tend to work only out in the community?

15 MS PINKNEY: Well, because I only had one day a week in that role, I used to come

16 in often very early in the morning because I just didn't have enough time. So I

17 would be called in – I would come in for meetings. I would always start the day

18 in the hospital and I would come in as well if I was needed, you know, for

19 anything.

20 MS FEATHERSTONE: So how then was communication fed out to the community,

21 because it's always sort of – communication is sometimes, you know, if you're

22 in the hospital, if on that day you get that communication about what's been

23 happening, how was the communication fed out and distributed to the

24 community?

1 MS PINKNEY: Because we had regular community midwives meetings and –

2 MS FEATHERSTONE: Which was led by…?

3 MS PINKNEY: Well, either the Head of Midwifery when – the first Head of Midwifery

4 that we had when I was first a matron, up until 2007, was a very – she was a

5 very visual person, you know, she was there, she was a presence on the unit

6 all the time and staff felt very supported by her. So she would come to the

7 community midwives meetings. She was very, very supportive of the midwives.

8 I have to say I'm not sure that she was perceived as being very effective at a

9 higher level. I don't think she was very strong at, you know, at a board level

10 certainly. The Head of Midwifery that came after her got off to a bad start, as

11 I've said, you know, with this meeting that she had. She was – she'd been a

12 matron and a midwife and led a unit. She had never, that we were aware of,

13 ever worked in a consultant unit, so then it seemed like did she have the

14 experience? It didn't feel that she supported us very well, you know, to then be

15 the Head of Midwifery across two consultant units and she wasn't very strong.

16 So she – I don't think she ever came to any of the community midwives'

17 meetings. She wasn't very visible really.

18 MS FEATHERSTONE: Okay. With the multidisciplinary meetings on the labour

19 ward or in the hospital, so, you know, were there other –

20 MS PINKNEY: There were meetings. The matrons, the senior midwives met with

21 the consultants on a fairly regular basis. There were directorate meetings with

22 the directorate manager, consultants, senior midwives. There were

23 supervisors' meetings and cross-bay meetings as supervisors and local, you

24 know, so…

1 MS FEATHERSTONE: Were governance issues discussed at directorate
2 meetings?
3 MS PINKNEY: Yes.
4 MS FEATHERSTONE: So if there'd been a particular SI that month or – would that
5 have been discussed there?
6 MS PINKNEY: Probably not there. I don't recall it would be discussed there. The
7 process for clinical incident reporting was – I mean, there were regular
8 meetings and it was led by one of our consultants and it involved midwives,
9 gynae staff as well, but it wasn't cross-bay. That was just – it was a local
10 meeting and actions were taken, but it wasn't disseminated very well.
11 Obviously, the system now is very different and obviously much more effective,
12 but I don't feel it was particularly effective at that time.
13 MS FEATHERSTONE: What about complaints? Did that come up as well, the
14 process of making formal complaints?
15 MS PINKNEY: We had a guideline, we had a process, but I don't recall it was
16 discussed at directorate meetings.
17 MS FEATHERSTONE: If there was a complaint about, in particular, what happened
18 in community, how would you know that there was a complaint about –
19 MS PINKNEY: Because it would come to me to be investigated, depending on what
20 the issues were.
21 MS FEATHERSTONE: And did you do the response or did that go back?
22 MS PINKNEY: It would go back to the – well, I would obviously investigate it and
23 write my response and then it would go back to the I think it's now called the
24 Customer Service Department, but it was Complaints and Litigation

1 Department. It would go back to them and then, depending on what the
2 person – if the person – you know, if the complaint was resolved, if the issues
3 were resolved at that level, or sometimes there would be meetings and people
4 would be invited in to discuss their issues.
5 MS FEATHERSTONE: And did you have an MSLC within the hospital?
6 MS PINKNEY: There had been one and then, for whatever reason, it was
7 disbanded. I wasn't really involved in that, but there had been one and I don't
8 know why it was disbanded or when that happened, but it seemed like it was...
9 I'm not quite sure, maybe around 2006, 2007.
10 MS FEATHERSTONE: And then was there any service user input after that?
11 MS PINKNEY: Yes, because we had a maternity – I can't remember what we called
12 it. We had a group where we met with – and users were part of that with – and
13 we had – consultants were invited and we had GPs and midwives, yeah, and
14 that happened, but again that was disbanded as well.
15 PROF MONTGOMERY: You said consultants were invited, did they go?
16 MS PINKNEY: Yeah. Yes. Yeah, most of the time, I would say.
17 MS FEATHERSTONE: And what was discussed at those meetings?
18 MS PINKNEY: Issues relating to maternity care, the way – you know, initiatives that
19 were being developed, you know, things like – we would talk about, let me
20 think... When we were developing the screening policy that was discussed
21 there. Just general day-to-day things that were happening.
22 MS FEATHERSTONE: And did recommendations come out of it and actions and
23 were they minuted meetings?
24 MS PINKNEY: They were minuted. I'm not quite sure about actions specifically. I

1 can't remember.

2 MS FEATHERSTONE: And were they distributed then to –

3 MS PINKNEY: Yes, they were.

4 MS FEATHERSTONE: The other thing I was going to ask you about was about

5 inpatient surveys and staff surveys. Did that happen within the unit?

6 MS PINKNEY: Yes, it did. I don't know about staff surveys as much, but there were

7 certainly patient surveys, particularly done in sort of antenatal clinic and – I

8 mean, it wasn't sort of a continual, ongoing process as it is now, but it was

9 done periodically.

10 MS FEATHERSTONE: And when the results came back, what happened to those?

11 MS PINKNEY: Well, it would be discussed and actioned, I guess, if that was – I

12 can't really recall, to be honest, but I'm sure that it was actioned, if there were

13 specific things that could be actioned.

14 MS FEATHERSTONE: Yes. Okay, that's just my first few; I'll come back.

15 DR KIRKUP: Okay. Stewart.

16 PROF FORSYTH: Thank you. Can I ask you about the time when you were

17 working in the labour suite, in the –

18 MS PINKNEY: I never really worked in the labour suite.

19 PROF FORSYTH: You didn't work in the labour suite at all.

20 MS PINKNEY: Only occasionally.

21 PROF FORSYTH: Right.

22 MS PINKNEY: Because my role was in community.

23 PROF FORSYTH: Yes, but I thought you came in and did some bank work.

24 MS PINKNEY: Yes, I would come in if – well, it wasn't bank. If the unit was short,

they would ring and we would go in for that shift. So it wasn't a planned…

PROF FORSYTH: Okay. Even from that experience, I'll come back to the community in a moment, but just in relation to that, we're interested in the relationship with the medical staff and you mentioned about there was also some communication between the senior midwives and consultants, but in terms of day-to-day practice I wondered how you felt, the midwives, how effective it was, the relationship with the obstetric and also with the paediatric staff. Did you think it worked well?

MS PINKNEY: We had very little formal contact with the paediatric staff. I've been thinking about this before I came really and they used to hold – the paediatricians used to lead a meeting periodically where they would look at interesting cases, but actually, in terms of things like clinical incident meetings and things like that, the paediatricians were never involved. So we used to see the paediatricians, but that would be, you know, when they came on to the labour ward if there was anything interesting happening, but there was very little formal contact with the paediatricians, in my experience.

PROF FORSYTH: And so if you suddenly had a baby post-natally unwell, did you feel the paediatric support was available when you needed it?

MS PINKNEY: Do you mean on the labour ward or generally?

PROF FORSYTH: Both.

MS PINKNEY: I would say yes. I would say yes, but I think that the – as I said, the day-to-day contact was informal and quite limited. But if there was an issue, they would generally be there. Yeah, they would.

PROF FORSYTH: Okay.

1 MS PINKNEY: Yeah.

2 PROF FORSYTH: In terms of the community, I think we've sort of touched upon it a
3 bit, about the communication between the community staff and the hospital, so
4 that if there was a baby being discharged who may have been a sort of
5 high-risk baby around the time of delivery, how did – in terms of ensuring that
6 the community midwife – midwifery staff were fully informed, did you feel that
7 process worked well?

8 MS PINKNEY: You mean communication from the midwives on the ward to
9 community?

10 PROF FORSYTH: Yeah.

11 MS PINKNEY: I think it depended very much on who was doing the paperwork
12 really.

13 PROF FORSYTH: Yes.

14 MS PINKNEY: It wasn't always as good as it could be. Sometimes it was excellent,
15 but I think at times the staff were under a lot of pressure in the hospital and
16 maybe – on occasion, maybe the communication wasn't always as good as it
17 could have been, but by and large and in the early days of when I was on
18 community – in the early days, you know, when I was young, we used to visit
19 people twice a day. We used to go out twice a day and then every day up until
20 day 10, so babies did get quite a lot of – and mums got a lot of input. Sadly,
21 that's no more. Not sadly that we don't go twice a day and we don't go every
22 day, but we don't...

23 PROF FORSYTH: And were you involved in terms of policies that were –

24 MS PINKNEY: In terms of community policies. I had little to do with the

1 development of hospital policies, but in community.

2 PROF FORSYTH: Something like, for example, group B strep policy.

3 MS PINKNEY: The group B strep policy was very much – do you mean historically
4 or now?

5 PROF FORSYTH: Well, historically, but obviously if it's changed now we'd like to
6 know about it.

7 MS PINKNEY: Historically it was the paediatricians. The paediatricians very much
8 wrote the policies in relation to group B strep and anything relating to the
9 paediatric side really. And now it's much more of a joined up process and
10 every – I mean, the guidelines are sent out across the Trust and everybody has
11 the opportunity to have input into the development of policies and it's a much
12 better process than it was in the past.

13 PROF FORSYTH: Right. What about the policy around a mother presenting herself
14 to the hospital concerned whether there's foetal movements or something else
15 and then is sent home? Was there a policy around that as to who – for
16 example, if you saw a lady in the community and were concerned and sent up?

17 MS PINKNEY: Now?

18 PROF FORSYTH: Well, historically as well.

19 MS PINKNEY: Sorry.

20 PROF FORSYTH: Did you feel there was a policy around that in terms of what you
21 would expect for the lady who was sent up to the hospital?

22 MS PINKNEY: I can't recall whether we had a specific policy historically for reduced
23 foetal movement, but if I had seen a woman in community with reduced foetal
24 movement, we do actually have now a day assessment unit, which we didn't

1 have in the past, so the woman would have been directed to the labour ward
2 and they would have dealt with that, and then, depending on what the situation
3 was would determine what happened next. If, you know, if the CTG was fine,
4 she had a scan and the growth was fine, then she would come back probably
5 to community. If there were any issues, then obviously the labour ward would
6 deal with that. Sometimes they would also maybe, you know, make her an
7 appointment to be seen in the next available consultant clinic. It depends on
8 what the situation was after the woman had been assessed.
9 PROF FORSYTH: Yes, yes, clearly. But you felt comfortable with those
10 arrangements.
11 MS PINKNEY: Well, I felt comfortable in my role because I knew what I needed to
12 do. Whether that was necessarily reflected in a policy, because I don't actually
13 recall if there was a policy in relation to that then, which there obviously is now.
14 PROF FORSYTH: Okay, thank you.
15 DR KIRKUP: Just before I pass on to Jonathan, just to pick up a point that you
16 raised there. You said if the CTG was fine; who made the decision on what
17 was a fine CTG?
18 MS PINKNEY: It would probably be the registrar on the labour ward or the
19 consultant, depending who was available at the time. Yeah.
20 DR KIRKUP: Okay. Jonathan.
21 PROF MONTGOMERY: Thanks very much. I wonder if I could ask you, so I can
22 understand better some of the things you've talked about, and I wanted to start
23 with and understand supervision, because you described a couple of things
24 that were dysfunctional – lack of support from the LSA, being called in to cover

1 the shortages of staff. Just explain for us how it should have worked and the
2 good sides of supervision.
3 MS PINKNEY: Well, supervision's about safeguarding mums and babies
4 fundamentally. It's about quality, ensuring quality and supporting midwives to
5 deliver a quality service, fundamentally and, you know, it's a role that if it works
6 well is massively important within maternity. You know, we're very fortunate
7 within maternity to have a system like supervision, which doesn't exist within
8 nursing. It raises challenges. It can be very, very challenging. It can be
9 challenging dealing with difficult situations. It can be very challenging dealing
10 with difficult situations when it involves people that you work with, potentially
11 colleagues, because supervision is not hierarchical. You are supervising
12 people that you work with every day and, as a clinician, you know, that can be
13 very challenging and it requires a considerable degree of integrity to be able to
14 separate one role from the other. It can be very difficult.
15 PROF MONTGOMERY: It would really help me, can you give an example of a bit
16 where it worked really well and a bit where that was difficult and didn't work
17 well from your time as supervisor?
18 MS PINKNEY: I haven't been a supervisor for seven years, but I suppose it came to
19 the fore really without sort of a specific situation, where you could maybe
20 identify that somebody had a specific learning need and that you were able to
21 put things in place to enable them to develop that role and that certainly
22 happened in sort of several situations that I was involved with. Midwives who –
23 or a midwife I can think of who had sort of failed to interpret maybe a CTG in
24 the way that it should have been done and so we were able to facilitate her to

1 develop in that area and I think she went away, actually, to another busy labour
2 ward area to gain some experience in that.
3 PROF MONTGOMERY: And. as supervisor, you would have stayed as her
4 supervisor through that, so you could see what she learned.
5 MS PINKNEY: Absolutely. Well, it very much depended really. If you were the – it
6 depended on what your role was as supervisor, because if you were
7 investigating – you know, if you were the investigating supervisor or you were
8 that midwife's – you could be there as the midwife's supervisor to support her
9 and to – I'm losing my thread.
10 PROF MONTGOMERY: I understand the difference. You're a regulator supervisor;
11 the intention to practise comes to you –
12 MS PINKNEY: You had to be very specific and clear about your role. If you were
13 investigating, then you needed to sort of take a step back, or if you were the
14 midwife's supervisor then clearly you needed to be there to support her.
15 PROF MONTGOMERY: How many of you were there and what was the balance of
16 investigation and the supervision part?
17 MS PINKNEY: How many were we? Well, it varied, because people sort of came
18 and went over the years. I would imagine we were probably, maybe, at best
19 about six.
20 PROF MONTGOMERY: And if there was an investigation, there would have been
21 two of you –
22 MS PINKNEY: There would be two of us investigating and a midwife would be the
23 supporting midwife, the supporting supervisor for the midwife.
24 PROF MONTGOMERY: An example of an investigation that wasn't very

1 satisfactory, that you didn't think – can you give us an example of the –

2 MS PINKNEY: Well, I felt – well, I suppose I could talk about the independent

3 midwife as well, who I felt extremely uncomfortable that this midwife had taken

4 on a very, very high-risk patient who wanted a home birth [redacted]

5 [redacted] And we were very

6 – you know, we were happy to support her, but she chose to employ an

7 independent midwife who lived in York, which is a considerable distance away,

8 obviously, from Barrow-in-Furness and this woman was, as I've said, high-risk.

9 I felt that it wasn't acceptable for a midwife who lived possibly three hours'

10 drive away to be taking on the care of this woman. I contacted the LSA to ask

11 for advice and basically they said, 'Well, you know, until something goes wrong

12 we can't do anything about it'. I actually contacted her supervisor of midwives

13 in York and spoke to her and said I was very concerned that this midwife was

14 taking on the care of high-risk women so far away, but it didn't really – didn't

15 really come to much and, in the event, the woman ended up delivering

16 [redacted] at home whilst our community midwives were en

17 route. So I felt very let down.

18 DR KIRKUP: Presumably the uterus was still intact at that point.

19 MS PINKNEY: Yes, yeah.

20 PROF MONTGOMERY: Thank you. Still with the example to help me make sense

21 of what's going on, there's been quite a lot of troubles and that's why we're

22 here, invited to the unit.

23 MS PINKNEY: Yes.

24 PROF MONTGOMERY: Can you give an example of how some of those worked

1 their way through the system that you described to Jacqui? I'd just like that feel of how you might have been involved in, it wouldn't have been a community problem necessarily, but discussing an example of a death on the ward in the MS.

5 MS PINKNEY: Well, I actually wasn't involved in any maternal deaths or I wasn't involved as a supervisor in any neonatal deaths, as I recall.

7 PROF MONTGOMERY: So they weren't discussed in any of the meetings that you were in.

9 MS PINKNEY: Well, if you're talking about specific issues, I had resigned as a supervisor in 2008. I actually have looked back through some of the minutes of meetings that were held at that time and I had given my apologies to several of the meetings and one of the meetings where it was discussed – sorry, one of the meetings where I was present, which I think was in the October of 2008, it wasn't actually discussed at that meeting. So I wasn't actually party to any sort of discussions around specific cases.

16 PROF MONTGOMERY: So it's your feeling that they were discussed and things were done, you just happened not to be there –

18 MS PINKNEY: I know that they... No, it wasn't that I didn't want to be there; I was on annual leave.

20 PROF MONTGOMERY: No, I said that you weren't there; I didn't mean you deliberately didn't go.

22 MS PINKNEY: Yes. As far as I could see in the minutes, I wasn't present when any of the issues were discussed and I was sort of backing out of supervision really at that time and, as I say, I did resign in 2008.

1 PROF MONTGOMERY: Did you say there was a system of follow-up, because
2 there were discussions at meetings that you weren't at?
3 MS PINKNEY: I'm sure it would have been discussed. It will have been discussed
4 at cross-bay supervisors' meetings, because they were being held quite
5 regularly. You know, they weren't just local meetings, they were cross-bay
6 meetings as well and I'm sure it will have been discussed at senior midwives
7 meetings across the Trust, because obviously it's, you know, a very serious
8 situation.
9 PROF MONTGOMERY: And I take it from that that you weren't involved in any of
10 the inquests there were.
11 MS PINKNEY: No.
12 PROF MONTGOMERY: The other thing I just wanted to understand a bit more was
13 around the staffing level discussions and you set out the process from the point
14 of view of the re-banding and all those sorts of concerns and I wondered how it
15 was justified by the Head of Midwifery. Did they make reference to
16 Birthrate Plus...?
17 MS PINKNEY: Birthrate Plus had been – I think it had – I'm not sure if –
18 Birthrate Plus had been done around – maybe around 2000 it had been done
19 initially and that indicated that there were, particularly at RLI, at Lancaster, I
20 think there were significant issues in relation to staffing. There were some
21 shortfalls identified at Furness, but the issues at Furness were more – or they
22 identified that they were more in relation to skill mix. I can't recall when it
23 happened again, because they did do Birthrate again, and that might have
24 been around 2009, 2010, somewhere like that and the information relating to

1 that wasn't actually disseminated to everybody, but I guess that that identified
2 staff shortages, because there was a massive recruitment drive. I can't just
3 recall when it was.
4 PROF MONTGOMERY: And how did the Head of Midwifery respond to the
5 concerns about safety?
6 MS PINKNEY: Do you mean following on from the meeting that we had –
7 PROF MONTGOMERY: You described the discussion on re-banding in the
8 2008-2010 period where they set out to change the staffing structure, so they
9 took quite a long time to implement it.
10 MS PINKNEY: I think staff were under enormous pressure. I think staff, as I said
11 before, felt devalued, because it seemed as if – obviously the Trust was under
12 financial constraints, as the NHS is generally, but it felt like that was driving
13 everything. That's how it felt to me and I do remember reading, you know, the
14 Trust logo that said, you know, 'The needs of our patients will drive everything
15 that we do' and it didn't feel like that. It felt like the need to save money will
16 drive everything we do.
17 PROF MONTGOMERY: And when the issues about safety were raised with the
18 Head of Midwifery, did she respond in any way?
19 MS PINKNEY: I don't know. I wasn't party to the discussions around what
20 happened then, because obviously those meetings were held at a higher level,
21 but the staff were extremely concerned and, as I said, there were several very,
22 very heated meetings with the Head of Midwifery and matrons and midwives
23 where the midwives clearly stated that it wasn't safe, that staffing levels were
24 not safe, particularly on nights.

1 PROF MONTGOMERY: And were you at some of those?

2 MS PINKNEY: That seemed to be the biggest issue.

3 PROF MONTGOMERY: What was the response from the Head of Midwifery?

4 MS PINKNEY: Well, I think the response was just that we've got to do it and how
5 are we going to do it and that's where the idea came from to put people on call
6 to cover the unit at night. But I think as well there was quite – certainly around
7 2008, there were quite significant levels of sickness as well, which impacted on
8 what was already happening. People felt that we were not a team and that's
9 very sad really, because we always had been a good team and the links
10 between community, labour ward, maternity had always been excellent, but it
11 just seemed to disintegrate really. It felt like well, we're not valued and, as
12 individual midwives, morale was rock bottom really.

13 PROF MONTGOMERY: Thank you. The last area for me, you talked about the fact
14 that the meetings – I can't remember the phrase you used, but it meant it
15 wasn't very cross-bay, they were local meetings on –

16 MS PINKNEY: There were cross-bay meetings as well.

17 PROF MONTGOMERY: I'm trying to get a picture for how, on both the hospital unit
18 and the community team sort of kept themselves aware of how things were
19 done in different places, how current awareness worked, what sort of support
20 you got for personal development and those sorts of areas. It's partly, as a
21 team how did you find it, but it's also what sort of support was there for
22 people's development?

23 MS PINKNEY: Well, we, as a team, were – we had mandatory training days where
24 we were required to go and update, you know, clinical skills and emergency

1 drills and that kind of thing, but we were also updated in terms of things that
2 were happening in relation to public health, all kinds of issues really. And there
3 were some in-house study days and things. People were encouraged, I would
4 think – I'm just – it's very difficult to remember what was happening at particular
5 times, but quite a number of colleagues were going through sort of degree
6 programmes and there was funding for the local university that people could
7 take advantage of to do modules and things, so…
8 PROF MONTGOMERY: And can you think of any particular service changes that
9 happened as a result of what was learned from either personal development –
10 MS PINKNEY: Well, I did a degree – part-time degree through – it seemed to go on
11 forever, I just can think when I graduated, but anyway I did a dissertation on
12 the role of the community support worker, which we hadn't had at that time.
13 And as a result of that we developed that role and they're absolutely invaluable
14 in our team now. We have an excellent – I'm rambling a bit now, aren't I?
15 Sorry.
16 PROF MONTGOMERY: No. I'm trying to get – you've described the system to me
17 and I'm trying to understand how it actually worked in practice, so that's really
18 helpful, thanks.
19 DR KIRKUP: Okay. Jacqui.
20 MS FEATHERSTONE: There was just one thing about record-keeping. As a
21 supervisor, were you involved with – you talked about mandatory training, so
22 as a supervisor were you involved in record-keeping sessions as part of that
23 mandatory?
24 MS PINKNEY: We obviously audited records on quite a regular basis and we

1 always did it as part – I don't know if you're aware that all midwives meet with
2 their supervisors and have an annual review and that's looking at any practice
3 issues they've identified and any practice issues that we may have identified
4 and we always audited three sets of notes of each midwife at that time. We
5 also – latterly, it became the responsibility of all band 7 midwives to audit so
6 many sets of notes every month.
7 MS FEATHERSTONE: And what happened with those audits?
8 MS PINKNEY: It was fed back to the – through the sort of risk management route if
9 there were any issues identified, but there was a midwife who – her role was
10 primarily to – I think I'm just getting a bit confused. If we identified through
11 supervision, then that would be something that the supervisors themselves
12 would look at, but if we were just doing – you know, if we were auditing as
13 band 7s, then you would feed back to the midwife concerned and then the
14 matron would get a copy also of that audit, yeah.
15 MS FEATHERSTONE: And what sort of things would you talk to your supervisee
16 about with regard to retrospective record-keeping?
17 MS PINKNEY: Well, we had a checklist.
18 MS FEATHERSTONE: Yeah.
19 MS PINKNEY: Yeah, so we would go through the checklist.
20 MS FEATHERSTONE: Yeah.
21 MS PINKNEY: We would go through the records and it would be anything or
22 everything, really.
23 MS FEATHERSTONE: Okay. But in particular, retrospective record-keeping, what
24 generally would happen within – we've looked at lots of notes and retrospective

1 record-keeping seems to be quite a lot. If you went through some notes, you
2 know, those retrospective records –
3 MS PINKNEY: Yes.
4 MS FEATHERSTONE: What sort of things would you be bringing up that you would,
5 you know, hope that that would – you know, you'd be able to see?
6 MS PINKNEY: I would want to see that it was clearly acknowledged that it had been
7 written retrospectively. I would want to see the date that it was written and the
8 date that it referred to. I would want to see that it was – that it recorded
9 actually what happened, obviously that it was signed and that the signature
10 was printed. I'm not sure –
11 MS FEATHERSTONE: Was it something that you would say that it was done
12 routinely or in the norm or would you say...?
13 MS PINKNEY: I don't think it was done routinely. I think it would be done in a
14 situation where a midwife was, you know, if the labour ward was extremely
15 busy and the midwife had not had time to complete the records at that point. It
16 certainly wouldn't be routine.
17 MS FEATHERSTONE: But in the sense that she didn't have any time whilst she
18 was working with that woman, but when she'd finished when you would expect
19 them to?
20 MS PINKNEY: As soon as possible. As soon as she was able and I'd also expect
21 that anything she had used to doc – even things like, you know, sometimes I've
22 seen paper towels used for people to document things on while they're in the
23 room and I would expect that to be actually added to the notes. Anything that
24 was written at the time on whatever medium really should also be in the notes.

1 MS FEATHERSTONE: Yeah, but before she left the shift you'd expect that –

2 MS PINKNEY: Absolutely, yes, I would.

3 MS FEATHERSTONE: Okay, that's what I wanted to ask, thank you.

4 PROF MONTGOMERY: Can I just ask, in follow-up to that, what your perception of
5 the pattern of record-keeping was at – between the midwives that you
6 supervised and would it be different in Furness from elsewhere? I can't quite
7 tell whether –

8 MS PINKNEY: I never audited any notes from elsewhere. I think generally the
9 standard was okay in the midwives that I supervised. I know that there were
10 issues with record-keeping and... Yeah, I'm not really...

11 PROF MONTGOMERY: Can I push you a little bit about what the standard is that's
12 okay and how that's generated? You obviously had an audit tool.

13 MS PINKNEY: We did have an audit tool.

14 PROF MONTGOMERY: How were the standards against which you were auditing
15 generated? Were they local, were they NMC standards or what?

16 MS PINKNEY: They were local standards incorporating NMC standards as well.

17 PROF MONTGOMERY: Thank you.

18 DR KIRKUP: Just to continue on that for a minute longer, was one of the standards
19 to do with the amount of retrospective record-keeping? I absolutely accept that
20 you have to do it sometimes –

21 MS PINKNEY: No, I don't think it was. I don't think it was one of the standards, no.

22 DR KIRKUP: Did it ever strike you that there was rather a lot of it in Furness?

23 MS PINKNEY: To be honest, most – a lot of the midwives I supervised were
24 community midwives, so they weren't necessarily labour ward records.

1 DR KIRKUP: Okay.

2 MS PINKNEY: They were antenatal records and care plans relating to antenatal
3 and postnatal care. So I didn't really supervise many labour ward midwives, so
4 I wouldn't say, in my experience, that I saw a lot of retrospective
5 record-keeping.

6 DR KIRKUP: Okay, thanks. We're nearly there. There's just a couple more that I
7 wanted to pick up with you. You talked a bit about the relationship between
8 midwives and paediatric staff. Can I ask you to make the same kind of
9 reflections on the relationship with obstetrics staff?

10 MS PINKNEY: I think we generally had good very relations with obstetrics staff.
11 They were a visible presence. I mean, the quality of some of the registrars we
12 had wasn't always great. I think there continues to be some issues with
13 medical staff in light of what's happened as a consequence of events.

14 DR KIRKUP: Just expand on that a bit for us.

15 MS PINKNEY: We have much more rigorous guidelines and processes in place, but
16 the midwives, I think, feel that we are practising under intense scrutiny and we
17 are very anxious that something will be missed and people will be held to
18 account, which is understandable but it doesn't seem to apply necessarily to
19 medical staff in the same way. In that if a midwife misses something, there'll
20 be a phone call, you know, and you will have to explain why you didn't do – for
21 example, a colleague forgot to plot – are you familiar with customised growth
22 charts?

23 DR KIRKUP: Yes.

24 MS PINKNEY: A colleague forgot to plot on a customised growth chart one

1 attendance and it didn't affect the outcome, but she was summoned to
2 Lancaster to explain why she hadn't done this. And we regularly see
3 customised growth charts that medical staff rarely fill in and these are the
4 women who are high-risk, so...
5 PROF MONTGOMERY: And whose responsibility is that to follow up, do you think?
6 MR PINKNEY: I don't know. I don't know whose responsibility. It feels like –
7 DR KIRKUP: Who does the summoning of the midwives to Lancaster?
8 MS PINKNEY: Whoever: risk – risk, midwife, whoever, whoever, I don't know,
9 matrons.
10 DR KIRKUP: Right. It will be somebody in the nursing and midwifery panorama.
11 MS PINKNEY: It would be, yeah, somebody within midwifery.
12 DR KIRKUP: Yeah.
13 MS PINKNEY: But we feel still that we have a long way to go, because obviously
14 this process has a long way to go and whilst we have very stringent guidelines,
15 as I've said before, which we were all able to contribute to and we have very
16 clear processes, there is definitely a feeling that people are practising much
17 more defensively and I don't think that necessarily is benefiting the women.
18 DR KIRKUP: Do you think that sense of scrutiny applies to the medical staff as
19 well?
20 MS PINKNEY: No, I don't think it does and I think my colleagues would agree that
21 the midwives – it seems to be the midwives and we work, you know, we're all
22 extremely anxious about, you know, will we get a brown envelope, will we get a
23 phone call? If I haven't done this, what will happen, what will be the
24 consequences? And it doesn't feel – and I might be completely wrong,

1 because I don't know what's going on up here, but it feels to me that there are
2 not the same consequences for medical staff.
3 DR KIRKUP: Is that a general view amongst your colleagues?
4 MS PINKNEY: Yes, absolutely.
5 DR KIRKUP: That naturally will lead to a fair amount of resentment.
6 MS PINKNEY: I don't think there's resentment; it just feels unjust. It feel unfair,
7 because the women that we're referring to the consultants are high-risk
8 women.
9 DR KIRKUP: Yeah.
10 MS PINKNEY: And, you know, we have to write the date, the time, your signature,
11 you print, you do – and half the time they don't – you know, it's –
12 DR KIRKUP: We might differ about the words, but I think we're describing the same
13 thing, but I'm keen to know whether relationships were good before the recent
14 scrutiny. I appreciate life's very difficult at the moment. You're in a goldfish
15 bowl, I absolutely understand that, but cast your mind back to before, say, to
16 2007, 2008. Are you saying that relationships were good at that time?
17 MS PINKNEY: Well, I felt that my relationships were good because I was a matron,
18 so I was seeing the consultants much more often than maybe my colleagues
19 were. So maybe that's not the question for me. I don't know how they
20 perceived that at that time.
21 DR KIRKUP: Okay.
22 MS PINKNEY: Yeah, I mean, even then really, I remember having a discussion
23 when we first introduced customised growth charts with one of our consultants
24 and saying, you know, 'The medical staff are not filling these in' and he said,

'Well, that's up to them. That's their clinical decision whether they do it or they don't' and, you know, sort of, 'it's not for you to say'. And I do think another consequence of what's happening now is that we have so many guidelines and so many policies and everybody is so extremely cautious that, in some ways, it's having maybe a detrimental effect for the women, because we fought long and hard to introduce midwife-led care against a particular consultant who would document in the woman's notes, you know, 'This midwife has taken responsibility; I therefore am absolving myself of respon' – you know, all this carry on. We fought long and hard to get midwife-led care and now the majority of women are having consultant-led care because of the way we're now practising. And I suspect, I don't know because I haven't seen the figures, but I suspect we're seeing far more assisted deliveries than maybe we would have done before, because people are practising very defensively and it isn't always to the benefit of women, not for low-risk women.

DR KIRKUP: Consultants writing things like that in the notes doesn't sound to me as if relationships were always very constructive. That doesn't sound to me like the sound of a constructive relationship.

MS PINKNEY: Well, I mean, that's going back. I mean, this is before any of this. We're talking Changing Childbirth, you know, mid-'90s, but that's how it was at that time. Everybody was consultant-led. You know, we fought very hard to get women back into the community, to make things low-risk and it almost feels to me like we're now in danger of going back the other way.

DR KIRKUP: Okay. In your role as supervisor of midwives you would come across instances where practice wasn't all that it should have been or knowledge

1 wasn't all as it should have been probably. I'm not talking about the isolated
2 incidents, they happen. The important thing is to recognise them and correct
3 them. Did you have any general concerns about midwifery practice? Was
4 there anything you thought was a particular –
5 MS PINKNEY: I think there were maybe the odd individual who raised concerns. I
6 think, broadly speaking, no. I think, broadly speaking, my impression, because
7 I wasn't a labour ward midwife, my impression was that the midwifery care was
8 good and I don't know how much of what was going on in terms of the politics
9 and things and the staffing levels influenced how people were able to practise.
10
11 DR KIRKUP: But other than that, you weren't aware of any systematic issues.
12 MS PINKNEY: I wouldn't say systematic, no.
13 DR KIRKUP: Okay. I mean, one thing that I'm bound to ask you about, there
14 appeared to be a systematic lack of knowledge about the significance of
15 hypothermia in a neonate. Does that surprise you?
16 MS PINKNEY: It does surprise me. It does surprise me, but – yeah, yeah it does
17 surprise me.
18 DR KIRKUP: But it wasn't something you came across.
19 MS PINKNEY: No, not in my practice.
20 DR KIRKUP: Okay.
21 MS PINKNEY: No.
22 DR KIRKUP: Okay. Jonathan.
23 PROF MONTGOMERY: Just one thing: you described how you were called in to fill
24 staffing shortages inappropriately.

1 MS PINKNEY: Yeah.

2 PROF MONTGOMERY: Was there a system whereby you could raise concerns
3 about staffing levels or any other things like concerns over safety, quality or
4 near misses?

5 MS PINKNEY: I suppose the process was through incident reporting.

6 PROF MONTGOMERY: And did people use that system? Did you use that
7 system?

8 MS PINKNEY: I don't think they used the system as well then as they do now. I
9 think people tended to use it more for – I think people tended to think it was for
10 major issues rather than staff shortages. I think people started to use it more
11 when the staff shortages and things sort of really kicked in and maybe as a
12 reaction to how they felt about, you know, the whole –

13 PROF MONTGOMERY: Did you ever have cause to use it?

14 MS PINKNEY: Well, I've used it many times. I've used it many, many times.

15 PROF MONTGOMERY: And what was the response? Did you see any response?

16 MS PINKNEY: Going back? Well, I think it mainly went through – we had the
17 clinical incident meetings where they were discussed and the risk manager at
18 that time always seemed to take the lead on it. If it was an incident involving
19 medical staff, then the – because we had a designated consultant who sat in
20 on that meeting and he would look into it. It never felt particularly effective, I
21 have to say.

22 PROF MONTGOMERY: You can't give us an example where you raised something
23 that –

24 MS PINKNEY: I can't give an example from – not going back, but it's certainly much

1 more rigorous now and it's very, very well and widely used.

2 MS FEATHERSTONE: Just going on from what Jonathan said, so if you were called

3 in where staffing wasn't safe, was there an escalation policy then or that you

4 would follow?

5 MS PINKNEY: No.

6 MS FEATHERSTONE: And if it was really unsafe did you ever shut the unit?

7 MS PINKNEY: No.

8 MS FEATHERSTONE: Did you try to?

9 MS PINKNEY: No, because by calling in people generally that would make sure that

10 staffing – you know, the staffing was okay. It was – I don't think we ever got to

11 the point where it was unsafe in times that I was involved that I can recall. I'm

12 sorry, I can't really recall.

13 MS FEATHERSTONE: That's okay, but sometimes it may have had the staff, but

14 actually the women, you know, you've got so many women that –

15 MS PINKNEY: Yeah and it isn't just about the staff, of course. It's about the skill

16 mix, isn't it?

17 MS FEATHERSTONE: Yeah.

18 MS PINKNEY: And I am not an experienced labour ward midwife, so, you know, if

19 ever I was called in, often I would go to the ward and then release a midwife

20 from the ward to go to the labour ward, because obviously she was better

21 equipped to deal with things than I was.

22 MS FEATHERSTONE: Okay, thank you.

23 DR KIRKUP: Anything further?

24 PROF FORSYTH: No, I'm fine, thank you.

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

2 MS PINKNEY: No, I don't think so. I hope it's been helpful.

3 DR KIRKUP: Well, in that case, I can bring the interview to a close and thank you

4 very much for coming and for being frank with us.

5 MS PINKNEY: Thank you.

6 DR KIRKUP: Very helpful, thank you.

7 (End of interview)