# THE MORECAMBE BAY INVESTIGATION

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)
Maternity and Neonatal Services Investigation

Thursday, 3 April 2014

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

Before:

Dr Bill Kirkup CBE – Chair
Professor Stewart Forsyth – Expert Adviser, Paediatrics
Dr Geraldine Walters – Expert Adviser, Nursing
Ms Jacqui Featherstone – Expert Adviser, Midwifery
Dr Catherine Calderwood – Expert Adviser, Obstetrics
Prof Jonathan Montgomery – Expert Adviser, Ethics

Ms Oonagh McIntosh – Secretary to the Investigation
Mr Nick Heaps – Deputy Secretary to the Investigation

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## PANEL MEETING

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Produced from the shorthand notes of Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

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[11.02 a.m.]

CHAIR: It is just after 11 o'clock so let us start the meeting formally. Welcome. Thanks to you all for attending. We have an apology from Julian. I do not think that we have any other apologies. Welcome also to Nick, Nick Heaps, who has joined us for his first meeting as deputy secretary to the Investigation. Thank you. It is too late to back out now! Nick is replacing Tom, who is going back to his substantive post, so I would like to formally thank Tom as well for the work that he has done in helping to set up the Investigation.

Matters arising from the last meeting.

MS McINTOSH: Some of them actually will fall into discussions that we are going to have later on, but there are four things that we said we would take away. One was to keep you updated on correspondence with the Parliamentary Health Service Ombudsman. We are still in correspondence with the Parliamentary Health Service Ombudsman. The Ombudsman has now explained what the statutory bar is and how they are interpreting it and applying it. It bars them from sharing their correspondence with complainants and correspondence with organisations who they are dealing with in respect of the complaint. They have pointed us in the direction of those other organisations who are actually all on our list already. The difficulty we may have, which might cause a slight time delay, is that those organisations have been asked for their correspondence and will not necessarily be supplying us with the Parliamentary Health Service Ombudsman's side of the correspondence. They may well, but they may not. We may have to go back and it is just a bit frustrating in that it has a time impact on the Investigation. The Chairman is writing back to the Ombudsman or to Mick Martin, who is the director of investigations at the Ombudsman's Office, explaining

that, as the Ombudsman stated in their most recent report about Morecambe Bay, they regretted that they had not investigated James Titcombe's complaint previously under a previous Ombudsman and, if they had looked at it again, they probably would have done. We are asking them for all internal documentation that relates to their decision making process and we have also asked them if they are going to confirm that members of the Ombudsman's office will be available for interviews, including the previous Ombudsman, in respect of that matter, which, as far as the Chairman is concerned, is not impacted by the statutory bar, which is two pieces of legislation that the Ombudsman is established under. It is still an ongoing issue, but it has made it into the Health Service Journal and the North West Evening Mail, because, obviously, the families are frustrated about it. James Titcombe, in particular, is understandably frustrated about it. The Ombudsman's office have explained to the Investigation that even if we were a public inquiry, they still could not cooperate with the inquiry. There are issues around that and those issues have been brought separately to the Secretary of State's attention and to the Permanent Secretary of the Department of Health's attention. There is a lot of interest in this and a lot of scrutiny which, actually, is helpful to the Investigation, so we are still working on it. That is just to give you a brief update on that.

CHAIR: Thank you. I think that the key point for us is to identify what the crucial issues are. The legislation is framed around protecting confidential personal data that is supplied to the Ombudsman in respect of complaints and what we need to make clear is we do not want them to show the information which relates to individuals, we want them to share their own internal documents, their internal emails and so on, but, unless we get to the point of polarising it, if I can express it like that, defining exactly what the

issues are, we are going to continue with this sort of a statement dance where they are saying that they are trying to help you as much as possible.

PROF FORSYTH: Obviously, at some point we will have to give some consideration to whether there is a piece of information that we are not getting which, actually, will be crucial when we come to present our Report, because what we do not want is our Report to be undermined over one small piece of information to which we were not able to have access. I think, as we go through our work, we need to think is there something that the Ombudsman's office may hold that we do not have and, really, fight to try and get access to it somehow, to try to ensure that we are as comfortable as possible with our Report at the end of the day and we do not feel that it is going to become another report which is shelved because we did not have full access to all the information.

PROF MONTGOMERY: I have two reflections on the back of that. I absolutely take that point. One is that I think that quite a lot is in the public domain from their reports that we could probably build observations on on what does not look as though it happened thoroughly. Even if we cannot get to the bottom of exactly why that it did not happen thoroughly, we can say that in terms of observation. The second point is, as well as interviewing people, we can ask some specific questions, can we not, so, even if they cannot disclose the reports, because they think they are covered, if we frame a couple of key questions that we need to know the answer, you know, were you aware of this or were you not aware of this, were you aware of this before such and such a date or not, then, even if we cannot get the person interviewed to answer that, we, presumably, can write to them and say that we have a set of questions which we have identified that we need to have the answer to and then we are not actually disclosing any reports and,

unless we are asking for personal information, they are not breaching the personal information point either. I think that we should work on a twin strategy, one of which is a way of getting direct access and the other is, well, how do we get indirect answers, which at least enable us to say that we have got them on the spot about this question.

DR WALTERS: At the moment we do not really know if there is any.

CHAIR: You are right, we do not know there was a decision not to investigate during the earlier period. We do not understand what the reasoning was that led to that decision. I absolutely agree with Stewart and Jonathan, but there is another issue, which relates to the public confidence in our Report when we produce it, if we are seen to have not been able to investigate things that people have already found of concern.

PROF MONTGOMERY: It would be easier for us if we were able to say that we note that the Healthcare Commissioner notes that it was wrong not to investigate and we have absolutely reached the same conclusion on what is available to us. We are not able to comment on whether there might be an explanation for that, because they have not shared the material but that is a better way of our authority being undermined than the situation where we end up saying that we think that it is probably right even though we cannot really tell. I think that we say that it is not all right and we have no ability to change that view, because they will not show it to us.

CHAIR: Absolutely. I would prefer if we can have demonstrable full cooperation up until the point where they are absolutely certain that the statutory bar applies. If we cannot do that, then I agree absolutely, yes.

DR CALDERWOOD: Do you think that you have done enough? I sometimes think that just keeping up the pressure that maybe there is a crack eventually. Presumably, it has been discussed right up the levels of the organisation.

MS McINTOSH: It has, and in a way we have not initiated that. James Titcombe had a meeting with the Secretary of State and he was pushing, which actually was very helpful to us, because we actually feel that it is fair to the Ombudsman to go through the same process that we are going through with some other organisations as well, so they cannot then criticise us when, if the Chairman decided he needed to go to the Permanent Secretary or to the Secretary of State and say, "This is frustrating and thwarting the work of the investigation", they could say, "Well, actually, we have been pushed around by the Investigation", so, actually, it has been very helpful. It has been brought to those people's attention by others who are now fully aware of the frustrations that we have got with our timeline.

PROF MONTGOMERY: Are there any other examples where other inquiries have had access to this? Did Bristol get access to it, for example?

CHAIR: That is a very good question. I do not think that they specifically asked, because I do not think that there has been a previous instance where people have been so concerned about a decision not to investigate. The PHSO role in this is relatively recent as well. They took over the role that was previously carried out by the Healthcare Commission and it was, when Ian Kennedy stood down and the Healthcare Commission was wound up, that that transferred to the PHSO. That legislation would not have applied to the Healthcare Commission.

MR MONTGOMERY: If it is legislation about the Health Service Commissioner role, that would have been possible, would it?

CHAIR: Yes, it was, but the Healthcare Service Commissioner role was not quite so immediately concerned with complaints at that point.

PROF MONTGOMERY: But I am just thinking there might be other things, not about

complaints but other information held within the Commissioner's files, because that goes back to the 1993 legislation.

MS McINTOSH: Yes, the Act.

CHAIR: We will check that point. I am not aware of it.

PROF MONTGOMERY: If you see the Home Secretary, you could ask him.

MS McINTOSH: We could ask the Permanent Secretary, because she was the secretary to the inquiry.

CHAIR: Yes.

MS McINTOSH: Thank you. The second thing that I promised to come back to you about was about the interview protocol and we are actually going to come to this as a substantive agenda item, but just to let you know your comments were incorporated and then it went out - and it was very helpful to have your comments back strengthening them ... You specifically said can you make reference to the GMC Code and to the NMC Code. That was really helpful. It went out. Interestingly, on the back of that, we got no comments about those things, so they were just accepted as the norm, which is really, really good, but we now had from some organisations a longer response of comments, questions and queries than the protocol itself. Some of them have raised some very helpful practicable suggestions which can easily be incorporated, some issues that are much more thorny and relate to evidence and documents and how the investigation is going to handle that, so we will come back to that later, but it is also something that we can talk about next week when the subgroup leads get together, thinking about interviews, because it is actually something that needs to be incorporated into the protocol. The timeline that I suggested last time that we met, which was that the comments would come in, we would turn them around and it would go out and it

would probably be on the website by the time we met today has not been achieved, and that is frustrating, but I think that there are things that we just need to bottom out and resolve, some of them we may need to take some legal advice about. I will talk to the Chair about that.

CHAIR: Sure.

MS McINTOSH: Data requirements. Hannah gave you two presentations at the last meeting. She makes her apologies. [redacted] What Hannah intends to do is pull together the data work that has been commissioned and we hope to have that in and she will collate that into a data pack which will be available for all of the panel to help support you, when relevant, for interviews, so all the work will be pulled together and Hannah will be able to update on that at the next meeting.

The last thing was the meeting with families which is a thing that has been ongoing since January when we met in Lancaster, when there had been an exchange between you and a number of families and you had offered them the opportunity for a meeting and you were going to update the Panel, because since the last meeting that has obviously happened. An update is going to be provided on that. That is everything from me.

CHAIR: Thank you. Do any colleagues have matters arising? I will cover the meeting in that case. We had a good turnout. It was encouraging to see quite a lot of people, not just from the original group of families, but also from the ones who had responded to the newspaper advert.

DR WALTERS: How many?

CHAIR: About 20, I think. They are not all separate families, there were some couples as well. We did a sort of general background for the people who had not been before, an

update on progress for both groups and then a question and answer session which was pretty daunting for people, because it was quite a large group, so, apart from James, who asked three or four questions, nobody else really wanted to talk, so what I suggested we did was break and group around the coffee table and have individual discussions, which went on for quite a long time. I think that both Oonagh and I got a lot of very useful feedback as a result of that. The general tenor of the meeting was positive, I think. People were saying that they can understand the frustrations over timing and access to information and all the rest of it, but they are absolutely backing the process that we are following. One of the items that I covered is the point that I wrote to you all about shortly after the meeting, which is the extension to the timeline. I guess that did not come as any great surprise to everybody, because it has been obvious that we were going to struggle, if it is June, for a little while, but apologies about the order in which it unfolded. I thought that it was important to talk to the families about it before anybody else on the principle of involving them as much as possible in these kind of things. As you know, I wrote to the Secretary of State and said that it was only sensible if we were to get a proper job done and he agreed to an extension to November. I hope that that does not cause you too much dismay in thinking of your other commitments and so on. But we really do need to do a proper job.

Reading the mood music behind the letter and the way that it was expressed, we do, however, have a firm deadline with November, to there will not be any further extensions. That probably comes as a relief to you, but slightly less so to me. I think that we can do it by November. Is there anything else that struck you about the meeting, Oonagh?

MS McINTOSH: No. It was interesting that there were new families there. There was [redacted] So I think that that was really good that they came forward. There was also [redacted] So I think they went away quite pleased that they had spoken to you as well. It was actually good that they had that chance.

CHAIR: This is a potential source of discord, though.

MS McINTOSH: Yes.

CHAIR: It is a familiar thing, and I keep harping on about this, and I am sorry, but it is a familiar thing [redacted] Even if you handle it as sensitively as you possibly can,

you are still liable to get discord arising from this kind of thing.

DR CALDERWOOD: From our point of view, it is the care that was provided.

CHAIR: Exactly.

DR CALDERWOOD: The explanation to them that the care that was provided contributed to a poor outcome, it is not our job to judge the severity of the outcome.

CHAIR: Exactly and indeed we would be interested in care that was substandard even if the outcome was fine. We are still interested.

DR WALTERS: So we do not know if those families have had a successful claim against the Trust or not.

MS McINTOSH: [redacted]

CHAIR: I am diving off on a slight tangent, but I think that it is absolutely relevant. You reminded me before the start that, if we are making a record, then we have to be conscious that jocular remarks look very different when they appear in print. We absolutely need to be able to discuss individual cases and their implications. We also have to be very careful that they are identified by the things that we say and just to record the fact that we are not producing a word-for-word transcript of the proceedings, we are producing a record of the proceedings, not a word-for-word transcript. It is worth recording that, I think.

DR WALTERS: How often are you going to meet the families?

CHAIR: As and when, I think. We did not commit to a fixed timetable otherwise the danger is that you have end up with very sterile discussions where we have nothing to say other than we are trundling along. If they are reflecting concern, I mean, what really prompted that one was various exchanges of email correspondence where people were expressing concern about what was going on, or, I think if we have anything significant to communicate to them, then we would ask, but we do not want to abuse the privilege, as it were, because we will get people turning up expecting to hear things and there is nothing to tell them.

PROF MONTGOMERY: Just reflecting on that fact, we need to try to keep open the possibility that that they might want to have the conversation about their care at some stage in the future.

CHAIR: Absolutely.

PROF MONTGOMERY: We have talked a bit about how we might enable families to get feedback of what we think the group have seen. I guess that we will have to take a view on what point the shutter comes down on that chronologically, because we will not exist after November when the report has come out. We might need to think about how we record the findings of the clinical group on those cases so there is at least ability for a letter to set out if they wanted to find out whether or not the clinical group thought there was a failure of care and that we capture that.

CHAIR: Yes. I think that we might need to offer people the ability to come and ask questions at a later stage, even after the Panel has been formally wound up. I am happy to do that. I would be very happy if anybody volunteers to help and support me on that, but that is up to you and your other commitments at the time.

MS McINTOSH: I think that that gets us into an area that has been raised about the interview

protocol, that for some of these families in the list, we have asked for a list of neonatal and maternal deaths for the time period. Those families do not actually know we are looking at their cases. The Trust have asked us just informally, they have not been heavy-handed about it, but they just want us to consider what the appropriate channel for communication is. They equate it with Alder Hey tissue retention and, actually, done with the best will in the world, actually, families did not know. The Trust do not want to be in a pickle down the line, having given us that information, we have gone up and done things and there is some reference down the line or somebody thinks that, actually, that was our baby or that was us and we have not had that conversation. I think they are just tricky cases, really.

CHAIR: This touches on sort of informal conversations that we have had on occasions, but we need to formalise this. I do think that we are looking at records that relate to people who have not made a complaint and we do not know what they have been told about the outcome of their claim and why. My view was that, where we are turning up one or two - not a vast number so far, but one or two instances - of substandard care we have a moral obligation to tell people that we have information relating to that particular case and, if they would like to, we will share it with them. I do not think that we force the information on them. I think that we have to say that there is something that we have found that you might like to know about, would you or not, and we must recognise the fact that some people will say no, we have closed the book on that. We do not want to be listed.

PROF MONTGOMERY: I think that it is really tricky to get that right, but we have to try and walk that tightrope, not least because we need to be asking ourselves if the duty of candour applied, what we would do in that. There is an obvious analogy with clinical

genetics and the so-called right not to know about things, so it might be some analogies of how you pitch it, so we might think about saying that we have looked at a whole range of cases and in those we have found some examples of poor practice, you were part of the range of cases, but we do not necessarily have to say that we found something about yours, then you give them the opportunity to ask the questions, "did you find anything about mine?" or we might feel that we need to say that we found something about your case that we would be happy to talk you through if you wanted to know about it, so it is about how we pitch it, isn't it, but I do not think we can knock off that opportunity.

DR CALDERWOOD: If we took the analogy of a unit examining their own cases in the way that we are doing, what would their response be to something that they find?

CHAIR: That would be where the duty of candour kicked in.

PROF MONTGOMERY: Yes. I think that they would be expected to disclose it under the new system. Of course, one possibility is that, actually, we do it through them.

DR CALDERWOOD: I am wondering whether, because, in fact, in the process, if there has been a poor outcome, we would expect the same standard of investigation into that. That may or may not have happened, but, let us say, that the best practice did happen, then whether a family has complained or not about the feeding back information or offering that information.

PROF MONTGOMERY: I think that that is quite interesting because it is about us working out what our job is and what actually is the job of the Trust, which we might be able to facilitate by putting back to them to say here is the list of things that you should be thinking about how you are handling. That is a tricky one, is it not, because we must not lose the trust of the families, being independent. I think that there is something

around how we work in a way that enables the future to be more positive. Part of that is not undermining the ability of the Trust to do the right thing in the future by taking that responsibility away from them.

DR CALDERWOOD: I am also thinking about if we see another pregnancy or care of another child, I would feel as someone looking after another pregnancy, where there has been a problem, you want to have dealt with that, but also communicated that to the family themselves, or you would want someone in a group that you knew and knew we were independent and could also communicate, but to have an outsider, that is the right word, making comments on care, there is a risk that that is what they said and is that really what ... because the ongoing care then, the reality is, potentially, with some of the same staff and it has not been dealt with.

PROF MONTGOMERY: There is also the risk - this is sort of the coroner's jurisdiction now - that we are seen somehow to prejudge a clinical negligence claim and, actually, we have quite a specific set of things that we can look at which are different from that. The duty of candour will require the Trust to flag up the possibility that there is a claim and, therefore, enable people to get their own advice about it. It is quite tricky, isn't it?

CHAIR: I think that, if the circumstances were not as they are, then absolutely it should be the job of the Trust and the clinicians who need to re-establish trust and set up the right environment for future representative care and all the rest of it. I think that the difficulty is that we have got a situation where there has clearly been some loss of trust in the Trust. Therefore, we have to find the best way to work through that to make sure that we discharge our duties to the families, all the families, not just the ones that have complained, but also that the Trust are getting the opportunity to demonstrate that they can do the right thing. It is not immediately clear what is the best mechanism to do

that.

PROF FORSYTH: I do not think that we can leave it in the hands of the Trust, because I think that there is a concern that at the same time we are not responsible for future support of families as such. I think that the passing of critical information that comes out of the Investigation for individual families would be a joint meeting with the Trust and representatives of the Investigation with the family. That would be one way of dealing with it. At least the family would I think be reassured that the information they were getting from the Investigation was coming directly to them, i.e. through us, but also recognising it is the Trust's obligation to try and take this forward and to deal with any consequences that may come from this information. To me, I think that I would feel comfortable with that if that was seen as an appropriate way forward.

PROF MONTGOMERY: There seems to be a thinking that if we do use the duty of candour as a starting point and ask ourselves when would the duty of candour bite on the examples that we are looking at, we might be able to create some form of pro forma which would actually be used to record where we thought that that happened and why it happened and act as if we were bound by the duty of candour. If we had that, we could then say to people, which is our process, you know, for every case that we have looked at, if we believe that this is triggered, we will have a record of that. Whether your case falls into that, this is how you find out about it.

CHAIR: Would you say that only to people where we think that we have or where we know that we have uncovered an episode of deviation from standard?

PROF MONTGOMERY: No, I think that we have to say that this is part of the way the Investigation has worked that it has made a record. I need to go back and read the duty of candour very carefully to see whether we can make this work. If we had the ability

to record where we thought it would be triggered, you could say to the whole Investigation that we have a process by which we look at cases. When we look at those cases, if we believe that it would trigger this, we will make a record of that, so that, if you wanted to find out whether that applied to your case, we will check that record. That might result in saying that we did not look at it, we have looked it and we did not find anything that triggered it or we did find something that triggered it, would you like to see the record?

CHAIR: But in that case we are saying it to everybody whose records we have looked at, which is potentially 200 plus people.

PROF MONTGOMERY: I think that we are saying that we have looked at it, but we will only have recorded it ... I mean, it is about how we describe what we have looked at, is it not, because we have looked at them at different levels?

CHAIR: Yes. We say that to people where we have done the full review, not where we have done the screening and identified no problems. I think that that is manageable and proportionate. I am concerned about approaching 200 people, the vast majority of whom there is not a problem underlying that.

PROF MONTGOMERY: I think that, as David would say, we have looked at 200 and we have done a screen of those which would not have generated this question for us. We have looked at X in detail and, when we looked at the detail, we also asked the question have they got these characteristics, we would not call it the duty of candour applies, we would say we are asking about serious risk of injury, avoidable, or whatever the phrasing is. If you want to know whether that was identified in your case, you can ask.

DR WALTERS: Another thing is that there is an even greater need for some individuals where there is no problem to have an independent clinician go through it with them and

say that there is no problem.

CHAIR: But these would be people who have come forward, who believe that there is a problem.

DR WALTERS: Yes. We might now have generated some who did not complain, but have reason to think that there is a problem. I think that just hearing stories from families, you know, and I am sure a lot of them have got cause for concern, but they hang on to a couple of lines in the notes, you know, "it says that there" and that is not right. There needs to be somebody to say that that is absolutely fine. I think that they would not accept a piece of paper that says, actually, there was no problem in your case, because they are still lurking, "I have seen these things".

PROF MONTGOMERY: I think though that if you have created some way of recording what happened, Oonagh, if contacted, would be able to say that, well, I have checked the record and the review did not flag up anything that they thought was in these categories, but we still have to have a process if people ask to talk about that.

DR WALTERS: Yes.

PROF MONTGOMERY: There might be some who say that that is a great relief, that is what I wanted to know, others who will say, well, I would still like to talk about it. I think that, responsibly, we have to be able to do that, do we not?

CHAIR: Absolutely.

PROF MONTGOMERY: What we are talking about here is what we would like people to think about doing. I think that that has to be quite defined about how we do that.

DR WALTERS: Yes, it is really starting with your pro forma and, you know, initial contact offers this. If you want to see someone here ... and we might actually decide whether there are some cases where it would need to be joint and there are some cases where - I

think that I suggested that, if there was no problem, but, if there was a problem, it would be better to just look at that.

CHAIR: Yes, I think that that is right. I see those as two distinct groups, though, that your argument would actually sort out at the outset. Are you happy with that? I think that that is very helpful, thank you.

DR CALDERWOOD: I do not know whether this is, necessarily, practical, but, if there was going through case notes with families or the examples that we were given and there is somebody with questions that then are answered, one of things that was flagged up in my mind, reading the notes, is that we do not know what we do not know and so, if there is a practice that I do not think is routine or would not be what I would expect, might it be thought that somebody on the unit listens to someone else to explain it or , if there is an opportunity, not necessarily with the family there, to hear why I would say that the reason that this is not usual is because of this guideline, this best practice document, because I almost feel that, if there is a recurrence of practice, how does that ever get broken, because, if they are landed with a report from above, the immediate reaction is, well, they don't know what is best, that is not the same here, we have to do this differently here because the women are different, the babies are different, the geography is different.

PROF MONTGOMERY: I agree with that.

DR WALTERS: There are no layers there.

DR CALDERWOOD: There is not. There would be a bit of groaning if we did not read the antenatal NICE guidelines, but the excuses remain the same, because there is no two-way dialogue.

CHAIR: I think that there are two aspects to this. One is before we produce the report and

during the interview process, I would expect that those kinds of issues would be the subject of dialogue as part of the interview, which will initiate the process and will enable us to understand why they thought that they were doing the right thing in some situations, even though we might not agree with them. Then after the report is produced, there is how we can best help the Trust to learn the lessons from it and incorporate them in improved practice and all the rest of it. I think that what you are touching on there is that we might not just want to dump a report from on high, we might want to offer to help them to do a bit more than that. Am I thinking correctly there?

DR CALDERWOOD: Yes.

PROF MONTGOMERY: There is a bit in between those two phases, that some inquiries do, which is would we show tentative conclusions about those things and have a meeting at which we actually have that discussions about are your babies different, are your women different before we finalise the report. That will involve a whole load of things, will it not, where we will need to check for accuracy with people on certain things. At some point we need to work out how that method is going to work. It could be that is where you would want to be able to say "We had a discussion with senior staff in the Trust about these preliminary findings and this is what they have said to us and this is what we thought about what they said."

CHAIR: Yes.

PROF FORSYTH: I think that it is a very good point from Catherine. When we are passing to the family, I am very keen on the idea of having a joint membership of this group in that a major term of reference that we have is to try to prevent these episodes happening again in future. I think that too often there is a situation where it appears in the report

make sure it does not happen again, but, actually, I think that it would be quite effective, when we are passing on information to the families, to have key Trust people there, so that they hear this as well. I think that that would be a very important learning opportunity for them as well and, hopefully, would begin to invest better practice and continuing better practice in that organisation.

CHAIR: I think that that is a very good point. I think, though, we do have to bear in mind that some of the families have been so put off the Trust by the way that they perceive they have been handled, dealt with and communicated with, would be a better way of putting it, they would not take part in that. They would not feel able to take part in any joint approach like that. We have to be sensitive to individual families. It is horses for courses, I think.

PROF MONTGOMERY: Do you think we have the opportunity to suggest to the Secretary of State there should be one year on meeting with the family and the Trust saying what has happened since we reported.

CHAIR: If you are volunteering to be a part of that, I will pass it on. I have been thinking about what happens afterwards and it is a very sensible thing to do.

PROF MONTGOMERY: Actually, it would not be a big commitment for us to say that we would reconvene to hear what the Trust has to tell us about what it has done and give the chance to families to reflect on that with us. I certainly would not want to go through whatever months it is going to be, but, actually, a day up here saying, has it been a constructive exercise, what has changed? I think would be quite a good thing to try to commit to.

PROF FORSYTH: Has there been a healing process? It is all a bit raw, I do not know how we define it.

DR CALDERWOOD: And then what happens if it has not?

PROF MONTGOMERY: I think that that is a new challenge for people to decide how to respond to, but, actually, if we set up a set of recommendations that had been impossible to implement for whatever reason, then it means that the problem is not in any way resolved, doesn't it? It would be a new exercise but you would need to think about what is still outstanding that we looked at and look to see what are the implications.

CHAIR: That is right, to think about what the implications of that would be. Yes, that is very helpful. Thank you. I need to touch on another aspect of the discussion, which was the point that we talked about really about attendance at interviews and how interviews are to be conducted. I was very reassured by the reaction that everybody present understood the point, that we wanted these to be information collecting exercises not an opportunity to grill people and make them feel uncomfortable. Everybody absolutely got that point and supported it. Quite a lot of people said that they would not want to attend themselves, partly because they would not feel comfortable themselves, but partly because they thought that they could see that that might be difficult for staff to deal with and they did not want to make it any more difficult than it had to be. It was a very constructive response.

Following the meeting we have had the letter which you have a copy of from one family. You will not have had a chance to read it yet so I suggest that we just take a moment or two to look at that. It is MBIP6.1. It is basically saying, yes, but I will not be attending, but ...

DR CALDERWOOD: Did you meet with that family during that time we went ...

CHAIR: No, they did not come to that particular meeting. I even volunteered to brief the

family by telephone afterwards which is why in the letter he starts out by saying ... and that was passing on the content of the meeting, really. I think that in the first two paragraphs there are a couple of specific questions about the case, but I think that we can pick those up separately. The first two paragraphs are the crucial ones. [Pause to read document] I think taking them in reverse order, actually, I think that the issue was raising questions, and my feeling based on previous experience is that it would actually be helpful if we invited them to submit specific points that they would like us to raise. We cannot guarantee that we can address absolutely everything, but if it is within our Terms of Reference and it is a proper area of enquiry, we should make every endeavour to do that.

DR WALTERS: And I wonder when we see the questions, maybe yourself, Bill, should really say, "What are you actually trying to get at?"

CHAIR: Yes.

DR WALTERS: If you just put something in one question, it might not be interpretable.

CHAIR: Absolutely. We need to understand the background, I agree. The more complex one I think is what we make available after the interviews. What it is suggesting really is does we get a record put up on the website or sent to them so that they would not need to be at the interviews, but they can see exactly what was said and what was answered. I think there are two issues about that. There may be more, but two strike me straightaway. One is the simple issue of capacity. It is going to take a significant amount of time to get written records sorted out and to get them corrected before we can do that. The second one is, if we do, then we are absolutely falling into the situation that we said from the start we would not get into, which is that people will be second guessing what the implications of it are. They will be writing the conclusions of

the report as they see them to be.

DR CALDERWOOD: Could they watch and/or listen in another room, so they are not physically present but can hear what is going on?

CHAIR: I think that we have some technological problems with this room. Julian was hoping to phone in to the meeting and it was not possible.

DR CALDERWOOD: That would solve it, because, in a way, I feel they are entitled to hear what is going on and, if you like, for the good process of the interviews, they could volunteer not to be there in order to help us.

PROF MONTGOMERY: We are audio recording, are we not?

CHAIR: Yes.

PROF MONTGOMERY: If they cannot hear it simultaneously, we might be able to provide the opportunity for people to come in if they wanted to listen.

MS McINTOSH: I think that we would have to check what our contract is. We are just in the middle of discussions about the service, are we not?

MR HEAPS: I do not know if the recordings that are made would be of sufficient standard. Excuse me, tell me if I am out of order. The problem is that, if you make a recording we would lose control of it if we sent it out.

CHAIR: We absolutely would not send it, we would offer the opportunity for somebody to come in and listen to it.

DR WALTERS: So are we saying to anybody who does turn up that you cannot record this yourself?

MS McINTOSH: Yes.

CHAIR: Yes, we are.

DR WALTERS: Technically, if they could be here, they could hear all this. Because they

are not here, they are saying that it is not fair that I cannot hear it.

CHAIR: Do you think that it is practicable, Oonagh?

MS McINTOSH: Practically, you can invariably overcome most obstacles. I am a bit nervous because I think that there will be people who will say, "Well, I don't want to turn up", but there will be other people who will ring in and say, "Well, I would like to come in a week on Wednesday and listen to it" or whatever, and, actually, some of the organisation of that would have to be sorted out. It is not impossible.

CHAIR: I would say there is one opportunity. We will offer a separate opportunity, it will be at the following time.

PROF FORSYTH: It does offer some logistics there, because they could be recording the recording.

MS McINTOSH: Absolutely. We would have to police that.

CHAIR: There would be the same restrictions, no recording devices, no mobile phones.

MS McINTOSH: We are going to have to police the interviews so that people have to hand in any recording device that they have or any mobile phone or their laptops, tablets. They will have to hand them in for that. I think that we would have to treat anything that was evidence that the Panel had heard in exactly the same way.

CHAIR: Absolutely, for the same reasons. It is an attractive thought that we could offer it. It is certainly better than written records. I am very, very nervous about written records for all the reasons that we spoke about earlier on.

PROF MONTGOMERY: The other thing is that in relation to particular questions that they have asked, then it might be possible to tell them what answers we got to those questions without necessarily giving them the audio or written recording if we can create enough time for someone to meet with them or call them and say, "We asked the

questions that you asked, these are some of the answers". It is a question really of whether that really satisfies the question.

CHAIR: Indeed, bearing in mind the volume of interviews that we are going to crank through whether it is achievable.

MS McINTOSH: And the answer to a question might, actually, come from a combination of answers from ten different people, so you might give somebody a snippet and they might just cling on to those two lines, might they?:

PROF MONTGOMERY: I was thinking that it would require one of us to be prepared to say, "I had a conversation with ... this is what I understand the answers to your questions to be".

MS McINTOSH: I think that another concern that I have, which may not be fair, is that the record of the proceedings, for example, the record of this proceeding here, if there are factual errors or there are inappropriate comments, we will take them out before the record of the proceedings is placed into the archives and, therefore, becomes FOI-able. I anticipate that lots of people who are involved and interested in the investigation will make an FOI request and those records of the proceedings will be released. If we assume that some of those people are people who have heard the recording, they will then recognise that the recording and the record of the proceedings may differ. They might differ because there are inaccuracies or, actually, sometimes,, believe it or not, there are sentences that we all say that actually make no sense at all.

CHAIR: I think that we explain the process, that we correct inaccuracies and that we remove irrelevant comments. Secondly, in offering up an opportunity to listen to a recording, all we are doing is offering the opportunity to be at the interview at one stage or another. You could say the same thing about people who were sat there listening to us

today. They could say, "Hang on, I distinctly remember some bad joke about something or other that is not in the record".

PROF MONTGOMERY: Although there is a difference, is there not, in terms of what you understand when you see someone saying something and when you just hear it. There is scope for a misunderstanding of what an interviewee says in the process, because, if all you hear is the audio bit and you do not see the body language, you might think they are being flippant when, in fact, they were not. There are some risks here, are there not?

CHAIR: There are, but, equally, we do not want to appear absolutely impenetrable in this process and I do not want to be saying to him, "You either attend or you get nothing".

PROF MONTGOMERY: No.

DR CALDERWOOD: I know there is a problem with the telephone, but there is wi-fi in this building. I am not sure about the quality, but could you do a live feed by Skype or FaceTime, one thing here picking it up and shown on a large screen through the wall. I do not know about the sound quality with a whole lot of us speaking.

CHAIR: That is true, but my experience of these things is the quality is very variable. The feed drops off for a while and you miss chunks. I also think that, bearing in mind that families are being quite sensitive about the need to not be too intimidating to interviewees, so having a sort of even a fairly discrete Skype camera pointed at them might be construed as a bit intimidating.

DR WALTERS: I think that the best we can probably do is the recording.

CHAIR: I think so.

DR WALTERS: And they would expect us to be using that.

PROF MONTGOMERY: That sounds as though the nearest to a solution is a slot in which

they could come and listen.

DR WALTERS: Yes, with all the caveats around - there might be issues of quality, they may get things slightly out of context, but the best we can do.

DR CALDERWOOD: One of the ways around that a little bit is that somebody who is actually in the room is sitting with the recorder so that ----

CHAIR: If there is a sharp intake of breath ...

DR CALDERWOOD: They could say, "Actually, I have made a terrible joke" there, you did not hear the joke but there was a sort of translation of the recording.

PROF MONTGOMERY: I guess that it all depends on how many really want to do this. If it is only one, then that probably becomes manageable, because they will probably listen to a couple and then decide that they either trust the process or they do not. If they do not, they will perhaps say that they do want to be here after all.

MS McINTOSH: And there will be key interviewees that they will want to hear from and they will not necessarily want to hear from everybody.

PROF MONTGOMERY: They may not want to hear all of it. They may actually say, "I just want to hear the bit where he answered my question" and then that will become a little more manageable, but we have to be able to set it up, just to sit and listen.

CHAIR: And you have to get good at working the fast forward bit.

MS McINTOSH: It takes you back a few years, does it not?

DR CALDERWOOD: Just on that, just to touch on some of the quite specific questions, having reviewed several sets of notes, one of the issues is the notes do not have the answers in them. Do we need to manage some expectations around that. I do not know. Because you can make some inferences from the fact that I might have missed that as something needing to be written down, but that is all I can say. I cannot then say

that, if it was written down, there is this, this and this that would help. The only thing that you could say is that this is not good documentation.

CHAIR: Sure.

DR CALDERWOOD: I just worry about whether some of the previous investigations have not given answers because they have not been able to.

CHAIR: I think that the advantage that we have, though, is that we can do a comprehensive set of interviews with every interviewee concerned. We can ask them. Yes, we will probably get a certain amount of "Well, I can't recollect exactly how we used to do things then" and so on. But we have the ability to correlate all this across a whole range of interviews that I do not think that anyone has had before. I am hoping that we can fill in at least some of those gaps, but, yes, there is clearly limitations on what we can establish from the written records just because of the nature of the written records.

PROF MONTGOMERY: We could make an observation about whether we think it is unacceptable that they are not in there, but we cannot make observations on what we guess might have been in there had it been recorded.

CHAIR: Absolutely. We can reinforce them in the view about the advantages of being able to correlate them by finding some reasonably significant bits of evidence from reviewing the cases that do not relate to complaints but relate to neonatal and deaths and stillbirths.

PROF MONTGOMERY: If we have a pattern and the recording was different in those cases, then that in itself is evidence, is it not? We have to be careful what inferences we can draw from it, but we are entitled to draw from it, whereas if, actually, it is all bad, then we cannot go much beyond the record keeping was awful.

CHAIR: Right. Can I suggest that we do a rapid feasibility study about how we might set

that up. If that proves to be something that we can offer or at least suitably modified by reference to the feasibility study, then we will respond to the letter on that basis.

MS McINTOSH: I will do.

CHAIR: Thank you. That takes us, I think, unless there is anything else under item 2 to number 5, evidence gathering.

PROF WALTERS: Can I just raise something else?

CHAIR: Sure.

DR WALTERS: I am conscious that we are not looking at anything outside of maternity.

CHAIR: Sure.

DR WALTERS: And, given that someone who came talked about her elderly mother's care, what the expectation is about that.

CHAIR: What I have said, although that may not be quite what has been understood, I agree, because of the difficulties of expectations here, but what I said is that we will pick up the clinical governance elements of that, but we will not do a clinical case review, because we will not have the right composition to do a clinical case review of that and it is not within the Terms of Reference. But there are clinical governance issues, potentially, raised by that which I guess would be similar to other cases.

DR WALTERS: Yes, it does take us down a different line of inquiry.

CHAIR: Yes. It takes you to a different part of the organisation, I appreciate that, but it is a parallel line of inquiry.

MS McINTOSH: Is it not the serious or untoward incidents bit?

PROF MONTGOMERY: Yes.

MS McINTOSH: It is not the neonatal death bit.

DR WALTERS: We perhaps have not got quite far enough into the detail yet.

MS McINTOSH: Right, let us park that for the moment. Can we come back to that next week when I wanted to talk about SUIs?

DR WALTERS: That would be great.

CHAIR: Good.

DR WALTERS: It was just very, very specific.

CHAIR: I know.

MS McINTOSH: In response to the notice, there were a couple more cases that came forward, where you had a review and you said - this is the lady who had a stroke, for example - it was about care rather than ... it fits into the same group as the lady who came to the meeting.

DR WALTERS: But we are not treating her in the same way as the maternity and neonatal cases?

CHAIR: No, not identically.

DR CALDERWOOD: On the time line process, the MBRACE confidential inquiry into child deaths has been published on 19th December and that is for deaths that occurred in 2012. Then perinatal deaths will be published in January of next year, which will contain again some information. I suppose that it is just to be aware.

CHAIR: And we need to ensure that we have not said anything that is incompatible with what it suggests and a conversation with those two groups at the appropriate time would be a good idea.

DR CALDERWOOD: The way that they are anonymised in those reports is that they mix different parts of different cases so that no one individual could possibly be identified. They will take elements of facts. I am not sure if that is what they are going to do, but the old reports did that, but there would be no expectation of being able to find cases

that we knew about within that report. I think that it is useful that we would be aware of what their recommendations are.

CHAIR: Absolutely, exactly so, yes. We would not want to say anything that even looked as if it was incompatible with what they were saying.

MS McINTOSH: Can I talk to you outside this to talk about that and who to go to?

DR CALDERWOOD: Yes.

CHAIR: The practicalities.

MS McINTOSH: Thanks.

CHAIR: That takes us on to item 5.

MS McINTOSH: This is just a quick oral update and I just had a very fleeting conversation with Jonathan earlier about it, because you must feel like the secretariat keeps coming back to you saying, "Well, we said we are going to do this and we have not and we have said we are going to get that and we have not", but I am quite conscious that, actually, some organisations have been incredibly able to be incredibly swift in responding and some organisations have not been resourceful or aware of where archived material is and, therefore, have been slower. Some appear to be being just a bit unhelpful and some are being extremely unhelpful, unintentionally. So quite a lot of material that would be of interest to Jonathan's subgroup, a sort of external response, material from organisations, for example, not a page in yet from the GMC, very little in from the NMC and the Department of Health legacy, which is PCT/SHA material, has come in such a heavily redacted format that it is quite unhelpful to actually even look at the type of complaints that were received, what concerns people had about care they were receiving, and what correspondence there was between organisations about that, so we are applying pressure - Catherine, going back to the point you raised earlier - we are

applying quite a lot of pressure on the Department of Health on the legacy side of it, because out of those 998 boxes we now have some papers from seven of those boxes and that has taken from 6th January to date to get material that has come in in a heavily-redacted form. It is a matter that I have talked separately to the Chairman about and he agrees that we need to have a serious conversation with the Department of Health about that. Combined with the Department's offer of help around the PHSO issues, it is a good opportunity to, actually, say we would appreciate a meeting and we would like to talk to you about this as well.

CHAIR: We would have to have the two things in sync, though.

MS McINTOSH: Exactly.

CHAIR: There is no point in talking about the legacy side until we know what the position is with the PHSO. That is part of my rationale for wanting to crystallise the issues with the PHSO.

MS McINTOSH: Hopefully, that will happen before we next meet. Hopefully, that will be able to be resolved. I am quite conscious that it is your subgroup that we have not got a raft of material about. You are probably quite relieved about that.

PROF MONTGOMERY: That is fine, because I did not have time to look at it, so I feel less guilty.

CHAIR: Enjoy it while you can.

MS McINTOSH: But we are trying.

PROF MONTGOMERY: We do have quite a lot of published expert material. If we know that that is the position ----

MS McINTOSH: Yes, you can work around it.

PROF MONTGOMERY: - what we can start to do is to think about, well, what can we do on

the back of that even before we get the other things?.

MS McINTOSH: Some of it creates difficulties with the work that has got to be done on the interview programme, because, actually, without that material we cannot then identify your interviewees. We have said that we will try as far as possible to have a structured approach to interviews and also not to be inviting people back and have to re-interview and have to enter into dialogue with people externally.

DR WALTERS: This would reflect so badly on the whole sort of infrastructure of the NHS, that for something as important as this there are no proper legacy documents. It is going to be terrible.

MS McINTOSH: It was just to let you know that and to sort of let the whole group know, because I know the conversation with the Chairman and the conversation with Jonathan is about letting the whole group know. What I hope we will be in a position to do is, by the time that the subgroups meet next week, actually, have a table, probably on the wall, that sets out what we asked for, what have we got and, crucially, what is missing, because one of the things that I think we need to do and we need to talk about next week is prioritising chasing up what is outstanding and prioritising that alongside the new requests that are coming from the subgroups, because for the Trust, in particular, the volume of material that that they are providing and collating from three different sites is actually quite challenging to them. We just need to be quite careful that we do it in an organised manner. We do not want to run the risk of cheesing off the Trust, because the Trust are being very cooperative on the evidence front, but, actually, they have got the volume of material and the complexity. Obviously, there is a significant volume being ploughed through in the Department of Health, but now it seems to be being ploughed through by some barristers as well and they are coming to us in a

format that just feels a bit unhelpful to you, especially when we have had other organisations - I am thinking in particular of the Trust and the Care Quality Commission, in particular - who have engaged with the spirit of the Investigation and supplied material, as much material as they possibly can, and are still looking for stuff and have, actually, said to us, "I am giving it to you now, but can we please have a conversation down the line when you decide what you are going to do with this?" which is fine, because we can then ...

CHAIR: Do our best to anonymise and all that stuff.

MS McINTOSH: Yes, and redacting names that definitely do not need to be shared even with an interviewee. Some people have entered into the spirit of things and some people are less inclined to.

CHAIR: It is probably at one stage removed, is it not?

MS McINTOSH: Yes.

CHAIR: The Department of Health process looks to me as if lawyers have come back, you know, as they do, with an extremely cautious approach.

MS McINTOSH: It is just very interesting that the Department of Health is supplying two lots of material, its own material, that has not all been subject to redaction and looking at the HSA/PCT stuff which seems to be going through a much more rigorous process.

PROF MONTGOMERY: Do we know whether we are the only sort of people after this sort of material at the moment or whether, actually, we are somehow caught up with a lot of people fishing in this pool and this is about protecting some completely different agenda?

MS McINTOSH: No, I think that it is us at the moment, but I think that what is interesting is that the Department has got a few investigations running at the moment and it has set

them all up and, probably, has not given thought to how it would manage those. It is now trying to put in place processes and we are probably just in at the wrong time. I will double check, because, if they are supplying material that does not need to be redacted who are we being lumped in with? I will check that.

PROF MONTGOMERY: You can see that they could come to it from different ways, but it could be that there is something very sensitive going on somewhere else and the lawyer has been asked to put the same make amount of care about making sure that no one can find anything they want to know out to all investigations, which could in the context of a national security or interrogation investigation be more understandable, but it just seems bizarre in relation to this one.

MS McINTOSH: Absolutely.

CHAIR: It does, yes, and redacting the chief executive of the Trust's name seems wholly weird. Is there anything else?

MS McINTOSH: It was just to give an update and there will be a more detailed update, because I think that it might feed into the work of the subgroups next week.

CHAIR: Absolutely. Shall we take the report of the subgroups then? Update on progress, clinical subgroup. Stewart.

PROF FORSYTH: Thank you, Chair. The clinical subgroup has met three times, three full days of reviewing case notes, 19th and 20th March and yesterday. We have also got a date planned for 15th April. I am looking for, possibly, another day in the week of 21st. We can confirm that later. The activities so far are to focus on three different categories of cases. First of all, the index cases, which are really the families who originally came to see us. Secondly, the responses to the notice that went into the local newspapers and, thirdly, the long list of perinatal deaths that cover the period of the

Investigation. [redacted]

pro formas. In the perinatal deaths during the period there were actually 204 cases.

Going through them, separately, the index cases, we have reviewed all of these cases now. The process has been that each case will be reviewed by a minimum of two reviewers and in many cases three or possibly four of us have reviewed the cases. In terms of the pro forma reviews, I reviewed all of the pro formas and from that I identified there were six cases that I felt that we would need to do a full case review on. In terms of the perinatal deaths, Bill has been screening those cases using information that the Trust has provided, which are very specific to the perinatal care. I think that out of the 29 or something cases there are two that we felt needed a full review. It looks as though, although there is a very large number in that list, we suspect about 10 per cent of these will require a full case review.

DR WALTERS: Ten per cent of 204?

PROF FORSYTH: Yes, so it is about 20 or so additional cases.

CHAIR: We should just clarify, the 204 include the RLI cases and the Barrow ones.

PROF FORSYTH: They are Trust wide and they also include, actually, clearly, cases that we are already looking at in the other categories as well.

DR WALTERS: But the 19 and the 22 are just Barrow, are they?

PROF FORSYTH: The in-depth cases, yes, are all Barrow.

DR WALTERS: And the newspaper ones?

PROF FORSYTH: The newspaper, no, at least a quarter if not more are from the Royal Lancaster Infirmary.

DR CALDERWOOD: Can I just check that you are talking about perinatal deaths? Have we also then looked at maternity?

PROF FORSYTH: And that includes maternity.

CHAIR: It is actually the maternal deaths and the neonatal deaths.

PROF MONTGOMERY: So we think we are talking about roughly 50 cases.

CHAIR: If you estimate, yes, how many may be for full review in total, it is probably about that.

PROF FORSYTH: It is probably going to be around 50. It may creep up as more cases become available, but, yes, we are being able to quantify the workload, I think, and we think over the last three or four days we have certainly got through about a third of them already. The strategy I think in terms of getting through the work is to try and cover as many of the case reviews by the end of April, because we feel that it is important we get as much information in terms of evidence for other subgroups and also for the cut-off of the interviews as well. That is why I am pressing people to try and give us a day here and wherever and I think that we have, actually, achieved more than I thought that we would achieve by this time.

DR WALTERS: I think that it is really impressive, actually.

PROF MONTGOMERY: In terms of what the output of that review looks like, would it be intelligible to someone like me?

PROF FORSYTH: I think that, in terms of outputs, I think that we are probably looking at different levels about this as well from different categories of cases. I think that we have already touched upon the families, who have very much been active and concerned who have come to see us. I think that our final output to them would be quite different. We have been talking about face-to-face discussions plus, probably, a

more formal and complete response. I think there is that level of output and I think that, otherwise, what we are picking up are definitely issues in terms of practice, which I think have thrown up issues regarding systems within the organisation. There are definitely some themes that are emerging. That is what we might expect to see at this stage. I think that one other issue that I think is important is, of course, when we are gathering clinical data with the names attached, I am just a bit concerned that we have got confidentiality and how we handle this data and how we present it. I have now got a spreadsheet from the pro forma patients just to set out their name, the date of incident, what was the notable factor, etc, what action has been taken within the Trust and what are informing some of the inquiry issues arising from this. I am concerned as to ensure that this does not get misplaced when it becomes available through Freedom of Information, etc at this stage and we have lost control of it. I am really looking for advice on that.

MS McINTOSH: Do you want an answer now?

PROF FORSYTH: That is the sort of summary. I think that it is important for the other subgroups to see what we are doing, because I think we, obviously, want to know how we can feed into the other subgroups effectively and as timely as possible.

CHAIR: Just a quick comment on that, if I may, I think that the cases need to be identifiable for the purposes of the other subgroups, because there will be stuff that we want to follow up with and, unless we can identify the cases, we will not be able to do that. However, they then need to be de-identified and we need to treat everything up to that point as working papers.

PROF MONTGOMERY: I do not think it is an FOI issue as such.

PROF FORSYTH: Because presentation data will be excluded.

CHAIR: The point is they are working papers. I think that the bigger issue to be honest is making sure that we can handle where we have copies of papers that have got identifiable information on them. I have mentioned this a couple of times in various contexts, the danger of leaving a case on the train or wherever. That is probably much bigger than anything else at the moment.

PROF FORSYTH: I think that Oonagh is going to give us instructions on this.

MS McINTOSH: I am. Actually, having gone home last night and reflected even on the meeting we had yesterday, where what we decided was I would not even let Stewart take the pro formas away with him because of the level of concern, but we agreed that we would send them to him electronically and I think that the safest way for us to do that, and there is going to be groan, I know, is actually we will open a temporary folder in Huddle for you, just for that. You can then collate those. Then that folder will be deleted when you have your composite picture. I think that that is safer than us just emailing them to you.

PROF FORSYTH: In terms of the pro formas that came in, these are in Huddle, under the sole clinical title, we were able to then click on "pro forma" and it came up. It was very straightforward. That is a satisfying part of it.

DR WALTERS: Just to check your denominator, Stewart, these transfers out that went to places like Liverpool and Manchester, would you be looking at them even if they didn't die?

CHAIR: Those are transfers of those who died, are they not?

DR WALTERS: These all died. So we have not got any transferred out that might have managed to survive disabled?

PROF FORSYTH: Yes.

PROF MONTGOMERY: But they would be complainants, would they not?

PROF FORSYTH: Yes, we have got complainants here. The index cases were those who were transferred elsewhere, who either died or survived and we have got data on them.

DR WALTERS: So we are not absolutely sure we got everything, are we?

PROF FORSYTH: I think that from our process perspective, the process has been to encourage families to come forward. We have this list. I think that is all we can do. At the end of the day, the things are already emerging of what we are seeing. Therefore, I think that getting one extra case or whatever is not necessarily going to alter our recommendations at the end of the day.

CHAIR: I think if somebody came along and said, "I have had a problem that I want you to look at", obviously, that would be different, but I think not somebody who has already registered a problem and expressed concern to us. As Stewart says, it is not going to add significantly to what we are discovering, anyway. There is a wealth of information about the cases we are looking at.

DR WALTERS: I accept that. It was just my pedantic brain wanting to know what is there. Stewart, can I ask you for the notes that we have been filling in, the pro forma that we agreed on the Leicester group?

PROF FORSYTH: Yes.

DR WALTERS: What is your feeling then about what additional detail or information, we would go back to them another time to look at the notes?

PROF FORSYTH: The pro formas that we filled in. These are going to be sent to me on Huddle. I am going to try to put that again on to a spreadsheet. There is no doubt that, when I do that, I will be querying some of the stuff and would want to go back to check on a number of the case notes again to be absolutely sure we have got a clear and

accurate picture of what happened. But the notes are going to be held here so that we can arrange to do that. I think that the first step is to put what we have scribbled on to the sheets on to a spreadsheet and then for all then to have a look at it and see if that really does reflect what we recall and for any of us to go back and check the case notes again.

DR CALDERWOOD: Because some of the other subgroups' information I would feel - I am sitting here thinking, well, what happened there in the risk management process and that would help me. That would give me more information about the case notes. It is obviously not contained in the case notes. So I would want the opportunity to then add more external information which would help.

PROF FORSYTH: I would agree entirely. I think that we are going to do half the picture, because the other half is what happened within the Trust in these cases. The correspondence that was exchanged between the patients, the families and the Trust management team, what action was taken, I think that, to be honest, you would then be looking at another ... In terms of the data that we feel we want to get into this, in an ideal world, virtually all the clinical stuff and then what else from a Trust management perspective and matching it up with each individual case.

DR CALDERWOOD: In fact, the way in which it is responded to in some cases would clearly change my view of what quality of care there had been. So, if there is something that you feel was not avoidable in a clinical sense, but then was dealt with in a less good way or you felt in a good way, but the whole thing could change, the whole picture changes your view of that case.

CHAIR: Yes. The way in which we are tackling it in a sense, we are not just pulling together one big jigsaw we are actually assembling three sub-jigsaws and then linking them

together. I think that that is right.

PROF MONTGOMERY: I think we need to be open to the possibility that things actually went wrong quite late. The clinical care is not the bit that in the end that will tell us what the picture looks like. It will be missed opportunities to put things right that went wrong and what feels like an ability to take something that may not have been so bad in the first place as a picture and make it a complete disaster in terms of what actually happened. Those things are all possible, are they not?

CHAIR: Absolutely. Are there any other questions of Stewart?

PROF MONTGOMERY: At what point would it make sense for us to look at the pro formas - at the end of the month?

PROF FORSYTH: The end of the month, that is the target, when we are trying to have as much complete data as possible. It will continue to be ongoing for some time yet, but I want us to have a substantial amount of data so I am looking at the end of the month. I do not know if that fits in with Oonagh's time scale.

CHAIR: The main road block, though, is the supply of information from the 204 cases from the Trust. They are struggling to produce things as fast as they can, that will be our road block.

PROF FORSYTH: Again, we had discussions about it yesterday, about different ways of doing that, but what came back following a conversation that Paul had with the Trust is that they are happy with the way they are doing it and I think they are definitely putting resources into that to make it happen. Certainly, we went through what we got, the first 29 cases, and we thought that was reasonable information on which to make an assessment and decide on further more detailed records.

PROF MONTGOMERY: Because I think that if we have in our minds that we will have

some thematic questions emerging out of this at the end of the month, even if we cannot get a lot of the information we are after, we could at least begin to trace those themes through the published reports and the information that we have got and see whether the jigsaws connect with each other or whether they run in parallel.

PROF FORSYTH: I think that we could do that.

CHAIR: Thank you. Geraldine.

DR WALTERS: We did not have quite so much of a fixed starting point as having to start with notes and cases. We met once and before the meeting we let Jacqui sort of carry on with the clinical stuff, she was doing the work there. Julian was going to look at the Trust Board papers, just to get a flavour of what was in there. I was looking at the policies and procedures. At the same time we got this list, which was really helpful, of all the neonatal deaths and the maternal deaths and transferred out and still births. We met. The policies do not really deal with an awful lot. There is, probably, a bit of housekeeping around the policies which they have not done, so lots of things are in draft and one or two which you would expect to be there, like whistleblowing, that were not there. In terms of content, going through each policy and each draft to see how it has changed over the years is not really a very good use of time, because most of them have been done to line up with T&STs, which do not really tell us very much about what the Trust are exactly doing other than they have a policy.

Surprisingly, Julian could not find any Trust Board papers. The only ones he could find were some that were in the public domain which he found very sort of sparse. There was not much in them. We have made a request back to Paul to actually ask for Trust Board papers and Trust risk management committee papers. You would expect that the sort of thing that we are interested in would go in detail to risk

management and then would somehow be dramatically summarised to go to the Trust Board. That is a little bit about how we are looking at it.

DR CALDERWOOD: Do you know what the level of distribution is? Not surprisingly, I find that it does not always go as high up the chain of command as you might wish.

DR WALTERS: Well, they do have a policy, which is their integration and incident, complaints, claims policy, which really just states what the format of the report should be to go to risk management. For each division, it should have going to the risk management committee, a list of complaints, a list of the claims. This is why it would be quite useful to see the whole thing to see how far they were getting. That line of enquiry has sort of stopped there for the minute until we can find the papers.

The next thing I then started to have a look at was to try to get a view of, if the Trust were looking at the data, what would they actually be seeing? I am really disappointed because I have got a poor person to put this on, but we have no projector. Really, in terms of looking at neonatal deaths and maternal deaths and the transfers out, if you are looking at those separately, for Furness and/or RLI, really until 2007, you would not have picked out a problem. This does not include the stillbirths, because the stillbirths on here do not say why they have ... For example, there are about 600 less births at Furness per year than there are at the Royal Lancaster Infirmary. Up until 2007, neonatal and maternal deaths: none, two, two. Royal Lancaster and Furness: 10, eight, 12. So, if I was the chief executive, looking at those, I would think that I have not got a particular problem in terms of deaths and the transfers out are pretty much the same.

In 2007 they go up to eight. So then, in our group, we started thinking about, well, what actually triggered the Fielding Inquiry. The Fielding inquiry was in 2009

and it referred to five unconnected serious incidents in 2008, but there had already been an internal audit report which we have not had sight of and a report to the CQC with recommendations and an LSA report, prior to the Fielding report. The question is what generated those. [redacted] [Projector came on]

Just to take you through those, the LCH column, that is maternal deaths and stillbirths and transfers out and then there is the number of births and the same for RLI. You can see that in 2004, 2005, 2006 just sort of wobbling along with about 0.2 per cent, say, at FGH and about 0.6 at Royal Lancaster Infirmary. Then you jump up to about 0.7 per cent, but, even if you are not looking at the percentages, you can obviously see there has been a hike in cases. The five disconnected cases were 2008, so, obviously, that eight in 2007 did not really prompt anything. The five in 2008, two [redacted] So only three out of those five were on the list. I think that what was true for the list was the James Titcombe argument and they then took their SUIs. We need to look at the SUIs, basically, which is proving a bit difficult. The Fielding report was commissioned by the chief executive with the support of the Trust Board, so what we are asking for is can we have any documentation which shows how that was decided upon. But the remit of that report was to say that recommendations had been made in the two previous reports and so this report was really just about how it progressed, onward improvements. I suppose that is sort of as far as we can get at the moment. We

then decided, through Jacqui, that we really needed to look at trends from 2007 onwards and we needed to know prior to 2007, although they are only ones or twos, were those cases generating SUIs or were they generating serious complaints. We have asked for that, but at the moment the response that we have got is that all the SUIs are anonymous so we do not know which they refer to. They must be linked under a patient's name.

Around about 2007 8, when we were linking with Jonathan, because then we were interested in what was the external organisation's response to the fact that they had these recommendations, so, internally from the Trust's perspective, we want to see what they did and whether they did the right things, whether they handled the complaints properly and whether the serious untoward incidents matched with the other cases. So were the SUIs all coming out with this is all about documentation [?], whereas you are saying this is bad judgment, sort of thing. Really, how did what was happening at the time impact on things like their FT application. I think that that is about as far as we got.

CHAIR: That is helpful. Thank you. One observation before I open it up wider is that you were talking very interestingly about what was going on in 2007/2008 and it was in 2008 it started to generate a concern. One of the 20 cases that I screened that Stewart [redacted] that it was one that I have said needed a full review and there was correspondence between the paediatricians in RLI and the paediatricians in FGH saying that there were lessons to be learned, what are you going to do? I thought that that might be very relevant to what prompted what.

DR WALTERS: Absolutely, because I think that labouring through some of these Trust

Board documents is probably going to yield less than that, because, again, if I was sitting in the Trust in 2007, if I was not getting any warning signals from the numbers, was I getting warning signals from the complaints from doctors kicking off from midwives writing to me and saying this lady is terribly unsafe, and that is something I think that it is going to be quite difficult to gauge.

CHAIR: It certainly is in that case. There was correspondence copied to the medical director of the Trust.

DR WALTERS: Yes.

CHAIR: Saying there was a problem. That sort of correspondence is not going to be in anything that we have asked the Trust for.

CHAIR: So we need to identify that case.

DR WALTERS: Yes.

CHAIR: Some of it is inpatient notes, but it will not all be.

DR WALTERS: No. I think that this is where the subgroups need to sort of coalesce a bit to try and form a picture, because quite a bit of the discussion that we had was, you know, some of their policies were in draft and some of them are a bit kack-handed, but, actually, that is not unusual.

CHAIR: Sure.

DR WALTERS: Would the Trust Board have selectively looked at numbers of deaths, neonatal transfers by site at Trust Board level, probably not. I think that we are sort of trying to really look out for what was there that they should have noticed and that letter is something pretty obvious. That is the way that we are looking at them at the moment. Stewart said this morning he felt that we should be looking further down the line at things like staffing levels and that sort of thing.

PROF FORSYTH: There is a tentative response to this. Were there any discussions within the Trust regarding staffing levels? The themes that are coming out of our review is that none of the parents are saying in their comments that there was not enough staff or a question around relief. You know, one mother could think that the midwife left her when she was particularly uncomfortable to go and look after two other mothers that were sort of about to deliver or whatever. I think that staffing levels and medical staffing again, I think, is something to look at from the paediatric point of view.

CHAIR: We will get the information pack which will have that in.

PROF FORSYTH: Certainly, the transfer out, it is not so much the transfer out, as well, it is actually the timing of the transfer out. There is quite a bit of evidence about babies being held up, who had a severely asphyxiated birth, with PHs of less than 7. Some of them do not really do much and then they start deteriorating and, of course, then there is contact with the retrieval team eight or nine hours or more further down the road. By the time that the baby then gets to the referral unit, the baby has died within a short time of arrival.

DR WALTERS: I think that we will only find that out from the interviews. I do not think we will manage to get that information from anything that is written down.

PROF FORSYTH: One thing is what is the interaction between Barrow and the neonatal network and what is the policy in terms of transfer out? What are the criteria? They should have something.

DR WALTERS: Yes, there should be criteria.

DR CALDERWOOD: Geraldine, I looked at a case last time which had some correspondence in it, which copied in lots of levels of staff, which had concerns by an obstetrician, who also said that there had been previous similar instances in his memory and something

needed to be done. That is one to look at as well. If I am remembering properly, I looked in detail at the CMIS report. There are funnel pots. They get more detailed as we get closer to the current time, but I do not think these were outliers on any of those plots, partly because of small numbers, but also partly because they were not outliers. The other one is the NHS Cumbria perinatal deaths which covered, I think, 2009 to 2011. The pattern of the stillbirths is different. The pattern was that they were term, which is not what you expect the rest to be. It is almost the detail of those and the management of those, because the physical numbers were not different in the Trusts, in South Cumbria and North Cumbria, because they did that very detailed report.

DR WALTERS: Actually, you do not get these data until quite late in the day. Actually, what I think we were trying to concentrate on is that, if you were sitting there at the time with the information that you had got, so, picking out an outlier on a normal weight babies but not anything else would have been something that I think would be beyond you.

CHAIR: I think that that is right.

DR CALDERWOOD: Most obstetricians would not know the pattern of stillbirths. I know it because I have an interest in preventing stillbirths, but that is something that I continually talk about, groups of people who do not know those figures and those proportions, so I think that you would have referred to that and said the same sort of numbers.

DR WALTERS: [redacted]

CHAIR: It is the nature of the cases, though, is it not, it is the individual concerns about individual cases which either did prompt correspondence and what happened to that, what action was taken to investigate it or in some cases just did not prompt concern.

The other one that I have referred to, one of the screened cases that I think is reviewed, but I mean the other one that I think is reviewed is a [redacted] and at the very least, and whatever the rights and wrongs of subsequent management, you would think that they would have a review. [redacted] You would think that they would have a review of that and said what have we learned from this. [redacted] should we have done something different?

DR CALDERWOOD: And what I think you might find, Geraldine, is that because there is no way of recording whether a still birth is intrapartum, we cannot code that, that is not coded, but what I am feeling from the notes is that there seems to be a significant proportion of intrapartum deaths.

CHAIR: Yes.

DR CALDERWOOD: We are going to have to compare that number with published literature, because if we were able to to find another Trust ... I thought that from the beginning because I hoped that we would be able to separate them and include them and we cannot. Because that is quality of care issue, an intrapartum stillbirth, different to an antenatal hospital admission stillbirth, I think that those numbers might be worth looking at, but that would have to be with us physically writing down antepartum, intrapartum, stillbirth that is not able to be pulled out at this stage.

PROF MONTGOMERY: So you cannot describe it as a historic evidence failure to miss that, but you could describe it as something that should be coded in separately.

DR CALDERWOOD: Also in the unit, Jonathan, if you were doing reviews, because it is

such a rare event in the unit, I would have thought that somebody would have said, "Hang on, we have already had one of those four months ago". That is the case, actually, in 2008 there are several and for a unit of this size it is almost once in a five-year incident.

PROF MONTGOMERY: So just two would be enough?

DR CALDERWOOD: Absolutely.

DR WALTERS: [redacted]

CHAIR: [redacted]

DR WALTERS: [redacted] had established that before they were known to have a problem or before they could have been expected to see that there was a problem, it is more about how they dealt with the individual cases and whether they did that properly. For the cases up to about 2007, we attempted to say we look at those, we give the right information to any of those sort of index cases, but, actually, after this it is more about did they really respond

them to trends and the findings of the recommendations? The Fielding report, because she starts off by saying that she is not about to make any more clinical recommendations, she is about to look at development and all that, but peppered throughout that are the sort of suggestions of quality work, doing what is routine, cost and cost effectiveness and alluding to the fact that, actually, the birth rate plus findings would have to be implemented with regard to financial position of the Trust and cost effectiveness.

PROF MONTGOMERY: Birth rate plus will have stuff on staffing levels, is that right?

DR WALTERS: Yes. It is historically a bit generous.

PROF MONTGOMERY: It was designed to make it better for midwives, was it not?

DR WALTERS: Yes. It was. There is a difference about how far away from it you actually are. The third thing was they are pretty naive when it comes to systems, governance, quality, guidelines, effectiveness, so they are the three things that look to that. I think that there must be more meaty recommendations in these previous reports that we have not seen.

CHAIR: Thank you. Is there anything else on that one?:

PROF MONTGOMERY: I think that the only thing in our discussion last week was how are we going to try and work out what the reasonable prevailing expectations were, because everyone was trying to think back to what would their organisation have done back at that time and I think that we will have real trouble finding objective ways of assessing that. I do not think that we have a solution to that. We can now look and think about what the Government's expectations are now. We can look and say that they have a set of policies that look quite plausible except they all seem to be in draft still and we can say that they do not seem to have been entirely followed through. You can make that

criticism. What is much more difficult is to know would other organisations at that time be in a similar state of flux and were they, therefore, better or worse than other organisations? I think that all that is going to be quite tricky to assess.

CHAIR: I think that that is absolutely right as far as overview of what was going on is concerned from what I said was the helicopter view, in terms of responding to incidents that happened and have taken place and so on, there is a separate ... I do not think that that has changed significantly since ..

PROF MONTGOMERY: And also part of this was that, once we get a better understanding why they commissioned the Fielding report, irrespective of what other people would have done, they have committed themselves to a course of action and, if they had done badly, then it is perfectly reasonable for us to reflect that.

CHAIR: Exactly.

DR WALTERS: I think that also what would be really difficult, which is why your staffing level comment made me sort of tremble a little bit, I think that it would be really difficult to track from 2004 to 2012 what the staffing levels were, because I do not think that they will be able to give that information.

PROF FORSYTH: We have the dates of the incidents and, actually, what was the staffing level that day. There were comments that there were insufficient staff and then the staff did not have time to speak to them and were rude and abrupt and, you know, all that. I think that we have got quite good evidence from the families about concerns about staffing and we, therefore, need to then match that up with, well, what was the staffing on that particular day or week, were there issues?

DR WALTERS: If we can find that, but, if they did not have an electronic staff record in 2005, whether they have still got paper copies of rotas, I really do not know. I think

that the other thing about the complaints is that I see that written in complaints all the time. You see that in a lot of organisations. You occasionally get the other thing, oh, there were lots of people standing around, no one was helping me, but you also get staff running around and there were not many of them. That is probably the case in, I would say, 75 per cent of all organisations. We have to make sure that we are not giving a higher bar in some aspects that we would ...

PROF FORSYTH: I agree, I think that that is right.

DR CALDERWOOD: The other difficulty, Stewart, is the level of activity at any particular time. It would be almost impossible to track that, but, if there were three other women fully dilated in the same hour or two, that does have an impact, but how to find that ...

CHAIR: It is a pretty wide event given the number of births that they do.

DR CALDERWOOD: Our difficulty is that we cannot. There does seem to be some comments about we had to leave the room to attend to another woman and in the notes that I have read, there were several looking after a post-Caesarean section lady, who left room. How do we ever track that?

PROF FORSYTH: Yes. Again, it is going to be systems rather than specific cases. I think that the specific cases are raising questions about the systems and I think that that is where the Trust staff will have to respond to some of these questions in relation to that.

CHAIR: That is something that we have to get into in the interviews. We will not find that out from the paper records.

Shall we move on to the third group?

PROF MONTGOMERY: As we go further away we have less to report. We have not really met although we had a bit of discussion in the margins of Geraldine's group. I think there are three things just to comment on. One is about how we are going to get in

some data and so we had a teleconference with Oonagh about, in those thousand boxes of things, what would one be most interested in and I think that there are a couple of things that might help us understand whether anyone perceived a system problem in this. The Primary Care Trust would have gone through a fitness for purpose process trying to analyse their strategies and whether they had a commissioning strategy and whether they were on top of the assessment of quality and services that they were commissioning and there would have been a whole set of documentation that would have been used by the SHA to scrutinise whether or not they thought that the Primary Care Trusts were up to scratch. That should tell us whether or not it registered in the system as a quality issue or not. The other thing is that the SHAs should have been going through a sort of dummy run process on the FT application, which should have included a board-to-board between the Trust and the SHA as a preparation for the board-to-board with Monitor. If they had done it in the same way as they did it in the areas that Julian and I know about, there would have been a whole data pack produced for the SHA to generate sets of questions for them and there would have been a rather slimmer data pack produced for the Trust to tell itself about what it knew. If we could just get hold of those, I think that we would begin to form a picture of whether this was something that was seen as an external system problem at that stage, so we are going to see if they can find those in the boxes. I do not know if we know whether you think they have found them.

MS McINTOSH: They did tell us that they would give us an update by the end of this week. We chased that and reminded them that we are awaiting a response but we asked for that as soon as we had the teleconference with you.

PROF MONTGOMERY: That is a frustrated line of enquiry at the moment, I think. The

second thing is that, in the absence of anything else, I think that we can get started with trying to construct a timeline of what was recognised by the external reports as going on, so I have just begun going through with a spreadsheet, Fielding, others, saying what does it record as having happened at particular times? If we get that timeline out, we then have some chance of trying to see whether the strands connect with each other at any point. So, if the clinical group was identifying cases that might come through to that, can we see where they connect, can we see whether the themes connect into that? I think that I can do some of that just from the report that we have all had already and see if we can get a timeline into it. That is the work that I am doing. That should help with the third bit which we are again picking up next week is about who we want to interview and when. If we can construct that timeline, it seems to make a bit of sense, and the thinking on the construction of that is probably that we should start locally and try to move up the food chain, because we do not really want to talk to the more senior people until we have a better idea of what we want to ask them about of what they could have known and then it becomes reasonable to find out (a) whether they did and (b) whether they thought that they should and see whether we think that they should. I think that we would really like to start with the people who are involved in doing those external reports and hear from them and then we can begin to ask the other people, so there is not much to report back, but that is the thinking so far.

CHAIR: Any questions? [No response] It is one o'clock, I suggest that we break for lunch for one hour.

[There was an adjournment for lunch from 1.00 p.m. until 2.00 p.m.]

CHAIR: We're up to item 7, I think, which is the Subgroup Leads Meeting on the 9th and 10th, and we've covered a certain amount of this already. But, Oonagh, let us know what else we need to take account of.

MS McINTOSH: Well when the meeting was first sort of discussed, the intention was that it would be to look at the approach of the subgroups – and any overlap in interviews, potential interviewees – to identify those. And also to look at the approach you were going to take to interviews, bearing in mind you wouldn't all be present all the time. And how we would make sure that the Chairman had questions and themes that needed to be addressed from each of the subgroups. So that was the initial thinking.

Obviously, as I've mentioned earlier in the discussion today, there are issues now that need to be discussed around the management of evidence prior to and during the interview process. It might be very early for any of the subgroups to consider what evidence they will need to share with interviewees. But I'd like you just to give some thought in between now and next week, and other members too – because that meeting was very much opened up to everybody, but it was primarily in the diaries of the subgroup leads and the Chairman – to actually think about any contribution or comments they want to make to that process. Because, as I said earlier, we need to resolve the outstanding issues to do with the protocol, so that we can get that out and get that published.

But also, another issue that we needed to sort out – and you've referred to it a couple of times, Geraldine – is around SUIs and incidents. It's one of those things that we've sort of pushed to one side because we've been prioritising getting the files from the Trust to do with the maternal and neonatal deaths, but actually we need to look at the SUIs and we need to kind of determine which of those we are going to select to

make the random sample. It's very difficult because the spreadsheet you've seen, which lists all of the SUIs, is not at all helpful to you in trying to pull out a sort of good sample for the Investigation to look at.

The Trust are also pressing us on this. They've let us know it will take some time to get files together, and so we just need to build that in. Although, as we're waiting such a long time for the Department of Health evidence, there'll be quite a bit of evidence still coming in. So there's that to look at.

DR WALTERS: What are you asking them for in the SUIs?

CHAIR: We're trying to get some detail of things like the nature of the incident and severity, so that we can make some decisions about which are the most sensible ones to sample from. Otherwise we're going to get a very small sample from a massive range of incidents, which will predominantly, by the nature of these things, turn out to be slips, trips and falls and minor staff accidents.

DR WALTERS: You see when I looked at it – and this is where I really burst into tears looking at Huddle – was that I got the list of incidents, and there's a column which says 'SUI, yes or no'. And they were nearly all 'no'. But it was taking so long to get to the end, I couldn't pick out any 'yes's. So I think if you can aggregate the 'yes's, there might not be too many.

CHAIR: It's probably on the spreadsheet, in which case we can just put them all together.

MS McINTOSH: We'll find that out.

DR WALTERS: Yes. Well I tried to do that. I tried to click at the top of the yes/no column, but it didn't seem to do it. But would another way around it be: when you get your list of issues, just say to them, 'Can you tell us which of these cases had an SUI raised?' And then you can get from one end of the sample to the other end, can't you?

CHAIR: Absolutely. So long as we can overcome this point that they stop insisting that they only store records of SUIs anonymised, in which case they'll say, 'We can't tell you because we can't link from the name you've given us to whether it was an SUI or not.'

DR WALTERS: Well if they've got Datix – if they've stored things on Datix – Datix has the Incident Report and should have a patient's name and number. And then that would generate a number which turns into an SUI. So I think they've got to go back to the Datix, not the list of SUIs.

CHAIR: Thank you. That's very helpful. We'll do that.

MS McINTOSH: So really, all I just wanted to say on that was: if anyone has got any point – if they're not coming next week to the meeting and they've got any points they want to chip in that they think we can usefully discuss about the interview programme, but not just about the protocol, but how the subgroups are going to work – I think it would be quite helpful to have those maybe by close of play on Monday. If you've got any comments, that would be helpful.

Chair, would you mind if I just went into point 9 as well – because this actually really shouldn't be a stand-alone, it should be tied in. It really is important that the Secretariat are advised as soon as you know whether anyone on the list of potential interviewees should be taken off the list or a name should be added to the list. I think one of the major concerns that interested organisations had with the draft protocol was the timeline. I mean we put a ridiculous timeline in of saying, 'We give you a week's notice to come.'

CHAIR: We said a minimum.

MS McINTOSH: A minimum of a week. And organisations have come back to us – some saying, 'That's ridiculous. I represent senior people and senior people need lots of time

to get ready for these things and they've got very busy diaries.' Some people have come back and said, 'Actually, we have a rota for staff and the rota is done four weeks in advance, and it might actually be clinically difficult for us to release people.'

But we're addressing some of that by suggesting having interviews in Barrow. So there are ways around some of those. But if you decide that you want to let someone see some evidence or want them to look at evidence in advance of their attendance, then that has got to be managed by the organisation that the evidence came from. Because we are still holding the line that we can't manage that process, or we are under pressure from organisations to facilitate that. So it's really important for us that we get the list of potential interviewees.

I was talking to the Clinical subgroup yesterday and they were saying they're starting to see names. Obviously you haven't all got to that stage yet but I think it's really important for us. We're going to start the interviews hopefully with the sort of environmental oversight of people, and then there might have to be a break because the Clinical subgroup will still be sort of finalising work and handing over to the Trust Response group that information. But, nevertheless, we'll need to give people notice, especially if they need to see material ahead of attendance. So it's just a plea, really.

CHAIR: We need to minimise the size of work. And yes I appreciate that some people would like to have more notice. We'll give them as much notice as we can. We said a minimum of a week; that would not be the standard practice. That was never the intention. But we can't afford to let this process stagnate at this stage and not really properly start the interviews until June or July.

DR WALTERS: I think you suggested, Jonathan, that we could maybe start with the external review of all this first. And actually we're only really going to be asking them about

their view.

MS McINTOSH: Yes, absolutely.

PROF MONTGOMERY: We ought then to be able to ask them about documentation and things that they used as part of their work which would enable us to cross-check whether we've seen that information. And who they reported it to and who they next talked to about it, and that would get us a picture of who we need to interview later on in the organisation.

DR WALTERS: Do you think we could interview, up to the latest, the end of August? Because then that would leave two clear months.

CHAIR: We'll interview into September, I've got no doubt. And there will probably be some loose ends to sort out in October. But the thing is – my experience is that you will have found out 80% of what you need to find out and therefore you start doing the report at that stage. And yes you go back and change things and add things in as you find out the last bits of information, but you don't want it strictly sequential.

DR WALTERS: I was just thinking, if we knew what the last point was we could be saying to people now that, you know, clinical staff – who we've probably got quite a good idea of – you could give them dates in August.

MS McINTOSH: I think we have some difficulty interviewing in August because actually it is a holiday period.

DR WALTERS: There'll be a portion who probably aren't going to be as busy, are there?

CHAIR: Of course. Indeed. And the place will still have to be covered clinically, so they can't decamp en masse.

PROF MONTGOMERY: But if we're going that far ahead, people are not going away for the whole of August. If you're having that discussion now, you'll have a series of days,

you might well be able to pick up some people.

CHAIR: I think we start putting them in as far in advance as we can. And that's addressing the point about notice as well as availability.

MS McINTOSH: Yes, absolutely.

CHAIR: Okay, thank you. Catherine?

DR CALDERWOOD: It was just – with your past experience of doing this sort of thing, I mean I can see there would be – almost going through the notes – it might be useful to speak to that person, that person, that person – but there may be, in one woman's care, 10 individuals, potentially, that we might want to talk to. And some of this is quite a long time ago. They have all sort of had time to reflect. There have been already investigations, etc, etc. How do we get away from the 'I don't remember', 'possibly I wrote that, did I?' and all of that. Because the whole process is very time-consuming, I think, probably, even with looking at the notes, you almost have 80% of your answers already.

CHAIR: That's right.

DR CALDERWOOD: So how do we choose what the most profitable interviewees will be?

CHAIR: Absolutely. I think that I would suggest that we interview people about specific details of specific cases only by exception. It's only where there is a particular issue that is really baffling us that we seek to do that – for two reasons. One is: we will absolutely run into not being able to get the person because they're now practising in New Zealand or whatever. When we do, they can't remember anything and they're basically trying to reinterpret their own notes in the same way as we're doing. And thirdly: because we will – I said two, there's three – we will run into this problem that they will demand time to be allowed to familiarise themselves with records, which will

prove really difficult to do.

There will be some cases where I think we do have to do it; where we just come across something that is so weird that we have to have the opportunity to ask somebody about it or several people about it. But by exception, not in the majority.

DR CALDERWOOD: But might the family's expectation be that they think somebody is going to be grilled and held to account and that might be individual staff members – because they have mentioned names to us.

CHAIR: There are a handful of people who we absolutely must interview and we must ask about some specific details. This is one reason why I think it would be a very good idea to get people to put their questions to us – like one family is talking about doing.

But I think the reason for doing that is because they feel very dissatisfied with the information that they've had already. One of the things that did reassure me about the meeting that we had on Monday, and some of the other conversations that I've had with people – the idea of seeing somebody grilled as part of their 'being held to account' is not foremost in their minds. What they want is information. What they want is the facts of what happened. Not to see somebody squirm. They were very clear about that.

PROF FORSYTH: Although I seem to remember – I've sat in on two or three of the cases – they very much want to know why an individual midwife did something or a doctor did something, and they wanted answers to that. As I say, I think, at the end of the day, we will have three or four or five of these cases where we'll have to have a lot of detail on them to try and answer their questions. That would be a sort of separate package as part of the inquiry, so to speak, because with the rest we're looking at right across the service and how this escalates up. How it escalates, the level of concern, etc., etc. And

I think, although I do feel that when we come to deciding who we interview, I think it's important to get – although we're only looking at more senior members of the Trust, I think we do need to get one or two consultants and senior midwives, etc., to come along and explain to us how they found the unit and what were their concerns.

CHAIR: Very much so.

PROF FORSYTH: And if they say, 'And we told our manager…', then when we come to the manager, then we can follow that through. For me, when we were looking at the process and how we go through it, I think we're best to start fairly low down and get the feedback from them, and then work our way up through the Trust and then out through to the SHA.

CHAIR: I think that's absolutely right. We simply must interview people who are actually working in the clinical unit on clinical practice. The only thing I was trying to steer us away from a bit, apart from the well-defined exceptions that we know about, is – you know, 'You said in your note on the 23rd July in relation to Mrs So-and-so how do you account for that?' That's not likely to be very productive, except in those isolated cases.

The idea of starting at the bottom and working up, as it were, was something we talked about previously, and we had this idea of the pyramid and how far up did the trail take us. I think, on reflection, it's a bit over-simplistic of me to suggest that. I think we do need to do that, but equally I think there are some people – for instance, Jonathan's people who've done the reviews – that we're absolutely certain that we want to ask now, and there's no reason why we shouldn't address it from both ends simultaneously.

PROF FORSYTH: The value of coming up – well there's a bit in the middle where we all

want to have an interview with them.

CHAIR: That's it.

MS FEATHERSTONE: I think it also goes back to asking the information earlier – whether they were complaints or SUIs – because in order to respond to a complaint or investigate, you have to have evidence. You've got to have your statements, you've got to have various information. So that would help a little bit of what has already been done. And our response to some of the people that we interview as well.

CHAIR: Yes.

MS McINTOSH: And the Trust are supplying us with that information of which of the maternal and neonatal deaths were SUIs. It just goes to show that it's not anonymised completely.

CHAIR: Okay. Anything else on the subgroup leads meeting or are we happy to pitch up and see how it goes and use the time as productively as we can? I know we're not all subgroup leads, but—

PROF FORSYTH: So are we still planning for it to be two days? I'm just thinking of booking train tickets.

MS McINTOSH: You've got a problem with one of the days, haven't you?

PROF MONTGOMERY: The first day I'm going to be in Warsaw, so I can be here the second day.

MS McINTOSH: And you're here both days anyway.

PROF MONTGOMERY: But Julian thought he could probably do the first day.

MS McINTOSH: He can do the first day… okay.

CHAIR: It seems to me that we might not need the full two days on deciding that particular bit of business, but what we can do – if everybody is prepared to do it and can attend on

whichever day – is that we can use it for subgroup business itself. So make best use of the time. If people are happy to be flexible, that might be the best way to schedule it.

MS McINTOSH: That's very helpful.

CHAIR: Okay, anything else on that one? Right, do you want to go onto item 8 now or do you want to carry on--?

MS McINTOSH: Sorry, I jumped around a bit. In your world's thinnest meeting pack, you've got a revised timeline, and some of you might recall we looked at this at the second Panel meeting, but of course it was then for a summer deadline so it's been slightly rejigged. I think the key thing at the beginning is that I suggested three more Panel meeting dates – simply because we are now spread to November. As you can see there, I'm not looking at the report meeting with the Secretary of State on the 1st November because we're looking at a Panel meeting on the 5th and 6th. But we'll probably be looking there at sort of sign-off discussions. And also, at that stage, it's been made clear to the families that by November the report will be submitted, so we might get attendance at that meeting. And the rest is pretty self-explanatory and very basic. It obviously needs to be fleshed out. But it's just those dates. What I might do is get Robert to send some electronic invitations to you, and you can maybe let him know your availability for the three months of panel meetings—

CHAIR: Can I make a sort of peevish, crusty old fogey who isn't quite up to date on the technology request here please? He's using a form of software that I don't have on my desktop PC. So if it just comes as a 'please find an invitation attached', I can't tell what the details are. So if you could just copy the details into the email.

MS McINTOSH: Right. Does anyone else have…?

CHAIR: It's just me.

MS McINTOSH: That's all right.

CHAIR: Sorry.

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

CHAIR: I am thinking that it's about time... They're pulling the plug on Windows XP so I think I'm going to have to upgrade my PC.

MS McINTOSH: We'll put the details in the email to you.

CHAIR: Thank you.

PROF FORSYTH: I have to give my apologies for both the 8th and the 12th.

MS McINTOSH: The 8th May and the 12th June. But we'll be having other meetings about interviews so we'll be able to catch up with things.

CHAIR: I think the nature of the Panel meetings – I mean a bit like today – is, over this period at any rate, until we get later on in the process, it's going to turn into kind of progress reports from the subgroups and sharing information from the subgroups anyway. So I think it's probably manageable without having to have complete attendance.

MS McINTOSH: Yes, okay. And that's it. I just wanted to let you know there were some more dates going into the diary. The final thing is – which probably was kind of part of agenda item 9 – is that I discussed availability with you [Chair] for the next couple of months, and I know that lots of you are holding dates in your diaries still for potential interviews. We'll be working on that over the next few days, and we'll be able to let people know the dates that we consider that we'll be holding interviews in May and June, and possibly July.

DR CALDERWOOD: Because May will be gone soon.

MS McINTOSH: Absolutely, absolutely. We might be just looking at the beginning of May

to do these sort of contextual interviews, and then having a break.

CHAIR: To some extent, the programme of interviews we need to build around the availability of the subgroup.

MS McINTOSH: Absolutely, yes. Exactly.

CHAIR: As we've said before, it will be too constraining if we have to have everybody present. So subgroup meetings, you [Stewart] are in the driving seat on those, I think. Okay, anything else on 9? Everybody content with that? Any other business?

DR WALTERS: I think, just with subgroup meetings – well, no, these meetings. I don't think we're getting enough out of them. Because we don't start until 11. We're nearly all here at about quarter to 10. We finish now. If we planned it, we could have kept going until five. And I didn't change my train ticket – even though we discussed that on the phone, because I didn't think anyone else would be gone. But did we just ought to just say, you know, if the meeting finishes at half-three, did we ought to try and have breakouts, sort of group breakouts for an hour or something?

CHAIR: Yes. I think we ought to use the time for subgroup meetings, yes. I don't want to change the start time of this meeting because it's partly planned so that if anybody should want to come from the Barrow area, they've got time to get here too. But, yes, I absolutely agree: we are not making best use of the day. And in fact the Clinical subgroup has been here since yesterday morning doing exactly as you suggest, yesterday and this morning. So I'm all for doing that.

MS McINTOSH: So, say from 3.30 to 5.00. Or whenever it finishes…

CHAIR: Again, it's up to subgroup leads. You arrange what suits you and your teams around the meetings.

MS McINTOSH: But stay and use the facilities.

DR WALTERS: But you see there's more than just the subgroups, isn't there? I mean, you know, because I now am waiting for your output in order for us to do the next bit. But it's just that if we aren't all thinking we're staying until five, there's no point in any of us individually booking at ticket later on. I just think we need it agreed.

MS McINTOSH: If we just extend it to five, yes.

CHAIR: Yes, okay.

DR WALTERS: I mean, if it's half-three to half-four or 10 until 11 – you know, if we all say we can be here at 10, and we're all happy to leave at half four, then although the meeting is 11 till 3.30, it doesn't matter, does it? But it does matter if no one else is here.

CHAIR: Yeah, no, it does. But equally then, I'm happy for people to arrange it flexibly, according to what suits them. And it won't necessarily – especially if I've been up the day before – it won't necessarily suit me to be here until five. The travel time back to Newcastle at that time of night gets really extended.

DR WALTERS: Okay. If people say, 'Actually, no, I have to go at half-past three', then we won't do it.

CHAIR: There are times when I would want to do that. There are other times when, if there's a significant bit of business to do, I'm happy to stay.

PROF MONTGOMERY: So should we spend some time next week working out what are the tasks for the subgroups that you could actually make some progress on? With an hour either before or after the meeting.

CHAIR: Yes.

PROF MONTGOMERY: Because actually it may be easier for us to meet in London, as we did last week, because actually it might be easier to have an hour at the end of the day

in London than add an extra hour to the Panel meetings.

DR WALTERS: We could add an hour from 10 till 11.

PROF MONTGOMERY: I agree with that entirely. Particularly if we're up the night before, actually 9.30 till 11 is quite a useful amount of time.

CHAIR: Yes, absolutely.

PROF FORSYTH: Particularly with the meeting here, because it's where all the notes are.

DR CALDERWOOD: I could make an extensive travel suggestion – flexible tickets would then solve that. Because if we were finished, everyone has something else to do, but if the meeting runs on, then we'll not get penalised.

MS McINTOSH: Not a problem.

CHAIR: Okay.

MS McINTOSH: She says… I keep waiting for the finance people to come down on me like a ton of bricks. I'll be coming to you for a job at the end of this!

CHAIR: So any other business? **(No)** Thank you. In that case, we'll confirm that the date of the next meeting is Thursday 8th May here – happy to be flexible about before and after. And let's make the best use of whatever time we have available this afternoon to do subgroup work. Thank you. Thanks for coming.

[The meeting concluded at 2.24 p.m.]

## FUTURE WORK PROGRAMME\TIMETABLE

**Panel Meetings in 2014**

Thursday 8 May

Thursday 12 June

Thursday 10 July

Proposed dates……

September 10 or 11?

October 8 or 9?

November 5 or 6 ?

**Draft timetable**

**2014**

| | |
|---|---|
| **April** | Receive evidence, load onto Huddle and undertake detailed consideration |
| | Identification of interviewees |
| | Consideration of evidence ongoing |
| | Interviews\hearing oral evidence |
| **May** | Receive evidence, load onto Huddle and undertake detailed consideration |
| | Identification of interviewees |
| | Interviews\hearing oral evidence |
| | 21\22 May – consideration of draft framework for Report |

| | |
|---|---|
| **June** | Interviews\hearing oral evidence |
| **July** | Interviews\hearing oral evidence |
| **August** | Preparation for final interviews<br>Report writing ongoing |
| **September** | Interviews<br>Report writing ongoing<br>Proof reading of draft Report |
| **October** | Report finalised and shared with families and interested parties |
| **November** | Report submitted to the Secretary of State for Health |
| **December** | Publication? |