

Friday, 15 November 2024

1
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
4 **MR DE LA POER:** My Lady, the first witness today is
5 Ms Ann Ford and I wonder if she might come forward to
6 the witness box, please.
7 MS ANN FORD (sworn)
8 Questions by MR DE LA POER
9 **LADY JUSTICE THIRLWALL:** Thank you, do sit down.
10 **A.** Thank you, my Lady.
11 **MR DE LA POER:** Please could you give us your full
12 name?
13 **A.** Before we do that, my Lady, is it okay if
14 I say something, please?
15 **LADY JUSTICE THIRLWALL:** Of course, you might want
16 to give your name first.
17 **A.** I'm sorry, my name is Ann Ford.
18 **LADY JUSTICE THIRLWALL:** Yes.
19 **A.** I would just like to offer my sincere
20 condolences and sympathies to the families affected by
21 these awful events, both on behalf of myself and the
22 CQC.
23 I do feel very sorry for their pain and suffering.
24 Thank you.
25 **MR DE LA POER:** Ms Ford, you have provided the

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1 **A.** It is.
2 **Q.** It also provided some information about the
3 inspection in February 2016?
4 **A.** Correct.
5 **Q.** The third statement, the one dated just a few
6 weeks ago, provides further detail about the inspection;
7 is that right?
8 **A.** Yes, it is.
9 **Q.** That statement was effectively volunteered on
10 the basis that you, and no doubt others at the CQC, took
11 the view that you had additional information that you
12 could provide the Inquiry with?
13 **A.** It was, yes.
14 **Q.** We will come back to the sequence of those
15 witness statements in just a moment, but let's first
16 introduce you.
17 You are currently the Director of Operations for
18 network north within the CQC; is that right?
19 **A.** It is, yes.
20 **Q.** Does that give you overall responsibility for
21 that area of the country so far as the CQC is concerned?
22 **A.** It is, yes, I am responsible for the
23 regulation of health and social care in that area.
24 **Q.** That will include inspections; is that right?
25 **A.** Yes.

3

1 Inquiry with three witness statements; we are just going
2 to identify each of those now. Is it correct that the
3 first is dated 24 June of this year?
4 **A.** Yes.
5 **Q.** The second, 8 August of this year?
6 **A.** Yes.
7 **Q.** The third, the 18 October of this year?
8 **A.** Yes.
9 **Q.** Is the content of those witness statements
10 true to the best of your knowledge and belief?
11 **A.** It is.
12 **Q.** If we just review, in summary form, what each
13 of those statements deals with. The first deals with
14 disclosure by the CQC; is that right?
15 **A.** Correct.
16 **Q.** When we say "disclosure", we are talking about
17 documents held by the CQC disclosed to the Inquiry?
18 **A.** Indeed.
19 **Q.** And that that statement was provided in
20 response to a request from the Inquiry formally under
21 Rule 9 of the Inquiry rules; is that correct?
22 **A.** Yes. Yes.
23 **Q.** Your second statement, also provided in
24 response to a Rule 9 request, provided further detail
25 about the disclosure process; is that correct?

2

1 **Q.** But also other aspects of the CQC's regulatory
2 responsibility?
3 **A.** Yes, it is.
4 **Q.** When did you take up that position?
5 **A.** I think it was about 2020. Thereabouts.
6 **Q.** Now, at the time that we are going to be
7 focused upon when we come to look at the inspection, you
8 had a different role, didn't you?
9 **A.** I did.
10 **Q.** You were the Head of Hospital Inspection?
11 **A.** I was for the North West, yes.
12 **Q.** You began in that role a couple of years
13 before the inspection took place?
14 **A.** I did, about 2014, yes.
15 **Q.** Beginning in that role of head of hospitals
16 2014, how long did you hold that role for?
17 **A.** About three years, I moved into another role
18 about 2017.
19 **Q.** You had been acting in the role for well over
20 a year, if not a full two years at the time of the
21 inspection. Did you regard yourself as having a good
22 control over what was required from a hospital
23 inspection?
24 **A.** Yes, I believe I had a good understanding of
25 the methodology, yes.

4

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

6 A. I am a Registered General Nurse and I have got
7 30, 30 years' experience as in a management role, and
8 I have been in regulation since about the year 2000.

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

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

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

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

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

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

5

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

4 A. Yes.

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

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

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

17 A. Yes, we met weekly.

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

25 A. Yes, I think he did, yes.

7

1 yourself effectively as an inspector?

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

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

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

11 Q. You were one of the inspectors?

12 A. Yes.

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

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

18 A. Yes.

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

25 A. Yes.

6

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

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

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

8 A. Yes, please.

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

13 A. Yes.

14 Q. Were you aware of that?

15 A. I was, yes.

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

18 A. Yes, I was aware.

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

23 A. I believe so, yes.

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

8

1 that right?

2 **A.** Yes, we did.

3 **Q.** Let's just try and understand what that means.

4 But before that, is it correct that the CQC had assumed
5 that all relevant material would be held in particular
6 places upon its filing system?

7 **A.** I think most of the records would have been
8 held on our customer records, CRM customer records
9 management system, and also on people's personal drives,
10 but we did have a huge amount of paper records as well
11 that were stored in the Newcastle office.

12 I think we knew that we had records both
13 electronically and physical paper records as well.

14 **Q.** When was it realised that there were those
15 additional records?

16 **A.** I can't remember the date exactly, I took
17 advice from the Inquiry's team regarding that.

18 **Q.** But it was late in the process?

19 **A.** I believe so, yes.

20 **Q.** It may be thought that it was quite an obvious
21 thing for the CQC at an early stage to think "I wonder
22 if there are any paper records relating to this because
23 our process at the time was for everybody to create
24 paper records"?

25 **A.** Mm-hm.

9

1 **A.** I believe so, yes.

2 **Q.** The upshot was that over 4,000 documents were
3 sent to the Inquiry identified as being relevant in July
4 of this year?

5 **A.** Yes, that's correct.

6 **Q.** Can you, on behalf of the CQC, recognise that
7 providing over 4,000 documents to a public Inquiry,
8 a matter of weeks before the oral evidence hearings are
9 about to begin, and over the summer period, was
10 unacceptable?

11 **A.** I think I would have to accept that the way we
12 managed the disclosure was not good enough and I think
13 there are profound lessons to be learnt and improvements
14 to be made.

15 **Q.** Well, I am going to invite you to consider two
16 specific words to see -- you have said "not good enough"
17 was it inadequate?

18 **A.** I'm not sure that I would agree that it was
19 inadequate, but it certainly could have been improved
20 upon.

21 **Q.** Was it unacceptable?

22 **A.** I think the delay was, yes.

23 **Q.** That's the timing issue. We are going to turn
24 to the second part of it which is the content issue.

25 Again, you have provided us a lot of information, but

11

1 **Q.** Would you agree, taking responsibility on
2 behalf of the CQC, that that was quite a significant
3 oversight on the CQC's part at an early stage?

4 **A.** Yes. I would, I would admit that. I think
5 our disclosure wasn't timely and it wasn't complete, and
6 I apologise for that.

7 **Q.** Well, we will just complete our review to
8 understand what you mean by "wasn't timely". You
9 provided the statement on behalf of the CQC in June of
10 2024 and the Inquiry was informed at about that stage of
11 the scale of the further documents the CQC had
12 discovered?

13 **A.** Yes.

14 **Q.** It was over 4,000, wasn't it?

15 **A.** It was.

16 **Q.** We just need to reflect upon the CQC's
17 starting assumption which was, in your words, most of
18 the documents would be stored in those Y drive and on
19 the customer or the client file?

20 **A.** Yes.

21 **Q.** In fact, that was quite a gross
22 underestimation of where the weight of the records would
23 be, wasn't it?

24 **A.** I think it was an underestimation.

25 **Q.** Well, a very significant underestimation?

10

1 I am going to try and distil this down.

2 Do you agree that the starting point is that in
3 2015, the CQC was notified by the independent
4 investigation -- Independent Inquiry into Child Sexual
5 Abuse -- that it should retain all material save for
6 a few identified categories?

7 **A.** Mm-hm.

8 **Q.** From that moment, the CQC should have adopted
9 a rigorous filing system to ensure that every single
10 record, save for that narrow exception, was carefully
11 retained in case it was needed?

12 **A.** Yes.

13 **Q.** We can deal with the exception point, we are
14 going to come to what class of material cannot now be
15 found, but that material all should have been retained
16 under the IICSA requirement, shouldn't it?

17 **A.** It should have, yes.

18 **Q.** Now, if we now reflect upon a separate reason
19 why the CQC might have thought to rigorously file its
20 material, in May 2017, the CQC was told that a police
21 investigation had been opened into events at the
22 Countess of Chester?

23 **A.** Yes.

24 **Q.** And that that investigation was in relation to
25 the increase in neonatal mortality?

12

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

13

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

15

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

14

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

16

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

5 A. That's correct.

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

7 A. Yes, I think it was too late.

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

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

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

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

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

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

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

17

1 A. Mm-hm.

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

4 A. Yes.

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

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

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

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

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

25 We looked extensively in every reasonable place

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

9 A. Mm-hm.

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

12 A. No, they have not been located.

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

15 A. No, they have not been located.

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

18

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

6 Q. My question was about the disadvantage --

7 A. Sorry.

8 Q. -- to you.

9 You say you have to rely on recall?

10 A. Yes.

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

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

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

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

20

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

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

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

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

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

22 **A.** I think that's unfortunate, yes.

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

25 "The CQC understood that the inspection team would

21

1 ..."

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

3 **A.** Yes.

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

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

10 **A.** I believe so, yes.

11 **Q.** If they were, they have been lost?

12 **A.** It would appear so, yes.

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

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

23

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

6 **A.** Yes.

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

8 **A.** No.

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

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

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

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

24 And you give some examples:

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

22

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

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

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

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

25 So we were reliant then on inspectors to pack the

24

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

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

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

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

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

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

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

25

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

3 **A.** Yes.

4 **Q.** Is that fair?

5 **A.** That's right.

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

7 **A.** Yes.

8 **Q.** And one of --

9 **A.** And one of the things we rely on.

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

13 **A.** Yes.

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

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

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

27

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

4 **A.** Yes.

5 **Q.** And nobody has told you that?

6 **A.** Not that I can recall.

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

11 **A.** Yes, and obviously they haven't.

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

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

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

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

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

26

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

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

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

14 **Q.** Let us turn to look at the inspection in 2016.

15 Some of these issues have been explored with the
16 witnesses yesterday, so I should just ask, are you aware
17 of what the witnesses, the CQC witnesses and the Special
18 Advisers, said yesterday to the Inquiry?

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

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

23 **A.** Yes, I heard their evidence.

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

28

1 needing to go to some documents.

2 **A.** Okay.

3 **Q.** We start from the position that in the
4 intelligence briefing that the CQC provided it was
5 suggested that there were no Serious Incidents reported
6 to NHS England when, in fact, we know that there was
7 a Serious Incident during the period the inspection was
8 focused upon, the death of Child D was reported on
9 STEIS?

10 **A.** Mm-hm.

11 **Q.** Firstly, do you acknowledge that that was
12 a way in which the intelligence document was inaccurate?

13 **A.** At the point on which the data pack is
14 prepared -- obviously there is an ongoing process with
15 the reporting of incidents and sometimes an incident can
16 take a while to get on to the system.

17 So at the point at which we shared the data pack,
18 that may be inaccurate the following week because there
19 will be other incidents applied. So I think what we --
20 we based -- so I think that incident may well have been
21 reported but not yet included in the data, if that makes
22 sense.

23 **Q.** Well, let's just have a look at the adequacy
24 of the overall system if that be right, because what
25 period was the CQC inspecting?

29

1 **Q.** -- precisely my point?

2 **A.** Yes, it should have been included.

3 **Q.** The evidence yesterday was to the effect that
4 the inspectors and in particular the Special Advisers
5 were misled because they didn't know that there was an
6 incident, and they say that if they had known about it,
7 they would have asked about it.

8 **A.** I think that's -- I think I wouldn't say
9 misled. We gave the information available. I don't
10 think we intentionally misled anybody. We based our
11 inspection on the intelligence that we had and the data
12 collection and the analysis of that data by the
13 analysts. So we gave that information in good faith.

14 **Q.** Well, nothing about my question was suggesting
15 that it was a deliberate act. My question was to the
16 effect that the inspectors were misled. In other words,
17 they did not understand correctly the true state of
18 affairs because they believed that on the one hand no
19 Serious Incidents had occurred.

20 **A.** Yes.

21 **Q.** Whereas on the other hand the truth --

22 **A.** In the children --

23 **Q.** -- was that one had occurred.

24 **A.** In the children's and young people's services.

25 **Q.** Exactly.

31

1 **A.** The inspection we usually look at retrospect
2 is 12 months.

3 **Q.** 12 months?

4 **A.** Yes.

5 **Q.** So starting in mid February 2015?

6 **A.** So we might start 21 February to 21 February.

7 **Q.** I understand. Now, Child D died in June of
8 2015.

9 **A.** (Nods)

10 **Q.** On 2 July, there was a Serious Incident Panel
11 meeting within the Countess when it was resolved to
12 report Child D's death on STEIS?

13 **A.** Mm-hm.

14 **Q.** That is the start of the process?

15 **A.** Yes.

16 **Q.** Your intelligence pack was created. I think
17 it's dated December 2015; is that right?

18 **A.** Correct.

19 **Q.** It would be a very unsatisfactory state of
20 affairs if a hospital decided to report a death at the
21 beginning of July if that was not --

22 **A.** No, that should have been -- that should have
23 been included.

24 **Q.** Well --

25 **A.** Yes.

30

1 **A.** Yes.

2 **Q.** So they were misled?

3 **A.** Yes.

4 **Q.** As a result, they did not ask potentially
5 important questions that they would have wanted to ask,
6 and that's a serious consequence from being misled; do
7 you agree?

8 **A.** I think when we look at incident management on
9 an inspection, what we do is we look at the range and
10 nature of the incidents reported. We look at the volume
11 of the incident reporting and what you are looking for
12 is a good level of reporting with a low incidence of
13 harm, that there is a good process for the investigation
14 of those incidents, that there is learning and any
15 learning is applied and monitored.

16 So we wouldn't necessarily look at every single
17 incident. We couldn't, we don't have the capacity to do
18 that. We wouldn't necessarily look at every single
19 incident in every single service because over the --
20 overall, it can be many hundreds, so we tend to random
21 sample incidents.

22 Now, I accept had we known there was a Serious
23 Incident we could have sampled that, but again it would
24 have been how it was investigated, what the findings
25 were, and how those -- any learning was applied.

32

1 Q. A number of points fall out of that. The
 2 first is that it would be a random sample taken from
 3 a population of one, because if they were to ask
 4 themselves "I wonder whether there's a particular worked
 5 example that we can explore", there is, in fact, only
 6 one Serious Incident?
 7 A. One.
 8 Q. It does seem quite likely, do you agree --
 9 A. We would have looked at that.
 10 Q. -- that that one would have been --
 11 A. Yes, we would.
 12 Q. Quite so, and that is consistent with the
 13 evidence we received from the people who would have made
 14 that decision --
 15 A. Mm-hm.
 16 Q. -- making.
 17 If we follow that up, Child D formed part,
 18 Child D's death formed part of, as I am sure you
 19 understand now, the increase in neonatal mortality?
 20 A. Yes.
 21 Q. Whilst nobody can know how that conversation
 22 would have developed, do you recognise it presented
 23 an opportunity for what CQC witnesses have consistently
 24 told us did not emerge to have emerged?
 25 A. I think in relation to that child, yes, we

33

1 you understand the mechanics of how that Serious
 2 Incident was not communicated to those conducting the
 3 inspection?
 4 A. Yes, I do. I think I --
 5 Q. Do you want to just explain how, with the
 6 death that occurred in June with the information being
 7 pulled together in December, did it state something
 8 which was in fact untrue?
 9 A. If that incident was reported as a Serious
 10 Incident on STEIS, it should have formed part of the
 11 data analysis had it been reported at that time.
 12 The information we had in the data pack for
 13 Children and Young Peoples Services, as I recall, said
 14 there had been no Serious Incidents, there had been no
 15 Never Events, and the incident reporting generally was
 16 of -- within expectations as I recall. And I think you
 17 can see that from the pack itself.
 18 Q. In terms of exactly what went wrong here, is
 19 it a question of that data not being visible to your
 20 data analysts, or is it a question of the data analysts
 21 having overlooked it?
 22 A. I couldn't honestly say. As I say, it's well
 23 out of my area of expertise.
 24 Q. Is that something that you can organise to be
 25 found out?

35

1 could have looked at that incident and it may have lead
 2 onto other questions about the mortality in the service.
 3 Q. Just so that we understand the potential
 4 significance of that piece of information not being in
 5 the hands of the inspector. It was capable, do you
 6 agree, of uncovering for the CQC the problem which
 7 existed, or at least part of it, which could have led to
 8 important follow-up questions?
 9 A. I think it certainly would have warranted an
 10 exploration of that incident which may have then led on
 11 to a broader conversation, yes.
 12 Q. Can you just help us. The intelligence report
 13 is pulled together by data analysts; is that right?
 14 A. It is.
 15 Q. What qualification does one need to become
 16 a data analyst at the CQC performing this kind of role?
 17 A. I don't know.
 18 Q. Is there any kind of quality assurance process
 19 over the drawing together of that information?
 20 A. Yes, I think there is. You'd -- data and
 21 insight team are highly technical and I am not really
 22 involved in the management or the running of that team.
 23 But I do know our data is quality assured and validated.
 24 So -- but I can't say any more than that, really.
 25 Q. Sitting there now, on behalf of the CQC, do

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1 A. I think we could, yes.
 2 Q. Well, that is helpful to know.
 3 Another aspect of the pre-inspection preparation is
 4 something called HES monitoring. HES stands for
 5 Healthcare Episodes Statistics?
 6 A. Yes.
 7 Q. We are just going to take this slowly. Can
 8 I ask you please to turn up your second statement, and
 9 in particular go to paragraph 3.9 because we just need
 10 to untangle some of what is said here and try and
 11 understand this process.
 12 A. My second statement, did you say?
 13 Q. Your second statement, please, yes.
 14 A. Thank you.
 15 Q. Do you have 3.9?
 16 A. Yes, I do.
 17 Q. We will just read it along together so that
 18 everybody knows what we are talking about:
 19 "Analysis of Healthcare Episodes Statistics (HES)
 20 by CQC during the course of the inspection did not flag
 21 the Trust as an outlier for higher than expected rates
 22 of perinatal or late neonatal mortality for the
 23 period April 2015 to December 2016."
 24 A. Yes.
 25 Q. Next paragraph:

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

9 Two more paragraphs:

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

14 "The number of perinatal deaths during the
15 2015/2016, quarters 2 and 4, [which you give as eight
16 and seven deaths respectively] were higher than most
17 other quarters which were less than 6, but to register
18 as a statistical outlier over this period, the data
19 would have had to include at least three standard
20 deviations from observed and expected indicator values.
21 Applied to the data for this period, the Trust was not
22 flagged as an outlier and the data was not examined
23 further at this time."

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

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1 **A.** That is my understanding, yes.

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

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

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

18 And when we carried out the inspection on that
19 understanding.

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

23 **A.** Yes.

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

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1 **A.** I do, yes.

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

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

8 **A.** Yes.

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

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1 number of deaths, and you say:

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

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

10 **A.** Wasn't an outlier.

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

13 **A.** Yes.

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

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

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

40

1 I think I have made -- I think I have made
 2 a mistake and I have confused the HES with the MBRRACE.
 3 **Q.** We just need to be absolutely clear about
 4 this.
 5 **A.** Yes, I need to think -- can I just take
 6 a moment to think?
 7 **LADY JUSTICE THIRLWALL:** Yes, absolutely.
 8 **MR DE LA POER:** Of course. You must do so, this is
 9 important for us to understand and if you want the
 10 references again, I can give you them.
 11 **A.** No, I have it here. Thank you. (Pause)
 12 Thank you. I think it's both. On reflection,
 13 I think it's both. I think the data is not in real-time
 14 and the deviation wasn't met.
 15 **Q.** But the significance of the deviation not
 16 being met is close to zero if the data set is
 17 incomplete, isn't it?
 18 **A.** Yes.
 19 **Q.** Because, in fact, it's potentially even worse
 20 than that, isn't it, because it may cause you to think,
 21 as inspectors, the outlier threshold has not been
 22 triggered when, in fact, the explanation for that is
 23 simply that the data hadn't all come in?
 24 **A.** Mm-hm.
 25 **Q.** And --

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1 realise that not all the data for that was in?
 2 **A.** Mm-hm.
 3 **Q.** Is that --
 4 **A.** I think we relied on our analyst colleagues to
 5 bring together data, to give us an overview of what the
 6 data indicated. The -- the data is really very
 7 important. But it's the start of the conversation, not
 8 necessarily the end of the conversation.
 9 And we would also expect a Trust to be monitoring
 10 its own themes and trends and be honest and open with us
 11 about any issues that they'd identified because they
 12 would know as well the time lapse in the data because
 13 they submit some of their -- they submit the
 14 information.
 15 And I think, at this point, we did not know that
 16 they were a statistical outlier. We did not know that
 17 there was a problem on the neonatal unit and we were --
 18 we were not alerted to the fact that it was.
 19 **Q.** I grant all that and in fact we need to be
 20 fair about this. Once all that data came in, because it
 21 didn't meet that three standard deviations, it wouldn't
 22 have triggered it anyway, but this is just going to the
 23 process --
 24 **A.** I understand.
 25 **Q.** -- that was being adopted. Do you think you

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1 **A.** That is -- that is correct, that is the
 2 process, yes.
 3 **Q.** Just think about this. You went along to the
 4 Countess of Chester presumably thinking to yourself the
 5 outlier threshold for mortality has not been met?
 6 **A.** That's correct, we did, yes.
 7 **Q.** But --
 8 **A.** Because had it been, we would have pursued
 9 a line of Inquiry.
 10 **Q.** But the significance of that was close to zero
 11 and, in fact, was misleading; do you agree? Because you
 12 may have thought it wasn't an outlier when in fact it
 13 was and the only reason you hadn't been told was because
 14 the data hadn't come in?
 15 **A.** Yes, that's right.
 16 **Q.** Can you see the very significant problem there
 17 is with that?
 18 **A.** I think there is always a problem when data is
 19 not in real-time.
 20 **Q.** But what is the point of outlier data if the
 21 data set is not going to be complete?
 22 **A.** I see. I take your point.
 23 **Q.** Does it follow that you went into that
 24 inspection, as everybody else, thinking, "This is not an
 25 outlier for mortality" in circumstances where you didn't

42

1 understood in 2016 that you were relying upon what was
 2 effectively a warning system that was based on
 3 incomplete data? Do you think you understood that so
 4 far as --
 5 **A.** I think we understood that the information we
 6 had was the -- right at the time. We knew that there
 7 was an ongoing process and we didn't only just inspect.
 8 We had an ongoing, we had process of ongoing monitoring
 9 and engagement with the Trust. And we expect -- and we
 10 certainly try to be open and transparent in our dealings
 11 with the Trust, and we would expect the Trust to be the
 12 same with us.
 13 So when we meet with them, when the data is -- or
 14 they identify a problem, we expect that open dialogue
 15 where we can look at the issue and manage it and where
 16 we feel the Trust is not managing it, regulate
 17 accordingly.
 18 **Q.** Now, the Inquiry has received a statement from
 19 Professor Sir David Spiegelhalter who spoke in quite
 20 general terms, he didn't use the name of the tool --
 21 **A.** Yes.
 22 **Q.** About a CUSUM tool that he had developed for
 23 the --
 24 **A.** Yes.
 25 **Q.** -- CQC in 2007. Just to try and close the

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1 loop, is it your understanding that what
 2 Professor Sir David Spiegelhalter is talking about is
 3 your HES tool or is there a different tool, or do you
 4 not know what he is talking about?
 5 **A.** I didn't know what he was talking about. It
 6 is a bit technical from a data point of view for me. It
 7 is not my field of expertise, data analysts, you know,
 8 we rely on the analysts for that. So I couldn't
 9 honestly say whether we used it or not, and I'd not --
 10 I'd not heard the term before the Inquiry gave it me.
 11 **Q.** Now, whether or not it would have met the
 12 three standard deviations, which presumably was
 13 a threshold set by whoever was creating the tool --
 14 **A.** Yes.
 15 **Q.** -- do you know whether or not it was capable
 16 this outlier signal, of distinguishing between deaths
 17 which were unexpected and unexplained and just the crude
 18 mortality figure?
 19 **A.** No, I don't. I don't know enough about the
 20 tool to be able to tell you that. No.
 21 **Q.** Because one of the things that we have heard
 22 consistently from the paediatricians, I am sure you can
 23 recognise the force of --
 24 **A.** Mm-hm.
 25 **Q.** -- is that it isn't just the fact that the

45

1 includes 378 lines of incidents.
 2 **A.** Mm-hm.
 3 **Q.** Our Special Advisers all say that that was not
 4 a table that they saw.
 5 **A.** (Nods)
 6 **Q.** Do you agree that the interpretation of the
 7 potential significance of paediatric incidents is very
 8 much a matter for the Special Advisers rather than the
 9 CQC staff?
 10 **A.** I think the -- the incidence is very much
 11 a matter for the Trust and for CQC because when we -- on
 12 an inspection like this, we look at how the Trust -- the
 13 Trust is charged with the responsibility of
 14 investigating those incidents and, as I say, that
 15 commitment to continuous improvement and learning.
 16 So when we look at incidents, we look at them in
 17 terms of the process and how they are discharging those
 18 responsibilities. If we feel they are not, then that
 19 would be a cause for us to do something different.
 20 **Q.** The evidence we had from the Special Advisers
 21 is that they, having looked at that now, identify
 22 incidents which may have prompted further discussion
 23 because they were inadequately described or they
 24 couldn't understand, using their expertise, what it was
 25 that was being talked about. That suggested, to use

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1 death rate is higher than expected, it's the fact that
 2 it's babies who weren't expected to die --
 3 **A.** Absolutely.
 4 **Q.** -- who were dying?
 5 **A.** Trusts don't have to report every death, but
 6 we do expect them to focus on unexpected and avoidable
 7 deaths. And we do expect there to be a robust process
 8 around that mortality and morbidity reviews, you know,
 9 child death oversight panels and so forth. And the
 10 investigation into those deaths lies with the provider
 11 who should then identify what went wrong, be open and
 12 honest about it and put it right.
 13 **Q.** Now, one of the data requests that were made
 14 of the Trust, you tell us in your witness statement, was
 15 made on 15 February, so the day before the inspection;
 16 that was a Monday --
 17 **A.** (Nods)
 18 **Q.** -- the inspection began on the Tuesday, which
 19 included paediatric incidents?
 20 **A.** Yes.
 21 **Q.** I am sure you have had a chance to remind
 22 yourself of this --
 23 **A.** I have.
 24 **Q.** -- and it was a table that was spoken about
 25 yesterday a number of times. It is a table that

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1 that word, a process problem because it's not recorded
 2 properly, but underlying that may be a genuine
 3 inadequacy in healthcare provision.
 4 So they say -- and they told us this -- that they
 5 would have wanted to explore some of those incidents
 6 with the clinicians and the people that they were
 7 dealing with during the inspection. That is what they
 8 say about it?
 9 **A.** (Nods)
 10 **Q.** Now, the first question really is this:
 11 requesting that information the day before the
 12 inspection has this consequence: your inspectors can't
 13 read it in advance of turning up, can they?
 14 **A.** No, not for the inspection starting the next
 15 day, but it's something that they can do over the course
 16 of the inspection and after the inspection and in the
 17 report-writing period.
 18 **Q.** They say they never saw those documents.
 19 **A.** The inspection team leader would have, would
 20 have seen it.
 21 **Q.** And who was the inspection team leader?
 22 **A.** Helen Cain was leading the inspection there.
 23 I think she would have had access to it. I can't say
 24 for certain whether she saw it, but she would have had
 25 access to it.

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

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

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

9 A. I think potentially, yes.

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

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

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

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

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

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

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

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

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

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

14 A. Not to my knowledge.

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

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

21 I don't.

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

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

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

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

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

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

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

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

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

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

12 A. Yes.

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

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

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

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1 increase. So on the face of it, for a relatively modest
 2 sized hospital, quite a significant number of cases?
 3 **A.** Mm-hm.
 4 **Q.** But do you know whether the minutes of the
 5 meeting for QSPEC and the Women's & Children's Care
 6 Governance Board in December 2015 were provided before
 7 the inspection?
 8 **A.** No, I don't.
 9 **Q.** If they were provided, do you agree the
 10 process -- well, do you agree the process should be that
 11 they should be provided to the CQC, those minutes, as
 12 part of the governance assessment is to look at the
 13 minutes of the meetings?
 14 **A.** Not always. Not always. But I think where
 15 there was an issue it should have been provided, yes.
 16 **Q.** That would be up to the Trust to decide
 17 whether or not the CQC --
 18 **A.** To disclose that.
 19 **Q.** -- needed to know that?
 20 If it was provided as being potentially relevant in
 21 the minds of the Trust, the process should then be that
 22 it's given to the --
 23 **A.** Relationship owner to look at and assess.
 24 **Q.** -- relationship owner and from there it's
 25 going to need to go to those with the clinical expertise

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1 **A.** That's right.
 2 **Q.** -- a week before the inspection?
 3 **A.** (Nods)
 4 **Q.** Was that February version to your knowledge
 5 provided to the CQC?
 6 **A.** Not to my knowledge.
 7 **Q.** Now, it was described as a draft at that
 8 stage --
 9 **A.** Mm-hm.
 10 **Q.** -- and it was provided to the Medical Director
 11 and the Director of Nursing the day before the
 12 inspection, the 15th --
 13 **A.** Yes.
 14 **Q.** -- upon request by the Medical Director,
 15 specifically by reference to the CQC inspection.
 16 **A.** Mm-hm.
 17 **Q.** What is your expectation of a Medical Director
 18 and Director of Nursing in receipt of such information
 19 at their interviews with the CQC in the following
 20 48 hours?
 21 **A.** I think they should have shared that with us.
 22 I think they should have made us aware of that.
 23 **Q.** Now, the Thematic Review was finalised on
 24 2 March, so after the --
 25 **A.** We were off-site.

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1 on the inspection so that they can see it and engage
 2 with it?
 3 **A.** If -- if issues are identified, yes.
 4 **Q.** Yes, and there doesn't appear to be any
 5 evidence that that, in fact, occurred, that total
 6 process. Would you agree that something, at some point
 7 in the process, appears to have gone wrong?
 8 **A.** In terms of the information sharing? CQC or
 9 with --
 10 **Q.** Yes, whether that lies with the Countess for
 11 not providing it or whether it falls to the CQC for not
 12 ensuring it ended up in the hands of the people who
 13 needed it.
 14 **A.** I think -- I think once there was a hint or
 15 an indication that there was a problem with mortality on
 16 that unit, my expectation would have been that the Trust
 17 alerted ourselves, NHS England, and any other party that
 18 there was a problem and they were looking into it.
 19 And I think, as part of that, any documentation,
 20 any audits, any reviews, any work they have undertaken
 21 should have been shared transparently and openly. That
 22 is my view.
 23 **Q.** Included within that view, no doubt, is the
 24 Thematic Review of neonatal mortality conducted by
 25 Dr Brearey and others --

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1 **Q.** -- the notified inspection, but before the
 2 inspection which took place on 4 March, which I think
 3 was an unannounced aspect of the overall inspection.
 4 **A.** Mm-hm.
 5 **Q.** Once finalised, bearing in mind it related to
 6 the period of the CQC review, should it have been
 7 provided to the CQC?
 8 **A.** That would have been my expectation, yes.
 9 **Q.** What was the CQC's stated policy on the
 10 generation or the provision of documents which are
 11 generated after the inspection but which related to the
 12 period that had been inspected?
 13 **A.** In terms of what was reported --
 14 **Q.** Well, did --
 15 **A.** -- or the actions taken?
 16 **Q.** I will put it bluntly. Did the CQC say in
 17 writing to the Countess of Chester, "If a document is
 18 generated after the inspection which relates to the
 19 inspection period, you need to give it to us"?
 20 **A.** Yes, I think we did in -- I don't think we
 21 were explicit about after the inspection, no. But
 22 I think it was understood that our expectation was this
 23 was different, you know, this just wasn't information,
 24 this was about an emerging serious concern and I think
 25 they should -- and it would have been our expectation.

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

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

8 **A.** Absolutely.

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

12 **A.** Absolutely.

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

19 **A.** It was, yes.

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

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1 (11.35 am)

2 **LADY JUSTICE THIRLWALL:** Yes.

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

9 **A.** (Nods)

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

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

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

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

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

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

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

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

23 **A.** Thank you.

24 (11.17 am)

25 (A short break)

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

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

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

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

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

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

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

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1 core interviews with Sir Duncan Nichol, Hayley Cooper,
2 Sue Hodgkinson and Tony Chambers.

3 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

25 So in the Consultants' focus group, I understood

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

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

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

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

22 They are the broad issues, as I recall.

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

25 **A.** No.

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

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

7 **A.** Yes, yes.

8 **Q.** -- in your witness statement?

9 **A.** Yes.

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

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

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

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

25 **Q.** On the day of the Consultant?

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

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

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

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1 published and disseminated to a group who were involved
 2 and needed to be sighted on it just two days earlier.
 3 Do you regard, on behalf of the CQC, that being
 4 an opportunity for the Countess to tell the CQC about
 5 that recent development?
 6 A. Of course. I think the whole inspection was
 7 an opportunity.
 8 Q. Now we come to the 29 April. I think the
 9 sequence is that you received a telephone call on that
 10 day and an email on 30th June.
 11 A. (Nods)
 12 Q. Thank you. I am now mistaking the date.
 13 Just tell us about that telephone call with
 14 Alison Kelly, please.
 15 A. Alison Kelly rang me and told me that there
 16 was -- they had identified an issue in the Trust, that
 17 there had been an increase in mortality for, I think,
 18 14/15, 15/16. I asked her what she was going to do
 19 about that. Again, the focus being the immediate and
 20 ongoing risk to anybody being cared for, the babies
 21 being cared for, in the unit.
 22 She said the Trust had made the decision to
 23 downgrade the unit, so the more poorly babies went --
 24 the intensive care babies went to another centre.
 25 I thought that was a good thing to do and it would also

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

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

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

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

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

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

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

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

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

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

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

13 **Q.** You think it had been published not on the
 14 29th, but on the 28th?

15 **A.** I think it was the same day.

16 **Q.** That is what I am trying --

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

18 **Q.** My understanding was it was published on the
 19 29th, I am trying to get the chronology right.

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

22 **Q.** Yes.

23 **A.** Yes.

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

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

6 **A.** Mm-hm.

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

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

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

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

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1 **A.** Yes.

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

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

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

23 **A.** Mm-hm.

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

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

7 **A.** Yes.

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

10 **A.** I think that is a very fair question.

11 **Q.** And is it --

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

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

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

25 So I think we could have considered -- we could

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

6 **A.** I think that's a fair reflection.

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

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

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

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

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

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

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

7 **A.** Yes.

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

15 **A.** That is a possibility, yes.

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

18 **A.** Caveats.

19 **Q.** -- needs to be added?

20 **A.** Mm-hm.

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

25 Help us. Does this reflect the content of your

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

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

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

11 **Q.** Thank you. We can take that down.

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

15 **A.** Yes.

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

19 **A.** Yes, Deborah Lindley, yes.

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

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

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

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1 A. Mm-hm.
 2 Q. -- should the CQC have been told about that
 3 further work?
 4 A. I believe so, yes.
 5 Q. Similarly, the day Paediatric Pathologist
 6 Dr McPartland was also instructed to look at some cases,
 7 is that another step that the CQC should have been told
 8 about?
 9 A. I believe so, yes.
 10 Q. Now, in terms of the police -- and you might
 11 just want to turn this up, it's the penultimate thing
 12 that I am going to ask you about, which is in your third
 13 statement at 9.2 --
 14 A. Excuse me.
 15 Q. No, take your time, please.
 16 A. Yes.
 17 Q. This is the statement that was volunteered
 18 once the Inquiry came underway --
 19 A. Yes.
 20 Q. -- and it contains a reflection. What you say
 21 is:
 22 "I am of the view that once the police
 23 investigation was launched, CQC was deferential to the
 24 police. We understood that the police investigation was
 25 extraordinarily complex and we did not wish to muddy the

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

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1 out"?

2 **A.** Yes, I think we could have been more curious
3 at that point to see whether the -- rather than thinking
4 we don't want to offend or upset or muddy or contaminate
5 anything that the police might be doing because we knew
6 it was such a complex investigation, I think we could
7 have been more curious around whether there was anything
8 for us to do at that point and that's what I mean about
9 professionally curious.

10 **Q.** And --

11 **A.** Because historically we waited for the -- we
12 have waited for the police to conclude their
13 investigation. But more recently, as relationships and
14 understanding matured, we have been able to do something
15 in tandem.

16 **Q.** Typically -- and we have seen this, it is in
17 the public domain at Grenfell -- that the Health and
18 Safety Executive and the Metropolitan Police have a
19 memorandum of understanding at an early stage so that
20 everybody knows what everybody is doing --

21 **A.** Doing, yes.

22 **Q.** -- from an enforcement point of view.

23 Is that something the CQC now thinks about in the
24 event --

25 **A.** Yes.

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1 **A.** Thank you. (Pause)

2 I think, on reflection, you can always do things
3 better. I think we applied the methodology as it stood
4 at the time. I think there are opportunities or there
5 were opportunities for us to learn and do things better.
6 I think your point about the sharing of the incidents,
7 the data quality, all of that were, were reasonable
8 questions for you to ask and I think we have
9 strengthened our approach in that regard over time.

10 So I think as professionals and as regulators, we
11 have to be open to continuous and ongoing improvement.

12 So I think we do have to understand and acknowledge
13 that with hindsight, could -- there were things we might
14 have improved upon; I accept that.

15 What I am finding it very difficult to accept is
16 the lack of transparency in not alerting us to those
17 concerns because I think we would have acted very
18 differently.

19 **Q.** Just explain to us why do you use the phrase
20 "I am having difficulty accepting that"; what do you
21 mean by that?

22 **A.** Well, I really do think the Trust had
23 a professional obligation and an obligation to patients
24 to be open and transparent with us. And I would have
25 liked to have known about those concerns much earlier

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1 **Q.** -- that it's aware of police investigations

2 which have an overlap with the CQC's jurisdiction?

3 **A.** Yes, I think it does. And we also use the
4 emerging concerns protocol, which is a number of
5 agencies can come together, when a risk or a theme or
6 a trendy emerges, and you can sit together and decide
7 who's doing what and formally record that, and who has
8 primacy and who can take it forward, the investigation,
9 and under what powers.

10 So the emerging concerns protocol is -- is quite
11 helpful in that regard.

12 **Q.** That's a reflection that you volunteered --

13 **A.** Yes.

14 **Q.** -- as part of the preparation once the Inquiry
15 was undertaken. I would just like to conclude by giving
16 you an opportunity to reflect from your perspective. We
17 have talked about many things, but do you think it's
18 fair to say that something has gone wrong here with the
19 CQC's involvement, not ascribing responsibility within
20 that, but something has gone wrong, do you think? The
21 CQC didn't uncover, weren't told something that they
22 should have known over a protracted period of time? Do
23 you agree?

24 **A.** Can I just take a moment to think about that?

25 **Q.** Of course you can.

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1 and then maybe -- well, I know we would have responded.

2 **MR DE LA POER:** Ms Ford, thank you very much for
3 answering my questions. Those are all the questions
4 I have for you.

5 **A.** Thank you.

6 Questioned by LADY JUSTICE THIRLWALL

7 **LADY JUSTICE THIRLWALL:** I have just got one or
8 two, if I may.

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** Just going back briefly to
11 the documents, they have not been located; either they
12 are lost or they have been destroyed?

13 **A.** I believe so, my Lady.

14 **LADY JUSTICE THIRLWALL:** On the destruction -- and
15 forgive me, I meant to go and check the transcript --
16 I think you said that six months after an inspection
17 must have been reported, that there was a direction that
18 documents could then be destroyed.

19 **A.** That's correct, my Lady, six months after the
20 publication of the report.

21 **LADY JUSTICE THIRLWALL:** Of the report. Thank you.

22 **A.** If there was no challenge, we could destroy
23 the paper records.

24 **LADY JUSTICE THIRLWALL:** Yes. Why do you think --
25 because we do have some of the records here --

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1 A. Yes.

2 **LADY JUSTICE THIRLWALL:** I am wondering when that
3 six-month rule was introduced or got rid of?

4 A. I think then when the IICSA directive came --

5 **LADY JUSTICE THIRLWALL:** Yes, in 2015.

6 A. -- I think that was better understood by some
7 than others; colleagues. When we did the paper project
8 to bring the papers back into the paper records, back
9 into CQC, because people still had them in their own
10 homes --

11 **LADY JUSTICE THIRLWALL:** Yes.

12 A. -- we were reliant on that safe return and the
13 tagging.

14 **LADY JUSTICE THIRLWALL:** Yes, and you have
15 explained that.

16 A. Yes, so I think -- I think some -- I can't be
17 certain, but I think it's a possibility that some were
18 destroyed.

19 **LADY JUSTICE THIRLWALL:** Yes. And you may have
20 said this already, but when was it that you went through
21 that paper retrieval process?

22 A. 2017.

23 **LADY JUSTICE THIRLWALL:** 2017. Thank you. What is
24 the current policy?

25 A. The current policy is that we retain the

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1 A. Mm-hm.

2 **LADY JUSTICE THIRLWALL:** The follow-up, I think was
3 by Ms Cain, was it, because you were in charge of the
4 well-led part of it?

5 A. Yes, yes.

6 **LADY JUSTICE THIRLWALL:** But you didn't go back?

7 A. When we were -- went back to follow up with
8 the Medical Director, do you mean, my Lady?

9 **LADY JUSTICE THIRLWALL:** Yes, the only follow-up
10 was with the Medical Director, wasn't it, I think?

11 A. Yes, we spoke with the Medical Director and
12 then the engagement with the Consultants, as
13 I understand it, and how they were managing those
14 concerns.

15 **LADY JUSTICE THIRLWALL:** Sorry, so did you actually
16 speak to the Medical Director?

17 A. No, not that I recall.

18 **LADY JUSTICE THIRLWALL:** You said "we", you meant
19 "she".

20 A. Yes.

21 **LADY JUSTICE THIRLWALL:** She raised it with the
22 Medical Director on the day and he said "we are working
23 on culture in the Trust".

24 A. Yes.

25 **LADY JUSTICE THIRLWALL:** The nurses said they had

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1 records for at least seven years. There are exceptions
2 to that. The policy has been revised many times since
3 then and now currently reflects best records document
4 practice.

5 **LADY JUSTICE THIRLWALL:** Thank you. You mentioned
6 the emerging concern protocol and just really a pick-up
7 for me: how does that link with Safeguarding Processes
8 and Working Together?

9 A. Well, again, most of the agencies have
10 a responsibility, when there is a risk emerging --

11 **LADY JUSTICE THIRLWALL:** Yes.

12 A. -- will meet and sometimes, if there is
13 a safeguarding issue, that we become the alerter. Each,
14 each of the regulators around the table, will have their
15 obligations under the Working Together to alert the
16 relevant local authority in respect of safeguarding
17 matters.

18 **LADY JUSTICE THIRLWALL:** Thank you. Then one last
19 question, if I may. You helpfully set out for us what
20 some of the Consultants were saying at that focus group.
21 They were saying that the Trust -- they were raising
22 concerns about staffing levels, one of the things, and
23 then the Trust was not listening to their concerns and
24 at times they felt that management was oppressive or
25 bullying, both words were used.

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1 not had any problems with culture, I think, from what
2 said. Nurses were positive about the culture --

3 A. Yes, they felt well supported. It was that
4 group of Consultants.

5 **LADY JUSTICE THIRLWALL:** A group of Consultants who
6 were raising concerns who didn't feel management were
7 listening and were?

8 A. Quite oppressive and bullying in their
9 approach.

10 **LADY JUSTICE THIRLWALL:** That is quite a -- that is
11 quite a thing to raise, isn't it?

12 A. It is.

13 **LADY JUSTICE THIRLWALL:** Also, it was in a sort of
14 partly anonymous session in that none of them was
15 identified, and you said that that's done deliberately.
16 Was that not something that warranted a bit more than
17 going straight to the Medical Director and saying
18 what --

19 A. No, you are quite right because we followed
20 that up after the inspection around the Freedom to Speak
21 Up --

22 **LADY JUSTICE THIRLWALL:** Yes.

23 A. -- and medical engagement and how the Trust
24 was managing those tensions, but we were doing that in
25 the context of not knowing --

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

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

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1 happened about what they had said.
 2 Mr De La Poer.
 3 **MR DE LA POER:** If I may just pick up on that,
 4 my Lady.
 5 **LADY JUSTICE THIRLWALL:** Yes, of course.
 6 **Further questioned by MR DE LA POER**
 7 **MR DE LA POER:** Ms Ford, the decision was taken to
 8 go and raise these matters with the Medical Director.
 9 Why not with Sir Duncan Nichol or Tony Chambers, who sat
 10 at the very top of the organisation?
 11 **A.** The Medical Director is usually responsible
 12 for the medical workforce, so -- and as peer-to-peer, we
 13 usually, in the first instance, will raise a concern
 14 with the Medical Director who is directly responsible
 15 for the engagement, the development and the support to
 16 the medical workforce.
 17 **Q.** But by the sound of it, one interpretation of
 18 what you were told is that the concern about oppressive
 19 and bullying culture was that the Medical Director was
 20 responsible for it.
 21 **A.** I don't know whether anybody ever said to me
 22 it was the Medical Director that was doing it, but we
 23 would have -- we would in the first instance have
 24 alerted the Medical Director for that.
 25 **Q.** I am not saying that they did, but unless

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

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1 Just remain standing, someone will ask you to take
2 the oath.
3 MS JULIE ANN HUGHES (sworn)
4 Questioned by MR CARR
5 **LADY JUSTICE THIRLWALL:** Thank you very much. Do
6 sit down.
7 **A.** Thank you.
8 **MR CARR:** Can we start, please, with your full
9 name?
10 **A.** Yes, my full name is Julie Ann Hughes.
11 **Q.** Ms Hughes, you have prepared a statement for
12 the purposes of this Inquiry, have you not?
13 **A.** I have, sir, yes.
14 **Q.** That statement is dated 28 August 2024.
15 **A.** It is.
16 **Q.** Can you confirm that the contents of the
17 statement are true to the best of your knowledge and
18 belief?
19 **A.** I can, sir, yes.
20 **Q.** You deal within your statement with your
21 professional background and you explain that you have
22 a Master's of Science degree in sociobiology?
23 **A.** Yes, I do, sir.
24 **Q.** You have a postgraduate qualification in
25 front-line management?

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1 Chester Hospital. You were part of the inspection team,
2 weren't you, for that inspection?
3 **A.** I was.
4 **Q.** You led the end of life team?
5 **A.** I did, sir, yes.
6 **Q.** That team was concerned with the care and
7 services provided to individuals in the last stages of
8 their lives?
9 **A.** Yes, sir.
10 **Q.** We can see from the notes that have been
11 provided that you also took part in an interview as part
12 of the Children and Young People Services?
13 **A.** Yes, sir.
14 **Q.** If we can turn up the relevant page of the
15 notes, it's at INQ0017339. If you turn, please, to
16 page 31, we considered notes from this part of the
17 inspection yesterday and that handwriting, it's not
18 yours, is it?
19 **A.** No, no, it isn't, I'm sorry.
20 **Q.** This looks like a note made by Helen Cain, and
21 if we look in the middle of the page, "Relevant Core
22 Service", that section, we can see "Children and Young
23 People" circled. Put in the box below: "CQC inspection
24 team attendees" it confirms that you attended along with
25 Helen Cain --

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1 **A.** I have.
2 **Q.** You are a Fellow of the Royal Society of the
3 Arts?
4 **A.** Yes, currently, yes.
5 **Q.** You were employed by the Care Quality
6 Commission as an inspector for over a decade --
7 **A.** Yes, sir.
8 **Q.** -- from June 2012 to June 2023?
9 **A.** That's correct.
10 **Q.** You explain that, in that capacity, you
11 conducted around eight inspections per quarter?
12 **A.** Yes, sir, yes.
13 **Q.** So 32 a year.
14 **A.** (Nods)
15 **Q.** As well as attending inspections, you would
16 also be involved in the other aspects of CQC regulation,
17 which was monitoring of Trusts?
18 **A.** Yes, sir, that's correct.
19 **Q.** So attending engagement meetings of the Trusts
20 and attending management review meetings --
21 **A.** Correct.
22 **Q.** -- which were internal CQC meetings?
23 **A.** Yes, sir.
24 **Q.** I want to look first, please, at your
25 involvement in the 2016 inspection of the Countess of

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1 **A.** Yes, sir, that's correct.
2 **Q.** -- for this part of the interview, and the
3 attendees at the interview, next box below,
4 Vicky Higgins, a specialist children's community nurse,
5 and Helen Griffiths, a diabetes specialist nurse.
6 Now, we also see in the description of Ms Higgins'
7 role what appears to say she was the lead for oncology
8 and palliative care, and in the next box down, "Summary
9 of points from the notes", first line: "EOL paed
10 strategy". Does that stand for end of life paediatric
11 strategy?
12 **A.** Yes, sir, yes.
13 **Q.** Is that the explanation for how you came to be
14 involved in this --
15 **A.** Yes, yes, it would have been -- it would
16 have -- the paediatric aspect would have come under end
17 of life services as a whole along with mortuary services
18 and things like that, so we explored each of the areas
19 within that core service.
20 **Q.** Because this interview would engage both
21 Children and Young Peoples Services and end of life, it
22 was a joint interview?
23 **A.** Yes, it was an effective use of the time we
24 had.
25 **Q.** Now, you will have gone back and looked at

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1 this note for the purposes of preparing your evidence.
 2 The notes do not appear to record, do they, any
 3 discussion of issues concerning neonatal mortality?
 4 **A.** No. No, sir.
 5 **Q.** Do you have any recollection of any discussion
 6 of issues concerning neonatal mortality at this meeting?
 7 **A.** Not at all, I'm sorry.
 8 **Q.** Thank you. We can take this document down.
 9 I want to consider now your involvement at the
 10 inspection as part of the Trust wide team. The Trust
 11 wide team, are those inspectors that carried out
 12 interviews, which looked at matters across all
 13 disciplines in the hospital?
 14 **A.** (Nods)
 15 **Q.** At paragraph 10 of your statement, you state:
 16 "My role in the Trust wide team was limited to
 17 leading focus groups."
 18 **A.** Mm-hm.
 19 **Q.** You go on in the final paragraph -- sorry,
 20 final sentence of that paragraph, to say:
 21 "I did not participate in any of the Trust wide
 22 inspection beyond running focus groups and did not
 23 conduct any interviews."
 24 **A.** No.
 25 **Q.** If we can get up another document, please,

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1 **A.** Yes, sir.
 2 **Q.** Then, on 18 February, the box that follows,
 3 there are two interviews with Ian Harvey in which your
 4 name is included as the team member to conduct the
 5 interview, one at 11.30 that has been highlighted and
 6 another later at 14:30.
 7 Looking at that timetable, it does appear that you
 8 are involved in a number of the core interviews.
 9 **A.** What would have happened, sir, I would have
 10 been there as a notetaker. As you can see by looking,
 11 there was always someone qualified to discuss at
 12 a strategic level the issue at hand.
 13 So in terms of the head of infection control, Dan
 14 Watson was with me and he would have led on that and
 15 I would have taken the notes. In terms of -- it was
 16 useful for me to be in with the board of director
 17 responsible for end of life care, because that just
 18 allowed me to hear that, that work.
 19 In terms of the complaints lead, that would have
 20 been led by Trish Rowson, with myself there as notetaker
 21 and an appropriate specialist adviser.
 22 **Q.** When you say in your statement you didn't
 23 conduct any interviews --
 24 **A.** No, I wouldn't conducted --
 25 **Q.** -- what you meant by that was?

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1 it's INQ0017287. Now, there are a number of different
 2 versions of this table. This is the version that you
 3 refer to in your statement.
 4 This document sets out doesn't it the schedule of
 5 core interviews and of focus groups?
 6 **A.** Yes, sir.
 7 **Q.** And if we just go through this document and
 8 see what the schedule provided for. This page we are
 9 looking at, we can see at the top, second box,
 10 "Wednesday, 17 February", so that's the date on which
 11 the interview set out on that page was scheduled, and we
 12 can see that your name is down for an interview with
 13 Hayley Cooper, halfway, roughly halfway down the page --
 14 **A.** Yes.
 15 **Q.** -- which is highlighted and that was an
 16 interview that you were scheduled to conduct with
 17 Ann Ford and the "Additional Comments" box says "Chair
 18 of Staff-Side."
 19 **A.** Yes, sir.
 20 **Q.** We will come back to this. If we can look at
 21 page 2 of this document now. At the top of the page,
 22 still dealing with the timetable for 17 February, there
 23 is an interview there for service leads for each of the
 24 core services and this is the end of leads, service
 25 leads interview?

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1 **A.** I would have taken notes, but I would not have
 2 led or conducted the interview.
 3 **Q.** If we look at page 3 of this document, please,
 4 this sets out the focus group, doesn't it?
 5 **A.** Yes.
 6 **Q.** We can see that the Consultants' focus group
 7 was scheduled for 18 February --
 8 **A.** Yes, sir.
 9 **Q.** -- at 8 until 9.30 and you were down with
 10 Michael Rees to conduct that focus group?
 11 **A.** Yes, sir.
 12 **Q.** That appears to be the only focus group that
 13 you were scheduled to undertake?
 14 **A.** Yes, sir.
 15 **Q.** If we can go back to page 1 of this document,
 16 please, the Julie Hughes interview. Sorry, the
 17 Hayley Cooper interview that you attended. You kept
 18 a note of that interview?
 19 **A.** I would have taken the -- the minutes of that
 20 interview.
 21 **Q.** Well, as you will be aware, your notes have
 22 been lost, cannot be found --
 23 **A.** Yes.
 24 **Q.** -- or were destroyed. What recollection do
 25 you have of what was discussed at that meeting?

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

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

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

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

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

18 **A.** Yes, sir, yes.

19 **Q.** And his background was as a qualified surgeon?

20 **A.** (Nods)

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

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

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1 **A.** No.

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

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

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

12 **A.** I don't specifically. I think there was maybe
 13 15, 14/15 people in the room, possibly.

14 **Q.** So 14 to 15 people in the room?

15 **A.** Yes.

16 **Q.** 14 to 15 Consultants?

17 **A.** Yes, yes, apart from ourselves.

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

20 **A.** Sorry, sir, I don't.

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

25 **A.** Yes, sir.

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

3 **A.** No, I wasn't the notetaker.

4 **Q.** -- it was Cara Taylor --

5 **A.** Yes.

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

7 **A.** Yes.

8 **Q.** -- who would have taken a minute.

9 **A.** Yes.

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

12 **A.** Yes.

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

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

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

24 **A.** It was.

25 **Q.** Not specific to any department?

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

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

6 **A.** Yes.

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

10 **A.** It is, sir, yes.

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

13 **A.** Yes, sir.

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

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

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

25 And the other one was to remind me to look at

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1 consent, and look at where that was at with consent.

2 **Q.** Just pausing you there, those notes that you
3 have just explained, are they matters that emerge from
4 the focus group or are they points that --

5 **A.** No, they are just -- sorry, they are just my
6 notes. The only thing that links to the focus group is
7 the asterisk in themes.

8 **Q.** It appears to read "bullying, lack of support,
9 staffing".

10 **A.** Yes, sir.

11 **Q.** Then the next two entries, 10.30, it looks "TC
12 re: Pennine"; is that at all connected to the focus
13 group?

14 **A.** I am so sorry. The --

15 **LADY JUSTICE THIRLWALL:** You don't need to be
16 sorry. It's just that's what we've got.

17 **A.** My note diaries only made sense to me; I'm
18 aware of that. It was just if I thought of something
19 I needed to remember I would just write it on whatever
20 day I was on.

21 **MR CARR:** The final line on that page, it's
22 difficult to read, what does that say?

23 **A.** I think it says "Evidence review".

24 **Q.** Okay. Does that relate to anything?

25 **A.** That relates to my end of life care.

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1 **MR CARR:** Before we do leave that page, the bottom
2 entry "Re BPAS!"

3 **A.** That's regarding another service, namely the
4 British Pregnancy Advisory Service which was something
5 else that was on my portfolio and I needed to check back
6 on.

7 **Q.** Then if we move forward to page 5. This is
8 quite hazy. What is being dealt with in this
9 photograph?

10 **A.** This is note on the BME focus group which
11 I was on that day, the Union one, which we have looked
12 at with Ann, in red is Mortality Reviews, which was an
13 area I needed to remind myself to go through.

14 **LADY JUSTICE THIRLWALL:** Mortality or what does it
15 says?

16 **A.** Mortuary, sorry, "Mortuary reviews". I can't
17 read my own handwriting, I do apologise. "Meeting in
18 training room 2" and "Feedback to MD."

19 **MR CARR:** Again, nothing specific there to the
20 Consultants.

21 **A.** I think the specific thing there is the
22 feedback to the MD where we would have taken the themes
23 that had arisen in terms of from the medical aspect of
24 the Trust and fed them back for his attention.

25 **LADY JUSTICE THIRLWALL:** So does that say "Feedback

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1 **Q.** At page 3 of this document, please, again can
2 you help us with this; do any of these entries relate to
3 the focus group?

4 **A.** No, sir. It relates to a separate service.
5 One is a start time and others are just who I needed to
6 call. One was Bridget at 12 and one was Helen at 2.30.

7 **Q.** That is Bridget Lees, another CQC inspector?

8 **A.** And Helen, yes, just to remind me I need to
9 call.

10 **Q.** Helen Cain?

11 **A.** Yes, sir.

12 **Q.** Now, she led the Children and Young Peoples
13 Services?

14 **A.** Children and Young People, yes, sir, yes.

15 **Q.** Do you recall why you needed to call her?

16 **A.** Sorry, no, I don't.

17 **Q.** Page 4 of this document, please.

18 **LADY JUSTICE THIRLWALL:** I'm sorry, Mr Carr, what
19 was the date of the diary there? Is that before the
20 inspection started, the phone calls?

21 **A.** I think it probably is, because it says COC
22 inspection, 6.50 am start.

23 **LADY JUSTICE THIRLWALL:** Yes.

24 **MR CARR:** We may make sense when we get to page 6.

25 **LADY JUSTICE THIRLWALL:** Thank you for that.

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1 to MD" and then "Re: Consultants"? Is that what it says
2 there?

3 **A.** Yes, yes.

4 **LADY JUSTICE THIRLWALL:** What does "SG" stand for?

5 **A.** "SG".

6 **LADY JUSTICE THIRLWALL:** Or is it 8?

7 **A.** It could possibly be a room number or a room,
8 you know, and I have just put in brackets where I need
9 to be.

10 **LADY JUSTICE THIRLWALL:** Yes, thank you.

11 Sorry, Mr Carr.

12 **MR CARR:** Thank you. So far as "Feedback to MD",
13 do we know what day this entry is for that we are
14 looking at on page 5?

15 **A.** I would have -- I don't -- I can't say

16 I remember clearly, but I think it would have been the
17 day after or late or the same day as the focus group,
18 once Helen the Specialist Adviser and I had our chance
19 to have a chat and go through and agree the themes that
20 we needed to feed back.

21 **Q.** If we turn to page 6, please, which may help
22 with identifying when some of these entries were made,
23 we can see the top left-hand corner, it looks like it is
24 an entry for a Monday, the 15th. That is the start of
25 inspection week.

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1 A. Yes, sir, yes.
 2 Q. It has those entries that we looked at, calls
 3 with Bridget Lees and Helen Cain. And then we see, on
 4 the other side of the page, the notes arising from the
 5 focus group, the bullying and then it's cut off by the
 6 photograph.
 7 Having looked at your diary, if we go back to
 8 page 2 of this document, the only entry that we have in
 9 these photographs dealing directly with what emerged at
 10 the focus group is that asterisk in black saying:
 11 "Themes: bullying lack of support staffing"?
 12 A. Yes, sir.
 13 Q. To be clear, those notes would have been made
 14 at what stage? Or this note would have been made at
 15 what stage?
 16 A. My personal -- whilst I was in the room whilst
 17 the issues were being discussed.
 18 Q. If we can turn now to page 1 of this document.
 19 This is a note of a telephone call with you, dated
 20 7 July 2023.
 21 A. Yes, sir.
 22 Q. You have seen this document again for the
 23 purposes of preparing your evidence, haven't you?
 24 Ms Hughes, you have seen this document for the
 25 purposes --

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1 towards the end of the criminal trial of Letby, wasn't
 2 it?
 3 A. Yes, sir.
 4 Q. Prior to this telephone call from the media
 5 adviser, at any time following the inspection leading up
 6 to this, had anybody from the CQC sought to discuss with
 7 you that 2016 inspection and what had happened at the
 8 Consultants' focus group?
 9 A. Not -- no, I don't think so. I -- myself, the
 10 Specialist Adviser, took what happened at it to the team
 11 room where the Trust, my team, were and it was these
 12 themes.
 13 Q. You are talking about at the inspection?
 14 A. At the inspection, yes.
 15 Q. My question was about after the inspection,
 16 because we have the inspection, at some point --
 17 A. Yes.
 18 Q. -- these notes go awry, they disappear. This
 19 is 2023, so between the inspection and 2023, did anybody
 20 at the CQC contact you and say "we don't have notes of
 21 this focus group, can you tell us what went on?"
 22 A. Not to my knowledge, sir, no.
 23 Q. If we look at the note and what is recorded,
 24 the first bullet point deals with dates, 17 February
 25 2.30 pm, so that accords with your diary but not the

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1 A. Yes, sorry, sorry.
 2 Q. It is a note that was made, as I understand
 3 it, by Kirstin Hannaford?
 4 A. Correct, yes.
 5 Q. That is who you had the telephone discussion
 6 with?
 7 A. I did, yes, sir.
 8 Q. And she is a media adviser at the CQC?
 9 A. She is.
 10 Q. We can see the heading "February 2016 CQC
 11 Comprehensive Inspection of the Trust"?
 12 A. Yes, sir.
 13 Q. It is a phone call to discuss the inspection
 14 in 2016. Now, can you help us with what prompted
 15 a telephone call in July 2023 to discuss the inspection
 16 in 2016?
 17 A. I got first a text and then a call saying "if
 18 you are available" because I had left in June 2023, "we
 19 would like to have a chat with you about a Countess
 20 inspection", and that's what prompted that call.
 21 Q. Did you understand that the telephone call was
 22 with a view to preparing a press release?
 23 A. I did because it was with Kirstin and I know
 24 she deals with media.
 25 Q. Because, July 2023, that was during and

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

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1 across, that they didn't feel supported to raise their
2 concerns, they didn't feel listened to.
3 **Q.** Okay. Looking at this note, it would be
4 incorrect to the way it's been drafted to suggest that
5 some Consultants raised concerns of an oppressive air at
6 leadership level, you were describing that as your
7 impression.

8 **A.** Yes, sir, definitely my impression.

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

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

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

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

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

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1 **LADY JUSTICE THIRLWALL:** Carla Taylor, did you say?

2 **A.** Cara.

3 **LADY JUSTICE THIRLWALL:** Cara. Thank you.

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

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

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

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

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

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

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

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

3 **Q.** It is an ad hoc meeting?

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

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

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

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

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

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

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

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

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

7 **A.** Yes.

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

11 **A.** Yes.

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

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

19 **A.** Yes, sir, that's correct.

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

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

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

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

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

9 A. Yes, sir.

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

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

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

21 A. Yes.

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

24 I will read paragraph 21, you say:

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

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

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

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

25 Q. Forgive me, my question was slightly
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1 raised at the Consultants' focus group meeting were
2 regarding a culture of bullying, the Consultants shared
3 with us that they felt their concerns were not being
4 listened to."

5 Paragraph 22:

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

8 At paragraph 24:

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

11 Paragraph 25:

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

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

17 A. Yes, sir.

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

20 A. No, sir.

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

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

2 A. Oh sorry.

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

6 A. Yes, sir.

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

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

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

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

21 Any specific concerns in relation to speciality --

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

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

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

5 A. Correct, sir.

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

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

12 Q. What was the response; can you recall?

13 A. I have no --

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

17 A. Not to my knowledge, sir, no.

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

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

23 Q. Bullying of whom?

24 A. The Consultants felt they were --

25 Q. By?

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1 2014, this would have meant that we, Ann or Bridget and
2 I would have taken this concern to the Medical Director
3 of the hospital. This would usually have been arranged
4 via CQC's inspection planner."

5 If I move on to paragraph 30:
6 "Unfortunately I cannot recall this meeting with
7 Ian Harvey. However, standard practice would have been
8 simply to report what was said by the Consultants to the
9 Medical Director."

10 Paragraph 31:
11 "Meeting with the Medical Director to report
12 concerns raised in a focus group was fairly standard."

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

16 A. Yes, sir.

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

20 A. Yes, that's fair.

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

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

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1 A. Senior medics and medicine, medicine leaders.

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

5 A. Yes.

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

9 A. Yes.

10 Q. Those concerns. And then in another section:
11 "We followed up directly with the Trust's Medical
12 Director."

13 Now, the way in which you deal with this in your
14 statement, it is your paragraphs 28 through to 31, you
15 say at paragraph 28:
16 "Following the Consultants' focus group I would
17 have gone back to CQC's team room at the hospital and
18 spoken to either Bridget Lees, inspection manager, or
19 Ann Ford, Head of Hospital Inspection, regarding the
20 concerns which had been raised. I would have informed
21 Ann or Bridget that the Consultants had reported
22 concerns about a culture of bullying at the hospital."

23 You then say, paragraph 29:
24 "Having regard to regulation 17 of the Health and
25 Social Care Act 2008 (Regulated Activities Regulations)

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

5 A. Yes.

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

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

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

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

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

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

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

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

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

10 **A.** Thank you.

11 **LADY JUSTICE THIRLWALL:** Mr Carr.

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

16 **A.** Yes, sir.

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

20 **A.** It did, sir, yes.

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

25 **A.** Yes.

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

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

11 **A.** (Nods)

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

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

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

20 **A.** Yes.

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

24 **A.** Absolutely.

25 **Q.** Was it your expectation that the final report

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1 **Q.** -- and the Trust?

2 **A.** Yes, sir.

3 **Q.** This is the agenda for a meeting in December.

4 We can see in box 1, can we not, the attendees,
5 Ian Harvey, Alison Kelly, Sian Williams, Ruth Millward
6 and then you and Debs Lindley on behalf of the CQC?

7 **A.** That's correct, sir.

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

11 **A.** Yes.

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

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

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

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

25 **Q.** What was the response that you got back?

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1 would be provided and in a timely fashion?

2 **A.** Absolutely.

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

5 **LADY JUSTICE THIRLWALL:** Thank you.

6 **MR CARR:** Subject to anything.

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

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

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

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

16 (1.11 pm)

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

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