

Friday, 17 January 2025

1

2 (9.30 am)

3 **LADY JUSTICE THIRLWALL:** Ms Brown.

4 **MS BROWN:** Yes, if we could call Mr Kark, please.

5 MR TOM KARK (affirmed)

6 Questions by MS BROWN

7 **LADY JUSTICE THIRLWALL:** Do sit down, Mr Kark.

8 **A.** Thank you.

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

10 **A.** Tom Kark.

11 **Q.** You have provided a witness statement to the  
12 Inquiry dated 24 July 2024 and is that true to the best  
13 of your knowledge and belief?

14 **A.** Yes.

15 **Q.** Mr Kark, you are a barrister called to the Bar  
16 at Inner Temple in 1982, appointed as Queen's Counsel in  
17 2010. Also in 2010 you acted as Counsel to the Inquiry  
18 in the Mid Staffordshire NHS Trust Public Inquiry  
19 chaired by Robert Francis, now Sir Robert Francis, and  
20 in 2018, you were asked by the then Minister of Health,  
21 Stephen Barclay, to examine the working and  
22 effectiveness of the Fit and Proper Person Test under  
23 Regulation 5 of the Health and Social Care Act 2008; is  
24 that correct?

25 **A.** Yes.

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1 Sir Robert Francis highlighting in 2013 the problem and  
2 despite the response of the Government in their  
3 Hard Truths document was it still identified as being  
4 a problem in January 2018 by Dr Kirkup?

5 **A.** Well, first of all the CQC wasn't given the  
6 sort of powers that the Government had said it was going  
7 to be given, and as I said in my report, they, frankly,  
8 as far as I could tell when I spoke to them, didn't want  
9 those powers and they are not set up to undertake that  
10 sort of exercise because in general terms, as you know  
11 better than I do, they, they regulate organisations.

12 And one of the central parts of the test was that  
13 directors should have the skills -- I can't quite  
14 remember the wording but the skills competence and the  
15 qualifications to undertake the role that they were  
16 being appointed to. But those weren't set out anywhere.

17 So what was happening was that if you had a very  
18 well-known very good teaching hospital you might have  
19 a queue round the block when they advertised for  
20 a director's position and they could use that test, you  
21 know, with a considerable amount of rigour.

22 If, on the other hand, you had a Trust that wasn't  
23 so popular, as it were, or attractive, and there was  
24 very often a dearth of applicants then what were the  
25 skills and competence to do a director's job became

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1 **Q.** The report you prepared with fellow barrister  
2 Jane Russell was published in February 2019 and you have  
3 set this out in your statement. But could I just ask  
4 you to explain what the reason was for the commissioning  
5 of that report in 2018 looking at the Fit and Proper  
6 Person Test as it applied to directors of hospitals and  
7 Health Trusts?

8 **A.** Yes, certainly. So the background is that  
9 Sir Robert Francis in his report recommended that there  
10 should be what he described as a new Fit and Proper  
11 Person Test with much stronger powers, including the  
12 power to effectively disqualify a director.

13 The Government responded to that with their  
14 document called -- and this is set out I think in my  
15 statement -- "Hard truths", where they made a, gave  
16 a number of assurances as to what they were going to do  
17 and they were going to give the CQC additional powers  
18 effectively to disqualify directors. And then I think  
19 in the middle of all of this Dr Bill Kirkup was  
20 undertaking a review of the Liverpool Trust, where  
21 things had gone badly wrong, and one of the things that  
22 he said was that there should be a review of the Fit and  
23 Proper Person Test. And I think that's what led to me  
24 being instructed to conduct that review.

25 **Q.** And why in your view was it that despite

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1 something of a sliding scale. So there was no benchmark  
2 for what any of that really meant.

3 So parts of the test were very easy to adopt, so  
4 you can check to see if somebody is on the DBS list, you  
5 can check to see if they have been erased by the GMC or  
6 whether they are bankrupt. Those were the what I have  
7 called in my report the "barn door" tests, those are  
8 very easy but the skills and competence and  
9 qualification was much harder and so that was one of the  
10 reasons certainly that I think the test was failing.

11 The second obvious reason was there was no power to  
12 disqualify. So what was happening, and this has been  
13 a problem in the NHS I think for a very long time, it's  
14 been identified by people long before I identified it,  
15 was the so-called revolving door of the NHS where people  
16 have potentially misbehaved or behaved very badly, they  
17 come to a settlement agreement with the Trust to save  
18 the Trust the bother of having to go through a full  
19 disciplinary process, part of that settlement agreement  
20 is a vanilla reference.

21 The director moves on to the next Trust down the  
22 road and the problems get --

23 **LADY JUSTICE THIRLWALL:** Did you say a nil  
24 reference or a vanilla reference?

25 **A.** Vanilla.

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1 **LADY JUSTICE THIRLWALL:** I thought that, just so we  
2 get it on the transcript.

3 **A.** One that says "X has been employed here  
4 between X date and Y date and their conduct was  
5 satisfactory" or something which is anodyne and  
6 unhelpful.

7 And so under the test as it was there was  
8 absolutely no way of closing that door off and also what  
9 was happening was that if, if a director had been found  
10 to have been misbehaving and they left a Trust, they  
11 would go into one of the other sections of the NHS:  
12 apparently NHS Improvement was often a welcome  
13 organisation, surprisingly.

14 They would spend a few years in some other bit of  
15 the NHS, then they would pop out again into another  
16 Trust and I think that was thought to be extremely  
17 unattractive.

18 **MS BROWN:** Just picking up on that, Mr Kark, so  
19 when your report was published in February 2019 that  
20 problem of poorly performing directors moving from Trust  
21 to Trust I think you refer to the revolving door that  
22 Robert Francis had highlighted. Your Inquiry or your  
23 report found that that was very much still a problem --

24 **A.** Yes.

25 **Q.** -- in 2019?

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1 Counsel to the Inquiry, but also then as someone writing  
2 a report, what was your understanding of why it took so  
3 long and particularly why it took so long for a response  
4 to your report that was requested from 2018 when you  
5 were commissioned to do it until 2023 when the framework  
6 came out?

7 **A.** Well, in some ways I thought the response to  
8 my report was quite quick. I don't mean to be flippant  
9 but things work very, very slowly. But also making, it  
10 is, it is easy to make a recommendation actually putting  
11 recommendations into practice I think one has to  
12 recognise takes a lot of effort and I think one does  
13 have to recognise that the work that must have gone into  
14 the framework was very extensive because of a lot of  
15 consultation et cetera. So I am simply pleased that  
16 there is now a framework and that something has  
17 happened.

18 Of course it could have happened quicker and it  
19 probably should have happened long before I reported.

20 **Q.** And the framework came out in August 2023.  
21 Are you aware of whether the Letby case was instrumental  
22 in promoting or prompting that framework coming out at  
23 that point?

24 **A.** I don't know.

25 **Q.** And just staying with the issue of

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1 **A.** Certainly. And when we spoke to a number of  
2 whistleblowers and to those who were responsible for --  
3 Speaking Up Guardians and the like, they all had stories  
4 of having been bullied effectively and found themselves  
5 out of a job, either the director who bullied them was  
6 continuing in that function or had moved to another  
7 Trust and I think Dr Bill Kirkup pointed out one of the  
8 problems was sometimes that a bullying manager would get  
9 moved to another hospital but within the same area and  
10 the person who had been bullied might find themselves  
11 actually still working for that individual.

12 So there was this constant sort of merry-go-round.

13 **Q.** Just thinking then a little bit about the  
14 chronology. We have got Sir Robert Francis's reporting  
15 in 2013, Dr Bill Kirkup in 2018, your report being  
16 published in 2019 and we will come to it, but the  
17 framework responding to your recommendation not being  
18 published until 2023, and it's correct, I think, that  
19 throughout this period from 2013 onwards, the problems  
20 that Sir Robert Francis had highlighted carried on being  
21 a problem?

22 **A.** They had been highlighted by Sir Ian Kennedy  
23 long, long before, and subsequently by Lord Rose and  
24 various others.

25 **Q.** And given your experience as well both as

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1 implementation of recommendations, are there any factors  
2 that you consider to be changed to hasten the process  
3 you have explained that it is a complex process putting  
4 recommendations into -- into practice. But are there  
5 any factors that you think could assist in that  
6 happening more quickly?

7 **A.** Do you mean in terms of when a report writer  
8 makes recommendations and then what happens?

9 **Q.** Yes, the process after a report, are there  
10 practical things that could assist in those  
11 recommendations being brought to fruition more quickly?

12 **A.** This, this has been looked at quite recently,  
13 hasn't it, by the House of Lords, the Select Committee  
14 or a Special Committee looked at the implementation of  
15 reports and it was interesting to read that the previous  
16 report that had been written by the same Committee in  
17 2014, half of the recommendations had been adopted by  
18 the Government and then never put into effect.

19 So it's not just Inquiry Chairs who have this  
20 problem.

21 One of the difficulties that I faced, and I am  
22 currently having to face in my other role, is that as  
23 soon as you have written your report, whether you are  
24 just a report writer as I was or you are a Public  
25 Inquiry Chairman, your power dissipates as soon as you

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1 have delivered your report and this is a common  
 2 complaint, I think, by Inquiry Chairs.  
 3 Robert Francis had the clever idea of keeping his  
 4 going, I think, for a while because he got the Health  
 5 Select Committee on board to review his recommendations  
 6 and I think -- as to which recommendations had been  
 7 brought into effect, and that was I think partly  
 8 successful. I think they did that for about two years  
 9 and then it got lost in the ether.  
 10 And other Chairs had taken steps like issuing an  
 11 interim report but holding the very, very final report  
 12 back so that they could still call people back.  
 13 But I think that is one of the main problems with  
 14 the Inquiries Act, that your power just dissipates once  
 15 you have delivered and I personally found it very  
 16 difficult keeping track of what on earth was happening  
 17 about my recommendations. It's even harder, if I may  
 18 say, so as a mere barrister; you have absolutely no  
 19 weight at all. And it was about four years later that  
 20 I discovered purely because I received an email and  
 21 somebody's title was the Kark Implementation Manager and  
 22 that was the first time that I knew I was being  
 23 implemented that many years later, because nobody had  
 24 contacted me until then.  
 25 So your report goes into the ether and very often

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1 settlement agreement ought not to be able to prevent  
 2 a reference from being full, open and honest."  
 3 It's here in your report you go on to talk at 8.22  
 4 about vanilla references and then at 8.23 seeking to  
 5 prohibit vanilla references which may paint a misleading  
 6 picture by omission.  
 7 And if I could just turning briefly to the facts of  
 8 the case that we are looking at, if we could go to  
 9 INQ0015683-0031, this -- just while we are waiting for  
 10 it to be called up, to explain, this is what's referred  
 11 to as the narrative announcement or what might be said  
 12 to be the reference that accompanied the settlement  
 13 agreement for Mr Chambers.  
 14 Looking down there to the third paragraph, just to  
 15 pick out one of the phrases, it says there:  
 16 "Tony's stepping down as CEO at the Countess is the  
 17 result of extraordinary circumstances and is not  
 18 a judgement on his ability as CEO but more a reflection  
 19 of his integrity as a leader."  
 20 Mr Kark, I am aware you don't know all the  
 21 circumstances of this case in detail. But is that the  
 22 sort of reference or announcement that led to your  
 23 concern that led to a recommendation in relation to full  
 24 and honest references?  
 25 **A.** Well, I would rather answer that in the

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1 it's very, very difficult to keep track of what's  
 2 happening.  
 3 So I think it would be -- sorry, this is a very  
 4 long answer to a short question. But I think it would  
 5 be very, very helpful to have somebody in the sponsoring  
 6 department who is tasked with keeping you in touch with  
 7 what is going on. And I know the Cabinet Office have  
 8 now set up their Inquiries Section, so that may help.  
 9 **Q.** And if we could turn now to a specific aspect  
 10 of your report and if we could call up INQ0012637, 0097,  
 11 and, Mr Kark, for your reference I think you have a copy  
 12 of your report in front of you, this is internal  
 13 page 91.  
 14 **A.** Thanks.  
 15 **Q.** So you deal there with settlement agreements  
 16 which we have touched on and you set out in your  
 17 statement that in order to carry out your review you  
 18 interviewed a large number of people: Trust Chairs,  
 19 Chief Executives, senior nurses, whistleblowers.  
 20 And dealing with settlements, what you say there at  
 21 8.21:  
 22 "The real issue with settlement agreements,  
 23 however, is not necessarily the agreement itself but the  
 24 agreement as to the nature of the reference that follows  
 25 the director out of one employment and into another. A

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1 generality, if I may, because I know nothing -- apart  
 2 from what I have read in the press, I know nothing about  
 3 Mr Chambers' circumstances, so I don't, with respect,  
 4 want to comment specifically on this. But what -- there  
 5 is, there has been I think a real problem, probably  
 6 contributed to by us lawyers, who make part of  
 7 a settlement agreement an agreed reference.  
 8 And I -- I think that that is very often something  
 9 which goes contrary to the wider duty of candour, the  
 10 duty of candour is obviously normally focused on the  
 11 patient experience. But it certainly can lead to  
 12 references which are not candid and which do not set out  
 13 the full circumstances of somebody's departure.  
 14 In -- in particular it's been used as a method of  
 15 avoiding a full disciplinary hearing. So it's much  
 16 easier for a Trust, and one can readily understand this,  
 17 to come to a settlement agreement if they can, pay the  
 18 individual off and agree a reference and make the  
 19 problem go away.  
 20 And that is often far cheaper for the Trust to do  
 21 but it has extremely unfortunate potential consequences  
 22 because that then becomes a problem for the next Trust  
 23 and I am not speaking about this specific case.  
 24 **Q.** Yes.  
 25 **A.** But -- but it's a very, very common, has been

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1 a very common problem and I do remember  
 2 a human resources director saying to me it would help  
 3 tremendously if there was something in the statute that  
 4 said: you can have a settlement agreement but it cannot  
 5 dictate the terms of the reference. Because that would  
 6 allow the Trust to say, well, I am very sorry but the  
 7 regulator won't allow us to do this.

8 **Q.** Thank you, that could go down now, please.

9 In terms of the framework we will come to in  
 10 a moment but while we are on the issue of references, in  
 11 terms of the framework that's been put in place now, do  
 12 you think that goes far enough to address that problem  
 13 with references?

14 **A.** Well, I have a bit of, this is the one area  
 15 where I had a bit of difficulty with the framework and  
 16 what it's actually saying. I don't know if it's  
 17 possible to get the framework up. It's your Inquiry  
 18 reference 0036.

19 **Q.** So it's, the framework is INQ0012645?

20 **A.** And then dash 0036. And it may just be my  
 21 lack of knowledge or understanding.

22 If you look to the second paragraph starting:  
 23 "request for board member references", requests for  
 24 board member references should not ask for specific  
 25 information on whether there is a settlement agreement

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1 this ended up. If you are starting off by saying that  
 2 you shouldn't, when you are asked for a reference, ask  
 3 for specific information about whether there has been  
 4 a settlement agreement, I can't understand why not, why  
 5 can't you ask the question at least?

6 And then I thought the words "organisations should  
 7 consider inclusion of the term", I don't think with  
 8 respect that is going to cut it once the lawyers get  
 9 involved in a settlement agreement.

10 I think this probably has to be statutory to cut  
 11 through -- or certainly stronger than this, to cut  
 12 through lawyers' demands, you know, "X won't sign this  
 13 unless you agree a settlement".

14 **Q.** Thank you.

15 If we can then, following on slightly from that, go  
 16 through your what your recommendations were so that we  
 17 can then follow them through. So if you could go back  
 18 now to your report, so INQ0012637-0133, and this is  
 19 internal page of your report page 127 where you set out  
 20 the recommendations.

21 **A.** Yes.

22 **Q.** If I may, I am just going to go through the  
 23 first five recommendations which are the most  
 24 significant for the purposes of this Inquiry to seek any  
 25 additional comments.

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1 non-disclosure agreement in place.

2 And then it goes a couple of paragraphs on:

3 "If there is a historical settlement agreement,  
 4 non-disclosure agreement already in place which includes  
 5 a confidentiality clause, NHS organisations should seek  
 6 permission from all parties prior to including any such  
 7 information in a board member reference."

8 Then the existence -- sorry skipping one paragraph,  
 9 well no, let's just ...

10 "Going forward NHS organisations should consider  
 11 inclusion of the term in any proposed settlement  
 12 agreements to state the information about the settlement  
 13 agreement can be included in the ESR."

14 And first of all I think those words "should  
 15 consider", it seems very weak to me. Either you are  
 16 telling them to do it or you are not telling them to do  
 17 it. And then:

18 "The existence of a settlement agreement does not  
 19 in of itself determine that a person is not a fit and  
 20 proper person."

21 And then, sorry, over the page, the top of the next  
 22 page:

23 "The reference should include information regarding  
 24 discontinued, outstanding or upheld complaints."

25 So I was just a bit uncertain about where, where

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1 Recommendation 1, sorry, we should have --

2 **A.** I think you are on the wrong page.

3 **Q.** It's 0133, I think we have got up there 0033.  
 4 It's 133, the page we are looking for.

5 So Recommendation 1:

6 "All directors, Executive, Non-Executive and  
 7 Interim, should meet specific standards of competence to  
 8 sit on the board of any health-providing organisation.  
 9 Where necessary, training should be available."

10 You go on to say:

11 "We recommend that high level core competencies  
 12 should be embodied in a schedule to the regulations and  
 13 that further guidance should be issued."

14 Going over the page, you say:

15 "We recommend that the CQC should during the  
 16 Well-Led Inspection review the evidence including  
 17 sampling appraisals in respect of the directors to  
 18 ensure that they are currently able to meet the core  
 19 competencies."

20 Is there anything in light of what has now happened  
 21 in terms of the framework that you think it would be  
 22 helpful to add to that or that sums up your  
 23 recommendation in terms of --

24 **A.** No, the framework obviously has -- the, what's  
 25 it called? The board members' framework obviously has

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1 to be read now in conjunction with the competency  
 2 framework.  
 3 **Q.** Yes.  
 4 **A.** I think I was encouraged to see that actually  
 5 the CQC does seem to have -- and I can't remember where  
 6 it is and, I'm sorry, but I think the CQC in the  
 7 framework is actually being asked to look at the, the  
 8 actual competencies that the director has and that's  
 9 something of a shift I think for the CQC because  
 10 certainly when I was speaking to them they were  
 11 obviously very process-driven and they would look to see  
 12 if there were references in the box, they would look to  
 13 see if a DBS check had been done, but they wouldn't  
 14 actually look at the quality of what was in the box.  
 15 And this, I think there is a bit of a shift here that on  
 16 a -- and I presume it's still on a Well-Led inspection,  
 17 if those still exist, I think they do, that the CQC are  
 18 actually now being asked to look at the quality of the  
 19 information.  
 20 I have looked at the competency framework.  
 21 **Q.** We can go to that now if you wish. I was  
 22 going to come to that?  
 23 **A.** Sure, sure okay.  
 24 **Q.** We can look at it together maybe just so that  
 25 we can work through the recommendations.

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1 "We recommend the setting up of an organisation  
 2 which will have the power to suspend and disbar  
 3 directors covered by Regulation 5 who are found to have  
 4 committed serious misconduct".  
 5 And you postulate a body that you refer to as the  
 6 Health Director Standards Council. I just wonder if you  
 7 could expand a little bit more, that recommendation  
 8 hasn't gone into place, there is now a consultation  
 9 that's going on, but what are your views now as to  
 10 whether there's a need for something along those --  
 11 those lines is, that is outstanding?  
 12 **A.** Well, I am certainly of the same view that  
 13 I was when I wrote the report. And indeed as I said,  
 14 Sir Robert Francis had effectively made the same  
 15 recommendation. And, sorry, some other august person  
 16 also made the same recommendation even before  
 17 Robert Francis but I can't remember -- I think it was  
 18 Sir Ian Kennedy, actually, recommended a body overseeing  
 19 all aspects of regulation to include senior healthcare  
 20 managers. So that goes back to 2001, I think.  
 21 So yes, certainly, I am of the same view.  
 22 I do think it's important to define precisely what  
 23 you are trying to do with this and there is a real  
 24 danger of over-regulating and of making the very  
 25 difficult job of senior managers in the NHS even more

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1 Recommendation 2:  
 2 "The central database of directors should be  
 3 created holding the relevant information."  
 4 And that's something that is addressed in the  
 5 framework?  
 6 **A.** Yes.  
 7 **Q.** Then on to page 136, internal page 130,  
 8 Recommendation 3 I think we have dealt with this, I am  
 9 just going through what the main recommendations were,  
 10 the creation of a mandatory reference requirement?  
 11 **A.** Yes.  
 12 **Q.** And it's very clear what your recommendation  
 13 was: full, honest and accurate mandatory employment  
 14 references and we have looked a little about your  
 15 reservations on the framework in relation to that.  
 16 Recommendation 4 then, page 137 internal page 131,  
 17 that the Fit and Proper Person Test should be extended  
 18 to all Commissioners and other arm's-length bodies?  
 19 **A.** Which they have done, I think. They haven't  
 20 done it by statute but they have done it in the, in the  
 21 framework.  
 22 **Q.** Yes. And then Recommendation 5, which is the  
 23 one that has not yet or has not been implemented, the  
 24 power to disbar directors for serious misconduct. You  
 25 say there:

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1 difficult. And as you will have read certainly when  
 2 I wrote my report, I think it was the King's Fund who  
 3 said that there was 37% of Trusts were missing at least  
 4 one director on their board.  
 5 So there was a real problem of recruitment to  
 6 boards and I think one has to recognise that in general  
 7 terms the job of being a senior Executive on the board  
 8 of a Trust is a very difficult one.  
 9 So that is why Jane Russell and I came down to  
 10 a very limited form of or very limited basis for  
 11 disqualifying directors and that is serious misconduct.  
 12 I know you are going to come on to the  
 13 consultation.  
 14 **Q.** Yes.  
 15 **A.** But I do think one's got to be very, very  
 16 careful with this and I remember Harry Cayton saying to  
 17 me when I spoke to him around this: you can't regulate  
 18 your way to a good culture and you can't regulate core  
 19 management. You have got to be very careful how you use  
 20 this.  
 21 **Q.** Thank you. If we could just, you deal with  
 22 that recommendation about what you see as misconduct and  
 23 if I could just look at one particular area of  
 24 misconduct that you highlight as a concern in your  
 25 report, so going back to page 0020 in our numbering,

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1 that's internal page 14 of your report.

2 **A.** Sorry 14?

3 **Q.** 14 of the report. For the bringing up on the  
4 screen it's INQ0012637-0020.

5 No, 0020, not 01. We are 100 pages too far on.

6 **A.** I am so glad to see you have got the same  
7 problems that we have got in our Inquiry.

8 **Q.** Yes, thank you.

9 This is -- you say at F there in your report:

10 "Apart from obvious misconduct such as dishonesty  
11 and crime [which I think you have referred to as the  
12 'barn door', the wide, easy tests] we think there should  
13 be a focus on behaviour which suppresses the ability of  
14 people to speak up about serious issues in the health  
15 service, whether by allowing bullying or victimisation  
16 of those who speak up or blow the whistle or by any form  
17 of harassment of individuals. There should be a focus  
18 on discouraging behaviour which runs contrary to the  
19 duty of candour, so any deliberate suppression or  
20 falsification of records or relevant information should  
21 be regarded seriously. Further serious misconduct  
22 should include reckless mismanagement which endangers  
23 patients."

24 I just wonder if you could expand a little on why  
25 you picked out and chose to put this in your report as

21

1 you appeared before the Health and Social Care Select  
2 Committee in March 2019?

3 **A.** Yes.

4 **Q.** And then you go on to say in paragraph 38:

5 "... I found it difficult to ascertain with any  
6 clarity which parts of my recommendation were being  
7 positively taken forward although I did discover in 2023  
8 that a 'Kark Implementation Group' has been set up ..."

9 And that is what you referred to already, that it  
10 was only by chance that you came across that.

11 At paragraph 41 you refer to:

12 "... September 23 following the convictions of  
13 Ms Letby, the Health Secretary in addressing Parliament  
14 on the setting up of your Inquiry reportedly asked the  
15 DHSC to review my fifth Recommendation."

16 Was it your understanding that with regard to the  
17 fifth Recommendation, so that is the disbarring of  
18 poorly performing or directors where there is an issue  
19 of misconduct, that whilst the framework may not have  
20 been --

21 **A.** Can I -- can I just -- I am so sorry to  
22 interrupt --

23 **Q.** Yes?

24 **A.** -- but it is important. It's not the  
25 disbarment of poorly performing managers, it is about

23

1 a specific example of what should be regarded as serious  
2 misconduct?

3 **A.** I think bullying and harassment has been  
4 endemic issue in the NHS for probably as long as it's  
5 existed. Again, when I wrote my report, I think it was  
6 the MDA or I can't remember which organisation came up  
7 with this figure that one in five doctors said they had  
8 been bullied or harassed.

9 I think the King's Fund said that somebody who is  
10 bullied, 60% of their cognitive function reduces. So it  
11 is a serious problem, but not just because of the effect  
12 that it has on the individual but because of the effect  
13 that it has on the culture of the organisation as  
14 a whole because if there is that fear factor in an  
15 organisation, that is obviously going to be extremely  
16 detrimental to an open and honest discussion about what  
17 has gone wrong. And so I -- I thought it was  
18 particularly important to identify this and to flag it  
19 up, that directors who behave in this way could expect  
20 to be sanctioned.

21 **Q.** If we can turn then now to -- so that's your  
22 report, if we can turn now to deal with what occurred  
23 following your report, we have touched on it already but  
24 if we could go to paragraph 36 of your statement, where  
25 you say that together with Jane Russell, your coauthor,

22

1 serious misconduct. Poor performance is a separate  
2 issue --

3 **Q.** Sorry --

4 **A.** -- that needs to be dealt with by performance  
5 management, sorry.

6 **Q.** Thank you for the correction, the terminology  
7 is important.

8 But in relation to the trigger effect of the Letby  
9 case, that was your understanding that that brought your  
10 fifth Recommendation back into focus?

11 **A.** I -- I can't remember how I discovered that  
12 but I think, I thought that was right, yes.

13 **Q.** And then at paragraph 42, you say that in  
14 December 2023 you attended a virtual meeting with  
15 Victoria Atkins MP and you recall that she was surprised  
16 there was still no central database of directors.

17 That of itself suggests that there isn't a proper  
18 system of follow-up between changing administrations or  
19 changing individuals.

20 Through all your experience and involvement with  
21 Inquiries, is that your experience that that is  
22 a problem, the loss of knowledge?

23 **A.** Yes -- well, I mean I have no doubt you spoke  
24 to Sir Robert Francis about this and his experience  
25 after, after he reported. But as I say, your report

24

1 goes out, and I am sure this won't happen to my Lady,  
2 but your report goes out into the ether and I think  
3 one's got to be very, very, very active to try to  
4 discover what is actually happening and of course there  
5 is sometimes quite a churn of civil servants. So the  
6 civil servant that you were dealing with from the  
7 sponsoring department during the course of your report  
8 may not be still there in a year's time.

9 I do remember this meeting with Victoria Atkins  
10 because she was absolutely astonished that there was no  
11 central database of directors and this had come about  
12 because when I was asked to do my report, the first  
13 thing I asked for was a list of all the Chief Executives  
14 of Trusts in the NHS and I was told that they didn't  
15 have one, that they could Google it for me and I found  
16 that surprising and I think Victoria Atkins found that  
17 very surprising as well.

18 But she did indicate then that the Government was  
19 interested in or had renewed interest in the fifth  
20 Recommendation which is I suppose as a result of that --  
21 the new consultation has been issued or perhaps that's  
22 purely because of the new Government. I don't know.

23 **Q.** Thank you. And if we could turn then to  
24 following that the framework that did come out in  
25 August 2023, so that's INQ0012645. So this is the

25

1 far too many regulators already. I read some of --  
2 I can't remember it might have been Sir Robert Francis  
3 who said there was something like 90 regulators.

4 **LADY JUSTICE THIRLWALL:** I think 130, yes,  
5 something like that.

6 **A.** Yes, a huge number of regulators.

7 So I think one has to, to recognise the cost and  
8 effort of doing this.

9 But having said that, one also has to recognise the  
10 cost of not doing it, and there is both an economic cost  
11 to not doing it and a personal cost to individuals who  
12 are affected of not doing it. And I am sure you will  
13 come on to it, but I think there are real potential  
14 benefits to people knowing that there is a body to whom  
15 they can go to complain which will be effective if they  
16 believe a senior director is truly misbehaving. But one  
17 has to recognise it, it is, it is a complex thing to do.

18 **MS BROWN:** Looking at those benefits in  
19 paragraph 68 of your statement, you helpfully summarise  
20 some of the benefits: stopping the revolving door,  
21 whereby badly or incompetent directors move from one  
22 Trust to another; empowering whistleblowers; empowering  
23 members of staff who have a serious grievance; and  
24 I think the point you were just making, to reassure the  
25 general public about the competence and good behaviour

27

1 framework that you say in paragraph 45 of your statement  
2 you understand the publication of the statement was in  
3 response to your report and recommendations and indeed  
4 that's what's specifically stated to be the case in the  
5 introduction and if we could go to page 4, so 0004, we  
6 see under "Purpose and benefits" first of all  
7 a reference to the recommendations from the Kark Review  
8 and that this framework is effective from  
9 30 September 2023.

10 I don't propose to go through it all, but you set  
11 out in your statement that in terms of your  
12 recommendations that it covers at least broadly your  
13 first Recommendation in terms of standards of  
14 competence, the second in terms of a central database,  
15 the third the mandatory reference requirement, the  
16 fourth extending it to arm's-length bodies, but not the  
17 fifth Recommendation in relation to disbarring  
18 directors.

19 Just if there is anything further you want to add,  
20 Mr Kark, into your understanding of why it was that  
21 successive administrations weren't acting on that fifth  
22 Recommendation at this point certainly?

23 **A.** I think it takes a lot of political will and  
24 effort to set up a new regulator. And, and I do  
25 understand that, and there is an argument that there are

26

1 of senior directors in the NHS.

2 All those strong reasons are about stopping bad  
3 behaviour. Your view of a regulator, I think you call  
4 it a mini regulator, do you think they should have  
5 a role as well in promoting best practice, continuing  
6 professional development, or do you think they should be  
7 because of the problem of over-regulation, just very  
8 much constrained to stopping the bad rather than maybe  
9 promoting the good?

10 **A.** There is a genuine tension, I think, there.  
11 Because although it's very tempting to go down the full  
12 regulation route, the GMC, revalidation, accreditation,  
13 et cetera, et cetera, one of the things that was  
14 impressed upon me when I was researching for this report  
15 was the importance of ensuring that the Trust board is  
16 still responsible for its own appointments and -- and  
17 mistakes.

18 And there is always the danger that if you set up  
19 an all-seeing, all-dancing regulator and I think that's  
20 part of -- that is one of the suggestions in the  
21 consultation, effectively, and also taking it down to  
22 a relatively low level of management, you could find the  
23 Trust board say, "Well, thank you very much, this is now  
24 down to the regulator. They have to approve whether  
25 these people are fit and proper and we are then safe in

28

1 appointing them".

2 And I don't think that is safe. I think the Trust  
3 board has to be responsible for ensuring that the people  
4 who they appoint are fit and competent to do the  
5 specific job that they do because on a, on a board, you  
6 will have all sorts of skills that are needed. You will  
7 have, you will need somebody with financial skills,  
8 obviously; you will need somebody with clinical  
9 understanding; you will have somebody, need somebody  
10 with organisational understanding, and my own view is  
11 that it has to be up to the Trust board to decide the  
12 competencies and skills for each of those within  
13 a framework.

14 And so that was why Jane and I came down to a sort  
15 of the minimum, which is when somebody's been seriously  
16 badly behaved you can disqualify them which I think the  
17 closest regulator does that we thought was the teachers  
18 who don't really step in, they don't get involved until  
19 there is a serious complaint against somebody.

20 So our own view was to avoid to start -- to start  
21 small, to avoid the whole idea of validation and  
22 accreditation which also will be much, much harder to  
23 set up.

24 **Q.** At paragraph 71 you deal with a particular  
25 problem that can arise in this sector which is the issue

29

1 can find that.

2 **A.** Sorry, it's dredging my memory back to the GMC  
3 days. But I think it is called Roylance.

4 **LADY JUSTICE THIRLWALL:** No, that is okay.

5 **A.** But it's very rare.

6 **LADY JUSTICE THIRLWALL:** It is not very common.

7 **A.** No, it is very rare and I think the GMC find  
8 it quite difficult to do.

9 **MS BROWN:** If we could come on then to the  
10 leadership competency framework. This is INQ0108668.  
11 Just at the first page.

12 **A.** I am so sorry. Could I just go back to that?

13 **Q.** Yes, of course.

14 **A.** What I do think you have got to be careful of  
15 is making sure that doctors aren't double penalised.

16 Same with nurses. So either you exclude them from the  
17 framework or you have some form of memorandum of  
18 understanding with the GMC as to who is actually going  
19 to take responsibility, but otherwise they are going to  
20 feel doubly under the cosh. Apologies, sorry.

21 **Q.** Yes. No, thank you for completing that.

22 So this is the competency framework which sets out  
23 the six leadership competency domains and again if we  
24 could go to page 3 we will see that specific reference  
25 is made to your review. We have looked already at one

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1 where doctors and nurses are already regulated by their  
2 own regulators.

3 **A.** Yes.

4 **Q.** And that is obviously something you have given  
5 thought to. I wondered if there was anything you wanted  
6 to add to that about whether that would be something  
7 that could be managed if there was a form of regulator  
8 for managers when they are already subject to their own  
9 professional regulation, whether you see that as an  
10 intractable problem?

11 **A.** Well, first of all, that to me is  
12 an encouragement to regulate directors because Medical  
13 Directors and Nursing Directors certainly said to me:  
14 this is unfair, if I make a mistake on -- a serious  
15 mistake on this board I can end up before the GMC and  
16 none of the other lot on the board can.

17 **LADY JUSTICE THIRLWALL:** Can I just ask you,  
18 Mr Kark, did you come across any examples where that had  
19 happened, that a doctor or nurse had been, had been  
20 dealt with by the GMC for management errors?

21 **A.** The only case that I can remember that there  
22 was -- there was a case called Roylance which I think is  
23 the one example I can remember, where a doctor was taken  
24 to the GMC on a management.

25 **LADY JUSTICE THIRLWALL:** Thank you, I am sure we  
30

1 of your concerns which was the bullying issue, the  
2 suppressing of someone who was trying to speak up.

3 If we go on to page 5, we have got the six  
4 leadership competency domains. And this is quite  
5 a difficult task, but looking at those competency  
6 domains, really just any thoughts you have as to whether  
7 they encapsulate, broadly speaking, the concerns you  
8 have and whether they are, whether that is adequate in  
9 effect to address your principal concerns when you did  
10 your report?

11 **A.** I -- I suppose as a -- as a lawyer I find this  
12 sort of language quite difficult to deal with because  
13 it's very aspirational and frankly a bit fuzzy.

14 So I can understand that these are high level or  
15 almost aspirational expectations but I would hope, and  
16 we do see this a little bit later on, that there would  
17 be much more specific competencies required of  
18 particular areas of expertise on a Trust board and if  
19 for instance we go to your page 0010.

20 **Q.** Yes.

21 **A.** You know, this sort of language: I contribute  
22 as a leader to ... the development of strategy.  
23 I assess and understand the importance ...

24 Well, that's great. But what about: I have got  
25 this qualification because ... or I have this experience

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1 and I will set it out ...

2 And maybe that's just because one looks at this as  
3 a lawyer and you are looking for something concrete,  
4 I find these quite high level and aspirational and  
5 I suppose I expected something much more concrete,  
6 although I accept that may be much harder to formulate.

7 I think there was -- if we go to 4, "Robust  
8 governance and assurance", your page 13.

9 **Q.** Yes.

10 **A.** I think you are getting closer to it there:

11 "I understand board member responsibilities, my  
12 individual contribution in relation to financial  
13 performance, establishing and maintaining  
14 arrangements ..."

15 And I understand that it would be for the, I think  
16 it's under the framework it's for the Chair to ensure  
17 that each of the appointments to the board can meet  
18 these competencies. And so it will be for the Chair to  
19 assess whether the individual they are appointing meets  
20 these.

21 And as I say maybe it's just the use of the  
22 language which seems more aspirational than concrete.

23 **Q.** Just to be clear, because the background page  
24 we went to refers to your review. This has been built  
25 because of your review but you didn't have a role in

33

1 I think that will have a very, very -- potentially very  
2 damaging effect on recruitment and promotion within the  
3 NHS. Those levels of management should be dealt with by  
4 performance within a Trust.

5 And as I said, the consultation is very wide. I am  
6 very pleased to see that there is a consultation so  
7 hopefully something will come from it. But I do hope,  
8 for what it's worth, that where we end up is very much  
9 more limited than some of the options that are on the  
10 table.

11 **MS BROWN:** Thank you very much, Mr Kark. I have no  
12 further questions for you. Mr Baker doesn't have any  
13 questions now, my Lady.

14 I don't know whether there is ...

15 Questions by LADY JUSTICE THIRLWALL

16 **LADY JUSTICE THIRLWALL:** All right. Thank you very  
17 much indeed, Mr Kark, for coming.

18 Since I was expecting a few more questions, do you  
19 mind if I ask you a few in the additional time that  
20 I now have?

21 **A.** No, of course.

22 **LADY JUSTICE THIRLWALL:** Just looking at the  
23 framework and I think one of the other witnesses  
24 described it as "extremely wordy". I mean, there really  
25 are a lot of -- it seems to me that's a reasonably fair

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1 this, in this document?

2 **A.** I'm afraid to say it was your Inquiry that  
3 drew my attention to it, I'm afraid. I have been doing  
4 other things. But, but I only discovered this as  
5 a result of your instructions to me.

6 **Q.** Thank you. And going to then the final  
7 document I wish to turn to, that's the consultation.  
8 This is INQ0108672.

9 **A.** Yes.

10 **Q.** This is a consultation of November 2024, so  
11 a very recent consultation on proposals to regulate NHS  
12 managers and really just an open question as to what  
13 your view is on this consultation process and where we  
14 are at this stage in terms of proposals to regulate NHS  
15 managers?

16 **A.** I mean I have only had a very brief look at  
17 this in the last couple of days. It's a very wide  
18 consultation, isn't it, in terms of the options that are  
19 offered and I haven't got the whole thing in front of  
20 me.

21 But it -- one of the options I think is regulating  
22 managers right down to Band 8A, B, C and D. And  
23 I understand that that has to be part of a consultation.

24 For my part, and for what this is worth, I very  
25 much hope that that isn't where this ends up because

34

1 description or it could be.

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** But one of the things that  
4 isn't mentioned anywhere is what qualifications are  
5 required, what experience is required and is there any  
6 reason other than perhaps there may be a philosophical  
7 reason why you want to talk about competency rather than  
8 qualification, although it's not easy to see why those  
9 two things should not be consistent one with the other.

10 **A.** I think they are.

11 **LADY JUSTICE THIRLWALL:** Yes.

12 **A.** Yes, I agree. I think they -- I am just  
13 wondering if competency ...

14 I suppose competency includes of course I suppose  
15 experience.

16 **LADY JUSTICE THIRLWALL:** Yes.

17 **A.** As well as learning and training as I suppose  
18 can qualification. But I think that either of those  
19 words could be used.

20 **LADY JUSTICE THIRLWALL:** Yes, it's a slightly  
21 curious thing because with doctors and nurses we can see  
22 what the qualifications are that are required --

23 **A.** Yes.

24 **LADY JUSTICE THIRLWALL:** -- and the experience that  
25 is required to move on within the profession and I am

36

1 sure that some of that could be characterised as  
2 competencies. But is the reason, do you think and you  
3 may not have a view about it, qualifications -- the  
4 issue of qualifications is avoided is because it's quite  
5 hard to pin down what exactly the qualifications are  
6 that you need to be a manager, a senior manager?

7 **A.** Although that is rather what I was expecting  
8 people to do.

9 **LADY JUSTICE THIRLWALL:** Yes.

10 **A.** And I -- I do think it's important that when  
11 somebody is being appointed to a Trust board, say they  
12 are the Chief Financial Officer, that they should also  
13 be expected to have some, some understanding for  
14 instance of clinical governance and I think that should  
15 be set out.

16 I think some of the great disasters that we have  
17 had at Mid Staffs and Liverpool were both subject to  
18 this, was that the finances overtook patient care. So  
19 you had these cost improvement plans that resulted in  
20 a huge degradation of the staff at the hospital.

21 And I just wonder if the -- if there was sufficient  
22 challenge or in fact we know there wasn't sufficient  
23 challenge on those boards from the Non-Exec Directors,  
24 just by way of example.

25 So when I suggested that there should be, should be

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1 (10.45 am)

2 **LADY JUSTICE THIRLWALL:** Ms Langdale.

3 **MS LANGDALE:** My Lady, I call our last witness.

4 **LADY JUSTICE THIRLWALL:** Do come forward.

5 PROFESSOR SIR STEPHEN POWIS (sworn)

6 **LADY JUSTICE THIRLWALL:** Do sit down.

7 **A.** Thank you.

8 Questions by MS LANGDALE

9 **MS LANGDALE:** Can you give us your name,  
10 qualifications and a brief career history, please.

11 **A.** Professor Sir Stephen Powis and I am  
12 a registered medical practitioner.

13 **Q.** You are currently National Medical Director;  
14 is that right?

15 **A.** I am National Medical Director at NHS England.

16 **Q.** Sir Stephen, you have provided three  
17 statements to the Inquiry, two statements in March 2024  
18 and one in April 2024.

19 You have obviously had support in preparing those  
20 statements, as detailed as they are. Can you confirm  
21 that the contents are true and accurate as far as you  
22 are aware?

23 **A.** I can confirm that.

24 **Q.** I understand before we go into the evidence  
25 within the statements and more generally, that you would

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1 specific competencies or qualifications, that's what  
2 I thought we were going to see. And I think some of  
3 this language, as I have said, is either too wordy or  
4 quite woolly. It's going in the right -- I do think it  
5 is going in the right direction.

6 **LADY JUSTICE THIRLWALL:** Yes, I understand that.

7 **A.** But I think it could be more specific.

8 **LADY JUSTICE THIRLWALL:** Well, those are my  
9 questions. There was one which I had which is actually  
10 for the next witness, so thank you very much indeed for  
11 making yourself available and coming in person, it's  
12 been extremely enlightening, thank you and of course you  
13 are now free to go.

14 **A.** Thank you very much indeed.

15 **LADY JUSTICE THIRLWALL:** The next witness I think  
16 is being called by Ms Langdale.

17 **MS BROWN:** Yes, so I think the suggestion was that  
18 we would take a break now so that the next witness would  
19 start after this morning break, an early morning break.

20 **LADY JUSTICE THIRLWALL:** I think we finished a bit  
21 earlier than we were expecting. Shall we say we will  
22 start again at quarter to and then we will see how we do  
23 for a further break in the morning. So quarter to 11.

24 (10.34 am)

25 (A short break)

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1 like to say a few words?

2 **A.** Yes. I have been a doctor in the NHS for  
3 almost 40 years and during that time, I have dedicated  
4 myself to improving patient care and ensuring patient  
5 safety. The events at the Countess of Chester were  
6 abhorrent and on behalf of the entire NHS, I apologise.

7 **Q.** We are going to come into the detail within  
8 statements and documents, but more broadly on behalf of  
9 NHS England at this point. You have obviously through  
10 Project Columbus and generally looked at the events  
11 surrounding Letby's work career and conviction.

12 What would you highlight, if anything, that  
13 NHS England might have done differently to avert these  
14 events or prevent some of the deaths happening when they  
15 did further down the line, if you like?

16 **A.** So we recognise that there were a number of  
17 missed opportunities where individuals within the Trust  
18 but also individuals outside the Trust including NHS in  
19 England and its legacy bodies that are now incorporated  
20 with NHS England could have intervened, could have asked  
21 questions, could have been more curious. That occurred  
22 within the Trust on a number of occasions.

23 NHS England was not aware of the increase in  
24 mortality until July 2016. At that point, it took the  
25 decision with the Trust to downgrade the unit to a lower

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1 level of neonatal care, that was in agreement with the  
2 Trust, it was quite appropriate at the time and then it  
3 agreed with the Trust that an independent review carried  
4 out by Royal College of Paediatrics and Child Health  
5 would be appropriate.

6 It was kept informed of that review, possibly could  
7 have asked more questions about the nature of the review  
8 but as it got towards the end of 2016 colleagues at  
9 NHS England and its legacy bodies were becoming more  
10 frustrated and more concerned about the openness and the  
11 transparency of what was occurring at the Countess of  
12 Chester and you can quite clearly see that in evidence  
13 going forward into 2017.

14 We were not aware that there was suspicion around  
15 a particular member of staff until March of 2017 and at  
16 that point it was our view that the correct thing to do  
17 would be to involve the police.

18 The Countess of Chester did that through the  
19 a conversation with the CDOP process, our chair of CDOP,  
20 but if that had not been done NHS England is quite clear  
21 that it would have informed the police itself.

22 **Q.** How significant in the piece do you think  
23 a suspicion about a member of staff was? You say you  
24 weren't aware of that particular detail?

25 **A.** Sorry, I missed the first part of that

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1 might have made that difficult to express that, concerns  
2 about a member of staff, whether you are a doctor or  
3 manager, what might have made that a difficult thing to  
4 articulate more widely outside the Trust and generally,  
5 do you think? Or do you not have a view on that?

6 **A.** I think there are three things relevant here.  
7 One is the culture within an organisation, that culture  
8 of curiosity and openness. Clearly from the evidence  
9 I have seen there were concerns around a particular  
10 member of staff at a very early stage right at the  
11 beginning when the first cluster of deaths occurred.

12 But as I have said, that curiosity to an extent was  
13 not shared and views of that were not shared with all  
14 members of the leadership team within the Countess of  
15 Chester and as I have already said, NHS England became  
16 increasingly concerned about openness and transparency  
17 and the culture of involving others.

18 Secondly, you have to have processes and systems in  
19 place to allow escalation. Those systems and processes  
20 were in place. Incident reporting was in place,  
21 safeguarding was in place.

22 An early version of Freedom to Speak Up was in  
23 place. In our view, they were not used in a way that  
24 they should have been used and that would have resulted  
25 in further escalation, further scrutiny and further

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1 question.

2 **Q.** How significant is that piece of information  
3 that there was suspicion about a member of staff in  
4 terms of what you, NHS England, or others might have  
5 done next?

6 **A.** Well, I think it was highly relevant during  
7 the period where there was increased mortality up to the  
8 end of June 2016, at the point that Lucy Letby was  
9 removed from the unit. During that period, 16 incidents  
10 were reported through our national learning -- reporting  
11 and learning system to NHS England, but only three of  
12 them, one at the very start of that period and two right  
13 at the end, were reported through our Serious Incident  
14 process; in other words, were declared as Serious  
15 Incidents.

16 If more had been declared then there would have  
17 been undoubtedly more scrutiny. That scrutiny came when  
18 two were declared in July of 2016. And I think that  
19 would have led to more scrutiny, to more questioning to  
20 more curiosity during that period.

21 And then afterwards, if we had known that there was  
22 concerns around an individual, we would undoubtedly have  
23 required the police to be involved at an earlier point.

24 **Q.** Just addressing the concerns about an  
25 individual and a member of staff. What do you think

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1 curiosity. And then finally you need to be aware of the  
2 possibility, however rare, however infrequently, that  
3 a healthcare professional could deliberately cause harm.

4 Clearly, that possibility did arise in the minds of  
5 the paediatricians at a very early stage and became more  
6 of a concern as 2015 progressed into 2016. But that  
7 concern was not shared or acknowledged in the same way  
8 by senior leaders within the organisation.

9 **Q.** We have seen in one of the safeguarding  
10 policies, I don't need to put it up, but there is  
11 a flowchart about information sharing, it is in  
12 a current safeguarding policy, when you can share  
13 information. Just in terms of data being shared in the  
14 NHS, do you think it's clear when information can be  
15 shared, for example about a member of staff and  
16 suspicions about them? Or do you think people may have  
17 felt a reluctance about talking about that, that it's  
18 confidential, it is an employment law issue, you have to  
19 be careful, those kinds of factors creeping in?

20 **A.** I can't pass judgment on -- on why that  
21 information was not shared but I don't think there was  
22 any barrier, nor should there be about any barrier, to  
23 share that information. If it is suspected that  
24 deliberate harm is occurring, then other agencies should  
25 be informed and of course foremost amongst those the

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1 police.

2 And there were instances within the NHS where  
3 circumstances have arisen in recent years where there's  
4 been concern of deliberate harm and in those  
5 circumstances the police have been informed immediately,  
6 our Chief Nurse, who has given a witness statement to  
7 the Inquiry in his previous role as Deputy Chief Nurse,  
8 has outlined one of those instances where that occurred.

9 **Q.** So in your experience those details are shared  
10 with NHS England if there is concerns about deliberate  
11 harm or a person?

12 **A.** Yes, they are shared and they should be  
13 shared.

14 **Q.** And they should be?

15 **A.** Yes.

16 **Q.** You are clear about that?

17 **A.** Yes, absolutely.

18 **Q.** Well, would people know at the time that it  
19 should be? Is that a policy, is that a culture? What  
20 would tell people in the hospital that they should be  
21 sharing that?

22 **A.** So in my experience -- and I have worked both  
23 as a Medical Director of a provider organisation in  
24 NHS Trusts and a National Medical Director within  
25 a regulator and a Commissioner, NHS England, I have

45

1 You also refer to:

2 Although insulin as a method of killing or harming  
3 babies has been used in non-neonatal settings, the  
4 particular vulnerability of neonatal babies to insulin  
5 (and air and milk) is recognised."

6 You gave as a second statement in relation to the  
7 work NHS England has done in respect of insulin, can you  
8 tell us about that, please? What surveys or initial  
9 insulin survey that's been conducted and what you have  
10 done in the light of this case?

11 **A.** Yes.

12 **Q.** Subsequent to this case?

13 **A.** If I may, my Lady, a little bit of context  
14 first.

15 So insulin is a widely used medication within  
16 healthcare to manage high levels of glucose most  
17 typically in patients who have diabetes. Its use in  
18 neonatal critical care units is infrequent. It's  
19 broadly used for two reasons, one is for that very  
20 reason to treat high levels of glucose diabetes but that  
21 is unusual in that particular setting. It is also used  
22 to reduce high levels or to aid in the reduction of  
23 dangerously high levels of potassium that can occur in  
24 certain circumstances, such as acute kidney failure.

25 So its use in neonatal units is much lower than in

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1 always taken the view and I believe that others, this is  
2 frequent amongst our other leaders that regulators are  
3 clearly there to regulate and ask the difficult  
4 questions but also there to support and to provide  
5 assistance.

6 So in my time as Medical Director, that involved  
7 regular conversations with other local Commissioners on  
8 incidents that were occurring within the organisation,  
9 as they do in all organisations, with appropriate  
10 scrutiny.

11 And so that information sharing and that shared  
12 endeavour, to learn from errors, to learn from mistakes,  
13 to learn when things go wrong, indeed learn when things  
14 go right, I think is and should be at the core of  
15 everything we do in the NHS.

16 **Q.** If we can have some of your statement on the  
17 screen, please. It's INQ0017495, page 152 and it's from  
18 your first statement, paragraph 609.

19 You set out the consistent failings that have been  
20 identified in previous Inquiries and investigations at  
21 paragraph 609 and at 610 say:

22 "There are two neonatal-specific risks we have  
23 identified in the light of how we understand [Letby]  
24 murdered or attempted to murder her victims and these  
25 relate to her use of air and milk."

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1 other settings within the NHS. But nevertheless, it is  
2 a drug that from time to time must be used and therefore  
3 should be kept within neonatal units.

4 We obviously noted the use of insulin and as we say  
5 here that was noted in, in the Clothier Report back in  
6 1994, too. And we were commissioned as a result of the  
7 circumstances around the Countess of Chester by the  
8 previous minister within the Department of Health to  
9 look further into the use of insulin in neonatal units.

10 We did that by conducting two surveys of neonatal  
11 units, to understand current practice around the use the  
12 storage the use of insulin in those units.

13 What we found was largely good practice around  
14 storage, around access to insulin, around the way it is  
15 used, with some variation. Variation mostly related to  
16 the presence of a pharmacist or the units to check and  
17 to aid in those processes around insulin and, and around  
18 staff training.

19 As a result of those two surveys we do not believe  
20 at NHS England that there are any significant changes  
21 that need to be made around the way insulin is stored,  
22 accessed and used. But we are sure that or we are  
23 noting we do note that there is a requirement to ensure  
24 that best practice is being used in all settings. So  
25 I have discussed this with the Chief Pharmacist for

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1 England and also for the National Clinical Director for  
2 neonatal care and we do commit to ensuring that we will  
3 do what we can to ensure that all units are operating at  
4 the highest level of best practice and I should also say  
5 that there is guidance in place from other entities,  
6 NICE and the Royal Pharmaceutical Society relating to  
7 the storage of drugs.

8 **LADY JUSTICE THIRLWALL:** If I can just be clear  
9 then, so largely good practice, some variation by which  
10 you mean not good practice?

11 **A.** Not necessarily not good practice but areas  
12 where we think practice could be strengthened and  
13 therefore --

14 **LADY JUSTICE THIRLWALL:** I suppose less than good.

15 **A.** Well, there are some additional components  
16 that some units could put in place such as --

17 **LADY JUSTICE THIRLWALL:** Which would make it  
18 better.

19 **A.** -- more oversight by a hospital pharmacist.

20 **LADY JUSTICE THIRLWALL:** Is there anything else  
21 other than that oversight? I am not suggesting that is  
22 not important.

23 **A.** Those were the two things that particularly  
24 came through on the surveys, but as I said I want to  
25 keep this under review and I will commit with the Chief

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1 insulin on neonatal units."

2 So INQ0107008. If we go to page 2. Have a look at  
3 the method of the survey at the bottom. "Findings" at  
4 page 3.

5 Page 4, "Current safe and secure practice in use on  
6 neonatal units".

7 You see there at paragraph 17:

8 "A few units reported using a combination of other  
9 strategies to ensure the safe and secure handling such  
10 as keeping records of staff who have accessed insulin."

11 We heard from the Countess of Chester about swipe  
12 data now. Can you expand on that how that works so?

13 **A.** So there are various ways in which access to  
14 drugs are -- or access to drugs is restricted and  
15 protected. Swipe systems would be one of those, other  
16 mechanisms of locking drugs. So we support those  
17 practices, that is good practice.

18 **Q.** And then we see conclusion, paragraph 23:

19 "Review identified good processes and practice for  
20 the safe and secure handling of insulin units.

21 Recommended neonatal units continue to follow national  
22 and local policies."

23 Given its capacity for catastrophic harm and the  
24 history of the Allitt case, Chua and Letby, a question  
25 at the outset particularly posed by the Families and

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1 Pharmacist and the National Clinical Director to ensure  
2 that we are doing what we can to promulgate best  
3 practice.

4 **LADY JUSTICE THIRLWALL:** Yes, sorry, so there are  
5 two things. I picked up oversight by a pharmacist, what  
6 was the second thing?

7 **A.** It was training around the use of drugs within  
8 neonatal units and insulin in particular.

9 **LADY JUSTICE THIRLWALL:** Training of whom?

10 **A.** Staff who -- so nursing staff in particular.

11 **LADY JUSTICE THIRLWALL:** And what's the plan in  
12 relation to the training then, is that something also  
13 the Chief Pharmacist is going to do?

14 **A.** So those are next steps and we would be very  
15 happy to provide you with further information as we  
16 develop those steps.

17 **LADY JUSTICE THIRLWALL:** If those steps were put in  
18 place you are as satisfied as you can reasonably be that  
19 that would then mean good practice everywhere.

20 **A.** Yes, yes.

21 **LADY JUSTICE THIRLWALL:** Thank you. If you would  
22 yes, please.

23 **A.** Yes.

24 **MS LANGDALE:** Can we have on the screen, please:  
25 "Summary of findings: safe and secure handling of

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1 parents was why shouldn't insulin be subjected to the  
2 same security safeguards as controlled drugs?

3 **A.** So many of the practices around controlled  
4 drugs of course are replicated in access to drugs such  
5 as insulin. The designation of a controlled drug is  
6 matter for the Home Office, not for NHS England.

7 But I think good practice around both controlled  
8 drugs, so there are additional requirements around the  
9 use of controlled drugs including governance structures,  
10 but many of those practices are replicated in the core  
11 business of managing drugs including insulin.

12 **Q.** And how extensive was the survey? It was  
13 developed using a multi directorate group within NHSE to  
14 include experts in patient safety but in terms of the  
15 seriousness with which the task was approached, could  
16 you expand on that for us?

17 **A.** We did an initial survey which was a smaller  
18 number of units and then the second survey expanded --  
19 I think the number is around 20, it is on one of the  
20 pages in the report. So I think it was a significant  
21 sample. So sufficient to get a clear idea of the range  
22 of practice.

23 **Q.** Thank you. That can go down now, please. The  
24 Inquiry also asked for feedback from neonatal units and  
25 more generally on the issue of CCTV and security?

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1 A. Yes.

2 Q. Perhaps having cameras in incubators, in  
3 neonatal units, for many reasons not simply detecting  
4 the rare case of deliberate harm or potentially being  
5 a deterrent in relation to that but also for parents  
6 separated from babies for whatever reason?

7 A. Yes.

8 Q. Health reasons, physical space in the  
9 hospital, being able to see their baby at all times when  
10 they wanted to, given the technology we have now with  
11 mobile phones et cetera. Do you have any views about  
12 that, Sir Stephen?

13 A. Yes, this is another aspect of care that we  
14 have considered and again a little bit of context which  
15 you briefly alluded to. So the use of CCTV cameras in  
16 these units is usually related to control of access into  
17 the unit and therefore is not targeted or directed at  
18 individual babies within the unit.

19 But as you say, increasingly, and the pandemic will  
20 have driven this to an extent, there has been uses of  
21 cameras, CCTV, within individual cots, mainly to provide  
22 live streaming to parents who cannot for a variety of  
23 reasons be at the cotside. We do think that is  
24 an important advance and we do think that there are  
25 opportunities to use that technology as a form of

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1 LADY JUSTICE THIRLWALL: -- that you have at the  
2 access to wards.

3 A. Yes.

4 LADY JUSTICE THIRLWALL: But just so I can  
5 understand: what would the privacy concerns be if you  
6 had -- a parent had the phone monitoring their child?

7 A. It's around issues such as breastfeeding and  
8 other things that might happen, it's around close  
9 contact with babies, so I think they are overcomable  
10 but --

11 LADY JUSTICE THIRLWALL: But I'm not sure -- if the  
12 monitor is in the incubator then you are not going to be  
13 breastfeeding --

14 A. Well, exactly it depends, it depends on the  
15 visual scope of the monitor. It depends exactly how the  
16 cot is monitored. I think these are all addressable but  
17 I think whenever you are introducing a technology like  
18 this it's -- it's important to recognise potential  
19 disbenefits as well as benefits and to explore those as  
20 well. But, as I say, we do think that this is an avenue  
21 worth exploring. My apologies it hasn't been in the  
22 statements, as I hope you would expect --

23 LADY JUSTICE THIRLWALL: There is no need to  
24 apologise, as time moves on and the idea came from the  
25 Inquiry --

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1 monitoring to ensure safety of babies as well.

2 There are pros and cons around doing that. There  
3 may be some privacy concerns, for example, that we need  
4 to take into account but we are of the view that that is  
5 worth exploring forward further and we do wish to  
6 understand a number of pilots with neonatal units to see  
7 how we can progress that. We do think there is value in  
8 that approach.

9 Q. You will be doing those pilots, is that  
10 a plan?

11 A. Yes. We will be doing that -- under the  
12 auspices of the Chief Nurse for England we will be  
13 undertaking that work and again we would be very happy  
14 to inform you and keep you up to date as that work  
15 progresses.

16 LADY JUSTICE THIRLWALL: Thank you. I don't think  
17 that's something that is in the statements and that is  
18 not a complaint, it is just sort of come out certainly  
19 we had some evidence from one of the Mothers in  
20 particular --

21 A. Yes.

22 LADY JUSTICE THIRLWALL: -- who talked about this  
23 sort of CCTV which is different from the sort of  
24 surveillance stuff --

25 A. Exactly.

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1 A. We have been reflecting on evidence as it's  
2 been presented to the Inquiry --

3 LADY JUSTICE THIRLWALL: Yes, of course?

4 A. -- and in discussions with the Chief Nurse we  
5 have decided that this would be an appropriate way  
6 forward.

7 LADY JUSTICE THIRLWALL: Yes. Good. That is very  
8 helpful and encouraging to know because certainly what  
9 is in the statements where all the problems are was, if  
10 I may put it, conventional CCTV, so the focus now is  
11 going to be on how to make a different form of it useful  
12 and you are going to pilot it. When are the pilots  
13 going to start?

14 A. I can't give you the exact details yet  
15 because, as you will have gathered, this is -- these are  
16 recent discussions but for all the reasons you have said  
17 around the use of this technology, we do think that  
18 there are opportunities here that we should explore.

19 LADY JUSTICE THIRLWALL: Yes and so when will you  
20 be able to update us on that? You or the chief nurse?

21 A. Can I commit to updating you in the next month  
22 or two?

23 LADY JUSTICE THIRLWALL: Yes, certainly, so shall  
24 we say by the beginning of March?

25 A. We can say by the beginning of March.

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

2 **MS LANGDALE:** Certainly one sees in nurseries and  
3 childcare now and when people have nannies or  
4 arrangements of that kind, it's not unusual just for  
5 everyone to accept that's a way of working, people get  
6 used to it --

7 **A.** Sorry, again I missed the first bit.

8 **Q.** It is not unusual for people to get used to  
9 that way of working that there is a camera but you are  
10 not doing anything in that context you are particularly  
11 concerned about?

12 **A.** Exactly. And therefore I think with the  
13 introduction of technology that can monitor more  
14 specifically the cot rather than the general area, then  
15 this is definitely an avenue that would be worth  
16 exploring and has the double benefit of providing  
17 where -- where needed that streaming element, that  
18 remote ability to see the baby but also provide that  
19 additional safety. But there are, as I say, further  
20 considerations that we would need to take into account,  
21 for instance around storage of material rather than  
22 simply live streaming.

23 **Q.** Can we have on the screen please your  
24 statement, so INQ0017495, page 107 and it's where you  
25 deal with the Medical Examiner system if it helps you to

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1 additional detailed information about that period  
2 because we were not directly involved in the development  
3 of a potential Medical Examiner system.

4 What I can give you assurance about is that in  
5 2018 -- and this is around the time that the Department  
6 of Health and Social Care published its response to the  
7 consultation it held in 2016 around the introduction of  
8 a Medical Examiner system in that period, summer,  
9 I think it was the late spring/summer of 2018,  
10 NHS England was asked, indeed I was personally asked, if  
11 NHS England would undertake to take responsibility for  
12 the implementation of the Medical Examiner system from  
13 that point, which we agreed to do. That had not  
14 necessarily been the consideration in the period that  
15 you have described prior to that. But colleagues at the  
16 Department of Health had determined that that would be  
17 the most appropriate way forward following the  
18 consultation.

19 We did that. And in my view --

20 **Q.** Sorry to interrupt you there, Sir Stephen, can  
21 we have the next page of the statement beginning  
22 paragraph 435 on the screen, so it's the next but one  
23 page where you are getting to now. Sorry, continue.

24 **A.** Yes. In fact we had been asked, I am sure it  
25 was around the summer of 2018, if we would take on that

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1 have it on screen at the time.

2 The Inquiry's been tasked to look at  
3 recommendations made by previous Inquiries, whether they  
4 have been implemented or not, and why they haven't been  
5 and you will readily appreciate that the  
6 Clothier Inquiry, some years ago now, provided or  
7 suggested, recommended, that pathology services in every  
8 case of unexpected child death where the death is  
9 clinically unaccountable should be provided and those  
10 examinations should take place.

11 That was in 1994. The recommendation clearly  
12 wasn't implemented around then. Would you like to  
13 expand on why it in your view it took so long for the  
14 Medical Examiner system to come into being?

15 **A.** So as you rightly said the recommendation for  
16 the Medical Examiner system has come out of previous  
17 Inquiries, including the Shipman Inquiry and,  
18 Sir Robert Francis' Inquiries into the events at  
19 Mid Staffs Hospital.

20 The development of the Medical Examiner system was  
21 under the auspices the Department of Health and social  
22 Care, I know you have heard from their witness two days  
23 ago, I know he has provided details as to the evolution  
24 of thinking around the Medical Examiner system.

25 I can't, and neither can NHS England, give you

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1 examiner system. We appointed the National Medical  
2 Examiner I think in 2019, National Medical Examiner,  
3 Alan Fletcher, who again you have heard from, sits in  
4 the patient safety team within my Medical Directorate at  
5 NHS England supported by the National Patient Safety  
6 Director and Alan then set about, with support from  
7 colleagues in NHS England, but also colleagues such as  
8 the Royal College of Pathologists, who have been very  
9 instrumental in the work underlying the Medical Examiner  
10 system, to implement a Medical Examiner system.

11 We did that at pace, as fast as we could, and  
12 I note that there was a pandemic, as you know, in the  
13 middle of this which set us back a little bit, but not  
14 substantially, and we have now, again you will have  
15 heard, rolled that system out within hospitals and more  
16 recently within primary care, within general practices.  
17 And I should pay public tribute to Alan in all the work  
18 he has done as the National Medical Examiner in driving  
19 that forward.

20 And that meant that we were ready for the  
21 introduction of the system on a statutory basis in  
22 September of 2024, just a few months ago, and we are now  
23 in the phase of moving from focusing -- these are  
24 discussions I frequently have with Alan -- from the  
25 implementation of the system to try -- to beginning to

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1 gather evidence around its benefits.

2 But what we are hearing that it has been well  
3 received by practitioners within the system but also by  
4 relatives and one of its main aims is to improve the  
5 transfer of information, the discussions that occur and  
6 the quality of care around bereavement with relatives  
7 who have been affected and of course other things such  
8 as improving death certificates and the accuracy of  
9 death certificates and the interaction with colleagues.

10 **Q.** Jeremy Hunt gave evidence to the Inquiry and  
11 accepted and offered an apology for the fact that in  
12 2015 to 2016 it was under his watch and Medical  
13 Examiners were not of course in place when some of these  
14 baby deaths would have been independently examined, had  
15 they been early on.

16 His evidence was that there weren't enough doctors  
17 at that time, doctors who could conduct that work, who  
18 weren't required on the frontline with the patients that  
19 they were dealing with. Do you have any evidence to  
20 provide on that point, whether there were enough  
21 doctors, whether there are enough doctors now to satisfy  
22 the Medical Examiner system in full?

23 **A.** Our experience since 2018 when we were asked  
24 to implement the system is that we have had very good  
25 uptake. We have, I am, I can't give you exact numbers

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1 that was and they were consistent with others.

2 What's the purpose of these targets for staffing  
3 and what is supposedly safe staffing, if they are  
4 honoured in the breach, if you like?

5 **A.** So we recognise that staffing of neonatal  
6 units has been an issue, that is why it is the focus of  
7 our neonatal delivery plans at the moment to increase  
8 staffing, we have made progress in increasing staffing  
9 within neonatal units in recent years and of course in  
10 a broader context, we agreed with the Government  
11 a long-term workforce plan for the NHS to increase staff  
12 overall, that was agreed 18 months ago. We are in the  
13 process of implementing it and doing a two-year review  
14 with the new Government, so we are committed to  
15 increasing the workforce.

16 And of course --

17 **LADY JUSTICE THIRLWALL:** Sorry, can I just ask you  
18 a question while it is in my mind. We heard evidence  
19 from Dr Camilla Kingdon from the RCPCH, I am sure you  
20 saw that --

21 **A.** Mmm.

22 **LADY JUSTICE THIRLWALL:** -- evidence and she said,  
23 if my memory serves me correctly and it may not, that in  
24 fact there was no provision within the workforce plan  
25 for further staff for neonatal units.

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1 but we have pretty much appointed all, or if not all,  
2 most of the examiners that we need around the country.  
3 I don't think we have had overall difficulties in  
4 doing that. And more recently we have also done that  
5 within general practice and primary care. As I have  
6 said, I think the system has been welcomed. That  
7 doesn't mean that, as ever, when you introduce a new  
8 system there are bumps to get over and there are  
9 glitches along the way, but we were ready for statutory  
10 implementation in September.

11 The Royal College of Pathologists, as I have said,  
12 have been champions of the work underlying this, they  
13 have contributed hugely. I don't think there's been  
14 resistance within the medical profession or with other  
15 clinical professions to introducing this. As ever,  
16 resource needs to be deployed and funding needs to be  
17 found in order to do this.

18 But I am delighted that it is in place, and as  
19 I say, I can give you assurance that at NHS England we  
20 have proceeded at pace to get this up and fit for  
21 purpose.

22 **Q.** On the subject of staffing, Sir Stephen, we  
23 have seen for the RCPCH report that was done at the time  
24 of events at the Countess of Chester, mention of reduced  
25 staff numbers and we have heard evidence now how common

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1 **A.** As is the case with the first iteration of  
2 that plan at all specialty levels, so that was not  
3 unique to neonatology or paediatrics, it would be the  
4 same in any other medical discipline, that is the work  
5 of the plan following that initial publication, so the  
6 specific -- other than general practitioners, where  
7 there was a specific commitment within the plan around  
8 an increase in GPs, for no other sub specialty of  
9 medicine was there in the detail in that plan  
10 a particular plan.

11 But we have recognised and the Royal Colleges are  
12 aware that that is work in the next steps of the plan  
13 and that is work that we are undertaking with the  
14 current Government at the moment.

15 **LADY JUSTICE THIRLWALL:** When do you foresee that  
16 that will have fruition?

17 **A.** It is one of these things where there is never  
18 an end point because medicine evolves and the point is  
19 to ensure that we are producing or training staff that  
20 are -- the relevant numbers of staff with the relevant  
21 skills and competencies for medicine as it develops and  
22 the demand as we see it and the demand in neonatology  
23 has been changing and the nature of births, women are  
24 giving birth later, for instance, we are seeing younger  
25 children who have been born prematurely surviving, so

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1 all of those things need to be taken into account in  
2 terms of determining the neonatal workforce. So what  
3 might be required in 2025 might be different in 2028 or  
4 2032 and of course for many --

5 **LADY JUSTICE THIRLWALL:** I understand that.  
6 I wonder when the next iteration --

7 **A.** We agreed with the Treasury and the previous  
8 Government that this would be reiterated every  
9 two years. Clearly we are in discussions with the  
10 current Government, as you know there has been a change  
11 of Government but we are working internally towards that  
12 two years' iteration would be the summer of this year  
13 but clearly that is subject to conversations with the  
14 current Government who quite rightly would want to  
15 review the plan agreed by a previous Government and  
16 I wouldn't want to over-commit on timings.

17 **LADY JUSTICE THIRLWALL:** No, I don't think you are  
18 over-committing, if I may say so. It's just really so  
19 I can have some understanding of when the numbers get or  
20 the consideration has been given to individual units, so  
21 in particular neonatal units --

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** -- when will they see what  
24 the workforce plan is for their doctors and nurses.

25 **A.** So this is not just about that national plan,  
65

1 and again on the national plan which by its nature will  
2 be higher level, the agreement with the previous  
3 Government was every two years. Two years is up this  
4 summer. But we are in conversations with the new  
5 Government as to how they might want to formulate that.

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

7 Then there was just one point which you reminded me  
8 of when speaking about the current Chief Executive at  
9 the Countess of Chester who had written really many  
10 months ago and has recently had a reply.

11 **A.** She has.

12 **LADY JUSTICE THIRLWALL:** Saying: we will have  
13 a meeting at some point.

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** But nothing arranged. It  
16 didn't feel to me as if there was any great urgency in  
17 the response from the regional office; is that a fair  
18 observation to make?

19 **A.** So that work has been ongoing within the local  
20 area around provision of neonatal care within Cheshire  
21 and Merseyside. Clearly it was not acceptable that it  
22 was such a length of time between the reply to her  
23 initial letter but I understand there have been  
24 conversations with the Countess of Chester and I am  
25 confident that that work is now progressing.  
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1 it's also around local work that is being undertaken.

2 There is local work being undertaken in Cheshire and  
3 Merseyside and this region and you have heard from the  
4 current Chief Executive of the Countess of Chester the  
5 desire to redesignate the unit. Again, the workaround  
6 staffing levels around the appropriate distribution of  
7 neonatal care within a region and an area as opposed to  
8 an individual hospital is all part of that work.

9 So the National Workforce Plan is part of that but  
10 it also has to take into account the local demand and  
11 local needs and local configuration of services.

12 **LADY JUSTICE THIRLWALL:** Yes, I think --

13 **A.** The final layer I put on that, and I have  
14 mentioned the National Neonatal Delivery Board, which  
15 again is there to ensure that there is a supply, not  
16 just in medical professions but in nursing professionals  
17 of course who have different career routes as well.

18 **LADY JUSTICE THIRLWALL:** I'm sorry, Ms Langdale,  
19 just to get to when they might have some idea of  
20 what's --

21 **A.** So I think on the local approach --

22 **LADY JUSTICE THIRLWALL:** Yes.

23 **A.** -- that work is being undertaken at the  
24 moment. Again I can't give you an exact timeline that  
25 is now a designated process to Integrated Care Boards  
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1 **LADY JUSTICE THIRLWALL:** Thank you.

2 **MS LANGDALE:** Yes, I think the response was to have  
3 a suggested meeting in January which at the time the  
4 witness had given evidence, that hadn't happened that by  
5 I think it was autumn of next year this overview of  
6 neonatal services in the region was going to be --

7 **A.** Yes.

8 **Q.** -- considered.

9 Which is some time to wait I suppose if they have  
10 been temporarily designated a lower tier for a number of  
11 years now?

12 **A.** Yes, and again as you are aware, these  
13 services, neonatal services, are specialised services  
14 that remain the accountability of NHS England at  
15 national level, they are on a prescribed list of  
16 specialised services. But we have in the last few years  
17 with the support of the Government been delegating  
18 responsibility down to local healthcare systems. The  
19 reason for that is that some components of maternity and  
20 neonatal care are locally commissioned and our view is  
21 that ensuring both that specialised commissioning and  
22 local commissioning is undertaken in one place is of  
23 benefit to the community and to patients.

24 So those decisions are now delegated down to ICBs  
25 and a joint committee of ICBs with support from the  
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1 region, which is the North West region, presently within  
2 NHS England. So these now are local decisions.

3 It has of course been nearly nine years since the  
4 unit was redesignated. Much has changed over that  
5 period and therefore it is quite right that any  
6 redesignation which we acknowledge is desired by the  
7 Countess of Chester is taken in the light of changes in  
8 local demand but also in local configuration of  
9 services. And that is exactly the work we would expect  
10 the Integrated Care Board to do with the support from  
11 the region and that is what they are currently doing.

12 **LADY JUSTICE THIRLWALL:** Is that the explanation,  
13 they have just been very busy?

14 **A.** Well, I think they have been looking for some  
15 time at the correct configuration of services in  
16 Cheshire and Merseyside but I will ensure that that work  
17 proceeds at pace.

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

19 **MS LANGDALE:** You mentioned the NHS long term  
20 workforce plan. It doesn't make any commitments to  
21 investigating in children's nursing; is that the case?

22 **A.** Yes.

23 **Q.** Why not?

24 **A.** This goes back to the fact that the original  
25 plan was at a very high level so it talked about

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1 is our 18 week standard for elective procedures and  
2 outpatients appointments.

3 So those broad high level targets apply across the  
4 board. There are standards and often this conversation  
5 I think is better thinking about standards than targets.  
6 Standards much more are around the level of provision,  
7 the level of care, the quality of care that we expect  
8 that we should be providing.

9 **Q.** Do targets link to funding, though? I mean  
10 I suppose the importance of what the target is linked to  
11 is if that's where more money comes in, you might give  
12 more emphasis to those areas than, say, children's  
13 services or neonates?

14 **A.** In general, the setting of targets and  
15 standards is not related to funding. The ability to  
16 deliver those standards and targets is.

17 But in the initial setting of standards and  
18 targets, then my experience is that they are very much  
19 based on what we believe is the right standard of care  
20 to achieve in whatever area that standard is applicable  
21 to, but you are perfectly correct that the ability to  
22 deploy resource, in other words funding, can determine  
23 whether those standards are met or not.

24 **Q.** And if I am meeting those standards or  
25 delivering that service well, presumably I will get the

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1 professions as a whole, rather than individual  
2 specialties and again that was not unique to Children  
3 and Young People, it was the same in any area of medical  
4 practice with the exception of general practice where  
5 there was a specific commitment.

6 But it was done in the understanding, and you can  
7 actually see that in the very latter pages of the plan  
8 a commitment to do the work and this we have always said  
9 would be done with the Royal Colleges to work on  
10 requirements for individual specialties.

11 That is not a simple task, it requires detailed  
12 modelling and detailed understanding of where we think  
13 services are likely to be in the next decade because it  
14 takes time, particularly with doctors, to train people  
15 fully to Consultant level but that is work that we are  
16 currently undertaking.

17 **Q.** Do you agree that the majority of targets set  
18 for Hospital Trusts concern care for adults and not  
19 children?

20 **A.** Not necessarily. So many of the targets that  
21 we set, the key constitutional targets are not  
22 age-specific they apply to all ages. They may not  
23 specifically apply to children and young people but they  
24 don't specifically apply to any age group, whether that  
25 is a four-hour standard for emergency care, whether it

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1 funding the next year to do the same and the same?

2 **A.** Yes, I think it's probably more complicated  
3 than that because funding comes through various streams  
4 to organisations such as hospitals. And there are  
5 a range of standards that we would expect hospitals and  
6 other providers to attain, many of those are set by  
7 clinical professionals, not just by the Government or  
8 Government policies, but many of them flow from the  
9 constitutional standards, the core constitutional  
10 standards.

11 **Q.** Can I go back to Inquiries and recommendations  
12 from Inquiries. The Clothier Inquiry around  
13 Beverley Allitt of course many years ago. How difficult  
14 is it for corporate memory to be maintained within the  
15 NHS when there's restructures of bodies, of regulators?  
16 How difficult is that? What are the barriers to making  
17 the memory of a case, for example, and its implications  
18 set down?

19 **A.** Clearly there are challenges. So again a bit  
20 of context which you have just described the NHS of  
21 course is ecosystem of many, many, many organisations,  
22 many of which have a statutory body and have their own  
23 governance structures.

24 So it's not the responsibility in our view of  
25 necessarily of one organisation to be conscious of

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1 recommendations or to have a role in implementing them.  
 2 To give two extreme examples, in a sense clearly Public  
 3 Inquiries such as this will generate or will produce  
 4 a set of recommendations that are generally for an  
 5 entire system of healthcare. Individual organisations  
 6 might commission reviews with recommendations that are  
 7 very specific to the particular service that they want  
 8 to examine.

9 Of course, in the latter case it would be the  
 10 responsibility of that organisation to ensure that they  
 11 implemented the recommendations that might come from an  
 12 external report, and to ensure that was done over time  
 13 in the case of a Public Inquiry, it is the  
 14 responsibility of other bodies, for instance  
 15 NHS England, Department of Health and Social Care, the  
 16 Cabinet Office, to implement those recommendations.

17 So in general I think how those recommendations are  
 18 implemented and the process of accepting them, depends  
 19 upon the nature of the recommendation. It depends upon  
 20 who the recommendation is targeted at and it's not  
 21 infrequent for recommendations to be directed at to  
 22 particular organisations and then of course a view of  
 23 which organisation or several organisations might be  
 24 best to implement that.

25 So if I give you a good example, if I may, from the  
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1 within NHS England to ensure that we understand those  
 2 recommendations and we set about implementing them.

3 I do think there is scope though for strengthening  
 4 this and you will have heard evidence from  
 5 Dr Rosie Benneyworth, Interim Chief Executive HSSIB.

6 **Q.** I am going to come to that in a moment, can we  
 7 go to her shortly?

8 **A.** Yes.

9 **Q.** Let's focus for a moment on remembering the  
 10 Allitt case. Sir Duncan, who was Chief Executive at the  
 11 time, was tasked by Baroness Bottomley to circulate  
 12 information surrounding that case and one of  
 13 the recommendations was to heighten awareness about the  
 14 case --

15 **A.** Yes.

16 **Q.** -- about the crimes of Beverley Allitt.  
 17 Didn't particularise how that might be done --

18 **A.** Yes.

19 **Q.** -- but to heighten awareness, moving forwards  
 20 in time, I suppose that is safeguarding in time, isn't  
 21 it, policies, thinking about deliberate harm from  
 22 a member of staff --

23 **A.** Yes.

24 **Q.** -- being a possibility?

25 **A.** Yes.

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1 Infected Blood Inquiry, is one the recent Public  
 2 Inquiries. So the recommendations within the final  
 3 report of the Infected Blood Inquiry contained some  
 4 recommendations which are in scope for the Cabinet  
 5 Office relating to the Civil Service and the matter of  
 6 Public Inquiries in general. There are some  
 7 recommendations that are very specific to healthcare  
 8 systems and therefore within the remit of NHS England.

9 So we have gone through a process and again we have  
 10 replicated this with other recent Inquiries with the  
 11 Department of Health and Social Care to be clear about  
 12 which recommendations should be led by which  
 13 organisation. We have a set for the Infected Blood  
 14 Inquiry which are led within NHS England by Chair,  
 15 a steering board, personally overseeing those  
 16 recommendations, giving advice to Government as to  
 17 whether they should be accepted and, if not, why not,  
 18 and that is an important part of recommendations that  
 19 that has been laid before Parliament and then the work  
 20 of implementing them.

21 So I can give you assurance that for recent  
 22 Inquiries -- and I include in this investigations such  
 23 as Donna Ockenden's Inquiry into maternity at Shrewsbury  
 24 and Telford and Dr Bill Kirkup's investigation into  
 25 maternity at East Kent that we have a rigorous process  
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1 **Q.** Can we have a look for these purposes at your  
 2 statement page 195, so it is INQ0017495, page 195. It's  
 3 paragraph 747, it begins. You set out helpfully the  
 4 governance structure for fulfilling NHS England's  
 5 statutory safeguarding responsibilities. It's quite  
 6 difficult to see the governance chart there, I don't  
 7 know if it gets any better if it's blown up. It does.

8 What assistance does NHS England provide to  
 9 NHS Trusts to help them comply with safeguarding  
 10 requirements?

11 **A.** Well, as I am sure the Inquiry is aware,  
 12 safeguarding is an interagency approach that involves  
 13 partners, not just in the health system but also in  
 14 local authorities and the police and others and there  
 15 are a number of key documents concerning safeguarding,  
 16 the Working Together --

17 **Q.** 2015?

18 **A.** -- guidance that was previously with the  
 19 Department of Education, now with the Department of  
 20 Health and Social Care, is one of those documents. The  
 21 intercollegiate document, produced by the Royal College  
 22 of Nursing but with input from many others is another.  
 23 The SUDIc guidance from the Royal College of  
 24 Paediatricians and Child Health again.

25 We bring that together within the SAF, the

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1 Safeguarding and Accountability Framework, produced by  
 2 NHS England which sets out our expectations around how  
 3 individual organisations within the NHS should approach  
 4 safeguarding, the guidance they should pay attention to,  
 5 the processes and structures they should put in place.  
 6 That is revised on a periodic basis and it is due  
 7 further revision soon.

8 **Q.** Can I ask that it's put on the screen,  
 9 Sir Stephen, your paragraph 749 --

10 **A.** Yes.

11 **Q.** -- which sets out NHS England facilitating  
 12 national sharing of best practice and safeguarding.  
 13 Various ways that it's done and they are listed on the  
 14 next page.

15 **A.** Yes.

16 **Q.** Including reference to an NHS safeguarding  
 17 app?

18 **A.** Yes.

19 **Q.** Who has access to that?

20 **A.** And there is reference there, which I was  
 21 going to allude to, to the NHS Standard Contract which  
 22 requires organisations to put in place these processes  
 23 and structures regarding safeguarding.

24 **Q.** And then at paragraph 752 you set out the NHS  
 25 Safeguarding Accountability and Assurance Framework

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1 **A.** Yes, again a bit of context. It is not  
 2 unusual for us to write national policies with the  
 3 ability for local organisations to modify and adapt  
 4 them. There is good reason for doing that because one  
 5 national policy doesn't necessarily fit every single  
 6 organisation. A good example of that, we may come on to  
 7 this, is the Patient Safety Incident Response plans,  
 8 where the Countess of Chester have adapted that plan for  
 9 their local circumstances including, for instance, the  
 10 fact that they are close to the Welsh border and they  
 11 have to take into account patients in Wales.

12 But I think there is merit in us considering  
 13 whether in safeguarding we can take more of a template  
 14 approach, as you have suggested, and I am very happy to  
 15 commit to the Inquiry that we will -- that I will  
 16 discuss that with the Chief Nurse who has responsibility  
 17 in this area and see whether we can take that approach  
 18 in a -- in a more defined way than perhaps we have  
 19 previously.

20 **Q.** Because there does seem to be confusion on the  
 21 ground at least from evidence we have heard about when  
 22 the SUDiC, the Sudden Unexpected Death in Infancy  
 23 guidance, should be followed as opposed to Child Death  
 24 Overview. Suggestions reading into a policy that you  
 25 might use both. I mean this isn't a good use, is it, of

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1 aiming to draw together and describe safeguarding roles  
 2 and responsibilities?

3 **A.** Yes.

4 **Q.** And at 755:

5 "The framework states robust arrangements including  
 6 the following:

7 "Identification of a named nurse, named doctor and  
 8 named midwife ... for safeguarding children."

9 **A.** Yes, those are the structures and processes  
 10 I was referring to.

11 **Q.** And then over the page, a suite of  
 12 safeguarding policies and procedures that support local  
 13 multi-agency safeguarding procedures. The Inquiry heard  
 14 from the current Chief Executive at the Countess of  
 15 Chester and asked questions about the current policies  
 16 and it would appear, would it, that Trusts write their  
 17 own policies, they may have guidance but would there be  
 18 some sense in a template provided by NHS England where  
 19 they add these details, for example setting out what you  
 20 said here, identification of a named nurse, doctor, so  
 21 that instead of everybody writing policies -- and they  
 22 will be variable, the Inquiry has seen that, having had  
 23 a survey and obtained them -- having a state-of-the-art:  
 24 this tells you what you need to know and what you need  
 25 to do policy, would that be helpful do you think?

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1 clinicians' time if it's taking six hours to fill in one  
 2 of these forms following a death?

3 **A.** So I think there is a separate discussion  
 4 around the time it takes to report and that is not just  
 5 for safeguarding. But in general, yes, we would agree  
 6 that there is scope for more clarity. There are clearly  
 7 a number of documents, we have discussed the SAF, aims  
 8 to bring those documents and guidance together but again  
 9 I can commit within NHS England and also in the work  
 10 that we do with partner organisations such as the  
 11 Department of Health and Social Care and the Colleges to  
 12 provide more clarity to these documents and guidance.

13 **LADY JUSTICE THIRLWALL:** I just wonder if they  
 14 could be made shorter.

15 **A.** There is always a balance between providing  
 16 too little detail and too much and it's one in all our  
 17 guidance and documents that we are always conscious of.  
 18 And if I may, my experience is you both hear from  
 19 practitioners that sometimes there is too much in  
 20 a document but equally from others that there is stuff  
 21 that they would have liked to have been in a document  
 22 and guidance that's not there.

23 **LADY JUSTICE THIRLWALL:** But it may be that there  
 24 is room, isn't there, for something short and clear for  
 25 when someone is having to know what to do right now

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1 where something more discursive and perhaps a bit more  
2 academic?

3 **A.** It depends a little bit on the nature of the  
4 document --

5 **LADY JUSTICE THIRLWALL:** Of course it does, we  
6 haven't had so far anyone complaining about documents  
7 being too short.

8 **A.** No, but it does in my experience, it is not so  
9 much the shortness of documents it's -- it's could you  
10 have such and such in it or include other information.

11 But it is a balance. It does of course depend on  
12 the nature of the document. The more technical  
13 documents tend to be longer and we are always striving  
14 to keep that balance but I will take those views back  
15 and ensure that we scrutinise that balance appropriately  
16 and make sure that we have the right balance between  
17 providing enough information but not documents that are  
18 too long.

19 **MS LANGDALE:** Can I take you to an NHS England and  
20 NHS Improvement document that isn't too long, I suggest,  
21 and it's INQ0107001 beginning at page 1.

22 We asked the Countess of Chester for all of their  
23 safeguarding policies and we didn't see this. You have  
24 helpfully produced this and it's titled "Managing  
25 Safeguarding Allegations Against Staff: Policy and

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1 discussion with the relevant communications team. All  
2 staff must be familiar with referral procedures for the  
3 protection of children and adults at risk."

4 Further down, 4.8:

5 "It is crucial that no action taken by NHS England  
6 and NHS Improvement to manage an allegation would  
7 jeopardise an external investigation."

8 If we go to 5.12 at page 8:

9 "Police and/or social care should be consulted when  
10 they are involved in any ongoing investigation and/or  
11 when criminal investigations are pending. The staff  
12 member's line management should be asked to provide  
13 appropriate support to the individual and keep them  
14 regularly informed while the case is ongoing. Further  
15 support may also be provided by Occupational Health."

16 And then there is an appendix at page 14 defining  
17 those at risk, harm and relevant conduct and we see some  
18 groups are particularly vulnerable, halfway down the  
19 page, children and young people in hospital. The fourth  
20 bullet point down. And then appendix 2 is a managing  
21 allegations process flowchart.

22 So it doesn't look, and I am sure I will be  
23 corrected by the Countess if we are wrong, as though  
24 they had that policy certainly within their disclosure  
25 in 2014/2015. It's clearly NHS England's responsibility

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1 Procedure".

2 If we go to page 3 we see what it deals with.

3 It's produced by the NHS Safeguarding Team,  
4 I should say. If we go to page 5, 3.3 the policy covers  
5 allegations made against staff both within and outside  
6 their NHS England and NHS Improvement duties, such as  
7 their private life, it lists what they are. The first  
8 one being:

9 "Commitment of a criminal offence against or  
10 related to a child young person or adult at risk."

11 Managing allegations, paragraph 4:

12 "Three separate actions must be considered when  
13 an allegation is made. Enquiries and assessment by  
14 child/adult social care into whether a child, young  
15 person or adult is at risk of harm or abuse or is in  
16 need of protection."

17 A police investigation of a possible criminal  
18 offence, doesn't overstate that.

19 Then we go over the page:

20 "The safety of the child, young person or adult at  
21 risk is of paramount importance and immediate action may  
22 be crucial in safeguarding an investigation. Where  
23 there is concern other individuals may be at risk of  
24 harm or abuse ... must be reported immediately.  
25 Reputational issues must be managed appropriately in

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1 to circulate policies and the like. But it's  
2 a significant document, isn't it, in the light of what  
3 we are examining?

4 **A.** (Nods)

5 **Q.** Thank you for producing it to us. But where  
6 do you think this went to in 2014/2015 and why would  
7 that not have been more widely known at the time?

8 **A.** My understanding, this is an internal  
9 NHS England document relating to our handling of  
10 safeguarding concerns, but I agree with you. It is very  
11 clear and it does provide the clarity that is required  
12 in terms of what to do, if there are concerns around  
13 a member a healthcare professional deliberately harming  
14 a patient.

15 And I think this is the sort of clarity that is  
16 required in documentation around safeguarding, and as  
17 I have said a few minutes ago, it is why I think we need  
18 to ensure going forward that this clarity is in all  
19 safeguarding documents and I will commit to ensuring  
20 that we do that both in the documents we are responsible  
21 for but also in our input into documents that are  
22 produced by other partners.

23 **Q.** So it appears at the time they won't have been  
24 sent anything like that and didn't have anything like  
25 that, there was a paucity of information around what to

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1 do with allegations that a staff member is causing  
2 deliberate harm?

3 **A.** So I can't give you clear evidence of the  
4 guidance that they had at the time in terms of those  
5 local policies but I think clearly one of the key  
6 learnings is around that clarity so that staff are  
7 absolutely clear in what they should do if they have  
8 a concern.

9 I think there are -- as we have discussed at the  
10 start there are many things the Countess of Chester  
11 could have done to raise those concerns, safeguarding is  
12 certainly one of those things. And you have heard  
13 evidence from staff and former members of staff at the  
14 Countess of Chester that in hindsight safeguarding  
15 should have been used. But we do need to be clear about  
16 this and that clarity is required.

17 **Q.** If we can go to another document, please,  
18 INQ0012911, page 1. This is the fourth edition in 2019  
19 of "Safeguarding Children and Young People: Roles and  
20 Competencies for Healthcare Staff".

21 And we see on the front page the contributing  
22 organisations. So not NHS England but a number of  
23 contributing organisations to this document. And we see  
24 if we go to page 19, this is looking at core  
25 competencies if we look at the top in the right-hand

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1 the documents I was referring to, ensuring there is  
2 clarity in the awareness of both -- both the awareness  
3 of deliberate harm but also what to do if there is  
4 deliberate harm I think could be improved.

5 **Q.** This is the kind of document that will be  
6 disseminated widely with this amount of collaboration,  
7 one would hope?

8 **A.** Yes.

9 **Q.** So it is an opportunity to set out the kind of  
10 knowledge NHS England has presumably looking at the  
11 previous document about incidents where those rare cases  
12 had occurred and deliberate harm has been caused and  
13 what needs to be thought about?

14 **A.** Yes, and as I said, it is not an NHS England  
15 document but we do work closely with Royal College of  
16 Nurses on a number of issues as we do with other Royal  
17 Colleges and in the commitment I made it work or input  
18 into documents that are produced by partner  
19 organisations then I, you know, commit to ensure that we  
20 make the case for the -- for clarity and within our own  
21 documents, we provide that clarity.

22 **Q.** And the final guidance document, if I can put  
23 this up, please, INQ0108740, page 1. This is the recent  
24 collaboration to produce investigating healthcare  
25 incidents where suspected criminal activity may have

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1 column, it does appear, "Awareness of professional abuse  
2 and raising concerns about the conduct of colleagues",  
3 so it is in and amongst this document which isn't as  
4 short as the last one but it sets out a lot of  
5 information.

6 And then at page 30, depending the tier that you  
7 are being trained to, this is all about training and  
8 clinical knowledge, we see at bullet point 3:

9 "Understanding the effects of parental behaviour on  
10 Children and Young People and the interagency response."

11 And we see "have an understanding of fabricated or  
12 induced illness".

13 So we have got specifically how the learning is  
14 directed to understanding abuse by family members but we  
15 don't see it repeated about recognising or clinical  
16 knowledge and understanding about recognising concerns  
17 in staff members. So again another gap that if it was  
18 plugged would help with this corporate memory, wouldn't  
19 it, and realisation?

20 **A.** Yes, this is the intercollegiate document that  
21 we have referred to previously. It's produced by the  
22 Royal College of Nurses. As you saw on the cover sheet  
23 on behaviour of a large number of organisations it is  
24 not an NHS England document but I would agree ensuring  
25 that there is clarity in this document, it was one of

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1 contributed. Again was this memorandum put together in  
2 the knowledge that there is a need for guidance in the  
3 handling of incidents involving criminal activity in the  
4 healthcare setting?

5 **A.** Yes. Again this is a Department of Health and  
6 Social Care document. I think you have heard evidence  
7 on this. This I believe replaces a previous MOU, it is  
8 an update to a prevent MOU and it's an important update  
9 because it does give clarity as to how the NHS and the  
10 police should work together.

11 **Q.** If we go to page 4 and 5 and see the  
12 contributors, we see the National Director of Patient  
13 Safety from NHS England. Might it have been sensible to  
14 have the NHS Safeguarding Team represented here or  
15 someone with a safeguarding role, whether that is an  
16 advocate for children or something else, because in  
17 expressing the test to be applied, the requirement to  
18 keep a child safe, such as in the internal document we  
19 went to, can't be emphasised enough, can it, in this  
20 kind of memorandum and somebody with that perspective  
21 might have introduced that thinking, do you think?

22 **A.** I wasn't personally involved in a production  
23 of the MOU so I can't give you the detail as to how that  
24 was considered and whether it was considered. The  
25 National Patient Safety Director is a senior member

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1 within the NHS England structure reporting directly in  
2 to me. It's certainly something I am happy to take back  
3 and discuss with colleagues at the Department of Health  
4 and Social Care.

5 **LADY JUSTICE THIRLWALL:** It may look as though  
6 safeguarding even now is not something that people  
7 automatically think about because one would think if it  
8 had been thought about it would have appeared here, it  
9 is difficult to see why it wouldn't or at least one  
10 would expect an explanation as to why it doesn't; in  
11 other words, there is other guidance as to what you do  
12 when it's a child --

13 **A.** So I wouldn't necessarily draw that conclusion  
14 because I think there are --

15 **LADY JUSTICE THIRLWALL:** Okay.

16 **A.** -- lots of documents relating and processes  
17 and structures related to safeguarding. Those are  
18 required, as I have said, in our standard contract and  
19 our other guidance to organisations and there is staff  
20 mandatory training, different levels of training for  
21 staff depending upon the particular interactions with  
22 Children and Young People.

23 **LADY JUSTICE THIRLWALL:** Yes, indeed, yes.

24 **A.** Sorry.

25 **LADY JUSTICE THIRLWALL:** No, I accept that

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1 know, involves all age groups; it is not specific to  
2 children. But I think that is a fair point and I am  
3 very happy to discuss it with Mr Vineall and colleagues  
4 at DHSC.

5 **Q.** That is something that people working in the  
6 NHS often say, all patients are vulnerable. There is  
7 a lot of vulnerable patients in particular categories,  
8 but by being in hospital, they may be vulnerable and  
9 ill.

10 Do you yourself see there is any distinction at all  
11 between the vulnerability of children and particularly  
12 the newborn and neonates or would you classify all  
13 patients as equally vulnerable in some sections?

14 **A.** I think probably the latter, I mean, there are  
15 clearly specific vulnerabilities for specific --  
16 specific groups of individuals who are vulnerable and  
17 there are specific policies directed at children and  
18 young people as opposed to other vulnerable groups.

19 But I think the -- in my experience, the knowledge  
20 of vulnerability and safeguarding has increased over my  
21 time as a doctor. It's certainly something that in my  
22 40 years I think has been strengthened but that is not  
23 to stay that it shouldn't be strengthened further and  
24 I think these are areas that always need to be kept  
25 under review.

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1 completely, it was just rather that it seems a curious  
2 absence from this document.

3 **A.** Yes, I can't comment further, but as I said  
4 I am very happy to take that up with colleagues at DHSC.

5 **LADY JUSTICE THIRLWALL:** Yes, thank you. I don't  
6 think Mr Vineall could help either about it, was my  
7 memory but I may have misremembered that. Anyway, thank  
8 you. Sorry, Ms Langdale.

9 **MS LANGDALE:** Because for example the key area  
10 where it may be relevant, for example, page 7 when the  
11 MOU applies:

12 "The MOU applies when more than one of the  
13 signatories needs to investigate in parallel  
14 any incident where there is a reasonable suspicion that  
15 a criminal offence has or may have been committed by an  
16 individual."

17 That is of course right in terms of memorandum but  
18 it's also to avoid risk to patients and particularly  
19 children who you are safeguarding, to keep them safe --

20 **A.** Yes.

21 **Q.** -- and to protect them from risk which should  
22 be a thinking in any decision that is ultimately made  
23 about sharing information and when?

24 **A.** Yes. I -- I agree this is something that we  
25 could look at further. Of course safeguarding, as you

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1 **Q.** You mentioned Dr Benneyworth before. Shall we  
2 go to her document --

3 **A.** Yes.

4 **Q.** -- at INQ0108741, page 1. So this was the  
5 collaboration between arm's-length bodies and the DHSC  
6 producing this document, "Recommendations but no action:  
7 improving the effectiveness of quality safety  
8 recommendations in healthcare".

9 If we can go to page 4 of the document, I would  
10 like to invite your comment on a number of the bullet  
11 points here, the findings made.

12 First of all:

13 "Failure to implement actions following  
14 recommendations ..."

15 This is not just from Public Inquiries, from  
16 reviews:

17 "... any other safety investigations can impact  
18 public confidence in the healthcare system and compound  
19 harm to patients."

20 Do you have a view about that?

21 **A.** Yes, so I think this and the findings of this  
22 review are incredibly important and we would support  
23 them. This is work that was commissioned by the  
24 Department of Health and Social Care on behalf of  
25 a group of Chief Executives of our arm's-length bodies.

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1 Latterly, we have been supporting this work within the  
2 National Quality Board, which is a cross-organisational  
3 national board looking at quality in healthcare  
4 I co-chair that with the Chief Inspector of Hospitals,  
5 so I have been close to this work that Dr Benneyworth  
6 has been undertaking and I think it makes a set of  
7 really important points, of which this clearly is one.

8 **Q.** What about the development of a searchable  
9 repository, which includes "recommendations made across  
10 the healthcare system may help to reduce the fact that  
11 some recommendations appear to duplicate or contradict  
12 others"?

13 **A.** So we would agree with that proposal. Of  
14 course it may not be one repository because as I alluded  
15 to earlier, it very much depends upon who the  
16 recommendations are directed at and who has  
17 responsibility.

18 So at the highest level, a Public Inquiry, clearly  
19 there are Public Inquiries that are not specifically  
20 related to healthcare, Grenfell Inquiry, Post Office  
21 Inquiry. It would be, in my view of NHS England,  
22 reasonable for the Cabinet Office, for example, to be  
23 the relevant holder of that repository.

24 For Inquiries, whether statutory Inquiries or  
25 non-statutory Inquiries related solely to healthcare, it

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1 Coroners' reports, Regulation 28 reports, for instance,  
2 HSSIB recommendations.

3 I think that is work to be determined. But as  
4 Dr Benneyworth points out, in the round lots of  
5 recommendations are made by lots of different bodies and  
6 by lots of different reviews and Inquiries.

7 **Q.** And the point has been made that that can be  
8 overwhelming for Medical Directors in individual Trusts  
9 trying to prioritise and know what to do with which  
10 recommendations when. Would you agree with that?

11 **A.** Not specifically -- well, I think this is not  
12 a specific issue for Medical Directors, I think it's for  
13 all leadership teams within organisations. Yes,  
14 I think -- and again Dr Benneyworth describes this, that  
15 a large number of recommendations that sometimes may not  
16 be constructed as helpfully as they might be, sometimes  
17 overlap, and without a prioritisation can be  
18 a challenge.

19 We have a role at NHS England, as do partners such  
20 as Department of Health and Social Care, Cabinet Office,  
21 in prioritising those recommendations and working out  
22 how they can best be implemented and again this depends  
23 on the nature of the recommendation. There are some  
24 recommendations that are best implemented by a change in  
25 national policy that can then be promulgated through to

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1 would be reasonable for the Department of Health and  
2 Social Care to hold that repository but it would also be  
3 reasonable for NHS England to hold a repository for  
4 recommendations that are made in Inquiries that it  
5 commissions, or for recommendations that it has the  
6 responsibility to carry out.

7 I think another important point is, as you know,  
8 structures within the healthcare system within the NHS  
9 change over time and that may be one of the contributors  
10 to recommendations not being fully implemented or  
11 tracked and for that reason Government bodies such as  
12 the Cabinet Office and DHSC, I might say, are more  
13 permanent structures I think would be appropriate over  
14 serious of a master repository. We have a repository  
15 for maternity recommendations within NHS England and we  
16 will be undertaking work to explore how we can expand  
17 that approach to recommendations across a variety of  
18 areas, not just maternity.

19 And the final point I would make, which I have made  
20 previously, is that recommendations come from a huge  
21 range of reviews, from Public Inquiries, through to  
22 individual pieces of work that individual organisations  
23 might commission themselves and there is a question as  
24 to if there were to be master repositories, which  
25 recommendations would be kept within that, is it all

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1 individual organisations.

2 There are some recommendations that do require  
3 individual organisations to take action themselves, it  
4 very much depends upon the nature of the recommendation.

5 So we talked about the recommendation in  
6 Sir Cecil's report into Beverley Allitt on incident  
7 reporting. That is a good example where over time that  
8 recommendation and others has resulted in the National  
9 Incident Reporting System. So that is a national  
10 policy.

11 So we agree repositories are worth considering but  
12 again we need to recognise there are a lot of  
13 recommendations and prioritisation does have to occur.

14 **Q.** One of our witnesses suggested that the person  
15 fit to do that might be the National Medical Examiner,  
16 letting medical directors know how to prioritise and  
17 when and what?

18 **A.** Yes, I noted Mr Hunt made that recommendation  
19 to you.

20 So it doesn't necessarily have to be me or the  
21 person in my role. But we do agree that there is a need  
22 for prioritisation. To an extent that already occurs,  
23 for instance in the response to recommendations made by  
24 Public Inquiries. But all recommendations have with  
25 them resource consequences, for example, and as part of

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1 responding to recommendations it is important to take  
2 a view as to what are the most important and most urgent  
3 to implement but also of course the nature of how they  
4 can be implemented and the resource required to  
5 implement them.

6 So we would agree in principle; whether it needs to  
7 be me or not I think is a second order question.

8 **Q.** If we look at bullet point 5 there is  
9 a current lack of visibility of ongoing work across  
10 arm's-length bodies that would enable collaborative  
11 working on related workstreams.

12 Why is there a lack of ongoing work across  
13 arm's-length bodies, do you think, because that does  
14 mean there will be duplication, wasted cost time and  
15 effort, similar to what we have been saying about Trusts  
16 drafting all their own lengthy policies?

17 **A.** I wouldn't say there is a complete lack of  
18 ongoing work and I have given you the examples of the  
19 response to the Infected Blood Inquiry and the recent  
20 maternity Inquiries as a good example of how in practice  
21 we as a set of partners, in this case the Department of  
22 Health and Social Care, the Cabinet Office, NHS England,  
23 NHS Blood and Transplant, who are the key implementers  
24 of the IBI recommendations, how we work together to  
25 ensure that there is clarity over who has responsibility

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1 important.

2 That is not always possible because the nature of  
3 recommendations but in my experience it does assist in  
4 the consideration and implementation of recommendations.

5 **Q.** Should new recommendations explicitly  
6 supersede previous related ones?

7 **A.** So I think as part of the process of setting  
8 recommendations, consideration should be made to  
9 previous recommendations. And where those new  
10 recommendations are explicitly designed to either build  
11 on or entirely supersede previous recommendations, again  
12 this is my own view, I think it would be useful if that  
13 can be made clear.

14 Clearly over time recommendations can be superseded  
15 because of legislative changes, that certainly happened  
16 with respect to the Clothier Inquiry, due to changes in  
17 the way healthcare is structured or indeed medical  
18 advances. So that is one reason why when you look back  
19 at previous recommendations you cannot directly see that  
20 it's been implemented at first sight because it has been  
21 superseded by others or by changes in practice, but I do  
22 think in general I would agree with you that being  
23 cognisant of previous recommendations and how a current  
24 recommendation impacts upon that would be useful.

25 **Q.** Do you think the House of Commons Select

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1 for which recommendation.

2 But I think what Dr Benneyworth is alluded to here  
3 is work around ensuring that individual components of  
4 the NHS, so CQC, HSSIB, for example, NHS England are not  
5 overlapping in work that results in a duplicity of  
6 recommendations in particular areas, so we would agree  
7 with her on that. And I think there was further work to  
8 be done as a consequence of the work she has done.

9 **Q.** If we look at page 7. There is reference to  
10 the National Recommendations Register for maternity and  
11 neonatal services. Do you agree that that initiative in  
12 the context of maternity and neonatal services could be  
13 replicated in other areas as well?

14 **A.** Yes, and that is why I have committed to  
15 within NHS England building on the work that's been done  
16 within the maternity and neonatal programmes, to  
17 expanding it to broader sets of recommendations that are  
18 pertinent to other areas of patient care.

19 **Q.** Is there a need to ensure recommendations are  
20 narrowly focused with specific outcomes?

21 **A.** Yes. Of course I would be hesitant to give  
22 the Inquiry a recommendation on your own recommendations  
23 but I think in general as a receiver of recommendations,  
24 the more specific they are, the clarity on who or what  
25 organisation should be responsible for that, I think is

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1 Committee is an appropriate mechanism for monitoring  
2 recommendations and their implementation?

3 **A.** So I think as part of that process of having  
4 a repository there is -- there should be a process of  
5 monitoring recommendations and again this is not just  
6 one organisation, it's all organisations who are  
7 responsible for recommendations. But we do that within  
8 NHS England. For instance, we are still -- for the  
9 Morecambe Bay Inquiry from a few years ago we are --  
10 until recently been monitoring the impact of those  
11 recommendations and the implementation of those  
12 recommendations.

13 So I can speak for NHS England saying that we are  
14 focused on ensuring that recommendations that we are  
15 responsible for are monitored and that there is  
16 a process for review.

17 But clearly with the volume of recommendations as  
18 you've alluded to, that can be a challenging task.

19 **Q.** Can we have on the screen, please, INQ0010447,  
20 page 1. This is an article that Dr Benneyworth I think  
21 produced for us. It's 2019 so the position may be  
22 different now, slightly different. Mapping the  
23 Regulatory Landscape, and we see results within the  
24 abstract:

25 "Our mapping revealed over 126 organisations who

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1 exert some regulatory influence on NHS provider  
2 organisations in addition to 211 Clinical Commissioning  
3 Groups."

4 And then we see at page 2:

5 "The need to map the regulatory landscape."

6 "This short overview of regulation history in the  
7 UK demonstrates a stream of structural reforms over the  
8 last 25 plus years which have gradually increased the  
9 extent and complexity of the regulatory structures."

10 Do you think a review, Professor Dixon-Woods  
11 suggested it might be conducted by the DHSC or by  
12 someone, of the number of bodies in the space and what  
13 can be done about that, if anything?

14 **A.** Yes, we do agree that although with good  
15 intent the patient safety landscape in terms of  
16 regulation and oversight has become over complex. Of  
17 course, those many organisations are not just NHS or  
18 Government or arm's-length bodies, there are a number of  
19 other groups who make recommendations and look at  
20 patient safety but when it comes to national bodies of  
21 Government or arm's-length bodies, we do believe that  
22 that has become over-complex. Indeed it was one of the  
23 recommendations of the Infected Blood Inquiry that the  
24 patient safety landscape should be reviewed. And you  
25 may be aware that the Department of Health and Social

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1 you want to look at it, it doesn't need to come up,  
2 that:

3 "Concerns about the effectiveness of the previous  
4 Serious Incident Frameworks have been raised in almost  
5 every previous Inquiry, investigation or review into the  
6 NHS or a specific NHS organisation ..."

7 Why is that, do you think, that it's been  
8 continual, that the issue of how reports are made has  
9 been raised?

10 **A.** So I think there were a number of themes that  
11 came out of those reviews and Inquiries that have led to  
12 the development of a new Patient Safety Strategy in 2019  
13 and also an evolution of the existing reporting system.  
14 And in general those themes were around moving from  
15 a culture that overly at times sought to or appeared to  
16 seek blame on individuals versus recognising that for  
17 the vast majority of incidents, it's not around the  
18 actions of a single individual but around a set of  
19 systems and processes that are either flawed or one  
20 component of them goes wrong.

21 Secondly, around a desire to move much more to  
22 a culture of improvement and therefore taking the  
23 learning often from a range of incidents, not just from  
24 an individual incident into a much more that thematic  
25 approach to learning and also then driving improvement.

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1 Care Secretary of State has commissioned Dr Penny Dash  
2 to undertake a review of the patient safety landscape.  
3 She is undertaking that review as we speak. We have,  
4 along with others, been inputting into that but we would  
5 agree that some rationalisation and clarity of that  
6 patient safety regulation landscape would be of benefit.

7 **MS LANGDALE:** Thank you. My Lady, I see we have  
8 been going for 90 minutes. It might be time for  
9 a break.

10 **LADY JUSTICE THIRLWALL:** Very good, thank you very  
11 much. We will take a break for the shorthand writer and  
12 for you.

13 **A.** Thank you.

14 **LADY JUSTICE THIRLWALL:** We will start again at  
15 half past 12.

16 **(12.14 pm)**

**(A short break)**

17  
18 **(12.30 pm)**

19 **LADY JUSTICE THIRLWALL:** Yes.

20 **MS LANGDALE:** Sir Stephen, I am going to move now  
21 please to the topic of how Serious Incidents are  
22 reported to NHS England, how they were at the time of  
23 the events and how they are now.

24 **A.** Yes.

25 **Q.** You say at paragraph 816 of your statement if

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1 Thirdly, around something that was very much heard  
2 from relatives, from patient groups, from public groups,  
3 that the engagement and the interaction with those who  
4 have been affected by incidents was not sufficient and  
5 this was happening too much over there, where we were  
6 not involving the views or the insight or involvement of  
7 patients and relatives.

8 So for all those and a number of other reasons  
9 around how the reporting systems were constructed and  
10 how data flows, we moved in 2019 to a new Patient Safety  
11 Strategy and a new system, PSIRF, Patient Safety  
12 Incident Report Framework --

13 **Q.** We will go to that, I will take you to that  
14 document in a moment.

15 **A.** -- which was described in the statement. But  
16 those were the key principles around the new direction  
17 of travel.

18 **Q.** If we go, please, to INQ0009236, page 1, this  
19 was the March 2015 Serious Incident Framework policy.  
20 If we go to page 13, it is page 12 of the document,  
21 page 13, INQ, in broad terms at the top:

22 "Serious Incidents are events in healthcare where  
23 the potential for learning is so great or the  
24 consequences to patients, families and carers, staff or  
25 organisations are so significant that they warrant using

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1 additional resources to mount a comprehensive response."

2 If we go over the page:

3 "Serious Incidents in the NHS include acts and/or  
4 omissions occurring as part of NHS funded healthcare  
5 that result in unexpected or avoidable death." And that  
6 has a footnote 8:

7 "Caused or contributed to by weaknesses in care,  
8 service delivery including lapse, acts and/or omission  
9 as opposed to a death which occurs as a direct result of  
10 the natural course of the patient's illness or  
11 underlying condition where this was managed in  
12 accordance with best practice."

13 This appears -- or the footnote appears to suggest  
14 you need to identify the death or injury as being caused  
15 by an act or omission partly as a consequence of  
16 treatment. So you referred to the need to blame or  
17 being concerned something had happened that was  
18 incorrect or wrong, that that takes you down the route  
19 of if there's something, you know, that's wrong as  
20 opposed to just unexpected, unaccountable, don't know  
21 what's happened?

22 **A.** So we would take the view that at the time the  
23 definition did include, and you gave the high level  
24 definition of a Serious Incident on page 1 at the start  
25 of an unexplained or unexpected death, that could not be

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1 openly to investigate proportionately and to let the  
2 investigation decide."

3 So that section appears still to refer to "acts or  
4 omissions within care" but if we go further on in the  
5 document "Reporting a Serious Incident", page INQ34,  
6 page 33 of the policy, we see there "Reporting a Serious  
7 Incident." Three bullet points including:

8 "Incidents which will give rise to significant  
9 media interest or the significance to other agencies  
10 such as the police or other external agencies.

11 "Reporting a Serious Incident must be done by  
12 recording the incident in the NHS Serious Incident  
13 Management System, STEIS or its successor system.

14 "The Serious Incident Report must not contain any  
15 patient or staff names and the description should be  
16 clear and concise."

17 Those are the extracts of the policy that are  
18 relevant to assessing and reporting. What do you say on  
19 behalf of NHS England should have been reported to you  
20 and when and with reference to which part of that  
21 policy?

22 **A.** Well, to be clear, without a level of detail  
23 of individual cases that I haven't reviewed, I will give  
24 that caveat but of the 16 incidents that were reported  
25 through the NRLS system, in other words were logged as

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1 explained by a particular omission or a particular act,  
2 should be considered by the relevant panel within an  
3 organisation, organisations had slightly different ways  
4 of dealing with this but in general incidents are  
5 reported by members of staff, reviewed by risk managers  
6 and then escalated to further review processes by senior  
7 leaders and our view is that it would have been expected  
8 and perfectly reasonable for many, if not all, of the  
9 incidents at the Countess to have been reported as  
10 Serious Incidents. The first cluster of three.

11 **Q.** Shall we go to the policy --

12 **A.** Yes.

13 **Q.** -- just to expand on what you are saying  
14 there.

15 If you go to page 14 of the policy, INQ number  
16 page 15, there is a section "Assessing whether an  
17 incident is a serious incident", at the bottom it says:

18 "Where it's not clear whether or not an incident  
19 fulfils the definition of a Serious Incident, providers  
20 and commissioners must engage in open and honest  
21 discussions to agree the appropriate and proportionate  
22 response may be unclear initially whether any weaknesses  
23 in a system or process, including acts or omissions in  
24 care, caused or contributed towards a serious outcome,  
25 the simplest and most defensible position is to discuss

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1 incidents, not all of them -- in fact, the majority of  
2 them -- were not escalated through, as far as I can see,  
3 to a Serious Incident Review Panel within the Countess  
4 of Chester for a further discussion as highlighted in  
5 this document as to whether they should be Serious  
6 Incidents or not.

7 There was clearly a -- that process clearly  
8 occurred for the first cluster of deaths in the summer  
9 of 2015.

10 **Q.** You are talking about the deaths of A,  
11 C and D, that cluster?

12 **A.** And of those D was reported as a Serious  
13 Incident but A and C were not.

14 Again, it's not entirely clear to me from the  
15 evidence I have reviewed why that decision was taken,  
16 I can't give you further clarity.

17 **Q.** There was a delay in antibiotics or concern  
18 there had been a delay, so therefore an omission or  
19 something that might have fit the category of that  
20 particular death being reported?

21 **A.** So -- so again, I think we would have expected  
22 those to have been reported and of course the fact that  
23 only one was reported meant that it did not trigger the  
24 concerns that a cluster of reports would have and a year  
25 later, as you are aware, when Baby O and P were reported

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1 as two, you know, very short time-span, that immediately  
2 triggered concerns amongst the Commissioners to  
3 scrutinise further and to seek further information.

4 And so if those in that initial cluster there had  
5 been a second or a third Serious Incident reported, I am  
6 confident it would have triggered the same level of  
7 inquiry and curiosity from Commissioners that occurred  
8 a year later.

9 **Q.** And if we look for completion's sake at the  
10 2016 policy, INQ0006466, page 3. We see again what  
11 should be reported is:

12 "An incident, event or circumstance which could  
13 have resulted or did result in unnecessary damage, loss  
14 or harm to patients, staff, visitors or members of the  
15 public."

16 So again reference to something that might have  
17 been done differently and might have been causative?

18 **A.** Yes, and again from the evidence that I have  
19 seen, even with that very first cluster of deaths,  
20 concerns around a particular member of staff were  
21 raised.

22 **Q.** Can that come down, please, and can we have  
23 a paragraph from your statement, INQ0017495, page 122.  
24 480b, if we can highlight at the top. You are  
25 addressing here Serious Incidents and you say:

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1 That is clear in the policy. But clearly if there are  
2 doubts, as the policy says, that incident should be  
3 subject to further discussion and that can include  
4 Commissioners and in my experience discussing with  
5 Commissioners whether something should be classified as  
6 a serious incident or not can be a valuable approach to  
7 take as well.

8 **Q.** Did NHS England undertake any analysis of why  
9 there is the variability, ie down to a lack of clarity  
10 round the framework, or local policies and practice?

11 **A.** Again that would have been done at an area or  
12 regional level. I cannot again off the top of my head  
13 give you details. But again we can go back and look to  
14 see whether we can find evidence that that review was  
15 undertaken and whether individual organisations were  
16 cognisant of any review.

17 I am pretty certain that discussions around rates  
18 of Serious Incident reporting would have been discussed,  
19 the quality surveillance groups, for example, but  
20 I can't say for sure that that was the case and when it  
21 occurred.

22 **Q.** You referred a moment ago to the Patient  
23 Safety Incident Response Framework, can we have that on  
24 the screen please, INQ0009265, page 1. And if we go  
25 through it, please, page 3 first sets out the NHS's

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1 "An oversight role (consistent with its patient  
2 safety responsibilities [at] the time) to ensure there  
3 was effective serious incident reporting and subsequent  
4 management of serious incidents by the lead commissioner  
5 (that is the Clinical Commissioning Group)."

6 And you say:

7 "The experience of the North Regional team at the  
8 time was that there was a wide spectrum in the approach  
9 taken by providers when reporting Serious Incidents.  
10 Some providers over-reported (in the sense that an  
11 incident was reported that did not meet the relevant  
12 thresholds set out in the framework) whilst many other  
13 providers under-reported".

14 How did they know where there was under-reporting,  
15 how did they ascertain that?

16 **A.** So at the time, if I remember correctly,  
17 certainly in terms of overall incidents it was possible  
18 to see whether you were an over-reporter of incidents or  
19 an under-reporter. I cannot specifically give you  
20 information on serious incidents per se, I am very happy  
21 to look at that and see if we have got further evidence  
22 that we could provide to you in terms of what was  
23 available to individual organisations at the moment, in  
24 a sense the benchmark.

25 Clearly there was judgement involved in, in this.

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1 approach to developing and maintaining effective systems  
2 and processes for responding to Patient Safety Incidents  
3 for the purpose of learning and improving patient  
4 safety:

5 "Patient Safety Incidents are unintended or  
6 unexpected events including omissions in healthcare that  
7 could have or did harm one or more patients."

8 It replaces the Serious Incident Framework. If we  
9 go to page 5.

10 "Compassionate engagement and involvement of those  
11 affected by a Patient Safety Incidents", page 7.

12 "Organisations are required to apply this framework  
13 in the development of maintenance of their Patient  
14 Safety Incident Response policy and plan."

15 Page 9, how to use it. We see bullet point 1  
16 includes national templates for developing a local  
17 Patient Safety Incident Response policy and plan.

18 And page 11 "What next?":

19 "Implementation and impact of this is being  
20 evaluated by National Institute for Health Research  
21 funded studies started in May 2022."

22 How would you expect this to apply in the same set  
23 of circumstances? You have commented you don't know the  
24 details of the circumstances, but Sudden and Unexpected  
25 Deaths, clinically unaccountable. What would you expect

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1 in these circumstances?

2 **A.** So as I explained before the break, perhaps  
3 after the break, this policy -- one of the aims of this  
4 policy was to drive much more towards thematic reviews,  
5 so bringing together an understanding of the incidents  
6 that were occurring frequently in an organisation rather  
7 than unconnected investigations on single incidents and  
8 in implementing this framework, Trusts have been asked  
9 to and have done that thematic analysis of their overall  
10 patient safety profile, therefore to drive where  
11 improvements need to be made.

12 So I think this would firstly have supported a much  
13 more thematic approach at the Countess of Chester.  
14 There were thematic reviews introduced but I think at  
15 the time or done at the time by lead, one of the lead  
16 paediatricians there. But I think this would have set  
17 out a stronger framework for doing those thematic  
18 reviews once there was concern around a series of deaths  
19 and other incidents of harm.

20 I think secondly this policy is, again as I have  
21 mentioned, driving much more towards involvement of  
22 patients, carers and others affected by incidents and  
23 I think that is one of the things that was missing in  
24 the Countess of Chester, the input from those who had  
25 been affected. And I think that would also drive

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1 (Pause) we see the goal of the programme:

2 "To support and enable organisations to improve  
3 their safety culture through embedding a continuous  
4 cycle of understanding the issue, developing a plan,  
5 delivering the plan and evaluating the outcome."

6 Then if we can go to 2, "Updates and priorities".  
7 INQ0009277, page 1.

8 "Bulletin: Setting out patient safety strategy  
9 priorities".

10 Over the page, page 2:

11 "Medical Examiners scrutiny of details now being  
12 extended from deaths in the acute settings to deaths in  
13 non-acute settings.

14 "Leaders and specialists should be ensuring  
15 information intelligence from Medical Examiner offices  
16 as feeding into clinical governance, patient safety and  
17 quality to surveillance processes."

18 That was in 2023.

19 Then we see December 2023, if we can go please to  
20 INQ0009278, page 1. It sets out highlights of the  
21 impact of the NHS Patient Safety Strategy:

22 "Identifying and recording patient safety incidents  
23 continues to save an estimated 160 lives per year  
24 through mitigation of risk."

25 Over the page, page 2. Various observations

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1 curiosity and a greater depth of learning and  
2 understanding of incidents.

3 **Q.** At paragraph 927 of your statement you say  
4 this has been well received by the health and care  
5 system. What do you mean the health and care system  
6 does that include clinicians, doctors, nurses on the  
7 ground?

8 **A.** Yes, as ever with the introduction of new  
9 systems there is a change but broadly the move towards  
10 the principles that I outlined that drove the evolution  
11 to the strategy have been supported. We are evaluating  
12 this approach but early signs are that it is being  
13 effective.

14 **Q.** Can we have a look, please, at INQ0009255,  
15 page 1. This is the NHS Patient Safety Strategy 2021  
16 update. We see at page 3:

17 "After a year establishing the strategy initiatives  
18 and adapting them for what is becoming the new normal we  
19 expect to meet some significant progress milestones in  
20 2021, expansion of the Patient Safety Specialist  
21 Network, publication of the Patient Safety Partners  
22 Framework and roll-out the new Patient Safety Incident  
23 management system."

24 And we see on page 6 patient safety infrastructure  
25 set out. I'll give people time to read that.

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1 including a second one:

2 "We estimate 414 fewer deaths, 2,569 fewer cases of  
3 moderate harm due to long-term opioids."

4 And then we see medication safety improvements below  
5 as well.

6 So would you like to say anything about this and  
7 whether, and if so, you expect this to impact on  
8 neonatal baby safety?

9 **A.** So we have, obviously the Patient Safety  
10 Strategy and PSIRF applies across the board to all  
11 patient groups, but we do feel that it is having impact  
12 it is supporting the work of the improvement programmes  
13 within maternity and neonatal safety specifically and  
14 you have some examples there.

15 I think another point, if I might, my Lady, I just  
16 want to make and you saw it in some of the previous  
17 pages that this is not a policy that exists in  
18 isolation.

19 You will have heard from other expert witnesses the  
20 need to have layers of processes that enable that --  
21 that I think in the words of one of your experts that  
22 you can't wriggle through the holes in the Swiss cheese  
23 and, so the National Medical Examiner system is an  
24 important adjunct to this, the safeguarding processes  
25 and principles we have discussed are an important

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1 adjunct to this, as are Freedom to Speak Up which I am  
2 sure we will come on to.

3 So these should be seen together. They are not  
4 mutually exclusive.

5 There are multiple ways in which concerns can be  
6 raised within the NHS. This relates obviously to  
7 specifically to incidents but it should not be seen in  
8 isolation to all the other work that is ongoing.

9 **Q.** Thank you. That can go down, please. I am  
10 now going to ask you to have a look at the documents  
11 which demonstrate what NHS England did know or when they  
12 began to know about events at the Countess of Chester.

13 I appreciate you are not the recipient at the time,  
14 but you have seen the documents so we can go through  
15 these, please. INQ0014630, page 1. This is the Serious  
16 Incident reporting for Child O.

17 And we see at page 2 "unexpected", referred to as  
18 unexpected death and the same for Child P, which we  
19 don't need to put up as well. But there's nothing in  
20 these reports of themselves was there to make  
21 NHS England aware of the wider concerns around the  
22 deaths of O and P, obviously "sudden" and "unexpected"  
23 are set out there but there was nothing further at that  
24 point, at the point of the Serious Incident Report?

25 **A.** No. So two points. As I have already alluded  
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1 concerns in the Serious Incident Reports we would have  
2 expected to have been informed of that as part of that  
3 reporting.

4 **Q.** If we look at page 1 the email circulating  
5 this to NHS colleagues, "immediate action" is described  
6 as:

7 "Escalation to Executive Team, NHS England, CCG and  
8 CQC, internal analysis of data and clinical case reviews  
9 whilst awaiting an independent review with amendment to  
10 the admission criteria and implemented supported by the  
11 Neonatal Network."

12 So awaiting an independent review. It's clear that  
13 NHS England became aware that the RCPCH was being  
14 conducted, weren't they?

15 **A.** Yes. And -- and the decision to have  
16 an independent review of the increased mortality over  
17 the previous year was a perfectly reasonable action that  
18 would not be atypical of concerns raised around  
19 mortality when that mortality was likely, as is the case  
20 more often than not in terms of a range of different  
21 factors, so that was supported by NHS England.

22 **Q.** Let me take us to the document that  
23 demonstrates that, 31 July 2016 INQ0014760, page 1. It  
24 is the surveillance report to the Regional Quality  
25 Surveillance Group Meeting, 31 July. We see section 2:  
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1 to, the submission of these two Serious Incidents for  
2 Baby O and P together in a very short period of time did  
3 trigger oversight and scrutiny from NHS England and its  
4 legacy bodies and Commissioners to enquire further to  
5 the Countess of Chester as to whether -- what level of  
6 concern NHS England should have.

7 It did as a result, and as a very rapid result,  
8 result in discussing around increased mortality and  
9 therefore the downgrading of the unit as a matter of  
10 protecting patients from a Level 2 to a Level 1 unit and  
11 a third incident Serious Incident was reported shortly  
12 afterwards --

13 **Q.** Let's go to that one, 7 July. That is the  
14 Serious Incident Reporting, the classification of the  
15 unit. So if we go to INQ0014636, page 1. If we go to  
16 page 3, the detail is set out.

17 **A.** So this formally reports and of course this  
18 was an agreed process with the Countess, the downgrading  
19 of the unit because of concerns around mortality.

20 What was in neither the reports on Baby O, Baby P  
21 or this Serious Incident report on or Serious Incident  
22 notification on the increased mortality as a whole was  
23 the information that a particular member of staff had  
24 been removed from the unit on 30 June 2016 and as that  
25 was an action that was specifically taken because of the  
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1 "Information updates on areas being managed locally  
2 within the Cheshire and Merseyside QSGs."

3 If we go over the page, page 2 Countess of Chester  
4 Hospitals Trust:

5 "Trust alerted Commissioners to concerns regarding  
6 deaths within the unit. Plan in place to downgrade  
7 three neonatal intensive care cots to Level 1 whilst  
8 a comprehensive investigation is carried out. Daily  
9 monitoring continues with weekly Executive reviews of  
10 any transfers out, capacity issues, incidents of  
11 maternity and neonatal unit. A Royal College of  
12 Paediatrics and Child Health RCPCH review has been  
13 arranged for 1 to 2 September 2016."

14 Then we see if we go to page 6 that the level of  
15 surveillance at that time was routine. If we see at the  
16 top, Countess of Chester, so it is not on "enhanced", it  
17 is on "routine". It is appendix 1 we need, page 6.  
18 Perhaps you could take it from me it was routine at that  
19 stage at --

20 **A.** Yes, this is a completely appropriate  
21 reporting through the appropriate governance structures  
22 of the concerns that had been raised concerning the  
23 increased mortality at the Countess of Chester, the  
24 response, the external review, and also as you can see  
25 here that other than those concerns within the neonatal  
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1 unit there was not at that time broader concerns around  
2 the Countess of Chester which again reflects the  
3 regulatory, its position within our regulatory framework  
4 at the time.

5 **Q.** If we can then please go to INQ0014639,  
6 page 1.

7 So this is a meeting on 12 September 2016. If we  
8 can go to page 2, it is North West Neonatal Operational  
9 Delivery Network setting out the actions:

10 "Countess of Chester has asked the RCPCH to perform  
11 an external review of neonatal deaths scheduled for 2 to  
12 3 September.

13 "The Operational Delivery Network Management Team  
14 has reviewed mortality rates and benchmarks them against  
15 other local neonatal units.

16 "Review of nationally collect collected data from  
17 MBRRACE in 2013 and 2014 has not identified Countess of  
18 Chester as an outlier."

19 Pausing there of course the relevant data wasn't  
20 available, was it, until 2017 and 2018?

21 **A.** Correct.

22 **Q.** And then the last point:

23 "The Operational Delivery Network data group is  
24 currently developing a monthly activity and outcomes  
25 dashboard. Neonatal mortality at ODN and locality

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1 so this is the regional -- this is the higher level  
2 quality surveillance group. The previous document was  
3 the local one. So what you are seeing here is  
4 a reporting of those concerns and the action that is  
5 taken, I have no reason to disagree with Margaret's  
6 assessment of why the text was set out as it is.

7 But I think in retrospect more could have been done  
8 to ask exactly what had happened in terms of the review  
9 and you will see in subsequent months NHS England became  
10 increasingly concerned as it asked for the Terms of  
11 Reference, as it asked for sight of the review, that  
12 that was not forthcoming.

13 **Q.** Let's go to the surveillance report for  
14 16 November 2016 which is INQ0106988, page 1. If we can  
15 go to page 3, please, Countess of Chester Hospital. It  
16 is the same summary, the background summary, but what's  
17 added here is:

18 "The initial feedback is that no immediate risk to  
19 patient safety have been identified. However, the  
20 reviewers have recommended a forensic deep dive into  
21 a number of identified incidents to be undertaken by  
22 an independent external consultant and this is currently  
23 being arranged. There are ongoing discussions locally  
24 as to whether the neonatal unit should be placed on  
25 enhanced surveillance."

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1 levels is one of the data items which ... monthly."

2 We see at page 3 of the document and page 4 the  
3 data that they collated. And then we see at page 7, if  
4 we go to 714687, sorry INQ0014687, page 7, this is  
5 minutes of the North Regional Quality Surveillance  
6 Meeting on 16 September 2016 and we see under:

7 "Cheshire and Merseyside: Countess of Chester  
8 Hospital sharing there are plans in place to downgrade  
9 three neonatal intensive care cots to Level 1. Whilst  
10 a comprehensive investigation is carried out, a  
11 Royal College of Paediatrics and Child Health review was  
12 carried out from 1 to 2 September which went well and  
13 therefore it has been agreed that the level of  
14 surveillance should be downgraded to 'routine'."

15 The Inquiry has received a statement from  
16 Margaret Kitching, the Chief Nurse North who says  
17 "I understood the comment the review went well" to mean  
18 there were no urgent patient safety issues being  
19 identified and also that the Trust had co-operated fully  
20 with the RCPCH for report.

21 Do you think retrospectively, asking for that --  
22 the Terms of Reference for the report or the  
23 instructions for the report would have been a sensible  
24 thing to do?

25 **A.** Yes. And that occurred at a point after this,

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1 So at the point it is still on routine surveillance  
2 and I don't think ends up on enhanced surveillance until  
3 2 December, I think?

4 **A.** Yes, this is -- this is around the point that  
5 concerns begin to increase; that NHS England is not  
6 hearing the full story.

7 **Q.** Then there is a letter received, INQ0008077,  
8 page 1 by the Assistant Regional Director of  
9 Specialised Commissioning, Andrew Bibby, it is an email  
10 from Director of Nursing Alison Kelly. And if we look  
11 at the end the first paragraph:

12 "You will be aware that I sent an update to  
13 Sue McGorry via email on 14 November 2016 explaining  
14 that the draft report had been received and was being  
15 checked by us for factual accuracy, this was sent back  
16 accordingly. We have only just received the final  
17 approved document from the Royal College."

18 Next paragraph:

19 "As a consequence, we currently do not have a final  
20 report of this part of the review and therefore are not  
21 comfortable in sharing the Royal College report until we  
22 have the details of the case review."

23 She explains:

24 "One of the recommendations of the report was that  
25 further independent case review was required of relevant

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1 cases. This is being undertaken by a neonatologist from  
2 London and they require a secondary pathology review on  
3 a small number of cases before their final report is  
4 completed."

5 So that did demonstrate there was investigation  
6 into specific deaths, didn't it?

7 **A.** Yes. And it demonstrated that there was  
8 further investigations ongoing but it also shows there  
9 was a reluctance to share with NHS England the contents  
10 of the report and that was beginning to trigger concerns  
11 around the openness and the willingness of the  
12 organisation to share the information pertaining to  
13 those reviews.

14 **Q.** We see, if that can go down please, and we  
15 have INQ0014771, page 4, this is a note made by  
16 Michael Gregory of a meeting with Mr Harvey,  
17 3 January 2017.

18 Mr Gregory's note is reviewed by RCPCH:  
19 "Very thorough report in due course no immediate  
20 concerns. Now advised further independent review,  
21 neonatologist London. Seen draft actions, further  
22 review."

23 So again demonstrating further investigation at  
24 least into the deaths or some events?

25 **A.** Yes. This was a note from the Medical  
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1 around the Countess of Chester.

2 **Q.** If we can go now, please, to INQ0014656,  
3 page 1, this looks, but you may be aware of other  
4 documentation, under the external review the first  
5 discussion in the detail of what's been communicated to  
6 the Families but there may have been ones that aren't  
7 recorded on paper, do you know when NHS England or  
8 regional bodies had sight of what Families were being  
9 told?

10 **A.** I don't have that again off the top of my head  
11 and again I can commit to seeing if we have further  
12 evidence that can assist the Inquiry.

13 **Q.** But if we look at "External review", it looks  
14 here at this meeting:

15 "IH confirmed the completed review will be shared  
16 with families and they would receive a copy.

17 "IH confirmed there was learning for the  
18 organisation that had been identified in the review  
19 pertaining to the care pathway.

20 "Action plan being developed by March end to be  
21 shared with Commissioners."

22 What would you understand identified in the review  
23 pertaining to the care pathway, what does "pertaining to  
24 the care pathway" suggest?

25 **A.** Well, I think that note would say to me that  
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1 Director of NHS Improvement and a conversation with  
2 Mr Harvey, the Medical Director of the Countess of  
3 Chester, and again it was a similar response in terms of  
4 the Trust as you have seen in that previous letter from  
5 December.

6 **Q.** And we then see at INQ0014644, page 1, if we  
7 can enlarge that second paragraph, please, this is  
8 Regional Specialised Commissioning Team North update  
9 9 February 2017:

10 "Have published the findings of the review into  
11 unexpected baby deaths in the neonatal unit. Review  
12 carried out by the Royal College. The review concludes  
13 there is no single cause or factor identified as a means  
14 of explaining the increase in their mortality rates but  
15 gives a series of recommendations that the Trust is  
16 already implementing. Trust handling comms and media.  
17 Unfortunately a solicitor dealing with one set of  
18 parents leaked details to The Sunday Times on the  
19 weekend before publication. Follow-up article is  
20 expected in this week's Sunday Times media coverage."

21 So that's information provided to them?

22 **A.** Yes. Again this is the Regional Specialised  
23 Commissioning team, which is different from those  
24 quality surveillance groups that you have seen earlier,  
25 but again it is documenting the increased concerns  
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1 the organisation was reporting that they had identified  
2 some learning and I think "pertaining to the care  
3 pathway" is a very broad terminology and very difficult  
4 from that note to be absolutely clear what that was  
5 relating to. And that would be one of the reasons that  
6 regional teams would have wanted to see the detail of  
7 the report.

8 **Q.** We then see an email 29 March from Mr Gregory  
9 to Andrew Bibby, that is INQ0014651, page 1. At the  
10 bottom, I just need the bottom email on to the next  
11 page, please:

12 "Hello, I spoke to Ian Harvey a few minutes ago ...  
13 told him we were aware of the meeting on Monday. To  
14 summarise our conversation, Ian had said at the start  
15 that they intend to make a significant announcement on  
16 Monday and that we would bear with them until this  
17 announcement was made."

18 Then if we go over the page:

19 "A clinician who Ian gave the impression may have  
20 another agenda on Monday night brought up a list of  
21 babies' names that he or she was concerned about."

22 Second paragraph:

23 "There is a member of staff whose presence has been  
24 seemingly disproportionate but as was discussed when we  
25 met, this was originally accounted for by rotas and  
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1 skill level. However when pushed about staff members,  
 2 Ian stated this matter was best dealt with when they  
 3 make the significant announcement about the decision  
 4 they have taken to speak to an appropriate body on  
 5 Monday. Clearly something very serious is going on and  
 6 they must have their hands tied somewhere. Not sure if  
 7 we can do any more until Monday unless we wish to  
 8 escalate further."

9 We then have another email, INQ0014660, page 1,  
 10 19 April:

11 "I am concerned that they are avoiding the issue  
 12 that we wish to see contacting the police, but I suppose  
 13 we should allow this call to occur. Then if they don't  
 14 call the police after speaking to CDOP, then perhaps  
 15 consider we insist."

16 So it's crystal clear at this point that Mr Gregory  
 17 wished to see contacting the police. But there is still  
 18 hesitation and at some point presumably in the preceding  
 19 weeks there had been discussion about that or days,  
 20 however many who knows?

21 But what was the hesitation from NHS England's  
 22 point of view if that's what you wished to see, about  
 23 ensuring that that happened as soon as you -- or that  
 24 view had been concluded, you know?

25 **A.** Well, to be clear, the email that you  
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1 INQ0014673, page 3.

2 If we look at the emails on page 3, you see at the  
 3 bottom:

4 "Theresa and James are discussing with Robert today  
 5 [this is 26 April]. I'd await this conversation. CDOP  
 6 [that's Child Death Overview Panel] could take weeks.  
 7 They are not sure awaiting their process will be timely  
 8 enough considering the level of concern".

9 The email at the top:

10 "Spoke with Teresa at lunchtime. We both think, as  
 11 does James P, we should just refer to the police now.  
 12 They are happy to make the call if it helps with Trust  
 13 relations".

14 If we go to page 2, so back in the sequence of  
 15 documents, we see Margaret Kitching:

16 "Dear all, I have copied Richard in as important he  
 17 is connected and I suspect he would want a call with  
 18 Lynn Simpson before taking such a decision outside of  
 19 the Trust."

20 If we go to the email at the top:

21 "Hi Margaret, I agree we do need Lynn involved and  
 22 maybe we should phone Tony in the first instance, but  
 23 I would be happy to do a joint call. I probably know  
 24 Tony better being an FT. Remind me what does CDOP stand  
 25 for?"

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1 previously showed, the 29 March conversation, was the  
 2 first time the region became aware of concerns around  
 3 a specific individual and certainly that went beyond any  
 4 performance issues and into potential criminal activity.

5 Obviously that raised the level of concern that had  
 6 already been apparent in terms of the unwillingness to  
 7 of the Countess of Chester to share information with  
 8 NHS England and I think you can see that very rapidly  
 9 that moved to a position within NHS England that the  
 10 police should be involved as a matter of urgency.

11 I don't think there was hesitancy on the part of  
 12 NHS England to do this because the Countess had already,  
 13 in essence, said that they would speak to CDOP and CDOP  
 14 has a police component. But I think again you will see,  
 15 and there is some other evidence that NHS England  
 16 colleagues at the time were clear that if the police  
 17 were not involved as an outcome of the conversation with  
 18 I think the chair of CDOP then NHS England would inform  
 19 the police themselves.

20 So I don't think it was a hesitancy. It was  
 21 a recognition that there was going to be a conversation  
 22 that would involve the police and if, for any reason, it  
 23 didn't then action would be taken by the regional team.

24 **Q.** Can we have a look please at INQ0014673,  
 25 page 3 and follow a series of emails through. So it's  
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1 Then we go back to page 1, an email from  
 2 Margaret Kitching to Richard:

3 "When I spoke with Tony [this is 26 April] he  
 4 explained that the independent investigations did not  
 5 identify any criminality. Two of their paediatricians  
 6 are disputing/casting doubt on the findings, hence them  
 7 taking further steps. We did discuss involving the  
 8 police which they intend to do if full assurance is not  
 9 gained. The two Ps could be the problem but we need to  
 10 be sure. Tony and the team want to exhaust internal  
 11 processes first as they recognise that involving the  
 12 police could cause further significant distress to the  
 13 families. I spoke with Vince and Michael and we agreed  
 14 I would speak to the Trust at that time. Michael is  
 15 worried that he believes they are being evasive, hence  
 16 escalation to the national levels. Tony is not happy at  
 17 this accusation as he believes they have been fully  
 18 transparent. I don't think we should involve the  
 19 police without appraising the Trust and giving them the  
 20 opportunity to explain and contact the police if  
 21 needed."

22 Response:

23 "Okay [at the top] I am sure Lynn will support your  
 24 line. However, if it transpires we do need to  
 25 subsequently involve the police, then the delay will not  
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1 look good and lead to further concerns for  
2 the Families."

3 Do you think in that email exchange there is  
4 considerable deference to the way the Trust have  
5 analysed the situation, those internally within the  
6 Trust?

7 **A.** I think there is quite appropriate discussion.

8 So I think, firstly, the region is clear that the  
9 police need to be involved. I think there is discussion  
10 and you can see that playing out here as to whether that  
11 should occur directly from the Trust or whether  
12 NHS England should, at that point, simply get the police  
13 involved.

14 I don't necessarily think it shows deference to the  
15 Trust. It recognises that there may be other  
16 considerations that are not known at the time to the  
17 region and that the further discussions on that should  
18 be undertaken with the Trust and the Chief Executive.

19 In the event, the conversation that the Trust,  
20 Countess of Chester, then had with CDOP did trigger  
21 police involvement and subsequently a police  
22 investigation.

23 **Q.** We see indeed 27 April, a meeting between  
24 Margaret Kitching, Stephen Cross, Ian Harvey and  
25 Vince Connolly, INQ0003193, page 1.

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1 that NHS England didn't have, which would have been  
2 interest -- of interest to the police in those  
3 conversations.

4 So I think it was perfectly reasonable to expect  
5 the Trust to contact the police and outline the -- their  
6 concerns to the police. NHS England would not have had  
7 all of that information. As you can see, there was  
8 extreme concern around the level of information that had  
9 been provided and of course if NHS England had contacted  
10 the police themselves, they would have -- of course the  
11 police would have been required to have direct  
12 discussions with the Countess of Chester.

13 So I think what you are seeing in these emails over  
14 the course of those weeks in April following the  
15 information given to NHS England, much later than it  
16 should have been as I have said, that there was concerns  
17 around criminal activity, potential criminal activity of  
18 a particular member of staff that the police absolutely  
19 needed to be involved; that it would be preferable, on  
20 balance, if that was something that the Trust did but if  
21 they were not going to do that then NHS England would  
22 involve the police directly.

23 **Q.** We see at INQ0014676, page 1, on 5 May,  
24 Mr Harvey updates Margaret Kitching about a meeting with  
25 the police and DCS Wenham, who's on the CDOP. He says

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1 In this meeting, she is told:

2 "The Trust also sought an independent legal opinion  
3 on evidence so far and the findings were that they could  
4 not see any evidence of criminality. An independent  
5 reviewer identified out of all of the deaths that four  
6 were unexplained and therefore recommended a broader  
7 forensic review. The Trust clarified this with the  
8 reviewer and it was determined that involving CDOP would  
9 enable a further consideration which would involve the  
10 police who is a member of the Child Death Overview  
11 Panel.

12 "Margaret Kitching thanked Ian Harvey for his time  
13 and briefing and recognised the Trust was doing all they  
14 could to resolve this. The involvement of CDOP and the  
15 police is welcomed."

16 Was it considered that, really, the Trust should be  
17 the one to phone the police? I mean it's clearly  
18 internally that is the -- we have heard evidence that  
19 people thought it was for the Trust or the Execs team to  
20 contact the police. Was that also the view of  
21 NHS England; that this was really their -- they were  
22 fully sighted on it, they knew what was going on and it  
23 was for them?

24 **A.** I think the view was clear that the police  
25 needed to be involved. The Trust obviously had details

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1 he will keep them, her updated.

2 Indeed we see on 12 May, if we can go, please, to  
3 INQ0014678, page 1, a further update to  
4 Margaret Kitching.

5 Would the point of contact for NHS England usually  
6 be in the regional directors with the managers?  
7 Presumably you wouldn't be dealing directly with  
8 clinicians or nurses or anyone else, would you?

9 **A.** Yes, that's correct. So mostly in terms of  
10 conversations with Trusts provider organisations, the  
11 conversations would occur between -- at the level of  
12 senior Executives, senior leaders such as the Medical  
13 Director, the Director of Nursing or the Chief  
14 Executive. That is not exclusively the case. There can  
15 be conversations directly with clinical teams.

16 I understand the view of NHS England at this time  
17 was that the police absolutely needed to discuss the  
18 concerns directly with the clinicians who had raised  
19 those concerns. You can see in this email that the  
20 police are informed of specific concerns by those  
21 paediatricians and that the police recognise that they  
22 needed to speak to the paediatric lead as the sender of  
23 the email and reports.

24 But from conversations I have had with colleagues  
25 in NHS England, my understanding is that they would have

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1 been very clear that the views of those paediatricians  
2 should be heard directly.

3 **Q.** That can come down, please. Then if we can  
4 have your statement INQ0017495, page 133, and it's just  
5 completing what and when NHS England would have known  
6 about those Sudden and Unexpected Deaths via Serious  
7 Incidents or increased neonatal mortality number of  
8 deaths.

9 It's the section that you deal with data, please,  
10 Sir Stephen, and set out what had been reviewed and what  
11 you would have ascertained from that.

12 I understand and the Inquiry's understanding is  
13 that the MBRRACE data was available to you 2017, 2018?

14 **A.** Yes.

15 **Q.** Was there anything, as you go through this, in  
16 the data you had at the time that alerted you to that  
17 increased number of Sudden and Unexpected Deaths?

18 **A.** So there was some conversations with the  
19 oversight -- sorry, the Operational Delivery Network and  
20 I believe the Chair of that network was involved in some  
21 discussions with Dr Brearey early in 2016 around  
22 reviews, thematic reviews of mortality.

23 The ODN was at a fairly early stage of its  
24 evolution there. They had only recently been set up in  
25 the couple of years before and they were not at that

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1 a member of staff it immediately took the view that the  
2 police should be involved and you have been through the  
3 discussions in those early weeks in April as to how that  
4 should be done. But it was in the event done through  
5 a discussion between the chair of the CDOP and the  
6 Countess.

7 **LADY JUSTICE THIRLWALL:** I'm sorry, Ms Langdale,  
8 just before you continue. I wonder if I can just check  
9 something because I'm not sure if it was a slip of the  
10 tongue or I misheard you.

11 You said that the first that NHS England knew  
12 anything about an increase in mortality was  
13 in July 2016.

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** And then you said that  
16 shortly after, a nurse had been removed from the unit.

17 **A.** So I was making the point that the Serious  
18 Incident reports were reported into local Commissioners  
19 after the nurse had been removed from the unit.

20 **MS LANGDALE:** Not that they identified that the  
21 nurse had been --

22 **A.** But those incident reports, as I have said,  
23 did not impart the information that somebody had been  
24 removed.

25 **LADY JUSTICE THIRLWALL:** No. That was my --

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1 point, in contrast to the work they do now, heavily  
2 involved in overseeing mortality.

3 So there was some knowledge within the ODN. That  
4 is clear from the evidence.

5 But in terms of when NHS England in terms of Local  
6 Commissioners and Specialised Commissioners and regional  
7 teams were aware of the increase in mortality, it was at  
8 the point that those two Serious Incidents were reported  
9 in July 2016 shortly after Lucy Letby had been removed  
10 from the unit on 30 June. And, again, the first time  
11 that regional teams became aware of possible deliberate  
12 harm by a member of staff was in that conversation, that  
13 email that you saw from 29 March 2017.

14 In relation to the increased mortality, the  
15 invitation to the Royal College of Paediatrics and Child  
16 Health to undertake an external review was, in the view  
17 of NHS England, a reasonable and proportionate response.  
18 You saw that in the governance papers that you have  
19 seen.

20 But as 2016 went on, there was increasing concern,  
21 as I have said, around the information that was being  
22 shared from the Countess. That really accelerated in  
23 the early months of 2017 and of course as soon as  
24 NHS England was aware that there were concerns around  
25 potential deliberate harm and criminal activity by

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1 I think you may have elided two things or I maybe only  
2 heard part of what you said.

3 **A.** Sorry, yes. Yes, sorry.

4 **LADY JUSTICE THIRLWALL:** No, that's all right --

5 **A.** As I said previously to be clear --

6 **LADY JUSTICE THIRLWALL:** Yes.

7 **A.** -- our expectation is in any of those three,  
8 perhaps all of them, there should have been a report  
9 that as a result one of the actions that had been taken,  
10 as a result of the concerns around those particular  
11 incidents, was the removal of an individual from the  
12 unit and that would have triggered questions and concern  
13 from NHS England had we have known that.

14 **LADY JUSTICE THIRLWALL:** When you say that the  
15 steps taken were appropriate, considered appropriate by  
16 NHS England, for example getting the RCPCH report,  
17 that's in the context of the information that had been  
18 given to them?

19 **A.** That's in the context that there had been  
20 an increase in mortality over the preceding year.

21 **LADY JUSTICE THIRLWALL:** Yes.

22 **MS LANGDALE:** The North West Operational Delivery  
23 Network, who would be sitting on that group who feeds  
24 back to NHS England or generally because I know the  
25 clinicians. But who else is on it?

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1 A. So typically clinicians. I am sure we could  
2 provide a list of exactly who was on the ODN.  
3 Some of that I am sure is in the written statement,  
4 but it would be typically led by clinicians with  
5 appropriate support from operational managers and  
6 administrative staff to assist with the ODN.

7 **MS LANGDALE:** Thank you. My Lady, I see the time.  
8 That is a good point to stop for the lunch break,  
9 I think.

10 **LADY JUSTICE THIRLWALL:** Very well. So we will  
11 adjourn now for lunch and we will start again at half  
12 past 2.

13 (1.30 pm)

14 (The luncheon adjournment)

15 (2.30 pm)

16 **LADY JUSTICE THIRLWALL:** Ms Langdale.

17 **MS LANGDALE:** Sir Stephen, can we move please to  
18 whistleblowing and Freedom to Speak Up and you say at  
19 paragraph 766 of your statement that NHS England expects  
20 staff to speak up externally if they don't want to speak  
21 up within their organisation.

22 What -- how is that communicated to staff, how do  
23 they know that?

24 A. So I think the first thing to say is our  
25 preference of course is for whistleblowing to be managed

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1 evolution. And we first issued national guidance,  
2 national policy in 2016.

3 So the period you have just outlined would be  
4 a period where there wasn't national policy or national  
5 policy had just been produced. So I think it would be  
6 the case that at that particular period, both local  
7 Freedom to Speak Up policies and national policies were  
8 certainly less embedded and less well known and  
9 understood.

10 Q. And when you say in your statement you would  
11 expect people to speak externally -- apart from  
12 NHS England, where would you expect them to take any  
13 concerns, to their regulators, to other bodies?

14 A. So the Care Quality Commission would be  
15 another source and in fact the CQC will receive many  
16 more concerns that NHS England does, that is our  
17 experience.

18 I think those would be the two main national  
19 bodies.

20 I can't rule out that people would raise concerns  
21 with the Parliamentary Health Standards Ombudsman and  
22 raise concerns initially to other parties but certainly  
23 if they are channelled through to NHS England we have  
24 a process for responding.

25 Q. You also tell us you have a webpage dedicated

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1 locally and for concerns to be raised through Freedom to  
2 Speak Up through local processes and of course resolved  
3 by local organisations near to where those concerns are.

4 But there are circumstances we recognise in which  
5 staff, healthcare professionals may wish for a variety  
6 of reasons to raise concerns directly with NHS England.  
7 We have set that out in our various Freedom to Speak Up  
8 policies that that is a possibility and we do receive  
9 a number each year of external -- in other words,  
10 external to NHS England -- concerns that are raised  
11 either directly --

12 Q. Who would they raise them to a safeguarding  
13 concern?

14 A. They can come through a variety of routes. We  
15 do have a Freedom to Speak Up team and there is  
16 information I think on our website as to how you contact  
17 them. But of course concerns can be raised with other,  
18 with senior members of NHS England. For instance, if  
19 a concern is raised with me, then I will seek the  
20 support and the advice of the Freedom to Speak Up team  
21 within NHS England.

22 Q. In 2015 to 2016, do you think there was less  
23 communication on that topic by NHS England to providers?

24 A. So I think the Freedom to Speak Up system in  
25 2015/16 was certainly at a very early stage of its

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1 to speaking up. Is that effective or sufficient?

2 A. So I think -- difficult to know. But I would  
3 say that we have seen increases in Freedom to Speak Up  
4 across the board over the last few years. I think the  
5 last reported year was 23/24, I am talking about all  
6 Freedom to Speak Up, everything that's been raised  
7 through Freedom to Speak Up across all organisations,  
8 I think are over 25% increase.

9 Certainly if you compare to five, six years ago  
10 every year I think we are seeing an increased number.  
11 So that would give me confidence that the system, the  
12 processes around Freedom to Speak Up in the round are  
13 better embedded and better understood and more people  
14 are using them.

15 When we survey -- when people who have spoken up  
16 are asked "would you speak up again?" those that have  
17 responded, about 80% said they would feel confident to  
18 speak up again.

19 So, yes, in 2015/2016 it was in early stage.  
20 I think it has moved forward substantially since then  
21 but there's clearly in my view and the view of  
22 NHS England more work that needs to be done.

23 Q. You mentioned the CQC a moment ago. They of  
24 course did an inspection in February 2016?

25 A. Yes.

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1 Q. And did not know about the increase in  
2 neonatal deaths on the unit after that inspection, or  
3 suspicions or concerns about a particular member of  
4 staff. What do you make of that? Does that lead you to  
5 question what they were asking?

6 A. So the CQC inspections at the time were broad  
7 whole organisation inspections and the neonatal unit  
8 would be only one part of that. Obviously I can't speak  
9 in detail. I do have experience of CQC inspections,  
10 I have chaired them myself in the past. But I have no  
11 great insight into that particular inspection and how it  
12 was carried out.

13 They did have access to some of the information.  
14 They have access to incident reporting. But of course  
15 they would have been looking at a whole range of data  
16 and as I outlined when we were discussing our quality  
17 surveillance groups and their oversight, there were, at  
18 that time, no regulatory concerns or other concerns  
19 around most of the other services. In the Countess of  
20 Chester the concerns that were arising were specifically  
21 highlighted on the neonatal unit.

22 Q. Can we have on the screen, please, INQ0017495,  
23 page 206, your statement from paragraph 784 onwards  
24 describing the Task and Finish Group.

25 We see there at paragraph 784 through to 787 you  
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1 to Speak Up in particular, our view is that we would  
2 agree that there are a number of things that could be  
3 strengthened including the independence of guardians,  
4 potentially the powers of the Guardians Office and  
5 I think that would be what we would want to focus on in  
6 terms of future work.

7 Q. The Inquiry has been hearing evidence from  
8 those who were guardians for Freedom to Speak Up at the  
9 time 2015 to 2016, that occupying those roles they had  
10 a number of other roles and they weren't particularly  
11 resourced either the time or the training to give to  
12 them. Is that a fair observation, do you think, knowing  
13 what you know about the roles at that time?

14 A. So we don't set any particular standard in  
15 terms of the number of Freedom to Speak Up Guardians an  
16 organisations should have. We do expect them, and again  
17 this is in our contracting arrangements, that they have  
18 Freedom to Speak Up -- there is a Freedom to Speak Up  
19 Guardian and that system and process is in place.

20 But again as I have said previously, every  
21 organisation differs in its structure and how it's  
22 organised and therefore we do give the freedom to  
23 individual organisations to determine the correct number  
24 of Freedom to Speak Up Guardians.

25 For example in NHS England, and similarly in  
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1 say:

2 "The Group's primary focus is on considering the  
3 escalation routes in suspected criminal or serious  
4 patient safety cases and whether there is potential to  
5 make improvements."

6 Could you update us on that and while you do, do  
7 you think there is any merit in having a safeguarding  
8 unit or a unit within NHS England where people can  
9 direct that level of concern, where they are worried  
10 about the deliberate acts of harm?

11 A. With respect specifically to Freedom to Speak  
12 Up?

13 Q. No, just generally in terms of when the staff  
14 are worried and they can't speak up within their own  
15 organisation and to go to someone nationally where they  
16 are not worried about patient details and such?

17 A. So I think the team within NHS England that  
18 does deal with external concerns and also with internal  
19 issues and concerns that are raised through Freedom to  
20 Speak Up within NHS England are, are that team.

21 So I am confident that we have a mechanism for  
22 receiving concerns and for dealing with them within the  
23 various policies and also of course we -- we are able to  
24 take protected disclosures as well.

25 I think when it comes to strengthening, to Freedom  
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1 Ambulance Trusts, for example, we are spread over a much  
2 greater geographical distribution than a hospital which  
3 is mainly based on one or two sites. So that gives  
4 a different set of considerations as to how you deploy  
5 the Freedom to Speak Up Guardians.

6 I do recognise that one of the things that we often  
7 hear from Freedom to Speak Up Guardians is whether they  
8 have enough time and we do encourage organisations to  
9 make sure that they have enough time.

10 I don't personally feel that that necessarily means  
11 somebody needs to do the Freedom to Speak Up or the  
12 guardian's job and nothing else, I think there can be  
13 advantages in having that as part of your work, that is  
14 a model we use within NHS England. But it is important  
15 that organisations resource Freedom to Speak Up  
16 processes and their guardians so that they can do the  
17 work that they need to do in a timely manner.

18 **LADY JUSTICE THIRLWALL:** Is there resource  
19 allocated to them specifically for that purpose?

20 A. That would be within the general resource of,  
21 of the funding of individual organisations. So it would  
22 be part of the funding -- overall funding streams. So  
23 in other words, I -- again I could confirm this for you  
24 it will not be ring-fenced funding to be used  
25 particularly for this, this aspect of work.  
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1 It will be a requirement that you do this within  
2 the overall funding of the organisation.

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

4 **MS LANGDALE:** The Inquiry has heard evidence that  
5 where concerns are raised by individuals, grievances,  
6 counter-grievances can be raised; is that something you  
7 are familiar with from an NHS England perspective,  
8 a cultural issue?

9 **A.** Yes, it is something that I am aware of. As  
10 I said I think and the evidence is that the great  
11 majority -- I think there have been over 140,000  
12 concerns raised through Freedom to Speak Up to date in  
13 terms of the last report, I am sure the vast majority of  
14 those are dealt with well and satisfactorily.

15 But there are inevitably those that are not  
16 resolved for a variety of reasons. And where  
17 individuals do suffer detriment or have a perception of  
18 suffering a detriment, that is undoubtedly something  
19 that we hear at NHS England, it is of course one of the  
20 reasons why concerns would be escalated up to  
21 NHS England, we will disproportionately see those that  
22 haven't been resolved as will other organisations such  
23 as the CQC.

24 But yes, I recognise that is an issue.

25 **Q.** And likewise in the context of performance  
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1 appropriate to use HR processes, performance and conduct  
2 processes and where to use Freedom to Speak Up processes  
3 but there is undoubtedly an interface and undoubtedly  
4 a proportion of the concerns that are raised fall in  
5 that financial expert.

6 **Q.** Professor Dixon-Woods made the observation  
7 that HR processes are very expensive within the NHS  
8 because they take so long, the investigations take their  
9 time to happen. Again, do you have any comment on that,  
10 is that your observation that people might be suspended  
11 on full pay for a considerable period of time or  
12 investigated with no resolution --

13 **A.** Yes.

14 **Q.** -- when they are worried about it and maybe  
15 will be exonerated at the end of the investigation, it  
16 is not good for anyone, is it, the delay?

17 **A.** No, and of course our preference is -- well,  
18 first our preference is that the culture of an  
19 organisation is such and the way an organisation works,  
20 the performance management, everything that exists  
21 within an organisation is such that minimises the chance  
22 that that will occur. But nevertheless there are  
23 circumstances where disagreements, disputes occur.

24 As much as possible and most of our performance and  
25 conduct processes, certainly true within medical  
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1 management, if there's performance management issues,  
2 although the example we were given was an admin case,  
3 that there would be responses to that that might invoke  
4 other processes and procedures. Are you familiar with  
5 that?

6 **A.** In terms of the relationship between issues  
7 for individuals?

8 **Q.** Yes. So if somebody is having performance  
9 management issues addressed to raise a grievance or  
10 concern about being bullied or --

11 **A.** Yes.

12 **Q.** Immediately; in other words, not before that?

13 **A.** So I think we can see in the data from Freedom  
14 to Speak Up concerns that there is a significant  
15 proportion which are, have their base in interpersonal  
16 or relationships between members of staff or between  
17 that line management arrangement.

18 So by no means are they all concerning patient  
19 safety, for example. Concerns can be raised around  
20 a whole host of issues and one of the issues to consider  
21 within Freedom to Speak Up is where HR processes are the  
22 most appropriate processes to use and where Freedom to  
23 Speak Up processes are the most important to use and  
24 there is an interface there and it's important that  
25 there is a clear understanding of when it would be  
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1 profession, always have a stage of informal resolution  
2 to try not to get to the stage of a formal process.  
3 Inevitably unfortunately that does happen from time to  
4 time and we recognise that it can take longer than  
5 actually anybody would want and sometimes there are, you  
6 know, very rational reasons for that. It's not simply  
7 delay on the part of people, it's involvement of  
8 external legal teams or external support or gathering  
9 appropriate information but it's in everybody's  
10 interests to resolve things as early as possible and  
11 where procedures have to be undertaken in terms of  
12 conduct in terms of performance, that they are done as  
13 quickly as possible.

14 **Q.** Council of Governors. You set out in your  
15 statement, I think it's paragraph 147, some of the  
16 duties and powers of the Council of Governors at an NHS  
17 Foundation Trust, including a duty to hold the  
18 Non-Executive Directors to account and to represent the  
19 interests of the public.

20 Would you expect the Council of Governors of  
21 a Foundation Trust to be informed of concerns about  
22 a member of staff deliberately harming babies and when,  
23 if at all, would you expect such concerns to be raised?

24 **A.** I think not at an immediate or early stage.  
25 As you have again alluded to, Foundation Trusts have  
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1 a particular form of governance that is unique to them  
2 and that is different from NHS Trusts. It is still the  
3 response and the governors have a very specific set of  
4 responsibilities around appointments of the Chair and  
5 Non-Execs and about approval of annual accounts. So the  
6 statutory requirements of governors are quite distinct.

7 I would expect first and foremost those concerns to  
8 be managed within the board of the organisation. There  
9 may be circumstances in which governors should be  
10 informed but I -- and again I am giving a personal view  
11 here from experience, that that might be later in the  
12 process rather than early in the process.

13 **Q.** What effect does the public nature of the  
14 Council of Governors meetings have on their ability to  
15 be informed?

16 **A.** Again, I think if you, again, I think this  
17 would be the same question for an NHS board because of  
18 course NHS boards occur in public.

19 I think you have to be clear about when you put  
20 something in the public domain the rationale for putting  
21 it in the public domain, that is not a question of  
22 transparency or openness but there are certain  
23 consequences of putting things in the public domain and  
24 so at the appropriate time it is right to have things in  
25 the public domain but careful thought needs to be

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1 Council of Governors to Trusts, to well-run Foundation  
2 Trusts?

3 **A.** The principle is that they add a public voice,  
4 it's not just the Council of Governors, it is the  
5 membership requirements, the Foundation Trust have to  
6 have a membership, it has that extra level of scrutiny  
7 from governors. It is providing a more direct public  
8 interest into the working of the organisation.

9 Clearly Non-Executive Directors function in part in  
10 that way in both Foundation Trusts and Trusts. But the  
11 principle behind Foundation Trusts was that added level  
12 of public interest, public scrutiny and public oversight  
13 would be enacted through the membership and Council of  
14 Governors of Foundation Trusts.

15 **Q.** Do you think in practice they will ever get to  
16 the nitty-gritty of where relationships are breaking  
17 down or there's serious concerns about individuals, for  
18 fear of sharing that information?

19 **A.** I don't think that is a fundamental role of  
20 the Council of Governors.

21 **Q.** Not to scrutinise that?

22 **A.** I think that is, it is their role to  
23 scrutinise the work of the board and through the  
24 statutory responsibilities that they have, but I think  
25 that is more territory of the board, the Executives and

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1 undertaken as to the appropriateness of that.

2 **Q.** Does NHS England have a role in ensuring  
3 Council of Governors are provided with adequate and  
4 timely information by directors of Foundation Trusts?

5 **A.** I don't believe we do have a direct statutory  
6 role specifically around that. The Foundation Trusts,  
7 as you may be aware, were set up on the principle that  
8 they would be more autonomous and be granted more  
9 autonomy than NHS Trusts, that is their public benefit  
10 organisations, the Council of Governors, are part of  
11 that autonomy and distinction from NHS Trusts.

12 So particularly in the early days of Foundation  
13 Trusts the distinctions in practice are now more blurred  
14 but in the early days, and I would include 2015 and 2016  
15 in perhaps the tail end of that period, the regulatory  
16 regime in place was unless there were significant  
17 concerns around a Foundation Trust, then they would be  
18 granted the autonomy to in effect manage their own  
19 business. That was the policy, that was the purpose of  
20 the policy and the regulatory regime that was enforced  
21 by Monitor, who were the regulator of Foundation Trusts  
22 in 2015/2016, albeit as part of NHS Improvement, that  
23 was the regulatory framework that was being followed at  
24 the time.

25 **Q.** What do you think they add in practice, the

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1 the Non-Executives, than necessarily the Council of  
2 Governors.

3 **Q.** But to scrutinise the board you would need to  
4 know how they were managing a difficult situation,  
5 wouldn't you, so it might take you into that territory?

6 **A.** Yes, I accept that there would come a point  
7 I think certainly where the Council of Governors would  
8 need to be informed and take a view. But as I say,  
9 first and foremost I think that would be

10 a responsibility of the Executive Team and the board as  
11 a whole, including the Chair and the Non-Execs.

12 **Q.** Your third statement, Sir Stephen, deals with  
13 Chief Executive moving on and generally related issues.

14 If we can go, please, to INQ0100828, page 13.

15 Paragraph 38, 39 and 40. So 0100828, page 13.

16 If we can all have a read of 38, 39 and 40.

17 (Pause)

18 So this all follows on further to September 2018 and  
19 we know that Letby is arrested July 2018 and we see at  
20 paragraph 39 NHS Improvement Chief Executive had  
21 a conversation with Sir Duncan Nichol in around 2018 and  
22 recalls being assured there were no misconduct concerns  
23 with Tony Chambers.

24 What level of enquiry might have been made in those  
25 circumstances, do you think?

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1           **A.** I can't give you exact detail. We obviously  
2 only have the evidence that we have seen in terms of  
3 those conversations but there were clearly conversations  
4 between the Chief Executive of NHS Improvement and the  
5 Chair of the Countess of Chester regarding the  
6 possibility of moving the Chief Executive to another  
7 organisation.

8           As you have heard, the Regional Director of  
9 NHS Improvement, at the time Ms Simpson, then was asked  
10 to facilitate a move and discussions were undertaken as  
11 to what that move might look like. In the event,  
12 Mr Chambers moved to the Northern Care Alliance, not  
13 a move that was directly facilitated by NHS Improvement,  
14 that occurred through contacts I believe he made  
15 himself, but there were discussions around moving him to  
16 other organisations within -- particularly within the  
17 North region.

18           **Q.** What would happen today? If that was  
19 a situation, someone had been arrested, that call was  
20 made, what would you expect to do? Would you find out  
21 what the issues were, would you diligently look at what  
22 had happened or would you accept what somebody said "not  
23 misconduct, nothing else"?

24           **A.** So I think the first thing to say is  
25 Ms Simpson has accepted in both oral and written

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1           So today we -- it is the role of regional directors  
2 within NHS England to -- and the national team at  
3 a higher level -- support the talent pool of Executives,  
4 to ensure that there is information around who might be  
5 available for posts and that is part in a sense of  
6 everyday business. It is, however, the responsibility  
7 of individual NHS organisations to appoint Executives.  
8 We have a role in appointing the Chairs of Trusts, NHS  
9 Trusts and Integrated Care Boards, not of Foundation  
10 Trusts.

11           So it is important that it is the organisation and  
12 they follow due process. That due process is being  
13 strengthened, so the recent iteration of the Fit and  
14 Proper Person Test published 18 months ago strengthens  
15 the Fit and Proper Person Test. It places a requirement  
16 upon boards to produce a standard board reference for  
17 every Executive and Non-Executive member of the board  
18 and to make that available to organisations including  
19 where individuals are moving to non-board roles so that  
20 there is strength and flow of information from  
21 organisations and we expect organisations who are  
22 seeking to employ somebody to look back at least six  
23 years in terms of that record of board references.

24           So we acknowledge that we need to strengthen the  
25 process of appointments and the scrutiny and with that

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1 evidence that in hindsight if she had known what she  
2 knows now at the level of detail that is now apparent  
3 she would not have been comfortable facilitating that  
4 move and she would, should have been better at joining  
5 the dots around what was occurring in the neonatal unit  
6 and the request to move Mr Chambers because of perceived  
7 or actual breakdown within the organisation of  
8 relationships.

9           A further bit of context. There are many examples  
10 where leaders struggle in one organisation but perform  
11 extremely well in another organisation. So it is not  
12 necessarily the case because somebody has not succeeded  
13 in the way that they or we would want them to do or the  
14 board of the organisation that they cannot succeed in  
15 another environment. That could be interpersonal  
16 relationships, it might be around particular styles of  
17 leadership in particular contexts, a whole host of  
18 reasons.

19           So we do wish to support and develop our Chief  
20 Executives, not least because we don't want to get in  
21 a position where we haven't got a pool of senior  
22 Executives so there are circumstances where we will take  
23 a supportive role and look to move. Now, clearly if  
24 there is misconduct, and if misconduct has been proven,  
25 that would not at all be acceptable.

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1 potential movements and that has been done.

2           **Q.** Did you read or listen to the evidence of  
3 Tom Kark KC this morning?

4           **A.** I didn't have time to hear his oral evidence,  
5 clearly it was immediately before me. I have seen some  
6 of his written evidence.

7           **Q.** Was there anything -- you may not have had  
8 an opportunity to look at it properly -- that you  
9 disagreed with within that, or have you not had an  
10 opportunity to look at that?

11           **A.** Obviously Tom Kark produced a report on this  
12 a number of years ago. We are busy implementing the  
13 recommendations of that report. The strengthening of  
14 the Fit and Proper Person Test that I have just  
15 mentioned is part of the response to those  
16 recommendations and indeed those -- that response should  
17 also be seen in the context of Sir Gordon Messenger's  
18 report and I know you have taken evidence from  
19 Gordon Messenger as well.

20           So on both, on the recommendations from both those  
21 reports, we are strengthening our guidance and policies  
22 for leadership, including competency frameworks, codes  
23 of conducts, some have been published, some are in the  
24 process of being published and of course as they become  
25 published we are very happy to share them with the

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1 Inquiry.

2 **Q.** Is it ever appropriate for NHS England to  
3 facilitate managed moves where an Executive faces a vote  
4 of no confidence, do you think?

5 **A.** So I think in those circumstances we would be  
6 very cautious to -- to facilitate moves without  
7 understanding more about why a vote of confidence was  
8 called.

9 Votes of confidence can be called for a whole  
10 variety of reasons, so it would be wrong to assume  
11 straight away that that was because of poor performance  
12 by an Executive Team, there may be something else  
13 driving that vote of confidence.

14 But you would certainly want to enquire as to the  
15 underlying reasons and rationale for why a vote of  
16 confidence from whatever group of staff had either  
17 occurred or was -- or there was a potential for it  
18 occurring.

19 **Q.** Do you think there is a problem in the NHS of  
20 failing Executives being moved from organisation to  
21 organisation in order to avoid the risk of employment  
22 disputes and the cost of them?

23 **A.** No, I wouldn't characterise it as that.  
24 I would repeat what I have already said: there is  
25 a desire to ensure that good leaders are supported and

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1 I am not aware that any particular steps were taken at  
2 that particular point, but again I would be very happy  
3 to look back and see if we have any evidence that we can  
4 provide to you.

5 **Q.** Thank you. A different but related topic. We  
6 are going to turn to look at senior leadership in the  
7 NHS. Can I put some senior salaries on the screen  
8 first, please, INQ0108797, 0158. It's the annual report  
9 on senior salaries for 2024.

10 INQ0108797, page 158.

11 So we see Medium Acute Trusts, Foundation Trusts,  
12 Medical Director roles, Chief Executive roles, if we go  
13 to 159 and 160 and then I am going to suggest we go to  
14 a table that your solicitor kindly prepared. This is  
15 the source material, so page 159 and 160 as well.

16 Then if we go to a separate INQ number it distills  
17 it more effectively INQ0108795, it is one page.

18 So we see there, I will wait until it gets there.

19 The Trust type, whether it is Acute, Mental Health  
20 or Community or Ambulance impacts on the pay scale and  
21 then we see the lower quartile median and upper quartile  
22 in amounts. So they are the salary grades.

23 We can also see from the Consolidated NHS Provider  
24 Accounts 23/24, if we can go to this please,

25 INQ0108794-0010, that when we see acute Trusts are the

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1 if they have difficulties in one organisation to not  
2 necessarily abandon them and assume that there is not  
3 room for them to be further developed, supported and  
4 succeed in other organisations, as I said there are  
5 examples where individuals have moved from difficult  
6 positions and succeeded elsewhere.

7 On the other hand, it would be entirely  
8 inappropriate and wrong for us to support the movement  
9 and further employment where there is clear misconduct.  
10 Clearly there is a judgement -- levels of judgement in  
11 between, in between those two positions and that is why  
12 we want to use our leadership frameworks, our competency  
13 frameworks to strengthen FTTP, Fit and Proper Persons  
14 Test, to ensure that we have more robust procedures  
15 around potential moves and not just moves but also  
16 appointments process around senior Executives and board  
17 members.

18 **Q.** Letby was charged in November 2020. Did  
19 NHS England take any steps at that time to follow up on  
20 the Executives of the Countess of Chester at the time of  
21 Letby's crimes, would that have been appropriate to do,  
22 to see what roles they were occupying?

23 **A.** So clearly police investigation occurring at  
24 the time, the amount of information that was in the  
25 public domain and known to NHS England was limited.

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1 best paid, if we look at 0010, the number of providers  
2 that are acute Trusts appear to be 75% of the section  
3 turnover. So 0108794-0010.

4 So we see there at the top if we highlight that  
5 sector turnover, 75% is acute.

6 That can come down. We are going to get to the  
7 question in a moment.

8 If we look, please, at INQ0108796, page 5. Sorry,  
9 not that reference. Can we have 108799, page 5, so  
10 0108799, page 5.

11 "NHS Pay and Conditions Circular 2024 applied from  
12 21 April 2024."

13 **LADY JUSTICE THIRLWALL:** I don't think we are  
14 looking at that at the moment.

15 **MS LANGDALE:** Sorry, that's 796, that is back in  
16 2015. That applied from 1 April 2015, that is not the  
17 document I meant to show, but it's there now. That's  
18 fine, that is the rates for salaries for doctors in 2015  
19 and this is annex 1, doctors and dentists in training  
20 first, page 5.

21 So we see there between those two pages for doctors  
22 and Executives, the Executives is public, and I am not  
23 suggesting by the way in 2015 those were the rates, they  
24 are publicly available as well, what was available or  
25 what the pay scales were for the directors at the time

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1 of the Countess of Chester, they are there within the  
2 Countess of Chester reports. But when we look at the  
3 pay scales generally for Executives across hospitals  
4 today, by public standards they are high salaries,  
5 aren't they?

6 **A.** So we will -- it depends what your comparator  
7 is, they are not the highest salaries within the public  
8 sector or within public servants. There are sectors  
9 where you will find higher salaries.

10 For the size of organisations that Chief Executives  
11 are overseeing, for instance some of our NHS Trusts are  
12 around £2 billion turnovers each year, our view is that  
13 they are not inappropriate and that the general view is  
14 that they sit at a reasonable level within the spectrum  
15 of public service pay.

16 Clearly if you were to compare them with the  
17 private sector you would reach potentially a different  
18 conclusion. Of course people are not simply just  
19 motivated by pay.

20 **Q.** Of course.

21 **A.** There is a large vocational element in  
22 clinicians and non-clinicians, including managers, who  
23 choose to work in the NHS so I think well, our view  
24 would be that they -- they are reasonably placed within  
25 the range of Public Sector pay.

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1 **Q.** How do you get people on to that graduate  
2 training scheme?

3 **A.** By appointments. Conflict of interest: both  
4 my children have been through that graduate scheme. It  
5 is through -- through application and through  
6 competition into those schemes. Typically it is post  
7 university but it doesn't have to be immediately after  
8 university.

9 **Q.** Does the NHS go round to universities, all  
10 universities in the country to encourage people?

11 **A.** Yes, I think schemes are well recognised and  
12 they have proven extremely popular and many of our  
13 senior leaders in the past gone through various graduate  
14 schemes. They are not the only route, clearly we have  
15 individuals who come into management positions in the  
16 NHS from other sectors, including from the Civil Service  
17 can come across. So there is no one route into  
18 management or through management and we do have Chief  
19 Executives and other Executives who come into the NHS  
20 direct from the private sector and from other  
21 industries.

22 **Q.** Is there a minimum qualification or specific  
23 qualifications, for example, around finance or  
24 communication?

25 **A.** There is a set of expected competencies and  
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1 **Q.** But they should be sufficiently attractive  
2 that the pipeline's important, isn't it?

3 **A.** Yes.

4 **Q.** Can you take that off the screen now, thank  
5 you.

6 So pipeline is the question. How do you secure for  
7 these key roles to our NHS you are getting the right  
8 people for the roles?

9 **A.** So many of our senior Executives within the  
10 NHS come through NHS management structures. Of course  
11 important to say at this point that if you look at  
12 senior Executive teams, a fair proportion are clinicians  
13 by background. Clearly in Medical Director posts, in  
14 Director of Nursing posts, that would always be the  
15 case.

16 But individuals in other posts, such as Chief  
17 Operating Officer posts, and indeed Chief Executive  
18 posts, can and do come from a range of clinical  
19 backgrounds including from the medical profession in  
20 some circumstances. So individuals come through the  
21 NHS, for those that have not come through clinical posts  
22 many will have come through our lower grade posts within  
23 the NHS, we have a graduate training scheme within the  
24 NHS which is very well-regarded amongst graduate  
25 training schemes.

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1 that is set out in the competency frameworks, but --

2 **Q.** Is competency the same, I mean it is  
3 experience as qualification?

4 **A.** Yes.

5 **Q.** You can gather experience, which is very  
6 useful, but qualifications --

7 **A.** I would contrast management routes and I think  
8 this is probably true in many sectors, for instance  
9 clinical careers, doctors and nurses, for example, there  
10 is a very clear career structure and a requirement for  
11 particular qualifications to proceed through  
12 a regulatory process.

13 That is not the same in the world of management.  
14 So the requirements are not as in a sense curricular or  
15 qualification-based in the way they would be for some  
16 professions.

17 **LADY JUSTICE THIRLWALL:** Can I ask you to pause  
18 there. The graduate training scheme is competitive and  
19 you have to be a graduate?

20 **A.** Yes.

21 **LADY JUSTICE THIRLWALL:** Presumably, the clue is in  
22 the title.

23 So presumably then there is an expectation that the  
24 people that are going to be described as your elite, and  
25 we have had that from a few people, will have a certain  
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1 level of academic achievement. I am not saying that is  
2 the only route to being a really good manager but it is  
3 clearly thought to be important.

4 **A.** Yes, but I would not say that it exclusively  
5 required that. So firstly, for that particular scheme  
6 yes, academic achievement not necessarily in  
7 a particular subject area.

8 **LADY JUSTICE THIRLWALL:** No, of course not.

9 **A.** But there are Chief Executives that have come  
10 through to being highly regarded Chief Executives who  
11 have come through routes that will not require that sort  
12 of academic --

13 **LADY JUSTICE THIRLWALL:** No, no and I understand  
14 that completely. But what I am just trying to get at is  
15 at least with the former route you can understand how  
16 people have got into the pipeline.

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** With other routes you can  
19 also understand because of the various areas of  
20 achievement --

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** -- that they have.

23 But the question I have posed to a number of  
24 witnesses before you, so I might as well pose to you as  
25 well, is if those who go through the elite route, have

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1 through the various pay scales that I think you showed  
2 me for Agenda for Change, which is the management  
3 scales, it is the scales for large number of our staff.

4 So we do have mechanisms within the NHS of  
5 supporting and developing individuals who want to go to  
6 high levels of leadership. But there is a plurality of  
7 routes into those leadership so that is not the only  
8 route. As I say, individuals can come direct from other  
9 industries, from other sectors, bringing experience of  
10 management in other industries and they can come up  
11 through largely experiential routes.

12 So there is a mix in there, but we would agree with  
13 you that one of our purposes at NHS England, but also  
14 for local organisations, is to provide that  
15 developmental support and training where appropriate to  
16 give people the skills and competencies that we are  
17 describing in the leadership framework.

18 **LADY JUSTICE THIRLWALL:** But it is inevitable,  
19 isn't it, that some people are just better at the job  
20 than others. That is the same across all sorts of --

21 **A.** It is the same of every walk of life, isn't  
22 it?

23 **LADY JUSTICE THIRLWALL:** Yes, yes.

24 **A.** So it's important to support people, to where  
25 they need to improve. I have been in the NHS 40 years,

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1 a particularly good experience of training, so you are  
2 academically able and then you get a very good  
3 experience of training, and opportunities in training,  
4 and one of the issues raised, and I will raise it as  
5 well, is: is there not a way in which that quality of  
6 training and preparation could be provided more widely?

7 **A.** Yes. And we have, through the NHS Leadership  
8 Academy, programmes of management training that many of  
9 our aspirant senior leaders go through and they are  
10 targeted at different levels as you go through your  
11 management career.

12 **LADY JUSTICE THIRLWALL:** When you say they are  
13 targeted do you mean the courses are targeted or are you  
14 targeting and talent-spotting the individuals?

15 **A.** So individuals on those schemes are very often  
16 talent-spotted and managed through local talent schemes  
17 and advised that: this would be an appropriate scheme if  
18 you ...

19 So, you know, a frequent conversation in terms of  
20 appraisal of individuals would be: in order to develop  
21 to the next stage, the next level of seniority, these  
22 are the skills, these are the -- this is the experience,  
23 this is perhaps the training and the courses that you  
24 might want to consider in order for you to get that  
25 level of skills, knowledge and experience to move up

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1 there are still things that I learn and still things  
2 that I every year reflect on in my annual appraisal that  
3 I could do better. I think that this is lifelong  
4 learning and lifelong development and I think that is  
5 what we want to promote and through the Leadership  
6 Academy, but also through lots of local initiatives as  
7 well and local schemes, that is what we are aiming to do  
8 is to develop a pipeline of future Executives  
9 recognising that we do need to ensure that there are  
10 other routes in to senior leadership positions because  
11 it is also important for the NHS that it brings in  
12 experience from other sectors and other industries and  
13 doesn't just rely on a pool of individuals who are  
14 through and through NHS. It's important to bring in  
15 learning from elsewhere too.

16 **MS LANGDALE:** How important is it that senior  
17 managers understand the work of clinicians, of doctors  
18 and nurses if they are not themselves clinicians?

19 **A.** So it is important and I think every Chief  
20 Executive, every Executive would understand that. Of  
21 course the business of delivering healthcare is not  
22 exclusively dependent on clinicians. There is a wide  
23 range of support services and, you know, from estates  
24 management through to financial management that goes  
25 into running an organisation.

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1 And of course that is where having a unified  
2 integrated board and Executive Team with a range of  
3 skills is important because it's very rare that one  
4 person can have all the skills and all that expertise.  
5 But, yes, it is important for senior Executive  
6 positions, including Chief Executives, that they have  
7 a good knowledge of what is essentially the core  
8 business of healthcare organisations which is the  
9 provision of healthcare, although of course clinicians  
10 who by and large deliver that require a certain set of  
11 competencies and skills that are different.

12 **Q.** Doctors and nurses of course are regulated,  
13 aren't they --

14 **A.** Yes.

15 **Q.** -- for their treatment of patients and can be  
16 held responsible for their treatment of individual  
17 patients.

18 What about senior managers where they are not  
19 doctors and nurses, do you think they are currently held  
20 to account for the impact decisions may have on  
21 individual patients in the same way doctors are?

22 **A.** Yes, they are held to account and of course in  
23 the case of NHS Trusts and Foundation Trusts it is the  
24 role of the board to hold those individuals to account.  
25 And there are mechanisms by which through holding

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1 I will --

2 **Q.** Why is now the right time?

3 **A.** Because I think as we are, we have  
4 strengthened as I have said our oversight, the  
5 competencies, the framework to support managers. But we  
6 do think that if we are going to go further, including  
7 in some of the recommendations that were made by  
8 Tom Kark, that would then move towards a regulatory  
9 framework.

10 In terms of things like registers and registers of  
11 professionals, that does require in our view  
12 a regulatory framework.

13 The point that I was going to make, which is  
14 a really important point for us, is one of the reasons  
15 we think it's the right time and we want to go further  
16 is because regulation is much more than just about  
17 simply striking people off and disbaring. In our view  
18 it is around that whole set of support, codes of  
19 conduct, professional support that you give to the  
20 development; that is certainly the case for regulators  
21 such as General Medical Council, the disbaring element  
22 is a small part of what they do and of course some of  
23 this is also around public confidence.

24 So we support the consultation on regulation. We  
25 would not wish for any regulatory system to be a simple

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1 organisations to account and our regulatory mechanisms  
2 within NHS England, but not just NHS England CQC and  
3 other regulators are important here, Executives can be  
4 held to account.

5 But on the matter of regulation, you are quite  
6 right that doctors, nurses, other clinical professions  
7 are regulated professions.

8 I am in a regulated profession. I am regulated by  
9 the General Medical Council. I work full time as  
10 a senior Executive within NHS England and my regulation,  
11 my annual appraisal, my revalidation through that  
12 regulatory process, is now entirely based on my  
13 performance as a senior manager because I no longer  
14 undertake clinical practice. So my scope of practice is  
15 now medical management and leadership.

16 In the case of Executives, managers who are not  
17 from those regulated professions and have not kept that  
18 professional regulation, we do believe that it is now  
19 the right time to look -- to go further in terms of  
20 regulation. As the Chief Executive of NHS England  
21 I have been quite clear on that in front of Select  
22 Committees that this is the right time to consider going  
23 further and that's why we support the current  
24 consultation being undertaken by the Department of  
25 Health and Social Care on regulation for managers.

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1 disbaring system. We do want it to be a wider system  
2 of development and support as per the other regulators.  
3 Why would we wish our clinicians to be regulated through  
4 one approach and our managers not to be regulated  
5 through the same approach? And there is much to learn  
6 from the way that other regulators operate as well.

7 So we will see what the result of the consultation  
8 is. But we are supportive of that consultation.

9 **Q.** Would you want to avoid your clinicians being  
10 regulated twice both by the GMC and then by a regulator  
11 for managers if they were managers?

12 **A.** So here I will give a personal view rather  
13 than necessarily an NHS England view.

14 So my preference would be to not have dual  
15 regulators for a number of reasons. The consultation  
16 sets out a number of options, they are all perfectly  
17 possible options. As I have said, clinical regulators  
18 or professional other professional regulators already  
19 act de facto as regulators for individuals who are  
20 registered with them entirely in management and  
21 leadership positions, so I think they have already got  
22 a process on which can be built.

23 And I think with sufficient co-operation and  
24 alignment between regulators, you could manage that  
25 through for the individual having only to be regulated

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1 by a single prime regulator.

2 But I acknowledge that there are a range of options  
3 and all of them are potentially workable.

4 **Q.** Going back to the Leadership Academy. Is it  
5 mandatory for NHS Trusts and FT Executive Leaders to  
6 undertake the training?

7 **A.** So we -- I don't think it is mandatory at the  
8 moment. We are developing for instance further work on  
9 induction and further support for managers but we would  
10 strongly advise and recommend that Executives go through  
11 those, those programmes.

12 **Q.** The competency framework, you have already  
13 mentioned that, and you said the appraisal framework was  
14 to follow by September 2024. Has that followed the  
15 appraisal framework?

16 **A.** There is a number of accompanying documents  
17 being prepared so I think it's important to see these as  
18 a suite of documents and supporting guidance in response  
19 but not just in response to the Kark and Messenger  
20 Reviews. A few have been published, I mentioned the  
21 ones they are in the statement. There is a few more in  
22 development.

23 I am hopeful that the -- well, fairly certainly  
24 that the certain that the induction framework will be  
25 published before the end of the financial year and we

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1 anonymous? It is my experience of 360 that everybody  
2 knows who it is?

3 **A.** So my experience of 360s is well, clearly you  
4 provide -- typically provide a list of individuals to  
5 the person organising the 360 around who you suggest  
6 information should be sought from.

7 **LADY JUSTICE THIRLWALL:** So you suggest that the  
8 person being appraised suggests --

9 **A.** Yes, but then when it comes to who has said  
10 what and often it is a combination of 360s of a set of  
11 standard question versus free text who has ticked what  
12 box in terms of the standard questions and who was given  
13 the free text.

14 In my experience, it's -- it's often difficult to  
15 tell, nor in my experience should you particularly want  
16 to know, what's important is the range of information  
17 that you are getting back and I think they are, they are  
18 a useful adjunct to appraisal they are not the sole  
19 input into appraisal but in my experience it is useful  
20 and within revalidation, within the  
21 General Medical Council we do expect for every  
22 revalidation cycle a 360 appraisal to be undertaken.

23 **MS LANGDALE:** Can I have please on the screen  
24 INQ0017495, page 272. This is where you reference the  
25 Perinatal Culture and Leadership Programme.

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1 are very happy to share a version of that with you and  
2 for the others documents that are under development,  
3 again very happy to share once we have near to final  
4 drafts.

5 **Q.** The Inquiry has heard evidence that it was the  
6 Chair of the board that appraised the Chief Executive at  
7 the time?

8 **A.** Correct.

9 **Q.** Would that still be the case?

10 **A.** Yes.

11 **Q.** Singularly or would other people feed into  
12 that?

13 **A.** So typically when a chair appraises a Chief  
14 Executive he or she will seek information from other  
15 colleagues. We would recommend the use periodically of  
16 360 appraisals, where anonymous feedback can be gathered  
17 from a range of colleagues, not just at Executive level  
18 but externally and other positions within an  
19 organisation. So we would expect that in that appraisal  
20 mechanism, as in other appraisal mechanism, the views of  
21 other individuals are taken into account to -- into that  
22 appraisal process but the appraisal itself will be  
23 between the Chair and the Chief Executive.

24 **LADY JUSTICE THIRLWALL:** Can I ask you about the  
25 360. You say anonymous. Are they effectively

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1 You say at 272, paragraph 1012:

2 "Perinatal Culture and Leadership Programme is the  
3 key means by which we are seeking to influence the  
4 culture of individual neonatal units and their  
5 relationships with maternity care by bringing maternity  
6 and neonatal managers together to work towards building  
7 positive team culture."

8 Can you expand on that for us, please?

9 **A.** So within our broader cultural approaches to  
10 improving and supporting culture in the NHS there are  
11 often specific programmes. This is clearly the culture  
12 and leadership programme in neonatology and perinatology  
13 so it is an example of where we seek to influence the  
14 culture of particular specialties and particular  
15 departments and units. It will -- if you require  
16 further details over and above what's in the statement,  
17 I am very happy to give them.

18 But typically, this sort of programme will,  
19 similarly to other programmes, focus on what good  
20 governance looks like, what data should be used within  
21 a particular service to drive improvement. How an  
22 improvement culture can be generated and sustained and  
23 how concerns can be dealt with.

24 **Q.** You also, if we go back in your statement,  
25 please, to page 178, set out the three-year delivery

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1 plan --

2 **A.** Yes.

3 **Q.** -- from paragraph 698. I don't know if it is  
4 possible to have that page and the next page 179 on the  
5 screen together. Could you set out in practical terms  
6 what's the endeavour here, what do you hope that this  
7 will achieve?

8 **A.** Well, the endeavour here is to improve  
9 maternity and neonatal services. We have had  
10 a maternity improvement plan or transformation plan in  
11 place for some time but the purpose of the three-year  
12 delivery plan was to build on that and take the specific  
13 recommendations from Donna Ockenden's review of the  
14 events at Shrewsbury and Telford and Dr Bill Kirkup's  
15 review of maternity in East Kent into the Maternity  
16 Transformation Programme and expand it more explicitly  
17 to include neonatology. So you can see in this exhibit  
18 the themes that are at the core of that listening and  
19 working with women and families, again we have touched  
20 on that previously, so ensuring that the patient  
21 experience the experience of mothers and parents and  
22 partners is much more integrated and much more  
23 integrated -- compassionately integrated into the work  
24 we do.

25 The theme on workforce we have touched on  
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1 developing guidance. A core part of developing guidance  
2 is engaging with stakeholders, engaging with others.

3 So for our leadership work we have been engaging  
4 with others expert in management as to what should shape  
5 that.

6 So that does mean that sometimes our development of  
7 policies takes a bit longer. I actually was asked about  
8 this in the Covid Inquiry a few weeks ago and getting  
9 the balance between getting policies out in a timely way  
10 and ensuring that you have taken a range of views in to  
11 inform that policy is a balance and we need to strike  
12 the right balance.

13 So I think that 90% is not necessarily just about  
14 trying to perfect. I think it's ensuring that we have  
15 done the appropriate engagement and the, got the  
16 appropriate input into ensuring that we have a policy  
17 that is fit for purpose.

18 **MS LANGDALE:** Thank you, those are my questions,  
19 Sir Stephen. My Lady there are Mr Baker -- or two  
20 people asking questions. I wonder if now is a good time  
21 take a 10-minute break because then I am confident we  
22 will still conclude within the time.

23 **LADY JUSTICE THIRLWALL:** Certainly. We will take  
24 a 10-minute break and start again at quarter to.  
25 **(3.36 pm)**

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1 previously as well and I have alluded to the work we are  
2 doing on ensuring that the workforce is a sustainable  
3 workforce and of the right size with the right skills.

4 We have again, theme 3, talked about patient safety  
5 and you can see there the transition to PSIRF is one of  
6 the key aims and then finally again we have talked about  
7 data. We have talked about records. We have talked  
8 about using data and again you can see in theme 4 that  
9 is at the core of that, so it is all the components that  
10 we have touched on today set out specifically for  
11 maternity in neonatal services and taking into account  
12 some of the specific recommendations from previous  
13 investigations.

14 **Q.** Sir Gordon Messenger gave evidence and offered  
15 this constructive criticism, he described it as: 90% of  
16 the time seem to be on perfecting or polishing the  
17 product as it were and only 10% embedding in an  
18 organisation when it should be the other way round.

19 Do you accept that or recognise what he is  
20 describing there?

21 **A.** I would nuance it, with great respect to  
22 Gordon, who has been a great help in supporting us in  
23 this work. I don't think we always necessarily strive  
24 for perfection. But we typically want to take in  
25 a range of views and a range of expertise when we are

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1 **(A short break)**

2 **(3.45 pm)**

3 **LADY JUSTICE THIRLWALL:** Mr Sharghy, just before  
4 you start, Ms Langdale, I think towards the end of the  
5 previous session we had some documents up about Chief  
6 Executives' pay and doctors' pay but I think they had  
7 become rather muddled. Certainly at one stage we were  
8 looking at a schedule of junior doctors pay so I wonder  
9 if that -- we don't need to take time on it now but  
10 perhaps the right documents can be identified and  
11 uploaded onto the website and maybe also the appropriate  
12 figures for the Countess of Chester.

13 Presumably it is in the annual report which we have  
14 got somewhere.

15 **MS LANGDALE:** Thank you, we will, thank you.

16 **LADY JUSTICE THIRLWALL:** Thanks, Ms Langdale,  
17 Mr Sharghy.

18 Questions by MR SHARGHY

19 **MR SHARGHY:** Sir Stephen, good afternoon.

20 I represent one of the Family groups involved within  
21 this Inquiry.

22 I have got three topics I would like to ask you  
23 some questions on and I hope I am not going to cover a  
24 lot of what you have already given by way of your  
25 evidence.

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1 A. Yes.

2 Q. The first topic is in relation to the  
3 information sharing and you gave a lot of evidence to  
4 this Inquiry about the expectations of NHS England, when  
5 it came to the Countess of Chester when they should have  
6 really precipitated the flow of information to you as an  
7 organisation?

8 A. Yes.

9 Q. Can you just help with answering this  
10 question: in the period between 2015 and 2017, so  
11 June 2015 is when --

12 A. Yes.

13 Q. -- child A dies?

14 A. Yes.

15 Q. And in relation to 2017 you said 29 March of  
16 2017 --

17 A. Yes.

18 Q. -- was when NHS England was first informed  
19 there was an individual associated with those events?

20 A. Yes.

21 Q. What powers did NHS England have to either  
22 strongly request, or if going further, compel Trusts to  
23 provide information that they have received regarding  
24 patient safety safeguarding concerns to NHS England?

25 A. Limited powers. As I have said in other  
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1 licences and standard contracts, there would have been  
2 requirements around structures and processes that were  
3 required in the Trusts such as safeguarding, such as  
4 incident reporting.

5 So that is different in a sense from being able to  
6 take regulatory action. That is saying: this is our  
7 expectations of you as an organisation, as a board, as  
8 to what you should provide.

9 But in terms of the principles of information  
10 sharing, it is good practice to share information.  
11 I don't think there is anything that would impede the  
12 information sharing in the interests of patients or  
13 public. And as I have said, we would have expected the  
14 Countess of Chester to share more information, not least  
15 because it enables the regulators to provide support and  
16 additional experience, additional set of eyes and  
17 assistance.

18 As I said earlier, regulators in my experience as  
19 a Medical Director, you can have challenging  
20 conversations with regulators, that is part of the role  
21 of regulation. But you can also have very supportive  
22 conversations where you can get people who have either  
23 more experience or have got different experiences to  
24 advise and because this was not reported upwards, the  
25 possibility of having additional eyes, additional  
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1 evidence, Countess of Chester was a Foundation Trust and  
2 the policy for Foundation Trusts was to deliberately  
3 give them the autonomy that was felt to be beneficial at  
4 the time in terms of developing services for local  
5 populations, that was on the basis of earned autonomy.

6 So if they were not manifestly breaching any of our  
7 requirements, regulatory requirements, if their  
8 standards of care as assessed by the Care Quality  
9 Commission and others were assessed to be good, then it  
10 was a light touch regulatory regime undertaken by  
11 Monitor, many of the quality elements would have been  
12 de facto delegated to the CQC and others although over  
13 that period, up to that time, Monitor were, to be fair,  
14 becoming more involved directly in quality concerns.

15 There were no particular regulatory concerns around  
16 the Countess of Chester in that period and the concerns  
17 that arose were very specifically in relation to the  
18 neonatal unit, although as I have said that exposed  
19 other concerns around the openness and the transparency  
20 of the organisation.

21 So we -- when I say "we", it would have been  
22 Monitor at the time and the CQC would be the two  
23 relevant regulators. They did have a power, the power  
24 of intervening, but there would have been quite a high  
25 bar for regulatory intervention through provider  
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1 curiosity, additional questions I think was lost.

2 Q. The Inquiry has heard a lot of evidence from  
3 multiple external organisations or indeed sometimes  
4 individuals about how the message, the narrative, was  
5 very tightly controlled by the Countess of Chester, both  
6 in relation to the cluster of deaths and the information  
7 around the increase but in particular in relation to the  
8 association of a particular healthcare professional with  
9 those collapses, with those deaths.

10 And is it still the case, as you sit here today,  
11 that the powers of NHS England to encourage, to where  
12 necessary require that level of co-operation is still  
13 the same as it was back in 2015, 2017?

14 A. There will have been some evolution in those  
15 powers. There has clearly been a subsequent Act 2022  
16 that brought the regulators together. But our powers of  
17 regulation are still fairly specific in terms of  
18 organisation and of course we do not have powers over  
19 individuals; that is the job of professional regulators  
20 by and large.

21 But I do think the situation has changed and I do  
22 think the ability to have additional scrutiny has  
23 strengthened and I would give you the Medical Examiner  
24 system as one example of a statutory system now in place  
25 that provides an extra level of scrutiny that cannot be  
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1 avoided when a death occurs that was not there in 2015  
2 and 2016.

3 So as I said earlier, it is never one single  
4 approach to this that is important; it's a suite of  
5 layers all of which that are designed to provide  
6 opportunities for escalation, to identify concerns, and  
7 to respond to them.

8 **Q.** Thank you. Can I move on to the second area  
9 of questioning and this is in relation to the Patient  
10 Safety Incident Response Framework in particular that  
11 Ms Langdale took you to.

12 But before I take you to that document and ask you  
13 a couple of questions, can I just ask you from the  
14 position of NHS England, how important is patient  
15 safeguarding and safety?

16 **A.** Patient safety is, is the prime at the very  
17 top of NHS England's responsibilities and I would say  
18 that for every leader within the health system that is  
19 and should be the top priority. "First, do no harm" is  
20 a phrase that you will recognise, it is a phrase that  
21 clinicians, you know, live by and it is the same for  
22 organisations and senior leaders: our first duty is to  
23 "first, do no harm".

24 **Q.** And following on from that, to what extent  
25 should resources be used as a justification or an excuse

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1 **A.** Yes.

2 **Q.** -- to finds trends, cultures. Is that a fair  
3 reflection of your answer?

4 **A.** Yes, one of the criticisms of the old policy  
5 was that it tended to see -- it tended to focus on  
6 specific individual incidents. At times, for instance  
7 you could be investigating the same incidents many times  
8 over in isolation and now of course in practice many  
9 organisations move to a much more thematic approach.  
10 A simple example would be pressure ulcers which often  
11 generate incident reports. You will learn more often by  
12 looking at those in the round as a series of incidents  
13 rather than just taking each in isolation.

14 So part of the aim of the new Patient Safety  
15 Strategy is to do that and I don't know whether you have  
16 had a chance to look at for instance the Countess of  
17 Chester's implementation, local implementation of that  
18 plan, but if you were to look at it, you would see they  
19 have identified the spectrum of incidents that are  
20 reported through their systems, they have themed them  
21 into various areas and then they have listed the  
22 improvement plans that they have in place around those  
23 and also the expectations around how incidents might be  
24 reported and then escalated.

25 And of course that approach will need to be

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1 not to implement steps and recommendations, improvements  
2 when it comes to patient safety?

3 **A.** Well, obviously it is important to acknowledge  
4 that particularly in financially challenging  
5 circumstances, senior leaders have to make a decision  
6 about where they deploy their resources. But I go back  
7 to my previous answer. At the very top of everybody's  
8 list is patient safety, "First, do no harm" and I think  
9 we are very clear, we are very clear currently that the  
10 priority is not to harm and therefore I would say  
11 deploying resources to support patient safety would be  
12 at or near the top of most people's priorities.

13 **Q.** Thank you. And when Ms Langdale took you to  
14 the framework document, which we will go to in a moment,  
15 I recorded your answer as to what the aim of the policy  
16 was --

17 **A.** Yes.

18 **Q.** -- and you said this:

19 **"Answer:** ... one of the aims of this policy was to  
20 drive much more towards thematic reviews, so bringing  
21 together an understanding of the incidents that were  
22 occurring frequently in an organisation rather than  
23 unconnected investigations on single incidents ..."

24 So in other words, looking at the global picture of  
25 events --

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1 iterated because over time there may be a different  
2 balance of incidents and every organisation has gone  
3 through that process and I think we have provided as  
4 an exhibit the template that we provide in order to do  
5 that process locally.

6 **Q.** And can we please have the framework document  
7 on the screen so you can see it, Sir Stephen, INQ0009265  
8 and if we can go to page 3. Ms Langdale took you to the  
9 second paragraph which was the change in relation to the  
10 definition of "safety incident"?

11 **A.** Yes.

12 **Q.** So the concept of a Serious Incident has been  
13 removed which is what the following paragraph says, so  
14 in one respect it's made it more straightforward; is  
15 that fair?

16 **A.** Yes.

17 **Q.** But that's come at a cost, hasn't it, because  
18 the following and the last sentence in that third  
19 paragraph, it says that:

20 "Instead the framework promotes a proportionate  
21 approach to responding to Patient Safety Incidents by  
22 open sharing resources allocated to learning are  
23 balanced with those approximate needed to deliver  
24 improvements".

25 So in other words, this framework on the one hand

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1 makes definitions of what the thematic process should  
2 look at but it brings in this process and the control of  
3 proportionality and if we can go to, please, page 6, the  
4 concept of proportionality is described in a bit more  
5 detail and I just would like your assistance with it.

6 Paragraph 1 under heading 3:

7 "Considered and proportionate responses to patient  
8 safety" says this:

9 "Organisations have finite resources for Patient  
10 Safety Incident Response. The framework supports  
11 organisations to use the incident response resources to  
12 maximise improvement".

13 That's sort of management-type speak. What does  
14 that actually mean in practice?

15 **A.** What it means in practice is that we -- so one  
16 of the points of incident reporting, it is not the sole  
17 point is to drive improvement, learn where things go  
18 wrong, and as I said earlier, increasingly learn from  
19 where things go right and ensure that that drives  
20 improvement in terms of ensuring that the process is  
21 structures, learning is in place so that doesn't happen.

22 At the heart of that is this shift I described  
23 earlier to an improvement culture rather than a blame  
24 culture.

25 But I think at the heart of your question

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1 issues to the full potential that it should do?

2 **A.** So that is the role of Commissioners and  
3 external bodies to work with organisations and to  
4 scrutinise and to ensure including the CQC which has  
5 that responsibility too to ensure that these systems are  
6 used, being used effectively, they are being used  
7 appropriately for their purpose and that they are  
8 driving improvement, but also able to help in the  
9 detection of incidents that require further scrutiny.

10 But as I also said, this is not in isolation and  
11 should not be seen in isolation. In fact, the document  
12 makes that point: it should be seen in relation to other  
13 mechanisms used where things go wrong, where there are  
14 concerns that includes the Medical Examiner system, it  
15 includes the safeguarding system and indeed can include  
16 the Freedom to Speak Up system.

17 **Q.** You are absolutely correct because this  
18 document does refer to probably half a dozen other  
19 guideline --

20 **A.** Yes.

21 **Q.** -- documents but therein lies another problem,  
22 Sir Stephen, which is what other witnesses describe as  
23 the rather wordy nature --

24 **A.** Yes.

25 **Q.** -- of NHS England and Department of Health

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1 perhaps -- and tell me if I am wrong -- is obviously we  
2 have previously discussed the need or if the incidents  
3 and the deaths at the Countess of Chester had reported  
4 as Serious Incidents they would have alerted  
5 Commissioners and therefore if the new policy does not  
6 make that distinction, would Commissioners have been  
7 alerted? And that is clearly something that needs to be  
8 addressed.

9 The new system ensures that all incidents are made  
10 available to a wide range of Commissioners including the  
11 ones that used to see the STEIS process and the NRLS  
12 process but we are conscious that we need to work and in  
13 much more real-time, but we are conscious that we need  
14 to work with Commissioners to help them to ensure that  
15 in their oversight they are able to pick out those  
16 incidents that need particular attention. So it does  
17 require that judgement within the organisation which is  
18 always required but it does also require that oversight  
19 from external bodies.

20 **Q.** But doesn't this new framework also lead to  
21 the likelihood that certain Trusts will use resources,  
22 whether it's financial resources, whether it's  
23 individual personnel resources, or indeed time  
24 resources, to not in fact take the necessary steps that  
25 they have identified give rise to risk and safeguarding

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1 policies, guidance procedures in that it's very rare, if  
2 at all, that a single document contains all of the key  
3 pieces of information so that an individual can use it  
4 as a reference and then seek further guidance if they  
5 need to. This document framework falls into that trap,  
6 doesn't it?

7 **A.** I wouldn't say that but I do take the point,  
8 and we have discussed that, that there is a balance  
9 between brevity of documents and ensuring that we have  
10 the detail in there that is required. But I am very  
11 happy to take that point back. I have said already that  
12 within safeguarding there is a need I think to be more  
13 clear on certain aspects of safeguarding, I accept the  
14 point that there is always a need to synthesise and to  
15 make as simple as possible, that that can occur in  
16 variety of ways, it can occur through some of our  
17 mandatory training, it can occur through documents that  
18 aim to synthesise which the SAF document in safeguarding  
19 does, but I am very happy to discuss that further with  
20 our Patient Safety Team and reflect further on that.

21 **Q.** The final point on this document is just at  
22 the bottom paragraph of page 6. There's reference to  
23 the framework setting no further rules or thresholds  
24 other than those set out in the Guide to responding  
25 proportionately to patient safety incidents to determine

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1 what needs to be learned from to inform improvement.  
 2 Further down in that paragraph, it says:  
 3 "If an organisation and its ICB are satisfied risks  
 4 are being appropriately managed and/or improvement work  
 5 is ongoing to address known contributory factors in  
 6 relation to the identified Patient Safety Incidents and  
 7 efficacy of safety actions is being monitored it is  
 8 acceptable not to undertake an individual response to an  
 9 incident other than to engage with those affected and  
 10 record that incident has occurred".

11 One of the key missed opportunities in this  
 12 particular case that the Inquiry is involved with is  
 13 that the initial view of the Executives and the  
 14 management was that part and parcel of the increase in  
 15 the deaths was because of a shortage of staff and that  
 16 was, that was a process that was ongoing?

17 **A.** (Nods)

18 **Q.** So if one applies this concept by way of the  
 19 background facts to this policy, it could lead, couldn't  
 20 it, to a Trust believing that if a problem is already  
 21 identified and something's been done about it, then no  
 22 individual response to an incident -- thematic review,  
 23 clusters, et cetera -- will take place?

24 **A.** So the aim of this is to ensure that you don't  
 25 in essence expend time and resource investigating

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1 "Nationally NHS England has strengthened neonatal  
 2 clinical leadership by appointing the first ever  
 3 National Neonatal Clinical Director."

4 I believe that is Dr Edi-Osagi?

5 **A.** (Nods)

6 **Q.** And also a National Neonatal Nurse Lead role  
 7 which, as I understand it, on the face of it is  
 8 Ms Weaver-Lowe?

9 **A.** (Nods)

10 **Q.** You then exhibit the two job descriptions and  
 11 a number of issues arise out of that. The first is that  
 12 it is a secondment role, in other words they are both  
 13 part-time roles?

14 **A.** (Nods)

15 **Q.** And by the advert that the role has attracted,  
 16 in terms of Dr Edi-Osagi, she has the equivalent of  
 17 15 hours per week to dedicate to this national role  
 18 which is a bottom up and a top down clinical role and  
 19 Ms Weaver-Lowe has got effectively two days' worth in  
 20 her week to effect the same process but from a nursing  
 21 perspective.

22 Can I ask why these two roles, which you say in  
 23 your witness statement are so crucial and critical to  
 24 the improvement process, are not full time roles?

25 **A.** So they are no different from any of our other

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1 repeated natures of the same incident as opposed to  
 2 directing your resources towards improvements and the  
 3 improvements that have been learnt. But the point you  
 4 make I acknowledge. It is important. And again,  
 5 judgement is required in the application of these  
 6 policies, it was required in the last policy. I don't  
 7 think you can take out that necessity for judgement from  
 8 senior leadership and clinicians entirely, that would  
 9 not be possible. But what you can do is in the work  
 10 around this and culture and how processes are undertaken  
 11 within the Trust, you can help to ensure that those  
 12 judgements are made correctly and in an appropriate and  
 13 the best possible way.

14 But you will always rely on judgements of  
 15 clinicians and managers in complex cases but I am very  
 16 happy to take the points that you have raised and  
 17 discuss them further with the Patient Safety Team.

18 **Q.** Final area of questioning is in relation to  
 19 the improvements in national clinical leads both in  
 20 terms of neonatal clinical leads and also nursing and  
 21 you deal with this in your first witness statement,  
 22 I won't take you to it because it is a very short  
 23 paragraph, it is paragraph, my Lady, 707, which is on  
 24 page 182 of Sir Stephen's first witness statement.

25 And, Sir Stephen you say this that:

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1 National Clinical Directors, the model for employing our  
 2 National Clinical Directors is on that secondment basis,  
 3 across the full range of NCDs they will typically have  
 4 usually between two or three days of time spent on the  
 5 National Clinical Director role and the remainder of  
 6 their role in their host clinical organisation. That  
 7 is -- there is nothing unique about that for this  
 8 particular role. That is the same across all National  
 9 Clinical Directors and has been for some time.

10 The importance of this was previously it was  
 11 a National Specialty Advisor role which had in a sense  
 12 a lower authority but also less time, so we have  
 13 increased that. When we establish these jobs we do work  
 14 with the relevant teams in which they will work within  
 15 NHS England to determine the amount of time that is felt  
 16 to be appropriate. That can vary over time.

17 And in fact I am currently discussing with the  
 18 Chief Nursing Officer for England, within which team  
 19 this role sits, whether we need to put in additional  
 20 time because of the nature of the role and the work that  
 21 is required at the moment.

22 **Q.** My question was slightly more nuanced.  
 23 I appreciate that that is the way that roles have been  
 24 across NHS England. But the question was more specific  
 25 in terms of: should these roles be full time roles,

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1 specifically because they are so integral to patient  
2 safety and safeguarding and the prevention of all of the  
3 horrific incidences that have happened that inquiries  
4 have led, and today with BBC News reporting Leeds  
5 Teaching Hospital, is it not time for NHS England to  
6 review the fact that these roles need to be full time?

7 **A.** I think you could make the same argument  
8 across a whole range of roles outside of maternity and  
9 neonatology. We review on a three-yearly cycle, we are  
10 focused on expanding the number of roles. As I say, we  
11 flex the amount of time, but one additional point  
12 I would make is it is a benefit that the individuals in  
13 those roles do also work clinically, in clinical  
14 environments because it means that they are direct  
15 connected in to the provision of service. And I think  
16 if you asked most of them, as I do, they would prefer to  
17 retain some clinical practice.

18 I don't. Members of my senior team who are  
19 National Medical Directors in various areas have  
20 a combination depending on circumstances, but clinicians  
21 will often tell you that it is a benefit to them and to  
22 their understanding of how it is working at the  
23 frontline if you want for them to do some clinical work.

24 So I think at the moment having that mixed model  
25 works. But I do agree it's important to make sure that

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1 a patient or do you mean the control measures that might  
2 be applied surrounding it?

3 **A.** I think we would mean all of those and of  
4 course that paragraph needs to be read with the  
5 subsequent paragraph which points to the fact that  
6 guidance on administration of insulin is in place but it  
7 is issued by other bodies, including NICE and the Royal  
8 Pharmaceutical Society. That is not unusual.  
9 NHS England is not the sole provider of guidance and we  
10 are very careful to ensure that where others can have  
11 a role, and sometimes a better place to issue guidance,  
12 then we -- then they do that. That can be independent  
13 of us. It can be with our support and input.

14 **Q.** Yes. And it's reading it in the context of  
15 the next paragraph was why I asked the question because  
16 guidance relating to the clinical use of insulin, the  
17 following paragraphs describe how it is administered  
18 what its purpose is and things like that. So if we  
19 could go on then please to paragraph 9.

20 I think this is more apposite to the issues in this  
21 case:

22 "NHS England is one of several bodies that has  
23 a role in relation to the management of medicines."

24 And the "management of medicines" it goes on to say  
25 in short:

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1 the time is reviewed and that is exactly what we are  
2 doing with the NCD for neonatology at present.

3 **MR SHARGHY:** Thank you, Sir Stephen. Thank you,  
4 my Lady.

5 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy.  
6 Mr Baker.

7 Questions by MR BAKER

8 **MR BAKER:** Thank you, my Lady.

9 Professor Powis, I ask questions on behalf of two  
10 of the Family groups. I have got relatively limited  
11 time so I am going to ask you specific questions about  
12 the regulation of insulin --

13 **A.** Yes.

14 **Q.** -- and the directives that are given regarding  
15 insulin and its management within a neonatal setting.

16 Your second witness statement deals with this  
17 exclusively, that is INQ0014552, and if I can go first  
18 of all to two specific paragraphs, the first is on  
19 page 2 and it is paragraph 5.

20 "NHS England has not issued guidance on the  
21 clinical use of insulin in a neonatal context."

22 And I just wanted to understand that statement  
23 a little bit more clearly. When you say "issued  
24 guidance on the clinical use of insulin in a neonatal  
25 context", do you mean how it is administered to

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1 "While NHS England provides guidance on best  
2 practice around the storage and handling of medicines,  
3 including through estates guidance described below at  
4 paragraph 13. It has no overarching statutory role in  
5 relation to the regulation of controlled drugs per se".

6 And so this paragraph brings into it two concepts?

7 **A.** Mmm mm.

8 **Q.** One is that NHS England has a role in relation  
9 to the management of medicine, so it could issue  
10 guidance as to how to manage risk associated with  
11 medicine, but then it also brings in the concept of  
12 controlled drugs which are a different thing all  
13 together and subject to specific statutory definitions?

14 **A.** So I think from memory this was in relation to  
15 some very specific Rule 9 questions provided by the  
16 Inquiry which I think will help you maybe see how it was  
17 shaped in this particular way.

18 We do have some statutory duties with respect to  
19 controlled drugs, you can see those two paragraphs down  
20 in paragraph 11. But I said earlier, in terms of the  
21 designation of controlled drugs, the Home Office would  
22 be the appropriate body and as I said earlier as well,  
23 much of the practice around the use of controlled drugs  
24 does read across to the practice of non-controlled drugs  
25 as well, so there is a big overlap, clearly there are

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1 additional regulatory and supervisory controls in place  
2 because of the nature of controlled drugs, but that does  
3 not apply to insulin.

4 **Q.** So to assist, a controlled drug is  
5 a controlled drug for what reason? Is there a specific  
6 reason why some drugs are chosen to become drugs?

7 **A.** Yes, for instance it would be opiates because  
8 of the addictive nature of opiates and --

9 **Q.** So they are drugs that have to be controlled  
10 because of a propensity of evil --

11 **A.** For a variety of reasons because of the nature  
12 of the compound, yes.

13 **Q.** Yes, because a large overdose of insulin would  
14 be just as fatal as a large overdose of diamorphine, so  
15 it is not necessarily the risk --

16 **A.** (Redacted).

17 **Q.** Yes.

18 **A.** As probably would be a large overdose of many  
19 drugs because of course many drugs can cause harm if  
20 they are given in the wrong quantities.

21 **Q.** So it's not the propensity of the drug to  
22 cause harm to a patient that causes it to be controlled?

23 **A.** It is another set of reasons.

24 **Q.** It is another set of reasons often relating to  
25 abuse of that drug?

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1 practice is in place as we discussed earlier.

2 **Q.** Yes. I mean, because of course the Families  
3 are concerned, and whilst they appreciate that many  
4 drugs could cause harm, insulin is implicated in quite  
5 a few cases where healthcare workers have attacked  
6 patients?

7 **A.** Mmm.

8 **Q.** Victorino Chua, Beverley Allitt, this case and  
9 also Colin Norris. Those cases all involved patients  
10 being given --

11 **A.** Yes.

12 **Q.** -- improper doses of insulin.

13 So it is a drug that is associated with these  
14 cases.

15 **A.** (Nods)

16 **Q.** We have, I think, heard that when it came to  
17 the Countess of Chester, insulin was stored in  
18 a cupboard that wasn't locked, there was no restrictions  
19 on people accessing it in terms of people working on the  
20 ward, it wasn't kept in defined doses; in other words it  
21 could just be taken out of a bottle, so nobody would  
22 know how much was being used and whether it corresponded  
23 with prescriptions. And those would be fairly common  
24 things on a ward, wouldn't they, when it comes to  
25 insulin?

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1 **A.** Yes, to a variety of factors, yes.

2 **Q.** Now, you have no powers as NHS England in  
3 defining what is and is not a controlled drug, that much  
4 is clear. But you do have powers in relation to giving  
5 guidance around protective or safety measures that might  
6 be taken in relation to specific drugs that aren't  
7 controlled drugs?

8 **A.** Yes.

9 **Q.** Yes. Has NHS England issued any guidance on  
10 measures that might be taken surrounding the storage of  
11 insulin?

12 **A.** So we have estates guidance relating to this  
13 but beyond that, as the statement says, I am not aware  
14 that we have issued specific guidance. However, as  
15 I said earlier, this is something that we have looked at  
16 in detail because of the Inquiry but also because and  
17 again related to the Inquiry a request from a former  
18 minister.

19 We do not think at the moment that we need to put  
20 in place additional measures but we are committed to  
21 continuing to ensure that we promote best practice and  
22 I have discussed this with the Chief Pharmaceutical  
23 Officer. If we -- I am very happy to go back and  
24 consider once again whether we need to write out  
25 specifically on this subject to ensure that best

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1 **A.** So in our survey I think we were assured that  
2 there were, in the majority of units, much stricter  
3 measures in place and when I alluded to previously  
4 promoting good practice, that element of storage and  
5 access was what I was referring to.

6 I agree insulin clearly has been implicated in  
7 other cases too. That is the reason that we wanted to  
8 scrutinise this in more detail. We have not reached  
9 a conclusion yet that other than promoting the practice  
10 that we see in the best of places, that additional  
11 controls are needed. But I am very happy, as I say, to  
12 continue discussing this with the Chief Pharmaceutical  
13 Officer for England and if we feel that it is  
14 appropriate to issue guidance around best practice, then  
15 we will do so.

16 **Q.** Yes, because control mechanisms could be  
17 relatively straightforward --

18 **A.** Yes.

19 **Q.** -- that --

20 **A.** Exactly, they are.

21 **Q.** So swipecard access to a box so you know who's  
22 taken it out would be a --

23 **A.** Yes, and in the report that we exhibited, that  
24 was exhibited earlier, I mentioned some of the areas  
25 where we saw variation and they are also areas that we

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1 can focus on. I mentioned ensuring that staff are  
2 trained in good practice around use and access to drugs.  
3 I mention the oversight of pharmacy, so pharmacists  
4 within the hospitals having a supervisory and checking  
5 element of dispensing and prescriptions.

6 Also in there which I think was flashed up, you may  
7 not have time to see it, I am sure you have looked at  
8 it, was the use of electronic prescribing which provides  
9 additional scrutiny and additional assurance. So there  
10 are a range of things.

11 And very happy to keep this under review because of  
12 exactly the importance you have placed upon it.

13 **Q.** Can I go to a slightly different but connected  
14 issue, because of course one of the features of insulin  
15 is if you are giving an insulin dose to a patient, the  
16 harm isn't visible immediately.

17 So if you give a patient a large dose of  
18 diamorphine, as Harold Shipman did, they would die  
19 relatively quickly?

20 **A.** It depends on how much you give.

21 **Q.** It depends how much you give, but with insulin  
22 of course the effects evolve over --

23 **A.** And again it depends on the dose that you are  
24 administering.

25 **Q.** Yes, but it is a drug that is detectable?

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1 I have no more questions.

2 **LADY JUSTICE THIRLWALL:** Thank you very much,  
3 Mr Kennedy, Mr Beer?

4 Thank you I just have one or two matters if I may.

5 I just have one or two matters, if I may.

6 **Questions by LADY JUSTICE THIRLWALL**

7 **LADY JUSTICE THIRLWALL:** You mentioned earlier in  
8 your evidence how you would have expected the Countess  
9 to have told NHS England more than they told them  
10 earlier than they did --

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** -- in a nutshell. Were  
13 there any consequences for the Countess from NHS England  
14 arising out of the fact that they hadn't done what they  
15 were expected to do?

16 **A.** As you will have seen in some of the evidence,  
17 they were put, particularly around neonatal at times, in  
18 enhanced surveillance.

19 **LADY JUSTICE THIRLWALL:** Sorry, I meant any  
20 consequences for the individuals; in other words, did  
21 anyone say, "Why didn't you tell us that before? What's  
22 going on?"

23 **A.** That would have -- from the point of  
24 NHS England at that time, as I say, we are regulators of  
25 organisations rather than necessarily individuals and we

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1 **A.** Yes.

2 **Q.** And one of the features of the Beverley Allitt  
3 case is that in effect the thing that caused her to be  
4 caught was a laboratory discovered a blood test result  
5 with this disparity between insulin and C-peptide --

6 **A.** Correct.

7 **Q.** -- that raised an alarm bell.

8 Now, of course, on the face of the evidence that  
9 this Inquiry has heard, the same thing happened here but  
10 didn't result in the same outcome. Is there a space for  
11 regulation or some sort of direction to be given to  
12 laboratories by NHS England about how they should react  
13 in circumstances where a low C-peptide is found  
14 corresponding with a high insulin level?

15 **A.** Yes, and there may be possibility around  
16 flagging of results, so again very happy to take that  
17 back and discuss further with the Chief Pharmaceutical  
18 Officer and with our pathology team.

19 **Q.** Yes, and a corresponding direction to doctors  
20 to understand that where this flagging comes in, it  
21 requires a specific response?

22 **A.** Yes, so flagging of important results is  
23 common practice. So again, let me take that back and  
24 reflect on it further.

25 **MR BAKER:** I am grateful. Thank you, my Lady

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1 would have expected that to have been done through board  
2 processes if there were concerns.

3 Our power is of --

4 **LADY JUSTICE THIRLWALL:** You mean internally within  
5 the Countess?

6 **A.** Yes, because our powers of regulation with  
7 respect to individuals are largely --

8 **LADY JUSTICE THIRLWALL:** That's the point. You  
9 don't have any --

10 **A.** -- with respect to organisations rather than  
11 individuals.

12 **LADY JUSTICE THIRLWALL:** Sorry. So technically --

13 **A.** Technically, we can't.

14 **LADY JUSTICE THIRLWALL:** -- you had no teeth, as it  
15 were, so far as the individuals were concerned and nor  
16 would you expect to have any. But, at a personal level,  
17 there was nothing said; that was just how it was and if  
18 anything was going to happen, it was going to happen or  
19 not within the board?

20 **A.** Yes, or again through referrals into  
21 regulatory bodies. Again, I can go back and look to see  
22 if we can find evidence as to whether that was done.

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

24 You said on a number of occasions that you will  
25 take things back and I just wonder perhaps in a month or

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1 so if you could let us have an update on the various  
2 things. We will let you know what you said it about.

3 You may remember it all but in case you don't --

4 **A.** I am sure the legal team have been taking  
5 a note of it and we will have a conversation with  
6 counsel and, if you so wish, we can agree a timescale  
7 for the number of items where I have indicated we can  
8 provide further information.

9 **LADY JUSTICE THIRLWALL:** Yes, I think I may have to  
10 say what the time will be, but I am extremely happy for  
11 you to discuss that with Mr Beer and see --

12 **A.** Absolutely.

13 **LADY JUSTICE THIRLWALL:** -- because some of the  
14 things you've said you'll take back, we probably don't  
15 need you to.

16 **A.** Yes.

17 **LADY JUSTICE THIRLWALL:** So we can perhaps come to  
18 some sort of agreement about that and then I will say  
19 when it has to be done by.

20 **A.** Yes.

21 **LADY JUSTICE THIRLWALL:** Good, thank you.  
22 Just briefly on governors in relation to Foundation  
23 Trusts. I mean, I appreciate Foundation Trusts were set  
24 up for particular purposes, including competition, which  
25 is no longer really a feature, is it --

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1 pertain in relation to NHS Trusts who don't have  
2 Foundation governance.

3 **A.** It absolutely does and it still pertains with  
4 respect to Foundation Trusts. And again, over time, as  
5 we have moved away -- and, remember, the intention in  
6 the 2012 Act was that all NHS Trusts became over time  
7 Foundation Trusts.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **A.** -- that intention were never crystallised and  
10 Government increasingly moved away from it. So, in  
11 a sense, we are now left with a situation where we have  
12 two models of governance and, in practical terms, the  
13 distinction between Foundation Trusts and NHS Trusts and  
14 how they are overseen has become less and less. And  
15 that is manifest that, rather than having one regulator  
16 for Foundation Trusts, one regulator for NHS Trusts, and  
17 a commissioner with some regulatory powers (ie,  
18 NHS England), the 2022 Act merged all of those into  
19 a single function.

20 **LADY JUSTICE THIRLWALL:** And I suppose at some  
21 point the question that will be asked is: what are  
22 governing bodies adding? Because if they are adding  
23 something, why haven't NHS Trusts got them and if they  
24 are not adding something, why have we got them?

25 Anyway, I am not asking you to answer that. It is  
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1 **A.** Yes.

2 **LADY JUSTICE THIRLWALL:** -- of the way the NHS is  
3 run. So we have got the governing bodies for Foundation  
4 Trusts but not in relation to NHS Trusts.

5 **A.** (Nods)

6 **LADY JUSTICE THIRLWALL:** It's not apparent what  
7 they add in terms of patient safety. I can see what  
8 they add in terms of public accountability. But is  
9 there anything that the governing bodies add in terms of  
10 patient safety that they don't have in NHS Trusts?

11 **A.** Other than that general oversight that we have  
12 discussed earlier, not specifically, nor in the  
13 responsibilities that they have. I would say I'm not an  
14 expert on the governance of Foundation Trusts. I did  
15 work in a Foundation Trust.

16 So over and beyond the responsibilities they have  
17 that I have described, I don't think there is any  
18 specific responsibility. But, again, we can go and  
19 check to make sure that is a correct interpretation.

20 **LADY JUSTICE THIRLWALL:** If there is --

21 **A.** That is not to say that that, that their  
22 ability to ask questions and be curious is not  
23 important. But, as I said earlier, fundamentally this  
24 is the role of boards of Executives and Non-Executives.

25 **LADY JUSTICE THIRLWALL:** Yes. Yes, and that must  
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1 just simply an observation one could, I think,  
2 legitimately make.

3 **A.** Yes.

4 **LADY JUSTICE THIRLWALL:** And it may or may not be  
5 important.

6 **A.** Yes, that would be a reasonable observation  
7 and probably one for Government rather than NHS England.

8 **LADY JUSTICE THIRLWALL:** Yes, you or me.

9 Do no harm: we are all familiar with it. And  
10 I don't know if you read the evidence of Mr Jarrold, who  
11 had produced a Code of Conduct back in the early 2000s.

12 **A.** Yes.

13 **LADY JUSTICE THIRLWALL:** And his first proposition  
14 was really quite an elegant description of or exposition  
15 of "do no harm" and we know that that Code of Conduct  
16 rather fell away.

17 I haven't had a chance to check during the break  
18 that we had. In these competencies for board members,  
19 does that feature anywhere, that kind of -- the sort of  
20 fundamental position?

21 **A.** I would have to have another look to give you  
22 the detail but what I was, I think, trying to expose  
23 earlier was that, in my experience, for the overwhelming  
24 majority or all of Senior Executives that requirement to  
25 provide safe services is paramount and Chief Executives  
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1 above all worry about ensuring that they have safe  
2 services.

3 Yes, there are always competing pressures,  
4 financial pressures, pressures of where resources are  
5 deployed, but a fundamental feature of healthcare, in  
6 a sense, is its ability -- you know, in the nature of  
7 what we do, unfortunately, harm can arise.

8 **LADY JUSTICE THIRLWALL:** Of course it can.

9 **A.** And therefore it is at the front of most  
10 people's minds and not just clinicians.

11 **LADY JUSTICE THIRLWALL:** Yes, but it seemed to me  
12 that it is something that ought to be made explicit if  
13 we are looking at ultimately the regulation of managers.  
14 It's been there forever for doctors and nurses, really.  
15 So that was simply just something I wanted to -- we can  
16 explore.

17 **A.** I am very happy to go and talk to the team who  
18 are developing these and see whether that might need to  
19 be made more explicit.

20 **LADY JUSTICE THIRLWALL:** Yes and you may just want  
21 to pass on to them Mr Kark's observation that the  
22 competencies were somewhat aspirational and fuzzy,  
23 rather than, as he had expected, concrete and clear.  
24 But, again, that's something I am sure you can take  
25 away.

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1 **A.** Yes, yes.

2 **LADY JUSTICE THIRLWALL:** But it may have been  
3 written by somebody else, I suppose. I just wondered if  
4 we could have a link to that.

5 **A.** Yes, we can provide --

6 **LADY JUSTICE THIRLWALL:** I am sure it must be  
7 there. Thank you.

8 The other thing, doctor, Professor Knight made the  
9 point that within the NHS, and in her experience  
10 recently, new systems are not talking to each other or  
11 old systems are not talking to each other as a result of  
12 which BadgerNet is not being kept up to date with all  
13 relevant information.

14 Presumably you recognise that situation and what's  
15 being done about it?

16 **A.** That was not something that was in my mind, so  
17 I have asked our teams to look into that and to check  
18 that.

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

20 No, thank you very much indeed --

21 **A.** Thank you.

22 **LADY JUSTICE THIRLWALL:** -- Sir Stephen, those are  
23 all my questions and that is the end of your evidence.

24 We are about to finish. I know some will have had  
25 their eye on the train but I think the train that they

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1 **A.** Yes, and there is a balance and my observation  
2 is that competencies also evolve over time. So when  
3 I started training in my specialty, renal medicine,  
4 40 -- well, 30 years ago -- the list of competencies  
5 described was very minimal. Over time they have  
6 expanded, curricula have expanded, as regulation has  
7 evolved.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **A.** So these are never fixed and there is  
10 a balance between being too descriptive and prescriptive  
11 and trying to list absolutely everything, and taking  
12 that more principled approach and getting that balance  
13 right I think is one of the judgments we will need to  
14 make.

15 **LADY JUSTICE THIRLWALL:** Yes, and I have passed on  
16 the evidence.

17 In relation to systems, you mention -- I think you  
18 said there was an app for safeguarding?

19 **A.** Yes. I think counsel might have said that  
20 rather than me but yes.

21 **LADY JUSTICE THIRLWALL:** I think it was in  
22 somebody's statement.

23 **A.** Yes.

24 **LADY JUSTICE THIRLWALL:** I thought it was your  
25 statement.

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1 may have been hoping to get will depart before they are  
2 on it, and I have a few closing observations. Please  
3 don't feel you have to wait for them. I will be about  
4 another three or four minutes, but you are free to go if  
5 you want to.

6 **A.** Thank you.

7 Closing remarks by LADY JUSTICE THIRLWALL

8 **LADY JUSTICE THIRLWALL:** Ms Langdale, that  
9 concludes the evidence listed for today and it marks the  
10 end of this phase of the Inquiry.

11 Since we began the public hearings on 10 September  
12 of last year, we have heard live evidence from 133  
13 witnesses. The Inquiry received 396 witness statements  
14 in response to requests made under Rule 9 of the  
15 Inquiries rules. Witnesses were chosen to give evidence  
16 after consultation with all Core Participants and the  
17 evidence has been directed to all of the Terms of  
18 Reference and the questions in the annex.

19 Two witnesses did not attend because of illness.  
20 Transcripts of the evidence given in the hearings are on  
21 the Inquiry website.

22 I am grateful to witnesses who came to give  
23 evidence and I am particularly indebted to the many  
24 Parents who provided witness statements and/or gave oral  
25 evidence of the terrible events and experiences in 2015,

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1 2016 and ever since. Their powerful evidence is an  
2 enduring reminder of the reason for this Inquiry.

3 Where a witness has not given evidence, the Inquiry  
4 legal team have uploaded the statement on to the website  
5 or, where appropriate, they have summarised groups of  
6 statements dealing with similar issues, read them into  
7 the record, and uploaded the summaries on to the  
8 website.

9 Whilst I don't rule out the possibility of any  
10 further live evidence, I am confident that any further  
11 evidence, if there is any, will not be lengthy.

12 I am expecting some additional written evidence  
13 where witnesses have been asked to provide it, and the  
14 last witness is a case in point, but this too will not  
15 be lengthy.

16 The next phase of the Inquiry is the preparation  
17 and submission by the Core Participants of their written  
18 closing submissions. They will be permitted to  
19 supplement them in oral submissions on 17 and 18 March  
20 in this building.

21 I have directed that the written documents be  
22 submitted to the Inquiry legal team on or before  
23 28 February and the timetable for the hearings will be  
24 set once we know how many people wish to speak and how  
25 long they expect to take.

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1 completed in accordance with the timetable. Thank you.

2 There is a great deal more to do, as you know. We  
3 will adjourn now and start again at 10 o'clock on  
4 17 March 2025. Thank you, all.

5 (4.38 pm)

6 (The Inquiry adjourned until  
7 10.00 am on Monday, 17 March 2025)

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1 The arrangements will be largely the same in March  
2 as they have been since September and there will be live  
3 links in accordance with the ruling that I gave in May  
4 of last year.

5 In the remarks at the beginning of this public  
6 hearing, I expressed my thanks to Liverpool City Council  
7 for making the Town Hall available to us. To that,  
8 I should add my profound thanks for the warmth of the  
9 welcome everyone connected with the Inquiry has received  
10 here from all those who work for the Council. They have  
11 helped make everything run very smoothly.

12 I would like to extend my thanks to the team of  
13 volunteers from the Coroners' Court Support Service who,  
14 between them, have been here every day to provide  
15 support to anyone in the building who has needed it;  
16 a total of 23 volunteers who have come from across the  
17 North West and the Midlands to assist. It's been public  
18 service of a very high order to give up so much time at  
19 the busiest, and then the coldest, time of the year.  
20 Thank you. Your kindness and good humour have been of  
21 great assistance to many who have passed through this  
22 Inquiry.

23 Finally, I thank all of those who have been present  
24 in this room and elsewhere doing a huge amount of work.  
25 The result has been that these hearings have been

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[1]</b> 83/18<br><b>Hall [1]</b> 222/7<br><b>hand [4]</b> 3/22 85/25<br>162/7 192/25<br><b>handling [7]</b> 50/25<br>51/9 51/20 84/9 88/3<br>126/16 204/2<br><b>hands [1]</b> 129/6<br><b>happen [8]</b> 25/1 55/8<br>151/9 152/3 157/18<br>193/21 212/18 212/18<br><b>happened [14]</b> 7/17<br>7/18 7/19 16/20 30/19<br>68/4 99/15 105/17<br>105/21 123/8 129/23<br>157/22 201/3 210/9 | <b>happening [9]</b> 3/17<br>4/12 5/9 8/6 9/16 10/2<br>25/4 40/14 104/5<br><b>happens [1]</b> 8/8<br><b>happy [24]</b> 50/15<br>54/13 79/14 89/2 90/4<br>91/3 110/20 131/12<br>131/23 132/16 160/25<br>163/2 178/1 178/3<br>180/17 196/11 196/19<br>198/16 206/23 208/11<br>209/11 210/16 213/10<br>217/17<br><b>harassed [1]</b> 22/8<br><b>harassment [2]</b><br>21/17 22/3<br><b>hard [3]</b> 2/15 3/3 37/5<br><b>Hard Truths [1]</b> 3/3<br><b>harder [4]</b> 4/9 9/17<br>29/22 33/6<br><b>harm [33]</b> 44/3 44/24<br>45/4 45/11 51/23 53/4<br>75/21 82/15 82/24<br>83/17 85/2 87/3 87/4<br>87/12 92/19 109/14<br>112/7 113/19 116/3<br>138/12 138/25 146/10<br>189/19 189/23 190/8<br>190/10 205/19 205/22<br>207/4 209/16 216/9<br>216/15 217/7<br><b>harming [3]</b> 47/2<br>84/13 152/22<br><b>Harold [1]</b> 209/18<br><b>Harold Shipman [1]</b><br>209/18<br><b>Harry [1]</b> 20/16<br><b>Harry Cayton [1]</b><br>20/16<br><b>Harvey [6]</b> 125/16<br>126/2 128/12 133/24<br>134/12 135/24<br><b>has [123]</b> 4/12 5/3<br>7/11 7/16 8/12 12/5<br>12/21 12/25 15/3<br>15/10 16/20 16/24<br>16/25 17/8 18/23<br>18/23 20/6 22/3 22/12<br>22/13 22/17 23/8<br>25/21 27/7 27/9 27/17<br>29/3 29/11 33/24<br>34/23 45/6 45/8 47/3<br>47/7 53/20 57/16<br>58/16 58/23 60/18<br>61/2 62/6 63/6 64/23<br>65/10 65/20 66/10<br>67/10 67/11 67/19<br>69/3 69/4 74/19 77/19<br>78/22 79/16 87/10<br>87/12 90/15 91/20<br>91/22 93/6 93/16 94/5<br>95/7 96/8 97/25 98/8<br>99/20 101/16 101/22<br>102/1 103/8 105/6 |
|----------|--|---|---|--|

|   |   |   |   |  |
|---|---|---|---|--|
| <b>H</b>  | 92/18 93/3 93/10<br>93/20 93/25 94/8<br>99/17 104/22 105/4<br>112/6 142/5 172/21<br>173/8 173/9 188/8<br>207/5 217/5  | 47/22 47/23 69/25<br>71/3 105/23 165/4<br>171/6 186/24 210/14<br>222/18   | <b>how</b> [70] 20/19 24/11<br>38/22 41/22 42/2<br>46/23 51/12 52/12<br>54/7 55/15 56/11<br>62/25 67/5 72/13<br>72/16 73/17 75/17<br>77/2 86/13 88/9 88/23<br>94/16 95/22 96/16<br>97/3 97/20 97/24<br>99/23 102/21 102/22<br>102/23 103/8 104/9<br>104/10 110/14 110/15<br>112/15 112/22 139/3<br>141/22 141/22 142/16<br>145/11 147/21 148/4<br>156/4 166/6 167/1<br>169/15 172/16 180/21<br>180/23 188/4 189/14<br>191/23 198/10 201/22<br>202/25 203/17 204/10<br>204/16 207/22 209/20<br>209/21 210/12 211/8<br>212/17 215/14 221/24<br>221/24 | 132/23 141/1 141/3<br>144/5 146/21 149/9<br>149/13 153/10 163/1<br>163/13 164/22 169/1<br>169/14 174/8 174/8<br>177/23 180/17 183/21<br>184/23 194/1 196/10<br>196/19 198/15 200/17<br>202/11 206/13 206/23<br>208/11 209/7 210/25<br>213/4 213/10 215/25<br>217/17 217/24 219/6<br>220/22 220/23 221/10<br>221/12 |
| <b>has...</b> [50] 114/4<br>120/12 121/10 121/14<br>121/17 122/13 122/15<br>128/23 130/14 144/20<br>147/7 149/4 155/6<br>157/25 158/12 158/24<br>160/1 177/14 178/5<br>179/9 179/11 182/22<br>188/2 188/15 188/21<br>188/22 192/2 192/12<br>195/4 197/10 199/1<br>199/15 199/16 199/19<br>200/9 202/20 203/22<br>204/4 204/8 206/9<br>208/6 210/9 213/19<br>215/14 218/6 220/17<br>221/3 222/9 222/15<br>222/25 | <b>heard</b> [24] 51/11<br>58/22 60/3 60/15<br>62/25 63/18 66/3 75/4<br>78/13 79/21 85/12<br>88/6 104/1 116/19<br>134/18 137/2 140/2<br>149/4 157/8 178/5<br>188/2 207/16 210/9<br>220/12               | <b>higher</b> [4] 67/2 123/1<br>159/3 165/9   | <b>however</b> [9] 10/23<br>44/2 44/2 123/19<br>129/1 129/20 132/24<br>159/6 206/14   | <b>I apologise</b> [1] 40/6<br><b>I appreciate</b> [2]<br>117/13 200/23  |
| <b>hasn't</b> [4] 8/13 19/8<br>55/21 192/17   | <b>hear</b> [4] 80/18 148/7<br>149/19 160/4   | <b>highest</b> [3] 49/4<br>93/18 165/7  | <b>HR</b> [3] 150/21 151/1<br>151/7   | <b>I ask</b> [6] 35/19 77/8<br>168/17 178/24 199/22<br>202/9   |
| <b>hasten</b> [1] 8/2   | <b>hearing</b> [5] 12/15<br>61/2 124/6 147/7<br>222/6   | <b>highly</b> [2] 42/6<br>169/10  | <b>HSSIB</b> [3] 75/5 95/2<br>98/4  | <b>I asked</b> [2] 25/13<br>203/15   |
| <b>have</b> [536]   | <b>hearings</b> [4] 220/11<br>220/20 221/23 222/25  | <b>him</b> [3] 20/17 128/13<br>157/15   | <b>huge</b> [4] 27/6 37/20<br>94/20 222/24  | <b>I assess</b> [1] 32/23  |
| <b>haven't</b> [9] 18/19<br>34/19 58/4 81/6<br>107/23 149/22 158/21<br>215/23 216/17  | <b>heart</b> [2] 193/22<br>193/25   | <b>himself</b> [1] 157/15   | <b>hugely</b> [1] 62/13   | <b>I believe</b> [5] 46/1<br>88/7 137/20 157/14<br>199/4   |
| <b>having</b> [19] 4/18 6/4<br>8/22 27/9 53/2 78/22<br>78/23 80/25 100/3<br>116/11 146/7 148/13<br>150/8 173/1 176/25<br>187/25 201/24 209/4<br>215/15  | <b>heavily</b> [1] 138/1  | <b>hindsight</b> [2] 85/14<br>158/1   | <b>human</b> [1] 13/2   | <b>I call</b> [1] 39/3   |
| <b>he</b> [19] 2/10 2/22 9/4<br>24/25 58/23 60/18<br>128/21 131/16 131/17<br>132/3 132/15 132/17<br>135/25 136/1 157/14<br>178/14 182/15 182/19<br>217/23   | <b>heighten</b> [2] 75/13<br>75/19  | <b>his</b> [13] 2/9 9/3 9/5<br>11/18 11/19 24/24<br>45/7 61/12 61/16<br>134/12 160/4 160/6<br>216/13                  | <b>humour</b> [1] 222/20  | <b>I came</b> [2] 20/9 29/14   |
| <b>head</b> [2] 111/12<br>127/10  | <b>held</b> [5] 59/7 173/16<br>173/19 173/22 174/4  | <b>holder</b> [1] 93/23   | <b>Hunt</b> [2] 61/10 96/18   | <b>I can</b> [20] 30/15<br>30/21 30/23 32/14<br>39/23 49/8 55/4 59/4<br>62/19 65/19 74/21<br>80/9 87/22 100/13<br>108/2 127/11 139/8<br>202/17 212/21 214/7  |
| <b>heading</b> [1] 193/6  | <b>Hello</b> [1] 128/12   | <b>holding</b> [3] 9/11 18/3<br>173/25  | <b>I</b>  | <b>I can't</b> [20] 3/13 15/4<br>17/5 19/17 22/6 24/11<br>27/2 44/20 56/14<br>58/25 61/25 66/24<br>85/3 88/23 90/3<br>108/16 111/20 143/20<br>145/8 157/1  |
| <b>health</b> [40] 1/20 1/23<br>2/7 9/4 16/8 19/6<br>21/14 23/1 23/13 41/4<br>48/8 53/8 58/21 59/6<br>59/16 73/15 74/11<br>76/13 76/20 76/24<br>80/11 83/15 88/5 89/3<br>92/24 94/1 95/20<br>97/22 101/25 112/20<br>114/4 114/5 120/12<br>122/11 138/16 143/21<br>163/19 174/25 189/18<br>195/25  | <b>help</b> [12] 10/8 13/2<br>76/9 86/18 90/6 93/10<br>182/22 185/9 194/14<br>195/8 198/11 204/16   | <b>Home Office</b> [2] 52/6<br>204/21   | <b>I accept</b> [3] 33/6<br>89/25 196/13  | <b>I cannot</b> [2] 110/19<br>111/12   |
| <b>health-providing</b> [1]<br>16/8   | <b>helped</b> [1] 222/11  | <b>Home Office</b> [2] 52/6<br>204/21   | <b>I acknowledge</b> [2]<br>177/2 198/4   | <b>I co-chair</b> [1] 93/4   |
| <b>healthcare</b> [28]<br>19/19 44/3 47/16<br>68/18 73/5 74/7 84/13<br>85/20 87/24 88/4 92/8  | <b>helpful</b> [4] 10/5 16/22<br>56/8 78/25   | <b>honest</b> [5] 11/2 11/24<br>18/13 22/16 106/20  | <b>I actually</b> [1] 183/7   | <b>I commit</b> [1] 56/21  |
|   | <b>helpfully</b> [4] 27/19<br>76/3 81/24 95/16  | <b>honoured</b> [1] 63/4  | <b>I agree</b> [5] 36/12<br>84/10 90/24 131/21<br>208/6   | <b>I contribute</b> [1] 32/21  |
|   | <b>helps</b> [2] 57/25<br>131/12  | <b>hope</b> [7] 32/15 34/25<br>35/7 55/22 87/7 181/6<br>184/23  | <b>I alluded</b> [2] 93/14<br>208/3   | <b>I could</b> [5] 3/8 11/7<br>20/23 148/23 172/3  |
|   | <b>hence</b> [2] 132/6<br>132/15  | <b>hopeful</b> [1] 177/23   | <b>I also</b> [1] 195/10  | <b>I described</b> [1]<br>193/22   |
|   | <b>her</b> [10] 46/24 46/25<br>67/22 75/7 92/2 98/7<br>136/1 199/20 210/3<br>219/9  | <b>hopefully</b> [1] 35/7   | <b>I am</b> [80] 7/15 8/21<br>11/20 12/23 13/6<br>15/22 18/8 19/21 21/6<br>23/21 25/1 27/12<br>30/25 31/12 35/5<br>36/12 36/25 39/11<br>39/15 49/21 59/24<br>61/25 62/18 63/19<br>67/24 71/24 75/6<br>76/11 79/14 83/22<br>89/2 90/4 91/2 102/20<br>109/5 110/20 111/17<br>117/1 117/9 129/11   | <b>I did</b> [2] 23/7 214/14   |
|   | <b>here</b> [26] 5/3 11/3<br>17/15 43/6 48/5 56/18<br>78/20 88/14 89/8<br>92/11 98/2 109/25<br>120/25 123/3 123/17<br>127/14 133/10 153/11<br>174/3 176/12 181/6<br>181/8 188/10 210/9<br>222/10 222/14 | <b>horrific</b> [1] 201/3   | <b>I discovered</b> [2] 9/20<br>24/11   | <b>I do</b> [19] 3/11 13/1<br>19/22 20/15 25/9<br>26/24 31/14 35/7<br>37/10 38/4 75/3 99/21<br>145/9 148/6 188/21<br>188/21 196/7 201/16<br>201/25   |
|   | <b>hesitancy</b> [2] 130/11<br>130/20   | <b>hospital</b> [15] 3/18 6/9<br>37/20 45/20 49/19<br>53/9 58/19 66/8 70/18<br>83/19 91/8 122/8<br>123/15 148/2 201/5 | <b>I don't</b> [36] 7/8 7/24<br>12/3 13/16 15/7 25/22   |  |
|   | <b>hesitant</b> [1] 98/21   | <b>hospitals</b> [8] 2/6<br>60/15 72/4 72/5 93/4<br>120/4 165/3 209/4   |   |  |
|   | <b>hesitation</b> [2] 129/18<br>129/21  | <b>host</b> [3] 150/20<br>158/17 200/6  |   |  |
|   | <b>Hi</b> [1] 131/21  | <b>hour</b> [1] 70/25   |   |  |
|   | <b>high</b> [15] 16/11 32/14<br>33/4 47/16 47/20  | <b>hours</b> [2] 80/1<br>199/17   |   |  |
|   |   | <b>House</b> [2] 8/13 99/25   |   |  |

|                               |                               |                             |                               |                             |
|-------------------------------|-------------------------------|-----------------------------|-------------------------------|-----------------------------|
| <b>I</b>                      | 219/24                        | 68/9 71/10 75/20            | 193/25 196/12 201/7           | <b>Ian Harvey [3]</b>       |
| <b>I don't... [30]</b> 26/10  | <b>I learn [1]</b> 172/1      | 129/12 215/20 219/3         | 201/15 201/24 203/3           | 128/12 133/24 134/12        |
| 29/2 35/14 44/10              | <b>I made [1]</b> 87/17       | <b>I suspect [1]</b> 131/17 | 203/20 204/14 204/16          | <b>IBI [1]</b> 97/24        |
| 44/21 54/16 62/3              | <b>I make [1]</b> 30/14       | <b>I take [2]</b> 81/19     | 207/16 208/1 209/6            | <b>ICB [1]</b> 197/3        |
| 62/13 76/6 90/5 124/2         | <b>I may [11]</b> 9/17 12/1   | 189/12                      | 213/9 216/1 216/22            | <b>ICBs [2]</b> 68/24 68/25 |
| 127/10 130/11 130/20          | 15/22 47/13 56/10             | <b>I thank [1]</b> 222/23   | 218/13 218/17 218/19          | <b>idea [5]</b> 9/3 29/21   |
| 132/18 133/14 148/10          | 65/18 73/25 80/18             | <b>I think [217]</b> 2/14   | 218/21 219/25                 | 52/21 55/24 66/19           |
| 154/5 155/19 164/13           | 90/7 211/4 211/5              | 2/18 2/23 4/10 4/13         | <b>I thought [7]</b> 5/1 7/7  | <b>identification [2]</b>   |
| 177/7 181/3 182/23            | <b>I mean [9]</b> 34/16       | 5/16 5/21 6/7 6/18          | 15/6 22/17 24/12 38/2         | 78/7 78/20                  |
| 187/11 191/15 198/6           | 35/24 71/9 79/25              | 7/11 7/12 9/2 9/4 9/6       | 218/24                        | <b>identified [21]</b> 3/3  |
| 201/18 214/17 216/10          | 91/14 134/17 168/2            | 9/7 9/8 9/13 10/3 10/4      | <b>I understand [9]</b>       | 4/14 4/14 46/20 46/23       |
| 221/9                         | 207/2 213/23                  | 10/11 12/5 12/8 14/14       | 33/11 33/15 34/23             | 51/19 121/17 122/19         |
| <b>I every [1]</b> 172/2      | <b>I meant [2]</b> 164/17     | 15/10 16/2 16/3 17/4        | 39/24 65/5 67/23              | 123/19 123/21 126/13        |
| <b>I expected [1]</b> 33/5    | 211/19                        | 17/6 17/9 17/15 17/17       | 136/16 137/12 169/13          | 127/18 127/22 128/1         |
| <b>I explained [1]</b> 113/2  | <b>I mention [1]</b> 209/3    | 18/8 18/19 19/17            | <b>I understood [1]</b>       | 134/5 139/20 184/10         |
| <b>I explained [1]</b> 113/2  | <b>I mentioned [3]</b>        | 19/20 20/2 20/6 21/11       | 122/17                        | 191/19 194/25 197/6         |
| <b>I expressed [1]</b> 222/6  | 177/20 208/24 209/1           | 22/3 22/5 22/9 24/12        | <b>I very [1]</b> 34/24       | 197/21                      |
| <b>I faced [1]</b> 8/21       | <b>I might [3]</b> 94/12      | 25/2 25/16 26/23 27/4       | <b>I want [1]</b> 49/24       | <b>identify [4]</b> 22/18   |
| <b>I find [2]</b> 32/11 33/4  | 116/15 169/24                 | 27/7 27/13 27/24 28/3       | <b>I wanted [1]</b> 217/15    | 105/14 132/5 189/6          |
| <b>I found [2]</b> 23/5 25/15 | <b>I misheard [1]</b>         | 28/10 28/19 29/2            | <b>I was [19]</b> 8/24 9/22   | <b>Identifying [1]</b>      |
| <b>I frequently [1]</b> 60/24 | 139/10                        | 29/16 30/22 31/3 31/7       | 14/25 17/4 17/10              | 115/22                      |
| <b>I gave [1]</b> 222/3       | <b>I missed [2]</b> 41/25     | 33/7 33/10 33/15            | 17/21 19/13 25/12             | <b>ie [2]</b> 111/9 215/17  |
| <b>I give [1]</b> 73/25       | 57/7                          | 34/21 35/1 35/23            | 25/14 28/14 35/18             | <b>if [235]</b>             |
| <b>I go [3]</b> 72/11 190/6   | <b>I move [1]</b> 189/8       | 36/10 36/12 36/18           | 37/7 59/10 77/20              | <b>if it [1]</b> 132/24     |
| 209/13                        | <b>I note [1]</b> 60/12       | 37/14 37/16 38/2 38/7       | 78/10 139/17 175/13           | <b>IH [2]</b> 127/15 127/17 |
| <b>I had [2]</b> 13/15 38/9   | <b>I noted [1]</b> 96/18      | 38/15 38/17 38/20           | 208/5 216/22                  | <b>ill [1]</b> 91/9         |
| <b>I have [64]</b> 4/6 12/2   | <b>I now [1]</b> 35/20        | 42/6 42/18 43/6 46/14       | <b>I wasn't [1]</b> 88/22     | <b>illness [3]</b> 86/12    |
| 13/14 17/20 24/23             | <b>I only [1]</b> 34/4        | 52/7 52/19 52/20 55/9       | <b>I will [17]</b> 33/1 49/25 | 105/10 220/19               |
| 32/24 32/25 34/3              | <b>I outlined [2]</b> 114/10  | 55/16 55/17 57/12           | 69/16 71/25 79/15             | <b>immediate [5]</b> 82/21  |
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| 84/17 89/18 93/5              | <b>I put [2]</b> 66/13 163/7  | 85/9 87/4 88/6 89/14        | <b>I wish [1]</b> 34/7        | 150/12 160/5 167/7          |
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| <b>S</b> | 71/12 82/4 91/6 94/12<br>97/17 102/25 107/18<br>109/25 110/6 111/20<br>114/3 116/6 127/25<br>140/14 141/18 141/24<br>143/10 144/3 146/1<br>156/8 157/24 166/11<br>169/4 170/12 171/8<br>178/25 180/1 186/21<br>189/17 190/10 196/7<br>198/25 199/22 201/10<br>202/23 203/24 208/11<br>211/21 211/24 213/10<br>213/18 214/13 214/21 | <b>Secretary [2]</b> 23/13<br>102/1<br><b>section [6]</b> 10/8<br>106/16 107/3 119/25<br>137/9 164/2<br><b>section 2 [1]</b> 119/25<br><b>sections [2]</b> 5/11<br>91/13<br><b>sector [6]</b> 29/25<br>164/5 165/8 165/17<br>165/25 167/20<br><b>sectors [5]</b> 165/8<br>167/16 168/8 171/9<br>172/12<br><b>secure [5]</b> 50/25 51/5<br>51/9 51/20 166/6<br><b>security [2]</b> 52/2<br>52/25<br><b>see [113]</b> 4/4 4/5<br>17/4 17/11 17/13<br>20/22 21/6 26/6 30/9<br>31/24 32/16 35/6 36/8<br>36/21 38/2 38/22<br>41/12 51/7 51/18 53/9<br>54/6 57/18 64/22<br>65/23 70/7 76/6 79/17<br>81/23 82/2 83/17<br>85/21 85/23 86/8<br>86/11 86/15 88/11<br>88/12 89/9 91/10<br>99/19 100/23 101/4<br>102/7 107/6 108/2<br>109/10 110/18 110/21<br>111/14 112/15 114/16<br>114/24 115/1 115/19<br>116/4 117/17 119/25<br>120/14 120/15 120/24<br>122/2 122/3 122/6<br>123/9 125/14 126/6<br>128/6 128/8 129/12<br>129/17 129/22 130/8<br>130/14 131/2 131/15<br>133/10 133/23 134/4<br>135/7 135/23 136/2<br>136/19 141/7 145/25<br>149/21 150/13 156/19<br>162/22 163/3 163/11<br>163/18 163/21 163/23<br>163/25 164/4 164/21<br>176/7 177/17 181/17<br>182/5 182/8 191/5<br>191/18 192/7 194/11<br>204/16 204/19 208/10<br>209/7 212/21 213/11<br>214/7 217/18<br><b>see December 2023</b><br><b>[1]</b> 115/19<br><b>seeing [6]</b> 28/19<br>64/24 123/3 127/11<br>135/13 144/10<br><b>seek [8]</b> 14/5 15/24<br>103/16 109/3 142/19<br>178/14 180/13 196/4<br><b>seeking [3]</b> 11/4 | 159/22 180/3<br><b>seem [3]</b> 17/5 79/20<br>182/16<br><b>seemed [1]</b> 217/11<br><b>seemingly [1]</b> 128/24<br><b>seems [4]</b> 14/15<br>33/22 35/25 90/1<br><b>seen [19]</b> 43/9 44/9<br>62/23 78/22 109/19<br>117/3 117/7 117/14<br>125/21 126/4 126/24<br>138/19 144/3 157/2<br>160/5 160/17 195/11<br>195/12 211/16<br><b>sees [1]</b> 57/2<br><b>Select [5]</b> 8/13 9/5<br>23/1 99/25 174/21<br><b>sender [1]</b> 136/22<br><b>senior [33]</b> 10/19<br>19/19 19/25 20/7<br>27/16 28/1 37/6 44/8<br>88/25 106/6 136/12<br>136/12 142/18 158/21<br>162/16 163/6 163/7<br>163/9 166/9 166/12<br>167/13 170/9 172/10<br>172/16 173/5 173/18<br>174/10 174/13 189/22<br>190/5 198/8 201/18<br>216/24<br><b>seniority [1]</b> 170/21<br><b>sense [10]</b> 73/2<br>78/18 110/10 110/24<br>159/5 168/14 187/5<br>200/11 215/11 217/6<br><b>sensible [2]</b> 88/13<br>122/23<br><b>sent [3]</b> 84/24 124/12<br>124/15<br><b>sentence [1]</b> 192/18<br><b>separate [4]</b> 24/1<br>80/3 82/12 163/16<br><b>separated [1]</b> 53/6<br><b>September [13]</b><br>23/12 26/9 60/22<br>62/10 120/13 121/7<br>121/12 122/6 122/12<br>156/18 177/14 220/11<br>222/2<br><b>September 23 [1]</b><br>23/12<br><b>sequence [1]</b> 131/14<br><b>series [4]</b> 113/18<br>126/15 130/25 191/12<br><b>serious [57]</b> 18/24<br>19/4 20/11 21/14<br>21/21 22/1 22/11 24/1<br>27/23 29/19 30/14<br>42/13 42/14 94/14<br>102/21 103/4 104/19<br>104/22 105/3 105/24<br>106/10 106/17 106/19<br>106/24 107/5 107/6<br>107/11 107/12 107/14 | 108/3 108/5 108/12<br>109/5 109/25 110/3<br>110/4 110/9 110/20<br>111/6 111/18 112/8<br>117/15 117/24 118/1<br>118/11 118/14 118/21<br>118/21 119/1 129/5<br>137/6 138/8 139/17<br>146/3 155/17 192/12<br>194/4<br><b>seriously [2]</b> 21/21<br>29/15<br><b>seriousness [1]</b><br>52/15<br><b>servant [1]</b> 25/6<br><b>servants [2]</b> 25/5<br>165/8<br><b>serves [1]</b> 63/23<br><b>service [11]</b> 21/15<br>71/25 73/7 74/5 105/8<br>165/15 167/16 180/21<br>201/15 222/13 222/18<br><b>services [20]</b> 58/7<br>66/11 68/6 68/13<br>68/13 68/13 68/16<br>69/9 69/15 70/13<br>71/13 98/11 98/12<br>145/19 172/23 181/9<br>182/11 186/4 216/25<br>217/2<br><b>session [1]</b> 184/5<br><b>set [61]</b> 2/3 2/14 3/9<br>3/16 10/8 10/16 12/12<br>15/19 23/8 26/10<br>26/24 28/18 29/23<br>33/1 37/15 46/19 60/6<br>60/13 70/17 70/21<br>72/6 72/18 73/4 74/13<br>75/2 76/3 77/24 87/9<br>93/6 97/21 103/18<br>110/12 112/22 113/16<br>114/25 117/23 118/16<br>123/6 126/17 137/10<br>137/24 142/7 147/14<br>148/4 152/14 153/3<br>154/7 167/25 168/1<br>173/10 175/18 179/10<br>180/25 181/5 182/10<br>187/16 196/24 205/23<br>205/24 213/23 221/24<br><b>sets [8]</b> 31/22 77/2<br>77/11 86/4 98/17<br>111/25 115/20 176/16<br><b>setting [12]</b> 19/1<br>23/14 47/21 71/14<br>71/17 78/19 88/4 99/7<br>115/8 121/9 196/23<br>202/15<br><b>settings [5]</b> 47/3 48/1<br>48/24 115/12 115/13<br><b>settlement [17]</b> 4/17<br>4/19 10/15 10/22 11/1<br>11/12 12/7 12/17 13/4<br>13/25 14/3 14/11 |
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169/10<br>169/25 171/5 172/13<br>173/10 174/16 176/19<br>179/2 179/5 179/9<br>179/11 179/12 182/22<br>187/22 201/18 215/1<br>216/10 217/17 220/22<br>220/24 222/10 222/13<br>222/15 222/16 222/21<br>222/23<br><b>who's [2]</b> 135/25<br>208/21<br><b>whole [13]</b> 22/14<br>29/21 34/19 70/1<br>118/22 145/7 145/15<br>150/20 156/11 158/17<br>161/9 175/18 201/8<br><b>whom [2]</b> 27/14 50/9<br><b>whose [1]</b> 128/23<br><b>why [42]</b> 2/25 7/2 7/3<br>15/4 15/4 20/9 21/24<br>26/20 29/14 36/7 36/8<br>44/20 52/1 58/4 58/13<br>63/6 69/23 74/17 84/6<br>84/17 89/9 89/10<br>97/12 98/14 99/18<br>103/7 108/15 111/8<br>123/6 149/20 161/7<br>161/15 162/11 174/23<br>175/2 176/3 199/22<br>203/15 205/6 211/21<br>215/23 215/24<br><b>wide [6]</b> 21/12 34/17<br>35/5 110/8 172/22<br>194/10<br><b>widely [5]</b> 43/4 47/15<br>84/7 87/6 170/6<br><b>wider [3]</b> 12/9 117/21<br>176/1<br><b>will [126]</b> 6/16 13/9<br>19/2 20/1 26/23 27/12<br>27/15 29/6 29/6 29/7<br>29/8 29/9 29/22 31/24<br>33/1 33/18 35/1 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|--|--|--|--|
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[16]</b> 179/20<br/>180/9 180/20 183/22<br/>184/20 189/18 194/17<br/>196/12 198/11 200/14<br/>200/18 202/15 209/4<br/>212/4 212/19 219/9</p> <p><b>without [4]</b> 95/17<br/>107/22 132/19 161/6</p> <p><b>witness [16]</b> 1/11<br/>38/10 38/15 38/18<br/>39/3 45/6 58/22 68/4<br/>198/21 198/24 199/23<br/>202/16 220/13 220/24<br/>221/3 221/14</p> <p><b>witnesses [10]</b> 35/23<br/>96/14 116/19 169/24<br/>195/22 220/13 220/15<br/>220/19 220/22 221/13</p> <p><b>women [2]</b> 64/23<br/>181/19</p> <p><b>won't [5]</b> 13/7 15/12<br/>25/1 84/23 198/22</p> <p><b>wonder [9]</b> 19/6<br/>21/24 37/21 65/6<br/>80/13 139/8 183/20<br/>184/8 212/25</p> <p><b>wondered [2]</b> 30/5<br/>219/3</p> <p><b>wondering [1]</b> 36/13</p> <p><b>Woods [2]</b> 101/10<br/>151/6</p> <p><b>woolly [1]</b> 38/4</p> <p><b>wording [1]</b> 3/14</p> <p><b>words [17]</b> 14/14<br/>15/6 36/19 40/1 42/14<br/>71/22 89/11 107/25<br/>116/21 142/9 148/23<br/>150/12 190/24 192/25<br/>199/12 207/20 211/20</p> <p><b>wordy [3]</b> 35/24 38/3<br/>195/23</p> <p><b>work [76]</b> 7/9 7/13<br/>17/25 40/11 47/7<br/>54/13 54/14 60/9<br/>60/17 61/17 62/12<br/>64/4 64/12 64/13 66/1<br/>66/2 66/8 66/23 67/19<br/>67/25 69/9 69/16 70/8<br/>70/9 70/15 74/19 80/9<br/>87/15 87/17 88/10<br/>92/23 93/1 93/5 94/16<br/>94/22 95/3 97/9 97/12<br/>97/18 97/24 98/3 98/5<br/>98/7 98/8 98/15<br/>116/12 117/8 138/1<br/>144/22 147/6 148/13<br/>148/17 148/25 155/23<br/>165/23 172/17 174/9<br/>177/8 180/6 181/23<br/>182/1 182/23 183/3<br/>194/12 194/14 195/3<br/>197/4 198/9 200/13</p> | <p>200/14 200/20 201/13<br/>201/23 214/15 222/10<br/>222/24</p> <p><b>workable [1]</b> 177/3</p> <p><b>workaround [1]</b> 66/5</p> <p><b>worked [1]</b> 45/22</p> <p><b>workers [1]</b> 207/5</p> <p><b>workforce [10]</b> 63/11<br/>63/15 63/24 65/2<br/>65/24 66/9 69/20<br/>181/25 182/2 182/3</p> <p><b>working [13]</b> 1/21<br/>6/11 57/5 57/9 65/11<br/>76/16 91/5 95/21<br/>97/11 155/8 181/19<br/>201/22 207/19</p> <p><b>works [3]</b> 51/12<br/>151/19 201/25</p> 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220/12 222/4<br/>222/19</p> <p><b>year's [1]</b> 25/8</p> <p><b>yearly [1]</b> 201/9</p> <p><b>years [25]</b> 5/14 9/8</p> | <p>9/19 9/23 40/3 45/3<br/>58/6 63/9 65/9 67/3<br/>67/3 68/11 68/16 69/3<br/>72/13 91/22 100/9<br/>101/8 137/25 144/4<br/>144/9 159/23 160/12<br/>171/25 218/4</p> <p><b>years' [1]</b> 65/12</p> <p><b>yes [198]</b> 1/4 1/14<br/>1/25 2/8 5/24 8/9<br/>12/24 15/21 17/3 18/6<br/>18/11 18/22 19/21<br/>20/14 21/8 23/3 23/23<br/>24/12 24/23 27/4 27/6<br/>30/3 31/13 31/21<br/>32/20 33/9 34/9 36/2<br/>36/11 36/12 36/16<br/>36/20 36/23 37/9 38/6<br/>38/17 40/2 45/12<br/>45/15 45/17 47/11<br/>50/4 50/20 50/20<br/>50/22 50/23 53/1 53/7<br/>53/13 54/11 54/21<br/>55/3 56/3 56/7 56/19<br/>56/23 59/24 65/22<br/>66/12 66/22 67/14<br/>68/2 68/7 68/12 69/22<br/>72/2 75/8 75/15 75/18<br/>75/23 75/25 77/10<br/>77/15 77/18 78/3 78/9<br/>79/1 80/5 86/20 87/8<br/>87/14 88/5 89/23<br/>89/23 90/3 90/5 90/20<br/>90/24 92/3 92/21<br/>95/13 96/18 98/14<br/>98/21 101/14 102/19<br/>102/24 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82/14<br/>82/20 83/19 85/19<br/>86/10 89/22 91/18</p> <p><b>younger [1]</b> 64/24</p> <p><b>your [112]</b> 1/9 1/13<br/>2/3 2/25 5/19 5/22<br/>5/22 6/15 6/17 6/25<br/>7/2 7/4 8/23 8/25 9/1<br/>9/14 9/25 10/10 10/11<br/>10/12 10/16 10/17<br/>11/3 11/22 13/17<br/>15/16 15/16 15/18<br/>15/19 16/22 18/12<br/>18/14 19/9 20/18<br/>20/24 21/1 21/9 21/25<br/>22/21 22/23 22/24<br/>22/25 23/14 23/16<br/>24/9 24/9 24/20 24/21<br/>24/25 25/2 25/7 26/1<br/>26/3 26/11 26/11<br/>26/12 26/20 27/19<br/>28/3 31/25 32/1 32/9<br/>32/10 32/19 33/8<br/>33/24 33/25 34/2 34/5<br/>34/13 39/9 45/9 46/16<br/>46/18 57/23 58/13<br/>76/1 77/9 92/10 98/22<br/>102/25 109/23 114/3<br/>116/21 132/23 137/4<br/>141/19 143/10 145/23<br/>148/13 151/10 152/14<br/>156/12 163/14 165/6<br/>168/24 170/10 176/9<br/>180/24 184/24 190/15<br/>191/3 193/5 193/25<br/>198/2 198/21 199/23<br/>202/16 211/8 218/24<br/>219/23 222/20</p> <p><b>yourself [2]</b> 38/11<br/>91/10</p> |
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