THE MORECAMBE BAY INVESTIGATION

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

Wednesday, 11 December 2013

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

Before:

Dr Bill Kirkup CBE -- Chair
Mr Julian Brookes -- Expert Adviser, Governance
Dr Catherine Calderwood -- Expert Adviser, Obstetrics
Ms Jacqui Featherstone -- Expert Adviser, Midwifery
Professor Jonathan Montgomery -- Expert Adviser, Ethics
Professor Stewart Forsyth -- Expert Adviser, Paediatrics
Dr Geraldine Walters -- Expert Adviser, Nursing

Ms Oonagh McIntosh -- Secretary to the Investigation
Miss Hannah Knight -- Analyst

PANEL MEETING

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

CHAIR: Hello. I think you are our sole observer this morning.

MR TITCOMBE: I feel extremely privileged.

THE CHAIRMAN: The privilege is ours but I am sorry you have come on your own. Thank you for coming. If I can get us underway in that case. This is the second meeting of the Morecambe Bay Investigation Panel, so hello and welcome. Thank you for coming. Same housekeeping as last time, that is we're not expecting any fire alarms. If any go off then we look to Oonagh of the secretariat to tell us what to do.

MS McINTOSH: Absolutely.

CHAIR: We will aim to break for lunch round about 12.30. The Panel has got some technical training on some of the IT systems that we're going to use, so we may need 45 minutes but we will make the decision nearer the time depending on how the morning is going. We should be through by 3.30 at the latest to allow people to catch transport. We have a full compliment today, so I would like to welcome Jacqui Featherstone who has joined us as an expert adviser on midwifery. Thank you. For your benefit and for James' benefit we need to do the introducing ourselves routine again.

Apologies to people who have heard and done this before. We do need to do it.

I am Bill Kirkup, I am chairing the Panel. I worked in the Department of Health until 2009, retired as Associate Chief Medical Officer at end of 2009 and have done various investigations since then, including the Hillsborough Independent Panel.

DR CALDERWOOD: I'm Catherine Calderwood and I'm an obstetrician in Edinburgh and I work in the Scottish Government as a medical adviser. I chair the Independent Advisory Group for the Confidential Inquiries into maternal and peri-natal death and, as you know, James I have met you.

MR TITCOMBE: I was going to say I'm absolutely sure I have met you.

DR CALDERWOOD: I'm involved in a lot of work in trying to reduce the rate of stillbirth and post-natal death and much more recently I have taken up a new part-time role in NHS England as an adviser.

MR TITCOMBE: Fantastic. Well, thank you.

DR WALTERS: I'm Geraldine Walters, I'm Executive Director of Nursing at Kings College Hospital NHS Foundation Trust. I have been Director of Nursing of (Inaudible) in the past, worked on the ...

THE STENOGRAPHER: Excuse me. Could you just speak up a

little bit, please?

DR WALTERS: Yes. Geraldine Walters, Executive Director of Nursing at Kings College Hospital. I'll leave it at that.

PROFESSOR FORSYTH: My name is Stewart Forsyth, I'm a paediatrician from Dundee. I have over 25 years of neonatal intensive care services in Tayside. I also had an academic role as a professor of paediatrics and latterly there as a Medical Director for the Health Authority. For the last three years I was chair of the Committee in Scotland which was looking at standards of neonatal care in Scotland.

MS McINTOSH: We've met. I'm Oonagh McIntosh, Secretary of the Investigation on secondment from the Department of Health.

MR BROOKES: James I am Julian Brookes. I'm currently part-time Deputy Operating Officer at Public Health England but my background is, among other things, working for the Department of Health where I was head of clinical quality and responsible for the implementation of the Clinical Governance Healthcare Commission and the National Patient Safety Agency and I have spent quite a number of years recently looking at doing investigations within the south-west.

PROFESSOR MONTGOMERY: I'm Jonathan Montgomery, I'm

Professor of Health Care Law at University College London and I also chair the Nuffield Council on Bioethics and the Health Research Authority, the latter being responsible for protecting and promoting the interests of patients and public in health research. I have a long interest in guidelines to guide professional practice and trying to integrate law and ethics but this is the first experience of this type of inquiry.

Up until the end of March this year I had involvement in local NHS as Chairman of a couple of Trusts and then an SHA and PCT in the Hampshire and the Isle of Wight area.

MS FEATHERSTONE: I'm Jacqui Featherstone, I'm head of midwifery and head of nursing Prince Alexandra Hospital in Harlow and I have been in post since January last year. I haven't done anything like this before but I have been involved in investigations within my own Trust and I have recently done quite a few investigations with other Trusts as well.

MR TITCOMBE: Thank you.

CHAIR: Thank you. Last time we were privileged to hear from seven of the affected families. James wasn't able to be present then and we were very anxious that you add to our tally of knowledge about all this by telling us about your experience, please, and I hand

over to you.

James Titcombe then spoke to the Panel about the birth and subsequent care of his son.

THE CHAIRMAN: Okay. Thank you again. That's added to the food for thought that we have had. I hope that you are able to stay with us. We're not very far away from lunch break now.

MS McINTOSH: We can do most of it quite quickly.

CHAIR: Let's take actions from the last Panel meeting and matters arising.

MS McINTOSH: Certainly. Thanks to colleagues in the team for the work that several of them have done on this. So it's the actions that we went through at the last meeting, some have been -- you have got at that at the paper right at the beginning, it's a sideways piece. Some of the actions have been completed and we will be discussing later on in the agenda. Some are still outstanding and will be reported on at the next meeting. There are two that I wanted to draw to your attention in particular.

One was at 1.3 which was the use of pseudonyms. We have started asking families whether or not they wanted to remain anonymous, the parents and/or the children, and we have made a decision within the Investigation that we're going to go back to those families obviously before any report is written just to be certain that they want to hold that view.

I would propose, rather than us discussing what pseudonyms we might use now, whether we just get agreement that we continue that appropriate approach of asking individual families when we are approached, and we are hoping actually that more families will come forward, and that if we do have to use a pseudonyms then

we would in the Investigation secretariat adopt a suitable name convention and get back to you on that. It's quite important that we record now that we're going to have to that conversation with individual families, even those who approach us cold and people have approached the Investigation, have they not, Tom? So that's one thing.

PROFESSOR MONTGOMERY: We haven't asked James that question?

CHAIR: I forgot to ask, I am sorry. I probably assumed the answer which was very wrong of me but would you want your story to remain anonymous?

MR TITCOMBE: Anonymity has never concerned me, as you know.

CHAIR: I got it right. Apologies for not having asked you.

MR TITCOMBE: Thank you.

PROFESSOR MONTGOMERY: This is not because of you but we need to find out about how your wife feels.

MR TITCOMBE: Sure.

CHAIR: Okay.

MS McINTOSH: The second point I wanted to raise was about the PALS, it has been raised again this morning. It's just to come back to Jonathan really. That we have added to our list, and we're going to come to it later, we have added Healthwatch and the former CHCs and the PALS when we approach the Trust. So it was just to let

you know that that has been picked up, although it says it's outstanding. It's outstanding simply because we have not collected evidence yet. So that's simply that.

If we can move on, the one paper that I prefer we cover after lunch would be 2.1, which is the key questions. At the last Panel meeting we spent a considerable amount of time starting to think and formulate the approach that the Investigation would adopt and I did say that I would prepare some sort of house rules and that would cover how we would recover evidence and what we would do with it. How the Panel would access the evidence and what they would do with it and also then what the Investigation would do with that material at the end. Obviously there would be other sections to it but I think it covers the three stages of evidence recovery, evidence management and evidence disposal and disposal/retention/public record. Anything that falls under that. So that was not being dismissive, it was an umbrella phrase.

Much of that will hinge on legal advice that we are in the midst of obtaining and, indeed, we have a meeting in London tomorrow about that. So the reason you have not got the draft house rules is actually if I wrote something now it could change by tomorrow and it would be a waste of your time to actually look into at the

moment. So the house rules document will be coming to you in between this meeting and the next meeting but it has to be shaped by other factors.

In the meantime, and I had several responses from colleagues to the draft letter and the approach and it's been really helpful getting people's views and going through the record several colleagues contributed to the discussion last week and looking at how we might break down the Terms of Reference to ensure that we're covering every element of that Term of Reference in the commission for the evidence to the relevant bodies. The list of bodies has now grown to 17 and Tom assured me in the course of this morning or yesterday when I said, "Is it ever going to stop growing?", he told me very confidently it would continue to grow.

So actually I think it is important that I have discussed with you that we build on some work that you started and we have already built on that and Hannah has worked on that as well and actually start expanding the questions that we need to ask to answer each Term of Reference so that we can make sure that we, on your behalf, commission the evidence to enable us to do that.

You have also not got in front of you a revised, and it's a much revised, version of the very lengthy letter that I painfully made you read last time because that

too needs to be informed by discussion that possibly we have after lunch on the questions. If we leave 2.1 at that stage.

CHAIR: Sorry.

MR BROOKES: Just in terms of that. Will we then have a discussion after lunch about the question about there are things we know we want and there are things we already have. Just in terms of momentum. There are things which are obvious we need. Perhaps we could be looking at those?

CHAIR: We might be looking at a two stage process where we go for the obvious things and go on with it but reserve the right to come back.

PROFESSOR MONTGOMERY: Can I ask to get some clarity about what is public domain information and what is confidential? Because we have a whole lot of documents which are already in the public domain which we have been discussing and it will be helpful to have a convention about headers on all the documents so that we're really clear what it is that's known to other people and what is only known within the confidentiality requirement.

MS McINTOSH: There is one paper in here that we have marked "not for circulation" but that's something that counsel are giving us advice on tomorrow. So we will

get there.

PROFESSOR MONTGOMERY: We need to know what the default is. If you are putting on it "not for circulation" it is confidential. Otherwise it is public domain information, then we would know that.

MS McINTOSH: Also within the strictures of the confidentiality undertaking that colleagues have signed. Just for your information that is a confidentiality undertaking that everybody has signed who is involved in the Investigation so that we can ensure that nothing goes into the wrong hands before it's been fully considered or before it's been...

MR TITCOMBE: Isn't that something families should decide?

MS McINTOSH: I don't think so. The Chairman might think differently but this is about sight of documehts in particular. It's just about the method, that we can have some control and responsibility and it makes sure we take on and observe those responsibilities and everybody in the team, everybody has signed it.

CHAIR: I mean, I don't want to pre-empt the discussion too much and, as you say, we are subject to legal advice tomorrow but I think it's perhaps worth saying that there is probably two categories here. One is personal confidential medical information that should stay confidential without limit and also other material

which we fully expect will become public at the end of the process but it will become public when we have had a chance to consider all the evidence that might be called.

MS McINTOSH: It's one of the reasons why we when we have done the chronology we actually were cautious last time because we were trying to be careful about it. We have revisited, in response to the point you raised about the chronology seems to cover everything from landing on the moon to picking up a pencil we have...

PROFESSOR MONTGOMERY: I'm not complaining on that. Unless you see it you don't get it.

MS McINTOSH: No, no. Colleagues in the documents and evidence team have worked on the chronology because the revised chronology and the beginning of a list of acronyms this again, we have discussed last time, will be material. It may need to be fine tuned but it will be material that will form contextual elements of the report. Therefore, you know, you will probably get this and at some point it will be placed on Huddle, which is the database we are going to learn about more, but it will be form part of this.

MR BROOKES: Just an the example then because we just have a conversation again about default position and anonymity and individual families. Yet we have the names of

families we saw at the last meeting on here. We just need to be consistent in terms of how we handle anything like that.

MR TITCOMBE: Can I ask a quick question? When I came to the Panel opening event, you mentioned you might -- how do you get everybody aware that they can submit information and all the families. There was talk of possibly an advert in the paper. Is there anything --

MS McINTOSH: Yes. My colleague upstairs [redacted] has been -- I have sent an e-mail to Tim this morning, he will not have seen it because he was busy setting up the hearing room with colleagues -- but we have a draft advert now and [redacted] has done stalwart work trying to establish which is the best of the local papers and there are a myriad and they come out on different days and whatever --

MR TITCOMBE: The Daily Mail, North West Evening Mail is a good one.

MS McINTOSH: It is just a case of which edition, which days, how do we capture -- what days are best days for them, what is the highest readership et cetera, and doing stuff online and doing things in the newspaper. So, there is a piece of work that is being done, there is an advert ready and it will go out in the next couple of days. Later on in the discussion we will get to an

agenda item on communications and it will be covered under that -- and how people can respond. That is the crucial thing.

MR TITCOMBE: Yes.

MS McINTOSH: Sorry. Chronology, acronyms, it is also now in Excel so it can be filtered and we are working on that and hopefully if you have any comments you will --

MR BROOKES: You pre-empted my question. That was the issue last time. I think we are on a whole range of trees here that we are trying to pull into one and it is quite difficult to use some of the --

PROFESSOR MONTGOMERY: You need both -- you need to see the whole lot so you do not miss anything. Also you need to try to filter it through.

MS McINTOSH: What I think you have got here, we have not got time now but maybe you want to look at it later, you have got the whole picture and two sub-sets of that. So what is related to the Trust and probably just related to the national appointments and things like that. Okay. Appointments to national bodies, I should say. That is that.

The next piece of paper is the paper that Hannah presented to you last time, which I have to say is very impressive that there were no comments on it. I need to take lessons from you, Hannah, because there are lots of

comments on my papers. Which was the potential source of data and it is just literally to get that signed off by the Panel. Hannah will talk to us shortly about some preliminary work that she has already done, but just so that colleagues are aware, and for Jacqui in particular, I know you got the papers last time but you were incredibly occupied doing other things. So these are going to be the sources of data that Hannah is going to work from for Term of Reference one. If there is anything that you want to add to that, you need to move very swiftly because that is what we are working from. Not to say we are intransigent on it, but we need to be commissioning and writing to those organisations to make sure that we have legitimate access to them.

CHAIR: Any comments on that within the next couple of days, please, by the end of the week?

MS McINTOSH: By Friday please, I. Know that is tight.

PROFESSOR MONTGOMERY: Sorry about this because you have rushed through. It just strikes me something we heard this morning that we need a dramatis personae and acronyms because working out who was who, what and when needs to be available to us.

MS McINTOSH: That is something that we were talking to each of the now 17 organisations about. For example we are meeting NHS England on Friday to talk to them about the

organograms for the PCT, the SHA and for NHS England now because there is a three-month period in our term of reference that includes them. So it is who had those jobs, what those jobs were and what did that mean. So it is more than just who.

PROFESSOR MONTGOMERY: I do not know whether this is possible, and whether it can be made public, but we have a series of midwives B and C and whatever. If we are able to understand how we connect these people together, that would be incredibly helpful. But I can understand that may have problems with confidentiality. But it is incredibly complicated already and we have only just started.

MS McINTOSH: The other thing I want to say is I know we will come back to the list of key issues under each of the Terms of Reference, but actually I have had a discussion with the Chairman and agreed that even though the organisations, the Trust in particular, have seen the draft letter and are aware that the volume of material, that the detail the Investigation will need, we do not think it is reasonable to send those letters out until we are completely content that they are what the Panel wants. Therefore, those letters will land now on people's desk in the first week in January and because actually we only have another, in all, 10

working days.

CHAIR: To be practical there is no point sending them out now.

MS McINTOSH: We want them to have fresh attention when everybody is there. Although we are having informal discussions we will come back to that, to the issues.

CHAIR: Any final points or questions on that? Should we break now then and aim to resume at twenty-past one or as near to twenty-past one as we can manage.

MR TITCOMBE: Bill, I am not going to be able to come this afternoon, I have got something to do, but can I just say to everybody thank you ever so much. I was so grateful to all of you for what you are doing and it means an absolute huge amount. I am really impressed and overwhelmed at how good this Panel is. Thank you ever so much for that. I will leave you with that. I mean sincere thanks.

CHAIR: No pressure. Thank you very much, James. It is very much appreciated. Thank you for coming.

(Luncheon adjournment)

CHAIR: We have got a fairly packed agenda to finish off. We need to work a little bit better than last time when it was only because a train was late I think that

most of you were able to get on it. So let us crack on.

We were going to go back to agenda item three actions and matters arising and consider paper 2.1. So if you can just briefly introduce that, please. Yes.

MS McINTOSH: Yes, thank you, Bill. As I mentioned earlier this was something that actually Stewart kick started, the actual structure is something that Stewart kick started, and other colleagues contributed to, possibly unknowingly, in their responses; Hannah and I have built on that and put in some questions under each individual Term of Reference.

These questions are: What does the Investigation need to answer to enable it to respond to the Term of Reference? So these are questions that you need to ask. What I am looking for is if you can spend a couple of minutes just reading it. It is very brief. If you just quickly read it and what I would hope is that colleagues might contribute more questions if that is appropriate and necessary; if it is not, fine.

CHAIR: Okay. Would anybody like to comment on it now or do you feel you want to take it away and give it some further thought?

MR BROOKES: I do not seem to have a copy of that in my pack.

MS McINTOSH: Here you go.

PROFESSOR FORSYTH: Maybe I can comment because it struck me when I was going home after the first meeting that really to try to sort out my own thoughts on what are we actually trying to answer here and obviously relate that to the Terms of Reference that have already been agreed. I think it is also almost trying to visualise the final report in these situations, you know, because, the last thing we want to do is get towards the end thinking, "My God, why did we not think of that?" It is trying to expend a little bit of time at the beginning thinking what really are the questions?

I think, having listened to the families last time, it is beginning to formulate in my own mind what some of the really fundamental questions are for this group as opposed to other investigations and reviews that have been undertaken, particularly trying to pick up certain questions. Some of the questions I put formed were tying to pick up what I thought the families really wanted as a fundamental. Clearly there are a number of other questions, how service was delivered et cetera. But I think what I want to feel comfortable with at the end of the day is we really almost try to draw a line under the issues in relation to the families. Therefore to try to go through each of the Terms of Reference with that in mind.

These are the questions I came up with, but clearly there are a number of other questions, I am sure, will be followed and then analogies then to match that up with the data because, as we have seen on Huddle, you know there is potentially tons of data. Therefore to try and keep focused it is going to be a major challenge for us.

I do not want us spending hours going through a whole lot of material, but actually what is the value of that?

PROFESSOR WALTERS: Yes.

PROFESSOR FORSYTH: We want to make it as effective as possible.

CHAIR: Yes. Okay. I agree with that. I think that is something that we need to come back to when we think about support and the best use of the Panel's time. That is probably the next meeting, isn't it? For the next meeting. Yes. Any other views/comments?

MR BROOKES: This is not specific questions, but what I had in my mind if I can just test this. The bits I was doing was "what happened" as a starting point -- that is partly to do with timeline et cetera, but exactly understanding that. A description of the facts; factual, this is what happened. Then the context and environment in which the organisation was working. So

what were the rules at the time? What was best practice? What was the things they should have been doing? What is the deficit, if there is a deficit, so that we can see, well, they should have done this and they did not.

You need to be absolutely clear on marrying up between what we can expect and recognise as good practice at the time, against what actually happened. Then, out of that, a full series of recommendations about that deficit.

I would quite -- I like to keep things simple in my mind; that is how I was thinking about it. I do not know if that helps anyone or not.

Then questions fall out of that because the first question is: What happened? Then you find out well what was the best practice at the time? That can be described. So you give some frame of reference in terms of what you can say in terms of the recommendations.

Just a suggestion but that is how I tended to see it in my mind.

PROFESSOR WALTERS: I hope you do not mind me saying the same thing in different ways, but I think the same things, similar things really.

I mean, the first thing, I think, really, really important that all these families get to sit down,

probably with an independent obstetrician with their own set of notes. I think for them that is going to be really important. I suppose reflecting on what Julian said, in a slightly different way, for me it is a bit like a Bowman Test; with the information that was around at the time, should anyone have realised, or would other organisations similarly not have really interpreted that data any differently from the way that the Trust did or the SHA did or anybody else did? That is why I think that the chronology is quite important, to know what was available at the time.

CHAIR: Yes, I agree. I am an optimist because I feel as if I have a reasonably clear picture of what is emerging on the clinical events. That may be over-optimistic or it may be blissful ignorance, but it feels as if there is a palpable target to aim at there and we can fill in the blanks the minute we get there.

What concerns me more is how far the ramifications of all of this go.

MR BROOKES: Absolutely.

CHAIR: Collusion. What conspiracy was there?

I is clearly a matter of deep concern to families, and how we are able to effectively investigate that and come to views one way or the other. That all feels more difficult to me.

MR BROOKES: Yes, I agree.

CHAIR: Jonathan?

PROFESSOR MONTGOMERY: I think I share that because our Terms of Reference keep talking about a Trust and, actually, I do not think that we can get into more than a small sub-set of what we are hearing and writing about, without looking at things, you know, more broadly. I wondered whether we needed to find a way, along with what happened, something about: What are the questions that were not, and possibly could not be answered, within the frameworks that were available to the families at the time? That would enable us to square the questions that still are there, because we will show we have taken them seriously by trying to record what are still outstanding issues and then go back and say, "Well, could they have actually been resolved earlier on?" and should they have been.

I would like to try to build in -- whether it is part of review and communication with patients and families, it is clear that that has not addressed all the questions that people have asked. The system maybe set up not to address them and that is something that you may want to draw out. I think that is a general point.

I think we need to decide now that we should be bold

about the fact that -- you did this in the earlier statement and what are you going to do? We have heard enough about what has happened between the Trust and other regulatory organisations and we could not possibly restrict ourselves to one --

CHAIR: Absolutely.

PROFESSOR MONTGOMERY: -- Trust.

The only other observation, very quickly, I will come back with it, I think the race issue has emerged today even more strongly. It did emerge last time but it has emerged strongly today. We need to make sure that we pick that up in terms of -- I think it is part of the questions around clinical outcomes, one of the possible factors, as well as specific individuals. It is a race issue. I do not know whether that is class as well, but it seems to be there.

CHAIR: Yes. Agreed. Any other questions?

Shall we draw that one to a close but ask if you would give some further thought to this and let us know any additions and modifications to it as it stands by, what shall we say?

MS McINTOSH: Monday.

CHAIR: Monday. Okay.

MS McINTOSH: Be generous.

CHAIR: Thank you. You have touched on this so many

times and I think it has been such an important part of the process today at the evidence from the families that it is clearly both very compelling and very effective. We cannot not be affected by hearing about it, I think. It prompts some questions about what should be our initial priorities for investigations that I would like to come back to.

Before we do that, we are going to consider data sources, I think. Hannah is going to give us a brief presentation on that and we will come back to that.

MISS KNIGHT: All right. A lot of what I am going to say you will not be surprised to know is about the local context in the Trust and the sites that often attend to the neonatal services. Then a little bit of very basic statistics from that data that we do have access to at the moment, which is hospital episode statistics.

We are probably all getting a sense of how the service is configured in the area, but this map might be helpful just for the location of the three maternity and neonatal services. Furness General is here, Royal Lancaster and Westmorland General Hospital.

It is a very rural geography covering an area of approximately 1,000 square miles.

DR CALDERWOOD: Hannah, can I just check, I think that I read somewhere that babies -- where are babies

transferred for a level three unit?

MISS KNIGHT: Various place, I believe. We have heard from families already that some babies were transferred to Liverpool Women's, and Manchester --

DR CALDERWOOD: Preston.

MISS KNIGHT: Preston and Newcastle. These are in Terms of Reference one it talks about looking at outcomes for those who are transferred and transferred elsewhere.

DR CALDERWOOD: Which is the closest, do we know where they tend to be -- is it Preston?

MISS KNIGHT: Preston.

DR CALDERWOOD: Which then is not part of this Trust, so that is an interesting thing to keep in mind itself.

CHAIR: There is an interesting difference between a crow-fly distance and travel-time distance as well. What is missing off the map there is Whitehaven and Carlisle which in terms of straight-line distance are closer than Preston, but travelling -- Whitehaven is there and Carlisle is just off the top. In terms of travel times they are really difficult. If you try to drive up the Coast Road from Barrow to Whitehaven you will never be seen again. What you do is you go inland to the M6 and back out again. It is that difficult.

DR CALDERWOOD: Yes.

CHAIR: All the flow from Barrow come this way.

DR CALDERWOOD: What level of unit is in Royal RLI neonatal unit?

MISS KNIGHT: None of them have level three.

DR CALDERWOOD: None are level three, I think it is two and level two -- Westmorland has none.

MISS KNIGHT: Westmorland has none.

PROFESSOR MONTGOMERY: It will be really useful to have that map of the catchment area delineated on it. I don't have a feel for how the present population is distributed, particularly how many of them are in the Barrow peninsula -- is that what it is called?

CHAIR: Furness Peninsula.

PROFESSOR MONTGOMERY: There is a really important part of this which is how insular the peninsular is for us to understand.

CHAIR: Yes.

DR WALTERS: Furness has only got a level two..

DR CALDERWOOD: It has level one.

MISS KNIGHT: One.

MS McINTOSH: Two is Lancaster, three is Preston.

PROFESSOR MONTGOMERY: Can you take me through level one, two and three?

DR CALDERWOOD: So, level one is growing room, you are really small, you need to be kept warm and somebody feeds you. Two is a bit more support; you might need a

bit of ventilation, not very much -- Stewart can be --

PROFESSOR FORSYTH: You have got babies who require intravenous lines and so on, oxygen therapy, but not necessarily full time, certainly not for long periods of ventilation. Then level three is intensive care.

DR WALTERS: I was wondering what paediatric cover would have been available at the weekend for James' baby. It would not have been a neonatologist as at the week.

PROFESSOR MONTGOMERY: That is a question when and it happen in the week.

PROFESSOR FORSYTH: I think --

CHAIR: There is a suggestion there is a preponderance of weekend deliveries.

PROFESSOR FORSYTH: I think staffing is going to be what we will have to spend some time on, just working on what staffing structures they have then and the level; if it is just bums on seat really, it is actually what competencies we want to try and tease out.

Just listening to they thought there was an [redacted] problem because they could not get the feeding tube down, that is technically just nursing staff trying to do that procedure. I mean there is a question about the heart. You know it seems to me as if there was nobody on site who really had a grip on

neonatology.

DR CALDERWOOD: You could have taken another step back, which would have been to say [redacted] If somebody had thought to look at the scan done antenatally they would have known there was not. I think nobody has even thought to even think about that. There is a level of just below that they are existing somewhere there and questions are not even being asked.

PROFESSOR MONTGOMERY: Again linked with that is that there is a question whether you look at do they do benchmarking? Do they have any sense of what their comparators are? That is a question for us as well. Do we need to think about where, if anywhere, is there a sufficiently similar configuration that we would be able to have a comparison. It is very unusual and I do not know if it is because -- it is clearly an unusual set up.

CHAIR: There will be nowhere exactly identical, there will be places with features in common, but I think we are getting ahead of the slides.

MISS KNIGHT: Okay. This green line delineates the number of deliveries, not first, delivery episodes in the Trust between 2004 and 2011/12 financial years. You

can see then that the Royal Lancaster has a range of about 1,600 to 2,000 deliveries a year. Furness General Hospital, a very small unit, have around 1,000 deliveries. It dips in 2005/6 to around 800 deliveries. Then it rises back up to above 1,000 but following it stays roughly stable around that level.

CHAIR: Do we have any indication why the dip?

MISS KNIGHT: It might be interesting --

PROFESSOR FORSYTH: That is the one thing that seems to have gone down. It seems to be a very tight then it changes, these two units.

MISS KNIGHT: I do not know why that is. The dip in the Trust total is explained by the dip at Furness General.

DR WALTERS: When did it become an MRU?

DR CALDERWOOD: That is the year it became an MRU. I do not remember exactly but that is it.

MISS KNIGHT: The median number of deliveries is just under 2,000 at the Royal Lancaster, and just over 1,000 at Furness General.

That dip that we see in the Trust total is not reflected at a national or regional level here. You can see from the slide that whilst at a national level there has been steady increase of about two percent a year in total number of deliveries; at a regional level the gradient is not -- there is a slight gradient but it is

not as steep as the national.

The local demography of this area and resident population is slightly older than the national average and considerably less ethnically diverse, with only about 2.4 percent of residents belonging to non-white ethnic groups. I do not have anything specifically about the maternal population at this stage with the whole; I will have that in time for the next meeting.

Then this slide is a little bit about deprivation within the region. The five district councils served by the Trust. Barrow-in-Furness has one of the highest deprivation scores, 32nd out of 326 councils.

Then this here is from the Public Health Observatory profile for the area. You see that the breastfeeding initiation it slightly worse than average. Smoking and -- sorry smoking here and breastfeeding here are both worse than average. Life expectancy is lower than in England as a whole in the regions of Barrow and Lancaster.

These are hospital standardised mortality ratios for the Trust in the dark blue; Furness General in a slightly paler shade of blue; and Royal Lancaster in green. Where the error bars are clear of the 100 line here, that indicates significant difference; higher than expected.

In three of the years, out of six years, Furness General has a higher hospital standardised mortality ratio than expected. This measure is calculated from, I think, it is the 20 conditions that account for 80 percent of mortality in the hospital, so this is not just looking at neonatal or maternal mortality it is across all patients.

This is a little data around SUIs during the period of investigation.

You can see that this is a little bit of data about SUIs during the period of investigation and you can see that the vast number of SUIs are accounted for by three conditions of which maternity services has the most number of incidents. So maternity, pressure ulcers and, I'm not sure ...

MR BROOKES: Hospital acquired ...

MISS KNIGHT: ... sorry, make up 52 per cent of all reported incidents to date. Of the 40 that relate to maternity services, this bar here, the majority were intra uterine deaths and 18 were graded as 170 and 15 were ungraded. So these 40 incidents, when I show you the next slide, this is looking at the total number of incidents reported each year and you can see there is a dramatic increase from 2011 onwards. So, sorry this is so small, the red bars at the bottom are the maternity

incidents. So very small numbers reported really up until 2011 where the majority of those 40 incidents were reported.

MR BROOKES: This is probably a reporting issue?

MISS KNIGHT: And actually this increased ---

PROFESSOR MONTGOMERY: Going back to the benchmarking question, I don't have much of a sense of what you would expect. I can see the sudden increase because we know that's scrutiny but it would be really helpful to think how did that compare to similar approximate reporting.

MISS KNIGHT: On line it's possible to see Trust level NRLS reports and in 2004 the Trust had one of the lowest reporting rates in the whole country and it now has one of the highest and it's indicative really of the improved culture of reporting rather than...

PROFESSOR MONTGOMERY: You have to be really careful not to appear to be criticising because they are reporting.

MR BROOKES: Absolutely.

DR WALTERS: A bigger issue here is that with the STEIS system you are told what to report. You have to report grade three and grade four pressure ulcers. Not many Trusts were doing that pre-2009. You also had to report still births, whether there was any suspicion about them at all. So the requirements of STEIS would start to skew the picture but '11 and '12 you

should still be able to benchmark against other Trusts because they should have been doing the same thing. But that green bar is pressure ulcers.

MISS KNIGHT: Yes, it is. This is moving on to HES data which I currently have access to. First looking at data completeness and looking at the HES maternity tail which is a collection of about 25 data items that should be filled in whenever there is a birth. Things like birth weight, gestational age, method of delivery, onset of labour and birth status.

I have taken an average measure of completeness across those six key data items. This is the Trust's level of data completeness on the dotted line and the national average in red. You can see that in 2004 the Trust was actually one of the best in the country in terms of its data completeness, well above the national average, which was 80 per cent. Something happened in 2006, 7, it dropped from 95 per cent right down to 25 per cent. So we have key data items missing for this year.

There was an improvement the following year and then they were back up to above the national average rates from 2008. But something happened in the financial year 2011 to '12, they dropped below the national average and I will shortly be receiving the next year's batch of

data hopefully before Christmas or early in the New Year.

PROFESSOR MONTGOMERY: Is that only at Trust level?

MISS KNIGHT: I have broken it down into hospital level and actually in both Furness General and the Royal Lancaster you saw this drop, so it's not just at one site.

DR WALTERS: Do we know when they had FT status?

MS McINTOSH: '11.

MISS KNIGHT: This type of drop might be explained by a change in IT system, perhaps that's one possibility.

MS FEATHERSTONE: It might be quite useful to have the midwife to birth ratio because that is quite -- to me it would be high, so, again; what it was, but we will know that with staffing issues, particularly when it drops.

MISS KNIGHT: Yes. It is largely midwives who enter the data that goes into the HES data.

MR BROOKES: I assume that dip -- is that dip unique to maternity in terms of HES completeness?

MISS KNIGHT: Yes, yes. The other fields in HES have a much higher completeness rate than the maternity tail. There are particular issues around maternity HES because it comes from a different source.

MS McINTOSH: They don't have to be completed?

MISS KNIGHT: I think it's mandatory to complete.

MR BROOKES: It's usually a contractual agreement. It

doesn't mean they do.

MISS KNIGHT: This is just a sort of background to the slide we have seen, if I go back, so here there was a national drive to improve the completeness of the maternity tail but the drop in this Trust happened before that drive was introduced and it was already on it's way up before that drive commenced, so it would be interesting to find out what happened.

This is all from HES and, as I mentioned, the maternity table data is missing so I haven't been able to draw on that, so instead I have used ICD 10 codes to identify still births and I don't have the national rates yet to compare these to but at Furness General you can see the trend really has been an increasing rate of still births, where at the Royal Lancaster ...

PROFESSOR FORSYTH: Can I check the vertical axis? The Y axis. Total still birth rates. That's going to be a number of still births per thousand a year.

DR CALDERWOOD: You would expect it's round five per thousand, Stuart. So it is 0.5 per cent.

PROFESSOR FORSYTH: These are percentages?

DR CALDERWOOD: What Hannah has got on the side is percentage.

CHAIR: That would be the rate there.

PROFESSOR FORSYTH: So that's a percentage rather than still

birth rates by definition?

MISS KNIGHT: I can change the axis for next time.

PROFESSOR FORSYTH: I think this is all around the changes in becoming a midwifery led unit. Around 2004, 2005 we seem to have got change in the delivery, which is we've got poor reporting of data starting around that time and the still birth rate going up. You'd begin to wonder if there is a pattern of not coping with additional deliveries across the whole organisation around that.

CHAIR: That's a hypothesis.

PROFESSOR FORSYTH: It is.

MISS KNIGHT: So unfortunately because the HES maternity tail data is missing this key item of birth status in the majority of records I have only been able to look at the ICD-10 codes, which don't distinguish between ante partum and intra partum still birth so that graph that I just showed you is all still births together but where the birth status field has been completed [redacted]

[redacted]

DR CALDERWOOD: [redacted]

[redacted]

MISS KNIGHT: They were either here or they were missing.

MR BROOKES: How easy would it be to identify the 14 and look at the cases?

DR CALDERWOOD: It's a very clear definition. Intra partum means that the baby was recorded as being alive on admission to the maternity unit and died during the process of being or during the delivery. So you can read case notes, you can't be in any doubt. It's the coding of it and I would also wonder about true ante partum still birth because that is the area before labour started but then there is the definition of labour and so I think we will have to discount this as not being robust enough to...

CHAIR: If we identify those 62 we can go through them and understand them properly.

DR WALTERS: Is that as it is now in terms of whole quantum? Is that normal?

DR CALDERWOOD: [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

MISS KNIGHT: [redacted]

DR CALDERWOOD: [redacted]

MISS KNIGHT: [redacted]

PROFESSOR MONTGOMERY: That doesn't sound a very high still birth rate.

DR CALDERWOOD: Well, we're not yet involved, that's fairly quick estimate.

CHAIR: That's three units.

DR CALDERWOOD: That's three units.

CHAIR: We want to know what's different.

PROFESSOR MONTGOMERY: It's important what would be the triggers for responding. It may be that we need to think about the families concerns being raised those triggers, rather than the statistical analysis. We're looking at the NHS consultants, you would expect there to be some discussions of what was going on.

MR BROOKES: If we do find that Barrow has a much higher rate then it is being obscured by the overall rate but you think you would pick that up as a Trust or you should do. You might miss it externally.

CHAIR: If what we're particularly interested in is the intra partum still birth rate in one unit out of three. You could easily see that there might be

something outlining that whole figure that's masking the over all trend.

DR CALDERWOOD: Julian, just back to that point. Certainly my feeling from these high level investigations is that the possibility of missing something because there are small numbers obscured in a bigger system and if you are not examining very clear definitions in detail it is actually very difficult to pick that up. It's not that they have not done their job properly. It's just understanding the subtleties.

MISS KNIGHT: The confidence intervals around the rates in hospitals that have such a small number of deliveries are so wide that it's much harder to detect outliers in small hospitals than it is in large hospitals. You see from the final plots that CMIS reports they are a funnel because the smaller units have much wider...

PROFESSOR FORSYTH: They should have, going from that point to that point. Each of the Trusts should have an individual report and a parental report.

MISS KNIGHT: Until 2009.

PROFESSOR FORSYTH: So that each of the units -- it should obviously be the data from each of the units in the Trust. So I don't think I would let a Trust Chief Executive off the hook because he didn't look at what was happening in each of the units.

PROFESSOR MONTGOMERY: I'm trying to get my head around what triggers would be.

PROFESSOR FORSYTH: They should be the reports.

MR BROOKES: It's also the level. Because I think there is a reasonable steer in terms of what would trigger within the Trust but if you look at it from outside from a regulator's point of view or from an exterior organisation point of view would you pick that up reasonably unless there were other indicators to actually make you start looking, ie, people dying. So I think there are different levels of test that we would want to deliver to the Trust and the unit and the Trust and then an external organisation scrutinising it.

CHAIR: Yes. We've got quite a lot to get through. Very useful discussion.

MISS KNIGHT: This is my last slide. I am not sure if it's so much of interest but I have been able to calculate the Caesarean section rates for the Trust there was an interesting pattern at Furness General sort of step wise rising.

DR CALDERWOOD: I wonder about, well, all sorts of theories there. Appointment of new consultants, a different mode of decision making because of inquiries, risk averse, a cultural change about deliveries. So although that doesn't seem to be directly relevant to still births, it might

actually be directly relevant.

PROFESSOR FORSYTH: What's interesting is not necessarily going up but how low it was before.

DR CALDERWOOD: As it may well be, Stuart. So setting the scene for Furness General Hospital, a thousand deliveries a year. So it seems to have about 800 and now it's got about 1,100, that is three to four babies a day. Any one of us on any one day would walk in and think where is everybody. It's a haven of calm as a labour ward. If there are five deliveries they think they have had the busiest day of the year, I mean, it's a drama. If you have two Caesarean sections in a day.

I work in a unit where we might have twelve every day. So the possibility of them, I don't understand this, "We were really busy. We couldn't see you for hours." I mean, what I am basing it on is I worked in two units both in Scotland with deliveries of about the same amount. The amount of thumb twiddling time there is -- there is lot of shifts when maybe nothing happens. There is nobody in labour at all.

PROFESSOR MONTGOMERY: We need that case by case.

DR CALDERWOOD: Yes. I mean, I suppose if you -- none of this is going unnoticed. The fact that the Caesarean section rates used to be that much and now the theatre staff are scrubbing twice as often. The theatre staff

will be able to tell you "We are doing lots more sections than we used to here, you know." In a unit like that there is, well, I would feel there is no place to hide and I might expect, partly because high risk women will be transferred elsewhere, so if you had a kidney transplant or you have got very difficult to control diabetes or asthma you might -- your population you might expect to be lower risk ---

MR BROOKES: Low risk.

DR CALDERWOOD: --- it's still an obstetric unit, Julian, so lower, but units like that and of that size often have a low Caesarean section rate for that reason because women who might be expected to be delivered by Caesarean section are delivered elsewhere. So it's very significant. Getting back to Hannah's point about the small numbers and having a clear picture of how that...

PROFESSOR MONTGOMERY: Do we need to know where these women live to make sense of the slide, We have left the point about if people are high risk and if they went to Lancaster. Do we need to know that or is that an added complication?

DR CALDERWOOD: Probably you take from that that I would be thinking that Furness might have a lower Caesarean section rate than RLI or a similar one and it's clear that that's a very significant difference. That's one

of the highest in the country. The country average is about 23, 24 per cent.

MISS KNIGHT: This is the actual...

MR BROOKES: 25 per cent.

DR CALDERWOOD: What's that 32?

MISS KNIGHT: Yes.

DR CALDERWOOD: They are private practices though. It is low.

CHAIR: Okay. Thanks for that. Thank you. I propose that we move straight on in that case to part 2 of item 5 which has prompted not just my concern about what we need to do overall, because I think we're beginning to shape that now, but for what do we need to address in the first place, particularly prompted by the accounts that we've heard this morning and seven others at the last Panel meeting.

I'm very grateful to Catherine because she put down her thoughts on paper and kicked off a process that I think is going to bear some fruit and I wondered if you would just take us briefly through paper 2.5 that sprung from those thoughts?

DR CALDERWOOD: Thanks, Bill. So I suppose I started on the train on the way home when I found myself thinking about the units that were similar in size to Furness General. I think what struck be about the accounts that

I heard is that in a small unit, any one of those families we heard from, and James Titcombe, they really rock the unit. I'm sure Jacqui will nod her head.

MS FEATHERSTONE: Yes.

DR CALDERWOOD: Especially in a small unit where everybody knows each other, the theatre staff are related to the midwives. The death of a baby in our care is a very significant event and it's very unusual. So the intra partum still birth rate we would think is around seven per cent of the total still birth rate, so one in every 3,000 deliveries statistically. So we might expect a unit like Furness General to have one intra partum still birth about every three years plus.

Now, again, this is a very small number and we haven't heard them all or which years they were in but I heard enough of a selection to think why is this very unusual event -- why am I hearing it again and again and again in a short period of time in one small unit and I think some of the other comments they made, of course, we haven't seen the case notes and we haven't had any corroboration of any, in fact, we also haven't got the full data, but I laid down what I felt in the first part of this paper that I was hearing from the families and I will tell you that you will find that I speak very directly, I couldn't sleep when I got home. I was

really distressed by those stories. One story is distressing enough, but one and another one and another one and although it was not accompanied by the case notes the fact that there were so many with such severe outcomes that I found it, as an obstetrician, where I, of course, unfortunately I'm used to dealing with still births and all of my job is not happy, but it just seemed the intra partum nature was more than I was expecting.

What I thought really was that what I had heard was non-compliance with clinical protocols and national guidelines. Frequent occurrence of intra partum failures of care. Some concerns I heard were of professional behaviour and competence of those individuals and the relationships of different types of staff working within the unit. Their attitude to incident and risk reporting and clinical governance structures and the ability of that organisation within their culture to learn from what had happened.

Oonagh and Bill have contributed to the paper as well, so I think that clearly in my mind a maternal death, two intra partum still births, two neonatal deaths and a severe hypoxic brain injury as a sample would have been enough but we know that there are other cases that we haven't looked into.

We have had a long list of inquiries and I have also

found the NHS Cumbria Peri-natal Mortality Review, which was done during 2012 but which looked at deaths for 2010 and 11 and was reported on in February of this year. What it looks at is the north Cumbria Trust and south Cumbria, which is Morecambe Bay and it looks at all perinatal mortality, so still births and deaths. What struck the confidential inquiry team was the pattern of still births in that it was very different between the two Trusts. We would expect about 40 per cent of still births to be small or restricted babies. In the north Cumbria Trust they fit that pattern but in Morecambe Bay Trust the babies are well grown babies and more of them at term.

So over a two year period there is a difference in the still births being seen in that confidential inquiry, which I felt corroborated my feeling about this intra partum concern.

Really I suppose what that brings us to is what do we need to do more urgently, Bill, and Geraldine picked up today about the families needing answers but it was also then echoing what people have said already today, what were going to be the deep dive investigations that were going to produce answers as to whether there is something fundamentally wrong with the practices that we need to look and my feeling would be that intra partum

still births, early neonatal deaths, which are a failure of intra partum care, and then neonatal deaths from sepsis, so that neonatal deaths are up to 28 days. We know that, we're not 100 per cent, but most babies should not die of sepsis in 2013. So that that would be a neonatal failure of care with all sorts of levels that you could undergo underneath that and whether, in fact, our information that some of these reviews done already by the hospital are not going to be helpful because we know they weren't SUIs and we know that they were investigated. There has been some reporting in the NHS Cumbria paper about poor medical records and also very poor level of incident reporting and they have looked, they have already pulled the incidents from those two years and I can't remember figures exactly but a substantial majority of them would not have been fit for purpose.

So the other information that we can get is that the new confidential inquiry process have got some legacy data from between 2003 and 2009. So this is data specific to the Trust which was sent to the Trust at the time and which has, particularly 2007, 8 and 9, really quite detailed analysis of the data. I have had a look at it and others, I think that pattern of the gestation and the fully grown still births is also

present in 2007 and 2008 or maybe it is 8 and 9, but two of the three years is the same pattern as the confidential inquiry.

So, again, this is information the Trust did have at the time but that we can look at in more detail and Hannah can have that.

I suppose from point 5 in our Terms of Reference, which is about the practices and safety of the Trust going forward, which is why I didn't sleep the second night, that perhaps we will need to be doing these pieces of work more immediately and perhaps interviewing staff and, I mean, we understand that there are some very positive changes, that the most recent NMC report is very positive, talks about the changes that have been made and that it's a happy place to work. Seven senior midwives have been appointed very recently who are from outside the Trust and outside the area, I think. So there are some very positive changes. I also understand there is a new consultant obstetrician who has an interest in obstetrics and who is making inroads into looking into guidelines and protocols.

So there is clearly work going on but perhaps we need to make ourselves content with the fact that this is a service that is - if we're concerned about intra partum events - that there are measures being taken by

that Trust to move forward to minimise these events going on.

I think I have also had some concern raised by their engagement with the new confidential inquiry reporting process. They were one of the last six Trusts to engage when the process started in 2012 and they currently have only reported one death in 2013. Statistically we might expect more than 25. So there are current questions perhaps that need answering. They are by no means the only trust in England -- in the United Kingdom sorry -- that have that level of reporting. But the vast, vast majority are very different.

PROFESSOR MONTGOMERY: If you compare that to the fact that some reporting increases dramatically, you would expect there to be over-reporting rather than under-reporting in this context.

CHAIR: Given what has happened.

PROFESSOR MONTGOMERY: Yes.

DR CALDERWOOD: I touched a little bit on CNST and I think it is probably a piece of information I got when I was doing quite a lot of "Googling" when I could not sleep. They have applied for it and have CNST level one, having been previously CNST level two prior to September of this year. There are all sorts of reasons that may underline

that; that is a fact and --

MR BROOKES: If I remember CNS is that maternity --

DR CALDERWOOD: I should have said that is a maternity -- specifically from the maternity. I think it is not -- it has not been universally thought as a good thing and, in fact, the process is changing in the near future. You must recognise it is not perfect, so I am not sure how much we need to read into that. But they were level two, you either apply to stay at that level if you don't want to risk failing that level you might go back to level zero, you might apply for level one because you are confident of achieving level one. But it has been level two and is now level one this year.

PROFESSOR MONTGOMERY: Do we know how long it has been level two?

DR CALDERWOOD: I am not sure.

PROFESSOR MONTGOMERY: I was struck by the fact that James Titcombe told us that they used their CNST status as a mark of reassurance for them.

CHAIR: 100 percent on four criteria. Yes.

PROFESSOR MONTGOMERY: You know, that was CNST level one that would not impress anybody.

CHAIR: That would have been level two. It was interesting they reversed it to level one.

I have to say though, that I do know that there are

a number of Trusts that take a very calculated decision on what the probabilities are. It is not an aspirational thing; they just say we are likely to lose money, we will just play safe.

DR CALDERWOOD: I think, Bill, that is very relevant because they may have looked at it and decided that rather than not doing it, it best to get level 1.

The only other piece of information, right at the end, is that -- this is all freely available -- is that through the Freedom of Information Act James Titcombe has had the information that there are currently 34 claims open in obstetric services at the Trust. The NHS, I think there will be quite a challenge to get information about those understandings so I suppose that maybe is just again a point to note.

PROFESSOR FORSYTH: I think the timing of the cases -- what the timing we have got, it will be helpful --

CHAIR: It will be --

PROFESSOR MONTGOMERY: You mean when the birth is.

DR CALDERWOOD: That will be useful.

MR BROOKES: Also it sounds like a high number -- it sounds like --

PROFESSOR MONTGOMERY: I think that is probably connected to when the births were because they could be taken. Could

be 21 years ago, in which case they may just be the product of the inquiry, they may think it is not raising awareness of it. But if they were all in the period that we are talking about then I think we might have to look at that.

DR WALTERS: Or before.

DR CALDERWOOD: And also some of them might be if they were for significant events like hypoxic brain injury, I think it would be interesting to know what they were in relation to.

PROFESSOR MONTGOMERY: I wonder whether anyway into that, rather than the SLAs, we could be interested in what the Board is talking about. The Board ought to be making some sort of assessment about risk exposure so --

MR BROOKES: Anything in the financial report?

PROFESSOR MONTGOMERY: So we might start by saying, "Well, what has been reported to the Board about exposure?" Because that may tell us the main thing that we need to know. If nothing has been reported and we know there are 34 open claims then that is a significant point.

CHAIR: I think that is a good point actually. Yes.

DR CALDERWOOD: So --

CHAIR: Can we take that as agreed?

DR CALDERWOOD: I was going to say, if anybody wants to I think we can. I am finished.

THE CHAIRMAN: Thank you for that. That is really helpful.

Can we take that as a concrete suggestion that we ought to pursue the Board discussion about these first and then the NHS.

PROFESSOR MONTGOMERY: If the Boards were clear it will be in the finance reports.

MR BROOKES: In their reports and their finance reports. Absolutely.

CHAIR: Going back to number one, we ought to ask the Trust about its processes for investigation, for reporting SUIs, for investigating them and for responding to them.

PROFESSOR MONTGOMERY: I would really like to know what happened to those reports. Who were they sent to? Where did they go? If they could describe where they they went that might tell us something.

MR BROOKES: I think that I absolutely agree that needs to be a priority. That there is some understanding of the flow of that information to other organisations as well, which I want to get my head round as well because it should be reported up, and what action was taken external to the organisation as well.

PROFESSOR MONTGOMERY: I was not aware -- there are other key documents added to my list today, but things like

the Fielding Report and the various things are actually very interesting to try to trace where did they go --

MR BROOKES: That is what I meant in terms of the knowledge. I think we need to understand that --

PROFESSOR MONTGOMERY: Because we might, in the same way we take a deep dive into some of the family cases; we might take a deep dive around some of what is hidden in key documents; where did they flow and what use was made of them?

CHAIR: As a result of them.

MR BROOKES: I think that is critical in terms of the governance review.

CHAIR: I think it also takes us into the interface between the Trust and the other organisations that we were talking about.

MR BROOKES: I do not have any difficulty -- I think this is really good. The question that I was trying to get in my head was: Are we concerned that there is a safety concern about the current service? If that is, yes, there is a concern and, therefore, is there something we feel we need to do as a matter of urgency? The second question is: Is this the right sort of information to give us the answer? If it is that is great. I am not professionally qualified to be able to answer that question.

Therefore, if we were to look at what is down here, is there anything else we should be looking at as well, which would then give us a relatively early sighting because if there is a safety issue, it is something that we will be required to act on early rather than wait until the end of the report. That is my only question. By doing this down here, will that give us sufficient confidence and assurance that it is okay? Or are there other things we should be adding to this?

CHAIR: Can we come back to that one? You are absolutely right.

Number two is about undertaking case reviews ourselves. My expectation from the outset really was that this would be a fundamental part of what we do. There is an issue about have we got the right resources to do that and have we got the right set up to support Panel members in carrying out what could become a very onerous process if we are not careful. I think that is something that we need to take a slightly longer look at. I am not sure we are in a position to say at the moment.

One thing I think came out of our conversation that could be really helpful is that if we have a meeting with some of the people who do this for a living and talk to them about their methodology and how they apply

it and what resources it takes and so on. Then we would be in a position to take a more considered view of that.

DR CALDERWOOD: There are Trusts identifying kind of like a sort of confidential-inquiry type methodology team when they are, for example -- their CMIS report has shown they are out in some way. There are a group of people who have done -- they've done about five over five years and have then become known as a team that will come in. They are based originally in the University of Leicester, but they use a very prescribed confidential inquiry methodology; that is a very thorough and multi-disciplinary team with a particular way of grading care et cetera. I think I do not understand the detail of that, because I do not do that, but I think that is what your aim, Bill, is to have.

CHAIR: Yes.

PROFESSOR MONTGOMERY: That will give us something that is comparable to similar things in other places because you have a standard set of definitions and --

CHAIR: Yes.

PROFESSOR MONTGOMERY: Were I in this Trust I would be minded to pay for that myself.

MR BROOKES: Yes. I was -- exactly my point.

PROFESSOR FORSYTH: I think it is difficult because if you listen to the families, their stories, I think as an

inquiry team we have got to try and get the most out of the story of that. For me I wonder whether we have some obligation, whether as a team ourself, somebody has to go through the case notes and -- because I think they are looking for answers to some of the questions. The young couple whose baby died of [redacted] -- was there a protocol for the management of peri-natal streptococcal infection? We are still learning today about a number of questions about temperature and those questions about pneumococcus -- was it a pneumococcal infection?

PROFESSOR MONTGOMERY: I think we need to be seen to do that in a way that is neutral between the family and the hospital. Commissioning someone else to do that, so we hear it as expert advice, will be quite --

PROFESSOR FORSYTH: I think that, but I think also --

PROFESSOR MONTGOMERY: It may also be available to the families afterwards but I think for us we have to have it done --

PROFESSOR FORSYTH: I think it will be very useful, whoever has to do it, at this stage.

I think because we are sort of dancing around the problem to a certain extent because there are systems all around but actually, at the moment, we do not know if it is sub-standard practice or not.

CHAIR: I think it is absolutely clear that it needs to be done, and it needs to be done in line with what are the right kind of protocols to do this kind of thing.

I do have a significant doubt about whether we ought to be commissioning anybody else to do it because I do think this is core business for us, and I think it is seen as core business for us.

PROFESSOR MONTGOMERY: In which case I think that if I were a member of staff, looking at the implications of it, I would be anxious about knowing you saw the families first, you then do this; when will you give us the chance to give their side? We are a mechanism that makes sure that no-one can say to us, you were duped in a deal. That is why I thought that a standardised way of doing it, that is established for other purposes that we used would be a really good answer to that question.

CHAIR: I am happy to adopt the best methodology that I can find; I am sure we all consent to that. But I think that we need to be very, very cautious about bringing people in to do what will be seen as core work.

If we could have the meeting with your contacts and report back to you hopefully --

MS McINTOSH: Who is "we"?

CHAIR: We should be involved in the meeting. I

will. I feel that Catherine would like to be involved, correct me if I am wrong. Would anybody else think it will be important they were involved?

PROFESSOR FORSYTH: I think this is really where it is best for the clinical part of the panel so maybe --

MS FEATHERSTONE: Yes.

PROFESSOR FORSYTH: -- might be interesting to get them together in the right time. I think that it will be helpful for us, if we did have medical areas, if possible.

CHAIR: That will be very useful.

DR WALTERS: Are we sure how many of these cases did not have an expert view overall already?

CHAIR: No.

DR WALTERS: Some of them did. Do we need to do it for all of them?

CHAIR: Well, I feel that we ought to review all of them.

PROFESSOR MONTGOMERY: There are a few hints that Tony Halsall got people he knew to do external reports. I think that we at least need to do enough to be able to ask the questions: Were these external reviews actually independent reviews? Or were they --

MR BROOKES: Were they adequate?

PROFESSOR MONTGOMERY: What is to be learnt about how you

commission those sort of things. I mean we may need to not do all of them but enough to ask the question --

DR WALTERS: I am sorry to be boring, but I don't think it can be yet another report for families to read. They have got to have the opportunity to ask some kind of questions.

CHAIR: Yes, yes.

DR CALDERWOOD: I would see, Geraldine, that that was some of them being as part of the review any way, but I would almost see that as additional, so that they -- because the other thing is that what we need to talk about how the review was done and how those are traditionally confidential so everything is redacted -- the staff, everything. Of course that then is not appropriate for them because it is different -- it is a narrative discussion you are having. I mean I would see it as somebody I had cared for, or been a consultant on their ward, who has intra-partum still birth I would do that as a matter of course in a review meeting with them, you know, X-many weeks later. That is what I would feel these families need is a debrief.

DR WALTERS: Yes.

DR CALDERWOOD: That is different than talking about the standard of care.

DR WALTERS: Yes.

DR CALDERWOOD: I am not sure that I would feel I would want to go through the notes with them necessarily not being part of the unit et cetera talking about it exactly. I would see it as a line-by-line practicality answering questions. Whether or not you were leading down the line then of coming up with this was sub-standard, this was adequate, this should or should not have been done, that is a very different process, which I think is the one that we would then have as an individualised process, like a confidential inquiry when it may not be confidential.

DR WALTERS: I think at the moment we cannot see who does that to people because it is certainly not people who work at Furness.

PROFESSOR MONTGOMERY: I mean I think that I must have said earlier that we do have a clear separation between who does that process, which I think we have to try to support, whether it is us doing it or whether it is supporting someone else, and the bit that generates our conclusions about the case. There needs to be clear water between us; our ability to exercise our judgment on what we have learnt and what we make of it; then the question of discussing that with them.

PROFESSOR FORSYTH: I think at the end of the day we would like to say that this has been mainly driven by the

families, continually unhappy and looking for answers. I think it will be difficult for us as a review group to not be able to say, as part of the review process, we reviewed the case notes of all the families concerned.

CHAIR: In the light of their concerns. I think we know some of the nuances of these people who they are concerned about and they would not necessarily come out in a purely standardised methodology. They would not necessarily look for evidence of dysfunctional relationships between obstetricians and midwives. We would be prime to do that. That is just one example.

Can I take that as the way forward on number two then? We will seek a meeting with the people and come to a view about what we need to carry out this effectively.

Number three. I think the initial thought is that we might drag in some of the key people involved in the service now and quiz them about it here. I think that there are some drawbacks about doing that. We probably will get -- given what has happened we will get a defensive response and a bit of a presentation and it feels a bit uncomfortable and we have to make an artificial divide between questioning about what happened now, and what happened in the past so we will have another bite at the cherry.

The alternative, which seems to be increasingly attractive, is that earlier in the New Year we, or a sub-group of "we", should go and visit the unit. That would give us a chance to see the geography --

MS FEATHERSTONE: I think that will be good.

CHAIRMAN: -- things will make more sense where -- "I rang the paediatrician". "Well where was the paediatrician?" We get a mental picture.

It will also allow us to have some slightly more -- absolutely not "off the record" because it will not be off the record, but slightly informal conversations where we will probably find out more about the feel for how it is operating now and steps they've taken, to satisfy ourselves that they are not running on the brink of disaster as we speak.

DR WALTERS: Well I would like to know how they interpret their current rate. How they have got it. I do not know whether that is Board reports or actually current staff who might not have been there a few years ago, just to sort of say, how do you interpret this? To see if there is any difference in there.

MS McINTOSH: If we actually get down to the unit. It should --

MS FEATHERSTONE: I think you would learn such a lot just

walking onto the unit, to be honest.

PROFESSOR MONTGOMERY: Absolutely.

MS FEATHERSTONE: You will get a feel of what is happening at this moment in time for reassurance for now, never mind what we are looking at before.

PROFESSOR MONTGOMERY: I mean, I absolutely agree with that. I think if we all went at the same time it would get less informative. I think that there is something around is it a big enough place that actually if we all go to the hospital, but only in pairs go to the maternity, or something, because it is about how do we get what we are after?

MS FEATHERSTONE: Yes.

MR BROOKES: It is about what we are asking questions about. I totally agree. You get the trauma reviews and within three or four minutes, colleagues were telling me, you get what the atmosphere is, what the culture was et cetera. It is incredibly important, I accept that.

I would not get too much from that in terms of the unit. It would be useful to see the unit, but I would like to be talking to some of the people about processes, the way they handle undue incidents, those kinds of things. Having those conversations there, I think, is better than trying to bring it in here, it is in their environment. You will get a much

probably more open discussion about it in terms of what is happening.

PROFESSOR MONTGOMERY: I think I would find it really helpful to sit down with the current Chair and say, "Tell me how you see what you are doing", because they will have a take on what is happening and what the challenges are going to be.

I think I can see that we can all go, do different things, so we will not swamp the place, and show an interest in the future as well an interest in past, which is probably an important part of getting the best from it.

MS McINTOSH: When we spoke to the Chairman the Chief Executive explained that they rotate Board meetings to the different sites in the Trust. If I spoke to the contact body there and checked if everything was in our favour, they might have a Board meeting there in January and, you know, and actually they might have their Board meeting and it will be an opportunity to actually have the right people there and not bring people in on extra days but actually just dovetail.

MR BROOKES: If it were that would be great, but I still think we need to see who else is there.

CHAIR: I agree.

MS McINTOSH: I think we are looking at the first couple of

weeks in January, or are we looking at it that quickly because I think there is an urgency around the discussions that we just had. Actually, we want to do that before we start looking at the evidence.

CHAIR: We will need to be a bit pragmatic about it because the chances of getting everything together are slim.

MS McINTOSH: It is not going to work, you cannot get the printer to work.

PROFESSOR MONTGOMERY: I said earlier, do people want to go on a weekend? I am just thinking that if we think there are issues about the weekend then you may want to walk around on a weekend.

CHAIR: Would you get to speak to the Medical Director?

DR WALTERS: We cannot do a sort of faux-CQC - if that is what you said. I think, to some extent, to what extent would that substitute talking to people here when we have said we will do that in the presence of the families if they should want to be around? I think we have got to balance that.

CHAIR: We cannot really go into the past too much, because that is formally part of the Investigation, which, as you say, we have agreed to do for the families.

Can I suggest that Oonagh explores at an early stage

what is going to be feasible and that we have, if necessary, an e-mail conversation about the practicalities of this based on the principles. Yes will that be good. Thank you.

CNST applications and assessments. We have had that. I think we are saying that it will be interesting to look at, at some point, but perhaps it is not urgent. It will not tell us much as an urgent matter. We can will defer that one.

Compliance with data recording points. Same category. We will need to look at it but it is nothing as a matter of urgency, I feel.

DR CALDERWOOD: I suppose it is one of the things I would ask on a site visit because I would think that we will want to speak to who is in charge of risk management, who is your "embrace" appointed person for filling in the forms? How many have you filled in?

MS FEATHERSTONE: And if they are all up-to-date, yes. You can get a lot from that.

DR CALDERWOOD: We can get a lot more, Bill, just from a visit rather than asking for the data. I think almost it is the questioning and the way it is responded to that will be quite interesting.

CHAIR: Okay, that sounds very sensible to me. If we wrap that one. In that case, thank you for that.

Can I come back to your question, Julian, which is do we feel that that process, which I think particularly pivots around the visit in January, is the right way to tackle this issue about how do we get a feel of what is happening right now. Will it suffice?

MR BROOKES: I would have thought if those conversations are within the back of the mind is this a safe service and we are talking to staff, you will get a pretty good feel. Then if we come away with even more worries, then there are maybe things we need to do. It will be a good test because I think that we are duty bound, if we believe there is a risk, to prioritise that. I think that is the point.

DR CALDERWOOD: Bill, I think the gold command was called because of the maternity and neonatal concerns, wasn't it?

CHAIR: Specifically to answer that question.

DR CALDERWOOD: It was then stepped down last year, so someone else has signed it off. I do not know. Do we know the details of that or can we know that?

MR BROOKES: I was thinking it will be a good thing to find out.

MS McINTOSH: Yes.

CHAIR: My view as well. Yes.

MR BROOKES: I certainly got the flavour that actually they

stood it down but I have never seen any evidence that their recommendations have been completed.

PROFESSOR FORSYTH: I was not sure what they concluded.

DR WALTERS: No, neither was I. They did not do anything tangible.

MR BROOKES: Maybe they made no recommendations then stood down again. There must have been some assurance process for them to decide that.

DR CALDERWOOD: Yes.

MR BROOKES: Are we comfortable with that?

CHAIR: I think they do have answers to that. We need to get to the bottom of it.

Anything else on that item? Thank you. I think that has been a really helpful discussion. Thank you for that.

Item six is future work programme and timetable. It says me, should be Oonagh.

MS McINTOSH: Okay. I think we have got submissions first. Consideration of submissions. Yes. Okay

that is all.

CHAIR: I was being over-optimistic.

MS McINTOSH: This is simply as you would expect, with anything, that you will get people raising concerns and this time, with the Investigation, about matters about their concerns or their issues with the NHS. We are just the latest body that has popped up on the radar so they bring their complaints to us. You will always get some of those. You will also get people, as we have got, who contacted us because they think that they have something that has arisen in the Trust, which is within the scope of the Investigation. You will actually get people, like when we saw the person last time who was actually raising issues about the level of care and the approach of the professional teams in the hospital, but they were outwith the maternal and neonatal services delivered.

What I just wanted to let you know is that we have started to get these contacts, which is actually really good because some of them are within the terms of reference. It is just for the sake of transparency letting Panel members know how we are dealing with them. It is pointless if we bring everything to your attention all the time, we looked at your faces when you saw the volume of material coming and you don't need us adding

Mrs X's query about something that is outside the terms of reference as well.

Actually it was just so that you know the process we are going through because it is perfectly possible that each of you will be in conversation with somebody and someone will say, "How do I contact? I want to talk to somebody about X". It is just the process that we are going through. It really links in with the agenda paper MBI2.88 that you will get, in fact, which is a draft later and a pro forma near the back, which ties in with what we were talking about earlier about when people do contact us, how do they contact us? And what do we ask for?

What we have come up with is a very general pro forma for people to complete, rather than people tell us their life history, or case history, and us at the end say, "Actually it is not for us to look at, you need to talk to X or Y organisation", then to have wasted a lot of time and they feel they have been rejected again, we just thought this is a mechanism for us getting a quick overview and establishing whether we need to drill down any further.

The one thing I want to just highlight again, is something that I have already mentioned to the Chairman, is that this might generally -- this process might well

generate more relatives wanting to come and tell you their story. I think that it is just to let you know that we have to be mindful of that and we have to be open to it and it maybe that at every meeting there is somebody who wants to talk to us about their case. Now that well might eat into the time we want to spend on other things, but keep in the forefront of our minds the purpose and the reason we're here.

You know, once in a small community people have said, "Well, I have been and talked to them", as some of the relatives said last week when we were leaving, "It was not as awful as I thought. I can now tell people." We can't then say, "We have heard enough." That would be ridiculous. So you are all so warm and cuddly! It's just that this might generate more approaches, it's the manner in which we are handling them. It's so if you are asked by anybody, "What is the process?" There is a process.

So that takes us through that agenda item.

CHAIR: Thank you.

MS McINTOSH: Very quickly, the advert is ready in draft. [redacted] has already found out which newspapers and journals we can advertise in to reach the communities we want, bearing in mind we don't know all the cases. So it's the same approach that we're adopting. When people

contact us we give them a pro forma, we get general information and then we will be able to determine whether we need to drill down.

What we promised to do is bring to each Panel meeting a standard summary so that you know what approaches you have had.

MR BROOKES: There will be some which are clearly outside the Terms of Reference but there will be some where it is grey and it may be that we need to take a collective view on that.

The other one is a much more practical issue. We need to be clear whether or not the person who is contacting them has the right authority to be authorising, asking us to investigate and the form doesn't put that quite in the same way it does to patients. They may not have the right to do that. That's quite a tricky one but we need to be clear on that. There is no point us investigating something and finding out somebody else has the authority.

MS McINTOSH: That's very true. We do have a case that might come to the next meeting which is somebody who is [redacted] of the affected child who has been in discussions but he's be telling us and we need to know. You are right, we will think through how we do that.

PROFESSOR MONTGOMERY: I have three questions, one and a

half have been dealt with. Just on that last one. I'm not sure that we would say that because someone is not authorised to give us the permission to investigate that that is outside our Terms of Reference because we might ourselves say irrespective of that it is so crucial to our Terms of Reference that we use our authority to do it. So you would expect we would have permission to do it but I don't think we would want not to be able to ask that question because we may need pick it up.

The remaining one is, we have a phone number on our headed note paper. If people ring up will whoever takes the call will they fill in this form if the person doesn't want to do it?

MS McINTOSH: Yes.

PROFESSOR MONTGOMERY: I wouldn't want to be accused of saying, "You couldn't have my story because you wouldn't fill the form in.

MS McINTOSH: Because you didn't. I think in the paper that you got at 2.6 we actually say if it's appropriate to do so. It is littered with "if it's appropriate" and "if it is ..." you know, there is a whole host of reasons why somebody may not be able to complete a proforma in ten minutes.

CHAIR: Okay. Thank you. Future work programme. So keen to talk about the future work programme. We know that we can't altogether finalise the approaches until

we've completed discussions with the lawyers. We hope to make progress in a meeting tomorrow afternoon.

We also need a set of house rules about how we're going to tackle these and who is going to do what but we can't do that because we've not got clearance.

In the meantime it does seem very good sense to set out and look at the timetable and that's what we have at paper 2.7.

MS McINTOSH: It's pretty self explanatory. The only thing I really wanted to make a plea about, we've already talked about going to meet the Trust, we've talked about having a meeting with the team at the University of Leicester. All of a sudden we are starting to put more things in your diary when you have a busy diary to start with. We have only got one Panel meeting. We haven't talked about when we hear evidence from people, which will have to be additional dates. I just wanted to just say, should we start talking to you and your PAs now about getting some extra dates in the diary whether you like it or not? We can always move them. Best to have them in, we can always take them out.

Also this timetable here is a general, a provisional one, it is not fleshed out. What I'm trying to get across to you and -- sorry, trying to share with you is the process, the reviewing the evidence is going to go

on for a long time and you might need to start and hopefully at the next panel meeting we can have a session on what the outline or the skeleton of the report might look like because actually there is a lot of work we're doing in the team already in trying to capture some of the approach in the data so that we can give it a context. We need to do that so it weaves in.

CHAIR: Thank you. Two comments. One is that Stuart and I will tell you we don't have a PA.

Secondly, I think the sooner we can start identifying a complete list of interviewees and start seeing them the better. I personally can start putting some slots in.

MS FEATHERSTONE: I agree we need to start putting slots in.

MR BROOKES: I think we need to almost blitz some of those interviews because the more we can do up front the more we have for consideration of evidence, etc. So we will do what we can. I would have thought we can get some consecutive days and just try and do things if we need to.

CHAIR: The other thing, I will float this now, I don't feel that we necessarily need to have a full compliment for all interviews. If we schedule the interviews so that we utilise that, for example, if we

have a clinical governance one we know that we need you there, if we do the ones that have a heavy clinical interest we can do it with you and so on.

PROFESSOR FORSYTH: Perhaps combining dates with the Panel members travelling here with the possibility, most of us are staying the night anyway. So we could do them.

CHAIR: That's a very interesting suggestion worth debating because how do people feel about this?

MR BROOKES: That's what I meant by blitzing.

CHAIR: Do you like the feel of overnight stays? Kick off mid-morning, start early next morning and finish in the afternoon? Or do we not like the idea of an overnight stay because that's too much of an imposition?

DR WALTERS: I wouldn't like them all to be overnight stays.

DR CALDERWOOD: Certainly if we are travelling to Barrow that would seem sensible. Quite a long journey, instead of doing it twice, get the interviews in. That might actually have some flexibility not all of the people we want to interview will be available at one particular time. To allow them some flexibility. It's actually not to do with interviewing but video conference. Is that allowed?

MS McINTOSH: To see witnesses, you mean?

DR CALDERWOOD: No, for Panel meetings.

CHAIR: I definitely wouldn't do it for witnesses, I have done some telephone interviews but if you need to look at people's reactions you have to seem them.

DR CALDERWOOD: I mean for Panel meetings.

CHAIR: It's theoretically possible.

MS McINTOSH: Technically it's not possible from this building. We would have to inquire from our landlords at Lancashire County Council whether or not they have got it at County Hall. We can inquire and find that out. We can look at what other Government departments have in Preston because there is HMRC sitting here, there is the DWP offices. I'm not saying they will have video conference. We will look and see. If not maybe it's a Leeds/London thing. We can use the facilities there. That's not impossible either.

TOM BACON: There may be other alternatives, video conferencing that we can rent out for the day. So there are options.

MR BROOKES: I think it's a good idea but we need to be mindful of the fact what we are based in the north west.

CHAIR: Of course.

MR BROOKES: Which is Preston.

PROFESSOR FORSYTH: I think, yes, we have to got to get the balance right.

DR CALDERWOOD: If there are additional dates then some not having to be here would also make it easier.

MS McINTOSH: Also it might be easier for some of the families to attend by video conferences. Because, for example, we had one relative who has contacted us and said she would like to come to this meeting but financially it's too much of a challenge at the moment. Video conference more locally, if we were setting it up and we were managing it, that might just be another option. Why don't we go away and look at what the options are..

CHAIR: Let's have a feasibility check. Yes?

PROFESSOR MONTGOMERY: I don't know if this might go with that, if we can't all attend and if that interview is captured on video, if it turned out later on that it was really important to understand exactly how someone said something and it was available it would be possible for people to see it. I wouldn't do anything special for that but if doing video conferencing also gave you that ability that might be useful.

MS McINTOSH: We will find out.

CHAIR: Okay. Anything else on future work programme? In that case that takes us to number 8, any other business. This time I'm operating under strict instructions that I've not got to take all the slot. Catherine?

DR CALDERWOOD: No, I don't think so.

DR WALTERS: No.

PROFESSOR FORSYTH: No.

MS McINTOSH: No.

MR BROOKES: No.

PROFESSOR MONTGOMERY: No.

MS FEATHERSTONE: I will be really quick. It's clear in my head, obviously that the Investigation advert is going to go out to families. What about the families that are now expecting babies and going into that hospital and their concern. We're saying that we are going to go in to make sure that it is safe now. The time that it takes the advert. I am concerned about what's going to that happen to them. I know it doesn't look like they can go anywhere else if they wanted. I know when it's happened recently people don't want to go there.

MS McINTOSH: It's very difficult, Jacqui. Because our terms of reference are in this year, June 2013, so we're looking at cases during a very recent period, up to a very recent period. Apart from stressing the point

point that we are looking at a past period in the advert, what I would propose to do with the advert is (a) I have already promised Cumbria Constabulary that we would clear it with them because they still have a live investigation ongoing. (b) It would be fair that the Trust would have to see it before it went out. They have a rather experienced media team working with them at the moment and I think it's only fair to them. So they are two of the organisations that I have already planned that we would kind of run it past before it went to print. What do you advise?

MS FEATHERSTONE: I suppose it's just if I was a first time mum and I didn't know anything about this, I'm not interested in this and then suddenly, oh, something comes up and this happened a long time ago and now they are investigating again, so is something still going on? I don't want to go there now and my friends don't want to go. Is it fair when things are safe there? That's my concern.

CHAIR: It's a very good point but I must say I think that there is a really interesting and quite heavily nuanced reaction in Barrow that there is a very significant section of the population has sprung to the defence of the hospital and they are very vociferous

about the fact that there is nothing wrong with it. It's a good hospital.

MR BROOKES: That's the ones with experience as well but there would be some reassurance if that conversation with the hospital was such that they felt that they could provide a number for people who were concerned or something so that there was a contact point, which is not to do with the Investigation, it's a contact point with the hospital where if someone has a concern and they are geared up to respond to that.

PROFESSOR MONTGOMERY: I agree with that because fundamentally the current service is their responsibility. I'm wondering where the commissioners are in all this though because that would be a commissioner issue. So we talked about the CCG.

MS McINTOSH: CCG couldn't fit a meeting in with us before Christmas because many of them are on holiday.

DR CALDERWOOD: I think the same point as Jacqui, if I was a midwife or obstetrician and I saw this in the newspaper calling for people.

MR BROOKES: There is an internal angle.

DR CALDERWOOD: There is. I mean, certainly in my experience the high level things that then seem blatantly obvious to whoever they have been sent to

never make it to the labour ward, so the first time is the night shift or the first edition of that paper comes in and they walk in, sit down and, "They are at it again". So it would be good to make staff aware, almost to make sure they see the wording of it as well because there is a high level that goes on in hospitals and people that actually deliver the babies may not have any inroads into it at all.

CHAIR: Yes.

PROFESSOR MONTGOMERY: Do we have a Q and A sheet about what the Iinvestigation is and is not that could be sent to the local wards?

MS McINTOSH: Yes, yes.

PROFESSOR MONTGOMERY: So they have it.

MS McINTOSH: We can say what we have done.

CHAIR: We need to do this in concert with the Trust communication.

DR CALDERWOOD: I meant to ask this previously of you, how much communication have the current Clinical Director and Head of Midwifery had? Do they know about us?

CHAIR: Yes, absolutely. They were very clear, the Trust, and they believed senior staff were fully conversant with the reasons for having this.

MS McINTOSH: The Trust have shared with us the draft communications they are sending to all staff in

maternity, there is letter saying we are going to have a method statement or here is the method statement.

One question I wanted to ask which maybe is linked, at the moment we've not engaged with, because we've not had any to need to, any of the unions or even the College of midwives. Because actually, we have obviously in the draft letter talked about disciplinary and complaints and that's where people's union representative would ordinarily be engaged. The Trust told you that they had stronger relationships now with the unions.

CHAIR: Yes.

MS McINTOSH: I don't know what the Panel view is on whether or not, you know, I am not trying to open the floodgates to communicate with everybody. Is there some value in communicating with the unions? Unison, Unite. I don't know. I don't want to go down that route if I don't have to.

CHAIR: One note of caution that I would want to strike would be that these would be people who staff want to bring with them as support when we talk to them.

MR BROOKES: There is a duty of care on employing organisations and I would expect them to be talking to their staff and there is call for that and whether we need to do anything else, I'm in two minds about that one.

MS McINTOSH: We do need to respond.

MR BROOKES: Fundamentally we expect the Trust to cover that. Other Investigations have taken that stance. It's being responsible as a Trust for staff to make sure they are properly supported. So there is no harm in reinforcing that line of responsibility to the Trust. I don't think we need necessarily enter conversations with the trade unions unless we needed to speak to them as part of the Investigation.

DR WALTERS: Have we asked any of the staff involved in the cases we're referred to?

MS McINTOSH: That's in the letter.

DR WALTERS: When will that information come back? When do we start to see the organisations? There are people there who know that.

CHAIR: I don't think there are any live cases at the moment. They have all been dealt with. Suspended by the Trust. No.

DR WALTERS: We don't know if anybody was removed from the register.

MR BROOKES: One person was referred to a professional body but it was not proceeded on.

MS McINTOSH: We are dealing with the NMC.

PROFESSOR MONTGOMERY: That does raise the question about levels and the turnover, Catherine was

saying about the rotations and I don't have much feel for it. Midwife staffing is being raised as an issue. So at some point I understand you said six months by six months and a sense of how the pattern changes.

CHAIR: Yes.

DR CALDERWOOD: There are four consultants and junior staff will be that many or less. Midwife to birth ratio would be helpful.

PROFESSOR MONTGOMERY: That would be very handy. Where the dips were.

PROFESSOR FORSYTH: It would be helpful if we could get this information, staffing structures and also details because what are the job plans? Where are they most of the time? So we do need to get that kind of level of detail to find who is actually on site.

PROFESSOR MONTGOMERY: Quite earlyish. So you can get a sense of ...

CHAIR: We need to understand it. We also need to understand how that has changed over time from 2004.

PROFESSOR MONTGOMERY: We need to how understand how it was changing elsewhere in that period as well.

CHAIR: Sure. Okay. Time of next meeting. It will be here but we're not quite sure whether it's 15 or 16 January for those of us with PAs. Thank you very much.

Much appreciated, as ever. I said I was going to describe this as the end of the beginning from the beginning. We are at the end of the beginning. If I don't see you again before Christmas have a good seasonal break and see you next year. Thank you.

(Adjourned)

THE MORECAMBE BAY INVESTIGATION

DATE	EVENT	COMMENTS
2008		
15-May	Barbara Young appointed as Shadow Chair of the Care Quality Commission (CQC)	
July	Cynthia Bower appointed Chief Executive of the CQC	
2009		
Early 2009	UHMB approved to go forward as an applicant for Foundation Trust (FT) status and forwarded from Department of Health (DH) Ministers to Monitor (prior to the Healthcare Commission reporting on Mid-Staffordshire NHS Trust in March 2009)	
	Authorisation later halted due to quality concerns (the first Mid-Staffordshire Inquiry in February 2010 made clear that the information on quality being used for FT applications needed improvement)	
January	NHS North West Strategic Health Authority (SHA), the Healthcare Commission and Monitor hold risk summit to discuss risks relating to radiology, Healthcare Acquired Infections (HCAIs), historical governance and cultural issues (at UHMB)	
30-Jan	UHMB application submitted to Department of Health FT applications committee	
04-Feb	A submission was put to Ministers (addressed to MS(H)) advising to support the application for Morecambe Bay's FT application to go to Monitor. The submission indicated that further assurance had been sought from the SHA on the Trust's MRSA performance, A&E performance, and compliance with information governance requirements and that assurance on actions being taken had been provided by the SHA. Advice in submission was accepted the following day	
February	Mitchell Report Review of Children's Services commissioned by Cumbria Primary Care Trust (PCT)	
March	The SHA was identified as the lead organisation to follow-up actions from the risk summit with UHMB	

May	UHMB FT application - further advice was put to Ministers on the UHMB FT application (addressed to the Minister of State in relation to the application in light of the initial Mid-Staffordshire findings. This indicated that some clinical issues were being investigated (including a complaint to the Pariamentary and Health Service Ombudsman (PHSO) about maternity services), but concluded that a review of available data had identified no material quality issues at UHMB. The submission therefore recommended that ministers did not need to qualify their support for UHMB proceeding to Monitor to be considered for authorisation	
May	Monitor put UHMB FT application "on hold" due to SHA concerns - Monitor determined they would not take an authorisation decision as planned due to the PHSO not being able to conclude whether an investigation into the SUI was necessary and also that the CQC was considering the complaint as well and were consulting their investigations team about how to proceed	
May	Monitor and DH sought clarification of apparent 'low levels of concern' identified within the UHMB organisation risk profile (ORP). CQC provided Monitor with an ORP as part of the FT process for aspirant National Health Service (NHS) trusts	
May/June	James Titcombe apparently referred his complaint against UHMB about the care his son received to the PHSO. The PHSO later (February 2010) concluded that an investigation would not provide a different outcome to what was already known	
June	CQC met SHA to discuss Trust's handling of the SUIs. SHA concluded it was satisfied with Trust's handling and reported no commonality between the five maternity SUIs	

June	Following the initial Mid-Staffordshire findings, the FT application assurance process was updated including introducing - minimum quality threshold, explicit role for NHS Medical Director, explicit requirement for CQC assurance on quality and safety and increasing the robustness of SHA sign-off. However, UHMB FT application was supported by the Secretary of State prior to the NHS Medical Director review was introduced into the process, and the process was not retrospectively applied to such Trusts	
August	CQC and PHSO met	
26-Dec	Barbara Young resigned as CQC Chair, effective from February 2010	
2010		
January	CQC North-West Planned Collaborative Review meeting held with all regulatory stakeholders. SHA participates and all agencies provide summary of concerns on all North West organisations. SHA informs stakeholders of current position at UHMB and that the Trust has commissioned Professor Dame Pauline Fielding to undertake a review of the incidents and clinical governance. All regulators continue with their performance management	
February	Jo Williams appointed as interim Chair of CQC	
April	CQC write to Monitor to confirm its level of concern had reduced to minor concerns. At this point, Monitor's FT assessment is restarted	
September	Jo Williams confirmed as substantive Chair of CQC	
September	CQC confirms to Monitor that UHMB rating is "green".	
October	UHMB authorised by Monitor and achieved FT status. (UHMB NHS FT)	
25-Oct	DH/CQC review meeting (Jo Williams, Cynthia Bower, Una O'Brien, David Flory, David Behan)	
2011		
Early 2011	CQC became aware of *Fielding Review*.	
June	CQC became aware of more issues with maternity services at UHMB NHS FT. CQC met SHA, Nursing and Midwifery Council (NMC) and Local Supervision Advisory Midwifery Officer to discuss scope of review of maternity services at the Trust.	

July	CQC and NMC undertake a joint review of maternity services, which included further unannounced inspections. The CQC and NMC found the Trust was not meeting seven out of 10 essential standards. Major concerns were found with suitability of premises, staffing arrangements and monitoring and quality of maternity services	
Late summer	Decision taken to conduct the CQC capability review	
08-Sep	Brief to Ministers (addressed to Minister of State (Health)(MS(H)) findings of CQC compliance report on maternity services at Furness General Hospital following inspection in June 2011. Refers to cluster of incidents in 2008, the Joshua Titcombe case and the police investigation	
14-Sep	Health Select Committee (HSC) accountability report published	
October 2011 to February 2012	DH carried out a Performance and Capability Review	
October	NMC: Review of UHMB NHS FT published by the NMC and the CQC	
10 & 11 November	DH Performance and Capability Review panel (chaired by Una O'Brien) and support team visited CQC. Met the CQC Board and CQC executive team. Also held separate meetings with staff and with stakeholders	
05-Dec	National Audit Report into CQC published	
2012		
January	MS(H) met local Members of Parliament.	
23-Jan	Public Accounts Committee (PAC) on CQC report	
30-Jan	CQC meeting with Ministers	
Late January	DH/CQC catch up (Jo Williams, Cynthia Bower, Una O'Brien, David Nicholson and David Flory)	
February	Monitor publishing outcomes of two reviews into lessons learned at UHMB NHS FT and management responses to an internal audit of the Trust	

THE MORECAMBE BAY INVESTIGATION

February	CQC, Monitor and SHA held risk summit about early findings of the investigation. CQC issued UHMB NHS FT with two further warning notices on use of mixed-sex accommodation and monitoring patients in A&E at Royal Lancaster Infirmary. CQC considered issuing a further warning notice on staffing at A&E at Royal Lancaster Infirmary but decided against this	
February	DH publishes its performance and capability review of CQC	
February	CQC Chief Executive, Cynthia Bower, announces her resignation	
February	Issue about effectiveness of CQC's regulatory activity at UHMB NHS FT raised at a CQC Board meeting	
09-Feb	DH Performance and Capability Review Panel met with the CQC Board to highlight key findings	
07-Mar	DH response to HSC accountability report into CQC published	
30-Mar	PAC report into CQC published and CQC response published	
June	CQC shared draft investigation report with UHMB NHS FT, SHA and DH	
July	Monitor publishes KPMG report about its role in the Foundation Trust application process for the Trust	
July	David Behan appointed Chief Executive at CQC	
July	NMC review of UHMB NHS FT commissioned by NMC	
July	CQC commissions Grant Thornton consultancy to carry out investigation into CQC handling of UHMB NHS FT	
30-Jul	DH/CQC catch up (Jo Williams, David Behan, Una O'Brien, David Nicholson and David Flory – UHMB NHS FT discussed)	
September	HSC annual CQC accountability hearing	
September	Deloitte Report into CQC's use of investigation powers under section 48 of the H&SC Act 2008 commissioned by CQC's Audit and Risk Assurance Committee (ARAC).	
30-Nov	Deloitte undertakes a feedback sessions with the ARAC.	
30-Nov	CQC ARAC Meeting - The Chair updated the Committee and stated that the review was progressing well and it was expected that the report from Deloitte would be available to discuss at the next ARAC. In the meantime the Chair would discuss next steps with the Chief Executive and Chair.	

06-Dec	CQC updates DH at Quarterly Account Review pre-meeting about the Deloitte report, which will go to CQC's ARAC in December.	
12-Dec	Deloitte undertakes a feedback sessions with the CQC Board and presents interim report.	
19-Dec	QAR Meeting - CQC discusses Deloitte findings with DH, stating the main message is that CQC is not strategic enough in the use of its powers.	
December	Deputy Chief Executive of CQC, Jill Finney, announces her resignation.	
2013		
09-Jan	HSC annual CQC accountability report published	
January	Jo Williams' term as Chair of CQC ends	
23-Jan	CQC ARAC Meeting - The Committee discussed and accepted the report, its recommendations and recommended this report go to the CQC Board who would be responsible for determining how and when the recommendations would be implemented	
28-Jan	Deloitte report formally delivered to CQC. Makes recommendations for how CQC could improve the use of its investigation powers. Also suggests CQC should question its generic approach to inspection, access to clinical advice for inspections and review communications across the organisation	
30-Jan	David Prior's term as Chair of CQC begins	
41304	CQC ARAC Meeting - Grant Thornton review, discussed. Individuals not already interviewed as part of the process but who had a connection to the matters investigated would be invited to send in their comments for consideration. This process was felt to be appropriate and was being handled in this way in order not to cause any further delay in concluding the report	
February	John Woodcock MP obtains Westminster Hall debate on UHMB NHS FT	

February	John Woodcock MP meets Parliamentary Under Secretary of State for Health (PS(H)). MP brings along local patient representatives including James Titcombe. Meeting establishes that local desire is not for a public inquiry but for an inquiry, in public, independent of the Trust.	
February	Local NHS and NHS England confirm to DH that they also want to see the eventual inquiry run independently of the Trust and other interested parties.	
February	Deputy Chief Executive of CQC, Jill Finney, leaves post	
05-Feb	Report of the Public Inquiry into Mid Staffordshire NHS Foundation Trust published	
08-Feb	CQC Board agreed new Board Standing Orders incorporating a mechanism for raising concerns	
March	PS(H) meets local MPs to discuss issues at UHMB NHS FT including review of services and recently announced cost savings programme	
March	Chair of independent Investigation appointed – Dr Bill Kirkup CBE	
07-May	DH response to HSC annual CQC accountability report published	
31-May	Professor Mike Richards appointed as Chief Inspector of Hospitals at CQC	
June	Grant Thornton report into CQC handling of UHMB NHS FT published	

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RESTRICTED PERSONAL

Name and address

XXXX 2013

Dear

Request for Information

Thank you for your reply to the Investigation's request for information.
OR
Thank you for contacting the Investigation.

To help the Investigation understand whether the information you wish to provide is within the Investigation's terms of reference, will you complete the attached proforma with the basic details of the incident and provide the names of the patient or (patients) involved.

Once the Investigation has had the opportunity to consider the detail you provide, in relation to the Investigation's terms of reference, you will be contacted, by your preferred means of communication, and informed of the next steps.

If you have any queries relating to the completion of the proforma or the information requested, please contact the Investigation at the address above.

Yours sincerely,

Oonagh McIntosh
Secretary to the Investigation

THE MORECAMBE BAY INVESTIGATION

MBIPM 2.8

Chaired by Dr Bill Kirkup CBE

Please complete this proforma to provide further information to the Investigation.

Full Name ----------

Address ----------

Daytime telephone number ---------- **Email address** ----------

Preferred method of contact ----------

Name of patient ---------- **Your relationship to patient** ----------

Name of the hospital at which the incident occurred ----------

Name of the hospital department in which the incident occurred ----------

Did the hospital consider the incident as a 'serious untoward incident'? (please tick the appropriate box)

YES ☐ **NO** ☐ **NOT KNOWN** ☐

Please provide a brief description of the incident including the date that it occurred ----------

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Have you taken any action following the incident? If yes, please provide brief details below. ----------

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Please return the completed proforma to the Morecambe Bay Investigation at the following address:

Morecambe Bay Investigation, 3rd Floor, Park Hotel, East Cliff Complex, Preston, PR1 3EA
Email: correspondence@mbinvestigation.org

Key Questions Relating to the Investigation's Terms of Reference

(1) **To review clinical outcomes between January 2004 and June 2013**

Key Questions:

A. Is there evidence of substandard care in maternity and neonatal services during the review period? For example:
   - Was the Trust a national outlier at any point during the review period for:
     - maternal mortality
     - intrapartum stillbirth
     - early neonatal deaths (within 7 days)
     - neonatal deaths (up to 28 days) from sepsis
   - Was mortality at the Trust higher than expected for particular causes of maternal/neonatal death (Panel to advise on which causes of death are most relevant to substandard care)?
   - Was the Trust a national outlier at any point during the review period for other measures of substandard care not relating to mortality, for example:
     - Maternal complications e.g. admissions to intensive care; postpartum haemorrhage; VTE; readmission to hospital within 30 days
     - Neonatal complications e.g. injury to neonate; Apgar score <7 at 5 minutes; term babies admitted to neonatal care; readmission to hospital within 30 days
     - Long-term complications associated with birth trauma e.g. patterns of hospital readmission related to hypoxic brain injury (Panel to advise on other long-term complications that are relevant to substandard care)
     - Infections e.g. MRSA, C-Difficile
     - Panel to suggest other measures of substandard care

B. If there is evidence of substandard care, does it relate to healthcare systems (strategic, commissioning, operational, clinical) and/or to specific management or clinical teams and/or to specific individuals?

Panel to suggest additional, relevant key questions under this ToR

(2) **To review the Trust Board's actions and governance procedures, and the relationship and communication between the Trust and patients and families, and other agencies**

Key Questions:

A. Is there evidence that the Trust's governance structures and procedures were inadequate during the period of the review?
B. Is there evidence that the claims of substandard care by the families were inadequately investigated by the Trust?

C. Is there evidence of a lack of transparency and honesty by the Trust when communicating with patients and their families?
D. Is there evidence that the Trust failed to communicate adequately with the SHA, CQC, Monitor, Coroner and Police?
E. Is there evidence that the Trust has changed its governance procedures to address shortfalls identified in earlier reports?

Panel to suggest additional, relevant key questions under this ToR

(3) **To review the Trust Board's responses to previous reports, and action taken as a result**

Key Questions:

A. Is there evidence that the Trust has responded effectively to restore public confidence in the quality of maternity and neonatal services?
B. Has the Trust responded adequately to recommendations in previous reports that have been published during the review period?
C. Do action plans reflect national clinical standards for maternity and neonatal care?
D. Is there evidence that workforce issues including capacity, training, performance assessment, and discipline have been addressed?
E. Are implementation plans complete or progressing appropriately to meet clinical standards and to ensure patient safety?

Panel to suggest additional, relevant key questions under this ToR

(4) **To make findings as to the adequacy of actions taken by the Trust to mitigate safety concerns**

Key Questions:

A. Will the actions that have been taken by the Trust ensure that national clinical standards for maternity and neonatal care will be met?
B. Are there governance processes and procedures in place that will assure
C. Commissioners, Boards and the general public that these standards will be maintained?
D. Are there processes in place to ensure that patients and families will be treated with trust and respect and that all communications will be transparent and honest?

Panel to suggest additional relevant key questions under this ToR

(5) To assess the Trust's ability to discharge its duties in delivering maternity services

Key Questions:

A. Does the Investigation have access to and\or knowledge of those changes that have been introduced either within the Trust or across to NHS to address the shortfalls it has identified through ToR 1 and 2?
B. Does the Investigation need to establish what the Trusts and its regulators minimum statutory and professional obligations are when delivering maternity services?

Panel to suggest additional, relevant questions under this ToR

(6) 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.

Key Questions:

A. Does the Investigation need to establish what, if any, relevant recommendations have been made in recently published reports eg. Francis Report and those Reports referred to in the terms of reference, and what action, if any, has been taken by: the Trust and its professional, regulatory and management authorities?

B. Does the Investigation need to be aware of constraints on any of the regulatory bodies that will impact on their ability to implement recommendations eg. the NMC is a four country regulator and requires the co-operation of governments in Wales, Scotland and N Ireland to implement change?

Panel to suggest additional, relevant questions under this ToR

Potential Sources of Data for the Morecambe Bay Maternal and Neonatal Services Investigation

The Morecambe Bay Maternal and Neonatal Services Investigation may wish to explore access to the following sources of data in relation to Term of Reference 1:

> *'To review the outcomes for mothers and babies that occurred during this time [between 1 January 2004 and 30 June 2013], including maternal and neonatal deaths that occurred in the Trust and in any other institutions to which patients were transferred'.*

1. **Hospital Episode Statistics (HES)**
   - HES is a record of all hospital admissions within the English NHS since 1989/90.
   - Each record contains information about the patient, their episode of care, and any diagnoses or procedures during that episode.
   - Hospital episodes that result in the delivery of a baby also capture supplementary variables (e.g. method of delivery; gestational age; birth weight) in the HES 'maternity tail'.
   - A unique identifier enables tracking of patients between hospitals.
   - HES includes deaths that occurred within hospital, and can be linked with the ONS death register to identify deaths that occurred after hospital discharge.
   - HES data could be used to review certain outcomes[1] for mothers and babies at the Trust and compare rates of these outcomes with other Trusts in the region / similar Trusts in England.
   - HES data is available at patient level which allows risk adjustment models to be developed to take patient case mix into account.

2. **Extract(s) from the Trust's electronic maternity record system (if available)**
   - Maternity Information Systems (MIS) are now used in the majority of maternity units to capture detailed demographic and clinical information related to each pregnancy and delivery under their care.
   - MIS data tends to be more detailed and more reliable than HES data.[2]
   - A list of questions regarding the use of MIS by the Trust during the period of investigation has been sent to the current Head of Midwifery in order to determine what data is captured electronically.

3. **Copies of the Trust's Maternity dashboard (if available)**
   - Dashboards serve as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance on the ground.
   - The use of maternity dashboards was recommended by the Chief Medical Officer in 2008.
   - We are exploring the use of maternity dashboards within the Trust during the period of investigation with the current Clinical Director and Head of Midwifery.

4. **Comparative benchmarking information based on HES (if available)**
   - Some Trusts purchase comparative benchmarking information from organisations such as Dr Foster Intelligence and CHKS. These companies provide comparative information on processes and outcomes of care, based on data submitted to HES.
   - We are exploring the use of benchmarking information within the Trust during the period of investigation with the current Clinical Director and Head of Midwifery.

[1] Including complications such as emergency caesarean section; unplanned readmission within X days of birth/delivery; third and fourth degree perineal tears; infection rates; injury to neonate. Note that data quality is not uniform among trusts.

[2] For example. variables such as Apgar score at 1 and 5 minutes tend to be mandatory.

- The Dr Foster Unit at Imperial College London (not to be confused with Dr Foster Intelligence - the commercial arm) also conducts analysis of routine HES data and notifies Trusts in confidence if they are mortality outliers.
- In 2013, the Royal College of Obstetricians and Gynaecologists (RCOG) developed a suite of performance indicators for all maternity units in England (based on 2011/12 HES data) and fed results back to trusts in confidence.

5. PEER database

- Administered by the Perinatal Institute (formerly the West Midlands Perinatal Institute)
- The PEER database holds detailed clinical data[3] on over 150,000 maternities in the West Midlands between 2009 and 2012.
- If available to the Investigation, this data could be used to investigate and/or compare rates of particular outcomes at the Trust with outcomes at other Trusts within the region.

6. RCOG Maternity Information Systems (MIS) Database

- This is a project being undertaken by the RCOG to collect detailed clinical information on maternity care, including maternal and neonatal outcomes, from 15 Trusts across the UK and link it to HES maternity data.
- The database will contain data on 100,000 deliveries that took place between April 2012 and March 2013.
- This is an alternative source of detailed, patient-level data for comparison of clinical outcomes among Trusts.
- The database is anticipated to be ready in early 2014.

7. Confidential Enquiries:

Centre for Maternal and Child Enquiries (CMACE)

- CMACE, and its predecessor, CEMACH, had been conducting national maternal confidential enquiries and perinatal mortality surveillance since 1 April 2003.
- CMACE was decommissioned in April 2011 when the contract for the national confidential enquiries maternal and newborn programme of work was awarded to the National Perinatal Epidemiology Unit (NPEU).
- If available to the Investigation, this data could be used to identify whether the Trust was a national outlier for maternal or perinatal mortality at any point during the period being investigated.

Maternal Deaths

- It is a government requirement that all maternal deaths should be subject to Confidential Enquiry, and all health professionals have a duty to provide the information required. In participating in a Maternal Death Enquiry, professionals are asked:
  i. To provide a full and accurate account of the circumstances leading to the woman's death, with supporting records.
  ii. To reflect on any clinical or other lessons that have been learned, either personally or as part of the wider context.
- Triennial reports were produced. The last report, published in 2011, contained data for 2006-08.

Perinatal Deaths

- CMACE also collected epidemiological and clinical data on all stillbirths and neonatal deaths in England, Wales and Northern Ireland.

[3] Over 100 data items per delivery.

- CMACE introduced annual national perinatal mortality reporting in addition to reporting to individual NHS Trusts, Strategic Health Authorities, Neonatal Networks and Primary Care Trusts. This allowed health care providers, commissioners and policy makers to benchmark themselves against national performance indicators and other organisations. The Trust should have retained copies of these reports.
- The last report, published in 2011, contained data for 2009.

Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)

- In June 2012, MBRRACE-UK was appointed by the Health Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths
- MBRRACE-UK is a collaboration between the NPEU and the universities of Leicester, Liverpool and Birmingham, University College London, Imperial College London, the stillbirth and neonatal death charity Sands and an Oxford-based GP.
- Data collection began again in January 2013. This means that no data was collected for maternal deaths that occurred in 2009-2012 and for perinatal deaths in 2010-2012.
- MBRRACE have retrospectively collected data on 85% of maternal deaths from 2009-2012 and will attempt to collect data on perinatal deaths in 2012. The first report is planned for Autumn 2014.

8. **National Neonatal Audit Programme (NNAP)**
   - NNAP was established in January 2006 and is currently commissioned by the Healthcare Quality Improvement Partnership (HQIP).
   - The audit addresses eleven questions and collects data on every baby admitted to a neonatal unit. From October 2008 units are named in all NNAP reports.
   - NNAP now covers 97% of English and Welsh neonatal units.

9. **National Reporting and Learning Service (NRLS)**
   - This is a database of NHS patient safety incidents reported by Trusts to the National Patient Safety Agency since 2004. In April 2013, the NRLS function transferred to NHS England.
   - A set of codes specifically relating to maternity and neonatal risks has now been introduced. These codes cover patient safety incidents as well as risks that are not necessarily preventable e.g. unexplained stillbirth. Is it unclear how many Trusts are now submitting these new codes.

   Never Events
   - This is a specific category of patient safety incident. Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
   - There are currently 25 such events, including 'in-hospital maternal death from post-partum haemorrhage after elective caesarean section' and 'retained foreign object post operation' (of which vaginal swabs are the most commonly retained object).
   - These incidents have been recorded since 2010.
   - When a never event occurs, providers should report it to their commissioners and the NRLS. Since the summer, reports should also be made to the Strategic Executive Information System.
   - Commissioners should publish the numbers and types of "never events" that have been reported to them on an annual basis.
   - Providers should also report never events directly to the Care Quality Commission as part of their existing requirements to report Serious Untoward Incidents.

10. NHS Litigation Authority (NHSLA)

- Maternity payments accounted for a third of total clinical negligence payments in 2012-13.
- The NHSLA administer a database of claims made by patients/families against NHS.
- Uncertain of precise content, but likely contains a detailed report of each maternity and neonatal claim.

11. Maternity service user experience survey

- This survey was conducted by the Healthcare Commission in 2007, and by the CQC in 2010 and 2013.
- It asks a sample of approximately 25,000 women who have given birth about their experiences of antenatal care, labour and birth, and postnatal care.
- Trust level data is published on the CQC website.
- The 2013 results are anticipated December 2013.

12. North Western Perinatal Survey Unit

- Based at St Mary's Hospital, Manchester
- This unit produced a series of annual reports containing regional statistics on maternal outcomes and perinatal mortality.
- Ceased to function in 2010 due to funding cuts and is no longer active.

PAPER FOR THE PANEL MEETING, 11 DECEMBER 2013

EVIDENCE FROM AFFECTED FAMILIES

At its first meeting, the panel heard from 7 families, and we hope to hear from a further two at the forthcoming panel meeting. The accounts that they gave were both moving and compelling, and raised clear matters for the panel to address, including:

- non-compliance with clinical protocols and national guidelines;
- frequent occurrence of intrapartum failures of care;
- professional behaviour and competence;
- professional relationships within the unit;
- incident and risk reporting;
- clinical governance; and
- organisational culture and learning.

We were particularly concerned to hear that five episodes that included a maternal death, two intrapartum stillbirths, two neonatal deaths and hypoxic brain injury were apparently not reported as serious untoward incidents (SUIs). This raises significant questions over the proper investigation of these incidents and the action taken to prevent recurrence and to learn from these events.

There have been various external reviews, some clinically led and some recent, including the Gold Command exercise last year specifically to address the question of current clinical risk in the unit. It is important that we do not seek to replicate those initiatives, nor risk stifling improvement work only just beginning to take root in the Trust. In response to the concerns that these accounts have raised, however, we do need to consider now how best to take a measured approach to assessing both what has happened and how the Trust has responded.

Six potential areas of evidence seem particularly relevant. Each is considered briefly below. ***Panel members are asked to consider whether, in light of these concerns, we should focus on giving these early attention, and whether others should be considered.***

(1) Previous clinical case reviews

This would comprise any\all reviews of clinical cases that took place either internally or by external bodies (particularly relevant in cases where there are no SUI reports to examine) and any\all actions that arose out of those reviews.

The Investigation needs to establish if, based on the number of events reported to it, the Trust (Furness General Hospital) is an outlier in relation to numbers of

intrapartum stillbirths and early neonatal deaths and injury due to intrapartum issues.

Background:

Catherine Calderwood advises that data is not collected separately for intrapartum stillbirths. Generally it is expected that intrapartum stillbirths would be around 7% of all stillbirths (overall stillbirth rate > 24 weeks gestation is 1 in 200) and would therefore expect an intrapartum stillbirth rate of approximately 1 in 3000 births. Furness General Hospital delivers approximately 1200 babies per year and women/babies at the highest risk are transferred to other hospitals if higher level neonatal care might be required for example. We might therefore expect an intrapartum stillbirth once every 3 years or less. It is recognised that due to low numbers it may be difficult to establish whether this hospital is an outlier.

MBRRACE-UK (the current provider of the new confidential enquiry data into maternal and perinatal deaths) have been asked, informally at this stage, to examine the legacy data they have from CMACE perinatal mortality report and the data collected since 2009. This will be provided in basic form initially for the panel on Wednesday. Data submitted to the new MBRRACE process will also be supplied to Catherine. MBRRACE has informed Catherine that the Trust will have been sent Trust-specific data and the funnel plots that are produced by the CMACE process. The Investigation could request the Trusts process for and response to these reports.

(2) New clinical case reviews

The Investigation might require a more detailed examination\review of case notes to establish its own position. In order to best investigate the quality of care provided by the Trust, all maternal deaths, intrapartum stillbirths and early neonatal (within 7 days) deaths could be examined in detail and all neonatal (up to 28 days) deaths from sepsis.

Background

Our initial expectation was that the panel would conduct case reviews, and panel members have been selected with this in mind, and to provide the necessary range of expertise and experience. Such reviews have been carried out confidentially elsewhere by external contractors, some of whom have considerable experience and use an established methodology. There would however be significant risks to delegating part of the panel's perceived core role, not least from families who have expressed confidence in the investigation and from the Secretary of State who is expecting the investigation to undertake this work. It would also raise difficulties and delay over anonymisation of records.

An option for consideration is to seek an early meeting with established reviewers to learn about their preferred methodology and apply that to any reviews the panel might undertake of cases. In light of what we hear, the panel

various data reporting exercises, including MBRRACE, ONS and regional returns.

There is evidence that Trusts which are poor at complying with data reporting requirements, for instance submitting late, incomplete and/or inaccurate returns, are more likely to be poor performers clinically.

(6) Current litigation

As a result of a Freedom of Information request made by James Titcombe, we are aware that there are currently 34 open claims in obstetrics from the Trust with the NHSLA. We could seek to establish from the NHSLA greater detail about these claims.

There are significant legal obstacles to overcome in using information derived from litigation that has not yet concluded, and it is not clear what, if anything, the NHSLA would feel able to release. Subject to appropriate legal advice, however, we could ask the question.

will be able to take an informed view of the best way to proceed and to provide the necessary support to panel members to carry out reviews effectively without an unduly onerous burden.

(3) Early interview of current key staff

We might consider conducting early interviews with key clinical staff to establish how the unit is currently functioning and the way that changes have been introduced to ensure that the service is safe and effective. We would need to establish carefully which staff interviews should be brought forward in this way, but the clinical lead for obstetrics and the Medical Director might be early candidates and the investigation could interview them again later should this be necessary.

The principal disadvantage would be that we would be conducting these early interviews with less than full knowledge and understanding of what has happened in the past, and therefore what are the key changes the investigation might consider need to be recommended to prevent recurrence.

Another option for consideration would be if a sub group of the panel were to visit early in the New Year the unit at Barrow to familiarise themselves with the layout of the maternity unit, meet key clinical and establish whether changes have been put in place and how the unit appears to function. As well as establishing the context for the evidence heard from the families and forthcoming interviews, this would send a positive message to the Trust and the clinical staff that the investigation wants to establish the current position in order to meet term of reference 5.

(4) CNST applications and assessments

We could establish at what level the Trust has applied for the Clinical Negligence Scheme for Trusts (CNST) operated by the NHS Litigation Authority (NHSLA) for the period 1 January to 2004 – 30 June 2013, and what the results were. The CNST offers three levels of discount to Trusts on their contributions to the scheme depending on the extent to which they can demonstrate risk management systems and results (there is a separate assessment for maternity services).

This would provide evidence on the confidence that the Trust had in its own processes over the period and the extent to which this was borne out by NHSLA assessments. It is well recognised, however, that Trusts take a commercial view of this, and are apt not to risk applying for a higher level for fear of losing all of their discount if they fail to meet the requirements. The Panel may wish to discuss whether, in light of the changes to the CNST that will be introduced soon whether this is a good use of the investigation's time?

(5) Trust compliance with data reporting requirements

We could take steps to establish the method, pattern, level of detail and response rate with which the Trust co-ordinates and submits responses to

CONSIDERATION OF SUBMISSIONS TO THE INVESTIGATION – RELEVANCE TO THE INVESTIGATION'S TERMS OF REFERENCE

Background

The Investigation has been contacted by individuals raising their concerns and complaints about the standard of care they have received both at the Trust and elsewhere in the NHS.

In addition the Investigation has also received an offer of assistance from a retired clinician and, positively, been asked if a member of the public (who experienced poor care at the Trust and also who was previously employed there) asking if she can contribute her suggestions on how the standard of care can be approved.

It is anticipated that additional communications will be received by the Investigation.

It would be helpful if the Panel would discuss the proposed approach the Secretariat should adopt to handling such submissions in order to develop a standard approach and, when necessary, protect anonymity.

Proposed approach

Submissions are received by the Investigation (via e-mail, telephone or in writing).

Submissions are acknowledged.

When appropriate, individuals are asked to provide additional background information using the template proforma (see MBIPM 2.8) or by telephone if more appropriate.

Completed proforma is considered by the Deputy Secretary to the Investigation or the Investigation's Documents and Evidence Manager to establish whether the matter raised falls within the Investigations terms of reference.

If not, a response is sent from the Investigation Secretary explaining the limitations placed upon the Investigation but providing them with the current details of who\which regulator is best placed to respond to their query\complaint.

If the matter raised does fall within the Investigation's terms of reference, details of the query\complaint will be anonymised and placed on Huddle for review by the Panel.

The Secretariat will establish in writing, or by telephone if appropriate to do so, whether the individual wishes their name, or the name of the patient, to remain anonymous. This exercise will be repeated before the Investigation Report is finalised.

If no anonymity is sought, the details on Huddle will be replaced with comprehensive details.

In cases where professional services have been proffered, the Secretary will discuss the communication with the Investigation Chairman and an appropriate response will be issued.

A summary of all "ad hoc" communications (anonymised and open) to the Investigation, and the responses issued to date\that month will be prepared for review at each Panel Meeting commencing in January 2014.

FUTURE WORK PROGRAMME\TIMETABLE

Panel Meetings in 2014

Wednesday 15 January or Thursday 16 January (TBC)

Thursday 13 February

Wednesday 5 March or Friday 7 March (TBC)

Wednesday 2 April or Thursday 3 April (TBC)

Thursday 8 May

Thursday 12 June

Thursday 10 July

Draft timetable

2013

December	Determine key questions from the terms of reference
	Commission evidence
	Finalise approach to the Investigation

2014

January	Receive evidence, load onto evidence database and commence detailed consideration
	Consider draft framework for Report
February	Consideration of evidence ongoing
	Identification of key witnesses
	Commence drafting of Report (explanatory and process definition chapters)

March	Consideration of evidence ongoing
	Identification of witnesses
	Report writing ongoing
	Commence interviewing witnesses and hearing oral evidence
April	Consideration of evidence ongoing
	Interviewing of witnesses\hearing oral evidence
	Report writing ongoing
May	Consideration of evidence ongoing
	Interviewing of witnesses\hearing oral evidence
	Report writing ongoing
June	Report writing ongoing
July	Report writing ongoing
	Proof reading of draft Report
August	Report finalised and shared with families and interested parties
September	Report published.