University Hospitals of Morecambe Bay
NHS Foundation Trust

**Chair and Chief Executive's Office**
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Tel: 01539 716695
Fax: 01539 795313
Web: www.uhmb.nhs.uk

Our Ref: JD/JB

21 October 2013

Dr Bill Kirkup CBE
Quarry House
Room 1W28
Quarry Hill
Leeds
LS2 7UB

Dear Dr Kirkup,

Thank you for your letter dated 21 October 2013 regarding the Morecambe Bay Investigation and confirmation of the open meeting that will take place on 1 November.

I would like to confirm at the outset that the Trust Board is fully committed to cooperating with and supporting the work of your Investigation Team.

The Board has agreed a number of principles to help the Trust and its employees in their dealings with the Investigation; these have been communicated to staff and will be formally ratified at the Public Board meeting on 30 October 2013. I felt it would the useful to share these principles with you. They are:

1. The Trust Board will be completely honest, open and transparent in its dealings with the investigation;
2. The Trust Board expects all employees of the Trust to be completely honest, open and transparent in their dealings with the Investigation;
3. The Trust will do its upmost to provide information to the investigation as quickly and accurately as possible;
4. The Trust Board will expect employees to be entirely cooperative if they are asked to assist in providing information to the investigation by the Internal Independent Investigation Project Team;
5. If current employees are requested to attend an evidence session by the investigation, the Trust Board will expect them to attend and assist the investigation with its enquiries;
6. The Trust Board will expect all current employees giving evidence to the investigation to provide factually accurate answers.

These principles have been shared with all current staff members.

The Trust Board recognises the importance of the Investigation to those families tragically affected by previous failures and to the wider community and as a consequence I have set up a dedicated Internal Investigation Project team to coordinate these matters. Judith Griffin is Director of the Internal Investigation Project team and will, along with Jo Borthwick, Assistant Chief Executive, act as the main point of contact and I will provide their contact details to the Secretary to the Investigation, Oonagh McIntosh.

The Trust will contact those individuals, both current and former staff members, that it anticipates you may wish to hear oral evidence from and will, at this initial stage, ask their permission to share their personal contact details with your Investigation Team.

Both the Chair of the Trust and I would appreciate the opportunity to meet with you following the open meeting to discuss how the Trust can be of most assistance to you and your team.

Yours sincerely

**Jackie Daniel**
**Chief Executive**

Cc. Oonagh McIntosh
Judith Griffin
Jo Borthwick

University Hospitals of Morecambe Bay
NHS Foundation Trust

**Trust Headquarters**
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Ref: JG/OM/001

**04 December 2013**

**STRICTLY PRIVATE & CONFIDENTIAL**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**Clarification Request – Terms of Reference**

The Trust is currently identifying documents and evidence that we anticipate will be required by the Independent Investigation.

I would be grateful if you could provide clarification regarding one of the reports identified in the 3rd Term of Reference i.e.

*'Monitor's review of the Trust's application for FT status (April 2010), October 2010'.*

Please can you advise if this is a report that will have been received by the Trust and if so is the above the full title of the report? Alternatively please confirm if the report was internal to Monitor and therefore will not have been received in the Trust.

Thank you in anticipation

Yours sincerely

**Judith Griffin**
**IIIPT Director**

University Hospitals of Morecambe Bay
NHS Foundation Trust

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**04 December 2013**

**STRICTLY PRIVATE & CONFIDENTIAL**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**Clarification Request – Evidence**

The Trust is currently identifying documents and evidence that we anticipate will be required by the Independent Investigation.

I would be grateful if you could provide clarification regarding the information that the Investigation will be requesting in respect of SUI's/SIRI's occurring in Maternity and Neonatal services.

Will the Investigation be considering: -

- Just maternal and neonatal deaths or all incidents that occurred in neonatal or maternity services that may not have resulted in a death?
- Stillbirths or intra-uterine deaths that may or may not have been reported as a SUI/SIRI?

Your clarification will assist the Trust in sourcing relevant and pertinent documentation and evidence.

Thank you in anticipation

Yours sincerely

**Judith Griffin**
**IIIPT Director**

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

3rd Floor
Park Hotel
East Cliff
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PR1 3EA

T: 01772 536376
E:correspondence@mbinvestigation.org

Ms Jackie Daniel
Chief Executive
University Hospitals of Morecambe Bay NHS
Foundation Trust
Westmorland General Hospital
Kendal
LA9 7RG

3rd January 2014

Dear Ms Daniel

**Documents and Evidence Required by the Morecambe Bay Investigation**

The Chairman of the Investigation, Dr Bill Kirkup, wrote to you previously introducing himself and explaining the work of the Investigation. He announced the Investigation's Method Statement on 1 November and stated that contact would be made with organisations involved in the Investigation to request documents and evidence.

Following helpful discussions between the Investigation and the IIIPT at the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust) to establish agreed ways of working, this letter sets out in greater detail the initial request for documents and evidence that the Investigation Chairman and his team of independent expert advisors require to be provided with in order for the Investigation to comply with its terms of reference. The terms of reference were announced in Parliament on 12 September 2013 and are attached for your ease of reference.

Management of evidence by the Investigation

The Investigation recognises that the Trust will need to know how material it is being asked to provide to the Investigation will be managed. It will therefore be helpful for you to know that material sought by and supplied to the Morecambe Bay Investigation from interested organisations and the families of those involved will be viewed and accessed by Investigation staff and the Investigation Panel only.

All Investigation staff, including the Panel, will view the material via a secure internet based database to which access will be controlled by the Investigation's Documents and Evidence Management Team and all Investigation personnel, including Panel members, are required to sign and adhere to the terms of a confidentiality undertaking.

Material and\or documents supplied to the Investigation will be collected from, or derived from, official files that are the property of interested organisations and\or individuals and will be considered by the Investigation as "working papers".

Working papers will be either returned to the relevant interested organisation\family at the end of the Investigation or destroyed by the Investigation and a record of all document destruction will be retained.

The Investigation has applied to the Information Commissioner for Data Protection Act Registration and fully understands its responsibilities holding evidence supplied by interested organisations.

Material and\or documents supplied to and considered by the Investigation will not be provided or shown to any witness in advance of their attendance, by the Investigation. Witnesses will be advised in advance of their attendance what specific topics or areas the Panel wish to ask them about and which of the Investigations specific term(s) of reference they are being invited to provide evidence in respect of.

Should any witness wish to be reacquainted with any material and\or document(s) prior to attending the Investigation for an interview or to give evidence, they will be advised by the Investigation to liaise with their employer, or former employer, to make any necessary arrangements for them to undertake any such preparation.

I trust that being made aware at this early stage of the protocol the Investigation has adopted regarding document management, it will assist the Trust in providing material as swiftly as possible.

<u>Background material required to assist the Investigation Panel that will not be considered as evidence to the Investigation</u>

The Investigation acknowledges that there have been numerous, and potentially significant, changes of personnel and associated lines of management and accountability during the period the Investigation's terms of reference cover. It would therefore assist the Investigation to both understand individual roles and responsibilities, and in navigating the evidence once it is received from the Trust, to be provided with, as a matter of urgency, organograms and\or structure charts for the Trust Board, for the period 1 January 2004 to 30 June 2013, that provide the Investigation with the full names, job\role titles and lines of management and accountability for:

- the Trust Chairs;
- all Trust Board members;
- all non-executive directors (with particular reference to those who Chaired relevant sub-committees of the Trust Board) and
- the heads of nursing and midwifery and the specialty teams in maternity and neonatal services, governance, disciplinary and complaints at the Trust for the period 1 January 2004 – 30 June 2013
- Clinical directors for maternity and neonatal services and the Trust Medical Directors for the Trust for the period 1 January 2004- 30 June 2013.

The Investigation also requires a synopsis of the management\command structure whenever a serious untoward incident arose at the Trust (a more detailed request for information from the Trust regarding serious untoward incidents is set out below). Again due to changes in the definition and management of serious untoward incidents in the period 1 January 2004 to 30 June 2013 the Investigation anticipates the Trust will provide several synopses for the time period being investigated.

Understanding the meaning of "the Trust" in the Investigation

When the Investigation refers to "the Trust" in respect of correspondence (eg. *"correspondence between the Trust and another organisation"*) the Investigation understands "the Trust" to include any, or all, of the following roles, or post holders, in post during the period 1 January 2004 – 30 June 2013:

- the Trust Chair;
- the Chief Executive;
- any other Executive Trust Board member (including specifically the Medical Director, the Nursing Director and\or the Director of Human Resources);
- any Trust non-executive Director;
- the Head of midwifery services and\or the Head of neonatal services;
- the senior manager(s) responsible for identifying and registering, managing and reporting on risk;
- the senior manager(s) responsible for identifying, managing and reporting on serious untoward incidents;
- the senior manager(s) responsible for ensuring audits were untaken, audit reports produced and shared with the Trust Board and responsible senior managers;
- the senior managers responsible for commissioning, considering and implementing the recommendations contained in Reports regarding the provision of maternity and neonatal care and the management of serious untoward incidents and
- the senior manager(s) responsible for handling, responding to, reporting and acting upon complaints made to the Trust.

Should the Trust wish to discuss the composition of this list it would be helpful to do so immediately upon receipt of this letter and prior to any evidence being submitted to the Investigation.

Material required by the Investigation

The evidence required to be provided to the Investigation by the Trust is as follows:

1. A list of all cases of maternal death, stillbirth (>24 weeks gestation) and neonatal death (up to 28 days) that occurred in the Trust (including all units within the Trust: Furness General Hospital, Royal Lancaster Infirmary, Westmorland General Hospital, Queen Victoria Hospital or Ulverston Community Health Centre) from 1 January 2004 – 30 June 2013. The list should state the details of those who died in the following order: surname, first name, date of birth, date of death, whether the death was a stillbirth, death of a baby or mother, the place of death, the cause of death and the names, roles and responsibilities of all staff involved in the care of the mother\baby during the intrapartum and neonatal period and a chronology of all of the actions undertaken in the Trust in respect of these deaths;

2. As far as the Trust is able to ascertain the following information - a list of all cases of maternal death, stillbirth or neonatal death that occurred following the transfer of a mother, baby or mother and baby from the Trust, to a specialist unit elsewhere. The list should state the details of those who died in the following order: surname, first name, date of birth, date of death, whether the death was a stillbirth or death of a baby or mother, the place of death, the cause of death, details of the unit and hospital to which the mother, baby or mother and baby was\were transferred and the names, roles and responsibilities of all staff involved in the care of the mother\baby prior to the transfer and subsequently and a chronology of all actions undertaken by the Trust in response to these deaths;

3. The Trust's definitions of both an incident and a serious untoward incident (SUI) for the period 1 January 2004 to 30 June 2013;

4. The policies and procedures for responding to both incidents and serious untoward incidents and the associated governance procedures for the period 1 January 2004 to 30 June 2013;

5. A list of all such incidents and serious untoward incidents for the period 1 January to 30 June 2013;

6. A list of all such incidents/serious untoward incidents that should be reported in maternity and neonatal services for the period 1 January 2004 to 30 June 2013;

7. A list of all serious untoward incidents that occurred at the Trust between 1 January 2004 and 30 June 2013 in maternity and neonatal services indicating: the date of the incident, location of the incident (hospital and unit), a brief description of the incident, the names of the staff involved, the outcome and whether an action plan was prepared after the event and what action was taken by the Trust including reference to disciplinary action taken or additional training provided to individual members of staff;

8. A list of incidents that occurred at the Trust between 1 January 2004 and 30 June 2013 in maternity and neonatal services indicating: the date of the incident, location of the incident (hospital and unit), a brief description of the incident, outcome and whether an action plan was prepared after the event and what action was taken by

the Trust including reference to disciplinary action taken or additional training provided to individual members of staff;

9. A record of the Trust Board's reporting and actions in response to incidents and serious untoward incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 including: minutes of governance and incident management meetings, what discussions took place with operational and nursing staff and at Divisional level, letters, e-mail exchanges and notes of telephone conversations between staff at the Trust that are pertinent and relevant to the specific case; letters, e-mail exchanges and notes of telephone conversations between staff at the Trust and individuals employed by or representing the North West Strategic Health Authority (including the Local Supervisory Authority for Midwives), Cumbria Primary Care Trust (PCT), North Lancashire Primary Care Trust (and its predecessor PCTs (Morecambe Bay PCT, Fylde PCT and Wyre PCT), successor Clinical Commissioning Groups (NHS Cumbria CCG and NHS Lancashire North CCG), NHS England, the Department of Health, regulatory authorities (including Monitor, the Care Quality Commission (CQC), the Healthcare Commission), the Health and Safety Executive, Cumbria Constabulary, individual patient(s) and\or their family\families, Public Health services (including the Health Protection Unit of the Health Protection Agency and the Public Health Observatory), those Trusts to which mothers and\or babies were transferred and any other relevant organisations such as HM Coroner for South and East Cumbria and HM Coroners elsewhere in the country, the Local Medical Committee, the General Medical Council and\or the Nursing and Midwifery Council in respect of any disciplinary action or supervision advised or taken and any additional training\development requirement identified for any member of staff at the Trust as a result of the Trust's review of an incident or a serious untoward incident and the related documentation from within the Trust, the NHS Litigation Authority in respect of any of these cases that resulted in claims for compensations and\or the payment of compensation, the former Community Health Council(s) and Healthwatch;

10. A record of the Trust Board's actions in response to relevant investigations published by the Parliamentary and Health Service Ombudsman including: minutes of Trust Board or Trust Board Sub-Committee meetings, letters, e-mail exchanges and notes of telephone conversations between staff at the Trust that are pertinent and relevant to the Trust Boards response to the relevant investigations, letters, e-mail exchanges and notes of telephone conversations between staff at the Trust and the Parliamentary and Health Service Ombudsman, individuals employed by or representing the North West Strategic Health Authority (including the Local Supervisory Authority for Midwives), Cumbria Primary Care Trust (PCT), North Lancashire Primary Care Trust and its predecessor PCTs (Morecambe Bay PCT, Fylde PCT and Wyre PCT), successor Clinical Commissioning Groups (NHS Cumbria CCG and NHS Lancashire North CCG), NHS England, the Department of Health, regulatory authorities (including Monitor, the Care Quality Commission (CQC), the Healthcare Commission), the Health and Safety Executive, Cumbria Constabulary, individual patient(s) and\or their family\families, Public Health services (including the Health Protection Unit of the Health Protection Agency and the Public Health Observatory), those Trusts to which mothers and\or babies were transferred and any other relevant organisations such as HM Coroner for South and East Cumbria and HM Coroners elsewhere in the country, the Local Medical

Committee, the General Medical Council and\or the Nursing and Midwifery Council, the NHS Litigation Authority, the former Community Health Council(s) and Healthwatch;

11. A record of the Trust Board's actions in responses to, and any subsequent actions taken following receipt of, the following reports:

- Monitor's review of the Trust's application for FT status (April 2010), October 2010
- The Fielding Report, August 2010
- Central Manchester University Hospital Diagnostic Review, December 2011
- PWC Governance Review, February 2012
- Gold Command Stocktake, April 2012
- Care Quality Commission (CQC) Investigation Report, July 2012
- Nursing and Midwifery Council (NMC) Review, July 2012
- The NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST) reports

12. A record of the Trust Board's actions in responses to, and any subsequent actions taken following receipt of, the following report:

- Review of Perinatal Mortality in Cumbria February 2013;

including minutes of the Trust Board and Trust Board sub-committee meetings, letters, e-mail exchanges and notes of telephone conversations between staff at the Trust that are pertinent and relevant to the Trust Boards response to the reports listed above, letters, e-mail exchanges and notes of telephone conversations between staff at the Trust and the reports' authors, Monitor, the Parliamentary and Health Service Ombudsman, individuals employed by or representing the North West Strategic Health Authority (including the Local Supervisory Authority for Midwives), Cumbria Primary Care Trust (PCT), North Lancashire Primary Care Trust and its predecessor PCTs (Morecambe Bay PCT, Fylde PCT and Wyre PCT), successor Clinical Commissioning Groups (NHS Cumbria CCG and NHS Lancashire North CCG), NHS England, the Department of Health, the Care Quality Commission (CQC), the Health and Safety Executive, Cumbria Constabulary, individual patient(s) and\or their family\families, Public Health services (including the Health Protection Unit of the Health Protection Agency and the Public Health Observatory), those Trusts to which mothers and\or babies were transferred, any other relevant organisations such as HM Coroner for South and East Cumbria and HM Coroners elsewhere in the country), the Nursing and Midwifery Council, the NHS Litigation Authority, the former Community Health Council(s) and Healthwatch;

13. Minutes of the Maternity Services Liaison Committee for the period 1 January 2004 to 30 June 2013;

14. All quality reports the Trust prepared, discussed and published during the period 1 January 2004 to 30 June 2013;

15. All patient and staff survey results for the period 1January 2004 to 30 June 2013;

16. All financial reports for the period 1January 2004 to 30 June 2013.

The Investigation will need to be assured, in writing, that the e-mails accounts, correspondence files and personnel files of staff who are no longer employed by the Trust have been reviewed and all relevant archive records have been identified, reactivated if necessary and interrogated prior to the Trust responding to this letter and the evidence requested being supplied to the Investigation.

The Investigation requires the evidence to be supplied in searchable PDF documents, in WORD or in EXCEL and to be sent or delivered to the Investigation by 3rd February 2014.

Discussions regarding the format and delivery of evidence should take place with the Investigation's Documents and Evidence Manager, Paul Roberts, via e-mail paul.roberts@mbinvestigation.org or by contacting him on 01772 536401.

In order to be assured that every effort has been made to identify and submit all of the evidence the Investigation is seeking it would be helpful if the response to this letter is signed by you and that as the Trust's senior manager you can confirm that all relevant material the Trust holds has been identified and provided. Ultimately, the Investigation wishes to be in a position to assure the Secretary of State to whom it is reporting that all evidence relevant and pertinent to its terms of reference has been considered.

Should you have any questions regarding the content of this letter please do not hesitate to contact Paul Roberts or me.

The Investigation may need to liaise with you again should any further material be required.

The Investigation recognises the commitment required by the Trust to supply all of the above material and is extremely grateful for the ongoing co-operation of the IIP Team.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

cc Jo Borthwick, Assistant Chief Executive
Judith Griffin, IIIP Team

enc Terms of Reference

University Hospitals of Morecambe Bay
NHS Foundation Trust

**Chair and Chief Executive's Office**
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**Sent Via Email**

Ref: JD/MC
09 January 2014

Dear Oonagh

**Documents and Evidence Required by the Morecambe Bay Investigation**

Thank you for your letter of 3 January 2014 setting out the evidence that the Investigation requires to be submitted by the Morecambe Bay Hospitals NHS Foundation Trust.

We are currently considering the letter and its requirements and have identified a number of points that require clarifying and/or confirming.

I am writing to advise you that I have asked Judith Griffin to act on my behalf and to communicate and discuss with you the contents of the letter and all other matters relating to the Investigation and the submission of documentation and evidence.

This should hopefully help ensure that the Trust is able to meet the requirements of the Investigation. Once this is completed and I am in position to do so, I will write in respect of your request on page 7 of the letter to confirm that the Trust has provided, where at all possible, all relevant and pertinent evidence.

Yours sincerely

**Jackie Daniel**
**Chief Executive**

CC: Judith Griffin
Jo Borthwick

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NHS Foundation Trust

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**Private and Confidential**

**14 January 2014**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**Documents and Evidence required by the Morecambe Bay Investigation**

I am writing in response to your letter addressed to Jackie Daniel dated 3 January 2014 (the letter) which sets out the evidence and documents that the Investigation require to be submitted by the Morecambe Bay Hospitals NHS Foundation Trust (the Trust). I have been authorised to respond on behalf of the Trust and to communicate and liaise with you, as appropriate, to ensure the Trust complies with the requirements of the Investigation.

The letter helpfully identifies the detail and breadth of what is required and, as you know, the Trust has indicated it will endeavour, insofar as is possible, to provide all the evidence required by the Investigation. To this end considerable action has already taken place and plans are in place for further intensive work in the coming weeks to ensure we can meet deadlines and provide a comprehensive response.

There are a number of points of clarification concerning your letter of 3 January and general queries concerning the approach the Investigation will be taking. To help manage these I have set out the remainder of this letter by referring to each page in turn. I hope this is useful.

Page 1 and 2 – Management of evidence by the Investigation

The Investigation, very helpfully, has identified how the documents and evidence the Trust provides will be managed. On the basis of this the legal advisors to the Trust agree that the Trust has a legitimate basis on which to disclose the requested information to the Investigation. When the Trust does disclose and provide information such disclosure will be subject to the commitments set out in your letter of 3 January 2014 as to how the information will be stored, accessed and managed and will be made on the assumption that satisfactory Data Protection Act (DPA) registration will be obtained. The Trust will also be undertaking a Privacy Impact Assessment to ensure that it complies with its own DPA registration and the Trust's Information Security Policy.

In providing the requested evidence and documents the Trust still requires clarification on how the Investigation anticipates hearing/presenting the evidence so as to ensure that it complies with its responsibilities with regards to data protection and so as to ensure adequate protection for the witnesses (with regard to their own data protection responsibilities) who may be asked to give evidence containing personal data.

In regard to material and documents being provided or shown to witnesses there are a number of points that we believe need further clarification and discussion seeing as the letter states that the Investigation will not be disclosing documents to the witnesses and that it is up to the witnesses to liaise with their employers/ex employers in this regard.

Briefly this covers:

- Will the Investigation provide a steer on which documents/what information it wishes to question an individual about so as to give the Trust and the individual witness an idea of which documents they may wish to review? Without such a steer, it may be that some witnesses feel it necessary to review all of the available documentation, which could be problematic.
- Will organisations/individuals have access to information supplied by other organisations? If there is information contained within the disclosure from other organisations that the Investigation wishes to use when questioning witnesses how will the Investigation ensure the witness is appropriately advised in advance of providing oral evidence?
- The Trust believes that witnesses from all organisations and both current and ex-employees should be subject to a consistent and fair process. The Trust will develop a protocol to inform its approach to making material and documents accessible to witnesses. Does the Investigation have a view as to how/if this can be applied consistently across organisations?

Clearly there are a number of outstanding detailed and technical queries and it may be helpful if this is clarified through discussion possibly including respective legal advisers. I would be grateful if you could advise how you wish to take this forward.

Pages 2 and 3 – Background Material required to assist the Investigation Panel that will not be considered as evidence to the Investigation.

I confirm that the organograms/structure charts for the Trust Board will be provided as a matter of urgency. Please can you confirm when asking for the heads of 'disciplinary' do you mean the Director of Human Resources (HR), Deputy Director of HR, Head of HR or the HR Business Partners who work within the divisions?

Page 3 – Understanding the meaning of "the Trust" in the Investigation

The Trust does not need to discuss the composition of the list set out under this heading. However for completeness we suggest that a number of roles/post holders are added to the list as this will inform the searches required to provide the evidence.

The roles/posts that we believe should be added are: -

- Head of Legal Services
- Trust Board Secretary/Secretary to the Board
- Assistant Chief Executive
- Personal Assistants to the Chairman, Chief Executive, Medical Director and Director of Nursing
- Divisional General Managers for maternity and neonatal services
- Clinical Directors for maternity and neonatal services
- Parliamentary Health Service Ombudsman lead officer
- Head of Integrated Risk Management
- Maternity Risk Manager

If during the process to submit evidence and documents we become aware of more roles/post holders we will advise the Investigation accordingly. Similarly if the Investigation on receipt of evidence identifies any roles/post holders it wishes to be included this will be accommodated in searches.

Pages 4 -7 – Material required by the Investigation

The following section will refer to each numbered point on the above pages.

Numbers 1 and 2

The majority of the information requested in numbers 1 and 2 is available to be provided to the Investigation by extracting from the relevant reporting systems and database. Initials searches have identified just under 200 cases recorded on the maternity information systems that meet the criteria set out in the letter. Of these circa 65 are recorded on incident reporting systems.

To undertake a detailed search of either 200 or 65 cases to identify any information not already recorded, including all the names of staff involved in the care of the mother/baby and a chronology of all actions taken by the Trust, will be time consuming and resource intensive. Whilst the Trust will undertake this exercise we

would find it helpful to have a steer from the Investigation as to whether it has a priority order for the cases to be considered.

Numbers 5 and 6

We have assumed that the time period covered in number 5 is 1 January 2004 until 30 June 2013. The Investigation has not indicated what information it requires to be included in the lists. We intend to run a report that provides non patient identifiable statistical information readily available on our incident reporting systems. This is likely to be in excess of 70,000 incidents. Please can the Investigation indicate and confirm if it has any specific requirements about the information it wishes to have included in the 'lists'.

Numbers 7 and 8

As with numbers 1 and 2 the majority of this information is available on relevant incident reporting systems. However not all the detail requested will have been routinely recorded. We believe the numbers of incidents requested in numbers 7 and 8 will exceed 3500. Please can I take this opportunity to advise you that for a period of time the Trust was on 'enhanced' reporting of maternity and neonatal incidents which will have impacted on total numbers. We will provide more information regarding this when the evidence is submitted.

As the Investigation will appreciate, the task to identify the case specific information (including disciplinary action taken or additional training provided to individual members of staff) that is not already included on the database will be considerable and could involve without more specific priority and criteria a review of over 3000 case notes plus all linked emails/documents.

It would be helpful therefore if, once we have supplied the evidence and information we hold on the reporting systems (relating to serious untoward incidents and all other incidents that occurred in maternity and neonatal services between 1 January 2004 and 30 June 2013) the Investigation could give consideration to the priority of cases it wishes to consider.

If it is helpful we can share with the Investigation in the next week information demonstrating what is routinely recorded on incident reporting systems. This will include in the majority of cases whether a Root Cause Analysis (RCA) and associated action plan was undertake.

Number 9

As noted above the number of incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 is approximately 65 cases. The depth and breadth of the information required by the Investigation as set out in number 9 is extensive and whilst we have already engaged significant additional resource and expertise to undertake the required searches it is unlikely we will be in a position to meet the 3 February deadline for all the information requested.

It would be helpful if you could discuss this as a matter of urgency.

Once the Investigation has received the information set out in numbers 1 and 2 and if it wishes to prioritise cases we will commence the detailed searches. However as noted above not all were recorded as SUIs/incidents, and therefore the information required will need extensive searches.

I would be grateful if, in advance of the searches commencing, we can define and agree the search terms to be used to help ensure that these are 'pertinent and relevant' and will meet the requirements and terms of reference of the Investigation.

Number 10

The Trust will undertake to compile a list of all the reports produced by the Parliamentary Health Service Ombudsman (PHSO) that are either specific to the organisation or have been published in respect of the wider NHS. We will then share the list with you to seek confirmation that the reports we have identified are pertinent and relevant to the requirements and terms of reference to the Investigation. Subject to your confirmation we will then undertake the searches identified in number 10. Please note that as with number 9 we will seek to define and agree with you the search terms we will use.

Numbers 11 and 12

We are taking the approach that the information set out in number 12 applies equally to the reports listed in number 11. We trust this is satisfactory.

Both number and 11 and 12 refer to the "Trust Boards actions". Please can you confirm if the Investigation is applying the meaning set out on page 3 of the letter i.e. when referring to "the trust" or is there any distinction when referring to "the Trust Board"?

Please can you confirm if the report "Monitors' review of the Trust's application for FT status (April 2010), October 2010" will have been received by the Trust. If so please can you provide further information so that the Trust can undertake the required search.

Can you also clarify if, when undertaking a search regarding a specific report, we should commence at the date the report was published/received or from when it was commissioned (if known).

Number 15

The letter requests 'all' patient survey results published 1 January 20014 to 30 June 2013. We are in the process of collating all the National Patient Surveys which are carried out by HCC/CQC. These surveys cover inpatients and are conducted every year along with one of the following: Out Patient Department; A & E and Maternity on a rolling 3 year programme.

There are numerous other surveys carried out, such as:

- National cancer surveys
- National patient safety surveys
- North West Advancing Quality surveys:
    - Pneumonia
    - Heart failure
    - Acute MI
    - Hip & knee
    - Patient experience
- Internal:
    - Various audit questionnaires
    - Matrons' questionnaires
    - Friends and Family (from April 2013)
    - Surveys conducted on patients for research purposes.

Please can you confirm if the Investigation is primarily requiring the national surveys or if it wishes to receive evidence relating to every patient survey carried out in the time period? If you are able to be more specific about the searches you wish the Trust to undertake in respect of the patient survey information this would be of help.

Number 16

We will provide all the financial reports that were presented to the formal Trust Board meetings in both public and closed sessions between 1 January 2004 and June 2013.. Please can you confirm if this is what is required by the Investigation and if not what specific finance reports does the Investigation wish to receive?

The Trust notes that the Investigation will require the Chief Executive of the Trust to confirm that all relevant material the Trust holds has been identified and provided. As already stated it is the intention of the Trust to fully cooperate with the requirements of the Investigation and the requested assurance will be provided at the stage when we have been able to clarify the queries set out above and once the required searches have been undertaken.

We will endeavour to meet the 3 February deadline for the majority of the submissions and, where possible intend to submit significant evidence before then. Subject to your response to the above queries we may need longer to complete some of the searches but this will be informed by any prioritisation and agreement of search criteria.

I look forward to hearing from you.

Yours Sincerely

**Judith Griffin**
**Director of IIIPT**

University Hospitals of Morecambe Bay
NHS Foundation Trust

**Trust Headquarters**
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**Private and Confidential**

**16 January 2014**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**Documents and Evidence required by the Morecambe Bay Investigation**

Further to my letter dated 14 January 2014 I would be grateful if you could give additional consideration to a point of clarification is respect of the evidence to be submitted to the Investigation.

In your letter dated 3 January 2014 page 6 number 14 you request "All quality reports for the Trust prepared, discussed and published during the period 1 January 2004 to 30 June 2013".

You will appreciate that the majority of the reports considered by the Trust include some element of 'quality'. We need therefore to be more specific in undertaking the required searches. We are currently collating the Quality Accounts from 2010 onwards but would find it helpful if you could advise, as soon as possible, if there are any specific reports the panel wishes to receive or alternatively the key areas the Investigation wishes to consider.

I hope you are able to provide some clarification and direction regarding this key evidence submission. I am happy to discuss if it would be helpful.

Yours sincerely

**Judith Griffin**
**Director of IIIPT**

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

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**VIA EMAIL**

Ms Jackie Daniel
Chief Executive
University Hospitals of Morecambe Bay
NHS Foundation Trust
Westmorland General Hospital
Kendal LA9 7RG

24 January 2014

Dear Jackie

**INFORMATION REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

Further to the Investigation's letter to you of 3 January, and Judith Griffin's helpful response of 14 January this letter formally sets out a further request that the Investigation has regarding local data the Trust may have, and may still, collect, collate and submit to various organisations, that will assist the Investigation address term of reference 1.

Informal discussions regarding the content of this letter have taken place between Judith Griffin and me and between the Investigation's Analyst, Hannah Knight and [redacted] and [redacted] in Judith's Team. I apologise that it has taken until now to set out our requirements formally.

Whilst the Investigation acknowledges that the questions it requires answers to may most appropriately be dealt with by the Head of Midwifery, Judith Griffin has indicated that [redacted] or [redacted] will be able to advise Hannah on what data sources are available.

The Investigation would therefore find in helpful to know:

1. Is an electronic maternity information system (MIS) used at any, or all, Trust sites?
    a. If so, when was this first introduced?
    b. Which software provider was initially used? (Euroking; Protos; Stork; CMiS, Medway etc)?

c. Were there any changes of MIS software provider between January 2004 and June 2013? If so, please give details and dates of the changes.

d. Does the Trust produce monthly reports using MIS data? If so, please provide details.

2. Does the Trust use a maternity 'dashboard' (clinical governance tool)?

   a. If so, when was this first introduced?

   b. How is the data for the dashboard generated?

3. Does the Trust purchase benchmarking services from a commercial company, e.g. Dr Foster or CHKS?

   a. If so, since when?

If an electronic MIS is in use, it would be useful for the Investigation's Analyst to have a more detailed conversation with the Head of Midwifery/responsible midwife regarding the data available within the system (those fields are mandatory, etc). Hannah Knight would like to explore the feasibility of gaining access to a patient-level data extract (i.e. one row per baby) for analysis. The Investigation would then discuss with the Trust providing a specification based on the data available.

I am conscious that the Investigation has taken up a considerable amount of yours, and your Team's time and this letter adds to that. However by obtaining answers to these questions the Investigation can eliminate the possibility of asking fruitless questions at a later date.

A practical first step would be if the Investigation could make arrangements for Hannah Knight to meet your Team shortly and discuss the availability and accessibility of data before the Investigation formally requests a subset of that data.

I am copying this letter to Judith Griffin, [redacted] and [redacted]

I am grateful for your help and any queries should be directed to Hannah.

Yours sincerely

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

cc: Judith Griffin
[redacted]

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

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Judith Griffin
Director, Internal Investigation
University Hospitals of Morecambe Bay NHS
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Westmorland General Hospital
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3 February 2014

Dear Judith

Your letter of 14 January refers.

You and I, and separately, Paul Roberts and members of your Team, have already spoken about the queries you have raised on behalf of the Trust. This letter seeks to clarify some points and hopefully answers some of the questions the Trust have raised.

As I explained the Investigation is currently working on the second phase of the evidence gathering process and will share its protocol on how it proposes the oral evidence sessions will be managed after it has been discussed by the Panel at its forthcoming meeting. The protocol should provide answers to the questions the Trust have asked regarding document management and any preparation individuals may wish to make prior to their attendance.

In answer to the queries you have raised:

Pages 2 and 3

We agreed that the Investigation will assess the material the Trust is providing on 31 January and if anything additional is required this will be sought from the Trust.

Page 3

By "the Trust" the Investigation meaning is as defined in the introductory paragraphs of its letter of 3 January.

Thank you for suggesting additional roles and\or posts to be added to the list provided by the Investigation. Your help with this is much appreciated.

Pages 4 – 7

Numbers 1 and 2

We agreed that the Investigation will consider the material that the Trust is providing by 31 January and if any additional information is required this will be sought once the detailed requirement has been determined by the Panel. As I explained, the Investigation Panel have already stated their intention to consider in detail the management of the serious untoward incidents.

Numbers 5 and 6

Again, we agreed that the Investigation will consider the material that the Trust is providing by 31 January and if any additional information is required this will be sought once the detailed requirement has been determined by the Panel.

Numbers 7 and 8

Again, we agreed that the Investigation will consider the material that the Trust is providing by 31 January and if any additional information is required this will be sought once the detailed requirement has been determined by the Panel.

Number 9

We have agreed that the Investigation will consider the material that the Trust is providing by 31 January and if any additional information is required this will be sought once the detailed requirement has been determined by the Panel. However, the Investigation's Documents and Evidence Manager has been in discussion with members of your Team regarding search terms and this matter is probably best resolved through helpful dialogue. If you wish to discuss this further I hope we can do so next week.

Number 10

It will be helpful to have sight of the list of all PHSO Reports. The Investigation considers that the approach you suggest is a sensible - and pragmatic - one as it is highly likely there will be PHSO Reports that will not need to be considered under the Investigation's terms of reference.

The Trust has, helpfully, provided details of the range of surveys it has available. We have discussed that there is a need for the Investigation to refine its request accordingly and there are currently discussions on-going between the Secretariat and the Panel. Once the specific requirements regarding the survey are established the Investigation will share them with you.

Number 16

The Investigation Panel wishes to consider, alongside the financial reports presented to the Trust Board and copies of its annual accounts, copies of annual plans for cost reductions. In particular the Investigation wants to be assured of the process the Trust Board undertook for considering the impact of any proposed reductions on the quality of the service and care it would deliver. I hope this might help your Team identify the relevant and pertinent documents for onward transmission to the Investigation?

The Investigation remains grateful for the help, advice and cooperation of the Trust and recognises the additional pressure the work of the Investigation is placing on staff.

I trust this response is helpful and I look forward to discussing matters further with you next week.

Yours sincerely

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

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**Private and Confidential**

**7 February 2014**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
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PR1 3EA

Dear Oonagh,

**Documents and Evidence Required by the Morecambe Bay Investigation**

I am writing further to recent correspondence and discussion between the Independent Investigation and the Trust to confirm the actions taken by the Trust and outstanding queries/work.

The letter dated 3 January set out the documents and evidence the Investigation required to be submitted by the Trust and requested these were submitted by 3 February 2014. Below I identify progress with the evidence/document collation and submission.

**Data Protection and Information Governance**

The Trust is satisfied that the assurances provided in your letter of 3 January regarding the management of information enable the Trust to be compliant with DPA and Information Governance requirements in the submission of the requested evidence. Whilst the outstanding queries identified in my letter of 14 January are still to be clarified I note that the protocol the Investigation is developing on how it proposes the oral evidence sessions will be managed is intended to provide further clarification.

**Process for Collating and Submitting Evidence and Documents**

There have been a number of helpful meetings and discussion between the Investigation Project Team in the Trust and the Investigations Document and Evidence Manager. This resulted in agreement on the method to be used in submitting evidence that will ensure data security. This is recorded separately.

To manage the process of evidence collection we gave your letter on 3 January a unique reference. Each section in the letter has then been given a unique sub-reference. The information in each sub-section has been collated into a folder which is submitted to the Investigation.

To verify and validate the information prior to submission we produced a detailed 'technical' process note – this is part of our internal process and is signed off senior manager in the Trust under delegated authority from the Chief Executive.

We have then produced a summary of each process note and submitted this to the Investigation with the relevant folder,

Each process note identifies the information submitted, any gaps and outstanding issues. The submission includes an overarching contents page.

**Information Submitted Prior to 3 February 2014**

The summary process note mentioned above identifies the information submitted which as far as possible we have endeavoured to ensure is comprehensive, robust and complete.

To date we have submitted the requested background information i.e. a SUI synopsis and Organograms. We have also provided detailed submissions in respect of the main headings 1, 2, 3, 4, 5, 6, 7, 8, 13, 15 and 16.

However, as identified in my letter of 14 January, there are a number of elements of the evidence requested that are not readily accessible with the systems that are in place or that would require extensive searches. These are recorded on the summary process notes.

Until we are in a position to clarify and agree with the Investigation the priority order and search terms that we should use we are not intending to do significant work or further searches on the above.

**Information Requested that Requires Further Clarification**

It was helpful to receive your letter earlier dated 3 February which provides a number of points of clarification and I note that once the Panel has had chance to consider the evidence submitted last week you will be in a position to provide further direction on requirements.

At this stage we have not commenced the detailed and extensive searches that would be required to fulfil the request for evidence set out in your letter under the heading number 9. We are currently undertaking more detailed searches in respect of 10, 11 and 12 albeit still awaiting further clarification. Please note that we continue to collate more evidence as clarification is received including further work on number 16 relating to financial reports.

In respect of heading number 10, next week we will provide a list of the national PHSO reports and a list of PHSO local investigations for consideration by the Panel to help determine which reports should be included in the intensive searches.

You may recall that I also wrote to you on 16 January requesting clarification on number 14 i.e. "All quality reports for the Trust prepared, discussed and published during the period 1 January 2004 to 30 June 2013".

We are currently collating the Quality Accounts from 2009 onwards but would find it helpful if you could advise, as soon as possible, if there are any specific reports the panel wishes to receive or alternatively the key areas the Investigation wishes to consider

It would be helpful if you could advise if you are yet in a position to confirm if the report 'Monitors review of the Trusts application for FT status (April 201) October 2010' will have been received by the Trust. If so we can undertake a more focused search. You will appreciate there is significant documentation and evidence relating to Monitor and we need to ensure we can manage the search process to enable the Investigation to receive the information it requires.

**Additional Information**

As you may expect, when we undertake the evidence and documentation searches, we are identifying additional information that may be of interest to the Investigation. A recent example would be minutes of a Governance Committee. These have not been formally requested but may be useful. It is likely that there will be other information identified as we continue the searches.

I suggest that in the first instance a discussion takes place with the Investigation Documents and Evidence Manager to discuss what evidence has been identified by the Trust and whether it should be submitted. If so we will make a formal submission and a due record will be established. Please can you confirm if this is acceptable.

I look forward to receiving further clarification following the Panel meeting next week.

Yours sincerely

**Judith Griffin**
**Director of IIIPT**

# THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

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**VIA EMAIL**

Ms Jackie Daniel
Chief Executive
University Hospitals of Morecambe Bay
NHS Foundation Trust
Westmorland General Hospital
Kendal LA9 7RG

24 February 2014

Dear Jackie

**INFORMATION REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

Further to the Investigation's letter of 24 January regarding local data that the Trust may have which is relevant to term of reference 1, the Investigation's Analyst, Hannah Knight met a group of staff from the Trust's Information and Health Informatics' Department with the Head of Midwifery on 10 February 2014.

At this meeting it was confirmed that the Trust used the Protos Evolution maternity information system to capture clinical details of maternity episodes at all sites between 2005 and June 2013, and that legacy data from this system is still held by the Trust.

This letter formally set out a request for an extract from this database covering all deliveries at the Trust during the period 1 January 2005 to 30 June 2013. The extract should be at the patient level (i.e. one row per baby) and should contain the following fields if available:

- delivery location
- date and time of birth
- mothers demographic details (age, ethnicity, socioeconomic deprivation)
- parity
- gravida
- lead maternity care professional
- fetal presentation
- onset of labour
- method of delivery
- gestational age
- birth weight
- sex

- delivery outcome (live birth; intrapartum still birth; antepartum stillbirth; termination of pregnancy)
- blood loss
- APGAR score at 1 and 5 minutes

If additional data fields are also available it would be useful if these could be included in the extract. An Excel spreadhseet or CSV file would be an acceptable format.

Hannah will be able to provide a more detailed data specification should this be necessary.

In addition to the data extract, the Investigation also wishes to request copies of the maternity dashboard which the Trust began using in 2011.

I am conscious that the Investigation has taken up a considerable amount of yours, and your Team's time and this letter adds to that, but I understand from Hannah that much of what we are requesting may already be in the required format.

I am copying this letter to [redacted] and [redacted] as well as Judith Griffin, who I will discuss this with when I meet her tomorrow.

I am grateful for your help and any queries should be directed to Hannah.

Yours sincerely

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

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**Sent Via Email**

Ref: JD/MC
07 March 2014

**STRICTLY PRIVATE & CONFIDENTIAL**

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**INFORMATION REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

I am pleased to confirm that actions are in place to respond to the specific information request set out in your letter of 24 February 2014.

I understand that a number of helpful discussions have taken place between members of your team and staff in the Trust to facilitate this

Yours sincerely

**Jackie Daniel**
**Chief Executive**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
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University Hospitals of Morecambe Bay
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12 March 2014

Dear Judith,

Thank you for your letter of 7 February 2014 and the time you gave the Investigation's Documents and Evidence Manager, Paul Roberts, and me to discuss these issues.

I apologise for the delay in responding, however, I needed to discuss certain matters with the Investigation Chairman. The investigation is nevertheless grateful that your Team have started to progress this work prior to receipt of this letter.

In our recent telephone conference, we agreed the following:

1. The Investigation will require all the available information in respect of all maternal and neonatal deaths that occurred between 1 January 2004 and 30 June 2013, as set out item 9 of the letter to the Trust, dated 3 January 2014 (the original letter). The Trust has advised the Investigation this entails supplying details in respect of 197 neonatal and 10 maternal deaths. We agreed that the urgent priority is for the Investigation to be supplied with the medical records in these cases. This will support the Investigation's clinical reviews of individual case notes.
2. The Investigation's Documents & Evidence Manager met your team to review evidence currently available to the Investigation to determine if there were any gaps and to identify any areas of duplication.
3. The Investigation will identify a random selection of serious untoward incidents (SUIs) from the information provided by the Trust at item 7 of the original letter. The Investigation will then require comprehensive information in respect of all SUISs in the random selection. The random selection will include SUIs from a cross section of departments at the Trust.

4. The Investigation will identify a random selection of incidents from the information provided by the Trust at item 8 of the original letter. The Investigation will then require comprehensive information in respect of all incidents randomly selected. The random selection will include incidents from a cross section of departments at the Trust.

The Investigation is currently reviewing the 7 categories of impact used for incident reporting and is identifying how the random selection will be made. As soon as the Investigation has made these decisions I can assure you they will be communicated to the Trust.

As you are aware the Investigation Panel invited families affected by events at the Trust to tell them about their experiences. It also placed a notice in local papers in January and February inviting the public to come forward with any information pertinent and relevant to its terms of reference. There has been a positive response to the notice.

The Investigation will communicate with you separately seeking additional material in respect of some of these cases as it is feasible that some of the cases may have been reported as incidents at the Trust. However, as the list of incidents is anonymised only the Trust will be in a position to confirm if they can be included in the sample group that the Investigation will review.

The Investigation fully recognises that it will be a significant undertaking to collate and submit all of the medical records it has requested at paragraph 1 above. It would be helpful if these cases could be supplied (as far as is possible) in chronological order commencing with maternal and neonatal deaths in 2004. If it were possible to supply the material in tranches, that too would be helpful. Perhaps your team would liaise with Paul in respect of the logistics.

The Investigation remains grateful for the cooperation and help it is receiving from the Trust.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
Director of IIIPT
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13 March 2014

Dear Judith,

**MONITOR'S REVIEW OF THE TRUST'S APPLICATION FOR FT STATUS (APRIL 2010), OCTOBER 2010)**

In its letter of 3 January 2014, the Investigation asked the Trust to supply a record of the Trust Board's actions in responses to, and any subsequent actions taken following receipt of, *Monitor's review of the Trust's application for FT status (April 2010), October 2010.*

As the Trust has, thus far, failed to identify any such correspondence in its trawl for documents to submit as part of the evidence gathering process, it had asked the Investigation to establish from Monitor whether a draft and\or final copy of the Report would have been shared with the Trust Board.

Monitor has advised the Investigation that:

*".....the Report referred to in the said letter was prepared for Monitor's purposes and was not shared outside of the organisation. ".*

The Investigation therefore acknowledges that the Trust will not have any material to submit to the Investigation in response to this specific request.

I hope this is helpful and I apologise if you and your colleagues have been conducting fruitless searches as a result of an error by the Investigation.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

# THE MORECAMBE BAY INVESTIGATION

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**VIA EMAIL**

Ms Jackie Daniel
Chief Executive
University Hospitals of Morecambe Bay
NHS Foundation Trust
Westmorland General Hospital
Kendal LA9 7RG

Date

Dear Jackie

**INFORMATION REQUIRED BY THE MORECAMBE BAY INVESTIGATION**

Further to the Investigation's letters to you of 3 and 24 January this letter formally sets out a further request that the Investigation has regarding Patient Advice Liaison Service reports on cases the Investigation is aware of, which the Trust may have, that will assist the Investigation address term of reference 1.

The names of the individuals that we would like the PALS reports if they are available is listed below:

I am copying this letter to Judith Griffin, [redacted] and [redacted]

I am grateful for your help and any queries should be directed to Hannah.

Yours sincerely

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

cc: Judith Griffin
[redacted]

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
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21 March 2014

Dear Judith,

Further to the Investigation's letter of 12 March 2014 the Investigation has given further consideration to how it can assist the Trust to prioritise the evidence it is collating for the Investigation.

The Investigation will require the full records in respect of the 207 neonatal deaths and maternal deaths that occurred during the period of the review. However, it would appreciate if the records in respect of those deaths that either occurred at Furness General Hospital or occurred after patients were transferred to other hospitals outside the Trust, could be provided as a matter of priority. I.e.

- full medical records in respect of 52 deaths at Furness General and
- full medical records in respect of 14 patients who were transferred to other hospitals.

Naturally it would be extremely helpful to the Investigation if these records could be supplied (as far as is possible) in chronological order commencing with maternal and neonatal deaths in 2004. If it is easier for the Trust to supply the evidence in tranches to speed up the supply of evidence, that would also be helpful to the Investigation.

In addition the Investigation requires the medical records in respect of the 19 stillbirths and at which hospital they occurred. It also needs to know if a root cause analysis was carried out in any of these cases and if so, in how many and which cases.

As with the records in respect of the neonatal and maternal deaths, the Investigation would appreciate the Trust prioritising and supplying the medical records for the stillbirths that occurred at Furness General Hospital (between 1 January 2004 and 30 June 2013) as a matter of priority.

Adopting the proposed approach to prioritising these cases, can you advise the Investigation by when the Trust might supply these records?

The Investigation also requests the following, additional, evidence:

1. All records and correspondence between PALS at the Trust and [redacted] at Furness General Hospital on [redacted]
2. All records and correspondence between PALS and the Trust and [redacted] on [redacted]
3. All reports and evidence that the Trust holds for CNST assessments between 1 January 2004 and 30 June 2013. The dates of the assessments and all related reports received from the NHS Litigation Authority should also be provided.

The Investigation hopes that providing some further clarity about the evidence it requires as a matter of priority, will be helpful to your Team, not least as the Easter leave season is beginning.

Perhaps your team would liaise with Paul Roberts regarding the logistical arrangements for the delivery of the evidence.

The Investigation remains grateful for the cooperation and help it is receiving from the Trust.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

University Hospitals of Morecambe Bay
NHS Foundation Trust

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24 March 2014

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh,

**Evidence Required by the Morecambe Bay Investigation**

Thank you for your letter dated 21 March 2014 which provides additional clarification to help the Trust in prioritising its work to collate and submit the documents and evidence requested by the Investigation.

As you are aware significant work is already taking place to identify and submit the documents and evidence requested. I will liaise separately with Paul Roberts to agree how hard copies of medical records can be safely and securely transferred to the Investigation.

It would be helpful if you could clarify a number of points in your letter. We are prioritising identifying and securing the medical records at Furness General but whereas your letter requests the *'medical records in respect of 52 deaths'* our data shows that there are 58 deaths for which you will require the medical records. We are working to provide these and have already obtained over half o plus the majority of the medical records relating to the 14 cases where death occurred following transfer to another hospital outside the Trust.

Subject to discussion with Paul Roberts we will be able to provide a tranche of these records before the end of March.

Your letter included a request for *'the medical records in respect of the 19 stillbirths and at which hospital they occurred'*. And then asks the Trust to prioritise and supply *'the medical records for the stillbirths that occurred at Furness General Hospital (between 1 January 2004 and 30 June 2013)'*

We do not recognise the number of 19 in respect of any of the data submissions to date or its inclusion on spread sheets. We also believe that the 207 maternal and neonatal deaths number includes all stillbirths that occurred within the time frame.

I would be grateful if you could clarify this point as a matter of urgency.

We note the further requests in respect of two cases relating to the involvement of PALS and also evidence and documents relating to CNST assessments. I confirm we will include these additional areas in our searches.

Yours sincerely

**Judith Griffin**
**Director of IIIPT**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

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28 March 2014

Dear Judith,

Thank you for the time yesterday you and your team afforded to Paul. He reported back that he felt the meeting had been very helpful for both sides.

A number of actions arose from the meeting for the Investigation to address. These are:

1. To identify how many of the 205 cases will be reviewed in detail.
2. To identify how many and which SUIs will be looked at.
3. To provide clarity on what the Investigation is trying to ascertain from reviewing SUIs – a review of specific individual cases, or to review the Trust's systemic approach to SUIs.
4. To identify which cases that were subject to a Root Cause Analysis are to be reviewed.

After the meeting Paul met with [redacted] and [redacted] to review the number of cases the Investigation is expecting to receive medical records for in relation to deaths at and transfers from, Furness General Hospital (FGH). The Investigation can confirm that it will review the cases of 54 neonatal and 4 maternal deaths, and the 14 patients who were transferred from FGH. This corrects the figures of my letter dated 21March. I apologise if this caused your Team any unnecessary work.

Additionally, clarity was provided on how the Investigation had been interpreting the evidence from the Trust in respect of stillbirths.

The Investigation appreciates the work done by the Trust in providing medical records for 29 cases, and has agreed that the remaining 43 cases from FGH will be provided within the next two weeks.

In my letter of 21st March, there was a request for "All reports and evidence that the Trust holds for CNST assessments between 1 January 2004 and 30 June 2013. The

dates of the assessments and all related reports received from the NHS Litigation Authority should also be provided." The Investigation recognises that this forms part of the evidence requested in the letter of 3 January 2014 at item 11.

The Investigation remains grateful for the cooperation and help it is receiving from the Trust. Should you require Paul, or any other member of the Investigation to attend further meetings in respect of providing evidence, please do not hesitate to contact me.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
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16 April 2014

Dear Judith,

Thank you for coming to meet with the team in Preston yesterday, it was very helpful to clarify the Trust's current priorities in respect of the evidence gathering process and how the Investigation secretariat can best communicate the expert panel's requests for additional material.

We discussed an informal discussion which took between [redacted] and your team on the 10th April, concerning a request for full medical records for a number of patients. I can confirm that the patients for which the Investigation would like to request full records are as follows:

The Investigation understands that for a number of these patients, the Trust will require additional information to enable the team to identify them. I have asked [redacted] to liaise with [redacted] and [redacted] to share any additional information that the Investigation holds on these patients to support this process.

The Investigation would be grateful if the Trust can provide the requested material by Thursday 8th May. I hope your team will give [redacted] an indication as to whether this is achievable.

Please do not hesitate to contact me if you or your team require any further information in order to fulfil this additional request.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

University Hospitals of Morecambe Bay
NHS Foundation Trust

**Chair and Chief Executive's Office**
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Ref: JG/NJC

25 April 2014

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh

**Evidence Submission - "The Fielding Report, August 2010"**

I am sending this letter to accompany the detailed evidence submission relating to the above report with its associated summary process note that records the approach taken by the Trust to ensure that the searches we have undertaken are robust and thorough.

However the Trust believes that there may be 'gaps' in the submission due to: -

1. The expected evidence never took place e.g. minutes of meetings were not taken
2. The evidence exists but we have been unable to find it using the search terms and parameters applied to date.

Whilst we have reviewed the evidence submission we have not undertaken a detailed 'forensic' follow through as we understand this process will be carried out by the Panel. We anticipate therefore being requested to supply supplementary evidence relating to the Fielding Report and will endeavour to respond to any such request from the Panel as quickly as possible. To assist in targeting further searches it would be helpful if the Panel could be specific and provide as much direction as possible e.g. indicate where the Panel believes a discussion took place, which forum/ date/ who was involved etc.

Please continue to be assured that the Trust will do all it can to provide the information requested by the Investigation but to help prioritise our approach and resources we have to have a 'cut-off' point as

we make evidence submissions with a full understanding that the Panel may want us to undertake further targeted searches.

Whilst this letter relates to the 'Fielding Report' I suggest that the issues and approach apply to the future evidence submissions relating to the reports the Investigation is considering.

Please let me know if there are any queries.

Yours sincerely

**Judith Griffin**
**IIIPT Director**

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Ref: JG/NJC

25 April 2014

Oonagh McIntosh
Secretary to the Investigation
The Morecambe Bay Investigation
Park Hotel
East Cliff
Preston
PR1 3EA

Dear Oonagh

I write with reference to our discussion last week and your letter dated 16 April 2014 seeking clarification on what the Trust's priorities are in respect of identifying material for the Investigation.

I know that you appreciate the commitment of the Trust to fully cooperate with the Investigations requests for evidence and we continue to use your letter dated 3 January 2014 as the main guide in our approach which has been informed through subsequent discussion and correspondence.

Significant evidence has already been submitted and we have used a summary process note with each submission to detail the approach taken, the search parameters and any known issues/gaps. Helpful clarification has been received from the Investigation on a number of queries raised by the Trust and this has helped inform our approach.

In addition to the submissions already made we are focusing on three key strands of work. Each is complicated and extensive requiring significant additional resource and time. The three strands are: -

1. To source and photocopy the medical case notes relating to neonatal and maternal deaths that occurred between 1 January 2004 and 30 June 2013. The case notes for all the cases occurring at Furness General Hospital have now been submitted to the Investigation minus a small number (<5) where we have still to locate the notes. We have also commenced

submission of the case note relating to cases at the Royal Lancaster Infirmary and our target is to complete this exercise by 1 May 2014 – subject to the notes being located. The detail of any issues/gaps will be contained in the summary process notes.

2. To provide the Investigation with the evidence associated with the 8 reports included in its Terms of Reference and as set out in the letter of 3 January. The initial searches of relevant emails, corporate systems and correspondence have completed and we are in the process of a final verification prior to submission. We aim to complete submitting this evidence by 8 May 2014. We anticipate that on receipt the Panel will make supplementary requests for evidence and we will endeavour to provide this as soon as possible. (Please note the covering letter associated with the submission relating to the "Fielding Report".)

3. The Panel have reviewed the first tranche of medical notes submission and last week provided the names and details of the first 12 cases where full and extensive searches are required. These searches have commenced and we will submit the information on a case by case basis once each search has completed. Unless we are advised differently, by the Investigation, we will prioritise the cases in the order the requests are received. It is difficult to quantify the work required or timescales as each case will depend on its complexity and the extent of the associated documentation and involvement of key members of staff.

   The full extent of the detailed case related searches is also unclear as we await the Investigation informing us of the all cases it wishes to review once the medical records have been considered

I know that you recognise that timescales are provisional and will be dependent on the additional clarification we are anticipated on the evidence required relating to SUI's.

There are a number of other factors that will impact on the timescales and extent of evidence submissions. These include: -

- Investigations being undertaken by other external bodies that require the Trust to submit evidence e.g. the current NMC Investigation
- Any preparation the Trust needs to put in place to support current and ex-employees invited to be interviewed by the investigation who need to access relevant documentation.
- Supplementary or additional requests for information received from the Investigation – type, complexity and number will need to be considered.
- The availability of key members of Trust staff to undertake the work. As the Investigation extends its timescale we have to accommodate existing annual leave commitments. Whilst the Trust will endeavour to manage and mitigate these, there may be some impact on submission timescales.

Please note that the 'algorithm' previously discussed and agreed has now been superseded by the approach the Investigation is taking to select the cases of neonatal or maternal death it wishes to review in detail. However all other aspects of the approach remain the same and I enclose with this letter an updated algorithm for your records.

I am sorry I am unable to be more specific but I know we both recognise the evolving and iterative process that will impact on priorities and timescale. If any particular difficulties are identified I will inform you at the earliest opportunity and as always we will respond to and facilitate any prioritisation identified by the Investigations Expert Panel.

Yours sincerely

**Judith Griffin**
**IIIPT Director**

Enc.

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# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Ms Jackie Daniel
Chief Executive
University Hospitals of Morecambe Bay NHS Foundation Trust
Westmorland General Hospital
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3rd Floor
Park Hotel
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Preston
Lancashire
PR1 3EA

13 May 2014

Dear Ms Daniel,

**Documents and Evidence Required by the Morecambe Bay Investigation**

Further to my letter of 3 January 2014 requesting evidence, I am now following up on progress to provide the outstanding evidence.

This letter sets out documents and evidence the Investigation considers remains outstanding from the list of material contained in its original letter. This is material that the Investigation Chairman and his team of independent expert advisors require to be provided with in order for the Investigation to comply with its terms of reference.

In addition, the Panel have identified further evidence they would like the Trust to provide.

Annex A to this letter sets out the evidence that remains outstanding from my original letter, and Annex B covers the additional evidence requested by the Panel.

You are aware that the Chairman and his Panel are reviewing the identified cases of maternal and neonatal deaths between 2004 and 2013. This is being undertaken by a process of screening medical records, and where an initial concern is identified by the Panel, they will undertake a full review of the case. Annex C to this letter identifies those cases for which full case details are required, that have not previously been requested.

Following helpful and constructive discussions between the Investigation and the IIIPT at the University Hospitals of Morecambe Bay NHS Foundation Trust to

establish agreed ways of working, the Investigation acknowledges the work the Trust has done so far in identifying, collating and providing evidence to the Investigation, and appreciates your continued cooperation.

It would be helpful if you could indicate when the material being requested will be available.

I am acutely aware that the Investigation Panel is still considering how information regarding a sample of SUIs should be provided. This is a matter of concern to the Trust largely because of the time and resource implications for you in providing the relevant material. Please be assured that this is a matter of concern for me too and I am in discussion with the Investigation Panel to establish how best the specific details they require can be identified, catalogued and provided to Judith Griffin and her team.

I am copying this letter to Judith Griffin [redacted] and [redacted]

I am grateful for your help and any queries should be directed to Paul Roberts.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

cc. Judith Griffin

## Annex A – Outstanding evidence

1. A record of the Trust Board's reporting and actions in response to incidents and serious untoward incidents relating to the deaths of mothers and babies for the period 1 January 2004 to 30 June 2013 (number 9 in the list of evidence from the original letter).

2. A record of the Trust Board's actions in response to relevant investigations published by the Parliamentary and Health Service Ombudsman (number 10 in the list of evidence from the original letter).

3. A record of the Trust Board's actions in responses to, and any subsequent actions taken following receipt of, the following reports (number 11 in the list of evidence from the original letter):

    - Monitor's review of the Trust's application for FT status (April 2010), October 2010
    - PWC Governance Review, February 2012
    - Gold Command Stocktake, April 2012
    - Care Quality Commission (CQC) Investigation Report, July 2012
    - Nursing and Midwifery Council (NMC) Review, July 2012
    - The NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST) reports

## Annex B – Additional evidence required

1. Midwife staffing levels and establishment numbers.
2. Birth rate plus staff estimations
3. Complaints reports to Board/Trust Governance Committee
4. Examples of serious maternity complaints and responses.
5. Examples of incidents, complaints, claims reports from 2008
6. SUI Reports – Incident numbers: 24629 July 2008, 25316 Sept 2008 and 52129 Sept 2011
7. Any examples of complaints, concerns or issues raised by obstetric/midwifery/neonatal staff or issues raised under the whistleblowing procedures and evidence of any follow up

## Annex C – Full case review files

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Ref: JG/OM/012

15 May 2014

Oonagh McIntosh
Secretary to the Investigation
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PR1 3EA

Dear Oonagh

**Evidence Submission to the Morecambe Bay Investigation - Legal Professional Privilege**

Following detailed searches relating to the individual cases identified by the Investigations expert Panel the Trust will, this week, commence providing the requested information.

The Trust remains committed to fully cooperating with the Investigation in the public interest and therefore intend to include, in the evidence submission, documents and information that may be subject to 'Legal Professional Privilege'. In providing this information the Trust has taken account of the assurances provided by the Investigation in its letter of 3 January 2014 concerning the management of information/documents including how these will be stored, used throughout the course of the Investigation and the intention to return/destroy such documentation at the end of the Investigation.

However in making information available that may be subject to legal professional privilege the Trust requests the Panel to note the confidential nature of such information, particularly when considering how, if at all, such information may be used during the interview process and in its final report.

Where the Trust identifies that any individual case submission is subject to a current and live legal claim the Investigation will be advised accordingly in the summary process note that accompanies each submission. The Investigation will appreciate that the confidential nature of any information subject to legal professional privilege in respect of these submissions will be heightened.

Please let me know if you wish to discuss the rationale for this approach.

Yours sincerely

**Judith Griffin**
**IIIPT Director**

University Hospitals of Morecambe Bay
NHS Foundation Trust

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**Sent Via Email**

Our ref: JD/MC
19 May 2014

Dear Oonagh

**Documents and Evidence Required by the Morecambe Bay Investigation**

Thank you for your letter dated 13 May 2014 following up on progress with providing evidence and identifying additional evidence requirements.

Since receipt of the letter we have held a helpful meeting with Paul Roberts and clarified a number of the items set out in the letter. I capture these in the response below referring to each annex in turn.

**Annex A**

1. The Investigation Panel has previously determined a revised approach to the original request set out at number 9 in the letter of 3 January 2014. The revised approach requires the Trust to submit the clinical records relating to all cases of maternal and neonatal death occurring between 1 January 2004 and 30 June 2013. The Panel then reviews these notes and identifies which cases require a full and detailed submission as set out in the original request. This process is well under way. Each of the searches will include a record of the Trust Boards reporting and actions in respect of the incident. This process is confirmed in the letter I sent on 25 April 2014.

   I believe this process supersedes the request set out in number 1 of annex A but please confirm if this is not correct.

   The Trust has commenced detailed searches on the first set of cases identified by the Panel and we anticipate the first submissions will commence this week. Please note that whereas we will endeavour to provide the information within 21 working days the timescale will be dependent on the number of cases identified by the panel and when these are requested.

   Please can I take this opportunity to request the Investigation to return all the hard copies of the medical records as soon as possible once considered by the Panel as these may need to be made available to clinical staff if they are invited to be interviewed about specific cases.

2. Thank you for the clarification that the Investigation requires evidence of actions relating to Trust specific Parliamentary Health Service Ombudsman (PHSO) reports and at this stage does not require the Trust to provide evidence relating to national PHSO reports.

The Trust has previously submitted to the Investigation a list of all the Trust specific PHSO reports. It would be helpful if the Investigation could determine which of the reports on the list it considers 'relevant'. The Trust will also look at the list and try to determine which ones we believe are relevant and share this with Paul Roberts.

Please note, that where the PHSO has investigated and reported on a case that is one of the cases identified by the Panel for a detailed search, then the relevant PHSO report and all associated Trust actions will be included in the case specific submission.

3. I confirm that the Trust will submit the remaining information and documents relating to 5 of the remaining reports on the list in annex A. Please note that the Investigation has previously confirmed, in your letter dated 13 March 2014, that the Trust will not have received 'Monitors review of the Trust application for FT status (2006) 2010' and, therefore unless you advise differently this is not now included in the submissions required from the Trust.

   I note also that you have not included the 'Review of Perinatal Mortality in Cumbria, February 2013' report (number 12 in the letter of 3 January 2014) but can confirm that this will be included in the evidence submissions.

   I confirm that we will complete the submissions relating to the outstanding 6 reports within 21 days.

**Annex B**

1. We will commence a search to identify midwife staffing levels and establishment numbers and assume the Investigation requires these for the period 1 January 2004 to 30 June 2013. It would help inform the search if the Panel could indicate if there are any particular reports it wishes to see. We are aware that much of the required information has already been obtained by the Information Analyst for the Investigation.

2. Birth rate plus staff estimations will be submitted, where available, for the time period covered by the Investigation.

3. Complaints reports to the trust Board/Governance Committee will be submitted within 21 days.

4. The detailed case submissions will include 'examples of serious maternity complaints and responses' Could the Panel please clarify what it requires as 'examples' in addition to the already requested evidence requirements.

5. The Investigation has already received a list of incidents that includes the year 2008. Case specific submissions where relevant will include complaints and claim reports from 2008. Could the Panel please clarify what is required as 'examples' in addition to the already requested evidence requirements.

6. SUI Reports – two of the 3 incidents identified in your letter have already been included by the Panel in the detailed searches it has requested following its review of clinical notes. These searches are already taking place. The Investigation will appreciate that the nature of such searches is extensive and time consuming. We will commence submissions this week and intend to work to a tight timescale but this will be dependent on the number of searches required, the complexity and extent of each and any other requests given priority by the Panel.

7. We will identify where possible, examples of whistleblowing by obstetric/midwifery/neonatal staff and aim to provide these by 30 June 2014.

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CHAIR: JOHN COWDALL
CHIEF EXECUTIVE: JACKIE DANIEL

**Annex C**

We have noted the list of cases that require a full search for evidence and this process has now commenced. As indicated above we will start submitting the first of the finalised searches relating to individual cases this week.

I would also like to advise you that the Trust believes it would be helpful for us to provide the Investigation with a full set of the agendas and minutes from 1 January 2004 to 30 June 2013 ( or from when established) for a number of relevant committees, namely: -

- The Trust Board
- The Audit Committee
- The Clinical Governance and Quality Committee ( and any predecessor committee)
- The Serious Incident Requiring Investigation (SIRI) Panel ( and any predecessor forum)

Before we commence collating this information I would be grateful if you could confirm if this would be helpful.

If additional clarification would be helpful on any of the above points please do not hesitate to contact me.

Yours sincerely

**Judith Griffin**
**IIIPT Director**

Westmorland General Hospital
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# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
Director of IIIPT
University Hospitals of Morecambe Bay
NHS Foundation Trust
Westmorland General Hospital
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02 June 2014

Dear Judith,

**Documents and Evidence for the Morecambe Bay Investigation**

Thank you for your letter of the 19 May 2014.

I am aware that Paul Roberts has already responded by email, confirming the Investigation would like to receive agenda's and minutes from the various Trust committee's listed in your letter.

Advice has been obtained from the Panel on the queries you raised. A response to each item of your letter, and the Panel response, where appropriate, is as follows:

**Annex A**

1. I can confirm that your interpretation of the revised process for reviewing clinical cases is correct, and that a copy of the Trust Board's reporting and actions will be included as part of the detailed submission on each full case.

   The Investigation received the first two sets of detailed case information (Bennett and Brady) on the 28 May 2014, and looks forward to receiving further material in due course.

   The Investigation is currently processing the medical notes you have provided, and [redacted] will be in contact to arrange repatriation of the majority of these within the week.

2. The Panel has reviewed the list of PHSO reports specific to the Trust that you provided. The following reports have been identified about which the Panel would like to see all the available information. The Investigation acknowledges that where the PHSO report relates to a case for which full information has already been requested, this will be included as part of that submission and not sent separately.

3. I can confirm from my letter dated 13 March 2014, that the Trust will not have received 'Monitors review of the Trust application for FT status (2006) 2010' and, therefore this can be deleted from the submissions required from the Trust.

   I acknowledge that the Trust will include the 'Review of Perinatal Mortality in Cumbria, February 2013' report in the evidence submissions.

**Annex B**

1. The Panel would like to see the WTE midwife numbers in the different wards by year, from 2004 – 2013 and an idea of how many midwives and support workers there were on each shift.
2. The Investigation acknowledges that birth rate plus staff estimations will be submitted, where available, for the time period covered by the Investigation.
3. The Investigation acknowledges that complaints reports to the trust Board/Governance Committee will be submitted within 21 days of the previous letter (13 May).
4. The main complaints that the Panel would like to see and the responses would be any from the families who spoke to us in the first instance. The Investigation recognises that this information is included in the list previously provided requesting full information disclosure.
5. The Investigation acknowledges that case specific submissions, where relevant, will include complaints and claim reports from 2008.
6. SUI Reports – in addition to the SUI's previously identified, two of which will be included in the full case information to be supplied, the Panel has identified additional SUI's for which they require full information. Due to the list of incidents being anonymised, it is not possible to confirm if any of these relate to requests for full case information already made, or which may be requested when further medical notes have been reviewed. The Investigation therefore recognises that if there is an outstanding request for full information relating to a case, the SUI information should be included as part of that submission. The list of SUI's that the Investigation needs more detail about is included at Table 1 at the end of this letter.
7. The Investigation notes that you will provide, where possible, examples of whistleblowing by obstetric/midwifery/neonatal staff by 30 June 2014. It would be much appreciated if these could be made available to the Investigation before then.

Should you require any further regarding this matter please do not hesitate to contact me.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

**Table 1 – List of SUI's to be reviewed**

| Incident Number | Date | Cause 1 | Site |
|---|---|---|---|
| | | | Furness General Hospital |
| | | | Furness General Hospital |
| | | | Westmorland General Hospital |
| | | | Furness General Hospital |
| | | | Royal Lancaster Infirmary |
| | | | Furness General Hospital |
| | | | Furness General Hospital |
| | | | Furness General Hospital |
| | | | Royal Lancaster Infirmary |
| | | | Furness General Hospital |
| | | | Furness General Hospital |
| | | | Royal Lancaster Infirmary |
| | | | Royal Lancaster Infirmary |
| | | | Royal Lancaster Infirmary |
| | | | Royal Lancaster Infirmary |
| | | | Furness General Hospital |
| | | | Furness General Hospital |

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**Sent Via Email**

Our ref: JD/MC
22 August 2014

Dear Oonagh

**Evidence Submitted by the University Hospitals Morecambe Bay NHSFT to the Morecambe Bay Investigation**

I write with reference to your letter dated 3 January 2014 and subsequent linked correspondence relating to the evidence the Investigation has requested the Trust submit, that is relevant and pertinent to the terms of reference of the Morecambe Bay Investigation.

I have been regularly briefed on progress with the Investigation and the work being undertaken by the Trust's internal project team and I understand that a meeting took place on 21 August 2014 between the Trust and members of your team to review and cross reference the evidence requested, submitted and received.

I am pleased to be advised that, with the exception of the documents identified below, the Trust has provided all the (where available) documents and material requested by the Investigation to date. This has required intensive and extensive searches of paper and electronic records and a structured approach has been followed from the outset. The use of technical and summary process notes that have been developed for each request and submission has provided a high level of assurance that every effort has been made by the Trust to identify and submit all of the evidence the Investigation has requested.

Each submission has required internal delegated 'sign' off by a nominated senior manager and a full record has been retained. On this basis as the Trust's Chief Executive I can confirm that every effort has been made by the Trust to identify and submit to the Investigation all relevant and pertinent material.

The Trust has additionally identified material which has not been requested by the Investigation but which may also be of interest. Through discussion and agreement with your team we intend to provide a list of this potentially additional evidence for the Investigations Expert Panel to consider and will then provide copies of documents if requested.

Finally, despite extensive searches and effort there are a small number of documents/records requested that we have been unable to locate. The details of these will be advised to the Investigation under separate cover but I want to assure you that I have been made aware of these omissions and, whilst they primarily relate to historic cases and/or systems, I have asked my Director of Governance to follow up those that need further internal investigation.

Recognising that there is likely to be further requests by the Investigation for relevant evidence I can assure you that the processes already in place will continue and the Trust remains committed to fully cooperating with the work of the Investigation.

I trust this letter helps provide you with the necessary assurances to be able to advise the Secretary of State that the Investigation has been able to consider all evidence relevant and pertinent to its terms of reference.

Yours sincerely

**Jackie Daniel**
**Chief Executive**

Westmorland General Hospital
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# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin
Director of IIIPT
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26 September 2014

Dear Judith,

**THE MORECAMBE BAY INVESTIGATION – TERMS OF REFERENCE 5 AND 6**

As you are aware University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust) has provided valuable material to the Investigation to assist the Chairman and Panel address its terms of reference 1 - 4.

The Investigation is now seeking further information from your organisation to address terms of reference 5 and 6. For reference, these are:

- to assess and make findings as to the Trust's ability to discharge its duties in delivering maternity services; and
- to make recommendations on the lessons to be learned for both the Trust and the wider NHS to secure the delivery of high quality care.

The Investigation Panel would like from the Trust detail of how it has responded to all relevant recommendations made in the following reports that are listed in its terms of reference:

- The Fielding Report, August 2010;
- Central Manchester University Hospital Diagnostic Review, December 2011;

- PwC Governance Review, February 2012;
- Gold Command Stocktake, April 2012;
- Care Quality Commission (CQC) Investigation Report, July 2012;
- Nursing and Midwifery Council (NMC) Review, July 2012; and
- The NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST) reports.

As you are aware the Investigation is due to report to the Secretary of State in November. I am therefore requesting you to set out the following information fully but succinctly. This will enable the Investigation Panel to review responses systematically and identify any specific matters that may require further discussion with you.

1. How the Trust addressed, at the time and subsequently, individual recommendations in each of the Reports listed above and what engagement process was undertaken to achieve this?

2. What, if any, arrangements have been put in place to help improve how your organisation works effectively with partner organisations to increase confidence in the maternity and neonatal services delivered by the Trust?

3. What policy changes, organisational changes, revised procedures and protocols and guidance have been put in place by the Trust in respect of any SUI/SIRI, maternal and/or perinatal death that occurs at the Trust now? and

4. What additional policy changes, revised procedures and protocols and information you consider the Investigation Panel should review in respect of terms of reference 5 and 6.

I recognise that some of the organisational changes you may refer to in your submission will require you to present information regarding those clinical and/or management arrangements that have been put in place to improve: the quality of the care delivered; management procedures and the responsiveness to incidents that occur and/or complaints made. Should any discussion need to touch on clinically confidential or management in confidence material, the Investigation will make arrangements for a closed session to be held at the Investigation's offices in Preston.

The Investigation requires the evidence to be supplied in searchable PDF documents, in WORD or in EXCEL and to be emailed to correspondence@mbinvestigation.org or delivered to the Investigation.

Discussions regarding the format and delivery of evidence should take place with the Investigation's Documents and Evidence Manager, Paul Roberts, via email paul.roberts@mbinvestigation.org or by contacting him on 01772 536401.

I would appreciate your response by close of play on **Thursday 9 October** and, if necessary, the Panel will arrange a subsequent meeting with you in week commencing **Monday 3 November**.

Should you have any queries regarding the contents of this letter, please contact me.

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

Judith Griffin, Director of IIIPT
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26 September 2014

Dear Judith,

**ADDITIONAL MEDICAL RECORDS FOR REVIEW**

The Investigation has recently received a completed proforma from a former patient at the Trust in response to the advertisement place in the local newspapers earlier this year.

Having reviewed the content of the proforma, the Chairman has determined that there is a need to review the medical records in this case. I wonder, therefore, if you could arrange for the medical notes to be collated and made available to the Investigation. I understand from Paul Roberts, that the more recent sets of medical records the Trust has been supplying to the Investigation have been sent electronically using Egress Switch. This system will be acceptable for the Investigation to receive the medical notes now being requested.

You will be aware of the timescale that the Investigation is working to, and I appreciate this request comes late in the day. However, it would be very much appreciated if the medical records could be provided at the earliest opportunity. At this stage the Investigation is not looking for full details of everything related to the case, merely the medical records to undertake an initial screening of the case.

The case in question relates to [redacted] formerly of [redacted] has now moved out of the area.

If you have any queries, please do not hesitate to contact Paul Roberts on 01772 536401 or by email at paul.roberts@mbinvestigation.org

Yours sincerely,

**OONAGH McINTOSH**
**SECRETARY TO THE INVESTIGATION**

# THE MORECAMBE BAY INVESTIGATION

**Chaired by Dr Bill Kirkup CBE**

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East Cliff
Preston
Lancashire
PR1 3EA

22 October 2014

Dear Judith,

**SUI INCIDENT –** [redacted]

You recently contacted the Investigation regarding Trust staff asking you for information following interview, about a case involving a wrongly sited epidural. The Trust understanding was that information regarding that case had not been provided to the Investigation unless it was part of the SUI material. The only other source the Trust considered was material provided by Cumbria Constabulary.

The Investigation can confirm that material provided by Cumbria Constabulary has only been used as background material, and is not being used as formal evidence.

The Investigation was made aware of the case independently following the advertisement in the local press. The Investigation has been able to cross reference this independent information with the SUI material provided by the Trust. Whilst the SUI material was anonymised, the Investigation has been able to corroborate the information. Consequently, and within the terms of reference, the Panel then asked several interviewee's about their knowledge of the particular case.

Whilst the Investigation was not able to provide you with an immediate response to your query, I hope the Trust can feel confident that we have been able to provide a satisfactory answer. The Investigation is confident that it is acting diligently in reviewing the material provided as evidence, and hopes that the Trust recognises this.

As always, if you have any queries, please do not hesitate to contact me.

Telephone: 01772 536376
Email: correspondence@mbinvestigation.org

Yours sincerely,

**PAUL ROBERTS**
**DOCUMENTS AND EVIDENCE MANAGER**