Thursday, 14 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, we are now moving to a phase of the oral evidence hearings focused on the Care Quality Commission. Before we begin, it is important we say something about documents.

Putting it neutrally, the disclosure process of material from the CQC to the Inquiry has not run smoothly, both in terms of its timing and its content.

As matters stand, we understand there are a number of documents which were created at the time which are no longer available. My Lady, you will be hearing from a witness tomorrow, Ann Ford, a person senior within the CQC, who will give evidence as to the detail of the disclosure process, which documents are missing and why.

So far as the evidence of today is concerned, you will be hearing from those who conducted the inspection in February 2016 whose evidence would have been assisted by such material and as such, it's important I identify the missing material before you hear that evidence.

As the Inquiry understands it, first, there are no records available of a number of the pre-inspection meetings.

Second, there are no records available of any of

the core interviews with senior managers during the inspection.

Third, there is an incomplete record of the focus group with the Consultants.

Fourth, there are a number of other records which might have been expected to exist for the period following the inspection which cannot be found.

As we have said, why this is so will be a matter for the evidence tomorrow, but we thought my Lady ought to know that before we get to the witnesses who would have been assisted by it.

LADY JUSTICE THIRLWALL: Thank you very much, Mr De La Poer.

MR DE LA POER: My Lady, I will turn over to Mr Carr for the first of our witnesses.

LADY JUSTICE THIRLWALL: Very well.

MR CARR: My Lady, good morning. The first witness is Helen Cain.

LADY JUSTICE THIRLWALL: Ms Cain, would you like to come forward.

MS HELEN CAIN (sworn)

Questions by MR CARR

LADY JUSTICE THIRLWALL: Do sit down.

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

A. Helen Cain.

Q. You have prepared a statement for this Inquiry dated 23 June 2024, haven't you?

A. Yes.

Q. Is that statement true to your best knowledge and belief?

A. Yes.

Q. So far as your background, you explain in your statement that by profession you are a children's nurse?

A. Yes.

Q. You undertook training, becoming a Registered Nurse in 1987, you worked then as a Staff Nurse before training as a Registered Sick Children's Nurse in 1990?

A. Yes.

Q. In terms of other positions, you trained as a Health Visitor in 1994?

A. Yes.

Q. In June 2015 you commenced full-time employment with the CQC as an Acute Hospitals Inspector?

A. Yes.

Q. You remained employed by the CQC until May 2018?

A. Yes.

Q. Now, the CQC inspected the Countess of Chester Hospital, undertaking visits in February and March 2016?

A. Yes.

Q. They published a report on the hospital following that inspection on 29 June 2016?

A. Yes.

Q. The way that inspections work is that different inspection sub teams inspect different services or departments within a hospital?

A. Yes.

Q. Your role for the inspection was as the Core Service Lead, so you led the team looking into services for Children and Young People's Services?

A. Yes.

Q. It was that team that inspected the neonatal unit at the Countess of Chester Hospital?

A. Yes.

Q. Following the inspection visit, it was you who wrote the section of the report on Children and Young People's Services?

A. Yes.

Q. You had on your core team two Specialist Advisers: Dr Benjamin Odeka and Mary Potter?

A. Yes.

Q. We will be hearing evidence from them later today.

How was their role as Specialist Advisers different to yours as a CQC employee?

A. I would -- I planned the inspection, I reviewed the evidence that was available prior to the inspection and planned where myself and the Special Professional Advisers would visit on which days. I very much approached from a regulatory perspective to inspect under the Health and Social Care Act, the Specialist Professional Advisers were there to provide clinical support, to ask if -- if I had any queries from a clinical perspective, perhaps about best practice, current guidance.

I would then -- we would all individually interview members of the service. We jointly interviewed members -- members of the management team for the core service. I would then review the templates at the end of each day, the note-taking templates that we had taken to ensure that enough evidence was collected to ensure that judgments could be made when the report and -- to satisfy the subheadings of the report.

Q. What you have advised so far is the support that they gave you during the inspection visits. So far as their involvement before the inspection visits and following the inspection visit, in the lead-up to the publication of the report, is it right that they have little to no involvement?

A. Yes.

Q. So their main function is to provide support during the visit itself?

A. Yes, and their clinical expertise.

Q. Before we turn to consider the inspection in more detail, if we take a step back to look at the context, inspections are one of the two main ways in which the CQC regulates care providers, isn't it?

A. Yes.

Q. The other being monitoring?

A. Yes.

Q. And monitoring includes things such as carrying out engagement meetings?

A. Yes.

Q. As that's where you visit a Trust and see Executives or senior managers at the Trust?

A. Yes.

Q. Management review meetings, which are internal meetings amongst CQC employees?

A. Yes.

Q. You can make decisions as to what action, if any, you need to take in respect of a regulated care provider?

A. Yes.

Q. Also receiving information and data and assessing information and data relating to Trusts quite

apart from an inspection?

A. Yes, yes.

Q. Is it right that the information gathered as part of monitoring can help to inform inspections?

A. Yes.

Q. Now, amongst the data and information that the CQC receives aside from preparation for an inspection, are those relating to notifiable safety incidents?

A. Yes.

Q. There are two systems that I want to ask you about, firstly NHS England's National Reporting and Learning System. That is a system that is used to report patient safety incidents, isn't it?

A. Yes.

Q. Where a Trust reports to the National Reporting and Learning System, that satisfies the obligation on a Trust to notify the CQC of such incidents?

A. Yes.

Q. That is because the CQC has access to reports to that system?

A. Yes.

Q. Another reporting system is the Strategic Executive Information System?

A. Yes.

Q. That's a system to which Serious Incidents or Never Events must be reported by Trusts?

A. Yes.

Q. Again is it right that the CQC has access to reports to that system?

A. Yes.

Q. Returning to the 2016 inspection. I want to look at the information gathered ahead of the inspection.

Can you explain the different ways in which the CQC receives information, specifically for an inspection?

A. The -- the Trusts were sent six months ahead of inspection requests through the Provider Information Report and that was a spreadsheet asking for a lot of detail about services provided, performance, anything that the Trust might hold that would be useful ahead of the inspection.

There was a Provider Information Return 1 and a Provider Information Return 2.

Also ahead of the inspection, CQC data analysts would review data from a number of sources and provide each inspector for each core service a data pack or an intelligence pack to -- to support the information for inspecting the Trust ahead of, ahead of the on-site visit.

Q. If we can deal then first with Provider Information Return. So that is documents provided by the Trust ahead of an inspection?

A. (Nods)

Q. As the inspector, the CQC employee, it was your job to review the Provider Information Return?

A. For the core service, yes.

Q. For the core service?

A. Yes, because it came, there was a Trust-wide section and there was a core service section and within that, there was evidence in -- for the safe, effective, caring, responsive and well-led domain so there was a number of documents that would fit in in either of those tabs.

Q. Then once you considered the Provider Information Return, there was an ability, wasn't there, for you to seek further information through a data request?

A. Not ahead of the inspection. Ahead of the inspection, you would have the Provider Information Return and the analyst pack. Data requests from a core service perspective would have been requested either while you were on site or after the inspection.

Q. If we can consider the role of the Special Adviser, Specialist Advisers.

Now, you have explained that they are not involved prior to the inspection?

A. Yes.

Q. Is there a process that you undertake, having looked at the Provider Information Return, to determine what documents, if any, you need to share with the Specialist Advisers?

A. I think it, at the -- on the first morning of the inspection you would meet with the Specialist Professional Advisers, I would -- I shared the inspection plan and would, and discussed what evidence we had, what information we had and if there were any areas that we specifically or I specifically felt needed further attention.

Q. Would you share documents received from the Trust, whether through a Provider Information Return or a subsequent data request, would you share that documentation with Specialist Advisers?

A. Yes. I -- I have done. I can't remember on the Countess of Chester whether there was a specific, any specific documents, but certainly -- or if there was anything in the documents that came that I was unsure about, any clinical questions I had, anything that I needed clarification on from a clinical perspective.

Q. So it sounds like -- correct me if I am

wrong -- the process is you consider the Provider Information Returns as part of your role and if there are documents which cause you concern, then you will share those with the Specialist Advisers for specialist advice?

A. Yes. And my understanding was that the -- the intelligence report or the data pack that we had that they were also provided to the Specialist Advisers.

Q. I am going to come to that in a few moments.

Dealing first, please, with the adequacy of the documents received as part of the Provider Information Return, paragraph 19 of your statement, you say the following:

"As noted at paragraph 8 above in preparing a statement I have only had access to the documents provided to me by CQC. I am confident that there were -- there was more information provided by the Trust as part of the PIR and in response to data requests which I have not been shown. I understand that CQC is working to locate these documents."

What you are describing there is although you had been given some documents for the purposes of providing this statement --

A. Yes.

Q. -- you think there were more documents

obtained by the Trust for the purposes of this inspection?

A. Yes. And the second cohort of documents that I received a couple of weeks ago, a lot of those I was referring to there have now -- were provided to me in the second collection of evidence.

Q. Can you explain the nature of the documents that weren't provided to you initially that have more recently been provided that would have made up the Provider Information Return?

A. I am trying to think what else came through.

I -- to be honest I can't think of a -- a specific document that would have made up the Provider Information Return.

Q. Again, dealing with this information or data and looking at paragraph 47 of your statement, please, there you state:

"I do not recall having any concerns about the sufficiency of the information provided by the Trust in the PIR. However, it is difficult to comment on this without access to all the documentation."

I want to cross-reference that with your paragraph 18 and there you describe that to the best of your recollection you requested additional documentation from the Trust ahead of the inspection?

A. Not ahead of the inspection. The -- the requested documentation as data requests were as part of the on-site inspection or following the on-site inspection. The PIR, or the Provider Information Return, you have prior to the inspection while you are on inspection and afterwards for the purposes of writing the report further data requests are made, and that is what I am referring to there.

By the time you get to inspection because of the six months lead-in time, a lot of the data is old data for want of a better -- and actually while you are on site, you want current data to inform the report.

Q. If we can have on screen, please, INQ0103249, if we turn, please, to page 3 of that document. The email in the bottom half of that page dated 15 February 2016 from John Cunningham to Ruth Millward at the Trust.

John Cunningham, he's a CQC employee, isn't he?

A. I don't -- I don't know, if I honest, I couldn't remember.

Q. This email -- and dated 15 February 2016, so that's a day before the inspection started.

A. I would not have made any requests. The -- it looks like the core service, the accident and emergency and surgical care, but my practice, I didn't -- as far

as I remember and I don't think I ever did for any inspection -- make any requests prior to the inspection.

Q. If we turn to page 4, please. This sets out a list of requests for documents and we can see the second half?

A. Yes.

Q. The bottom half of that page is made up of requests for documents concerning Children and Young People's Services. Is it your position that these requests were not made by you?

A. No, they would have been made by me. Can we go back to the date of the --

LADY JUSTICE THIRLWALL: Sorry did you say "No, they would have been"?

A. They would have been made by me, yes, these would have been my requests but my -- the inspection period -- it tended to be the inspection period I would have counted as that week. I mean, to be honest, I can't remember whether the Monday was -- but I would have made it in this inspection period. Maybe I am not making myself clear. The -- that week was the inspection period. The period of the on-site inspection.

MR CARR: So you asked to see the date, it is on page 3. It is 15 February 2016, so it is a day before

the first visit.

A. So it must -- the, that was the period of the inspection week. So it would have been that -- that I would -- I would take as the week of the inspection.

Q. Back to page 4. So these requests for additional documents in this service area, these have come from you?

A. Yes, and as part of the inspection as part of the on-site inspection.

LADY JUSTICE THIRLWALL: Do you know why you would have said "pre-inspection requests"?

A. I think no, I don't. If I am honest, my understanding is that that was the inspection week so although we hadn't arrived on site, that was the week of the inspection.

LADY JUSTICE THIRLWALL: So I suppose from the perspective of the hospital, these were requests made before the inspection? Because it was before you were in the hospital.

A. Yes, from the Trust's perspective. But I think it would have -- from my CQC perspective this was part of the on-site inspection.

Making the distinction between these and the Provider Information Report that would have been sent evidence through up to six months before the inspection.

LADY JUSTICE THIRLWALL: Yes. But so we are clear, you did ask for them before you got to the hospital?

A. Before we were actually on site.

LADY JUSTICE THIRLWALL: Yes, yes, thank you.

MR CARR: Thank you. And you described a few moments ago that one of the reasons for a data request might be that by the time you arrive at a hospital the information obtained under a Provider Information Return might be a bit out of date?

A. Yes.

Q. So if we look at some of the entries here, fourth from the bottom: Paediatric speciality meeting minutes for the last two months, while they wouldn't have been included in a Provider Information Return that came six months previously?

A. They couldn't have been because I wouldn't have asked for them if they had.

Q. Yes. The penultimate entry you have asked for minutes from the Paediatric Mortality and Morbidity Meeting from 10 December 2015. Why were you asking for that?

A. Because it's -- it's part of the inspection process, part -- for the subheading of incidents in the safe domain to ensure that, for the -- to see how the Trust assure themselves that they are reviewing deaths

and learning from them.
Every Trust should have a mortality and morbidity process. Part of the inspection process is to identify how the Trust assure themselves they are learning from that, they are following the process and learning from deaths and subsequently assure the CQC that the process is in place and it's being followed.
Q. Page 5 of this document, please. The first entry.
"Incidents relating to neonates and paediatrics, last 12 months"?
A. Yes.
Q. So you are asking there for incidents leading right up to the time of the inspection?
A. Yes.
Q. Again that is presumably because you want the most up-to-date information as to what's going on in the hospital?
A. Yes.
Q. Did you receive all of the documents that you requested?
A. No.
Q. Which documents did you not receive?
A. The only one that I can remember specifically is the Mortality and Morbidity Meeting minutes from

10 December.
Q. When did you receive the documents that you had requested?
A. It could -- it was -- it could be immediately, it could be during the period of the inspection. It could be subsequently following the on-site visit.
Q. Do you know which of those applied here?
A. I'm sorry?
Q. Do you know which of those timeframes applied on this inspection, did you --
A. It was that -- it would -- it could be any time. The Trust -- during the inspection the Trust were questioning, we were -- the CQC requested a lot of documents from the Trust and it was quite an undertaking for the Trust to provide all the documents for all the core services as they were required.
LADY JUSTICE THIRLWALL: Sorry, just so that I understand this, so you made the request for all the documents that we are looking at now before you got there but then did you make more requests for more documents while you were there?
A. It is possible.
LADY JUSTICE THIRLWALL: Well, can you help a little bit more than that?
A. Sorry, yes, yes, I would have done. Normal

practice, I -- I would take although the day before the on-site inspection it is part of the inspection period which is I think where my confusion has come between making them months before or weeks before and the day before. If it was the week of the on-site inspection that I would -- my interpretation is that that is part of the inspection week.
Those documents that we had asked for would come through in tranches, either myself or any of the other core services leads, it could be the next day, it could be with -- on the inspection time, we were on site, it could be subsequent to the site visit.
MR CARR: What was the nature of the further documents that you requested after 15 February?
A. I am sure -- I would have to have a look to see what I have requested.
Q. The other page is page 4.
A. There would definitely be staffing information because during the on-site inspection, nurse staffing on both the paediatric unit and the neonatal unit was identified as a cause of concern.
Q. In circumstances where a data request is not made until the day before the inspection visit starts, and may not be responded to until after the inspection visit occurs, any documents received afterwards can't be

discussed with the people you are interviewing?
A. Usually the request for a document has come as a result of an observation or a discussion on site.
Q. Well, this request is dated 15 February, so it can't have come as a result of an observation or a discussion?
A. I'm sorry, I think -- there were -- you would -- there would be a normal number of documents that you would request as a matter of course to support the judgment making. And this -- you would -- these are part of those requests.
Q. Wouldn't you want to see up-to-date information and to receive it prior to conducting interviews?
A. It -- it would depend on the information. Some of it is information that you require to -- to support the judgment. Some of it is to provide assurance of what, of the service that's been provided. So not every piece of evidence requested would require a conversation. You wouldn't need to ask about every piece of evidence.
Q. Yes, but you wouldn't know what you need to ask questions about or not until you have received it and assessed it?
A. Not necessarily. Because some of the

information you would ask -- you would request would -- you would request for every inspection. Not all of it would be focused from a conversation.

Q. We can take that document down now, thank you.

Can we consider information relating to deaths and mortality, please.

If we turn to paragraph 20 of your statement, you say there:

"I would expect to receive information relating to neonatal deaths prior to an inspection."

A. Yes.

Q. At paragraph 22, you say:

"I would hope to receive information regarding an increase in neonatal deaths before or during an inspection."

Would you not expect also to see information about an increase in neonatal deaths rather than hope?

A. The -- I think the distinction is the information would be about neonates, about -- it would be expected -- that's what I would expect to see. If there was an increase I would, I would hope that that would have been highlighted in the evidence.

Q. Why would you not expect an increase in neonates to be part of the evidence that you see?

A. Can you repeat the question again, please?

Q. Why would you not expect an increase in neonatal deaths to be part of the evidence that you would see?

A. Well, I would hope it would be provided but not -- not every Trust would, would highlight if there was an increase. Often mortality is -- is one of the things that we would always look at, always -- or the CQC would always look at as part of the inspection process.

If there was anything out of the ordinary, that's what I would hope that the Trust would highlight that.

Q. The query is why isn't there an expectation, is an increase in mortality not something that you would expect to see as a matter of course for an inspection and if not, why not?

A. Well, I would expect it but I wouldn't -- I am not, I wouldn't think not every Trust would -- would provide it.

Q. Not every Trust would meet your expectation --

A. Possibly.

Q. -- is your concern but your expectation is if there is an increase --

A. That.

Q. -- you would want to see it?

A. Absolutely.

Q. At paragraph 24 you state:

"At the time of this inspection, I would not have known how many neonatal deaths would be usual for the neonatal unit and how many would constitute an increase. At that time, I would be reliant on either the Child and Young People's Services Special Advisers or the Trust itself to highlight any such increase in deaths to me. This did not occur in relation to this inspection."

How would you expect the Trust to highlight neonatal deaths and how many would be usual for the unit?

A. When we discussed in a discussion because mortality and morbidity was discussed as part of the interview with the -- at the core service level with the core service, the leadership team for the specialty.

Q. So your expectation is that that is information that would emerge at interview?

A. Yes.

Q. But why wouldn't you expect it to be provided in advance?

A. Because my experience was that some Trusts you would have to ask for the information rather than it being automatically provided.

Q. When you describe being reliant on Children and Young People's Specialist Advisers, as to what is

a usual number of deaths for a neonatal unit or what constitutes an increase, how would the Specialist Advisers be able to advise you on that if they aren't given the data contained in Provider Returns?

A. Because it's not always -- not all of it is in the Provider Return. And I think it would be in the -- because they were in the interviews with us, with me when I interviewed the service leaders and we talked about neonatal mortality and morbidity. I think if there was anything out of the ordinary that's where I would hope the Special Professional Advisers would be able to provide that clinical expertise and that knowledge of perhaps what would be normal for a unit of this size.

Q. At any point did you raise with either the Trust or the Specialist Advisers or the CQC that you were missing information as to the usual death rate or what would constitute an increase in neonatal mortality?

A. No.

Q. At paragraph 25 of your statement, when addressing unexpected or unexplained deaths, you say and it's the final sentence of that paragraph:

"I would expect unexpected or unexplained deaths to have formed part of the documentation provided to the CQC."

Now we are about to look at some of the documentation. But from who and how would you expect that information to be provided?

A. Through the Provider Information Return.

Q. When you considered the Provider Information Return did you find anywhere in there clear documentation setting out details regarding unexpected or unexplained deaths at the neonatal unit?

A. Not that I remember.

Q. Again, did you raise with the Trust or the CQC the absence of that information?

A. No.

Q. I asked you earlier about the two NHS England reporting systems: the National Reporting and Learning System and the Strategic Executive Information System, so the systems for reporting serious incidents and patient harm incidents?

A. Yes.

Q. You explained that the CQC tracks those systems as part of its monitoring. For the purposes of preparing your evidence, you have been provided the spreadsheets, haven't you, showing entries on those two systems --

A. Yes.

Q. -- containing reporting made by the Trust.

Now, I am not going to put that document on screen because it contains sensitive third party information but you will have seen from those spreadsheets that on 3 July 2015, the Trust reported to the Strategic Executive Information System for Serious Incidents and Never Events the inspected potentially avoidable death of Child D?

A. Yes.

Q. It was reported as a Serious Incident, due to what was reported as a delay recognising sepsis.

Were you made aware of that report in the course of your preparations for the inspection?

A. Not that I can remember.

Q. The deaths of Child A, Child C, Child D, Child E and Child I were reported to the National Reporting and Learning System in the months prior to your inspection. Were you aware of the reports made to the National Reporting and Learning System?

A. No, not that I remember.

Q. Given the CQC has access to that information and tracks those systems, should it have been provided to you?

A. My -- my understanding is that the intelligence report provided by the CQC data analysts reviews Serious Incidents Never Events and provides that

information for the core service ahead of the inspection.

I don't remember from the intelligence pack those being highlighted.

Q. We will look at some of the documents relevant to the inspection in a few moments. But they don't identify, do they, the report of the Serious Incident of Child D?

A. No.

Q. And they don't make any mention at all, do they, of the entries that I have described, to the National Reporting and Learning System, in respect of Child A, Child C, Child D, Child E and Child I?

A. No.

Q. Had you been given access to this information would it have changed your approach in preparing for or conducting the inspection?

A. Yes.

Q. How so?

A. Because it would have been more of a focus of the inspection. There would have been more direct questions asked about mortality and morbidity.

Q. And something that you would have investigated?

A. Absolutely.

Q. A document that you did receive, and again I am not going to put it on screen because of the sensitive third party information it contains, is one that I understand was prepared by the Trust, it is a spreadsheet titled "NNU Paediatric Incidents 1 December 2015 to 31 January 2016".

A. Yes.

Q. You know the spreadsheet that I am referring to?

A. Yes.

Q. It contains in total some 377 entries?

A. Yes.

Q. It's arranged over six columns with a column for an ID number?

A. Yes.

Q. A column for the date of the incident?

A. Yes.

Q. A column for the location of the incident?

A. Yes.

Q. And then there is a column which is colour coded for actual harm with green for none, yellow for low, so low harm, orange for moderate harm and red for severe harm?

A. Yes.

Q. Then there is a description of the incident in

question?
A. Yes.
Q. What was your understanding as to the basis for that document, how it had been prepared?
A. It was a list, with detail, of all the incidents that had been reported in the Children and Young People's Service within that timeframe.
Q. The presentation of that document, is that a standard document that you would see for most inspections?
A. Yes.
Q. It's quite a substantial document, isn't it?
A. Yes.
Q. It runs to some 25 pages with as I said what appears to be 377 entries. Are you confident that you would have read each and every entry or is it likely that you would focus only on those coloured red for severe or orange for moderate?
A. I would have looked at every incident.
Q. Eight entries in that table include in the description death, don't they?
A. Yes.
Q. Now the first query. Would you expect all neonatal deaths on a unit to be included in a table such as that?

A. Yes.
Q. And those eight entries, they are all marked green for none, aren't they, in the "Actual harm" column?
A. Yes.
Q. Can you explain your understanding of the "no harm" categorisation? It's paragraph 58 if you want to see what you said in your statement.
A. My understanding was the clinician completing the incident form made the assessment that no harm had occurred as a result -- direct result of the clinical care provided.
So not that the death in itself wasn't harmful but in their opinion when they were completing the incident form, that no harm had occurred as a result of the treatment or care.
Q. Did it strike you as odd that cases involving death were marked "no harm"?
A. No, for the reasons I have just mentioned.
Q. Did you share or discuss this table or the entries in the table with the Specialist Advisers?
A. I can't remember.
Q. Do you think this is a document that you should have shared or discussed with the Specialist Advisers?

A. I think incidents would have been discussed. I can't remember exactly the detail of, of the conversation.
Q. Dr Odeka, one of the Specialist Advisories and we are going to be hearing evidence from him later today, but in his statement when looking at this table he reviewed it for the purposes of his statement. He says that the categorisation struck him as inaccurate and he wondered if the data was being inputted into the Datix system incorrectly.
Now, if you had had a discussion with him about this table, at the inspection, and he told you that he considered the categorisations to be inaccurate, how would that have affected your conduct of the inspection?
A. It would have been one of the questions asked with the service leads.
Q. If you can turn to your paragraph 57, please. It's the first sentence. When dealing with this table you say:
"Overall, nothing from the table of incidents appeared immediately concerning when I reviewed it in advance of the inspection."
That would suggest, then, when looking at the table, reading all of the entries, you weren't concerned as to whether the categorisation, particularly of events

involving child death, was or might be incorrect?
A. No.
Q. Going back in your statement to paragraph 51, and again this is a reference to one of the entries in that table, it's one concerning Child A and it's entry 188 in the table, the spreadsheet.
You describe the entry there, what the entry in the table says is:
"Sudden and unexpected deterioration and death of a patient on the neonatal unit after full resuscitation. Requiring postmortem."
So within the description in the table you have a reference, don't you, to a Sudden and Unexpected Death?
A. Yes.
Q. There is a suggestion -- well, it's clear, not a suggestion -- that the cause of death is yet to be ascertained?
A. Yes.
Q. It is awaiting postmortem.
Now whilst this has been marked "no harm" in the table, there's nothing in the description that explains or seeks to justify why it's been marked "no harm"?
A. But there was no evidence, there was no -- nothing in the description to suggest that there was any

harm caused.

Q. Well, it may be that you are making the same point. The description identifies a sudden and unexpected deterioration and death. There is no cause of death. There is nothing on the face of that description which would justify a no harm or any other categorisation, there is an absence of an explanation for how to categorise it?

A. Yes.

Q. Now, in light of that, wouldn't you want to explore at the inspection, for instance, why the death was unexpected and whether an explanation had been obtained?

A. The role of the inspection is not to look at specific -- specific incidents. It's to ensure that there is from a regulatory perspective, there is a process in place to ensure incidents like this are identified, reported, identified, investigated and lessons learnt.

So individual examples of incidents would not be pursued. But, however as part of the inspection, evidence would be requested to ensure that that mortality and morbidity process was being followed. So as part of the inspection and certainly in my inspection report I do mention that I reviewed three incident

reviews to ensure the process was taking place so that how -- to identify how the Trust assured themselves that they were investigating incidents and learning lessons and how that information was disseminated.

Q. Part of the regulatory function and considering, for instance, whether incidents are properly reported and lessons learnt would involve, wouldn't it, considering whether incidents are properly categorised?

A. Yes.

Q. If on reading a table you saw an entry involving an unexpected death without an explanation, that would be a very pertinent -- that would be marked "no harm", that would be a pertinent example to test the processes in place for reporting and learning lessons?

A. Yes. But like I said, I -- my report states that I looked at three incident reviews, I can't say which incidents they were but that to ensure that the process was being followed.

Q. Well, paragraph 49 of your statement deals with the entry in the table concerning Child E and although not set out in your statement, the entry in the table, it's line 200, also lists the death as an unexpected one, albeit marked green for "no harm".

Again a similar question: wouldn't that warrant

discussion and exploration to test the system of reporting, to test the system of categorisation?

A. And the process was tested, like I say, I did -- we talked about incidents with numerous members of staff about incident reporting, about what would be reported, how it would be reported, how things were investigated, how lessons were learnt.

And as part of that process, I reviewed three incident reports. I can't tell you which ones they were because that's part of the information that I have not been privy to. But so it was tested, the process was tested. I just can't tell you which specific incidents it was.

Q. You say the process was tested. How was it tested?

A. I would, I requested the reviews so I would look -- looked at the review reports to ensure that the mortality and morbidity process was being followed, that the appropriate information was included in the report, if there were any lessons learnt, what the actions were, and how they were disseminated to staff, where they would be discussed, whether that be at governance meetings as well as Mortality and Morbidity Meetings and what -- what the progress was with the actions as a result.

Q. How did you test the categorisation of incidents within Children and Young People's Services?

A. Through discussion with staff so I would ask, I asked staff as a matter of course in an inspection: what would you report? How would you report it? What type of incidents would you report? Where would you find the policy? Do you know what the policy says? Could you access it?

Often I would ask individual members of staff what was the last incident you did report, did you have feedback, were there any lessons learnt? How are lessons learnt shared? And where are they discussed?

Q. Please can we have up on screen INQ0017411. The section of your statement dealing with this is at paragraphs 59 to 62. What we have on screen is an email from Alison Kelly at the Countess of Chester Hospital to Ann Ford. Ann Ford is another CQC inspector, isn't she?

A. No, she's actually -- she was actually the head of hospital inspection at the time of this inspection.

Q. Forgive me, she's a CQC employee rather than a specialist adviser?

A. Yes.

Q. And this is an email that you address in your statement. If we look under the heading "Context", you

will see that what Alison Kelly writes is:

"The Trust has identified an increase in the number of deaths of newborn babies differing levels of prematurity on our neonatal unit in 2015 to 16 and now in 2016 to 17 compared to previous years.

"An in-depth thematic medical review of the individual cases was undertaken internally followed by a subsequent peer review by a Consultant from Liverpool Women's Trust. However the reviews have failed to identify any cause or common theme for this increase. These reviews were submitted as part of our recent CQC inspection data pack."

Now, the first point to make is in terms of the date of that email it is 30 June, so that is the day after the CQC inspection report had been published?

A. Yes.

Q. The final line of the paragraph I read, that is in parentheses, that suggests that two reviews were shared with the CQC and you have been given access to those reviews for the purposes of preparing your statement, haven't you?

A. Could you clarify which reviews you mean?

Q. Yes, it is the Dr Brigham report from 2015?

A. Yes.

Q. November 2015, forgive me. And the Thematic

Reviews involving Dr Subhedar from February 2016 and then another version dated March 2016?

A. Yes.

Q. Now, in your statement you explain you do not recall seeing any of those reviews?

A. At the time of the inspection?

Q. Yes.

A. No.

Q. At paragraph 62 of your statement you say:

"I do not think I requested this review from the Trust. If it was requested by anyone else at CQC it may have been one of the senior members of the CQC team."

In respect of the comment "I do not think I requested the review from the Trust", were you aware, before seeing for the purposes of preparing your statement, that those reviews had been undertaken?

A. No.

Q. Was there any discussion of those reviews during your inspection?

A. No.

Q. Now we can, I can put -- we can take that down now please, thank you.

I can put the reviews up if necessary but you have looked at both of them, the November 15 review starts by stating:

"In response to a perceived increase in number of stillbirths and neonatal deaths at the Countess of Chester Hospital in 2015 it was decided to set up a panel to independently review all of these cases again."

The February 2016 Thematic Review starts by saying:

"There was a higher than expected mortality rate on the neonatal unit in 2015."

Now, if you had become aware of the existence of those reviews, during your inspection, would you have requested them?

A. Absolutely.

Q. Had you received and considered those reviews and for the moment I am talking just about those two, so the November 2015 review and the first version of the Thematic Review dated February 2016, how would that have affected your preparation for or conduct of the inspection?

A. Rather than just review the mortality and morbidity process and how it was being followed and how the Trust were assuring themselves in more general terms, there would have been specific questions asked about what action is being taken following identification of either a perceived or an increased rate in neonatal mortality.

Q. Paragraph 67 of your statement, the second sentence, you state:

"I would have hoped to have been provided with the information in these reviews."

Again I am going to ask you about the use of the term "hope". Would you not expect to receive the reports or at least the information contained in them?

A. If -- if a review of this nature had taken place, I would have expected it. However, not all Trusts are as open and transparent as you would hope that they would be in the inspection process.

Q. Would the fact that two internal reviews had been carried out -- well, sorry, two reviews, one internal one, involving a Consultant from another hospital, what would that tell you about the level of concern about the neonatal mortality?

A. It would tell me that they had identified that there was an increase in mortality, that it had been recognised and that clinicians were looking into why that was. It's -- for want of a better expression, spikes in mortality happen within healthcare. It's about identifying it and trying to explain or find the reasons for it.

So that would suggest to me that they had identified it and were investigating further. Having

reviewed each case individually, they were also looking at neonatal mortality in a wider context to see if they could identify anything, any common cause, anything that could be acted on.

Q. The second version of the Thematic Review and we will get it up, it's INQ0003251, please. Now, although on the first page there it has the date, 8 February, 2016, which refers to a meeting, this version of the document is actually dated 2 March and so that is after the planned visits at the hospital in February, it's a day before the unplanned visit because you went back in March, didn't you?

A. Yes, I did.

Q. 4 March.

It is some four months prior to the CQC report being published --

A. Yes.

Q. -- isn't it?

If we look at page 7 of this document, please, and it's at number 1 on that page, under the heading "Themes identified during discussion of all cases", and this is one change from the previous version of the report in that you can see there:

"One sudden deterioration. Some of the babies suddenly and unexpectedly deteriorated, but there was no

clear cause for the deterioration/death identified at postmortem."

So clearly identifying there unexpected and unexplained deaths.

Now, three questions, please: firstly, if the first report had been provided to you, that is the 8 February version of this report, had been provided to you prior to or at the inspection, would you expect an update of that same report also to be provided?

A. Yes.

Q. Even if that first report had not been provided to you at the inspection, would you expect this updated version of the report, particularly in light of what is highlighted on the screen in front of you at number 1, would you expect a reporting containing that to be provided to you prior to the finalisation of the report?

A. Yes.

Q. If you had received this document, post the planned visit, but just before you returned for the unplanned visit, what would you have done with it? Would you have been able to conduct further investigations as a result?

A. It would -- there would have been further enquiries made, it would have been one of the -- one of

the focus, a focus of the unplanned visit. It would have given an opportunity for questions to be asked.

Q. So a point that you have made in respect to a number of these entries that we have looked at and in a number of documents that we had gone to is that, well, if you had seen that information, it would have given you an opportunity or you would have asked more questions, you would have focused on the issues arising.

Is the position that when you went to the inspection you didn't focus on issues concerning neonatal mortality, you didn't ask direct questions in those areas, because you were unaware of the concerns that we now know there were?

A. Yes.

Q. Now, on a related point, if we can -- we can take that down, please -- go to another document, INQ0103620, and it is page 7 of that document, please. Now, this is titled "Self Assessment from PIR", it is Provider Information Return.

So this appears to be a form filled out by the hospital ahead of inspection where they assess themselves and identify what they think their ranking should be?

A. Yes.

Q. For services for children and young people,

which was the sector that you were dealing with, we can see it is a very positive self assessment, isn't it?

A. Yes.

Q. It's the most positive -- well, equally with maternity and gynaecology -- of all the services?

A. Yes.

Q. Three good, two outstanding.

What impact would a positive self-assessment like this have on your preparation for an inspection?

A. It wouldn't have any impact.

Q. Well, you have commented that if you had known about some of the concerns that we have been looking at, then you would have asked more direct questions about those concerns.

Does the converse apply? So where you have a service which is representing itself as "good" and "outstanding", does that give a level of reassurance or mean that you don't have to focus questions so much on any troubled areas?

A. No, because the -- the inspection and the core service frameworks which we followed and the key lines of enquiry, you would look at every area equally and follow the evidence.

So prior to inspection, if there was anything that you particularly wanted to look at you would identify

it, but as part of the inspection process, all areas would be looked at.

If a Trust thought that they were outstanding in caring, that wouldn't mean that you wouldn't look at caring. You would look at it equally regardless of how they rated themselves.

Q. We can take that down. If we look please now at document INQ0101422. This is a document created by the CQC. It is labelled "Pre-inspection document".

What is the purpose of this document?

A. It's to bring together evidence that -- by the CQC analysts evidence that is available to support the inspection.

Q. So I have seen references in the evidence to a data pack. Is this the data pack?

A. This and the intelligence document, the subsequent intelligence document that was used in the presentation.

Q. Is this a document which would be provided to the Specialist Advisers?

A. To my recollection, yes.

Q. And if we look, please, at page 5 of this document we have here a summary of analysis. So this will be based on the Provider Information Returns and the other documents available to the CQC?

A. Available to the CQC analysts, yes.

Q. Whilst there are other versions in the documents provided by the CQC of this, it doesn't appear that this analysis was ever updated. Have you seen another version of this document with this information --

A. The inspection plan has actually got a differing date for the no Never Events and Serious Incidents -- sorry, the intelligence pack.

Q. Because we see there the first entry "No Never Events or Serious Incidents have been reported by the Trust between November 14 and October 15."

Well, you know from looking at that entry on the STEIS report that that's not correct, is it?

A. Now -- now, yes.

Q. There's nothing in this document about reports to the National Reporting and Learning System, is there?

A. No.

Q. We will look at one more document before the break, please. We can take that down now. It is INQ-- sorry, ready? -- INQ0106785.

And if we go, please, to page 7. This is titled "Inspection framework". We didn't need to zoom in on that, we don't need to zoom in.

It's page 7. This is titled "Inspection Framework

NHS Acute Hospitals". Are you familiar with this document?

A. Yes.

Q. And it appears to act as a guide for the issues to be considered for the purposes of a Children and Young People's Services inspection?

A. Yes.

Q. In particular for preparing the report?

A. Yes.

Q. If we look, please, at page 10, in the second half of the page, the box titled "Safe".

To clarify, "safe" is one of the categories against which you would be inspecting a hospital and grading it?

A. Yes.

Q. In the first box under the heading it describes what safe means:

"By 'safe' we mean people be protected from abuse and avoidable harm."

The box underneath that requires further investigation:

"Never Events involving children and young people Serious Incidents involving children and young people reports to NRLS re: moderate and above incidents."

A. Yes.

Q. And so that is identifying all the categories

that you need to look at in order to make a determination, an assessment of the safety of a service?

A. Yes.

Q. And if we look at page 11, please, the next page, under the heading "Incidents", and relevant to S2, "What is the track record on safety?"

The first bullet point:

"What is the safety performance over time based on internal and external information?"

So looking at safety performance, you would want to look at outcomes and you would want to look at outcomes over a period of time to see how a service is performing?

A. Yes.

Q. Bullet point 2:

"How does safety performance compare to other similar services?"

So you would want to carry out a comparison with like services?

A. Yes.

Q. 3:

"Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and

externally?"
Now, the reference to reporting externally safety incidents, that would be reporting externally to whom?
A. NRLS, STEIS. At the time the Clinical Commissioning Group; those sorts of people.
Q. Now, in respect of those first two entries:
"Safety performance over time, how does safety performance compare?"
Did you obtain evidence as to the safety performance over time or the comparison with like units?
A. That was the intelligence that the CQC analysts provided.
Q. At page 19 of this document, please, under the heading "Effective":
"Requires further investigation ..."
Sorry, two boxes down, in bullet points "NRLS incident" and that is not restricted, is it, it doesn't say "only moderate"? That has an NRLS incident and then secondly STEIS -- Serious Incident, STEIS, Never Events.
So in order to assess in the "effective" category this document is suggesting that you look at the entries on those reporting systems or you obtain evidence of the entries?
A. But all those incidents that would be going to NRLS and STEIS would be part of the multiple incidents

that were reviewed as part of the spreadsheet.
So they would be on the incident spreadsheet, they would then be reported -- those that required reporting would then be reported up to NRLS or STEIS.
So they should have already been part of the incident spreadsheet.
Q. Yes, you reviewed the incident spreadsheet. It doesn't identify does it whether any of the entries were reported to NRLS or STEIS?
A. Not that I am aware of,, that I can remember.
Q. When I was asking you earlier about the STEIS report in respect of Child D, your recollection was that you were unaware that there had been a report to STEIS in respect of Child D?
A. Yes.
Q. You were unaware of the reports in respect of several children to NRLS?
A. Yes.
MR CARR: My Lady, that would be a convenient moment for a break, if it pleases you?
LADY JUSTICE THIRLWALL: Thank you very much indeed. So we will take a break now and we will come back in at 20 to.
(11.21 am)
(A short break)

(11.40 am)
LADY JUSTICE THIRLWALL: Mr Carr.
MR CARR: Thank you. I asked you about the document dated December 2015, the pre-inspection document and I took you to what you said about Never Events being reported and you mentioned that there had been an update from the December document to the intelligence briefing. I just want to get that intelligence briefing back up, it's INQ0103620.
So that we can understand the purpose of this document, it appears to be a PowerPoint presentation for, a presentation on 16 February, the first day of the inspection visit?
A. Yes.
Q. It would be a presentation to who?
A. To all the inspection teams.
Q. And so the Specialist Advisers would see this?
A. Yes.
Q. Would they be given a copy of it as well or would it just be on the screen?
A. I don't know, to be honest.
Q. If we go to the section dealing with Children and Young People's Services the summary of intelligence is takes up only two pages. Page 27. We see the first bullet point there:

"No Never Events or Serious Incidents reported up to January 2016."
So although it is right to say that the December 2015 document was updated to January 2016 --
A. Yes.
Q. -- it still has the same omission, doesn't it?
A. Yes.
Q. The summary of intelligence doesn't include, does it, any entries from the National Reporting and Learning System?
A. No.
Q. Thank you. We can take that document down. There is a pre-inspection briefing pack which presumably was provided to you and Specialist Advisers which set out the key lines of inquiry to explore?
A. Yes.
Q. I am not going to take you to that, I am going to move forward, please, to the inspection itself. Now, ahead of the inspection, a week before, there was a listening event for patients on 9 February 2016, but as I understand it you didn't attend that?
A. No.
Q. Did you receive any feedback of any issues raised at that meeting?
A. Not that I remember.

Q. There was a briefing inspection -- sorry, an inspection briefing session on 10 February but again I don't think you attended that?

A. I can't remember, to be honest.

Q. As to interactions with the Special Advisers, did you meet or have any discussions with the Special Advisers before turning up at the hospital for the inspection?

A. I can't remember but my usual practice was to telephone the Special Advisers just to introduce myself. That was my usual practice. I can't say for sure whether this happened at the Countess of Chester.

Q. Now, the visit, the planned visit occurred over three days: 16, 17, 18 February?

A. Yes, and if I am correct, possibly on the Friday, the -- possibly the 19th as well if -- I am trying to think. That inspection week tended to be three and a half days for the CQC staff, that's generally what happened, you would have three days with the SPAs and then I am sure the CQC staff were around until the Friday lunchtime.

Q. 16 February you did a walk through the neonatal unit with Yvonne Farmer?

A. Yes.

Q. You also did a walk through the paediatric

unit, so the 16th was walk around the units and getting familiar with the hospital?

A. And collecting evidence as we went, so any observational evidence, perhaps cleaning checklists, anything -- anything that was obvious from an observational perspective.

Q. On 17th and 18th you conducted a number of interviews. Now you have described those in your statement at paragraphs 88 to 108: I count 16 interviews in total and some interviews with were multiple members of staff?

A. Yes.

Q. Now, at paragraph 113 of your statement, please, you state:

"I did not discuss concerns about an increase in neonatal deaths with any of the interviewees."

Paragraph 114:

"I did not discuss concerns about unexplained or unexpected deaths with any of the interviewees."

Is the position that you didn't discuss unexplained or unexpected deaths at all?

A. We discussed mortality and morbidity in the process, not specifically unexplained or unexpected deaths.

Q. So there's no discussion of neonatal

mortality?

A. Yes, discussions on neonatal mortality, absolutely. In the lead, in the service leads' interviews we discussed neonatal mortality.

Q. I am going to take you to those notes in a few moments, but that was a discussion of Mortality and Morbidity Meetings, there was no discussion, was there, of mortality rates, the experience of mortality at the hospital?

A. Nothing, no, nothing like that.

Q. No discussion of incidents of unexplained and unexpected deaths at all, so not simply there was no discussion of concerns; the topic of unexpected and unexplained deaths was not discussed?

A. No.

Q. None of the entries in the table of paediatric incidents that I have taken you to concerning death, none of those were discussed?

A. Not specifically.

Q. And nothing on the NRLS or STEIS concerning deaths was discussed because you weren't aware of those entries?

A. No, because all the entries -- any entries to NRLS and STEIS would have come from the incident table. So --

LADY JUSTICE THIRLWALL: Sorry, would you mind just saying that again because there was noise.

A. Certainly. The NRLS and STEIS reports would have come from the incident table. So all the incidents in the table, those that were required would have then gone to NRLS or STEIS.

MR CARR: Turning to the discussion of -- forgive me, my Lady.

LADY JUSTICE THIRLWALL: Yes, sorry do go ahead.

MR CARR: Thank you. Turning to the discussion of Mortality and Morbidity Meetings that you have described. Can we have on screen please, INQ0017339. Page 206.

These are your notes of a meeting, aren't they?

A. Yes.

Q. And this was a large meeting as we can see in that there were a number of attendees, we can see in the middle of the page the box for attendees, we have Dr Brearey, Dr Jayaram, Anne Murphy, Sarah Jackson, Gill Mort, Karen Townsend, Karen Rees and Eirian Powell?

A. Yes.

Q. This was a meeting I think you described it as a team leads meeting?

A. A service leads meeting, a core service leads meeting.

Q. All three of the -- or rather you as the inspector and the two Specialist Advisers all attended this meeting?

A. Yes.

Q. The discussion that you have referred to, which was of Mortality and Morbidity Meetings rather than neonatal mortality, we see your notes of it at page 207. It is the bottom third of the page, I know you have translated this in your witness statement, it's difficult to read.

Can you help us with that section?

A. Certainly. So Mortality Morbidity Meetings we discussed, there was five from the neonatal unit last year, four this year, with obstetricians and midwives.

Neonatal mortality, two last year depending on the cases to be discussed. Two paediatric mortality meetings numbers were fairly small. Majority were teenage suicides for the last meeting. Awaiting an action plan from a serious case review, cases were reviewed by the Cheshire and Merseyside Neonatal Network and peer review and monthly governance meetings, paediatric, neonates, obstetricians, gynaecology and governance board.

Q. If we can zoom out, there is a note on the right in the margin of that box to the bottom right

text.

Yes. Can you tell us what that says?

A. The leads told us that the neonatal meetings hadn't happened as frequently as they would have liked but they were back -- back on track now.

Q. Thank you. If we can go back to the main box then and zoom in and just try to understand this. We can zoom in. The "times 5 from NNU last year, time 4 this year", so that's referring to Mortality and Morbidity Meetings?

A. For the Perinatal Mortality Meetings so with the obstetricians and the gynaecologists -- obstetricians and the midwives, I beg your pardon. Then neonatal mortality was separate and they were two from last year.

Q. So your understanding was that there had been two meetings last year and the numbers of meetings were fairly small?

A. For the neonatal unit.

Q. Did you enquire as to how many cases were being discussed at these meetings?

A. No.

Q. Did you ask any questions as to the themes emerging from these meetings?

A. No, I don't think we did here.

Q. You make the point and we can take that down you make the point -- thank you -- at your statement paragraph 93, that when describing that section of the notes I just took you to you say:

"I would like to be clear again here that there was no mention of an increase in deaths. If such an increase had been raised this would have been recorded in my notes and further enquiries would have been raised."

The point you are making is when looking at those notes, the discussion is about meetings rather than about mortality rates?

A. Yes. I'm sorry, can you tell me what paragraph you are referring to again?

Q. Forgive me, it is paragraph 93 of your statement, which is at page 16. If you look at paragraph 93 and go four lines down.

A. Yes. So it wasn't specifically deaths, it was about the process of reviewing mortality and morbidity.

Q. Yes, the point emerges here and it emerges in other parts of your statement that I have already taken you to is that at no point during your visit were you told about any increase in neonatal mortality; that is your recollection, isn't it?

A. Yes, that is right.

Q. You weren't told about any concerns about an increase in neonatal mortality?

A. No.

Q. You weren't told about any concerns about incidents of unexpected and unexplained deaths?

A. No.

Q. You weren't told about any concerns as to a correlation between those incidents and a member of staff?

A. No.

Q. Concerns about potential deliberate harm by a member of staff?

A. No.

Q. Did you ask any of the interviewees questions directly related to neonatal mortality?

A. Only insofar as neonatal mortality and morbidity in the process, as far as I can remember.

Q. So is the answer to the question no?

A. No.

Q. Was -- particularly we have looked at the guidance to key lines of inquiry, to report writing, the focus on safety performance. Wasn't discussion about an outcome like mortality, wasn't that important to discuss in order to assess the safety of the unit?

A. I think by discussing the process and how the

Trust assured themselves that they were assured was part of that, about that safety process. How they investigated, reported, investigated, reviewed and assured themselves that mortality and neonatal morbidity was being reviewed, investigated as appropriate.

Q. We know that there were concerns on the unit about the increase in mortality. I have already asked you questions about the Thematic Review and the internal review.

Did you or your team ask any questions that you consider should have elicited that information?

A. I think discussing neonatal mortality and morbidity would -- should have elicited some information about if there were any concerns or any increase. That would have been the opportunity for that to be raised.

Q. If I understand your answer correctly I think what you are saying is: well, we were having a discussion about neonatal mortality within the context of meetings and so the Thematic Reviews being relevant to that, it should have been volunteered at that stage?

A. It wasn't just about meetings, though; it was about the whole mortality morbidity process. So it was about how, how they approached neonatal mortality morbidity. So although meetings were mentioned and the number of meetings, that would have been the opportunity

to -- to advise that there was -- there were concerns, there had been an increase, that there was a Thematic Review had taken place. But that was the opportunity.

Q. Yes, that was an opportunity for it to be volunteered, but my question is slightly different. My question is: did you or your team put questions to the interviewees to which you think the answer ought to have been or should have been: we have these concerns, there's been this Thematic Review?

A. Not -- not direct questions as far as I -- I -- from that meeting, from the statements I have read and the notes I'm not sure if one of the Special Advisers actually spoke about mortality but that's from reviewing the evidence.

Q. My question wasn't restricted only to that interview with the team leads. My question was in respect of your entire -- your entire period during the inspection, so in any of the interviews.

A. My understanding is that one of the Special Advisers discussed mortality.

Q. Do you, or did you, once you worked at the CQC, find that there could be a reticence or a reluctance amongst staff who were being inspected to volunteer difficulties or concerns that they were having of their own volition?

A. On some occasions.

Q. You have made the point in respect of documents you would expect to see and I asked you earlier about information relating to increases in neonatal mortality and unexpected and unexplained deaths. In your statement you said you had hoped to see it and when I asked you questions about it, I think to summarise your evidence, the position was: well, you would expect to see it, but some hospitals don't send it?

A. (Nods)

Q. In those circumstances, and given the reluctance that can sometimes occur, wouldn't you ask, for instance, open questions to interviewees that might give them an opportunity or encourage them to volunteer information such as: is there anything causing you concern at the moment?

A. Yes.

Q. Did you ask that question?

A. I think in, in -- from my -- from my recollection in the interviews I -- I used to conduct with staff, I would very much, I would ask: is there anything you're particularly proud of, is there anything you could do better? Is there any -- and I always used to finish the interviews with: is there anything else

you think we should know, anything you would like to tell us?

And that --but that wouldn't specifically be about neonatal mortality. It would be about --it could be about anything.

And I think that's where a lot of the concerns regarding staffing were raised and if I remember rightly, one of the interviews from the paediatric department, the information that came that occupancy -- bed occupancy rates weren't always accurate as they could be because of how they were -- how they were checked -- the time of day that occupancy rates were -- were assessed.

So certainly at the end of every interview, it very much there was an opportunity for whoever we were speaking to or I was speaking to for them to -- to -- and like I say it wouldn't necessarily be about safety. It could be about -- about staffing, it could be anything. It could be about facilities, it could be about equipment, it could be about training.

There was an opportunity at the end of the interviews for whoever we were -- I was interviewing to tell us anything that they wanted us to know.

Q. Yes, so that catch-all question gave an opportunity for interviewees to raise concerns?

A. Yes, and that was -- I -- that was a standard way to -- to sort of finish an interview.

Q. Would you ask a more pointed catch-all question such as, rather than "is there anything you want us to know?", "is there anything that concerns you? Is there anything you are investigating at the moment?"

A. I certainly wouldn't have said "investigating". I may have said "concerns". But I would have also said "or anything you are particularly proud of?" Because the inspection process isn't just about finding things that perhaps aren't as they should be but also it's to give a complete and accurate picture of a Trust's performance, whether that be positive or a negative. So it's an overall picture.

Q. If we can on screen, please, INQ0017339.

Now, at paragraph 99 of your statement, you describe your interview with Eirian Powell and we will need to go forward, please, to page 200 of this document.

Subparagraph (i) of paragraph 99, you say that:

"One of the points discussed was a positive relationship with doctors."

Are you able to expand on nature of that discussion? And you may want to do so by looking at these notes, they are difficult to read, I think the

relevant part might be the second half of the page.

A. Yes. And it was -- the feedback was that there was a positive relationship between the nursing staff and the Consultants, that it was a positive working relationship. And actually they also -- she also said that working -- there was a positive working relationship with maternity and obstetrics and gynaecology.

Because while maternity and children and young people were different services, actually the maternity service sort of provided the patients for the neonatal unit so -- so it was -- although they were different core services, it was important that they worked well together.

Q. Thank you. We can take that down. There is evidence that we will be hearing in due course about a focus group of the Consultants and I know that you weren't present at that focus group. There is some evidence to suggest that at the focus group issues were raised as to a bullying culture and an oppressive air at leadership level.

In the course of your interviews and your inspection, did you hear any concerns of that nature?

A. No.

Q. At the end of the inspection visit, how do the

Specialist Advisers, if they do, how do they give you their specialist advice or their views, is there a debrief?

A. At the end of every day on site, the whole -- the whole team came together for corroboration and each core service would feed back any sort of high level findings that they had. But prior to that, the core service lead on the Special Advisers would get together to discuss what -- what their findings were because not all interviews were conducted with all three members of staff. We would all go and visit speak to different people and come back and feed back and then at the end of every day, the core service lead would collect their note-taking templates to go through that evening.

Q. Is it predominantly a verbal feedback session or do they provide written analysis or --

A. No.

Q. -- written documents --

A. No, it was verbal, to support what was already in the note-taking templates.

Q. Now, in the course of the preparation of the report and prior to the publication of it, there was a meeting on 26 May 2016, an NQAG meeting which you attended?

A. Yes.

Q. There was some discussion of a possible inadequate rating --

A. Yes.

Q. -- in safety for Children and Young People's Services. But ultimately we can get the report up, it wasn't an inadequate rating.

Can you address the concern that there was in the debate as to whether there should be an inadequate rating or not?

A. Could I have a look at the meeting minutes?

Q. It's INQ0017295, at page 10.

The fifth column "High level ratings indicators".

We see "panel" --

A. Yes, yes. And that was about whether there had been an inadequate rating considered due to the concerns found. So staffing was -- was a major consideration and the lack of advanced paediatric life support staff at night on the paediatric unit.

So that was the reason for this meeting is to challenge the evidence, to speak with the inspector to find if, how -- how they had got to their determination even though they had read the report and it's, we discussed about whether it should be "requires improvement" or "inadequate" and my position, having been on site was that there were significant issues,

particularly with staffing in both the neonatal unit and the children's and paediatric services.

However, risks were mitigated, managers were aware of the risks, and were actively -- had actively described scenarios and experiences that they had moved to to mitigate that risk. They could describe actions that were being taken.

So my view at that point was that managers we had spoken to were aware of the situation, and were actively trying to address and mitigate any risk.

Q. So the decision was made and it's reflected in the final report, which we can now look at, that "safe" would be graded "requires improvement"?

A. Yes.

Q. The INQ reference 0017433 at page 106, please, so this is the section that you drafted, isn't it?

A. Yes.

Q. From page 106, Services for Children and Young People.

"Safe" "requires improvement" but everything else ranked good?

A. I'm, sorry say that again?

Q. "Safe" has been graded "requires improvement"?

A. Yes.

Q. Everything else has been graded "good"?

A. Yes.

Q. The overall grading as well is "good"?

A. Yes.

Q. If we go forward to page 107, we can see in the text on the right of the page, when addressing safety under "requires improvement" a number of bullet points explaining why there was a "requires improvement" grading. Again it's mainly staffing issues, isn't it?

A. Yes.

Q. Do you want to summarise the basis for the finding "requires improvement" as set out there?

A. The paediatric staffing, the staffing on the paediatric unit didn't reflect our Royal College of Nursing guidance and the neonatal unit didn't follow British Association for Perinatal Medicine guidance for staffing on a number of occasions. It was a risk on the Risk Register and staff had told us throughout that staffing was a concern for them.

Q. If we can look, please, at page 108, left-hand side, under the -- this is the second bullet point on the left under the term "however" there is a section there about:

"... incidents being reported appropriately with the majority being 'low' or 'no harm'."

I have asked you many questions on that, that

table. Your evidence, as I understand it, is that that categorisation was tested by you looking at three particular examples --

A. Yes.

Q. -- and determining that their categorisations were correct?

A. Yes, but not just the categorisation, it was actually the fact that the reviews were conducted and investigated appropriately. So it was about incident reviews.

Q. Under the heading "Incidents" on that page on the left-hand side, second bullet point?

A. Yes.

Q. "No Never Events or Serious Incidents reported" -- well, you have seen the entry on the first STEIS, so that remains, doesn't it, carries over from the other CQC documents that we have seen, that remains an error?

A. That is the information that was provided in the intelligence briefing and the previous draft of the -- the data pack.

Q. There is no discussion in this report, is there, of mortality -- of neonatal mortality at the unit?

A. Not specifically. There's obviously

a neonatal mortality process, but not rates of neonatal mortality, I don't think.

Q. We can take that document down.

Now, moving away from the inspection and perhaps a short point. You were subsequently involved with the Trust in 2017 in the monitoring rather than the inspection side --

A. Yes.

Q. -- of CQC regulation, you became for a brief period the regulation owner?

A. Relationship owner.

Q. Relationship owner, sorry, forgive me.

A. Yes.

Q. You attended an engagement meeting and that was in December 2017 and a management review meeting in November 2017?

A. Yes.

Q. Now at that point, the CQC were aware that a police investigation was under way --

A. Yes.

Q. -- and that had been communicated by the Trust?

Were you aware that the police investigation was into or arose out of concerns and suspicions relating to a member of staff and deliberate harm by that member of

staff as at November 2017?
A. I think possibly then, yes, I think.
Q. Dealing finally, then, with some reflections. Dealing finally with some reflections, looking back particularly on the inspection.
The CQC inspection did not detect the concerns that we know existed at the neonatal unit. What is your explanation for the failure to detect those concerns?
A. I think some of it is the -- the data, the -- the there is always a lag with data and sources of data so I think that is -- is an issue is a consideration. And I think very much the on-site inspection you can ask a lot of open questions, a lot of general questions but you are very much reliant on -- on people's responses.
MR CARR: Thank you, my Lady, I have no further questions for this witness.
LADY JUSTICE THIRLWALL: Thank you. Mr Deakin, do you have any questions? No, thank you.
Ms Cain, just one or two from me.
Questions by LADY JUSTICE THIRLWALL
LADY JUSTICE THIRLWALL: You have mentioned a number of times the intelligence and that comes to you from the data analysts?
A. Yes.
LADY JUSTICE THIRLWALL: Just so I have understood

this: it's they who should have picked up the reports to the NRLS?
A. My understanding is that they, they review, yes, and they bring that data together ahead of an inspection to provide to the core service leads.
LADY JUSTICE THIRLWALL: And so the purpose of the data analysts really is to save the team the effort of looking for that information, I don't mean that in a disparaging way.
A. No.
LADY JUSTICE THIRLWALL: But that is their role?
A. Yes.
LADY JUSTICE THIRLWALL: Then they then present it to you?
A. Yes.
LADY JUSTICE THIRLWALL: But they are still part of the CQC process?
A. Yes.
LADY JUSTICE THIRLWALL: What explanation is there for the fact that there was no reference to the NRLS in the intelligence pack?
A. I'm sorry, I don't know, I can't answer, I don't know what the explanation would be.
LADY JUSTICE THIRLWALL: What's the process for quality assuring the data analysts, do you know?

A. Again, I'm sorry, I can't answer, I don't know.
LADY JUSTICE THIRLWALL: Do you know anything about their background, what actually their qualifications are, what their instructions are.
A. No, I'm sorry, I don't. I'm sorry.
LADY JUSTICE THIRLWALL: So you are just -- I don't mean "just", but you are the passive recipient of what they tell you?
A. Yes, of the data they provide, yes.
LADY JUSTICE THIRLWALL: Thank you.
On a second related point, we looked at a slide with colours of the Countess of Chester's own self-assessment of how they were doing and I know earlier in the evidence I think from someone working in risk in the hospital, we saw a form that had been filled in in some detail, a sort of self-assessment.
This is obviously a different thing. I want to know whether you know that whether the document with all the colours on came from the Countess or again was something that was produced by the data analysts having analysed the data from the Countess?
A. The self-assessment?
LADY JUSTICE THIRLWALL: Yes, the one with all the colours on, yes.

A. That would have come from the Countess of Chester.
LADY JUSTICE THIRLWALL: In the colours?
A. That was their self-assessment as part of the Provider Information Return, as far as I am aware.
LADY JUSTICE THIRLWALL: That is what you would have assumed it was?
A. That was their self-assessment, yes.
LADY JUSTICE THIRLWALL: Yes, certainly, I just wanted to make sure that it wasn't a sort of a restatement of it in a slightly different form by a data analyst?
A. No, my understanding is each Trust prior to inspection rated themselves, assessed themselves against the domains.
LADY JUSTICE THIRLWALL: I see, thank you, that is helpful.
Mr Carr asked you a number of times about the difference between what you would expect and what you would hope. Can I just check that my understanding is correct?
So your professional expectation would be that the information that you were then being asked about would be and should be provided?
A. Yes.

LADY JUSTICE THIRLWALL: And the reason you expressed it, sometimes as hope, is because experience has shown you that people do not always provide the information that you would expect as a matter of professionalism?

A. Yes.

LADY JUSTICE THIRLWALL: Why do you think they do that? Why do they hold back?

A. Pardon?

LADY JUSTICE THIRLWALL: Why do you think they hold back?

A. I think some Trusts would rather you find out -- find it for yourself. I think some, as with perhaps the self-assessment here, they want to show themselves in the best light possible. And some Trusts are better than others at acknowledging their risks and challenges.

My experience was certainly as a relationship owner for other Trusts you would have one Trust who every time there was something significant rather than waiting to -- for me to detect it on NRLS or STEIS, they would phone up and say: we are declaring a Serious Incident, this is what's happened, this is what we are doing about it immediately, as soon as we have our Serious Incident report, we will pass it to you. Others --

LADY JUSTICE THIRLWALL: Would that be between inspections?

A. Yes, and that would be the relationship owner.

LADY JUSTICE THIRLWALL: I see.

A. So if I was a relationship owner for a Trust, I actually had one Trust who would pick up the phone, very transparent, this has happened, this is what we are doing about it immediately, the rapid review or the SBAR, the investigation report, and these are the measures we have put in place immediately.

Other Trusts you would wait, it would wait and you would find it on NRLS or STEIS.

So two very different approaches in the relationship with the Care Quality Commission.

LADY JUSTICE THIRLWALL: Just to go back to my earlier question, would the relationship owner as a matter of course be checking NRLS in respect of the hospital with whom they had the relationship?

A. Yes.

LADY JUSTICE THIRLWALL: Thank you. Those are my questions. Mr Carr, do you have anything else?

MR CARR: No I don't, thank you very much.

LADY JUSTICE THIRLWALL: Thank you very much, you are free to go.

A. Thank you.

MR CARR: My Lady, the next witness is Dr Odeka, may I call him.

LADY JUSTICE THIRLWALL: Sorry, Dr Odeka, I didn't see that you had arrived. Do come forward.

DR BENJAMIN ODEKA (sworn)

Questions by MR CARR

LADY JUSTICE THIRLWALL: Do sit down.

MR CARR: Can you provide your full name, please?

A. Dr Benjamin Odeka.

Q. You have prepared a witness statement for this Inquiry, haven't you, and it's signed and it is dated 10 June 2024?

A. Yes, yes.

Q. The contents of that witness statement, are they true to the best of your knowledge and belief?

A. Yes.

Q. You give evidence in that statement, don't you, of your professional background, you have been a Consultant in paediatrics and gastroenterology since 1994?

A. That's correct, yes.

Q. You describe at your paragraphs 3 and 4 a variety of academic posts and positions of responsibility?

A. Yes.

Q. That includes being a tutor at the University of Manchester from 1994 to 1996, a Clinical Director of paediatrics for eight years, a clinical area lead for paediatrics for two years, a Divisional Medical Director and Associate Medical Director for Women's and Children 2006 to 2009?

A. Yes.

Q. And you have particular experience in safeguarding, having chaired the Safeguarding Group for the Child Health Division?

A. Yes.

Q. So far as your role with the CQC you explain at paragraph 5 of your statement that you have assisted with CQC inspections since June 2014?

A. Yes.

Q. The 2016 inspection at the Countess of Chester Hospital with which we are concerned, you think was your fourth such inspection?

A. Yes.

Q. You were a Specialist Adviser --

A. Yes.

Q. -- on that inspection and that's distinct from a CQC inspector, isn't it?

A. Yes.

Q. Do you want to explain the difference in the

roles, as you understood it?
A. As a professional adviser, we or for myself were meant to give a professional slant and support to the CQC interpreting medical issues that they might encounter during inspections and to make the inspections more clearer in terms of interpreting medical issues they encounter during inspections.
So in short it's just to advise them on medical issues picked up at inspection using their templates of inspection but to put a medical angle to it.
Q. The role isn't simply advisory, is it, you are an active participant, you partake in interviews during the inspection?
A. Yes.
Q. There were some interviews, judging from the notes, that you undertook alone, so without the other two?
A. Yes.
Q. Specialist Adviser and CQC Inspector?
A. Yes.
Q. And the division appears to have been you focused more on interviewing doctors, whereas the other Specialist Adviser, who was a nurse, she did more of the interviews with nurses?
A. Yes, that's correct.

Q. Was there any training that you received from the CQC or elsewhere for the Specialist Adviser role or was it unnecessary?
A. There was a brief training. It's -- it wasn't a detailed training as such but you had introductory training of induction and explained to us what the role was and I think what they did was they looked at our background to match what they expected from us to the role and that formed the basis of the short training that they gave us.
Q. I wanted to turn now to the documentation that you receive ahead of and for the purposes of an inspection visit and you explain in your statement the information you receive is quite limited, isn't it?
A. That's correct. Yes.
Q. You don't receive the Provider Information Return?
A. No.
Q. Or the documents submitted as part of a Provider Information Return and you don't receive the response to data requests --
A. No.
Q. -- from a Trust?
A. No.
Q. And what you say at paragraph 10 of your

statement is:
"As a Specialist Adviser I would ordinarily expect to receive the following information in advance of an inspection: information regarding the venue, the reason for the inspection, the focus of the inspection from CQC, any particular areas of concern or red flags to be aware of."
A. That's correct.
Q. You are aware that the CQC will gather a lot of documentation for the purposes of an inspection?
A. Yes.
Q. Also as part of their ongoing monitoring?
A. Yes.
Q. But that doesn't get provided to you as a Specialist Adviser?
A. No.
Q. At paragraph 13 you say:
"Provider Information Returns and data requests were matters for the CQC Inspectors. I would only receive information which CQC and in particular the CYP inspection lead ..."
And that is Children and Young Person's Services inspection lead --
A. Correct.
Q. -- Helen Cain "consider to be relevant."

So you did understand there to be a process that if there were particular documents which were a cause of concern or which called for specialist advice then you would see those?
A. I would -- I would be informed of such and subsequently I will be provided with such information if they deemed relevant and necessary.
Q. Can I try to understand, please, what it was that you were sent. So paragraph 42 of your statement, you describe, if you find it, receiving the information pack in advance of the inspection. You say it was received by email and you understand searches are ongoing within CQC to locate this email and its attachments.
Now, I want to see if we can identify that document. Have you subsequently seen a copy of the pack that you think you were sent?
A. I think I have seen a copy of it.
Q. Is it the intelligence briefing pack?
A. Yes.
Q. If we can get that document up, it is INQ0103620. So this is the document?
A. Yes.
Q. As I understand it, it was a PowerPoint presentation. Are you saying you would have been sent

it by email as well?
A. Sorry, this is not the -- this is not the one that is sent which is which contains the -- for the Women and Children's Division. It's not this one. This was -- this was a presentation at the -- on the day of the inspection itself, this was the intelligence presentation on the day.
Q. Okay, we can take that down. INQ0101422.
Now we have this document. It's labelled "Draft Pre-Inspection Document, 22 December 2015", the document that you are describing, is it --
A. This, yes.
Q. It's like this?
A. Yes.
Q. If we go forward, please, to page 5, we have a summary of analysis on this page into the next page -- I will go to the next page in a moment -- against the five domains of regulation: "Safe", "effective", "care" and "responsive" and "well led".
Now, this version of the document is dated December 2015. Do you believe that you received an updated version of this document or was this the one that you received for the inspection?
A. I can't -- I can't be very specific here, but it looked familiar but I am not, I am not very clear

about it. It's a long time now.
Q. And is it -- would it be typical for you as a Specialist Adviser for the information that you receive to be limited to this kind of document?
A. Yes.
Q. Would the extent of the information contained in such a document be similar in its scope to what's contained in this version?
A. Yes, maybe not as detailed but similar, yes.
Q. If, for instance, we take the "safe" section. Nothing in positive analysis, nothing in negative analysis. Then neutral analysis it says:
"No Never Events or Serious Incidents have been reported."
And we will come back to that.
There's another bullet point dealing with pressure ulcers and falls.
Bullet point 3 deals with questions in the children's survey. Now, the children's survey, is that a survey that goes out to patients?
A. Yes.
Q. Then bullet point 4, a comment on the staff skill mix. It seems quite light in terms of evidence that's been given to you as a Specialist Adviser ahead of going into inspecting a hospital to assess its

performance?
A. Yes. Can I -- okay, I think the answer is yes, but when we look at our inspection templates we are looking at -- looking at governance issues. So even if the information given not as robust as it should be, we have the -- I do have --we do have a template where we look at the overall picture using the key lines of inquiries to try and expand on that because we have the scope that we need to examine.
So even with limited information like this, we still have to go through the whole gamut of it.
Q. I have seen the inspection briefing pack -- and you can take this down now -- we can go to it if we need to, but that is a document which sets out the areas for the inspectors to probe at inspection, doesn't it?
A. Yes.
Q. It doesn't contain information about the actual Trust?
A. No.
Q. So for you as a Specialist Adviser you are not given access to the wealth of information that the CQC has and you are going into a hospital, you are given the analysis at the level which I have just taken you to, so a summary of four bullet points, one of which is a survey, one of which is staff skill mix.

There doesn't seem to be much that you can provide specialist advice on in terms of data prior to the inspection?
A. Correct, yes. It's not -- not detailed, not robust enough for inspection, yes.
Q. Now, you weren't given ahead of the inspection, were you, any information relating to neonatal mortality at this unit?
A. No.
Q. At paragraph 14 of your statement, you say:
"In my role as a Specialist Adviser I would not necessarily expect to receive information concerning neonatal deaths directly in advance of an inspection but would have such information if this was available to the CQC inspector."
And just so that I can make sure I am understanding that, is the point that you are making there: well, if the information has gone to the inspector then you would expect it to be shared to you but if the inspector doesn't have it, so if Helen Cain doesn't have that information, then she can't share it with you?
A. No.
Q. Is that the point you are making?
A. The point I am making is they might receive the details of neonatal deaths. That may not be given

to me directly, but mentioned as part of our inspection plan, if it's an area that needs to be looked at closer, then in that context, they also want to ask if the deaths have actually been reviewed appropriately and adequately and that's where I come in, to now advise on that, to see if the -- if the different enquiries have been made as to the reasons for deaths or the reasons for the issues raised in the mortality reports, so I think that is where I come in.

Q. Do you know who it is who makes the decision as to whether or not you as a Specialist Adviser doctor, with the experience that you described, should consider for instance data or evidence on neonatal mortality?

A. Sorry, I didn't quite -- can you just repeat the question again, please?

Q. I said who is it -- as you understand it, who is it that makes the decision about whether you should consider the data. So what you have described is the information comes in, the CQC will decide whether or not you need to see it, I am trying to work out who at the CQC makes that decision as to whether specialist advice is needed on data?

A. I think -- I think the lead inspector will be the person to do that because she will be the direct communicator with myself. If she had concerns or she

has data that she needed to be advised on, she would actually share it directly with me.

So if I don't have access to the data and the lead inspector has access to the data then she would actually ask me if she has any issues to raise.

Q. You comment again paragraph 14 it is the last sentence, that your expectation is that that information would essentially be filtered down to you if there was a concern which you have addressed or if it was a red flag issue and there's a number of ways in which there can be concerns or red flags about neonatal mortality, aren't there?

A. Yes.

Q. One issue might be: well, if the unit or the hospital was an outlier?

A. Yes.

Q. Another might be if there was a significant increase in mortality beyond what is usual for that particular hospital?

A. Yes.

Q. If the doctors themselves had concerns about the increase?

A. Yes, that is useful information.

Q. If there were incidents of unexpected and unexplained neonatal deaths?

A. Yes.

Q. If there were concerns about the correlation between a member of staff and those unexpected and unexplained deaths and suspicions of potential deliberate harm?

A. I'm not sure -- I am not -- it might be mentioned but I'm not sure if that's -- that will be something that will be discussed in such meetings.

Q. Well, I am asking you about the circumstances in which you would expect details about neonatal mortality to be communicated to you as a red flag and I am suggesting those factors that I just went through would all be red flags where you would expect it to be communicated to you?

A. Yes.

Q. At paragraph 17, you say:

"In respect of unexpected and unexplained deaths I would expect CQC to be informed about unexpected or unexplained neonatal deaths that these would be identified at local level, ie within a particular hospital. Unexpected or unexplained neonatal death could still be a red flag even if the hospital's overall statistics remained within the regional or national trends. If an unexpected or unexplained neonatal death was identified as a red flag I would expect this

information then to be filtered down to me through the Children and Young People's Inspection Lead."

Now, is the point that you are making there is that even if the statistics on death might not constitute an outlier, if you suddenly have, particularly within a neonatal unit, incidents of unexpected and unexplained deaths, that in itself is a red flag?

A. Yes, it will be, yes.

Q. You have seen for the purposes of preparing your evidence for this Inquiry the Thematic Review carried out in February 2016?

A. Yes, please.

Q. The review by Dr Brigham in November 2015. Both of them identify an increase in neonatal mortality at the unit. In light of that and the concerns we know that there were, that is information that -- or do you think that is information that the Care Quality Commission and your team should have been provided with?

A. Yes.

Q. At paragraphs 46 to 48 of your statement, you address the spreadsheet of neonatal incidents that was provided to the Care Quality Commission by the Trust as part of the data for the inspection.

Now, because of the sensitive third party information in that document, I am not going to put it

on screen. But you are familiar, aren't you, with the document that I am referring to?
A. Yes.
Q. It is a table with some entries marked and colour coded by the degree of harm?
A. Yes.
Q. Green for no harm. Yellow for low harm?
A. Yes.
Q. That is a document that you did not see prior to preparing the evidence here?
A. Yes.
Q. It wasn't shown to you by the CQC or by Helen Cain?
A. No, it wasn't shown.
Q. There was no discussion with you by anybody at the CQC about that table?
A. No, no discussion.
Q. Or the contents of it?
A. No.
Q. You have reviewed it to prepare your statement.
Now the first question is this: would you expect all neonatal deaths at the unit to be included on a table like that?
A. Yes.

Q. Now, there are on my calculation eight entries in the table involving death, all of which are marked green -- coloured green and marked "none" in the "Actual harm" column.
This is something that you were asked to address in your statement and you say at paragraph 46:
"On the face of the document the categorisation of incidents involving neonatal deaths as 'none' in the 'Actual harm' column immediately strikes me as inaccurate; clearly a neonatal death is a significant event. It appears that this may be due to the data being input into the Datix system incorrectly. However, I would need to see the key which was used to inform the recording of incidents in order to comment more categorically on whether the non-categorisation for actual harm was incorrect."
So immediately striking that those entries are marked green for "no harm".
If this document had been shared with you, or if you had been asked questions about it, what would you have done?
A. I would have checked the entry itself and enquired about the decision or the reason behind the decision. But having looked at that particular entry, I think I have some idea as to why they have categorised

it in that fashion.
Q. So had you received the table it's something that you would want to investigate and test the categorisation of?
A. Yes, yes.
Q. Is that something that you would explore at the interviews?
A. The interviews was -- excuse me, was to confirm that the entries --
Q. Yes.
A. -- and also to speak to the -- the managers -- when I mean the managers, those who actually lead in governance, produce that document. Then I would explore what they have done about it and to see if the actions they have taken, if it's in line with good practice and if it also addresses the issue and if there are any lessons to be learnt from those.
So it's the process I would be interested in looking at and that would be something that CQC would be interested in in terms of making a decision.
Q. But the point is because it strikes you as inaccurate, that would be something that you would want to look into to --
A. Yes.
Q. -- find out what's happened --

A. Yes.
Q. -- and assess whether it is appropriately categorised or not and investigated. Is that correct?
A. Yes, that is correct, yes, sir.
Q. Your paragraph 47C, just to take one example, if we may, you address there the entry on that table concerning Child A and that's entry 188 in the table.
Now in the table, the details of the incident are given as: sudden and unexpected deterioration and death of a patient on the neonatal unit after full resuscitation requiring postmortem.
Now, if you had seen that in advance and seen that it had been entered as a "no harm" or green for a no harm entry, is that a particular incident that you would want to explore as part of your inspection?
A. Yes.
Q. There are a number of features here. One the fact that it is a Sudden and Unexpected Death, so is that something that would ring alarm bells?
A. Yes.
Q. You have connected to that, don't you, that at the time of the entry, you have a cause of death that is unclear, it is awaiting postmortem?
A. That's right.
Q. So would you want to explore at the inspection

what the postmortem said and whether a cause of death had been established?
A. Yes, I would and obviously most of the deaths would have been referred to the Child's Death Inquiries so I would want to know the outcome of such inquiries.
Q. What would you explore based on that description? For instance, whether the SUDIC guidelines were complied with, would that be appropriate to your regulatory investigations?
A. Yes.
Q. But in the event of course you didn't see this table?
A. No.
Q. And there was no discussion of those events at inspection?
A. No.
Q. Now, there are two reporting systems which the Care Quality Commission track.
So there's the National Reporting and Learning System to which patient harm events are reported and there is the Strategic Executive Information System for Serious Incidents and the CQC has access to reports to those systems, doesn't it?
A. I can't answer to that because I don't know.
Q. You have seen, again as part of your

preparation for giving evidence to this Inquiry, you have seen spreadsheets showing reports by the Trust to those two systems, haven't you --
A. Yes.
Q. -- in the period --
A. Yes.
Q. -- covering that prior to your inspection?
Were you, for the purposes of the inspection or during the inspection, informed by the CQC of the reports in those table concerning children?
A. No.
Q. Do you think you should have been?
A. Yes.
Q. Were you aware, did it come up during the inspection that the death of Child D had been reported to the Strategic Information System for Serious Incidents and other events as an unexpected potentially avoidable death and as a Serious Incident due to a delay recognising sepsis?
A. No.
Q. Turning to the visit itself. You were involved in a number of interviews, weren't you?
A. Yes.
Q. As you have explained already, your focus was mainly on interviewing the doctors. You interviewed, on

my reading of the notes, you interviewed Dr Brearey?
A. Yes.
Q. Dr V, Dr Lowe, Dr Gibbs, Dr Cooke?
A. Yes.
Q. Sorry. You also took part in the large interview with the team leads with both of the other members of your inspection team?
A. Yes.
Q. When I said you interviewed Dr Brearey, that was an additional interview to the interview as part of the team.
So you would have seen him as part of the large interview, but you also had a separate interview with him?
A. Yes, that's correct.
Q. Turning to your statement, paragraphs 87 and 88 please. Paragraph 87, are you there?
"I do not recall discussing concerns about an increase in neonatal deaths with any of the interviewees. If this had been discussed I would expect it to be recorded in the notes."
Paragraph 88:
"I do not recall discussing concerns about unexplained or unexpected deaths. Again I would expect any discussion of this nature to have been recorded."

Just looking at both of those sentences. It's correct, isn't it, that it's not only that concerns about an increase in deaths or concerns about unexplained or unexpected deaths was not discussed. Those topics weren't discussed at all?
A. Not at all.
Q. We have already seen there was a discussion in the team leads' interview as to Morbidity and Mortality Meetings but not a discussion as to neonatal rates on the unit.
A. No.
Q. Sorry, neonatal mortality rates on the unit.
Wouldn't discussion of outcomes at the neonatal unit, including for instance mortality rates, instances of unexpected or unexplained deaths, wouldn't that be an important topic to explore for the purposes of assessing safety of the unit?
A. Yes.
Q. Why wasn't it explored?
A. I -- the -- the incidents reports is what triggers such discussions because we will get the reports of incidents, you look at -- we look at the way it's been investigated, the outcome and the processes involved in that. But since those information were not available to myself, it wasn't -- so all we will do it

in that instance would be to look at processes. So that discussion did not take place and that's the reason for that. That wasn't --

Q. So in the interviews that you attended --

A. Yes.

Q. -- were any of the interviewees asked questions about neonatal mortality?

A. No, it didn't come up in a discussion.

Can I just explain a bit there? Can I?

LADY JUSTICE THIRLWALL: Yes.

A. Right. The questions to the doctors, the trainees and also parents reflects around incidents reporting, that comes up in our discussion. Are incidents reported in the unit? And are they discussed? Are they properly done? And do you get feedback? So that's the prompt that triggers situations where they can come up with things.

So it's not that we go in and ask for specific cases. You look at the processes and the processes actually brings up things that we explored in detail and I think that that's the way the inspection format goes.

Q. You have suggested that having the information that you weren't provided with would have caused you to ask direct questions --

A. Yes.

Q. -- as to issues of neonatal mortality?

A. Yes.

Q. Because you didn't have that information, that's the reason you didn't ask direct questions?

A. Correct, yes.

Q. It wasn't volunteered by the interviewees in your interview sessions?

A. None of them.

Q. As an inspector and from your experience in healthcare more broadly, can there be a reticence amongst staff subject to an inspection to volunteer difficulties or concerns that they have without being asked?

A. They do. They do. Some, some do. Because even when you don't ask direct questions and if we go through the incidents reporting system and we say, "Do you report incidents and are they investigated and do you get feedback from the incidents reported?" it actually gets them to tell us things that they didn't volunteer initially.

So, yes, some of them do.

Q. Well, that's asking questions about reporting systems. What I am asking questions about more specifically is concerns about increases in neonatal mortality, instances of unexpected, unexplained death at

the unit.

Now, you weren't aware of that.

A. No.

Q. We know that there were concerns about that at the hospital. Did you ask any questions which, in your view, should have elicited that information?

A. The questions we -- that I asked generically should have brought that up.

Q. Such as?

A. Do you report incidents? Do you have a process of reporting incidents in the unit? And are the incidents, are they investigated? And do you get feedback from ...?

That's the standard process questions that we ask on incidents.

Q. Forgive me. That will tell you there is a process, but it wouldn't -- that question is not or might not elicit concerns about increased neonatal mortality.

Do you ask in an open sense: Is there anything in the unit which is causing you concern, anything that you are having to investigate at the moment?

A. I can't recall if I asked in that -- questions in that line.

MR CARR: My Lady, I am conscious of the time.

I probably only have a short amount more, but I am happy to break now if that's more convenient.

LADY JUSTICE THIRLWALL: It's probably a bit more convenient for the witness if we continue and finish. How much longer do you think?

MR CARR: About five to 10 minutes. Is that all right if we continue?

A. Yes, yes.

LADY JUSTICE THIRLWALL: Yes, let's do that, Mr Carr.

MR CARR: Thank you.

We have seen and you have been shown notes regarding the Consultants' focus group as part of the inspection. You weren't at the Consultants focus group, but one of the themes that emerged from that group was a bullying culture.

In the course of your discussions with interviewees, were any concerns raised with you about a bullying culture?

A. No.

Q. Were any concerns raised with you at all by any of the Consultants that you spoke to, any of the doctors you spoke to?

A. Not that I can recall. Anything different from the report I have already -- is in my statement.

Q. Paragraph 100 of your statement deals with feedback that you provided to the Children and Young People's Inspection Lead, so that's Helen Cain, based on your findings at the inspection.

Now, does your role come to an end at the end of inspection week?

A. That's right, yes.

Q. And so what you are describing here is the feedback that you give to Helen Cain, who will then go on to prepare the section of the report?

A. That's right, yes.

Q. When you say you provided a narrative, was that in writing or was that verbal?

A. We do have a verbal discussion. Then we will give, we provide our written notes, all the recorded interview notes, we hand everything over at that time in addition to the --

Q. Do you recall what your feedback was?

A. Sorry, can you repeat that again?

Q. Do you recall what your feedback was? You said, you say in your statement you provided a narrative based on your findings at the inspection.

What were the issues that you raised with her?

A. The -- sorry, I couldn't quite hear that.

Q. It's paragraph 100.

A. Yes. Please.

Q. "I provided a narrative to the CYP inspection lead based on my findings at the inspection."

A. Yes.

Q. I am asking if you can help us to understand what that narrative was. What did you tell her?

A. Just the findings.

Q. Which were?

A. Which were the things written in my notes, all the things.

Q. The interview notes that we have?

A. Correct. Because I would have told her the key findings. And in the front of the notes there is usually a summary. I usually summarise the key points, so the key points would have been discussed with her.

MR CARR: My Lady, thank you. I have no further questions for Dr Odeka.

LADY JUSTICE THIRLWALL: Thank you. Mr Deakin.

MR DEAKIN: My Lady, if I may.

LADY JUSTICE THIRLWALL: Yes, of course.

Questions by MR DEAKIN

MR DEAKIN: Thank you. Dr Odeka, I just have a few questions, please.

A. Okay.

Q. Is it your understanding that it's the role of

the CQC to investigate individual incidents of concern or processes?

A. Not individual concerns, but processes.

Q. Thank you. The role of a Specialist Adviser, can you just explain what your role as a Specialist Adviser is again, please, very briefly?

A. The role is to support the CQC from its professional standpoint, giving advice on medical-related issues, to help with the inspection and also to support and interpret processes as they relate to medical investigations. Just basically to advise them on different medical aspects of the inspection.

Q. Thank you. In advance of the inspection, you were provided with information and you were taken through some of that?

A. Yes.

Q. I don't propose to take you through it again.

At the time, do you consider that you were provided with enough information to fulfil your role as a Specialist Adviser in this process?

A. Yes. And can I just qualify that, please?

Q. Please.

A. Right. The answer is yes, but the proviso is that I would, I would have assumed that the CQC had all the information and that the information they now

provide to me is assumed to be the filtered one that are relevant to the inspection. So in that regard I have said yes. So it's a qualified yes.

Q. Thank you. Finally, and following on from that, would it be right to say that there could be all sorts of different issues in a hospital. Would you be expected to be informed about all potential issues of concern even if they were not in fact of concern?

I can ask that slightly convoluted question another, another way?

A. Please.

Q. You have been asked a lot of questions about whether or not you should have been informed about neonatal mortality rates.

I want to step back from that. Neonatal mortality is one issue among a host of potential issues in a hospital, is that fair?

A. Yes.

Q. If an issue is not of concern, the CQC has no reason to think that an issue is of concern, would you expect to be informed about a range of issues as a matter of course or would you only expect to be informed of issues in advance of the inspection that stood out for some reason?

A. I think the information that's for reasons we

would be expected to be informed.
MR DEAKIN: Thank you very much.
Thank you very much, my Lady.
LADY JUSTICE THIRLWALL: Thank you very much, Mr Deakin.
Have you got anything arising out of that, Mr Carr?
MR CARR: No, I don't. Thank you very much.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Dr Odeka.
A. Thank you.
LADY JUSTICE THIRLWALL: We will rise now until 10 past 2.
(1.08 pm)
(The luncheon adjournment)
(2.10 pm)
LADY JUSTICE THIRLWALL: Mr Carr.
MR CARR: May I call Mary Potter, please.
LADY JUSTICE THIRLWALL: Ms Potter, would you like to come forward.
MS MARY POTTER (sworn)
LADY JUSTICE THIRLWALL: Thank you very much, do sit down.
Questions by MR CARR
MR CARR: Can we start with your full name, please.
A. Mary Potter.

Q. You have prepared a witness statement for this Inquiry dated 21 June 2024, haven't you?
A. Yes.
Q. Are the contents of that statement true to the best of your knowledge and belief?
A. Sorry?
Q. Are the contents of the witness statement true to your best knowledge and belief?
A. Yes.
Q. So far as your professional background, you are a nurse, aren't you, you qualified in 1973 and you've worked as a Registered Sick Children's Nurse in the past?
A. Yes.
Q. In 2004 you trained to become a RCN representative, a Royal College of Nursing representative?
A. (Nods)
Q. You became a Specialist Adviser in Children's Services for the CQC in July 2014?
A. I think it was 2012, but it might have been 2014.
Q. At paragraph 6 of your statement, you state your recollection to be that you completed three or four inspections, the last of which was the inspection for

the Countess of Chester in February 2016?
A. Yes.
Q. That's the inspection that I will be asking you questions about. Your recollection was that it was the only inspection you undertook involving an inspection of a neonatal unit?
A. Yes.
Q. So far as the role of a Specialist Adviser, can you describe your understanding of that role and how it differed to, for instance, a CQC Inspector?
A. Yes, as a Specialist Adviser on the -- for the duration of the inspection, we go in on a daily basis and we observe what is happening in the clinical areas on that day and make comments about what we are actually seeing.
Q. So the visit itself occurred over three days of announced visits and then there were two other days of unannounced visits, only one of which involved Children and Young People's Services. So you would have been present for the three day's worth of announced visits?
A. Yes.
Q. Outside of your presence during those three days, what was the extent of your involvement in the inspection process?

A. Sorry, could you expand on that?
Q. So you visited for three days?
A. Yes.
Q. Three days' worth of inspection, and we are going to come on to that in a few moments. But putting that to one side, what was the role of a Specialist Advisor either running up to the actual visit or in the period following the visit?
A. As a Specialist Adviser I wasn't involved in anything prior to the actual inspection of the clinical areas.
Q. So --
A. Sorry.
Q. Forgive me.
A. Post the inspection, we may have been called to do an unexpected visit, but on this occasion I never was, so my only involvement was the actual three days of the inspection.
Q. Did you ever receive any training for the role of Specialist Adviser?
A. Yes.
Q. Where was the training, who provided the training?
A. The CQC provided the training and it was to my recollection because this is eight years ago, so longer

than that since I did any training, I think it was all done remotely.

LADY JUSTICE THIRLWALL: Eight years ago, it was done remotely?

A. Sorry?

LADY JUSTICE THIRLWALL: All done remotely eight years ago, did you say?

A. Probably -- now that you have questioned that, no, probably not. But it was a long time ago and I don't remember what was involved in my actual training. But I had some training about the role of the Specialist Adviser.

LADY JUSTICE THIRLWALL: But you can't remember what, what it was?

A. No, it -- it was around how we would be expected, what we would be expected to look for.

MR CARR: You were a Specialist Adviser with a nursing background?

A. Yes.

Q. We have heard evidence from the other Specialist Adviser who was a doctor. So between the two of you, Specialist Adviser doctor, Specialist Adviser in nursing, were there different issues that you would provide specialist advice on?

A. Yes.

Q. How was the division of work or advice arranged between the two of you?

A. As a Specialist Adviser from a nursing background my main role was to look at the clinical areas and observe the service provision of, from that area.

Q. When it came to interviews looking at the notes, it appears that you focused on interviewing nurses, most of the nurses and Dr Odeka did more of the doctors?

A. Yes, I don't recall interviewing anybody other than nurses or care providers, healthcare assistants.

Q. If I can turn to documentation provided to you ahead of the inspection. For the purposes of you preparing your statement to this Inquiry, you have seen, haven't you, the Provider Information Returns, and the responses to data requests that the hospital sent to the CQC?

A. This was sent to me in preparation for making -- preparing my statement.

Q. Yes. About at the time of the inspection the point that you make in your evidence is you wouldn't have seen those documents?

A. No.

Q. What you describe is receiving an information

pack which was given to you on the first day of the inspection?

A. On the inspection, yes.

Q. So prior to arriving at the hospital, you received no document containing any detail about the service at all?

A. No.

Q. So you arrive on day one and you receive an information pack. Now, there's a few different documents and I want to see if we can work out quite what the data pack was. If we can look, please, at INQ0101422, does this look like the data pack that you are describing?

A. Yes, to my recollection.

Q. Now, this version has draft marked on it, it's titled "Pre-inspection document 22 December 2015".

A. I don't recall seeing a pre-inspection document.

Q. That was the point of my question. So the draft pack that you described receiving on the first day --

A. The draft pack on -- on the day would have included the service provision of the Trust or organisation we were inspecting. What provisions they, they had, what services they provided I do not recall

seeing anything prior to that, that included a pre-inspection document.

Q. So this document was not part of the information pack and is not the information pack?

A. Not that I recall.

Q. If we can look at INQ0017286, this is the inspection team briefing pack. Now, is this the document that you say you received on day one?

A. From my recollection this would have been the document.

Q. Now, what this document does is, there is a few introductory pages, we can look at page 11, please. Now, part of this pack there is an agenda for an inspection briefing section, 10 February at 2.

Did you attend that briefing section?

A. Not to my knowledge or recollection.

Q. Your recollection is that in fact you didn't receive this document until day one --

A. Yes.

Q. -- of the inspection which was on the 16th.

Now, I have skipped over a few introductory pages that have individual's contact details. If we go to page 14, a section dealing with the services to be inspected, we can see the penultimate heading "Services for Children and Young People" and that's the service

that you were inspecting?
A. Yes.
Q. But there is nothing in there which is specific to the Countess of Chester, is there? This is generic information about services for children and young people?
A. (Nods)
Q. Then if we go forward, please, to page 16, this is a section of the document that deals with the key lines of inquiry, which contains the prompts for you to use when conducting interviews?
A. Yes.
Q. It's aimed at obtaining evidence for the purposes of the inspection report?
A. (Nods)
Q. Now, again this runs over several pages, it's split into the different domains that you were inspecting "safe", "effective", "responsive", "well led".
But there's nothing in these key lines of inquiry which is specific to the Countess of Chester, is there?
A. No, this is a general, a general document for how we -- we would -- the things we would look for during an inspection.
Q. So in fact these are the same key lines of

inquiry that you would see on other inspections?
A. Yes.
Q. Then there are some concluding pages, page 32, which has procedures for the visit. And finally within this document, page 35, which deals with escalation procedures "Where an issue of concern arises". This is the bit in bold in the middle of the page "Where an issue of concern arise during an inspection", but again that is all generic, isn't it, nothing specific?
A. Yes, it's a generic one.
Q. So going into the inspection, you receive this document which tells you nothing about the service you are about to inspect. Did you receive anything else which did contain information about the Countess of Chester?
A. Not to my recollection.
Q. Was that usual for a CQC inspection that you as a Specialist Adviser turn up on day one --
A. Yes.
Q. -- and you don't know anything about -- you don't have any advance information about what you are inspecting?
A. No.
Q. That was usual or --
A. Sorry, yes, this was usual that we wouldn't

receive anything specific.
Q. The next document please, INQ0103620. Now, this appears to be a PowerPoint presentation, slides from a PowerPoint presentation. You see there "Intelligence presentation 16 February 2016". Do you recall if you went to this presentation?
A. I think this was, yes, yes, to that. This would have been the first discussion we had on the morning of the first day of the inspection.
Q. If we go to page 7 of this document, please.
So when you are going through these slides, the first few slides deal with Trust-wide issues and once you got to slide 7, there is information as to Children and Young People's Services', which of course you are most directly concerned with?
A. Yes.
Q. So the first thing that you -- the first bit of data that is specifically relevant to Children and Young People's Services that you would have seen would have been this slide?
A. I believe so.
Q. We can see the title, can we not, "Self-assessment from PIR" so it's Provider Information Return. So it's clear this is how the Trust is assessing their own performance?

A. (Nods)
Q. But for Services for Children and Young People we can see it is a positive assessment, isn't it, three "goods" and two "outstandings"?
A. Yes.
Q. When you see an assessment like that, "good" for safe "good" for effective, "outstanding" for caring, "outstanding" for responsive and "good" for well-led, how does that shape your approach to the inspection in the upcoming days?
A. Seeing this document wouldn't have shaped my approach to an inspection. My approach would be that I go in and comment on what I personally am seeing of the service provision during the inspection.
Q. So your approach would be the same even if it was "requires improvement across the board"?
A. Sorry.
Q. Your approach to the inspection would have been the same even if the self-assessment was "requires improvement"?
A. Yes.
Q. If we go forward, please, to page 27 and here we have what is described as a summary of intelligence findings. So this is the first real data that you would have seen about the service that you were about to

inspect?
A. (Nods)
Q. "No Never Events or Serious Incidents reported up to January 2016."
What conclusion would you draw from seeing that entry?
A. Again, I would try not to allow any of this to influence how I approached the inspection and I would be asking to look at their data recording myself.
Q. Looking at this page, the data contained on this page, and thinking particularly about the domains of safety and effectiveness, are there any other entries on that page which are relevant to the assessment of safety or of effectiveness?
A. Sorry, can you expand on that? I am not really sure what you are asking.
Q. Yes. The inspection is according to the key lines of inquiry?
A. Yes, yes.
Q. The key lines of inquiry are in five different domains?
A. Yes.
Q. One of those domains is safety?
A. Yes.
Q. We looked at the document briefly before, but

within those key lines of inquiry there are prompts for safety, so the evidence that you are looking for or looking at in determining safety. Another is "effective", one of the prompts looking at effective.
So what I am asking is when you look at these bullet points this is the first bit of information you have about the Trust, are there entries on that slide which are relevant to either of those two domains?
A. No. Again I'm not sure what you are actually asking me.
LADY JUSTICE THIRLWALL: Perhaps we will move on, Mr Carr.
MR CARR: We can take that document down.
LADY JUSTICE THIRLWALL: Actually, just before you do that, could I just ask a question.
MR CARR: Yes, of course.
LADY JUSTICE THIRLWALL: The second last bullet says paediatrics is -- and then it's something WTE.
A. Sorry, it's gone off my screen.
LADY JUSTICE THIRLWALL: I know, it's coming back.
A. Sorry.
LADY JUSTICE THIRLWALL: Can you just -- I'm sorry Mr Carr, could you remind us of the page?
MR CARR: Yes -- no.
LADY JUSTICE THIRLWALL: Here it is.

MR CARR: Up a page, I think.
LADY JUSTICE THIRLWALL: The next.
MR CARR: It is page 27.
LADY JUSTICE THIRLWALL: Thank you. Do you see the second last bullet paediatrics is "2.19 WTE over establishment". What does that mean?
A. The over establishment so "WTE" is whole time equivalent, so they are saying that they have more staff than their establishment calls for.
LADY JUSTICE THIRLWALL: So that is more staff than they would expect to have?
A. Than they would expect to have.
LADY JUSTICE THIRLWALL: Thank you.
Is that something that you would have explored?
A. I would have explored it with the nursing establishment in general with the staff on the ward and the manager of the ward.
LADY JUSTICE THIRLWALL: Which ward?
A. Sorry?
LADY JUSTICE THIRLWALL: Which ward?
A. The areas -- the clinical areas I was inspecting, so the neonatal unit and the children's wards.
LADY JUSTICE THIRLWALL: Thank you. Sorry, Mr Carr.

MR CARR: Thank you.
One of the documents that was provided to the CQC by the hospital was a spreadsheet titled "NNU paediatric incidents 1 January 2015 to 31" -- sorry, forgive me, 1 February 2015 to 31 January 2016. It is a document that you wouldn't have seen at the time of the inspection but you have seen it for the purposes of providing your statement for this Inquiry, haven't you?
A. (Nods)
Q. It is a table that has the coloured column to the left marking incidents or categorising incidents according to harm, with the majority of them being in green.
Now, having looked at that document, what you say in your statement, and I am considering your paragraph 34, you say:
"Unless specific concerns relating to this document were identified by the lead inspector, I would not have expected to receive this document in my role as Specialist Adviser."
Is the process then that you are describing: lead inspector looks at this document and would only come to you if the lead inspector identified concerns that she wanted your input on?
A. Yes.

Q. On a document such as this, and in particular issues as to categorisation of incidents, would that be something that you would give specialist advice on or would you expect Dr Odeka to be the appropriate person to give specialist advice or would it be both of you?

A. We -- we would both have given some input on that. But obviously our perspectives in it would be slightly different and I would be doing it from the perspective of the nurses on the ward or clinical area.

Q. You say at paragraph 35 of your statement:

"Having not had access to this document at the time of the inspection, I am unable to comment on why these incidents have been categorised as they have been."

Well, of course categorisation was done by the hospital. The question for you is: if you had received this table at or during the inspection, and considered it, what impact it would have had, if any, on your approach to the inspection?

A. It's very difficult to say what -- what approach, if any, it would have had on my -- sorry, influence on my approach to the inspection.

Had -- had I seen causes for concern, I would have explored that further and I would have spoken with the inspector asking: is there further information that we can see? Or: is there anything you want us to be

specifically asking for information around, from the people I was seeing on the ward?

Q. So if you identified something which caused you concern you would investigate further?

A. Certainly.

Q. I understand that. Having looked at the table, the query is whether it contains matters which would have caused you concern. There are eight entries in a table in which the description of the incident includes death. Each of those entries is marked green for none in the "Actual harm" column.

Would that categorisation have been something that would have caused you concern leading to you to investigate further had you seen it?

A. Now I would say yes, you know, if incidents -- if concerns were raised with me or I seen a document that was raising concerns I would have asked for further information or for it to be looked into further.

Q. The question is whether you would be concerned by an entry which is marked green, "no harm", in circumstances where it involves neonatal mortality, not that the description itself states concern?

A. I -- I believe that I would want more information about how they got to the "no harm" category.

Q. National Reporting and Learning System, Strategic Executive Information System. Those are both reporting tools operated by NHS England that NHS Trusts report patient incidents to?

A. (Nods)

Q. The Strategic Executive Information System, that's for Serious Incidents, patient harm incidents must be reported to the National Reporting and Learning System.

You have again, for the purposes of the preparation of your evidence for this inquest (sic), you have been provided with spreadsheets showing reports from the Trust to those two systems, haven't you?

A. Yes, for the preparation of my statement, yes.

Q. Yes, you didn't see them at the time?

A. No.

Q. I took you to that PowerPoint presentation where the first entry said "no Serious Incidents reported"?

A. (Nods)

Q. Now, having seen the reports by the Trust, you have seen that in fact there was a Serious Incident report, wasn't there, in respect of the death of Child D?

A. I don't recall it.

Q. Had you been provided with entries from the National Reporting and Learning System and the Strategic Executive Information System relating to neonates at the Countess of Chester ahead of the inspection, how would that have impacted your approach to the inspection?

A. As I say, it's -- it's eight years ago and information would have allowed me or prompted me to ask different questions to what I was asking during the inspection. But I can't now say how that would have been because at that point I didn't have that information.

Q. What different questions do you think you would have asked?

A. I say again it's difficult now to say in hindsight what I would have done differently. But I think I would have wanted more information about the Serious Incident.

Q. At the inspection you were involved in a number of interviews. You in particular attended an interview with the two other -- the two other members of your team and the team leaders within the neonatal unit.

If we can go, please, to INQ0017339, page 164.

Now, we have looked earlier today at notes made by Helen Cain of this same meeting, but this is your

handwriting, isn't it?
A. This is my handwriting, yes.
Q. So this is your note of the same meeting. The third line down:
"Mortality and Morbidity Meetings equals five last year. Planned four this year -- CS."
What does CS refer to?
A. Sorry, I didn't hear that question.
Q. The CS that is highlighted on the screen, what, what is that a reference to? Or is it C-5 caring 5, is it one of the prompts?
A. I think it's C-5 but as I say, this was eight years ago and I can't fully recall.
Q. The next sentence:
"Neonatal depend on number of cases to be discussed."
What's your recollection as to what was said at this meeting as to Neonatal Mortality and Morbidity Meetings?
A. My recollection is that all the cases would have been discussed. It's very difficult, as I said, eight years on, to really recall what that sentence means.
Q. Now, you have considered your notes of the interviews that you conducted, you have also seen the

notes of others. Based on those notes and based on your recollection, did you discuss -- we can take this down, did you discuss directly with any of the interviewees neonatal mortality?
A. No.
Q. You didn't discuss therefore concerns about neonatal mortality?
A. No.
Q. Instances of unexpected and unexplained deaths?
A. No, because we weren't given information around that on, during the inspection.
Q. When you say you weren't given information, did you directly ask any -- did you directly ask anybody that you interviewed about neonatal mortality?
A. No.
Q. You didn't ask and it wasn't volunteered by anybody who you interviewed?
A. It wasn't.
Q. Did you ask any question that you think should have elicited an answer describing concerns about neonatal mortality given that there were concerns on the unit?
A. To my recollection, I didn't ask any specific questions.

Q. Yes, I am thinking less about specific questions, but whether you asked any general questions any open questions that could have encouraged an interviewer to share with you concerns they had, such as do you have any concerns on this unit? Is there anything unusual? Is there anything that's worrying you? An open question?
A. No, I didn't ask any of those questions.
I did ask how staff felt about when an incident had occurred how they were supported and what feedback they got and what learning, if anything, came from those incidents.
Q. Were you not keen to understand, particularly for the purposes of the assessment of safety and the assessment of effectiveness, what the performance was so far as outcomes, neonatal mortality was?
A. We -- we dealt with what we saw during the inspection.
Q. In paragraph 71 of your statement, and here you are making reference to the Thematic Review from February 2016 which references increased mortality and also the November 2015 Dr Brigham report, and again you didn't see those at the time of the inspection?
A. No.
Q. You saw them subsequently. But at

paragraph 71, you say:
"I had been asked to provide a view on the relevant significance of these matters referred to above and whether they should have been raised by interviewees. I think these matters were relevant and significant to the inspection and my expectation would be that they would be raised by interviewees such as Band 6 nurses and above where they were aware of these."
You go on to say:
"I appreciate that it can sometimes be difficult to provide these kinds of disclosure in the presence of colleagues or managers and we offered the opportunity for one-to-one fact-focused interviews during the inspection to accommodate for this."
Were you taken up on that offer of --
A. No.
Q. If you look, please, at paragraph 40 of your witness statement?
A. Sorry, which?
Q. Paragraph 40.
A. 14?
Q. 4-0. Do you have it?
A. Yes.
Q. This is another paragraph dealing with those reviews, the Thematic Review and the Dr Brigham review.

You say in the first sentence that:
"The provision of the Thematic Review or peer review ahead of an inspection would not have changed my approach to the inspection insofar as there was a CQC process for inspections and for inspectors and Specialist Advisers to follow."
But you go on, don't you, in the rest of that paragraph to explain how receiving that information would have shaped your approach to the inspection and would have changed the areas of focus and the areas of questioning?
A. (Nods) I believe that it would have done had I had that information prior to my inspecting the clinical areas and interviewing staff. I may have asked different questions but I was -- I did not have that information.
Q. During interviews when you are asking staff about safeguarding policies, safeguarding practice and safeguarding knowledge, how do you go about testing the safeguarding knowledge of the people you are interviewing?
A. I wouldn't say that we tested the knowledge. I would have a conversation with them just to see if they were aware of the safeguarding processes within the Trust.

Q. In the course of that conversation would you -- would you ask them, for instance, what the safeguarding processes were?
A. Yes.
Q. Rather than just saying: have you had safeguarding training, and they say yes, would you seek evidence that demonstrates the person before you did actually and could articulate what safeguarding processes were?
A. Yes.
Q. You were not at the Consultants' focus group; that was conducted by another member of staff.
As you will be aware as part of your -- part of the preparation of your evidence for this Inquiry, there were some concerns or concerns noted at the Consultants' group of a culture of bullying.
In the course of your interviews with staff members predominantly nurses did you hear any evidence were you told of any culture or bullying at the hospital?
A. No, I asked a number of staff how they felt they were supported in their clinical areas and by their senior staff and I -- nobody said to me they had concerns about how they were supported. Nobody voiced any concerns about bullying with me.
Q. And beyond the concerns about staff numbers

which is described at paragraph 85, you say:
"To the best of my recollection some staff expressed concerns during interviews that staffing was not adequate and there were times when the ward unit was short-staffed".
Aside from that, were there any concerns that emerged during your participation in this inspection?
A. Not that I can recall now.
Q. In terms of providing feedback because you were not involved at all, were you, in the writing of the report?
A. No.
Q. You have explained you were there for three days and that's it and then the report is written by Helen Cain.
At the end of the three-day inspection, did you provide feedback to Helen Cain?
A. At the end of each day of the inspection, we provided feedback on that day's inspection.
MR CARR: Thank you, my Lady, subject to any questions Mr Deakin may have, those are my questions.
LADY JUSTICE THIRLWALL: Thank you, Mr Carr. Mr Deakin?
Thank you very much indeed, Mrs Potter, you are free to go.

A. Thank you.
LADY JUSTICE THIRLWALL: Would you take the oath please.
LADY JUSTICE THIRLWALL: Do sit down.
A. Thank you.
Questions by MR DE LA POER
LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.
MR DE LA POER: Please could you state your full name?
A. Elizabeth Childs.
Q. Ms Childs, is it correct that on 22 June of this year you provided the Inquiry with a witness statement?
A. Yes.
Q. Is the content of that witness statement true, to the best of your knowledge and belief?
A. Yes.
Q. We will begin briefly with your background. Did you qualify as a nurse in 1977?
A. Yes.
Q. Did you subsequently work in a management role within Women and Children's Services?
A. Yes.
Q. Did you obtain a Master's in Healthcare Management in 1999?

A. Yes.
Q. In 2000, did you become the Executive Director of Nursing at an NHS Foundation Trust?
A. Yes.
Q. And was the role of Deputy Chief Executive added to your portfolio in 2009 for the same Trust?
A. Yes, yes, it was.
Q. In 2011, did you qualify as an Executive coach?
A. I did.
Q. Did you subsequently become a Non-Executive Director at a different NHS Trust, in 2013?
A. Yes.
Q. I think you retired from that Non-Executive role in 2019?
A. Yes, I did.
Q. If we deal with your experience of the CQC.
In 2014, did you start acting as a Specialist Adviser on an ad hoc basis for CQC inspections?
A. Yes.
Q. And did you undertake that special advisory role during the period 2014 to 2016?
A. Yes, I did.
Q. You estimate in your witness statement, is this correct, that you did between five and six

inspections in that role?
A. Yes, that is an estimation, yes.
Q. And of those five or six, you say that you were the chair for two of them?
A. Yes, that's right.
Q. Of course as we know you were the Chair for the inspection of the Countess of Chester in February 2016?
A. That's right.
Q. Can you help us. Do you think that was the first time you acted as chair or the second time?
A. I think it was the second time I acted as chair.
Q. And was the Countess of Chester the final inspection you were involved in or did you have subsequent inspections in 2016?
A. I think that was the final inspection that I was involved in.
Q. So in this sense, you were the most experienced that you ever became of acting as an inspector and chair --
A. Yes.
Q. -- at that inspection?
A. Yes.
Q. Can you tell us please in your own words what

the role of chair of a CQC inspection involves?
A. It involves supporting the head of hospital inspection who's a CQC employee, it involves making sure that the team that you have in front of you particularly the specialist professional advisers are used to the best advantage. It involves ensuring that you have a thorough but a fair and respectful inspection because you are working through a hospital that's engaged in its duties.
You help to lead or you lead with the head of hospital inspection the -- the briefing sessions and the corroboration sessions when people come together and you listen to the evidence that's been provided and if there are issues, any issues that are raised, you deal with those areas of concern which we probably discussed with the head of hospital inspection. And my experience is that as a chair you would usually be involved in the interviews of senior people in the organisation, such as the chairperson, the Chief Executive, the Director of Nursing.
Q. In that list of responsibilities, you identify that the role of the chair was to ensure a thorough investigation?
A. Yes.
Q. Does it follow from that that if it transpires

that the investigation -- or the inspection, rather -- was not thorough, that the person who bears responsibility for that overall would be the Chair?
A. I think that would -- let me think.
Alongside the head of hospital inspection because as a chair you only have responsibility for those days you are actually in the on-site inspection, not prior to the inspection or following the inspection.
I suspect you would have some responsibility for ensuring it was thorough. But you would hope that also the head of hospital inspection who does this full time actually would work closely with you to ensure that that was the case.
Q. One of the things I am sure you will appreciate is that an important principle is accountability?
A. Yes.
Q. And if I have understood your last answer, that if it is objectively determined that a particular inspection was insufficiently thorough, the person who would be accountable for that would be the Chair and also the head of hospital at the CQC.
A. I think that's --
Q. Is that a fair way of characterising it?
A. I think that is probably a fair assessment,

yes.
Q. At least that was your view at the time?
A. Yes. I only hesitate because the role of the chair is quite a minimal role in just those few days that you are on site in the organisation.
Q. That being the case, just to explore this with you further, is it a surprising statement you have made then that you are on the one hand accountable for the thoroughness of the investigation but on the other have only a very limited role within it? Just help us to understand that apparent tension?
A. In gathering the statement, putting the statement together for this Inquiry, and you can look at information that you may not have had sight of, that was prepared ahead or seen ahead of the inspection and how the detail following the inspection, it allows you to realise that your role is actually quite limited.
It's not exactly as a chairperson would normally carry a role where you may have a clear overview from start to finish of a process.
Q. So the idea that you may be one of the two people accountable is that simply your interpretation or is that something that was part of any training or information given to you by the CQC when telling you: you are the Chair, you are ultimately responsible for

making sure that this is thorough?
A. No. There would be no communication from the CQC about that aspect of the Chair's role.
Q. So that has come from your own reflection?
A. It is just my own interpretation to your question.
Q. Now, I mean this with the greatest of respect, but you hadn't in fact done very many inspections --
A. No.
Q. -- prior to becoming a chair?
Just looking back on it, if it's right that you are accountable for the thoroughness of an investigation, does it surprise you that you were appointed to the role of chair and considered suitable for that when you had relatively limited experience of even being involved in inspections?
A. It does surprise me now. I am sure at the time it probably didn't surprise me that much. I don't recall having any training at all as being a chair. It was more to do with the seniority of the role you had outside of the CQC.
Q. Well, plainly it was important that any person who sat down with the leadership team of any Trust was able to speak to them on an equivalent level of seniority?

A. I think that's exactly right, yes.
Q. And so part of your function was to do exactly that?
A. Yes. Yes.
Q. But I think you have described your understanding of the remit as being broader than just being an appropriately senior person for those interviews because you have talked about liaising with the head of hospitals and ensuring that the whole process worked?
A. Well, yes, you didn't just interview the senior people in the organisation. You actually were, I suppose, overseeing the Specialist Advisers who were there. I was a Specialist Adviser, they were Specialist Advisers making sure that actually they were supported if they needed support and they were used to the best of their advantage along with the head of hospital inspection, who of course is much more used to inspections than I was.
Q. That person, so we are all clear, is a person called Ann Ford at the time?
A. That's right yes.
Q. We will be hearing from Ms Ford tomorrow.
A. Yes.
Q. At the time, did you think that the culture of

inspectors should be one of curiosity?
A. The culture of inspectors?
Q. Yes, should -- should the inspectors be curious?
A. Yes.
Q. Was it part of your role to encourage that curiosity?
A. Yes, it would have been part of the role although it was quite a strict format that people followed. But you would expect that people would ask questions and if that might lead to further questions and they would look for evidence to support what they were asking the questions about.
Q. You have talked about a role as in a way managing the Special Advisers and how they operated, was there an opportunity for you to say: Right, well this is the inspection that I am the chair of, this is what I am hoping we are all going to achieve? Did you have that short of leadership role where you spoke to the team and told them how you wanted it all to run or how you thought it should run?
A. There was a format at the pre-inspection briefing that you would just welcome everybody -- that was a Zoom call. You would welcome everybody and say that, you know, the culture is that we are polite, we

are respectful, so you just go through those headings. There was no further -- I don't recall there being a further sort of opportunity to really engage fully with people. At the start of the inspection, you would again reiterate the behaviours you expected of people.

Q. And was one of those behaviours, being curious?

A. I don't remember using the word "curious".

Q. So let's just consider the inspection in February 2016 and please bear with me here, I am going to provide quite a lot of information in quite direct terms about what we know now --

A. Okay.

Q. -- as at the morning of 16 February --

A. Yes.

Q. -- and the position at the Countess.

We know now that in the nine months prior to that first morning, Letby murdered five babies and attempted to murder four more. We know that now. We know that during the inspection she attempted to murder another baby.

Her murders had caused an unexpected increase in the neonatal mortality rate for the neonatal unit in that nine-month period previously. We know now that staff at the hospital had identified that unexpected

increase in mortality?

A. (Nods)

Q. All of the seven Consultants were aware of it, including the Lead Clinician for children's services, and the neonatal lead. The lead nurse for children's services and the neonatal unit manager was aware of it and the recent deaths had caused considerable distress, we know, amongst junior doctors and nurses.

We also know that the risk and patient safety department was aware of the unexpected increase and the obstetrics department was aware of the unexpected increase and that the Medical Director and the Director of Nursing were aware of it and that the local neonatal network was aware of it, or at least one of its members was.

We know now that numerous investigations had been undertaken including a Thematic Review trying to understand that unexpected increase and that despite all of the investigations that were undertaken, no non-sinister explanation for that unexpected increase had been identified.

In the week before your inspection, we know that there was a Thematic Review meeting which brought together all of the deaths and said that there was no common theme for the unexpected increase and that that

draft report was sent to the Medical Director and the Director of Nursing the day before you attended and I am just going to bring up an email that you won't have seen before --

A. No.

Q. -- INQ0003140. If we go to the bottom email there, this comes from Ian Harvey the day before you arrived. "Dear Steve", and if we just scroll down:

"Am I correct in thinking that you commissioned an external review of recently neonatal deaths? If so, is there any early feedback ahead of this week's visit?"

That is a reference to your visit. If we go up, we can see that Dr Brearey, who is one of the people your team interviewed, explains a little bit about what occurred and we know that he attached to that email the draft minutes of the meeting which had taken place just seven days before this email exchange.

Finally at the top we can see that Dr Brearey's email was then forwarded by Mr Harvey to the Director of Nursing, Alison Kelly, with some comments about the interpretation of it.

A. Yes.

Q. The final thing we know -- and I promise that there is a question coming at the end of this -- that over and above all of that, over the nine months prior

to your inspection, four Consultants at least, two nursing managers, and one Risk and Safety Lead had identified or were otherwise told that Letby was associated with the unexplained spike. And that in the case of the four Consultants they had varying degrees of concern that that association may suggest causation.

Now, I am sure you will agree with this, the CQC did not identify any of that in the inspection; is that right?

A. That's right.

Q. In fact the CQC published a report which said that particular part of the hospital was "good"?

A. The safe element was "requires improvement" but overall --

Q. Overall "good"?

A. -- it was "good".

Q. So members of the public may find that a surprising state of affairs?

A. (Nods)

Q. Now, plainly one explanation is that it was deliberately hidden from the CQC and you can't comment upon that directly. But there is no documentary evidence that any direct lie was told.

What I am hoping you might be able to assist us with, reflecting on all of that information, much of

which I daresay you knew already --
A. No.
Q. Well, reflecting upon that information, was there anything about the CQC inspection that you think failed to draw that out in some way?
A. I was able to look through the transcripts of the interviews that had been held with the paediatricians and the nurses and the unit managers of the Children's and Young People's Services and the neonatal service.
I wasn't involved in those interviews, but I did have a chance to look through them and make a comment and I -- nowhere could I find a comment or the words "Concern", "unexplained", "unexpected" in those notes.
The Mortality Morbidity Meetings were mentioned in three of those notes, briefly in a couple, but no transcripts that would say that actually this was raised with a level of concern. That's all I can say, I wasn't in those interviews but I did look through those records and that's, I could not find evidence of that being written down.
Q. So it wasn't volunteered, you can't see evidence of it being volunteered?
A. I don't -- I would have to say I could not see evidence that it was volunteered.

of a standard meeting, "Is there anything that you think I should be aware of or anything that you are concerned about that we haven't talked about yet?"
A. And quite often at the end of a session, you would finish with, "Is there anything else you want to tell me that we haven't discussed?" And also you would probably say, you know, we'd hope that people would say, "There's opportunity if you wish to raise something individually to a CQC member of staff" and it would be anonymised.
And throughout the organisation there was opportunities, you know, posters that would allow staff to use what they might see as the whistleblowing policy but to come forward if they had a concern that they didn't wish to discuss in a -- in a forum where other people were with them.
Q. Now, you didn't yourself, because it wasn't your role, speak to anybody in the children services area?
A. No.
Q. But you did speak to Ian Harvey and to Alison Kelly?
A. Yes.
Q. And you have seen the email that --
A. Yes.

Q. If inspectors are operating and the Special Advisers are operating curiously, would you expect them to be asking questions that might draw that out?
A. Well, you would expect that they would be discussing them, mortality and morbidity meetings, and you would depend on the answer in a sense to lead you to where the next question is.
If there's a discussion that we have Morbidity and Mortality Meetings and we know that we look at the actions taken and the learning from that and we haven't yet found any common themes but there hasn't been a mention of a rise in deaths, then actually you would see that as good practice; that each neonate that dies has a review of the care that's undertaken with junior staff engaged in that, actions are identified, lessons are learnt.
There was evidence from those notes that actually action from incidents was passed through staff on safety briefings, et cetera. So you would be following that lead.
I think without somebody giving you information that it's an unexpected number or a rise in our number, using those terms, it may be difficult to think that you would pick that up.
Q. Well, one way to pick it up is to say as part

Q. -- chain the day before.
Did you ask either of them, "We have talked about all of that. Is there anything else that you think I should be aware of or that I need to know or that you are worried about?"
Did you ask that question to either of them?
A. I can only say I may have asked. I can't absolutely remember, but I would have asked, "What are the serious concerns or risks you have around patient safety?" That's usually one of the questions I would ask. "Tell me what those serious risks are. Where are you most concerned? What are you doing to mitigate against that?"
So that would be one of the regular sort of questions that I would ask around the safety and quality of patient care generally. You know, not asking about a particular -- neonates because I wouldn't have considered that to be something to ask but generally, "What are the serious risks? Are there any concerns you have about care? What are you doing about those concerns? What are you doing to mitigate those concerns."
That would be a question that I would ask.
Q. Drawing on your experience as a Executive Director of Nursing and as a non-executive director, if

you had an unexpected increase in a mortality rate in any department, and that there was a Thematic Review done of those cases and that review came back and said, "We cannot identify a common theme that explains this", is that something that a Director of Nursing or a non-executive director should regard as an area of concern?

A. I think it is. It's also an area of good practice in that sense that actually you've investigated to that point, you have investigated, you have had a concern, there's a raised number, you have looked at that. You have had a Thematic Review. You haven't as yet found any common thread.

Q. So --

A. But you have taken it seriously to the point that you have looked at it through a Thematic Review.

Q. Good practice you haven't ignored it. But the fact that it remains potentially unanswered, is that something that you would regard as being sufficient to arise in a meeting with somebody like you coming to inspect?

A. What you would probably want to do is follow on with that. So, you know, "Okay, there's no common threads. Where do we go from here? Where are you going to go next? What are you going to do?"

And then, you know, if -- part of CQC's role because they have a consistent monitoring would be to say, "Keep us informed. We need to know what the next steps are that you are going to take."

Q. So just to absolutely tie you down. Does it cross the threshold, as I have described it to you, for being something that should be brought up at a meeting with the Chair of a CQC inspection or is it sufficiently well under control not to reach that level?

A. Sorry, could you say that -- ask that question again?

Q. Of course.

A. I'm not sure --

Q. I am just inviting you to put yourself in the position of Director of Nursing --

A. Okay.

Q. -- or Medical Director?

A. Yes.

Q. They've got lots of things to talk to you about as an inspector. We know that they received a report which said: Here is the increase in deaths, no common theme has been identified. There's some further detail behind it.

I'm just trying to understand whether your view is: Well, if that's sort of information coming in just

before the inspection, I really ought to raise it with the inspector, or the special adviser or do you think: Well, it might not need to be raised?

A. I think it's -- it was common practice to feel that you should always raise things early if there was a concern rather than wait until it was too late.

So with CQC, what we would tend to do is let them know ahead, "We've got a bit of a concern here, this is what we are doing about it", and then it's on their agenda.

If nothing comes of it then actually that's all well and good, but if there's further work on that that raises something else then they have already been made aware of it.

Q. Now, the Inquiry has received some evidence to the effect that if you tell the CQC about your problems there's going to be an adverse consequence for you or potentially because they are going to give you a bad rating. Is that -- whether it's correct or not or whether that's the right way of thinking about it -- is that an attitude that you are aware of existing within the National Health Service?

A. No, no.

Q. You have never heard anybody say, "Don't tell the CQC" or "We don't need to quite let them know yet,

this may turn out to be nothing. We don't want them worrying about this or putting it on our rating."

A. I don't feel that that was something that was commonly thought through the NHS, no.

Q. Turning to the detail of your particular involvement in this inspection. You hadn't had any previous involvement with the Countess of Chester before this?

A. No.

Q. And your first involvement with the inspection was, I think you tell us, a pre-inspection briefing call?

A. Yes.

Q. And did you also receive a pre-inspection briefing pack?

A. Yes.

Q. And was that -- it sounds like you got it before 16 February?

A. Yes.

Q. You are satisfied you did?

A. Yes.

Q. You weren't involved in any of the information gathering that produced that pack, is that right?

A. That's right.

Q. One part of -- well, let's have a look at

a document. It's the children's pack, INQ0101422.
That's termed a pre-inspection document, it's dated 22 December 2015. Do you recall whether this was within your pre-inspection pack?
A. Yes, this was. Yes, this was part of the pre-inspection pack.
Q. Now, you had a background in children's services as a clinician, didn't you?
A. Yes.
Q. But that wasn't your function at this particular inspection. Is this something that you will have read before you went to the inspection?
A. Yes. This would have come out prior to the pre-inspection briefing, which was held on the 10th February. So there would have been an expectation that anybody who was attending the pre-inspection briefing would have looked at the -- the pre-inspection pack.
Q. Now, just one query as to whether you noticed it at the time and if so whether it was in any way a problem. If we look at page 6, we can see there is a summary of analysis presumably provided by people at the CQC based on information that they were --
A. I have got page 5 up on my screen.
Q. It's page 6, it's document page 6.

A. Sorry. Okay, yes.
Q. No trouble at all. But this, this appears to be information gathered by the CQC and prepared for the inspectors?
A. Yes.
Q. Now, "Well-led" is blank.
A. Yes.
Q. Is that something that was common, that there would be a blank field about an important area that you were looking at?
A. I can't remember if it would be common in the pre-inspection briefing pack or not to be quite honest.
Q. And if you were reading that, would you be sufficiently concerned about that absence to say, "We need to know that before we come along", or would you just say, "Well, I am sure we will find that out when we get there."
I mean, how important is this?
A. I think I would assume that that would be found out when you get there, when you start talking to staff and asking them about their role, the way they work within the organisation, et cetera.
Q. Thank you. We can take that down. The next document I want to ask you about is a table of neonatal incidents. I think you have had a chance to have a look

before you have come in today to give your evidence.
I'm not proposing to put it on screen.
A. Okay.
Q. You say in your statement that you don't recall having seen that?
A. No.
Q. If you had seen it, do you think it would have made a difference to your approach, is it something that you would have looked at and thought I need to ask about this?
A. That's the table with the 200 -- or a long list of the incidents in the unit?
Q. Yes, exactly so.
A. Quite possibly if you were in the Children and Young People's team, you would look at those, some of those in more detail and want to ask, pick one or two out for example to ask the questions of them.
I think from memory there were a couple where there was very little detail around the neonatal deaths. So those in particular you may want to say, "Can you explore, can we explore this a little bit further?"
Q. Sitting there now, the fact that you don't have a memory of having seen that table, does that suggest that it's likely that you weren't sent it in advance or as part of your inspection?

A. No, no, I had not seen that table.
Q. You had not seen --
A. I had not seen that table until I had it sent to me in readiness to put the statement together.
Q. And the third and final pre-inspection document, INQ0103620. This is the intelligence presentation?
A. Yes.
Q. Was this something that you will have seen before the inspection or on the day of the inspection?
A. This is on the day of the inspection.
Q. And was this a presentation to the Trust or was it just within the inspectors that this presentation was --
A. I think it was just to the inspectors in the presentation -- in the inspection team.
Q. So it's a way of preparing you for what you were about --
A. It is a way of preparing everybody for the inspection which was about to -- which had started that day.
Q. Others have been asked about this. We can go to page 7 and see the self-assessment where we can see for services for children and young people that the hospital has rated itself as "good", "good",

"outstanding", "outstanding" and "good" across the five domains?

A. Yes.

Q. How important was the fact that the hospital thought that it was doing well in particular areas to you in formulating what you were going to explore or examine?

A. I don't know that it would have had such an impact on you. Your job was to look at evidence in front of you that you had gathered from that. It -- it may have related to that but I don't think that, you know, that influenced.

So if you saw "outstanding", I don't think you were thinking, right, this is going to be outstanding. It was your job to actually look at the evidence against the key lines of inquiry and standardise the approach to the inspection.

Q. Your answer, if I may say, is broadly similar to the three previous witnesses that we have had about this.

A. Phew.

Q. Well, it is important to get your perspective.

But if it wasn't going to make any difference, why do you think you are being told this on the morning of your inspection? What's the value of that information

if all you are going to do is say, "Well, that's what they think. I am now going to get on with what I think I need to do"?

A. It would be worrying if actually a Trust felt it was outstanding in very many areas and you found that it required improvement. That would indicate to you that maybe this is a Trust that isn't really understanding, you know, its services.

So in that respect you might think, well, you know, we are seeing something very different from this organisation. So that would make you sort of question things, wouldn't it?

Q. But that's only a comparison that's valuable once you have conducted your own independent assessment.

A. Yes, it is. Yes, it is.

Q. But I am trying to understand why before you go in you thought you were being told what they thought about themselves when you were effectively just going to ignore that?

A. I can't say what value it had then.

Q. Page 34, please, within this document. This is the recap key messages. The fourth bullet is:

"Data quality and reporting issues in some areas of the Trust."

Do you recall whether that was something that you

actively investigated or tried to get to the bottom of with the interviews that you conducted?

A. I honestly can't recall. The -- the interviews that I conducted, I have very little memory of those, I'm afraid. Unfortunately, I haven't been able to see any of the records of those either.

Q. No. Well, that is because they cannot be found.

A. Yes.

Q. When I say that, you shouldn't think that I am implying criticism of you.

A. No, no, I don't.

Q. So we can take that down and just deal with some other areas of information. Did you know anything about healthcare episodes statistics or HES?

A. Vaguely.

Q. What did you understand that was?

A. It was a way of comparison between different organisations in terms of their performance and patient incidents and deaths.

Q. And did you expect to see the output of that as part of your preparation so that you would be told in advance what the big data picture was?

A. I'm not sure that I expected to see that.

Q. Is it fair to characterise your reaction that

from the fact you only knew it vaguely that this wasn't a big part of what you understood was going to be important for the inspection process?

A. I think had it been something that was off-kilter, we would have been informed about it prior to the inspection.

Q. So it would only come to you if it was identified in advance that that data had suggested a problem?

A. Yes.

Q. Before you attended, did you have any reason to think that there had been an increase in the mortality rate on the neonatal unit?

A. Before I ... ?

Q. Attended the inspection?

A. No.

Q. Before you attended the inspection, did you know anything about suspicions which may have existed about a particular member of staff being connected with that mortality rate?

A. No.

Q. The Thematic Review document, which you have seen referred to in those emails --

A. Yes.

Q. -- do you have any recollection of having seen

a Thematic Review of neonatal mortality?
A. I did not see a Thematic Review, no.
Q. I have characterised that document to you now. It's about 10 pages long or so and it goes through each of the deaths, looks at different factors --
A. Yes, yes.
Q. -- identifies some areas for improvement but says ultimately no common theme. Is that a document that should have been provided to you and the inspection team beforehand, do you think? Is it a document that would have been valuable to your inspection?
A. I think it would have been, as we said earlier, giving CQC a heads up that there had been a concern raised and this is the work that had been undertaken to try and identify a little bit more about that concern.
Q. So does it all come to this: that your position is that you should have been told about whatever concerns existed certainly about the increase in mortality rate?
A. Yes.
Q. And that that should have come before you started?
A. Or as we started discussing with the paediatric team or the Medical Director or the Director

of Nursing.
Q. We will just identify the people that you interviewed. I can bring a document up but I'm sure you can take it from me you interviewed the non-executive Director for Quality and Safety, Mr Higgins?
A. Yes.
Q. The Chair, Sir Duncan Nichol?
A. Yes.
Q. The Director of Nursing, Alison Kelly?
A. Yes.
Q. The Senior Information and Risk Owner, also Alison Kelly?
A. Yes.
Q. The chief operating officer, Lorraine Burnett?
A. Yes.
Q. That was all on the 17th. And then on the 18th, the Senior Lead for HR Sue Hodkinson, the Chief Executive Tony Chambers and the Medical Director Ian Harvey?
A. Yes.
Q. As you have told us you have got no notes available to you to refresh your memory from that?
A. No, I haven't.
Q. Were notes kept of those meetings?
A. Oh, absolutely.

Q. Who kept those notes, who was the scribe or was everybody writing their own notes?
A. Well, you could write yourself and there would be a second person with you, a CQC person, who would also be transcribing.
All of the records would be handed in at the end of any inspection. It was really important that every record you had was handed in to CQC, which obviously became part of the process of taking the report writing forward.
Q. Was it your practice to make notes?
A. It was my practice to make notes, yes.
Q. So do you think for each of these interviews there existed, at one time, your record of what was said?
A. Yes. And there was a, you know, a table that you would use from CQC that you could write them down on, yes.
Q. Now, you have told us your recollection is extremely limited.
A. Yes, I'm afraid so.
Q. You do have a recollection of Alison Kelly becoming distressed in your meeting with her?
A. Yes.
Q. And just tell us what you recall she became

distressed about.
A. Well, we visited in February, as you know, and it was the middle of winter, winter pressures, what we call in the NHS winter pressures, and the hospital was under a great deal of strain with patients who were ready for discharge, but couldn't be discharged.
So really things had come to pretty much a standstill in terms of, you know, putting people through A&E, emergency admissions, trying to get elective surgery in, trying to move people out that didn't require the acute hospital beds any more, and extra beds had been opened, surgery had been cancelled.
And I recall this specifically because I have been in that situation many a time myself and I -- I knew how dreadful that situation is because as much as you try there's very little you can do to sort of alleviate it. And so you worry about the quality of care that's being given to people, you worry about the staff that are working extremely hard, and maybe having to do overtime et cetera. So it's a real concern.
Q. I think in fact you subsequently spoke to Ann Ford to effectively make the observation, "I wonder if we'd had a different picture if we'd come at a different time of year."
A. Yes, yes.

Q. In terms of other things that you have recorded in your witness statement that were or weren't said, you say that you can't recall discussing a situation of any unexpected or unexplained increase in neonatal deaths and that you can say, with absolute certainty, that there was no mention of any suspicion or correlation with a member of staff and neonatal deaths?

A. Yes.

Q. And had that, had either of those things been raised, would they have provoked a reaction from you?

A. Yes, I would have discussed those with -- well, you might have asked more questions in the actual interview itself. But I think I would have discussed those with the Head of Hospital Inspection, that concerns had been raised that maybe we hadn't been made aware of before the inspection, particularly correlations between staff members and, you know, patient deaths. That's a serious issue.

Q. You record in your statement that staff were generally positive about the culture of the organisation?

A. Yes.

Q. And that they spoke positively about the visibility of the CEO and Director of Nursing?

A. That wasn't necessarily just the Children's

Unit. I think that was when I was asked to give an account of the interviews that had taken place with other staff groups, yes.

Q. Yes. So this is you giving your overview as Chair effectively?

A. Yes. I wasn't involved in any of those but I looked through all of the transcripts and I was trying to get an overview for the purposes of the statement and the Rule 9.

Q. You say your review caused you to find that generally interviewees gave positive accounts of the care they delivered to children and young people?

A. Yes.

Q. That in two interviews the issue of the Children's Unit not having a voice at board level was raised?

A. Yes.

Q. However, you say the neonatal unit department manager gave a slightly different impression?

A. Yes.

Q. That person is Eirian Powell. I think you say that she described the board as being visible and supportive?

A. Yes.

Q. You say that staff shortages were most

frequently mentioned?

A. Yes.

Q. And that there was real concern about that?

A. Yes.

Q. But that the nursing shortages in particular were long-standing?

A. Yes.

Q. Your involvement as you have told us was effectively for three days?

A. Yes.

Q. That's the 16th, 17th and 18th.

The inspection continued on the 19th?

A. Yes.

Q. But even though you were Chair, that wasn't your function to be present for that?

A. No. That was I think a CQC wrap-up meeting. I'm not quite sure how that was addressed.

But no, we stayed for the three days that we were conducting the inspection in the hospital itself.

Q. And it would appear there was some sort of connected visit in very early March, but I don't think --

A. An unexpected -- an unexpected?

Q. I'm not sure I would go that far but it appears to be connected with -- the follow-up is

connected with the February visit.

For my purpose, what's important is you didn't go back in March?

A. No. No, I didn't, I didn't go back.

Q. And you say in your witness statement you don't believe you went to any post-inspection meetings?

A. No, that was the quality summit and my name was on the template and I wasn't present at the quality summit.

Q. And you weren't involved in the drafting of the report?

A. No, no, I wasn't.

Q. Or provided with the email sent by Alison Kelly on 30 June?

A. No, no.

Q. So I would just like to invite you to reflect and you have had a little bit of processing time, although I have been asking you questions about it; if it is thought that something's gone wrong with this inspection --

A. Yes.

Q. -- the process overall and everybody involved in it, where do you think improvements might be made to try and prevent that in the future? And when I say something gone wrong, an important piece of information

does not appear to have made it to the CQC and as a result the CQC has given a report that suggests that effectively there isn't a big problem when there is?

A. I think if some of the raw data that was seen in the Provider Information Returns was seen by the people who were going to inspect the service, the specialist professional advisers, not just the CQC Inspectors, then actually they potentially would actually use that to base further questions on.

So I think that would have been helpful rather than just a summary of.

I think it's made me think about the role of the Chair undoubtedly because, you know, an expectation really, when you use that terminology, is that somebody's there at the start and right through to the finish and in a sense signs something off. So whether that's the right terminology for somebody who's called in for three days just to provide some sort of sense of leadership alongside the Head of Hospital Inspections is maybe not the right terminology.

Or if you do want somebody to do that role who's external to the CQC, it needs to be thought through differently so they can give more time to it and they are not somebody who's, you know, already working and just doing this as another issue.

Yes, can you say the question again because I have sort of forgotten where we are with that?

Q. No, not at all. I mean, one possibility is you say it was your practice to ask quite a general open question?

A. Yes.

Q. But it seems that that was something that you decided to come up with rather than something you were trained to do or it's something that you were told in every meeting, "You need to make sure that you're asking this" in case people aren't being forthcoming on the basis that people may not want to volunteer information but they may be less likely just to lie.

Do you think that that's the sort of thing that inspectors need to be doing, not just focusing on process but just asking people to step back and say, look --

A. Yes, I do.

Q. Sorry.

A. I do. But I can't say with any certainty that that wasn't already in place, that maybe it was suggested that at the end of every interview or focus group one of the final things should be, "Anything else you need to say? Anything else that anybody wants to say that we haven't yet covered?"

I can't recall that that was something, but it may well have been something that was actually explored with all the Specialist Advisers and CQC Inspectors that that's how you would finish off every interview or every focus group.

Q. And --

A. It's certainly important I think that that would be stated. It was obviously very important that you allowed people to know that they could come and see you independently if they had a concern and that that would be confidential.

Q. You frame that question in terms of "Anything you want to say?" Isn't there a slightly tighter question which is, "Is there anything that you think you should tell us?", not that you necessarily want to, but that you --

A. Yes.

Q. You know --

A. Yes, I think that's probably a better word to use. "Is there anything that you think you should tell us that we haven't already covered?"

Yes, I think that's a better word.

MR DE LA POER: Yes, thank you very much indeed.

Those are my questions, my Lady.

LADY JUSTICE THIRLWALL: Any questions, Mr Deakin?

MR DEAKIN: No questions.

LADY JUSTICE THIRLWALL: Thank you. I have no questions either, Mrs Childs, so thank you very much, you are free to go.

A. Thank you.

MR DE LA POER: My Lady, that concludes the evidence for today. As my Lady knows there are two further witnesses from the Care Quality Commission tomorrow morning.

LADY JUSTICE THIRLWALL: Very good. Thank you very much, Mr De La Poer. So we will rise now until 10 o'clock tomorrow morning.

(3.44 pm)

(The Inquiry adjourned until 10.00 am, on Friday, 15 November 2024)

I N D E X