Friday, 15 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, the first witness today is Ms Ann Ford and I wonder if she might come forward to the witness box, please.

MS ANN FORD (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Thank you, do sit down.

A. Thank you, my Lady.

MR DE LA POER: Please could you give us your full name?

A. Before we do that, my Lady, is it okay if I say something, please?

LADY JUSTICE THIRLWALL: Of course, you might want to give your name first.

A. I'm sorry, my name is Ann Ford.

LADY JUSTICE THIRLWALL: Yes.

A. I would just like to offer my sincere condolences and sympathies to the families affected by these awful events, both on behalf of myself and the CQC.

I do feel very sorry for their pain and suffering.

Thank you.

MR DE LA POER: Ms Ford, you have provided the

Inquiry with three witness statements; we are just going to identify each of those now. Is it correct that the first is dated 24 June of this year?

A. Yes.

Q. The second, 8 August of this year?

A. Yes.

Q. The third, the 18 October of this year?

A. Yes.

Q. Is the content of those witness statements true to the best of your knowledge and belief?

A. It is.

Q. If we just review, in summary form, what each of those statements deals with. The first deals with disclosure by the CQC; is that right?

A. Correct.

Q. When we say "disclosure", we are talking about documents held by the CQC disclosed to the Inquiry?

A. Indeed.

Q. And that that statement was provided in response to a request from the Inquiry formally under Rule 9 of the Inquiry rules; is that correct?

A. Yes. Yes.

Q. Your second statement, also provided in response to a Rule 9 request, provided further detail about the disclosure process; is that correct?

A. It is.

Q. It also provided some information about the inspection in February 2016?

A. Correct.

Q. The third statement, the one dated just a few weeks ago, provides further detail about the inspection; is that right?

A. Yes, it is.

Q. That statement was effectively volunteered on the basis that you, and no doubt others at the CQC, took the view that you had additional information that you could provide the Inquiry with?

A. It was, yes.

Q. We will come back to the sequence of those witness statements in just a moment, but let's first introduce you.

You are currently the Director of Operations for network north within the CQC; is that right?

A. It is, yes.

Q. Does that give you overall responsibility for that area of the country so far as the CQC is concerned?

A. It is, yes, I am responsible for the regulation of health and social care in that area.

Q. That will include inspections; is that right?

A. Yes.

Q. But also other aspects of the CQC's regulatory responsibility?

A. Yes, it is.

Q. When did you take up that position?

A. I think it was about 2020. Thereabouts.

Q. Now, at the time that we are going to be focused upon when we come to look at the inspection, you had a different role, didn't you?

A. I did.

Q. You were the Head of Hospital Inspection?

A. I was for the North West, yes.

Q. You began in that role a couple of years before the inspection took place?

A. I did, about 2014, yes.

Q. Beginning in that role of head of hospitals 2014, how long did you hold that role for?

A. About three years, I moved into another role about 2017.

Q. You had been acting in the role for well over a year, if not a full two years at the time of the inspection. Did you regard yourself as having a good control over what was required from a hospital inspection?

A. Yes, I believe I had a good understanding of the methodology, yes.

Q. Just help us a little bit in terms of your background. We don't need an entire CV, but do you have a clinical background or other background prior to that role that equipped you for the role of head of hospitals?

A. I am a Registered General Nurse and I have got 30, 30 years' experience as in a management role, and I have been in regulation since about the year 2000.

So I have got 24 years' experience of regulation of health and social care.

Q. Just fleshing that out a little bit, when you say "a management role" was that a management role in any particular NHS hospital, or was it outside of the NHS?

A. No, it was, it was both. I was a ward sister, I was a nurse tutor, I worked at the health authority in a commissioning role, I have worked in the independent sector as a manager, and I came into regulation into Liverpool Health Authority in about 2000.

Q. Did you have any particular knowledge or experience of children's services within the NHS?

A. Children's service is not my experience, no, it's not my background.

Q. On the one hand, taking us to 2016, head of hospitals, but also did you attend the inspection

yourself effectively as an inspector?

A. No. I -- I didn't attend the inspection, but I was inspecting the well led component of the -- of the inspection. I had a team to inspect each of the core services.

Q. I may have just misunderstood your answer slightly. You have said you were inspecting the well led, does that make you an inspector?

A. Yes, I was part of the well led team, yes, I see what you mean.

Q. You were one of the inspectors?

A. Yes.

Q. No, I am sure it was my question.

So you effectively had a dual role, oversight over the whole process, but also a boots-on-the-ground role interviewing people, trying to understand what was going on in that hospital during that inspection?

A. Yes.

Q. The second part of my questioning will be looking at that inspection. The first part is going to focus upon the CQC and disclosure. Now, you provided your first statement in June of this year in response to the Inquiry seeking to understand what the CQC was doing with the disclosure process; is that right?

A. Yes.

Q. At the beginning of your statement, you identify yourself as the appropriate person to make the statement; is that right?

A. Yes.

Q. Because although you don't work in the inquiries part of the CQC or necessarily the disclosure part, you have oversight and understanding in all of that and responsibility for the whole area; is that right?

A. I have a responsibility for the regulation of the whole area and the Countess of Chester was in my patch, so I had oversight of the Trust, yes, I did.

Q. You tell us in your statement that you have spoken to a significant number of people within CQC to try and understand what was going on so that you could provide the Inquiry with an accurate update?

A. Yes, we met weekly.

Q. Now, if we take a couple of steps back from the time at which you gave that statement, in the early part of this year, Mr Trenholm gave two statements on behalf of the CQC effectively setting out what he understood at that time the CQC's corporate understanding was of the inspection and the Countess of Chester; is that right?

A. Yes, I think he did, yes.

Q. Is it fair to say that after he gave those statements a very significant number of documents came to light that Mr Trenholm will not have known about when he was seeking to assist the Inquiry with the CQC's corporate position?

A. I'm not sure I understand your question.

Q. Well, perhaps I will ask that at the end?

A. Yes, please.

Q. What the Inquiry was told in May, just before you provided your statement, is that in the search for documentation the CQC had realised that the Inquiry required a broader scope of information?

A. Yes.

Q. Were you aware of that?

A. I was, yes.

Q. In effect, the CQC had interpreted the Inquiry's request too narrowly?

A. Yes, I was aware.

Q. At the time that Mr Trenholm was drawing together information and trying to understand what had gone on, the CQC's understanding about what the Inquiry needed was too narrow?

A. I believe so, yes.

Q. What happened next was that in May of this year, the CQC employed a system called e-Discovery; is

that right?
A. Yes, we did.
Q. Let's just try and understand what that means. But before that, is it correct that the CQC had assumed that all relevant material would be held in particular places upon its filing system?
A. I think most of the records would have been held on our customer records, CRM customer records management system, and also on people's personal drives, but we did have a huge amount of paper records as well that were stored in the Newcastle office.
I think we knew that we had records both electronically and physical paper records as well.
Q. When was it realised that there were those additional records?
A. I can't remember the date exactly, I took advice from the Inquiry's team regarding that.
Q. But it was late in the process?
A. I believe so, yes.
Q. It may be thought that it was quite an obvious thing for the CQC at an early stage to think "I wonder if there are any paper records relating to this because our process at the time was for everybody to create paper records"?
A. Mm-hm.

Q. Would you agree, taking responsibility on behalf of the CQC, that that was quite a significant oversight on the CQC's part at an early stage?
A. Yes. I would, I would admit that. I think our disclosure wasn't timely and it wasn't complete, and I apologise for that.
Q. Well, we will just complete our review to understand what you mean by "wasn't timely". You provided the statement on behalf of the CQC in June of 2024 and the Inquiry was informed at about that stage of the scale of the further documents the CQC had discovered?
A. Yes.
Q. It was over 4,000, wasn't it?
A. It was.
Q. We just need to reflect upon the CQC's starting assumption which was, in your words, most of the documents would be stored in those Y drive and on the customer or the client file?
A. Yes.
Q. In fact, that was quite a gross underestimation of where the weight of the records would be, wasn't it?
A. I think it was an underestimation.
Q. Well, a very significant underestimation?

A. I believe so, yes.
Q. The upshot was that over 4,000 documents were sent to the Inquiry identified as being relevant in July of this year?
A. Yes, that's correct.
Q. Can you, on behalf of the CQC, recognise that providing over 4,000 documents to a public Inquiry, a matter of weeks before the oral evidence hearings are about to begin, and over the summer period, was unacceptable?
A. I think I would have to accept that the way we managed the disclosure was not good enough and I think there are profound lessons to be learnt and improvements to be made.
Q. Well, I am going to invite you to consider two specific words to see -- you have said "not good enough" was it inadequate?
A. I'm not sure that I would agree that it was inadequate, but it certainly could have been improved upon.
Q. Was it unacceptable?
A. I think the delay was, yes.
Q. That's the timing issue. We are going to turn to the second part of it which is the content issue. Again, you have provided us a lot of information, but

I am going to try and distil this down.
Do you agree that the starting point is that in 2015, the CQC was notified by the independent investigation -- Independent Inquiry into Child Sexual Abuse -- that it should retain all material save for a few identified categories?
A. Mm-hm.
Q. From that moment, the CQC should have adopted a rigorous filing system to ensure that every single record, save for that narrow exception, was carefully retained in case it was needed?
A. Yes.
Q. We can deal with the exception point, we are going to come to what class of material cannot now be found, but that material all should have been retained under the IICSA requirement, shouldn't it?
A. It should have, yes.
Q. Now, if we now reflect upon a separate reason why the CQC might have thought to rigorously file its material, in May 2017, the CQC was told that a police investigation had been opened into events at the Countess of Chester?
A. Yes.
Q. And that that investigation was in relation to the increase in neonatal mortality?

A. Yes.
Q. Eleven months earlier, the CQC was told by Alison Kelly that there had been an increase in neonatal deaths which applied to the period of the inspection?
A. Yes.
Q. Putting those two pieces of fairly simple information together, is it fair that in May 2017 the CQC was on notice that the police was investigating a period which included the inspection conducted by the CQC?
A. I think that's reasonable, yes.
Q. At that point, is there any record within the CQC that the CQC said, "we may hold information relevant to that investigation, we need to be careful and file it all"?
A. Not that I am aware of, no.
Q. On behalf of the CQC, do you accept that that thought process should have been had in May 2017?
A. I think that would have been a sensible thing to do.
Q. Now, we heard yesterday that Ms Cain said that she believed that by the end of 2017 that she was aware that the police were identifying a specific member of staff. At that stage, it is not just an investigation which might be corporate manslaughter or gross

negligence manslaughter necessarily, but here focus on a member of staff which gives rise to the possibility of a murder investigation; do you agree?
A. I do.
Q. Was that another opportunity for the CQC to say, "we may hold material which is relevant to a murder investigation"?
A. I think it was, yes.
Q. We know that there was an incident co-ordination meeting on 4 June 2018, forgive me, the first of its type, chaired by NHS England, where there was express discussion of what was going on with the police investigation.
Do you agree that that was another opportunity for the CQC to pause and say, "we need to get our house in order no case this is relevant to a police investigation"?
A. I don't believe that I was part of that group.
Q. I am not suggesting you were, I am asking corporately --
A. Corporately.
Q. -- for the CQC?
A. Yes, I believe yes, it was, yes.
Q. You will forgive me, but you are the witness who the CQC has identified and you have acknowledged --

A. Yes.
Q. -- that you are appropriate to speak to these issues.
A. Yes.
Q. It is very important that there is accountability where there has been errors, do you make that concession on behalf of the CQC?
A. I think there were a number of missed opportunities and you have highlighted some of those.
Q. Let's continue. We know that a month later, an arrest occurred, another missed opportunity, do you agree, for the CQC to get its house in order?
A. I do.
Q. 12 November 2020, charge of Lucy Letby. Another missed opportunity for the CQC to get its house in order; do you agree?
A. I do, but I think -- I think if you look at what we know now and what we knew then -- and our systems have significantly improved since that 2016 inspection -- so I think we would have been better placed in 2020 to provide information than we were because we were not at that point as heavily reliant on paper records, and I think the electronic records about our dealings with the Trust would have been more available.

Q. Well, let's just think about that answer for a moment. The core interviews and indeed some of the records of the Consultant focus group were paper, weren't they?
A. They were.
Q. What needed to happen with those was that somebody or a team of people identified at the earliest possible stage where they were, ensured that they were scanned and retained electronically or otherwise filed in a way that was robust and accessible?
A. Yes.
Q. Do you agree?
A. I think that was a missed opportunity, yes.
Q. We start from the proposition that the closer to the time that happens, the easier --
A. Yes --
Q. -- and more complete it's going to be. As time passes, the challenge is going to increase?
A. I agree.
Q. We have just marked a number of clear, as you have conceded, missed opportunities. We, of course, had the trial in October 2022, very widely publicised; another opportunity, would you agree, for the CQC to get its house in order?
A. Of course.

Q. It would appear that, in fact, it was not until September 2023, on the very eve of the Inquiry being announced, that a missive went round telling the CQC that records need to be pulled together?

A. That's correct.

Q. That is, would you agree, far, far too late?

A. Yes, I think it was too late.

Q. What explanation is there that the CQC can offer for why all of those opportunities were missed?

A. I don't have an explanation. I think I would have to -- for why those opportunities were missed.

I think at the time, we were very, very focused on the Trust itself, rather than our input into any subsequent investigation. I think with hindsight that was a real shortfall in our record-keeping and in our records and documents management.

Q. Now, let's just reflect upon what the consequences of those missed opportunities are.

We deal with this in your statement. You can take it from me or I can take you to the paragraph, but I will try without taking you to your statement.

If we start with meetings before the inspection, what you say is:

"Although the CQC considers that the following meetings could have taken place, its searches and

inquiries so far have not revealed any corroborative evidence of the fact that they did or anything that was discussed at (1) a pre-inspection meeting with the Countess of Chester Trust during February 2016; (2) a meeting between the CQC and the Countess of Chester NHS Trust during February 2016; (3) a quality summit meeting dated 29 February 2016; (4) a quality surveillance group meeting dated 28 July 2016."

A. Mm-hm.

Q. Is that correct, that is the position as at today; those documents haven't been found?

A. No, they have not been located.

Q. You also say that no notes from a listening event on 9 February 2016 have been found.

A. No, they have not been located.

Q. In terms of the substance of the inspection itself, what you tell us is: unfortunately the CQC is unable to locate the notes from meetings with Sir Duncan Nichol, that is the Chair, Ruth Millward, that is to say the head of risk and safety, the meeting with the Staff-Side representative, the safeguarding lead, the non-executive director for quality and safety, Alison Kelly, that is to say the Director of Nursing, Lorraine Burnett, Ian Harvey, that is to say the Medical Director or the complaints lead?

A. Mm-hm.

Q. Now, those were a number of those meetings that you yourself attended?

A. Yes.

Q. In your own words, what is the extent of the disadvantage to you, as a potentially important witness, about the fact that the CQC cannot find those notes?

A. Well, I am reliant on the power of recall and I am also reliant on the inspection report and I am also reliant on some of the information stored by others.

So the Quality Surveillance Group, for instance, is led and managed by another stakeholder, so I would have to refer to them for that.

But I think what possibly may have happened is that at the time of that inspection our records management policy was that within six months of the inspection, and six months of publication of the report, the records of the inspection could be destroyed. And I don't think or I believe that the excerpt directive wasn't particularly well understood, and I think some of those records may have been destroyed in accordance with that previous policy.

That may be a possible explanation for why we can't locate them.

We looked extensively in every reasonable place

that we thought we would find the records. I put together quite a big resource team to do that in advance of the Inquiry and, as I said earlier, I do accept that the response was not timely or comprehensive enough and for that I apologise.

Q. My question was about the disadvantage --

A. Sorry.

Q. -- to you.

You say you have to rely on recall?

A. Yes.

Q. It is now 2024, that was 2016. Would you agree that that is a substantial disadvantage to you as a witness?

A. I think I would have been a lot more confident had I had the records, but I do believe that I can recall the range, nature and substance of that inspection.

Q. Well, we can test that right now. Do you recall whether in any of the meetings that you attended, whether you or anybody else conducting the interview on behalf of the CQC said to any of the people you were questioning, "Are there any concerns that you think the CQC should be aware of?"

A. I can say with confidence that I believe we did because most of -- at the end of each interview it

was standard practice for the interviewers to say to the interviewee: "Is there anything else that you would like to tell us? Is there anything that we have missed? Is there anything you want to share with us?" And that was quite common practice. So I believe we will have said that.

Q. If I was to take a particular interview and ask you specifically about that person, and say, "Was that question asked in that interview?" Would you be able to tell us with certainty whether it was?

A. Not with absolute certainty, no. But the probability would be that we asked that question. I think we did that at most focus groups, we did that at most interviews and we also had the prompts and the key lines of inquiry that we used and part of that is asking about challenges, risks and issues for escalation.

So I think there is a strong possibility that we asked that question in those interviews.

Q. Can you recognise nonetheless that it is unsatisfactory that there is no contemporaneous record one way or the other on that point?

A. I think that's unfortunate, yes.

Q. In relation to the Consultants' focus group, you say:

"The CQC understood that the inspection team would

..."

That's the client record management, isn't it?

A. Yes.

Q. "... or the Y drive as suspected or because original papers were not kept or were destroyed that any information contained with them is no longer within the CQC's possession."

There are documents which you don't even know whether they were generated; is that right?

A. I believe so, yes.

Q. If they were, they have been lost?

A. It would appear so, yes.

Q. If we look at a practical consequence for a public Inquiry, this public Inquiry, one of the ways, is this correct, that the CQC have sought to help the Inquiry as best it can with the documents it has is to scrape diary entries to try and identify who was at which meeting because you don't have any notes of the meeting to confirm that fact; is that right?

A. Well, I think we tried to look everywhere where we thought -- records could be reasonably stored and I think I gave a full list of those searches in my statement, and we searched using keywords like Countess of Chester, Countess, Chester. We searched people's personal drives, the Y drives, SharePoint, the customer

have generated paper rather than electronic notes as this was the practice at the time. Any such notes like other 2016 inspection notes discovered as part of the disclosure process were expected to be held within the paper record archives."

A. Yes.

Q. You haven't found any such paper notes?

A. No.

Q. But I think that it's right to say that there are some other records that have been found which at least give a partial picture of those meetings?

A. I believe there are, yes. A colleague at the time kept her own notes separately to the paper notes.

Q. Then in relation to other documents -- and we will just need to understand in a moment what you are saying about this -- what you say is:

"We have also continued to make further enquiries in relation to any additional documents that we would have expected to have been generated by the inspection process but which we have not encountered. We are not able to say that such documents definitely existed but there remains a possibility that some items were created but because of some human factors ..."

And you give some examples:

"... such as the documents not being stored in CRM

records management system. As I said, we went through about 500 plus boxes of paper records stored in Newcastle.

We looked everywhere that we felt we would reasonably have records stored. We did have some technical difficulties because a couple of our ex-employees, a couple of ex-colleagues, had moved on and when we changed IT provider, we couldn't get into their accounts because the accounts with the old provider had been deleted and they had not transferred into the new provider.

So there were some technical difficulties. I can't give you a full response to that because obviously that was allocated to people who understand the tech systems much more comprehensively than I do, but that is my understanding of the searches we carried out.

I think the paper project in 2017, because at that point -- and I remember myself -- after an inspection, you would have a large amount of paper in your possession in your office at home and we, the CQC, ran a paper project where we asked colleagues to return any records they held to their local office for storage and for scanning by the person we were -- the people we were contracted with Iron Mountain.

So we were reliant then on inspectors to pack the

records appropriately, to tag and label them and to submit them into our local offices. I remember I took mine to the Preston office, people took theirs to their local office.

Then they went round to Iron Mountain for scanning. But again, we were reliant on people following that process correctly.

Q. Doesn't this only illustrate to understand the impact of the failure to seize earlier opportunities that the closer to the time this had been done, the easier it would have been, if documents had not been treated as they should have been, to go back to those individuals and say, "well, you did this inspection not that long ago, we can't find your records, let's have a conversation while everyone still has a memory of it as to where those records might be"?

A. Yes, I think that would have been the right thing to do.

Q. Has the data protection officer at the CQC been notified of the problems that have been identified with finding material?

A. I am -- I -- my honest answer is I can't recall.

Q. Well, given your position of responsibility and your oversight over this and all the conversations

that you have had with everybody about it, would you have expected somebody to have told you if that had happened?

A. Yes.

Q. And nobody has told you that?

A. Not that I can recall.

Q. Do you think, from the position of knowledge you have, that the data protection officer at the CQC should be aware that the CQC cannot find a significant quantity of its records?

A. Yes, and obviously they haven't.

Q. Do you think that there should be a very careful and thoughtful discussion about whether or not the Information Commissioner's office should be notified of this?

A. I think we should have that discussion, yes.

Q. Knowing what you know now, not predetermining the outcome of that discussion, but can you see that there may be good reasons to make that formal notification?

A. I think -- I can't say, I can't say from the present vantage point, but we will certainly have the discussion.

Q. Now, if we look at the CQC's regulatory function, one of the things that CQC does is to go into

hospitals and care homes and scrutinise a document's approach to record-keeping?

A. Yes.

Q. Is that fair?

A. That's right.

Q. It's one of the things that you do?

A. Yes.

Q. And one of --

A. And one of the things we rely on.

Q. Yes. And you hold organisations to account and are critical of them in the event they do not manage their records properly; is that right?

A. Yes.

Q. And yet we seem to be in a position here, do you agree, that the CQC has fallen significantly short in a domain, an area where it is charged with the responsibility of holding others to account; do you agree?

A. I do agree in that we would hold a provider to account for poor record-keeping and we would expect that provider to acknowledge the shortfall and to address it. And I think CQC has to model that same behaviour and I think this Inquiry has highlighted that we have got some significant work to do around that.

Q. I am going to move in just a moment to the

inspection, but as we have been through all of these stages and reached the end of my line of questioning about it, I just want to give you one further opportunity on behalf of the CQC to provide us with a reflection and, if you consider it appropriate, an apology. Is there anything further you wish to say to what you have said already?

A. No. I think I have said that our response to the Inquiry was not timely or good enough. And for that I do apologise.

And you have an undertaking from me and my colleagues that we will look into why that happened and what we need to do to prevent it happening again.

Q. Let us turn to look at the inspection in 2016. Some of these issues have been explored with the witnesses yesterday, so I should just ask, are you aware of what the witnesses, the CQC witnesses and the Special Advisers, said yesterday to the Inquiry?

A. No, only, No, I am not -- I have not seen their statements, so...

Q. Did you hear their evidence or read the transcript?

A. Yes, I heard their evidence.

Q. Right. That is the important thing because it may allow us to short-circuit some matters without

needing to go to some documents.
A. Okay.
Q. We start from the position that in the intelligence briefing that the CQC provided it was suggested that there were no Serious Incidents reported to NHS England when, in fact, we know that there was a Serious Incident during the period the inspection was focused upon, the death of Child D was reported on STEIS?
A. Mm-hm.
Q. Firstly, do you acknowledge that that was a way in which the intelligence document was inaccurate?
A. At the point on which the data pack is prepared -- obviously there is an ongoing process with the reporting of incidents and sometimes an incident can take a while to get on to the system.
So at the point at which we shared the data pack, that may be inaccurate the following week because there will be other incidents applied. So I think what we -- we based -- so I think that incident may well have been reported but not yet included in the data, if that makes sense.
Q. Well, let's just have a look at the adequacy of the overall system if that be right, because what period was the CQC inspecting?

A. The inspection we usually look at retrospect is 12 months.
Q. 12 months?
A. Yes.
Q. So starting in mid February 2015?
A. So we might start 21 February to 21 February.
Q. I understand. Now, Child D died in June of 2015.
A. (Nods)
Q. On 2 July, there was a Serious Incident Panel meeting within the Countess when it was resolved to report Child D's death on STEIS?
A. Mm-hm.
Q. That is the start of the process?
A. Yes.
Q. Your intelligence pack was created. I think it's dated December 2015; is that right?
A. Correct.
Q. It would be a very unsatisfactory state of affairs if a hospital decided to report a death at the beginning of July if that was not --
A. No, that should have been -- that should have been included.
Q. Well --
A. Yes.

Q. -- precisely my point?
A. Yes, it should have been included.
Q. The evidence yesterday was to the effect that the inspectors and in particular the Special Advisers were misled because they didn't know that there was an incident, and they say that if they had known about it, they would have asked about it.
A. I think that's -- I think I wouldn't say misled. We gave the information available. I don't think we intentionally misled anybody. We based our inspection on the intelligence that we had and the data collection and the analysis of that data by the analysts. So we gave that information in good faith.
Q. Well, nothing about my question was suggesting that it was a deliberate act. My question was to the effect that the inspectors were misled. In other words, they did not understand correctly the true state of affairs because they believed that on the one hand no Serious Incidents had occurred.
A. Yes.
Q. Whereas on the other hand the truth --
A. In the children --
Q. -- was that one had occurred.
A. In the children's and young people's services.
Q. Exactly.

A. Yes.
Q. So they were misled?
A. Yes.
Q. As a result, they did not ask potentially important questions that they would have wanted to ask, and that's a serious consequence from being misled; do you agree?
A. I think when we look at incident management on an inspection, what we do is we look at the range and nature of the incidents reported. We look at the volume of the incident reporting and what you are looking for is a good level of reporting with a low incidence of harm, that there is a good process for the investigation of those incidents, that there is learning and any learning is applied and monitored.
So we wouldn't necessarily look at every single incident. We couldn't, we don't have the capacity to do that. We wouldn't necessarily look at every single incident in every single service because over the -- overall, it can be many hundreds, so we tend to random sample incidents.
Now, I accept had we known there was a Serious Incident we could have sampled that, but again it would have been how it was investigated, what the findings were, and how those -- any learning was applied.

Q. A number of points fall out of that. The first is that it would be a random sample taken from a population of one, because if they were to ask themselves "I wonder whether there's a particular worked example that we can explore", there is, in fact, only one Serious Incident?

A. One.

Q. It does seem quite likely, do you agree --

A. We would have looked at that.

Q. -- that that one would have been --

A. Yes, we would.

Q. Quite so, and that is consistent with the evidence we received from the people who would have made that decision --

A. Mm-hm.

Q. -- making.

If we follow that up, Child D formed part, Child D's death formed part of, as I am sure you understand now, the increase in neonatal mortality?

A. Yes.

Q. Whilst nobody can know how that conversation would have developed, do you recognise it presented an opportunity for what CQC witnesses have consistently told us did not emerge to have emerged?

A. I think in relation to that child, yes, we

could have looked at that incident and it may have lead onto other questions about the mortality in the service.

Q. Just so that we understand the potential significance of that piece of information not being in the hands of the inspector. It was capable, do you agree, of uncovering for the CQC the problem which existed, or at least part of it, which could have led to important follow-up questions?

A. I think it certainly would have warranted an exploration of that incident which may have then led on to a broader conversation, yes.

Q. Can you just help us. The intelligence report is pulled together by data analysts; is that right?

A. It is.

Q. What qualification does one need to become a data analyst at the CQC performing this kind of role?

A. I don't know.

Q. Is there any kind of quality assurance process over the drawing together of that information?

A. Yes, I think there is. You'd -- data and insight team are highly technical and I am not really involved in the management or the running of that team. But I do know our data is quality assured and validated.

So -- but I can't say any more than that, really.

Q. Sitting there now, on behalf of the CQC, do

you understand the mechanics of how that Serious Incident was not communicated to those conducting the inspection?

A. Yes, I do. I think I --

Q. Do you want to just explain how, with the death that occurred in June with the information being pulled together in December, did it state something which was in fact untrue?

A. If that incident was reported as a Serious Incident on STEIS, it should have formed part of the data analysis had it been reported at that time.

The information we had in the data pack for Children and Young Peoples Services, as I recall, said there had been no Serious Incidents, there had been no Never Events, and the incident reporting generally was of -- within expectations as I recall. And I think you can see that from the pack itself.

Q. In terms of exactly what went wrong here, is it a question of that data not being visible to your data analysts, or is it a question of the data analysts having overlooked it?

A. I couldn't honestly say. As I say, it's well out of my area of expertise.

Q. Is that something that you can organise to be found out?

A. I think we could, yes.

Q. Well, that is helpful to know.

Another aspect of the pre-inspection preparation is something called HES monitoring. HES stands for Healthcare Episodes Statistics?

A. Yes.

Q. We are just going to take this slowly. Can I ask you please to turn up your second statement, and in particular go to paragraph 3.9 because we just need to untangle some of what is said here and try and understand this process.

A. My second statement, did you say?

Q. Your second statement, please, yes.

A. Thank you.

Q. Do you have 3.9?

A. Yes, I do.

Q. We will just read it along together so that everybody knows what we are talking about:

"Analysis of Healthcare Episodes Statistics (HES) by CQC during the course of the inspection did not flag the Trust as an outlier for higher than expected rates of perinatal or late neonatal mortality for the period April 2015 to December 2016."

A. Yes.

Q. Next paragraph:

"I should explain that HES provides data to monitor a range of maternity indicators which include perinatal mortality and late neonatal mortality rates. Statistical outliers are identified using cumulative (CUSUM methodology) and CUSUM [you tell us] involves analysis of the cumulative sum of differences between data points in order to identify trends in data over time."

Two more paragraphs:

"For the period April 2015 to December 2016, the Countess of Chester did not register as an outlier for higher than expected rates of perinatal or late neonatal mortality.

"The number of perinatal deaths during the 2015/2016, quarters 2 and 4, [which you give as eight and seven deaths respectively] were higher than most other quarters which were less than 6, but to register as a statistical outlier over this period, the data would have had to include at least three standard deviations from observed and expected indicator values. Applied to the data for this period, the Trust was not flagged as an outlier and the data was not examined further at this time."

That is what you told us in your second witness statement.

A. That is my understanding, yes.

Q. Do you agree that, in your second statement, you say that the Countess was not identified as an outlier by this statistical modelling, and the reason you give is because the number of deaths did not meet the at least three standard deviations; that seems to be the reason that you give in your second statement.

A. There are two sets of data that -- well, a number of datasets that we will use around mortality. I think the one that we rely on most for neonatal mortality is the MBRRACE data. The HES data.

So what we tend to do is -- well the analysts tend to do is bring together all the data from a variety of sources and determine whether or not that the Trust is an outlier and my understanding and the understanding I shared with the inspection team that the Trust was not an outlier for mortality.

And when we carried out the inspection on that understanding.

Q. Yes. What you say in your second statement, just to come back to it, is the reason, according to your second statement --

A. Yes.

Q. -- that it was not an outlier -- and I am looking here at 3.12, where you give us the actual

A. I do, yes.

Q. Now, let's just have a look at one paragraph of your third witness statement, please. Paragraph 4.2.

Again, so that everybody can follow what we are saying, I will just read it out to you and you can perhaps follow along: "The briefing pack..." you tell us -- I'm sorry, have you found it?

A. Yes.

Q. "... was a comparative analysis of a trust's performance using a standard set of indicators. This included available metrics on mortality and 'outliers' and other contextual data about the service. During the preparation of the inspection of [the Countess of Chester] in 2016, the Statistical analysis of Healthcare Episodes Statistics ... by CQC as part of the 'outliers' programme did not flag [Countess of Chester] as an outlier for higher-than-expected rates of perinatal or late neonatal mortality for the period April 2015 to December 2015. This means that the data did not show a statistically significant difference between the actual number of deaths and expected number of deaths over this period. This is because the data for neonatal mortality was and still is published retrospectively and the data of the 2015-16 was not available at the time of the inspection."

number of deaths, and you say:

"But to register as a statistical outlier over this period the data would have had to include at least three standard deviations from observed and inspected indicator values."

What you appear to be saying there is that the data was analysed, it did not meet the three standard deviation threshold, therefore the Trust wasn't an outlier?

A. Wasn't an outlier.

Q. That is what the plain English means; do you agree?

A. Yes.

Q. But by the time we get to your third witness statement -- and again it may be that I am just misunderstanding this -- you say in the last two paragraphs that the data didn't show a statistically significant difference, in other words it didn't meet that criteria, but then you add this:

"This is because the data for the neonatal mortality was and is still published retrospectively and there was no data available at the time of the inspection."

A. I think, I think that's true. That some of the data was not available.

I think I have made -- I think I have made a mistake and I have confused the HES with the MBRRACE.

Q. We just need to be absolutely clear about this.

A. Yes, I need to think -- can I just take a moment to think?

LADY JUSTICE THIRLWALL: Yes, absolutely.

MR DE LA POER: Of course. You must do so, this is important for us to understand and if you want the references again, I can give you them.

A. No, I have it here. Thank you. (Pause)

Thank you. I think it's both. On reflection, I think it's both. I think the data is not in real-time and the deviation wasn't met.

Q. But the significance of the deviation not being met is close to zero if the data set is incomplete, isn't it?

A. Yes.

Q. Because, in fact, it's potentially even worse than that, isn't it, because it may cause you to think, as inspectors, the outlier threshold has not been triggered when, in fact, the explanation for that is simply that the data hadn't all come in?

A. Mm-hm.

Q. And --

realise that not all the data for that was in?

A. Mm-hm.

Q. Is that --

A. I think we relied on our analyst colleagues to bring together data, to give us an overview of what the data indicated. The -- the data is really very important. But it's the start of the conversation, not necessarily the end of the conversation.

And we would also expect a Trust to be monitoring its own themes and trends and be honest and open with us about any issues that they'd identified because they would know as well the time lapse in the data because they submit some of their -- they submit the information.

And I think, at this point, we did not know that they were a statistical outlier. We did not know that there was a problem on the neonatal unit and we were -- we were not alerted to the fact that it was.

Q. I grant all that and in fact we need to be fair about this. Once all that data came in, because it didn't meet that three standard deviations, it wouldn't have triggered it anyway, but this is just going to the process --

A. I understand.

Q. -- that was being adopted. Do you think you

A. That is -- that is correct, that is the process, yes.

Q. Just think about this. You went along to the Countess of Chester presumably thinking to yourself the outlier threshold for mortality has not been met?

A. That's correct, we did, yes.

Q. But --

A. Because had it been, we would have pursued a line of Inquiry.

Q. But the significance of that was close to zero and, in fact, was misleading; do you agree? Because you may have thought it wasn't an outlier when in fact it was and the only reason you hadn't been told was because the data hadn't come in?

A. Yes, that's right.

Q. Can you see the very significant problem there is with that?

A. I think there is always a problem when data is not in real-time.

Q. But what is the point of outlier data if the data set is not going to be complete?

A. I see. I take your point.

Q. Does it follow that you went into that inspection, as everybody else, thinking, "This is not an outlier for mortality" in circumstances where you didn't

understood in 2016 that you were relying upon what was effectively a warning system that was based on incomplete data? Do you think you understood that so far as --

A. I think we understood that the information we had was the -- right at the time. We knew that there was an ongoing process and we didn't only just inspect. We had an ongoing, we had process of ongoing monitoring and engagement with the Trust. And we expect -- and we certainly try to be open and transparent in our dealings with the Trust, and we would expect the Trust to be the same with us.

So when we meet with them, when the data is -- or they identify a problem, we expect that open dialogue where we can look at the issue and manage it and where we feel the Trust is not managing it, regulate accordingly.

Q. Now, the Inquiry has received a statement from Professor Sir David Spiegelhalter who spoke in quite general terms, he didn't use the name of the tool --

A. Yes.

Q. About a CUSUM tool that he had developed for the --

A. Yes.

Q. -- CQC in 2007. Just to try and close the

loop, is it your understanding that what Professor Sir David Spiegelhalter is talking about is your HES tool or is there a different tool, or do you not know what he is talking about?

A. I didn't know what he was talking about. It is a bit technical from a data point of view for me. It is not my field of expertise, data analysts, you know, we rely on the analysts for that. So I couldn't honestly say whether we used it or not, and I'd not -- I'd not heard the term before the Inquiry gave it me.

Q. Now, whether or not it would have met the three standard deviations, which presumably was a threshold set by whoever was creating the tool --

A. Yes.

Q. -- do you know whether or not it was capable this outlier signal, of distinguishing between deaths which were unexpected and unexplained and just the crude mortality figure?

A. No, I don't. I don't know enough about the tool to be able to tell you that. No.

Q. Because one of the things that we have heard consistently from the paediatricians, I am sure you can recognise the force of --

A. Mm-hm.

Q. -- is that it isn't just the fact that the

death rate is higher than expected, it's the fact that it's babies who weren't expected to die --

A. Absolutely.

Q. -- who were dying?

A. Trusts don't have to report every death, but we do expect them to focus on unexpected and avoidable deaths. And we do expect there to be a robust process around that mortality and morbidity reviews, you know, child death oversight panels and so forth. And the investigation into those deaths lies with the provider who should then identify what went wrong, be open and honest about it and put it right.

Q. Now, one of the data requests that were made of the Trust, you tell us in your witness statement, was made on 15 February, so the day before the inspection; that was a Monday --

A. (Nods)

Q. -- the inspection began on the Tuesday, which included paediatric incidents?

A. Yes.

Q. I am sure you have had a chance to remind yourself of this --

A. I have.

Q. -- and it was a table that was spoken about yesterday a number of times. It is a table that

includes 378 lines of incidents.

A. Mm-hm.

Q. Our Special Advisers all say that that was not a table that they saw.

A. (Nods)

Q. Do you agree that the interpretation of the potential significance of paediatric incidents is very much a matter for the Special Advisers rather than the CQC staff?

A. I think the -- the incidence is very much a matter for the Trust and for CQC because when we -- on an inspection like this, we look at how the Trust -- the Trust is charged with the responsibility of investigating those incidents and, as I say, that commitment to continuous improvement and learning.

So when we look at incidents, we look at them in terms of the process and how they are discharging those responsibilities. If we feel they are not, then that would be a cause for us to do something different.

Q. The evidence we had from the Special Advisers is that they, having looked at that now, identify incidents which may have prompted further discussion because they were inadequately described or they couldn't understand, using their expertise, what it was that was being talked about. That suggested, to use

that word, a process problem because it's not recorded properly, but underlying that may be a genuine inadequacy in healthcare provision.

So they say -- and they told us this -- that they would have wanted to explore some of those incidents with the clinicians and the people that they were dealing with during the inspection. That is what they say about it?

A. (Nods)

Q. Now, the first question really is this: requesting that information the day before the inspection has this consequence: your inspectors can't read it in advance of turning up, can they?

A. No, not for the inspection starting the next day, but it's something that they can do over the course of the inspection and after the inspection and in the report-writing period.

Q. They say they never saw those documents.

A. The inspection team leader would have, would have seen it.

Q. And who was the inspection team leader?

A. Helen Cain was leading the inspection there. I think she would have had access to it. I can't say for certain whether she saw it, but she would have had access to it.

Q. How about the people with the clinical expertise to interpret that and to ask meaningful questions about it. I mean, aren't they the ones who need to see it?

A. I think it would have been helpful to share it with them, yes, if it wasn't.

Q. Do you agree that is another missed opportunity to uncover what was actually going on here?

A. I think potentially, yes.

Q. Why was it not until the day before that the CQC was asking for material that would be relevant to the people who were conducting the inspection?

A. It was an ongoing process. So we look at the data pack, we plan the inspection, Helen Cain, I was confident, was -- and Benjamin and the Specialist Adviser, I was confident that they had an idea of what they needed to do while they were there.

I think we often made data requests pre, during and after the inspection, to add to our intelligence, to add to our thinking and to underpin our judgments.

So it's not uncommon for people to be asking for information before, during and after the inspection.

Q. Is there any good reason why it wasn't asked for before?

A. I don't think it was part of the data pack

unless, so I think, I think it's important that we had -- we did have information around the incidents, around the incident reporting. The service specific I think it might be worth for future asking with the data pack. I think that would be a good thing to do.

Q. Well, it is just the sort of document, 378 lines is not something that you can glance at and digest.

A. I think we -- looking at -- you know, hindsight is a wonderful thing, and I think when we look back now we followed the process of the inspection accordingly. Could it be improved? Yes, I think it could and have we improved it? Yes, I think we did.

So I -- if you are expecting an organisation to continuous learning and improve, as I mentioned earlier, we have to model that behaviour ourselves. So where there is opportunities for learning we have to take them and we have to be honest about the learning and we have to apply it.

Q. Please don't think for a moment I am suggesting that there shouldn't be learning from this, but you have used the word "hindsight". Do you need hindsight to recognise, at the time, that asking for a document which is dense with information about individual patients, asking for that the day before and

not ensuring that it is put under the nose of the people who can interpret it and ask questions in good time is a problem?

Do you need hindsight to recognise that problem, or is that something that should have been recognised at the time?

A. Yes. I think it would have been a good thing to do.

Q. Now, Dr Brigham did a review that was badge neonatal, but in fact had an obstetric lens, as it's been termed by others, towards the end of 2015. Was that a document that was provided to the CQC before the inspection?

A. Not to my knowledge.

Q. Now, as we understand it, the CQC has disclosed a copy of that report to the Inquiry from the client relationship management folder, and the inevitable inference from that is that at some point the CQC has come into possession of that document?

A. I -- I don't recall seeing it in 2015. I don't.

Q. Well, it would be quite an important document to consider, wouldn't it?

A. I think it would -- if I can explain how information was managed at that time. Each Trust had

a relationship owner and an assigned inspector and the relationship owner managed, if you like, the business as usual, engagement and monitoring, with the -- with the inspector and the inspection manager.

I necessarily would only be included if there was deemed to be a particular risk or -- so I -- the day-to-day oversight of the Trust was not, was managed by me but not carried out by me. So I may not have seen it, although the inspector may have done.

Q. Well, it was something that the inspector should have seen if the CQC had it?

A. Yes.

Q. Because it does, in fact, specifically refer to the increase in neonatal mortality.

Now, that document was referred to in the minutes of a QSPEC meeting at the Trust in December and in the minutes of the women and children's care governance board meeting in December. I will just tell you the terms that it's referred to. In QSPEC, it is recognised as being an increase in neonatal and stillbirths during the period January to November, so that information is in those minutes.

In the Women & Children's Care Governance Board meeting, a panel has been set up to review each case individually and there are 18 cases is said about that

increase. So on the face of it, for a relatively modest sized hospital, quite a significant number of cases?

A. Mm-hm.

Q. But do you know whether the minutes of the meeting for QSPEC and the Women's & Children's Care Governance Board in December 2015 were provided before the inspection?

A. No, I don't.

Q. If they were provided, do you agree the process -- well, do you agree the process should be that they should be provided to the CQC, those minutes, as part of the governance assessment is to look at the minutes of the meetings?

A. Not always. Not always. But I think where there was an issue it should have been provided, yes.

Q. That would be up to the Trust to decide whether or not the CQC --

A. To disclose that.

Q. -- needed to know that?

If it was provided as being potentially relevant in the minds of the Trust, the process should then be that it's given to the --

A. Relationship owner to look at and assess.

Q. -- relationship owner and from there it's going to need to go to those with the clinical expertise

on the inspection so that they can see it and engage with it?

A. If -- if issues are identified, yes.

Q. Yes, and there doesn't appear to be any evidence that that, in fact, occurred, that total process. Would you agree that something, at some point in the process, appears to have gone wrong?

A. In terms of the information sharing? CQC or with --

Q. Yes, whether that lies with the Countess for not providing it or whether it falls to the CQC for not ensuring it ended up in the hands of the people who needed it.

A. I think -- I think once there was a hint or an indication that there was a problem with mortality on that unit, my expectation would have been that the Trust alerted ourselves, NHS England, and any other party that there was a problem and they were looking into it.

And I think, as part of that, any documentation, any audits, any reviews, any work they have undertaken should have been shared transparently and openly. That is my view.

Q. Included within that view, no doubt, is the Thematic Review of neonatal mortality conducted by Dr Brearey and others --

A. That's right.

Q. -- a week before the inspection?

A. (Nods)

Q. Was that February version to your knowledge provided to the CQC?

A. Not to my knowledge.

Q. Now, it was described as a draft at that stage --

A. Mm-hm.

Q. -- and it was provided to the Medical Director and the Director of Nursing the day before the inspection, the 15th --

A. Yes.

Q. -- upon request by the Medical Director, specifically by reference to the CQC inspection.

A. Mm-hm.

Q. What is your expectation of a Medical Director and Director of Nursing in receipt of such information at their interviews with the CQC in the following 48 hours?

A. I think they should have shared that with us. I think they should have made us aware of that.

Q. Now, the Thematic Review was finalised on 2 March, so after the --

A. We were off-site.

Q. -- the notified inspection, but before the inspection which took place on 4 March, which I think was an unannounced aspect of the overall inspection.

A. Mm-hm.

Q. Once finalised, bearing in mind it related to the period of the CQC review, should it have been provided to the CQC?

A. That would have been my expectation, yes.

Q. What was the CQC's stated policy on the generation or the provision of documents which are generated after the inspection but which related to the period that had been inspected?

A. In terms of what was reported --

Q. Well, did --

A. -- or the actions taken?

Q. I will put it bluntly. Did the CQC say in writing to the Countess of Chester, "If a document is generated after the inspection which relates to the inspection period, you need to give it to us"?

A. Yes, I think we did in -- I don't think we were explicit about after the inspection, no. But I think it was understood that our expectation was this was different, you know, this just wasn't information, this was about an emerging serious concern and I think they should -- and it would have been our expectation.

This is not just things that can help you make a judgment in your inspection. This was really, really significant issue and I think they should have made us aware of that immediately.

Q. Do I understand you are saying that outside of the inspection regime, this is something the CQC should have been notified about?

A. Absolutely.

Q. It wouldn't have mattered whether you were inspecting them in February or not, that should have been brought to the CQC's attention?

A. Absolutely.

Q. In the situation where at least some of the people involved on the ground didn't regard it as an emergency -- and there is some evidence to suggest that in some people's minds it was not an emergency -- nevertheless, it was relevant, wasn't it, to the CQC inspection period?

A. It was, yes.

Q. Setting aside the emergency notify anyway, I am just trying to understand how a Trust would know that they were under an expectation to provide documents which are finalised after an inspection to send it to you. How would they know that if you haven't told them expressly that that's what you require?

A. As part of the ongoing relationship management model -- so if we take the inspection to one side and a risky emerges, the Trust -- the expectation is, in that spirit of openness and transparency -- and they are the principles on which we have -- hold our relationships with providers, that they will be open and transparent with the regulator and the regulator with them. That when an issue like that emerges, it is important that they alert us to it at the earliest opportunity.

Now whether that is pre, during or post an inspection, the Trust, my expectation was that they would alert us to the concerns that were emerging on that unit.

MR DE LA POER: My Lady, I have a little more for the witness, but I wonder, given the balance of work this morning, that it would be appropriate for us to take our break at our normal time now and I will then be able to conclude relatively swiftly after that break and we can then move to our final witness.

LADY JUSTICE THIRLWALL: Yes, certainly. We will take a break now and we will start again at 11.35.

A. Thank you.

(11.17 am)

(A short break)

(11.35 am)

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: Ms Ford, one final aspect of the pre-inspection documentation. We have asked each of the CQC witnesses about the self-assessment form and each of them told a variation on this; that they looked at it and then decided to make their own independent judgment about each of those domains.

A. (Nods)

Q. What is the point of the self-assessment?

A. The point of the self-assessment is to sort of test out the Trust's view of its own services and its perception of where it might be in terms of quality, safety and performance. And we use it as a piece of information, but we are never really influenced by it in terms of our own judgments which we do based on the evidence we find during the inspection.

So it's an opportunity for the Trust to showcase some of the things it does well, to be clear about some of its challenges and what it's doing about that, and to talk about how it is performing in terms of its -- the quality of service delivery to patients.

Q. Is it a document that the inspectors actually need to see before they carry out the inspection, if they are simply going to ignore it?

A. Well, I don't -- I don't suppose they ignore it. Well, I'd like to think they didn't because I certainly don't, because I do like to see how the Trust perceives itself and compare that to the findings because it does tell you something about the way the Trust operates.

So there was some outstanding self assessments there, particularly around the caring domain, which we didn't agree with.

Q. I wasn't suggesting it did influence, but it just seemed to me that -- and I am not suggesting it isn't relevant at some point -- it's just why is it being provided at the start as opposed to "now we have conducted our independent inspection we can test that against how the Trust thought it was at the start of the process". It is just trying to understand; do you see?

A. Yes, I understand what you are saying, yes.

Q. I am not saying it is irrelevant, it is just why do the inspectors need to see it as part of the documents they get.

A. Because I think it gives them some insight into how the Trust perceives itself.

Q. Turning to the inspection itself, you participated -- and if you need to be reminded I can bring up a document, but I am sure you can recall -- in

core interviews with Sir Duncan Nichol, Hayley Cooper, Sue Hodkinson and Tony Chambers.

A. Yes.

Q. Sitting there now, do you have a recollection of each of those meetings and the faces of those people and the conversations you had with them?

A. Yes, I -- I do, I would recognise the people again if I saw them and I have others. There is no record, as you quite rightly said.

The prompts and the key lines of inquiry, I have a reasonable idea of what we would have discussed in those meetings.

Q. What was Sir Duncan Nichol telling you about how the Trust was?

A. Well, he felt that the -- as I recall, he talked about the vision and future of the Trust in terms of the model hospital and the work they were doing around that. He talked about his confidence in the Executive team and he talked about the challenge in scrutiny of the board, as I recall, because they are the topic areas we tend to speak with, speak to the chair about.

Q. Mr Chambers, the Chief Executive, what did he tell you?

A. I can't recall verbatim, but again, he told us

about when we -- when we worked through the -- when we worked through the -- the prompts. Sorry, I couldn't remember the word "the prompts", the interview prompts, where he is asked what the plans were for the Trust, what the current risks and challenges were, what the -- what the Trust was particularly proud of. What support, you know, so if there was an issue around perhaps delayed transfers of care, I am not saying we did, it is just by way of an example, we would ask what the system support was like around that because it impacts on the flow of the hospital.

So some of it would be bespoke and some of it would be more general.

Q. You have just listed the questions he was asked; what did he say in response?

A. Well, I think they were quite committed as -- they were quite committed as an Executive team to engagement. They were quite committed to improving services, as I recall, and they were quite committed to the model hospital and taking the service to the next level.

They are the broad issues, as I recall.

Q. There was also a focus group with Consultants; did you attend that?

A. No.

Q. Do you recall being told about any of the things that dropped out of that focus group?

A. Yes, I do. At the end of -- at the end of each of the inspection days, we hold what we called a corroboration session. So all of the core team leaders would come together and meet with their teams and they would discuss the findings of the day, who they had met, what they found, what they'd heard, what they'd read, what they saw, what they'd been told. And at the end of the day, the Chair and I would sort of be at the front of the room and we'd go through each core service over the five domains and they would give the headline feedback of what would happen -- what happened.

Q. That is the process. What were you told came out of the Consultant focus group?

A. When we talked about the focus group, I was told that the Consultants -- because more generally we had feedback and I think I did a focus group with the nurses who were quite positive about the culture in the Trust, that the Consultants had raised that -- no, I'm sorry, I am going the long way around things here, but we don't normally take the names and the role of people, we just know they are a Consultant or a nurse because it encourages people to speak more freely, we think.

So in the Consultants' focus group, I understood

that they had raised some concerns about staffing levels, they had raised some concerns about the Trust not listening to the concerns, and they had raised some issues about the Trust not responding to those concerns and at times they felt management was oppressive.

Q. You used the phrase "bullying culture" --

A. Yes, yes.

Q. -- in your witness statement?

A. Yes.

Q. Now, these Consultants, were they just Consultants from the Children's Services or are these Consultants drawn from across the hospital?

A. No, I think the whole idea of the focus group is that you opened it up to all Consultants. So we -- you know, there would have been a mixture of disciplines there. So I don't know how many of them were Paediatric Consultants or how many of them were surgeons, we just knew that they were Consultants at the hospital.

Q. Having been made aware that that came out of the focus group, were those concerns raised with any member of the senior management team during the inspection?

A. I believe they were. I believe they were raised with the Medical Director on the day.

Q. On the day of the Consultant?

A. I think that was fed back on the day.
Q. What is your understanding of what his reaction to that was?
A. That he -- he -- that more broadly they were working on culture in the Trust and that he would speak to the Consultant body and he would begin to address those concerns.
Q. Do you understand whether he acknowledged those concerns in the sense that he didn't dismiss them, but recognised that they were valid and needed addressing?
A. I couldn't say because I was not at the meeting. I was not at the meeting with the Medical Director post the focus group.
Q. Bearing in mind there is no record of that conversation, I am not doubting for a moment it took place, but there is no record of it. Can you see that that is a very clear worked example of the problem of not having those records to understand exactly what was communicated to him, what the Consultants were concerned about, and exactly what his reaction was? Can you see that that's a problem for this Inquiry?
A. I think I have acknowledged already that, you know, the record-keeping is a challenge to the Inquiry. And I -- I agree. It would have been so much more

helpful had they been there.
Q. Now, we can deal with this globally and you have already indicated that, before the visit, nobody alerted you or the CQC, you say, about the increase in neonatal mortality or the concerns that existed in the minds of some about Letby's association with that rise.
During the visit, was the CQC notified of either of those matters?
A. Not to my knowledge. I -- and it certainly and I know it would have been. I am certain it would have been. If anybody would have raised that, it would have been escalated to me and to the Chair.
Q. Well, that, I suppose, is the question. What would you expect exactly the CQC's reaction to being told that information during an inspection to be?
A. Well, immediately, I would have wanted to understand what the Trust was doing about any immediate and ongoing risk to the babies in the unit.
So I would have wanted to know what they are doing to mitigate that risk. How -- who else they have informed. That would have been my prime -- my first and foremost concern was the management of the immediate and ongoing risk to the babies. And then obviously, once I was assured that that was mitigated, we would look more broadly and start to look at things like when did

you know, how did you know, the staffing, that -- that sort of conversation would have taken place.
But immediately I felt -- and I did, I think, focus on the immediate and ongoing -- once I knew, the immediate and ongoing risk to the patients, the babies.
Q. What was the first date of your knowledge?
A. I think it was 29 July, the day after we published the inspection report, I got a phone call from the Director of Nursing, Alison Walsh.
Q. 29 June, I think.
A. June, sorry, apologies. You have probably gathered dates ...
So Alison rang me.
Q. Can I just pause you there, we are going to come to that conversation in a moment.
A. Yes, okay.
Q. Your evidence is that you didn't know before that. Just a couple of events to cover, one in particular.
There was an unannounced visit on 4 March, we have already touched upon that, and we know that that involved inspectors going to the Children and Young Person's Services?
A. Mm-hm.
Q. The Thematic Review had been formally

published and disseminated to a group who were involved and needed to be sighted on it just two days earlier. Do you regard, on behalf of the CQC, that being an opportunity for the Countess to tell the CQC about that recent development?
A. Of course. I think the whole inspection was an opportunity.
Q. Now we come to the 29 April. I think the sequence is that you received a telephone call on that day and an email on 30th June.
A. (Nods)
Q. Thank you. I am now mistaking the date.
Just tell us about that telephone call with Alison Kelly, please.
A. Alison Kelly rang me and told me that there was -- they had identified an issue in the Trust, that there had been an increase in mortality for, I think, 14/15, 15/16. I asked her what she was going to do about that. Again, the focus being the immediate and ongoing risk to anybody being cared for, the babies being cared for, in the unit.
She said the Trust had made the decision to downgrade the unit, so the more poorly babies went -- the intensive care babies went to another centre. I thought that was a good thing to do and it would also

help with the staffing because the closure of those cots meant that there would be a better nurse ratio for the other babies that were being cared for there as well. So that assured me that until the root cause was identified, that the immediate risk to babies was to some degree mitigated.

I asked what else they were going to do. She said there had been an independent review that had supported the -- supported the assertion around the mortality, that they were going to do a deep dive, they were going to invite the Royal College in, which again I thought was a good thing to do because they are specialists in the field and they would be able to identify any failings that their own reviews had been unable to do so. I thought that was a good thing.

They were then looking at staffing and competency which seemed appropriate.

So my immediate thinking about the response she shared with me, I was reassured that they were -- they were taking action.

That was then confirmed in the email and at that point, I was still unaware of any concerns around Lucy Letby.

Q. Well, that was to be my next question. We know that the Consultant body met on 27 June and it was

then resolved to contact the Medical Director which occurred and we know that another meeting took place involving senior nursing staff and the Medical Director on the 27th, and that there were then some subsequent meetings later in the week.

A. Mm-hm.

Q. And that the substantial part of those meetings were spent talking about Letby.

Do you think that's something that the CQC should have been alerted to at that stage?

A. I think we should have been alerted to the fact that there were concerns about a practitioner on the unit, and I think they should have told us how they were managing that. So whether they, you know -- at that time, we didn't know what the range and nature of the allegations were about Lucy Letby.

So I would have expected them to say "we've got concerns about a member of staff. We've removed them from the unit. We've put them under..." -- you know, I would have expected them to let us know that they were carrying out an investigation and in the interim, while they were concerned, she was taken away. So again, part of the mitigation of immediate and ongoing risk. So I would have expected them to share that. If not the intimate detail because of the employer/employee

relationship, I would have certainly wanted to know that that had happened.

Q. Now, as to the timing of that call and the publication of the report, were the Trust on notice that the report was going to be published that day?

A. Yes, yes, we usually agreed the publication date with the report. The two comms teams work together around the publication of the report.

Q. Had the report been formally published before you received that call?

A. Yes. Yes, it was the day before, I think. Or a day or so before.

Q. You think it had been published not on the 29th, but on the 28th?

A. I think it was the same day.

Q. That is what I am trying --

A. Yes, it was the same day. Sorry.

Q. My understanding was it was published on the 29th, I am trying to get the chronology right.

A. You are quite right. The phone call was the same day, the email was the day after.

Q. Yes.

A. Yes.

Q. At the time of the phone call, had the report been published?

A. Yes.

Q. Just in terms of this, obviously even when the terms are given to you, a highly significant piece of information which applied to the period that the report was talking about, what thought, if any, did you give to thinking: "well, I am now worried that that report isn't giving the full picture, we need to withdraw it or take it down from the website". Was there any consideration of that given at the time that this phone call came in, did you attach that significance to it?

A. At the time of the phone call, no, there wasn't because what I was most focused on was the immediate management of the ongoing risk to patients. That was my focus. You know, what are they doing? If there is a mortality issue here, what are they doing to mitigate that risk? And that was my first thought, I have to be honest. I didn't even think about the report at that point.

Q. Just reflecting upon it now -- and we appreciate that the report is a snapshot in time and you have emphasised repeatedly that this is an ongoing relationship and information comes to light --

A. Mm-hm.

Q. -- members of the public accessing that report would see what you say about the unit and nowhere in the

report is an indication that there is a pretty substantial issue that is being -- that has arisen during the inspection period. I mean, would it have been appropriate to take the report down, or is that not appropriate in your view, bearing in mind you have just had that information when it was hot off the press --

A. Yes.

Q. -- which directly related to the period that the report was commenting upon?

A. I think that is a very fair question.

Q. And is it --

A. I didn't -- I didn't on the day, I didn't, you know, I have to be honest. Was it something we could have considered later? And maybe we should.

I suppose there's a balance to be had -- and I am only thinking this through now -- there is a balance to be had, isn't there, you know, because a lot of what we said about the Trust was accurate based on the information we had at the time.

We would have published the report. The caveat -- we -- we would have published a report with information that there was a mortality outlier on the neonatal unit that was under investigation, which would have been accurate.

So I think we could have considered -- we could

have considered amending the report. But I think it was accurate at the point of publication.

Q. Just building on that answer, I am not for a moment suggesting other than it might be appropriate to reflect upon whether or not an addendum or caveat could be added --

A. Yes.

Q. -- you will be aware that members of the public might look at that and say: "well look, the CQC has been in right in the middle of this and they have said they have not identified any problem, we can rely on the CQC to tell us whether there is a problem or not," you can see how members of the public rely upon you as a regulator in that way?

A. That is a possibility, yes.

Q. That, presumably, would inform the thinking about whether or not some kind of an addendum --

A. Caveats.

Q. -- needs to be added?

A. Mm-hm.

Q. Now, after your telephone call, we know an email was sent the following day. Let's just bring that up on screen. INQ0017411. Now, you have seen this before, so we don't need to look at all of the detail.

Help us. Does this reflect the content of your

call? Is this as good and accurate a record as we are going to get of what you were told the day before? Is there any more information in here? Is there any less information in terms of just understanding what you were told the day before?

A. I think that's a fair reflection.

Q. As you have told us in relation to the day before, in this email, would it have been your expectation that there would have been some mention that there was a member of staff had been identified and that steps were being taken to better understand that concern?

A. And the risk had been mitigated, yes, there would.

Q. Yes, we know that, as at the 29th of your call, Letby it would appear, was still operating on the neonatal unit. So if you had been told that, so let's just hypothesise here, you are told on the 29th there is also a concern raised about a member of staff that we are looking into, what would your reaction have been?

A. What are you doing about that? How are you mitigating that risk? And certainly I would have either relocated her or suspended pending investigation.

Q. That would have been advice given as a regulator as to what you need to do to reassure us?

A. Yes. We can't -- we can't tell an employer what to do with an employee, but we could certainly make -- we could certainly say: "my advice would be to ..." And then it's up to the Trust to take it, but I think we would expect them to take that sort of advice.

Q. Knowing yourself, as you do, is that the sort of advice that you would have given if you had been told this?

A. I think so, yes. I know so.

Q. Thank you. We can take that down.

Now, subsequent to the report, there are a series of engagement meetings and I think they were conducted by the relationship manager --

A. Yes.

Q. -- who you have already mentioned. Is that person for the period that we are concerned with somebody called Debs Lindley?

A. Yes, Deborah Lindley, yes.

Q. Just to take a couple of examples, no doubt you have a general understanding of this although you weren't participating directly, we know, for example, that there was a meeting on 22 December 2016 with Ms Lindley. We know that the RCPCH report was mentioned, but there was no mention about the nurse.

A. Mm-hm.
Q. We know on 17 February of the following year, which is at a time when the Consultants were pressing hard for further action from the Trust, there was reference to the RCPCH report, but no discussion recorded about neonatal mortality.
I am sure you have said this to us already, but to your mind, were those opportunities for the CQC to be informed about the concern about the nurse?
A. Yes. I believe so.
Q. We know that dropping out of the RCPCH report Dr Hawdon, Consultant Neonatologist, was instructed. Were the CQC ever notified of that, do you know?
A. We were told that the Trust were commissioning the Royal College to carry out the review.
Q. Yes.
A. And they were agreeing the Terms of Reference which would have been what we expected to happen.
Q. But the RCPCH recommended that Dr Hawdon should be instructed. Did you know about that additional forensic case note investigation?
A. No. No.
Q. Is that, bearing in mind the RCPCH said: "further work needs to be done in this area, this isn't the end of it" --

A. Mm-hm.
Q. -- should the CQC have been told about that further work?
A. I believe so, yes.
Q. Similarly, the day Paediatric Pathologist Dr McPartland was also instructed to look at some cases, is that another step that the CQC should have been told about?
A. I believe so, yes.
Q. Now, in terms of the police -- and you might just want to turn this up, it's the penultimate thing that I am going to ask you about, which is in your third statement at 9.2 --
A. Excuse me.
Q. No, take your time, please.
A. Yes.
Q. This is the statement that was volunteered once the Inquiry came underway --
A. Yes.
Q. -- and it contains a reflection. What you say is:
"I am of the view that once the police investigation was launched, CQC was deferential to the police. We understood that the police investigation was extraordinarily complex and we did not wish to muddy the

waters or interfere with this important investigation. In addition, the CQC consideration of the level of risk was reduced by the fact that there was a police investigation and that Letby had been removed. However, I consider that this is an area where the CQC could potentially have been more professionally curious."
I just wanted you to expand on that and what is it that you are saying there?
A. When we heard that there was a police investigation, we have powers for criminal prosecution under specific incident guidance, and normally we would look at that in terms of whether we should have done an investigation into the Trust.
I think the police had primacy, obviously, because this was a criminal investigation. I think we should have considered earlier whether or not we could have done something in tandem with the police rather than -- because we are bound by the statute of limitations and because -- I think what we could have done is considered that earlier in case there was an opportunity for us to carry out our own investigation under -- under that regulation.
Q. Let's just reflect upon your limitation point.
A. Yes.
Q. The offences that the CQC is many empowered to

prosecute --
A. That's right.
Q. -- are strictly limited by time?
A. Yes, they are.
Q. I think there are two timescales running which relate to the date of knowledge --
A. Yes.
Q. -- and an absolute cut-off. The sort of things that the CQC can investigate are important things, such as whether the duty of candour was observed --
A. Mm-hm.
Q. -- and of course whether or not patients were effectively exposed to a risk of harm by a failure to provide care adequately?
A. (Nods)
Q. These are important tools in the CQC's regulatory armoury?
A. Yes, they are.
Q. But they are time-barred?
A. Yes.
Q. Is what you are saying here that there should have been some thought that, "look, an absolute statutory time limit is running here, we need to make sure that we have thought about this before that runs

out"?
A. Yes, I think we could have been more curious at that point to see whether the -- rather than thinking we don't want to offend or upset or muddy or contaminate anything that the police might be doing because we knew it was such a complex investigation, I think we could have been more curious around whether there was anything for us to do at that point and that's what I mean about professionally curious.
Q. And --
A. Because historically we waited for the -- we have waited for the police to conclude their investigation. But more recently, as relationships and understanding matured, we have been able to do something in tandem.
Q. Typically -- and we have seen this, it is in the public domain at Grenfell -- that the Health and Safety Executive and the Metropolitan Police have a memorandum of understanding at an early stage so that everybody knows what everybody is doing --
A. Doing, yes.
Q. -- from an enforcement point of view.
Is that something the CQC now thinks about in the event --
A. Yes.

Q. -- that it's aware of police investigations which have an overlap with the CQC's jurisdiction?
A. Yes, I think it does. And we also use the emerging concerns protocol, which is a number of agencies can come together, when a risk or a theme or a trendy emerges, and you can sit together and decide who's doing what and formally record that, and who has primacy and who can take it forward, the investigation, and under what powers.
So the emerging concerns protocol is -- is quite helpful in that regard.
Q. That's a reflection that you volunteered --
A. Yes.
Q. -- as part of the preparation once the Inquiry was undertaken. I would just like to conclude by giving you an opportunity to reflect from your perspective. We have talked about many things, but do you think it's fair to say that something has gone wrong here with the CQC's involvement, not ascribing responsibility within that, but something has gone wrong, do you think? The CQC didn't uncover, weren't told something that they should have known over a protracted period of time? Do you agree?
A. Can I just take a moment to think about that?
Q. Of course you can.

A. Thank you. (Pause)
I think, on reflection, you can always do things better. I think we applied the methodology as it stood at the time. I think there are opportunities or there were opportunities for us to learn and do things better. I think your point about the sharing of the incidents, the data quality, all of that were, were reasonable questions for you to ask and I think we have strengthened our approach in that regard over time.
So I think as professionals and as regulators, we have to be open to continuous and ongoing improvement.
So I think we do have to understand and acknowledge that with hindsight, could -- there were things we might have improved upon; I accept that.
What I am finding it very difficult to accept is the lack of transparency in not alerting us to those concerns because I think we would have acted very differently.
Q. Just explain to us why do you use the phrase "I am having difficulty accepting that"; what do you mean by that?
A. Well, I really do think the Trust had a professional obligation and an obligation to patients to be open and transparent with us. And I would have liked to have known about those concerns much earlier

and then maybe -- well, I know we would have responded.
MR DE LA POER: Ms Ford, thank you very much for answering my questions. Those are all the questions I have for you.
A. Thank you.
Questioned by LADY JUSTICE THIRLWALL
LADY JUSTICE THIRLWALL: I have just got one or two, if I may.
A. Yes.
LADY JUSTICE THIRLWALL: Just going back briefly to the documents, they have not been located; either they are lost or they have been destroyed?
A. I believe so, my Lady.
LADY JUSTICE THIRLWALL: On the destruction -- and forgive me, I meant to go and check the transcript -- I think you said that six months after an inspection must have been reported, that there was a direction that documents could then be destroyed.
A. That's correct, my Lady, six months after the publication of the report.
LADY JUSTICE THIRLWALL: Of the report. Thank you.
A. If there was no challenge, we could destroy the paper records.
LADY JUSTICE THIRLWALL: Yes. Why do you think -- because we do have some of the records here --

A. Yes.
LADY JUSTICE THIRLWALL: I am wondering when that six-month rule was introduced or got rid of?
A. I think then when the IICSA directive came --
LADY JUSTICE THIRLWALL: Yes, in 2015.
A. -- I think that was better understood by some than others; colleagues. When we did the paper project to bring the papers back into the paper records, back into CQC, because people still had them in their own homes --
LADY JUSTICE THIRLWALL: Yes.
A. -- we were reliant on that safe return and the tagging.
LADY JUSTICE THIRLWALL: Yes, and you have explained that.
A. Yes, so I think -- I think some -- I can't be certain, but I think it's a possibility that some were destroyed.
LADY JUSTICE THIRLWALL: Yes. And you may have said this already, but when was it that you went through that paper retrieval process?
A. 2017.
LADY JUSTICE THIRLWALL: 2017. Thank you. What is the current policy?
A. The current policy is that we retain the

records for at least seven years. There are exceptions to that. The policy has been revised many times since then and now currently reflects best records document practice.
LADY JUSTICE THIRLWALL: Thank you. You mentioned the emerging concern protocol and just really a pick-up for me: how does that link with Safeguarding Processes and Working Together?
A. Well, again, most of the agencies have a responsibility, when there is a risk emerging --
LADY JUSTICE THIRLWALL: Yes.
A. -- will meet and sometimes, if there is a safeguarding issue, that we become the alerter. Each, each of the regulators around the table, will have their obligations under the Working Together to alert the relevant local authority in respect of safeguarding matters.
LADY JUSTICE THIRLWALL: Thank you. Then one last question, if I may. You helpfully set out for us what some of the Consultants were saying at that focus group. They were saying that the Trust -- they were raising concerns about staffing levels, one of the things, and then the Trust was not listening to their concerns and at times they felt that management was oppressive or bullying, both words were used.

A. Mm-hm.
LADY JUSTICE THIRLWALL: The follow-up, I think was by Ms Cain, was it, because you were in charge of the well-led part of it?
A. Yes, yes.
LADY JUSTICE THIRLWALL: But you didn't go back?
A. When we were -- went back to follow up with the Medical Director, do you mean, my Lady?
LADY JUSTICE THIRLWALL: Yes, the only follow-up was with the Medical Director, wasn't it, I think?
A. Yes, we spoke with the Medical Director and then the engagement with the Consultants, as I understand it, and how they were managing those concerns.
LADY JUSTICE THIRLWALL: Sorry, so did you actually speak to the Medical Director?
A. No, not that I recall.
LADY JUSTICE THIRLWALL: You said "we", you meant "she".
A. Yes.
LADY JUSTICE THIRLWALL: She raised it with the Medical Director on the day and he said "we are working on culture in the Trust".
A. Yes.
LADY JUSTICE THIRLWALL: The nurses said they had

not had any problems with culture, I think, from what said. Nurses were positive about the culture --
A. Yes, they felt well supported. It was that group of Consultants.
LADY JUSTICE THIRLWALL: A group of Consultants who were raising concerns who didn't feel management were listening and were?
A. Quite oppressive and bullying in their approach.
LADY JUSTICE THIRLWALL: That is quite a -- that is quite a thing to raise, isn't it?
A. It is.
LADY JUSTICE THIRLWALL: Also, it was in a sort of partly anonymous session in that none of them was identified, and you said that that's done deliberately. Was that not something that warranted a bit more than going straight to the Medical Director and saying what --
A. No, you are quite right because we followed that up after the inspection around the Freedom to Speak Up --
LADY JUSTICE THIRLWALL: Yes.
A. -- and medical engagement and how the Trust was managing those tensions, but we were doing that in the context of not knowing --

LADY JUSTICE THIRLWALL: No, I understand that.
A. -- what the concerns were.
LADY JUSTICE THIRLWALL: I think I am just looking to see what happens when someone did at least say something, although not at all what --
A. Yes, I think --
LADY JUSTICE THIRLWALL: -- should have said. I understand that. So what was the follow-up?
A. Well, the follow-up would be: "What have you done? How are you engaging your medical workforce? What response have you made to them?" And that would be done as part of the ongoing engagement.
LADY JUSTICE THIRLWALL: By?
A. By the Relationship Manager.
LADY JUSTICE THIRLWALL: This would be Debbie --
A. Debs Lindley and Bridget, yes. I think the other thing, my Lady, if I may say, is that the Consultants I wish would ...
We did create some opportunities for them to speak with us on site.
LADY JUSTICE THIRLWALL: Yes, we have heard about that --
A. I do wish they had taken that opportunity.
LADY JUSTICE THIRLWALL: Yes, I think that point has been made. I just wanted to know about what had

happened about what they had said.
Mr De La Poer.
MR DE LA POER: If I may just pick up on that, my Lady.
LADY JUSTICE THIRLWALL: Yes, of course.

Further questioned by MR DE LA POER

MR DE LA POER: Ms Ford, the decision was taken to go and raise these matters with the Medical Director. Why not with Sir Duncan Nichol or Tony Chambers, who sat at the very top of the organisation?
A. The Medical Director is usually responsible for the medical workforce, so -- and as peer-to-peer, we usually, in the first instance, will raise a concern with the Medical Director who is directly responsible for the engagement, the development and the support to the medical workforce.
Q. But by the sound of it, one interpretation of what you were told is that the concern about oppressive and bullying culture was that the Medical Director was responsible for it.
A. I don't know whether anybody ever said to me it was the Medical Director that was doing it, but we would have -- we would in the first instance have alerted the Medical Director for that.
Q. I am not saying that they did, but unless

somebody said it isn't coming from the Medical Director, then there exists a risk that that is what they are trying to tell you. I am just wondering, on reflection, do you think that that was a sufficiently robust response to those concerns and whether you should have, in fact, spoken to a spread of management to try and understand exactly where this was coming from and whether they understood as a board?
A. Yes, I see your point.
Q. Yes.
A. I think if I was going to escalate it any further, you are right, I should have, you know, escalated it to the Chair.
Q. Why do you think, then, that it wasn't escalated to the chair?
A. I think, at that point, we were confident or felt confident that the Medical Director would be as good as his word and tackle it. And I think what we should have done is, if it hadn't have been managed effectively and we felt that during the engagement, then we should have raised it with the Chair.
Q. But if the complaints had been about the Medical Director, he could have just said: "yes, of course I am dealing with this" --
A. But there are other indicators about -- there

are other indicators around medical culture that is available to us. So there would have been the feedback from junior doctors, the feedback from the Consultants, the medical engagement scores. There are other surveys and tools we can use to measure medical engagement.
So I think we would have kept an eye on those as well, and if we were not satisfied, then we should have escalated to the Chair.
Q. Do you know whether or not Ms Lindley did follow up that particular concern as part of her relationship management role?
A. I don't know because I had moved into another role at that point.
Q. But you can say that you would have expected her to?
A. I would have expected all the findings of the inspection to be followed up.
MR DE LA POER: My Lady, those are all my follow-up questions.
LADY JUSTICE THIRLWALL: Thank you very much indeed. You are free to go.
A. Thank you.
MR DE LA POER: If I may, my Lady, I will turn over to Mr Carr now for our final witness today.
LADY JUSTICE THIRLWALL: Yes, Mr Carr.

Just remain standing, someone will ask you to take the oath.

MS JULIE ANN HUGHES (sworn)

Questioned by MR CARR

LADY JUSTICE THIRLWALL: Thank you very much. Do sit down.

A. Thank you.

MR CARR: Can we start, please, with your full name?

A. Yes, my full name is Julie Ann Hughes.

Q. Ms Hughes, you have prepared a statement for the purposes of this Inquiry, have you not?

A. I have, sir, yes.

Q. That statement is dated 28 August 2024.

A. It is.

Q. Can you confirm that the contents of the statement are true to the best of your knowledge and belief?

A. I can, sir, yes.

Q. You deal within your statement with your professional background and you explain that you have a Master's of Science degree in sociobiology?

A. Yes, I do, sir.

Q. You have a postgraduate qualification in front-line management?

A. I have.

Q. You are a Fellow of the Royal Society of the Arts?

A. Yes, currently, yes.

Q. You were employed by the Care Quality Commission as an inspector for over a decade --

A. Yes, sir.

Q. -- from June 2012 to June 2023?

A. That's correct.

Q. You explain that, in that capacity, you conducted around eight inspections per quarter?

A. Yes, sir, yes.

Q. So 32 a year.

A. (Nods)

Q. As well as attending inspections, you would also be involved in the other aspects of CQC regulation, which was monitoring of Trusts?

A. Yes, sir, that's correct.

Q. So attending engagement meetings of the Trusts and attending management review meetings --

A. Correct.

Q. -- which were internal CQC meetings?

A. Yes, sir.

Q. I want to look first, please, at your involvement in the 2016 inspection of the Countess of

Chester Hospital. You were part of the inspection team, weren't you, for that inspection?

A. I was.

Q. You led the end of life team?

A. I did, sir, yes.

Q. That team was concerned with the care and services provided to individuals in the last stages of their lives?

A. Yes, sir.

Q. We can see from the notes that have been provided that you also took part in an interview as part of the Children and Young People Services?

A. Yes, sir.

Q. If we can turn up the relevant page of the notes, it's at INQ0017339. If you turn, please, to page 31, we considered notes from this part of the inspection yesterday and that handwriting, it's not yours, is it?

A. No, no, it isn't, I'm sorry.

Q. This looks like a note made by Helen Cain, and if we look in the middle of the page, "Relevant Core Service", that section, we can see "Children and Young People" circled. Put in the box below: "CQC inspection team attendees" it confirms that you attended along with Helen Cain --

A. Yes, sir, that's correct.

Q. -- for this part of the interview, and the attendees at the interview, next box below, Vicky Higgins, a specialist children's community nurse, and Helen Griffiths, a diabetes specialist nurse.

Now, we also see in the description of Ms Higgins' role what appears to say she was the lead for oncology and palliative care, and in the next box down, "Summary of points from the notes", first line: "EOL paed strategy". Does that stand for end of life paediatric strategy?

A. Yes, sir, yes.

Q. Is that the explanation for how you came to be involved in this --

A. Yes, yes, it would have been -- it would have -- the paediatric aspect would have come under end of life services as a whole along with mortuary services and things like that, so we explored each of the areas within that core service.

Q. Because this interview would engage both Children and Young Peoples Services and end of life, it was a joint interview?

A. Yes, it was an effective use of the time we had.

Q. Now, you will have gone back and looked at

this note for the purposes of preparing your evidence. The notes do not appear to record, do they, any discussion of issues concerning neonatal mortality?

A. No. No, sir.

Q. Do you have any recollection of any discussion of issues concerning neonatal mortality at this meeting?

A. Not at all, I'm sorry.

Q. Thank you. We can take this document down.

I want to consider now your involvement at the inspection as part of the Trust wide team. The Trust wide team, are those inspectors that carried out interviews, which looked at matters across all disciplines in the hospital?

A. (Nods)

Q. At paragraph 10 of your statement, you state:

"My role in the Trust wide team was limited to leading focus groups."

A. Mm-hm.

Q. You go on in the final paragraph -- sorry, final sentence of that paragraph, to say:

"I did not participate in any of the Trust wide inspection beyond running focus groups and did not conduct any interviews."

A. No.

Q. If we can get up another document, please,

it's INQ0017287. Now, there are a number of different versions of this table. This is the version that you refer to in your statement.

This document sets out doesn't it the schedule of core interviews and of focus groups?

A. Yes, sir.

Q. And if we just go through this document and see what the schedule provided for. This page we are looking at, we can see at the top, second box, "Wednesday, 17 February", so that's the date on which the interview set out on that page was scheduled, and we can see that your name is down for an interview with Hayley Cooper, halfway, roughly halfway down the page --

A. Yes.

Q. -- which is highlighted and that was an interview that you were scheduled to conduct with Ann Ford and the "Additional Comments" box says "Chair of Staff-Side."

A. Yes, sir.

Q. We will come back to this. If we can look at page 2 of this document now. At the top of the page, still dealing with the timetable for 17 February, there is an interview there for service leads for each of the core services and this is the end of leads, service leads interview?

A. Yes, sir.

Q. Then, on 18 February, the box that follows, there are two interviews with Ian Harvey in which your name is included as the team member to conduct the interview, one at 11.30 that has been highlighted and another later at 14:30.

Looking at that timetable, it does appear that you are involved in a number of the core interviews.

A. What would have happened, sir, I would have been there as a notetaker. As you can see by looking, there was always someone qualified to discuss at a strategic level the issue at hand.

So in terms of the head of infection control, Dan Watson was with me and he would have led on that and I would have taken the notes. In terms of -- it was useful for me to be in with the board of director responsible for end of life care, because that just allowed me to hear that, that work.

In terms of the complaints lead, that would have been led by Trish Rowson, with myself there as notetaker and an appropriate specialist adviser.

Q. When you say in your statement you didn't conduct any interviews --

A. No, I wouldn't conducted --

Q. -- what you meant by that was?

A. I would have taken notes, but I would not have led or conducted the interview.

Q. If we look at page 3 of this document, please, this sets out the focus group, doesn't it?

A. Yes.

Q. We can see that the Consultants' focus group was scheduled for 18 February --

A. Yes, sir.

Q. -- at 8 until 9.30 and you were down with Michael Rees to conduct that focus group?

A. Yes, sir.

Q. That appears to be the only focus group that you were scheduled to undertake?

A. Yes, sir.

Q. If we can go back to page 1 of this document, please, the Julie Hughes interview. Sorry, the Hayley Cooper interview that you attended. You kept a note of that interview?

A. I would have taken the -- the minutes of that interview.

Q. Well, as you will be aware, your notes have been lost, cannot be found --

A. Yes.

Q. -- or were destroyed. What recollection do you have of what was discussed at that meeting?

A. The Staff-Side representatives generally because they are mostly -- it is in relation to obviously unions and the unions's perception of the Trust and what's happening in the Trust and staffing levels and staff surveys, and that's the type of issues that would have been discussed in a Staff-Side representative meeting.

Q. Do you recall if any concerns were highlighted at this meeting as to issues in the neonatal unit?

A. I'm sorry, sir, I don't. I don't remember, I do apologise.

Q. If we move forward now in the chronology, please, to the focus group -- and we can take this document down.

Now, you attended the focus group with Michael Rees and you explain in your statement that he was a Specialist Adviser, so not a CQC employee.

A. Yes, sir, yes.

Q. And his background was as a qualified surgeon?

A. (Nods)

Q. Now, we do not have a full note of the focus group, do we?

A. All my notes would have been handed in to CQC and, as I have since left, I have no access to their system, so I don't know what's been provided.

Q. What you say in your statement is that you didn't take a note of the focus group --

A. No, I wasn't the notetaker.

Q. -- it was Cara Taylor --

A. Yes.

Q. -- who was somebody who was shadowing you --

A. Yes.

Q. -- who would have taken a minute.

A. Yes.

Q. But you are aware, aren't you, that those notes have not been traced?

A. Yes.

Q. Now, whereas the schedule indicated that the focus group was due to take place between 8 and 9.30 on 18 February, you state, at paragraph 15 of your statement, that you think the date recorded in your diary for the focus group is more likely to be accurate and that's 2.30 pm on 17 February.

A. Yes, I think so. I would say what I have written down daily was likely to be more accurate, yes, sir.

Q. If you can help us with the purpose of the focus group; it was for Consultants across the hospital?

A. It was.

Q. Not specific to any department?

A. No.

Q. It is the whole point of being Trust wide, and what is the purpose of a focus group, what's it designed for?

A. The focus group is designed to have a confidential forum for staff to tell the regulator anything they think we should know, anything that's pertinent to the -- the inspection, any of their concerns or issues.

Q. Do you recall whether any of the neonatal Consultants, paediatricians, attended?

A. I don't specifically. I think there was maybe 15, 14/15 people in the room, possibly.

Q. So 14 to 15 people in the room?

A. Yes.

Q. 14 to 15 Consultants?

A. Yes, yes, apart from ourselves.

Q. Do you recall any individuals or specialties who attended?

A. Sorry, sir, I don't.

Q. Now, there are a number of accounts as to what was reported at that focus group and what was done as a result, so we are going to look through what evidence we do have available --

A. Yes, sir.

Q. -- and see if we can try and piece it together.

Now, although the note that was taken hasn't been traced, what we do have are images of the brief notes that you made yourself --

A. Yes.

Q. -- in your diary, and we will look at those first. It's INQ0017319. If we can turn, please, to page 2. Now that is your handwriting, isn't it?

A. It is, sir, yes.

Q. Thank you. As I understand it, these were notes that you say you made during the focus group?

A. Yes, sir.

Q. Can you take us through what those notes deal with?

A. Initially, the first set of notes, written in blue pen for some reason, deal with things I wanted to remind myself to check in terms of end of life care and that's why it is stuff like "incident report across EOL" is just an aide memoire for me to look at incident reporting.

"Shadow staff" is fairly explanatory. I would want to spend some time shadowing a palliative and a general nurse dealing with patients at the end of their life.

And the other one was to remind me to look at

consent, and look at where that was at with consent.
Q. Just pausing you there, those notes that you have just explained, are they matters that emerge from the focus group or are they points that --
A. No, they are just -- sorry, they are just my notes. The only thing that links to the focus group is the asterisk in themes.
Q. It appears to read "bullying, lack of support, staffing".
A. Yes, sir.
Q. Then the next two entries, 10.30, it looks "TC re: Pennine"; is that at all connected to the focus group?
A. I am so sorry. The --
LADY JUSTICE THIRLWALL: You don't need to be sorry. It's just that's what we've got.
A. My note diaries only made sense to me; I'm aware of that. It was just if I thought of something I needed to remember I would just write it on whatever day I was on.
MR CARR: The final line on that page, it's difficult to read, what does that say?
A. I think it says "Evidence review".
Q. Okay. Does that relate to anything?
A. That relates to my end of life care.

Q. At page 3 of this document, please, again can you help us with this; do any of these entries relate to the focus group?
A. No, sir. It relates to a separate service. One is a start time and others are just who I needed to call. One was Bridget at 12 and one was Helen at 2.30.
Q. That is Bridget Lees, another CQC inspector?
A. And Helen, yes, just to remind me I need to call.
Q. Helen Cain?
A. Yes, sir.
Q. Now, she led the Children and Young Peoples Services?
A. Children and Young People, yes, sir, yes.
Q. Do you recall why you needed to call her?
A. Sorry, no, I don't.
Q. Page 4 of this document, please.
LADY JUSTICE THIRLWALL: I'm sorry, Mr Carr, what was the date of the diary there? Is that before the inspection started, the phone calls?
A. I think it probably is, because it says COC inspection, 6.50 am start.
LADY JUSTICE THIRLWALL: Yes.
MR CARR: We may make sense when we get to page 6.
LADY JUSTICE THIRLWALL: Thank you for that.

MR CARR: Before we do leave that page, the bottom entry "Re BPAS!"
A. That's regarding another service, namely the British Pregnancy Advisory Service which was something else that was on my portfolio and I needed to check back on.
Q. Then if we move forward to page 5. This is quite hazy. What is being dealt with in this photograph?
A. This is note on the BME focus group which I was on that day, the Union one, which we have looked at with Ann, in red is Mortality Reviews, which was an area I needed to remind myself to go through.
LADY JUSTICE THIRLWALL: Mortality or what does it says?
A. Mortuary, sorry, "Mortuary reviews". I can't read my own handwriting, I do apologise. "Meeting in training room 2" and "Feedback to MD."
MR CARR: Again, nothing specific there to the Consultants.
A. I think the specific thing there is the feedback to the MD where we would have taken the themes that had arisen in terms of from the medical aspect of the Trust and fed them back for his attention.
LADY JUSTICE THIRLWALL: So does that say "Feedback

to MD" and then "Re: Consultants"? Is that what it says there?
A. Yes, yes.
LADY JUSTICE THIRLWALL: What does "SG" stand for?
A. "SG".
LADY JUSTICE THIRLWALL: Or is it 8?
A. It could possibly be a room number or a room, you know, and I have just put in brackets where I need to be.
LADY JUSTICE THIRLWALL: Yes, thank you. Sorry, Mr Carr.
MR CARR: Thank you. So far as "Feedback to MD", do we know what day this entry is for that we are looking at on page 5?
A. I would have -- I don't -- I can't say I remember clearly, but I think it would have been the day after or late or the same day as the focus group, once Helen the Specialist Adviser and I had our chance to have a chat and go through and agree the themes that we needed to feed back.
Q. If we turn to page 6, please, which may help with identifying when some of these entries were made, we can see the top left-hand corner, it looks like it is an entry for a Monday, the 15th. That is the start of inspection week.

A. Yes, sir, yes.
Q. It has those entries that we looked at, calls with Bridget Lees and Helen Cain. And then we see, on the other side of the page, the notes arising from the focus group, the bullying and then it's cut off by the photograph.
Having looked at your diary, if we go back to page 2 of this document, the only entry that we have in these photographs dealing directly with what emerged at the focus group is that asterisk in black saying: "Themes: bullying lack of support staffing"?
A. Yes, sir.
Q. To be clear, those notes would have been made at what stage? Or this note would have been made at what stage?
A. My personal -- whilst I was in the room whilst the issues were being discussed.
Q. If we can turn now to page 1 of this document. This is a note of a telephone call with you, dated 7 July 2023.
A. Yes, sir.
Q. You have seen this document again for the purposes of preparing your evidence, haven't you? Ms Hughes, you have seen this document for the purposes --

A. Yes, sorry, sorry.
Q. It is a note that was made, as I understand it, by Kirstin Hannaford?
A. Correct, yes.
Q. That is who you had the telephone discussion with?
A. I did, yes, sir.
Q. And she is a media adviser at the CQC?
A. She is.
Q. We can see the heading "February 2016 CQC Comprehensive Inspection of the Trust"?
A. Yes, sir.
Q. It is a phone call to discuss the inspection in 2016. Now, can you help us with what prompted a telephone call in July 2023 to discuss the inspection in 2016?
A. I got first a text and then a call saying "if you are available" because I had left in June 2023, "we would like to have a chat with you about a Countess inspection", and that's what prompted that call.
Q. Did you understand that the telephone call was with a view to preparing a press release?
A. I did because it was with Kirstin and I know she deals with media.
Q. Because, July 2023, that was during and

towards the end of the criminal trial of Letby, wasn't it?
A. Yes, sir.
Q. Prior to this telephone call from the media adviser, at any time following the inspection leading up to this, had anybody from the CQC sought to discuss with you that 2016 inspection and what had happened at the Consultants' focus group?
A. Not -- no, I don't think so. I -- myself, the Specialist Adviser, took what happened at it to the team room where the Trust, my team, were and it was these themes.
Q. You are talking about at the inspection?
A. At the inspection, yes.
Q. My question was about after the inspection, because we have the inspection, at some point --
A. Yes.
Q. -- these notes go awry, they disappear. This is 2023, so between the inspection and 2023, did anybody at the CQC contact you and say "we don't have notes of this focus group, can you tell us what went on?"
A. Not to my knowledge, sir, no.
Q. If we look at the note and what is recorded, the first bullet point deals with dates, 17 February 2.30 pm, so that accords with your diary but not the

schedule we looked at earlier --
A. Yes.
Q. -- and we have addressed that. Then the next bullet point deals with the issues that arose. It says:
"Some Consultants raised concerns relating to staffing levels, lack of staffing, bullying culture, senior medics who talked of a lack of support from leadership team."
Now, those issues, staffing levels, lack of staffing, bullying culture, lack of support, those are matters which are dealt with in, in the note in your diary made at the time, aren't they --
A. Yes, sir.
Q. -- which we just looked at. Then the next subparagraph, next bullet point, "Oppressive air at leadership level". Now, that phrase is not contained in your diary in the photographs we just --
A. No, correct.
Q. -- looked at.
The first question is: did you state during this call that Consultants raised concerns about an oppressive air at leadership level?
A. I don't think I said they raised it, I think in my conversation with Kirstin I was describing a general oppressive air because that is what came

across, that they didn't feel supported to raise their concerns, they didn't feel listened to.

Q. Okay. Looking at this note, it would be incorrect to the way it's been drafted to suggest that some Consultants raised concerns of an oppressive air at leadership level, you were describing that as your impression.

A. Yes, sir, definitely my impression.

Q. Now, the next bullet point refers to a meeting with the Medical Director. It says:

"A meeting was held with the Trust Medical Director that same day at 4.30 pm and the concerns expressed by Consultants were discussed."

Now, the schedule that I took you to originally with those interviews with Ian Harvey, those schedule interviews weren't on 17 February, were they, they were on 18 February?

A. What -- the reason it wouldn't have been a scheduled discussion it was because we felt, as a group, the three of us who were in that Consultants' group, that we really need to flag this with the Medical Director that these Consultants are not feeling supported and don't feel listened to.

So it wouldn't be a scheduled meeting as such, sir, it would just simply be a request to feed back some of

the issues that were emerging as part of the inspection process.

Q. It is an ad hoc meeting?

A. It's an ad hoc meeting, yes. It wouldn't be scheduled.

Q. You say "the three of us decided", three of you being?

A. Yes, what happens is you come out of the focus group, you all look at -- go through your thoughts and okay, these are the themes that we need to pick up on immediately, and the fact the Consultants were saying they didn't feel listened to, they didn't feel supported, that would have been fed straight back to the Medical Director.

Q. My question is just trying to establish when you said "The three of us decided to raise with the Medical Director", you are describing yourself and which?

A. Myself, the specialist advisory and the notetaker because we all heard the same things in the room.

Q. Sorry, I didn't quite catch that; the specialist advisory and who?

A. And the note take, Cara Taylor, who was a new inspector who was shadowing and taking notes.

LADY JUSTICE THIRLWALL: Carla Taylor, did you say?

A. Cara.

LADY JUSTICE THIRLWALL: Cara. Thank you.

MR CARR: Did the three of you decide then to go and speak to Ian Harvey?

A. It would have been myself and I'm not sure if the Specialist Adviser came with me who went to speak to the Medical Director.

Q. Okay, we will come back to that. What I want to look at next, we can take this document down, please, and turn to the press release, INQ0104624, page 2, please.

In the first paragraph on that page, second line down, the sentence that starts on the second line:

"Inspectors also received some concerns from hospital staff about a lack of support from management when they tried to speak up which we highlighted directly to senior Trust staff as an issue that they needed to address."

Then, if we turn to page 3, the second box, the second paragraph, that deals with the focus group as well. That second sentence:

"Those concerns related to staffing levels, a lack of support from senior management and Consultants who felt there was a culture of bullying and were concerns

they could raise with management were ignored. We followed up directly with the Trust Medical Director that same day to relay those issues so that action could be taken in response."

Now, this is the press release that was prepared by Ms Hanniford.

A. Yes.

Q. Those sections would have been prepared on the basis of the discussion with you about the Consultants' focus group?

A. Yes.

Q. We see reference in that press release to a lack of support when staff tried to speak up and that concerns raised with management were ignored.

Now, again, just trying to get the best account of this that we can, your diary entry made on the day does refer to a lack of support, but doesn't say that concerns being raised by Consultants were being ignored?

A. Yes, sir, that's correct.

Q. The basis of the contention that Consultants raised at the focus group, concerns were being raised but being ignored, what was that? Was it purely recollection or was it documented elsewhere?

A. I think it would probably be purely recollection of the whole conversation.

Q. Did you tell Ms Hanniford in your discussion in July 2023 that that's what occurred at the Consultants focus group?

A. No, in my discussion with Kirstin last year I basically read out what was in my notes and what I had left in my memory.

Q. The note that we have in your diary says: "Themes bullying, lack of support, staffing"?

A. Yes, sir.

Q. That is what I am trying to work out how you have gone from there to Consultants say they are raising concerns and they are being ignored?

A. I don't have an answer to that, sir. I didn't see the press release prior to it being released because I no longer worked for CQC and I have not -- I had that conversation and I have not spoken to Kirstin Hannaford since.

LADY JUSTICE THIRLWALL: I think you said that it was the notes and I think you said "what I had left in my memory".

A. Yes.

MR CARR: If we can look, please, at how this is dealt with in your statement to the Inquiry.

I will read paragraph 21, you say:

"To the best of my recollection, the concerns

raised at the Consultants' focus group meeting were regarding a culture of bullying, the Consultants shared with us that they felt their concerns were not being listened to."

Paragraph 22:

"Despite my best efforts, I cannot recall the concerns raised in any more detail than this."

At paragraph 24:

"I am sure that there were no specific concerns raised about the neonatal unit."

Paragraph 25:

"I cannot recall any concerns regarding neonatal staffing being raised."

Judging from your statement, it appears your recollection is limited to the fact that concerns were raised --

A. Yes, sir.

Q. -- but you don't recall anything about what those concerns were?

A. No, sir.

Q. If you don't recall what concerns were raised, what is the basis for saying you are sure that no specific concerns were raised about the neonatal unit?

A. Because in the focus group, Consultants from across specialties, what we would -- what I would ask

them is: "okay, what are the key things you need me to know? What can we do while we are on inspection? What are the key areas you want us to look at?" And their answers were things like, "we are not listened to. We feel that the management doesn't take our concerns seriously, doesn't listen to us, and we feel that the senior medical management has a kind of bullying culture".

At that point, during that focus group, I can't say there was any single specialty Consultant who raised specialty concerns, so nobody said: "there is a real concern about neonates". Nobody said: "there is a real concern about oncology". It was a generalised focus group with a multi-disciplinary team of Consultants.

Q. Whilst you now can't remember what the concerns were, do you remember if, during that focus group, you would have explored the concerns, so where a Consultant --

A. Yes, I would have asked: "is there anything you can tell me?" Given the nature of the group and the facts there was more than a number of people in it, one of the things which was standard at the end of the focus group was to say: "if you are really worried, you can always tell CQC anonymously using..."

Q. Forgive me, my question was slightly

different --

A. Oh sorry.

Q. -- and to be clear, the Consultants reported that they had concerns that senior management weren't listening to or weren't responding to them?

A. Yes, sir.

Q. My question is: if you had been told that, would you have explored with the Consultants: "well, what are the concerns that management ..."

A. Yes, absolutely, and it would have been noted in my diary because that is exactly what I would have fed back to Ann Ford to Bridget and to ultimately to the Medical Director.

Q. You say it would have been noted in your diary, but it is not noted in your diary. I have just looked at your diary and --

A. No, if anyone had said to me if I -- when we are having those discussions, it's like: "okay, what can you tell me? What are your concerns?" And what's in my diary is the concerns that were raised by the group.

Any specific concerns in relation to speciality --

Q. Again, we are slightly at cross-purposes.

Let me put it this way. You would have said to the Consultants: "Do you have any concerns?"

A. Yes.

Q. One of the responses was: "well, a concern that we have is that when we raise things with management they are not taken seriously, not listened to"?

A. Correct, sir.

Q. What I am asking you is: would you then have gone on to ask the Consultants: "well, what are those things that you are raising with management that management aren't taking seriously?"

A. Yes, we would have said: "can you give us specifics?" We would have asked for specifics.

Q. What was the response; can you recall?

A. I have no --

Q. Do you recall whether at the focus group you were told that any Consultants had concerns with patient safety?

A. Not to my knowledge, sir, no.

Q. You refer to a culture of bullying. Who was it that was being bullied?

A. The Consultant body felt that the senior medical managers -- they felt there was a culture of bullying within the medical faculty, sir.

Q. Bullying of whom?

A. The Consultants felt they were --

Q. By?

A. Senior medics and medicine, medicine leaders.

Q. Now, again just trying to clarify one other point. We saw, didn't we, when I took you to those two sections in the press release --

A. Yes.

Q. -- we saw an assertion which stated: "we highlighted directly to senior Trust staff as an issue that they needed to address..."

A. Yes.

Q. Those concerns. And then in another section:

"We followed up directly with the Trust's Medical Director."

Now, the way in which you deal with this in your statement, it is your paragraphs 28 through to 31, you say at paragraph 28:

"Following the Consultants' focus group I would have gone back to CQC's team room at the hospital and spoken to either Bridget Lees, inspection manager, or Ann Ford, Head of Hospital Inspection, regarding the concerns which had been raised. I would have informed Ann or Bridget that the Consultants had reported concerns about a culture of bullying at the hospital."

You then say, paragraph 29:

"Having regard to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations)

2014, this would have meant that we, Ann or Bridget and I would have taken this concern to the Medical Director of the hospital. This would usually have been arranged via CQC's inspection planner."

If I move on to paragraph 30:

"Unfortunately I cannot recall this meeting with Ian Harvey. However, standard practice would have been simply to report what was said by the Consultants to the Medical Director."

Paragraph 31:

"Meeting with the Medical Director to report concerns raised in a focus group was fairly standard."

What you appear to be describing in your statement is what standard practice would be having received the sorts of concerns that you did?

A. Yes, sir.

Q. It sounds like you don't have any recollection as to whether that actually happened at the time; is that fair?

A. Yes, that's fair.

Q. Do you have any recollection of a meeting with Mr Harvey, either on the 17th or of the scheduled meetings on the 18th, where you told him about the concerns that had emerged at the focus group?

A. I don't, sir, I'm sorry.

Q. Your schedule meetings with Mr Harvey -- and I am sorry, I am calling them your schedule meetings, you explained you didn't conduct them, but you kept a note --

A. Yes.

Q. -- those notes again that we do not have, do you have any recollection of the issues discussed at those meetings?

A. No, I don't have recollection of specifics, I am so sorry.

Q. The standard practice that you have described at paragraph 28 to paragraph 31 of raising these concerns, these issues, with the Medical Director, would that have been appropriate in circumstances where the Consultants were reporting to you in a confidential focus group that they were being bullied by senior managers?

A. It -- it -- yes, it would have been appropriate to take it to the Medical Director as he carried overall responsibility for medics across the Trust and he was -- basically there was no one else to go to but the Medical Director at that point. It was to make him aware that the regulator was aware of these concerns and would be monitoring them going forward.

Q. Did you raise -- do you have any recollection

of raising the issues that arose in the Consultants' focus group about concerns of bullying or management not listening with the other sub teams?

A. I'm sorry, sir, I don't. I don't remember.

MR CARR: My Lady, I am conscious of the time I have one further short topic to explore.

LADY JUSTICE THIRLWALL: I am sure you would like to get finished before we break for lunch, so shall we do that?

A. Thank you.

LADY JUSTICE THIRLWALL: Mr Carr.

MR CARR: Thank you. I am going to move away now from the 2016 inspection. I asked you earlier about the other side of CQC regulation which involves monitoring of Trusts.

A. Yes, sir.

Q. You were involved as a CQC employee in monitoring. Some of your monitoring activity involved the Countess of Chester Hospital, didn't it?

A. It did, sir, yes.

Q. I want to ask specifically about an engagement meeting in December 2016, it's INQ0017298, whilst that is being brought up, to confirm again an engagement meeting is a meeting between CQC Inspectors --

A. Yes.

Q. -- and the Trust?

A. Yes, sir.

Q. This is the agenda for a meeting in December. We can see in box 1, can we not, the attendees, Ian Harvey, Alison Kelly, Sian Williams, Ruth Millward and then you and Debs Lindley on behalf of the CQC?

A. That's correct, sir.

Q. Now, at this stage, the Care Quality Commission was aware that there was an increase or had been an increase in neonatal mortality?

A. Yes.

Q. They were aware that the RCPCH had visited the hospital for the purposes of a service review. This agenda, which appears to incorporate a note is very brief. If we can look at entry number 2, please:

"Areas for discussion. Action plan. Neonatal review. Novel Events and Serious Incident."

In respect of the neonatal review, do you recall what was discussed about it?

A. I -- I recall this meeting, I can't say in great detail, but I do recall that we were asking where they were up to with that review, what any initial findings were and asking for anything they could share with us at that point in time.

Q. What was the response that you got back?

A. I think it was fairly limited. I think it was a limited response. To -- my memory is we had not saw sight of the review at this time, but it was a standard agenda matter, so we could ask the Trust: "okay, where are we with this? What's happening?"

Q. Mr Trenholm from the CQC, in his corporate statement to this Inquiry, states that at this meeting the CQC, so that is you and Ms Lindley, were informed that the RCPCH report was at the draft factual accuracy stage and that a request was made for that report?

A. (Nods)

Q. Do you recall being -- whether you were told, that the report was at the draft factual accuracy stage?

A. I don't recall being told it was at draft, sir.

Q. Now, we know from other evidence that we have seen that the RCPCH's final report was sent to the Trust on 28 November 2016, so prior to this engagement meeting.

A. Yes.

Q. If the Trust had that report, was it your expectation that you would be told that they had the final report?

A. Absolutely.

Q. Was it your expectation that the final report

would be provided and in a timely fashion?

A. Absolutely.

MR CARR: My Lady, thank you. Those are my questions.

LADY JUSTICE THIRLWALL: Thank you.

MR CARR: Subject to anything.

LADY JUSTICE THIRLWALL: Mr Deakin? No, thank you very much, and I have no questions.

Thank you very much indeed for coming to help us today, you are free to go now.

MR CARR: My Lady, that concludes the evidence for today.

LADY JUSTICE THIRLWALL: Very good. Thank you. We will rise and start again at 10 o'clock on Monday morning.

(1.11 pm)

(The Inquiry adjourned until 10.00 am, on Monday, 18 November 2024)

I N D E X