1 Wednesday, 15 January 2025
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Ms Langdale.
4 **MS LANGDALE:** My Lady, may I call Professor
5 Sir David Spiegelhalter, please.
6 PROFESSOR SIR DAVID SPIEGELHALTER (affirmed)
7 Questions by MS LANGDALE
8 **LADY JUSTICE THIRLWALL:** Thank you very much
9 indeed, Dr Spiegelhalter, do sit down.
10 **MS LANGDALE:** Can you give us your name and
11 qualifications, please?
12 **A.** My name's David Spiegelhalter, I am Emeritus
13 Professor of Statistics at the University of Cambridge.
14 **Q.** And you are an author on books on statistics;
15 is that right?
16 **A.** Yes, yes, I have written various academic
17 textbooks and more popular books on statistics.
18 **Q.** And you say in your statement you have mainly
19 worked as a medical statistician; is that right?
20 **A.** Yes, I have worked as an academic and medical
21 statistician trying to -- specialising in new methods,
22 statistical methods in medical statistics.
23 **Q.** You have prepared two statements for us,
24 Sir David, one dated January 2024 the other dated
25 January 2025.

1 Can you confirm the contents are true and accurate
2 as far as you are concerned?
3 **A.** As far as my knowledge, my knowledge, yes.
4 **Q.** Before we enter into the detail of the
5 evidence in the statements, I understand you would like
6 to say something?
7 **A.** Yes. Yes. My evidence is going to concern
8 counts of deaths, neonatal mortality rates and so on.
9 This is the language of statistics and I realise that it
10 can sound rather harsh and cold when it actually
11 addresses individual tragedies for patients, families
12 and staff; that is what statistics does. But
13 statisticians do realise that underneath all their data
14 lie these individual stories and all the humanity and
15 complexity.
16 But I personally feel and my whole profession feels
17 it is only by aggregating those individual stories into
18 summaries that one can get a feeling for the magnitude
19 of what has happened and if possible design systems to
20 detect problems as early as possible.
21 **Q.** So what is the role of statistics in the
22 context of our health service then?
23 **A.** Sorry, I am having -- I am finding it
24 difficult to hear.
25 **Q.** What is the role of statistics in our health

1 service?
2 **A.** Well, all sorts of roles of course. You know,
3 working clinical trials and epidemiology and just, just
4 the general statistics of how the health service is
5 working, we hear them all the time.
6 My particular interest, and our interest here, is
7 in terms of actually keeping track of in particular
8 adverse events, whether I have particularly worked on
9 surgical outcomes and so on trying to spot clusters of
10 failures, and in other contexts where one would like to
11 detect as quickly as possible where problems are
12 arising.
13 And the reason why statistics are so important is
14 that, you know, numerous studies and personal experience
15 have shown that humans are not very good at judging
16 data, they can miss long-term trends, slowly
17 accumulating changes, they can miss that.
18 And on the other hand they can get, you know
19 perhaps pay too much attention to sporadic runs of, you
20 know, bad outcomes due to unknown factors and trying to
21 find patterns that may not actually exist. So these are
22 well-known human characteristics and that is why -- that
23 is why we need statistical analysis.
24 **Q.** You tell us that you worked in the context of
25 previous Inquiries with the Shipman Inquiry, Bristol

1 Royal Infirmary Inquiry; that's right?
2 **A.** And Infected Blood Inquiry.
3 **Q.** And Infected Blood.
4 Can we look at the Shipman Inquiry first and can
5 I ask if we have on the screen please, INQ0008966,
6 page 4.
7 This is a page from your first statement,
8 Sir David, and pages 4 and 5 contain graphs, charts?
9 **A.** Yes.
10 **Q.** I don't know if it's possible to have both
11 pages on the screen, Mrs Killingback, at the same time.
12 If not, we can have 4 and then 5.
13 **A.** Yes, I have got it now. So we produced that
14 graph based on data that was collected by someone else
15 on behalf of the Harold Shipman Inquiry chaired by
16 Dame Janet Smith. And the first picture on page 4
17 illustrates the kind of plot, sometimes called VLAD
18 plots, or Observed minus Expected plots, which are --
19 which are common in this whole area and used extensively
20 in clinical monitoring.
21 In this case it's looking at the observed numbers
22 of deaths in Harold Shipman's practice both for males
23 and females and subtracting from it the number that
24 would be expected.
25 Now, the number expected you calculate just from

1 the death rates in the community, in which
2 Harold Shipman was working and taking into account the
3 breakdown of his practice in terms of ages and sex and
4 you can work out how many deaths you would expect to
5 have happened each year. And by looking at the observed
6 amounts expected and accumulating that, not just looking
7 at each year but getting a cumulative total you can see
8 a steadily increasing amount of what can be called
9 excess deaths.
10 I avoid that phrase whenever I can. I think it can
11 be, I have used it in the past and I regret it because
12 in fact if you looked across all hospitals half of them
13 by this definition would have excess deaths, you know,
14 half of all hospitals are worse than average.
15 So it can be a very misleading term because it
16 suggests some, some problem.
17 However, when those numbers get big enough you
18 really do have a problem or there was a problem with,
19 with Harold Shipman. What's interesting is that by
20 1997, he had 180 excess deaths of females and about 40
21 of males about 220 and this corresponded almost exactly
22 to the number of deaths that he was, that the Inquiry
23 concluded that he had definitely committed as murder.
24 So just this statistical system identified almost
25 exactly how many victims he had got.

1 But the statistical issue is where do you, if you
2 were plotting that which nobody was, where would you,
3 where would you blow the whistle, where would you draw
4 the line and the problem is you have got 26,000 GPs in
5 the country and you can't start investigating all of
6 them all the time so you have to have fairly stringent
7 criteria for identifying a problem.
8 We adapted in that case industrial quality control
9 techniques that it actually been developed in the
10 Second World War and were used for identifying when
11 a production line had gone a bit out of kilter, we
12 adapted those to this medical context and on page, top
13 of page 5, one can see the results.
14 That means producing a slightly different statistic
15 not very complicated but it enables you to draw
16 horizontal lines on the graph that act as thresholds,
17 triggers for alerts or alarms.
18 And from that we concluded that there's this very
19 basic system by 1985, just looking at female deaths
20 alone would have triggered a very strong alarm indeed
21 that he's, his mortality rate was substantially or
22 double what would be expected.
23 And if people had actually acted on that, if that
24 system had been in place, and investigated him, that
25 would have been after only 40 murders instead of over

1 200.
2 **Q.** So the fact that the signal happened would not
3 of itself have told anybody that Dr Shipman was
4 a murderer, but it would have necessitated investigation
5 by a human to look at what was happening?
6 **A.** This is one of the most important points.
7 A statistical monitoring system cannot say why
8 something has happened. In a way it's the standard
9 phrase "correlation is not causation". We can say that
10 he does have excess mortality and he's got a higher
11 mortality rate, we cannot say why.
12 I wonder if we could -- maybe you are going to come
13 to it -- talk about when my colleagues investigated
14 a monitoring system?
15 **Q.** Of course.
16 **A.** Yes. When my, my colleagues in the Shipman
17 Inquiry later tried out a similar system on 1,000 GPs
18 around the country, and found that 12 triggered an
19 alert, one of whom was Shipman but 11 actually triggered
20 before Shipman did.
21 These GPs were investigated, completely
22 confidentially, and it was found that they were working
23 with hospices, with retirement communities. They, they
24 had -- they were experiencing a very high mortality rate
25 for the very best of reasons. And that for me, there's,

1 in Dr Edile Murdoch mentions this and shows the graph in
2 her witness statement. This, you know --
3 **Q.** Shall we put that on the screen while you are
4 speaking?
5 **A.** Yes.
6 **Q.** Let's take these two off --
7 **A.** If we could put that up.
8 **Q.** -- INQ0106962, page 12. So this is an extract
9 of a second statement from Dr Murdoch who's the
10 Consultant neonatologist and chair of the NHS England
11 Maternity and Neonatal Outcomes group and in her
12 statement she also refers to the Shipman data. So let's
13 put that graph up, since you have referred to it.
14 **A.** Yes.
15 **Q.** Just blow the top up. We don't need
16 paragraph 36.
17 **A.** Yes, the top picture just shows 12 GPs who
18 signalled and Shipman was only one of those. As I said,
19 the others were -- were confidentially investigated,
20 found to be very good and generous GPs. And if we could
21 go back to open to the whole page again, I would just
22 like to support -- you have got it somewhere else, but
23 Dr Edile Murdoch gives a very succinct phrase about the
24 fact that a signal can only indicate that someone should
25 look carefully at what is going on. It cannot indicate

1 the reason for any signal.
2 **Q.** Thank you. That can go down. Bristol Royal
3 Infirmary, tell us, if you can, anything about data
4 collection there or statistical analysis that could or
5 did assist?
6 **A.** Yes. I -- I headed the team of statisticians
7 for the Bristol Royal Infirmary Inquiry. One of the
8 issues there is that there were seven different datasets
9 on mortality and in the cardiac surgery for -- for
10 congenital heart disease and none of them agreed. That
11 really taught me about the fact that it's extremely --
12 people might think that it's very easy to count the
13 number of serious events that happen. But different
14 datasets disagree for all sorts of reasons, even
15 counting how much surgery there had been.
16 And so it -- it shows it's very difficult to get an
17 absolutely precise number. However, by looking at
18 multiple datasets we could get a very strong picture
19 which was so strong that it didn't actually matter, you
20 know, whether we had the numbers precisely right or not.
21 And the point about Bristol is that it was a clear
22 outlier, by which I mean there was clear water between
23 it and the other 11 centres we were looking at which
24 were reasonably tightly clustered, not completely, and
25 Bristol stuck out very clearly indeed. It was a classic

1 case of an outlier, again, which should have been
2 detected earlier. You know, we demonstrated that if --
3 a good monitoring system in place would have blown
4 a whistle substantially before that actually occurred.
5 **Q.** In the context of language used, can you
6 explain the difference for us, please, between an
7 outlier, when there is an alarm, when there is a signal.
8 Do these have technical terms; what are the differences?
9 **A.** Yes, there is not an exact definition for
10 this. I don't know -- I have got a picture in my
11 second report of a, you know, which shows ...
12 **Q.** Shall we have that on the screen, INQ0108786,
13 page 3.
14 **A.** So I tried to illustrate with a simple
15 diagram.
16 **Q.** Do you want to wait actually it is up, sorry
17 Sir David.
18 **A.** Yes, let's wait until it comes up.
19 **Q.** Just give people a moment to see it.
20 (Pause)
21 **A.** Yes, the picture at the top, that sort of
22 distribution is supposed to show what is the typical
23 distribution of results say across centres or within
24 centres over time. There's always variability that goes
25 on both because of the way of, you know, unforeseen

1 circumstances or because of some differences in case mix
2 and so on, so there's always variability.
3 Now, it's useful to try to distinguish two
4 archetypical cases although it's not a hard and fast
5 division. The first which I have mentioned already with
6 regard to Bristol is an outlier, somebody who's clearly
7 separate from the bulk of the other centres -- I have
8 lost my page.
9 **Q.** We all have. It will come back in a moment,
10 it is a technical issue, I think.
11 **A.** It's not just me, okay.
12 **Q.** But we saw it. Do continue?
13 **A.** Okay. An outlier which is where there is
14 clear water between it and the bulk of the other, of the
15 other centres. However, the other archetypal situation
16 is where someone is high or in the tails or fairly
17 extreme; in other words, they are still kind of within
18 the distribution but up in the tails.
19 And traditionally, and this is just convention, in
20 the tails is considered, a tail of about 2.5% about,
21 1 in 40 chance of being higher than that. If you are in
22 the tail that contains a 40th of the distribution, that
23 would be considered as high or extreme or in the tails
24 and would be considered a reason for an alert.
25 Classically, it would be two standards deviations.

1 However and something that was in a way much
2 further out a real outlier, suspicions of that would be
3 an indication for an alarm, something that you were
4 pretty convinced is not just normal variation, but
5 there's some special cause behind it. And obviously you
6 can be in between, this is not a -- you are not one or
7 the other, but it's fairly -- I think it is quite
8 a useful division to make and it is one that's made
9 within this whole area of statistical monitoring.
10 **Q.** And that can come down now, thank you.
11 Infected Blood, what about the role of statistics
12 there or analysis?
13 **A.** The role of statistics in Infected Blood, we
14 deliberately refused to try to answer questions on when
15 something could have been detected earlier, something
16 that we did do for the Shipman Inquiry.
17 But we did agree to try to answer the question of
18 how many people had been infected with contaminated
19 blood products or contaminated blood, and how many
20 people had subsequently died.
21 For that, for some areas we could do that with
22 considerable confidence: for example, for HIV due to
23 multiple data sources, registries and so on, that one
24 could triangulate to some extent and be fairly confident
25 about the numbers.

1 For other areas, hepatitis C, in particular, we had
2 to model it, we can't count them. Many people will have
3 been infected by hepatitis C and will still not know.
4 So we had to just estimate that from statistical
5 modelling. Therefore we have a substantially more
6 uncertainty about the results.
7 For hepatitis B we refused to answer how many
8 people had been infected. The evidence was so poor and
9 we would not feel confident about making any numerical
10 judgment at all.
11 So again that reflects the fact that certain
12 questions can be answered and certain other questions no
13 matter how worthwhile sometimes the data is just not
14 there.
15 **Q.** At the time of the Mid Staffordshire Inquiry
16 there was a Dr Foster unit, wasn't there, at
17 Imperial College --
18 **A.** Yes.
19 **Q.** -- running data? Do you know much about how
20 that one worked at the time?
21 **A.** Yes, the --
22 **Q.** That has ceased, hasn't it?
23 **A.** The Dr Foster system was very good and it used
24 modern CUSUM methods, I knew the team, and were
25 operating sending alerts in to the -- what was then the

1 Healthcare Commission, I think, I think before it became
2 CQC.
3 CQC had its own or Healthcare Commission had its
4 own mortality monitoring system that I helped design, we
5 might come to later.
6 **Q.** You can tell us about that now.
7 So 2007, around then, you were involved in helping
8 to design the system at the CQC?
9 **A.** Yes. After the Bristol Inquiry I had
10 a secondment to the Healthcare Commission for one day
11 a week in developing monitoring systems and their
12 risk-based investigation systems and inspection systems
13 that the Healthcare Commission developed. And in
14 particular we built a statistical monitoring outlier
15 detection system for mortality that monitored every
16 Trust in the country, and for every Trust, 150 or so
17 indicators.
18 So I think we were monitoring at least 10,000
19 simultaneous in mortality indicators using
20 administrative hospital episode statistics data.
21 The point about that is that it's impossible for
22 a human to monitor this centrally and so if this was
23 done now it would be considered as artificial
24 intelligence in that it was automatically screening
25 10,000 or so signals and identifying when a human should

1 look at it.
2 It set off a signal, "a human should look at this
3 data", and it may -- the apparent outlier could have
4 been because of just a data entry problem or so on. So
5 it was making no conclusion about why the system had,
6 had, you know, issued an alarm an alert or an alarm.
7 It, it just said: a human should look at this.
8 I should emphasise this was an outlier detection
9 system, it was looking for really extreme results. If
10 it had, if it had been triggering from just results that
11 had been that were high, it would have been overwhelmed
12 by signals.
13 **Q.** Too many?
14 **A.** It would be completely impractical so because
15 this was a central system operating nationally, it could
16 only look at the most extreme results. And it got
17 turned on just about the time of Mid Staffs and
18 Mid Staffs went "ping ping ping ping", it identified it
19 immediately as having issues.
20 **Q.** So you support that system as a safety system
21 to detect outliers in the way that it can?
22 **A.** Yes, I -- I thought it was excellent and
23 I left the, I stopped working for them and I know that
24 it carried on being used right up to the start of Covid,
25 it was being used at the time at Countess of Chester

1 during 2015/16. It stopped being used at the time of
2 Covid and as far as I know, has not been reintroduced.
3 **Q.** And what do you think about that?
4 **A.** I think it's very unfortunate indeed. As far
5 as I know, it was operating well. I saw some of the
6 outputs. It was in a way issuing a controllable number
7 of alerts about apparently spikes in mortality right
8 across the NHS.
9 I think it's very unfortunate that a system like
10 that is not working because Dr Foster is not doing this
11 any more. You know, when I am sitting here again at
12 another Inquiry into something that's going on, I don't
13 want to be hearing: why wasn't there a monitoring system
14 in place?
15 **Q.** And you say indeed in one of your statements
16 that it's over the last two decades that there have been
17 real advancements on monitoring systems in this country.
18 Why is that? Why has it happened in the last two
19 decades?
20 **A.** Well, I think it is because of the scandals
21 I think it is because of Bristol and Shipman and that
22 provoked a lot of interest in these methods in -- among
23 the medical community and in the statistical community.
24 Even before Bristol I was working closely with Great
25 Ormond Street because a surgeon there Marc de Leval, had

1 a cluster of failures, he had a series of deaths from
2 doing a switch operation for transposition of the great
3 arteries. And, you know, was really shocked by this he
4 went and retrained, changed his methods and then had
5 100 -- did 100 without a death.
6 But we wrote a paper, a really, you know, path
7 breaking paper, on how these industrial quality control
8 methods could be used within surgery to detect such
9 problems rapidly and these have become adopted. We
10 could talk about that later in the areas where these
11 have become adopted and become completely standard.
12 Similarly, you know, in heart surgery there was 20
13 or so years ago, 25 years ago there was concern about,
14 you know, differing mortality rates across the country,
15 an obsession with league tables and so on. And adult
16 cardiac surgery were some of the first to start
17 standardising data collection, publishing the results by
18 Trust, even by individual surgeon, again that stopped,
19 I think, which is a real shame. You used to be able to
20 find out every surgeon, cardiac surgeon in the country,
21 his individual rates of -- mortality rates, risk
22 adjusted for the severity of the illness and my
23 understanding is that since all that occurred, perhaps
24 there's some people stopping operating.
25 It now makes very little difference where you are

1 operated on in this country. The experience in America
2 and the US is that by dedicated data collection,
3 comparison of the results across centres, you get a huge
4 reduction in the variation across centres.
5 **Q.** Can we go to your second statement, please,
6 INQ0108786, page 1. I am going to ask you to define
7 some of the terms, please, if you would?
8 **A.** Sorry, I didn't hear that.
9 **Q.** To define some of your terms, if you would.
10 If we look at this page 1.
11 **A.** Yes.
12 **Q.** "Fixed period versus continuous monitoring"?
13 **A.** Yes, yes.
14 **Q.** And you refer to retrospective audit and
15 prospective real-time monitoring?
16 **A.** Yes.
17 **Q.** In your earlier statement.
18 Can you expand, please, on this?
19 **A.** Yes, in my, in my first statement
20 I distinguished, I think appropriately, two types of
21 surveillance. What I call retrospective audit, which is
22 the type that MBRRACE have traditionally done of
23 collecting data and for usually a year, then some time
24 afterwards reporting that data for the whole year and
25 producing annual results.

1 The other type is where you are continuously
2 monitoring what's going on, there's no concern about the
3 start and the end of a particular year, you are just
4 treating it as a series of observations.
5 Now, the point is that, I think a better term for
6 that would be "fixed period" versus continuous
7 monitoring.
8 Because although in my first witness statement
9 I call this "prospective real-time monitoring" that is
10 only in perhaps an extreme version, I think an
11 appropriate version, because continuous monitoring might
12 for example only report quarterly or so on. It may not
13 be, you know, day by day or even week by week.
14 So I -- I think the big distinction is between
15 looking at aggregated results over a year perhaps in
16 a fixed period and systems that accumulate evidence over
17 time regardless of moving from one year to the next.
18 And both I think are really vital.
19 **Q.** Why are they both vital?
20 **A.** Yes, I think the continuous monitoring is
21 there for early detection of problems. That's what it's
22 built for. It's built to, you know, sound alerts, you
23 know, which could lead to different forms of
24 intervention.
25 The fixed period is much more concerned with the

1 bigger picture for what's going on across the country
2 and allow comparisons across centres as, as for the
3 whole -- looking at the whole picture, comparing
4 everybody, trying to spot differences on a larger scale
5 across, across the country.
6 Again fixed period quite often can be three years
7 as well, it doesn't have to be just annual. It could be
8 a moving, a moving window.
9 **Q.** And the continuous monitoring, would that be
10 something that a Trust could view its own at its highest
11 because it wouldn't have gone through the appropriate
12 steps and measures to be a national picture, they can
13 view their own continuous monitoring, is that the idea?
14 **A.** Exactly. The fixed period has traditionally
15 been a system where people sort of submitted data to
16 a central registry and then some time afterwards,
17 possibly a year or two years afterwards, a report comes
18 out, you know, in which the, their performance is
19 examined and relationship to other -- other centres,
20 perhaps similar, similar centres.
21 And there is a problem with that of people feeling
22 a lack of ownership of the system and the feeling that
23 it's -- you know, in a way it's always too late.
24 The continuous monitoring is very a very different
25 picture. At its best there is a strong feeling of local

1 ownership.
2 The -- I am a big admirer of what's happened in
3 congenital heart disease, again since Bristol, where the
4 system is that individual centres do their own, there is
5 central monitoring, but individual centres do their own
6 monitoring, produce graphs that are presented at the --
7 at the regular meetings of all the staff -- Morbidity
8 and Mortality Meetings, in which all the staff are
9 present, all the nurses and everybody to examine the
10 trends and to see what's going on rapidly. Where little
11 blips on the graph can be -- people know who they are,
12 they know the patient who is the -- produced that change
13 in the graph.
14 We will come to that, I am sure, but the systems
15 that are now being developed for neonatal monitoring,
16 you know, MOSS and the real-time MBRRACE system, both
17 have that, you know, potential to be absolutely part of
18 the routine practice of a unit.
19 **Q.** If we can have on the screen please
20 INQ00067551, so 00067551, this is a screenshot that
21 Professor Knight explained to us and indeed it's already
22 out of date, there's a more sophisticated or I think
23 another option now looking at data within MBRRACE.
24 But my question, Sir David, is directed at the
25 skill required for people reading the data and looking

1 at the data within a unit?
2 **A.** Yes.
3 **Q.** Professor Knight spoke about it would be
4 better to have a lead person who understood the data,
5 understood how to access it, what it meant.
6 **A.** I -- I agree that the monitoring systems, the
7 dashboards that are being introduced and being piloted
8 can at first -- at first -- appear rather complex and
9 daunting. Experience shows that very quickly people
10 learn how to interpret them and use them.
11 So I agree that a lead person who has been trained
12 deliberately is important for when these systems are
13 introduced but the evidence, the practical evidence
14 suggests that when people feel an ownership, when they
15 can identify as I said a blip in the graph with someone
16 they know, their own experience, then that, that very
17 rapidly leads to a development of local skills for
18 interpretation.
19 **LADY JUSTICE THIRLWALL:** Just before you continue,
20 we still haven't got the document.
21 **MS LANGDALE:** I know. I am going to give the
22 reference again. Just give me one moment, Sir David, it
23 is INQ0006755, page 1.
24 There.
25 **A.** Yes, so this is the MBRRACE real-time

1 monitoring system looking at days between deaths.
2 Now, the point about that is that every mark on
3 that graph is an individual patient. We know people --
4 you could put a very local unit, nurses could put a name
5 on these, on these patients. That produces a feeling of
6 real, of ownership, responsibility and so on.
7 And graphs like this can look, you know, daunting
8 when you first look at them. But that's not the way to
9 evaluate them. You need to --
10 **Q.** You don't need to be a clinician to evaluate
11 them, you can be a manager, you can be a Medical
12 Director?
13 **A.** No, no, it is absolutely vital that managers
14 and nurses of every scale should be able to understand
15 these you know, with, with some experience. Not
16 immediately, you don't look at them and immediately
17 grasp what they mean, so with some experience --
18 **Q.** In terms of entering the data, does the whole
19 system rely on people entering the data as they should?
20 **A.** It absolutely relies on the quality of the
21 data entry. And one of the principles that, you know,
22 I and many others propose is that you should only ever
23 enter data once so there, you do not require specialist
24 data entry for monitoring system.
25 You there should not be an additional burden on

1 staff, this should be an asset to staff and not
2 a burden.
3 That means that the data entry of course has to be,
4 you know, carefully done by people who are obsessive
5 about correctness and accuracy. Who -- and, you know,
6 that again requires, you know, appropriate procedures
7 for making sure that's -- making sure that's done.
8 But experience in other areas such as intensive
9 care show that this is possible. Of course, you know,
10 again, you know the multiplicity of information systems
11 that exist now in hospitals should mean that this is,
12 you should not have to enter data specially, the data
13 should be just there and visible by everybody.
14 **Q.** Can we have on the screen now please -- that
15 can go down, the document there, your statement again,
16 INQ0108786, page 2?
17 **A.** Sorry, I -- while this graph is still up,
18 could I just make a quick point?
19 **Q.** Of course.
20 **A.** This was developed, this shows 2019 as
21 a real-time monitoring system. Since then, MBRRACE have
22 developed, have started putting some statistical process
23 control metrics on this, in other words to use this
24 graph and others I believe as -- to -- to sound alerts
25 which is a very natural development to do and it seems

1 to me that it's an extremely valuable innovation because
2 otherwise you are relying again on human intuition and
3 looking at graphs and humans are not, as I have said
4 before, very good at it.
5 You know, very -- humans are not very good at
6 judging when something's beyond a coincidence or things
7 are happening too close together and so on because, you
8 know, events do tend to cluster and so on and this
9 actually to determine whether something is, you know,
10 too surprising and should be examined, is -- is
11 a professional issue. It's a professional thing, it
12 cannot be left up to human intuition. Sorry to repeat
13 myself.
14 **Q.** Not at all?
15 **A.** But it is my bread and butter.
16 **Q.** So can we go now to 0108786, page 2 of your
17 statement where you set out some principles for
18 monitoring systems. You have been involved, perhaps
19 while we are calling that up, with the MOSS project.
20 Dr Bill Kirkup of course conducted an Inquiry into
21 maternity and neonatal services in East Kent. His
22 report was published in October 2022 and a taskforce was
23 established as recommended by Dr Kirkup to drive the
24 implementation of a system capable of differentiating
25 signals for maternity and neonatal outcome measures.

1 You have been involved in that as well, haven't
2 you, working with Dr Bill Kirkup, do you want to tell us
3 about that?
4 **A.** Yes, I -- I -- I really welcomed Bill Kirkup's
5 commentary on East Kent and the Government response was
6 to say: yes, we agree and to invest in an NHS-based
7 neonatal surveillance system and maternity surveillance
8 system. So this was the MOSS project and I was asked to
9 be an advisor on that project, and I still am, with Bill
10 and others and right at the beginning I came up with
11 just aspects I thought were important and it's quite
12 a useful summary I think of this sort of ideas, the
13 statistical ideas which concerned me and which I have
14 already mentioned a number of.
15 So just to go through those. There is the
16 possibility of multiple indicators, you don't need just
17 a single monitoring system, but you might combine common
18 outcomes as has been done or combine outcomes into
19 what's known as the basket, but just a pooled measure
20 and that's been done in MOSS.
21 The importance of using cumulative data both to
22 identify long-term trends and sudden shifts in
23 performance, setting explicit thresholds, usually two
24 thresholds, an alert and an alarm threshold, which would
25 identify different levels of unusualness and would

1 trigger different management actions.
2 It is not my job to say what those actions should
3 be. Generally, the first level would be known as an
4 alert level and that would trigger an internal
5 investigation. Going above the next level, it goes
6 above an alarm level, would perhaps trigger a central
7 investigation.
8 So -- but that -- what is done is not part of my
9 role. As I say, that is management actions.
10 Minimise burden on staff. This is absolutely vital
11 and again the rapid feedback using attractive
12 visualisations to encourage local ownership of the
13 system. This is not some alien thing being imposed on
14 people but something that people welcome, they go to and
15 they can identify with this shared by all staff.
16 So, and as far as I know those -- all those
17 principles have been sort of taken into account in the
18 MOSS project which I am very pleased with.
19 Can I just -- while it's up there, can I just point
20 again to the little statement that I tried to refer to
21 earlier in my 4.2, when Dr Murdoch said:
22 "The signal is simply a prompt for a rapid
23 assessment to understand what has caused the signal."
24 In other words the signal -- again, sorry to go on
25 about it, does not indicate the cause. It just says

1 someone should look at this.
2 **Q.** Sure. Can I refer you to something else in
3 Dr Murdoch's statement, if we go to INQ0108744, page 7.
4 The Inquiry asked Dr Murdoch whether MOSS could
5 measure preterm neonatal deaths or whether there would
6 be limitations on the effectiveness of the data analysis
7 in including premature babies as a separate group with
8 any joint data analysis and her response should be on
9 the screen at the moment.
10 If you can read paragraph 27 at the bottom and we
11 can scroll slowly through 27, 28, 29 and 30?
12 **A.** Yes.
13 Yes, again I should emphasise this is not, not my
14 job. You know, what the -- the design of a system in
15 terms of what outcomes are being monitored is, is
16 determined by the aims of the system, what is it trying
17 to detect, what is it trying to ...
18 And MOSS and the real-time MBRRACE system are doing
19 different things and are monitoring different outcomes.
20 MOSS only looks at term births because as you said it is
21 designed to support the improvement in maternity and
22 neonatal outcomes at term.
23 So the -- any -- it is not looking at neonatal care
24 of premature babies, it was not what it was designed
25 for, whereas the MBRRACE system is looking at events for

1 any babies born after 24 weeks' gestation. So they are
2 looking at different metrics, you might expect them to
3 signal in different circumstances, sometimes in the same
4 circumstances and I have got to say it's still being
5 worked out how these two systems --
6 **Q.** Work alongside.
7 **A.** -- might be used, how they might fit together,
8 hopefully how they might complement each other.
9 So I -- I -- that is it still in a state of flux at
10 the moment, MOSS is being piloted in a range of
11 hospitals, the MBRRACE system is being added on to their
12 existing system that was plotting the graphs which we
13 have seen at the moment. They also use different in
14 a way statistical methods to -- to trigger alerts.
15 So these are different systems. And it remains to
16 be seen how they might complement each other.
17 **Q.** And whilst instinctively certainly I suppose
18 for people entering the data or even viewing the data
19 that's produced it might be preferable to have one
20 system. It looks, do you agree, with paragraph 29 of
21 the statement in front of you, with Dr Murdoch's analogy
22 to think about a car whether a number of targeted
23 signals that have been designed to be specific to the
24 safety issue that they relate to, provided the user
25 knows what each signal relates to --

1 **A.** Yes.
2 **Q.** -- it is more effective to have a number of
3 specific signals than one generalised signal, a single
4 red light on a dashboard?
5 **A.** Yes, I think that is a reasonable thing.
6 I mean, there is some overlap in the cases, the
7 events that were triggered, you know, that would go into
8 both MOSS and the MBRRACE system but they are measuring
9 different things and they -- they might agree and they
10 might disagree and I think that would give some
11 additional insight into what is going on because these
12 systems -- again they are just signals saying: have
13 a look at this. They are not the answer to the problem
14 and so there's, you always need the ability to drill
15 down further, you know, to start looking at what has
16 triggered these, what sort of events?
17 **Q.** In practical terms, would it be a lot more
18 onerous to furnish data to two systems or do you think
19 it --
20 **A.** Well, it shouldn't be because again the data
21 should be there anyway. If, if it's -- if it's onerous
22 to put the data in then the system isn't working
23 properly. It really shouldn't be an additional burden
24 to the staff. These should just be assets to them.
25 **Q.** Can we go back to your statement please, at

1 page 3, so INQ0108786, page 3 and it's where you deal
2 with risk adjustment?
3 **A.** Oh, yes.
4 **Q.** Can you explain to us the significance of
5 risk-adjusted systems and how more effective they are,
6 how they are being developed and the limitations
7 currently?
8 **A.** Well, risk adjustment came to particular
9 prominence within adult cardiac surgery because there is
10 a big variation in the severity of illness and the risks
11 involved in people being operated on and if you just
12 count what are known as crude mortality rates, which is
13 what MBRRACE call them, it's again a rather harsh term,
14 but it just means how many people have died out of how
15 many operations, then that was considered unfair to the
16 surgeons doing the more advanced surgery.
17 And so the risk adjustment methods were developed
18 in which for every patient detailed patient specific
19 information is collected as to the severity of their
20 illness and by, you know, a pretty basic statistical
21 method, you use that to actually calculate an
22 expected -- well, it's actually a probability of, of
23 death or survival for that particular patient.
24 So that means that if a very high risk patient is
25 being operated on, and they do unfortunately not

1 survive, the surgeon is penalised less than if it was
2 a very low risk patient. And that, sorry, I am using
3 the term of "penalised" I really shouldn't say that,
4 I should just say it contributes to a signal less than
5 if it was a low risk patient who died.
6 And so that it is generally considered advisable
7 where possible to risk adjust for pre-existing
8 conditions in order to -- so that the signal is
9 sensitive to what might be considered unexpected deaths,
10 rather than deaths which while not expected were, were
11 not so unlikely.
12 And so within for example paediatric intensive care
13 and adult intensive care, where there is standardised
14 data collection upon admission, national standardised
15 data collection, they can risk adjust and so they, every
16 patient when they come into intensive care, you know, it
17 sounds again very harsh, is given a probability of
18 survival, that they will in fact survive or die.
19 And that's used then to -- within the monitoring
20 system which in fact is the system we developed for
21 Harold Shipman, they used, to in a way take more notice
22 of what one might consider as unexpected deaths.
23 **Q.** Is it easier to risk adjust for adults with
24 a known medical history than for neonates, for example?
25 **A.** Yes.

1 **Q.** Newborns?
2 **A.** The point is in some areas cardiac surgery,
3 the risk factors are known. We can collect them fairly
4 easily, it is fairly easy to develop a formula.
5 Even in paediatric cardiac surgery it was, it's
6 really quite challenging, it took a long time to develop
7 a system because there is such an enormous variety of
8 different conditions, it's very difficult just to
9 summarise the condition of the child in a limited number
10 of metrics.
11 And so there -- the MBRRACE system does do one of
12 their metrics, does do some risk adjustment on basic
13 ideas such as gestational age and so on but just
14 essentially demographic data.
15 But risk adjusting for pre-existing conditions of
16 neonates, again that's a clinical issue but my
17 understanding is that that would be challenging. So not
18 only would you have to decide the important risk
19 factors, you would have to standardise data collection
20 across the entire country and that's a big ask.
21 It is very challenging. It has been done in
22 certain areas such as intensive care and adult cardiac
23 surgery and, you know, of course it is an ideal
24 situation which I would hope people might move towards
25 but it's quite a big ask but until that happens it does

1 mean that in a way everyone -- every case contributes,
2 is given the same weight in the monitoring system which
3 may not be entirely appropriate.
4 **Q.** And indeed a monitoring system or a data
5 uploading system could require you said unexpected
6 deaths but sudden and unexpected could be a factor
7 uploaded in any event in a monitoring system, a human
8 factor?
9 **A.** Yes, but, you know, to calculate expected
10 deaths requires a formula, it is an algorithm, which has
11 to be developed on a good database and then has to be
12 applicable to every new patient. So it's -- it's
13 a matter of really of data availability --
14 **Q.** Okay.
15 **A.** -- is the limitation.
16 **Q.** Can we scroll up to have the whole of
17 paragraph 8, please. So 8.1 to 8.7.
18 This is your statement -- a bit further down,
19 please, scrolling. So 8.1 can we see as well.
20 This is your response to what the MBRRACE system
21 showed for 2015 to 2016 at the Countess of Chester and
22 of course we have heard from Professor Knight and we
23 have looked at the figures you refer to here.
24 Which would you prefer, Sir David, to tell us what
25 the MBRRACE data represents looking at your statement or

1 would you like me to put the figures that were in the
2 MBRRACE report and the table? Which is easier for you?
3 You have summarised it here.
4 **A.** I think -- I mean, this is all taken from the
5 MBRRACE report.
6 **Q.** Yes.
7 **A.** So I'm not sure, I think this probably is
8 sufficient, I refer to the figures.
9 **Q.** This will suffice.
10 **A.** So the idea is that in my first witness
11 statement I was covering completely general issues about
12 the vital importance of statistical monitoring systems,
13 right across the board, in all clinical areas and how in
14 a way it's I think more than unfortunate that they have
15 not been in place in neonatal care but that is now being
16 remedied.
17 But in the second report, I did have a look at what
18 systems did say at the time in 2015 and 2016 at Countess
19 of Chester using the evidence that's been provided to
20 the Inquiry because this was not previously available.
21 Some of it was, some of it wasn't.
22 And this is very much in the spirit of, as we did
23 perhaps with Shipman, because for Shipman none of those
24 monitoring systems were in place, this was a purely in
25 a way imaginary world: if things had been in place, what

1 might they have said? And so this is both what systems
2 did say and perhaps what they could have said.
3 **Q.** What they could have said earlier because they
4 said it in 2017?
5 **A.** Yes, could have said earlier.
6 **Q.** And 2018?
7 **A.** So the MBRRACE system has been going for some
8 time, it's a well-established system, it reports -- for
9 neonatal deaths, it reports two outcomes: a crude
10 neonatal mortality rate, which is just the number of
11 deaths divided by the number of admissions to the
12 neonatal -- no, it's birth, the denominator is births,
13 not admissions to neonatal unit.
14 And it also records adjusted and stabilised
15 neonatal mortality rates, which is more complex.
16 There's some adjustment for demographic risk factors of
17 the mother and child, including ethnicity and
18 gestational age. And the stabilisation is a little bit
19 difficult to explain. It's a way of trying to eliminate
20 some of the random variation that one gets from year to
21 year due to in a way risk factors that have not been
22 taken into account and that, that means that estimates
23 are sort of pulled in or shrunk towards the mean of the
24 relevant group to allow for some unexplained variation
25 between units.

1 It's designed to identify extreme units in the
2 tails of the distribution, not outliers, and it is
3 important; it is not an outlier detection system, it's
4 an in the tails detection system and that should be very
5 clear.
6 In Lisa Annaly's witness statement she said that --
7 I should also say --
8 **Q.** That is the CQC statement, Lisa Annaly?
9 **A.** Yes, I should say that MBRRACE then summarises
10 centres in terms of colours, we are particularly
11 interested in red, which means they are estimating it's
12 10% higher than the average for their -- for their tier
13 for their group.
14 And so for 2015 it concluded more that it was red,
15 more than 10% higher; 2016 up to 10% higher. It's
16 important to note that the 2015 data was only published
17 in 2017 and the 2016 only published in 2018. So again
18 showing one of the problems with these retrospective
19 fixed period audits.
20 Professor Knight's witness statement is slightly
21 different, saying that in 2015/2016 Countess of Chester
22 was red for both crude and adjusted and stabilised
23 neonatal mortality rates in both years.
24 In my next point I do -- you know, just being red
25 is not a major signal. In 2015, around 30% of units

1 were classified as red both for crude and adjusted and
2 stabilised rates.
3 So, you know, on its own that's, it says they are
4 high, it certainly doesn't indicate they are outliers.
5 But actually Countess of Chester's crude neonatal
6 mortality rate in 2015 was 2.96 per 1,000, there were
7 about 3,000 deaths -- 3,000 births, so that means there
8 is about, there was nine deaths they had counted in
9 their definition in its tier and it was the highest in
10 its tier of centres with 2,000 to 4,000 deaths a year.
11 I have to say only just. Blackpool had eight
12 deaths compared with Countess of Chester's nine.
13 So again it was high, it was in the tails, one
14 would not call that an outlier.
15 And similarly for 2015, it's adjusted and
16 stabilised rate was the highest in the tier, Burton
17 being second highest and a little way behind in 2016.
18 Again 30% of units were red for the crude neonatal
19 mortality rates which puts -- which is -- so it is not
20 a very discriminating metric, it is certainly not
21 indicating an outlier but again Countess of Chester was
22 the highest for adjusted and stabilised rates out of the
23 39 units in its tier and rather higher than Sherwood
24 Forest at 1.26.
25 So MBRRACE identified of course after substantial

1 delay, Countess of Chester as having higher rates in
2 2015 and 16. It was highest in its tier but I -- that
3 would not be considered generally an outlier but it
4 would be sufficient to generate a signal and alert
5 warranting investigation.
6 **Q.** Can you have a look now, please, at
7 paragraph 1 onwards, if we scroll down. So at
8 a national level you say it would have warranted
9 investigation, what was seen, but what could have been
10 known locally --
11 **A.** Yes.
12 **Q.** -- what about the mortality data on its own to
13 the hospital have shown, can you take us through
14 paragraph 11, please?
15 **A.** This -- I have done all of this since Monday,
16 I should say because it is only on Monday that
17 I received or became aware of or I think this document
18 is now public, document INQ108781.
19 **Q.** Shall we put that on the screen first?
20 **A.** Can we put that up there? It is rather
21 important.
22 **Q.** This was dealt with with the Countess of
23 Chester corporate witness and is the evidence in
24 relation to numbers of death that the Inquiry has
25 received, so it's INQ0108781.

1 **A.** Just as some background before we get to that.
2 The point is that all the monitoring systems I am
3 talking about, the MBRRACE, the CQC outlier detection
4 system, MOSS and so on, all make use of information from
5 other centres in order to assess what's going on in
6 a unit. It's comparing with other centres, it's -- and
7 so on.
8 However, an alternative approach is just to use the
9 data from a unit alone, to try to identify where the
10 changes happen and there are a variety of what are
11 called SPC, Statistical Process Control, methods in
12 place to do that, I think some of which have been
13 implemented now by the MBRRACE real-time data monitoring
14 system.
15 **Q.** You see on this document, Sir David, the first
16 is the Lead Clinicians in a summary saying what he
17 understood the number of deaths were.
18 The second was the ward manager with numbers of
19 deaths and emails. And the third is something that the
20 Head of Risk and Patient Safety and the Director of
21 Nursing drew together preparing a position paper on
22 neonatal mortality.
23 And we see there under the heading "Mortality
24 Data":
25 "Data discrepancies between the differing systems

1 in place has led to a number of challenges in obtaining
2 an accurate account of ... unit activity over time."
3 **A.** Yes.
4 **Q.** "Having reviewed outputs et cetera the actual
5 number of deaths occurring within the neonatal unit
6 recorded from January 2010 up to including June 2016 is
7 as follows ... "
8 And there are the numbers that they have ...
9 **A.** Yes, I would like to draw attention to that
10 first sentence they give:
11 "Data discrepancies between the differing systems
12 in place has led to a number of challenges in obtaining
13 an accurate account of the neonatal unit activity over
14 time."
15 I think, you know, that again represents what
16 I reinforces what I said before about Bristol, is that
17 one would naively think that these numbers would be
18 clear and recognised and agreed by everybody. But in
19 fact that's not the case and so I would not want to make
20 any comparisons on a system over time unless I felt that
21 it had all been collected to a common standard using
22 a common protocol.
23 Assuming this has been done now in this table, you
24 do get a series of from 2010 a number of neonatal unit
25 deaths: 1, 3, 3, 2, 3, 8. And I think it's important,

1 you know, on the face of it yes, that is a change. But
2 it requires, what I have done is actually look, do some
3 you know pretty statistics to get an idea of how big
4 a change that is and what sort of attention that might
5 warrant.
6 **Q.** Shall we go back to your statement?
7 **A.** Yes.
8 **Q.** So we go back to INQ0108786, page 5.
9 **A.** As I said, I should emphasise all that has
10 been done since Monday.
11 **Q.** If you want to caveat or add to it afterwards,
12 please do?
13 **A.** Yes, I am.
14 **Q.** If you think there is anything that you need
15 to correct or change or would like to add, we don't want
16 you to be under pressure of time in any way?
17 **A.** If we go on to the next page, page 6. Yes.
18 Yes. So the number of deaths between 2010 and
19 2014, 1, 3, 3, 2, 3, it actually shows surprising
20 consistency. I would have expected more variability;
21 a 4 and a 0 and so on.
22 Anyway, it went up to 8 in 2015. Again,
23 I apologise if this sounds harsh in describing tragic
24 events.
25 So one approach is just to say: well, we have got

1 those five years of data and then it goes to 8, how
2 surprising is that? And if we assume -- I'm sorry about
3 the technical language, but statistically one would
4 assume that observations are from what is called a
5 Poisson distribution which is just the rate of
6 distribution we expect for rare events. We would say
7 the average over that period was 2.4 deaths per year and
8 we can think of that as some sort of underlying rate.
9 And there is uncertainty about that because there
10 is only five numbers that contribute to it.
11 Allowing for that uncertainty, and doing a little
12 bit of technical stuff, the probability of getting eight
13 or more deaths in 2015 I assessed to be around 0.008.
14 Just by chance alone, assuming that nothing had actually
15 changed, that the underlying rate had stayed the same,
16 the probability of getting, you know, eight or more is
17 that which is about -- which is less than 1%.
18 That would generally be considered sufficient to
19 trigger an alert signal, someone should look at this
20 locally. But not extreme enough to be considered an
21 outlier and I think this is very useful to put this in
22 perspective.
23 There are about 150 neonatal units in the UK
24 covered by MBRRACE and therefore we would expect one
25 signal of this magnitude to occur each year just by

1 chance alone. Through no underlying cause, nothing
2 special changing at all.
3 So I think it's important to give it that sort of
4 context that this is a surprising event within Countess
5 of Chester but from a national level, this is not very
6 surprising at all; we would expect this to happen every
7 year, somewhere, somewhere.
8 You know, an alternative is to say: well, what if
9 the underlaying rate were three neonatal deaths per year
10 then the probability of getting eight or more deaths is
11 about 2%, again an alert signal. And to put this in
12 perspective we would expect three such signals in the UK
13 just by chance alone.
14 I do emphasise, which I didn't write here, that
15 I am only looking at 2015 data because that was the
16 complete data I had in that table. Since 2016 was also
17 a high year that would of course generate an additional
18 signal but what I am saying is that the 2015 data alone,
19 taken completely internally, would justify an alert,
20 an internal investigation, that this is unusual.
21 **Q.** And clearly the Lead Clinician and the ward
22 manager were talking about an unusual number of deaths
23 at a human level there in the unit?
24 **A.** Yes, which no doubt happened but what I am
25 saying is that a background statistical method analysis

1 would have done that automatically.
2 **Q.** Is there anything else you would like to say
3 about that topic before I take the statement off and
4 move to a different question?
5 **A.** No, I think that's, that's it. I mean, all
6 sorts of -- you know, I mean, that is a very short
7 series of five observations, so I wouldn't want to do
8 anything massively sophisticated with that. But it's
9 exactly the situation where real-time monitoring, you
10 know, at least continuous time monitoring is so vital
11 you shouldn't even have to wait until the end of a year
12 if something is going on.
13 **Q.** Thank you. That can come down.
14 Sir David, are you able to give examples of where
15 the use of statistical monitoring systems have worked
16 effectively in the healthcare sector to promote patient
17 safety and prevent harm and conversely where such
18 a system has failed to do that?
19 **A.** Yes, I would point to the continuing success
20 and use of PICANET in paediatric intensive care which
21 adopted the systems we presented in, in Shipman and they
22 combine both types of system.
23 And I wonder if we could just go to my first
24 evidence, my first witness statement.
25 **Q.** Yes, we can.

1 **A.** I produce a graph from PICANET.
2 **Q.** I will just get it on the screen, INQ0008966,
3 page 3.
4 **A.** Just to say a bit more. Yes. PICANET does
5 the real-time monitoring and has got alert and alarm
6 systems, fully risk-adjusted and I think has been a huge
7 success.
8 But they also do a retrospective analysis for -- on
9 a three-year period looking across all centres that they
10 are monitoring and they use this device called a funnel
11 plot that I and others developed, you know have -- have
12 proposed many years ago and it's become very popular and
13 I particularly like it because what it shows is the
14 funnel broadly shows where would you hope centres to lie
15 in.
16 It's a funnel because small centres you expect
17 a lot more variability just by chance alone. They can
18 have good years and bad years just because they have got
19 such small numbers, you get a lot more variability, so
20 you tolerate that more. Whereas for large centres, you
21 have much less tolerance for variability: you expect
22 them to have a pretty constant rate and so what that
23 shows is amazingly the, the paediatric intensive care
24 lie within the funnel. They, they point out -- yeah,
25 what's interesting is ZE, Harley Street, is just outside

1 the funnel and they say it is not going to be flagged as
2 an outlier as it closed in 2020.
3 So I -- I think this sort of system is incredibly
4 valuable and it allows them to make statements like:
5 "there was no evidence that any paediatric intensive
6 care unit had an excess mortality rate compared to what
7 would be expected based on a level of sickness at the
8 time of admission across the three-year reporting
9 period".
10 If that's correct, it doesn't matter which
11 intensive care unit you go to in the country, which is
12 an amazingly important thing. And if you plot adult
13 cardiac surgical results, they look like that now they
14 are in the funnel; it doesn't really matter who you go
15 to. Obviously centres are all different but what that
16 shows also is it is completely pointless to produce any
17 sort of league table or to say who's top and who's
18 bottom. It's all nonsense. They are indistinguishable
19 essentially.
20 So an enormously powerful tool to incept. But of
21 course when somebody lies outside then it is another
22 matter and it would trigger these outlier detection
23 these are quite extreme limits. So those would trigger
24 a national -- you know, a central investigation.
25 So I think that again shows the power of

1 retrospective national audits over a fixed period, but
2 of course it's too late in a way. Much too late. If
3 there is a problem there, it should have been detected
4 by a real-time monitoring system. This is an assurance
5 to people that, you know, it doesn't really make
6 a difference where you go but if there is a problem, you
7 shouldn't have to wait for it to be an outlier here.
8 **Q.** That is how it works effectively. Would you
9 say any failures are failures of the system because of
10 time delay, that you don't get in there early enough?
11 **A.** It is certainly a failure because systems
12 weren't in place, you know and I think neonatal care
13 shows that.
14 I -- I don't know of -- I don't know enough about
15 where there's been delays in, I can't say there's been
16 a delay in finding something a problem because of only
17 using retrospective data. Quite possibly. I can't --
18 I can't quote an example. I am sure there have been.
19 **Q.** While we are on your statement, can we go to
20 the previous page, page 2 and give you an opportunity to
21 comment, if you want to, either on the National
22 Maternity Dashboard or the National Neonatal Audit
23 Programme?
24 **A.** No, I -- as I said, there have been so many
25 programmes about monitoring, you know, neonatal care and

1 maternity care, I am not going to make a general
2 statement about that.
3 **Q.** Okay.
4 **A.** My interest is completely restricted to this,
5 you know, rather technical issue of early detection of
6 using statistical systems of problems.
7 **Q.** That can come down, thank you.
8 How can, should policies, procedures or guidance be
9 drafted to ensure the data is accurately collected,
10 entered and analysed to avoid missed opportunities? Do
11 you think hospitals and those analysing the data, there
12 needs to be shared policy around that? Or do you
13 think --
14 **A.** Well, I mean, this is happening anyway because
15 of, you know, hospital information systems are being
16 used. That means that one person enters the data and
17 then it's being used everywhere by everybody.
18 So quality control about data entry now should be
19 an integral part of medical care because that data then
20 is -- you know, can be accessed, can be used, will be
21 used.
22 So again it's -- I -- it's very easy for me because
23 I just say that data should be only entered once and it
24 should be accurate and there should be -- you know,
25 there should be a responsible individual who takes

1 responsibility for that, ultimate responsibility for
2 that.
3 It's not, I am very fortunate it is not my role to
4 actually discuss the implementation of those, of that,
5 of that data collection. Sorry, I avoid those things.
6 **Q.** Fair enough. Can you have a look, please,
7 finally from me at this document, INQ0004657, page 1.
8 When it comes up, Sir David, this is a Risk Register at
9 the hospital and we see at the top, if we can highlight
10 the top, in July 2016 there's a record of the risk:
11 "Potential damage to reputation of neonatal service
12 and wider Trust due to apparent increased mortality
13 within the neonatal unit."
14 You have seen the numbers on Monday and they were
15 circulated. The use of the word "apparent", is that
16 something a statistician would say? I am just trying to
17 understand that word.
18 **A.** I mean, I think I don't think that's --
19 I think we would avoid that phrase because the mortality
20 rate has gone up.
21 **Q.** The deaths are absolute; they happened?
22 **A.** You know, there is 2, 3, 3, 3 and then it went
23 to 8. So I think the number, the mortality rate has
24 gone up.
25 Whether that actually indicates a change in the

1 underlying in a way mortality risk, what the
2 statistician might call the underlying rate, the
3 long-term rate is, is another matter that would have to
4 be identified or whether it's a run of, you know,
5 particularly just in a way circumstances, unusual
6 circumstances have led to that, is a matter for
7 investigation.
8 So I don't think -- I think I wouldn't use that
9 phrase myself. I would say there is increased mortality
10 of undetermined cause, perhaps, or something like that.
11 **Q.** But the numbers have gone up?
12 **A.** The numbers have gone up.
13 **Q.** The fact is that they are small numbers as
14 well?
15 **A.** The numbers have gone up, they are small
16 numbers, but just because numbers have gone up does not
17 mean necessarily that, you know, that, you know, there
18 is a special cause for it. That is something to
19 investigate.
20 **Q.** As is explained, that needs investigation?
21 **A.** It needs to be investigated.
22 **Q.** Before Mr Skelton, I think, is going to ask
23 you questions, is there anything else that I have left
24 out you would like to add?
25 **A.** Just -- I would like to mention in my second,

1 my recent report. I did look at what MOSS and the CQC
2 monitoring system ...
3 **Q.** Yes.
4 **A.** Well, the CQC modelling system did say MOSS
5 might have, would have said, had it been in place at the
6 time.
7 **Q.** Shall we go to that INQ --
8 **A.** Yes, could we go --
9 **Q.** -- 0108786, so the CQC outlier system,
10 paragraph 9.
11 **A.** Yes. So when we come to that, the CQC --
12 **Q.** Page 4.
13 **A.** You know, I feel a connection with the system
14 because I helped design it and as I said, it was
15 designed to monitor thousands of outcomes right across
16 the NHS using routine administrative data but it wasn't
17 definitely an outlier detection system looking for
18 really odd results, not just extreme results otherwise
19 it would have been overwhelmed.
20 Lisa Annaly reported that it did not flag as
21 outliers in 2015 and '16 and that was reinforced by
22 Ann Ford's statement. In a way I am not surprised, in
23 a way. I don't know how high it would have to be to
24 trigger but it would have had to be really quite
25 remarkable.

1 **Q.** For Dr Shipman it was 40, but different
2 system?
3 **A.** But Bristol would have been a bigger idea of
4 would have triggered with an outlier. Shipman would
5 have eventually triggered as an outlier but the Bristol
6 should have would have triggered as a clear outlier.
7 And in the next section 10, I talk about MOSS
8 because Dr Murdoch in her second witness statement, the
9 MOSS team did run the Countess of Chester data through
10 but always keeping in mind this is just on term births,
11 this is not considering pre-term births and she reports
12 that if MOSS were in place at the time, the signals
13 would have prompted a standardised critical safety
14 assessment to understand why the signal occurred. It
15 was an alert, not an alarm. It just got up to the level
16 to trigger a local investigation, standard safety
17 critical assessment at the local level, which -- so
18 again reinforces that, and that again was not even
19 looking at premature babies, that the signal at Countess
20 of Chester would not be sufficient to trigger a real
21 outlier.
22 **Q.** No.
23 **A.** But would have been sufficient to trigger, as
24 it did, you know, using statistical methods, an
25 investigation, local investigation.

1 **Q.** And you are clear that that's what was
2 triggered, an alert for an investigation, not an outlier
3 but something that required investigation?
4 **A.** Yes, so that again, from a -- whatever did
5 happen with the benefit of hindsight and if these
6 methods had been in place, it would have been triggered.
7 **Q.** Sure.
8 **A.** And I think having a statistical system in
9 place to trigger something, not only does it happen
10 fast, but in a way it avoids a lot of argument because,
11 you know, it's gone, it's been pre-designed, these are
12 predetermined thresholds that have been set, there are
13 standard operating procedures. It is almost no longer
14 a matter of discussion: sorry, that's happened, this is
15 what now must take place. And I think that's
16 a considerable advantage.
17 **Q.** But as we have said, the MBRRACE data was only
18 available 2017 and 2018 --
19 **A.** Yes, yes.
20 **Q.** -- respectively?
21 **A.** Again now they have got a real-time monitoring
22 system. Again I don't think it is a choice between the
23 two. PICANET show the huge advantage of both having
24 a continuous monitoring system and, you know, every year
25 doing a retrospective audit almost as reassurance to

1 the -- to the wider community because this is public.
2 **Q.** Thank you. Anything else before I hand over
3 to Mr Skelton?
4 **A.** No, I think that is everything I wanted to
5 say.
6 **MS LANGDALE:** Mr Skelton.
7 **LADY JUSTICE THIRLWALL:** Mr Skelton.
8 Questions by MR SKELTON
9 **MR SKELTON:** Sir David, I ask questions on behalf
10 of one of the Family groups.
11 **A.** Sorry?
12 **Q.** Sir David, I ask questions on behalf of one of
13 the Family groups. Can you hear me okay now?
14 **A.** Fine.
15 **Q.** I am going to use your book, if I may,
16 I'm afraid I confess I haven't read all of it but I have
17 got through most of it and I didn't understand most of
18 it.
19 **A.** Good.
20 **Q.** But I understood some of it.
21 You have talked about retrospective analysis in
22 your note this week looking at the 2015 and 2016 data.
23 What about real-time analysis, because we know for
24 example that the first murders occurred within
25 two weeks, so three murders within two weeks in

1 June 2015. Is it possible for you to say whether your
2 real-time analysis would have picked up that cluster as
3 being a signal, or a "ping", as you put it, or would it
4 just have been like the three airline crashes over
5 a 10-year period, something more likely?
6 **A.** Yes. No I think, I can't say because
7 I haven't done the analysis, but a proper real-time
8 analysis would not just, I just looked at data for the
9 whole of 2015, but a real cluster of events, it would,
10 it should pick up without having to wait to the end of
11 the year, if that is the case.
12 And I -- but I haven't run it through any system
13 but statistical systems are designed to pick up
14 a cluster like that as quickly as possible.
15 You mention the fact that in my book I talk about
16 the fact that, you know, clusters do occur --
17 **Q.** Yes.
18 **A.** -- across the whole, you know, if you look in
19 the bigger picture, you know, over 10 years, you know,
20 looking over the whole world you will get many, you
21 know, such events occurring. And I think that's -- the
22 difference in perspective there is between a local just
23 looking at the data itself and if you look at a whole
24 national system where you do have to take into account
25 that you are looking at many units and lots of things

1 will be happening in those, in those units, that is why
2 I said that the 2015 count you would expect something
3 like that somewhere every year in the UK.
4 So that means that when you are looking at many
5 units you have to be really cautious about making the
6 grand claims about apparently outlying results.
7 If you are looking just within a unit, a single
8 system, not looking outside, then really it's much of
9 a self-contained system, you still must be cautious
10 because bad things, you know, do tend to cluster but the
11 statistical approach should be able to identify the
12 difference between -- I mean, I hate to use this phrase,
13 a sort of random cluster, just a run of bad outcomes and
14 the idea is it should identify where there has been some
15 systematic change for whatever reason.
16 **Q.** So it's telling you something basic: something
17 might be going on which is out of the ordinary, you need
18 to investigate?
19 **A.** Yes.
20 **Q.** And your last point to Ms Langdale I think was
21 that the system must respond to that, that is the
22 benefit of it?
23 **A.** Yes.
24 **Q.** So there is going to be standardised response
25 of investigation. I would like to ask, really all of my

1 questions are going to be about how to respond to the
2 "ping", not in terms of paediatrics or neonatology but
3 all the things you talk about in your book are about the
4 way people respond to uncertainty and it is that that
5 I would like to just test with you.
6 The first thing I would like to ask you about is
7 layperson's understanding of homicide and in
8 a healthcare context in particular.
9 From your involvement in the Shipman case and your
10 knowledge of other cases, and indeed the public
11 knowledge, it seems that homicides in a healthcare
12 context are exceptionally rare, there's been half
13 a dozen or so convictions over the last 50 years. Is
14 that a fair statement?
15 **A.** I -- of course, those are just the
16 convictions, we don't know --
17 **Q.** Indeed.
18 **A.** -- what else might have happened but yes, it
19 is rare, yes.
20 **Q.** So there is a known unknown about the people
21 that may have been murdered without anyone ever
22 realising?
23 **A.** Yes, yes.
24 **Q.** Do you think that that fact which will bear
25 upon a layperson's mind --

1 **A.** Yes.
2 **Q.** -- the fact that I think there are over
3 a million patients treated in the NHS a day, so I am not
4 going to try and do the arithmetic, but billions of
5 patients treated over a 50-year period, and half a dozen
6 people murdering them in that time, it is a tiny, tiny
7 fraction of the number of patients. Do you think that
8 statistic has any rational value?
9 **A.** I think the rarity of an event, it is
10 important to take it into account when, when judging
11 evidence. This is a standard, you know, it is known as
12 a Bayesian argument, that if things are rare you have to
13 be very careful about the use of detection systems the
14 classic idea being perhaps breast screening which is,
15 you can say, 90% accurate in terms of if you have got
16 cancer it will detect it 90% of the time; if you
17 haven't, it will reassure you 90% of the time correctly.
18 However, because the people being screened, it's
19 quite rare, when you get a positive mammogram, the
20 majority of those are false positives. Now, this is
21 quite -- I do it in the book and do it in multiple books
22 it is quite difficult, it is not intuitive, it is not
23 intuitive. The fact that if something's rare, even
24 a fairly accurate detection system will mainly be
25 detecting false positives.

1 **Q.** But in terms of the person responding to
2 a suspicion, that is my focus. The fact that it's
3 something exceptionally rare will inevitably infect your
4 thinking?
5 **A.** Yes. It's actually quite a tricky thing
6 because, I mean, it is a bit like a clinician
7 investigating a disease. They have to keep into account
8 that rare things do happen.
9 **Q.** Absolutely.
10 **A.** But of course actually you do investigate the
11 more common things and the very, very rare things. You
12 require a much bigger signal in order to take them
13 seriously.
14 **Q.** And the consequences of what you are dealing
15 with will also bear upon that analysis as well so
16 something might be very, very rare and inconsequential
17 but something might be very, very rare and highly
18 consequential, which is your rare disease or in this
19 case a homicide?
20 **A.** Yes. And I think this is -- I mean, it's --
21 it depends, if you are thinking yes if -- if there is
22 a severe consequence, then obviously you take it, you
23 know, for example in cancer diagnosis or something like
24 that, even if the signals, if it's quite a low
25 probability, then you do full investigation because the

1 consequences of getting it wrong are extreme.
2 And so you are absolutely right that the rareness
3 of something and the severity of in a sense a mistake do
4 dictate the, you know, what actions one might take.
5 I mean, the problem is as you said that in the end,
6 what I am describing are things with a standardised
7 operating procedures, statistical systems respond in
8 a certain way and they need to be designed to take these
9 aspects into account in order to prevent excessive
10 attention to what may be false alerts at the same time
11 as not letting through a problem for whatever reason,
12 whether it is a crime or not.
13 So, I mean, in any investigation you are trading
14 off to some extent the two types of mistake you can
15 make.
16 **Q.** Yes, there is an interesting tension though
17 between the learning from the Allitt Inquiry, which was
18 that if certain types of event occur, you should think
19 the unthinkable and not exclude the rare event which
20 would be the murder of a child or a patient and, at the
21 same time, the practitioner on the ground thinking:
22 Well, this isn't going to happen in my hospital --
23 **A.** Yes.
24 **Q.** -- this happens in someone else's hospital in
25 some other year in the past and it's how the responding

1 person rationalises those tensions?
2 **A.** Yes. But again that's getting outside my
3 area, I am not a psychologist of decision-making and
4 I -- you know that is not my area. If you think of it
5 purely from, you know, I don't like this phrase,
6 a rational, a sort of reasonable perspective then, you
7 know, even rare events need to be kept in mind. But
8 they would tend to need, you know, stronger evidence in
9 order to bring them to the fore.
10 **Q.** You talk in your book about putting
11 uncertainty into numbers and using multiple sources of
12 information, aggregation, as you call it, metacognition.
13 Could you explain what metacognition means in the
14 context of responding to an unusual and uncertain event?
15 **A.** Yes, I talk about what makes people good
16 forecasters and good at making judgments in the face of
17 uncertainty and one of those is taking advantage of
18 multiple sources of information. The metacognition is
19 having some insight into one's own biases. So basically
20 having some self-reflection that acknowledges what you
21 might be bringing to the argument and actually possibly
22 distorting the evidence.
23 So trying to avoid confirmation bias where you only
24 look for things that support what you already thought.
25 I know I am a chronic optimist and so I have to try to,

1 you know, in any situation, control myself, you know, to
2 have some insight into your own personal -- you know,
3 like we all have got, our own, you know, characteristics
4 that we use in our judgments and try to -- it is very
5 difficult but try to have some insight into those.
6 **Q.** You were speaking in the context of
7 forecasters, but I am trying to apply the same sort of
8 sensibility or rationalism to the person analysing
9 retrospective events: presumably the same
10 characteristics apply when you try to look at what
11 happened in the past as you are when looking into the
12 future?
13 **A.** Yes, yes, but as I said it's actually quite
14 difficult to do, but one should always try to, you know,
15 reflect on your cognitive process, reflect on how you
16 are thinking about stuff, that is very --
17 **Q.** The third characteristics was humility and it
18 is a theme that comes up again and again in your book,
19 it is the limits of knowledge and the limits of your
20 understanding or your own personal characteristics which
21 seems to be quite an important aspect of the rational
22 response to an uncertain situation, could you explain
23 that?
24 **A.** Yes, I think in the book I hardly mention
25 rationality but I mention a lot about humility, so again

1 the humility is to try to think: I may be wrong. You
2 know, that not to have overconfidence about one's
3 judgments and to -- well, it's what humility is, to have
4 a -- to have a -- how can I explain humility apart from
5 saying it is humility? Yes, not to be so confident
6 about your judgments that you blind yourself to evidence
7 that might be pointing in another direction.
8 **Q.** So would it be fair to try and use your three,
9 aggregation, metacognition and humility, to try and
10 understand how best to respond to an uncertain situation
11 that is occurring in a healthcare context. Is that
12 a fair starting point at least?
13 **A.** Yes, it could be. Again it's not, how people
14 actually deal with situations of uncertainty is not my,
15 you know, professional expertise whatsoever. It's --
16 what I am more concerned with is how one could set up
17 systems that in a sense don't take that off their
18 shoulders but produce a standardised response to
19 particular signals.
20 **Q.** And one of the other aspects I think you talk
21 about when you are dealing with making decisions in
22 response to signals is constructing a list of actions,
23 with the consequences of actions. So you need to work
24 through logically your plan and where it might lead you
25 in response to an uncertain situation. Is that a fair

1 summary?
2 **A.** Yes, the ideal approach in situations of
3 uncertainty is that you do list what your options might
4 be and then you think of what -- under each option what
5 the consequences might be. You know, in a theoretical
6 point of view you -- you -- you would actually put
7 probabilities and values on all of those but that's, you
8 know, rarely applicable in practice.
9 But just structuring the problem in terms of what
10 are -- you know, what are the options, what are the
11 unknown quantities and what are the possible futures is
12 obviously a valuable thing to try to do.
13 **Q.** Do you have any other guidance for someone
14 dealing with an uncertain statistical situation and
15 responding to it in a healthcare context where the
16 consequences are extremely serious of the
17 decision-making?
18 **A.** Again I feel this is somewhat outside my
19 expertise, except again to go back to the
20 characteristics that you -- that you mentioned before,
21 which is trying to keep an open mind of seeking multiple
22 perspectives, you know, from people with different views
23 and having been cautious about overconfidence in any,
24 about any particular conclusion.
25 **Q.** I think it's also important, as I understand

1 it, one of your chapters is about communication of
2 uncertainty; that the person who is dealing with
3 uncertainty communicates it successfully -- properly and
4 fairly and in a trustworthy way to those that are making
5 decision?
6 **A.** Yes, I mean that -- that again is -- I even --
7 I am quite critical of some people who are not very good
8 at that or don't want to do that and I have got to say
9 politicians are -- part of their job is to always appear
10 completely confident about everything they say and all
11 their conclusions.
12 But I think trustworthy communication of
13 uncertainty acknowledges what is unknown and
14 acknowledges limitations of - of what is known. But
15 also emphasises the fact that more will be known and
16 things will change. And that's part, that sort of in
17 a way provisionality, this is not the final word,
18 I think is part of trustworthy communication in a state
19 of uncertainty in that we will learn more and things
20 will change.
21 **MR SKELTON:** Thank you, Sir David, those are all my
22 questions.
23 **LADY JUSTICE THIRLWALL:** Thank you very much
24 Mr Skelton, anyone else have any questions for
25 Sir David?

1 Ms Langdale, there was just one thing I wanted to
2 check. You began asking a question about Dr Foster
3 system when you were going through the chronology and
4 then we diverted to look at something else, was there
5 anything about the Dr Foster process that you wanted to
6 bring out in evidence?
7 Further questions by MS LANGDALE
8 **MS LANGDALE:** None other than Sir David also knew
9 of that system that it would have raised the signal that
10 you said in respect of the --
11 **A.** Sorry?
12 **Q.** You go on. You tell us about Mid Staffs --
13 **A.** Mid Staffs.
14 **Q.** -- and what that system would have told us?
15 **A.** That was, you know, a monitoring system would
16 have very quickly raised signals on that.
17 Questions by LADY JUSTICE THIRLWALL
18 **LADY JUSTICE THIRLWALL:** Thank you. I have just
19 got really a couple of very small points.
20 The first is, are you aware of some evidence that
21 we had the other day in relation to BadgerNet which is
22 another data collection system, that in some places it's
23 no longer being used, either data is not being put in,
24 ie because a new system in a particular hospital or
25 hospitals does not speak to the other system, it's kind

1 of rather dispiriting evidence because the point you
2 have made repeatedly, it seems to me quite rightly, is,
3 you know, single data entry is very important.
4 **A.** The lack of intra-operability of medical
5 systems, whether it's between hospitals, whether it's
6 between hospitals and other agencies, whether it's
7 between general practice and hospitals, is an utter
8 disaster in this country. Utter disaster.
9 It's absurd that I have one system for my GP and
10 one system for my hospital and there is no communication
11 between the two. So that's just from a very personal
12 level.
13 So these things make a statistician or anyone
14 involved in information despair because the whole point
15 about, you know, the modern world is that you shouldn't
16 have to put in information twice. You know, we put it
17 in one place and you should just be able to transfer it
18 to another one, now obviously with appropriate protocols
19 and privacy constraints and things like that.
20 But it doesn't surprise me but it's deeply
21 depressing.
22 **LADY JUSTICE THIRLWALL:** Yes, thank you. And thank
23 you also for the clarity of the explanations that you
24 have given us in the course of your evidence. I don't
25 have any more questions for you. Tempting as it would

1 be to invite you to develop some of the areas that you
2 say are -- you rightly say are outside your area of
3 expertise, but upon which I am sure we would be helped
4 in all sorts of aspects.
5 So thank you very much for coming today, I know
6 it's not been convenient and you've worked in a very
7 short timeframe in recent days, so renewed thanks for
8 that and if I may just add on a personal level thanks
9 also for all the reassurance and authoritative guidance
10 you gave us during the pandemic, when your voice was
11 very much more familiar, it was rather interesting to
12 see the voice and the person all in one place today so
13 renewed thanks for that and you are now free to go.
14 Thank you.
15 **A.** Thank you very much indeed.
16 **LADY JUSTICE THIRLWALL:** And we will rise now until
17 12 o'clock.
18 **(11.43 am)**
19 **(A short break)**
20 **(12.00 pm)**
21 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
22 **MR DE LA POER:** My Lady, our second witness for
23 today is Mr William Vineall, I wonder if he would like
24 to come forward, please.
25 **LADY JUSTICE THIRLWALL:** Would you like to come

1 forward, please, Mr Vineall.
2 MR WILLIAM VINEALL (sworn)
3 Questions by MR DE LA POER
4 **LADY JUSTICE THIRLWALL:** Do sit down.
5 **MR DE LA POER:** Please could you state your full
6 name?
7 **A.** William Graham Robert Vineall.
8 **Q.** Mr Vineall, is it correct that you have
9 provided to the Inquiry three witness statements, one
10 dated 5 April, the other the next 14 August, and the
11 third 30 August, all of last year?
12 **A.** That's correct.
13 **Q.** And is the content of those witness statements
14 true to the best of your knowledge and belief?
15 **A.** Yes, it is.
16 **Q.** Are you currently the director of NHS Quality
17 Safety and Investigations?
18 **A.** Yes.
19 **Q.** Have you held that role since 2020?
20 **A.** Yes.
21 **Q.** That's you as at today?
22 **A.** That's right.
23 **Q.** Let's go all the way back to the start of your
24 career, when did you join the Civil Service?
25 **A.** I joined the Civil Service in 1998.

1 **Q.** And which department did you join?
2 **A.** Department of Health.
3 **Q.** And have you been in the Department of Health
4 since that time?
5 **A.** Yes. I went out to a regional office for
6 a year but that was actually at that time a part of the
7 Department of Health, so, yes.
8 **Q.** In that time, have you been aware of a number
9 of Inquiries and investigations that have taken place
10 into the functioning of the NHS, many of which were
11 critical of the circumstances that were found?
12 **A.** Yes, they were, yes, I have.
13 **Q.** In particular --
14 **A.** May I -- sorry, may I make -- I wanted to make
15 a point of apology at the outset. May I do that just
16 before we get into the question?
17 **Q.** Of course, but Mr Vineall may I apologise for
18 taking you into that before?
19 **A.** No, that is fine, I wanted to go into the
20 rubric.
21 So I just wanted to start by saying that on behalf
22 of the Department of Health and Social Care that we
23 fully endorse the apology that the previous Secretary of
24 State made at the Inquiry last week on behalf of the
25 health system, and that the Department is indeed

1 ultimately responsible for the NHS insofar as there were
2 lessons not learned from Inquiries and systems not
3 followed through from policies that could have helped
4 potentially prevent part of this awful tragedy.
5 So I just wanted to say that at the start.
6 **Q.** On the subject of previous Inquiries, did you
7 in fact have a role in the Mid Staffordshire Public
8 Inquiry?
9 **A.** Yes. Not the Mid Staffordshire Public
10 Inquiry, I was the Secretary of the first Mid Staffs
11 Inquiry which was a non-statutory Inquiry. It wasn't,
12 like this, subject to the 2005 Act and that was 2009 to
13 '10 and it was into the functions of the hospital,
14 whereas the Public Inquiry was into the regulatory
15 structure around the hospital.
16 **Q.** As we move forward through your career, what
17 position did you hold within the Department of Health
18 during the period 2015 to 2017?
19 **A.** 2015 to '16 was the first year I was
20 a director and I was responsible for the CQC, I was
21 responsible for some investigations, principally
22 Morecambe Bay and the Jimmy Savile investigations at
23 that time and I was also responsible for professional
24 regulation.
25 What changed after 2016 which was when my post was

1 made substantive was I maintained the responsibility for
2 CQC and quality and safety, I had a sort of formal
3 expanded role for Inquiries and investigations across
4 the Department, excepting Covid, which I wasn't involved
5 in when it came, and I also took up responsibility for
6 maternity policy, which I had until 2023 and in 2021
7 I picked up the brief on health ethics and all those
8 kinds of things, and actually in 2016 I also took on the
9 litigation role.
10 So I had -- 2015/16 I had a narrower role on
11 quality, safety and professional regulation. 2016
12 onwards I had a broader role, which was Inquiries,
13 litigation and patient safety that I still have,
14 maternity that I got then, and no longer have.
15 **Q.** Remaining with the theme of your knowledge and
16 understanding of Public Inquiries, I think you also gave
17 evidence to the Infected Blood Inquiry relatively
18 recently?
19 **A.** I did. I gave evidence in May 2021 with the
20 Secretary of State at the time and I was particularly
21 giving evidence on the compensation -- not the
22 compensation, the payment arrangements that we had in
23 place then for people who were the victims of
24 Infected Blood and I was the lead official in this role
25 for the Infected Blood Inquiry since 2018, including up

1 til now.
2 **Q.** Would it be fair to say that you have a very
3 good understanding from all the various roles and
4 positions that you have held, including that as
5 a witness, of how Public Inquiries work and are supposed
6 to work?
7 **A.** Yes.
8 **Q.** Are you familiar in the sense that you have
9 heard it said, whether true or not is a different
10 matter, but are you familiar with the concern which
11 exists in some quarters that sometimes things don't get
12 done until a public servant is confronted with the idea
13 of having to give evidence at a Public Inquiry about
14 that topic?
15 **A.** Yes, I have heard that said. What do I think
16 of that? I don't think it's wholly untrue and I don't
17 think it's wholly true. What -- what is the purpose of
18 a Public Inquiry? It's to bring an external rigorous
19 focus beyond the confines of departmental structures to
20 issues that the Government considers are of significant
21 importance and particularly in a Public Inquiry to do it
22 in a way that is rigorous and is able to call people
23 substantively, whether they want to come or not and
24 I think in more recent years a good development, to try
25 and give a sense of explanation and understanding, if

1 you can't give full closure, to the people who have been
2 the victims of the errors that are by and large under
3 discussion at Public Inquiries.
4 **Q.** We have talked in the generality there. We
5 will come back to that in due course. But just to tell
6 you where we are going today, there are 11 topics that
7 I want to ask you about, I will signpost them as we go.
8 The first is really a summary that we seek from you
9 about the DHSC's role and its relationship with NHS
10 England and in particular I think there have been some
11 developments that you speak about in your third
12 statement which bring us up to date.
13 So just in summary form what is the role of the
14 DHSC and what is its relationship with NHS England?
15 **A.** Yes. DHSC is a Government Department headed
16 up by the Secretary of State that makes policy and does
17 some other things, which I will come back to in
18 a minute.
19 NHS England is an arm's-length body of the
20 Department of Health and Social Care and is established
21 in statute with particular sets of roles and
22 responsibilities.
23 How does that break down into the practicalities?
24 The Secretary of State has a set of powers to provide
25 a comprehensive health service, to reduce inequalities

1 to promote quality, all those sorts of things.
2 He takes that forward through -- through his
3 Department, through five main ways: us supporting him in
4 strategy, in direction, us being the accountable unit
5 back to Parliament for both expenditure through the
6 Permanent Secretary and in all of the accountability
7 functions that we help ministers discharge through their
8 accountability to Parliament debate speeches,
9 Parliamentary questions, all those sorts of things.
10 Then we have two other functions that are pretty
11 unique to Government Departments, not just us: one is we
12 do legislation and we do funding, so that is sort of one
13 point together; and then secondly obviously we deal
14 with, you know, unforeseen events that only a Government
15 Department can catch as a catch-all, say, something like
16 Covid or in my area when we changed the arrangements for
17 GP indemnity because they won't working four or five
18 years ago, and we did that.
19 NHS England by contrast -- or complementary, not by
20 contrast, it is by contrast but it is complementary --
21 has responsibility really for the day-to-day operation
22 of the NHS. How does it execute that? Through its
23 arrangements with Foundation Trusts and with NHS Trusts,
24 with ICBs, now that they exist since 2022, Integrated
25 Care Boards, and through the Integrated Care Boards the

1 various primary care practitioner contracts: GPs,
2 dentists, optometrists and the like, which are
3 contracted through the ICBs.
4 NHS England has some also has some pretty big
5 practical functions that is it coheres on behalf of the
6 NHS: one of them is all the mechanics of workforce;
7 a second one is digital; a third one is education and
8 training.
9 So if you take those two things together and the
10 point I would like to end on is the togetherness, we are
11 at the top end of the process with the policy and the
12 strategy and the ministers and the big picture funding
13 issues.
14 They are then taking those forward through the
15 contracts and arrangements and the structures that they
16 operate on our behalf and there's a meeting point in the
17 middle which is roughly at the point of the mandate and
18 the planning guidance where the two come together.
19 Obviously since 2012 we have been separate
20 organisations, we were previously under one roof, we
21 have been walking down a path towards greater
22 co-ordination ever since and certainly our new set of
23 ministers from July made it perfectly clear that we
24 should be complementary and working in lockstep with one
25 another so that a Policy and Strategy decision that we

1 may make at one end of the system translates to
2 an effective policy and hopefully improved health of the
3 individual receiving the care at the other end.
4 So it's one thing with a division and we work
5 together.
6 **Q.** And is there a physical co-location to --
7 **A.** No, there isn't. So NHS England are now
8 located at Wellington House at Waterloo and we are at
9 39 Victoria Street. In the previous pre-2012
10 arrangement we were, or at least headquarters of the NHS
11 was in the same building and, if you like, the
12 headquarters function the NHS is now separated. But to
13 be perfectly honest the thing has only been going in one
14 direction since 2012 which is to bring us closer
15 together so I don't think the geographic distinction is
16 significant.
17 **Q.** So that being, I am sure you would agree, very
18 much a thumbnail sketch of, or summary, as I invited you
19 to give, of the DHSC's role and its relationship with
20 NHS England.
21 I will move to my second topic, which is one that
22 you deal with in your first witness statement. It may
23 help you to turn it up, so if you could go to page 42 of
24 your first witness statement. This is under the heading
25 of improvements in patient safety or developments in

1 patient safety.
2 And all of this will be published on the Inquiry
3 website in due course so we don't need to go through it
4 line by line but there are some that I would like to
5 pick out with you.
6 **A.** Yes, sorry.
7 **Q.** The first is at your paragraph 121, which is
8 a -- and I am simply taking them in the order they
9 appear in your witness statement here, which is
10 a proposal as you set out there or a plan for a series
11 of statutory instruments in relation to professional
12 regulatory bodies. Do you see that?
13 **A.** Yes, I have got it, sorry.
14 **Q.** Now, the first thing bearing in mind that we
15 have had a change of Government since then, is: is it
16 still intended to roll out those statutory instruments
17 or is that a matter which is under consideration?
18 **A.** No, it is, it is still the plan. And I was
19 enquiring about this, or this general point before --
20 before I came here and the reform and changes to
21 professional regulation have been quite a long time in
22 the works, partly because it takes a lot of legislation
23 to change all the different regulatory bodies,
24 professional regulatory bodies.
25 But the Government does still plan, I think, to

1 write fairly shortly setting out what its plans in those
2 areas are, which are about greater consistency and some
3 modernisation of the arrangements. We have to make them
4 a bit more svelte and focused and consistent.
5 **Q.** You have said that is to:
6 "... modernise their workings and give them the
7 powers and flexibility to make their systems fairer and
8 faster and more effective in [the] public protection."
9 **A.** Yes.
10 **Q.** Can you give us some examples of the sort of
11 changes that are likely to be brought in?
12 **A.** I can't give the examples in detail, but
13 I know that one of the things that has been in people's
14 minds from a long time is to have a broader consistency
15 of approach about how you handle things, you know, when
16 you are disciplining in professional regulation or when
17 you are bringing complaints to bear, because people get
18 different experiences through different sets of
19 organisations when they are ostensibly, you know, asking
20 for the same issue.
21 And we need to look at ways of making that, you
22 know, both more consistent and more efficient.
23 **Q.** One of the matters that Dr Clamp gave evidence
24 about --
25 **A.** Yes.

1 **Q.** -- he being the Chief Exec of the PSA, was
2 about the possibility of a shared Code of Conduct
3 between professional regulators or at least a core that
4 they shared with possible subsidiary codes specific to
5 their profession.
6 Is that any part of these coming --
7 **A.** I don't know of any specific plans about that
8 and I think I would have thought that professional
9 regulators, you know, are quite keen on having their own
10 codes because it gives some distinction to their
11 professional bodies which are very different.
12 **Q.** I think from Dr Clamp's perspective thinking
13 about it at the patient end, which of course is the
14 interest that the Department is able to represent, that
15 knowing that the person you are dealing with is going to
16 be subject to exactly the same standards which are all
17 to be found in the same place --
18 **A.** Yes.
19 **Q.** -- that everybody else that they deal with
20 are, may be helpful to the patient's experience of the
21 care they receive?
22 **A.** Yes, I think -- I think things to make
23 consistency of behaviours and experience for the
24 individual coming to the organisation is, is very
25 sensible. I don't think that has to absolutely

1 translate into an absolute commonality of rubric or code
2 for each of those organisations.
3 **Q.** I think it was not as between organisations,
4 but as between -- I suppose it may be you are saying the
5 same thing, but as between individual professionals so
6 where you are treated by a team of nurses and doctors
7 that the patient knows that there are certain things
8 that each of those people, the language being identical,
9 are bound to observe?
10 **A.** I don't know of plans to draw that out
11 specifically but I can entirely see the logic of what
12 he's suggesting.
13 **Q.** Well, it may be, and I know that bearing in
14 mind there is a consultation what you can say on it is
15 limited, but that will feed into also the idea that
16 there is if there is a code for senior managers, that
17 they too will be the subject --
18 **A.** There will be a consistency; I take your
19 point.
20 **Q.** Exactly so.
21 So in terms of the roll-out of that statutory
22 instrument or instruments, is there any planning in
23 place for what training will accompany that in terms of
24 how it will affect individual frontline staff and how
25 members of staff will be informed about the effect of

1 the changes?
2 **A.** Well, I don't know the details of that but
3 I would have thought that if there were any plans, we
4 would need to ensure, a bit like the argument with
5 manager regulation, that if you are going to make
6 changes they are appropriately supported so that people
7 can come up to the standards so there are not things
8 that they go in unsupported about and therefore can't
9 achieve because obviously the point of professional
10 regulation, indeed any regulation, it's meant to be
11 a virtuous circle that both improves standards and makes
12 standards that the public can expect that much clearer.
13 **Q.** So although you can't say sitting there that
14 you know of such plans, does your evidence amount to
15 this: such plans will be necessary as part of the
16 rollout of this to make sure that everybody knows what
17 the changes mean for them?
18 **A.** I think you -- yes, I think you would have to
19 look very carefully at the support you give to people if
20 you are going to change what they are expected to do.
21 **Q.** Yes, and from whom should that support come?
22 **A.** Well, it should probably come from the
23 professional regulators themselves. I imagine the PSA
24 would have some -- would want to have some input into
25 that on the basis that they in a sense oversee

1 professional regulators and I think, you know, I imagine
2 the Department would want to know that it was done in
3 a sufficiently consistent and uncomplicated way and that
4 it was useful for both the patients particularly and the
5 professionals and that therefore --we will probably come
6 on to it later -- you know, the likelihood of
7 an effective implementation was maximised at the outset.
8 **Q.** Whilst each of those professional regulators
9 may, and perhaps should, support their own membership in
10 terms of educating the public across the piece, does
11 ultimately responsibility lie with the Department given
12 the Department is bringing about this change?
13 **A.** I don't think it doesn't -- I don't think it
14 lies just with the Department. I mean, you said
15 "ultimately". Because of course the professional
16 regulators are independent organisations that are
17 accountable to Parliament, they aren't directly
18 accountable to us, you know, the GMC, 1861, pre-exists
19 the health service by nearly 100 years.
20 So we always in our work with professional
21 regulators look for them to take the lead so we can
22 maximise the importance of independent, you know,
23 self-regulation.
24 But at the same time, the Department would need to
25 clearly have a role if we are going to be promulgating

1 these changes through a set of new policies.
2 **Q.** Continuing to your paragraph 123, which is
3 just over the page, the duty of candour is one of those
4 improvements in patient safety standards which you
5 identify in a list of a number of such initiatives.
6 In relation to the duty of candour, is the
7 Department aware of the concern which has emerged from
8 some quarters in this Inquiry about the challenge of
9 applying that to circumstances in which a person
10 suspects deliberate harm?
11 **A.** Yes, we are and of course we were asked to do
12 a consultation on our statutory duty of candour by the
13 previous Government and we published the results of that
14 last November under this Government in conjunction with
15 a consultation on manager regulation and that showed
16 that the duty of candour was working in places but was
17 probably somewhat underwhelming in totality. And other
18 people, you know, Lord Darzi said in his report that the
19 NHS still struggles with the duty of candour, Judy Smith
20 in her piece here said the duty of candour had made good
21 progress but there was still more work to do.
22 And I think we would agree, and the Inquiry has
23 probably shown, that there is still more we can do to
24 popularise the duty of candour as it stands in addition
25 to the potential extensions, you know, into management.

1 **Q.** The issue that I would like you to consider
2 though is not just about the visibility and application
3 but whether or not guidance is required to help people
4 in that very particular circumstance of where they
5 suspect deliberate harm and whether the duty of candour
6 does or doesn't apply and if it does, at what point.
7 Because of the peculiarly --
8 **A.** Yes.
9 **Q.** -- and distressing act of telling a family
10 member or perhaps a patient that there is such
11 a suspicion when such a suspicion may be resolved into
12 nothing?
13 **A.** Well, duty of candour does apply but obviously
14 in extreme situations is there a case where you need to
15 give it further bolstering? I mean obviously one of the
16 things we have done and that we have published before
17 Christmas was the memorandum of understanding in
18 relation to the Williams Review about if you feel that
19 you need to go to the police because it's not just
20 a normal duty of candour, I didn't quite explain the
21 thing properly, but it's something more significant,
22 that that memorandum of understanding, one, offers
23 a process to do that; but probably more importantly, and
24 the point that you are getting at, gives people
25 an authority to do that if they feel that they need to

1 do so in particular circumstances.
2 **Q.** Well, we will come back as a separate topic to
3 that.
4 **A.** Yes.
5 **Q.** Remaining with your list. At paragraph 123d,
6 you identify the fact that the first Patient Safety
7 Commissioner was established in 2022. My question about
8 this is, as you acknowledge that role is limited to the
9 safety of medicines and medicinal devices, is there any
10 consideration being given to extending that remit?
11 **A.** Well, it more or less has been extended
12 because the logic of the position and the need for the
13 role to expand has become fairly apparently fairly
14 quickly. It was done for medical and medical devices
15 because we wanted to put it in legislation and the piece
16 of legislation going through was about medical devices
17 so there was a degree of pragmatism in 2020, it was, you
18 know, at the height of Covid and there wasn't that much
19 legislation going through Parliament, but that was to
20 sort of straighten medicines up, having left the EU.
21 And obviously one of the things that Henrietta Hughes
22 has done in her two plus years in the post has been to
23 look at things like redress in the case of sodium
24 valporate and mesh and to make the case for the fact
25 that speaking up is a virtue not just because you should

1 be able to hear what patients have got to say but
2 because what patients have got to say can also
3 contribute to the quality of the health services.
4 And she is the person in a sense on behalf of the
5 Department and NHS England who's taken forward all the
6 work on Martha's Rule which is, as you know, being able
7 to go for not a second opinion but a further doctor
8 review if you see signs of deterioration.
9 So that role has already extended and I think has
10 proved popular with the people who have been able to
11 benefit from it and obviously it amplifies the patient
12 voice and it is a consistent presence that is able to
13 make those points.
14 **Q.** Does anything in your view need to be done to
15 regularise the situation to make clear that the role is
16 more expansive than it was originally specified to be?
17 **A.** I would say no because everybody's fairly
18 aware of the fact, is what I would say.
19 **LADY JUSTICE THIRLWALL:** Does she have more
20 resources as a result of this --
21 **A.** She doesn't have more resources; she has the
22 same resources.
23 **LADY JUSTICE THIRLWALL:** Same resources. Are there
24 any plans to increase those?
25 **A.** There aren't at the moment, no.

1 **LADY JUSTICE THIRLWALL:** So does that mean she is
2 doing more for the same -- with the same resources?
3 **A.** She is doing more and different I would say.
4 **LADY JUSTICE THIRLWALL:** But it is the more that
5 I am particularly interested in.
6 **A.** She is doing as much as she can, that is what
7 I would say.
8 **LADY JUSTICE THIRLWALL:** Yes.
9 **MR DE LA POER:** Now, at your paragraph 124, you
10 deal with the NHS Patient Safety Strategy which you
11 identify as being led by the NHSE.
12 **A.** Yes.
13 **Q.** Could you just briefly give us a summary of
14 what this is as a springboard to just a couple of
15 questions that I am going to ask you about it?
16 **A.** Yes, well, I mean, over and above the
17 initiatives that the Department has taken forward, you
18 know, the science of patient safety and the challenge to
19 reduce avoidable harm is effectively what's encapsulated
20 in the Patient Safety Strategy and in a sense that is
21 why it is a lead of the NHS, not the Department, because
22 it is about the on-the-ground improvements in patient
23 safety and trying to quantify the harms avoided and
24 potentially the resources saved as a result of improved
25 systems and improved awareness and heightened powers of

1 investigation and a greater degree of openness in terms
2 of discussing errors.
3 And obviously the components of the Patient Safety
4 Strategy are effectively safety alerts, a syllabus,
5 safety champions, so some of the infrastructure, and two
6 significant changes that have been going on and are now
7 virtually complete, which is the Learning from Patient
8 Safety Events, which is the replacement for the two
9 systems, NICE and STEIS, that they used to have for
10 collecting patient safety data and that's been taken
11 forward in line with having a more sophisticated way of
12 being able to analyse large amounts of data because you
13 have system learning rather than just having a group of
14 people who are able to analyse a cut of the data which
15 is what you would have done in a sense 15 years ago when
16 this started.
17 And then the Patient Safety Incident Response
18 Framework, I know there is a lot of acronyms here,
19 replaces the Serious Incident Framework which is how do
20 you handle the most serious incidents and gives a degree
21 of flexibility to the people on the frontline to be
22 proportionate in how they respond to those events,
23 number one, and number two puts an onus very much on
24 engaging with patients and involving them and
25 understanding what their concerns are and learning from

1 them in the handling of those events. And it came out
2 in 2019 it replaced a strategy that went back to
3 something like 2012 and going back to my kind of
4 division of labour point, it is the principal tool by
5 which NHS England pursues patient safety on the ground
6 on a day-to-day basis over and above any other
7 initiatives that might be taking place.
8 **Q.** Does the Department have any oversight over
9 the success or otherwise of that programme?
10 **A.** Yes, I mean we sit on the National Patient
11 Safety Committee which is a committee like we have got
12 for all sorts of other things which is where you bring
13 experts together and NHS England and people from the
14 Department and although we haven't had any formal
15 read-out of the progress of this, which really, you
16 know, the old systems were switched off I think last
17 April, so we have only had the new system fully in place
18 for a short period of time, but I was at a presentation
19 before Christmas where it was very, it was very clear to
20 me that the new systems were working and particularly
21 the PSEF was very popular with staff because it allowed
22 them to focus on the things that were most important
23 with a degree of flexibility but the same amount of
24 accountability rather than in the old system where you
25 often had to investigate the same incident multiple

1 times with nugatory amounts of learning.
2 **Q.** In terms of the Learn From Patient Safety
3 Events part of that strategy, and this is a level of
4 detail, albeit an important level of detail, do you know
5 whether or not that integrates seamlessly with the
6 National Neonatal Audit Programme?
7 **A.** I don't know the answer to that. I expect it
8 probably doesn't entirely, and I was aware I have been
9 told that my predecessor here this morning was saying
10 that we have a question to address about how different
11 databases speak to each other. I imagine -- well, LFPSE
12 is going to be oracular of all patient safety incidents
13 and the other programme that you mentioned is probably
14 more specific to a certain number of maternity
15 incidents, but I can't describe the precise
16 interrelationship.
17 **LADY JUSTICE THIRLWALL:** Sorry, Mr De La Poer.
18 Just so you understand, we did have some evidence
19 I think about two weeks ago about the fact that
20 different systems don't speak to each other. I -- I was
21 simply asking whether Professor Spiegelhalter was aware
22 of that and he described it as "very disappointing"
23 which one can understand, so just so you know the
24 context.
25 **A.** Yes. No, I mean it was Marian Knight he was

1 talking about, wasn't he?
2 **LADY JUSTICE THIRLWALL:** That's right, yes.
3 **A.** And MBRRACE and MOSS and how they relate.
4 **LADY JUSTICE THIRLWALL:** Yes.
5 **MR DE LA POER:** I mean, is that a problem that the
6 Department recognises as being a real and pressing one?
7 **A.** Yes, I think the Department recognises that we
8 can always do more to integrate systems and information
9 such that the right information is available but you
10 know the burden is, is, is reduced wherever possible in
11 terms of collection. And obviously, I mean, LFPSE and
12 PSIRF have been examples of trying to have much more
13 systematic arrangements that take advantage of
14 technology rather than the old much more paper-based
15 systems.
16 **Q.** Is there a plan that you are aware of to make
17 sure that all of those legacy systems that are
18 continuing to operate are going to be completely
19 integrated, so in other words --
20 **A.** I don't -- I don't have any knowledge of an
21 overarching plan to do that.
22 **Q.** Well, ought there to be such a plan?
23 **A.** I'm not sure if there ought to be a plan but
24 we could always look more carefully at those issues.
25 **Q.** Doesn't it require quite a systematic approach

1 where you identify every single legacy system, you make
2 an assessment of how well it integrates and then you
3 take software steps to make sure that the two speak to
4 each or --
5 **A.** It would do and that would be something
6 predominantly for NHS England because they are
7 responsible for the digital arrangements in the NHS.
8 **Q.** But from the Department's point of view that
9 is an objective that you would regard as being
10 an important one?
11 **A.** I think it's always an important one. But
12 I don't know of current plans about it, so I can't
13 commit us to any further activity than saying I think
14 it's an important issue.
15 **Q.** And a question for NHS England, you would say?
16 **A.** I think the practicalities would be a question
17 for NHS England. They would probably say there is
18 a question of overall strategy for us as well. So it
19 might go both ways.
20 **Q.** Well, how is this Inquiry to resolve that if
21 each side is or potentially, and I appreciate we aren't
22 heard what NHS England say on this to ensure that what
23 needs to be done is done?
24 **A.** Well, as I have said, it is an important point
25 for consideration, but I can't commit to anything

1 further at this time.
2 **LADY JUSTICE THIRLWALL:** Leaving aside whether you
3 can commit to anything, just so that I am clear, there
4 is at the moment no plan and no intention to seek to
5 integrate systems?
6 **A.** There is no plan that I am aware of.
7 **LADY JUSTICE THIRLWALL:** Well, you would likely
8 know, wouldn't you, if there was one?
9 **A.** Yes.
10 **LADY JUSTICE THIRLWALL:** Yes. And no intention to
11 have such a plan?
12 **A.** I don't know about intention. I only know
13 that I am not aware of a plan at the moment. So I mean,
14 I -- I don't know.
15 **LADY JUSTICE THIRLWALL:** All right. Thank you.
16 **MR DE LA POER:** Martha's Rule is a development
17 which you deal with in your third witness statement,
18 again remaining with my topic 2 of developments at
19 paragraph 11, you touch upon it.
20 Part of this initiative envisages the opportunity
21 for a second opinion for patients --
22 **A.** Yes.
23 **Q.** -- put crudely.
24 Are you aware of any steps being taken by the
25 Department or NHS England to ensure that in the case of

1 paediatrics there are sufficient paediatric staff to be
2 able to operate in that second capacity?
3 **A.** No, I am not aware of anything specifically in
4 relation to Martha's Rule that specifically focuses on
5 paediatric staffing numbers.
6 **Q.** For it to be effective, would you agree there
7 needs to be confidence that there are sufficient staff
8 to perform that secondary function if required?
9 **A.** Yes, I think that would be true for most sets
10 of services. But I think Martha's Rule is about
11 changing attitudes and having a system that enables
12 large, larger numbers of people to come forward and ask
13 for another view if necessary and I certainly know that
14 from the most recent data from the last couple of months
15 there were around about 500, 600 instances where people
16 came forward and about three-quarters of those came from
17 families or advocates or family members.
18 So I think although those numbers in the world
19 picture of the number of patients the NHS sees are
20 small, I think it demonstrates the proof of concept and
21 that there will be some good learning to come from
22 Martha's Rule.
23 **Q.** National Neonatal Safety Champion, are you
24 aware?
25 **A.** Sorry, can you just say that again?

1 **Q.** The National Neonatal Safety Champion?
2 **A.** Yes, yes.
3 **Q.** Part of your preparation included an extract
4 from the RCPCH President's witness statement?
5 **A.** Yes.
6 **Q.** Where she identifies that a National Neonatal
7 Safety Champion is something that both the RCPCH and
8 BAPM, a perinatal charity, or organisation rather, have
9 been calling for. Is the implementation of a National
10 Neonatal Safety Champion something that is in
11 contemplation or development?
12 **A.** My understanding is that advice is going to go
13 to ministers shortly.
14 **Q.** Finally on the topic of changes, although some
15 of these will be matters of detailed questioning in due
16 course. Can you identify any change which is specific
17 in the last decade to changing the culture? So here we
18 are not talking about reports that identify that culture
19 is a problem; we are talking about practical initiatives
20 which are aimed at changing culture?
21 **A.** Well, I think there's a number of initiatives
22 that have had culture as part of what they have tried to
23 achieve. Part of the reason why we introduced the duty
24 of candour was to encourage greater openness, we have
25 talked about that.

1 I think it's working. I think it's fair to say it
2 probably isn't working as quickly as we'd like and that
3 is what -- the gist of other evidence. The reason why
4 we introduced the Health Services Safety Investigation
5 Branch was to try and encourage a culture of openness
6 where people could come forward and speak up about
7 patient safety issues and could do it in the confidence
8 of a safe space and obviously, you know, throughout the
9 work of the CQC since 2014, you know, the question of
10 being safe and responsive and Well-Led has been trying
11 to encourage people to speak up.
12 And obviously in response to the Robert Francis
13 Report in 2015, we introduced the Freedom to Speak Up
14 Guardian and the series of National Guardians which are
15 advisory and facilitation roles across the NHS and in
16 NHS Trusts that try and encourage a culture of speaking
17 up if people otherwise feel nervous and give people
18 advice and try to ensure that the ability to speak up
19 per se doesn't come into conflict with any of the other
20 systems that are, you know, around in the NHS.
21 So we have had -- probably not all of them, but we
22 have had quite a lot of significant and major
23 initiatives and I suppose over and above that, you know,
24 there have been you know regular statements by, you
25 know, successive ministers about the importance of

1 boards operating in an open way and boards that are
2 curious and boards that are -- that listen to patient
3 experience and have both the facts that we were just
4 talking about, PSIRF and LFPSE, and some of the stories
5 at their disposal so that you get open organisations and
6 not closed organisations.
7 **Q.** My third topic, likely to be my most
8 substantial, is memorandum between the police and NHS
9 bodies.
10 **A.** Yes.
11 **Q.** And you deal with this in your second
12 statement --
13 **A.** Yes.
14 **Q.** -- Starting at paragraph 3.
15 **A.** Yes.
16 **Q.** And in providing the context for the
17 development of the first memorandum of understanding, if
18 I can term it that?
19 **A.** Yes.
20 **Q.** You start with the date of 2000 and the expert
21 group chaired by the then chief Medical Officer Sir Liam
22 Donaldson and the report published at that time, the
23 title of which was "An organisation with a memory:
24 Report of an expert group on learning from adverse
25 events in the NHS."

1 **A.** Yes.
2 **Q.** So that's the origin of the first MOU; is that
3 correct?
4 **A.** Yes, that's right. I mean, you know the kind
5 of modern patient safety movement really sort of dates
6 from the turn of the century because we became aware of
7 systems in other organisations, including aviation, that
8 were just, I mean, to cut a long story short, were more
9 systemic about handling and learning from their mistakes
10 and part of their process of doing that was they were
11 more open about them when they happened and I think it's
12 fair to say that wasn't the culture or the system in the
13 NHS.
14 And Liam, when he was the Chief Medical Officer,
15 really spearheaded all of these moves and obviously was
16 encouraged by, you know, some of the hospitals in
17 America that were doing sort of cutting edge work on
18 that. And "An organisation with a memory" was the first
19 time we tried to get to an acknowledgement of how can we
20 better catch both facts, fact and stories and the
21 information about things that had gone wrong to make
22 things go right in the future.
23 And therefore this memorandum of understanding,
24 although it didn't come out until 2006, was in a sense
25 one of the things around about that time that was being

1 produced. The National Patient Safety Agency that I was
2 talking about before dates from about that time.
3 So that was the contextual source.
4 **Q.** So let's bring up that MOU, INQ0014686.
5 If we go to page 2., we can see what is said in the
6 foreword:
7 "As a result, the police and HSE may conduct
8 initial investigations into matters of concern reported
9 to them and the threshold for taking these forward is
10 usually set at a high level."
11 So it's the fourth paragraph.
12 **A.** Yes.
13 **Q.** "This means that such an investigation should
14 take place only when there is clear evidence of a
15 criminal offence having been committed or where a breach
16 of health and safety requirements is the likely cause or
17 significant contributory factor."
18 So that is the foreword. If we then move forward
19 to page 5, please. We can see paragraph 1. Again
20 I will just read it into the record, it's not a document
21 the Inquiry has looked at in any detail before:
22 "NHS patient safety incidents involving unexpected
23 deaths or serious untoward harm and requiring
24 investigation by the police and/or the HSE are rare.
25 However, there has been an increase in the number

1 reported in the past few years. Such incidents must be
2 handled correctly both for the sake of the public's
3 safety as well as confidence in the NHS, police and HSE
4 and in the interests of fairness and justice."
5 So that is the start of the introduction.
6 If we look to paragraph 2, we can see that the
7 first in the list of things that is are said to be
8 important and need to be ensured is public and patient
9 safety is assured. Again you will forgive me,
10 Mr Vineall, if I just identify each of these before we
11 come to a question.
12 **A.** Yes.
13 **Q.** Page 6, paragraph 3, we can see that:
14 "To achieve these objectives it's important the
15 three organisations communicate and work with one
16 another in a consistent and well-coordinated manner.
17 This will include informed decision-making about those
18 incidents that require investigation by the police
19 and/or HSE, appropriate discussion and continued
20 attention to the matter of safety. Sharing information
21 and timely discussion are essential ingredients for such
22 outcome. Both need to be conducted in a way that do not
23 impede the statutory responsibilities and duties of the
24 three organisations or the Coroner or jeopardise any
25 legal proceedings."

1 And I'd just simply bookmark for the time being
2 what's said there about sharing information and timely
3 discussions are essential ingredients according to this
4 MOU.
5 If we then move forward to page 7 of the document,
6 we can see that guidelines are referred to. Pausing
7 there for a moment, Mr Vineall, you can confirm that
8 accompanying this document was a set of guidelines and
9 we are going to have a look at that in just a moment?
10 **A.** Yes.
11 **Q.** We won't come to it just yet, but that's again
12 just a call forward to a document we are going to look
13 at in a moment.
14 If we then move forward to page 11, please. We can
15 see "Patient safety incidents that may involve the
16 police or the police and HSE" is the heading.
17 About a quarter of the way down at 2.7:
18 "The types of patient safety incident that may
19 prompt an NHS Trust to involve the police are those that
20 display one or more of the following characteristics:
21 evidence or suspicion that the actions leading to harm
22 were intended, evidence or suspicion that adverse
23 consequences were intended, evidence or suspicion of
24 gross negligence and/or recklessness in a serious safety
25 incident including as a result of failure to follow safe

1 practice or procedural protocols."
2 So I have read the whole paragraph including all
3 three bullet points. But the language, would you agree,
4 in this document is talking about evidence or suspicion
5 as being a threshold for the involvement of the police?
6 **A.** Yes.
7 **Q.** Then if we move forward please to page 19, we
8 can see -- and we don't need to read all of this -- but
9 there are a number of paragraphs devoted to the
10 importance of securing and preserving evidence which, as
11 a matter of common sense, would you agree, ties back to
12 the importance of timely contact and communication as
13 one of the consequences of such timely contact is
14 evidence can be secured and preserved?
15 **A.** Yes.
16 **Q.** So that's the MOU as at 2006. Let's turn now
17 to the guidelines which I think were published some
18 months later in November 2006.
19 **A.** Yes.
20 **Q.** These are at INQ0107019 and we see that it's
21 expressed as being in support of the document that we
22 have just had a look at.
23 Now, this is just a Department of Health, as it was
24 then, document. So whereas the other was an agreement
25 between a number of organisations this is in effect

1 internal guidance to the NHS?
2 **A.** Yes, it's the handbook.
3 **Q.** For how, the how?
4 **A.** Yes.
5 **Q.** So look at page 4, please. We can see that
6 the aim is stated there; that this is:
7 "... to provide practical advice to NHS
8 organisations about what to do when faced with a patient
9 safety incident or incidents that may require
10 investigation by the police or HSE.
11 And again that just to note that theme of
12 preserving and safeguarding evidence is one in the list
13 which falls beneath that.
14 If we move forward please to page 8 of the
15 document. We will see at paragraph 17 at the bottom
16 under the heading, "Making a referral to the police
17 and/or HSE: "
18 "There will be occasions when the NHS will need to
19 refer matters to the police. NHS organisations may need
20 to consider whether a safety incident should be reported
21 to the police and/or HSE. In these circumstances it is
22 best practice to make early contact with the police
23 and/or HSE to discuss concerns and to take their advice
24 on further [if we just go over the page, thank you]
25 action. The NHS organisations risk management or

1 equivalent person with risk management responsibility
2 with the agreement of the Chief Executive or
3 nominated representative should take responsibility for
4 ensuring that this advice is sought and, if necessary,
5 a referral made."
6 So again just pausing to note what people are being
7 told in a practical sense: that effectively, do you
8 agree, what this paragraph is saying is if you are not
9 sure speak to the police to take advice before you
10 formally refer anything?
11 **A.** Yes.
12 **Q.** Again, would you agree that that serves the
13 objective that we have already looked at of ensuring
14 that evidence is preserved and that the contact is
15 timely?
16 **A.** Yes. If in doubt speak to the police and if
17 you do so, hold on to any relevant evidence.
18 **Q.** Exactly. Finally, paragraph 18 in terms of
19 the text of the guidance and then we will look at two
20 case studies:
21 "It is impossible to present a comprehensive list
22 of examples that may prompt an NHS organisation to
23 consider a referral. Most incidents are investigated by
24 the NHS. Therefore, circumstances should be
25 sufficiently serious and criminal intent suspected to

1 warrant a police investigation. This decision should be
2 taken by an appropriately senior person preferably at
3 Executive level in the organisation."
4 So again we see that the threshold, as expressed in
5 this practical guidance, is seriousness and suspected
6 criminal intent?
7 **A.** Yes.
8 **Q.** Now let's just see how that is expressed in
9 example terms. So we go to page 10, please. We have
10 the first of a number of case studies and we are going
11 to look at number 1 and number 2. Now, I will just
12 pause to leave this on the screen. I am not going to
13 read it out.
14 But, in summary, if we go over the page to page 11,
15 thank you very much indeed, we can see that there was
16 a concern in this example about equipment and, in
17 particular using the language of the example we see at
18 the top of the box, in the lower half of the screen, the
19 second sentence:
20 "It was unusual for suction units to be out of
21 order so the possibility that someone had tampered with
22 them was considered. The ward manager contacted the
23 senior manager and risk manager. After discussion with
24 the Clinical Director they called the police."
25 So in this example, there is a suspicion based on

1 a possibility, effectively of an unusual event in the
2 context of a serious outcome that led to internal
3 discussion and the police were contacted.
4 So that's example 1. Do you agree that is a fair
5 summary of the substance of it?
6 **A.** Yes.
7 **Q.** If we look at example 2, which is on page 15,
8 we can see here, thank you very much indeed, the concern
9 here is following a patient being found deceased and
10 a syringe attached to his intravenous line, that
11 although there was a history of taking overdoses given
12 that it was considered by the staff as a scene
13 effectively, following discussion, the Trust board lead
14 for patient safety and the crash team contacted the
15 police, and police then came in and the incident was
16 resolved. As we can see in the bottom box, "Police
17 decided no foul play".
18 But again on the incident we have here an unusual
19 event, albeit that there was a context that might
20 explain it, a concern, the police were brought in?
21 **A.** Yes.
22 **Q.** Again, fair summary?
23 **A.** Yes. But not -- not with a role for the
24 equipment like the first example.
25 **Q.** I beg your pardon?

1 **A.** But not with a role for the equipment like the
2 first example.
3 **Q.** No. The final case study for us to look at is
4 on page 24. Again just to highlight this. This is
5 a different sort of circumstance. This is a concern
6 about a patient who wasn't responding correctly.
7 We can see that there was some investigation into
8 equipment and there was discovered to be a particular
9 problem with the equipment that, as a result of that,
10 the Coroner was notified and in fact in the example the
11 Coroner reported it to the police because of the
12 similarity between that and other cases. So not a case
13 in which the police were directly contacted but a case
14 in which similarity identified by the Coroner resulted
15 in the police being called?
16 **A.** (Nods)
17 **Q.** So those are the matters that I would like to
18 look at in this document.
19 If we just return to what you say about how the
20 roll-out of this occurred and you deal with that in
21 paragraph 10 of your second statement. Thank you very
22 much indeed, we can take that document down.
23 You tell us that it was launched with a training
24 programme which was delivered at a regional level and
25 which was about encouraging good relationships between

1 police and their NHS Trusts; is that right?
2 **A.** Yes.
3 **Q.** Then as we move forward in time, what you say
4 in your witness statement is that there came a point
5 when it was archived. I mean, do you know, sitting
6 there, exactly why it was archived?
7 **A.** No, I don't sitting here know exactly why it
8 was archived. I don't know that. My more than
9 speculation but less than absolute certainty is that
10 there were a lot of documents where the organisations
11 that they were addressed to ceased to exist when we had
12 the 2012 changes because it was a wholesale change and
13 that some documents, as we have said here, therefore got
14 archived and the archiving, you know -- there is no
15 evidence that there was a positive decision, that's what
16 we say at the top of paragraph 12, to do the archiving.
17 So it may be that it was an oversight because
18 people thought given that we don't have PCTs and
19 Strategic Health Authorities and all the other things
20 that it had been addressed to, that it was archived as
21 a result.
22 **Q.** And does that mean that it meant that as far
23 as the people on the frontline and their managers were
24 concerned, that when we reach 2016 and clinicians within
25 the Countess of Chester are raising with senior managers

1 about needing to contact the police, that as at that
2 point in time there wasn't in fact any guidance for them
3 to turn to?
4 **A.** I think that's right. I mean there is no --
5 it's clear that some people were still using the
6 document, so it was existing in places in the NHS. But
7 the fact that it had been archived meant it wasn't
8 a live document at the time because of the decision that
9 had been made to archive it and therefore the Williams
10 recommendation to reintroduce it.
11 **Q.** And having reviewed it together there, do you
12 agree that had it been a live document or there been an
13 equivalent in similar terms, that would have been
14 a useful thing for people in the position of those in
15 the Countess of Chester?
16 **A.** I think it would have been useful. I don't
17 think it's the only thing you needed.
18 People have the ability, if they think there is
19 a significant problem, to go to the police and as you
20 know the ex-policeman Mr Wenham said, you know, in
21 evidence here, you know, people can pick up the phone
22 and go to the police.
23 So whilst I agree with you that there wasn't an MOU
24 that people could immediately turn to, I don't think
25 that stopped people approaching the police in the normal

1 course of events.
2 **Q.** Well, whilst of course they can do that, where
3 as may be found to be the case there is a dispute
4 between people within the hospital about whether the
5 threshold had been reached, having something in writing
6 that has come from the Department or from NHS England
7 saying in terms: This is an example of where calling
8 the police is perfectly acceptable, this is where you
9 have a suspicion or evidence, contact the police
10 early ... Those are just the sort of documents that
11 will be useful in breaking such a deadlock because each
12 party can look at them and those in favour can say:
13 Look at this. We ought to do this?
14 **A.** Yes, I think they certainly contribute to
15 breaking what you describe as a deadlock. I also think
16 that they're useful because they give people authority
17 to act.
18 But I do want to reiterate that I don't think they
19 stop people from going to the police anyway and I think
20 our expectation of a decently operating organisation was
21 if they had a significant doubt about whether or not to
22 go to the police then they should go to the police.
23 **MR DE LA POER:** Well, we will fill in the history
24 and then bring ourselves right up to date but perhaps,
25 my Lady, after the lunch break.

1 **LADY JUSTICE THIRLWALL:** Very good. So we will
2 adjourn now and start again at 2 o'clock.
3 **(1.02 pm)**
4 **(The luncheon adjournment)**
5 (2.00 pm)
6 **LADY JUSTICE THIRLWALL:** Yes.
7 **MR DE LA POER:** Mr Vineall, we have moved to the
8 point in our chronology in relation to this MOU to 2018.
9 **A.** Yes.
10 **Q.** When Professor Sir Norman Williams reported
11 under the heading "gross Negligence Manslaughter in
12 healthcare" and I will ask for that document to come up
13 on your screen, INQ0002383. You see it's dated
14 June 2018 and if we move forward, please, to page 25,
15 our focus will be on paragraph 9.13 initially. So there
16 we see what Professor Williams says is the principles of
17 this MOU, referring to the document in the preceding
18 paragraph, which is the one that has been archived, and
19 the relationship that is set out between police
20 investigations and local safety investigations is as
21 relevant today it was in 2006. However, the MOU has not
22 been renewed since the demise of ACPO in 2015. The
23 panel believes that a similar MOU should be developed to
24 set out the respective roles of the police, CPS, HSE and
25 health service bodies such as the CQC and HSSIB, as they

1 were, and healthcare professional regulators in
2 investigating unexpected deaths in the healthcare
3 setting in order to ensure that patient safety lessons
4 can be understood and acted upon.
5 If we then go over the page, we see the third
6 bullet point that a new memorandum is one of
7 Professor Williams' recommendations.
8 So that is June of 2018, so thank you, we can take
9 that down. Now, Professor Williams' work was something
10 that was mentioned in your first witness statement.
11 Paragraph 105 -- forgive me, page 105 you will need to
12 turn to.
13 **A.** Yes.
14 **Q.** And we will see it appears on the preceding
15 page under "Update on key recommendations" and what you
16 say in this statement which was dated in the spring of
17 last year --
18 **A.** Which page am I on, or paragraph?
19 **Q.** Page 105. The paragraph is paragraph 24d, it
20 is the final --
21 **A.** Yes, got you.
22 **Q.** -- subparagraph on page 105?
23 **A.** Yes.
24 **Q.** What you say is:
25 "Arrangements between the NHS, police and CPS when

1 there is an investigation: following the Williams review
2 a new MOU is being developed to replace the 2006
3 protocol."
4 So that's the only mention of it in your first
5 statement, namely that work is in train.
6 So turning then to some questions about this. Why,
7 given that the recommendation was in June of 2018, was
8 there no new protocol at the time that you were giving
9 your statement in early 2024?
10 **A.** Well, the simple answer is it hadn't been
11 finished and the more longer considered answer is that
12 we could and should have done it sooner. We did have
13 Covid and it did prove more complex to agree than
14 I think anybody had expected at the outset.
15 But it wasn't ready at that time and it was still
16 in train in April and it was being developed.
17 **Q.** So just help us to understand that a bit
18 further. Do you know when after Professor Williams'
19 report somebody first sat down and began to work on
20 this, was it immediately or was it not until 2024?
21 **A.** No, I couldn't tell you when but I am pretty
22 sure that some work started before Covid, not in a huge
23 amount of detail but there were some, some startings and
24 then it stopped and then it picked up in earnest
25 afterwards.

1 **Q.** And the highly publicised circumstances around
2 Letby's trial, it would appear, were insufficient by way
3 of catalyst to finish that?
4 **A.** I wouldn't say they were insufficient catalyst
5 to finish it, I would say that work was ongoing and it
6 was finished in an expeditious way but as I said at the
7 start, it took some time.
8 **Q.** So in an expeditious way?
9 **A.** Yes.
10 **Q.** Why do you say it was finished in an
11 expeditious way?
12 **A.** Because we did it as quickly as we could
13 recognising that we had had Covid and we had the
14 complexity and then we tried to get it completed and we
15 did get it completed, you know, at the end of last year.
16 **Q.** So when was the -- well, help us just to
17 understand the process, given that you say it was done
18 as expeditiously, was it written by somebody within the
19 Department and then sent out to individual signatories
20 for their comments?
21 **A.** That happened on a number of different
22 occasions because there was a lot of toing and froing
23 between the various parties is my understanding. It was
24 a document that the Department finally produced but
25 there was a committee. It took some time in the way of

1 these things to get responses from some people to what
2 were complicated issues and to pull everything together.
3 And, and it was completed, as I say, at the end of
4 last year and then published quickly.
5 **Q.** 17 December of last year?
6 **A.** That's right.
7 **Q.** So approximately 20 days before you came to
8 give your evidence?
9 **A.** Yes, yes.
10 **Q.** And we are going to have a look at that
11 document now, as you say, it deals with some complicated
12 issues but it isn't a very long document, is it?
13 **A.** No.
14 **Q.** And I would just like for us to bear in mind
15 what you say about expeditious as we consider it,
16 INQ0108740. So it appears in this way because it's
17 a document available online, isn't it?
18 **A.** That's right.
19 **Q.** I am sure there is a pdf version of it but
20 this is effectively extracted from the online version
21 which is why it appears to read as a webpage. We can
22 see the date of publication. And just speaking in
23 general terms, it is very similar in a number of
24 respects to the 2006 MOI; is that right?
25 **A.** Yes, it is.

1 **Q.** Would you say that it contains any major
2 innovation or improvement over that 2006 MOU?
3 **A.** I'm not sure it contains particular
4 innovations. I think it's an improvement because it is
5 up to date on the side of the NHS in particular with the
6 different structures. The one in 2006 had heavy
7 reference to the Health and Safety Executive who in
8 a sense were a sort of backstop function for
9 investigations into matters in the NHS at the time
10 whereas when we get to 2024 we have got CQC and HSSIB
11 and other organisations, so I think there are some
12 pretty significant changes to the infrastructure that
13 needed to be reflected in what we said.
14 I think some of the language about learning and
15 speaking up is obviously with the benefit of the
16 knowledge of the intervening 18 years. But I mean the
17 original recommendation of, of the Williams Review was
18 to I don't know if they use the word "replace", but was
19 effectively to replace and update what had preceded.
20 So I think it's fair to say that the structure and
21 the purpose aren't vastly different. But I think
22 there's a reasonable amount of the detail that means it
23 is a considerably more useful document in terms of the
24 advice and the facts and the structure that it explains
25 than if we had still had the 2006 version.

1 **Q.** So let's move forward to page 6 and we can see
2 there that at paragraph 2.3 the recommendations of
3 Professor Sir Norman Williams are set out as being
4 effectively the history of this document, so recorded
5 there.
6 Is there any reason why the fact that there was
7 effectively no MOU for a period of time not recorded
8 here because I just invite you to consider this and
9 comment on it, an uninformed reader may think reading
10 that that there was an MOU in 2006 that that subsisted,
11 Professor Williams made the recommendation that he did
12 and the new MOU came out and not included within that
13 history is the fact that there was a period of time when
14 there was no MOU?
15 **A.** Well, I don't think that's a deliberate
16 exclusion and obviously if you read the Williams Review
17 it's very clear that there hadn't been anything since
18 the archiving in 2015.
19 **Q.** So let's turn to the substance of what this
20 says. Can we move forward please, to page 7. We can
21 see at the bottom section 4:
22 "When the MOU applies.
23 "The MOU applies when more than one of the
24 signatories needs to investigate in parallel any
25 incident where there is reasonable suspicion that

1 a criminal offence has or may have been committed by an
2 individual providing healthcare services in a health or
3 care setting that leads to or significantly contributes
4 to the death or serious life-changing harm of a patient
5 or service user."
6 So just to flag at this stage one particular phrase
7 that we are going to come back to. If we go to the
8 preceding page just to look at it, you will see that the
9 phrase "reasonable suspicion" is used as being a trigger
10 for when the circumstances apply or when the MOU
11 applies. So let's just have a look and see paragraph
12 4.5, which is back on the next page.
13 Here would you agree that this is addressed to the
14 NHS organisation and its state of mind?
15 **A.** Yes.
16 **Q.** "It may not be immediately clear following the
17 incidents that a criminal offence may have been
18 committed. The types of incidents that may prompt an
19 NHS organisation to involve the police are those that
20 display one or more the following characteristics:
21 reasonable suspicion that the actions leading to harm
22 were intended to cause harm or reasonable suspicion of
23 gross negligence and/or recklessness."
24 So do you agree we again see that threshold state
25 of mind as being reasonable suspicion?

1 **A.** Yes and it's, it's a prompt for people in
2 those circumstances to be curious.
3 **Q.** So just focusing on the language of
4 paragraph 4.5, that what it's saying is if an incident
5 occurs where you have a reasonable suspicion that the
6 actions leading to harm were intended to cause harm, you
7 might call the police?
8 **A.** (Nods)
9 **Q.** So let's go and have a look at the definition
10 as given by this document of what "reasonable suspicion"
11 means and that's on page 23.
12 "A person is taken to have a clear and reasonable
13 suspicion in this context if they have clear, objective,
14 specific facts, observations or evidence that justify
15 that suspicion. The grounds for suspicion are taken to
16 be objective if a reasonable person given the same
17 information would form the same suspicion."
18 So my question which I will then follow up
19 dependent on your answer is: doesn't that set the bar
20 too high for contacting the police?
21 **A.** No, I don't think it sets it too high.
22 **Q.** So let's look at it from a different
23 perspective. Reasonable grounds to suspect, which means
24 the same thing, is a statutory threshold test for
25 particular actions within a police investigation which

1 interfere with an individual's rights and that's a lot
2 of legal verbiage to say: one needs reasonable grounds
3 to suspect if one is a police officer before you can
4 arrest someone, so in other words it is a state of mind
5 within a developing investigation.
6 It is not the state of mind that necessarily
7 a police investigation starts with?
8 **A.** (Nods)
9 **Q.** And the police investigations can just start
10 with suspicion.
11 So that is the first point as to why the threshold
12 may have been set too high, because effectively the
13 language is adopting an important legal threshold when
14 you are interfering with the rights of a citizen, not
15 the test for whether the police are going to open
16 an investigation which is a lesser state of mind, or can
17 be.
18 So that's the first thing. Do you have any comment
19 about that and whether you agree or disagree with the
20 analysis that I have just presented you with?
21 **A.** Well, I don't have any comment because
22 I wasn't aware of the difference.
23 **Q.** All right.
24 Secondly, if we look at the language here, we know
25 from the facts of the Countess of Chester that there was

1 a disagreement between some senior managers and some
2 paediatricians about whether the threshold had been met
3 to contact the police and you will have heard phrases
4 like "gut feeling" no doubt permeating.
5 But what witnesses have agreed was in fact being
6 said is the clinicians exercising their expert judgment
7 were saying: these were deaths which I would not have
8 expected and I have a good gauge on when to expect
9 a death. We have investigated all of the ordinary
10 explanations which may go to quality of care and
11 excluded them, and we are left with an explanation that
12 is supported by the fact that such a person would have
13 been able to do it in the sense that they had access.
14 And a number of members of staff and one in
15 particular, Sue Hodkinson, talked about that wasn't
16 evidence. Nowhere within this definition are you
17 accommodating the expert opinion of a clinician, are
18 you?
19 **A.** Well, I think we are because I think
20 a reasonable suspicion can be brought forward by the
21 expert view of a clinician.
22 **Q.** Well --
23 **A.** And if you look at the context here about
24 clear objective, specific facts, observations or
25 evidence, the doctors in particular had quite a lot of

1 objective and specific facts that they utilised to make
2 their case and indeed there were also a set of
3 observations which just weren't made by the doctors but
4 by the nurses too that one person was on the ward at the
5 time of all of the deaths.
6 So there was quite a lot of evidence that to my
7 mind would -- would fit with making a case for
8 reasonable suspicion.
9 **Q.** Well, firstly you say that they had facts.
10 I think the main fact they had was the fact that
11 Letby was present, that was a fact.
12 **A.** Yes.
13 **Q.** The rest was opinion which --
14 **A.** Well --
15 **Q.** -- or certainly in large part was opinion
16 which does not appear. If one looks at the list here
17 "clear objective specific facts, observations or
18 evidence", we don't seem to see that language included?
19 **A.** Well, I think an opinion can be an observation
20 and an opinion can be taken as evidence if it's
21 justifiable so I don't think opinions are entirely
22 excluded, particularly from observations.
23 **Q.** So you think that that adequately
24 accommodates?
25 **A.** I think it can do, yes.

1 **Q.** Because obviously one of the big concerns of
2 this Inquiry is whether or not current systems would
3 provide the adequate protection if they were applied to
4 those past circumstances and a pretty good rule of thumb
5 is if they wouldn't, then they are inadequate?
6 **A.** Mm-hm.
7 **Q.** We can see here:
8 "The grounds for suspicion are taken to be
9 objective if a reasonable person given the same
10 information would form the same suspicion."
11 Again, if we just test that by reference to the
12 facts that we have.
13 If you had a non-clinical person as a director who
14 is effectively the gatekeeper, they may consider
15 themselves a reasonable person but they aren't going to
16 be able to understand it in the way that the clinicians
17 will understand it from their expert point of view.
18 Doesn't this give rise to the risk that an Executive
19 Director will say: well, I am a reasonable person,
20 I don't have a suspicion, therefore, there is no
21 reasonable suspicion?
22 **A.** Well, I don't think an Executive Director
23 would have a particularly greater hierarchy in the
24 groups of people who can have -- who are reasonable
25 people or have grounds for suspicion. And I mean in

1 this case, there were quite a few different people who,
2 you know, looked at the rota and things like that and
3 came to the conclusion that -- that that was a fact that
4 was worth investigating.
5 So inevitably you are sometimes going to have
6 discussions between different reasonable people but
7 I don't think that scenario that you have described is
8 automatically the case. And I don't think this would
9 stop people going forward with their concerns.
10 I also think the fact -- I mean, as you said
11 yourself earlier that there is, that this MOU now exists
12 again is a way of giving credibility and support to
13 people who feel that they need to go and test out their
14 reasonable suspicions.
15 **Q.** But isn't it capable, given that we know that
16 there was resistance from the top of the hospital to
17 contacting the police, isn't it capable of having the
18 very opposite effect that a board or a Chief Executive
19 who is resistant will say: I don't think your suspicion
20 is reasonable, I'm not reporting this.
21 And that by importing this term of "reasonable"
22 rather than setting it at the threshold which is capable
23 of starting any police investigation, that you are in
24 fact creating a barrier rather than a pathway?
25 **A.** No, I don't accept that this is creating

1 a barrier rather than a pathway and I come back to what
2 I said earlier, that it is obviously the expectation
3 that people on a board, and indeed people who are
4 serving on a board, would have a sensible overview of
5 the range of events going on in their organisation and
6 would understand where, you know, a clearly unusual set
7 of events like the ones we are talking about would be
8 grounds for further examination and I think that would
9 generate reasonable suspicion in people's minds so
10 I'm afraid I don't think it is a barrier.
11 **Q.** But we know on our facts that people were
12 resistant to calling the police?
13 **A.** People were resistant to calling the police
14 but you are asking me if this MOU would make it easier
15 for people to call the police and I am saying I think it
16 would. The fact that people didn't, they didn't for all
17 the reasons that you have been through over the last
18 couple of months, and indeed as you said earlier the
19 fact that they didn't is partly as a result of the fact
20 -- well, not partly as a result of the fact, may have
21 been aided and abetted by the fact at that time we
22 didn't have a memorandum of understanding.
23 **Q.** So let's just test this against the examples
24 given in the previous guidelines. We know that we had
25 a situation where there was a concern that there was

1 a possibility of harm either by way of deliberate harm
2 either way of tampering with a machine that didn't
3 ordinarily -- wasn't ordinarily defective or because
4 a patient was dead and a syringe was inserted into the
5 line, would you regard both of those examples as passing
6 this test?
7 **A.** Yes, I would. I mean, they are slightly more,
8 I mean when you were reading them out earlier they are
9 slightly more conventional patient safety incidents
10 whereas this is something that is more in the realm of
11 more extremely unusual, certainly in the context of the
12 health service.
13 **Q.** Well, they were resolved as patient safety
14 incidents as a result of the involvement of the police
15 and the investigation at the time?
16 **A.** Yes.
17 **Q.** Those at the coalface simply know this is
18 unusual, I think that harm is a possibility, deliberate
19 harm is a possibly, that is why I think the police
20 should be involved and I am just wondering whether you
21 think looking at that test that those which were
22 previously examples of good practice would in fact pass
23 the new threshold?
24 **A.** Yes, I think they would pass the new
25 threshold. I mean, I just -- I do.

1 **Q.** Do you think there's a problem with this MOU
2 in terms of the fact that it is trying to deal with, as
3 we saw earlier, two very different challenges for the
4 NHS, namely on the one hand gross negligence
5 manslaughter, which is extremely legally complex?
6 **A.** Yes.
7 **Q.** And on the other hand, potential deliberate
8 harm, which might be said to be extremely emotionally
9 complicated because it involves an allegation against
10 a member of staff and that is bound to provoke
11 reactions?
12 **A.** Well, I think it can deal with both of them.
13 I don't see a reason why it can't deal with both of them
14 and obviously the memorandum was agreed in conjunction
15 with all the relevant organisations, including, you
16 know, the police and the HSE and all the professional
17 regulators and they came to a conclusion that this was
18 a suitable document to meet that Inquiry recommendation.
19 **Q.** Do you know where the origin of the word
20 "reasonable" -- which in the previous guidance it was
21 simply "suspicion", where the word "reasonable" has come
22 from and what it is intended to add?
23 **A.** I don't -- I don't know that. I don't know
24 that.
25 **Q.** Do you think there is merit in you, bearing in

1 mind you told us a moment ago that you didn't perceive
2 a difference between "reasonable suspicion" and
3 "suspicion" and I have drawn to your attention the way
4 that lawyers use it, that that's worth having another
5 look at?
6 **A.** Well, I mean, we are due to -- we have only
7 just sent the guidance out and we are due to see how
8 it's going in some months time so I am sure we can take
9 cognisance of what you have suggested.
10 **Q.** What was their legal input into the language
11 there of "reasonable suspicion"?
12 **A.** Yes, there was. Because I mean, we had --
13 I don't know the details but we had lawyers, you know,
14 involved in the capturing of this thing it wasn't just
15 written off its own back and obviously it had to be
16 agreed pretty carefully with a range of organisations,
17 much larger range of organisations than in 2006.
18 **Q.** And if we look at page 24, we will see that in
19 fact that appears to be a copy and paste from a legal
20 dictionary rather than an independent bespoke
21 definition?
22 **A.** (Nods)
23 **Q.** But quite aside from whoever was responsible
24 for that, there were lawyers having input into this --
25 **A.** Yes. My understanding is there were lawyers

1 having input into it because we wouldn't have written
2 a document like that without ensuring it was legally
3 assured.
4 **Q.** Now, one of the things that this document
5 doesn't contain which the previous documents did, and in
6 particular the guidelines, was the idea that if in
7 doubt, as you characterised it, make an informal
8 approach to the police to find out what they think. Is
9 there any good reason why that sentiment is not included
10 in this document?
11 **A.** No, I just think it was focusing on the -- on
12 the details of the issue but I think it's, it's clear
13 and I don't think it would have taken this piece of
14 guidance to make the point that if people are in doubt
15 at a local level and they see something serious that
16 they think may be the result of malevolent behaviour
17 that they are able to call the police. I mean, that is
18 a I think it's fair to say a common sense expectation
19 that we would all have of most institutions.
20 **LADY JUSTICE THIRLWALL:** Do you think -- sorry,
21 Mr De La Poer, that is very neatly encapsulated if I may
22 say so. Is there any reason why we ought to look at
23 whether a really clear statement of what you should do
24 in that situation couldn't be put on one page?
25 **A.** Well, we can take that away and give it

1 consideration.
2 **LADY JUSTICE THIRLWALL:** But is it something you
3 think that's of value?
4 **A.** Well, it may be, I think there would be quite
5 a lot of difficulty in trying to replace something that
6 we have only just put out and pulled together. I am not
7 saying that bureaucratically but just because it would
8 I think potentially reduce the impact but I think
9 something I think we are going to have a look at how
10 this is going after a year, it's just been promulgated
11 through various bodies and is still being discussed at
12 events and whether in the light of that period it
13 appears there is something that you are suggesting that
14 would improve and build on what we have got, then
15 obviously we stay open-minded about that.
16 **LADY JUSTICE THIRLWALL:** May I just ask one other
17 question, Mr De La Poer, which I should have noticed
18 before now but if we look at 0007, chapter 4, when the
19 MOU applies. And I must say I hadn't picked this up but
20 it applies when:
21 "... more than one of the signatories needs to
22 investigate in parallel any incident."
23 I just wonder what's that getting at? So it
24 applies when more than one of the signatories.
25 **A.** I think it's getting at the fact that if one

1 of the organisations raises the issue and another one
2 responds in, in kind, then that's a way to take things
3 forward and that is often between, you know, the
4 healthcare provider and the police.
5 **LADY JUSTICE THIRLWALL:** And the police.
6 **A.** Yes.
7 **LADY JUSTICE THIRLWALL:** Yes, so it presupposes an
8 earlier stage, doesn't it?
9 **A.** Yes, that you have established a set of facts
10 that you think are credible.
11 **LADY JUSTICE THIRLWALL:** There must be something
12 that's taken you to the police in the first place or to
13 somebody else, a regulator?
14 **A.** Yes, yes.
15 **LADY JUSTICE THIRLWALL:** Thank you. I hadn't
16 noticed that earlier but I think it's probably
17 important.
18 **A.** I think the presupposition that you say is
19 a working assumption that this MOU is here if you have
20 originally found to have, let's call it a problem, in
21 your local workplace and you feel that you have got to
22 take it to the next stage and therefore this MOU gives
23 you a guide for how to achieve that.
24 **LADY JUSTICE THIRLWALL:** Once you have taken it to
25 another body?

1 **A.** Yes.
2 **LADY JUSTICE THIRLWALL:** One of the other
3 signatories, then it applies.
4 **A.** Yes, yes.
5 **LADY JUSTICE THIRLWALL:** Yes, all right, thank you.
6 **MR DE LA POER:** Although, if I may, my Lady if we
7 look at 4.5 --
8 **LADY JUSTICE THIRLWALL:** Yes.
9 **MR DE LA POER:** -- that is talking about the prior
10 stage because that is talking about when the NHS
11 organisation which is operating on its own may reach out
12 to the police.
13 **LADY JUSTICE THIRLWALL:** Yes.
14 **MR DE LA POER:** So the trigger for taking it to
15 that joint investigation stage still, would you agree,
16 appears to pass through the threshold of reasonable
17 suspicion?
18 **A.** Yes, I don't think -- I wasn't arguing against
19 the point of reasonable suspicion. I was just sort of
20 expanding on the process point.
21 **Q.** Is it a concern for the Department that cases
22 which ought to be the subject of a police investigation
23 get there as quickly as possible?
24 **A.** Yes, I mean, obviously.
25 **Q.** Well, you say it's obvious. But if we were to

1 look back at the opening statement made on behalf of the
2 Department, there isn't in fact any mention of
3 contacting the police in that. When serious concerns
4 develop about an individual the opening talks about the
5 importance of going to the NMC. I am just wondering
6 whether that was deliberate, an oversight or just not
7 thought to be a necessary point for the Department to
8 make?
9 **A.** I think probably the last.
10 **Q.** So I am going to turn to my topic 4, please.
11 So we can take that down. The timing of implementation
12 of the Medical Examiner system.
13 **A.** Yes.
14 **Q.** Here we note that that system was introduced
15 on a national basis on 9 September of last year; is that
16 right?
17 **A.** That's right.
18 **Q.** That there had been an ongoing serious of
19 pilots since about 2019; is that right?
20 **A.** Yes, there had been a basically national
21 non-statutory scheme since 2019 and there had been pilot
22 schemes running since 2005/6/7 in a much smaller number
23 of places across the country, single figures.
24 **Q.** And that announcement was made just two days
25 before this Inquiry opened its oral evidence hearing; is

1 that right?
2 **A.** Yes, I mean, the date of the implementation
3 had been announced in April.
4 **Q.** As the 9 September?
5 **A.** As 9 September. And was actually was
6 announced in a written ministerial statement in April
7 and reannounced because obviously we had to go to the
8 new Government to get approval for, you know, proceeding
9 with the policy, at the end of July.
10 **Q.** And bearing in mind that by April the Inquiry
11 was established --
12 **A.** Yes.
13 **Q.** -- what reassurance, if any, can you give as
14 to whether or not that scheme was rolled out nationally
15 as a result of this Inquiry?
16 **A.** No, it wasn't rolled out nationally as
17 a result of this Inquiry. Medical Examiners is a long
18 story but to answer your specific question, we got to
19 a position in 2018 after various twists and turns, which
20 I can go into if you want, where there was a decision
21 that Medical Examiners should operate through the NHS.
22 It was a consultation in 2016 in response to the
23 consultation in 2018 that said Medical Examiners should
24 be in the NHS.
25 The legislation didn't allow for that at the time

1 because in 2012 the legislation had transferred Medical
2 Examiners from an NHS function to local government and
3 in the intervening period, you know, the Department and
4 the Government had come round to the fact it was better
5 in the NHS.
6 We didn't immediately have legislation available.
7 And I was just coming into my responsibility for this at
8 that time, mid-2019. What was decided effectively by my
9 predecessor, with me inheriting it, was the way to go
10 forward was to enable both the National Medical Examiner
11 and the Local Medical Examiner legal provisions to be
12 turned on, so they were established as posts, but for
13 them to not in any way operate the new medical
14 certificate cause of death which is the second doctor
15 sign-off that the Medical Examiner gives to the
16 attending doctors cause of death and is in a sense the
17 second -- the second doctor opinion that gets to the
18 heart of what was the matter in the Shipman case.
19 So that is the kind of fulcrum bit.
20 So we then ran between mid-2019 and last September
21 what we called loosely the non-statutory scheme. So we
22 didn't have the actual medical certificate cause of
23 death being what needed to be signed off by the Medical
24 Examiner before you could get a death certification.
25 So we got to the middle of 2019 and that system was

1 established and we did actually try to legislate for the
2 changes to bring the system back to the NHS in 2019 and
3 we had a bill which was doing that and putting HSSIB
4 similarly on a statutory footing. And that was
5 introduced to the Lords in November 2019 and had
6 a second reading and then it fell because we had
7 a general election. And after the general election we
8 had Covid and we then reintroduced -- sorry, we
9 introduced the Health and Social Care Bill which took
10 the clauses that had been in the 2019 Bill into that
11 Bill which passed into law and gave us the 2022 Act that
12 had Medical Examiners back in NHS statute where they had
13 actually originally come from in 2009, if you go back
14 far enough.
15 And we continued to operate the non-statutory
16 scheme for the two years between 2022 and last
17 September: one, because we still wanted it to bed down;
18 secondly because we had good but not a complete
19 engagement from the GP world and we wanted more coverage
20 and awareness and ownership before we introduced the new
21 scheme; and thirdly because we needed time to introduce
22 the new thing and lots of other logistical arrangements.
23 So the short answer to your question is after 2019
24 we had a non-statutory scheme. We tried to legislate,
25 which would have enabled us to bring it into statutory

1 focus at the end of 2019. We didn't, one of those
2 things.
3 We then had Covid. We did legislate in 2022 and
4 then we had the period before the introduction last
5 September.
6 So we had had about -- we had had five years or so
7 of full coverage through the hospitals and by the time
8 we got to last September we were up to about two-thirds
9 of GPs being engaged.
10 Obviously you couldn't force that because it was
11 a non-statutory scheme. So that's how we got to the
12 introduction in September that was confirmed by the
13 Government last July after we sought their approval for
14 the package of measures that they had inherited from the
15 previous Government and asked them if they wanted to go
16 forward with it.
17 **Q.** What is your understanding of the relationship
18 between the Medical Examiner system and HSSIB?
19 **A.** Well, the Medical Examiner system is a part of
20 death certification reforms, so it sits within that
21 context and it provides a focus on getting patterns of
22 care, including malevolent patterns of care, which is
23 where it comes from, from Shipman.
24 But also, and I think this has grown in the
25 20 years since Shipman, about giving people

1 an explanation of deaths for all of those that are
2 non-coronial deaths, whereas previously it was only the
3 coronial deaths that got, you know, significant
4 attention.
5 HSSIB, which is how we say it, has a slightly
6 different purpose, which is it's not part of the death
7 management system. First of all it is an arm's-length
8 body of the Department of Health and the purpose of the
9 organisation is really a few of the things that were
10 alluded in the 2006 document in the blurb at the front
11 which is to give a better focus on investigations for
12 the purposes of learning and for the purposes of
13 promulgating that learning across the NHS.
14 And they take a number of sort of sentinel cases
15 each year and then they distribute the learnings and
16 they put requirements on different organisations to
17 respond to specific recommendations.
18 So Medical Examiners is a -- is a catch-all system
19 is a part of the death certification system and gives
20 everybody one, a check and two, an explanation of why
21 somebody has died, for all the non-Coronial cases, about
22 85%, 85% Medical Examiners, whereas in contrast HSSIB
23 has a sort of much tighter end learning and safety focus
24 within the NHS for particular patient safety incidents
25 and operates a safe space whereby the information can be

1 held centrally and examined and also has a separate
2 function, there isn't an equivalent one for Medical
3 Examiners, which is about encouraging improved learning
4 and competence in undertaking investigations locally, so
5 every time something happens in a sense the one area
6 where the two areas elide is you are trying to give
7 everyone through the Medical examiner system a better
8 explanation of a death and in HSSIB you are trying to
9 get people to be better at investigations locally when
10 they need them, so in both instances lack of
11 understanding or a lack of explanation from the health
12 service at the ground floor doesn't generate the need
13 for greater enquiries up the line so that is where there
14 is a point of similarity or a point of similar purpose,
15 but they are two very, very different structures.
16 **Q.** Is information shared between the two
17 directly?
18 **A.** No, it isn't.
19 **Q.** Bearing in mind they have that overlap, do you
20 think there should be some direct conduit?
21 **A.** Well, I think I mean obviously Medical
22 Examiners, the system is four months old so, I mean,
23 more or less bedded in. I think we will need to take
24 the learning from the kind of trends that the Medical
25 Examiners are finding and it may be that some interface

1 with HSSIB is going to be useful and similarly
2 vice versa, but they are both pretty new. HSSIB has
3 only been going in current statutory format for
4 16 months but I take your point.
5 **Q.** Topic 5, the consultation in relation to the
6 regulation of senior managers and --
7 **A.** Yes.
8 **Q.** -- the Code of Conduct.
9 Was the potential regulation of senior managers
10 something that was in contemplation in 2023?
11 **A.** I don't think it was in contemplation. It was
12 under discussion and consideration and, you know, we
13 have shared the documents with you that showed the
14 debates that were happening at the time. But I don't
15 think we ever got to a contemplation of actually doing
16 a consultation that that didn't happen. Whereas
17 obviously that changed when the new Government came into
18 place in 2024 because it was one of their manifesto
19 commitments and now we are taking that forward.
20 **Q.** So again perhaps answering the concern that
21 may exist in the minds of some, the timing of the
22 consultation, namely right in the middle of these
23 hearings, was in fact entirely unconnected?
24 **A.** It was entirely unconnected, to be perfectly
25 honest. We -- you know, when we were sending you the

1 evidence before the election, as it turned out, although
2 we didn't know it at the time we were sending it to you,
3 you saw the documents that were discussing the pros and
4 cons of regulation and the various issues relating to
5 it. But there wasn't a hard and fast plan, therefore
6 I say not in contemplation to get that out as
7 a consultation document. Obviously the Government
8 published it, the now Government published its manifesto
9 at the end of May, it included a commitment to manage
10 the regulation and the Secretary of State made perfectly
11 clear, when he came in, that he wanted that to happen as
12 quickly as possible.
13 We did clearly -- we were obviously fairly au fait
14 with the arguments, so we were able to put together
15 a consultation and that was published, you know, as, as
16 quickly as possible and came out at the end of November
17 because ministers want to do that consultation and they
18 want to make progress as quickly as possible.
19 So I would -- well, I wouldn't, I am saying
20 genuinely that the fact that the consultation went out
21 in November was a function of it being a manifesto
22 commitment and a clear commitment of the Secretary of
23 State and obviously officials, you know, respond to the
24 wishes of their ministers and the timings.
25 **Q.** You have had a chance to consider the evidence

1 of Mr Jarrold.
2 **A.** Yes.
3 **Q.** I am just going to bring up the document that
4 he produced, INQ0107810 and we will go to page 7. What
5 I am not going to go into is the precise mechanics here
6 of what regulation might look like bearing in mind
7 that's subject of a consultation by your Department.
8 This is more about a principle. Mr Jarrold gave
9 evidence about the formulation of this and in particular
10 the:
11 "Make the care and safety of patients my first
12 concern and act to protect them from risk."
13 I mean, is it thought within the Department that
14 that should be the first responsibility of NHS managers?
15 **A.** Well, the equivalent Code of Conduct to this
16 document is something that NHS England is working on at
17 the moment with a number of bodies. So the manager
18 regulation is doing -- well is doing a slightly
19 different thing.
20 As I understand it, and, I mean, NHS England are in
21 charge of the code, the code of leadership and conduct
22 for NHS managers is focusing on values and purposes and
23 commitments in its current iteration.
24 **Q.** And does that statement there fit within what
25 you understand, what did you say values, commitments?

1 **A.** I think, I think it would fit within those
2 values and commitments as I understand it. But it
3 doesn't to my understanding state that precise phrase
4 in, in the current version.
5 **Q.** And do you, as the Department, have an
6 understanding for why not given the public's concern
7 about how senior managers might prioritise what they are
8 doing?
9 **A.** Well, I think we as ministers made fairly
10 clear that patient safety is a significant priority and
11 I think, you know, there are other ways in which we can
12 explain that patient safety is significant. I don't
13 think it's a deliberate omission in the code and
14 obviously the current code is being discussed with
15 various other organisations as well and I think they
16 consider that the six rounded values are the best way of
17 explaining what should be a Code of Conduct for NHS
18 managers.
19 **Q.** I am sure you chose your words carefully, you
20 said "significant". Mr Jarrold's perspective, he not
21 being in Government or in the Civil Service, his
22 perspective is that that needs to be the primary
23 commitment as opposed to one of a number of potentially
24 competing ones which will inevitably include the
25 management of money.

1 Does the Department have a view on whether that
2 should be the primary?
3 **A.** I don't think we have a hard view on it but,
4 I mean, we can certainly feed that back in terms of how
5 the code is being developed. I think we certainly do
6 agree that the range of things that I have spoken about
7 make clear that patient safety is an absolute priority
8 for everybody providing services, including managers.
9 **Q.** I am certainly not going to paraphrase what
10 Mr Jarrold has said about why he formulated it in this
11 way, but you can satisfy everybody here that you have
12 read that and you understand what he is saying?
13 **A.** Yes.
14 **Q.** My sixth topic is that of corporate memory and
15 there are a number of aspects to this. We have already
16 touched upon Sir Ian Donaldson's report "An organisation
17 with a memory" back in --
18 **A.** Liam Donaldson.
19 **Q.** Sorry, forgive me, Liam Donaldson's report "An
20 organisation with a memory", do you agree it's somewhat
21 ironic that that report, "An organisation with
22 a memory", led to the production of an MOU which was
23 then lost to the mists of time in terms of why it was
24 then withdrawn?
25 **A.** Well, I think as I said before it's

1 unfortunate.
2 **Q.** But it appears to be that that occurred in the
3 context of an effort to develop a memory about events
4 and --
5 **A.** I think the MOU itself, to be precise,
6 occurred in the context of a large organisational
7 restructure and that that document was archived as an
8 oversight. I think the "organisation with a memory"
9 he's talking about as I think I said the learning from
10 Patient Safety Events, not necessarily the handling of
11 memorandums and codes, although I take your general
12 point.
13 **Q.** And we have a number of strands of evidence
14 that have developed about corporate memory and the
15 difficulties that there appear to be with it.
16 Mr Jarrold, as you have seen, had a degree of
17 uncertainty about what exactly happened to his code and
18 why it appears to have fizzled out. Dr Clamp says on
19 behalf of the PSA he doesn't even know whether that
20 original code is still policy because he can't find
21 an answer to it.
22 Is that problem generally, which was also spoken to
23 by Professor Smith, about the lack of version control or
24 iterations, the fact that new policies come along but
25 old ones aren't withdrawn, is that something that the

1 Department recognises as a problem for the NHS?
2 **A.** I think we think it's an issue and I wouldn't
3 quite describe it as version control I think there is
4 a slightly wider issue that lots of people have brought
5 up and Gordon Messenger encapsulated in his report and
6 the Secretary of State in November completely concurred
7 with, which is we need to get better and more structured
8 at how we support managers and organise training and
9 have that as a systematic approach that isn't
10 particularly dependent on a particular time or
11 a particular issue.
12 And of course one of the reasons why regulation of
13 managers is so important, not just for the obvious
14 reasons of having a set of structures for professional
15 improvement and public confidence, is I think that if we
16 do, when we do get to having that system, it would mean
17 that things like training and codes and memorandum of
18 understanding would always be necessary because you have
19 to -- you have an established regulated profession who
20 need those sorts of documents for their support.
21 So I think there is a question about how we can be
22 more systematic about those things. So I think in
23 a sense if we are going to be regulating managers what
24 goes hand in hand with that is having a more
25 sophisticated set of arrangements to support those

1 managers, which was in a sense the point Helene Donnelly
2 made when she came here, which she said manager
3 regulation is fine, but please make sure people are
4 supported to do it. So they are not, I mean, a point
5 you are making to me before lunch, they are not exposed
6 when they have got a new set of responsibilities and
7 they don't feel they have got the necessary support to
8 carry them out effectively.
9 **Q.** And if it is an issue, and clearly in the
10 minds of some people a problem, whose responsibility is
11 it that we have reached this stage now with the
12 uncertainty we have, who ought to have ensured that
13 rigour and structure was imposed sooner?
14 **A.** Well, I suppose you know previous
15 administrations should have done. But, I mean, I think
16 there's been a pretty -- a pretty clear picture since
17 the Messenger Report came out, which was June 22, that
18 we need to ensure between ourselves and NHS England that
19 we have more structured long-term arrangements for these
20 things and of course it's -- as I said before, it's the
21 decision of this Government to go ahead with manager
22 regulation and that provides, you know, a significant
23 bolstering tool of that which I think, you know, is
24 extremely welcome and obviously that is a result of the
25 set of ministers taking a lead on this issue.

1 **Q.** Wider than the issue of those policies which
2 apply directly to senior managers, there is a school of
3 thought that there is a significant amount of time and
4 resource at a local level writing policies which are
5 applicable to the institution which are in fact carbon
6 copies of policies which exist elsewhere or which are
7 very only slightly different to those other policies.
8 Does the Department have a view about whether there
9 should be a central policy centre within the NHS for
10 writing a number of these policies or the core of
11 a number of policies to save time at the local level to
12 avoid these things being written from scratch?
13 **A.** I don't think we have got a hard and fast
14 position but I think the basic thing I would say is
15 probably we would see ourselves and NHS England as
16 having the job of producing most of those policies
17 obviously in conjunction with other people with whom we
18 discuss them, but for producing them, and once produced,
19 we would hope having done that necessary consultation,
20 small C, that they were suitable for use.
21 And it's never our assumption when we produce
22 a policy that it needs to be replicated or duplicated or
23 regurgitated for the purposes of its implementation. So
24 the example Jane Tomkinson gave on Monday which was, you
25 know, they have got a SUDiC policy of 150 pages long,

1 you know? Why, when there is a 70-page Child Death
2 Review policy that we did in 2018 and is still extant do
3 you need to do that duplication? No, you don't. Maybe
4 there is something for us about making clear, you know,
5 when we produce a policy that we think it's fit for
6 purpose and use, but we never require people to rewrite
7 or reorder a policy on its production from the centre.
8 **Q.** So does it come to this then: the Department
9 and NHS England's position is that such common policies
10 are produced at the central point and it's then up to
11 individual hospitals to decide whether they are going to
12 adopt that or start again?
13 **A.** No, it's not a question of whether they are
14 going to adopt it, there was no question of "whether" in
15 what I said. What I was talking about was the "how".
16 Clearly we operate in a structure that if you
17 produce guidance and if you direct it and if you send it
18 to Trusts and all those other things, going back to my
19 opening answer to your question, the expectation -- in
20 fact the requirement -- is that people then deliver on
21 it. And obviously the fulcrum body for doing that is
22 the board, that is what you have boards for: they hold
23 the organisation to account. NHS England holds the
24 board to account on our behalf and we promulgate
25 a certain set of key priorities that we want NHS England

1 to send down the line through the mandate and the
2 planning guide.
3 So it's not a question of whether; it's a question
4 of how. And the "how" is -- my previous answer is you
5 probably don't need to you know rewrite or regild things
6 if they have already come out. And the second "how" is
7 clearly that it is the responsibility of organisations
8 locally led by their boards to implement policies
9 according to what the Government and NHS England have
10 set out, because we are all part of one structure.
11 **LADY JUSTICE THIRLWALL:** Sorry, Mr De La Poer. So
12 does that mean there's a straightforward
13 misunderstanding certainly at the Countess of Chester?
14 I think we were told there are 2,000 policies --
15 **A.** With the, you know --
16 **LADY JUSTICE THIRLWALL:** -- in the hospital.
17 **A.** There may well be a lot of policies. I am not
18 denying the fact that there are different policies.
19 **LADY JUSTICE THIRLWALL:** No, but the reason I am
20 asking you about that is if the hospital is under the
21 impression that they have to draft individual policies
22 for everything, then --
23 **A.** I don't think they --
24 **LADY JUSTICE THIRLWALL:** -- that is a lot of
25 management time which we were told about which is being

1 spent on something which is entirely superfluous.
2 **A.** I don't think they necessarily do, is my
3 starting point. There will be some things inevitably
4 where you need to explain the guidance or the
5 practicalities of it but there is no need to rewrite or
6 completely reboot all the pieces of guidances we send
7 out. We send them out so they can be used by people and
8 critically and more and more over the years, you discuss
9 those with groups of people, I mean, including the NHS
10 in a sense of the regional tier and the ICBs and the
11 sort of higher ends of the Trust. You know, we at
12 NHS England would interface with them on significant
13 pieces of policy in order that it is something that is
14 going to be useful as, as sent out.
15 The days when the Department was a sort of separate
16 semi-academic institution writing these things, you
17 know, by itself disappeared many years ago and good
18 practice in any production of policy guidance is to
19 sense-check it, is to discuss it, is to consult on it,
20 in order that when it goes out, it is correct.
21 So, I mean, when I saw that evidence I did think:
22 yikes that isn't our expectation that you have to then,
23 you know, regenerate that into a different product on
24 each and every occasion. And when there are, I mean all
25 right, let's take Medical Examiners as a live example.

1 We put out -- I mean, that was a big change for 70 years
2 we put out a reasonable amount of guidance on gov.uk
3 that we thought was going to be appropriate for people
4 to be able to operate the Medical Examiner system. We
5 did not engage in discussions about, you know, producing
6 extra pieces of guidance in order, you know, that that
7 was better understood.
8 You always -- I mean, in this instance the National
9 Medical Examiner, the Regional Medical Examiner, the
10 Medical Examiner's office, you always have people in the
11 system who are responsible for that certain area of
12 policy who can do that bit of explanation and
13 understanding for people who may be less au fait. But
14 we don't have an expectation that on the production of
15 a piece of guidance that then necessitates an equal and
16 parallel exercise on its receipt.
17 **LADY JUSTICE THIRLWALL:** Yes, even if it is not
18 equal and parallel the point is that it is understood
19 that something has to be done and that someone has the
20 time to do that when they might be doing something else.
21 **A.** Yes.
22 **LADY JUSTICE THIRLWALL:** That latter part is my
23 addition. So if there is that misunderstanding it needs
24 to be removed, doesn't it, so that Trusts know and the
25 boards know that they don't have to rewrite it for local

1 conditions or whatever it is?
2 **A.** Yes, I mean, they have to implement it.
3 **LADY JUSTICE THIRLWALL:** Yes.
4 **A.** And they have to have structures in place for
5 the implementation and they have to have ways of
6 assuring themselves that it's been implemented but the
7 core of the policy, the purpose of the policy does not
8 need to be rewritten because in the end you write policy
9 once because you think it is applicable across the piece
10 and because we have a single NHS and we want
11 a consistent health service.
12 **LADY JUSTICE THIRLWALL:** I feel we are slightly
13 moving away. I just want to be clear about what is
14 expected of the Trust. Sorry, is it the fact that the
15 guidance goes out or the directive goes out and the
16 Trust has it, this is what we have to implement, and
17 this is how we are going to implement it?
18 **A.** Yes, that is -- that is what we expect.
19 **LADY JUSTICE THIRLWALL:** But that, I mean I am
20 assuming that is not something that would be very
21 complicated or complex, the implementation?
22 **A.** No, it shouldn't be. I mean, look, we -- we
23 try and write guidance in such a way that it achieves
24 its aims and objectives and does so in a -- in a fairly
25 clear and efficient manner. And if you put anything on

1 gov.uk you have to make the language into plain English
2 so that anybody can read it and understand it. So there
3 are quite some pressures on us, which are good
4 pressures, to improve the clarity of our policy making.
5 And it certainly isn't the expectation that on
6 receipt of a piece of policy it then needs rewriting or,
7 you know, reframing.
8 **LADY JUSTICE THIRLWALL:** Thank you, so that is
9 something obviously for me to consider what, if
10 anything, needs to be done about that, for reasons that
11 are obvious. Can I just ask you something else because
12 you were about to go back on to Medical Examiners,
13 I think.
14 **A.** Yes.
15 **LADY JUSTICE THIRLWALL:** We heard evidence from
16 Jeremy Hunt, who as well as being Health Secretary had
17 been Chancellor more recently and it's really just to
18 help about this: talking about the willingness or the
19 desire to introduce Medical Examiners, if I may say so,
20 what you have described as has been a sort of -- not
21 quite an iterative process but an introduction an
22 openness to it, and then some piloting.
23 And the way Mr Hunt described it was that this was
24 Medical Examiners were something that he had been
25 supportive of but the NHS did not support it for

1 financial reasons and it was when he -- either it came
2 across his desk or he instigated it, one way or the
3 other he decided to tell the Treasury to make the money
4 available.
5 Is that something which accords with your
6 recollection of how it went?
7 **A.** Well, let me tell you what my recollection is
8 because it is the sort of the other part of the story
9 that I didn't go through with you because you didn't
10 precisely ask me about it.
11 The other thing that was difficult with Medical
12 Examiners was the funding.
13 **LADY JUSTICE THIRLWALL:** Yes, that is why I thought
14 I had better ask you about it.
15 **A.** Yes, exactly. The funding started off life,
16 the funding was assumed to come with the NHS when it
17 started life in 2009, when we got to 2012 it was then
18 back in local government, there was no funding to do it.
19 **LADY JUSTICE THIRLWALL:** So change of Government,
20 or the Lansley Reforms?
21 **A.** No, 2012 was the Act.
22 **LADY JUSTICE THIRLWALL:** Those were the reforms.
23 **A.** So the 2012 Lansley Reforms went into local
24 government, ergo it was going to be a local government
25 provided service so it would have come out of local

1 government funds and -- and the likelihood was there
2 would have been some charging involved because one, that
3 is how local government raises quite a lot of its money;
4 two, there was already various charging regimes, the
5 crematorium forms and all the rest of it that existed in
6 the death certification system.
7 We then got to a position where that wasn't
8 resolved and by 2018 we had got to a position which he
9 answered in my previous question to you, Mr De La Poer,
10 which was we decided the service should operate out of
11 the NHS and we had been public about that and we had
12 made that clear.
13 How did we fund the non-statutory scheme whilst it
14 was still a local government function? We had some
15 central funding from the NHS that we "found", and we
16 also had we used the crem Form 5, crem Form 5 was the
17 form that families used to pay the doctors for funerals
18 and was an arrangement that came out of the 1953 Birth
19 Registration structures and in a sense although it was
20 in the time of the NHS kind of preceded the sort of
21 concept of the NHS and it was just something doctors did
22 and it just went straight to doctors, it didn't come
23 through any of us, it was effectively just an
24 arrangement between effectively local government, crem
25 Form 5 and the doctors.

1 So we used that money, to cut a long story short,
2 we took that money, stopped using crem Form 5 and we
3 added that money to our central funding that paid for
4 the non-statutory scheme, okay? So that was how we
5 provide for the non-statutory scheme and that was how we
6 paid for the non-statutory scheme until 2022 and the
7 reason why it was 2022 was because we had a spending
8 review in 2022.
9 The important thing that happened between 2020 and
10 2022 was we made some reflections obviously for the very
11 sad circumstances of Covid, a lot of people died, there
12 was a lot of focus on bereavement, most of the people
13 dying were in the hands of the health service and the
14 person who worked for me on Medical Examiners at the
15 time directly said: William, we have got a position
16 where the Medical Examiners are going to be in the NHS,
17 we understand that, the purpose of the Medical Examiner
18 policy as well as finding out suspicious patterns of
19 deaths is very much to give, as I was just saying,
20 an explanation and to help with people at their moment
21 of need.
22 But actually what we are also going to say is that
23 is going to be NHS service and we are going to charge
24 you for it. Charging people at that point is obviously
25 rather difficult and insensitive; and secondly, we don't

1 tend to charge people for NHS services apart from a few
2 long-established things in primary care.
3 So we went back to ministers a couple of times
4 during the Covid period and put what I have said to you
5 in sort of fuller terms and combined that with
6 a proposal that --
7 **LADY JUSTICE THIRLWALL:** 2022, the spending review?
8 **A.** This was being done in 2021.
9 **LADY JUSTICE THIRLWALL:** I see.
10 **A.** 2020 and 2021 so sort of in a sense, you know,
11 as a result of our observations in Covid we went back to
12 ministers and said: we think a better solution given the
13 service subject to the passage of the Act in 2022 is
14 going to go in the NHS, that there shouldn't be a charge
15 for Medical Examiners and it should be funded in the
16 normal way in the way that other NHS services are, which
17 is out of the money granted to Parliament for NHS
18 services and they said yes to that.
19 So we got to a position by 2022 where a couple of
20 things combined, one, the Act got passed, so the Medical
21 Examiners was back in the NHS; and two ministers had
22 agreed to funding through the NHS and we secured the
23 funds through the spending review to do that; and three,
24 the previous arrangements we had had using crem Form 5
25 and all the rest of it they stopped and that all

1 happened to take place at the time that Covid was
2 stopping in the spring of 2022. So the Ministry of
3 Justice who had been going to take away crem Form 5 at
4 the time we introduced the Medical Examiner statutory
5 system withdrew it at that time because it wasn't needed
6 any more for their purposes, and we had sorted out the
7 funding stream.
8 So we got to a position in 2022, finally, where
9 Medical Examiners was back in NHS legislation. We had
10 the agreement that the Medical Examiner scheme should be
11 funded in the typical way through the NHS and we had
12 secured the resources in the spending review for that.
13 And when I say secured the resources, what I mean
14 is the cost of the Medical Examiners offices is
15 basically the cost of the scheme, it is about
16 £50 million, which is about 400K for each of the 129
17 Medical Examiner offices, which gets you three or four
18 part-time staff and an administrator. That's what I'm
19 talking about and then there's a bit of central costs
20 for us on the forms and a few other things, but about
21 50 million for the scheme on the ground, 7 million for
22 the rest of it.
23 So between 2022 and 2024, and indeed now, we have
24 been funding the non-statutory scheme and since
25 September the statutory scheme through the settlement

1 that we reached in the spending review.
2 **LADY JUSTICE THIRLWALL:** Very good.
3 **A.** And that's now completely normalised and it's
4 there and it is in the baseline.
5 **LADY JUSTICE THIRLWALL:** That was my last question
6 so it is in the --
7 **A.** It is in the baseline.
8 **LADY JUSTICE THIRLWALL:** Yes.
9 **A.** Because it applies to every Trust, there is
10 basically a sum which exists within every Trust
11 baseline, even though I said 129 officers, there's 125
12 in England and they cover about two Trusts each because
13 you don't have one Trust each, you have about two Trusts
14 per Medical Examiners Office.
15 So now we are back to a perfectly conventional
16 position where we have legislation that establishes it
17 in the NHS and we pay for it through the normal route
18 which is through the funds that go to the health service
19 and there is no charging at all.
20 And the charging thing was difficult for a long
21 time, as long as it was in local government it was going
22 to be charged for and then we had to make the case for
23 it to have the normal pattern of funding through the
24 NHS. That's what happened between 2019 and 2022 and
25 that system, those structures have run since 2022 with

1 the difference that we turned on the full statutory
2 scheme last September.
3 **LADY JUSTICE THIRLWALL:** Thank you. Sorry,
4 Mr De La Poer.
5 **MR DE LA POER:** Not at all my Lady.
6 Topic 7, the introduction or potential introduction
7 of an overriding objective of patient safety in
8 employment matters in the context of the NHS and here
9 the evidence the Inquiry has heard is from Professor
10 John Bowers King's Counsel and you have had
11 an opportunity to consider his evidence and you will
12 understand the context for that on the facts the Inquiry
13 has been investigating, namely the fact that Letby
14 raised a grievance process and in the end those who were
15 raising concerns about the threat that she may pose as
16 far as they were concerned ended up apologising and
17 potentially compelled into mediation, although that
18 never came to pass.
19 Professor Bowers gave evidence about this being
20 a wider problem in the NHS or a wider challenge the use
21 of grievance processes and other employment processes
22 and the risk that patient safety gets lost in it, so
23 that is the run-up to wicket.
24 Does the Department have a view about whether what
25 Professor Bowers is proposing is a good idea?

1 **A.** No, we don't have a firm policy position. But
2 I read the evidence with interest and obviously what he
3 was saying was you shouldn't let, you know, matters of
4 grievance or HR, to use his words occlude the need to
5 follow through on patient safety incidents.
6 And I think we would say that clearly there is
7 obviously a place for HR policies, you know correctly
8 managed. But we also think that if there is a patient
9 safety issue people should be encouraged to speak up
10 through the various routes that I have discussed,
11 whistleblowing or Freedom to Speak Up Guardians.
12 Whistleblowing is, you know, in a sense when it gets
13 more extreme, often because people don't take the
14 concern seriously. And otherwise you should be able to,
15 you know, freely raise a patient safety incident through
16 Patient Safety Incident Response Framework and other
17 mechanisms.
18 I think again it comes partly back which I sort of
19 think he was saying in part, it partly comes back to the
20 culture of the organisation that you should have an
21 organisation that tolerates people being able to follow
22 up patient safety concerns of whatever kind and you
23 should be able to distinguish between that and genuine
24 HR issues. But there shouldn't be a need to use HR
25 issues to resolve patient safety matters and in a sense

1 we know that that is the -- that is the difficulty that
2 whistleblowers sometimes feel that they are forced into.
3 **Q.** So that is the aspiration it shouldn't happen.
4 He's made a practical suggestion which is above and
5 beyond the existing structures but actually to ensure
6 that those who are have that concern in front of them
7 whether it be a grievance or a disciplinary process,
8 that they are reminded as you are approaching this you
9 must remember patient safety at all times or however
10 it's framed, that's his suggestion. You have told us
11 there is no policy position on that as yet.
12 Is it something that the Department is going to
13 take away having considered as evidence and reflect on
14 whether that additional nudge in terms of culture is one
15 that should be introduced or has it been ruled out
16 already?
17 **A.** No, it hasn't been ruled out. I think we
18 can -- we can look at it. I would say, you know,
19 "additional nudge on culture" is a nice way of putting
20 it because I think -- I think you have to be careful
21 that you don't introduce more myriad new systems that
22 might get in the way of what we hope are natural
23 responses to speak up through the existing mechanisms.
24 **Q.** My eighth topic is seeking to refine or
25 improve the overall system of regulation and this is

1 a short topic but we have heard from a number of
2 witnesses from the outset when Sir Robert Francis gave
3 his evidence about the proliferation of organisations
4 within the NHS with a regulatory function, sometimes
5 126, sometimes 130, some people aren't sure how many.
6 Is the problem for the patient is that often they
7 don't know who they should be turning to and what the
8 role of the different organisations is for.
9 Is that a problem that is recognised by the
10 Department in the sense that the NHS is just too
11 complicated at the moment or does the Department not see
12 that as a problem?
13 **A.** I don't think either of those things would
14 quite be the position. Within that large number of --
15 that large number you quote, whatever, you know,
16 whatever it is constructed of, part of it is made up of
17 professional regulatory bodies with long standing, part
18 of it is made of by Royal Colleges with long standing,
19 part of it is made up by arm's-length bodies that have
20 pretty long standing.
21 So if you start to deconstruct the large figure,
22 quite substantial parts of that figure are long set and
23 long established and if we were to say: we won't have
24 the GMC we won't have the Royal College of Physicians
25 and we won't have the CQC or NHS England, I think you

1 would be in a slightly unusual position.
2 The part of the Francis evidence that referred to
3 the -- you know, the distinction between, you know,
4 regulatory requirements and professional requirements,
5 the professional requirements have long, you know,
6 existed and as I said earlier, you know, pre-date even
7 the NHS and have always operated in a sort of
8 independent structure within the NHS.
9 I think it is important that we are always looking
10 carefully at, you know, regulatory and other bodies
11 outwith the areas I have sketched out and of course in
12 recent years we have actually taken steps to simplify
13 the system. First of all we went down from having five
14 or six bodies that were responsible for the NHS on
15 a day-to-day basis to one, which is NHS England, we
16 don't have the TDA, we don't have Monitor, we don't have
17 NHS Improvement, we don't have NHS Digital and we don't
18 have Health Education England, so there is one
19 simplification. And secondly we have obviously got the
20 outstanding Penny Dash review that is looking at, you
21 know, whether there is any better co-ordination between
22 the number of the patient safety bodies.
23 So I think, you know, my mid-point between your two
24 poles that you asked is obviously we are always mindful
25 of not complicating the system. At the same time there

1 is a good reason for a number of the organisations that
2 we have. So you have to strike a balance between having
3 the requisite number of organisations to give the right
4 amount of oversight or indeed improvement or data
5 capture and ensuring, as you were saying to me earlier,
6 that that still enables the people on the ground to, you
7 know, operate and do their day jobs fairly unencumbered.
8 Obviously one the things that's going on with CQC
9 at the moment is going back to a more focused approach
10 to how they collect data rather than slightly
11 complicated arrangements they have had in the last
12 couple of years.
13 So we are always trying to look at where we can
14 improve data and data management tasks. But at the same
15 time, there is a pretty good reason for a large number
16 of the organisations that we presently have.
17 **MR DE LA POER:** My Lady, I have three more short
18 topics and then there is permission for 15 minutes'
19 worth of questions. I wonder whether this would be
20 a convenient moment, but my expectation in terms of my
21 remaining time is about 15 minutes or so.
22 **LADY JUSTICE THIRLWALL:** Very good. So we will
23 take the break now and we will come back at 25 to 4.
24 **(3.17 pm)**
25 **(A short break)**

1 **(3.35 pm)**
2 **LADY JUSTICE THIRLWALL:** Yes.
3 **MR DE LA POER:** Mr Vineall, topic 9, senior
4 managers moving and being moved.
5 **A.** Yes.
6 **Q.** Evidence has been given, including from
7 Tony Chambers and Lyn Simpson about the existence of
8 what is dubbed the "donkey sanctuary", that was
9 Mr Chambers, and Lyn Simpson in writing talked about
10 rehabilitation periods and their standard lengths.
11 Does the Department consider that there is
12 a problem in this area that needs addressing?
13 **A.** Well, I'm not sure if the Department has
14 a fixed position on this but speaking on behalf of the
15 department, I think there are some issues that arise
16 from the set of evidences you have just been referring
17 to.
18 I don't recognise certainly the first phrase and
19 I don't recognise the second phrase as established good
20 practice. I would say two things, first of all, moving
21 people per se is not wrong. It happens in all walks of
22 life, I have been moved. It happens.
23 I think the issue is if you are moving people in
24 circumstances that are complicated and, shall we say,
25 a little bit murky then it is a different thing. If you

1 are moving people to rehabilitate them because they are
2 going to get better and it's all fine that's okay. If
3 rehabilitation is a catch-all for helping people to
4 shuffle on because something has gone wrong that hasn't
5 been addressed and acknowledged, that is a wholly
6 different matter.
7 And I worked in a region 25 years ago and some of
8 it happened then. So it's been happening for a long
9 time but I think increasingly people understand that and
10 it really goes to some wider policy issues here, that if
11 you are going to move people on, you need to do it in
12 a reasonably open and transparent way, you need to have
13 the full facts at your disposal, which without having
14 time to go into the details one way or another wasn't
15 the case here, people weren't being told the whole
16 story, said they weren't being told the whole story, it
17 is not quite clear what was happening.
18 And I think you have to have an ability to check
19 people's credentials if you are going to move them,
20 which in a sense the Fit and Proper Person Test is the
21 start of being able to do that. And fundamentally if
22 you have a situation in which you move people through
23 approaches that, you know, could best be described as
24 delphic or opaque, you probably need a regulatory
25 structure so you can have some reference point to what

1 that person is like.
2 Now, of course as we were just rehearsing before
3 the break, we don't have a system -- we don't have
4 regulation of managers at the moment, we just don't have
5 it. We have regulation of lots of other things but we
6 don't have regulation of managers. So if you take all
7 of that in the round I think the practices that we have
8 seen here probably wouldn't be right by any measure and
9 present some structural issues that I think the
10 Government is, you know, full tilt ahead at addressing.
11 **Q.** Well, regulation of senior managers in
12 whatever form it may come to pass --
13 **A.** Yes.
14 **Q.** -- may address that in part?
15 **A.** Yes.
16 **Q.** But doesn't there need to be very clear
17 guidance on what needs to be done if a person is to be
18 moved, in other words as you have just listed and they
19 are just common sense, you need to establish the full
20 facts you need to act transparently?
21 **A.** Yes, I mean, one would hope you didn't really
22 need to say that because it would be a part of good HR
23 process anyway and of course leaving aside if there are
24 untoward reasons for moving people, part of the reason
25 why you move people is to get a right fit between the

1 individual and the organisation so it's not very good HR
2 practice in terms of talent if you don't a proper
3 structure.
4 The fit and proper fern test is starting to give us
5 a sense I think of places where, having done checks on
6 individual's credentials and profiling and references
7 and all the rest of it, you can start to distinguish
8 between the people who genuinely need development, and,
9 I mean, development in the proper sense of the word and
10 the people for whom there is a fundamental problem and
11 the Fit and Proper Person Test has only been operating
12 in full form for a bit over a year, but my understanding
13 is that when NHS England went back to Trusts and said
14 are you operating this process, 100% of Trusts said they
15 were and there were figures produced that showed a low
16 sort of small single figurish number of people for whom
17 there were significant problems of the kind you might be
18 alluding to here and a much larger number of people
19 fortunately for whom you need some kind of development.
20 So I think we have got, you know, some of the
21 components of the approach in place, we don't have
22 manager regulation in place clearly because we are
23 consulting on precisely what format, that is
24 something --
25 **LADY JUSTICE THIRLWALL:** I'm sorry Mr Vineall,

1 I hope this is not a question of the pot calling the
2 kettle black, but you are speaking really quickly.
3 **A.** Sorry.
4 **LADY JUSTICE THIRLWALL:** And the shorthand writer,
5 who is very quick, I think is probably find this a bit
6 hard.
7 **A.** All right, I will slow down.
8 **LADY JUSTICE THIRLWALL:** If you could go just a bit
9 slower.
10 **A.** I think I had more or less finished that
11 sentence which was to say we have got the components of
12 the system in place.
13 But we need to draw it together and it may well be
14 that emerging from that we need some clearer, you know,
15 protocols if you like about how you approach these
16 situations in order that we can distinguish where
17 there's a significant and serious problem and where
18 there is a more conventional issue of moving somebody to
19 a different position.
20 **MR DE LA POER:** And is that something that
21 responsibility for which would sit with the Department,
22 that you are handing that down to NHS England saying:
23 this is what we need to do or is it internal to NHS
24 England for them to produce it?
25 **A.** If we did that I think it would be something

1 that we would need to share on, probably I would have
2 thought. Because, I mean, manager regulation is led by
3 us with their very significant involvement, Fit and
4 Proper Person they do the mechanics of but we are
5 heavily engaged. So I think it would sit across those
6 two.
7 **Q.** Topic 10, the Child Death Review process?
8 **A.** Yes.
9 **Q.** Very narrow.
10 **A.** Yes.
11 **Q.** The Inquiry has received evidence, we don't
12 need to go into the precise geography, that a potential
13 failing in the existing system is, particularly with
14 neonates who may never have been themselves resident
15 anywhere, that by taking the families' residence address
16 as determinative of the area as opposed to the place in
17 which they died can lead to deaths being spread across
18 a number of Child Death Overview Panels.
19 Is that an issue that the Department recognises as
20 requiring some adjustment or finesse?
21 **A.** Well having seen the evidence that's been
22 presented in the Inquiry, and I wasn't -- I don't do
23 children's policy so I have learnt up about CDOPs and
24 all the rest of it, I think there probably is an issue
25 we need to look at. So we had seven deaths here that

1 went to four different committees, two of which were to
2 the one that was related to Cheshire and predominantly
3 Cheshire. And that meant that you couldn't get any
4 sense of patterning because it was too split up which is
5 in a sense what Hayley Frame said in her evidence piece.
6 The legislation in the Children Act 2004 says you
7 must examine it by residency and you may examine it by,
8 you know, by wider areas.
9 So I think we need to clear up, you know, how --
10 how optional the second of those is, if you look at the
11 history of the guidances over the period of time, the
12 2010, 2018 and 2023 guidance allow for some optionality.
13 The 2013 and the 2015 guidance, which is the ones
14 that the hospital was operating against in the period of
15 this time, didn't and said you needed to do it according
16 to the residence.
17 Now of course what's changed since the 2004
18 Children Act is that the Department of Health received
19 the responsibility for Child Death Reviews in 2018.
20 Why was that? It was because of the Wood review in
21 2016 that said 45% of neonatal deaths are in the health
22 service so would it not be logical for us to take over
23 that responsibility?
24 The majority of those neonatal deaths are either
25 going to be in hospital or people who are transferred

1 into hospital, so the hospital is the place of the
2 death.
3 So there would be a logic, wouldn't there, in
4 ensuring that whatever arrangements we have are grouped
5 around those sets of institutions, hospitals with
6 neonatal units, that see the majority of those deaths.
7 So I think we do need to take away and look at
8 that. I'm not positing a position because we haven't
9 got one and we haven't been through it and we need the
10 approval of our ministers, but I can see from the
11 evidence presented that there is something fairly
12 straightforward you could do to clear up this issue and
13 I notice somebody last week -- I can't remember who it
14 was -- who said you could do it at the ICB level. There
15 is only 42 ICBs, you would get bigger pattern on
16 a number of 42, et cetera. So I think there is an issue
17 once we have seen what the Inquiry reports on that we
18 need to look at.
19 Our guidance has been pretty well received and was
20 quite -- I think considered quite good but we last
21 updated it when we took over the responsibility in 2018
22 so obviously as and when the Department decides that
23 that needs to be looked at again, this is an issue that
24 we need to address in that.
25 **Q.** Topic 11, my final topic, the tracking and

1 implementing of Inquiry recommendations?
2 **A.** Yes.
3 **Q.** And your reaction to me providing you with
4 that title suggests that this is a topic that you may
5 have something to say upon?
6 **A.** Yes, yes. So what have we heard here and in
7 other places? That there is a lot of recommendations
8 and we need to do something better to organise ourselves
9 in the response. That's kind of the gist of the
10 argument, isn't it; is that fair?
11 **Q.** Precisely so.
12 **A.** What I would say is this is an issue the
13 government recognises. There is a House of Lords report
14 from September making that very point which is due to be
15 responded to very shortly I think in the next several
16 weeks. We did a piece of work through HSSIB through
17 Rosie Benneyworth who was here last week and I think
18 spoke about it sort of positing the issue that we have
19 a lot of different activity coming into organisations
20 the point from earlier recommendations and we need to do
21 something to corral that better. Our minister's
22 response in September was to crack on with the thinking
23 about that when the report came out.
24 We have done some preliminary work on that, the
25 Dash Review is looking at this issue and I think is

1 going to say something about it in its forthcoming
2 report. So that should give us the basis alongside the
3 HSSIB report and whatever the Government at Cabinet
4 Office level comes out with to take it forward.
5 I think the description that somebody said that
6 this was untenable, I don't recognise it as untenable
7 because there is quite a lot of things from Inquiry
8 recommendations that we implement, like HSSIB, like
9 Medical Examiners, like Fit and Proper Person Test.
10 But I do recognise that at the local level people
11 feel there are a lot of recommendations coming on to
12 them although I note that Jane Tomkinson said precisely
13 the opposite when she was asked about it the other day
14 so it is not everyone's view, but there is a view there
15 is quite a lot coming down the line. I also think there
16 is the question about how we track Inquiry
17 recommendations.
18 I do actually think we track Inquiry
19 recommendations quite carefully but I think there is the
20 question of returning to the efficacy of things once you
21 have either implemented them or either implemented but
22 still ongoing is going to be important.
23 So I suppose in summary there is a pipeline that
24 I think will establish a clearer Government position on
25 this issue. There's some preliminary work we have done

1 in the Department. I recognise that we need to look at
2 this issue in the round, I don't think the present
3 position is untenable but I think everybody agrees there
4 is room for good improvement and we certainly want to be
5 a part of that.
6 **Q.** One of the pieces of work which the Department
7 engaged with was the schedule created by this Inquiry
8 into previous recommendations?
9 **A.** Yes.
10 **Q.** And that identified a very large number of
11 recommendations and provides a line by line commentary
12 upon whether it's been implemented, rejected and so on.
13 And your Department contributed to the Inquiry's
14 understanding of each of those; is that right?
15 **A.** That's correct.
16 **Q.** In terms of taking a step back, you have been
17 a civil servant in the Department of Health and Social
18 Care for a very long time?
19 **A.** Yes.
20 **Q.** When you looked at that document, were you
21 surprised at where the balance lay in terms of
22 recommendations being implemented or not or did it
23 accord with what you were expecting that piece of work
24 to produce?
25 **A.** Well, what I expected to show which certainly

1 when we did our returns to you showed was that we had
2 implemented quite a number of Inquiry recommendations
3 and there was a set that was implemented ongoing. So
4 there was further work to do to continue with their
5 implementation but they had been taken forward. And
6 that they were a small number that had either been
7 superseded or had been disagreed with which the
8 Government is able to do.
9 I think the thing that did strike me is that there
10 was quite some commonality in the recommendations that
11 come forward. So we have to ensure that our solutions,
12 you know, have a longevity that mean issues don't
13 continue to come up.
14 I do think going back to my earlier theme it is
15 important that in implementing recommendations, you know
16 there is an expectation on the front line that they will
17 take them forward in a serious manner and we do still
18 have an issue at the moment that there is too much
19 difference between how people do things, which I think
20 comes back to the previous discussion about cultures and
21 boards.
22 So I don't think -- I don't think I was
23 particularly surprised by what I found. I think my two
24 learning points are if we are still having quite a lot
25 of Inquiries that are saying the same thing, we need to

1 have a hard look at some of our solutions, that is the
2 first thing and probably a statement of the obvious.
3 And the second thing I would say is that you get to
4 a point with recommendations that they cease to add
5 value, so sort of honed and focused recommendations
6 I think are the things that hold the Government best to
7 account rather than sort of a voluminous list.
8 **MR DE LA POER:** Mr Vineall, thank you. Those are
9 my questions. There is permission for one of the CP
10 representatives to ask you some further questions.
11 **LADY JUSTICE THIRLWALL:** Mr Baker.
12 Questions by MR BAKER
13 **MR BAKER:** Thank you, my Lady.
14 Mr Vineall, I ask questions on behalf of two of the
15 Family groups. Can you hear me clearly enough?
16 **A.** Yes, now I can hear you fine.
17 **Q.** At a number of points in your witness
18 statements you refer to a need to establish
19 a transparent patient safety culture within the NHS. In
20 this sense when you talk about transparency, are you
21 talking about a system which is candid with those who
22 are harmed?
23 **A.** Candid with those who are harmed and candid
24 about the problems that arises from those harms in order
25 that you can learn better for the future and hopefully

1 diminish the number.
2 **Q.** So a healthy patient safety culture is one
3 that confronts the issues that cause patient harm, is
4 upfront about them and is clear with those who are
5 injured?
6 **A.** Yes, and has all of those things I think sort
7 of supported energetically by its board and the way it
8 behaves and indeed the information it receives at the
9 board.
10 **Q.** Yes, and I don't need to take you to it but it
11 is paragraph 123 of your first witness statement, you
12 talk about measures being put in place to foster
13 a transparent safety culture since 2012.
14 Am I to understand that it would be fair to say
15 that there are still -- there is still progress to be
16 made in taking the NHS to a transparent safety culture?
17 **A.** I think there is still progress to be made.
18 I think it is very good in some places. I think it has
19 improved overall because we didn't have things like
20 candour any more and all the -- you know, we haven't
21 quite got there with the duty of candour, we are part of
22 the way there. But the unfortunate thing is you do
23 see -- well, one, you see a number of Inquiries but
24 probably more pertinently, the Inquiries that you see
25 don't come up with dissimilar problems.

1 So we have got -- we have still got pockets where
2 I don't think it works properly and, you know, my
3 personal evidence of that is some of the issues that
4 have come up in this Inquiry are not unfortunately that
5 dissimilar from what came up in the first Mid Staffs
6 Inquiry when I was sort of sitting on the other side of
7 the desk and that was 15 years ago.
8 So we have got some things that are, you know,
9 long, long term problematic, I think I don't think they
10 are systemic to the NHS as a whole at all. But we have
11 got pockets of problems where it appears that people
12 don't recognise the generality of messages from
13 an Inquiry even though they may be focused on one
14 institution.
15 **Q.** I mean, there must be some aspect of either
16 generic NHS culture or deviant NHS culture which has
17 a major problem with transparency because it keeps
18 coming up over and over again in the Inquiries?
19 **A.** That's a good question.
20 What would I say to that? I would say that there
21 is a -- there is a difficulty that in some places, be
22 that on the clinical or the managerial side, people feel
23 it is a weakness to say that we have got something
24 wrong.
25 **Q.** Yes.

1 **A.** And I think in other walks of life, we have
2 moved away from that and we are moving away from it in
3 the NHS, but we need to go a bit faster.
4 And we do have some problems -- and I think this is
5 a case in point -- where when you have got a problem,
6 you do everything to try and solve the problem other
7 than absolutely face up to it.
8 **Q.** Yes.
9 **A.** And of course if you absolutely face up to it,
10 you usually end up in a better place in due course.
11 And we have done, we, the Department, over the
12 years have done a lot of work externally to try and push
13 people to do that with regulators and inspectors and
14 champions and all of those things, but there is also
15 a point that you need the organisation to take -- to
16 take on its responsibility.
17 And if I can give you one example of positivity
18 from recent Inquiries to illustrate that. We have got
19 an Inquiry that's finishing quite soon, the David Fuller
20 Inquiry, into the man who was, you know, a necrophiliac
21 in the mortuary and is now in prison.
22 And the first part of the Inquiry was into the
23 hospital and it said to the hospital: you made quite
24 a lot of mistakes here and you should have picked up on
25 this chap sooner and why did he have his own access to a

1 swipe card to the mortuary and things like that.
2 This had all happened over a period of years going
3 back to the, you know, 90s or 80s; a long time. And the
4 Maidstone and Tunbridge Wells Trust said: Yes, okay,
5 there is a problem here. We need to address it.
6 So the first report had 16 recommendations for the
7 Trust and we published the response some time last year
8 I think in the autumn and they had done them all. Now,
9 when I went down to the Trust what struck me was that
10 they were pretty open about learning from their mistakes
11 and they thought it was an issue to resolve and in
12 resolving it, it would be for the betterment of the
13 Trust overall.
14 So there are lots of good practice like that and
15 I think, it's a generality, but I think if you had had
16 that similar incidence 30 years ago in another part of
17 the NHS they probably wouldn't have responded in as open
18 a way. They would have thought it's an appalling story.
19 So there is work to do, but there are good signs of
20 progress.
21 **Q.** It's clear that the Department at least
22 recognises some of the issues or indeed promotes the
23 issues because you have the duty of candour being put in
24 place, you have whistleblowing protection being put in
25 place?

1 **A.** Yes.
2 **Q.** But I think you have read through the
3 transcript of Jane Tomkinson's evidence?
4 **A.** I have.
5 **Q.** She very candidly accepted that despite all of
6 that regulation, an instruction coming down to the Trust
7 it's just ignored in this, in this case. It appears to
8 be just bypassed. I mean, that's a cultural issue. How
9 do you deal with that? Is that through better
10 regulation of managers?
11 **A.** Well, I think manager regulation, for all the
12 reasons that I have said, would help and no doubt it
13 would help in relation to this. It's pretty odd that
14 we've got a significant group of professional people who
15 aren't regulated. I mean that's anomalous as Dr Kingdon
16 said.
17 I think there is a point, and it was always the
18 kind of contrary criticism of what we did, was that you
19 can carry on regulating people as long as you want but
20 actually for some people it won't shift the dial.
21 I think regulation absolutely has a role. We were
22 right to do all the things we did. But there comes
23 a point at which you have got to generate some of those
24 things from within.
25 And I think it does come back, as we said in these

1 statements, to having boards that are, you know, curious
2 rather than looking for security, as the board in this
3 instant wasn't, are sensitive about quality of patient
4 care, do listen to patient stories, aren't defensive and
5 don't enable tribalism amongst their different groups of
6 professionals, which clearly was the case here.
7 And I think, you know, we have got -- we have got
8 to get boards to do more work to look at their culture
9 themselves.
10 We promulgate, we exhort, we set policy, we
11 encourage. Our ministers can use their political
12 position, we can use our official position in terms of
13 issuing guidance, but in the end you are sending it out
14 to a group of people who are responsible for an
15 organisation that isn't something you're in day-to-day
16 charge of.
17 And maybe one of the solutions in a sense, going
18 back to what I was saying earlier today, is that if you
19 had a more structured programme of training both for
20 managers and clinicians, in some of these governance
21 issues you might greater openness because there are lots
22 of people, including the evidence you've seen,
23 Judith Smith, Michael West, who make clear that if you
24 have the right culture and the right governance you
25 probably get better patient outcomes.

1 So there is more we can do. But there is also more
2 the NHS can do and I think NHS England, you have, they
3 have been pretty, pretty enthusiastic in taking forward
4 the leadership and development and training programme.
5 But as Jane said there's a point at which you have
6 to get, you know, a sensible reception from the other
7 side. And, you know, with somebody like her at the helm
8 you are obviously going to get it because she recognises
9 the issue. You do have some places where the whole
10 thing is a bit intractable and we have to do more to
11 make sure that that stops.
12 **Q.** Yes. If I can come on, very briefly, to
13 candour as it interacts with patient safety reporting.
14 **A.** Yes.
15 **Q.** So there is an anonymous patient safety
16 reporting system NRLS, which allows patient safety
17 issues to be reported to a central database as
18 I understand it?
19 **A.** Yes.
20 **Q.** That's correct?
21 **A.** What did you say the acronym was?
22 **Q.** NRLS.
23 **A.** Yes. Well, it -- the National Reporting and
24 Learning Service.
25 **Q.** Yes. Now, what is done with the information

1 that is deposited in the NRLS?
2 **A.** Well, the NRLS was the scheme we had until,
3 you know, just a couple of months ago, which was the
4 main point of reporting for Trusts into NHS England for
5 patient safety incidents and that used to have -- a cut
6 of that data was analysed centrally to look for patterns
7 of care. But that now has been moved into the Learning
8 from Patient Safety Events, which is a more
9 sophisticated database, with machine learning that gives
10 my colleagues in NHS England who run patient safety more
11 larger real-time data that allows you to give messages
12 back out to the NHS about patterns of particular care.
13 So in a sense that is a -- it's a sophisticated
14 data management function which has just been recently
15 upgraded. It obviously is dependent on, on sensible
16 reporting and one of the issues we saw here was the
17 whole sort of knowledge of Datix and all of those
18 things --
19 **Q.** Yes.
20 **A.** -- was a little bit different between
21 different people and so it wasn't exactly clear what was
22 being reported when.
23 **Q.** But Datix is something that's reported
24 internally within the Trust and isn't --
25 **A.** Yes.

1 **Q.** -- isn't anonymous?
2 **A.** Yes.
3 **Q.** Whereas, so if you were to write down on
4 a Datix, "I am concerned that Nurse Letby is attacking
5 patients", then you would have to fill that Datix in.
6 The Trust would see that, it's not an anonymous
7 reporting. Whereas NRLS and its successor adopted as
8 their models the aviation reporting system in the US
9 where people could anonymously report safety issues --
10 **A.** Yes.
11 **Q.** -- and they would be acted upon.
12 Now, I looked at the NRLS data published online
13 through its website and the most recent published
14 information was from 2022 and it records in the period
15 between April 2021 and March 2022 over 90,000 incidents
16 were coded as patient abuse by staff or third party.
17 Now, I'm assuming by far and away the vast majority
18 of those are by third party rather than by staff. But
19 is anything done with that information? If somebody in
20 this case had reported a safety incident relating abuse
21 by staff, would anybody have done anything in response
22 to that?
23 **A.** Well, you would have expected somebody to do
24 something locally about because clearly the reason for
25 reporting into NRLS and then eventually back to

1 NHS England is to look at the, you know, totality of the
2 data and work out if there are any patterns.
3 But I mean in a sense, as I was saying to you
4 before, it's incumbent on the organisation locally to
5 have an understanding of reporting procedures and to
6 understand issues that are of concern.
7 In some places, you have low reporting because
8 people aren't sufficiently engaged in the process. In
9 other places, you have high reporting because people are
10 zealous about patient safety incidents and often high
11 reporting is an example of better learning.
12 So the precise numbers don't indicate in a sense
13 how good or bad an organisation is. They just tell you
14 about whether they are open about their mechanisms or
15 not.
16 **Q.** But these central reporting systems, are they
17 just a big warehouse where people send their concerns
18 and they are collated by statisticians and data
19 analysts?
20 **A.** I don't think they are just a warehouse
21 because, we try, because I mean --
22 **Q.** I don't mean a literal warehouse.
23 **A.** No, I know, I know you don't. I don't think
24 they just languish in the warehouse, I think that's your
25 point because NHS England do send the details and the

1 information back out to the NHS and I was referring this
2 morning to the fact that we did get a presentation about
3 how more better data could be produced in real-time as
4 a result of these new systems and it was, it was quite
5 persuasive that there will a lot more to learn more
6 quickly.
7 So I think and, you know, the replacement, LFPSE
8 and PSIRF, are very popular in the NHS and people think
9 they've, you know, they have improved arrangements also
10 not just in terms of the quality of the information but
11 in terms of the time taken and the efficiency that goes
12 with it.
13 **Q.** But in terms of a concerned member of staff
14 in, for the sake of argument, the Countess of Chester
15 Hospital, who wishes to report something centrally for
16 somebody to take action and help them because nothing
17 has been done locally, there isn't a mechanism, is
18 there, they have to use a Datix?
19 **A.** Well, the mechanism, the mechanism is intended
20 to get you the global and if you like the larger-scale
21 learnings. I mean if somebody had a concern like that
22 locally you would expect them to raise it through the
23 normal routes anyway and for the organisation to be, you
24 know, open and sensitive enough that they were going to
25 respond to it.

1 **Q.** Finally on a linked topic, the Inquiry heard
2 evidence from Dr Rosie Bennyworth from the Health
3 Services Safety Investigations Board and in particular
4 I asked her questions about protected disclosures --
5 **A.** Yes.
6 **Q.** -- in the context of their investigations.
7 **A.** Yes.
8 **Q.** Now, isn't there a tension between systems
9 which have the effect of reducing transparency and the
10 need for candour with those who are affected by the
11 incidents?
12 **A.** Yes. So and, and the bit she didn't answer
13 was the bit about why did we set up HSSIB in that way.
14 So the reason we set up HSSIB in what way was
15 because we had a problem with people speaking up as
16 discussed earlier and seen in this Inquiry and we knew
17 from the aviation industry that their sort of black box
18 approach of having the totality of the evidence in that
19 case in relation to a flight or a crash we might do well
20 to replicate that for the purposes of learning and that
21 that would encourage people to come forward. So there
22 would be a greater transparency and openness about
23 people's contribution and engagement.
24 But because we established HSSIB for the purposes
25 of, I mean, literally not just in terms of the phrase

1 "learning rather than blaming" and not for litigation
2 purposes that would be sealed unless the GMC or
3 a Coroner or, in exceptional circumstances, the PHSO
4 gave a court order to access it because you are always
5 going to have the rare exceptions. So that was the way
6 we set up HSSIB.
7 HSSIB is a learning organisation and we thought
8 that that was the best way to generate more learning.
9 You know, the trade off on the quid pro quo is that for
10 the outside world there isn't the transparency about the
11 precise details and events. On the other hand, the
12 findings of the investigations are absolutely
13 promulgated across the NHS.
14 So it's an approach. It doesn't cover all patient
15 safety incidents. It isn't the way we would, you know,
16 expect people to behave in the NHS. We would expect
17 them to talk and talk openly. But I think it's there
18 for a purpose because we had uncovered in a number of
19 investigations, including Morecambe Bay, which is really
20 where the recommendation came from, although the idea
21 had been mooted by one or two people previously, that
22 that was a good way forward to get out of this bind
23 where a family has a Serious Incident that they want
24 investigating, we want to investigate it for the
25 purposes of learning and we can't get right evidence to

1 do so. So that -- that's the logic of HSSIB.
2 **Q.** But it's possible, isn't it, to be told
3 information by somebody to accept it as credible and to
4 use it as part of your decision-making as to what
5 happened and for that to be communicated to the injured
6 parties without revealing who gave you that information
7 or indeed --
8 **A.** Yes, it is. And I mean, you know, the duty of
9 candour is predicated on being open about information
10 with people and --
11 **Q.** That's owed by the Trust to the injured
12 person, not by the HSSIB to the injured person?
13 **A.** Yes, that's right, the HSSIB is in a different
14 framework for its investigations so that's a small
15 subset. The duty of candour we have just explained.
16 And -- and of course there is, you know,
17 NHS Resolution, our litigation organisation, litigation
18 and safety learning organisation, makes very clear that
19 saying sorry is not an admission of guilt and people
20 should be encouraged to do that.
21 So from all angles we are trying to get to
22 a position of greater openness whether it's through
23 candour, regular interaction, whether it's through the
24 point at which something may turn into a case for
25 litigation or may not and then I think separately from

1 those two we have got the approach to HSSIB which is for
2 the purposes of safety learning.
3 **Q.** Yes, but there at all stages has to be
4 candour --
5 **A.** Yes, I mean there has to be candour with a --
6 with a big and a small C and, you know, I mean clearly
7 the evidence from this Inquiry is that there were quite
8 a lot of instances where there wasn't candour of any
9 kind --
10 **Q.** Yes.
11 **A.** -- and that was -- that contributed to the set
12 of problems. I have found in doing this job for
13 a number of years that there are two things that usually
14 go on where there's a problem. One is can you actually
15 sort out the problem, why it happened and explain it to
16 the small I injured party, and the second one is people
17 feel nervous about that and therefore they engage in
18 behaviour that isn't transparent and you have an even
19 worse job to try and unpick what was actually the truth
20 because somebody has been a bit evasive or difficult
21 about it and I think if -- we are desperate to drive the
22 latter out of the system so that we can concentrate on
23 the former.
24 **MR BAKER:** Yes, thank you. My Lady, I'm sorry if
25 I have gone slightly over time.

1 Questions by LADY JUSTICE THIRLWALL
2 **LADY JUSTICE THIRLWALL:** Thank you very much indeed
3 Mr Baker. Is there anyone else? No. Thank you.
4 Just one or two from me if I may, Mr Vineall.
5 **A.** Yes.
6 **LADY JUSTICE THIRLWALL:** I think in the Terms of
7 Reference I am asked to look at the accountability of
8 managers. We have rather focused on regulation of
9 managers not least because the consultation that has
10 come out which is obviously a subset of
11 accountability --
12 **A.** Yes.
13 **LADY JUSTICE THIRLWALL:** -- and may be thought to
14 be a very sort of physical demonstration of how you hold
15 people accountable. When you wrote your -- I think it
16 may have been your second statement --
17 **A.** Yes.
18 **LADY JUSTICE THIRLWALL:** -- or it may have been
19 your first. I'm sorry.
20 **A.** About manager regulation.
21 **LADY JUSTICE THIRLWALL:** Yes, at page 255, at that
22 point you were sort of setting out what the arguments
23 against regulation might be.
24 **A.** Yes.
25 **LADY JUSTICE THIRLWALL:** Or could be. I noticed

1 that that's how you described what they could include
2 and you began with: difficulty defining the skills and
3 competencies required of senior managers who are less
4 easily and clearly delineated than the clinical
5 competencies which are less clearly delineated and
6 knowledge needed for clinical health professions.
7 I understand the point that you are making, it's
8 probably not a reason not to regulate. I think the
9 point really is that it is not entirely clear what is
10 expected of managers and what they actually achieve.
11 Some managers, you can see a really good one when they
12 are working, but when you try and define what that is in
13 advance presumably it's quite difficult since that
14 argument was even one that was potentially something
15 that you could have thought people might raise.
16 **A.** Yes. So two parts to that; is the point in
17 255 Part A insurmountable? No. That was written under
18 the previous government.
19 **LADY JUSTICE THIRLWALL:** No, I understand that.
20 **A.** The current government is pretty clear that,
21 you know, we can find ways through these things.
22 **LADY JUSTICE THIRLWALL:** But on that first point,
23 is the way through or is one way through to be very
24 clear about what a good manager looks like to use that
25 horrible phrase?

1 **A.** No, I think it is, and that's why when the
2 Secretary of State was here in Liverpool, you know, in
3 his speech in November which just preceded the
4 announcement that -- the manager regulation wasn't
5 announced at the same time, he was making the case, as
6 he said not always terribly popular, that we need more
7 managers and we need better managers and a corollary of
8 having better managers is that you have better training;
9 hence the very senior manager pay framework, hence the
10 leadership development programme that NHS England is
11 doing, hence the work he has asked General Sir Gordon
12 Messenger to do on talent management.
13 So I think there is strong recognition from this
14 set of ministers that if you are going to regulate
15 effectively you have to have both the fence of the
16 standards that you are regulating against and you need
17 an infrastructure and a framework which is going to
18 enable people to deliver that; a bit like the
19 Helené Donnelly point: it's fine to regulate managers
20 but please can they be given the right support so that
21 they can do the job properly.
22 And we don't have that description at the moment.
23 **LADY JUSTICE THIRLWALL:** Yes. But first of all you
24 have to have the right people in post, don't you?
25 **A.** You do have to.

1 **LADY JUSTICE THIRLWALL:** Perhaps in an ideal world,
2 we would have had managers whose role and scope was well
3 understood by everyone and you would have had good
4 managers. Then the question of regulation would have
5 arisen. But what we are doing now is thinking if we want
6 to regulate, then in order to do that, we have to take
7 those prior steps. I am not saying that that's not
8 a good idea, but that is how we have got here, isn't it?
9 **A.** Yes, yes. I mean, the other way, or maybe the
10 way I put it is we are doing it in a sense the other way
11 round; that we have got management in different formats
12 and now we are saying: Let's regulate it. Whereas what
13 you usually do when you establish a profession or
14 a group is as they develop you regulate in lockstep.
15 The Royal College of Physicians was established in
16 contradistinction to quackery and they said: Right,
17 we're not quacks, we are doctors and then we'll go from
18 there.
19 Now for management, I think -- I thought about this
20 before I came here -- there are identifiable groups of
21 people. There's the people who do the general
22 management training scheme, a tiny number, the elite;
23 they've been there since 1956, Judy Smith said.
24 **LADY JUSTICE THIRLWALL:** Yes, we've heard evidence
25 some about that.

1 **A.** So 1. 2) there are the group of people a lot
2 of whom have been to the Inquiry and who I have seen
3 throughout my career in the NHS which is people who
4 started as clinicians, often but not always nurses, who
5 become managers and doctors who become managers and
6 become Chief Executives, there's a second group.
7 There's the group of people who are a lot of people
8 in the health service -- who would have been me if
9 I hadn't moved from the NHS into the Department -- who
10 start off at the ground floor and work their way up and
11 maybe don't go through as many schemes but still become
12 managers. And then obviously there's the group of
13 people who come in later in life.
14 A lot of people when we, you know, introduced the
15 Trust movement in the early '90s there were quite a lot
16 of people who came in from large organisations,
17 including the Armed Forces because they had an
18 understanding of structures and systems. There is, you
19 know, there is the faculty of management and leadership
20 in medicine which has quite long established and quite
21 good rubrics for what a decent manager who's come from
22 clinical life looks like.
23 **LADY JUSTICE THIRLWALL:** Sorry just to cut across
24 you, but what's clear is there are lots of routes into
25 management.

1 **A.** Well, but there are lots of groups, there are
2 lots of groups who are there already and there are lots
3 of routes. So your point which is we are sort of
4 regulating but we have already got quite a lot of the
5 groups in place they need to inform how we do that
6 regulation.
7 **LADY JUSTICE THIRLWALL:** Yes.
8 **A.** That's the point that was --
9 **LADY JUSTICE THIRLWALL:** Yes. No, I understand.
10 **A.** -- that the sort of posited point I was
11 making.
12 **LADY JUSTICE THIRLWALL:** I understand that. The
13 other thing which unsurprising you haven't referred to
14 but what I think is certainly something to be considered
15 is historically the sort of resentments or tribalism,
16 call it what you will, between the clinicians on the one
17 hand, the managers on the other, the first thinking that
18 the second are seeking to sort of take over --
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** -- and the second thinking
21 they are being talked down to to put it --
22 **A.** That's a good summary.
23 **LADY JUSTICE THIRLWALL:** I think, it is my
24 observation that that has rather changed so that it's
25 now the doctors who feel talked down to and the managers

1 who feel that they are in the ascendant. That's a very
2 general observation.
3 **A.** Yes.
4 **LADY JUSTICE THIRLWALL:** But it certainly is not
5 an observation I think one would have made 20 years ago.
6 So there has been that shift. I think it probably goes
7 to the question of culture, the sort of understanding
8 and mutual respect of the qualities of the other person.
9 I mean, it doesn't just go to managers and doctors or
10 nurses or whoever. But there needs to be that
11 understanding what the other person is doing, respect
12 for what they are doing and then a collaborative
13 approach, which I know is very easy to say, and I think
14 it's much harder to actually achieve or seems to be?
15 **A.** I think that's important, very important. And
16 I mean it was interesting that Gordon Messenger said in
17 his original report in the summer of 2022 that to him,
18 coming from the Armed Forces, he thought the NHS
19 appeared like of federated ecosystem, which was a great
20 phrase. And then he followed on by saying: in which
21 managers don't feel they have the right profile, in
22 which the medical culture can be sometimes a little bit
23 difficult to get on with, in which people aren't always
24 respectful of one another and in which across the piece
25 equality, diversity and inclusion is not what it should

1 be and not what it is in other walks of life. So ...
2 **LADY JUSTICE THIRLWALL:** Yes. I mean we obviously
3 heard his evidence about that. It's not very
4 surprising.
5 **A.** Yes. So we have got a bit of an issue across
6 the piece that the cultures aren't talking to each
7 other.
8 **LADY JUSTICE THIRLWALL:** Can I just ask a sort of
9 supplementary question. Sorry, I don't mean to cut
10 across you.
11 **A.** That's all right.
12 **LADY JUSTICE THIRLWALL:** You can always finish off
13 if you want to.
14 **A.** No, I've finished more or less.
15 **LADY JUSTICE THIRLWALL:** But we have a situation
16 where you have got the graduate scheme --
17 **A.** Yes.
18 **LADY JUSTICE THIRLWALL:** -- which you described as
19 an elite scheme and Professor Smith talked about, you
20 know, it's not quite fair that people who come in in
21 a different way don't have those same opportunities.
22 Well, irrespective of whether it's fair or not it's
23 the way it is. But, is there not a way of providing the
24 same quality of training for people who come in via
25 different routes, the people in those different groups

1 that you were identifying?
2 **A.** Yes, I agree with that and she's quite right,
3 which is if you are not, you know, through that elite
4 route which exists in all sort of equivalent
5 multi-national organisations -- they all have graduate
6 schemes for the top people, don't they -- you need some
7 structures for all the rest of the people who are coming
8 in. And I noticed, you know, what is
9 Sir Gordon Messenger was saying was you need to do this,
10 you know, you need middle management and early entry and
11 mid-career points just like you would have in any other
12 large organisation.
13 So we do need to do all of that work and
14 NHS England, you know, are starting out on some of these
15 things; a management training programme, they have
16 obviously got the leadership competency framework for
17 boards so they have got the top-end stuff. So we do
18 need to do that.
19 And I think you could end -- we would hopefully end
20 up with a virtuous circle where we have regulation of
21 managers so people know what it means to be a manager
22 and we have training structures that support people to
23 become better managers. And that way both doctors and
24 the general public and anybody else understand that
25 management is a reputable profession.

1 And if there have been situations where there's
2 been this movement round to one person feeling they have
3 the upper hand to the other person feeling they have the
4 upper hand, we can end that and agree that we all need
5 to be on the level. That's where you want to get to.
6 You know, my experience of working with clinicians
7 is, you know, they're good, clever and decent people to
8 work with.
9 I think when you get difficult situations or
10 extreme situations, like the one we have been talking
11 about here, you do get a reversion to that tribalism and
12 we do unfortunately see that in the worst cases that
13 I was just discussing previously and we sometimes see
14 that through boards and through the leadership of those
15 groups and organisations, and we really need to be
16 moving away from that.
17 **LADY JUSTICE THIRLWALL:** Regulation of managers may
18 be one way of doing that, but it's not all, is it?
19 **A.** Regulation of managers is a component part of
20 that.
21 **LADY JUSTICE THIRLWALL:** Yes.
22 **A.** Regulation of managers is there because it's
23 anomalous that we don't have it.
24 **LADY JUSTICE THIRLWALL:** I think Mr Jarrold said
25 rather wisely was that actually what you want is a Code

1 of Conduct not regulation because it's not a profession,
2 whereas you have put it: it's a lot of professionals,
3 but there isn't a sort of recognised --
4 **A.** There isn't recognised --
5 **LADY JUSTICE THIRLWALL:** -- management.
6 **A.** I mean, I didn't agree with -- I mean his
7 point was slightly, I think he said you shouldn't
8 regulate managers because you can't define them as
9 a profession. Now, I'm not --
10 **LADY JUSTICE THIRLWALL:** Yes, that's absolutely
11 what he said, yes.
12 **A.** I am not persuaded about that.
13 **LADY JUSTICE THIRLWALL:** Yes.
14 **A.** We know what the NHS is.
15 **LADY JUSTICE THIRLWALL:** That's why we go back to
16 the point we made about what you want them to do.
17 **A.** Management has existed for 100 years and you
18 can pretty well explain what it is; systems in
19 organisations and pulling things together and making
20 something from component parts.
21 We have, the point I was making to you, we have
22 a number of different professional management groups in
23 existence at the moment. It cannot be impossible to
24 draw that into a structure for, you know, a profession
25 of management that is properly regulated both at the top

1 level where it paradoxically is probably slightly easier
2 to do it --
3 **LADY JUSTICE THIRLWALL:** Yes.
4 **A.** -- and through the routes coming down.
5 I just, you know -- we can do that.
6 You know, that's what we are intending to do.
7 **LADY JUSTICE THIRLWALL:** Yes. What about at the
8 levels of ward managers, which is a different role and
9 a more circumscribed role, but what is the thinking
10 behind what the standard should be for people in those
11 situations? Because that has the ability, doesn't it,
12 to make people's lives quite difficult?
13 **A.** Yes. I don't -- I don't think I have as
14 knowledgeable an answer to that. The only answer
15 I give, which is a little bit packed but is true, which
16 is we are asking, well, we are asking within the
17 consultation at what level regulation of managers should
18 apply; top, middle, right down to the bottom end.
19 And there is a very important question about what
20 we do in terms of those people who, if you like, are
21 double qualified; some of the people who have been here
22 who started off as clinicians and became managers. Do
23 we write management into their clinical practice or do
24 we have something that sits across the two?
25 **LADY JUSTICE THIRLWALL:** Yes.

1 **A.** So I think, you know, we need -- there's,
2 I mean the consultation has a lot of detailed questions
3 quite a lot of which are about scope and level.
4 **LADY JUSTICE THIRLWALL:** Yes.
5 **A.** Because 1) we need to make sure we include the
6 right people and, secondly, we need to ensure that the
7 nature of the regulation is proportionate, right-touch
8 regulation, which is a bit jargonistic --
9 **LADY JUSTICE THIRLWALL:** It is.
10 **A.** -- but it's the point about be common-sensical
11 in how far, you know, in the structures you use to
12 regulate people. You know, one of our professional
13 organisations, the Health and Care Profession Council
14 holds accredited registers for new professions.
15 So I'm not saying in saying any of that that that's
16 the way we are going to go with management regulation.
17 But I am saying that proportionate regulation does exist
18 from those emerging professions that that organisation
19 looks after to the sort of, you know, most sophisticated
20 brain surgeon who works for the Royal College, you know,
21 who has some regulation through the GMC and the
22 Royal College of Surgeons.
23 So you have got to be sensible and obviously
24 whenever you regulate something and you are starting
25 off, you have got to have some ability to bring on

1 people who are mid-career into that and you don't want
2 to introduce it with such sort of -- so much
3 infrastructure that it's off-putting to getting people
4 to come in and you know starting that career.
5 So, you know, how you land and introduce this thing
6 you have to be careful about.
7 **LADY JUSTICE THIRLWALL:** Yes, but if someone wants
8 to be a doctor or a nurse they are not put off by the
9 fact that they're going --
10 **A.** No, no, I am not saying they are not put off.
11 But you just make sure, if you are going from having
12 nothing at all to something, you have to make sure the
13 something is of the right proportion.
14 **LADY JUSTICE THIRLWALL:** Yes.
15 **A.** And, you know, it isn't sort of, you know,
16 extreme.
17 **LADY JUSTICE THIRLWALL:** Yes. Understood.
18 Then doctors and nurses I think pay for their
19 regulator, don't they?
20 **A.** Yes.
21 **LADY JUSTICE THIRLWALL:** I'm sorry I have not had
22 a chance yet to read the consultation. But is that part
23 of the picture, that managers will have to pay for their
24 regulation?
25 **A.** Well, no decision has been made on that and

1 I am now going from memory, but in the front of the
2 consultation document we pointed out where certainly in
3 setting up infrastructures costs would be likely to fall
4 to government. I think that that's as much as we said.
5 **LADY JUSTICE THIRLWALL:** I'm just thinking about
6 the resentments and the opportunities for things to be
7 done a bit better.
8 It would be -- it seems an obvious human response,
9 that if one group is not having to pay for their
10 regulation and the others are, I think that's just
11 a very easy way of making people feel resentful, leaving
12 aside questions of pay and hours and how long they have
13 had to work to get there, et cetera, et cetera.
14 There's a lot to think about --
15 **A.** Yes.
16 **LADY JUSTICE THIRLWALL:** -- as I know you know. A
17 separate question --
18 **A.** So a plea for consistency there, I think is
19 what you were saying.
20 **LADY JUSTICE THIRLWALL:** Yes, consistency across
21 the piece.
22 A separate and different question. I don't want to
23 take a long time over the memorandum of understanding.
24 **A.** Yes.
25 **LADY JUSTICE THIRLWALL:** The December 24 document.

1 But just really to make the observation there is no
2 reference anywhere to the question of safeguarding, you
3 know, what you do in a situation where the harm is being
4 done or you suspect, on whatever basis, you suspect that
5 harm is being done to a child and there is no reference
6 to that. Was that, as far as you know, a deliberate
7 omission?
8 **A.** I don't know, but we can take it away and look
9 at it.
10 **LADY JUSTICE THIRLWALL:** Yes. It seems to me
11 because the guidance there is very clear as to what has
12 to be done in whatever the situation, including to
13 healthcare professionals, to everyone. So it may be it
14 may have been an oversight, but if you wouldn't mind,
15 would you be able to just do a short couple of
16 paragraphs on whether or not it was omitted
17 deliberately?
18 **A.** Yes, we'll send that to you.
19 **LADY JUSTICE THIRLWALL:** Just to finish that off.
20 **A.** Definitely.
21 **LADY JUSTICE THIRLWALL:** Thank you very much.
22 Does anybody want to ask anything arising out of
23 that? No.
24 Happily, it's 29 minutes past 4 so we finished on
25 time. Thank you very much indeed, Mr Vineall, for

1 coming to give your evidence. You are free to go.
2 We will start again tomorrow at 2 o'clock.
3 **MR DE LA POER:** I believe so, my Lady, yes.
4 **LADY JUSTICE THIRLWALL:** 2 o'clock tomorrow. Thank
5 you all.
6 **(4.29 pm)**
7 **(The Inquiry adjourned until 2.00 pm,**
8 **on Thursday, 16 January 2025)**
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