

Tuesday, 14 January 2025

(10.00 am)

(Proceedings delayed)

(10.03 am)

**LADY JUSTICE THIRLWALL:** Mr Bershadski.

Evidence read by MR BERSHADSKI

**MR BERSHADSKI:** Yes, good morning, my Lady.

My Lady, the Inquiry has received a number of witness statements which contain evidence relating to whistleblowing and the Freedom to Speak Up system in the NHS and related issues.

The following is a summary of some of that evidence:

Dr Jayne Chidgey-Clark is the current National Guardian. This is an appointment by the CQC. The role was created as a result of recommendations made by Sir Robert Francis KC's Freedom to Speak Up Review.

Dr Chidgey-Clarke has provided the Inquiry with a statement dated 21 February 2024. She is unfortunately not able to give evidence today. The Inquiry will be asking Dr Chidgey-Clarke to produce a further short statement.

Dr Chidgey-Clarke explains that the National Guardian's Office is an independent office hosted by the Care Quality Commission. It leads, trains

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implementation of the role does not always accord with the NGO's guidance and guardians are not always sufficiently well resourced.

The NGO provides mandatory training to guardians and offers support calls.

The NGO maintains a directory of guardians: as of December 2023, there were 1,165 guardians appointed and since 2017 they have managed more than 100,000 cases.

In 2022 to 2023, nearly a third of cases involved alleged inappropriate behaviours; 21.7% involved bullying and harassment; over 25% involved worker safety and well-being; and 19% related to patient safety and quality.

The NGO does not have authority to ensure compliance but it works in partnership with the CQC and NHS England to support this. According to the NGO's 2023 survey of guardians, 86% of respondents felt supported by their Chief Executive and 77% by senior management. However, only 66% felt supported by managers.

The proportion of respondents who felt Speak Up was taken seriously in their organisation 78%, was down 6 percentage points compared to results in 2020. Almost two-thirds of respondents, 66%, identified the belief that "nothing will be done" was a barrier to workers in

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supports and reviews a network of Freedom to Speak Up Guardians, hereinafter referred to simply as "guardians", throughout England.

It does not investigate individual whistleblowing cases but may signpost individuals to alternative sources of advice and support. She explains that there is a national Freedom to Speak Up policy which sets minimum standards across the NHS and that NHS Trusts and providers of NHS services are required under the NHS Standard Contract and other rules to appoint a guardian and follow the NGO's guidance.

The NGO has developed documents including Freedom to Speak Up guidance, tools to be used by boards, e-learning modules to be used by those working in healthcare and a universal job description for the guardian role.

Dr Chidgey-Clarke explains that the role of a guardian is to ensure that all staff have the capability to speak up and to engage the board in all Freedom to Speak Up matters. The guardian's role is complementary to traditional routes of speaking up, such as through line management, patient safety reporting and HR processes.

The National Guardian's Office itself does not employ guardians. Dr Chidgey-Clarke notes that the

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their organisation speaking up.

Dr Chidgey-Clarke considers implementation of recommendations of reviews such as Kark and Messenger to be vital to support improvement in Speak Up culture.

She notes that the NGO's annual surveys demonstrate that a significant number of guardians consider protected characteristics, such as ethnicity, act as barriers to speaking up.

The Inquiry has received a statement from Bernadette Rochford, she is former whistleblower, commissioner, manager and nurse and is currently a principal Freedom to Speak Up Guardian at Essex Partnership University NHS Foundation Trust.

Ms Rochford notes a number of barriers to effective Freedom to Speak Up processes, including the following: the remit of the guardian role is now very wide. It encompasses "Anything that gets in the way of someone coming to work and doing their job".

Accordingly, the time and resources of the job have widened and there is a need to introduce prioritisation to the work.

The implementation of the guardian role in terms of pay banding and the number of guardians is variable. There is insufficient training within the NHS regarding how to speak up. Managers are often so overloaded that

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1 they struggle to respond appropriately to concerns,  
2 ostracisation by peers can act as a barrier and the  
3 organisational complexity of the NHS.

4 She notes that some guardians feel they have  
5 suffered "detriment for just doing their role", and  
6 "some have resigned because of this".

7 She makes a number of suggestions. Guardians  
8 should be fully supported, receive regular supervision  
9 and be linked to a region network and buddy system. The  
10 question of whether guardians should be employed  
11 directly by the organisations in which they work should  
12 be reviewed. Organisations should have greater guidance  
13 on what local Freedom to Speak Up metrics should be  
14 reported and how casework should be documented and  
15 retained. Management lines should be clearly  
16 communicated so that members of staff know who to  
17 escalate concerns to.

18 It should be made clear to staff that they should  
19 "report suspicions rather than wait for evidence".  
20 There should be one organisation which has  
21 responsibility for enforcing Speak Up concerns and  
22 an independent review of whistleblowing and the role of  
23 Employment Tribunals in the NHS should be carried out.

24 Professor Narinder Kapur is currently a visiting  
25 professor of neuropsychology at

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1 Nick Hulme has over 40 years experience in health  
2 and social care and over 13 years experience as a Chief  
3 Executive. He is currently the Chief Executive Officer  
4 of East Suffolk and North Essex NHS Foundation Trust.  
5 Mr Hulme notes, as do many other witnesses that key  
6 barriers to speaking up are fear, "staff may also feel  
7 that it is too risky to challenge the status quo" and  
8 futility, "nothing will happen so it is just not worth  
9 it".

10 He notes that leadership roles are often undertaken  
11 by clinicians with little to no formal leadership  
12 training or preparation, including as regards speaking  
13 up.

14 Mr Hulme observes that improving relationships  
15 amongst staff increases confidence to speak up. To this  
16 end he recommends that staff undertake apprenticeships  
17 within different departments and the use of coaching and  
18 organisational development he notes that a:

19 "... culture of openness and honesty in which all  
20 colleagues are able to raise concerns will not be  
21 achieved through one simple speak up message, campaign  
22 or policy. It needs to be embedded within the  
23 culture... truly listening is to hear the concern, take  
24 the relevant action and then, where appropriate,  
25 communicating about it."

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1 University College London and an honorary Consultant  
2 neuropsychologist at Imperial College NHS Trust.

3 He raised concerns while a Consultant at  
4 Addenbrooke's Hospital Cambridge and is the Human  
5 Factors Advisor to CORESS, the confidential reporting  
6 system for surgery.

7 Professor Kapur considers that there are currently  
8 significant failings in how whistleblowers are treated  
9 in the NHS. He highlights the case of nurse  
10 Amin Abdullah who died in 2016 after setting himself  
11 alight following his dismissal while working at  
12 Charing Cross Hospital in London.

13 Professor Kapur says that since guardians are  
14 employees of the organisations in which they work, they  
15 "face a clear conflict of interest if they try to stand  
16 up to management". Accordingly, he suggests that  
17 guardians should be employed by an external body which  
18 can then ensure that any investigations or disciplinary  
19 procedures are carried out fairly.

20 He supports regulation of managers in the NHS and  
21 suggests training regarding whistleblowing and fairness  
22 of investigatory and disciplinary procedures.  
23 Professor Kapur also suggests a review of the role of  
24 the legal system in whistleblowing cases involving the  
25 NHS.

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1 His own Trust has taken measures including holding  
2 a board development session with the National Guardian,  
3 revising their Freedom to Speak Up policy, introducing  
4 training for managers, creating new posters for staff,  
5 increasing the number of Freedom to Speak Up Guardian  
6 assistance and delivering town hall events. Mr Hulme  
7 supports the introduction of professional regulation for  
8 managers with associated training and development and  
9 access to expertise and support.

10 Professor David Oliver is a Consultant physician in  
11 geriatrics and general internal medicine. He is  
12 a visiting professor at City University of London and is  
13 also a columnist for the British Medical Journal.

14 He notes that since many managers in the NHS are  
15 already registered with a clinical regulator and are  
16 therefore already professionally bound to raise and act  
17 on concerns, the regulation of managers may not be  
18 a "panacea for some the problems identified in the Letby  
19 case".

20 His view is that if there is to be regulation of  
21 managers then any manager found to have suppressed or  
22 ignored the concerns of a whistleblower should be barred  
23 from employment in the NHS.

24 He notes that whilst professionals are obligated by  
25 their regulator to raise concerns, failures to do so

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1 rarely lead to regulatory action and whilst he welcomes  
2 the Freedom To Speak Up Guardian system he notes that  
3 whether it has been successful or not is inconclusive.

4 Sir Andrew Morris is a Non-Executive Director on  
5 the board of NHS England and was previously chair of  
6 NHS Improvement. He has worked in the NHS for over  
7 45 years and has been a Chief Executive at Trust level  
8 for over 25 years.

9 He believes that the Freedom to Speak Up system has  
10 improved the culture in the NHS and is making  
11 a difference, although "in some organisations further  
12 improvement and refinement is required."

13 He notes that each Trust has a Freedom to Speak Up  
14 Non-Executive Director champion on its board. His  
15 experience is that the Chief Executive of a Trust is  
16 particularly influential in setting the tone of speaking  
17 up and that it is important that the board should send  
18 a clear signal that "no detriment will result from  
19 speaking up".

20 Sir Andrew makes a number of recommendations in  
21 relation to Freedom to Speak Up.

22 "Better communication to staff of what to do in  
23 exceptional circumstances if they have a very serious  
24 concern regarding safety and they feel that their  
25 organisation is not addressing the issue adequately."

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1 "There is substantial evidence that in significant  
2 parts of the NHS there remains a culture that inhibits  
3 members of staff from raising concerns about patient  
4 safety."

5 Sir Stephen makes a number of recommendations.  
6 Each NHS organisation board should create a culture  
7 which is seen to be:

8 "... welcoming and supportive of those that speak  
9 out and explicitly seeks to learn rather than punish.  
10 This culture needs to be accompanied by the organisation  
11 being committed not only to listen to staff but act on  
12 their insights."

13 The message needs to be reinforced to all  
14 healthcare staff as part of education systems that one  
15 of their core responsibilities is speaking out when they  
16 see poor practice or behaviours. And staff should have  
17 a "menu of options for speaking out", such as regular  
18 surgeries, run with a Freedom to Speak Up Guardian where  
19 staff can raise concerns.

20 The Inquiry has received a statement from  
21 Dr Henrietta Hughes. Dr Hughes has been the Patient  
22 Safety Commissioner for England since September 2022 and  
23 was previously the National Guardian for a period of  
24 five years from 2016. She explains that the Patient  
25 Safety Commissioner's role is to promote the safety of

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1 Currently not every Freedom to Speak Up Guardian  
2 has an open invite to the board through the Freedom to  
3 Speak Up Non-Executive Director champion. More training  
4 for managers regarding speaking up and Freedom to Speak  
5 Up should be incorporated into appraisals at all levels.

6 Regarding the regulation of managers, he considers  
7 that the Fit and Proper Person Framework in place since  
8 August 2023 should be allowed to "bed in and then be  
9 reviewed before a final decision on whether full  
10 regulation is required."

11 Sir Stephen Moss has held managerial posts in the  
12 NHS at board level for over 30 years and was Director of  
13 Nursing and then Chief Executive at Queen's Medical  
14 Centre in Nottingham. In 2009 he was asked to take on  
15 the role of chairman at Mid Staffordshire NHS Foundation  
16 Trust. He was a trustee of a charity, Patient Safety  
17 Learning, between 2018 and 2024 he notes that:

18 "It is vital that NHS staff feel able to raise,  
19 report and discuss safety concerns and opportunities for  
20 improvement. This is not simply a principle at that  
21 applies to healthcare but is vital across all safety  
22 critical industries. When organisations have a culture  
23 that seeks to assign blame when things go wrong, harm is  
24 more likely to happen."

25 However, he considers that:

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1 patients and promote the views of patients of and other  
2 members the public with regard to the use of medicines  
3 and medical devices.

4 In that role, she has made a number of  
5 recommendations in relation to the implementation of  
6 Martha's Rule which empowers patients and their families  
7 to seek an urgent review from a critical care outreach  
8 team. She chairs the Martha's Rule Working Group  
9 meetings.

10 Dr Hughes notes that the patient safety landscape  
11 is complex with over 100 organisations holding some  
12 relevant responsibility and that there are many  
13 different channels that patients and their relatives and  
14 carers can turn to. She notes that complaint systems  
15 can feel formalised.

16 Dr Hughes says that leaders and managers are not  
17 held to account for patient safety and the patient voice  
18 in the same way as they are on finance.

19 Inductions training for Non-Executive Directors  
20 provided by NHS Providers does not currently include  
21 patient safety. There is no system of national learning  
22 from patient complaints.

23 Dr Hughes concludes by saying that a cultural shift  
24 of listening to patient and staff voices when speaking  
25 up about patient safety and care is needed throughout

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1 the healthcare system.

2 Ms Georgina Halford-Hall is the Chief Executive of  
3 WhistleblowersUK. This provides a confidential  
4 reporting platform for whistleblowers. Over 50% of  
5 reports to WhistleblowersUK come from the NHS.  
6 WhistleblowersUK has been contacted by Freedom to Speak  
7 Up Guardians who have raised their own concerns after  
8 trying to represent whistleblowers and who have been  
9 undermined and targeted. Some have felt bullied and  
10 forced out of their roles.

11 Ms Halford-Hall also says that many whistleblowers  
12 have reported receiving little more than generic  
13 information and a "shoulder to cry on" from their  
14 Freedom to Speak Up Guardians. She therefore considers  
15 there are failures and inadequacies in the Freedom to  
16 Speak Up system.

17 WhistleblowersUK supports the creation of an office  
18 of the whistleblower with the statutory power to be able  
19 to intervene in whistleblowing cases, protect the  
20 public, support the whistleblower, oversee regulatory  
21 investigations into whistleblowing cases and direct the  
22 prosecution of any individual or organisation seeking to  
23 illegally punish or silence a whistleblower.

24 Ms Halford-Hall notes the particular problem of  
25 vexatious referrals to regulators. She is highly

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1 since 2008. Treatments provided include talking  
2 therapy, cognitive behavioural therapy and treatment for  
3 addiction.

4 All staff at NHS Practitioner Health undergo  
5 safeguarding training.

6 It is NHS Practitioner Health's view that medical  
7 errors or significant untoward incidents should be dealt  
8 with as learning events and that the blame culture in  
9 the NHS is hugely detrimental.

10 Peter Duffy was a whistleblower at University  
11 Hospitals of Morecambe Bay NHS Trust whilst working  
12 there as a Consultant urological surgeon in 2015. His  
13 experiences there are outside the Terms of Reference of  
14 this Inquiry. He is currently the Chair of  
15 WhistleblowersUK.

16 He notes a number of barriers to speaking out: fear  
17 of being ostracised by peers; the gradual normalisation  
18 of poor practice; a feeling of loyalty to one's  
19 employer; and fear of detriment. Mr Duffy notes that  
20 regulators rarely sanction professionals for not  
21 whistleblowing and safeguarding and suggests greater  
22 regulatory support for whistleblowers. He too suggests  
23 a review of the role of the legal system in  
24 whistleblowing cases.

25 The Inquiry has received a statement from

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1 critical of the Public Interest Disclosure Act and the  
2 fact that whistleblowing is dealt with primarily via  
3 Employment Tribunal proceedings.

4 Ann Paul is the Chief Executive of Doctors in  
5 Distress, a charity which promotes and protects the  
6 mental health of all healthcare workers and aims to  
7 prevent suicide in the medical profession.

8 Ms Paul notes that the risk of suicide among mental  
9 health professionals is elevated compared to the  
10 national average. Nurses in particular are four times  
11 more likely to take their own lives than people working  
12 in other professions. She notes that the key  
13 occupational factors behind this are a culture of  
14 self-sacrifice, bullying, the pressure to toughen up,  
15 staff shortages and workplace violence and abuse.

16 Ms Paul suggests that a more positive culture where  
17 the well-being of staff members is prioritised will lead  
18 to better retention and a happier workforce.

19 Dr Zaid Al-Najjar is the Medical Director at NHS  
20 Practitioner Health. This is a mental health service  
21 established in 2008. It provides mental health  
22 treatment to medical practitioners who are at increased  
23 risk of mental health conditions compared with the  
24 general population. It sees some 600 self referrals per  
25 month. 30,000 people have accessed treatment services

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1 Mr Phillip Brear, who was a police officer from 1973  
2 until retiring in 2005. He was then appointed the  
3 deputy head of the Gaming Board of Great Britain and  
4 in 2007 the Head of Regulation and then the Gaming  
5 Commissioner for the Government of Gibraltar.

6 Mr Brear currents his experience of being  
7 a governor of a NHS Foundation Trust for a period of  
8 time in 2022.

9 Mr Brear states that there is an ongoing dispute  
10 between him and an NHS Foundation Trust which is  
11 addressed throughout his statement. This issue is not  
12 relevant to the Terms of Reference of the Inquiry.

13 Mr Brear is highly critical of the conduct of board  
14 meetings within NHS Foundation Trusts. He considers  
15 that board papers are unnecessarily long and deprecates  
16 a practice he says is prevalent whereby publicised board  
17 meetings are held which are designed to overwhelm the  
18 average reader, followed by private meetings from which  
19 the public and governors are excluded.

20 He considers that governors are regularly prevented  
21 by Foundation Trusts from playing a meaningful role. He  
22 is highly critical of NHS Providers, which he describes  
23 as a "pressure and lobby group" for Foundation Trusts  
24 and of alleged failures by NHS England and the CQC to  
25 intervene in his case.

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1 The Inquiry has also received a witness statement  
2 from Mr St John Brown. Mr Brown was a senior  
3 vice president at Philips Medical Systems until 2001 and  
4 was chairman of Medical Imaging Partnership, a private  
5 diagnostic imaging provider between 2016 and 2019.

6 He was a governor of a hospital in West Sussex  
7 between 2017 and 2023. Like Mr Brear, Mr Brown details  
8 significant problems during his tenure as a governor.  
9 He is highly critical of NHS England which he considers  
10 was "pulling the strings" behind a planned merger with  
11 another Trust. Mr Brown considers that the current  
12 Foundation Trust and Council of Governors structure is  
13 "not fit for purpose".

14 These issues fall outside the Terms of Reference of  
15 the Inquiry.

16 Dr McLean is a retired police officer. He was  
17 appointed as Chair of Bradford Teaching Hospitals NHS  
18 Foundation Trust on 1 May 2019 and held that role until  
19 he resigned on 3 October 2023.

20 He has provided the Inquiry with a statement in  
21 which he details his experiences whilst Chair.  
22 Dr McLean, like Mr Brear and Mr Brown, sets out the poor  
23 responses to his raising of concerns.

24 He says that he raised nine issues about the  
25 performance of the Chief Executive Officer who was

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1 **A.** On behalf of CQC and myself I want to express  
2 our deepest and sincere condolences and sympathies to  
3 the Families for their loss and for the grief they have  
4 been through and what they are still going through.

5 Thank you, my Lady.

6 **MR CARR:** Mr Dzikiti, you are the Interim Chief  
7 Inspector of Healthcare at the Care Quality Commission,  
8 the CQC.

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

10 **Q.** You have prepared, haven't you, a statement  
11 dated 9 December 2024?

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

13 **Q.** Are the contents of that statement true to  
14 your best knowledge and belief?

15 **A.** That's correct.

16 **Q.** By way of your professional background, you  
17 explain at paragraph 2 of that statement that you have  
18 a background in healthcare?

19 **A.** Yes.

20 **Q.** You qualified as a registered mental health  
21 nurse in 2002?

22 **A.** That's correct.

23 **Q.** You've worked in and managed mental health  
24 services in London?

25 **A.** Yes.

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1 accountable to him. One of the issues raised concerned  
2 significantly protracted investigation relating to  
3 serious neonatal incidents.

4 These issues fall outside the Terms of Reference of  
5 the Inquiry. Accordingly, the decision has been taken  
6 only to publish this summary of Mr Duffy, Mr Brear,  
7 Mr Brown and Dr McLean's evidence.

8 My Lady, that concludes a summary of Freedom to  
9 Speak Up witness statements and I think Mr Carr is  
10 taking the next witness.

11 **LADY JUSTICE THIRLWALL:** Thank you very much  
12 indeed, Mr Bershadski.

13 Mr Carr.

14 **MR CARR:** My Lady, thank you. My Lady, if I may  
15 call Mr Chris Dzikiti, please.

16 **LADY JUSTICE THIRLWALL:** Mr Dzikiti.

17 MR CHRIS DZIKITI (sworn)

18 Questions by MR CARR

19 **MR CARR:** Do sit down.

20 **A.** Thank you.

21 **MR CARR:** If we can start, please, with your full  
22 name.

23 **A.** My name is Chris Dzikiti and, my Lady, if  
24 possible, if I can say a few words at the start?

25 **LADY JUSTICE THIRLWALL:** If you want to.

18

1 **Q.** You've worked for a commissioning team at  
2 NHS England?

3 **A.** Yes.

4 **Q.** You've worked at an Integrated Care System --

5 **A.** Yes, that is correct.

6 **Q.** -- prior to the role at the CQC.

7 Now, in addition to your statement you refer to the  
8 two witness statements that had been provided to the  
9 Inquiry from Ian Trenholm?

10 **A.** That's correct.

11 **Q.** Statements dated 12 February 2024 and  
12 4 April 2024.

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

14 **Q.** At the time of signing those statements,

15 Mr Trenholm was the CQC's Chief Executive?

16 **A.** That's correct.

17 **Q.** But he has since stepped down from that role?

18 **A.** That's correct.

19 **Q.** You state that you have been briefed on those  
20 statements by Mr Trenholm?

21 **A.** I have -- I've looked at the statements that  
22 has been provided by Mr Trenholm but I haven't spoken to  
23 Mr Trenholm.

24 **Q.** And in your statement you say you are able to  
25 adopt the statements of Mr Trenholm?

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1 A. That's correct.  
 2 Q. Paragraph 9 of your statement.  
 3 A. That's correct.  
 4 Q. And you are here to speak to the matters  
 5 raised by Mr Trenholm?  
 6 A. That's correct.  
 7 Q. Now, by way of overview, the CQC, it's the  
 8 independent regulator of healthcare in this country?  
 9 A. That's correct.  
 10 Q. And it regulates providers of healthcare such  
 11 as NHS Foundation Trusts?  
 12 A. Yes.  
 13 Q. Like the Countess of Chester?  
 14 A. That's correct.  
 15 Q. And the CQC has the power to take civil or  
 16 criminal enforcement action where regulatory standards  
 17 are not being met?  
 18 A. That's correct.  
 19 Q. And as Mr Trenholm explains in his statement,  
 20 we will be going to various parts of his statement, but  
 21 the regulatory standards are those set out in the 2014  
 22 regulations?  
 23 A. That's correct.  
 24 Q. Those regulations include Regulation 12 which  
 25 is concerned with providing care and treatment in a safe

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1 must include investigation and may also include referral  
 2 to an appropriate body."  
 3 Now, in line with your previous answer about  
 4 Regulation 13 extending to deliberate harm, that section  
 5 I have just read out would also apply to allegations of  
 6 deliberate harm, wouldn't it?  
 7 A. Yes, that's correct.  
 8 Q. Okay we can take the statement down for now.  
 9 More broadly, Mr Dzikiti, how was Regulation 13  
 10 assessed and regulated in the context of neonatal and  
 11 paediatric care in hospitals in 2016?  
 12 A. So as, as part of the planning of the  
 13 inspection, my understanding from the information I have  
 14 accessed and the staff I have managed to speak to within  
 15 CQC, so there would be a plan, that plan would include  
 16 looking at the data which was available. That data  
 17 would have come through from NHS England because  
 18 NHS England are responsible for collecting data from  
 19 providers in terms of STEIS, the National Reporting and  
 20 Learning System also so that information would be  
 21 collected by our analysts.  
 22 In 2016, our analyst will create a data pack, in  
 23 that data pack that will include information, for  
 24 example if there was any instances of harm or avoidable  
 25 harm it would be included in that data pack which would

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1 way?  
 2 A. That's correct.  
 3 Q. Regulation 13 which is concerned with  
 4 safeguarding service users from abuse and improper  
 5 treatment?  
 6 A. That's correct.  
 7 Q. The intention of Regulation 13, protecting  
 8 patients from abuse or improper treatment, that would  
 9 extend, wouldn't it, to deliberate harm?  
 10 A. That's correct.  
 11 Q. And if we can look at Mr Trenholm's first  
 12 statement, it's INQ0012634. My Lady, it's your tab 2.  
 13 **LADY JUSTICE THIRLWALL:** Thank you.  
 14 **MR CARR:** If we go to page 26 of that statement.  
 15 It's paragraph 26, Mr Dzikiti, I am going to highlight  
 16 here.  
 17 Here Mr Trenholm is describing the guidance on  
 18 Regulation 13.  
 19 **LADY JUSTICE THIRLWALL:** That is paragraph 126.  
 20 **MR CARR:** Yes, 126, yes 126.  
 21 And if we look at the second sentence of  
 22 paragraph 126:  
 23 "The guidance also states that where a provider  
 24 becomes aware of any allegation or evidence of abuse  
 25 they must take appropriate action without delay which

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1 then be shared with inspectors or the inspection team.  
 2 Also they would highlight if there were any issues to  
 3 focus in, in those data packs and as part of that  
 4 planning, the inspection teams would go through the data  
 5 packs. Also there was an opportunity as well for  
 6 inspectors, for example the lead inspector could request  
 7 for information from, from the Trust which they could  
 8 Provider Information Request, or PIR.  
 9 And as part of the inspection process the providers  
 10 are required to submit that information to the  
 11 inspection team and so using all that intelligence they  
 12 would look and see if there were any, any issues in  
 13 terms of safety for patients or safety for especially in  
 14 that area.  
 15 During that time we are doing comprehensive  
 16 assessments, which meant we were doing more core  
 17 services. From my memory I think we were doing nine  
 18 core services of Countess of Chester Hospital. As part  
 19 of those services Children and Young People were part of  
 20 those services and also maternity services were part of  
 21 those services and they would look at the data to look  
 22 at if there were any issues of concern prior to going to  
 23 an inspection.  
 24 Q. Thank you. We are going to spend some time  
 25 looking at the approach to data and what data was

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1 available.

2 **A.** Yes.

3 **Q.** And we will get to that in a few moments, but  
4 thank you for the full answer.

5 Is a summary of the answers to the question as to  
6 how Regulation 13 was assessed in the context of  
7 neonatal care that it is essentially data led, so  
8 assessing Regulation 13 starts with the data?

9 **A.** Yes so data is the starting point because then  
10 it informs what key lines of enquiries the team would  
11 then focus on. So data was the starting point because  
12 it would give you, you know, the focus of which areas  
13 you should focus on and we had key lines of enquiries,  
14 or some people would call them KLOEs, which then the  
15 team would use to further discuss with the team. There  
16 was also an opportunity to observe care when you are  
17 doing inspections to see how practitioners, nurses or  
18 doctors carried themselves out in terms of delivering  
19 care.

20 There was also an opportunity to speak to staff and  
21 to speak to people who had used services to understand  
22 their experience of care during their admissions. So  
23 there were so many other areas to focus on to try and  
24 understand whether Regulation 13 was being complied on.

25 **Q.** The answer there focused on inspections. If

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1 into both aspects?

2 **A.** It does.

3 **Q.** Both inspection and monitoring?

4 **A.** Monitoring, yes.

5 **Q.** There will be national data returns which are  
6 received by the CQC on a regular basis?

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

8 **Q.** And notifiable safety incidents which we will  
9 come to and you have already mentioned it, STEIS and RLS  
10 which the CQC has an ongoing access to?

11 **A.** (Nods)

12 **Q.** Now, as for inspections, how effective are  
13 they as a means of discovering failings by members of  
14 staff at a healthcare institution?

15 **A.** So like I said at the start, data is the  
16 starting point and inspections give the team of  
17 inspectors and Specialist Advisors an opportunity to go  
18 into a service, spending time observing care, observing  
19 interactions between staff and patients or service  
20 users, it also give inspection teams an opportunity to  
21 speak to the staff about their experience in terms of  
22 either working in an organisation, experience of what's  
23 going on in that service.

24 So, for example, when we attend a hospital you can  
25 talk to people about -- staffing levels, for example, is

27

1 we just take a few steps back and consider the way in  
2 which the CQC regulates, inspection is one element of  
3 regulation?

4 **A.** Yes.

5 **Q.** The other is monitoring, isn't it?

6 **A.** Yes.

7 **Q.** And by monitoring, that involves the CQC  
8 having a relationship --

9 **A.** Yes.

10 **Q.** -- with a Trust and keeping their performance  
11 under review?

12 **A.** Yes, that -- that's correct.

13 **Q.** And it also involves engagement meetings where  
14 CQC Inspectors will meet with representatives from the  
15 Trust?

16 **A.** Yes.

17 **Q.** And management review meetings which are  
18 internal?

19 **A.** Internal.

20 **Q.** CQC meetings where decisions are made as to --

21 **A.** Yes.

22 **Q.** -- enforcement or any issues for  
23 investigation?

24 **A.** That's correct.

25 **Q.** And the analysis and receipt of data feeds

26

1 a big issue and most services will express concerns  
2 around you know staffing issues.

3 In some services, where we have gone in and found  
4 some concerns around for example an area where there has  
5 been restrictive practice which is not about this  
6 incident we are talking about today but just giving an  
7 example of what's available in other sectors we regulate  
8 for example in mental health, if we are not clear about  
9 what has happened and we want to look at more detail  
10 because most mental health services has got CCTV camera,  
11 we can request for example to look at CCTV to see an  
12 episode of an incident that has happened.

13 Also then when you think about, for example,  
14 talking to people use services, their families, giving  
15 feedback of what has happened in those services.

16 So I believe if the question is whether inspections  
17 help to identify (a), the poor practice or any issues or  
18 areas of improvement, I believe inspections do so.

19 **Q.** If we can turn then to the Countess of Chester  
20 Hospital and specifics --

21 **A.** Yes.

22 **Q.** -- relating to that.

23 I want to start with the CQC's position as to its  
24 knowledge of events at the hospital and again we will go  
25 to Mr Trenholm's evidence, this time his second witness

28

1 statement. My Lady, your tab 3.  
2 INQ0017809. If we go forward, please, to page 16,  
3 it is paragraph 73. It reads:

4 "We first became aware of concerns regarding deaths  
5 on the neonatal unit on 29 June 2016, the day our  
6 inspection report was published. At the CQC, Inspector  
7 Deborah Lindley received a call from Alison Kelly,  
8 Director of Nursing and Quality at Countess of Chester  
9 NHS Foundation Trust informing her the Trust had  
10 identified an increase in the number of deaths of  
11 newborn babies ... differing levels of prematurity on  
12 the neonatal unit in 2015 to 2016 and now 2016/17  
13 compared to previous years."

14 There has obviously been extra disclosure that the  
15 CQC has found since Mr Trenholm's witness statements.  
16 Does paragraph 17, the section I have just read out,  
17 still represent the CQC's position as to when it became  
18 aware of this issue?

19 **A.** Yes, from my understanding, yes.

20 **Q.** And is it the case that it's not simply that  
21 this is a date that the CQC first became aware of  
22 concerns, it was the date they first became aware that  
23 there was an increase in deaths on the neonatal unit at  
24 all?

25 **A.** From my understanding, this is the date we  
29

1 position is because and as you will have seen, there  
2 have been serious shortcomings in the CQC's disclosure  
3 to this Inquiry, hasn't there?

4 **A.** Yes.

5 **Q.** You will have seen the transcript of the  
6 evidence that Ann Ford gave to this Inquiry?

7 **A.** (Nods)

8 **Q.** The position is, so far as disclosure is  
9 concerned, in light of the policy adopted by the CQC,  
10 following the directive from the IICSA Inquiry, all  
11 records relating to the 2016 inspection ought to have  
12 been retained?

13 **A.** That's correct.

14 **Q.** And they weren't, were they, there's documents  
15 that have not been found?

16 **A.** (Nods)

17 **Q.** The CQC originally provided disclosure to the  
18 Inquiry in February and April 2024, but the Inquiry had  
19 to make a further Rule 9 request after that initial  
20 disclosure which led to around 4,000 documents being  
21 provided in July 2024?

22 **A.** (Nods)

23 **Q.** Just shortly before the oral hearing started;  
24 that's correct, isn't it?

25 **A.** Yes.

31

1 knew about an increase into neonatal mortality rate.

2 **Q.** And up until that date, 29 June, the  
3 monitoring conducted by the Care Quality Commission, so  
4 the meetings, the relationship, the data analysis, the  
5 inspection visit, the report writing and publication had  
6 not detected the increase in neonatal mortality, let  
7 alone concerns about it?

8 **A.** Yes, from my understanding, no.

9 **Q.** And staying in that statement, if we go  
10 forward to paragraph 94, it's page 20, please. I will  
11 be coming back to this paragraph, but it is the first  
12 sentence I want deal with now:

13 "Review of available records indicate that CQC  
14 first became aware of a criminal investigation on  
15 15 May 2017 following an engagement call with the  
16 Trust."

17 And again, the question is: does that remain the  
18 CQC's position notwithstanding the additional  
19 documentation that has been discovered?

20 **A.** Yes, that's correct, Mr Carr.

21 **Q.** Thank you, we can take that statement down for  
22 now.

23 Part of the reason I asked you the questions that  
24 I just did about state of knowledge and whether  
25 Mr Trenholm's statement still represents the CQC's  
30

30

1 **Q.** The explanation given was that the CQC  
2 interpreted the Inquiry's original request too narrowly.

3 Do you adopt on behalf of the CQC Ms Ford's  
4 evidence that the delay was -- delay in providing full  
5 disclosure was unacceptable?

6 **A.** That's correct.

7 **Q.** And that from as early as 2017, when the CQC  
8 became aware of the police investigation it would have  
9 been sensible for the CQC to turn its mind then to the  
10 preservation of documents?

11 **A.** That's correct.

12 **Q.** And it remains the case up until now that  
13 there are a significant number of documents which have  
14 not been found or provided, including notes of the  
15 pre-inspection meeting with the Countess of Chester --

16 **A.** Yes.

17 **Q.** -- in February 2016?

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

19 **Q.** Notes of the listening event on  
20 9 February 2016?

21 **A.** That's correct.

22 **Q.** Notes of any of the core interviews with  
23 senior members of staff at the hospital as part of the  
24 inspection in 2016?

25 **A.** That's correct.

32



1 **Q.** Full notes of the Consultants' focus group  
2 meeting?  
3 **A.** That's correct.  
4 **Q.** And notes of the quality summit meeting in  
5 February 2016 and the quality surveillance group meeting  
6 in July 2016?

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

8 **Q.** Ms Ford accepted in her oral evidence that the  
9 CQC needed to have a discussion, internally have  
10 a discussion about whether or not the Information  
11 Commissioner should be formally notified of the loss of  
12 a significant quantity of records.

13 Are you able to update us as to whether that  
14 discussion has been held and the CQC's position?

15 **A.** Yes. So our data protection officer has  
16 reviewed those information which we are currently no  
17 longer able to find and concluded that there was no  
18 requirement to -- to refer to -- to the IOC -- ICO,  
19 sorry, the Information Commissioners Office, in terms of  
20 the missing documents.

21 But also managed to have a conversation with ICO to  
22 explain our position and ICO did agree that most likely  
23 because our data protection officer felt that there was  
24 no personal information which was missing in those  
25 documents or included in those documents; there was no

33

1 by going again to Mr Trenholm's statement, his first  
2 statement, INQ0012634. If we turn to page 37 of the  
3 statement, and this is where the section on data starts.

4 It's 193. I want you to look at where Mr Trenholm  
5 describes CQC Insight. He states:

6 "We use CQC Insight to monitor potential changes to  
7 the quality of care. CQC Insight brings together in one  
8 place the information we hold about services and  
9 analyses it to monitor services that provide a location  
10 or core service at level."

11 And then at paragraph 194:

12 "Our inspectors and assessors regularly check  
13 CQC Insight."

14 And what he is describing here it is an electronic  
15 system, isn't it?

16 **A.** Yes.

17 **Q.** Which analyses and explains various data  
18 sources available to the CQC?

19 **A.** That's correct.

20 **Q.** And it would follow, wouldn't it, from the  
21 fact that at the inspection in 2016 the CQC were unaware  
22 of increased mortality at the Countess of Chester,  
23 CQC Insight had not identified that increased mortality?

24 **A.** Yes, that's -- that's correct. And my  
25 understanding being the Insight report in 2016, some of

35

1 requirement to make an official referral to ICO which  
2 ICO agreed with.

3 **Q.** Can we turn now to the issue of data.

4 **A.** Yes.

5 **LADY JUSTICE THIRLWALL:** Sorry, Mr Carr, just  
6 before we leave that, is there a note of that somewhere?

7 **A.** Yes, we can -- I can make sure that's provided  
8 to the Inquiry if it's needed, yes, I will take that  
9 back.

10 **LADY JUSTICE THIRLWALL:** Thank you very much, just  
11 for completeness. Thank you.

12 **A.** Thank you.

13 **MR CARR:** Yes, turning to the issue of data.

14 **A.** Yes.

15 **Q.** You have already explained that it's the  
16 starting point for assessing for instance  
17 Regulation 13 --

18 **A.** Yes.

19 **Q.** -- in respect of neonates and paediatric care  
20 and it is obviously important to both effective  
21 monitoring --

22 **A.** Yes.

23 **Q.** -- inspection regulation as a whole?

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

25 **Q.** If we can begin the exploration of this issue

34

1 the information there, there was a data lag in some of  
2 the information. So for example if you look at some of  
3 the information we use there will always be a three or  
4 six months data lag sometimes into the information.

5 **Q.** Yes, I have looked through both of  
6 Mr Trenholm's statements and I know there are some data  
7 statements we are going to go to in a few moments --

8 **A.** Yes.

9 **Q.** -- to try to understand the extent of the data  
10 lag.

11 What Mr Trenholm explains in his second statement  
12 is, for instance, the MBRRACE data for 2015, 2016 didn't  
13 come through until -- wasn't available to the CQC until  
14 November 2017?

15 **A.** Yes, a year later, that's correct.

16 **Q.** So on MBRRACE there is a significant lag?

17 **A.** Yes.

18 **Q.** And it's about two years, isn't it?

19 **A.** Yes.

20 **Q.** So MBRRACE is not going to provide, as it  
21 were, up-to-date data?

22 **A.** No, it doesn't provide real monitoring like on  
23 a regular basis or current real monitoring data you  
24 need.

25 **Q.** Thank you, we can take that statement down.

36

1 Another source of data and analysis is the Hospital  
2 Episodes Statistics, HES?

3 **A.** Yes.

4 **Q.** Now, Ann Ford gave oral evidence on this  
5 topic, it was also covered in her witness statements,  
6 her second and third witness statements, but there was  
7 a degree of confusion between the two statements.

8 In her oral evidence the position reached was that  
9 HES data was not in real-time either. There was also  
10 a lag on HES data?

11 **A.** Yes, that's -- that's correct. That's my  
12 understanding.

13 **Q.** More recently, the CQC has provided two  
14 statements dealing with data and if we can look at the  
15 statement from Lisa Annaly first, please, it is  
16 INQ0108742. My Lady, it is your tab 5. This is  
17 a statement dated 18 December 2024.

18 And Ms Annaly, she is a Deputy Director of  
19 Analytical Content for the CQC.

20 **A.** That's correct.

21 **Q.** And she sets out in this statement a number of  
22 different data sources available to the CQC. If we turn  
23 to page 3 of her statement, please, at the bottom of the  
24 page, paragraph 2.1.4.1, she describes the outliers  
25 programme that the CQC ran between 2009 and 2020.

37

1 to bring that at a later stage if that's helpful to the  
2 Inquiry.

3 **Q.** Ms Annaly goes on to deal with the use of  
4 Hospital Episodes Statistics, HES.

5 If we look further down on page 4, paragraph 2.1.  
6 6.1, she describes it as, second line of the paragraph:

7 "A key data source for the analysis of mortality  
8 for services provided in NHS hospitals."

9 **A.** Yes.

10 **Q.** But then if we go forward to page 13 of her  
11 statement, at the bottom of that page into the next  
12 page, paragraphs 3.6 and 3.7, she makes a similar point  
13 to the one I think you make where she says:

14 "I would not myself describe the tools that CQC use  
15 as typically employing data available to CQC at the  
16 point of data collection.

17 "Although CQC has processes in place to bring in  
18 new data and keep data sources up to date, there is  
19 often a lag between the point of data collection and its  
20 availability to CQC for analysis so I would not  
21 characterise our tools as operating in real-time."

22 Then the next paragraph, 3.7:

23 "As such I am unable to identify a CQC prospective  
24 mortality monitoring tool of the sort Sir David  
25 defines."

39

1 It appears to have stopped because of Covid.

2 **A.** Yes, can I just --

3 **Q.** Yes.

4 **A.** -- read that section if that's okay?

5 **Q.** Yes.

6 (Pause)

7 **A.** Thank you, Mr Carr.

8 **Q.** Yes, the question that I have for you about  
9 the outliers programme is whether you could help us to  
10 understand the time lag, if any, on the outliers  
11 programme, so what period would the outliers programme  
12 cover at any one time?

13 **A.** So, so my -- my understanding is the outliers  
14 programme used different sources of data, so it didn't  
15 use just one source of data. So it used for example the  
16 hospital, hospital episode statistics data, it also used  
17 other sort of published data from any reviews around  
18 mortality data and all those data sources, they were  
19 different there were different lags to when those  
20 statistics were provided to CQC.

21 I can't clearly cover each part of the data  
22 sources, how long the data lag was but my understanding  
23 was there was never a data source which didn't have  
24 a lag, but I am not able to give you exactly in terms of  
25 how long the lag was on each data source but happy to --

38

1 And gives us an example of real-time monitoring  
2 systems.

3 She is referring in paragraph 3.7 to the statement  
4 to the Inquiry from Professor Spiegelhalter, isn't she?

5 **A.** Yes.

6 **Q.** He states that the CQC had a prospective  
7 mortality monitoring tool that he helped to set up. But  
8 is it the CQC's position that there was no real-time  
9 monitoring in 2016?

10 **A.** No, there was never a real-time monitoring of  
11 data in 2016.

12 **LADY JUSTICE THIRLWALL:** You say there was never  
13 one?

14 **A.** No. Yes, we didn't have it.

15 **MR CARR:** Does that remain the case today?

16 **A.** Yes, that, that remains the case.

17 **Q.** And are you able to help us with what the time  
18 lag on data is currently?

19 **A.** So majority of the patient safety data we use,  
20 it, it comes through NHS England, which is through STEIS  
21 and AOS which is now being replaced by Learn from  
22 Patient Safety Events. Because the data is submitted by  
23 providers to NHS England and then NHS England has to do  
24 its own processes of managing the data before it's then  
25 shared with us on a weekly basis. So we get a count on

40

1 a weekly basis, that's my understanding. But, so you  
2 are looking at possibility from my understanding three  
3 to six months' lag but some information may come to us  
4 quicker in the sense of depending when it has been  
5 submitted by the provider to NHS England and how long  
6 NHS England take to process the data and then when it  
7 comes to us but at least because we are getting it on  
8 a weekly basis that might improve the data lag.

9 So my understand is it varies depending on when the  
10 information is being submitted by the provider to  
11 NHS England.

12 We -- we don't have a means in terms of getting the  
13 same data that goes to NHS England because the  
14 understanding is trying to make sure there is not too  
15 much data requests being asked of providers to be sent  
16 to us as well to be sent to NHS England. That is why  
17 STEIS and Learning from Patient Safety Incidents data  
18 goes via NHS England.

19 **LADY JUSTICE THIRLWALL:** So what is the lag within  
20 NHS England?

21 **A.** It depends. Normally it's a few days they  
22 need to process the data before it comes to us.

23 **LADY JUSTICE THIRLWALL:** Right. So the three to  
24 six months lag derives from what? A failure of the  
25 hospitals to send the information to NHS England?

41

1 just takes a few days for NHS England to sort it out.

2 **A.** For some of the data, yes, for some of the  
3 data, my understanding being there is no standard  
4 approach in terms of how long it takes for each data to  
5 be submitted. So the lag it's, it's a variation between  
6 different organisational data which has been submitted.

7 So an example is some organisations from my  
8 understanding from our analysts is some data might come  
9 to us as quickly as less than a month. But some might  
10 take three to six months but more --

11 **LADY JUSTICE THIRLWALL:** So the source of your  
12 information is the people in your organisation. So you  
13 have asked them?

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** But it sounds as though  
16 the delay, if there is one, which I am assuming there  
17 is --

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** -- occurs either at NHS  
20 England or before it gets to NHS England.

21 **A.** That would be my understanding.

22 **LADY JUSTICE THIRLWALL:** But somebody must know the  
23 answer to those questions?

24 **A.** Yes, I can -- I can take that back, my Lady,  
25 if that's okay to get the specifics.

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1 **A.** It depends on how long it has taken them to  
2 send that information to NHS England --

3 **LADY JUSTICE THIRLWALL:** I'm sorry to cut across  
4 you, but how soon, what are they required to do? What  
5 is required of the hospital? How soon after an incident  
6 are they expected to report it?

7 **A.** Our expectation from my understanding from  
8 talking to analysts is as soon as there has been an  
9 incident they should be able to update or report that  
10 incident to NHS England and my understanding being that  
11 actually if anything more comes into light they are also  
12 able to update those records they have submitted to  
13 STEIS for example.

14 **LADY JUSTICE THIRLWALL:** So what's the explanation  
15 for the three to six month lag, as far as you know?

16 **A.** This is my understanding, and I might have to  
17 get more information from the analysts to submit to the  
18 Inquiry, but my understanding is the whole time between  
19 submission to NHS England, the process in NHS England  
20 then to be submitted to us, that may take that time.

21 But in some --

22 **LADY JUSTICE THIRLWALL:** Sorry, I think  
23 I misunderstood you again.

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** I thought you said that it

42

1 **LADY JUSTICE THIRLWALL:** Well, I am just wondering  
2 what the point of that would be because the people in  
3 your organisation have told you what they think.

4 **A.** Yes.

5 **LADY JUSTICE THIRLWALL:** What we want to know is  
6 what actually is the answer, which presumably NHS  
7 England can help about?

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** So that might be where we  
10 need to direct the questions.

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** Have I understood that  
13 correctly?

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

15 **LADY JUSTICE THIRLWALL:** All right. Well, we will  
16 do that, thank you.

17 Sorry, Mr Carr.

18 **MR CARR:** Thank you. It would be beneficial,  
19 wouldn't it, mainly to inspections and to monitoring, to  
20 have information as soon as possible, to have as close  
21 to real-time data as possible?

22 **A.** Yes, yes that would be really helpful, yes.

23 **Q.** In respect of the 2016 inspection, the  
24 position of the inspection team considering Child and  
25 Young People's services is that they were unaware of the

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1 increase in neonatal mortality and it was not discussed  
2 at the inspection. And Helen Cain's evidence, she was  
3 the CQC Inspector leading that team, is that she was  
4 also unaware of neonatal mortality and did not know how  
5 many deaths would be usual for the neonatal unit.

6 Now, does CQC consider that that is information  
7 that inspectors ought to be armed with on an inspection?

8 **A.** Yes, if -- if that information was available,  
9 yes, I would expect that that information would serve  
10 a purpose and be helpful in informing our key lines of  
11 enquiries if it had been made available.

12 **LADY JUSTICE THIRLWALL:** So just to unpack that  
13 answer a little bit.

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** Making it available,  
16 I understand that.

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** You say if that  
19 information were available. But are there any  
20 circumstances in which the information wouldn't be  
21 available to the hospital about the number of babies who  
22 had died on their neonatal unit?

23 **A.** Yes, so my understanding being, you know, that  
24 information you would expect it to be available to the  
25 hospital.

45

1 to it?

2 **A.** Yes, yes, that's correct.

3 **Q.** And the CQC also has access to the Strategic  
4 Executive Information System, so that is STEIS, and  
5 that's a system for reporting Serious Incidents or  
6 Never Events?

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

8 **Q.** Now, we know, and you will have seen from the  
9 transcripts of the evidence of the CQC Inspectors, that  
10 on 3 July 2015 the Trust reported to STEIS the  
11 unexpected, potentially avoidable death of Child D.

12 **A.** Yes.

13 **Q.** That was reported as a Serious Incident due to  
14 a recorded as a delay in recognising sepsis?

15 **A.** Yes.

16 **Q.** And the deaths of Child A, Child C, Child D,  
17 Child E and Child I were all reported to the National  
18 Reporting and Learning System in the months prior to the  
19 CQC's inspection in February 2016?

20 **A.** Yes.

21 **Q.** Does the CQC accept that the members of the  
22 Children and Young People's services inspection team  
23 should have been aware of those reports?

24 **A.** So my understanding was when that information  
25 was, was shared and unfortunately, when it had been

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1 **LADY JUSTICE THIRLWALL:** It is difficult to see how  
2 it wouldn't be.

3 **A.** Yes, it would be, it would be available to the  
4 hospital.

5 **LADY JUSTICE THIRLWALL:** Yes.

6 **A.** So what I was trying to say is then if it had  
7 been shared with us.

8 **LADY JUSTICE THIRLWALL:** No, I understand that  
9 part --

10 **A.** Yes.

11 **LADY JUSTICE THIRLWALL:** Yes, thank you. So it  
12 should have been shared with you?

13 **A.** Yes, yes.

14 **MR CARR:** Staying within data but turning now to  
15 notifiable safety incidents. One of the datasets that  
16 the CQC has access to are reports to NHS England's  
17 National Reporting and Learning Systems, NRLS; that's  
18 correct, isn't it?

19 **A.** Yes.

20 **Q.** And that is a system used to report patient  
21 safety incidents and there is a duty on healthcare  
22 providers to notify the CQC of those incidents?

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

24 **Q.** And the way that -- one the ways they can do  
25 that is by reporting to NRLS because the CQC has access

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1 submitted to NHS England those had been rated as "low",  
2 low harm or low instances, because the definition of  
3 "high" or "moderate to high" instances from NHS England  
4 was based on the organisation of the provider who would  
5 have accepted that they had contributed to the incident  
6 taking place.

7 If they felt that that was due to their  
8 contribution or poor practice, or part of their staff  
9 contributing to those deaths, they would then rate  
10 themselves as "low" and that's my understanding that's  
11 actually possibly why this had been missed because  
12 people would have looked at instances which were rated  
13 as "moderate" to "high"?

14 **Q.** We will come on to the categorisation --

15 **A.** Yes.

16 **Q.** -- and how, if at all, that is interrogated by  
17 the CQC. You will have seen the evidence of, in  
18 particular, Mr Odeka but also Ms Potter?

19 **A.** Yes.

20 **Q.** And of course the report of the death of  
21 Child D was to the STEIS system as a Serious Incident.

22 So my question is, putting aside the fact that they  
23 were marked as "low"?

24 **A.** Yes.

25 **Q.** Does the CQC, looking at those reports, both

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1 the STEIS report and the NRLS reports, accept that those  
2 reports should have been seen by the inspection -- the  
3 entirety of the inspection team?

4 **A.** Yes, I would want that information to have  
5 been seen because it would have then informed our key  
6 lines of enquiries.

7 **Q.** Because the Inquiry heard evidence from all  
8 three members of that inspection team Helen Cain,  
9 Benjamin Odeka and Mary Potter, that they were unaware  
10 of the report to STEIS in respect of Child D?

11 **A.** (Nods)

12 **Q.** Unaware of reports to NRLS and the Specialist  
13 Advisors did not see that table of neonatal incidents?

14 **A.** Yes.

15 **Q.** And in light of the evidence that they gave,  
16 which is that it would have affected their approach to  
17 the inspection, clearly they should have seen them?

18 **A.** Yes. From -- from looking at the practice  
19 during 2016 inspection, my understanding being the data  
20 packs which had been created, yes, the Specialist  
21 Advisors could have benefited from seeing that  
22 information, but unfortunately they were not able to see  
23 that information because the practice then was that  
24 information would be shared with them in terms of the  
25 data packs I had of the inspection.

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1 **LADY JUSTICE THIRLWALL:** In relation to STEIS, to  
2 the STEIS report, what's the explanation there?

3 **A.** Yes. So the information would have been  
4 submitted to -- my understanding is the information  
5 would have been submitted to STEIS by the providers.  
6 But in that process of submitting the information they  
7 would have categorised those instances --

8 **LADY JUSTICE THIRLWALL:** The same answer?

9 **A.** Yes, as low. Hence then, by the time the  
10 information would come to CQC, those instances wouldn't  
11 have been categorised as moderate to high, they would  
12 have been categorised as low because providers then  
13 would have assessed and think because they had not  
14 contributed to the harm happening, they wouldn't then  
15 rate that as moderate to high.

16 **LADY JUSTICE THIRLWALL:** But earlier you were  
17 saying that the number of deaths should have been made  
18 available to you. But in fact there was the system for  
19 collecting information about deaths, which the hospital  
20 did comply with.

21 But that information didn't get to the inspection  
22 team because of a categorisation issue?

23 **A.** Yes, so what I have said, my Lady, is that is  
24 -- I would prefer that information to be available to  
25 inspectors.

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1 And also then, you know, there was an analyst who  
2 would present the data to the inspection team on the  
3 day, what they called Day Zero, for example, just before  
4 the inspection and unfortunately the Specialist Advisors  
5 did not see the whole data which had come through like  
6 my explanation before possibly from my understanding  
7 from talking to analysts it was because of the  
8 categorisation of the data, hence they didn't see it  
9 because it had been categorised as low harm.

10 **LADY JUSTICE THIRLWALL:** So the error -- firstly,  
11 was there an error by the data analysts?

12 **A.** No. From my understanding there was no error  
13 because they what they would do, because of the amount  
14 of data they receive, they would then categorise the  
15 data by looking at moderate to high risks instances,  
16 unfortunately from my understanding is these instances  
17 were not part of the moderate to high, hence they  
18 wouldn't have looked at them because that was the  
19 process they would follow in terms of looking at  
20 analysing data.

21 **LADY JUSTICE THIRLWALL:** So that is information  
22 about deaths that was not going to be passed on to the  
23 inspection team?

24 **A.** Yes, it wouldn't have been passed to the  
25 inspection team.

50

1 **LADY JUSTICE THIRLWALL:** As a general proposition  
2 so get rid of that filter by the analysts?

3 **A.** Yes, so my expectation would be if there was  
4 an unexpected death or avoidable harm, that information  
5 should be considered as part of an inspection process.

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

7 Sorry, Mr Carr.

8 **MR CARR:** Thank you, my Lady. If we take it in  
9 stages, I am going to deal with the STEIS record first  
10 and then the NRLS because the issue of categorisation  
11 and no harm/low harm, that refers to the NRLS entries --

12 **A.** Yes.

13 **Q.** -- not to STEIS.

14 Now, if we look at the intelligence presentation  
15 for the inspectors, it's INQ0103620, my Lady, it is your  
16 tab 10, if we go forward to page 27, and this is a slide  
17 dealing with the Children and Young People core service,  
18 a summary of intelligence findings.

19 We see bullet point 1:

20 "No Never Events or Serious Incidents reported up  
21 to January 2016."

22 And in light of the report to STEIS in respect of  
23 Child D, that is incorrect, isn't it?

24 **A.** Yes, I -- I would want to take that back and  
25 have a further review. But if the --

52

1 **LADY JUSTICE THIRLWALL:** This is something that's  
2 been seen before in the Inquiry.

3 **A.** Yes, yes.

4 **LADY JUSTICE THIRLWALL:** So it is something that  
5 should have been drawn to your attention?

6 **A.** Yes, it should, it should have been included,  
7 yes. If that is the question, Mr Carr, yes.

8 **MR CARR:** We can take it in stages, because  
9 following the exploration of this issue with the CQC  
10 Inspectors, as I have indicated further witness  
11 statements have been provided dealing with data and if  
12 we take that down and look at the statement of  
13 Lynn Andrews this time, it's INQ0108743.

14 That is your tab 6, my Lady.

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

16 **MR CARR:** A statement dated 20 December 2024.  
17 Now, Ms Andrews, she is a senior analyst at the CQC  
18 and she was responsible for putting together --

19 **A.** Yes.

20 **Q.** -- that presentation document I just took you  
21 to?

22 **A.** That's correct.

23 **Q.** And what she explains, if we go forward,  
24 please, to page 11, paragraph 43, she states:

25 "CQC's data packs and intelligence presentation

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1 So there is nothing in that description which would  
2 alert the Child and Young People's Services inspectors  
3 that this is data which is relevant to their inspection?

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

5 **Q.** As for the maternity and gynaecology pack that  
6 Ms Andrews refers to, we see that at INQ0103668, my Lady  
7 that is your tab 9, page 7. And in the neutral analysis  
8 section, in the middle of the page at the top, again, we  
9 have reference to seven Serious Incidents were reported  
10 between November 14 to October 2015.

11 And if we can go forward two pages, please, to  
12 page 9, we see a breakdown there of STEIS incidents.

13 Now, having looked at those three pages from the  
14 presentation slides and from this maternity and  
15 gynaecology pack, there is nothing that would alert the  
16 members of the Children and Young People's services in  
17 either document to the fact that this is a serious  
18 incident in neonatology, is there?

19 **A.** Yes.

20 **Q.** And you have considered the transcripts of the  
21 oral evidence of the CQC Inspectors and there is nothing  
22 in their evidence to suggest that they were aware of any  
23 need to consider maternity data as part of their  
24 inspection?

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

55

1 report that no Serious Incidents were reported in the  
2 Children and Young People's core service, this was due  
3 to neonatology being considered under the maternity core  
4 service for the purposes of data collection and  
5 analysis. This was standard for all inspections. The  
6 intelligence presentation and the maternity and  
7 gynaecology data pack both refer to seven Serious  
8 Incidents which include the death of Child D."

9 And the point that is being made here is that while  
10 the CQC didn't miss, as it were, the report to STEIS in  
11 respect of Child D, the analysts were aware of it and it  
12 was in the data packs put in the maternity section?

13 **A.** Yes.

14 **Q.** Now, with that in mind, we can go back to the  
15 intelligence presentation. So we can take that  
16 statement down, please, and bring back up INQ0103620.  
17 And this time if we look at page 26, this is the slide  
18 dealing with the maternity core service and to be clear  
19 maternity would be being dealt with by a completely  
20 different inspection team?

21 **A.** Inspection team, yes.

22 **Q.** The third bullet point on the slide refers to:  
23 "A further seven Serious Incidents between  
24 February 2015 and January 2016 in addition to seven in  
25 the reporting period. No themes identified."

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1 **Q.** In circumstances where the neonatal unit is  
2 being inspected by the Child and Young People's Services  
3 team, wouldn't -- or shouldn't rather -- neonatology  
4 data be considered under that core service?

5 **A.** It -- it should have, it should have been  
6 considered under that service, you know, it should have  
7 gone under the Children and Young People service. But  
8 one could also consider the fact that this was a whole  
9 team which was doing different core services. The -- my  
10 understanding being when for example the presentation of  
11 the intelligence was being done, it wasn't done to  
12 individual teams for those core teams or core services;  
13 it was done to the whole inspection team.

14 So -- so if there was any information which  
15 possibly needed further clarification, I would hope or  
16 expect that teams would share that information if that  
17 information was available because they were all working  
18 together even though they were focusing on different  
19 core services. But actually the starting point is it  
20 was one team but then divided to look at different core  
21 services.

22 **Q.** So your expectation would be that the members  
23 of the maternity team, having dived beyond what's in the  
24 documentation and seen the STEIS report they should have  
25 flagged that to the Child and Young People's Services

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1 team?

2 **A.** That's -- that's what I would expect.

3 **Q.** I return to my question. Wouldn't it make  
4 more sense for neonatology data to be contained in the  
5 core service that is inspecting the neonatal unit?

6 **A.** Yes, it, it would -- it would help because  
7 that's where it should have been and that was the  
8 expectation -- I suspect that was the expectation  
9 because that's where the data was supposed to have been  
10 presented in Children and Young People.

11 **Q.** Does it remain the case?

12 **A.** No, now currently neonatal data or information  
13 or services are now looked at as an additional service.  
14 So they are now a standalone service. So in our new  
15 assessment framework, they would sit in its own  
16 assessment service group, even though the teams that  
17 might end up assessing might be the same teams like  
18 Children and Young People and maternity services but it  
19 would be looked specifically on its own as a service  
20 line.

21 **Q.** So is the position at present that those  
22 inspecting a neonatal unit will be provided with the  
23 neonatal data?

24 **A.** Yes, because it would be in its own assessment  
25 service group.

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1 because it contains sensitive third party information  
2 but you have seen it.

3 **A.** Yes.

4 **Q.** It's a substantial document, isn't it; it's  
5 got some 377 entries --

6 **A.** Yes.

7 **Q.** -- in it on my calculation?

8 They are not date ordered, are they, it is not  
9 chronological, the table?

10 **A.** No.

11 **Q.** And within that table, there are eight entries  
12 in which the description involves death, but each of  
13 those entries has been marked green for no harm.

14 **A.** (Nods)

15 **Q.** Now, what Ms Andrews says in her statement at  
16 paragraph 48 is that it is standard practice when  
17 completing analysis of NRLS incidents, particularly when  
18 the datasets are large, for analysts to begin with  
19 reviewing the level of harm focusing on those reported  
20 as "moderate", "severe" and "death". Given the volume  
21 of reports made on NRLS it was not viable for analysts  
22 to read detailed descriptions of every report. The CQC  
23 data analyst team would have first filtered out the  
24 incidents marked "no harm" and "low harm".

25 And it appears to follow from that, doesn't it,

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1 **MR CARR:** My Lady, that might be an appropriate  
2 time.

3 **LADY JUSTICE THIRLWALL:** Yes. Thank you, Mr Carr.  
4 So we will take a break now for just over a quarter  
5 of an hour and we will start again at quarter to 12.

6 (11.29 am)

7 (A short break)

8 (11.46 am)

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

10 **MR CARR:** My Lady, thank you.

11 Mr Dziki, we are still looking at the approach to  
12 data. I want to move now from STEIS, please, to NRLS  
13 entries and you touched upon this earlier in your  
14 evidence. This is where there's different  
15 categorisations of harm.

16 Now, this statement from Ms Andrews also deals with  
17 the analysis of NRLS entries. If we can it up on screen  
18 it's INQ0108743, my Lady it's your tab 6. If we go  
19 forward, please, to page 12 and look at paragraph 48.

20 In that paragraph Ms Andrews describes the type of  
21 analysis undertaken on NRLS entries and it's the sort of  
22 entries we see in that table titled "NNU Paediatric  
23 Incidents" that you have already alluded to with the  
24 different categorisations of harm.

25 Now, I am not going to put that table on screen

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1 that so far as the data analysts are concerned, this is  
2 a spreadsheet, they have simply removed the low harm so  
3 they wouldn't be considering these entries at all?

4 **A.** Yes.

5 **Q.** Is that correct?

6 **A.** Yes, that's correct, yes.

7 **Q.** She goes on to make the point in the final  
8 sentence of that paragraph:

9 "The raw data includes the full list of incidents  
10 with all detail were available to the inspection team to  
11 access. It was standard practice for the CQC inspection  
12 team to access on our system the SPA did not have access  
13 to the CQC systems and it would be for the core service  
14 lead to share the raw data with them if they needed to."

15 Now, that reflects, doesn't it, the oral evidence  
16 that was given by Helen Cain, the lead of the inspection  
17 team, and the two Specialist Advisors from the Countess  
18 of Chester inspection in 2016, that the Specialist  
19 Advisors did not have access to that table, did they?

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

21 **Q.** So it was left to the non-specialist, the  
22 service lead, Ms Cain, to determine the significance of  
23 those entries and to decide whether or not to share it  
24 with the more specialist members of the team?

25 **A.** Yes, that's -- that's correct.

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1 **Q.** Is that a weakness in the inspection system or  
2 the data analysis system?

3 **A.** I think if, if you are looking I think the  
4 starting point I suspect is the definition. You know,  
5 you know defining death of a baby is low or no harm  
6 I think that is where the challenge is because then that  
7 definition means for the analyst in CQC they were  
8 looking for moderate to severe harm and then they missed  
9 out those entries because of the categorisation of  
10 actually making it green.

11 So I think that's the, that is starting point.

12 And then the second point I suppose is the lead  
13 inspector would have had to access the system, right,  
14 but you would then need a reason to access the system,  
15 you know, instead of relying on the data packs. I would  
16 assume during that time, that with everything that was  
17 going on, preparing for inspection, managing, you know,  
18 the team, getting the Specialist Advisors on board,  
19 I would find it may be unlikely for the lead inspector  
20 again to use the data packs one and after using the data  
21 packs go back to the CQC system to look for more  
22 information, especially knowing that actually analysts  
23 had already done the analysis, I would find that  
24 I suppose challenging for, for the lead inspector.

25 But my point being I think the starting point is

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1 table for the purposes of giving evidence to the  
2 Inquiry, the categorisation of incidents struck him as  
3 inaccurate and it is something that he would have wanted  
4 to look into at the inspection had he been made aware of  
5 it?

6 **A.** Yes, and, and I can see why that point because  
7 like I said you know looking at a baby's death, you  
8 know, you wouldn't really classify that as no harm. But  
9 that's the issue I am saying the root cause if I was  
10 looking at the root cause is that definition that  
11 enables people to classify a baby's death as no harm or  
12 low harm.

13 **Q.** Well, there are two issues, aren't there?  
14 Firstly there is the question of the adequacy of  
15 reporting, categorisation of death.

16 Now, as the regulator, is it the CQC's role to  
17 ensure that incidents are being properly reported?

18 **A.** My understanding from talking to analysts is  
19 the definition I suspect from I would need maybe to  
20 double-check this, is the definition given I think by  
21 NHS England as part of the organisation submitting data  
22 to NHS England.

23 **Q.** There is a question of the definition and the  
24 categorisations but my question is about regulation. Is  
25 it the role of the CQC to consider whether or not

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1 how harm or death are defined and from the provider  
2 point of view submitting information and categorising  
3 that it's low harm.

4 **Q.** Just on your point about what the lead  
5 inspector would look at. Is what you are saying that  
6 you would expect the lead inspector to rely on the  
7 analysis carried out by the data team?

8 **A.** And, and if there were any concerns I suspect  
9 to be flagged to give them the reason to go into more  
10 detail in terms of what more to look at on the system.

11 **Q.** But in that scenario, the data analysts  
12 wouldn't be flagging issues about the entries marked  
13 "low harm" or "no harm", because they had filtered them  
14 out and not considered them at all?

15 **A.** Yes.

16 **Q.** So if the position is as you have described  
17 it, the lead inspector relies on the data analysts then  
18 those low and no harm entries are just not being  
19 considered at all?

20 **A.** (Nods)

21 **Q.** And in the event in the Countess of Chester  
22 inspection, we know that not only did those entries not  
23 get shared with Dr Odeka and Mary Potter, the Specialist  
24 Advisors, both confirmed in evidence they didn't see  
25 them -- Mr Odeka explained that having looked at the

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1 a healthcare organisation is properly categorising  
2 patient safety incidents?

3 **A.** Yes. I would want to think so, yes.

4 **Q.** Would it not be difficult to carry out the  
5 function of regulating reports without consideration  
6 being given to all the categorisations rather than  
7 simply filtering out low and no harm reports?

8 **A.** Yes, I think, I think there is in hindsight  
9 looking back, part of the learning I suppose is thinking  
10 about -- when like I said at the start that this data is  
11 coming to us, there is a question I suppose thinking in  
12 the future and working with other stakeholders to think  
13 about, you know, how the data one is submitted and  
14 whether there is room for us to go back and consider as  
15 a regulator should we be receiving data directly to us  
16 as a regulator of health and social care rather than  
17 actually relying for the data to go somewhere else and  
18 then come to us.

19 Whereas if it's coming to us then I suppose we have  
20 got more control to quickly look at that data, you know,  
21 over a period of time instead of actually relying on the  
22 data coming via other means.

23 So I suppose what I am saying is there's more work  
24 I supposed to consider going back thinking about going  
25 forward in terms of how data is shared with us because

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1 it's not directly coming to us.

2 **Q.** But the issue that we are considering now is  
3 not one about whether or not you had the data. The data  
4 was there. The issue is the analysts don't consider at  
5 all, they filter out the low and the no harm?

6 **A.** Yes.

7 **Q.** And on your interpretation, the inspection  
8 lead may not be considering what has been filtered out  
9 by the analysts and on the evidence we know that the  
10 specialists were never given access to that information.  
11 So it's not an issue of the CQC getting the information,  
12 it's a question of who, if anybody, at the inspection is  
13 looking at it?

14 **A.** Yes, and my understanding from talking to  
15 analysts being because of the volume of data they are  
16 processing, on a regular basis and considering my  
17 understanding being at any given time, we are doing  
18 several assessments or inspections of organisations, so  
19 our analysts are constantly, maybe during that time my  
20 understanding is Lynn was looking at five other  
21 organisations in terms of data packs.

22 So I think because of the volume my understanding  
23 is they would then have to filter in order for them to  
24 go through all the necessary information and thinking  
25 about as well, you don't want to miss "moderate" to

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1 opportunity for the CQC inspection team in February 2016  
2 possibly to explore the issues of death?

3 **A.** I mean, when you -- obviously in hindsight  
4 when you look at then what happened and transpired, you  
5 know, you would want to think: actually, yes, there  
6 should have been more there done to a certain extent.  
7 But if the question is: did the inspectors and the  
8 people working then follow the process which was in  
9 place during that time, my understanding is yes, they  
10 followed the process which was in place at that time.

11 But in hindsight now when you look back, actually  
12 I think possibly more could have been considered.

13 **Q.** So what learning or changes have the -- well,  
14 what has the CQC learned and what changes, if any, have  
15 they made as a result of that hindsight?

16 **A.** So now all the information which comes from my  
17 understanding is all the information we get through NHS  
18 England, it's uploaded on our dashboards, right. So  
19 because all the information is loaded on our dashboards  
20 at any given time, people have got access to that  
21 information. So, for example, relationship owners  
22 inspectors, even outside of the inspection time they  
23 have got access to look at those services, to consider  
24 if there is anything they feel actually warrants more  
25 investigation or more time to look at it.

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1 "severe harm" being recorded in that volume of data.

2 Hence the need for them to filter the data.

3 That is my understanding of their position.

4 **Q.** Does the approach remain, does it remain the  
5 position today that data analysts will not look at  
6 reports which are categorised "low" or "no harm"?

7 **A.** I think from, from learning I think over years  
8 now, this is nearly eight years, there's a bit about  
9 professional curiosity as well in terms of when you are  
10 looking at things because now I am looking at hindsight  
11 that actually you know you want to test, you know, over  
12 period of time that actually by filtering you test that  
13 methodology, is it working by actually taking random  
14 samples of looking at that information to make sure  
15 actually there's nothing being missed?

16 But in terms of the definition it's true from my  
17 understanding it still remains the same definition of  
18 actually how providers would report data to NHS England.

19 **Q.** Specifically in light of the evidence that was  
20 given by the CQC Inspectors to this Inquiry to the  
21 effect that had that information -- it is the Specialist  
22 Advisors, had the NRLS data been provided to them, they  
23 would have wanted to ask more questions. Dr Odeka's  
24 evidence that the categorisation of incidents that  
25 struck him as inaccurate, wasn't that a missed

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1 So I am hoping where we are using data now has  
2 improved in the sense that all the information is now  
3 going into our dashboards, that is my understanding from  
4 analysts that all the information that's coming from the  
5 STEIS, it is all going straight into the dashboard, so  
6 there is someone who is constantly looking at that  
7 information and if there's anything they read or they  
8 see that gives them some concern, they will refer that  
9 to the inspectors. But also the whole point of actually  
10 gathering intelligence in terms of how we are using  
11 intelligence from different sources, either from people  
12 who are raising concerns, giving feedback of care to us  
13 who are calling our customer centres, you know, other  
14 organisation data we are picking up from either research  
15 or data being built up by other organisations like NHSE,  
16 for example, all that information is now being put in  
17 one place in those dashboards to inform what we do going  
18 forward.

19 **Q.** Do Specialist Advisors have access to that?

20 **A.** Specialist Advisors, my understanding is they  
21 can see the information. We, since 2016 we started  
22 using the CQC Insight which brought all the data into  
23 one place and the inspector, the lead inspector can get  
24 that lead information to Specialist Advisors, I am not  
25 aware that Specialist Advisors can access CQC systems

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1 but the lead inspector can provide that information  
2 to -- to CQC Specialist Advisors.

3 **Q.** If we can move now to a connected topic,  
4 please, which is information gathering ahead of  
5 an inspection more broadly. There are, we have heard  
6 evidence, two forms of information provided ahead of  
7 an inspection, a Provider Information Return --

8 **A.** Yes.

9 **Q.** -- which would be provided several months  
10 before an inspection and so might be out of date by the  
11 time of the inspection?

12 **A.** Yes.

13 **Q.** And then data requests which are made just  
14 before an inspection which will bring the data up to  
15 speed?

16 **A.** Yes.

17 **Q.** And should paint a picture of the current  
18 state of affairs.

19 Now, in the 2016 inspection at the Countess of  
20 Chester Hospital, the data requests for Children and  
21 Young People Services was made a day before the visit so  
22 in the same, in the inspection week is what Helen Cain  
23 explained, but a day before the actual inspection visit  
24 commenced. And the response to the data request she  
25 explained would not necessarily come in before the

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1 because you have identified some gaps in terms of the  
2 intelligence we -- we have gathered.

3 So whether it was a weakness then, I wouldn't  
4 comment on that. But my understanding being, you know,  
5 they had information and unfortunately the information  
6 they had didn't give them the concerns around the  
7 mortality increasing.

8 **Q.** Thank you. I understand the point that you  
9 make about the ongoing ability to request data and the  
10 need to be able to request data as issues arise.

11 The question really is this: should that process of  
12 requesting data after a Provider Information Return  
13 months before an inspection, should that start prior to  
14 inspection week?

15 **A.** And, and I guess from experience of seeing  
16 inspections going on, information is requested from the  
17 provider. Some comes a week before. Some comes a few  
18 days before depending on how the volume of the  
19 information we are requesting.

20 If it's quite straightforward information then it  
21 can come earlier, so your point about can you get it  
22 a week before, yes, you can depending on the volume and  
23 the complexities of the information you are requesting.  
24 I wouldn't sit here and say more time is better. You  
25 know, if you could get more time with the data before

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1 visit, it's only made the day before so data could come  
2 in during or after the inspection visit.

3 Now, is that a weakness in the inspection system,  
4 the fact that documentation and potentially substantial  
5 documentation, we have already dealt with the table of  
6 neonatal incidents, doesn't come in in time for the  
7 inspectors to consider it thoroughly?

8 **A.** From, from what I have seen in terms of it's  
9 a process we go through when you are doing  
10 an inspection, you are going to request information  
11 before the inspection, you are going to request  
12 information sometimes during the inspection in the sense  
13 that you might speak to a member of staff or you might  
14 speak to a service user that actually triggers something  
15 that you want to explore more. So you would for example  
16 request maybe an incident report that hasn't been  
17 included and then even after the inspection you can  
18 still request information because I always -- we always  
19 look at data as a process as part of the process of  
20 inspection and sometimes you might have to request that  
21 information at different points of time.

22 Whether it is -- it is a weakness, it depends on  
23 whether you have got that data you need to go through  
24 your key lines of enquiries. But what I am saying you  
25 can get that data even after the inspection itself

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1 you do the inspection, yes, then you can review the  
2 information.

3 But our way of working, and I have been part of  
4 inspections, is every data that comes in, you know,  
5 because you are requesting data for a specific  
6 information, you are trying to clarify, so you know what  
7 you are looking for, that is why you are requesting that  
8 data for, and it does work. You know, you can actually  
9 get the intelligence you need but definitely yes, if we  
10 could get more time with the data, the better, because  
11 then it will inform much better questions to ask as part  
12 of the inspection.

13 **Q.** If we can deal now, please, with the internal  
14 review, so the Thematic Review and the Brigham Review.  
15 The Inquiry has received a fourth witness statement from  
16 Ann Ford, it's INQ0108674. It is dated  
17 11 December 2024, so it follows the oral evidence she  
18 gave to this Inquiry.

19 At paragraph 5 of the statement on that page, under  
20 the heading "Provision of documents from the Countess of  
21 Chester Hospital to the CQC" she refers to oral evidence  
22 given by Ian Harvey in which he stated that he would  
23 have forwarded the Thematic Review to whoever was  
24 responsible for sending the documentation through to the  
25 CQC.

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1 The purpose of this statement was to respond to  
2 that suggestion, isn't it, and to set out the CQC's  
3 position on receipt of the Thematic Review and the  
4 Brigham Report?

5 **A.** My understanding this was never received  
6 before the inspection and everyone I have spoken to are  
7 quite clear about that position.

8 **Q.** If we look at the second page of the  
9 statement, we see what is set out about both the  
10 Thematic Review at paragraph 7, that it was never  
11 received from the Countess of Chester, and in respect of  
12 the Brigham Review, dealt with at paragraphs 8 and 9,  
13 that that was provided to the CQC but not until  
14 April 2018?

15 **A.** That's correct.

16 **Q.** So more than two years after the inspection.

17 What is the CQC's position on, dealing first with  
18 the Thematic Review, whether those reviews should have  
19 been provided to the CQC?

20 **A.** I think the fact that there was a Thematic  
21 Review taking place it concludes that there were  
22 concerns about the mortality rates going up and I think  
23 I strongly believe that information should have been  
24 shared with the CQC before or immediately when I suspect  
25 Terms of Reference were being drawn to have that

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1 a final version?

2 **A.** Yes.

3 **Q.** Are you saying that the final version should  
4 be provided to the CQC?

5 **A.** Yes.

6 **Q.** And what about the draft version?

7 **A.** I mean, if -- if there is any -- my  
8 expectation will be if there is any learning coming  
9 through, if there is anything they are discovering in  
10 that, during the draft report they should be sharing  
11 with CQC and they are welcome to say it is a draft, you  
12 know, because the whole point of having a draft is to  
13 start informing if there is anything that needs to  
14 happen in terms of improvement around patient safety.  
15 So you can't wait until you have got a final report.  
16 Draft reports are welcome because that is the starting  
17 point in terms of patient safety.

18 **Q.** Now, I will read a section of Mr Trenholm's  
19 first statement rather than put it up on screen. It's  
20 a short extract but what he says at paragraph 60 of his  
21 first statement is: if a Trust has any significant  
22 concerns about quality we expect those to be raised with  
23 the relationship holder, together with the action the  
24 Trust is taking to address them. If the Trust has  
25 commissioned any external reviews, those should be

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1 Thematic Review completed. As part of the engagement  
2 with CQC, I would expect the Trust or the provider to  
3 share that information, that's being transparent, that  
4 is being open and also from my experience of attending  
5 inspections, one thing we are quite clear about is  
6 asking the team, especially the senior leaders, in terms  
7 of "is there anything else you are concerned about, is  
8 there anything you are worried about, is there anything  
9 that keeps you wide awake at night, or anything you just  
10 feel possibly at this point in time you don't have the  
11 evidence and you just wanted to share with CQC?" And  
12 that has been my experience of all the inspections  
13 I have been to.

14 So if the question you are asking about the  
15 Thematic Review or even the Brigham Report, if this  
16 information was available to the Trust, I would strongly  
17 expect them -- it is an expectation really that they  
18 would have shared that with CQC before the inspection.

19 **Q.** And to be clear, what you are saying should  
20 have been shared, one you indicated that if they are  
21 carrying out a review then there is some concern, so it  
22 is a concern that should be shared?

23 **A.** Yes.

24 **Q.** And once the reports are finalised, there are  
25 two Thematic Reviews: there was a draft investors and

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1 disclosed -- it says "these as a matter of course", but  
2 the "these" is superfluous, so should be disclosed as  
3 a matter of course.

4 Now, in light of the evidence you just gave a few  
5 moments ago, is it the case that that also applies to  
6 internal reviews, internal reports, those should also be  
7 disclosed as a matter of course?

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

9 **Q.** Turning now to the inspection itself and you  
10 have considered the transcripts of the inspectors and  
11 I am not going to go through in any detail what was  
12 discussed at individual interviews.

13 The evidence from the inspectors is that they were  
14 not told during their inspection about increase in  
15 neonatal mortality or incidents of unexpected and  
16 unexplained deaths --

17 **A.** Yes.

18 **Q.** -- or any concerns relating to it.

19 Is the CQC's position that they should have been  
20 told that by staff at the Countess of Chester Hospital?

21 **A.** Yes, because if it was well known within the  
22 Trust and the Thematic Review appears to have already  
23 started during our inspection, yes, that information  
24 should have been shared with the inspectors.

25 **Q.** And does it follow then that the CQC considers

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1 that there was a failure by staff at the Countess of  
2 Chester to volunteer that information to the CQC  
3 Inspectors?

4 **A.** Yes.

5 **Q.** Does the CQC recognise that there can at  
6 inspections be a reluctance by staff to volunteer  
7 information of concern?

8 **A.** There is a possibility, yes.

9 **Q.** You indicated a few moments ago that during  
10 inspections, one of the things that you would raise at  
11 interviews are questions like: "is there anything that's  
12 concerning you, anything that keeps you awake at night?"  
13 Is that a standard requirement of inspectors to ask  
14 those sorts of questions?

15 **A.** I -- I would expect -- I mean, like I am  
16 saying the inspections I have observed and I have been  
17 to that line of questioning, it takes place and in  
18 a more collaborative way really in terms of just trying  
19 to understand where an organisation is because our  
20 expectation is we work with organisations and providers  
21 around patient safety that actually we all can learn  
22 from instances.

23 So if there is anything to share, there is  
24 an expectation that they should be sharing and  
25 internally we talk about some of the areas in terms of

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1 those concerns, my understanding from, from some of the  
2 team members who attended that inspection is there was  
3 information around, there were some posters around the  
4 hospital, for example, which said: CQC are here, if you  
5 have got anything you want to share with us, please do  
6 come and talk to us.

7 There are some instances where staff have expressed  
8 to me that they have even arranged, you know, to go  
9 outside of the hospital to meet people to talk about any  
10 concerns that they might have.

11 There were some boxes in place for people to put in  
12 feedback if there was anything they wanted to raise. So  
13 in terms of what the inspection team did on that day to  
14 try and facilitate an environment or an opportunity for  
15 people to express any concerns or any other feedback  
16 they wanted to give back, unfortunately that didn't  
17 happen.

18 I'm not sure why that didn't happen from a point of  
19 staff telling us. Obviously there's an issue around the  
20 data in terms of actually, you know, just professional  
21 curiosity I suppose in terms of what else could have  
22 been asked during that time.

23 But my hope is people should be free to speak up  
24 and should not feel that if they speak up, something  
25 would happen to them.

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1 asking questions around what areas to focus on.

2 **Q.** Is there a requirement either as part of  
3 training of inspectors or elsewhere, is there  
4 a requirement that inspectors ask hospital staff  
5 explicitly whether they have any issues of concern in  
6 addition to anything that has been discussed at a visit?

7 **A.** I mean, in terms of support inspectors one  
8 thing I am clear about is around questions around: is  
9 there anything else you want to add, is there anything  
10 else, you know, you feel CQC need to be aware of? And  
11 that's -- that's common practice and we talk about that  
12 all the time, there is some pointers in during that  
13 inspection time in terms of questions you might ask.

14 So yes, I -- I will be surprised if there is an  
15 inspector in CQC who is not aware of that.

16 **Q.** In respect of the 2016 inspection of the  
17 Countess of Chester we have already looked at issues to  
18 do with monitoring and data but in respect of the  
19 inspection specifically, what is the CQC's position on  
20 the reason for the failure to detect the concerns about  
21 the increase in neonatal mortality or neonatal mortality  
22 itself?

23 **A.** I think there's something around -- and we  
24 have touched on this earlier in terms of the staff,  
25 whatever reasons behind staff not being able to express

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1 So we try by all means, the CQC we have provided  
2 guidance around that, around whistleblowing, around  
3 Freedom to Speak Up, and trying to encourage staff to  
4 speak up and we are seeing it now, we get more people,  
5 whistleblowers, we get more people speaking up and we  
6 use some of that information to inform our intelligence  
7 for where do we go to in terms of inspections

8 **Q.** The failure -- it appears so far as the CQC is  
9 concerned from the answer you just gave, the failure to  
10 detect the concerns was due to the fact that staff did  
11 not disclose their concerns to the CQC Inspectors?

12 **A.** That, that's one but one can also argue that  
13 the leadership as well of the Trust, like from what we  
14 know I am saying -- obviously in hindsight from what we  
15 know it appears as if, you know, the review or the  
16 Thematic Review might have already possibly started or  
17 been considered during that time and my question in my  
18 head is: why was that information not shared because it  
19 was the previous year as well. I think if I am not  
20 mistaken it was, if my memory serves me right, between  
21 14/15 and 15/16 financial years.

22 **Q.** The Brigham Report was 2015.

23 **A.** Yes.

24 **Q.** The Thematic Review was 2016.

25 **A.** Yes.

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1 Q. February and March.

2 A. Yes, exactly.

3 Q. The Inquiry has heard evidence that for  
4 members of staff at an institution that is being  
5 inspected it can be difficult to express views in  
6 a group setting and so the question that follows from  
7 that is whether there is a need for more private  
8 one-to-one interviews between inspectors and members of  
9 staff or at least giving all members of staff, whether  
10 it's by way of email, an opportunity for private  
11 meetings with inspectors rather than large group  
12 meetings?

13 A. Yes, and -- and as part of the inspection  
14 process, my understanding during that time as well that  
15 there will be contact information for CQC. We have got  
16 now additional contact centre so if people are not  
17 feeling comfortable to talk they can, you know, contact  
18 privately, contact us.

19 Obviously now time has moved on, we now know,  
20 understand more about Freedom to Speak Up,  
21 whistleblowing, and we always give those opportunities  
22 for staff to speak -- to speak to us even to the extent  
23 of we have had staff have come asking us to speak to us  
24 as a group of staff, instead of one person although  
25 sometimes it can be a lot for one person to -- to

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1 focusing on outcomes for patients and part of our  
2 strategy in 21/22 was around people and communities and  
3 it was more about thinking about people's experience of  
4 care, you know, talking to people who use services to  
5 understand their experience of care also making sure we  
6 speak to their families to understand the experience of  
7 their relative being looked after in a service.

8 So, yes, the single assessment framework, the main  
9 aim was one, to make sure we focused on patient  
10 outcomes, we focused on people's experience of care,  
11 also gave us the opportunity to go into service on  
12 a more regular basis because sometimes it would take  
13 a long time before we went back in but the single  
14 assessment would enable us to go back in on a more  
15 regular basis.

16 Q. There is of course the recent Dash Report,  
17 which was a review of the single assessment framework  
18 rather than the form of assessment in 2016 at the  
19 Countess of Chester Hospital. One of the concerns  
20 identified in that review was the lack of focus on  
21 outcomes and insufficient evidence of assessments and  
22 inspections that considered the outcomes of care. Are  
23 you able to update us with the CQC's response, if any,  
24 to that report and any work that is being done to  
25 improve focusing on outcomes of care?

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1 speak up about a concern.

2 Now we see sometimes groups of staff and of nurses  
3 or doctors coming and wanting to have a conversation  
4 with CQC in private to talk about concerns.

5 So we try by all means and my understanding during  
6 that time as well those opportunities were available  
7 for, for people to express any concerns. But what I am,  
8 what I am now saying is even with all that available,  
9 you know, we know that sometimes the culture and the  
10 leadership in an organisation can still hinder people  
11 from expressing their concerns, despite everything  
12 I have spoken about in terms of trying to facilitate  
13 those conversations.

14 Q. Since 2016, the CQC moved to a different  
15 framework of assessment, the single assessment  
16 framework. And is it likely that the single assessment  
17 framework would be better able to elicit concerns than  
18 the position in 2016 at the Countess of Chester and if  
19 so, how?

20 A. There's -- the whole point I suppose moving  
21 into the single assessment framework, which will be  
22 changing to assessment framework, was because it gives  
23 CQC the opportunity to go into services on a regular  
24 basis that was the aim. And it also focused on certain  
25 aspects in terms of the quality of services, also

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1 A. Yes. In terms of that review, we, we accepted  
2 the recommendations from talking to Penny Dash in full  
3 and now work is ongoing in terms of one, thinking about  
4 how best, because I think the challenge was more about  
5 the implementation of that new framework rather than the  
6 framework itself. Like I said, for example the main  
7 reason why the framework was brought in was one, we  
8 needed to go into service on a regular basis, we needed  
9 to focus on patient experience of care and outcomes of  
10 care and so we have looked at that actually how best do  
11 we implement the single assessment framework? And as  
12 part of that work we asked Sir Mike Richards to look at  
13 the implementation of that work and we are now starting  
14 to focus on how best we focus on implementation of that  
15 work.

16 For example, we are looking at for example we have  
17 got a new Chief Executive Officer, Sir Julian Hartley,  
18 and are in the process of now recruiting more chief  
19 inspectors for each sector we regulate. So thinking  
20 about mental health, thinking about secondary specialist  
21 care, primary community care and other social care.

22 The focus being those leaders in as chief  
23 inspectors who focus more on their areas of expertise  
24 and think about the outcomes of patient care and think  
25 about the experience of care within CQC. So that's the

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1 work we are starting to undertake now as we reset our  
2 position in terms of how we work with our providers.  
3 But mainly also to think about one area we are  
4 really keen on working on with and we have started  
5 working on and we have been doing some work in the last  
6 year is how we work with experts by experience and  
7 people who have used services before thinking you about  
8 how they become part and parcel of our inspection  
9 methodology, because they understand the experience of  
10 being in a service so we want their input in describing  
11 what good care looks like and the whole feedback that  
12 will help us to focus mainly on outcomes going forward.

13 **Q.** It sounds like there is ongoing work?

14 **A.** It is, it is ongoing work. And our Chief  
15 Executive just started on, on the 2 December and our  
16 previous interim Chief Executive had already started  
17 looking at those recommendations going forward.

18 **Q.** I was going to ask you about leadership of the  
19 CQC. There was obviously Mr Trenholm, who was Chief  
20 Executive?

21 **A.** Yes.

22 **Q.** And he stepped down and was replaced and  
23 I think you are now on to perhaps the third or fourth  
24 Chief Executive since Mr Trenholm. So it sounds like  
25 there's been a period of flux at the CQC.

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1 improve services going forward, including the maternity  
2 services and including neonatal services as well as part  
3 of that work going forward. And definitely learning  
4 from this process from this Inquiry as we go along.

5 **Q.** So a period of flux at the senior level at  
6 Chief Executive level has been destabilising but with  
7 the new Chief Executive and the plan that you have  
8 outlined, you feel more confident that stability will  
9 return, is that a --

10 **A.** Yes, I am, I am really confident and like  
11 I said, you know, the staff who work in CQC some of them  
12 who have been in CQC for a very, very long time, I talk  
13 to them I am a chief inspector now, I am also the Exec  
14 Director of Operations and I can see, you know, the deep  
15 commitment and wanting to improve what we do as  
16 a regulator and, and the standards we, we have set for  
17 ourselves going forward should be higher than the  
18 standards we set for the services that we regulate.

19 So that is our ambition going forward.

20 **Q.** Staying with the theme of leadership and  
21 Well-Led, but turning back now to regulation and in  
22 particular the inspection of the Countess of Chester  
23 Trust. The report following the inspection in 2016  
24 rated the hospital as "good" in the Well-Led campaign  
25 and you have raised in your evidence, albeit with the

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1 How -- well, what would your observation be on the  
2 leadership of the CQC in that time?

3 **A.** So there has been -- like I said there has  
4 been changes. We have had several Chief Executives  
5 during this time and obviously, you know, leadership is  
6 key in ... and it's been challenging to say the least  
7 but when I look around at what we, we now have, in terms  
8 of the focus we have, in terms of improving ourselves as  
9 a regulator for health and social care and when I also  
10 look at the people who work in CQC, the staff who work  
11 in CQC, their commitment to patient safety, their  
12 commitment to improving and, and making sure people are  
13 safe in services, I am really, really inspired and  
14 reassured that actually we are starting to take the  
15 steps forward to think about how best we can improve as  
16 an organisation.

17 Like I said, you know, changing Chief Executives  
18 can destabilise an organisation but now we are in  
19 a position where we have got a permanent Chief Executive  
20 Officer in place, we are recruiting chief inspectors to  
21 support the work we need going forward. We are quite  
22 clear about where we need to go to in terms of the work  
23 we need to do with other key stakeholders, the work we  
24 need to do with providers in Trusts and social care  
25 services in terms of actually the work we need to

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1 benefit of hindsight some concerns about leadership at  
2 the Trust at the time.

3 So can you help us with how the Well-Led category  
4 is assessed and how the good categorisation can be  
5 arrived at?

6 **A.** Yes, so, so for, for Well-Led, really, you are  
7 looking at leadership and the culture of the  
8 organisation in terms of how that organisation is led.  
9 But the majority of that information of gathering the  
10 information also comes from -- as part of the inspection  
11 of doing Well-Led you would have reviewed some core  
12 services so you would have spoken to service users or  
13 patients before you would have spoken to the staff who  
14 work in that organisation ahead of doing the Well-Led  
15 which was always and still announced because you want to  
16 make sure people you want to interview are present to be  
17 interviewed.

18 So there is an element of using the information you  
19 have gathered from the inspection you have already  
20 undertaken and spoken to staff, spoken to patients.

21 Then you need to look around governance, how  
22 governance is being addressed within the organisation in  
23 terms of, for example, you know, risk. How is risk  
24 assessed and managed, are there policies in place that  
25 help staff to understand risk assessment and risk

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1 management, how are instances, for example, managed in  
 2 terms of, you know, is there a learning culture in this  
 3 organisation? For example, if there is an incident are  
 4 they learning from it? On top of that there is  
 5 an expectation as well to think about the board itself,  
 6 how sighted is the board in terms of those instances in  
 7 terms of the learning that needs to happen?

8 In some organisations you have got multiple lines  
 9 of service lines, for example, so you can have six  
 10 service lines or five service lines. How is that  
 11 information cascaded across the organisation in terms of  
 12 learning? Are there audits taking place to understand  
 13 where the services are at in terms of their practice?  
 14 And how is that information used to -- to inform  
 15 practice? Is there anything else happening in terms of  
 16 complaints? What kind of complaints are being received  
 17 and how are complaints being managed by organisations  
 18 going forward and are they learning from those  
 19 complaints? For example the Patient Advice Liaison  
 20 Service, how is it being used? People call it PALS.

21 And the other information you sort of need to look  
 22 in terms of anything else that the -- that the  
 23 leadership is doing to improve itself going forward, in  
 24 terms of things like Speak Up, how is Speak Up being  
 25 managed, you know and are there any data and records to

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1 are any issues around, you know, staffing levels is to,  
 2 you know, ask the organisation in terms of what are  
 3 their plans, you know, is there an action plan to  
 4 address staffing levels and -- and we know over years,  
 5 you know, staffing levels has been an issue in the NHS  
 6 in social care especially when you look at nurses. You  
 7 know, there has been a challenge over years in terms of  
 8 vacancies in most organisations.

9 So at CQC we totally appreciate the context in  
 10 which organisations are operating in. But still we  
 11 expect because you need the staff to in order for you to  
 12 provide safe care. So what we would expect is an  
 13 organisation to have an action plan in terms of how they  
 14 are addressing those gaps. What else are they doing in  
 15 terms of recruitment, you know, other organisations,  
 16 they would look at international recruitment, for  
 17 example, thinking about other roles that could be  
 18 introduced into the organisation.

19 So there are other action that is an organisation  
 20 can take, so we would be expecting that the  
 21 organisations are taking those into, into consideration.

22 **Q.** If we can move away from the inspection and to  
 23 the monitoring of the Trust following the inspection.  
 24 And I am not going to go through every single element of  
 25 the chronology. But if we can start with the disclosure

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1 show how it's being managed, how is the organisation  
 2 learning from Speak Up or whistleblowing?

3 All that information, that is the information we  
 4 look as part of considering whether an organisation is  
 5 well-led or not, but as part of the inspection then you  
 6 speak to the chairperson of the organisation, you will  
 7 speak to the Chief Exec to the Medical Director, you  
 8 also speak to the Chief Nurse to try and understand how  
 9 the Executive Team works together and also thinking  
 10 about the Non-Executive Directors, how they also work  
 11 within that organisation.

12 So it's quite a comprehensive assessment in areas  
 13 we pick to really determine how well-led that  
 14 organisation is.

15 **Q.** Sticking with the 2016 report. In the "Safe"  
 16 category, the rating in Children and Young People's  
 17 services at the Countess of Chester Hospital was  
 18 "requires improvement" and one of the issues identified  
 19 in the report was staffing levels, nurse staffing  
 20 levels?

21 **A.** Yes.

22 **Q.** What regulatory action, if any, can the CQC  
 23 take where there are concerns about staffing levels; is  
 24 there anything that the CQC can do about that?

25 **A.** There is an expectation, obviously if there

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1 to the CQC of the increase in neonatal mortality and we  
 2 can look at the email, it's INQ0017411.

3 Now you will have seen this email, this is an email  
 4 dated 30 June 2016 from Alison Kelly and it follows  
 5 a telephone conversation the day before on 29 June, same  
 6 day the CQC report was published.

7 And in this email, details of the increase in  
 8 mortality or some details of the increase in mortality  
 9 are given. Now, what we see under the heading  
 10 "Context", we can see there reference to the internal  
 11 reviews, actually that is the Brigham Report and the  
 12 Thematic Report and we have already addressed that.

13 And we see in the next paragraph reference to the  
 14 fact that an independent review from the RCPCH has been  
 15 commissioned. Now, what this email does not say  
 16 anywhere, does it, is that there were concerns of  
 17 potential deliberate harm?

18 **A.** (Nods) Yes, yes.

19 **Q.** Now, given the CQC's position is that they had  
 20 not in fact received the Thematic -- well, what's  
 21 described here as the in-depth Thematic Medical Review,  
 22 which I think is the Brigham Report or the subsequent  
 23 peer review, which is the Thematic Review, should the  
 24 CQC have requested those documents from the Trust?

25 **A.** Yes, I -- I would yes, that is the

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1 professional curiosity I was talking about earlier.  
 2 Yes, because that information had not been, you know,  
 3 submitted to us or forwarded to us, I would see the  
 4 value of us requesting for that information to be sent  
 5 through.

6 **Q.** Well, the position is we have an assertion and  
 7 Alison Kelly has dealt with this in --

8 **A.** Yes.

9 **Q.** -- her evidence and doesn't contend that those  
 10 reviews were sent?

11 **A.** Yes.

12 **Q.** But on the basis of the email there is an  
 13 assertion to the CQC that two reviews have been sent to  
 14 the CQC.

15 Now, we have as of that December statement from  
 16 Ms Ford that I have taken you to, the position of the  
 17 CQC is we were never sent the Thematic Review, we were  
 18 only sent the Brigham Review in 2018?

19 **A.** Yes.

20 **Q.** So in light of that, in response to the  
 21 assertion that "there are these reviews and we have  
 22 provided you with them", is there evidence that the CQC  
 23 took any steps to determine whether they had those  
 24 reviews and, if not, to request them?

25 **A.** Yes, and my understanding from talking to --

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1 service. From my understanding, the Trust obviously  
 2 then downgraded the service to Level 1. They closed  
 3 some, some beds which meant then the service could  
 4 manage in terms of staffing levels because some of those  
 5 services, some of those beds had been closed so that's  
 6 what the Trust was doing and also informing CQC in terms  
 7 of the Royal College of Paediatricians and Child Health,  
 8 its review which was taking place as an external review  
 9 of what was going on, and also making sure actually that  
 10 all the other external people were being contacted, for  
 11 example, NHSE in terms of what was happening and letting  
 12 them know about the instances.

13 I think that was the position of CQC in terms of  
 14 making sure all those things were taking place and my  
 15 understanding the follow-ups in terms of the engagement  
 16 which was taking place, there was then an expectation  
 17 that actually in the follow-up of the conversation they  
 18 were having with CQC with the Trust they were looking  
 19 at, for example, the action plans which were in place  
 20 going forward and thinking about what else the Trust was  
 21 doing to okay make sure the service remained safe.

22 **Q.** We will look at some of the subsequent  
 23 engagement meetings, but the question really is  
 24 following receipt of this email, it raises an increase  
 25 in neonatal mortality which CQC were not previously

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1 to the team obviously I do get that when, during this  
 2 time, I think the focus my understanding is the focus of  
 3 the team or the relationship owner Ms Ann Ford was now  
 4 about the safety of those babies in, in the unit and  
 5 that was the focus in terms of: actually are babies  
 6 safe? What is the Trust doing? So they didn't focus on  
 7 actually -- you know, these documents haven't been sent  
 8 to us.

9 Their focus was more on: actually, let's make sure,  
 10 you know, the babies are safe, let's make sure the Trust  
 11 is doing all it can and get some assurance. On --  
 12 obviously on hindsight you look back and think:  
 13 actually, because we didn't have all the details about  
 14 what had transpired in terms of the reviews taking place  
 15 yes, it would have been helpful very, very helpful to  
 16 request for that information to be sent to us, then it  
 17 would have then informed our monitoring process going  
 18 forward.

19 **Q.** Well, do you know what steps, if any, were  
 20 taken by the CQC on the back of this email as a result  
 21 of this email?

22 **A.** Like I said, I think the starting point was  
 23 actually making sure that the service was safe and  
 24 asking the Trust to reassure CQC in terms of the steps  
 25 they were taking to address the issues within the

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1 aware of.

2 And the question is: should the CQC have taken  
 3 steps to obtain or at least request information as to  
 4 why there had been an increase in deaths?

5 **A.** I mean on hindsight, definitely yes. You need  
 6 to understand a bit more in terms of what has happened.  
 7 Like I am saying I think the focus during this time was  
 8 safety for, for the babies. But I do get your question,  
 9 Mr Carr, in terms of actually I think that also comes to  
 10 the point I am saying about the professional curiosity  
 11 of actually a bit more of wanting to understand a bit  
 12 more in terms of actually we were not given this  
 13 information during the inspection. And then  
 14 consideration should have been -- unfortunately I wasn't  
 15 there, but in my head these considerations possibly  
 16 should have been given in terms of: actually can, we  
 17 have more information?

18 But from what I have spoken to the team my  
 19 understanding is was the Trust at that point in time  
 20 doing everything it needed to do, they were downgrading  
 21 the service, they have asked for an external review to  
 22 take place. There was a Thematic Review then taking  
 23 place. So it seems as if the Trust was doing everything  
 24 at that point in time, in terms of making sure babies  
 25 were safe, and also making sure there was an external

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1 review to look at why this was happening in terms of the  
2 increase in mortality rate.

3 **Q.** That was the review being undertaken by the  
4 RCPCH?

5 **A.** Yes.

6 **Q.** But so far as the CQC is concerned, that's the  
7 regulator. Shouldn't the CQC have taken steps to try  
8 and discover more about the increase in neonatal deaths,  
9 you have reference there to two different reviews. They  
10 could have been requested for instance?

11 **A.** Yes, that's, and that point I have, I've  
12 accepted that point in terms of consideration should  
13 have been, that is the professional curiosity, you know  
14 like I wasn't there but I am looking in hindsight  
15 thinking about that professional curiosity of: actually  
16 this information wasn't shared with us during the, the  
17 inspection time and we didn't have access to that. Then  
18 that was maybe a good point to consider actually getting  
19 that information being shared when we were informed  
20 about the incidences.

21 **Q.** As for the review by the RCPCH which is  
22 referred to here, did the CQC ever ask to see the Terms  
23 of Reference for that review?

24 **A.** My memory doesn't serve me right.  
25 I wouldn't -- we can come back to you on that, but

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1 **A.** Yes.

2 **Q.** Now, what Mr Trenholm says about this meeting  
3 in his second statement it's a short section. I will  
4 read it out. On describing this appointment he says --  
5 this meeting, sorry:

6 "We were informed that the RCPCH report was at the  
7 draft factual accuracy stage and we requested a copy of  
8 the final report."

9 Now, given the date, 22 December, if Mr Trenholm is  
10 right, given what we know now, that was incorrect,  
11 wasn't it, because the final RCPCH report was with the  
12 Countess of Chester?

13 **A.** Yes.

14 **Q.** In circumstances where the hospital had the  
15 final report, should they have been provided at, if not  
16 by, the time of this meeting?

17 **A.** Yes. It should have informed the discussion  
18 of the meeting, so the expectation is, you know, if the  
19 discussion is going to be helpful, is to provide the  
20 report in advance of that meeting.

21 **Q.** If we go forward to what appears to be the  
22 next engagement meeting, it's INQ0017300 and this is  
23 a meeting on 17 February 2017. And we see item 3 under  
24 strategic update from the Trust, (i), key risk areas.  
25 Neonatal services.

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1 I can't recall anything about that. But my expectation  
2 will be that if a Trust is requesting an external  
3 review, those Terms of Reference should be shared with  
4 the relationship owner because the fact that you are  
5 going externally it means you are concerned, you are  
6 worried and it would be my expectation that actually the  
7 Terms of Reference are shared with CQC.

8 **Q.** But there is two sides of that coin, isn't  
9 there? On the one hand you say the Terms of Reference  
10 should be shared by the Countess of Chester with the  
11 CQC. If the Countess of Chester fails to share them,  
12 then shouldn't the CQC request them?

13 **A.** Yes. That -- that would be but on this  
14 occasion I am not so sure whether this had been  
15 requested. It is something I can come back to the  
16 Inquiry about.

17 **Q.** I want to move forward in the chronology, if  
18 we can, to the engagement meeting in December. There  
19 was one in August but I am going to look to at the one  
20 in December. INQ0017298. Yes, that is an engagement  
21 meeting at the Countess of Chester on 22 December 2016.

22 And we can see item 2, areas for discussion, action  
23 plan, neonatal review, Never Events and Serious Incident  
24 and the reference to neonatal review is to the RCPCH  
25 review, isn't it?

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1 IH, reference to Ian Harvey:

2 "... explained that following the publication of  
3 the external review by the Royal College Paediatrics and  
4 Child Health this month, the parents of children that  
5 were contactable were informed and the report has been  
6 shared with them and key stakeholders."

7 So this postdates the publication of the RCPCH  
8 report and that was, as we know, the redacted version of  
9 the report. Did the CQC receive the redacted or  
10 confidential report?

11 **A.** Unfortunately, I'm not aware of the -- whether  
12 CQC received the redacted report or not and apologies on  
13 that. I can come back on you on that.

14 **Q.** In circumstances where there are two versions  
15 of the report, so one that included references to the  
16 concerns and allegations in respect of Letby, is it the  
17 CQC's position that both versions of the report should  
18 be provided to them?

19 **A.** Yes. That's -- that's the open and  
20 transparency that we hope that every organisation, every  
21 Trust would work with us on that.

22 That would have been, yes, our expectation.

23 **Q.** Should there, in the CQC's view, be  
24 an obligation that service reviews or external reviews  
25 are required to be shared with them?

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1 A. Yes.

2 Q. How would that be facilitated? Would it be  
3 an obligation on the hospital to provide copies once  
4 they received them?

5 A. Yes, because -- because there is an ongoing --  
6 and the whole point during that time of having  
7 a relationship on as a single point of contact was  
8 building relationships with people. And at CQC we  
9 believe having a relationship with providers or with  
10 Trusts it's really helpful because you build those  
11 relationships based on honest transparency and being  
12 open that actually when issues do arise then people have  
13 got a point of contact of someone to talk to or to share  
14 information with, which would be the expectation for,  
15 for any provider we regulate.

16 But they use that mechanism of communication to  
17 share anything they -- which needs to be shared,  
18 especially something as serious as this.

19 Q. Now, is it the case that at this stage,  
20 so February 2017 and following the publication of  
21 a version of the RCPCH report, were the CQC still  
22 unaware that there were concerns of deliberate harm?

23 A. I'm not clear on the dates really in terms of  
24 when the issue of deliberate harm came into effect and  
25 I will need to, to double-check that.

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1 police and ultimately, in the last line of that  
2 paragraph:

3 "The police have indicated that a further review of  
4 the deaths may be undertaken by a relevant specialist."

5 So whilst Mr Trenholm identifies this as being the  
6 point at which the CQC became aware of a criminal  
7 investigation, it's still not clear on the face of this  
8 email that the CQC were aware that there were concerns  
9 of deliberate harm by a staff member?

10 A. Yes. I mean, when -- when I reviewed the  
11 email yesterday the email is quite clear in terms of  
12 police involvement. But, yes, it doesn't make it clear  
13 that there was deliberate harm to -- to the babies, yes.

14 Q. And you can't help us with when the CQC became  
15 aware of concerns about deliberate harm?

16 A. My memory doesn't serve me right. I will --  
17 I'll -- it's something I am more than happy to go back  
18 and double-check because I would expect that to have  
19 been documented.

20 Q. Now, in terms of the monitoring, so following  
21 the disclosure in June 2016 and in the period that  
22 followed, are you able to identify any action taken by  
23 the CQC in light of the concerns and the investigations  
24 that were being -- the concerns that were had and the  
25 investigations that were being carried out, both by the

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1 LADY JUSTICE THIRLWALL: Would you expect a record  
2 to have been made of that?

3 A. Yes. Yes, I would expect a record to have  
4 been made when we were contacted or informed of that.

5 LADY JUSTICE THIRLWALL: So on the face of it,  
6 there is no reference to it in this meeting.

7 A. Yes, no, I can't see it referenced in the ...

8 MR CARR: There was the section of Mr Trenholm's  
9 statement --

10 A. Yes.

11 Q. -- I took you to at the beginning of my  
12 questions when he referred to an email in May 2017 as  
13 being the first point that the CQC was aware of  
14 a criminal investigation. Now, that email is  
15 INQ0017303.

16 Now, I understand from what Mr Trenholm says in his  
17 statement that this email follows a engagement call the  
18 day before on 15 May 2017 and it describes, in the third  
19 paragraph in the middle of the page, the paragraph that  
20 starts, "However, the neonatologists were still  
21 concerned ..."

22 And this letter reports of a Child Death Overview  
23 Panel which requested the Trust seek assurance from the  
24 police regarding any unnatural causes for the deaths.

25 It goes on to describe the CEO writing to the

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1 RCPCH and then by the police? What was the CQC's role?

2 A. I think from, from everything I have reviewed  
3 and the conversations I have had with some of the staff  
4 involved I think CQC's position was they continued  
5 having the engagement meetings with, with the Trust and  
6 at some point, like I said, there was an action plan.

7 They continued, you know, talking about that action  
8 plan, asking updates in terms of progress of some of the  
9 reviews that had taken place, and what also was  
10 happening in terms of monitoring that service, making  
11 sure that service was still safe for babies who required  
12 Level 1. And, there's -- there's a point about actually  
13 when the police were involved whether there was a point  
14 for, on reflection, for CQC to think about what was our  
15 role.

16 My understanding during that time police will  
17 always take primacy in terms of those criminal  
18 investigations that police were taking.

19 We, we were maturing as an organisation. I think  
20 it wasn't long before we had got our -- some of our  
21 criminal enforcement powers and as an organisation we  
22 were maturing.

23 So looking back and reflecting, I think especially  
24 if you look at the timeline and the events that took  
25 place since 29 June onwards, could we have considered at

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1 some point, especially when even the police were  
 2 involved in May 2017, could we have considered our  
 3 position of, of CQC in terms of what we could have been  
 4 doing during that time whilst police were carrying out  
 5 their investigation, considering that police  
 6 investigations normally takes -- take time anyway?

7 So in hindsight, on reflection, we think possibly  
 8 a consideration should have been. But my understanding  
 9 is then police would always take primacy during that  
 10 time.

11 If that incident was to happen again now, would we  
 12 wait for police to complete their investigation?  
 13 Absolutely not. When you consider as well that we have  
 14 got a statute limit of three years in terms of what we  
 15 can do as CQC. So when you put everything in  
 16 consideration on reflection, then possibly consideration  
 17 should have been made on our position at CQC.

18 **Q.** Well, the danger is that if the CQC does await  
 19 the police investigation, you have just identified there  
 20 is a statutory limitation of taking enforcement action?

21 **A.** Yes.

22 **Q.** So if you don't investigate, then you can lose  
 23 ability to take any enforcement action at all?

24 **A.** Yes.

25 **Q.** Is it your understanding that it was the  
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1 NHS Improvement.

2 So what I am saying, on reflection, there are so  
 3 many areas that I could think of possibly, you know, one  
 4 could have considered during that time to try by all  
 5 means to make sure we build a case in terms of what was  
 6 happening during that time in, in Countess of Chester  
 7 Hospital.

8 **Q.** In summary and in respect of the monitoring,  
 9 does the CQC consider that it should have done more to  
 10 interrogate what was going on because if we -- the  
 11 chronology we have just looked at, the CQC was told it  
 12 had been sent the Thematic Review and the Brigham  
 13 Report.

14 Its position is it hadn't; it never requested  
 15 clarification or those documents. It only received the  
 16 redacted RCPCH report and then when it was published to  
 17 the entire world and it appears to have been unaware of  
 18 the suspicions of deliberate harm for an undefined  
 19 period but at least a year.

20 Now in light of those factors, does the CQC as  
 21 regulator accept that it should have known, it should  
 22 have done more to know what was going on at this  
 23 hospital?

24 **A.** I mean, questions should have been asked.

25 I mean, I think that's -- it all comes down like I said  
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1 police investigation that led to the CQC effectively to  
 2 take something of a backseat in terms of its monitoring  
 3 because there wasn't an inspection of Child and Young  
 4 People's services in 2018 either, was there?

5 **A.** Yes, and, and also the -- I suspect it was  
 6 also during the time that we sort of changed the  
 7 methodology as well from comprehensive to, in my  
 8 understanding, to risk-based inspections towards  
 9 2018/2019.

10 And from what I have seen, I wouldn't necessarily  
 11 say whether it was taking a backseat or not, Mr Carr.  
 12 I would think, at that point, I suppose the focus was  
 13 more of my understanding was the engagement with the  
 14 Trust, thinking about what was being done to -- to make  
 15 sure, you know, babies were safe in those services and  
 16 what the organisation was doing and monitoring that.

17 But I am saying -- obviously I wasn't there -- but  
 18 when I look back now, I think that that the point of  
 19 professional curiosity of thinking about what else is  
 20 happening and also thinking about focusing on possibly  
 21 safeguarding, you know, thinking about, you know,  
 22 looking at it from a lens of safeguarding and thinking  
 23 about what else could be done and I suppose thinking  
 24 about, you know, what else could other organisations,  
 25 you know, between ourselves, NHS England,  
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1 to the professional curiosity of just asking questions  
 2 in terms of like if you follow the timelines like you  
 3 have articulated, Mr Carr, you know, were there points  
 4 where possibly one could have actually as a regulator  
 5 think about asking more questions and, you know,  
 6 requesting the documents to be submitted to us.

7 Like I said, I am not aware or can say yes or no  
 8 whether those documents were requested during that time.  
 9 But I would expect that, you know, if someone is saying  
 10 to you, you know, we are carrying out a review, you  
 11 would want to know more about the review if, if, if what  
 12 is going on the Terms of Reference. Yes, there will be  
 13 that expectation, especially now if something would  
 14 happen now, those are the questions I will be asking in  
 15 terms of wanting to know more.

16 **Q.** Just to close this topic, Mr Dzikiti, you  
 17 started your previous answer with a qualification  
 18 "possibly" and just reflecting on, for instance, the  
 19 email referring to the Thematic Review and the Brigham  
 20 Report we don't need to qualify that with: it would have  
 21 been possible to request.

22 If you are being told by an entity that you  
 23 regulate there has been an increase in neonatal  
 24 mortality, we have done two reports on it, that is  
 25 something that the regulator should be asking for, isn't  
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1 it?  
 2 **A.** Yes. Yes. Now I would.  
 3 **MR CARR:** My Lady, is that a suitable time?  
 4 **LADY JUSTICE THIRLWALL:** Very good. So we will  
 5 rise now and we will start again at 10 past 2.

6 (1.09 pm)

7 (The luncheon adjournment)

8 (2.10 pm)

9 **LADY JUSTICE THIRLWALL:** Yes.

10 **MR CARR:** My Lady, thank you.

11 Mr Dzikiiti, if we can consider, please, the duty of  
 12 candour. I am going to take you to two sections of  
 13 Mr Trenholm's first witness statement, INQ0012634.

14 If we turn to page 10, please, you will see there  
 15 a section, Mr Dzikiiti, titled "Duty of Candour" and at  
 16 paragraph 43, Mr Trenholm describes what that duty is.

17 Have you considered that bit?

18 **A.** Yes.

19 **Q.** And if we go forward, please, to page 30 of  
 20 the statement -- sorry 3-0, forgive me -- and we see  
 21 another section titled "Duty of candour".

22 Paragraph 151, Mr Trenholm describes two types of  
 23 duty of candour notifications, statutory and  
 24 professional and he states that in the following  
 25 sentence:

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1 memory serves me right, we have successfully prosecuted  
 2 organisations around duty of candour, I think seven of  
 3 them.

4 **Q.** Seven?

5 **A.** Seven I am aware of, we have prosecuted in  
 6 terms of duty of candour.

7 So it is an expectation, you know, as time moves on  
 8 I suppose we are getting better as we mature as an  
 9 organisation in terms of how we deal with that, but our  
 10 expectation is quite clear, our guidance is quite clear  
 11 of what we expect organisations to be in terms of  
 12 openness and in terms of being transparent.

13 **Q.** Insofar as the duty is concerned, do you  
 14 accept that the regulator duty by the CQC is a duty on  
 15 an organisation rather than --

16 **A.** Yes, it is to the organisation, yes.

17 **Q.** And so far as successful prosecutions, are you  
 18 able to help us with what the fine was or the result of  
 19 a successful prosecution was?

20 **A.** I mean, I can't, I cannot recall the exact  
 21 fine but I think one I can remember I suppose because it  
 22 is public knowledge, it is Plymouth NHS it was around  
 23 the issues of being transparent when harm has happened  
 24 to a service user, to a patient, and we felt that  
 25 actually they were not being open and transparent

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1 "CQC's guidance relates to the statutory duty which  
 2 we regulate as opposed to the professional."

3 Is it the position then that the CQC in terms of  
 4 regulation regulates the organisation rather than the  
 5 individual?

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

7 **Q.** The Inquiry has heard evidence from  
 8 Sir Robert Behrens, and I think you have been directed  
 9 to a section of the transcript of evidence where he  
 10 deals with the duty of candour and one of the criticisms  
 11 that he made was that the duty of candour does not work  
 12 because it doesn't apply to individuals; and, secondly,  
 13 that the fines are too small to impact the behaviour of  
 14 leaders.

15 What's the CQC's position in respect of the duty of  
 16 candour as it applies to organisations?

17 **A.** For -- for organisations? So, I mean for  
 18 organisations we are quite clear of our expectations as  
 19 set out in, in the statement in terms of what we expect  
 20 organisations to do when it comes to being open and  
 21 transparent. There is something about when, for example  
 22 harm is happened, you know, we expect that to be open,  
 23 the organisation, and also make sure there is support to  
 24 the people who are the victims of that harm happening.

25 I think over the years, I think since 2020, if my

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1 throughout the process of dealing with that Serious  
 2 Incident and -- and we successfully prosecuted them.

3 In terms of what was the fine, I can always come  
 4 back, my Lady, if that's okay, in terms of the exact but  
 5 we can provide more details on those seven which I've  
 6 referred in terms of more details if required.

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

8 **MR CARR:** If we go forward, please, to page 32 of  
 9 the statement. At paragraphs 164 and 165, under the  
 10 heading "CCTV", and we can see that Mr Trenholm  
 11 addresses the issue of CCTV here stating that there's  
 12 not information held by the CQC on the number of Trusts  
 13 with CCTV and at paragraph 165 he addresses a potential  
 14 basis to impose conditions of registration in respect of  
 15 CCTV.

16 Has the CQC done any more work in relation to the  
 17 potential benefits of CCTV specifically on neonatal  
 18 wards?

19 **A.** Not that I am aware of.

20 **Q.** Is there anything that you can add to these  
 21 two paragraphs on CCTV?

22 **A.** I mean, I do, do I agree with, with what  
 23 Mr Trenholm was referring in terms of the complexities  
 24 when it comes to CCTV? Hence, we don't have a position  
 25 as such on what organisations can do. But what we have

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1 tried to do is to provide some guidance on those  
2 organisations who decide to -- to use CCTV camera on  
3 areas they should consider of things like if you use  
4 CCTV, how do you use it? Where do you store the  
5 information? Who's got access to the information? And  
6 then consider in the right to respect for private and  
7 family life.

8 So what I am saying is some organisations not in  
9 neonatal services but for example in mental health CCTV  
10 is more regularly used by, by providers and like I said  
11 earlier, it has to a certain extent informed some of our  
12 inspections, especially when we are trying to gather  
13 more information about an incident.

14 **Q.** Did you say -- sorry, I may not have caught it  
15 correctly, did you say the CQC does provide guidance to  
16 healthcare providers?

17 **A.** Yes, for those who want to -- to use CCTV in  
18 terms of what areas some -- to consider.

19 **Q.** The issue of medication is addressed in both  
20 of Mr Trenholm's statements. If we go forward, please,  
21 to page 35 of this statement, and if we look at  
22 paragraph 184, Mr Trenholm states:

23 "The vast majority of cupboards, including  
24 controlled drug cupboards, are not electronic and would  
25 be open with a key or using a coded keypad. Ordinarily

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1 **Q.** So it would be beneficial?

2 **A.** It would be beneficial, yes, but we don't have  
3 a position at CQC.

4 **Q.** And I asked the question broadly in respect of  
5 medications. Has the CQC, in light of the events that  
6 we are concerned with at this Inquiry, has it done any  
7 work or has it reached any view in respect specifically  
8 of insulin and whether extra steps need to be taken for  
9 the secure storage of insulin or access to it?

10 **A.** Not, not that I am aware of.

11 **Q.** And if you stay on this -- sorry, in fact if  
12 you go back to page 32, thank you, and paragraph 162,  
13 this is Mr Trenholm's first statement, it states:

14 "CQC's guidance on how providers can meet the  
15 regulations has not been revised in light of the Letby  
16 case and nor have the regulations that underpin our  
17 work."

18 Now, this is the first statement, the statement  
19 from February 2024. In light of the evidence that has  
20 been heard at this Inquiry, have any changes now been  
21 made to guidance or the regulations underpinning the  
22 CQC's work?

23 **A.** Obviously we are going through changes in CQC.  
24 And, and as part of those changes I think one thing  
25 I can sort of reflect on thinking about, about is

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1 therefore there would be no record of someone accessing  
2 the cupboard unless they removed an item where there was  
3 a legal requirement for it to be recorded, such as  
4 certain and controlled drugs."

5 Is the CQC's view that this needs to change and  
6 that there should be an electronic system for accessing  
7 any drugs?

8 **A.** I suppose this, this sits with providers. So  
9 we, we haven't issued in terms of guidance on how  
10 providers should look after medicines or, you know,  
11 controlled drugs. What we are quite clear is there has  
12 to be a process of managing medicines and controlled  
13 drugs.

14 If your question is about what we think in terms of  
15 whether there has to be an electronic way of managing  
16 medicines I suppose it's for providers to consider the  
17 best way which it safely can be, you know, implemented  
18 and managed within a provider to make actually you are  
19 quite clear in terms of who is accessing medicines,  
20 especially controlled drugs and I do appreciate the  
21 point Mr Trenholm was making of actually it's hard to  
22 tell who has accessed those medicines if you are using  
23 a key to lock and unlock a cupboard, whereas possibly  
24 an electronic way of accessing might help in giving that  
25 information going forward.

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1 discussions around the statute limitation of three years  
2 where it's a challenge in terms of trying to -- to  
3 investigate, to address concerns, investigate, bring  
4 a prosecution or enforcement within those three years.

5 And my understanding from talking to -- to  
6 colleagues and legal colleagues is previously I think  
7 that they have attempted to -- to request considerations  
8 of that statute of limit to be considered whether it can  
9 be taken or not, but I do appreciate there is some  
10 concerns around, you know, how long can it be, you know,  
11 you make it, once you take the, those limitations, then  
12 the providers don't know how long it would take for  
13 something to come as a case towards them.

14 But I think for us it is one area we have been  
15 reflecting on in terms of just the limitations of those  
16 three years.

17 But I suppose some of the work in terms of just  
18 actually learning from the issues I discussed earlier  
19 around professional curiosity, thinking about, you know,  
20 how we use our data and definitely. But one which comes  
21 to mind is that limitation of three years.

22 **MR CARR:** My Lady, those are my questions for  
23 Mr Dziki. I know that Mr Sharghy has some questions.

24 **LADY JUSTICE THIRLWALL:** Mr Sharghy. Thank you,  
25 Mr Carr.

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1 Questions by MR SHARGHY

2 **MR SHARGHY:** Good afternoon, Mr Dzikiti. I ask  
3 questions on behalf of one of the Family groups involved  
4 within this Inquiry.

5 Can I just ask you briefly on a matter that Mr Carr  
6 asked some questions with you a few moments ago and that  
7 was in relation to the duty of candour and I listened to  
8 your answer very carefully in regards to what the CQC  
9 expects or expected of Trusts in particular in relation  
10 to the provision of information to service users and  
11 also indeed to the CQC.

12 If, however, the Trust are less than forthcoming,  
13 as the Countess of Chester the Inquiry has heard was  
14 over the relevant period, that makes it less likely, for  
15 example, that the service users or their family are  
16 informed of any issues regarding care; that's right,  
17 isn't it?

18 **A.** Yes.

19 **Q.** And if the Trust are less than forthcoming  
20 with clear information as to what has happened, what may  
21 have gone wrong, or indeed investigations, they are  
22 likely to also keep that information from the CQC, the  
23 GMC, the NMC and other regulating bodies; is that right?

24 **A.** There's a likelihood, yes, there is  
25 a likelihood.

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1 they don't follow those instructions, then we will use  
2 our powers to -- to make sure we prosecute for that.  
3 Like I gave an example we have successfully prosecuted  
4 seven organisations for some of those reasons for not  
5 one being open and transparent. So we have got means  
6 and mechanisms to make sure we get providers to  
7 understand that. And we have been quite clear in terms  
8 of what we expect from providers in terms of duty of  
9 candour.

10 **Q.** Is the CQC and its inspectors now routinely  
11 asking the sort of questions you have just indicated?  
12 In other words is that part of the training for the  
13 inspectors, is that part of any guidance that they have  
14 provided are rather than expecting information to simply  
15 voluntarily be provided, that they will proactively  
16 curiously ask those questions?

17 **A.** Yes, because we have got those regulations  
18 now. You know, we have got Regulation 12, we have got  
19 it, it is clear, it is clearly articulated in terms of  
20 that expectation. So every organisation we inspect, we  
21 assess, we are following the regulations we have got to  
22 make sure actually they are compliant of the regulations  
23 and as part of looking at Well-Led, for example, we are  
24 looking at that in terms of the leadership, in terms of  
25 the culture of that organisation about being open, about

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1 **Q.** Yes, and so therefore the Trust or Trusts sit  
2 right at the heart and centre of information provision  
3 regarding notifiable incidences, concerns, issues  
4 regarding safeguarding?

5 **A.** Yes.

6 **Q.** The position the Inquiry has heard a lot of  
7 evidence on in relation to 2015 over to 2017/2018 was  
8 one where the Trust was less than forthcoming and in  
9 some cases deliberately withheld information, not just  
10 from the CQC but other regulators and other external  
11 bodies.

12 What steps can the CQC take to ensure that where  
13 Trusts are less than forthcoming, the CQC can elicit and  
14 indeed in some respects require key information that  
15 would set about further assessment and Inquiry regarding  
16 safeguarding?

17 **A.** Yes, I mean, when it comes to safeguarding,  
18 safeguarding is everyone's responsibility. You know we  
19 are quite clear about that. And, and we have got  
20 enforcement powers and we can use those powers to  
21 request for information and ask a provider to provide  
22 that information. Like I said at the start, our  
23 expectation and we are quite clear about duty of candour  
24 is that transparency, that openness and if an  
25 organisation is not, you know, we will require it to, if

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1 being transparent, in the event that as we gather  
2 intelligence, and we have improved our work in terms of  
3 how we work with other organisations, with other bodies.  
4 For example, you know, on a regular basis every  
5 fortnight I meet with the National Medical Director at  
6 NHSE, you know, Professor Powis, to talk about what's  
7 happening across healthcare and shared intelligence.  
8 Every month I meet with NHSE to look at their recovery  
9 support work they do for organisations plus the HSE to  
10 talk about what is happening and sharing information.  
11 And if we get to know some information that we should  
12 have been told by the provider from other intelligence  
13 gathering, then we will make sure that we follow it  
14 through with that provider to make sure we understand  
15 why that information has not been shared with CQC, for  
16 example.

17 **Q.** Thank you.

18 Moving on to the final question on duty of candour.  
19 What role does the CQC play in the monitoring of those  
20 that it then does enquire into, either write letters of  
21 notices to or indeed prosecute, to ensure that they  
22 actually are learning from what has befallen them  
23 before?

24 **A.** Yes, and that's -- you know, part of the  
25 engagement meetings and follow-up meetings is actually

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1 having those conversations, understanding about actually  
 2 is there learning taking place and internally as well,  
 3 the conversations we have about actually in terms of  
 4 those organisations my expectation would be that, you  
 5 know, engagement lead who's the single point of contact  
 6 in those regular touchpoints with providers  
 7 understanding how is the organisation learning? How are  
 8 they moving on from what has happened?

9 So if you have been prosecuted for an offence, what  
 10 is the learning? And when we go back in, for example,  
 11 to look at Well-Led is thinking about we look at the  
 12 learning from previous instances, how has that learning  
 13 been shared across the organisation to make sure  
 14 everyone is fully aware about what is expected?

15 **Q.** Thank you.

16 Can I move on to another topic now and that is in  
 17 relation to the culture the CQC is routinely finding  
 18 within various Trusts in the NHS more generally. And  
 19 for this it might be helpful if I put in front of you  
 20 the first witness statement of Mr Trenholm and what he  
 21 has said in relation to this factor and it is  
 22 INQ0012634, internal page 51. And it's paragraphs 267,  
 23 269 and 270 in particular.

24 If I start with paragraph 267, Mr Trenholm refers  
 25 to a question the Inquiry has asked regarding

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1 much with the majority of the evidence that this Inquiry  
 2 has heard as to what was occurring at the Countess of  
 3 Chester between 2015 and 2017.

4 If these problems have been existing for that  
 5 length of time, what is the CQC capable or able to do to  
 6 help Trusts and the NHS nor widely to address them?

7 **A.** So -- so some of the reflections from  
 8 Mr Trenholm is the work we do at CQC. So the National  
 9 Maternity Programme, for example, we do that work as  
 10 a response to what was happening at Shrewsbury and  
 11 Telford review and we, we undertook all the services we  
 12 had not inspected, for example before 2021 to look at  
 13 what is happening in maternity care and came up with  
 14 some recommendations. We published a report last year  
 15 on the work we had done in 2023, for example,  
 16 highlighting some of the challenges in maternity care  
 17 but we did not just highlight the issues or the  
 18 challenges. We also -- as part of the publication we  
 19 published a programme of work or some recommendations,  
 20 a programme of work to offer to providers in terms of  
 21 tools they can use to improve maternity care and also  
 22 our expectation of what we are expecting from maternity  
 23 services.

24 On top of that we have had continuous discussions  
 25 with NHS England, for example, to think about actually

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1 recommendations from previous Inquiries.

2 What he says is:

3 "Our maternity inspection programme has however  
 4 shown that despite multiple recommendations for  
 5 maternity services, we have found shortfalls in the  
 6 quality and safety of care including concerns about the  
 7 identification and management of risk to women and  
 8 babies and strong safety narrative where quality and  
 9 safety is well understood and embedded throughout the  
 10 service."

11 He then goes on at paragraph 269 to specifically  
 12 refer to the state of care annual assessment that  
 13 a report on this carried out 2021, 2022 and 2023 and  
 14 says this:

15 "In our latest report published on 29 October 2023,  
 16 we set out that many people are not receiving the safe,  
 17 good quality maternity care that they deserve. Our  
 18 report notes issues around leadership, staffing, and  
 19 communications."

20 The following paragraph just specifically picking  
 21 up on this says, last sentence:

22 "We also have concerns about problematic working  
 23 relationships between service level managers, neonatal,  
 24 midwifery and obstetric leaders."

25 All of what Mr Trenholm has said here chimes very  
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1 some of the work they are doing in NHS England to  
 2 provide the maternity services with the requirement of  
 3 improvement tools they need to improve maternity  
 4 services.

5 One issue we keep on picking up and it comes  
 6 on-coming out in almost every review we do, it is around  
 7 workforce, for example. There is a challenge around  
 8 having enough workforce. So having those conversations  
 9 and talking with NHS England in terms of what can be  
 10 done to make sure there is enough workforce in terms of  
 11 midwives in those services.

12 So instead of just us highlighting the gaps in  
 13 maternity services like I said we are also highlighting  
 14 improvement tools to support those organisations in  
 15 terms of the work that they need to do but on top of  
 16 that, we are also using our enforcement powers. It's  
 17 public knowledge we have prosecuted some organisations  
 18 for failure. In Nottingham for example we have  
 19 successfully prosecuted them for two, for failure in  
 20 terms of the care expected to be given to mothers and  
 21 babies in those services.

22 So that's for me what we are saying to providers  
 23 is: our expectation is we expect high quality of care in  
 24 terms of maternity services. Where we find shortfalls  
 25 and gaps, where we require enforcement powers to be used

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1 we are using those and successfully prosecuting those  
2 services.

3 **Q.** I understand the enforcement powers,  
4 I understand the actions taken once you identify  
5 an issue, but this particular matter in terms of  
6 relationship cultural problems that exist and have --  
7 continued to exist, is that something that the CQC is  
8 able to also provide recommendations on other than the  
9 number of nurses, the number of midwives et cetera? Or  
10 is this for another organisation?

11 **A.** I mean, I mean I know definitely in terms of,  
12 you know, cultural issues, I know NHS England has got  
13 a programme which looks at culture, you know, helping an  
14 organisation to think about their culture and to develop  
15 their culture and think about the practice in that  
16 culture. But also for us I think, I think for CQC when  
17 we look at Well-Led of that organisation we are also  
18 looking at the leadership in that organisation in terms  
19 of what the leadership is like, things like for example  
20 you know Freedom to Speak Up, whistleblowing, especially  
21 Freedom to Speak Up, you know, the psychological safety  
22 and emotional safety for staff to be able to highlight  
23 within they see poor practice or even just an element of  
24 a likelihood of poor practice; that people are able to  
25 raise it before it becomes a big problem within those

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1 about safeguarding, about how important safeguarding is,  
2 how important organisations should be working together  
3 especially regulators, ourselves, you know, NHS England  
4 thinking about professional bodies, how best can we work  
5 together to try and support maternity services and  
6 system working as well.

7 I think in 2022 the Health and Social Care Act 2022  
8 gave us some powers as CQC to look at system working  
9 which we have not started using but we are hoping very  
10 soon to be using, to look at system working about how  
11 are actually organisations within the system working  
12 together to make sure, for example, they are providing  
13 safe care and for example they are addressing issues in  
14 maternity services because some of those things need to  
15 be a system-wide approach.

16 And there's more in terms of learning as well, in  
17 terms of seeing, you know, is there more we can do in  
18 terms of keep on encouraging our staff. Like I said  
19 earlier the professional curiosity of thinking about  
20 actually what more can you ask, what more can you even  
21 just trusting your instinct and also keep on promoting  
22 Freedom to Speak Up, keep on promoting whistleblowing,  
23 to make sure actually people feel safe to identify that.

24 I think earlier on there was some reflections  
25 around whether there is, you know, regulation for, for

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1 organisations.

2 So that's part of what we do and we do our Well-Led  
3 to make sure we are assessing those services to make  
4 sure actually, you know, in terms of Freedom to Speak  
5 Up, like I said, how well is it working? Because we  
6 know that when it is working, people are able to raise  
7 some concerns with us and we have used that intelligence  
8 to go in to check for ourselves what's happening in the  
9 service before actually we get to a point where we have  
10 got high instances happening.

11 **Q.** Thank you.

12 Final question. Having reflected not just on the  
13 evidence that the Inquiry has heard to date but also  
14 indeed the self-reflection that the CQC has carried out,  
15 in your view, what more does the CQC need, whether it's  
16 funding, whether it's additional resources or  
17 inspectors, or what does it need to be able to do more  
18 effectively to do what Mr Trenholm indicated, which is  
19 actually allow Trusts to provide the safe and good  
20 quality maternity care that they deserve?

21 **A.** Well, I think on, on reflection you know there  
22 are so many points to focus on. Something about what we  
23 do as a healthcare system and all of us, I mean in terms  
24 of CQC including other stakeholders, in terms of system  
25 working, when I look back and think I mentioned early on

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1 senior managers. I think, yes, serious consideration  
2 should be, should be made to think about whether it's  
3 something as a healthcare system we should consider  
4 regulating managers especially within the NHS, I think  
5 it's something to take back to -- to discuss and reflect  
6 on.

7 **MR SHARGHY:** My Lady, thank you, those are my  
8 questions.

9 Questions by LADY JUSTICE THIRLWALL

10 **LADY JUSTICE THIRLWALL:** Thank you very much,  
11 Mr Sharghy. Presumably that has already been thought  
12 about, given the consultation at the moment?

13 **A.** Yes.

14 **LADY JUSTICE THIRLWALL:** Is there a view from CQC  
15 about it?

16 **A.** Yes. I mean, for us I think it's -- we would  
17 contemplate it and say it's something seriously to  
18 consider from our part.

19 **LADY JUSTICE THIRLWALL:** Yes, I appreciate it is  
20 something to consider. But is the review about whether  
21 it should be done or not?

22 **A.** At the moment we, we haven't referred  
23 ourselves per se to say should we be doing it, but if  
24 I was talking about a position, it is something we will  
25 need to seriously consider who does it.

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1 **LADY JUSTICE THIRLWALL:** Right.  
 2 **A.** I think that would be the question who does it  
 3 and I think for CQC we have had some conversations about  
 4 is that something possibly we could do because we do it  
 5 for other sectors, we do it for social care, for  
 6 example, and independent health where they have got  
 7 registered managers, so we do that.  
 8 So it's something we would think possibly we might  
 9 be able to help going forward.  
 10 **LADY JUSTICE THIRLWALL:** So in principle you think  
 11 regulation is a good idea and the issue is by whom it  
 12 should be done; is that a fair summary?  
 13 **A.** Yes, I think it is, it is a good, a good idea  
 14 but more will need to be discussed in terms of the  
 15 process of doing it. Yes.  
 16 **LADY JUSTICE THIRLWALL:** You mentioned the response  
 17 to the Dash Report and I just want to make sure I have  
 18 properly understood this. You talked a lot earlier in  
 19 your evidence about process and not at all about outcome  
 20 but then when you were talking about the response to  
 21 Dash, my understanding is that this is a shift to  
 22 processes which are much more outcome focused; is that  
 23 right?  
 24 **A.** Yes, that's correct, yes.  
 25 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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1 **LADY JUSTICE THIRLWALL:** Yes, that is all right, we  
 2 are just slightly at cross-purposes.  
 3 Thank you. One of the points that was made in the  
 4 statement, and I think you have also picked it up, is  
 5 that there's too much information for the analysts to  
 6 look at the detail and so they have devised a way of  
 7 just reducing the amount of information by taking out  
 8 certain levels, so the low harm/no harm sections?  
 9 **A.** Yes.  
 10 **LADY JUSTICE THIRLWALL:** The other way of doing it  
 11 I suppose would have been to have more analysts so  
 12 that's a resources issue, presumably?  
 13 **A.** Yes.  
 14 **LADY JUSTICE THIRLWALL:** Yes. Okay. Thank you.  
 15 Going back to the 2016 inspection. The outcome was  
 16 that under the Well-Led section, the Countess was rated  
 17 as "good".  
 18 **A.** Yes.  
 19 **LADY JUSTICE THIRLWALL:** And we don't have the  
 20 notes for the reasons that we have already gone through.  
 21 But we do have some evidence which you will have read  
 22 from one of the advisors that she held a focus group  
 23 with a large group of Consultants, not just  
 24 paediatricians, but Consultants generally.  
 25 **A.** Yes.

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1 Looking at the position of analysts, obviously we  
 2 have only looked at part of what they do in the context  
 3 of a particular inspection of a particular hospital.  
 4 But just so that I understand it, the analysts are not  
 5 clinically trained; is that right?  
 6 **A.** No.  
 7 **LADY JUSTICE THIRLWALL:** And so their job is to  
 8 look at the information that comes in, the numbers and  
 9 then to draw something from the numbers to analyse them  
 10 and see if there's something to be said; is that what  
 11 their role is?  
 12 **A.** Yes, and what I would hope, my Lady, is over  
 13 a period of time talking to the analysts, for example,  
 14 I was talking to who have been looking at healthcare  
 15 records for nearly two decades. Over time some of them  
 16 have gained that expertise because it's something they  
 17 do on a daily basis, but their background --  
 18 **LADY JUSTICE THIRLWALL:** Well, what expertise?  
 19 **A.** No, what I mean is of looking at medical  
 20 records.  
 21 **LADY JUSTICE THIRLWALL:** How to look at -- do they  
 22 look at medical records?  
 23 **A.** No, sorry, I am talking about the information  
 24 we receive we, especially safety data. Sorry, pardon  
 25 me.

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1 **LADY JUSTICE THIRLWALL:** And that the only note  
 2 that there is to the effect that they were raising  
 3 the fact that senior medical management were bullying or  
 4 some such phrase.  
 5 **A.** Yes.  
 6 **LADY JUSTICE THIRLWALL:** Now, is that not something  
 7 that perhaps ought to have featured somewhere in the  
 8 consideration of whether the hospital was Well-Led?  
 9 What should have happened to that information?  
 10 **A.** I think my expectations would have been, you  
 11 know, further conversations. So I would --  
 12 **LADY JUSTICE THIRLWALL:** Further conversation with  
 13 whom?  
 14 **A.** With, for example, the Chief Executive or the  
 15 Chair. Because it's quite serious, you know, in terms  
 16 of -- if you have got a team saying there are some  
 17 issues around bullying or harassment. So I would  
 18 have -- my expectation would have been further  
 19 conversations to really clarify, to go under the skin of  
 20 what was really happening with the most senior people  
 21 within the organisation and the Chief Executive and the  
 22 Chairperson would have an ideal person to have those  
 23 conversations with.  
 24 **LADY JUSTICE THIRLWALL:** Yes, thank you. I think  
 25 we know that the advisor believed she may have raised it

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1 with the Medical Director but she wasn't sure and he  
2 didn't have any recollection of it having been raised  
3 with him. But I think your point is the question should  
4 have been raised at a higher level with the Chief  
5 Executive.

6 **A.** Yes.

7 **LADY JUSTICE THIRLWALL:** And the Chair.

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** I mean, is it fair to say  
10 that it's quite surprising that that information didn't  
11 find its way to the right people?

12 **A.** Yes, and -- and we did apologise obviously  
13 some of that information we don't have access to.

14 **LADY JUSTICE THIRLWALL:** No, no but what we have  
15 got?

16 **A.** But, yes, it is when I look back now on  
17 reflection, yes, you know, it was right to raise it with  
18 the Medical Director but it was also very, very  
19 important to raise it with the Chief Exec and the  
20 Chairperson.

21 **LADY JUSTICE THIRLWALL:** Yes, and then something,  
22 presumably the Consultants would have had some  
23 expectation having said something --

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** -- in the interests of  
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1 appears in the email. Was there not, do you think,  
2 an expectation that the person receiving that  
3 information and the CQC more generally would have gone  
4 back immediately to say: well, hold on a minute. Where  
5 is the report? We haven't got it. You know, whether or  
6 not there was a mistake about whether it had been sent  
7 is not the issue.

8 The point is you didn't have it so far as anyone  
9 can tell and there seems to have been no challenge of  
10 all the people that you spoke to, not you personally but  
11 CQC spoke to to say: well, this is important  
12 information, why were we not told where is the openness  
13 and where is the honesty in relation to that? Would you  
14 not have expected that?

15 **A.** Yes, I would have -- my Lady, I would have  
16 expected that because I suppose when I look back and  
17 think how the events transpired, we published a report  
18 and then we were then informed immediately after  
19 publishing the report about the reviews which had taken  
20 place.

21 **LADY JUSTICE THIRLWALL:** We have been through that,  
22 I don't want to cut you off, you have explained all of  
23 that.

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** What there isn't is any  
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1 being open and transparent and actually nothing  
2 happened?

3 **A.** No.

4 **LADY JUSTICE THIRLWALL:** That is the reality, isn't  
5 it?

6 **A.** (Nods)

7 **LADY JUSTICE THIRLWALL:** Then going back to what  
8 wasn't said. So June 2016 you get the email which we  
9 have gone through in detail, but you know the one  
10 I mean?

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** Which says you have  
13 already had our Thematic Review and then it says quite  
14 a lot else following up on a telephone conversation?

15 **A.** Yes.

16 **LADY JUSTICE THIRLWALL:** Which coincided with the  
17 publication of the report, that was probably the prompt  
18 I think for the call?

19 **A.** Yes.

20 **LADY JUSTICE THIRLWALL:** But again, I mean, just  
21 briefly. You don't need hindsight I don't think for  
22 this. We have got a team of inspectors or an inspector  
23 and advisors who have not been told anything about  
24 mortality in the neonatal unit.

25 Then some months later they are told that which  
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1 challenge of the hospital for the absence of that  
2 information before 30 June. There's just no challenge  
3 at all.

4 **A.** Yes, no, I would have expected a challenge.

5 **LADY JUSTICE THIRLWALL:** Yes. Well, there should  
6 have been a challenge, should there not?

7 **A.** Yes.

8 **LADY JUSTICE THIRLWALL:** And the reason I am so  
9 interested in this is because it may indicate the extent  
10 to which there was any effective probing of the  
11 information that was being given during the course of  
12 the inspection, given its total absence when this  
13 information, which on any view was pretty startling, was  
14 received.

15 Is that a fair inference to draw, do you think?

16 **A.** I think, yes, one could conclude that and one  
17 thing I -- I totally agree with you is, you know, yes  
18 you know we should have, we should have probed a bit  
19 more, that professional curiosity I was talking about  
20 earlier, we should have asked more questions --

21 **LADY JUSTICE THIRLWALL:** You must be a bit cross  
22 apart from being curious?

23 **A.** Yes, but asking the question.

24 **LADY JUSTICE THIRLWALL:** Yes.

25 **A.** And, and to a certain extent holding people to  
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1 account in terms of actually, you know, we didn't see  
2 this information, can we see the information? So it is  
3 no longer just a question of: we did not see the  
4 information, it's now you have got the information can  
5 we have the information?

6 **LADY JUSTICE THIRLWALL:** And "why didn't you tell  
7 us about it before"?

8 **A.** Before, exactly. So those questions, I would  
9 have expected them to be part of the conversations.  
10 Even in the follow-up conversations we had, I would have  
11 expected those conversation.

12 **LADY JUSTICE THIRLWALL:** Yes, thank you very much  
13 indeed.

14 Ms Richards, I'm sorry, I didn't ask if you have  
15 any questions.

16 **MS RICHARDS:** No, it's okay.

17 **LADY JUSTICE THIRLWALL:** I am sorry to ask at  
18 a later stage. Anyone else want to ask anything else?

19 No. Good, thank you very much for coming to give  
20 your evidence. You are now free to go.

21 **A.** Thank you, my Lady, Mr Carr, thank you.

22 **MR CARR:** Thank you.

23 My Lady, I am going to hand over to Ms Brown who is  
24 dealing with the next witness.

25 **LADY JUSTICE THIRLWALL:** Thank you very much  
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1 a neonatal unit but I have cared for patients in  
2 neonatal units as part of my role as a bereavement  
3 nurse, yes.

4 **Q.** And in 2004, you were involved in setting up  
5 the bereavement and donor support service?

6 **A.** I was indeed.

7 **Q.** In 2016, you were awarded an MBE in  
8 recognition of your work within nursing and specifically  
9 in the area of bereavement?

10 **A.** Yes.

11 **Q.** Also in 2016 you became a patron of the Good  
12 Grief Trust, the umbrella charity for over 1,000  
13 charities for bereavement support?

14 **A.** Yes.

15 **Q.** In 2017, you led the immediate support and  
16 aftercare of the Families of the deceased victims from  
17 the Manchester Arena bombing?

18 **A.** I did.

19 **Q.** And in 2022 you commenced role as A corporate  
20 Director of Nursing at the Royal Liverpool University  
21 Hospital and you retired from that post last year in  
22 June 2024?

23 **A.** I did indeed.

24 **Q.** Could you just briefly outline what that last  
25 post encompassed, your most recent post?

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1 indeed, Mr Carr, and I think we have got Ms Murphy  
2 coming to give evidence, haven't we?  
3 Do come forward. Sorry to have kept you waiting so  
4 long, we are just going to wait for everyone to settle  
5 down with the change of counsel and then it will be your  
6 turn, I know there is nothing worse than waiting all day  
7 so I am very grateful to you for being here.

8 MS FIONA MURPHY (sworn)

9 **LADY JUSTICE THIRLWALL:** Do have a seat.  
10 Questions by MS BROWN

11 **MS BROWN:** Could you please give your full name?

12 **A.** I am Fiona Doune Murphy.

13 **Q.** And you provided a statement to the Inquiry  
14 dated 1 August 2024 and is that statement true to the  
15 best of your knowledge and belief?

16 **A.** It is indeed.

17 **Q.** If I can start by dealing with your  
18 qualifications, expertise and some of the roles and  
19 experience you have in relation to bereavement, you are  
20 a Registered Nurse and have worked in a number of  
21 hospitals in critical care; is that correct?

22 **A.** It is.

23 **Q.** Have you ever worked in a neonatal unit as  
24 part of that?

25 **A.** So I haven't specifically had a role in  
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1 **A.** So my final post in my nursing career of  
2 40 years gave me the responsibilities of looking after  
3 three hospitals, so I looked after the Royal Liverpool,  
4 I looked after Aintree Hospital and I looked after -- my  
5 responsibilities were quality improvement, my  
6 responsibilities were end of life care and bereavement  
7 and my responsibilities were the ward accreditation  
8 systems across the organisation. I looked after the  
9 Chaplaincy teams, I looked after all patient experience  
10 responsibilities across each of the hospital sites and  
11 everything to do with that. And had major input into  
12 the international collaborative for end of life care  
13 with Liverpool University to pursue the SWAN model of  
14 end of life care, which was one of the reasons that  
15 I came over to Liverpool.

16 **Q.** Thank you. And your current situation, are  
17 you now retired or do you still have a role within the  
18 NHS as your current role?

19 **A.** So I have retired but I still do work with the  
20 Good Grief Trust and I still do a little bit of work  
21 outside of the NHS.

22 **Q.** Thank you. Turning to first of all look at  
23 the SWAN model that you discuss in your statement, if we  
24 could just have up INQ0108720. And that should be the  
25 front page of the booklet setting out the SWAN system.

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1 We see there at the bottom of that heading page:  
2 "To promote dignity, respect and compassion at the  
3 end of life and after death."

4 Which I think is self-explanatory.

5 But the next phrase:

6 "Permission to act and break the rules that don't  
7 exist."

8 Could you just explain that a little, please?

9 **A.** Of course I can. So historically, when nurses  
10 in particular look after end of life care patients or  
11 patients that are dying immediately have died, often  
12 healthcare professionals, particularly nurses, are often  
13 fearful of either distressing a family more than they  
14 are already distressed because the person that they love  
15 has just died, so we are frightened of upsetting them  
16 more but doing something with their deceased relative,  
17 their dead baby or the person that they care for, or we  
18 are frightened of getting something wrong because we are  
19 frightened of going outside of process.

20 So often, we can make a situation worse because we  
21 are fearful of getting something wrong.

22 So we often -- and the majority of NHS staff, don't  
23 have advanced communication education or training and so  
24 our generalists are not specialists in end of life care  
25 in whatever field of nursing they work in. So whether

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1 asking a family what matters to them right in this  
2 moment in time because we are not breaching anything and  
3 nobody is going to get into trouble by asking somebody:  
4 what really matters to you right now?

5 **Q.** Thank you. And if we could go then to page 6  
6 of this policy, I think that probably illustrates -- and  
7 this policy is not too full of words, it sets it out  
8 very clearly, if we can go to page 6. Sorry, it's  
9 INQ -- 005 is the reference, one back. Yes.

10 So Ms Murphy, could you just -- obviously we have  
11 got the acronym SWAN there, but just set out briefly  
12 what those four steps are and how that helps the nurses  
13 to break the rules when necessary and give the care  
14 under the SWAN principles.

15 **A.** So we have tried to simplify it. The SWAN  
16 model, when I and others -- when we created the SWAN  
17 model it was just to make it as simple -- and one-page  
18 "read it, understand it" -- as possible.

19 Private space: really, really important. The use  
20 of language: really sensitive, communicate with the  
21 family. Step out the box. We really need to know  
22 what's important to a family and those walking alongside  
23 that journey with them to make sure that we can  
24 facilitate it and not just talking the talk. Are the  
25 needs of the family being met, are they documented? Are

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1 you work in a neonatal unit, whether you work in  
2 a critical care unit, whether you work in any aspect of  
3 healthcare, we are not skilled particularly unless we  
4 have chosen to do an advanced communication skills  
5 course or a bereavement end of life care course where we  
6 are equipped with a skillset to be able to have  
7 a difficult conversation, or we are really attuned to  
8 our end of life care bereavement policies within our  
9 organisation which are usually pages and pages long.  
10 And the pressures on the nursing staff, so I am  
11 going to say nursing staff because it's usually nursing  
12 staff that look after these families that are in acute  
13 bereavement phase, that is one of hundreds of policies,  
14 and do not go and read those pages and pages of policies  
15 so they don't know the minutiae of what's in that  
16 information.

17 So often staff don't understand all the things that  
18 they can go and do. So --

19 **Q.** Can I just stop you there by going on to the  
20 policy because I think if we look at that, that will  
21 help us go through that.

22 **A.** So I am just trying to describe permission to  
23 act. So the SWAN model is about it's okay to have  
24 conversations that matter with families and we are not  
25 always breaking policy by having a conversation and

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1 we reviewing them?

2 You might ask a family something of what they want  
3 in one moment and half an hour later they may have  
4 changed their mind because you might have planted  
5 a seed, they might have had a conversation and actually  
6 maybe the sibling that they didn't want bringing in  
7 because they didn't think it was right, they have  
8 thought about it had a chat and maybe they do want to  
9 bring that sibling in half an hour. So it's really,  
10 really important that we go back and we have that  
11 conversation again and often repeated and making sure we  
12 are reviewing and having those conversations again.

13 So I just think it's really simplistic; the more  
14 simple we make things the more chance people are going  
15 to adhere and do what we need them to do.

16 **Q.** And the page we are looking at here is the  
17 SWAN model care for individuals who have Sudden  
18 Unexpected Death. Obviously the Inquiry are looking  
19 specifically at neonatal death.

20 **A.** Yes.

21 **Q.** Are there things that you would like to add in  
22 terms of that best practice that would be specific to  
23 neonatal care where there's been a Sudden and Unexpected  
24 Death?

25 **A.** So I think, you know, it can be adapted to any

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1 setting and I think a group of neonatal specialists  
2 could sit and tweak that accordingly. But actually that  
3 could be -- in my opinion that could be picked up and  
4 tweaked up to the neonatal setting in exactly the same  
5 way.

6 A Sudden and Unexpected Death in any setting is  
7 a Sudden and Unexpected Death and actually the processes  
8 are very, very similar. So actually the specialists in  
9 each of those areas, a Sudden and Unexpected Death in  
10 the community would be tweaked in a very similar way so  
11 I actually think the specialists in those particular  
12 areas could have a look at it and see how they could  
13 tweak that themselves, if it needed tweaking.

14 Q. Thank you. And if we could just go over to  
15 the next page, then, page 0006. We will see there again  
16 very briefly but clearly set out some of the actual  
17 practical examples we see in terms of under "Good for  
18 the dying patient, dignity and respect, well-informed  
19 and prepared, compassionate care". And then probably  
20 relevant to the neonatal context in terms of family and  
21 friends, "Informed and prepared, practical support" and  
22 examples are given of the practical support in terms of  
23 drinks and food provided, car parking, "Supported  
24 moments and memory-making".

25 Is there anything you would like to expand upon  
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1 a really practical moment. So that liaison,  
2 collaboration with the Consultants, with the specialist  
3 nurses for donation, that you are working with  
4 collaboratively, these relationships I cannot stress  
5 enough how important they are with the people that we  
6 are working with.

7 And I think a benefit of the SWAN model is that  
8 these things are prompts so that we are not missing  
9 anything and often all of these things that we are  
10 discussing here today are things that nursing staff are  
11 often really frightened to raise because they are  
12 difficult conversations because we are also fearful that  
13 we don't want to distress the family further. But  
14 actually, we are not distressing the family further; we  
15 are actually giving the family some control in a really  
16 uncontrolled situation and I think that's really  
17 important at this really awful time.

18 Q. And the SWAN model, you referred to this in  
19 your statement, was created and developed in 2012. It's  
20 since been rolled out across 70 care organisations you  
21 say in your statement. Are you able to give  
22 an indication of the number of hospitals that are now  
23 using the SWAN model?

24 A. So all of the time more organisations, not  
25 just in the UK but abroad, are taking on the SWAN model.  
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1 there in terms of those very sort of practical points in  
2 terms specifically with a neonatal death?

3 A. So I think those conversations with families  
4 for supported moments, memory-making are really, really  
5 important and neonatal unit, as in any other death,  
6 I think those conversations to ask what is important to  
7 those family members really, really matter.

8 And that takes me to families, sometimes they want  
9 to take their babies home after death, and that's okay.  
10 That can be done. But unless we have those  
11 conversations, after death we don't know that until we  
12 speak to those families, but we don't want to miss that  
13 opportunity.

14 That -- that's okay but we need to have those  
15 conversations so that we can ensure that we can make  
16 those memories happen because they may want to put their  
17 deceased baby in their Moses basket in the nursery that  
18 they had prepared at home, but we can facilitate those  
19 things. That's really, really important.

20 So I think it's those conversations that really,  
21 really matter. They are really, really important.

22 Neonatal donation is really, really rare but it's  
23 still really important and it may be possible. Those  
24 conversations are also really, really important and you  
25 don't want to miss that opportunity because that's also  
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1 Just in the last month, a hospital in Portugal have  
2 implemented the SWAN model. They are coming from  
3 everywhere and that's because the model is out there as  
4 part of the International Collaborative for Best Care  
5 for the Dying.

6 Many organisations across the UK, and I am not sure  
7 since I have left work in June last year, how many.  
8 When I left in June last year, we had an International  
9 SWAN Summit in June and there were 55 organisations in  
10 the UK that had adopted the SWAN model of care. And we  
11 had done a research study, which was funded by the  
12 Burdett Trust, who had looked at all sorts of indicators  
13 and I think the paper actually is in the pack as  
14 evidence and actually the organisations where there had  
15 been Executive support through the CQC outputs were  
16 doing really well with the SWAN model and their outputs  
17 were really, really good but the ones where there wasn't  
18 senior leadership support, the implementation was  
19 proving to be really, really difficult.

20 So my advice and my advice would be we need really  
21 senior leadership within the organisations for the SWAN  
22 model to work.

23 Q. And with those organisations that are adopting  
24 or have adopted the SWAN model, that would include  
25 neonatal units with it?  
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1 A. Yes.

2 Q. That includes hospitals with neonatal units.  
3 What is it that leads to a hospital to adopting the  
4 SWAN model? How is that --

5 A. The organisations that I have personally  
6 worked with or the jurisdictions have been under the  
7 Coroners' jurisdictions and it's been really, really --  
8 the catalyst for implementation of the SWAN, my Lady,  
9 has been because we have worked really closely with the  
10 Coroners' jurisdictions and I think that's because the  
11 Coroners have seen particularly the benefits of having  
12 a bereavement nurse and that was definitely part of the  
13 catalyst of me moving to Liverpool from  
14 Greater Manchester because our, the Coroner in Liverpool  
15 wanted to have a bereavement nurse within his Coroners'  
16 Office. And that had really helped.

17 I am also aware in Newcastle that was exactly the  
18 same way that the hospital took over the SWAN model, was  
19 because their Coroners' office up there wanted  
20 a bereavement nurse. So I think the support of the  
21 Coronial service has been really, really helpful in  
22 ensuring the SWAN model within those organisations.

23 Q. Is it your view that the SWAN model should in  
24 fact be rolled out entirely across the NHS?

25 A. I think the benefits and the reduction in  
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1 really, really important and that was all levels of  
2 staff from Band 6 upwards in all aspects of end of life  
3 care and bereavement.

4 And so when something specific in regard to end of  
5 life care and bereavement happened in their specialist  
6 area they were equipped with the skillset to be able to  
7 have the advanced communication skills to be able to  
8 look after patients and families. Death happens  
9 24 hours a day and we need the staff on site 24 hours  
10 a day to be able to have those conversations that  
11 matter, to be able to support our Consultant colleagues  
12 is that we are having compassionate conversations with  
13 families seven days a week, 24 hours a day to provide  
14 a better service.

15 Q. And when you say a postgraduate course, that  
16 would be a continuation at the end of their studies or  
17 that would be something they would -- a course they go  
18 to having worked?

19 A. We did it as modules, we did it as standalone  
20 modules.

21 Q. Moving to a slightly different but related  
22 topic, memory boxes, you refer in your statement to hand  
23 and footprints memory-making. Could you explain  
24 a little bit more about that in the context of  
25 a neonatal unit?

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1 complaints in the organisations where the SWAN model  
2 is -- speaks volumes and that actually speaks for itself  
3 because you can see complaints drop quite dramatically  
4 and I think the fact that you can see complaints within  
5 organisations in regard to bereavement and end of life  
6 care reduce is a quite a clear indicator.

7 Q. And you spoke there about training bereavement  
8 nurses. How does the training work, would it be that  
9 all nurses working would have some training of the SWAN  
10 or would there be specific nurses who would be the  
11 champions, so to speak?

12 A. So the -- I think the SWAN model could work in  
13 many ways. My fundamental belief is I think that every  
14 single nurse, midwife who works in healthcare should be  
15 trained in the SWAN model, should be trained in end of  
16 life care or bereavement. Some organisations don't call  
17 it the SWAN model. The principles are exactly the same.

18 But I think everybody should be trained in end of  
19 life care and specifically bereavement care to take some  
20 of the fear away and I think that is definitely sporadic  
21 around the country, that is -- it needs to be a core  
22 part of our training. Particularly in Liverpool we did  
23 something new: we start the educating staff at postgrad  
24 level which was really, really important. We educated  
25 24 staff on a postgrad SWAN scholarship and that was  
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1 A. So I think, so the idea of memory-making in  
2 adults from -- for the SWAN model was taken from the  
3 work that was done on neonatal units, that wasn't  
4 something that was created for neonatal units from the  
5 work that we were doing on the SWAN model, that was  
6 something that had always historically happened on  
7 neonatal units that was something that neonatal units  
8 have been outstanding at offering to families, certainly  
9 in the neonatal units that I worked in when I did any  
10 bereavement care. And actually that's how it  
11 transferred to our adult community families of which get  
12 offered and have all of the mementos that we offer that  
13 came from neonatal units.

14 So that's really, really important to stress and  
15 say that is nothing new in a neonatal unit. But I think  
16 memory-making is really, really important for it to be  
17 offered to everybody and I think, I hope that the  
18 memory-making happens in all neonatal units and that is  
19 a normal part of practice and there are so many  
20 charities out there that provide memory boxes for free  
21 to neonatal units and, and I would like to think that is  
22 something that we would be accessing because it's so  
23 easy to do because so many families who have lived  
24 through the tragedy of losing a baby from a neonatal  
25 unit want to so much give back.

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1 And these are the most precious resources that  
 2 families hold on to and it is really important that --  
 3 that memories are offered to families.  
 4 **Q.** And just picking up then on what you were  
 5 saying in terms of the numbers of charities that are  
 6 involved in this area. We have, the Inquiry have had  
 7 statements from SANDS who have hospital liaison advisors  
 8 from Bliss who have a Baby Charter and also local  
 9 charities who work in specific geographical areas.  
 10 Obviously as patron of the Good Grief Trust, you  
 11 are aware of the extent of the bereavement charities.  
 12 How does the SWAN model work so that there is  
 13 a consistent approach over what is a large body of  
 14 different charities working the sector?

15 **A.** So the Good Grief Trust is purely the umbrella  
 16 and the charities are registered with their contact  
 17 details and number. With the Good Grief Trust, you put  
 18 in your postcode where you live, anybody can put in  
 19 their postcode where you live and it will take, tell you  
 20 what charities are available in your postcode area and  
 21 the waiting times and what the access is for you to get  
 22 support from that particular charity from whatever your  
 23 need is, for whatever type of death and bereavement your  
 24 family has experienced, so that you have got immediate  
 25 access and I think that is what's really, really

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1 representative organisations including Bliss, SANDS,  
 2 Child Bereavement UK and Together for Short Lives".  
 3 So there would appear to be when drawing up these  
 4 frameworks good collaboration with the charity sector,  
 5 would that be your experience?

6 **A.** Yes.

7 **Q.** And if we could then turn to page 14, and  
 8 that's the section of this framework that deals with  
 9 loss, grief and bereavement care and we see there just  
 10 going down, I am just going to pick out a few sentence:

11 "After the death of a baby, parents and the  
 12 extended family will require bereavement support."

13 Going on to the next paragraph:

14 "Care of the baby after death is an important  
 15 element of bereavement care and parents may wish to  
 16 participate in the physical care of their baby's body  
 17 after death as well as memory-making activities."

18 And then going down again it talks about the  
 19 situation of the loss of a twin or triplet, noting there  
 20 may be additional complexity of needing to care and  
 21 support surviving siblings."

22 And then in the last paragraph talking about the  
 23 issue of a subsequent pregnancy and the need for  
 24 tailored care and support which takes their previous  
 25 loss into account.

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1 important and the Good Grief Trust is an overarching  
 2 bereavement charity, it is not a specific type of  
 3 bereavement charity, it is an all-encompassing  
 4 bereavement charity.

5 **Q.** And how does the SWAN model engage with all  
 6 those different charities, is there --

7 **A.** So we refer to -- so depending on our families  
 8 that we are working with, we will refer them to any of  
 9 the charities that is needed for that particular family  
 10 and we work with all the charities.

11 **Q.** Thank you.

12 If we could pull up now INQ0108773. This is  
 13 a policy, Ms Murphy, that came in a framework after you  
 14 had retired --

15 **A.** Yes.

16 **Q.** -- but I think you have been shown a copy of  
 17 it in preparation for giving evidence today, and this is  
 18 a framework from the British Association for Perinatal  
 19 Medicine. And if we could just go to page 6 first of  
 20 all, we will see there in the paragraph just below the  
 21 last two lines:

22 "The framework for practice has been developed by  
 23 consensus."

24 It goes on to say:

25 "BAPM is grateful for input from parent

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1 Would you agree with all those principles in  
 2 relation to bereavement care, where there's been  
 3 a neonatal death?

4 **A.** Absolutely I would, yes.

5 **Q.** And looking at that policy and we are going to  
 6 come on to the neonatal and the bereavement pathway. Do  
 7 you think there is any risk of confusion or  
 8 overburdening of the NHS with the fact there are  
 9 a number of different schemes? We have looked at the  
 10 SWAN scheme, this is the BAPM, we are going to look at  
 11 the Pathway scheme in a moment. There is the Bliss  
 12 Charter, the SANDS liaison advisors. Is there any risk  
 13 that there is confusion or is there sort of a cohesive  
 14 approach despite the different schemes that exist?  
 15 **A.** So I have read -- and I have just recently  
 16 this week read this because this is the first time  
 17 I have seen this one that's currently in front of us and  
 18 I have read them all. And when you read them, so this  
 19 is in more depth than the others, they are all saying  
 20 the same thing.

21 There's very little difference in each of the  
 22 policies. For staff on the shopfloor doing the doing,  
 23 I alluded to when I first started speaking in my opinion  
 24 staff need simple, staff need quick, and staff need  
 25 something that's really, really concise.

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1 We need something that we can just pick up and we  
2 can just really, really concisely understand that we, we  
3 know what we need to do and because the workload is  
4 massive and we don't want to get it wrong.

5 So all of this is absolutely, this is a fantastic  
6 piece of work written by really well-articulated  
7 academics who have got a brilliant reputation and the  
8 people that have written this document have been really  
9 great at writing the document.

10 But it needs to be consolidated. For me as a nurse  
11 on the shopfloor, before I had got into a really senior  
12 position I needed a pocket card that I could pull out of  
13 my pocket because I have got hundreds of policies that  
14 I need to follow, so that I know that I am not going to  
15 get it wrong.

16 **Q.** And that probably flows into the next topic  
17 I was going to turn to which is something you stress in  
18 your statement about clear communication. And you say  
19 that one of the things bereaved parents appreciate is  
20 good clear communication by someone who's providing  
21 immediate support so they have one point of contact.

22 **A.** (Nods)

23 **Q.** What is the best way of ensuring that happens  
24 in a neonatal setting?

25 **A.** So I honestly believe the Consultant that is  
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1 within the organisation that could co-ordinate that  
2 care. Because when that family go home, if we say we  
3 are going to ring them because we are always in whatever  
4 organisation you are in heavily criticised if we say we  
5 are going to give them a call in a week or in a couple  
6 of days just to see how they are, once we have talked  
7 them through what the next steps are of picking up the  
8 MCCD or: you need to do this to organise the funeral,  
9 and we say we are going to ring them on Thursday and  
10 then we don't ring them until the Monday; that's  
11 horrific for a family and feedback and lots of hospital  
12 complaints is that's horrendous.

13 If we say we are going to ring a family on the  
14 Thursday, we must ring them on the Thursday. And if we  
15 have got somebody that's coordinating that diary of our  
16 families that we are going to ring at 2 o'clock on  
17 a Thursday, we need to make sure we are coordinated and  
18 we ring that family at 2 o'clock on a Thursday and we  
19 maintain that. That is absolutely vitally important  
20 because that's our first part of maintaining our trust  
21 and our relationship with that family.

22 And for me, that is a real basic and that is  
23 a starting point of us increasing our reputation and our  
24 trust and our pride in what we do. That's really  
25 important and that's simple.  
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1 looking after the family needs to articulate the  
2 immediate -- the death -- the futility of the baby's  
3 death and I think they need to be supported with the  
4 nurse that's looking after them. If there is  
5 a bereavement nurse on that unit, that needs to be with  
6 that person, ideally a trained neonatal nurse that's had  
7 an advanced communication skills training session  
8 education package. That would be in the ideal world.  
9 I don't know how normal it is for neonatal nurses to  
10 have advanced communication skills, I don't know how  
11 normal that is.

12 That would be the ideal because then when the  
13 Consultant's gone to do his/her work, then the neonatal  
14 nurse can go over what the Consultant has said and  
15 reiterate what has said because the chances are the  
16 family will not be able to be able to absorb everything  
17 that's been said and they can just go over it nice and  
18 gently in really clear gentle language because you won't  
19 take it in. And they can write it down so the families  
20 can understand exactly what's saying and that's not for  
21 any other reason than they have just been given the  
22 worst news possible and I think that's really, really  
23 important that that happens.

24 For me, in an ideal world there would be  
25 a bereavement specialist, midwife, bereavement nurse  
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1 **Q.** Thank you.

2 Turning to a slightly different topic, that of  
3 Medical Examiners. As I am sure you are aware that  
4 became a statutory scheme from September 2024 having  
5 existed previously.

6 A key aspect of course of the Medical Examiner  
7 system is that the bereaved family are able to speak to  
8 the Medical Examiner in the immediate period following  
9 the death and I just wondered your observations on how  
10 that is working in practice from the perspective of the  
11 bereaved family?

12 **A.** So I retired in June last year and it came in  
13 September, so actually my lived working experience it  
14 hadn't come in to statute before I had finished.  
15 However, we had started working with that model across  
16 Liverpool before I had finished work and we were really  
17 fortunate because we had got bereavement nurses in our  
18 organisations across the city footprint.

19 So I was really used to working with Medical  
20 Examiners and bereavement nurses and certainly across  
21 Greater Manchester we were used to working with  
22 bereavement nurses across all my Hospital Trusts and  
23 bereavement nurses and we were very used to working with  
24 bereavement nurses in the Coroners'.

25 So we didn't know how it was going to work. So in  
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1 Manchester we modelled the bereavement nurses and the  
 2 Medical Examiners in exactly the same way that we did  
 3 with the Coroners that the Coroners' Officers would  
 4 speak to the bereaved families for the Sudden and  
 5 Unexpected Deaths and then the Coroners' Officers, once  
 6 they had done their formalities, would refer -- offer  
 7 the option to the bereaved families of: we have  
 8 a bereavement nurse here, would you like us to pass on  
 9 your details?

10 Inevitably the families would say yes, please, and  
 11 the bereavement nurses would pick up Coroner's referral.  
 12 So we decided to do exactly that with the Medical  
 13 Examiners in Greater Manchester. And it didn't for some  
 14 reason it didn't work in exactly the same way.

15 So we tried something different, we didn't want the  
 16 families to be bombarded with phone calls, so we didn't  
 17 want them to get a Medical Officer to ring them and then  
 18 a Medical Examiner to ring them and then a bereavement  
 19 nurse to ring them. So we decided that either a medical  
 20 examiner or a bereavement -- or a bereavement nurse  
 21 would ring them, or a Medical Officer or a bereavement  
 22 nurse, so they would get two phone calls rather than  
 23 three and that seemed to work really well.

24 Whereas in Liverpool we got a Medical Examiner and  
 25 a bereavement nurse would make the phone calls so the  
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1 sensitive situation of a neonatal death, is it your view  
 2 that there should be a bereavement nurse who is there to  
 3 facilitate that rather than a direct contact, although  
 4 obviously parents may have a direct contact if they  
 5 wish, but they should have the ability to have the  
 6 assistance of a bereavement nurse?

7 **A.** Absolutely and that, that was always the case  
 8 particularly more so in Manchester than Liverpool  
 9 because obviously Alder Hey and that wasn't part of my  
 10 remit in Liverpool, but in Greater Manchester that was  
 11 very different.

12 We dealt with a lot of child deaths, particularly  
 13 in, in Greater Manchester. But just to say the joint  
 14 education of Medical Officers and Examiners routinely  
 15 happened in Liverpool, all our training was together and  
 16 also the bereavement nurses were always invited to the  
 17 Medical Examiners' training. We were just a team.

18 **Q.** Clearly you have got very specialist  
 19 experience in relation to the learning from the  
 20 Manchester Arena which was a different and particular  
 21 situation. But in terms of what this Inquiry is looking  
 22 at and where there could in a situation be police  
 23 involvement, is there anything you feel were learnings  
 24 from Manchester Arena that have a crossover to  
 25 a situation where there's a neonatal death and there is  
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1 Medical Examiner would make the phone call, offer them  
 2 a bereavement follow-up phone call and then the  
 3 bereavement nurse would make the phone call and usually  
 4 go and do a home visit if it was something complicated  
 5 and offer them one of the three levels of bereavement  
 6 support and that seemed to work really, really well.

7 **Q.** So if we could maybe go to INQ0012363, this is  
 8 the Good Practice Series that the National Medical  
 9 Examiner's Office produces a number of Good Practice  
 10 models and this is the one that relates to child deaths.  
 11 And we see there if we can then go to page 4 of that  
 12 policy, 004, we see at 3, paragraph 3:

13 "Recognise that while all deaths require sensitive  
 14 interactions with bereaved people, the death of a child  
 15 is likely to be particularly traumatic. Medical  
 16 Examiners and Medical Examiner Officers should ensure  
 17 that bereaved families are informed clearly that  
 18 participation is entirely voluntary."

19 Then it goes on:

20 "Take advice from childhood neonate bereavement  
 21 leads on their approach to bereaved parents and  
 22 participate in training opportunities."

23 So I presume you would agree with that, that  
 24 advice? And I suppose the question is: in order for the  
 25 Medical Examiners' system to work in the particularly  
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1 cause for concern about what has happened with  
 2 a situation of possible deliberate harm?

3 **A.** So, so I think just, just to say that you know  
 4 unfortunately if, if you do need to refer to the police  
 5 from any area that you work in in a healthcare setting,  
 6 which will happen, does happen, drug error, mistake,  
 7 whatever that may be, and we have to call our police  
 8 colleagues, that open and honest conversation with the  
 9 SIO, I have learnt so much particularly through the  
 10 Manchester Arena -- you know, it was amazing what we  
 11 learn.

12 It was really prickly at first okay, the FLOs in  
 13 Greater Manchester felt the bereavement nurses were  
 14 going to step on their toes, what their job was, but  
 15 actually once we sat in a room and we knew our remits  
 16 and our roles were really, really different, we had  
 17 a totally different skillset. When we looked after all  
 18 of the victims we learned so much from each other and,  
 19 yes, process was followed the whole way through. Every  
 20 bit of legal process had been followed caring for those  
 21 families bar none.

22 We were able to teach the FLOs lots of things that  
 23 we could do with those families in regard to  
 24 memory-making without absolutely causing anything that  
 25 would impede or cause any issues to the care that they  
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1 needed to provide for their process and policies and  
 2 they were able to teach us so much for a disaster that  
 3 was happening because we really didn't know, we just  
 4 wanted to care for these deceased victims.

5 And if you are in a hospital setting and we need to  
 6 get police involvement because of a Sudden and  
 7 Unexpected Death, there are still things -- so we  
 8 couldn't necessarily take memories, handprints or  
 9 footprints in the moment because of a crime scene as  
 10 being because of a baby but we can sit with a family and  
 11 we can be really, really open and honest and say: today  
 12 we can't create memories and handprints and footprints  
 13 of your baby but what we can do is we can speak to the  
 14 police and they are going to be able to tell us when we  
 15 can do that and we will tell you immediately and we will  
 16 be able to go and do those tomorrow evening because  
 17 that's when they have said that we can ...

18 So actually really, really importantly by keeping  
 19 families informed every step of the way and we are not  
 20 saying: no, you can't have any of those things, and that  
 21 blanket that they want to have wrapped round their baby,  
 22 that the police don't want us to wrap round that baby  
 23 because they don't want us to hinder process. We can  
 24 say but it's okay because we can put the blanket at the  
 25 bottom of the baby and when the police's postmortem has

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1 The question is: is that something that you think  
 2 is happening on neonatal units at the moment?

3 **A.** So I can't honestly sit here and say "yes, it  
 4 is" or "no, it isn't" because I truly don't know.

5 I haven't been in a neonatal unit for the last four,  
 6 three and a half years, so I don't know.

7 I would like to think it was happening but  
 8 I really, really don't know. My last experience in  
 9 a neonatal unit was absolutely it happened and it was  
 10 a -- it was a tragic but a beautiful experience that was  
 11 my last experience, but I really don't know.

12 **Q.** If we could just turn now to the National  
 13 Bereavement Care Pathway and if we could call that up,  
 14 it's INQ0108675 and as you are aware, Ms Murphy, the  
 15 National Bereavement Care Pathway covers different types  
 16 of loss and this is a specific document, the one we are  
 17 looking at, the guidance document specifically for  
 18 neonatal death.

19 If we could just turn to page 5 first of all. So  
 20 this is one of the very long policies, 43 pages of  
 21 detailed guidance. But this page sets out the  
 22 principles and just glancing through those, they are the  
 23 things you have already been speaking about: parent led  
 24 bereavement care, bereavement care training to all  
 25 staff, bereaved parents are informed about support,

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1 finished, they have promised that they are going to wrap  
 2 that blanket around your baby. And that might not be  
 3 what they want to hear, but do you know what, those  
 4 families will respect and cope far better than thinking:  
 5 What's going to happen, I don't know, because they know  
 6 something and that's a far better place to be.

7 And I think by building relationships with our  
 8 police colleagues and our Coroners, that is a much  
 9 better place to work.

10 So for me enhancing our relationships with our SIOs  
 11 and our Coroners and our Medical Examiners can only be  
 12 of massive benefits to our patients and our families  
 13 that we are caring for. That has got to be a good  
 14 thing.

15 **Q.** And at paragraph 15 of your statement you set  
 16 out some of the principles in the particular context of  
 17 death of a baby on a neonatal unit in terms of best  
 18 practice and you have covered some of those already.

19 But what you say is the anticipated death or fact  
 20 of death should be articulated by the Consultant with  
 21 responsibility for the baby that that should be with  
 22 a bereavement midwife or nurse available for immediate  
 23 follow-up that the conversation should be face to face  
 24 in an area of privacy and parents should be given as  
 25 much or as little time as they wish with their baby.

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1 there is a bereavement lead in every healthcare setting.  
 2 Going down, the preferences of bereaved families are  
 3 sought, bereaved parents are offered opportunities to  
 4 make memories and there is a little bit more detail  
 5 there but that is the essence of it.

6 So those are the standards set out in this pathway  
 7 and presumably that would be again something that you  
 8 would endorse?

9 **A.** 100%.

10 **Q.** And if we could just go through what else is  
 11 covered in this pathway just to have your views. If we  
 12 could go to page 7, please, we see there  
 13 "Communication":

14 "All communication with parents ... the experience  
 15 of pregnancy loss or the death of a baby must be  
 16 empathic, sensitive, non-judgemental and parent-led."

17 And that chimes with the SWAN principles, would you  
 18 agree?

19 **A.** Yes.

20 **Q.** And then if we can turn on to page 18, this is  
 21 a section that deals with multiple births and I just  
 22 wanted your views on whether you think that is something  
 23 that is covered in training on bereavement. It sets out  
 24 here in the middle of the main paragraph:

25 "Parents should be offered specialist bereavement

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1 support if one baby has died and another baby is still  
2 being cared for in the neonatal ward."

3 Is that an area that you think is being addressed?

4 **A.** So again, it's three and a half years since  
5 I have been on a neonatal unit and I don't think it was  
6 addressed enough. I don't think education is addressed  
7 enough around the country. I think it's sporadic,  
8 I think in some areas it's fantastic and in other areas  
9 it's ad hoc. That's where I was at three and a half  
10 years ago.

11 I think -- but I am not a neonatal nurse  
12 specialist, I am a bereavement nurse, so I want to be  
13 really, really clear on that. But I think education and  
14 more education is absolutely key.

15 **Q.** Thank you. If we can just look very briefly  
16 then at page 19, I think we can, we have talked but this  
17 pathway emphasises memory making which we have  
18 discussed.

19 Then if we could go on to page 27 and you have  
20 referred to this slightly when talking about the  
21 Manchester Arena situation, but discussing a postmortem  
22 examination with parents, is there anything you feel the  
23 Inquiry should be aware of with that specific situation,  
24 the difficulties and the sensitivity of discussing  
25 a postmortem?

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1 haven't discussed quite so much, but that looks at care  
2 and support for parents in the community and the issue  
3 of ongoing care and support. What are your views in  
4 relation to that? We've been talking quite a lot about  
5 memory making within the hospital and communicating  
6 within the hospital, but clearly when the parents go  
7 home, I wonder what your thoughts would be about that,  
8 the ongoing care?

9 **A.** So the SWAN model when implemented in the  
10 organisations those bereavement nurses will support  
11 families out in the community for as long, up to an  
12 inquest if they are under the care of the Coroner, and  
13 will slowly provide an exit strategy with those parents  
14 and refer to different support groups and needs for  
15 whatever that family may or may not need.

16 There is also SWAN services out there in the  
17 community, so in district nursing services, et cetera,  
18 in some areas and care home settings, et cetera. So  
19 it's not just for NHS Trusts per se.

20 So if they are in neonatal, in hospitals where  
21 there are neonatal units those bereavement nurses would  
22 support out into the community when those families go  
23 home. So that's really important to say that. Or if  
24 there's a bereavement midwife within the neonatal unit  
25 and there's SWAN service within the organisation those

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1 **A.** I think that perhaps discussing postmortem is  
2 definitely an area that there is fear, is fear of having  
3 those conversations. But actually that's again another  
4 area that we perceive it to be really, really difficult.  
5 If a family don't want to talk about postmortems,  
6 obviously it's very different. If it's a Coroner's-led  
7 postmortem it is an option. But if it's a hospital-led  
8 postmortem and we are having that conversation it's an  
9 area of perceived difficulty.

10 A family have just been given the worst news  
11 possible. Their child is dead and actually any  
12 subsequent conversation that we have they will say "yes"  
13 or "no" to. We are not going to make their grief worse  
14 because we are having a conversation with them.

15 Even in the faith arena, they will say "yes" or  
16 "no". And the way we have that conversation in a gentle  
17 manner it's the right thing to do. We have to have  
18 these conversations. It's all part of having the family  
19 having some control and we can't second-guess what they  
20 are going to say. It's often really, really important  
21 for them to be given a choice so that they can have  
22 a benchmark because all of this is often part of their  
23 future and that's really, really important. So that  
24 again comes down to education.

25 **Q.** If we could go on to page 33, something we

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1 two teams could link up because they could provide  
2 support for each other and that would be a quick win for  
3 an organisation. So that also would be really useful to  
4 know.

5 I worry a little bit here about care and support  
6 from GP services because of the current situation within  
7 our wonderful NHS and the difficulties that we are  
8 currently having within our GP services out there in the  
9 community. And I don't know how much support is out  
10 there in regard to bereavement care.

11 And I think particularly at the moment I think  
12 support per se for anybody is really, really difficult  
13 and I couldn't put my hand on my heart and say to you,  
14 "I think there's great bereavement support out there in  
15 our community" because I truly don't know. But I would  
16 challenge that in the current situation that we have got  
17 across the UK.

18 **Q.** Finally, Ms Murphy, in terms of questions that  
19 I will be asking you, having all your experience of  
20 40 years-plus, a lot of that work in the bereavement  
21 sector, what would you see if you were able to give one  
22 piece of advice in terms of improving the bereavement  
23 care to those parents who find themselves in the  
24 situation of having a baby who's died on a neonatal  
25 unit? What do you think is the one thing that would

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1 improve that service most, would be the most effective  
2 change that could be made?

3 **A.** I am truly sorry for any parent who has been  
4 through the loss of a baby or a child. It's not written  
5 that way, we're not supposed to lose our children and  
6 I am genuinely truly, truly sorry for anybody that's  
7 experienced that. And that's not just for our Families  
8 that you are here to do this Inquiry for today and I am  
9 sure that's for some people that are sat in this room or  
10 people that are listening because it is really, really  
11 common. So I am genuinely sorry.

12 If there was one thing that I would change is when  
13 there's a baby loss, remember, when we are looking after  
14 these families we are dealing with adults. We are  
15 speaking and caring for adults, to help adults get  
16 through their next tomorrow and help them with their new  
17 normal, and their new normal is life without their baby  
18 or their child.

19 So all we can do to make their new normal is we  
20 absolutely have got to prioritise education and make  
21 every single generalist in healthcare a specialist in  
22 bereavement care. Because all of us that work in  
23 healthcare work 24/7 and somebody will die on our watch  
24 and we have got to be equipped. It is not a specialist  
25 role; it's a generalist role and it's our

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1 So some of the bereavement nurses definitely are  
2 trained counsellors without a doubt -- so I was  
3 a trained counsellor -- but we didn't practice as  
4 counsellors because obviously if you counsel somebody  
5 too soon into their bereavement you can potentially  
6 cause harm. So there it's, you know -- we, we band it  
7 around the term "counselling" when people are bereaved.

8 But actually, evidence suggests if we offer  
9 counselling within, you know, six months -- so I am just  
10 being generic here, some people need counselling  
11 immediately because they might have experienced three or  
12 four losses quite close together of people, so they  
13 might need counselling immediately -- but most people we  
14 would potentially cause them harm if we, if they had  
15 formal counselling too soon.

16 So we wouldn't recommend somebody have formal  
17 psychological counselling until six months after their  
18 bereavement. So you would provide immediate support,  
19 and immediate support can be quite complex. It's not  
20 just sitting and patting somebody's hand. It can be  
21 quite complex taking them through the next steps.

22 So some organisations when they advertise for the  
23 role of bereavement midwife or a bereavement nurse, they  
24 require a counselling qualification as part of the job  
25 interview process. So it's very, very different

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1 responsibility.

2 So our job is to fix it through education and  
3 empower the workforce to take responsibility. So look  
4 after each other and let's educate the workforce.

5 **MS BROWN:** Thank you very much, Ms Murphy. There  
6 will be a few more questions from Mr Baker.

7 **A.** Thanks.

8 **LADY JUSTICE THIRLWALL:** Mr Baker.

#### Questions by MR BAKER

9 **MR BAKER:** My Lady. Mrs Murphy, I ask questions on  
10 behalf of two of the Family groups. I would like to ask  
11 some very brief questions about the role of  
12 a bereavement nurse or midwife and then go on to  
13 a couple of examples from two of the families who  
14 I represent.

15 So in terms of the limits on what the bereavement  
16 nurse or midwife can do when providing bereavement care,  
17 rather than end of life care, if a family member  
18 requires counselling or psychological therapy, is it  
19 correct to say that the bereavement midwife or  
20 bereavement nurse isn't trained to provide that  
21 themselves but they will provide support in signposting  
22 or referring the family member through to a different  
23 service?

24 **A.** So it would depend where you worked.

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1 depending where you go for that role.

2 **Q.** So the qualification of a bereavement midwife  
3 or nurse may be different in different places?

4 **A.** Yes.

5 **Q.** But there will be cases where there is a need  
6 for immediate referral into adult mental health  
7 services?

8 **A.** Yes, yes.

9 **Q.** Is there any -- and I'm sorry to use this  
10 term -- but is there any "priority lane" for referral  
11 via bereavement services into mental health services?

12 **A.** Yes, sometimes there is. So in Manchester we  
13 could refer through Saint Mary's Hospital and so it  
14 didn't mean to say you would get in tomorrow, but  
15 obviously relationships. You could, you could refer  
16 into Saint Mary's and quite often you could get  
17 a referral in rather than go through -- the bereavement  
18 nurses could do a referral in rather than having to send  
19 the patient via their GP.

20 **Q.** Yes.

21 **A.** We could do it that way. We could fast-track  
22 a referral.

23 **Q.** Do you think that that --

24 **A.** But that was only in Manchester.

25 **Q.** Yes.

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1 A. I couldn't speak about what happened in  
 2 Liverpool or in other areas.  
 3 Q. Do you think that should be a mechanism --  
 4 A. Yes, I do. Yes, I do.  
 5 Q. -- that's in place because otherwise adult  
 6 mental health services are under pressure --  
 7 A. Absolutely.  
 8 Q. -- and if referrals are coming through GPs for  
 9 counselling or even psychological therapy --  
 10 A. Agreed, yes.  
 11 Q. -- it may not be provided or it may not be  
 12 provided for a long time?  
 13 A. Yes.  
 14 Q. So you would think it of benefit if --  
 15 A. Yes, I do.  
 16 Q. -- the bereavement midwife or bereavement  
 17 nurse --  
 18 A. Yes.  
 19 Q. -- or the bereavement service could make  
 20 a fast-track referral?  
 21 A. And -- and bereavement midwives and  
 22 bereavement nurses are senior nurses. They are not  
 23 junior nurses within an organisation. They are senior  
 24 nurses within an organisation with lots of lived  
 25 experiences. They're the equivalent to a ward manager

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1 referred to investigations being carried out by the  
 2 Trust into an increased rate of neonatal death in the  
 3 unit.  
 4 Now this is occurring a year later. Would you  
 5 expect the bereavement services, a bereavement nurse to  
 6 retain contact with a family over that length of time so  
 7 as to facilitate interactions between families in  
 8 hospitals when it comes to issues such as that: There  
 9 is now going to be an investigation relating to the  
 10 circumstances of your child's death?  
 11 A. I think that's quite hard for me to comment on  
 12 because I'm not sure of what the interaction would have  
 13 been.  
 14 Q. Well, there was no interaction at all from the  
 15 hospital.  
 16 A. So --  
 17 Q. There may be a variety of reasons for that  
 18 obviously --  
 19 A. Yes.  
 20 Q. -- which have been explored by the Inquiry.  
 21 But in the general sense, would it provide a point of  
 22 contact between the hospital and the bereaved parent if,  
 23 if something like that had happened in the future?  
 24 A. So I am going to say not necessarily. It  
 25 would be very dependent on the level of interaction that

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1 or sister. Their banding is that of a senior nurse.  
 2 Q. Yes, and I am going to come on to two  
 3 examples, one involving Mother C and one involving  
 4 Mother E. Now, these are given examples amongst my  
 5 client group not because they are the only examples but  
 6 because --  
 7 A. Yes, yes.  
 8 Q. -- because they provide an indication of some  
 9 common features.  
 10 Now, Mother C described that whilst her son was  
 11 dying that Letby would intrude into, into the room and  
 12 impose herself on that process, the process of them  
 13 spending time with their son.  
 14 Again, if we had in place formal, trained  
 15 bereavement nurses or a bereavement midwife in this  
 16 case, would you expect them to take carriage of  
 17 providing the end of life care and controlling who had  
 18 access to the room in the circumstances in which that  
 19 access took place?  
 20 A. I would.  
 21 Q. In terms of more long-term interactions with  
 22 Mother C, she gives an account how in July 2016, so  
 23 about a year or so following death of her son, her  
 24 husband became aware, through WhatsApp messages from  
 25 a friend, of articles in the Chester Chronicle that

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1 there had been from the, the identification of the baby  
 2 being in the dying phase of his life, dying, and what  
 3 the interaction had been from that point and the  
 4 communication between the family and the bereavement  
 5 nurse.  
 6 Only around 14% of families want -- all families  
 7 want next steps, Level 1 bereavement support. Every  
 8 family want: I don't know what I'm doing. Where do  
 9 I need to go? I want to make memories. All families  
 10 want some level of Level 1 bereavement support.  
 11 About 35-40% of families want Level 2, which is  
 12 a follow-up phone call, maybe a home visit, "How are you  
 13 doing? Where are you up to with the funeral? Do the  
 14 siblings need some support? How's your husband?" A cup  
 15 of tea, chat, you know a little bit more intense.  
 16 But only around 14% of families want more  
 17 intense -- because the family units are brilliant --  
 18 Q. But in terms of the hospital announcing that  
 19 it is doing something, I mean, you would expect,  
 20 wouldn't you, if that was going to be handled  
 21 sensitively, that the bereavement service would play  
 22 a part in interacting with families?  
 23 A. So, in my experience, if there had been  
 24 a complaint raised, I don't know whether there had --  
 25 I don't know because I wasn't involved in anything,

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1 I wasn't involved in the family -- in my experience if  
 2 a complaint had been raised and maybe the governance  
 3 Complaints Team from the organisation rather than  
 4 a bereavement person may have contacted the family.  
 5 But it's quite hard for me to answer because  
 6 I genuinely don't know.

7 **Q.** Would you see a benefit though in everybody  
 8 who has an interactive role of bereaved people having  
 9 some form of bereavement training?

10 **A.** Oh, I think absolutely having a key worker and  
 11 a bereavement nurse. But I think it is really dependent  
 12 on what that relationship's been like in the beginning.

13 A bereavement nurse making contact when there's  
 14 been no contact after 12 months, I think would be rather  
 15 difficult.

16 **Q.** Okay. The final point, because you have  
 17 already given some evidence about postmortem  
 18 interaction, so interaction surrounding postmortems,  
 19 which is relevant to Mother E. It's in relation to her  
 20 experiences when it came to the memory box and this  
 21 shows another side to the memory box in relation to her  
 22 experiences. But it may be something that is replicated  
 23 in other cases which I will come to.

24 So she said that the memory box for her son was put  
 25 together by Letby and so all the memories she has are

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1 on the door and take a box of memories to that family.  
 2 It's a really great way of breaking down a communication  
 3 with that family and saying, "Hiya, it's Fiona. I am  
 4 just coming in to check how you're doing" and taking the  
 5 memory box with you.

6 So that would get round that. That's what I can  
 7 say to you, and that's always been my practice. I would  
 8 never allow a family to walk out of a hospital having  
 9 taken a relative in to get well --

10 **Q.** But should there be -- should one avoid the  
 11 treating nurses being involved in that process because  
 12 of the potential --

13 **A.** Often, often families have a brilliant  
 14 relationship with their nurse and they adore their nurse  
 15 that's been looking after their relative, and they have  
 16 a great experience with their nurse that's been looking  
 17 after them. And, you know, that nurse that's been  
 18 looking after them that's delivered beautiful care and  
 19 has done their end of life care, mouth care with  
 20 Prosecco because that was their mum's favourite flavour,  
 21 or their child on the paediatric ward's favourite  
 22 flavour was Ribena and so they have done mouth care with  
 23 Ribena, you would want that standard of care from your  
 24 nurse that was looking after you.

25 So you wouldn't want to stop that practice, would

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1 the things that are in the box, photographs, the hair  
 2 being cut, involve Letby, the person who murdered her  
 3 child.

4 Now, that's going to be a rare occurrence but one  
 5 might foresee circumstances where a nurse carries out  
 6 that service, creates a memory box, who is later  
 7 implicated in some form of negligence relating to the  
 8 death which taints the memory box for the family because  
 9 it was put together by somebody that they feel is  
 10 responsible, at least in part, for the death.

11 How do you get round that sort of problem?

12 **A.** So hopefully I can give you a little bit of  
 13 insight. I would never allow our practice to be that --  
 14 not just for a neonatal unit, so I am not saying this  
 15 just for a neonatal unit.

16 **Q.** Yes.

17 **A.** I am saying for any person that comes into my  
 18 organisations that I have worked in, I wouldn't allow  
 19 them to come into the hospital with a relative and go  
 20 home, on the same day, with a box instead of their  
 21 beautiful relative. To me that's horrific.

22 I love memory boxes. They're a really positive  
 23 thing but for me it's a fantastic way of a bereavement  
 24 nurse -- going round to knock on the door and seeing  
 25 them is a lovely way to go round to their home and knock

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1 you?

2 **Q.** No. But you may have a situation where it's  
 3 imposed upon the family, which is what it was in the  
 4 case of Mother E?

5 **A.** Okay.

6 **Q.** She imposed it.

7 **A.** So I think that's a little bit of a dilemma  
 8 that we need to be really, really mindful of.

9 I absolutely concur with you and agree. I don't  
 10 like memory boxes being given to families at a bedside.

11 I think it's a not nice thing to do and I think we need  
 12 to think about that really, really carefully. However,

13 I do love memory boxes and I think they are a really  
 14 important part of a bereavement journey.

15 **MR BAKER:** Thank you.

16 Thank you, my Lady, those are my questions.

17 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.

18 Are there any other questions for Mrs Murphy? No.

19 Well, Mrs Murphy, thank you very much indeed for an  
 20 enlightening evidence session and you will be glad to  
 21 know you are now free to go.

22 **A.** Thank you.

23 **LADY JUSTICE THIRLWALL:** Thank you very much  
 24 indeed.

25 **A.** Thank you very much.

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1 **LADY JUSTICE THIRLWALL:** Ms Brown.  
 2 **MS BROWN:** My Lady, there is a summary of some  
 3 evidence of bereavement that was going to be read in but  
 4 I am conscious that we haven't had a break.  
 5 **LADY JUSTICE THIRLWALL:** Yes, quite. Yes, I had  
 6 forgotten that.  
 7 **MS BROWN:** I don't imagine it will take more than  
 8 20 minutes, if that, to read in. But we could either do  
 9 that another time or after a break.  
 10 **LADY JUSTICE THIRLWALL:** Shall we just take  
 11 10 minutes and come back in at quarter past 4. I hope  
 12 that's not inconvenient. Thanks, Ms Brown.  
 13 (4.03 pm)  
 14 (A short break)  
 15 (4.17 pm)  
 16 **LADY JUSTICE THIRLWALL:** Ms Brown.  
 17 **Evidence read by MS BROWN**  
 18 **MS BROWN:** My Lady, the Inquiry has heard the  
 19 evidence from parents of the babies named on the  
 20 indictment. This included evidence of their experience  
 21 at the hospital after the death of their babies.  
 22 Jane Tomkinson, the current Chief Executive Officer  
 23 of the Countess of Chester Hospital NHS Foundation  
 24 Trust, deals with the issues of support from bereaved  
 25 parents at paragraphs 25-42 of a statement to the  
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1 care which is shared with paediatricians and given  
 2 access to counselling."  
 3 Turning to the present day. Sir Stephen Powis, the  
 4 National Medical Director of NHS England, in his  
 5 statement to the Inquiry refers to bereavement care. He  
 6 says:  
 7 "In 2022-23, NHS England provided 2.26 million of  
 8 national funding to support Trusts to expand the number  
 9 of staff being trained in bereavement care and increase  
 10 access to specialist bereavement services.  
 11 "In 2023-2024, NHS England are investing  
 12 5.9 million in bereavement care to enable all Trusts to  
 13 implement a seven-day provision and increase the number  
 14 of staff trained in bereavement care".  
 15 The Inquiry has sought evidence on support for  
 16 families for babies being treated in neonatal units  
 17 including evidence on bereavement support from leading  
 18 charities in this sector.  
 19 Bliss was founded in 1979 and works with all  
 20 neonatal units in the UK and describes itself as  
 21 existing to give every baby born premature or sick  
 22 in the UK the best chance of survival and quality of  
 23 life. Bliss offers emotional support and information to  
 24 families, provided online support and in 19 neonatal  
 25 units offers in person meetings with Bliss-trained  
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1 Inquiry.  
 2 She notes that in 2015 and 2016:  
 3 "The expectation would have been that families of  
 4 a baby who died on the neonatal ward would meet with  
 5 their named often obstetrician and, if requested, the  
 6 paediatrician who had treated their baby.  
 7 "The normal practice was for the Consultant  
 8 paediatrician to write to the mother's GP to inform them  
 9 of the baby's death. The hospital would notify the  
 10 Cheshire West and Cheshire Child Health Department of  
 11 the death and the child's medical record would be  
 12 updated by the Trust so that no inappropriate  
 13 correspondence was sent out to the bereaved parents."  
 14 Jane Tomkinson refers in her statement to  
 15 a neonatal standards review dated July 2016, which she  
 16 states:  
 17 "... records that counselling services were on  
 18 offer with leaflets and a contact number outside the  
 19 neonatal unit door, information in the parents'  
 20 accommodation and in the SANDS bag. This bag would  
 21 contain information, cards, a teddy and information on  
 22 where to go and seek support on return home."  
 23 Jane Tomkinson also notes in terms of any future  
 24 pregnancy:  
 25 "The mother would be allocated high-risk maternity  
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1 volunteers. Bliss have their own information for  
 2 bereaved families but also refer families to specialist  
 3 bereavement organisations.  
 4 Caroline Lee-Davey, the Chief Executive of Bliss in  
 5 her statement to the Inquiry notes:  
 6 "Across each of Bliss's services we aim to support  
 7 parents and carers to be more involved in their baby's  
 8 care on the neonatal unit. This means helping them to  
 9 provide hands-on care, such as skin to skin, to be  
 10 partners in decision-making about their baby's care plan  
 11 and to be advocates for their and their baby's needs.  
 12 Our support for parents or carers aligns to our work  
 13 with healthcare professionals who we encourage to make  
 14 sure parents, carers and families are integrated into  
 15 care for babies by removing barriers to participation;  
 16 for example, in emphasising the importance of  
 17 psychological support on neonatal units so that parents  
 18 can access the support which helps them to feel  
 19 comfortable in that role."  
 20 The Bliss Baby Charter is a nationally recognised  
 21 quality improvement programme which supports neonatal  
 22 units to deliver high-quality family-centred care where  
 23 families' needs, views and experiences are explicitly  
 24 prioritised within care planning and delivery.  
 25 Bliss note in their statement to the Inquiry that  
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1 whilst they are a national neonatal charity, some  
2 charities supporting families and babies in neonatal  
3 care are more localised, working in particular hospitals  
4 or geographical areas. One such charity is Spoons,  
5 a neonatal family support charity, operating in  
6 Greater Manchester, registered as a charity in 2016.

7 The statement to the Inquiry of Rebecca Lowe,  
8 a trustee of Spoons Neonatal Charity notes:

9 "Our role is to ensure that the neonatal voice is  
10 heard."

11 SANDS is a UK charity that exists to reduce the  
12 number of babies dying and to support anyone affected by  
13 the death of a baby before, during or shortly after  
14 birth. The full statement of Clea Harmer, the Chief  
15 Executive of SANDS, will be uploaded to the Inquiry  
16 website.

17 SANDS has existed for more than 40 years and  
18 provides a range of bereavement support, including  
19 a helpline and an online community in addition to having  
20 approximately 100 regional support groups.

21 SANDS also produces memory-making resources,  
22 a bereavement support book and has a network of football  
23 clubs which provide peer support for men through sport.

24 SANDS leads the National Bereavement Care Pathway  
25 project which commenced in 2019 and 2020 and is

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1 signed up to the National Bereavement Care Pathway in  
2 January 2024.

3 SANDS also works with Tommy's, a charity carrying  
4 out research into pregnancy loss and premature birth  
5 in the UK in a joint policy unit to raise concerns about  
6 maternity and neonatal care with policy makers. This  
7 work includes identifying key recurring themes from  
8 previous reviews and reports into maternity and neonatal  
9 services.

10 The joint policy unit has also looked at NHS board  
11 oversight of maternity and neonatal services. This  
12 review identified issues regarding the quality and  
13 content of reports and data presented to NHS boards,  
14 noting that reports to boards frequently have large  
15 quantities of hard to digest information with data  
16 spread across multiple reports and little analysis to  
17 draw attention to trends that might suggest that there  
18 is an issue with the care.

19 The review noted that few board papers include  
20 external data to contextualise local performance against  
21 national trends and targets. The statement from SANDS  
22 notes that the review of NHS board oversight highlighted  
23 the need for:

24 A) further guidance on the minimum metrics to be  
25 submitted to boards to provide an early warning of

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1 currently being implemented across NHS Trusts.

2 The project aims to improve the quality and  
3 consistency of bereavement care received by parents  
4 after pregnancy loss or following the death of a baby.  
5 The pathway offers guidance, workshops and access to  
6 training and resources for NHS Trusts. The pathway  
7 addresses different types of loss including specific  
8 guidance related to neonatal death.

9 The SANDS statement to the Inquiry also describes  
10 the role of their liaison volunteers stating:

11 SANDS hospital liaison volunteers provide a link  
12 between hospitals, SANDS local support groups and SANDS  
13 national services. These specially trained local  
14 volunteers signpost NHS staff working within the  
15 hospital to SANDS resources, support services, training  
16 and bereavement care guidance for NHS staff. Thus they  
17 enable parents and families to access support after  
18 pregnancy loss and baby death. There are currently 114  
19 SANDS hospital liaison volunteers throughout England and  
20 Scotland. SANDS' long-term aim is to ensure that every  
21 hospital in the UK has access to a hospital liaison  
22 volunteer.

23 Clea Harmer notes in her statement to the Inquiry  
24 that the Countess of Chester Hospital has had a SANDS  
25 hospital liaison volunteer since September 2023 and

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1 service quality and safety declining;

2 B) better ward to board communication to  
3 contextualise data, more analysis from clinical service  
4 leaders to interpret metrics and more board member  
5 engagement with wards and staff;

6 C) reports which reflect on and contextualise  
7 metrics and trends over longer timeframes and regular  
8 service monitoring dashboards;

9 D) a review of current systems and processes in  
10 each Trust as to whether boards have meaningful  
11 oversight over the quality and safety of services;

12 E) transparent reporting of issues discussed  
13 outside of public board meetings;

14 F) a review of whether financial certainty and  
15 reputation management is prioritised over a culture of  
16 learning and improvement; and.

17 G) clarity over the role of local maternity and  
18 neonatal systems in oversight of quality and safety and  
19 the implications for Trust board responsibilities.

20 The SANDS statement to the Inquiry comments:

21 "Recent reviews and investigations of maternity and  
22 neonatal services have identified the lack of a culture  
23 of safety within organisations as a key recurring  
24 problem. Staff working within services must feel more  
25 able to escalate concerns about care whenever necessary

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1 without fear of repercussions. We fear that too often  
 2 reputation management is prioritised over a culture of  
 3 learning and improvement. We must focus on systems  
 4 change including the support NHS Trusts need to embed  
 5 and sustain improvements to move away from a culture of  
 6 denial and blame and instead to incentivise candour,  
 7 support improvements and systematically revisit  
 8 recommendations to ensure sustained change.  
 9 "Without a just culture of openness and without  
 10 blame, mistakes and system errors will continue to be  
 11 downplayed or even covered up by Trusts that  
 12 incentivised to demonstrate infallibility. This needs  
 13 to be tackled at every level from clinical training to  
 14 management ethos to resource allocation. We need  
 15 a system that applauds honesty and transparency  
 16 highlighting what needs to change."

17 The statement from SANDS concludes by saying:  
 18 "Listening to the voices and experience of bereaved  
 19 parents will help to drive a change in culture and must  
 20 be at the heart of all policies developed to save  
 21 babies' lives and improve future care."

22 **LADY JUSTICE THIRLWALL:** Thank you very much  
 23 indeed, Ms Brown.

24 So that concludes the evidence for today. We will  
 25 start again tomorrow morning at -- is it 10 o'clock

1 tomorrow?

2 **MS BROWN:** I believe so, yes.

3 **LADY JUSTICE THIRLWALL:** Thank you very much  
 4 indeed. Tomorrow at 10.

5 **(4.29 pm)**

6 **(The Inquiry adjourned until 10.00 am,**  
 7 **on Wednesday, 15 January 2025)**

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