1
2 **MS BROWN: Thursday, 26 September 2024**
3 **(10.00 am)**
4 **LADY JUSTICE THIRLWALL:** Good morning. As many of
5 you will be aware already, since we last sat in the
6 Council chamber we have heard a great deal of evidence
7 from a large number of parents in person, online or
8 read, and transcripts of live evidence and many of the
9 detailed statements are on the website already. Those
10 from yesterday will be available very soon.
11 I repeat my profound thanks on behalf of the
12 Inquiry to all parents who have contributed either with
13 evidence or supporting the person giving evidence and
14 that concludes the evidence in respect of Part A of this
15 Inquiry.
16 This morning we are moving to two days of evidence
17 in respect of the broader NHS. It comes from
18 Professor Mary Dixon-Woods, Dr Joanna Garstang and on
19 Monday, Sir Robert Francis. None of them has been asked
20 to comment on or consider the facts of this case because
21 obviously the evidence has only just begun.
22 The reason we are hearing from these witnesses now,
23 immediately after the evidence of the parents, is to
24 inform the Inquiry about the systems and processes that
25 were in place at the material time and the studies that

1 have been done into how people behave. It is to examine
2 the historical context and to provide a backdrop to the
3 evidence in respect of Part B, which will begin with
4 evidence from some of the doctors on Tuesday of next
5 week. In due course I will consider it, all of that
6 evidence, in the context of the facts of Part B and of
7 course when considering Part C.
8 Ms Langdale.
9 **MS LANGDALE:** Thank you. May I call the witness.
10 **PROFESSOR MARY DIXON-WOODS (affirmed)**
11 **Questioned by MS LANGDALE**
12 **MS LANGDALE:** Please do sit down. Can you give us
13 your name and qualifications?
14 **A.** Hello there. I'm Mary Dixon-Woods and I'm
15 Professor of Healthcare Improvement Studies at the
16 University of Cambridge. My qualifications include
17 a PhD.
18 **Q.** I'm going to ask Professor Woods that we put
19 on screen pages 2 and 3 of your CV -- not of your
20 report, of your CV -- and we see you currently work at
21 the THIS Institute. Can you tell us something about
22 that work?
23 **A.** Thank you. THIS Institute, it stands for The
24 Healthcare Improvements Studies Institute. It's
25 a centre at the University of Cambridge funded by The

1 Health Foundation which is an independent charitable
2 organisation and its mission is to build the evidence
3 base for how to improve patient safety and quality of
4 care.
5 **Q.** And what's the staffing, how big is it?
6 **A.** We have a team of about 60 people who study
7 how to improve quality and safety and to communicate
8 about it.
9 **Q.** And I think you have done work on the duty of
10 candour in that institute?
11 **A.** Yes. We have studied duty of candour,
12 speaking up, openness policies and influences on what is
13 called employee voice.
14 **Q.** And you have various appointments of
15 distinction set out on page 2 and you are qualified to
16 comment in an up-to-date sense on patient safety issues
17 and research in this area?
18 **A.** I believe I am qualified to comment in this
19 area, yes, thank you.
20 **Q.** As the Chair has already said, you haven't
21 been asked to comment on the facts or background to this
22 Inquiry, but you have provided a lengthy report which
23 has been available to core participants and their
24 representatives since August and is now available on the
25 website publicly, as I understand it. Can you confirm

1 the contents of that report are true and accurate as far
2 as you are concerned?
3 **A.** I can confirm the contents of that report are
4 true and accurate as far as I know.
5 **Q.** I'm going to dip into parts of that report
6 today, Professor Dixon-Woods, and ask you to comment on
7 it, or to set out and expand on some of the things you
8 say within it, but at the outset may I say thank you for
9 providing this report and the detail contained within
10 it.
11 If we go first of all to page 8 of the report.
12 **A.** Sure, I would like to say at the outset --
13 I would like to express my profound sympathies for The
14 Families for the terrible suffering they have endured.
15 **Q.** Professor, you set out at page 8 of your
16 report and earlier the concept of the bad apple problem
17 and the dangers of not recognising bad apples exist.
18 Can you expand on the concept and what you say the
19 dangers are and also the case illustrations that you
20 rely on there to demonstrate the issue?
21 **A.** Thank you. The modern patient safety
22 movement, which is to say the study of patient safety
23 and the attempts to improve it systematically can
24 probably be dated to about 25 years ago and much of the
25 learning from that time was based on the principle that

1 patient safety incidents and accidents arise from error,
2 unintended behaviours, unintended actions, and that the
3 correct approach to addressing patient safety would be
4 to design better systems. That's absolutely correct.
5 If you persist in blaming people for things that
6 are actually defects in the systems, then you're
7 unlikely to solve the problem and an example would be
8 something like overdoses that are accidently given. You
9 want to design a system that essentially prevents people
10 from -- or inhibits people from doing that.
11 One of the challenges of operating what's called
12 a no blame approach in order to improve systems is that
13 you may inadvertently fail to identify another threat to
14 patient safety, which is the bad apple problem. Bad
15 apples are people who demonstrate grossly incompetent or
16 substandard clinical practice but nonetheless persist.
17 They demonstrate unacceptable behaviours, which might
18 include things like abuse, bullying, racism or
19 disrespectful or negligent care, or what I call
20 transgressive behaviours, behaviours that are so
21 transgressive they reach the threshold for criminality
22 and that might include murder, assault, rape and other
23 violations.
24 An analysis I did published in 2010 focused
25 specifically on doctors and a series of cases that had

1 arisen throughout the 2000s, including the Harold
2 Shipman case, which I can speak about if of interest,
3 and the analogy that is often used in-patient safety is
4 the "Swiss cheese model", that an incident may occur if
5 the kind of holes that are meant to -- a number of holes
6 line up so the barriers that prevent an incident
7 happening essentially align, but what was shown was that
8 Shipman essentially like a snake managed to wriggle
9 through the holes and was able to commit his terrible
10 actions.
11 The challenge of not identifying a bad apple was
12 also illustrated by the Beverley Allitt case and I can
13 say more about that, if of interest.
14 **Q.** Yes, say more about the Allitt case.
15 **A.** The Allitt case involved a State Enrolled
16 Nurse at Grantham in Lincolnshire and she committed
17 a series of murders over actually about a three-month
18 period and it was initially the -- the series of
19 incidents was initially attributed to poor staffing, to
20 other challenges on the ward including poor estates and
21 so on, and the doctor who began to suspect it was in
22 fact Allitt who was responsible for the incidents was
23 initially treated as having fanciful ideas and was not
24 treated seriously. Partly this was because there wasn't
25 a recognition that bad apple behaviour can sometimes be

1 the source of problems and because there wasn't a very
2 clear procedure for dealing with it. It wasn't until
3 a group of doctors at the Queens Medical Centre in
4 Nottingham who were receiving a very high number of
5 cases from Grantham raised the alarm and spoke to their
6 Head of Department, who then called the doctor at
7 Grantham, that the action was finally taken.
8 **Q.** One of the recommendations you refer to in
9 your report from the Clothier Inquiry that investigated
10 events at Grantham was this: the main lesson that the
11 Grantham disaster should serve is to heighten awareness
12 in all those caring for children of the possibility of
13 a malevolent intervention as a cause of unexplained
14 clinical events. That was the recommendation and we
15 will be investigating in this Inquiry whether and to
16 what extent there was learning from that, but from your
17 perspective how can that be achieved to heighten
18 awareness?
19 **A.** I think the key thing is that we recognise
20 some of the human behaviour that's involved in
21 identifying what may be a very unusual pattern of
22 events. I can speak about that. The second thing is
23 that there is a procedure for dealing with it. I think
24 our procedures for dealing with these kinds of very
25 transgressive, unusual incidents have remained

1 underdeveloped in the NHS and we know from other areas,
2 like fraud or sexual abuse, unless you've got the
3 procedures in place it's very difficult for
4 organisations to deal with them. I think there is
5 an absence of clarity about what you do in -- confronted
6 with an unexpected series of highly transgressive
7 events, particularly in those caring for children.
8 **Q.** What are you speaking of there when you say
9 "procedures"? Do you mean referral procedures,
10 employment procedures, picking things up? Which type of
11 procedures?
12 **A.** A procedure that you would follow in this
13 event. If somebody is suspected of fraud, there is
14 a series of steps that the organisation knows what to
15 take. I'm not sure that the same clarity is there in an
16 event that somebody is suspected of murder, for example,
17 or attempted murder, so what may happen is that patient
18 safety incidents are handled through patient safety
19 incident processes, they are entirely separate from
20 issues -- or not entirely separate, but effectively are
21 sequestered from issues to do with discipline and HR
22 issues, so may enter a different process which remains
23 confidential and those two systems don't necessarily
24 handle very well issues of highly transgressive
25 behaviour.

1 **Q.** You articulated in that answer when people are
2 suspected of murder or attempted murder. How easy is it
3 to voice those concerns in the way that you have just
4 expressed them?
5 **A.** It is extremely difficult. We have done
6 a large number of studies about the influences on
7 speaking up and speaking out. There is a very large
8 academic literature on employee voice and it is
9 typically difficult to articulate concerns about
10 individuals, as compared with articulating concerns with
11 systems. When a concern about somebody behaving in
12 a particularly transgressive way is identified by
13 somebody, they may be met with what's called the
14 "credibility gap" which was identified in the Shipman
15 Inquiry and they may struggle to be heard or to progress
16 the concern.
17 **Q.** What's a credibility gap?
18 **A.** The credibility gap is -- typically appears
19 when the issue at hand is so extraordinarily egregious
20 that it is difficult to believe that somebody could have
21 committed it and in the Shipman Inquiry the -- this
22 arose when Dr Linda Reynolds, who was a GP in a surgery
23 neighbouring Shipman's, became concerned at what she saw
24 as an excess of deaths in his practice. She was
25 sufficiently concerned that she went to the Coroner

1 to -- she went -- she reported it and the police
2 investigation that followed was essentially incompetent
3 because it did not consider the possibility that Shipman
4 might be murdering his patients and we see similar
5 challenges in other Inquiries which include the
6 inquiries, for example, into Jimmy Savile and other
7 cases where there is something so extraordinarily
8 egregious that it is at first met with essentially
9 a lack of credulity.
10 **Q.** So the credibility gap in your view impacts
11 both on the people who might be witnessing something
12 that doesn't feel right, and also the people responding
13 to that?
14 **A.** Yes, the credibility gap has generally been
15 used to describe the response when somebody first raises
16 the issue.
17 **Q.** On page 9 of your report, paragraph 2.2.1, you
18 deal with the certainty that something is wrong and is
19 an occasion for voice and you say:
20 "Some situations are easily and straightforwardly
21 recognised as sources of concern, for example where
22 there is unequivocal risk or harm or when an egregious
23 injury or violation has already taken place. But many
24 others are fraught with ambiguity. Possible
25 opportunities to speak are more complicated when they

1 relate to an emerging or established pattern rather than
2 to a specific, easily defined incident. Such patterns
3 may lead to a generalised sense that things are 'not
4 right', even though each individual incident or signal
5 may be minor."
6 I just want to ask you about that, the sense that
7 things are not right. We have already heard evidence
8 from parents where their babies died or collapsed, it
9 just didn't feel right, their babies were well, stable,
10 they didn't understand what happened. They didn't know
11 what happened then but it didn't feel right. How does
12 that issue impact on this? What should somebody do when
13 something doesn't feel right?
14 **A.** This is a very challenging problem to deal
15 with. Organisational systems are set up so they tend to
16 deal with things incident by incident. It may be
17 difficult to convert something that is an intuitive
18 sense or an unease into something that an organisation
19 can actually handle. There may not be the -- what we
20 sometimes call the sensors available to listen to that
21 and --
22 **Q.** What does that mean, sorry, the sensors
23 available --
24 **A.** Sensors, so we often talk about
25 problem-sensing behaviours, which you see in highly

1 functioning organisations. They are alert to possible
2 signs that something might be going wrong, they are
3 actively seeking information and the metaphor is that
4 they have their sensors turned on, they may have
5 multiple different sensors, they may be listening to
6 signals of soft intelligence, which may come in the form
7 of conversations, it might come in the form of talking
8 to patients, talking to staff on the wards, as well as
9 taking in data streams from hard data which may come
10 from clinical audits and other sources.
11 So it is very, very difficult to deal with those
12 more inchoate less well formed senses that something is
13 not right and I'm not sure I have a quick solution for
14 it, but one of the things you would see in a high
15 performing organisation is they have that sensor turned
16 on and they begin to look at other sources of data, they
17 will triangulate it, they will look at are there other
18 things happening in this situation, do we have a -- are
19 we having under-reporting of incidents, are we having
20 misclassification of incidents, are we having data from
21 external sources that is giving us some sense of there's
22 something else going on here.
23 **Q.** Over the page at page 10, at the end of the
24 top paragraph, you say:
25 "Concerns related to behaviour or conduct are often

1 seen as potentially harder to judge and more
2 discomfiting to evidence and to articulate."
3 In a healthcare setting, again probably not
4 a straightforward answer, but how can that be achieved
5 if there is an uncomfortable situation or a sense of
6 unease in any department, ward, risk assessment? How
7 can that be tackled?
8 **A.** Those issues where you've got some amalgam of
9 poor systems and poor behaviour are typically extremely
10 difficult to handle at the moment because they get
11 channeled through different processes, different
12 departments, different procedures of -- for example,
13 a complaints handling process from patients may not have
14 very much to do with an HR process that applies to
15 a staff member. There may be other data coming in from
16 clinical audits and so on. They don't necessarily get
17 synthesised very easily into a single picture and
18 I think that's probably what needs to happen.
19 If we return to the issue of bad apples I think
20 that's particularly poorly developed, what happens when
21 there's a concern that there may be some transgressive
22 behaviour at hand here. It can be very, very difficult
23 for somebody to raise that issue because they will be
24 readily identifiable very often as the source of the
25 concern. It may be difficult to investigate. People

1 may be reluctant to come forward. There may be all
2 kinds of challenges with taking this forward.
3 **Q.** You deal with it later -- and we will come to
4 it later -- when you address HR issues, but you raise
5 the issue of confidentiality complicating this, so if
6 there were concerns about transgressive behaviour that
7 need investigating how can that be adequately addressed
8 if there's such a tight confidentiality ring?
9 **A.** I think it's very, very difficult to address
10 in the present legal environment that applies to HR
11 issues because they are governed by processes that are
12 designed for employment in general and not for dealing
13 with patient safety issues, so Trusts are beholden to
14 that set of laws and requirements when something has
15 entered into an HR process and, as we saw from, say,
16 East Kent, the investigation there was very clear that
17 the HR processes essentially deferred dealing
18 effectively with what was a very poor culture and a poor
19 environment on the maternity units there.
20 **Q.** Can you just succinctly summarise for us what
21 that issue was?
22 **A.** The issues there were egregious bullying, poor
23 behaviour towards colleagues, poor behaviour towards
24 patients, poor behaviour in relation to professional
25 responsibilities, so, for example, Consultants not

1 coming in even when they were on call, leaving doctors
2 who were inexperienced on their own on the ward to
3 handle complex situations, racism, other forms of
4 discriminatory behaviour and when a Head of Midwifery
5 attempted to deal with the situation, a collective
6 grievance was taken out by the staff on the ward and
7 the Head of Midwifery ended up leaving because she was
8 advised it would be -- that essentially her position was
9 untenable, so that situation ended up being unaddressed
10 for several more years.
11 If we come back to HR issues, again I can talk
12 about it, but issues that are cultural in character are
13 very, very difficult to deal with because HR processes
14 are set up to deal with one individual at a time.
15 If you have bad apple behaviour it may be difficult
16 to parse out which particular individual is responsible
17 and you may have a cluster of bad apples in a particular
18 situation. One bad apple we know from the research
19 literature tends to have a very bad effect on the whole
20 group, when they -- when you get a kind of cluster
21 together, it's really very adverse.
22 **Q.** Tell us more about that, the bad apple effect
23 on those in the barrel, when it is transgressive
24 behaviour?
25 **A.** The bad apple effect has been studied

1 extensively by psychologists who have done experiments
2 where they have done things like put somebody into
3 a group situation and they have been briefed to behave
4 badly in particular ways. An example might be that they
5 basically withhold their labour, so they let others do
6 all the work and they sit back, but another example
7 might be being very hostile or aggressive towards
8 others, and when you do those experiments you see that
9 the teams that have a bad apple in them perform much
10 less well, they express much more anxiety, they
11 demonstrate huge effects in terms of group cohesion and
12 so on. So it's really important to deal with the bad
13 apple problem, but I'm not sure the way the NHS is set
14 up at the moment is able to do that as effectively as it
15 needs to.
16 **Q.** And is your concern in that employment context
17 that there's no patient at the centre, or child
18 safeguarding at the centre?
19 **A.** Once it enters into an employment process
20 there may be concerns to address the issue because it's
21 got a patient safety component, or it's got a child at
22 the centre of it, but it's governed by a whole lot of
23 different processes. The people involved may be
24 supported by their unions and the focus switches to
25 essentially protecting the Trust from legal risk

1 associated with Employment Tribunals or other outcomes
2 of an HR process.
3 **Q.** Further down on the same page, at 2.3, you
4 refer to patient safety and the problem of many hands.
5 What do you mean "The problem of many hands"?
6 **A.** The problem of many hands describes
7 a situation where there is no shortage of actors or
8 agencies or bodies in a situation, but where there's
9 no -- it's very difficult to identify who was
10 responsible and this can happen at a system level, so
11 you have multiple bodies that are intended to supervise
12 or set standards for a particular area, but it's hard to
13 compile all of that information into a single synthetic
14 overview of the area.
15 This was called out -- I'm not sure if that exact
16 term was used, but Sir Robert Francis identified it in
17 his report into the Mid Staffordshire disaster and what
18 was happening there was lots of information about things
19 going very badly wrong, but not compiled into a single
20 picture and not clear whose job it was to take action.
21 You do get something of the same kind of thing happening
22 within organisations itself. As we said earlier, there
23 may be some unease, there may be some concern, but who
24 it is that is responsible for taking action may be less
25 clear.

1 **Q.** And you say, just as you have now:
2 "Healthcare in England is characterised by
3 an exceptional level of institutional complexity. There
4 is no single statute governing healthcare, so services
5 are subject to multiple statutory requirements and
6 sanctions of both a civil and criminal nature."
7 Standing back from it, is there need for that
8 institutional complexity in your view?
9 **A.** The institutional complexity is pretty
10 extreme. Some of it arises from requirements outside of
11 healthcare entirely, for example health and safety
12 legislation, data protection, that's not specific to
13 healthcare. Within healthcare there is institutional
14 complexity because of different legal regimes and
15 different regulatory structures that have set up
16 different bodies.
17 It's hard to say whether we need that level of
18 complexity but what we do need is coordination and
19 coherence and synthetic overviews so that we don't end
20 up losing information and that there's clarity about
21 whose job it is to take action, whose role it is to take
22 action in a particular circumstance.
23 **Q.** How far can the system harmonise regulatory
24 standards or the number and nature of regulators in your
25 view?

1 **A.** That's not a straightforward question to
2 answer because healthcare isn't responsible, for
3 example, for much of the legislation governing
4 employment, so of itself it can't resolve that. I do
5 believe that we need a review and consultation on how
6 employment law works in healthcare situations and other
7 situations where there is a lot of exposure to risk of
8 public harm.
9 When attempts have been made to reduce what were
10 called arm's length bodies they have sometimes stripped
11 out functions that were actually extremely useful at the
12 time and it got lost as they have been absorbed into
13 other bodies, so I would be reluctant to comment
14 specifically on what we could do to rationalise the
15 situation. It clearly does need to be rationalised.
16 Whether that involves reducing the number of bodies or
17 whether it requires some kind of overview to address
18 that issue I'm less clear about, but it would require
19 a programme of review and consultation to come up with
20 the right answer.
21 **Q.** And who would be best placed to do that, to do
22 that rationalisation and overview?
23 **A.** Structurally it's probably the Department of
24 Health but I think it would need a lot of co-design,
25 consultation and review in order to take it forward.

1 **Q.** Do you think the level and the number of
2 organisations and the attendant bureaucracy that comes
3 with that is suffocating for those working in healthcare
4 settings?
5 **A.** What we have in healthcare organisations is
6 a problem we call "priority thickets" which is to say
7 there are so many recommendations, standards, targets,
8 and incentives that they're expected to meet that it
9 becomes very rapidly overwhelming and it crowds out
10 attention to things that may be arising internally or
11 being able to craft their own vision of how the
12 organisation might progress.
13 Those targets, expectations, priorities, come from
14 multiple sources. They are not prioritised. They often
15 aren't even costed. They require a huge amount of work
16 internal to organisations to turn them into operational
17 reality and I think we are -- it is -- we end up
18 essentially creating -- I'm reluctant to use the term
19 "bureaucratic" because actually an awful lot of what's
20 called bureaucracy is essential, it's essential for
21 accountability, it's essential to produce data, so you
22 do need a functioning bureaucracy in order for health
23 systems to operate, but I don't think we are currently
24 running the health system in a way that makes it easy
25 for those running organisations to be absolutely clear

1 about what are the priorities and what they should do
2 first, second and third.
3 **Q.** In your last paragraph on page 11 you say:
4 "Too many organisations with a say in providers'
5 activities may also impose significant costs and
6 inefficiencies."
7 What organisations are you thinking of there?
8 **A.** There are multiple organisations that can
9 issue recommendations, offer suggestions, make
10 requirements to NHS bodies. Sometimes those
11 expectations compete, they conflict, they fail to cohere
12 and they may -- they may make recommendations that
13 require an awful lot of large-scale design that
14 organisations are often ill-equipped to do. So you can
15 get -- without getting into too many names, you can get
16 Care Quality Commission, NHS England, what used to be
17 called Health Education England, which is responsible
18 for training, you can get NHS Resolution. There are
19 multiple bodies operating in the system, probably of the
20 order of about 100, and you have also got bodies like
21 the Health Service Investigation Branch, which has now
22 been renamed, but there are recommendations coming out
23 all the time.
24 I spoke to one person who runs a maternity unit
25 recently and she has 903 actions that she is supposed to

1 be taking forward in her unit. That's not feasible and
2 it's a classic example of priority thickets.
3 **Q.** Culture. We asked you about culture in the
4 NHS and what impacted on it and how you would define it
5 at page 13 of your report. You say at paragraph 3:
6 "A further complexity is that culture is very
7 rarely, if ever, uniform across organisations."
8 Can you help us with that? How is it that you can
9 end up with pockets of a healthcare setting that perform
10 well and have patients at the centre, and other pockets
11 might not?
12 **A.** That's a very, very common finding and it's to
13 do with the way humans behave. Culture is essentially
14 shared ways of doing, thinking, talking, behaving. It's
15 patterned and it is passed essentially down through
16 generations as people are socialised into the way things
17 happen on a particular unit or ward or service line.
18 Culture can also cut across professions. So people may
19 be socialised into a nursing culture, a surgeon culture,
20 an occupational therapist culture, and they have very
21 different ways of doing and saying and thinking about
22 things.
23 Within a single NHS Trust it is extremely common to
24 get what are called cultural mosaics and you may have
25 one part of the hospital that is doing very well, is

1 very serious about patient safety, understands how you
2 do improvement, is very committed, very patient focused
3 and you may have, in fact, a unit right next door that
4 is doing much less well.
5 Some of that comes down to leadership, some of it
6 comes down to the level of support available, some of it
7 comes down to the ability to have difficult
8 conversations, to offer challenge, and a lot of it comes
9 down to basic workplace conditions which are often quite
10 adverse in the NHS.
11 **Q.** You say at the bottom of page 13:
12 "Cultures are powerfully influenced by structural
13 issues, by features of organisational and institutional
14 systems, and by their broader environments (including
15 the budgetary and policy environment, broadly
16 conceived)."
17 Can you expand upon that: so what are the impacts
18 of these various features?
19 **A.** Some of what we're talking about when we're
20 talking about culture is norms, which is to say the
21 normal way of doing things and you can have a norm which
22 is entirely untethered to structural issues, by which
23 I mean things like IT systems, operational systems, the
24 state of the estate, the facilities, the ability to --
25 essentially the work system, design how things get moved

1 from one section to the next. Some of that doesn't work
2 well in the NHS. Many people have to work in
3 circumstances that are not conducive to good behaviour
4 because they have extremely heavy workloads and the work
5 systems -- the structural aspects of their work are
6 hostile essentially to behaving well, so the norms get
7 influenced by that. If there's an expectation you're
8 going to be highly civil to colleagues but you're
9 dealing with a very frustrating environment, you feel
10 that you're not valued, you feel that every step you
11 take involves three steps back in order to get the thing
12 you want done, that norm becomes strongly influenced by
13 the structural environment.
14 What I think is also important here is that the NHS
15 is a multi-layered institution, it's not a single
16 organisation. Some of the behaviours that you see
17 playing out in organisations essentially are modelled on
18 behaviours that are external to NHS organisations,
19 they're coming from the centre, they're coming from the
20 Government, they're coming from the national bodies who
21 don't -- at least historically have not always behaved
22 particularly well towards their colleagues in the
23 provider organisations. It can be very aggressive and
24 that can then be seen as a norm that gets passed down
25 again.

1 **Q.** You say at page 14 at the end of the second
2 paragraph where you refer to staffing shortages, that
3 they can reduce.
4 "... teams' ability to notice and react to small
5 signs of safety deterioration and affect their capacity
6 for debriefing, mentoring and informal knowledge-sharing
7 which are all important to maintaining a culture of
8 learning, teamwork and cooperation."
9 That largely speaks for itself, but teamwork,
10 identifying that, how important is teamwork in
11 a healthcare setting, or on any unit or ward?
12 **A.** Teamwork is absolutely indispensable and it is
13 one of those words that sounds a bit fluffy but in fact
14 we can show experimentally the impact it has on outcomes
15 and it requires that the team has very clear
16 understanding of each other's roles, the tasks they need
17 to do, the ways they need to communicate with each other
18 and the -- essentially standards of behaviours. They
19 need to be really clear about the goals they're trying
20 to achieve and they need to be learning all the time, so
21 every time something goes wrong they need to be figuring
22 out how to do it well.
23 When we have looked at very high performing teams
24 there are a very characteristic set of things that they
25 are doing and that will include preparation in advance

1 of a shift, it will include debriefing afterwards, there
2 will be a very clear way of handling something that
3 didn't go as well as it should. Very importantly there
4 will be multi-disciplinary training so it's always clear
5 what is happening and why and you will see that they are
6 using very powerful techniques like simulation, so they
7 will be given a scenario and taken through that in the
8 equivalent of real-time --
9 **Q.** Is that in the NHS you have seen that
10 demonstrated?
11 **A.** This would be in the NHS. This is uneven but
12 in the highest performing units this is what they're
13 doing and it will be exactly like the way you train
14 emergency responders. They -- you can't make up what
15 you need to do in an emergency situation, you have to be
16 absolutely prepared for it, so you prepare for that by
17 doing simulations, so people are clear about the tasks
18 that they need to do, they're clear about who is going
19 to do them, they're clear about how they are going to
20 communicate with each other while they're doing them and
21 then they debrief afterwards because the simulation will
22 never go perfectly but much better it goes imperfectly
23 in a simulation situation rather than in a real one and
24 they will learn from that, so the debriefing is very
25 important.

1 If you have a situation where there are huge
2 production pressures, so people are under enormous
3 demand from patient acuity, from workload pressures, it
4 is tragically sometimes the case that training and that
5 kind of teamwork work is the first thing to go and
6 people aren't making time for it.
7 **Q.** And in those best examples that you refer to
8 was there a consistency of team members or was that not
9 a variable or did you not examine that?
10 **A.** Multi-disciplinary training for emergencies
11 typically will involve a situation where the team don't
12 know each other. They have essentially been improvised
13 for the situation so you have to know how to behave, you
14 have to know what the tasks are, you have to know how to
15 communicate when you come together in an emergency.
16 Our colleagues who have done this kind of training,
17 say in maternity, have shown huge improvements in
18 outcomes of problems like shoulder dystocia where people
19 are trained in this way and using simulation, using high
20 quality debriefing, it's absolutely clear what they're
21 going to do and that problem has largely -- I wouldn't
22 say disappeared, but it is massively improved from where
23 it was 15 years ago because of that kind of
24 intervention.
25 We don't see unfortunately that kind of teamwork at

1 board level, which we might come back to a bit later.
2 **Q.** We will. You say at paragraph 3.1.3:
3 "As a general principle, 'the broader environment
4 within which organisations operate emits powerful
5 injunctions about what they should look like and what
6 they should be doing'. This is especially true in the
7 NHS, where the wider institutional contexts have major
8 influence on culture in provider organisations through
9 budget setting, directions and guidance, priority
10 setting and regulation ..."
11 I want to link this to safeguarding, if I may.
12 When we were first looking for experts to help us in
13 this area of patient safety and particularly
14 safeguarding of children, or child protection, we were
15 met with a number of people saying that safeguarding
16 wasn't their area of expertise, patient safety was.
17 First of all does that resonate with you and is it seen
18 as somebody else's problem and all to do with parents
19 harming children rather than potentially staff?
20 **A.** Thank you and I would say I know a lot about
21 patient safety and quality of care and much less about
22 safeguarding. That may just reflect my particular field
23 of work, but I think it's probably fair to say
24 safeguarding and patient safety are not -- patient
25 safety management are not as well integrated as they

1 could and should be.
2 **Q.** And one question arising from what you say at
3 3.1.3 is how might the importance of safeguarding
4 children be reflected in governance models, assurance
5 models and budgets? Would it help if it was reflected
6 that children deserve a particular attention or
7 protection under safeguarding rules and guidance?
8 **A.** I think that's fair and one of the -- going
9 back to our discussion about priority setting earlier --
10 sorry, priority thickets, unless something is signalled
11 to organisations as something they need to be paying
12 attention to, unless it's very, very clear that this is
13 an injunction about how they need to give priority to
14 it, it is likely to fall down the priority list and
15 there have been complaints over many years that
16 maternity and neonatology were Cinderella areas, they
17 weren't necessarily on the top of the board's agendas
18 because of the kinds of things that were prioritised in
19 the NHS. I think things have improved particularly in
20 neonatology quite significantly in the last few years.
21 **Q.** In what way?
22 **A.** Many of the things that we have seen in terms
23 of the introduction of the Perinatal Mortality tool, the
24 Child Death Review process, the national audit, the
25 databases and so on, I think we have actually seen quite

1 significant improvements number of those areas in recent
2 years, last seven to eight years.
3 **Q.** Can I ask you now about institutional secrecy,
4 at page 17 of your report. First of all, perhaps if you
5 could just give us a definition of institutional
6 secrecy?
7 **A.** The term is my own and I have adapted it from
8 a phenomenon called structural secrecy which was
9 described in the analysis of the Challenger disaster and
10 structural secrecy, which arose in the context of NASA,
11 was used by the sociologist Diane Vaughan to explain how
12 information can become hidden through the way systems
13 are organised and that's a very useful idea. What
14 happened in the Challenger disaster was that information
15 that was important to understanding that this -- that
16 there were risks in the design of the space shuttle did
17 not essentially bubble up or surface in the approach
18 taken.
19 I prefer to use the term "institutional secrecy" in
20 the context of the NHS and it has two components. One
21 of them is the way structures and systems function and
22 that will tend to suppress some information because of
23 the way they're handled, but the second is -- the second
24 very important component here is human sense-making and
25 culture, so there's a systems component and there's an

1 aspect of how humans process information and culture and
2 I will be very happy to talk through how that may
3 influence the recognition of a patient safety risk.
4 **Q.** Can I ask you this first of all: how would
5 good -- how does good communication between colleagues
6 assist with this? If people at the top don't know
7 what's going on, there's a number of ways that can be
8 approached, isn't it, what people are saying to them and
9 also how they're listening, what they're asking about,
10 their curiosity. So what do you say about the need for
11 communication to prevent institutional secrecy?
12 **A.** Institutional secrecy is endemic to
13 organisations. There isn't going to be -- this is
14 a feature of the way organisations operate because not
15 all information can go to the top of the organisation,
16 it's got to be organised so that you're dealing with
17 things at different levels, so it's an inevitable
18 feature of how organisations are organised.
19 What you do need is systems that are able to pick
20 out issues of concern. We actually don't have
21 a shortage of signals being sent through organisations.
22 There are thousands and thousands of patient safety
23 incidents reported to the NHS every day. There are
24 thousands and thousands, about a quarter of a million,
25 of patient complaints per year. What is very difficult

1 is to work out which of those is one that you need to be
2 concerned about in the sense of taking immediate action
3 to safeguard people and the volume is not the issue, but
4 there are aspects of culture that may -- and
5 organisational sense-making that may obstruct
6 recognition of an unusual transgressive problem in
7 particular.
8 **Q.** What aspects obstruct?
9 **A.** Doctors will say with diseases there's a kind
10 of natural history to them, so something like a mole,
11 you know how that's going to evolve if you don't
12 intervene to deal with it.
13 So the first thing is that there is a way of making
14 the concern known that people can speak about it, they
15 can be heard about it. The second is the way that's
16 processed, whether that's heard, whether it's classified
17 as being a signal.
18 The third will be the priority given to it and then
19 the fourth is the action taken in response and none of
20 this is very easy actually, so a characteristic thing
21 that might happen is that somebody raised a concern
22 about a systems issue which might be understaffing, it
23 might be corridor care and the organisation is unable or
24 essentially it isn't able to make the improvement that's
25 sought. Some of the issues that are raised may be not

appropriate for a huge organisational response, but may be very important to the person, they may have interpersonal difficulties and so on.

With a highly unusual -- going back to our conversation at the beginning, highly unusual situation involving transgressive behaviour by an individual, there is a pattern -- a fairly well understood pattern -- of how that's going to develop, which we know from studies of disasters in other areas. So what will happen is there is an accumulating set of warning signs and soft signals. There may be information coming in from other sources. There may be all kinds of -- to go back to our -- the sensors may be picking up different kinds of things and it may be some time before people begin to recognise that there is something amiss here.

What can happen is that the people who are responsible for taking action judge them inappropriately and that may happen for a reason, so for normal human sense-making. They may not recognise the pattern, they may classify it as something else and when they classify it as something else, for example as some sort of interpersonal dispute or an HR issue, they enter into something called cultural entrapment which is very difficult to escape from. They keep understanding the issue in the same way, they keep applying the same

actions and it's not disrupted unless something else happens.

Now, in --

Q. Pausing there, what's the important of reflection then for most people assessing any information, particularly information of concern, to be reflective and thoughtful about what you're doing with that?

A. Yes, that will be very important but I also think -- so what I'm describing, cultural entrapment, these normal heuristics and biases is what explains why this happens and this can happen anywhere, any time. This is normal behaviour and I think understanding this will be helpful for preventing the next disaster of this nature in the sense that this isn't necessarily bad people, this is people getting trapped in a normal process of sense-making.

Where it becomes pathological is when people are also -- when that is overlayered with denial, defensiveness, inability to accept challenge and that's what we saw, for example, with East Kent. There were multiple signs that things were going very badly wrong there, but people kept -- the senior level of the organisation kept interpreting it as unhelpful criticism, hostility, et cetera, et cetera.

In teamwork, when we study this in healthcare, when you're training a team in how to handle an emergency, we know that there's a problem called loss of situation awareness which has been found in every high stress human endeavour, including the aviation industry. So loss of situation awareness means you forget how to -- you get trapped in your first understanding of the situation and when healthcare teams are being trained this is a known risk, so you train them what to do, which will include, for example, having somebody else on the team to offer a challenge. You train them that this is a problem they're going to fall into and you have various processes so you can essentially release them from getting stuck with that.

We do not have an equivalent for something that's unfolding over a longer time at board level or senior executive level or managerial level. They may not realise that they're stuck in this loop of the first understanding unless something disrupts it.

Q. Can we go to page 19 of your report, "normalisation of deviance". You say in the penultimate paragraph:

"Over time, these challenges can mean that a phenomenon known as 'normalisation of deviance', described by ... Vaughan ... emerges. Normalisation of

deviance occurs when people within an organisation become desensitised to a deviant practice or behaviour that it is no longer recognised as deviant. It can ... 'neutralise signals of danger, enabling people to conform to institutional and organisational mandates even when personally objecting to a line of action'."

Do you want to expand before I ask you a question about that?

A. Sure. I think this is a very useful phrase and again was -- emerged in the context of the analysis of the NASA disasters and again it's a common finding in healthcare settings that you get normalisation of deviance. You may have some very poor conduct, very poor behaviour, and over time it becomes accepted as "just the way things happen around here", "just the way he behaves or she behaves", and people end up -- it becomes extremely difficult to raise challenge in a situation where everybody else seems to think this is the normal way of carrying on.

Q. And is that linked to futility of voice: there's no point saying anything because it will carry on?

A. Voice futility is another problem. The normalisation of deviance means that people actually become desensitised to the fact that this is actually

1 terrible behaviour, they just accept the way it is. If
2 they -- and that may prevent them ever speaking up about
3 it because it is just accepted as normal. If they do
4 speak up, the voice futility issue kicks in, sometimes
5 because the way it is handled through an HR process
6 means they're never told what the outcome is, sometimes
7 because the Trust doesn't appear to fix the problem,
8 which might be a systems issue, and it may also kick in
9 when the issue that they're raising in fact isn't the
10 issue that they think it is, it's when you --
11 **Q.** Can understaffing -- sorry, have you finished
12 there? Can understaffing and care backlogs in
13 paediatric services attribute to normalisation of
14 deviance?
15 **A.** Yes, we know this. Production pressures is
16 what Diane Vaughan calls them in the context of
17 normalisation of deviance, people start cutting corners,
18 they start to do things in a perhaps sloppier way
19 than -- essentially to get through them quickly, and the
20 same thing happens in NHS contexts where there isn't
21 enough resource, where the systems are poorly designed,
22 where the staffing isn't equal to the demands of the
23 clinical workload. Again, you get tolerance of
24 standards that really aren't appropriate.
25 **LADY JUSTICE THIRLWALL:** I seem to have a memory

1 of -- was there a CQC report quite recently which talked
2 about normalisation?
3 **A.** Yes, yes.
4 **LADY JUSTICE THIRLWALL:** That was in the context of
5 maternity services, I think.
6 **A.** Yes.
7 **MS LANGDALE:** Psychological safety, page 20 of your
8 report. You say in the last paragraph:
9 "When staff feel able to speak up without fear of
10 retaliation or embarrassment, share ideas and ask
11 questions, it can help to foster a culture of openness,
12 improve team performance, and, in turn, help to improve
13 performance and the safety of the service.
14 Psychological safety can enable people to raise concerns
15 about their patients, report adverse events, and to
16 communicate across professional boundaries."
17 How can senior managers and boards contribute to
18 this issue?
19 **A.** Psychological safety is a very important
20 concept and actually was originally developed in the
21 context of neonatal units in the US and it is exactly as
22 you describe it, so people feel safe in speaking up. It
23 doesn't mean that there is a niceness going on and it
24 doesn't mean that everything people say has got to be
25 treated as gold, but it does mean that people can speak

1 up and be confident that they will be heard and not be
2 gaslighted or not be criticised or not be treated as
3 ridiculous if they do say something. I'm not sure that
4 is fully understood or fully operationalised throughout
5 the NHS, either at board level or in the bodies that
6 interact with boards.
7 **Q.** So what -- let's start with boards. What
8 helps a board to support that concept, that people can
9 speak up? What should they be doing to enable that?
10 **A.** That's described in the psychological safety
11 as leadership inclusiveness and it's demonstrating
12 a willingness to hear, so offering the floor, being open
13 to challenge, when somebody says something, respecting
14 it, thanking them for it, being open to criticism and
15 really quite specific behaviours that leaders need to
16 demonstrate when somebody is offering discomfiting
17 information.
18 **Q.** And what about thinking about how the
19 information is received by a board, because there might
20 be formal processes, but being open to different routes
21 of receiving information, speaking to different people,
22 are they examples?
23 **A.** They are examples. We do have a problem that
24 there is only so much bandwidth that boards have and
25 they may be receiving packs of 600 pages of papers for

1 each board meeting. They may be confronted with
2 multiple priorities coming in from multiple sources and
3 the capacity to listen to things that may be poorly
4 formulated, poorly formed, still inchoate senses may be
5 correspondingly reduced. I think we have to again
6 accept that there's a reality here about how much boards
7 can deal with, so the act of speaking up is very
8 important and it's very important that that's happening
9 at all levels. What I would expect to see in a well run
10 organisation is that there's an openness to what we call
11 soft intelligence and that once there is a concern about
12 something that that is being escalated through the right
13 kinds of routes, so it is made known to the board rather
14 than being suppressed lower down because those lower
15 down in the organisation will be aware that if they have
16 escalated something, they should be treated seriously.
17 **Q.** And in the end is this all about people,
18 whether they're senior managers or board members? You
19 and I might receive the same information, we might have
20 different questions arising from this that information
21 or responses, that that does happen? Do you see that in
22 any of your reviews of what has happened in some of the
23 high functioning units, for example, and some less
24 functioning units?
25 **A.** Some of it is very much about people and we

1 have characterised that board behaviours in it
2 particular tend to be on a spectrum from what we call
3 comfort-seeking, and these will be behaviours that are
4 orientated towards finding the best possible version of
5 any story, through to problem sensing where the board is
6 actively looking for discomfiting information, it
7 welcomes being told about problems, it wants to know
8 where the issues are and it's seeking to support
9 improvement.
10 It is very much about people but it is also about
11 systems and capacities. When you see an organisation
12 that's struggling, they very often are struggling
13 because they have very limited capacity for improvement,
14 so when yet another issue lands on their -- in their
15 600 pages of board papers, it's -- they're exhausted,
16 they have no way of actually making the problem better
17 and so they might just try to make it go away and
18 I think again that's something we haven't necessarily
19 got right yet with how organisations that are struggling
20 are supported to improve.
21 **Q.** How can the RCPCH, the Royal College of
22 Nursing and other membership organisations help to build
23 a culture of psychological safety?
24 **A.** They can do that in several ways, but I think
25 it's also probably worth recognising that the two bodies

1 you have listed are of different types. So the Royal
2 College of Paediatrics and Child Health is a medical
3 Royal College and it's not allowed to be a trade union.
4 It's purely a professional body that there's to promote
5 professional standards and has a role in assuring
6 registration of doctors as paediatricians, that --
7 essentially in setting examples and admitting them to
8 the profession.
9 The Royal College of Nursing has a dual status. It
10 is both a trade union and a professional body and there
11 may be a question about whether those two roles are
12 necessarily in comfortable -- a comfortable duality.
13 I think they can -- those kinds of bodies have a very
14 important role in promoting psychological safety. They
15 may be able to help their members and fellows with
16 understanding their responsibilities as leaders and they
17 may be able potentially to help with sense-checking
18 whether a concern is a concern.
19 **Q.** Focusing on the Royal College, what more could
20 the Royal College do to support safety in paediatrics or
21 neonatal care?
22 **A.** Royal College of Paediatrics and Child Health?
23 **Q.** Yes.
24 **A.** The Royal Colleges have a very important set
25 of responsibilities. Some of those are to do with

1 producing clinical guidance in particular areas and they
2 will typically be synthesising evidence from particular
3 evidence and saying this is what the service should look
4 like and this is the standards of care that might apply.
5 They also have a very important role in developing
6 people as leaders and showing what professional duties
7 look like, what professional responsibilities might
8 entail, role modelling those qualities and many of the
9 Royal Colleges, including the Royal College of
10 Paediatrics and Child Health, run quality improvement
11 programmes that seek to support people in making
12 improvements in specific clinical areas, so the Royal
13 Colleges have a very important role because they are the
14 sort of professional voice and also set the kind of
15 professional expectations for a particular area.
16 **Q.** Do you think there should be a separate
17 framework for patient safety covering neonatal units or
18 one framework covering all paediatric neonates?
19 **A.** I'm not a neonatal specialist. You need
20 a patient safety framework that covers everything, that
21 is generic. The standards that apply in a neonatal unit
22 and in a paediatric ward are likely to be different in
23 the sense that you're doing different things, the care
24 of people -- the care of people and families is going to
25 be different and so we have traditionally had different

1 audits and traditional standards that apply, so I think
2 you probably do need a framework that applies -- that
3 has generic components and is bespoke to the specifics
4 of clinical settings.
5 **Q.** You start at page 24, but perhaps we can put
6 up page 25, "What good looks like for culture in
7 healthcare organisations" and particularly you move on
8 to neonatal units.
9 First of all, what would you define as a healthy
10 culture? You have said what impacts on culture, but
11 what's a healthy culture, or in some of the high
12 functioning units that have done the teamwork,
13 synthesisations that you refer to, what is the culture,
14 how would you describe it?
15 **A.** We think there are probably eight features of
16 a very healthy culture. One of those is being very
17 clear about what you're there for, what the goals are,
18 what are the values driving you, what constitutes
19 inclusive, respectful and safe care. In a neonatal unit
20 that's going to include respect for patients and their
21 families and respect for colleagues.
22 A second feature is going to be clarity about the
23 standards of service and of practice, so everybody is
24 clear about what it is that the standards are that they
25 are expected to deliver on. Those standards come in

1 from multiple sources but people in the unit will know
2 this is the standard of care we provide, here is what
3 that looks like.
4 A third feature is going to be very consistently
5 reinforced standards of behaviour and conduct and that's
6 very important in terms of culture, that there isn't
7 tolerance of bad behaviour, there isn't tolerance of
8 rudeness towards patients, towards families, isn't
9 rudeness towards colleagues, there is an absence of
10 racist and discriminatory behaviour.
11 Fourth feature would be optimised teamwork, team
12 communication and coordination and that's going to look
13 like teams that function very well in terms of having
14 shared goals, clarity about the tasks that they're going
15 to deliver and coordination and ability to deal with the
16 inevitable conflict that occurs in teams.
17 A fifth feature will be the orientation towards
18 problem sensing and voice and nurturing of conditions
19 for psychological safety which we have been discussing.
20 A sixth is having effective systems of clinical
21 governance, the ability to monitor quality and safety of
22 care and good systems for risk management.
23 A seventh is highly effective operational and
24 clinical systems, so people are working in conditions
25 that enable them to do their best work, and the final

1 one is leadership and management.
2 **Q.** You set out at page 26 at the end about how
3 you might change safety culture. What's required to
4 change the safety culture in neonatal care and how can
5 it be done?
6 **A.** On page 26?
7 **Q.** Yes.
8 **A.** Are we looking at the same page?
9 **Q.** Yes, you begin:
10 "Research specifically on healthy cultures in
11 neonatal care has been relatively limited ... a US study
12 identified ..."
13 Et cetera and you continue there. I'm not inviting
14 you particularly to read parts of that section, but just
15 in considering, as you have there, how change to some of
16 the things that you have pointed out, the teamwork, the
17 goals, clarity of standards, practice -- you have set it
18 out clearly. How can that be achieved where it is not
19 taking place?
20 **A.** Thank you. That is a very long-term project
21 and it requires multiple interventions and multiple
22 things to be done, so if you're going to tackle
23 something like an adverse culture you need to start with
24 a diagnosis of what the challenges are. You're going to
25 need very strong leadership that is absolutely clear

1 about the -- what the teams are there for. You need to
2 be working on the -- making sure that the conditions
3 people are working in, the management systems and so on,
4 are good. You need to have an absolute clarity about
5 how you're handling poor behaviours. You need to be
6 very clear about the clinical standards and making sure
7 that all of those are engineered essentially so people
8 can achieve them.
9 You need to have the capacity to have many, many
10 many, many conversations, many of them difficult in
11 nature, so the ability to offer challenge but also very
12 importantly to reward and respect differences of
13 opinion.
14 You need to be role-modelling how to accept
15 challenge and you need to have very strong training in
16 place and a capacity built in for reflection, debriefing
17 and figuring out how to do better. I could probably
18 talk all afternoon, so I will stop there.
19 **Q.** You have referred to debriefing, as you did
20 earlier, with staff shortages and the difficulties
21 around mentoring. What is the importance of debriefing,
22 reflection, discussion, learning?
23 **A.** That's really essential. So if an incident
24 has occurred it is often quite impactful for the staff
25 and for -- as well as for obviously the families and the

1 patient who is affected. If you're doing debriefing it
2 means you have a structured way of doing that that's
3 safe so people can learn from it and then you're
4 producing the improvement that's needed for fixing it
5 for the next time, so the debriefing is really essential
6 as part of a learning culture.
7 **Q.** Of course it requires time, doesn't it?
8 **A.** It does, yes.
9 **Q.** Time and energy from staff, leaders and
10 generally?
11 **A.** Yes.
12 **Q.** Page 45 you start and address the topic
13 "Problems in HR systems in the NHS and the influence of
14 the wider institutional and legal environment". You
15 touched on it earlier, particularly page 47, paragraph 4
16 beginning "NHS organisations often experience a high
17 level of HR issues ..."
18 So page 47, paragraph -- it will come up for
19 everyone else in a moment, Professor, but would you like
20 to set out and provide examples -- you clearly referred
21 to one earlier with East Kent, there may be others -- of
22 why you say this has become burdensome and the
23 difficulties from a patient perspective with the HR
24 processes and procedures?
25 **A.** Sure. So HR processes are handled in the NHS

1 through HR departments who are variably well resourced
2 and variably well staffed and they have to operate
3 complex procedures which will typically involve
4 coordination with other parts of the hospital.
5 Typically an issue will appear on the ward or in
6 the office and eventually be escalated to an HR
7 department. By that time it may already have become
8 quite difficult. Many people who are line managers in
9 the NHS are not necessarily trained for the task and
10 they are what are called "accidental managers", so they
11 may have already mishandled it by the time it gets
12 through to the HR Department. Once the HR Department
13 gets involved they have to operate according to the
14 expectations of ACAS and they are typically very much
15 focused on ensuring procedural propriety in the handling
16 of the complaint.
17 These complaints -- or the issue -- so there's
18 basically two types of things that they might end up
19 handling: one is a disciplinary issue where somebody is
20 thought to be engaged in poor conduct or behaviour, and
21 the second is a grievance where somebody has raised
22 a complaint against the employer. There are different
23 procedures that may be activated depending on which of
24 those it is and those procedures are variable and
25 variably well designed and can consume enormous amounts

1 of people's time to operate them and if it concludes
2 with disciplinary action against an employee, it can
3 involve all kinds of other challenges. The unions may
4 get involved or other representatives and the Trust may
5 become extremely focused on avoiding progression to an
6 Employment Tribunal.
7 The reasons they are keen not to go to Employment
8 Tribunals is because of the costs involved which often
9 can run into hundreds of thousands of pounds of legal
10 costs for them, tying up of executive time and very
11 uncertain outcomes of Employment Tribunals themselves,
12 so what they may do is move towards a settlement
13 agreement, so essentially they settle with the employee,
14 which means that it doesn't go to an Employment Tribunal
15 but the Trust reaches a deal essentially with the
16 employee. So they exit the organisation, sometimes with
17 a payment, sometimes with an agreed reference, and the
18 problem from the perspective of the original employer
19 has been handled, but that person may then be picked up
20 elsewhere in the NHS without the record following them.
21 **Q.** You said at the beginning you are not
22 obviously an expert in employment law but where is the
23 gap? What's not being considered in those situations if
24 it is taking a great deal of time and there's
25 investigations and taking people off other tasks?

1 **A.** Well, yes, they are handled through HR
2 departments and they are focused on essentially ensuring
3 employment -- compliance with the expectations governing
4 that process.
5 The Trust may have very legitimate patient safety
6 concerns or concerns about bullying, harassment,
7 et cetera, et cetera, but they may become subordinated
8 to the handling of this process and I give the example
9 of an individual at a hospital that over 15 years was
10 subject to nine separate investigations relating to
11 their conduct. They were eventually dismissed. They
12 appealed but they still work -- but the unit where they
13 were working declined to have them returned, so the
14 Trust eventually dismissed the person and they went to
15 an Employment Tribunal which did find in favour of the
16 Trust but that went on over many, many years, consumed
17 a huge amount of executive level time and the process
18 was very legitimate in the sense that it followed all of
19 the correct procedures but it was extremely difficult to
20 deal with the behaviour and the conduct. The
21 representation for the doctor meant that there were --
22 it took a very long time and what we saw at East Kent,
23 as reported by Bill Kirkup, was that the Trust felt
24 completely powerless to act against the Consultants
25 because they felt that if they did take them to

1 a tribunal they would probably lose.
2 **Q.** Can you look please at page 48 at the top,
3 paragraph 4.5.1.
4 **A.** Yes.
5 **Q.** You refer to the ACAS guidance and you say:
6 "Some NHS organisations interpret this as meaning
7 that those raising concerns must speak to the person
8 they are complaining about in the first instance, before
9 any further action is taken."
10 Then you say:
11 "A different challenge is that those who are the
12 subject of concerns may take advantage of organisational
13 processes, perhaps using HR procedures strategically,
14 for example by introducing delays and deflections,
15 making counter grievances or claims of discrimination,
16 perhaps supported by their trade union ..."
17 Do you want to expand on that?
18 **A.** Yes. So first, employment law and protecting
19 employees is important and it's important nothing I say
20 is interpreted as meaning that we shouldn't protect
21 employees, but it is like drugs, everything that is
22 overall good can also have side-effects or a dark side
23 and that's some of what we're seeing here, so one of the
24 ways -- and this showed up in the East Kent report. If
25 you're obliged in the first instance, if you have got

1 a concern about somebody, to discuss it with them first
2 that may be a very powerful disincentive to raising it
3 because you're then revealed as the person who has the
4 concern and you may just then create a very difficult
5 working environment.
6 A different challenge is that people who are
7 actually behaving badly may be able to engage in all
8 kinds of counterclaims, grievances, they may be
9 strategically advised by their union representatives on
10 what to do in order that they essentially don't end up
11 with a disciplinary outcome. So these are very complex
12 problems that NHS organisations are having to deal with.
13 **Q.** So you think the grievance can be used to
14 prevent a disciplinary outcome, getting a grievance in
15 first?
16 **A.** Definitely.
17 **Q.** And do you have experience or examination of
18 cases dealing with that?
19 **A.** This is exactly what happened in the East Kent
20 situation. The people involved took out a collective
21 grievance against the Trust and the Trust then
22 essentially dropped their action and failed to deal with
23 the bullying and other transgressive behaviours on that
24 unit.
25 **Q.** On the question of bullying you use the phrase

1 at page 49, the top paragraph, of "bullying up". Can
2 you expand on that and what you mean by that?
3 **A.** Bullying up -- we often think of bullying as
4 being bullying of more junior people or people lower
5 down in the organisational hierarchy. What you can also
6 get is bullying up, where essentially people are
7 bullying their bosses or others and they may do that by
8 making allegations against them, claiming that they are
9 racist, claiming that they are harassing, or claiming
10 that they're not listening and that's a very, very
11 difficult problem to deal with, which again we don't
12 have a very good process for doing.
13 **Q.** What do you mean "we don't have a good
14 process" for dealing with that?
15 **A.** There's a kind of impatience with the boss
16 claiming that they are being bullied from below and it's
17 not -- you know, HR issues are not easy to deal with
18 anyway, but this one is adding complexity to it.
19 **Q.** Because we're ready to see the doctors are the
20 ones who are arrogant, perhaps, from previous inquiries
21 or understanding of events and not ready to think that
22 other groups could be combative or difficult from --
23 **A.** I think that's fair, yes.
24 **MS LANGDALE:** My Lady, I see the time. I think
25 this might be a good time to stop for the morning break?

1 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.
2 Professor Dixon-Woods, we're going to take a break
3 of 15 minutes, so we will start at 25 to 12. Thank you
4 very much.
5 **(11.18 am)**
6 **(Short Break)**
7 **(11.34 am)**
8 **MS LANGDALE:** Professor Dixon-Woods, if we can go
9 to page 92, please, of your report and at paragraph 8.2
10 you refer to improvement programmes in neonatology and
11 you refer to The Vermont Oxford Network in the US and
12 the Getting It Right First Time, an NHS national
13 programme. Can you tell us about those two different
14 models, compare and contrast, and tell us what we can
15 learn from them?
16 **A.** Thank you. The Vermont Oxford Network I have
17 given as an example of a collaborative approach to
18 quality improvement that's been used in the US and this
19 has been very successful in securing improvement in
20 a number of outcomes over the last 30 years or so,
21 including, for example, reduced mortality. It's doing
22 that through a combination of things, one is very high
23 quality data that it is using to monitor quality of
24 care, the second is having high quality solutions that
25 it is proposing to its members and providing support for

1 implementation, and the third thing is nurturing of
2 highly collaborative approach to doing that improvement,
3 so there's an ethos of learning together, sharing
4 together and working together to achieve shared goals.
5 I gave that example because all of the evidence
6 from the research we do on quality improvement and
7 improving quality and safety generally suggests that
8 those three components are the key elements of
9 a successful improvement system. You need to have the
10 excellence of data, you need to have -- data and
11 analytics, I should say.
12 **Q.** Why do you say data and analytics?
13 **A.** Because you can collect as much data as you
14 want but if you haven't got the analytic expertise to
15 interpret it correctly, you don't get anywhere and the
16 NHS tends to be low on analytic capability.
17 **Q.** Is that people, analytics by people?
18 **A.** Yes, yes.
19 **Q.** So data sends a signal, gives you an alert and
20 then you need people to interrogate it and see what it
21 means?
22 **A.** What you would be typically doing is
23 collecting a lot of data, say, on -- an example would be
24 something like infection rates and you might want to
25 check are your infection rates going up or down over

1 time. You can't tell that necessarily just by
2 eyeballing a graph, you need to use specific statistical
3 techniques to detect whether you are getting something
4 that's unusual or not, and that's not necessarily
5 a skill clinicians are going to have, they will need
6 people with data analytics expertise to make sure the
7 data is clean and to apply the correct statistical
8 techniques so you don't draw the wrong conclusion.
9 In the UK we have a very large infrastructure of
10 clinical audits, about 30 of them run by the Healthcare
11 Quality Improvement Partnership which is funded by NHS
12 England and they run things like MBRRACE, which
13 I referred to extensively in my report, and the National
14 Neonatal Audit Programme.
15 They typically collect the data from the Trusts and
16 then feed it back again. What they don't have typically
17 is an improvement architecture that goes around that, so
18 it's left up to the units to make that improvement
19 themselves and they are variably capable of doing so.
20 So the Vermont Oxford Network I think does combine
21 the three elements I think you need and that's data and
22 analytics, the ability to come up with what look like
23 good solutions and a collaborative approach to doing it.
24 So the national audits are a very underappreciated
25 element of the NHS, they are a very important resource,

1 but we don't necessarily have the improvement support
2 around it to make the most of the data that we have and
3 while we used to have a lot of collaboration based
4 programmes, they disappeared largely over the last
5 ten years or so.
6 **Q.** Can you give me examples of the ones that have
7 disappeared that you thought were effective, or it's
8 unfortunate that they have disappeared, to say the
9 least?
10 **A.** Yes, so examples were the cancer
11 collaboratives did very good work and they were defunded
12 effectively and have largely disappeared. I'm not an
13 expert on those so we would need to check what I have
14 said is correct, but my understanding is that they do
15 not exist in the form that they used to.
16 Getting It Right First Time is a national programme
17 that is -- uses many of the techniques that we -- that
18 are likely to be effective. What they do is they
19 compile a package of data about an individual service
20 and a specialist team goes in and presents that data to
21 the service and explains how they sit within comparator
22 Trusts and so on, and the idea is that that's meant to
23 give insight into where the Trust might be particularly
24 an outlier, where it might be doing well and that they
25 are stimulated to come up with a programme of

1 improvement.
2 Again, GIRFT as it is called, Getting It Right
3 First Time, it doesn't necessarily have a huge
4 improvement architecture around it, it's meant to be --
5 **Q.** Sorry, a huge ... I didn't hear that?
6 **A.** Getting It Right First Time is the name of the
7 programme.
8 **Q.** You said it didn't have a huge ...
9 **A.** It doesn't have a big improvement architecture
10 associated with it; again, it is assumed that the Trust
11 will largely make that improvement themselves. They do
12 make recommendations to national bodies but the
13 improvement work is expected to be done by the units.
14 There has been one cycle that I know of in
15 neonatology which was in 2020 and that, for example,
16 identified a lot of issues to do with the then use of
17 the Perinatal Mortality Reporting Tool.
18 **Q.** Is this a voluntary take-up for Trusts or
19 a requirement, or don't you know?
20 **A.** I don't think it's voluntary but it's not
21 a programme on which I'm fully an expert so that would
22 need to be checked.
23 **Q.** But do you think improvement programmes
24 designed specifically for neonatology is a very positive
25 way forward to improve neonatology?

1 **A.** What we see in any area where you have secured
2 improvement is that you need something that's very
3 specific to that specialty and that service line and
4 there are very specific features you then have to have
5 built into an improvement programme and one of the
6 things that's very important is that there is some sense
7 of what needs to be standardised nationally and what you
8 can safely leave up to the units to do for themselves
9 and one of the things we see with improvement programmes
10 that don't work is that they leave too much up to the
11 units to do themselves, so an example is in maternity
12 there is a very sensible principle that you should be
13 monitoring the mother to detect whether there are any
14 signs of deterioration and you can do this using
15 structured tools which are called early warning scores.
16 When these were first introduced in the NHS it was left
17 up to every maternity unit to do it for themselves, so
18 we now have 147 different Maternity Early Warning Scores
19 and they vary in terms of the thresholds, the scoring,
20 the actions that are going to be triggered, they vary in
21 terms of things that are going to be counted as even
22 things as basic as a fever, and this is not a very
23 sensible way of doing things because you have different
24 standards in different units and basically people are
25 not getting the same care.

So NHS England has now taken that programme over and is now introducing a national Obstetric Early Warning Score but really you might think an improvement programme could have done that from the beginning and what we know from the work we do is that if you co-design that with the staff and very importantly with the families, with the patients, you can get to something that is a good solution and that is nationally agreed and then the job is implementation rather than having to design the whole thing from scratch individually every single time.

So there are very specific things that you can do if you do improvement work on a large scale, if you do the co-design work really carefully right at the beginning.

Q. Moving on to "Defining an effective senior manager, including leadership qualities and behaviours". At page 95 of your report, you set out at 9.2 qualities. Can I ask you first of all what you mean by a senior manager here?

A. The term "senior manager" is widely used but it's not always clear what it means. An NHS Trust will typically have a board which comprises Non-Executive Directors and these are people who are not employed by the Trust, they are external parties who come in to help

with the running of the Trust and they might be from multiple different backgrounds, and then they will have Executive Directors and that will typically include the Director of Nursing, the Director of the -- the Medical Director, the Chief Executive Officer, the Chief Financial Officer and so on. So they comprise the board and they are sometimes referred to as the "Senior Management Team".

In reality you are going to have lots of other people who function as senior managers in the NHS and they will include clinical directors, these are people who lead large clinical departments, and so on down through the structure of directorates.

I don't personally find the term "senior manager" very helpful if we're not clear about exactly who we are talking about.

Q. I suppose the leadership and management at any level there should be some fundamental core skills or attributes that do well across the board?

A. That's right. Exactly.

Q. So what would you choose to highlight from page 95 or perhaps expand upon why you say some of these goals, clarities are important?

A. I think probably all of these are important. I think the behaviours and the role modelling of

behaviours and the commitment to dealing with transgressive behaviours are all-important. The demonstration of leadership inclusiveness, so you are nurturing psychological safety. The skills to interpret soft intelligence in an intelligent way and use it alongside the other datastreams that you're going to have coming in and I think the commitment to improving workplace conditions in so far as you possibly can is vital.

I think the other thing I would say is the commitment to good management cannot be underestimated. We have had more than a decade of denigrating NHS managers as being essentially non-productive and pushing things to the frontline, about you an awful lot of what we're describing requires a huge amount of management resource to handle HR issues, to work with data, to understand how to interpret it, to set up audits, all of that is very demanding of managerial time and if the managers -- we don't know, but if the managers aren't there to do it, the clinical staff are too busy clinically to do it and that's where you start getting degradation.

Q. And of course some of these roles that you have identified, medical directors, clinical directors, are doctors, practising doctors?

A. Yes.

Q. How does that -- would you adapt the skills required, are they the same? How does that work in practice for people who have their own clinical practice?

A. The qualities I have identified here I think apply to anybody in a senior role, whether they are at board level or below. I think they are all important.

A clinical director will typically be running a large clinical directorate. Those jobs tend to be quite under-resourced. They might be running it on 12 hours a week and they're expected to deal with every issue that comes at them as well as running their clinical practice as well.

Q. One of the items you have here is "exercises good judgment in selecting priorities for attention and action." Exercise good judgment, is there work that you have done or been involved in in how you learn that exercising good judgment?

A. Not directly. What we do know is that if you look at, say, issues that come to the attention of Freedom to Speak Up guardians, they actually deal with a large number of concerns and many of those are not patient safety concerns in the sense that we would understand them, strictly speaking. A lot of them --

1 a large volume of them are essentially interpersonal
2 conflicts, not getting on with people, not liking the
3 way they do things, issues to do with essentially
4 misalignment over clinical priorities or how to do
5 things.
6 There is a skill which I don't think we have ever
7 codified about how you essentially figure out this is an
8 unusual incident, or an unusual pattern that I'm hearing
9 about that I need to do something about. I think there
10 are some hints in some of the inquiries we were talking
11 about earlier. In the case of Shipman, for example,
12 Dr Reynolds identified that there was a very unusual
13 pattern to the deaths that she was observing, for
14 example they were mostly women, the deaths were mostly
15 occurring at home, mostly in the afternoon and the
16 patients were found sitting up in their clothes. That's
17 a very, very unusual set of features and the subsequent
18 epidemiological analysis essentially confirmed that,
19 that this was a very unusual pattern.
20 So that is where you would hope that when something
21 as unusual as that, with such distinctive features is
22 presented to a senior manager, they would recognise that
23 this is kind of out of the ordinary.
24 We were talking about the example of natural
25 history and a GP would be skilled in telling a mole from

1 a freckle, or a mole to be worried about from something
2 that is not going to turn into something more malignant
3 and it's a similar skill here which I don't think we yet
4 know how to characterise appropriately.
5 **Q.** Moving now to recommendations, page 101, we
6 asked you what recommendations do you think this Inquiry
7 should make in the light of its Terms of Reference under
8 C, a question we have asked across the board for
9 witnesses.
10 10.1.1, you refer to the HR issues that you
11 mentioned earlier and you say:
12 "A review and consultation on the wider
13 institutional environment relating to employment law and
14 practices and professional regulation should be
15 undertaken to inform an NHS-wide framework for managing
16 this risk."
17 You said earlier you thought the Department of
18 Health and Social Care were probably the best equipped
19 to do that. Is there already the body of material
20 collected to identify the issues you say are raised in
21 respect of managing disciplinary processes, counter
22 grievances, staffing issues when processes take a long
23 time?
24 **A.** Thank you. I feel this is an area that's been
25 significantly understudied and under-recognised.

1 Bill Kirkup's report into East Kent brought it I think
2 very vividly into light, but the whole area of HR
3 practice has received limited attention, either in
4 policy or in practice.
5 There's a body of literature that demonstrates that
6 if you improve HR and operational management generally
7 you can hugely improve productivity and general
8 performance in organisations.
9 I think there is some information out there, but
10 I would actually quite like to see a really good study
11 of this area, a proper review and that would incorporate
12 what we already know but I think get the data on this
13 and engage with the people and co-design how the risks
14 could be managed. I think it's a terrifying task for
15 a lot of Trusts at the moment how to handle something
16 like this, because the clarity isn't there about the
17 processes, the procedures and they're dealing with
18 several different imperatives.
19 **Q.** And the priorities? Is the process there for
20 dealing with what the priorities are?
21 **A.** The priorities for?
22 **Q.** The priorities of patient safety and providing
23 good care --
24 **A.** Yes, yes.
25 **Q.** -- for everyone?

1 **A.** Absolutely. They're dealing with multiple
2 conflicting priorities, imperatives and once it enters
3 into one process it's governed by the expectations, the
4 norms, the laws governing that process so it's possible
5 we need a completely different way of handling the issue
6 of transgressive behaviour.
7 **Q.** "Recognise the risks of institutional
8 secrecy".
9 You say at the end of that paragraph:
10 "The risks of institutional secrecy are
11 significantly increased when there are comfort-seeking
12 behaviours or instincts towards denial and concealment,
13 so those bodies involved in direction and oversight of
14 NHS provider organisations should be accountable for the
15 possible impacts of their own behaviours, policies and
16 practices and their role in blame games."
17 Two questions, if I may. Please can you identify
18 which or who those bodies are and how you suggest they
19 should be made more accountable?
20 **A.** Thank you. I mean, this goes back to our
21 conversation of earlier when we were talking about
22 comfort-seeking versus problem-sensing behaviours.
23 I think, as I was saying then, institutional secrecy is
24 just a feature of organisations, so I think recognising
25 that it's a challenge and that it needs to be very

1 actively managed would be a very important step forward.
2 When you get bodies -- as it would have been at the
3 time -- like Monitor or NHS Improvement that are engaged
4 in behaviours that make it very difficult for leaders to
5 raise concerns or to say that there's something going
6 wrong in their organisation, who are incentivising what
7 might be regarded as gaming, whose own behaviours are
8 bullying, then that leads to a sense that it's not safe
9 for leaders to speak up or to raise a concern. I still
10 think there is an issue that isn't not -- there isn't
11 a safe space for something very unusual happening in the
12 organisation to be discussed, to get feedback on it, to
13 promote reflection and blame games is a very important
14 concept from the political science literature, but
15 essentially it says that very often organisations are
16 engaged in games of trying to pass the blame, who is
17 going to end up with the blame for something going wrong
18 and it very often lands back in the Trust but actually
19 there's a whole architecture of other organisations who
20 may have contributed.
21 **Q.** So how should those -- I, mean you have
22 mentioned predecessor organisations, Monitor,
23 NHS Improvement. How should they have been more
24 accountable for their involvement in that process, the
25 second part of that?

1 **A.** It's to do with the standards we discussed
2 a moment ago, that you would expect the same standards
3 from those bodies, that they encourage psychological
4 safety, that they are open to challenge about their own
5 behaviour, that they are demonstrating listening, that
6 they are focused on how they can support and help rather
7 than blaming others and it goes back to some of our
8 earlier conversation about the multiplicity of bodies
9 who are able to make recommendations that are uncosted,
10 haven't been fully operationalised and then expect NHS
11 organisations to get on with them and blame them when
12 they don't.
13 None of this is to say that NHS organisations
14 themselves don't sometimes behave very badly, they
15 sometimes do, and that is particularly the case when
16 there is denial and concealment and they are not
17 escalating issues either.
18 **Q.** Would a system of low-level reporting of
19 problematic behaviours, transgressive behaviours, by
20 staff on a confidential basis be something which could
21 identify transgressive behaviours and is that feasible,
22 is that practical to have confidential reporting?
23 **A.** This is the kind of thing I think is a very
24 interesting idea that would need a lot of piloting and
25 testing to establish whether it actually works. There's

1 a huge amount of interpersonal conflict in large complex
2 organisations and I guess the worry would be that you
3 get a large number of essentially low-level complaints
4 coming through to that and it's still very difficult to
5 pick out which is the really malignant behaviour.
6 That's not to say it wouldn't work, I just would like to
7 see quite a lot of testing of it. I would like to see
8 a lot of attention given to board development so they
9 are aware of the problems of institutional secrecy, they
10 are aware that when a problem appears that has a very
11 unusual character that's one to be especially attentive
12 towards and that they are directly handling the issue of
13 transgressive behaviour as a specific type of risk.
14 **Q.** 10.1.4:
15 "Address the need for evidence-based improvement
16 efforts."
17 You say:
18 "This is likely to be best achieved through an
19 infrastructure that operates collaboratively and at
20 scale to understand problems, co-design and test
21 solutions with patients and staff, and evaluate them,
22 and through supporting implementation."
23 What infrastructure changes are proposed to achieve
24 those aims?
25 **A.** We have a history of improvement programmes in

1 the NHS that are not necessarily very well designed and
2 that aren't implemented effectively or consistently.
3 One of my colleagues recently did a review of maternity
4 programmes, for example, and there have been over 50
5 large-scale improvement programmes in maternity since
6 2010. Only 15 of those have been evaluated and many of
7 those demonstrate weaknesses in terms of tackling -- the
8 extent of which even their own recommendations are based
9 on evidence, whether they have involved patients in the
10 design and the priority given to things like inequality.
11 So there is an awful lot of effort that goes into
12 improvement programmes but it's not necessarily clear
13 that they always work. The things that you need to make
14 improvement are the things we discussed earlier. You
15 need really good quality data, you need a collaborative
16 infrastructure so people can work together and co-design
17 problems and test them before they are put in at scale
18 and you need a capacity for evaluation and I don't think
19 we have that currently in the NHS. In my institute we
20 have been working on some examples of this and it's
21 really extraordinary what you can achieve when you work
22 directly with the staff and with patients.
23 **Q.** So you have been working on the evaluation?
24 **A.** No, we have been working on how you
25 co-design -- sorry, we have been working on evaluation,

1 but we have been working on how you co-design programmes
2 with staff and families so you turn the best available
3 clinical evidence into something that is workable on the
4 ward, that respects the interests of patients and takes
5 their views in how it's going to work into advance, it
6 has training programmes so that you can implement it
7 that involves patients themselves in the design of those
8 training programmes, so you've got communication that is
9 respectful and inclusive and that is linked to data
10 sources so you can assess whether the improvement is
11 occurring.
12 Organisations are currently extremely variable in
13 their element to do improvement work and I don't think
14 we have yet worked out how to support those but it's not
15 helpful to keep pushing recommendations and expecting
16 that they're going to turn them into something that
17 always works and we saw that, for example, in relation
18 to the implementation of the duty of candour and Freedom
19 to Speak Up guardians.
20 **Q.** 10.1.5, "Improve workplace conditions and
21 behaviours".
22 You say:
23 "Improving workplace conditions and behaviours is
24 a priority for improving culture, and will require ..."
25 A number of things, one of them "making workforce

1 stewardship a key priority". Who would you identify to
2 take on the role of workforce steward and responsibility
3 for workforce stewardship?
4 **A.** Thank you. I think that needs to be signalled
5 at policy level and then made a priority for NHS
6 organisations but with the right support. Currently the
7 conditions people have to work in are often extremely
8 adverse. They impact on their wellbeing. We don't have
9 a framework of workforce standards and I believe that
10 should be in place and should be monitored.
11 I think we need much more than we have in terms of
12 work system design by which I mean roles, tasks,
13 technologies, all of the things that we know are
14 important to making improvement. They should be based
15 on a discipline known as human factors and again that is
16 highly successful when implemented well. We need better
17 workforce planning and we need training and education
18 that develops people rather than the current often quite
19 dispiriting approaches we have to training in the NHS
20 which is often online training that doesn't build
21 collaborative ethos, that doesn't improve teamwork and
22 that isn't necessarily a very useful experience for
23 people.
24 **Q.** Again, are you suggesting that should be at
25 a policy level, workforce standards that can be

1 monitored?
2 **A.** Yes.
3 **Q.** At 10.1.6 you refer to "Improve and value
4 management at all levels", not just senior leadership
5 and you say it:
6 "... needs to be strengthened at all levels of the
7 NHS. This will require, at a minimum, fuller
8 implementation of the findings of the Messenger review,
9 but will also require that management is recognised as
10 a key priority for the NHS, is resourced and trained for
11 appropriately, and is valued by political leadership."
12 Can you explain first of all how you propose to
13 strengthen management at all levels?
14 **A.** Thank you --
15 **Q.** How could that be done?
16 **A.** I think the first thing is to stop the
17 discourse about managers being dead wood in the NHS.
18 It's absolutely clear we need to strengthen this and
19 that's what the Messenger review said. The Darzi review
20 which published very recently confirmed the same thing:
21 we're undermanaged in the NHS and with better management
22 we could enable clinical staff to do their roles more
23 effectively. So strengthening means (a) recognising it
24 as something that's actually very important to the NHS;
25 a second thing is resourcing it properly, being really

1 clear about what managers need to be doing. It needs to
2 be trained for appropriately and that again requires
3 quite specific kinds of training and at the senior
4 leadership level an example of the kinds of things we
5 might do is much more board development work and
6 clinical director level work that could include, for
7 example, coaches attending meetings and then debriefing
8 afterwards, it could include simulations where those
9 teams are asked to handle a tricky issue and then are
10 debriefed afterwards and at the -- at other levels it's
11 going to mean building in the capacity for doing things
12 like operational management and ensuring that HR and so
13 on are all sufficiently resourced for the tasks that
14 they need to do.
15 **Q.** Nurses and doctors of course have professional
16 obligations to patients?
17 **A.** Yes.
18 **Q.** So those they care for in the hospital. Do
19 you think managers should have the same obligation, same
20 professional obligation?
21 **A.** I think there is a case to be made for having
22 a set of NHS management standards. I think that would
23 help to professionalise NHS managers. I don't think
24 that should apply just to the senior management level.
25 I think there's a very strong case to be made that

1 everybody who works in the NHS should be professionally
2 registered and part of a profession that nurtures the
3 growth of that profession, that is clear about the
4 standards and so on.
5 If we were to move down that route there would need
6 to be clarity about what the liabilities are because
7 managers are often having to deal with things that are
8 out of their control in some sense. They deal with an
9 enormous amount of political pressure. They are often
10 having to balance competing priorities, so that would
11 require a lot of very careful design and testing before
12 implementation, but in principle I think it's a good
13 idea.
14 **Q.** You also, at 10.1.6, say:
15 "This will require ... fuller implementation of the
16 findings of the Messenger review ..."
17 Which particular findings are you referring to
18 there?
19 **A.** The findings relating to the valuing of
20 management I think were a very important conclusion of
21 the Messenger review. Messenger also commented that the
22 "fit and proper person" test had not been fully
23 operationalised and I think that could be something to
24 be reviewed, but the general emphasis on recognising the
25 role of the management in the NHS and the need to

1 resource it properly and to train and set standards for
2 it are the major parts of that.
3 **Q.** When you say -- and you have explained again
4 in oral evidence -- management should be recognised as
5 a key priority for the NHS, how do you suggest that
6 might be recognised, the success or otherwise of that in
7 practice?
8 **A.** The first thing I think would probably be to
9 give it political priority. The second would be to
10 design a framework for it and do that consultative --
11 collaboratively with staff and with patients so it's
12 clear what the expectations are, making sure that that's
13 consistent with good practice in other areas and
14 possibly a programme of registration so the -- there
15 would be some professional regulation of that function
16 in the NHS.
17 **Q.** Finally from me, Professor Dixon-Woods, in
18 terms of the recommendations or areas for thought you
19 have suggested, what do you think are perceived
20 potential problems in implementing any of those
21 recommendations?
22 **A.** All of them are going to be problems. They
23 all require resourcing. They all require the use of
24 attention which is a very scarce resource in the NHS.
25 They're all going to require really high quality

1 co-design. No recommendation is free of its
2 side-effects. Everything that has a bright side tends
3 to have a dark side as well.
4 What I can say is we now I think know quite a lot
5 about how to do this sort of stuff well, so drawing on
6 the evidence base about doing this well will be key. We
7 have a long history of recognising that clinical
8 practice needs improvement. We do not have the same
9 history of targeting management, of targeting how you
10 turn a recommendation that's in the form of a legal
11 requirement or an examination for a new role into
12 practice and it seems to me that's some of where we need
13 to be building the evidence base for the future.
14 **Q.** How much in practice do you think managers
15 who, if they are not medically trained themselves, need
16 to understand the work of those who are clinically
17 trained and the decisions they make and the choices they
18 make?
19 **A.** They absolutely need to understand that and
20 that's got to be a respect on both sides. I'm not
21 a clinician myself, but I spend a lot of time trying to
22 understand what the clinicians are doing and why they
23 are doing it that way and I think the same duty applies
24 to managers. If you don't understand the work being
25 done there's every possibility that you will not do

1 things in a helpful way. You may misrecognise things.
2 You may design systems that don't meet clinical needs.
3 You may for one reason or another exclude the patient
4 concerns from what you're doing. So I think it's
5 absolutely essential that the clinical managers
6 understand -- sorry, non-clinical managers understand
7 the nature of the work being done.
8 **MS LANGDALE:** Thank you, Professor Dixon-Woods.
9 Those are my questions.
10 My Lady, slightly earlier than anticipated,
11 Mr Skelton KC, followed by Mr Baker KC, both have
12 permission from you to ask some questions.
13 **LADY JUSTICE THIRLWALL:** Very well. Thank you very
14 much indeed, Ms Langdale. Mr Skelton.
15 **Questioned by MR SKELTON**
16 **MR SKELTON:** Thank you, my Lady.
17 Professor Dixon-Woods, my name is Peter Skelton. I'm
18 one of the barristers representing one of the Family
19 Groups, just so you're fully aware.
20 I'm going to ask you about speaking up and
21 whistleblowing broadly as a topic. I appreciate
22 Ms Langdale has asked you about it to some extent
23 already but I would like to get into more detail about
24 what happens on the ground for those complaining and
25 responding.

Three broad issues, just so you can start thinking. I would like to explore what's going on in the mind of the person who is thinking about making a complaint, particularly when they're dealing with transgressive behaviour, which is a particularly difficult form of behaviour to respond to. Then what's going on in the mind of the person receiving the complaint and how they're dealing with it and the biases and systems that may be brought into play. Then if I may, may I turn to identifying the key changes that you think could be made that would improve the responses of both those hypothetical individuals faced with that difficult scenario.

As I say, I would like to address those issues in the specific context of transgressive behaviour?

A. Yes.

Q. And particularly extreme transgressive behaviour of the type that you know underpins this Public Inquiry which is criminal behaviour because it is particularly unusual, but it is also particularly difficult to handle and it is quite different, it may be said, from routine neglect or negligence or medical mishaps or system failures that other Inquiries have looked at. Is that clear enough for you?

A. Yes, thank you.

Q. I've got 15 minutes so I'm going to need your help to keep it very focused.

A. Sure.

Q. Thank you. First of all, the identification of transgressive behaviour. One of the themes that the Inquiry may hear from in due course is how difficult it was for those who were working in a hospital environment -- how difficult it is for those in a hospital environment to sort of identify things that are outside of normal human and professional experience. Does that accord with your understanding and research?

A. Absolutely, yes.

Q. What can assist that person in trying to understand what they might first sense before they rationalise?

A. The kinds of things that they would do is often talk to somebody else, a trusted colleague, to sense check essentially what's going on. That first discussion might be quite consequential. If the other person is dismissive or acts as if the speaker is being melodramatic or fanciful, that may suppress their willingness to bring it up again for some time.

What you will sometimes find is that people begin to find a number of allies. They sense out how might be sympathetic to hearing about this issue and that group

may together come to a view that there is something wrong. They may be pulling in information or intelligence from different sources, they may have seen different things, so that first conversation is very high consequence and then there's a typical set of behaviours that may ensue after that.

The issue of a system issue versus a person issue is a very important one here. People are generally much, much more uncomfortable about raising issues about a person and particularly anxious about raising an issue about a person that's involving a transgressive behaviour, in part because of the credibility gap I was discussing earlier, that the fact that they may be just met with incredulity when they try to raise it.

Q. Presumably they themselves may be second-guessing their own judgment?

A. Exactly.

Q. If the transgression isn't quite as obvious as it could be?

A. Yes.

Q. So there's a sense of personal isolation to begin with?

A. Yes.

Q. "Am I right in my own judgment?"

A. Yes.

Q. Then what you're saying is there's a process by which you start to find allies and discuss things and your concerns coalesce into something more significant?

A. That can happen, yes.

Q. Cutting straight to it: what can help that person who initially has that unease about the transgression to speed up the process by which they can bring it to the fore and have it acted on?

A. I think there are probably a number of things you could have. Some Trusts have anonymous reporting lines so people can ring and speak to somebody. That person then needs to be very well trained and needs to be able to recognise a transgressive incident when it first occurs. They also need to have a process to follow. Organisations can't function without processes and, as I was saying earlier, I think those processes are ill-defined and end up channelling things down routes that aren't necessarily terribly helpful.

Q. Just pausing there, it may be seen during the course of this Inquiry that the whistleblowing or speaking up policies weren't in fact used by those that could have used them.

A. Yes.

Q. We can't pre-empt exactly what people will say --

1 **A.** Yes, yes.
2 **Q.** -- but is that your experience and if so,
3 bearing in mind that this received a huge amount of
4 fanfare in 2015 after Robert Francis' report and it has
5 been rolled out nationally, there has been training
6 given, the policies are writ large in every hospital
7 round the country, what is stopping people from using
8 that policy and using that anonymous route you
9 identified?
10 **A.** Do you mean the -- there's two policies.
11 There's the duty of candour requirement and there's
12 Freedom to Speak Up guardians?
13 **Q.** Freedom to Speak Up specifically for the
14 present purposes?
15 **A.** Yes. Freedom to Speak Up guardians are a role
16 that has been extremely variably implemented and we
17 report a lot of the research we did on this. Some
18 organisations were very wholehearted in how they
19 implemented the Freedom to Speak Up guardian role, they
20 took it very seriously, they had job descriptions for
21 that person, they advertised for them, they set up all
22 kinds of systems to raise staff awareness, screensavers,
23 email campaigns, posters. They made sure that person
24 had enough time available. They provided admin support
25 and they made sure that the person was primed to listen.

1 Other Trusts took that role much less seriously.
2 They sometimes assigned it to somebody who was already
3 in a senior position, so appeared remote and distant
4 from staff so they were too scared to go to that person
5 anyway. There was very little awareness raising. Staff
6 were unaware of the availability of the person or they
7 felt that they wouldn't be welcomed if they did bring
8 something up and the person had too little time and no
9 admin support to help with following up, so some of it
10 was to do with how the role was implemented and not
11 everybody who was in those roles was necessarily
12 receptive to the kind of issues that people might bring
13 up.
14 **Q.** So a huge variety of reasons why it may not
15 have worked?
16 **A.** Yes.
17 **Q.** Is it your general experience that it can work
18 as presently set up if implemented?
19 **A.** Yes. The Freedom to Speak Up guardian is
20 a complex role in the sense that they are mainly
21 a signposter. They don't actually have a role in
22 sorting things out by themselves. They can advise the
23 person on which route something needs to go down. So if
24 somebody comes to a Freedom to Speak Up guardian with
25 a transgressive behaviour I believe it's still the case

1 that it could be that there still isn't a clear route by
2 which you could be absolutely confident that was going
3 to be resolved. The Freedom to Speak Up guardian can't
4 resolve it by themselves.
5 **Q.** One of the major themes that came out from
6 Robert Francis' review and indeed I think from your own
7 report, is the repercussions problem, so the person who
8 is thinking about raising the concern is immediately
9 thinking about themselves and what might happen and that
10 could be a variety of things, it could be professional
11 ostracisation, breakdown of personal relations,
12 disciplinary proceedings, all sorts of things as well as
13 the basic moral injury of raising something which could
14 be wrong.
15 Again, how does one address that concern which is
16 a huge weight on the decision-maker?
17 **A.** Yes, I think that's very fair. There are
18 multiple influences on why people don't speak up and
19 creating the psychological safety so people feel they
20 can has got to be a key responsibility of the hearer and
21 that's often going to take hearer courage. It's very
22 discomfiting for somebody to raise an issue about
23 another person, particularly relating to their practice.
24 If we just think about how uncomfortable it is to tell
25 somebody they smell, multiply that by thousands of folds

1 if you think they're engaged in some extremely
2 transgressive behaviour and if you've got it wrong it
3 may be that that does have repercussions, so the
4 creating of psychological safety is going to be key
5 here.
6 I think the other problem with the Freedom to Speak
7 Up guardian role that didn't quite work is that they
8 ended up attracting a large volume of concerns that were
9 actually not really patient safety concerns and it goes
10 back to the dysfunctional nature of many HR functions in
11 NHS organisations.
12 **Q.** Creating that safety I recognise as being
13 important, but how is that going to present to the
14 person who doesn't know the guardian, who hasn't used
15 the system, who isn't familiar with the person they are
16 about to speak to, doesn't know that it's going to be
17 safe? How can the system improve the complainant's
18 thinking about the safety they're going to find?
19 **A.** I think one of the things you could do is take
20 the Freedom to Speak Up guardian out of the Trust. The
21 person is -- the Freedom to Speak Up guardian is
22 employed by the Trust, has to be paid for by the Trust.
23 It was one of those unfunded recommendations, so the
24 Trust has to -- had to find the money for that person
25 out of their own resource.

You could have a -- use the same resource and create independent essentially people -- an independent panel of people you could go to with those kinds of concerns who have no allegiance, if you like, with the Trust where they are from. I think you would probably find you have still got a lot of concerns being taken to that panel, but it is one possible route. Again it would require a lot of design and testing to see if it would work.

Q. Just going back to the disincentives that are in the mind of the person who is thinking about the complaint, obviously the whistleblowing legislation is designed to stop them being disciplined, but there are other aspects which it doesn't help with and that is the -- what's going on in the unit. If you're working in a very small professional team with people you are very close to professionally, possibly personally as well, if you were the person who is breaking the omerta and raising a very serious concern about a member of staff who may well be loved and liked by a number of colleagues, you can't -- it's very difficult to protect you from that. Again, what thinking has been done about that aspect?

A. You're absolutely right, the whistleblowing legislation really only protects you from detriment.

It's very difficult to establish detriment and a lot of the detriment people experience in reality is not of a legal standard of detriment, it's things like being excluded from tea breaks, people not liking you any more, feeling that you're a difficult person, you may end up being -- in order to move forward with the issue having to accept some blame yourself.

I don't know that we have a solution to a lot of this other than -- I mean, what we do know from the examples that we have looked at is that you usually need some kind of external action to take place. It will never be resolvable at unit level.

Q. Can I suggest to you a couple of things that could be thought about. One is the anonymity or confidentiality which you were talking about when you speak to the guardian, is maintaining that through the process so in fact you as whistleblower are not overtly identified and become, as it were, almost like an accuser in court; that doesn't happen.

A. Yes.

Q. Is that a realistic possibility?

A. It's -- I would like that. In reality it may be very difficult to preserve the anonymity because the person who knows about it may be very -- may be the only person who knows about it, they may be the only person

who witnessed the incident. In order to get them to give evidence to an investigation, which might be the one conducted by the HR team, they would still need to -- they might be identified through that process. It's remarkably difficult I think the way things are framed at the moment to preserve anonymity in the way that might be ideal for these situations. This is why I think having some kind of independent broker in this situation might be helpful.

Q. Is another aspect related to the answer you have just given to take the problem away from the complainant and the person who is receiving it or has to manage it and resolve it takes ownership of the problem, so in other words you are raising an issue but you are not part of its resolution necessarily?

A. In principle that's how the systems are supposed to work at the moment. In practice, the person who raises the concerns does typically remain involved through a series of things, but I agree, I would like to sit down with staff and patients and co-design a better way of doing this and test it possibly through simulations. I don't want to be very specific about what that might look like without doing that.

Q. One of the factors I think building on what you have said that may have occurred in the present

situation is that things became adversarial?

A. Yes.

Q. So there were attempts to make things inquisitorial, in other words to have neutral independent oversight and investigation, but they kept devolving into an adversarial position. Now, again without commenting of course on the events in question, how can you maintain that independence in a process where it leaks out that someone has made an accusation and the accuser denies it and it immediately becomes problematic?

A. Yes, that's very, very challenging. The issues about descent into kind of an adversarial process I think are part of the natural history of these things. If you have got one team who have constructed the problem as being, for example, a bullying one and that might appear much more credible on first glance, then the organisational sense-making that takes place after that would essentially trap them in that explanation and it goes back to our discussion of organisational sense-making from earlier.

If you have another group who become trapped in another explanation they equally become trapped and then it becomes very difficult to break the deadlock. I think this is why some sort of honest broker in these

1 situations, the inability of senior management handling
2 this to accept challenge, to be debriefed on what
3 they're doing, possibly through an independent person
4 that could be a coach who comes in to help them with
5 this, so you're moving towards a kind of challenge to
6 the understanding and breaking of the entrapment, but
7 the cultural entrapment is a consistent feature of what
8 we see in essentially organisational degradations.
9 **Q.** So there might be scope for from early on
10 providing more independence --
11 **A.** Yes.
12 **Q.** -- for the person who is independent having
13 more ownership of the problem and keeping it as
14 inquisitorial as possible, rather than it becoming
15 adversarial?
16 **A.** Yes.
17 **Q.** And preserving anonymity and confidentiality
18 in so far as possible throughout the process until it
19 becomes impossible?
20 **A.** Yes.
21 **Q.** Just going back to the original premise which
22 was the recipient -- I have asked you about the person
23 complaining but briefly the recipient of the complaint,
24 you have talked in your report about a number of sort of
25 human sense-making processes that go on and Ms Langdale

1 has asked you about that in detail. To some extent,
2 though, sense-making processes are inherent to human
3 beings?
4 **A.** Yes.
5 **Q.** And you're not going to be able to change them
6 but you are going to be able to make forcing mechanisms
7 to make people challenge their own ways of thinking?
8 **A.** Yes.
9 **Q.** So the credibility gap, the inability to see
10 transgressive behaviour because you simply don't want to
11 see it. What forcing mechanisms can you put on
12 a manager to ensure that occurs?
13 **A.** Thank you. I think that goes back to the
14 discussion we were having earlier that we know a lot
15 about how to handle this in emergency situations. There
16 are people who study things like which behaviour -- when
17 there is smoke, which door people go out of and so on,
18 this relates to situation awareness, and when teams are
19 trained in how to handle emergencies there are specific
20 ways you have to train them, there are specific roles
21 people have to take on. I think something like this for
22 handling non-clinical situations that -- and something
23 that's evolving over a longer period of time so we
24 understand the natural history and the points at which
25 to intervene and the specific interventions which is

1 likely, as you say, to be independent challenge, putting
2 to people the stories, the narrative arc that typically
3 develops in the absence of some kind of challenge so
4 people are constantly revisiting their assumptions and
5 they are open to other ways of considering what the
6 problem might be.
7 **Q.** There is an analogy I suppose with the murder
8 detective who -- the sort of A, B, C of murder, assume
9 nothing, believe no one, challenge everything. So when
10 faced with a concern you bring that openness of mind to
11 its resolution, absolute openness of mind?
12 **A.** Yes, some of it is definitely dispositional.
13 **Q.** But do you think in other industries, for
14 example in the airline industry, there is a laminated
15 chart that the captain has to go through before they can
16 take off and with a concern that's brought,
17 a whistleblowing concern, do you think it would be
18 helpful to have literally a forced process which you
19 must do to resolve that concern, typically if it is
20 about transgressive behaviour which may raise
21 safeguarding or patient safety issues which may
22 otherwise not be dealt with unless the person who is
23 responding is forced to deal with them?
24 **A.** Thank you. The airline industry has a lot of
25 learning to offer us. They have checklists which are

1 actually largely mechanical on take-off and landing and
2 so on which have been generally successful in preserving
3 safety. They have also dealt with things like the
4 terrorist threat which is clearly a form of
5 transgressive behaviour. That requires a lot of careful
6 handling so you don't end up with essentially security
7 theatre, so a lot of performative screening of things
8 and procedures and so on, so there are dangers with the
9 checklist approach as well.
10 I think what I would really like to see is
11 a framework for handling transgressive behaviour that
12 allows clarity about what needs to happen, what are the
13 things you need to think about and that isn't a yes/no
14 checkbox thing, but directs attention in the ways that
15 need to be directed, that offers clarity in terms of
16 procedures and processes to be followed and I keep
17 emphasising that these are not there in the way that we
18 would hope for. If you look at the Savile Inquiry one
19 of the reasons why sexual abuse wasn't being escalated
20 was because the processes and procedures were inadequate
21 at the time that these abuses were happening.
22 So organisations need clarity about the steps they
23 need to follow and that's what I would like to see,
24 a framework, but it would incorporate the kind of
25 challenge that you're asking about.

1 **Q.** So not necessarily as simplistic as the chart
2 I'm mentioning but something --
3 **A.** Yes.
4 **Q.** -- similar as an established process of
5 relative simplicity that could be used in each case?
6 **A.** Yes and I would strongly emphasise the need
7 for the families to be involved in the design of that
8 and their say to be part of the challenge that's offered
9 to the board.
10 **Q.** Yes. I think Mr Baker is going to be asking
11 about precisely that in a few moments.
12 Just lastly -- I think I have used up all my time,
13 but are there any other suggestions when it comes to
14 speaking up, both from the perspective of the
15 complainant and the recipient, which you would urge this
16 Inquiry to recommend?
17 **A.** Thank you. I would recommend attention to all
18 of the voice pathway, so the speaking up I think we know
19 a fair bit about, the hearer courage, and the hearer
20 behaviours we know less about, what happens next, how
21 the concern is to be judged. The priority to be given
22 to it relative to all of the other priorities facing an
23 organisation and the actions to be taken and the actions
24 to be taken are not necessarily always very
25 straightforward, so we call this a "warrant for action",

1 what counts as a warrant for action, and then what is
2 the response that should be made. I think there needs
3 to be clarity on that entire end-to-end process and we
4 have possibly focused excessively on the speaking up end
5 of things -- I don't mean excessively in the sense that
6 it didn't deserve it, it absolutely did, but we haven't
7 got enough attention to the other things that are really
8 important in actually taking things through to action.
9 **Q.** Thank you very much.
10 **A.** Thank you.
11 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
12 Mr Baker.
13 **Questioned by MR BAKER**
14 **MR BAKER:** Professor, my name is Richard Baker,
15 I ask questions on behalf of the other group of
16 Families. Can I begin by thanking you for a very
17 compelling and erudite report.
18 **A.** Thank you.
19 **Q.** I'm going to ask you some questions about the
20 duty of candour and if we could begin please by going to
21 page 75 of your report and to paragraph 7.1.1.
22 **A.** Yes, thank you.
23 **Q.** So you set out here the events that led to the
24 creation of the duty of candour, referring of course to
25 the very well-known case of Robbie Powell.

1 **A.** Yes.
2 **Q.** It's correct to say, isn't it, that before the
3 implementation of Regulation 20 of the Health and Social
4 Care Act Regulations of 2014 there was no legally
5 enforceable duty of candour, which is what you say here,
6 which meant, in terms, prior to April 2015 there was no
7 legally enforceable requirement for NHS Trusts to be
8 honest with those who had been injured by their errors.
9 There is though a difference, isn't there, between
10 a legally enforceable right or obligation and a moral
11 obligation, or indeed good practice?
12 **A.** That's true.
13 **Q.** So prior to 2015 would a well-run hospital
14 with a healthy safety culture have been open and candid
15 with those who were injured by its errors?
16 **A.** They absolutely would and although there
17 wasn't a legally enforceable duty, the National Patient
18 Safety Agency, in 2005, published guidance on exactly
19 this topic. It set out ten principles of openness and
20 it explained what needed to happen if there was an
21 incident, which aimed to ensure that all involved,
22 patients, families and healthcare professionals would
23 feel supported.
24 That guidance was not as well implemented as you
25 would hope, so they updated it in 2009 with further

1 documentation, but that was to do with lack of concerns
2 of impact, so there definitely was an expectation from
3 a national body about openness, but it wasn't made
4 legally enforceable until, as you say, April 2015.
5 **Q.** Yes. In fact there was also -- I appreciate
6 the duty of candour is an institutional obligation, but
7 there would also have been professional obligations upon
8 those, for example registered with the GMC, to be open
9 and candid about errors when they occurred.
10 **A.** That's right, so we can distinguish between
11 the organisational duty of candour and what's now the
12 statutory duty of candour and the professional duty of
13 candour, which did exist and was updated in 2015 around
14 the same time as the organisational duty of candour.
15 **Q.** So if we have a moral obligation upon
16 individuals, professional obligation upon individuals
17 and also a good safety culture obligation upon
18 institutions, what goes wrong that we need to have
19 a duty of candour that's legally enforceable?
20 **A.** One of the things that goes wrong is that once
21 an incident becomes something that's going to be handled
22 through a legal process, the Trust lawyers get involved
23 and they may give advice that is contrary to what you
24 would expect if the duty of candour is operating. They
25 may basically seek to reduce the amount of information

1 that's released, they may mitigate it in some way.
2 A second thing that can happen is that all kinds of
3 things can happen at Trust level that may be largely
4 invisible, but are very highly consequential in terms of
5 disclosures. An example would be incidents had to be
6 reported through an incident reporting system that
7 required grading as to whether they were a serious
8 incident or something below. A serious incident
9 triggered a certain series of actions which included
10 reporting to the families and conduct of a specific type
11 of investigation.
12 If the incident never got graded as a serious
13 incident that just didn't happen and there is evidence
14 that some incidents that should have been classified as
15 serious incidents weren't. We saw that at East Kent,
16 for example.
17 **Q.** Yes. Another feature -- and again it's not
18 unique to this set of circumstances and of course
19 without pre-judging the evidence that may be heard in
20 this case -- is a desire by the Trust to protect its
21 reputation or perhaps not be willing to face up to
22 institutional problems within itself?
23 **A.** Yes, that's the problem -- that's the
24 behaviour we were describing as comfort seeking and it's
25 essentially a behaviour that is focused on the good news

1 and that is uncomfortable with being uncomfortable and
2 that may be orientated towards essentially preserving
3 a veneer of all being well when in fact it isn't.
4 That may be motivated by all kinds of things.
5 Reputation would be one of them. A second would be
6 avoiding heavy-handed interventions from external
7 organisations. A third one is essentially the -- the
8 emotional labour involved in dealing with a big issue of
9 this kind.
10 I think a fourth thing is that many organisations
11 are not well prepared for a situation of crisis. They
12 haven't got a way of dealing with something like this
13 where they are confident they're taking the right steps
14 and there is a -- in some places, sadly, an
15 institutional instinct towards denial and concealment.
16 **Q.** But all of those things had carried on
17 existing --
18 **A.** Yes.
19 **Q.** -- since the duty of candour was introduced,
20 or the legal obligation was introduced. How does having
21 a legally enforceable duty of candour stop those
22 factors, in circumstances where having an obvious moral
23 obligation, or even an individual professional duty
24 wouldn't have stopped them?
25 **A.** I think the legal duty of candour has been

1 a very important intervention, but has been variably
2 well implemented by Trusts and I described that in our
3 report. Some Trusts took it very seriously and went to
4 a lot of trouble to make sure staff were trained and
5 were motivated to comply.
6 The duty is not easy to implement because it
7 requires a set of procedures and not all Trusts are
8 operationally excellent at creating operational change.
9 It also requires a lot of behavioural change on the
10 behalf of the professionals and implementing the
11 disclosures was not easy for professionals. It was
12 emotionally difficult for some of them. They had some
13 anxieties, for example making disclosures when they
14 thought that the abuser might be the person they were
15 having to make the disclosure to.
16 So it's another example of where something that
17 looked like a good idea could have done with a lot more
18 co-design with the families and with the staff before it
19 was implemented. It was one of those things that was
20 left up to NHS Trust to figure out how to do it.
21 The big kind of feature of the duty of candour is
22 it gave legal force to that duty, so CQC can and now is
23 taking action in the event of breaches, so families do
24 have a remedy, potentially, and Trusts are now I think
25 much more aware of their need to comply with this or be

1 liable for prosecution or fines.
2 **Q.** So if I summarise that in -- probably
3 oversimplify it in two ways, one is that if you were
4 a high functioning Trust with regards to patient safety,
5 then you probably would implement the duty of candour
6 quite effectively, but there again you were probably
7 already one of those Trusts who would have been
8 fulfilling those sorts of duties.
9 If you were a dysfunctional Trust, the likelihood
10 is that you would fail to implement the duty of candour
11 effectively within your own organisation and that is why
12 in a number of healthcare scandals, even since 2015, we
13 see recurrent episodes of failure to meet the duty of
14 candour.
15 **A.** I think if your Trust is having difficulty
16 anyway, your ability to implement something like the
17 duty of candour is going to be challenged and if that's
18 compounded by comfort seeking behaviours then you're
19 really looking at difficulties.
20 The challenge of implementing something like the
21 duty of candour was significant because it required so
22 much organisational engineering, culture and behaviour
23 change and so on, and again it goes back to what I was
24 saying earlier, I think a lot of that could have been
25 much better supported.

1 The practice of saying "Hey, we've got a new duty,
2 you've got to implement it", and leaving it up to the
3 Trust to figure out how to do it themselves I think is
4 one that we have shown many, many times means that you
5 get extreme variation in how well it is done and it's --
6 the costs involved are often underestimated, so this was
7 something the Trust had to find from existing resources
8 and if they were already struggling this was going to
9 be -- this was going to be really very hard for them, so
10 it's also a cultural disposition and if you are a Trust
11 who basically just doesn't do this kind of thing,
12 doesn't have the right disposition, if we like, then it
13 was particularly prone to problems.
14 **Q.** Yes, and I think the cultural issue is
15 important because we can see very clear intersections,
16 can't we, between issues such as Freedom to Speak Up --
17 **A.** Very much so.
18 **Q.** -- duty of candour, indeed patient safety as
19 an overarching issue, because they are all intertwined,
20 they are all often symptoms of a bad culture, that
21 there's no candour or no Freedom to Speak Up and that
22 patient safety suffers.
23 **A.** I think that's absolutely true and, you know,
24 what you might see in an organisation that isn't --
25 hasn't got the right culture at the top is something

1 comes in like introduce a Freedom to Speak Up guardian
2 and this is treated as a kind of tick boxing exercise,
3 "We need to ensure we've got one, we need to send in
4 a report every year", and it is done in a fairly
5 lacklustre kind of way, possibly just find muggin's turn
6 and give the job to them, whereas in organisations that
7 have got a highly open, learning committed culture, they
8 would have put a lot of effort into finding the right
9 person, briefing them and, as I said earlier, providing
10 them with the resources that they need and encouraging
11 staff to come forward rather than treating it as
12 literally yet another duty.
13 **Q.** It has been variably enforced over the years
14 in terms of the CQC taking action --
15 **A.** Sorry, I didn't hear the beginning.
16 **Q.** The duty of candour has been variably enforced
17 over the years in terms of the CQC prosecuting for
18 breaches of it. I mean in other industries, for example
19 the construction industry, quite punitive health and
20 safety laws and penalties have been seen to bring around
21 a change in culture and practice on construction sites,
22 for example, for fear of a penalty more than anything
23 else. Is there scope here for greater enforcement and
24 greater penalties against Trusts who breach the duty of
25 candour?

1 **A.** I think the first action by the CQC in
2 relation to duty of candour was 2019, so that was four
3 years after the introduction, and the first prosecution
4 I think was 2020, so that's five years afterwards. You
5 probably do need to leave some time for the Trust to
6 implement it, but I think that could have been greatly
7 speeded up with the right kind of support, but once
8 there was a kind of clarity that there was a period of
9 embedding, then I think there is scope for greater
10 enforcement action.
11 **Q.** Thank you.
12 **A.** It again signals the seriousness of the
13 requirement.
14 **Q.** Yes, and penalties can sometimes be a driving
15 force behind why people make changes. It might not be
16 why we would want them to do it, but it might be the
17 thing that forces them to do it.
18 **A.** Sorry, I didn't hear that again.
19 **Q.** Penalties might often be the driving force as
20 to why people change practices, for fear of a penalty,
21 and it may not be the reason we want them to do it, we
22 would rather they did it on their own volition, but it
23 can be effective.
24 **A.** They can be. I mean it's -- we haven't really
25 evaluated the effect of regulatory fines on healthcare

1 organisations because it takes more resource out of
2 organisations that are already struggling.
3 I think there are many things we could do to
4 support improvement that are not regulatory action and,
5 for example, with the openness policies that was never
6 treated as a quality improvement programme, so the
7 resource that needed to be put into the design wasn't
8 there and then the kinds of things that we know work,
9 data, collaborative improvement, feedback and so on,
10 they weren't in place either, so I think you probably
11 need a range of things if you're going to implement
12 something like this effectively in ways that essentially
13 encourages authentic and genuine commitment to the
14 interests of patients that isn't necessarily because it
15 was a big stick going to be waved, but the big stick
16 should be there if there's still non-compliance,
17 absolutely.
18 **MR BAKER:** Thank you, Professor. Thank you,
19 my Lady. I have no more questions.
20 **LADY JUSTICE THIRLWALL:** Thank you very much
21 indeed, Mr Baker.
22 Ms Langdale, have you any other questions?
23 **MS LANGDALE:** No more questions, my Lady.
24 **LADY JUSTICE THIRLWALL:** Thank you very much
25 indeed.

1 Professor Dixon-Woods, thank you very much indeed
2 for coming this morning, firstly for providing the
3 report and then answering so helpfully so many
4 questions. You are free to go, as they say.
5 **THE WITNESS:** Thank you very much.
6 **LADY JUSTICE THIRLWALL:** We will start again with
7 the evidence of Dr Garstang at 2 o'clock. We will rise
8 now.
9 **(12.47 pm)**
10 **(The luncheon adjournment)**
11 **(2.00 pm)**
12 **LADY JUSTICE THIRLWALL:** Mr De la Poer.
13 **MR DE LA POER:** My Lady, our witness for this
14 afternoon is Dr Joanna Garstang. I wonder if I could
15 ask Dr Garstang to come forward to the witness box,
16 please.
17 **DR JOANNA GARSTANG (affirmed)**
18 **Questioned by MR DE LA POER**
19 **LADY JUSTICE THIRLWALL:** Do sit down, Dr Garstang.
20 **MR DE LA POER:** Can we begin, please, with your
21 full name.
22 **A.** I'm Joanna Jane Garstang.
23 **Q.** And you are a medical doctor, is that right?
24 **A.** That's correct.
25 **Q.** Before we come to just briefly covering your

1 CV, can I just check that you've got a copy of your
2 witness statements with you in the witness box?
3 **A.** I have, yes.
4 **Q.** So if you would like to turn to the first of
5 those witness statements that you gave, which is dated
6 20 March 2024 -- do you have that?
7 **A.** I do, yes.
8 **Q.** Can you confirm for us please that the content
9 of that is true to the best of your knowledge and
10 belief?
11 **A.** It is, yes.
12 **Q.** Before we turn to that introduction, you gave
13 a second witness statement to the Inquiry, is that
14 right?
15 **A.** That's correct, yes.
16 **Q.** Dated 13 July 2024?
17 **A.** That's correct.
18 **Q.** And is that also true to the best of your
19 knowledge and belief?
20 **A.** Yes, it is, yes.
21 **Q.** Dr Garstang, turning back to your first
22 witness statement we're going to begin by just
23 introducing you, then we're going to define some key
24 terms. Our third topic this afternoon will be looking
25 at the standards in 2015/2016. Our fourth topic will be

1 to look at the standards now and we will have a fifth
2 topic which will just cover a number of general matters,
3 including your reflections and recommendations.
4 **A.** Thank you.
5 **Q.** So we will start with the introduction,
6 please, which you do comprehensively in the first
7 paragraph of your first witness statement. I will just
8 run you through it. Please could you confirm that you
9 are employed as a Clinical Associate Professor of Child
10 Protection at the School of Nursing?
11 **A.** That's correct.
12 **Q.** And that you are so employed having qualified
13 much earlier in your career as a medical doctor?
14 **A.** Correct, yes.
15 **Q.** Were you appointed to that role in June 2023?
16 **A.** That's correct, yes.
17 **Q.** Is that described as a clinical academic post,
18 the clinical duties of which are as a Consultant
19 Community Paediatrician?
20 **A.** That's correct, yes.
21 **Q.** Based in Birmingham Community Healthcare NHS
22 Trust?
23 **A.** That's right, yes.
24 **Q.** And are you the Designated Doctor for Child
25 Death at Birmingham and Solihull Integrated Care Board?

1 **A.** That's correct, yes.
2 **LADY JUSTICE THIRLWALL:** And the School of Nursing
3 is the University of Birmingham?
4 **A.** It is, yes.
5 **LADY JUSTICE THIRLWALL:** Thank you.
6 **MR DE LA POER:** Were you employed as a Consultant
7 Community Paediatrician at the Birmingham Community
8 Healthcare NHS Trust and as that Designated Doctor
9 between June 2017 and May 2023?
10 **A.** That's correct, yes.
11 **Q.** Moving on to your paragraph 1.3, were you
12 a Visiting Senior Clinical Lecturer in Child Protection
13 at the School of Nursing between September 2021 and
14 May 2023?
15 **A.** That's correct, yes.
16 **Q.** An Honorary Clinical Research Fellow in the
17 Institute of Applied Health Research at the University
18 of Birmingham between 2019 and 2021?
19 **A.** That's correct, yes.
20 **Q.** And although I promise you we won't go through
21 every single one of your very many qualifications, just
22 the final one there you can perhaps help us with. You
23 say in your witness statement that you were an NIHR
24 Doctoral Research Fellow at Warwick Medical School from
25 2010 to 2015 when you completed your PhD.

1 Firstly, is that right?
2 **A.** That's correct, yes.
3 **Q.** Secondly, can you just help us with NIHR?
4 **A.** That's the National Institute of Health
5 Research, so they are a major funder for medical
6 research.
7 **Q.** And looking at what you do in practice now, is
8 it right to say that much of your clinical work involves
9 the investigation of unexpected child death?
10 **A.** Yes, that's about sort of half -- half my work
11 is leading the practical investigation side, assuring
12 the quality of Child Death Review across the whole of
13 Birmingham and Solihull and the other half of the work
14 is actually then researching into child death from the
15 University of Birmingham. That makes two halves but
16 there's another part as well which is actually providing
17 some national support for Child Death Review through the
18 Association of Child Death Professionals.
19 **Q.** As part of that role, are we right to
20 understand that you are also part of the Child Death
21 Overview Panel?
22 **A.** That's correct, as Designate Doctor I sit on
23 that panel.
24 **Q.** We will come in a moment to what exactly that
25 is, but let's just conclude our review of your

1 expertise. Your PhD, which we have established was
2 between 2010 I think and 2015, was that an evaluation of
3 the joint agency investigation of Unexpected Infant
4 Deaths?
5 **A.** It was, yes.
6 **Q.** So in simple terms were you looking at how
7 effective joint investigations or multi-agency
8 investigations were?
9 **A.** It was, but it was also looking from the
10 parents' perspective as well and making sure that we got
11 our investigations compassionate and supportive, as well
12 as effective.
13 **Q.** And the last one that I will draw attention to
14 in terms of what you list there: are you a member of the
15 scientific committee of the Lullaby Trust, which is a UK
16 support organisation for Sudden Infant Death?
17 **A.** That's correct, yes.
18 **Q.** Now, that concludes what I wanted to take from
19 your witness statement. I have just been asked to
20 confirm a couple of other things, please. Are you the
21 Chair of the Association of Child Death Review
22 Professionals?
23 **A.** That's correct, yes.
24 **Q.** And again we will come to who they are. Are
25 you a specialist medical advisor to the National Child

1 Mortality Database?
2 **A.** That's correct. That's a funded post.
3 **Q.** And through that funded post have you been
4 working with NHS England since 2019 with a hiatus during
5 the pandemic?
6 **A.** I was appointed by -- to work for NCMD just
7 over a year ago, so that was how the funding from NHS
8 England sort of -- *(unclear)* from my work in NCMD only
9 started a year before.
10 **Q.** In terms of your work in the last 12 months
11 have you been involved in the following: firstly, in
12 October 2023 did you produce a Child Death Review
13 Safeguarding, Accountability and Assurance Framework
14 presentation?
15 **A.** I reviewed that, yes.
16 **Q.** You reviewed it?
17 **A.** Yes, I certainly didn't write it.
18 **Q.** Did you produce videos in November on
19 a similar topic?
20 **A.** Oh, yes, I produced videos, yes, along with
21 a colleague.
22 **Q.** I think they were made available on FutureNHS
23 platform, is that right?
24 **A.** Yes.
25 **Q.** And have you been in discussions with NHS

1 England in April of this year in relation to the Draft
2 Safeguarding, Accountability and Assurance Framework
3 questions for Child Death Review?
4 **A.** I don't think it was in April unless I have
5 written it in here. I know I'm certainly having
6 conversations with them at the moment as they draft new
7 guidance.
8 **Q.** Have you advised on the statutory safeguarding
9 Child Death Review dataset during the spring of this
10 year?
11 **A.** I have regular conversations with NCMD about
12 how we update datasets, almost on a weekly basis we're
13 as a team discussing how we improve things.
14 **Q.** Has that led to a data-sharing agreement with
15 the National Child Mortality Database?
16 **A.** Sorry, data-sharing agreement between who?
17 **Q.** I believe it's being suggested it's with NHS
18 England?
19 **A.** I mean, I think there is lots of existing
20 data-sharing agreements for NHS data to go to the
21 National Child Mortality Database. I think we're
22 looking at establishing another data-sharing agreement
23 about a different sort of safeguarding dashboard but
24 that's still a work in progress.
25 **Q.** I think it's described as a draft in the notes

1 that I have been given, is that fair?
2 A. Yes, I think it's fair, yes. It's certainly
3 not -- not up there yet. It's a work in progress.
4 Q. That concludes my first topic, Dr Garstang.
5 We're going to just define three important terms or
6 concepts which hopefully will help people navigate your
7 evidence.
8 The first we're just going to talk briefly about is
9 the idea of safeguarding and I think this is something
10 that you are keen for people to understand is that you
11 do not hold yourself out as a safeguarding expert in the
12 broadest sense of safeguarding, is that right?
13 A. Yes, I mean that's right. My -- I have done
14 some research in safeguarding and I have sort of -- but
15 my particular expertise is in Child Death Review but
16 there is a big overlap because our most challenging
17 child deaths are those that have a safeguarding element
18 to them.
19 Q. Of course there are, I'm sure, very many
20 definitions of exactly what safeguarding is, but it's
21 the overarching concept of keeping people who may be
22 vulnerable safe from harm?
23 A. Absolutely. It's more than just child abuse
24 and neglect.
25 Q. And in its broadest sense it will include

1 adults although that's not your focus and that's not
2 this Inquiry's focus?
3 A. Absolutely it does include vulnerable adults.
4 Q. And of course it includes non-fatal
5 circumstances as well?
6 A. Yes, definitely, yes.
7 Q. But here we're going to focus on fatal
8 circumstances because we're going to come to our second
9 term for definition which is the notion of Child Death
10 Review and could you just please tell us briefly what
11 the Child Death Review process is in terms of its
12 headline points?
13 A. Okay, so in England the Child Death Review
14 process is defined by the 2018 Statutory Guidance and
15 what it consists of is the holistic review of a child's
16 death, meaning that we look at sort of all the factors
17 relating to why that child may have died, so looking at
18 their sort of underlying vulnerabilities, whether they
19 were premature, had an illness, were born with
20 a malformation, or in fact they were sort of perfectly
21 healthy.
22 We look at the domain of what we call the physical
23 environment, so physical safety, that might be say for
24 some babies about safe sleeping or with a road traffic
25 accident about road safety. The social environment

1 which is very much about parenting ability and parenting
2 decisions and service delivery, which is sort of did we
3 get our services right, not just healthcare but other
4 services as well, education, police, fire.
5 So you have those four domains and you consider the
6 whole of the child's life and it's very different to the
7 adult way of looking at deaths, so the adult Learning
8 from Deaths framework, hospitals will review their
9 treatment of the patient for their final admission, so
10 it's much, much broader what we look at.
11 Q. Does it apply to all children regardless of
12 the circumstances of their death?
13 A. Absolutely, it -- from a child who dies
14 shortly after birth who may actually be born so
15 prematurely that they couldn't survive, up until a young
16 person the day before their 18th birthday; the only
17 exclusion being a baby who is stillborn because by law
18 they're not a child.
19 Q. Does the Child Death Review process in the
20 case of every child death have as its final stage the
21 Child Death Overview Panel?
22 A. That's correct, yes.
23 Q. You have already referred, that's a panel that
24 you sit on and again just in headline terms for us,
25 please, what is the function of the Child Death Overview

1 Panel?
2 A. So there's lots of review processes up until
3 the Child Death Overview Panel, or CDOP as it is
4 referred to, and CDOP is very much assuring that the
5 reviews up to that point have been done well, that we
6 have got all the information we need, standardised
7 coding of deaths because then all the information goes
8 to the National Child Mortality Database and it is
9 really important that we code things uniformly so that
10 you can have learning at a national level.
11 And also because we have an organisational memory
12 and a local footprint, we look at -- I mean, in our
13 meetings in Birmingham we're a big CDOP so we will have
14 20 deaths to review in a morning and see 150, 160 in
15 a year. We kind of know what's normal for us and so we
16 can see if there's a particular issue and so therefore
17 we can sort of take action, if it's something to do with
18 a healthcare provider we might make requests that they
19 take issue, or if it's a public health issue we can make
20 recommendations that way for public health as well.
21 Q. One of the things you alluded to is -- this is
22 my paraphrase of your answer so correct me if I am
23 wrong -- this idea that in the CDOP you sit on, you do
24 have the capability of spotting patterns, is that fair?
25 A. That's right because we're a team who have

1 been together for quite a while.
2 **Q.** Now, we will come to some of the limitations
3 in the CDOP process a little later, but just in general
4 terms, does that mean that the CDOP, so the Panel that
5 sits at the end of this process, is very well-equipped
6 to detect potential cases of deliberate harm, or not
7 very well-equipped, or does it rather depend upon the
8 circumstances?
9 **A.** It -- CDOP is completely reliant on the
10 information given -- passed to it from the hospitals or
11 other agencies sort of further upstream because the
12 people sitting round the table at CDOP are independent
13 from the care of that child, so if, for instance, it
14 happened to be one of my patients that we were
15 discussing I would not be in the room. So it's to give
16 that sort of degree of anonymity and independent
17 oversight.
18 Now, certainly prior to the statutory guidance in
19 2018, often the quality of information that CDOPs got
20 from hospitals was very limited, so it really tied their
21 hands and it was an uphill struggle for a CDOP to get
22 relevant information for children who died in hospitals
23 because hospitals kept their Mortality Review
24 information themselves and saw it as theirs and not
25 appropriate to share with CDOP.

1 Thankfully that has changed and the quality of
2 information now available for Child Death Review in
3 England is world leading, that we're much better than
4 pretty much any other country.
5 **Q.** Finally on CDOP, because, as you have alluded
6 to, it sits at the end of a process and that there are,
7 depending on the given circumstances, a number of
8 investigative steps that might occur before the process
9 reaches its final stage, what does that mean for the
10 potential length of time between the death of the child
11 and the CDOP convening to consider that?
12 **A.** I mean, there's certainly a few months, so it
13 varies. If, for instance, it is a death of a child say
14 with cancer who has been under palliative care, there's
15 no postmortem and there's no concerns about care, that
16 child may come through to CDOP relatively quickly,
17 depending -- say within sort of three or four months.
18 There has to be a Child Death Review meeting held by the
19 professionals who cared for that child before the case
20 comes to CDOP, so providing that step is taking place in
21 a timely manner, a straightforward case will come
22 quickly.
23 But if there has got to be particularly
24 a postmortem, or other multi-agency investigations, it
25 may well be a year or sometimes more before that child

1 is reviewed at CDOP, particularly at the moment with the
2 shortage of paediatric pathologists, it's typically for
3 our -- our children who need a Joint Agency Response and
4 postmortem it's a year plus before we get through to
5 CDOP.
6 **Q.** Is that length of time capable of affecting
7 how well CDOP is able to potentially detect patterns of
8 behaviour and that sort of thing?
9 **A.** I think it is, providing -- because we have --
10 you can't do your job with half information so therefore
11 you've got to have all the information there. I think
12 what it takes for people at CDOP to be very inquiring
13 and challenging and sometimes to demand that we don't
14 sign a case off and we get further information. I mean,
15 admittedly it's very rare we're thinking about
16 deliberate harm, particularly from a professional, but
17 much more it's about if we think that there have been
18 issues to do with healthcare, healthcare provision, and
19 then we're often going back to Trusts and asking for
20 them to review again or start a new investigation.
21 **Q.** So CDOP is going to recur through the topics
22 we're covering but I just want to move on to one final
23 concept. The SUDI, sometimes SUDIC, can you just tell
24 us, please, what that acronym stands for and what it
25 means in practical terms.

1 **A.** So SUDI or SUDIC, it's the Sudden Unexpected
2 Death of an Infant or Child. SUDI for an infant, more
3 broadly we talk about SUDIC now, infant or child. It is
4 just a descriptive term at the point of presentation for
5 a child who has died suddenly and unexpectedly. Most
6 deaths will go on to have an explanation and then be
7 given a cause of death, so it's just a marker for
8 a sudden death that needs detailed investigation.
9 **Q.** We're going to look at the evolution of the
10 circumstances in which that investigation occurs and the
11 nature of it in just a moment, but firstly does it
12 follow from what you have said that effectively SUDIC,
13 so those sudden unexpected deaths, are effectively
14 a subset of the overarching Child Death Review process?
15 **A.** Yes, I mean probably -- I'm thinking in
16 Birmingham for comparison we have about 160 deaths
17 a year and we start a SUDIC or a Joint Agency Response
18 investigation for between 30 and 40 deaths a year.
19 **Q.** To the extent that from your national roles
20 and your wider learning you are able to help us, is
21 that, do you understand, broadly representative?
22 **A.** It's probably broadly representative but there
23 are sort of variations in how often -- it's not entirely
24 clear cut and often there is some discussion between
25 professionals as to whether a death is really sudden and

1 unexpected. I mean, for instance, if a child or baby is
2 found suddenly dead in bed, well absolutely, but
3 for instance children with life-limiting conditions may
4 die more quickly than expected and often there may be
5 discussions as to whether it's appropriate to start, or
6 you start a Joint Agency Response investigation and
7 rapidly decide actually no, the death was expected, so
8 it varies a bit. I think maybe Birmingham probably does
9 slightly more than most because we have a very
10 supportive Coroner and police who are very supportive
11 and it's very much in the forefront of everyone's minds.
12 **Q.** Is the national data for the number of these
13 SUDIC cases or Joint Agency Responses -- is that
14 captured anywhere that you're aware of?
15 **A.** It's captured by National Child Mortality
16 Database, yes.
17 **Q.** And for how long has that been the position,
18 do you know?
19 **A.** National Child Mortality Database started
20 collecting data on child deaths in 2019.
21 **Q.** I'm generalising here because we're going to
22 look at the detail of it, but are the fundamental
23 constituents of a SUDIC process or a Joint Agency
24 Response that firstly it starts very, very early?
25 **A.** Yes, within -- pretty much it should start as

1 soon as it is recognised that it's an unexpected death.
2 **Q.** Secondly, that it is a multi-agency response,
3 that is to say it is not just the doctors who are there
4 at the point of death, or who have come to certify the
5 death, it goes far beyond them?
6 **A.** Yes. Police are always involved and social
7 care as well.
8 **Q.** And does it involve a person who holds the
9 role of Designated Paediatrician?
10 **A.** The Designate Doctor sort of overall is there
11 to advise, but you have a lead health professional
12 because it wouldn't be possible for me in my role to
13 manage all 40 cases in Birmingham, particularly as you
14 have to have an immediate response out of hours. So you
15 have a senior healthcare professional who is
16 a Consultant Paediatrician or sometimes a specialist
17 nurse who pulls the team together and leads the health
18 response -- health part of the investigation.
19 **Q.** Would you expect that person to potentially
20 have been involved in the care of the child before death
21 or are they independent from the care of the child that
22 they may have received?
23 **A.** I mean, the vast majority of Joint Agency
24 Responses are for children who die suddenly and
25 unexpectedly, so therefore they haven't got much of

1 a footprint with healthcare services.
2 In the rare cases where we have to run a Joint
3 Agency Response for a child who has died very suddenly
4 as an in-patient, then we would fully expect the
5 paediatrician who was caring for that child to be part
6 of that Joint Agency Response. Whether they have the
7 skills to actually sort of chair it, so to speak, may
8 depend and the -- and either a Designate Doctor or the
9 specialist nurse may be there to support them, but they
10 are definitely needed to be part of that team
11 investigating that death because they've got that
12 knowledge of the child.
13 **Q.** So we will come back to the detail as it was
14 and as it is and we will start with as it was, so this
15 is my next topic, please, the standards at the time, and
16 we're going to look at four domains here. The first is
17 we're going to look at the statutory guidance; then
18 we're going to look at the guidance issued by the Royal
19 College of Paediatrics and Child Health; then we will
20 look at some overarching NHS guidance and finally in
21 this topic we will look at the position in Wales.
22 So we will begin please with the statutory
23 guidance. My Lady, you have this behind tab 6.
24 **LADY JUSTICE THIRLWALL:** Thank you.
25 **MR DE LA POER:** This is the document referred to as

1 "Working Together" as a shorthand but what I will ask,
2 please, is for the INQ0013235 to be brought up on our
3 screen. We will start at page 1 and we can see the full
4 title is rather more comprehensive.
5 Thank you very much indeed.
6 We can see there, Dr Garstang, the rather fuller
7 title that is emphasising what will become a theme in
8 your evidence that this is about inter-agency working.
9 **A.** Yes, correct, yes.
10 **Q.** Now, we have brought up the March 2015
11 version. In fact there were predecessors to this,
12 weren't there?
13 **A.** Yes, every few years, yes.
14 **Q.** Was one of the predecessors the 2013 edition?
15 **A.** It was, but certainly the Child Death Review
16 element of 2013 was virtually identical to 2015.
17 **Q.** So although this is the version that is, if
18 you like, in force for the period that the Inquiry is
19 focused upon, in fact it doesn't contain things which
20 were new or unique as compared to the earlier guidance
21 when it comes to the process we're going to be looking
22 at?
23 **A.** That's correct, yes.
24 **Q.** So could we move forward, please, to
25 paragraph 7. We're just going to go through this and,

1 Dr Garstang, I hope you will forgive me but I'm just
2 going to, through you, introduce some of these key
3 concepts. So page 7 of this document, please. We can
4 see -- can I just check that that is page 7?
5 **LADY JUSTICE THIRLWALL:** It is paragraph 7 you're
6 asking for, is it?
7 **MR DE LA POER:** Thank you, yes. We're going to
8 have a look first at paragraph 6 here which is in the
9 centre of our screen. Thank you very much indeed. The
10 sentence begins:
11 "This statutory guidance should be read and
12 followed by ..."
13 Then it gives a list and can we see that within
14 that list, Dr Garstang, is included social workers and
15 professionals from the health services?
16 **A.** Correct, yes.
17 **Q.** And we can see at paragraph 7 that:
18 "All relevant professionals ..."
19 So in other words those who have just been
20 identified:
21 "... should read and follow this guidance so that
22 they can respond to individual children's needs
23 appropriately."
24 **A.** Correct, yes.
25 **Q.** If we move forward, please, to the next page,

1 and we can just pause at the top there. We see at
2 paragraph 12 the guidance is aimed to:
3 "... help professionals understand what they need
4 to do, and what they can expect of one another, to
5 safeguard children."
6 And if we look to the last sentence in that
7 paragraph:
8 "In doing so, it seeks to emphasise that effective
9 safeguarding systems are those where ..."
10 And it then gives a list of effective safeguarding
11 systems. Included in that is the first bullet point
12 which is absolutely central, would you agree, to the
13 whole idea about child safeguarding, which is:
14 "The child's needs are paramount, and the needs and
15 wishes of each child, be they a baby or infant, or an
16 older child, should be put first, so that every child
17 receives the support they need before a problem
18 escalates."
19 **A.** Yes, absolutely.
20 **Q.** And the second bullet point:
21 "All professionals who come into contact with
22 children and families are alert to their needs ..."
23 **A.** Yes.
24 **Q.** And:
25 "... and any risks of harm that individual abusers,

1 or potential abusers, may pose to children."
2 **A.** Yes.
3 **Q.** Then if we move down, please, to the bottom of
4 page 8 we can see that paragraph 14, which is a little
5 further down, identifies key principles and again can
6 you confirm that this is the position, that safeguarding
7 is everyone's responsibility: for services to be
8 effective each professional and organisation should play
9 their [part to the full] ..."
10 **A.** Absolutely, yes.
11 **Q.** And again a child-centred approach, that they
12 need to be based on a clear understanding of the needs
13 and views of children?
14 **A.** Yes. I just say for child death you still
15 take it that even though a child has died they have the
16 right to have their death investigated fully, the right
17 that we learn from their death and also you're thinking
18 of future children's rights to not die from the same
19 thing. So that's how it sort of relates to child death.
20 **Q.** Thank you. If we keep scrolling down and
21 I promise you we won't look at every single line within
22 this, but these are important principles. The heading
23 "Safeguarding is everyone's responsibility" is obviously
24 one of those key principles just identified and we can
25 see that a non-exhaustive list is given, which includes,

1 for example, paediatricians, but presumably you would
2 say includes managers and nurses as well in an NHS
3 setting?
4 **A.** Absolutely, yes.
5 **Q.** At paragraph 20 "A child-centred approach":
6 "Effective safeguarding systems are child centred.
7 Failings in safeguarding systems are too often the
8 result of losing sight of the needs and views of the
9 children within them, or placing the interests of adults
10 ahead of the needs of children."
11 **A.** That's correct.
12 **Q.** Another important principle, would you agree?
13 **A.** Very much.
14 **Q.** So can we move forward please to page 17 and
15 here we have paragraph 24 and I will just read it out
16 again and perhaps you can help us with what it might
17 mean in practice:
18 "Fears about sharing information cannot be allowed
19 to stand in the way of the need to promote the welfare
20 and protect the safety of children."
21 It goes on to say:
22 "To ensure effective safeguarding arrangements:
23 "All organisations should have arrangements in
24 place which set out clearly the processes and the
25 principles for sharing information between each other,

1 with other professionals and with the LSCB ..."
2 That's the Local Safeguarding Children Board?
3 **A.** That's correct, so yes, all health
4 organisations sort of within a local area would have
5 proper data-sharing arrangements, absolutely, to support
6 safeguarding.
7 **Q.** And the second bullet point:
8 "No professional should assume that someone else
9 will pass on information which they think may be
10 critical to keeping a child safe. If a professional has
11 concerns about a child's welfare and believes they are
12 suffering or likely to suffer harm, then they should
13 share the information with local authority children's
14 social care."
15 **A.** That's correct, yes.
16 **Q.** And again this is a recurring theme which is
17 perhaps moving slightly away from child death but
18 nonetheless you will be I'm sure very familiar with it.
19 The idea of involving the local authority and in
20 particular the local authority's designated officer is
21 absolutely central, isn't it, to working together with
22 children?
23 **A.** Well, absolutely, yes, but I mean one of the
24 sort of key mantras of safeguarding is that no child has
25 ever died because people shared too much information,

1 that the onus is always it is better to share
2 information, and that, yes, the protecting children is
3 your fundamental responsibility and not the adults or
4 organisations or anything else around them and to always
5 keep the children at the forefront.
6 **Q.** We're going to move forward, please, to
7 page 52. Here we have the section 11 duty under the
8 Children Act of 2004 and at paragraph 3 in this section
9 we can see the organisations and people that section 11
10 applies to and at the second bullet point we can see
11 that "NHS organisations, including the NHS England and
12 Clinical Commissioning Groups, NHS Trusts and NHS
13 Foundation Trusts" are all within the scope of the duty,
14 is that right?
15 **A.** That's correct, yes.
16 **Q.** Over the page, please, we can see what is
17 expected of those organisations in terms of the
18 arrangements they should have in place, namely that they
19 should:
20 "... reflect the importance of safeguarding and
21 promoting the welfare of children, including ..."
22 And there are a number of these bullet points which
23 are relevant, the first:
24 "A clear line of accountability for the
25 commissioning and/or provision of services designed to

1 safeguard and promote the welfare of children."
2 We will leave commissioning to one side, but where
3 one is providing services designed to safeguard that
4 needs to have a clear line of accountability, is that
5 correct?
6 **A.** Yes, yes.
7 **Q.** Second bullet:
8 "A senior board level lead to take leadership
9 responsibility for the organisation's safeguarding
10 arrangements."
11 **A.** Yes -- I mean yes.
12 **Q.** We then at the fourth bullet point have:
13 "Clear whistleblowing procedures, which reflect the
14 principles in Sir Robert Francis' Freedom to Speak Up
15 review ..."
16 We heard something about that this morning from the
17 witness, Professor Dixon-Woods, but is that something
18 that was so far as 2015 was concerned something that was
19 expected?
20 **A.** If it was in Working Together, it would have
21 been expected.
22 **Q.** Then we have at the sixth bullet point
23 a reference to a designated professional lead:
24 "... (or, for health provider organisations, named
25 professional) for safeguarding."

1 Again is that where the role you have might fall
2 into?
3 **A.** Yes, you had designates at ICB level or CCG
4 level, as it was then, and named within healthcare
5 organisations.
6 **Q.** We can see the seventh point is about the safe
7 recruitment practices for individuals who are permitted
8 to work regularly with children and then we can see at
9 the next one, and this is a topic that the Inquiry will
10 be returning to:
11 "Appropriate supervision and support for staff,
12 including undertaking safeguarding training ..."
13 And the sub-bullet effectively amounts to this,
14 doesn't it, Dr Garstang: that the employers need to
15 ensure that their staff are competent to carry out their
16 duties with the appropriate level of safeguarding
17 knowledge?
18 **A.** That's correct, yes.
19 **Q.** And if we turn over the page, please, we can
20 see two further sub-points which are the mandatory
21 induction and then this:
22 "All professionals should have regular reviews of
23 their own practice to ensure they improve over time."
24 So safeguarding is not a static thing?
25 **A.** Yes, correct, yes, you do annual safeguarding

1 updates. It's expected.
2 **Q.** Then the last one to look at here is:
3 "Clear policies in line with those from the LSCB
4 for dealing with allegations against people who work
5 with children. Such policies should make a clear
6 distinction between an allegation, a concern about the
7 quality of care or practice or a complaint."
8 Then it goes on to define in three ways how
9 an allegation may relate to a person who works with
10 children and I would just like to just focus on the
11 wording here, Dr Garstang, and see if you can help us
12 a little with it. The first bullet is:
13 "Behaved in a way that has harmed a child, or may
14 a have harmed a child."
15 The second is:
16 "Possibly committed a criminal offence against or
17 related to a child; or
18 "Behaved towards a child or children in a way that
19 indicates they may pose a risk of harm to children."
20 So we see that word "may" used in the first and
21 third and "possibly", so in terms of your understanding
22 what is the threshold for concern before you do
23 something?
24 **A.** I mean, what it means here is that you only
25 have to have concerns that it might have happened. You

1 don't need to prove -- it's not up to you to prove it
2 before making a referral. Certainly -- I mean I have --
3 these cases -- it's obviously very difficult when
4 there's concerns that it might be a staff member who has
5 harmed or might have harmed a child, so you would expect
6 that there would be discussions within that healthcare
7 organisation with the Trust's safeguarding team and
8 getting advice from them, but if there was any doubt
9 they would make that referral to allow a proper
10 investigation. It's not up to an individual
11 organisation to do the investigation themselves because
12 you have only got that one element of the picture. The
13 other agencies may have much more information.
14 **Q.** In terms of an individual who isn't part of
15 the formal safeguarding structure, so they're not the
16 Designated Doctor or they're not formally badged as
17 somebody in the safeguarding hierarchy, what is the
18 level of concern that they need to have in order to
19 raise it with someone internally who is a part of that
20 safeguarding structure?
21 **A.** Well, if they've got any concern they should
22 be going to their Trust safeguarding team for advice.
23 That is what the -- all Trusts have safeguarding teams,
24 that's what they're there for. Often clinicians are
25 going to the safeguarding teams -- I mean not

1 necessarily about this, but whether it is appropriate to
2 make a referral to social care for a child who is at
3 harm from their family and discussing what to do next,
4 so they are there to advise and support healthcare --
5 well, professionals within their organisation.
6 **Q.** Thank you. We're going to move forward,
7 please, just to note at page 56, halfway down the
8 page -- we don't need to look at the detail of all of
9 this but we can see from the heading that it expressly
10 deals with health services as part of its guidance, is
11 that right?
12 **A.** That's correct, yes.
13 **Q.** If we just have a look at paragraph 16, for
14 example:
15 "All staff working in healthcare
16 settings - including those who predominantly treat
17 adults - should receive training to ensure they attain
18 the competences appropriate to their role and follow the
19 relevant professional guidance."
20 If we go over the page we can see "Within the NHS",
21 again this idea of a named or designated doctor and
22 a named or designated nurse, third bullet:
23 "All providers of NHS funded health services,
24 including NHS Trusts, NHS Foundation Trusts and public,
25 voluntary sector, independent sector and social

1 enterprises should identify a named doctor and a named
2 nurse (and a named midwife if the organisation provides
3 maternity services) for safeguarding."
4 **A.** That's correct, yes.
5 **Q.** So that is, in a sense, generality of the
6 guidance?
7 **A.** Yes.
8 **Q.** But we're going to now move to what it says
9 about the specific circumstances of a child death and we
10 will find that, please, on page 81. This is under
11 the heading of "Child Death Reviews" so this is, as we
12 described it before, not immediately focusing in on the
13 sudden unexpected death element, but this is the process
14 that covers all children.
15 **A.** Correct, yes.
16 **Q.** And we can see reference there to the Local
17 Safeguarding Children Board and in particular the
18 responsibilities in that blue box. This may be outside
19 of your expertise, Dr Garstang, but I wonder if you can
20 just help us. In terms of the LSCB, it is required by
21 the regulations to have responsibility for:
22 "Collecting and analysing information about each
23 death with a view to identifying ..."
24 And then the second (ii):
25 "Any matters of concern affecting the safety and

1 welfare of children in the area of the authority."
2 Now, in practice is that something that they need
3 help with, or are they just expected to do that whether
4 or not any matter of concern is drawn to their
5 attention?
6 **A.** I mean, my take on that is that's the process
7 of Child Death Review. You're looking to identify
8 anything that can be done to stop children dying in
9 future and to improve the sort of lives of children,
10 rather than just being purely looking at it from
11 a safeguarding perspective. That is part of it but not
12 all of it.
13 **Q.** So a safeguarding concern may be a matter of
14 concern but --
15 **A.** Yes.
16 **Q.** -- so might hygiene or countless other
17 factors?
18 **A.** Road safety -- yes.
19 **Q.** In terms of identifying any wider public
20 health or safety concern arising from a particular death
21 or from a pattern of deaths in that area, presumably
22 that is predicated upon the Local Safeguarding Children
23 Board being made aware of all of the deaths that might
24 form a pattern?
25 **A.** Yes. I mean, generally local -- it was

1 usually quite straightforward back in sort of -- going
2 back to sort of 2015 for this guidance getting --
3 knowing that a child had died, but getting hold of all
4 the relevant information and relating to that death in
5 2015 may have been more difficult.
6 The one issue that was relevant here and also still
7 is an issue is that the CDOP footprint is based on where
8 the child's home address is and not where they died and
9 so therefore, for example I use Birmingham because I'm
10 familiar, we have a national level Children's Hospital
11 there, so probably only around a third of children who
12 die in Birmingham Children's Hospital get reviewed by my
13 CDOP, the other two-thirds are split over the rest of
14 the country because they provide a national level
15 paediatric intensive care, so that does make it much
16 more difficult for CDOPs to have that oversight because
17 some of your children are dying elsewhere.
18 **Q.** You have made that point very clearly, if
19 I may say so, and rather than leave it to the end, let's
20 just deal with it now.
21 **A.** Okay.
22 **Q.** What, in your view, is the solution to that
23 particular problem?
24 **A.** I mean, it's already been looked at with
25 the -- this year's Working Together has in part

1 addressed that and said that CDOPs need to have
2 oversight of all the deaths in their area, regardless of
3 where children live and to think about which CDOP should
4 actually do the review, so, for instance, again using
5 Birmingham as an example, if a child dies in Birmingham
6 Children's Hospital having been an in-patient there for
7 most of their life, as sometimes happens, then it kind
8 of makes sense that their death is reviewed by
9 Birmingham CDOP.
10 If on the other hand a child dies following a road
11 traffic accident in Wolverhampton and is airlifted to
12 Birmingham Children's Hospital and dies shortly
13 afterwards, it makes much more sense that probably the
14 learning comes from Wolverhampton, but it needs
15 a discussion probably on a case-by-case basis.
16 The electronic platform we use for CDOP reviews at
17 the moment doesn't allow for transfer of cases although
18 they are working on it to change it, but also it takes
19 a lot more time to do it and Child Death Review is a bit
20 of a poor relation to safeguarding and NHS funds are
21 tight, that to do Child Death Review well takes a lot of
22 resource and thankfully in Birmingham we have invested
23 well in it but I'm aware that my CDOP probably has much
24 greater resources than many others in terms of the
25 amount of doctor time and admin time to make sure that

1 we have a high-quality review.
2 **Q.** Well, we will come back to the issue of
3 resources in our final section.
4 Can we move forward, please, to page 83 which is
5 going to give us a flowchart which is to be followed for
6 all child deaths and here we're looking at, if you like,
7 the generic process before we look at what additional
8 steps may be taken if the death is sudden and unexpected
9 and we can see there as it moves down the flow diagram
10 that that large box towards the bottom left-hand corner
11 is the CDOP meeting.
12 **A.** Mm-hm.
13 **Q.** Which follows, as you have already described,
14 a number of earlier steps.
15 **A.** Yes.
16 **Q.** And we can see that that may not be the end of
17 it, that first meeting, because there may be further
18 enquiries that are required?
19 **A.** Yes, sometimes yes, in which case you pause
20 the CDOP and you come back to CDOP when you've got all
21 the right information to complete your review.
22 **Q.** If we go over the page, please, to page 84, we
23 will see -- and I'm not going to read all of these out
24 but they are now -- they form part of the Inquiry
25 record. We can see the responsibilities of the Child

1 Death Overview Panel are all set out there. As I say,
2 at this stage we need do no more between us than
3 acknowledge that there is a comprehensive list which I'm
4 sure you will agree captures what they were expected to
5 do in 2015?
6 **A.** Yes.
7 **Q.** We're now going to move forward, please, to
8 page 85 where we're going to come to that subset of the
9 Child Death Review process which is unexpected, sudden
10 and unexpected death and there is, as we're about to
11 see, can you confirm, a whole section of Working
12 Together in 2015 devoted to this?
13 **A.** That's correct, yes.
14 **Q.** It begins with a definition that we will see
15 in more than one place, that:
16 "... an unexpected death is defined as the death of
17 an infant or child which was not anticipated as
18 a significant possibility for example, 24 hours before
19 the death; or where there was an unexpected collapse or
20 incident leading to or precipitating the events which
21 lead to death."
22 You have already told us something about the fact
23 that reasonable people can reasonably disagree about
24 whether a death was unexpected, depending upon the
25 presentation of the child in the preceding period, but

1 this is the definition that they should be centering
2 their discussion around, is that right?
3 **A.** Yes, and that's still the definition we use
4 and I think it's important to note it makes no reference
5 to where that collapse takes place. Whilst most
6 unexpected deaths happen outside of hospital, they can
7 and do sometimes happen in hospital and that -- there is
8 no mention that you exclude an unexpected death just
9 because it has happened in an in-patient area.
10 **Q.** 13, back again to that important role:
11 "The designated paediatrician responsible for
12 unexpected deaths in childhood should be consulted where
13 professionals are uncertain about whether the death is
14 unexpected. If in doubt, the processes for unexpected
15 child deaths should be followed until the available
16 evidence enables a different decision to be made."
17 So the grey areas are accommodated: if in doubt,
18 start the process?
19 **A.** Absolutely: if in doubt, start; you can always
20 stop.
21 **Q.** Then we have 15, which may shed some further
22 light on the circumstances this applies in:
23 "When a child dies suddenly and unexpectedly, the
24 Consultant clinician (in a hospital setting) or the
25 professional confirming the fact of death (if the child

1 is not taken immediately to an Accident and Emergency
2 Department) should inform the local Designated
3 Paediatrician with responsibility for unexpected child
4 deaths at the same time as informing the Coroner and the
5 police."
6 **A.** Yes, that's right, though in reality the local
7 Designated Paediatrician is not going to be notified in
8 the middle of the night for every case. Often that
9 responsibility is devolved to the Consultant
10 Paediatrician on call to hold the case until working
11 hours.
12 **Q.** Now, one of the things the Inquiry will be
13 investigating -- and I'm not here descending into the
14 facts, but just describing an area of investigation --
15 is the fact that whether different Consultants and
16 doctors being involved in different deaths meant that
17 relevant information didn't come together in one place
18 as quickly as it might otherwise. That's a matter for
19 us to investigate.
20 If the Designated Paediatrician is informed in
21 every case, whether or not it's in the middle of the
22 night or the next morning, does that potentially address
23 that issue?
24 **A.** It does. So, for instance, in Birmingham I'm
25 aware of all the cases that my colleagues are managing

1 and in our -- and I have a team of nurses as well who
2 are aware of them, so if we have any -- if there are any
3 particular challenges and often there are because no
4 case is ever straightforward, we can sit down and talk
5 and work out what to do.
6 **Q.** Moving forward, please, to page 86 and it is
7 just a matter that you draw attention to in your witness
8 statement. If we have a look at paragraph 17 we can see
9 that -- the final sentence in that paragraph:
10 "In all cases when a child dies in hospital, or is
11 taken to hospital after dying, the hospital should
12 allocate a member of staff to remain with the parents
13 and support them through the process."
14 I think you are aware of some debate as to whether
15 or not this applied to hospital settings. Does that
16 sentence which you have drawn attention to help you with
17 your understanding of where it applied?
18 **A.** Yes. I mean, to me it makes clear that it
19 should happen, irrespective of where the child has died
20 and I think it sort of confirms certainly relating back
21 to the RCPCH Child Protection Companion, again that
22 supports that principle.
23 **Q.** We will certainly come and have a look at
24 that, although I promise you not in this much detail,
25 shortly.

1 If we move forward, please, to page 87 and just
2 look briefly at paragraph 19, we have another
3 responsibility in terms of notification:
4 "Where a child dies unexpectedly, all registered
5 providers of healthcare services must notify the Care
6 Quality Commission of the death of a service user - but
7 NHS providers may discharge this duty by notifying NHS
8 England."
9 Now, in practical terms what does that mean and how
10 much in your experience is it observed?
11 **A.** To be honest, I really -- I'm not sure how
12 that works or what it means for NHS England or what they
13 do with the data. I certainly wasn't aware of it --
14 I mean, I was aware of the requirement in 2015, but
15 I think it was very much probably an administrative
16 task. I suspect now it's covered by the notification to
17 the National Child Mortality Database.
18 **Q.** Which as you have told us didn't come into
19 being until 2019?
20 **A.** Yes.
21 **Q.** Again we will just bookmark this for later
22 evidence sessions, but we can see that the Designated
23 Paediatrician for Unexpected Deaths in Childhood is
24 given a specific section there inside that box at the
25 bottom, is that correct?

1 **A.** Yes, yes.
2 **Q.** And it is they who are ensuring that all
3 people who need to know are notified and the list
4 includes Coroner, police, local authority.
5 **A.** That's correct, yes.
6 **Q.** Of course that is necessary, isn't it, for
7 there to be a multi-agency response?
8 **A.** Yes, you can't do a multi-agency response
9 without notifying the other agencies.
10 **Q.** Over the page, page 88, paragraph 22:
11 "If a doctor is not able to issue a medical
12 certificate of the cause of death, the lead professional
13 or investigator must report the child's death to the
14 Coroner in accordance with a protocol agreed with the
15 local Coronial service."
16 **A.** That's a fundamental medical practice.
17 **Q.** Over to page 91 we're going to get a flowchart
18 and here we have already touched upon this, the idea
19 that there may be some uncertainty about whether this
20 applies only to community settings and we're going to
21 have a look at the historical background to this and why
22 people may have thought that, or whether it applies more
23 generally. You have given the firm view that this
24 applies more generally to all child deaths, but when one
25 has a look at this particular flowchart does it look to

1 you that it seems to be based upon a community death,
2 rather than a hospital death?
3 **A.** I mean it certainly looks much more like
4 a hospital -- sorry, like a community death, but I mean
5 of our 40 Joint Agency Responses a year in Birmingham we
6 might have one that relates to an in-patient death, so
7 therefore any flowchart which is summarising a process
8 is going to point much more towards the majority
9 process.
10 **Q.** Regardless of that, is this clear from it,
11 that we talked about timescales, we've got a period of
12 the first two to four hours, so in other words working
13 at speed?
14 **A.** Absolutely. Pretty much -- if you're in the
15 Emergency Department and you are initiating a Joint
16 Agency Response, if the police aren't there already,
17 whereas very often they automatically are notified by
18 ambulances with an out-of-hospital child cardiac arrest,
19 you're picking up the phone and asking the police to
20 come in and if it's a sudden collapse in hospital, when
21 the hospitals are sort of phoning up a SUDI or a Joint
22 Agency Response doctor for advice, our first line is
23 "Have you called the police?" because they need to be
24 there.
25 **Q.** Thank you very much indeed. We can take that

1 document down. So that's the review of Working Together
2 in 2015 and you have already told us that what we have
3 just looked at is materially the same as what was the
4 position in 2013, so I would just like to go back in
5 time even further, just to try and understand the
6 evolution of this process because this may be relevant.
7 The language that we saw there in terms of the
8 definition of an unexpected death, was that language
9 that was first devised by the Royal College of
10 Paediatrics and Child Health?
11 **A.** Actually the first definition of term of SUDI,
12 Sudden Unexpected Death in Infancy was from the
13 CESDI-SUDI studies from Peter Fleming and team which was
14 I think in the early 1990s or possibly the 1980s. That
15 was where the first use of the term "SUDI" came from.
16 **Q.** So the term is coined there but in terms of
17 when it first came into guidance, did we see the Royal
18 College of Paediatrics and Child Health use it?
19 **A.** Yes, with the 2004 RCPCH and RCPath guidance.
20 That's when it sort of hit the mainstream if that's ...
21 **Q.** Now, in terms of the circumstances which were
22 envisaged that would be subject to that process, what
23 was the focus of that document?
24 **A.** The 2004 focus was absolutely around your
25 classic sudden infant death, baby found unexpectedly

1 dead at home, and it didn't mention sort of really
2 anywhere about hospitals or older children or any sort
3 of unusual circumstances. It was very much focused on
4 a classic case at home.
5 **Q.** So giving clear guidance for those
6 circumstances, not referring to wider circumstances in
7 a particular hospital setting but not saying "You
8 mustn't follow this guidance" either?
9 **A.** Yes, it didn't say "Don't", but it didn't
10 mention that you might do it for a hospital death.
11 **Q.** So that's the first RCPCH publication. If we
12 then move forward to May 2013 which is obviously the
13 year that that version of Working Together that we have
14 spoken about, 2013, had materially the same information
15 in, and in that year did the Royal College of
16 Paediatrics and Child Health publish a Child Protection
17 Companion?
18 **A.** Yes, it did, yes.
19 **Q.** This isn't dealt with in your witness
20 statement, but I understand it is a document that you
21 have some familiarity with?
22 **A.** Yes.
23 **Q.** And, my Lady, it's at tab 10 of your bundle.
24 I wonder for this, please, if we can bring it up on
25 screen INQ0108020. We can move forward, please, through

1 this document to page 151. Thank you very much indeed.
2 We will begin here. This is under the heading
3 "Infant and Child Deaths". If we move towards the
4 bottom of the page we can see there's a reference to
5 a Serious Case Review.
6 **A.** Yes.
7 **Q.** According to this guidance a Serious Case
8 Review, which is not a term that we have been looking at
9 previously, must always be held where abuse or neglect
10 of a child is known or suspected.
11 **A.** Yes. I mean, a Serious Case Review is
12 different to a Child Death Review. It's a safeguarding
13 review and it's looking at -- it's not an investigation
14 into what happened and the cause of death, it's about
15 sort of learning for improving safeguarding systems, so
16 it's a separate process and a child would have both
17 a Serious Case Review and a Child Death Review if they
18 died from abuse or neglect.
19 **Q.** I think in fact if we look at the second (ii),
20 it also applies if the child has been seriously harmed?
21 **A.** Yes.
22 **Q.** So if we go over the page, please, to 152 and
23 again just looking for more information about what this
24 process requires, at 15.2.10 it is described as "...
25 more in-depth and focused review than that involved in

1 the Child Death Overview process. It is specifically
2 focused [as you just told us] on learning lessons to
3 improve the way agencies and individuals work, both
4 individually and collectively, to safeguard and promote
5 the welfare of children."
6 **A.** Yes, so it's a much more -- serious case
7 reviews are much more in-depth, looking at the
8 multi-agency safeguarding, yes.
9 **Q.** If we then move forward to the next page
10 please, we can see the heading "Child Deaths", so that's
11 the start of the section dealing with child deaths and
12 if we go over the page, please, and we have some
13 definitions and do we see there a familiar definition at
14 15.4.1, defining what an unexpected child death is?
15 **A.** Absolutely, yes.
16 **Q.** Express reference there to the SUDI or SUDIC
17 process.
18 **A.** Yes.
19 **Q.** And on the face of it no distinction in that
20 definition as to location?
21 **A.** Absolutely, yes.
22 **Q.** We can see at the bottom of our screen there,
23 15.5.1:
24 "When a child dies suddenly or unexpectedly,
25 a coordinated and timely multi-agency response provides

1 the opportunity to support the family through their
2 bereavement, and to investigate that child's death
3 thoroughly and sensitively."
4 And so this is absolutely, would you agree, aligned
5 with the statutory guidance?
6 **A.** Yes, I mean this was a sort of distillation of
7 the statutory guidance, of the Kennedy Guidance and
8 Working Together is a I suppose easy distillation for
9 a working paediatrician, that's what this was aimed for
10 and in fact the authors of this chapter were people who
11 had contributed to Kennedy and were experts in SUDI.
12 **Q.** We're just going to look at a couple more
13 passages in terms of just looking at this point as to
14 what the expectation was in these guidance documents.
15 If we look at page 155, and we look at 15.6.3:
16 "These processes would not normally apply to
17 children dying in hospital from known causes, or those
18 with known life-limiting or life-threatening
19 conditions."
20 So a natural inference from that is that it would
21 otherwise apply to children dying in hospitals?
22 **A.** Yes, absolutely, yes. The inference is that
23 if you don't know why the child has died and they're
24 an in-patient in hospital, you should be doing the
25 unexpected death process.

1 **Q.** Just one last page to look at in here because,
2 as you have told us, it's a working guide for -- or
3 a guide for working paediatricians which aligns with
4 guidance that we have already looked at in considerable
5 detail.
6 Can we go to page 160 because there flagged for the
7 reader is a -- this is under the heading "Records and
8 Reports" and could we scroll down, please, because
9 there's a cut out box which is a reference to
10 recommendation 68 from the Victoria Climbié Inquiry in
11 2003:
12 "When concerns about the deliberate harm of a child
13 have been raised, doctors must ensure that comprehensive
14 and contemporaneous notes are made of these concerns.
15 If doctors are unable to make their own notes, they must
16 be clear about what it is they wish to have recorded on
17 their behalf."
18 Just help us, Dr Garstang, in practice how
19 important is it that when people have concerns that they
20 write them down?
21 **A.** Well, it is sort of drummed into you through
22 medical training that if you don't write something down,
23 it didn't happen, so it's very important to document as
24 well but also when you're handing over cases -- yes,
25 I mean you're -- writing notes is a principle of medical

1 practice.
2 **Q.** So we're going to move away from this document
3 and just complete our review of the Royal College
4 documentation. We don't need to bring it up, so we can
5 take that down from the screen. Thank you very much
6 indeed.
7 Can you confirm that in November 2016 the Royal
8 College updated that 2004 guidance which had been
9 written from that community point of view?
10 **A.** Yes, that's right, yes.
11 **Q.** We're not going to go to any of the detail of
12 that, Core Participants have access to that, but
13 firstly, is it still the guidance that the RCPCH has
14 issued for SUDIC?
15 **A.** It still is. It's woefully out of date but
16 we're not able to update it at present.
17 **Q.** I can assure you there is going to be
18 an opportunity in our second session just to deal with
19 that, but in terms of clearing up where it applied is
20 there, for example, express references to deaths on
21 neonatal units?
22 **A.** I can't remember the exact wording. It says
23 it wouldn't normally apply in a neonatal unit but that
24 doesn't mean it shouldn't apply because absolutely we --
25 sadly on a neonatal unit each year there are many

1 deaths, but it's only very occasionally we need to do
2 a Sudden Unexpected Death in Infancy investigation.
3 **Q.** Is that because sudden and unexpected deaths
4 on a neonatal unit are themselves rare events?
5 **A.** Yes. I mean again going back to Birmingham,
6 with our 160 deaths a year, 80 of those are babies in
7 their first month of life, the majority of whom die on
8 neonatal units and it's about once a year that -- so one
9 of those 80 we might need to do a SUDI investigation
10 for, so it is a rare event.
11 **Q.** We will move on to the broader framework
12 guidance and you have looked at this in considerable
13 detail in your second witness statement. Again, we
14 don't need to bring up the detail of it, partly because
15 we're not going to see what we might have been looking
16 for in it and I will ask you just to explain that in
17 a moment, but were you asked by the Inquiry to have
18 a look at the Safeguarding Assurance Framework from
19 2013?
20 **A.** Yes, I was, yes.
21 **Q.** And was that a document that before now, in
22 all of your experience in this area, that you had ever
23 come across before you were asked to look at it?
24 **A.** No, I hadn't seen it before this Inquiry, no.
25 **Q.** Did you review it as we requested you to?

1 **A.** Yes, I did.
2 **Q.** And in terms of the 2013 guidance, in summary,
3 what was your conclusion about the adequacy of that
4 document as far as Child Death Review was concerned?
5 **A.** It was inadequate. It barely mentioned it,
6 which probably explains why I wasn't familiar with it.
7 **Q.** Were you also asked to look at the 2015
8 version of the same framework?
9 **A.** Yes. I was, yes.
10 **Q.** And did you reach the same conclusion?
11 **A.** I did, yes.
12 **Q.** Well, in the second session we will look at
13 the latest version of the framework. We will just
14 conclude this session, please, as I said I would, by
15 having a look at the position in Wales.
16 Now, up until now, certainly as far as the
17 statutory guidance was concerned, was that for England?
18 **A.** Yes, the -- well, certainly the 2018 Child
19 Death Review guidance applies only to England and
20 Working Together -- forgive me, I am not quite sure
21 whether that applies to Wales as well, or whether they
22 have their own version of it, but I'm sure it would be
23 very, very similar.
24 **Q.** I'm sure that we can check that very easily,
25 but in terms of guidance that's been issued specific to

1 the child death process was there guidance in force in
2 2014?
3 **A.** So the PRUDiC guidance, yes, but it had much
4 less of a statutory basis.
5 **Q.** Now, the PRUDIC guidance -- my Lady, you have
6 this behind tab 5, if we can just bring that up on
7 screen. We're just going to have a look at the couple
8 of pages within it. That is INQ0106967.
9 If we turn, please, to page 3 of that guidance, we
10 can see at paragraph 1.1:
11 "This procedure sets a minimum standard for
12 a response to unexpected deaths in infancy and
13 childhood. It describes the process of communication,
14 collaborative action and information-sharing following
15 the unexpected death of a child."
16 At 1.2 it makes clear that it begins at the point
17 of death and ends with the completed record of child
18 death being sent to the Child Death Review programme.
19 At 1.3:
20 "This procedural response will be followed when:
21 "A decision has been made that the death of a child
22 is unexpected or
23 "There is a lack of clarity about whether the death
24 of a child is unexpected or
25 "The cause of a child's death is not apparent and

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1 it is not possible to issue a death certificate."
2 So again, aligning with the expectations of Working
3 Together: if in doubt, follow the procedure?
4 **A.** Correct, yes.
5 **Q.** At 1.5, again aligning with this common theme
6 we have seen:
7 "This is a multi-agency procedural response
8 intended to ensure consistency across Wales, and is not
9 agency or discipline specific. It outlines what needs
10 to be achieved and gives broad suggestions about the
11 roles of agencies. It does not replace existing
12 internal agency or professional procedures."
13 Critically there, the first words of it, it's
14 multi-agency?
15 **A.** Yes.
16 **Q.** Now, if we go to page 6 -- we don't need to
17 work our way through it for reasons that we will get to
18 immediately after this page, but we can see that it
19 provides guidance for specifically unexpected death as
20 a hospital in-patient?
21 **A.** Yes, that's right, yes.
22 **Q.** There's a flow diagram that follows.
23 If we go to page 7, we will see at 3.1 a familiar
24 definition, would you agree, Dr Garstang?
25 **A.** Yes, yes.

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1 **Q.** At 3.2 an express statement that it applies in
2 all circumstances, including deaths in hospital
3 settings?
4 **A.** Yes.
5 **Q.** If we then move forward to page 8 we are going
6 to have a look at the position in terms of where a child
7 dies unexpectedly in another area because of course this
8 is guidance for Wales --
9 **A.** Yes.
10 **Q.** -- and all of the deaths that the Inquiry is
11 considering in detail occurred in England.
12 **A.** Yes.
13 **Q.** We can see that at 6.3, according to the
14 guidance:
15 "When a child dies in England, but is normally
16 resident in Wales, the PRUDiC or the English Child Death
17 Overview Panel process may occur wherever and however
18 the family and the principles of the PRUDiC process will
19 be best served."
20 **A.** Yes.
21 **Q.** Does that envisage some consultation with the
22 family about the process?
23 **A.** I mean, it would do, but I must say, having
24 never worked on the Welsh borders or in Wales, I'm not
25 an expert on how this actually happened in practice.

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1 **Q.** Nor will I ask you to do more than confirm
2 your expectation that there would be some kind of
3 cross-border agreement?
4 **A.** Absolutely, yes.
5 **Q.** Why in your view is it important that there is
6 such an agreement?
7 **A.** Well, because otherwise children will fall
8 through the net. I mean, we have sort of cross area
9 arrangements throughout England because it's very common
10 with a major hospital that a child in cardiac arrest may
11 be taken out of their local area to a Children's
12 Hospital and you have then got to initiate a SUDIC
13 process and hand it back to the local area where the
14 child lives.
15 **Q.** Two final matters before I'm going to ask the
16 Chair to take a break -- and we can take that document
17 down -- and they relate to your personal experience.
18 Firstly, in terms of your experience in Birmingham,
19 you talk in your witness statement about the position in
20 November 2017 and I think that was when you returned to
21 frontline clinical practice, is that right?
22 **A.** I mean, I returned to clinical practice from
23 my PhD in the summer of 2015, but the role I was in in
24 Coventry didn't involve anything to do with child
25 deaths.

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1 **Q.** So that was your first exposure to how it was
2 working in practice on the ground?
3 **A.** Yes, yes, was the summer of 2017 when
4 I swapped to work in Birmingham.
5 **Q.** And at that stage what was your experience
6 about the approach to SUDIC and in particular the
7 approach to SUDIC and hospital deaths?
8 **A.** It was a bit of a culture shock actually
9 coming back to frontline SUDIC having been I suppose
10 from an academic SUDIC background because in those
11 intervening years the definition of what was included in
12 the SUDIC had vastly expanded, so, for instance, when we
13 started out in 2008 when I was doing -- I was helping
14 run the training courses with the people who had written
15 the original 2004 guidance, we never thought of
16 including hospital deaths, we never thought of any child
17 with a life-limiting condition would ever have a SUDIC
18 response, and then in sort of 2017 when I'm back on the
19 frontline it -- many more children being included in
20 SUDI, so children who died in hospitals, children who
21 have life-limiting conditions but died unexpectedly, so
22 yes, it was a big change. My thought is I suspect it
23 must have come with the 2013 Working Together and that
24 would fit with the 2014 PRUDiC guidance, but, I mean,
25 I'm supposing that as I wasn't actually there on the

1 frontline at the time those changes came in.
2 **Q.** But it was well-established upon your return?
3 **A.** It was. There was no doubt about it because
4 we had -- as I said, these are rare events and when they
5 happen, whichever of my Consultant colleagues is on call
6 is usually contacting me or other colleagues just
7 checking they are doing the right thing because they are
8 not straightforward, so you tend to remember them.
9 **Q.** The final topic is this and it's a short one:
10 in your view, back in 2015/2016, who, if anyone, had
11 responsibility to ensure that the frontline doctors and
12 nurses knew about the system that needs to have come in
13 around 2013?
14 **A.** So that would have come to the Local
15 Safeguarding Children Board because at that point they
16 were responsible for Child Death Overview Panels and for
17 what was called the rapid response, or the SUDI
18 response, so they had sort of ultimate responsibility
19 but through the Designate Doctor for, as it was then
20 called, Unexpected Death to make sure that everyone knew
21 and everyone trained and there were good local protocols
22 because you have to have protocols and policies between
23 Coroners, police and healthcare for it to run smoothly.
24 **Q.** So in terms of filtering that information
25 through to the frontline, when you get to any given

1 individual you're looking at the Designated Doctor for,
2 as it was called, Unexpected Death?
3 **A.** Yes, at that point it would have been the
4 Designated Doctor for Unexpected Death's responsibility
5 to make sure that everyone knew what to do.
6 **MR DE LA POER:** Dr Garstang, thank you.
7 My Lady, I wonder if that would be a convenient
8 moment for a break?
9 **LADY JUSTICE THIRLWALL:** Yes, thank you very much
10 indeed. We will have a break until 25 to 4.
11 **(3.18 pm)**
12 **(Short Break)**
13 **(3.35 pm)**
14 **LADY JUSTICE THIRLWALL:** Mr De la Poer.
15 **MR DE LA POER:** My Lady, thank you.
16 Dr Garstang, we're going to move from the standards
17 of 2015/2016 to my fourth and penultimate topic, the
18 standards now, and we start as we did before with the
19 statutory guidance. Is there a 2023 version of Working
20 Together?
21 **A.** Yes, there is.
22 **Q.** Does that set out for Sudden Unexpected Deaths
23 in Childhood and Infancy, does that set out a process
24 much like the one we have looked at for the 2015
25 version?

1 **A.** Yes, but it's the summary. It refers back to
2 the 2018 Child Death Review statutory and operational
3 guidance, which is much more detailed.
4 **Q.** So it effectively incorporates a separate
5 piece of guidance which is exclusively devoted to that
6 topic?
7 **A.** Yes.
8 **Q.** And that came in in 2018?
9 **A.** It was published in 2018. It was sort of
10 required to be enacted from October 2019.
11 **Q.** As you say, that's a much more detailed
12 document than we saw in the 2015, but does it in summary
13 envisage a JAR, a Joint Agency Response?
14 **A.** Yes, it does, yes, it talks of the Joint
15 Agency Response, yes.
16 **Q.** No difference between that and a multi-agency
17 response?
18 **A.** No, it's exactly the same but they decided to
19 change the terminology.
20 **Q.** Again, is that envisaged that in the case of
21 a child who falls within the definition of a Sudden
22 Unexpected Death, for that to be geared up very quickly?
23 **A.** Yes, that you're starting it sort of within
24 a couple of hours of the death, yes.
25 **Q.** Are similar or the same agencies involved as

1 was envisaged in 2015?
2 **A.** Yes, it's police, healthcare, social care,
3 with the Coroner's investigation running sort of in
4 parallel but working very closely with them.
5 **Q.** In terms of the Police, and this will be as
6 true now as it was in 2015 subject to training, what
7 value does the police bring to that situation?
8 **A.** Well, the police are there on behalf of the
9 Coroner and they give a lot of background information,
10 so they will know about a family's criminal records or
11 other concerns and they will sort of -- the police you
12 work with are -- there are specialist child abuse
13 police officers, so they've got a very good handling of
14 child abuse and neglect and they will -- I mean, we all
15 offer each other challenge. They will sort of challenge
16 paediatricians sometimes, have we thought appropriately
17 of safeguarding, or we may challenge them. But I think
18 also it means that if there's then -- if you do have
19 soft concerns about something, you're not having to pick
20 up the phone to somebody you have no relationship with
21 or you don't know that actually they're already a part
22 of your core team so it's very easy to have those
23 discussions.
24 **Q.** I'm sure I know what you mean, but can you
25 just define for us what you mean by "soft concerns"?

1 **A.** Well, I suppose if you were worried that abuse
2 or -- much more soft, something like neglect had
3 contributed to a child's death, you might want to talk
4 it through with the police and think "Well, actually are
5 we right to be concerned about" -- in most cases it is
6 to do with parents' actions, that is this right "Are we
7 right to be concerned about this or actually we're
8 overthinking it?" So it's actually just having somebody
9 from another agency to talk through your concerns and
10 come up with usually an action plan of what further
11 information do we need to do together to reassure
12 ourselves or to escalate things further.
13 **Q.** Would you expect if there were concerns about
14 a member of staff, for example, in the context of the
15 death, would you expect that to be discussed with
16 the police with a view to taking soundings from them
17 about what they thought might be the next steps?
18 **A.** Absolutely. If there are concerns about
19 a member of staff, yes, we would expect to go down the
20 sort of local -- the LADO, the Local Authority
21 Designated Officer route. I mean, much more commonly
22 that might be an issue of actually it's not that that
23 person -- that person may be in a position of --
24 a position of trust but it's not actually -- and what
25 I'm thinking about that it might be the parent of the

1 child who is in a position of trust when a child has
2 died unexpectedly, that perhaps you might be thinking do
3 you need to go down a LADO route. It's incredibly
4 unusual that it is a healthcare professional that you
5 are worried has been involved in the child death -- or
6 causing the child death, but absolutely we would be
7 discussing that with them and very much with social care
8 because they are the people with the responsibility for
9 managing LADO.
10 **Q.** You have described it on a number of occasions
11 being incredibly rare or very rare. Does the existing
12 system accommodate it though?
13 **A.** It does, completely. I mean, for example,
14 there is one case in Birmingham that has been reported
15 in the press where there were concerns that a healthcare
16 professional may have harmed a child in intensive care
17 and my team were notified within hours of the event.
18 The hospital contacted us for advice of what to do and
19 our advice was "We have to call the police now", so the
20 police were called in the middle of the night and by the
21 following morning we had got a strategy meeting deciding
22 what to do and later that day we were having positions
23 of trust meeting.
24 **Q.** And when you say you've got to call the police
25 now, is that call the police as a member of the public

1 might call the police, or is that call the police in the
2 context of their responsibility within the Joint Agency
3 Response?
4 **A.** It was call the police as in the on call
5 police officer for a Joint Agency Response who is
6 a trained child abuse -- and have a conversation about
7 what actions we need to take.
8 **Q.** So I'm going to move on from the statutory
9 guidance as it is now, other than to ask you, in your
10 view, is that statutory guidance adequate?
11 **A.** Yes, the 2018 Statutory Guidance I think is
12 adequate but like all guidance it does need updating in
13 some extents, for instance the Medical Examiner system
14 has come into play since the guidance was written, but
15 largely it stands.
16 **Q.** Whose responsibility is it to update that
17 particular piece of guidance?
18 **A.** It would be the Department for Health.
19 **Q.** Moving to the Royal College, you have already
20 alluded to the fact that the 2016 guidance is the extant
21 guidance and I may be wrong in this recollection, but
22 you may have used the word "woeful" to describe how out
23 of date it is, but whatever term might be used, is it
24 very out of date?
25 **A.** It is. The problem is that the 2018 guidance

1 refers to a Joint Agency Response and gives several
2 different categories of death that need this
3 multi-agency approach, such as deaths from trauma,
4 suicide, unattended stillbirth, as well as your classic
5 Sudden Unexpected Death in Infancy or Childhood.
6 The 2016 guidance is written from the point of view
7 of a Sudden Unexpected Death in Infancy, full stop, and
8 mentions you could possibly use some elements for an
9 older child, so you've got guidance written for a sudden
10 baby death being used to investigate a 17-year old who
11 has died by suicide. It just doesn't work and also
12 there is no guidance on how you manage a death of
13 a child with a life-limiting condition, or the death of
14 a child on an in-patient unit and so I think that's what
15 causes confusion, that Police want to follow everything
16 to the letter because that's the police mentality.
17 Doctors like grey areas and nobody feels supported in
18 making the right decision.
19 **Q.** We're going to come to the hurdles and
20 obstacles to updating that guidance, but just taking
21 a step back, you will I'm sure be familiar with concerns
22 that are expressed generally about there being too much
23 guidance, that we have to look in a number of different
24 places. If there is already this statutory guidance,
25 what need, in your view, is there for the RCPCH guidance

1 to be updated as opposed to simply withdrawing it,
2 clinicians told "look at the statutory guidance"?
3 **A.** The statutory guidance just covers the high
4 level principle. It doesn't actually tell you what
5 you're actually doing in your investigation, so
6 for instance your multi-agency information sharing
7 meetings, who needs to be there, what the purpose is for
8 a child who has died suddenly at home by doing a joint
9 home visit, what you might -- how you might manage
10 a death of a child in hospital where you need to follow
11 those processes, so, yes, it is very much needed because
12 otherwise -- and I think you do need detailed guidance
13 when you're in a multi-agency environment because all
14 the different professions have got different
15 perspectives and it makes it much easier, particularly
16 when you're often dealing with rare events to actually
17 have some detailed guidance that is based on good
18 scientific evidence of what you should do and also
19 informed on what's right for families too.
20 **Q.** So the update is 100% necessary. Is it right
21 that the RCPCH have agreed to lead in the creation of
22 that update?
23 **A.** They have, but it's the funding that's the
24 issue.
25 **Q.** Who is responsible for the funding?

1 **A.** That's NHS England.
2 **Q.** Is there a target completion date for that
3 that you're aware of, or is it simply on the to-do list
4 to be done at some point when the money is available?
5 **A.** Yes, once we've got the -- there is a team of
6 us from the National Child Mortality Database who have
7 been working sort of jointly leading the work with the
8 Royal College and it's probably the best part of
9 a year's work because it will cover many different
10 circumstances of death in the existing guidance, so it's
11 the best part of a year's work but until we have funding
12 agreed we can't even start so it's just on hold waiting.
13 **Q.** We will come back to the RCPCH when it comes
14 to training and general awareness, but staying with the
15 guidance framework, we have the Safeguarding Assurance
16 and Accountability Framework which there is a 2024
17 edition of, is that correct?
18 **A.** That's correct, yes.
19 **Q.** Now, you were in the earlier session not, if
20 I may paraphrase it, terribly impressed with the
21 previous versions in terms of Child Death Review. What
22 is your view about the current version?
23 **A.** It's even less adequate given that
24 responsibility for Child Death Review is now Department
25 of Health rather than Department of Education, so it

1 should be assured through NHS processes and it
2 fundamentally forgets to assure it.
3 **Q.** And how is that to be remedied?
4 **A.** Well, either it needs to be included in the
5 Safeguarding Assurance Framework sort of assuring the
6 whole of the Child Death Review process as set out in
7 the 2018 guidance, or there needs to be a separate Child
8 Death Review Assurance Framework but at the moment it is
9 just missed.
10 **Q.** Whose responsibility is that?
11 **A.** That would be I expect NHS England.
12 **Q.** PRUDiC, the guidance in Wales, there is a 2023
13 version of that. Is it right that that includes
14 passages referring to neonatal deaths and unexpected
15 deaths on paediatric and critical care units?
16 **A.** It does, yes.
17 **Q.** So very much cited on that area that has only
18 just seemed to be percolating into people's
19 consciousness?
20 **A.** Yes.
21 **Q.** Do you know whether there is guidance at an
22 overarching level about how cross-border relations
23 should be arranged?
24 **A.** I know there are regular cross-border meetings
25 between the sort of Welsh Healthcare Trusts and the

1 English Healthcare Trusts that are on that border. I'm
2 not part of those meetings because Birmingham isn't on
3 the border, but there's also a separate Four Nations
4 group where leaders from each -- from England and the
5 devolved nations meet to discuss high level principles
6 of Child Death Review.
7 **Q.** So there is communication but no particular
8 document or protocol, memorandum of understanding that
9 you're aware of?
10 **A.** No, you would have to ask the people from that
11 sort of Welsh/English cross-border group.
12 **Q.** Thank you. So that deals with the document.
13 My fifth and final topic is a number of general
14 questions arising out of these processes and in
15 particular we will start with the Child Death Review
16 process. In your first witness statement you express
17 concern, as you frame it, about the accountability for
18 CDR. Can you just explain to us what your concern is
19 and what the solution might be?
20 **A.** I mean, my concern is that Child Death Review
21 is the poor relation of safeguarding and that most
22 hospital managers and even sort of high up within
23 NHS England, the managers do not understand the Child
24 Death Review process, so they don't hold Trusts to
25 account when they don't follow it. So there are a lot

1 of Healthcare Trusts that still haven't implemented the
2 2018 Child Death Review guidance, particularly holding
3 Child Death Review meetings, informing parents of Child
4 Death Review processes. There's ICBs that have not
5 commissioned an appropriate Joint Agency Response to
6 make sure that there is a healthcare professional
7 available to lead it, so -- but there's no one holding
8 these Trusts or people to account when they don't comply
9 with the statutory guidance, in part because there isn't
10 that understanding at a very senior level and I guess
11 from the Trust point of view if there's nobody holding
12 you to account and you've got numerous different
13 pressures, why are you going to do something?
14 **Q.** So in practical terms what is required to
15 achieve that? Do we need metrics, so measurements of
16 who does it and some sort of audit of those
17 measurements? Is it as basic as that?
18 **A.** I would have thought, yes, that actually just
19 making sure -- checking ICBs and Trusts' compliance with
20 guidance would be a start because at the moment we have
21 an idea through the information that we get at the
22 National Child Mortality Database but you're looking at
23 the sort of outcomes of those processes rather than
24 actually the processes themselves.
25 **LADY JUSTICE THIRLWALL:** When you said there was no

1 understanding at senior level, who are you talking about
2 as the senior level? I don't mean names, but just what
3 level are we talking about?
4 **A.** I mean, I think actually within a quite
5 high -- at regional and at national level in NHS England
6 as well there's a really good understanding of
7 safeguarding because I think safeguarding has been part
8 of our bread and butter for generations. The Child
9 Death Review, if there's a question, they come to me.
10 I'm happy to help but it's not my job and that's the
11 same with other of my senior colleagues within the sort
12 of national network of designated healthcare
13 professionals. We haven't built up that expertise yet.
14 **LADY JUSTICE THIRLWALL:** Thank you.
15 **MR DE LA POER:** Now, you also express a concern
16 about the lack of visibility of the Child Death Review
17 process within the Royal College. Can you just explain
18 to us what your concern is?
19 **A.** So, I mean, I'm -- I'm pleased to report that
20 things have improved since then. Basically everyone --
21 as a paediatrician, pretty much every paediatrician is
22 going to have patients who die, so you have all got to
23 be able to -- even if you're not leading the Child Death
24 Review process, you have to be able to contribute to it
25 meaningfully and it's not just about safeguarding. Most

1 of Child Death Review is actually about quality of
2 healthcare and public health, so it should be a core
3 part of paediatrics, yet for many years we were trying
4 very hard and saying to the Royal College of Paediatrics
5 and Child Health "We're a big group of paediatricians,
6 we need to be represented in the College, we need to be
7 able to train people in Child Death Review" -- because
8 certainly when I was an undergraduate or even a junior
9 paediatrician, Child Death Review didn't exist so there
10 is a generation of Consultants who really don't
11 understand the processes because they are new processes
12 and until very recently it was a bit of a -- it was
13 a bit of a brick wall, that Child Death Review was
14 "Well, you can go to the Child Protection
15 Standing Committee", which is all about child
16 protection, which is the minority of child deaths.
17 I mean, I'm pleased to say that we have since had
18 conversations with Steve Turner who is the new President
19 and Child Death Review is now a Special Interest Group,
20 so it's beginning to get sort of representation in the
21 Royal College and filter through a bit more.
22 **Q.** Can you just timestamp that for us. How
23 recently are we talking about?
24 **A.** I think we met in August. I would have to
25 check my diary for the exact date but in that timescale.

1 **Q.** The summer of this year?
2 **A.** The summer of this year, yes.
3 **Q.** So in terms of the visibility to start with,
4 is that a complete answer or is that just a step in the
5 right direction?
6 **A.** It's a step in the right direction.
7 **Q.** What else needs to occur?
8 **A.** We need national training on Child Death
9 Review for all paediatricians so they know their
10 responsibilities and how to contribute to it. We need
11 proper national training, multi-agency training for
12 Joint Agency Response, so there -- years back we ran
13 a national course, then for various reasons people
14 retired, it needed updating, so it stopped and whilst
15 there's a lot of training in local areas, in terms of
16 the quality, some qualities are really good but if you
17 have a local area who is doing the Joint Agency Response
18 very badly, the chances are the training isn't very good
19 either, so we actually need to have some national joint
20 training because it's really important if you're going
21 to work on a multi-agency basis that actually you train
22 with your colleagues so you understand their
23 perspectives.
24 **Q.** Is that training under the banner of the
25 RCPCH?

1 **A.** It never was under the banner of the RCPCH.
2 Somebody needs to take it forward, but at the moment the
3 only mechanism we have is this group which is the
4 Association of Child Death Review Professionals, which
5 is a sort of "Okay, we're an official organisation,
6 we're all set up as a community interest" -- I will try
7 and get the phrase right, but we're a properly
8 established group, but it's all busy working
9 professionals who are doing it as part of their day job
10 and actually the time it takes to set up proper training
11 and things like that is actually a bit out with our
12 resource at the moment.
13 **Q.** So which organisation or organisations do you
14 think is best placed, subject to their own funding
15 concerns, to provide that sort of level of training?
16 **A.** I mean, I think it would be helpful to
17 actually really have the leadership from the Royal
18 College to support us with this because also it sort of
19 brands us as this is actually mainstream paediatrics
20 rather than a little fringe group.
21 **Q.** Now, on the subject of funding you express
22 concerns within your witness statement about the
23 implementation of Child Death Review and the funding
24 challenge there is for that. Here I think we're
25 concerned with sums which are or aren't ringfenced. Can

1 you just help us with what your understanding of that is
2 and what your concern is?
3 **A.** Well, so back when CDOPs were set up in 2008
4 there was ringfenced funding given for three years to
5 local authorities through safeguarding budgets to set up
6 CDOP and for Joint Agency Response.
7 At the end of those three years the money stopped
8 being ringfenced and it had to come out of existing
9 budgets, so what has happened is that particularly with
10 the 2018 Child Death Review guidance there is an
11 expectation that hospital -- well, the healthcare
12 organisation caring for a child at the time of death, if
13 it's a death that doesn't need a Joint Agency Response,
14 holds an holistic Child Death Review meeting, so that's
15 considering all the sort of domains relating to that
16 child, inviting in GPs, school representatives, social
17 workers, anyone who has had that footprint with that
18 child, and that's much more complicated than the old
19 style what used to be called "M and M", or Mortality and
20 Morbidity meetings, so hospitals -- somewhere like a big
21 teaching hospital that's got a paediatric intensive
22 care, it is going to take a lot of resource to do it
23 properly and budgets are pressed, so some -- well, some
24 hospitals have done fantastic jobs in setting up proper
25 Child Death Review meetings and along with that is also

1 the funding for what's called the key worker, which is
2 dedicated bereavement support for the parents. Other
3 Trusts have pretty much done nothing, partly because
4 they haven't got the funds to do it and I mention the
5 reason why the key worker is so important, it's not just
6 about bereavement support. Part of the key worker's
7 role is to tell parents about Child Death Review, to ask
8 them if they've got any questions they want answering,
9 or if they've got any concerns or feedback they want to
10 be considered at that Child Death Review meeting and
11 most children who die are very complicated and have had
12 lots of healthcare teams involved with them. The
13 parents have been with them throughout that journey and
14 the parents know where things slip through the net and
15 if we don't ask the parents, we won't know and it will
16 limit what we can learn from deaths. We may not pick
17 up -- well, we probably would pick up many less
18 healthcare performance issues because we're not actually
19 asking the people who know and also it's important the
20 parents then get the feedback afterwards and that just
21 isn't happening.
22 **Q.** So if I can just reflect back what you have
23 said, parents are an essential part of this process, but
24 sometimes for funding or structural reasons they are
25 just not being included?

1 **A.** Yes, they're not being included, or they're
2 being sent a sort of -- a sort of very formulaic
3 legalistic letter saying "There is a review into your
4 child, would you like to say anything?", which for most
5 bereaved families is sort of completely inappropriate
6 and off-putting.
7 The other part of this is also the Joint Agency
8 Response that needs fully funding because you have to
9 have either specialist nurses or paediatricians on call
10 to provide the service and there are some parts of the
11 country where they have never funded a healthcare
12 professional to go out and do the -- do a Joint Agency
13 Response.
14 **Q.** I'm going to move on from the Child Death
15 Review process and move into safeguarding, a topic which
16 is related at the very least, because you were asked by
17 the Inquiry as to what you thought was the best practice
18 for a clinician in a safeguarding situation in
19 a hospital and can you just tell us please what you
20 would do if you had a concern?
21 **A.** A concern in general about safeguarding or
22 a concern about a staff member?
23 **Q.** About a staff member.
24 **A.** I mean, these are really difficult situations,
25 but you have to bear in mind that your duty is always to

1 your patient, even if that -- or to safeguard children
2 and even if that child has died, it's still
3 a safeguarding matter because other children are
4 potentially at risk. So, I mean, the process would be
5 that you would go to the safeguarding team in your
6 healthcare organisation for support. I wouldn't be
7 expecting a paediatrician on a ward to be picking up the
8 phone to the local authority. I would be expecting them
9 to be talking to their safeguarding team and then the
10 safeguarding team either encouraging that doctor or --
11 well, supporting that doctor to make that referral
12 through positions of trust to the local authority.
13 What I would not expect is any management
14 involvement in that, that you absolutely do not need
15 management permission to make a referral through LADO.
16 Out of courtesy of course you would let management know,
17 but it's not their decision whether that --
18 a safeguarding referral is made or not.
19 **Q.** We saw from Working Together that there is
20 an expectation that there will be a safeguarding role at
21 board level. Just help us to understand how on the one
22 hand you wouldn't speak to management, but the
23 safeguarding lead might be a member of management? How
24 does that work?
25 **A.** Well, the safeguarding lead -- I mean, there

1 will be a head of safeguarding in a Trust. It's usually
2 a senior nurse supported by named nurse, named doctor
3 and other safeguarding professionals, but if you're
4 making a positions of trust referral the chances are you
5 are -- it's something you're going to be making fairly
6 rapidly, but if you are working in safeguarding it is
7 imprinted on your mind that you are -- your primary
8 responsibility is to safeguard children or vulnerable
9 adults, that is why you are in safeguarding. So yes,
10 you may sit on the board because you are there to
11 represent safeguarding, but you should fundamentally
12 understand that your responsibility is absolutely
13 towards children and vulnerable adults.
14 **Q.** So to use some less formal language, if that
15 board member is wearing a number of hats you would
16 expect that if a safeguarding issue was raised with them
17 they would put on their safeguarding hat and leave the
18 other ones to one side?
19 **A.** Well, yes, because they're on -- because
20 safeguarding is always your first principle anyway, but
21 they are sitting on the board as they are there wearing
22 a safeguarding hat on the board. I mean, I suppose
23 sometimes people may have two roles but fundamentally
24 safeguarding comes first.
25 **Q.** Is child safeguarding sufficiently prioritised

1 in hospitals, do you think?
2 **A.** I mean, I think that's difficult for me to
3 answer because I work in a community -- as a Community
4 Paediatrician for a Community Trust rather than
5 a Hospital Trust and certainly hospitals do have -- most
6 have safeguarding teams, there's lots of safeguarding
7 training, but like everything else sometimes there's
8 competing priorities.
9 **Q.** Are you able to give us any indication of the
10 degree to which nationally there is compliance with the
11 expected requirements for -- with Working Together, for
12 example? You have already indicated that it's a mixed
13 picture, but is it mainly good, is it mainly bad, or is
14 it just not possible from your position to make that
15 assessment?
16 **A.** I couldn't make that assessment.
17 **Q.** Now, we heard this morning from
18 Professor Dixon-Woods something about the duty of
19 candour and we're going to hear much more about that
20 from Sir Robert Francis KC on Monday, but do you see the
21 duty of candour having any significance in the context
22 of safeguarding, or are they two separate and distinct
23 ideas?
24 **A.** I would say they go hand in hand because your
25 primary -- if you're working in -- well, safeguarding is

1 everyone's responsibility. I mean that's the mantra
2 that goes whether you are in healthcare or whatever, but
3 certainly if you are a child health professional,
4 safeguarding is absolutely paramount and with that goes
5 the sort of duty of -- I mean, duty of candour is part
6 of that so I don't see them as separate at all.
7 **Q.** I think what we saw in Working Together back
8 in 2015 was the idea that concern about anything else
9 should play no part in terms of speaking up about the
10 concern that you have about the child.
11 **A.** Yes, absolutely, yes.
12 **Q.** As far as staffing levels are concerned, is
13 that something you can help us with as far as its
14 potential impact on safeguarding or is that because you
15 don't work in a hospital and that's principally what
16 we're concerned with, something outside of your
17 expertise?
18 **A.** All I can say is we take note of it at Child
19 Death Review and sometimes we have commented if we
20 thought that unsafe staffing has contributed to
21 a child's vulnerability, but no, it's not something
22 I'm -- as I don't work in a hospital, I don't have
23 a sense of staffing levels.
24 **Q.** So it can give rise to a risk, that's what you
25 would identify at CDOP level?

1 **A.** Yes, yes.
2 **Q.** But whether or not it impacts upon how
3 successfully situations are managed through the
4 safeguarding framework, that's outside of your
5 understanding?
6 **A.** Yes.
7 **Q.** Thank you.
8 The final topic is your views on potential
9 improvements and you have touched on a number. I would
10 like just for you to consider one that isn't within your
11 statement. It may be the case in some schools and
12 social care settings that there is a logging of low
13 level concerns on a confidential basis, which can then
14 be looked at in the round. I don't know whether you're
15 familiar with that occurring in any particular
16 situation, but in principle is that something that you
17 think might have a value here, or is that really that
18 overview provided by other organisations and
19 individuals?
20 **A.** I mean, my understanding of the logging of
21 sort of low-level safeguarding concerns in schools --
22 I mean that's part of a child safeguarding record and
23 it's the equivalent to us writing in the medical notes
24 that, for instance, a -- about children missing
25 appointments, or turning up looking hungry and dirty, so

1 I don't see it being any different. I can't see
2 though -- having a logging system about concerns about
3 staff and safeguarding, I think that would be something
4 slightly different.
5 **Q.** It wouldn't perhaps fall into the definition
6 of low-level?
7 **A.** Yes, yes.
8 **Q.** The police. You have told us about the role
9 they play and the fact that they should receive training
10 if they're on CDOP. Do you think there should be some
11 form of national level agreement between the police and
12 the NHS in terms of their involvement with concerns that
13 the NHS may bring to them, or do you think as far as the
14 Child Death Review process is concerned that's all
15 adequately dealt with within the existing framework?
16 **A.** I think it's reasonably sort of well-managed
17 that, yes, there are some -- there's a National Police
18 Child Death Working Group which I sit on as the sort of
19 health representative and I think we work quite well
20 together, but you also need your local agreements and
21 your local protocols of how you will respond to child
22 deaths.
23 **Q.** So that's the framework. What about training,
24 joint training about the police. Is that an area that
25 could do with improvement as far as you are concerned?

1 **A.** I think that's really important because whilst
2 the police have got very good training for child deaths,
3 it largely doesn't include a child health perspective
4 and when you train together you actually understand each
5 other's perspective much better and it makes it much
6 more effective than, for instance, a lecture delivered
7 by a paediatrician or a pathologist to the police on
8 a single agency course.
9 I think one of the challenges though is always
10 about budgets because any independent course such as we
11 had at Warwick, you have to pay for it. Police have got
12 limited training budget, so they're going to prioritise
13 their own internal courses first because that meets
14 the police internal requirements, so it is a real
15 challenge.
16 **Q.** The police are one element of the Joint Agency
17 Response. You have told us about the training and the
18 need for joint training. How about the Coronial
19 process, which is obviously strongly connected to the
20 Joint Agency Response? Are there improvements to be
21 made there?
22 **A.** Yes, I think there are, because there are some
23 areas where actually the -- where the 2016 guidance that
24 we want to update is at odds with Coronial law and so
25 that causes friction and is interpreted differently in

1 different areas and can have sort of a significant
2 impact on families' experiences.
3 I think it's also really important Coroners are
4 trained and I'm well aware that some Coroners really
5 don't have much understanding of Joint Agency Response
6 and child death processes, whereas others have got
7 a very good understanding, but again funding for
8 multi-agency training is a problem because again budget
9 for Coroners' training doesn't extend really for very
10 much outside the Coronial system and it's not the same
11 as me going along and giving a talk to Coroners, that
12 you have to work together on your training to get the
13 most out of it.
14 **Q.** Now, moving to an adjacent process to the
15 Coronial one and bringing us right up-to-date,
16 9 September I think it was that Medical Examiners
17 arrived on a national statutory footing. We just need
18 to deal with their role in all of this, but firstly can
19 you just explain to those who are unfamiliar what is
20 a Medical Examiner and how does their role relate to the
21 Coroner's?
22 **A.** Okay, I'm not an expert in this, but I've got
23 hopefully a reasonable understanding, but you might want
24 to double check I get everything right. So Medical
25 Examiners are all doctors and their job when -- so when

1 a patient dies, a medical certificate for a cause of
2 death has to be written if you know why that patient has
3 died. If you don't know, or for instance they have died
4 following an operation or it's potentially unnaturally,
5 it's automatically referred to the Coroner. But for the
6 patients who die and the doctors think they know why
7 they have died, they used to just write the medical
8 certificate for cause of death. Now it has to be
9 referred to the Medical Examiner to agree the cause of
10 death, partly to make sure that death certificates are
11 more accurate, but also what the Medical Examiner will
12 do is review the case records to make sure that cause of
13 death fits, but also checking that there aren't any
14 major care concerns and they will put a call-in to the
15 family asking if they've got any care concerns, and this
16 has been happening in hospitals on a sort of pilot
17 process, gradual roll-out for a couple of years, but it
18 has now just become law for everything and sometimes the
19 Medical Examiner will say, "Actually the case needs to
20 go back to the Coroner, it's not appropriate to issue
21 a death certificate."
22 **Q.** Is that an important safety net, do you think,
23 in the context of Child Death Review?
24 **A.** It should be, bearing in mind though most
25 Medical Examiners are going to be adult doctors and

1 their training may not have included very much on Child
2 Death Review and how they link in with processes.
3 There's also the potential overlap that you've got the
4 key worker asking families for any concerns or comments
5 and you've got somebody phoning up from the Medical
6 Examiner's office, so there's also a potential
7 duplication there.
8 **Q.** And a potentially unnecessary additional
9 intrusion?
10 **A.** Absolutely, yes.
11 **Q.** So in principle a good idea, but dependent
12 upon the training and qualifications and experience and
13 resources of the Medical Examiner who the case comes to?
14 **A.** Yes. I think it's -- we need to wait and see
15 and I'm sure there will be teething issues before we get
16 it right.
17 **MR DE LA POER:** Dr Garstang, those are all the
18 questions that I have for you.
19 There are no Core Participant questions so,
20 my Lady, can I turn to you to see if you have any
21 questions for the Doctor.
22 **Questioned by THE CHAIR**
23 **LADY JUSTICE THIRLWALL:** Yes, thank you,
24 Mr De la Poer.
25 Dr Garstang, thank you very much. I just have two

1 questions, if I may, arising out of two things that you
2 mentioned earlier and the first was you made the very
3 powerful point that if you don't ask the parents who
4 have had the closest connection with the child and their
5 care, you won't know what you need to know in order to
6 carry out an effective review and you pointed out the
7 inappropriate nature of some of the letters that get
8 sent out and I have some idea of that from the evidence
9 I heard last week and the beginning of this week.
10 Sorry, that's a long preamble but what I would like
11 to know from you is whether or not receiving a letter
12 a year or even longer after a death may be very
13 difficult for parents, to which the answer obviously is
14 going to be "yes", isn't it, so what can be done --
15 insofar as there is an ongoing process, can parents be
16 kept up-to-date, if they want to be obviously?
17 **A.** Absolutely. So we have recently -- I have
18 recently been running a research project. This was
19 around parents whose children have had -- have died in
20 hospices or in hospital with a palliative care, so where
21 it's been fully expected that the child is going to die.
22 And coming up with a system for key workers to talk to
23 them about Child Death Review and actually the first
24 thought should be that within a few days of death you're
25 mentioning the process, giving parents sort of written

1 information about it but not forcing it on them because
2 some parents will be ready for it, others won't, but
3 then over the next few weeks giving them a chance to
4 contribute either by filling out a structured feedback
5 form, or for some families it will be in conversation
6 with their key worker.
7 Very important to keep parents updated throughout
8 the months it may take to pull together a Child Death
9 Review meeting because for a very complicated child who
10 dies in intensive care you've got multiple specialties
11 you've got to pull together and that is going to take
12 probably six months to get everyone round the table,
13 even if you don't need a postmortem, and then again
14 finding time -- making sure that key worker then goes
15 and either has a phone call or sees the parents
16 afterwards to feedback, or arranges -- if it's a complex
17 medical situation, arranges an appointment for them to
18 go back and talk to the Consultants to actually hear the
19 answers from the paediatrician or the surgeon.
20 So yes, so we have designed a process that is
21 along -- we have designed it with bereaved parents and
22 also professionals working in Child Death Review
23 hopefully to get something that is -- that's right for
24 families, but we also recognise that some bereaved
25 families will want nothing to do with us, that for them

1 Child Death Reviews -- their child has died, they don't
2 want to -- it's too awful, they don't want to know, and
3 that is perfectly fine too.
4 **LADY JUSTICE THIRLWALL:** Yes, thank you very much.
5 Then you mentioned in relation to funding the fact
6 that in some parts of the country there's never been any
7 funding for Joint Agency Response. Are you able to say
8 whereabouts in the country?
9 **A.** Well, everyone got the funding in 2008.
10 I hate to say it's largely in London. So a key part of
11 the Joint Agency Response is that a paediatrician or
12 specialist nurse goes out with the police within
13 24 hours of the child dying to visit the family at home.
14 For babies it's absolutely vital that we see where that
15 baby was when they died, this is in terms of
16 particularly things like Sudden Infant Death Syndrome,
17 to sort of look at what were the risks in the sleeping
18 environment. But also to get that really detailed
19 medical history for a lot of our older children who die
20 suddenly and unexpectedly, you need a really detailed
21 medical history which a hard-pushed Registrar in an
22 Emergency Department is not going to get when a child
23 has just suddenly died, and yes, there's a large part of
24 London where that just doesn't happen. The police go
25 and take photos and then show them "Here is a photo of

1 a cot". Well, I can't interpret a photo of a cot
2 without a parent telling me where the baby was, where
3 the bedding was, how the baby was that day. So it's
4 really inadequate in many parts, but I think Trusts or
5 ICBs take comfort that if their neighbours aren't doing
6 it either, it's very easy to think actually that's
7 acceptable, whereas if we didn't do joint visits in the
8 West Midlands our Coroners would be furious with us.
9 **LADY JUSTICE THIRLWALL:** With that vivid image in
10 mind, thank you very much indeed.
11 Mr De la Poer, there's nothing else you want to
12 raise?
13 **MR DE LA POER:** Nothing arising from that, my Lady.
14 Can I just ask Dr Garstang to remain there as
15 I thank her very much and I'm sure my Lady will thank
16 her as well, but Ms Brown has just got a short matter to
17 read into the Inquiry record now and then I think that
18 will conclude us for today.
19 **LADY JUSTICE THIRLWALL:** Thank you. Dr Garstang,
20 you don't need to sit and listen and certainly not
21 sitting there, so thank you very much indeed for your
22 significant contribution today.
23 Ms Brown.
24
25

1 **Statement read by MS BROWN**
2 **MS BROWN:** Yes, my Lady, it's just to note that the
3 Inquiry have obtained a statement from Dr Claire Thomas
4 of Public Health Wales and in that statement it
5 addresses the current processes in Wales regarding
6 unexpected baby deaths, as detailed in the Procedural
7 Response to Unexpected Deaths in Childhood 2023, known
8 as PRUDiC, and the Wales safeguarding procedures.
9 The statement also addresses the situation that was
10 addressed in 2015 to 2016 in Wales and also considers
11 the issue of information-sharing in 2015 and 2016 and
12 areas of suggested improvement for cross-border
13 information-sharing and that statement will be uploaded
14 shortly to the Inquiry website.
15 **LADY JUSTICE THIRLWALL:** Thank you very much
16 indeed, Ms Brown.
17 I think that concludes our proceedings for today.
18 We will start again next Monday at 10 o'clock for
19 Sir Robert Francis. Thank you all very much.
20 **(4.21 pm)**
21 **(The Inquiry adjourned until 10.00 am**
22 **on Monday, 30 September 2024)**
23
24
25

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