

Tuesday, 7 January 2025

(10.00 am)

LADY JUSTICE THIRLWALL: Welcome back. Ms Brown.

MS BROWN: My Lady, the Inquiry has adopted a proportionate approach to the calling of witnesses to give oral evidence. Witnesses were selected to give evidence following consultation with all Core Participants. With a very few exceptions, the Inquiry has now finished hearing from witnesses whose evidence is relevant to Part B of the Terms of Reference.

Part B is concerned with the conduct of those working at the Countess of Chester during the period June 2015 to May 2017. As the evidence relevant to Part B was heard, documents or sections of documents to which the witness was referred were uploaded to the Inquiry on a daily basis.

In addition, a summary of the evidence from all doctors and a further summary of the evidence of all nurses who had provided witness statements to the Inquiry but were not called to give oral evidence was read into the transcript.

In order to complete the evidence in relation to Part B, the Inquiry will also upload to the website a number of written statements provided to the Inquiry

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Heather Wilshaw-Jones, Senior Clinical Scientist at Liverpool Clinical Laboratories.

Sarah Davies, Senior Clinical Scientist at Liverpool Clinical Laboratories.

Emma Taylor, Director of Children's Services for the Cheshire West and Chester Council.

Helen Brackenbury, Director of Early Help and Prevention, Cheshire West and Chester Council.

Paul Jenkins, the Local Authority Designated Officer for Cheshire West and Cheshire Council.

Sian Jones, business manager for the Local Safeguarding Children Board for Cheshire West and Cheshire Council.

Dr Lawrence Andrew Dickson, Chair of Child Death Review Panel.

David Hunter, interim Chair of Merseyside Child Death Overview Panel.

Mike Leaf, Chair of Lancashire Child Death Overview Panel.

David Milligan, reviewer for the Royal College of Paediatrics and Child Health.

Graham Stewart, reviewer for the Royal College of Paediatrics and Child Health.

Margaret Kitching, Regional Chief Nurse North.

Christine Hurst, Coroner's Officer.

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by the following individuals. I will read out the names of these individuals with their role at the relevant period.

Jane Evans, Head of Nursing for Urgent Care, Countess of Chester Hospital, to September 2015.

Mr David Semple, Divisional Leader for Planned Care and Consultant obstetrician at the Countess of Chester Hospital.

Karen Milne, named midwife and Safeguarding Children Lead at the Countess of Chester Hospital.

Sarah Harper-Lea, head of Legal Services at the Countess of Chester Hospital.

Claire Raggett, Executive Office Manager and Executive Assistant to the Chairman and Director of Corporate and Legal Services.

Gill Golt, the head of Communication and Engagement at the Countess of Chester Hospital.

Dr Martin Sedgwick, Divisional Medical Director for Urgent Care and Consultant Physician and Cardiologist at the Countess of Chester Hospital.

Stephen Cross, Director of Corporate and Legal Services at the Countess of Chester Hospital.

Dr Bill Yoxall, Consultant Neonatologist, Liverpool Women's Hospital, and a member of the Cheshire and Mersey Neonatal Network Steering Group.

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Stephanie Davies, Coroner's Officer.

Andrew Bibby, Assistant Regional Director of Specialised Commissioning North.

Erica Saunders, Director of Corporate Affairs Alder Hey Children's NHS Foundation Trust.

Julie McCabe, Director of North West Neonatal Operational Delivery Network.

Kristian Garsed, Regulation Adviser for the NMC, Nursing & Midwifery Council.

Michael Gregory, NHS North Commissioner.

Robert Cornall, NHS North Commissioner and Regional Director for Specialised Commissioning in the north region.

Kirstin Hannaford, Senior Media Adviser to the CQC.

Turning to the coming two weeks, the focus of all evidence which will be called will be on Part C; that is to say on the wider NHS. Given that this evidence deals with NHS structures outside of the Countess of Chester Hospital, and is substantially forward-looking, it is the Inquiry legal team's intention to publish these statements in full unless there is good reason not to.

Such reasons may include matters such as personal sensitive information concerning individuals and material irrelevant to the Inquiry's Term of Reference.

I will now hand over to Ms Langdale KC.

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1 **LADY JUSTICE THIRLWALL:** Thank you very much,
 2 Ms Brown.
 3 **MS LANGDALE:** My Lady, may I call Professor Knight,
 4 please.
 5 **PROFESSOR MARIAN KNIGHT (sworn)**
 6 Questions by MS LANGDALE
 7 **LADY JUSTICE THIRLWALL:** Thank you,
 8 Professor Knight, do have a seat.
 9 **MS LANGDALE:** Professor, can you give us your
 10 qualifications, please?
 11 **A.** An MA from the University of Cambridge, MBChB
 12 from University of Edinburgh, DPhil from the University
 13 of Oxford and Fellowship of the Faculty of Public
 14 Health.
 15 **Q.** And your current employment?
 16 **A.** I am Professor of Maternal and Child
 17 Population Health at the University of Oxford.
 18 **Q.** You kindly provided a statement, Professor,
 19 dated 10 January 2024 and I am going to ask that that
 20 statement is on the screen so people can follow the
 21 questions and answers this morning. INQ0006757
 22 beginning at page 1. Perhaps while that's being put on
 23 the screen, Professor, that was obviously written a year
 24 ago now, this statement, and we will go to parts of
 25 that.

5

1 Tool. So we have much more detailed guidance, we have
 2 worked with parents to develop that guidance further and
 3 that is also new since my statement was written.
 4 **Q.** We will come to that as well in a moment,
 5 thank you.
 6 So if we look then at your statement on the screen,
 7 page 1, can you tell us firstly please about the
 8 Maternal Newborn and Infant Clinical Outcome Review
 9 Programme, what is that intended to do?
 10 **A.** So it is -- it is one of I think about 40
 11 national audits commissioned by the Healthcare Quality
 12 Improvement Partnership on behalf of NHS England and the
 13 devolved nations.
 14 Our remit is to conduct surveillance of all
 15 perinatal deaths, so that's stillbirth and neonatal
 16 deaths up to 28 days of age, as well as maternal deaths,
 17 as well as confidential inquiries into maternal deaths
 18 and selected neonatal deaths or morbidities.
 19 **Q.** If we go to the next page of your statement,
 20 we see at paragraph 3 you set out the surveillance that
 21 MBRRACE undertakes. Where do you obtain the data from
 22 and how is the data obtained?
 23 **A.** So we obtain the data in several ways. So the
 24 initial reports of a death come from the hospital where
 25 the death occurred and that's notified to us through

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1 **A.** Yes.
 2 **Q.** Is there any overview or update you would like
 3 to give us before we begin? Events that happened since
 4 then?
 5 **A.** Yes. So just -- in my statement I refer to
 6 the introduction of statistical process control
 7 functions in the real-time data monitoring tool that we
 8 provide to Trusts, just to say that's all been included
 9 now. So, for example, some of the -- I provided
 10 a screenshot of the viewer back in January last year.
 11 That's been superseded by some of the new functions.
 12 So in addition to the evidence that I provided at
 13 the time, I have provided you with the current version
 14 of the user guide which has some more detail of those
 15 new functions which enable looking at variation unusual
 16 variation in -- in events.
 17 **Q.** We can go to that when we look at the
 18 screenshot. In fact, you can set those out. Anything
 19 else in the broader canvas that you want to comment on
 20 at the outset?
 21 **A.** So the other additional information guidance
 22 for Trusts that's been introduced since my statement is
 23 further guidance and templates for interaction with
 24 parents who have been bereaved, who have -- whose child
 25 has died with regards to the Perinatal Mortality Review

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1 our -- in case of a perinatal death through our online
 2 notification system.
 3 We will then cross-check notifications of deaths
 4 with routinely available statistics. So we get
 5 information for England and Wales from the Office for
 6 National Statistics and from the equivalents in
 7 Northern Ireland and Scotland.
 8 **Q.** Is it mandatory or not for information about
 9 deaths to be provided to MBRRACE?
 10 **A.** It is part of Quality Accounts and also in the
 11 case of perinatal deaths, part of the Maternity
 12 Incentive Scheme, one of the requirements is that all
 13 deaths are notified within seven days to MBRRACE.
 14 **Q.** What level of compliance do you find you have
 15 in respect of that?
 16 **A.** Compliance is good. So in terms particularly
 17 since the Maternity Incentive Scheme requirement came
 18 into place, which is since the events of 2015 and 2016,
 19 we now see nearly 100% of deaths notified within that
 20 time.
 21 **Q.** Would you attribute that to the Maternity
 22 Incentive Scheme?
 23 **A.** That's certainly made a difference, yes.
 24 **Q.** If we look at paragraph 4(b), you refer to the
 25 active communication with parents to ensure they are

8

1 told that a review of their care and that of their baby
2 will be carried out. This is -- how is that done, you
3 have said you have updated that but how do you have that
4 communication?

5 **A.** So that is not our remit.

6 **Q.** Sure.

7 **A.** So this paragraph refers to the Perinatal
8 Mortality Review Tool which is a comprehensive tool for
9 hospitals to use. It includes prompts to consider all
10 aspects of the mother's care and the baby's care, to
11 determine issues underlying the deaths and areas where
12 care can be improved but also to give parents an
13 understanding of -- of why their baby has died.

14 Parent contribution to that process obviously is
15 absolutely essential and -- and yet we were aware that
16 that engagement was not always happening and -- and
17 indeed parents were not always told that a review was
18 even taking place.

19 So beginning from a study conducted called the
20 Parent Study we have developed a succession of materials
21 to enable the hospitals to engage with parents to ensure
22 parents have a named contact, to keep them informed
23 about review processes, to enable them to input
24 questions into the review process and to ensure that
25 they get an output from the review in lay language that

9

1 having -- you know, whether those improvements are
2 genuinely effective.

3 **Q.** Paragraph 7, the next page of your statement.
4 You set out what deaths are reported to MBRRACE. Can
5 you just tell us what deaths are reported and the
6 rationale for those deaths being included?

7 **A.** So our -- our remit is to conduct reviews to
8 conduct surveillance of stillbirths as well as neonatal
9 deaths. Stillbirth is a legal definition, that
10 a stillbirth is a baby born without sign of life --
11 signs of life after 24 weeks of gestation. For
12 a neonatal death the -- the guidance is obviously a baby
13 born with signs of life. There's no gestational age
14 cut-off for that and we know that between 22 and --
15 well, 22 to 24 weeks there is variable responses to the
16 birth of a baby in terms of whether that baby has signs
17 of life and is offered supportive care or offered
18 resuscitation and neonatal intensive care. So we
19 therefore collect information on all births with signs
20 of life from 20 weeks' gestation onwards as well as
21 fetal losses so babies that are born without signs of
22 life at 22 and 23 weeks to make sure we have -- we have
23 got all of the information about -- about all babies
24 because of some of the variations in practice.

25 **Q.** So unlike MOSS, you actually take data in

11

1 is understandable that they can -- that they will have
2 but can also ask questions about.

3 **Q.** And when was that study undertaken?

4 **A.** So the PMRT started in 2018, so the study that
5 was that has informed that took place then but as I said
6 we have also been taking undertaken further engagement
7 in 2024 to update those materials with further
8 interviews with bereaved parents.

9 **Q.** Are you able to measure how effective any
10 improvements have been?

11 **A.** So we have certainly seen improvements in
12 the -- in the numbers, in the proportions of parents who
13 are informed about a review and who have been able to
14 input into their review. So those proportions have
15 increased when we look at the statistics from the
16 Perinatal Mortality Review Tool.

17 There's actually a piece of research funded by the
18 National Institute for Health and Care Research being
19 undertaken at the moment interviewing parents about
20 their experiences of the review process which will give
21 us some more qualitative understanding of whether that
22 has improved experiences for parents. We can -- it's
23 really important we have both a qualitative, so parents'
24 actual reports of their experiences as well as the
25 numbers. We need both to be able to tell whether we are

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1 relation to premature babies, don't you?

2 **A.** We do.

3 **Q.** We will come --

4 **A.** Yes.

5 **Q.** -- to MOSS later but what is your
6 understanding about what that system does or analyses?

7 **A.** So MOSS only takes information about term
8 babies who are either stillborn or died in the neonatal
9 period. Also it includes information about babies who
10 have had brain injury. So a relatively small proportion
11 of babies that die in the perinatal period.

12 **Q.** If we go to the bottom paragraph 9 of this
13 page, and then on to the next paragraph, you tell us
14 about your online reporting system. How does it work?
15 What are the timings of reports that you get from
16 hospitals, who is completing the data? How does it work
17 in practice?

18 **A.** So in each hospital we have a lead reporter.
19 There are usually -- there will be more than one
20 nominated reporter who is able to enter the data but we
21 have a lead neonatal reporter and a lead maternal
22 reporter. They have to complete a notification as
23 I mentioned within seven days, that is part of the
24 Maternity Incentive Scheme and then we have more
25 detailed surveillance data and the requirement for that

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1 is 30 days to complete those data.

2 The additional surveillance data is important to
3 get more understanding around the characteristics of --
4 of the mum and the baby as well as her pregnancy. So we
5 can -- it helps give more nuanced understanding of the
6 characteristics of the babies that are dying. It also
7 helps to make the real-time data monitoring tool more
8 helpful to hospitals to be able to look at the patterns
9 of baby deaths that are occurring.

10 **Q.** We see at paragraph 10 information collected.
11 You set out there that the data has you have just said
12 consists of information about mother and baby. How much
13 information do you get about the death itself? For
14 example, would you expect to receive information about
15 whether the death was sudden, unexpected, or that there
16 was suspicion around a member of staff, would that kind
17 of material be guaranteed through this system?

18 **A.** So we do get basic information about the cause
19 of death as -- as it has been classified by -- by the
20 hospital. We in the MBRRACE surveillance system would
21 not get information about suspicion of a member of
22 staff. We use coded data, it's a code called CODAC
23 which has I think nine broad categories of which one is
24 unknown and indeed other.

25 The -- the data which might have more of the type

13

1 **Q.** Or clinical information?

2 **A.** Exactly, yes.

3 **Q.** I am going to ask that we scroll slowly
4 through the statement so people can read it and then we
5 stop at paragraph 19.

6 (Pause)

7 You tell us at paragraph 19:

8 "Three mortality outcomes are calculated by the
9 MBRRACE UK perinatal team based at the University of
10 Leicester and reported for each organisation:
11 stillbirth, neonatal death and extended perinatal death.
12 These mortality rates are presented in several different
13 ways as a crude mortality rate and as either
14 a stabilised mortality rate or a stabilised and adjusted
15 mortality rate."

16 Can you explain those three terms for us, please:
17 the crude mortality rate, stabilised, and stabilised and
18 adjusted?

19 **A.** So the crude mortality rate is very simply the
20 number of deaths as the numerator over the total number
21 of births in the denominator, so for any one year,
22 that -- that would be the crude mortality rate.

23 We know perinatal deaths are fortunately relatively
24 rare and that does mean that there is some random
25 fluctuation in the data that can make it appear as if

15

1 of information you are talking about would be in the
2 Perinatal Mortality Review Tool -- although, you know,
3 I have to say because the actions of a member of staff
4 in -- in -- you know, when we are thinking about murder
5 is not something that we encounter commonly. The
6 Perinatal Mortality Review Tool has been developed to go
7 through the most -- the care pathways and the most
8 common causes of death that you would expect in the
9 perinatal period. So it does not have a substantial
10 section about homicide, for example.

11 **Q.** Are you aware to what extent unknown features
12 in the coding? Would that trigger anything of any
13 concern, I mean that covers a broad category, doesn't
14 it, of itself?

15 **A.** It is a very broad category and -- and
16 unfortunately we do come to the -- at the end of the day
17 even after a very detailed and thorough review and
18 a postmortem, it is not uncommon particularly for
19 stillborn babies for the cause of death to be unknown.
20 I can't give you a percentage off the top of my head,
21 it's certainly been improving over recent years as -- as
22 postmortem rates have improved.

23 But it is -- the fact that a cause of death might
24 be unknown on its own would not be a trigger for concern
25 in the absence of any other concerning --

14

1 there are very big changes in rates which are partly
2 explained -- could partly be explained by random
3 variation on the basis of small numbers.

4 So the stabilised rate takes into account that that
5 random variation or common cause variation is the
6 terminology used in the NHS Making Data Count guidance.

7 Stabilised and adjusted rate takes into account
8 differences in the population of women giving birth and
9 the population of babies cared for by different
10 hospitals. We know, for example, that large hospitals
11 with a neonatal intensive care unit and a surgical unit
12 will be caring for women who are at higher risk of poor
13 perinatal outcomes more likely to have babies who are
14 sadly more likely to die because, for example, they have
15 congenital anomalies or are born prematurely.

16 So they -- the adjustment we do takes into account
17 some of those characteristics and I have to say only
18 some of those characteristics because we can only adjust
19 for things where we have national information. So we
20 can adjust for maternal age, we can adjust for maternal
21 deprivation and we can adjust for gestational age at
22 birth, but it's a relatively limited number of things we
23 can adjust for.

24 For example, we can't adjust for maternal health
25 conditions which we know will impact on the health of

16

1 her baby because we don't have national information that
2 would allow us to do that.

3 **Q.** Obviously you wouldn't be able to adjust for
4 unknown conditions for the mother or the baby?

5 **A.** No. No, exactly.

6 **Q.** Presumably it's more difficult to make risk
7 adjustments for a newborn infant than it is for a mother
8 where you have got at least the data or more data from
9 her?

10 **A.** Exactly, for a newborn infant we have very
11 limited information other than the gestational age and
12 the sex of the baby which are the two main things.

13 **Q.** If we scroll through, please, the statement to
14 section 2 at paragraph 28.

15 If we continue to scroll down, please to section 2.
16 You tell us here that the report with data for trends up
17 to and including 2015 was released to the Trust on
18 15 June 2017 and the report with trends up to and
19 including 2016 was released on 8 June 2018. So before
20 we look at what signals were or were not generated, can
21 you tell us about that lapse in time, if you like,
22 between the signals themselves and when they are
23 reported?

24 **A.** So as I mentioned we get data from different
25 sources and cross-checking data with the routine sources

17

1 **Q.** In June 2024?

2 **A.** 2024.

3 **Q.** Mm-hm.

4 **A.** So we then processed the data, gave it back to
5 the Trusts to cross-check that they were, that the data
6 were correct in August and gave them all of September to
7 do that. That cross-checking process has several
8 purposes: one of the purposes is checking the
9 gestational age of those babies that I mentioned that
10 are born between 20 and 24 weeks, some of whom would be
11 included in the statistics, some of whom wouldn't.

12 The information we get from the Office for National
13 Statistics also includes terminations of pregnancy which
14 we would exclude from mortality statistics, so that's
15 also part of the cross-checking that goes on.

16 Once we have the cross-checked data, we can then
17 produce the stabilised and adjusted rates which we can
18 then -- which we then publish as I say February the
19 following year. So that is about a 14-month -- 14
20 months from the end of the year in which the babies were
21 born who then subsequently died bearing in mind that
22 some of them will have died in January of 2024 because
23 we use a birth year because the only denominator we have
24 is births and so we use births that occur in the
25 calendar year.

19

1 means that we can't start any of that cross-checking
2 until we get data from those routine sources. So we --
3 and I should say that timeliness has improved slightly
4 since -- since the dates here, so if -- if events were
5 to happen now, the -- the Trust reports -- the Trusts
6 would be getting their reports in February.

7 **Q.** February, which month are you talking about
8 there?

9 **A.** So February of the -- so for deaths of babies
10 in 2015, we would -- let me. So for deaths of babies
11 that occurred in 2023, for example, we will be giving
12 the Trusts their report in February 2025. If I explain
13 the -- so we don't get information from the Office for
14 National Statistics final information until the end of
15 June which we then have to cross-check process and give
16 it back to the Hospital Trusts for them to cross-check
17 their data. So they get data to cross-check in
18 August/September.

19 I am -- if I use current years to make at least --

20 **Q.** Please do?

21 **A.** So -- so I am talking about deaths of babies
22 that were born in 2023. We receive the final data from
23 the Office for National Statistics in June. In fact, we
24 didn't get the Scottish data until a bit later than
25 that.

18

1 So that is the delay for -- for publishing that,
2 that single number. But obviously hospitals have, have
3 access. They -- they know how much deaths are
4 occurring, they have access to the online viewer which
5 shows them how many deaths there have been the
6 characteristics of the deaths that have been reported
7 live time, so there is other information beyond that
8 single report. Now, that was not the case when these --
9 the deaths of these babies occurred.

10 **Q.** Let's look at what was reported and then look
11 at what people could access online now. So if you go to
12 page 9 of your statement. Figures 2 and 3.

13 So tell us what these represent in terms of the
14 data from the Countess of Chester, the death data in
15 2015 and 2016.

16 **A.** So if we look at figure 2, you will see at the
17 bottom the year of birth. So if we look at year of
18 birth 2015, what this presents are the crude rates that
19 I described, so the simple number of deaths occurring as
20 the numerator with the denominator total number of
21 births occurring at that hospital.

22 The top line is extended perinatal deaths which is
23 very simply the total number of stillbirths and the
24 total number of neonatal deaths, so deaths of babies up
25 to 28 days of age.

20

1 The -- the second line in 2015 is the stillbirths
2 so the orange dot there is the -- is the rate of
3 stillbirths and then the red dot below that is the rate
4 of neonatal deaths.

5 For 2016, you can see the rate of stillbirths is
6 apparently much lower whereas the rate of neonatal
7 deaths has overtaken that and remains as a red dot.

8 Figure 3 is the stabilised and adjusted rate that
9 I mentioned so that takes into account random variation
10 as well as some adjustment for the characteristics of
11 mothers and babies that we know about.

12 So you will see that that when you look at the
13 stillbirth line that has removed that apparently big
14 decrease because that -- there is obviously
15 a substantial element of random variation to that and
16 indeed has identified that the stillbirth rate is -- is
17 we categorised it as yellow rather than being green,
18 yellow in this instance being between 5% and 15% lower
19 than the national average.

20 The neonatal death rates although the rates are --
21 don't appear as extreme you will still see that they are
22 both still classified as red, which means that they are
23 more -- in the time this was done 10% more than the
24 average for the group of hospitals which the Countess of
25 Chester belonged to.

21

1 the last -- last set of data that had a red signal.

2 **Q.** Was that within Tier 2s or the same level or
3 generally across?

4 **A.** No, that was across -- across all hospitals.

5 **Q.** So it needs a human to evaluate whatever it
6 means?

7 **A.** It is, exactly. And we can only do -- we can
8 only do a limited number with numbers. What we really
9 need for anything is more information and the review of
10 each baby's care and actually understanding the story of
11 what happened to the baby is essential to actually
12 understand, you know, how we can make a difference, how
13 we can improve care to change what we are doing and --
14 and reduce the -- the death rate.

15 **Q.** If we look, you have also helpfully attached
16 this if we go to INQ0006749, page 91, we see the
17 Countess of Chester red, we see another hospital further
18 down, Kettering General as red. As you say, the red
19 requires evaluation as to what it represents?

20 **A.** Exactly. Yes.

21 **Q.** And if we look at 2016, it's page 96,
22 00067500096.

23 **LADY JUSTICE THIRLWALL:** 6750. We have got --

24 **MS LANGDALE:** So INQ0006750, page 96.

25 Still saying 6749 at the bottom, so it will catch

23

1 We -- we don't compare hospitals against a national
2 rate. We actually compare hospitals against an average
3 rate for the group to which they belong because we know
4 as I mentioned at the beginning that if -- if you are
5 a large hospital with a neonatal intensive care unit
6 where you have lots of extremely preterm babies and
7 a surgical unit those babies will have a higher death
8 rate than babies born at a smaller unit which doesn't
9 have those intensive care facilities.

10 So we compare in -- in five different groups
11 against hospitals of similar characteristics. So the
12 red dot in this instance shows that the rate at the
13 Countess of Chester for neonatal deaths is more than 10%
14 higher than the average for hospitals with similar
15 characteristics in terms of the neonatal care and their
16 birth population.

17 **Q.** Do you classify that as a signal?

18 **A.** It is a signal. The advice we give to
19 hospitals is that they should be reviewing in detail the
20 deaths of the babies that occurred in their care,
21 although that is a recommendation that all deaths should
22 be reviewed.

23 Just worth bearing in mind that the number of
24 hospitals that will have that signal is quite
25 substantial. I think it was 55 for example last year in

22

1 up, won't it?

2 There we have the 2016 position with the orange.

3 **A.** Worth pointing out that that orange is the
4 overall extended perinatal mortality rate in -- in this
5 page that you have noted. At the time these reports
6 were published we didn't do the -- the
7 red/amber/yellow/green colour coding for stillbirths and
8 neonatal deaths separately which we now do.

9 **Q.** Right.

10 **A.** You can see from my statement that it was
11 a red for neonatal deaths in 2016 as well as 2015.

12 **Q.** That can come down if we go back to your
13 statement, which was 0006757, page 10, if we go to
14 paragraph 32. You point out at paragraph 32 that
15 MBRRACE reports neonatal mortality based on place of
16 birth, not place of death.

17 Why is it done in that way? What's useful when
18 collating deaths around place of birth?

19 **A.** So the simple reason is that that is the only
20 straightforward denominator we have. To calculate any
21 rate we need a denominator total number of babies at
22 risk and the only easy easily available denominator rate
23 we have is the number of babies born in a Trust.

24 And we know that babies that are born that become
25 unwell will be transferred elsewhere and because of

24

1 neonatal networks and pathways of transfers of care, we
 2 don't have any easy denominator that would allow us to
 3 calculate a rate for deaths occurring in a Trust and
 4 again this brings me back to statistics can tell us
 5 something but they can't tell us everything and actually
 6 more understanding of the circumstances around each
 7 individual death, whether it occurred at your Trust or
 8 whether it occurred -- whether the mother was cared for
 9 in your Trust but her baby died elsewhere, that's what's
 10 going to give us more information than -- than a simple
 11 rate.

12 But -- but fundamentally the reason we use babies
 13 that were born at your Trust is because we don't have
 14 another denominator to allow us to calculate the rate.

15 **Q.** You mentioned the input of families and
 16 mothers earlier. Do you think the input of parents is
 17 really important in understanding the story?

18 **A.** It's absolutely crucial. You know, listening
 19 to parents, parents have a unique perspective on the
 20 events that surrounded the woman's pregnancy, the baby's
 21 birth as well as the baby's subsequent care. You know,
 22 we -- we need all aspects of care to be assessed and
 23 reviewed and parents' perspectives is absolutely
 24 critical to that.

25 **Q.** If we go to section 3 of your statement, "More
 25

1 On the left-hand side are a range of filters that
 2 can be used to look at different groups of babies to
 3 help potentially look at where there are clusters of
 4 deaths occurring together, the characteristics of those
 5 babies. On this screenshot I have -- I have filtered
 6 the data so it's just showing neonatal deaths but for
 7 the whole of the Trust data it -- it would show, it
 8 would show stillbirths as well.

9 We can look at the next category down, it is around
 10 the timing of death so that will show us whether it is
 11 an early neonatal death or a late neonatal death,
 12 whether the baby was admitted to the neonatal unit and
 13 again I have filtered on this for this example.

14 We can look at how long the baby survived, that is
 15 the next category but perhaps the other one relevant to
 16 thinking about the events at Countess of Chester is that
 17 one can also filter to look at the gestational age at
 18 birth of the babies that had died, which is the next
 19 category. I won't read through all the rest but you can
 20 see all of the other characteristics that we can
 21 potentially use that the hospital can potentially use
 22 to -- to look further at the patterns of deaths that are
 23 occurring in their -- in their hospital.

24 Just going back to reference to our discussion
 25 around causes of death, you will see here what is listed
 27

1 effective use of neonatal data", you tell us since
 2 May 2019 MBRRACE has provided all Trusts and health
 3 boards with a real-time data view which enables
 4 immediate and ongoing monitoring of all still are births
 5 and neonatal deaths reported to MBRRACE UK and the
 6 document you attached was INQ0006755, page 1. If we can
 7 go to that, please, 0006755, page 1.

8 You say this has been updated since. But can you
 9 talk us through, please, what clinicians might be able
 10 to access at the time?

11 **A.** So this is obviously a still screenshot from
 12 what is a live tool --

13 **Q.** Yes, sure.

14 **A.** -- that -- that clinicians and staff can
 15 interact with.

16 If I talk you through very basically what it --
 17 what it is.

18 So you can see a large graph in the middle. What
 19 we present in this graph are the number of days between
 20 deaths. So perhaps counterintuitively a high number, so
 21 a graph that is -- that is presenting a big number is --
 22 is a good thing in this instance because it means there
 23 is a much longer gap between deaths occurring and so
 24 a low number means more deaths are occurring, more
 25 frequently.

26

1 as CODAC Level 1 and CODAC Level 2. Those are the
 2 different levels of the classification of causes of
 3 death, so Level 1 is the nine broad groups and then
 4 Level 2 are sub categories of those groups. So again it
 5 may enable you to see that actually there is a group of
 6 babies who are dying at a particular gestational age who
 7 were born at a particular gestational age and from
 8 a particular cause by using that tool.

9 **Q.** There is some reference to cause then? From
 10 what you are saying, there is some reference to cause
 11 very specific --

12 **A.** Some reference -- exactly, it is based on that
 13 CODAC classification so bearing in mind the events in
 14 question may not be specific enough to be able to, to
 15 pick up the -- the -- these events as being murder. But
 16 would certainly, if it was unclear/unknown, you know,
 17 that would come out from -- you could look at that from
 18 the data viewer.

19 As I mentioned, this -- this has now been modified
 20 and I provided some supplementary information in that we
 21 have now got statistical process control functions built
 22 into this so that the hospital will be able to look at,
 23 to give an indication whether there is any of the
 24 variation that they are seeing is common cause
 25 variation, random variation, or whether it might be
 28

1 special cause variation where there is a more imperative
 2 to actually go and -- and look at what is -- what is
 3 happening around the pattern of deaths.
 4 Although, you know, as I -- and I am sure you will
 5 hear this from Professor Spiegelhalter, with relatively
 6 uncommon events there is a limit to what you can
 7 actually do with statistics. So actually having
 8 somebody at the hospital who has an understanding of
 9 their data is really important but also that review
 10 process for every death, so that actually you are
 11 looking because the Perinatal Mortality Review Tool will
 12 produce a summary report around all of the issues that
 13 have been identified with -- after review of each
 14 individual death, that's got the parents' input into it,
 15 it's got the clinician's input into it, we also
 16 recommend that it has an external review member so there
 17 is an external perspective from another unit included in
 18 the review of all the deaths.

19 And you need that as well. We would never be able
 20 to just use this tool to identify where we need to make
 21 a change, where we need to improve care.

22 **Q.** So when you say somebody at a Trust who
 23 understands their data, so somebody who may say: well
 24 look, we have three, four, now I have got 10 ... they
 25 have a perspective of a unit and understanding their

29

1 will trigger something in your mind that actually
 2 I don't think any of us would -- would look past. You
 3 know, we would all want to understand what is -- what is
 4 happening and that review process will be what will help
 5 us do that.

6 **Q.** We will be hearing from
 7 Professor Spiegelhalter next week but he makes the
 8 observation in his statement that had data been
 9 collected and properly analysed, Dr Shipman could have
 10 been detected as unusual after only around 40 deaths.
 11 But in terms of numbers for individuals, each number is
 12 huge, isn't it, each death is so significant and the
 13 effect of your evidence is that you can't rely on
 14 numbers alone to know what a move from two to three to
 15 seven to nine to 10 means; you need someone who
 16 understands the unit and the babies?

17 **A.** Exactly. We can't rely on numbers alone.
 18 I mean, I -- we talk a lot about evidence-based medicine
 19 and that tends to be numbers but I think we should also
 20 talk about narrative-based medicine and for me there was
 21 an editorial in the -- some years ago now which talked
 22 about narrative-based medicine and not or, for me we
 23 have to have both the statistics and the stories.

24 So I lead the maternal death confidential inquiries
 25 which is globally regarded as the gold standard. There

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1 data, is that relevant to understanding significance of
 2 data?

3 **A.** It is relevant. As I said, we, we can, we
 4 can -- because, because perinatal deaths are trivial
 5 rare, we know that statistics are limited. So you know,
 6 we, we -- in a statistical process control chart,
 7 typically and the Making Data Count guidance is that you
 8 know, it doesn't trigger a signal until six events have
 9 occurred, because by random chance you will get four
 10 events occurring in a row, not uncommonly. And it's
 11 always a balance between the sort of cry wolf, you know,
 12 expecting hospitals to investigate apparent clusters
 13 frequently with picking up a signal of, of when there
 14 really is a concern and we will never be able to have
 15 just one or the other.

16 I -- I don't think hospitals can ever rely solely
 17 on a statistical process control chart, no matter what
 18 it -- what is included and how it's done. And we say
 19 this all the time: all baby deaths need to be reviewed,
 20 need to be reviewed thoroughly and only with that
 21 additional information can we interpret what we see in
 22 a statistical process control chart. If you as
 23 a clinician are in a hospital where you know that one
 24 baby dies maybe you have three, four baby deaths in
 25 a year and then you have three deaths in a month, that

30

1 are 16 maternal deaths per year in the UK. We are never
 2 really going to be able to show a major statistical
 3 change in those deaths but by reviewing every death
 4 telling the women's stories, identifying common areas of
 5 care where we can improve, we have made a huge
 6 difference to the care of women giving birth and we need
 7 the same sort of approach for perinatal deaths.

8 **Q.** If we can take that document from the screen
 9 and go back to your statement please, which is 6757,
 10 page 11, so 0006757, page 11, paragraph 37, you raise
 11 the point that you consider individuals within each unit
 12 should be given responsibility for regulator monitoring
 13 of the data.

14 Can you expand on this for us, please, how do you
 15 think this real-time viewing is that the same as
 16 continuous viewing? Being able to see it as you go
 17 along, if you like?

18 **A.** So I mean at its simplest it is having
 19 a person with the responsibility to actually be looking
 20 constantly at those data. So we know -- so we know how
 21 often the tool is accessed, so we know that there are
 22 some hospitals where it's accessed once every couple of
 23 months. There are some hospitals where it is accessed
 24 several times a week. So that -- but up until now
 25 there's been -- there is nothing that mandates use of

32

1 the tool.

2 I think -- I don't know whether I have confused
3 everybody listening but, you know, I think even -- even
4 in my simple description of the tool I suspect many of
5 you are slightly perplexed and actually to use it
6 properly to be able to look at it, to understand the --
7 the nuance of, you know, the filtering that you can use
8 to get a better understanding of your data, it -- it
9 needs somebody who -- that is part of their role, they
10 have had some of that training and it is not something
11 that can be done as a sideline on top of, you know,
12 full-time clinical shifts. It does need to be somebody
13 with that responsibility.

14 **Q.** And a clinician or not?

15 **A.** It doesn't need to be a clinician. It --
16 clinicians will undoubtedly need to be involved. You
17 know, the -- but it could be a person with a quality
18 improvement background, with analytical expertise but
19 who would need to be able to explain what the data was
20 showing to the clinicians in the unit.

21 One of the advances that -- that I think the --
22 that you will maybe come to later, that the MOSS group
23 has, is developing with us is the governance process
24 around use of the tool so as MBRRACE we have no, we
25 can't -- we have no power to ensure recommendations we

33

1 Professor Knight.

2 I would like you also, please, if we can have on
3 the screen to read the second statement of Dr Murdoch
4 which is INQ0108744, page 1. You have touched upon MOSS
5 which we know is primarily aimed at identifying
6 potential critical safety issues in maternity care and
7 it is still in its development stage. So broadly
8 speaking different from your position at MBRRACE in
9 terms of looking at deaths or neonatal deaths and
10 premature deaths.

11 You nod, but how do they differ, the two tools?

12 **A.** So I think it's important that, that I --
13 I reserve judgment on, on MOSS at the moment and
14 I should say that I am speaking as an individual.
15 I don't have any legal advice and I am not presenting on
16 behalf of an organisation.

17 It is still in development. It is reliant on some
18 routine data and routine data is not always high
19 quality, so I don't know how good it will be. It is
20 reliant on a new notification system which is also still
21 in development and it is relatively limited in terms of
22 the number of deaths included, but the difference from
23 the deaths that we -- from what we have is that it also
24 includes babies who have had a severe brain injury.

25 My understanding of MOSS is that it is designed to

35

1 make are implemented. We have no power to mandate that
2 organisations use the tool. We obviously have some
3 basic training materials but there's really good
4 training materials from NHS England in the Making Data
5 Count guidelines.

6 And part of the what's been developed with the MOSS
7 group is that that governance process would be put in
8 such that hospitals use the data and that there is
9 somebody whose remit it is who is trained to use the
10 data, but they still have to be listened to. So it
11 still -- all of these processes require, you know, the
12 Board to take things seriously when -- when it is being
13 flagged by a person who is looking in detail at the
14 data.

15 **Q.** And you say at paragraph 38 of your statement:
16 "I consider there should be an established
17 escalation route to senior management level to ensure
18 that any concerns are taken seriously and an appropriate
19 action plan put in place."

20 So that's a matter for each Trust managing data as
21 far as you see it --

22 **A.** Yes.

23 **Q.** -- that they can access as they go along?

24 **A.** Yes, exactly.

25 **Q.** That concludes your statement,

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1 look at events occurring on a labour ward. So for the
2 purposes of this Inquiry, it's largely irrelevant in
3 terms of, you know, one wouldn't expect it to be
4 generating a signal in response to events occurring
5 because of a member of staff action on a neonatal unit.

6 On the other hand, we would expect the MBRRACE tool
7 with the statistical process control charts it has now
8 to be able to show where there is that unusual special
9 cause variation which we would expect to trigger further
10 investigation.

11 **Q.** And equally MOSS is developing maternity care
12 signals, that is a good thing too, isn't it, we are
13 comparing apples and pears here --

14 **A.** Exactly, and I think --

15 **Q.** In terms of this Inquiry and a broad range of
16 maternity services?

17 **A.** I think the point that Dr Murdoch makes in her
18 statement, you know, we would never expect one complex
19 organisation to have one single signalling system.
20 I think she likens it to car mechanics; you would expect
21 more than one signalling system.

22 There always has to be a balance, you know, if we
23 have got signals going off, here, there and everywhere,
24 sorry, we are not going to be able to see the -- the
25 most important signals amongst the noise and that's, you

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1 know, some of the reasons for the statistical process
 2 control chart.
 3 So I think recognising that the two things are
 4 different and doing -- doing different things is, is
 5 important. What is a really positive development for me
 6 is as I have already said around the governance process
 7 because it's no use having signalling systems if nobody
 8 knows they are there, nobody uses them but more
 9 importantly nobody responds to them so that governance
 10 process is -- is essential and that's where, you know,
 11 I refer to that in my statement a year ago and I do
 12 think that's a positive development if -- if that
 13 happens as anticipated from -- from what the MOSS group
 14 are proposing.

15 **Q.** Can we just then scroll through this statement
 16 and see if you agree with it. If we go -- we have read
 17 the first page, second page sets out what's the safety
 18 signal system. You have seen this before,
 19 Professor Murdoch(sic) --

20 **A.** Yes.

21 **Q.** -- so we can go at a reasonable pace.

22 **LADY JUSTICE THIRLWALL:** Professor Knight.

23 **MS LANGDALE:** Professor Knight, sorry. We have
 24 seen Dr Murdoch's statement before. If we go to
 25 figure 1, what she sets out at paragraphs 15 to 17,

37

1 **Q.** And if we continue and scroll to paragraph 27.
 2 Dr Murdoch makes the points that MOSS deliberately
 3 doesn't measure preterm deaths or stillbirths because it
 4 was designed to support the improvement of maternity and
 5 neonatal outcomes at term.

6 So MBRRACE will remain the only analysis of that
 7 preterm data?

8 **A.** Yes, exactly.

9 **Q.** If we continue to paragraphs 29 and 30. She
 10 says:

11 "It is common in other sectors to have a number of
 12 signalling systems and data monitoring tools operating
 13 concurrently."

14 Would you agree with that?

15 **A.** So as I said, I think I mean it is -- it is
 16 often a criticism in maternity that there are multiple
 17 organisations inspecting, providing grades, providing
 18 red, amber, green ratings and I think it is always
 19 a balance between -- between signal and noise.

20 I -- I have not been involved in development of the
 21 MOSS, I am not party to the thinking around it. It does
 22 add in the babies with brain injury.

23 But the real-time data monitoring tool could
 24 include those if they were reported to MBRRACE, it could
 25 indeed include deaths beyond 28 days if they were

39

1 would you agree with that?

2 **A.** I guess I -- I don't quite understand why the
 3 real-time data monitoring tool isn't a safety signal
 4 system because it is to me.

5 So I think, I think I -- I wouldn't say that MOS is
 6 the first system of this nature. It is a system.

7 **Q.** For maternity care I suppose it is saying to
 8 be developed for maternity care in a broader context?

9 **A.** So I think for labour ward care which is where
 10 it is designed, but obviously the real-time data
 11 monitoring tool is looking at perinatal deaths the
 12 majority of which will be deaths in relation to
 13 pregnancy and subsequent maternity care. Obviously the
 14 majority of deaths that occur are amongst preterm
 15 babies.

16 **Q.** She does refer at paragraph 17 to the MBRRACE
 17 real-time data monitoring tool providing real-time
 18 monitoring of perinatal deaths et cetera. So -- and
 19 then there is a summary of differences between MOSS and
 20 MBRRACE.

21 **A.** And the key -- well, I mean, it sets it out,
 22 that -- that that is exactly correct, those are the key
 23 differences in terms of the different groups that MOSS
 24 is planning to include versus the real-time data
 25 monitoring tool.

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1 included. I -- I don't know how confusing it's going to
 2 be to hospitals to have two different signalling systems
 3 and I think that that's an important consideration.

4 As I say I haven't seen the training materials. It
 5 will -- it will depend.

6 If it's very different groups of people responding
 7 to the two, then -- then there is potential. But it is
 8 a worry I have of having more than one system in
 9 maternity.

10 **Q.** Dr Camilla Kingdon from the RCPCH told us
 11 there are a number of places where data has to be
 12 provided in neonatal care and she told us that the new
 13 electronic patient healthcare records don't talk to the
 14 BadgerNet system that's used for NNAP, for example. Are
 15 you aware how easy it is for data to be entered in
 16 relation to the MBRRACE system or not?

17 **A.** So we, we still -- so we have our own system.
 18 So the data are entered directly into the surveillance
 19 system we have and it's a regular discussion. You know,
 20 could we get that information from any other source?

21 So we know that there is information in there that
 22 we can't get from other routinely available national
 23 sources of data, say, for example, hospital statistics
 24 or the maternity services dataset. Either the data
 25 items are not all there or they are not well completed,

40

1 so we know we can't get it from that.

2 In theory, we might be able to get the data
3 directly extracted from hospital systems and this is
4 probably where Dr Kingdon's advice comes in -- her
5 evidence came in. All of those systems are different.
6 There are I don't know how many different systems but
7 although there are some different electronic patient
8 record systems that are used across quite a number of
9 hospitals, there's no one system that covers all of them
10 and the way to extract data from each of those
11 individual systems to -- to feed into a surveillance
12 system is -- is very complex.

13 Just to give you an example from a totally
14 different area, I run a national system of surveillance
15 of outcomes following paediatric surgery and we have got
16 a pilot research project funded by the NIHR and it's
17 taken us nearly three years to get to the point of
18 having six hospitals where we have been able to extract
19 data from. Four of them are using the same electronic
20 patient record system to different systems, one of them
21 is having to rely on manual data entry from the -- from
22 the clinicians because they just cannot extract the data
23 from their -- from their electronic system.

24 So -- so it is, it is quite complex to get
25 information from different systems. Not everybody uses

41

1 the joint use of the tools. We don't have any input
2 into developing the MOSS tool.

3 We have provided data for the MOSS group to input
4 into their tool to test it because obviously we do have
5 the perinatal deaths data and the MOSS tool can't go
6 live until they have got data flowing into it which
7 I understand is coming from the single perinatal event
8 notification system which again is still in development,
9 it's not got an anticipated go live date yet.

10 So we -- we definitely worked jointly together and
11 this proposed joint working was sent to me and clearly
12 anything that strengthens the governance around use of
13 the real-time data monitoring tool responding to it is
14 a positive from my point of view. So obviously, you
15 know, I would agree with that.

16 **Q.** So good discussion around governance and joint
17 tools is happening?

18 **A.** Yes. I haven't, as I said, I -- where
19 I slightly hesitate is I don't know how confusing it
20 will be for people to be looking at two different
21 systems.

22 I think probably with -- with regard to and
23 I obviously don't want to -- to teach you your job but
24 with regard to neonatal units and neonatal deaths,
25 particularly of preterm babies, the MOSS system is not

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1 BadgerNet any more. People are moving away from -- from
2 BadgerNet.

3 I -- everybody has heard many stories of NHS IT and
4 the challenges around it but I think we should, we
5 should -- shouldn't under-estimate how difficult it is
6 to get information out of systems. And that's one
7 reason why we have a data entry system of our own so
8 that the data is -- are entered manually.

9 But we have to be conscious of the burden that
10 places on -- on reporters to have to enter that data.

11 **Q.** Thank you. Can we have on the screen please
12 INQ0102043, page 1, and it's an email to you,
13 Professor Knight, from Dr Murdoch. I don't know if it
14 is an email, it is an exhibit to her statement and it is
15 the proposal to work in partnership with MBRRACE on
16 developing procedures.

17 The partnership or discussions. As far as you are
18 concerned, what discussions have you been having this
19 extends to four pages. But what's the position as far
20 as you are concerned?

21 **A.** So there is a joint group which I am not
22 a part of so that -- the -- my colleagues from the
23 University of Leicester are part of the MBRRACE
24 collaboration, are part of that group. And that is
25 largely around the joint governance, the joint training,

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1 going to be relevant because those babies would not
2 be -- their deaths would not be included in that safety
3 signalling system tool.

4 So the -- there shouldn't be that confusion if we
5 were -- if we were talking about events like those that
6 occurred at the Countess of Chester.

7 **MS LANGDALE:** Understood. Thank you,
8 Professor Knight.

9 My Lady, that might be a good time to take a short
10 break.

11 **LADY JUSTICE THIRLWALL:** Very good. We are going
12 to take a 15-minute break and we will start again at
13 11.30.

14 (11.12 am)

(A short break)

15 (11.30 am)

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

17 **MS LANGDALE:** My Lady, Professor Knight, can we
18 have on the screen please INQ0018029. Professor Knight,
19 you have been sent this already. It's a document from
20 NHS England Specialised Commissioning titled "Schedule
21 2 -- The Services."

22 "Service Specifications: Neonatal Critical Care"
23 regarding categories of neonatal critical care and
24 neonatal unit dated March 2024.

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1 If we can move slowly through that document, just
2 so people can see broad headings. Then when we get to
3 page 14 of the document, we see there "Standards for
4 Family Experience, Communication and Facilities."

5 If we could highlight that and scroll down through
6 to the following page. I will give people a chance to
7 see that.

8 (Pause)

9 We see reference to a number of matters including
10 parents, carers must be kept informed, must receive
11 regular updates from all health professionals involved
12 in the care of their baby.

13 And at the bottom:

14 "Family Involvement and Feedback."

15 Third bullet point:

16 "A range of tools must be in place to measure parent
17 experience which balances real-time and retrospective
18 feedback. This must be in a form which can be
19 nationally and regionally benchmarked."

20 You touched upon earlier when you were doing your
21 reviews and speaking of earlier work the need to
22 communicate with parents. You have seen this document.
23 How important do you think this is and do you think this
24 is a very helpful plan setting it out in this way?

25 **A.** So I guess I can only speak from the
45

1 I'm not sure if that really helps answer your
2 question.

3 **Q.** No, no. MBRRACE has been collecting data on
4 maternity and neonatal care over a number of years. Has
5 it noticed any trends in neonatal mortality and, if so,
6 what are they?

7 **A.** So neonatal mortality has gradually decreased
8 over the past few years. Obviously things change,
9 changed slightly with the -- with the pandemic but
10 overall neonatal mortality has gradually decreased. It
11 is a slow decrease that the previous government had
12 a target which I can't remember exactly but we are
13 obviously not on -- not on track to meet that target.

14 And we know that with both neonatal mortality and
15 stillbirths, so perinatal mortality overall, we are,
16 have higher rates than similarly developed nations, so
17 there's always more we can do. The important thing for
18 me, I am a public health physician, so we have to
19 recognise that we can't do everything within neonatal
20 units, we do have to think much more widely than that
21 and think about population health, deprivation other
22 aspects of care which are probably not within the remit
23 of this Inquiry.

24 I think it's perhaps been, we have assumed we can
25 do everything in the hospital and we can't. We do have
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1 perspective of the work I do which is around reviewing
2 the care of babies who have died. Parent involvement is
3 absolutely crucial and I think there are elements of
4 this that -- that absolutely echo what, what we have in
5 our guidance, a named lead who is responsible to -- for
6 receiving and responding to concerns.

7 Communication is obviously at the heart of
8 everything we do as health professionals and making sure
9 that parents are at the heart of the care of their baby
10 through that very basic communication is absolutely
11 going to be central to us providing the best quality
12 care. You know, we know that parents provide elements
13 of care to their babies on the neonatal unit as well
14 as -- as well as staff. So absolutely it is central.

15 What role this guidance will have in terms of
16 changing any culture where that communication is not
17 optimal, I'm not sure. I'm not in the best position to
18 answer that.

19 You know, party -- the discussion we had earlier is
20 that we -- we have undoubtedly seen improvements in
21 involvement of parents in the review processes after
22 they have had a bereavement after they have lost their
23 baby, still work ongoing to see whether that whether
24 their experiences have improved with that. But we do
25 know that more proportionately parents are involved.
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1 to think wider than that but we can still undoubtedly
2 improve care in the hospital and continue to improve
3 care in the hospital.

4 **Q.** Do you think it would be helpful if MBRRACE
5 was able to send information to integrated care boards
6 or share continuous or real-time viewing with integrated
7 care boards?

8 **A.** Yes, absolutely. So we the permissions we
9 have to receive identifiable information come from the
10 Confidentiality Advisory Group of the Health Research
11 Authority and you will forgive my -- I think it's an
12 exemption under section 251 of the Health and Social
13 Care Act. That may have changed so don't -- don't take
14 my word on that.

15 But that, that information can only be used by us
16 for the purposes of producing the mortality rates and
17 the real-time data viewer for Hospital Trusts. When you
18 interact with that real-time viewer, you will see that
19 if you hover over any of the dots on that graph you will
20 see quite a lot of details about individual babies who
21 have died which may enable you to identify that baby and
22 so that means that information can only be used under
23 the terms of our permissions by people in the direct
24 clinical care team, so that's by people in the Trusts.

25 And at the moment, people with oversight either in
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1 integrated care boards or NHS England are not considered
 2 part of the direct clinical care team. So in order for
 3 the viewer to be accessed or usable by them, we either
 4 have to monitor it, we either have to modify it to make
 5 it perhaps less useful and there are -- we would have to
 6 remove any dates. So there are -- there are challenges
 7 in making it usable, but with no potential
 8 identification of individuals. But it's possible.

9 So we could -- we could have a limited version
 10 which could be used by integrated care boards or other
 11 commissioning organisations or --

12 **Q.** So -- sorry.

13 **A.** Or we need a directive from the Secretary of
 14 State which says that it should be used by them. And
 15 that is my understanding of the legal position. I am
 16 not a lawyer, so I will obviously defer to legal teams
 17 on that. But at the moment, because of the governance,
 18 because of the permissions that we have to receive the
 19 data we can't -- the viewer can't be used at -- at an
 20 Integrated Care Board or NHS England level.

21 I think that would be a good thing if it could be
 22 with the caveat that those individuals would need to be
 23 trained to understand the data as well because we --
 24 it's that balance between regularly investigation --
 25 investigating what may be random variation versus

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1 incorporate neonatal care on to the board and would be
 2 responsible for oversight for all matters relating to
 3 neonates, including for example looking at MBRRACE data?

4 **A.** Yes, I -- I'm not sure I have an immediate
 5 answer. I guess my -- my immediate thoughts are that
 6 that person needs to involve maternity as well. So for
 7 me, it should be a maternity and children's champion
 8 because the care of babies starts before they are born
 9 and just including neonatal care and care of children
 10 may be -- may miss some of the vital aspects of care
 11 that we need to ensure are continuing to improve.

12 I think -- I mean, when we are thinking about the
 13 care of children and the care of neonates it is very
 14 different so whether a single individual should cover
 15 all of that -- you know, there is a big difference
 16 between a one-week old and an 18 year old or even 14, 15
 17 year old when -- when children are moving to adult
 18 services.

19 So I -- I think it's challenging to have a single
 20 children's champion, whether it should be a maternity
 21 and early years champion might be perhaps more useful.
 22 I don't know.

23 **Q.** Finally from your perspective, what difference
 24 has it made having a National Clinical Director for
 25 Neonatology?

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1 targeted investigation where there's real concern on the
 2 background of that we should be reviewing and learning
 3 from every death of every baby that happens in all of
 4 our hospitals.

5 **Q.** And why do you say it would be a good thing
 6 leaving aside the modifications and confidentiality
 7 issues and the legislative issues?

8 **A.** ICBs obviously have the remit for
 9 commissioning care and oversight for their whole
 10 population, so need information about the care that is
 11 being -- that is received by their population and
 12 therefore you know and the outcomes of that care for
 13 their population which is why it ... and the real-time
 14 data viewer as I hope it's become clear in the evidence
 15 this morning is much more informative than a single dot
 16 once a year in a report, although we have, you know,
 17 interactive maps, it -- it gives -- and, you know, the
 18 clue is in the name: real-time. So, you know, the lag
 19 is not there in the same way as it is with us publishing
 20 single mortality rates once a year.

21 **Q.** Professor, you may or may not have any
 22 comments to make on my last two questions but I am going
 23 to ask you them in any event.

24 Do you think Hospital Trusts and the Integrated
 25 Care Board should have a children's champion to

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1 **A.** The National Clinical Directors are
 2 an important voice for patient care and at the moment my
 3 understanding is that there is a single Clinical
 4 Director for effectively Children and Young People
 5 throughout years nought to 18 and it -- back to my
 6 previous answer, neonatal care and the care of premature
 7 babies for me is very different from other aspects of
 8 children's care.

9 I have heard the analogy, you know, there is a --
 10 there's a National Clinical Director for every body part
 11 and one single clinical director for all of Children and
 12 Young People, so I think it is an important
 13 consideration and when we know that the majority of
 14 deaths occur in the neonatal period and in infancy,
 15 having an individual with that remit, with that
 16 responsibility, I can see that could add value.

17 **Q.** There is one, there is a director, a National
 18 Clinical Director for Neonatology.

19 **A.** For neonatology --

20 **Q.** Yes?

21 **A.** -- as opposed to Children and Young People.

22 **Q.** But that is not something -- you wouldn't have
 23 dealt with that person or that office?

24 **A.** I think I know -- I now know who you are
 25 talking about but it's not -- it is not a person that

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1 I have had any interaction with.

2 But as I mentioned my -- my -- I lead the maternal
3 side and although I lead the overall programme, the
4 focus of my work is on maternal. So my main interaction
5 as a Clinical Director is for obstetrics.

6 **MS LANGDALE:** Thank you. Those are my questions
7 and I think, my Lady, Mr Baker King's Counsel may have
8 a few more.

9 Questions by MR BAKER

10 **MR BAKER:** Thank you, my Lady. Professor Knight,
11 I ask questions on behalf of two of the Family groups.

12 MBRRACE as an organisation is about reducing risk
13 through audit through the interpretation of data that's
14 provided to it by other people. And so I understand
15 it's not an organisation that carries out its own
16 independent investigations into specific deaths.

17 But what role does it have in identifying patient
18 safety issues and seeking to have those redressed?

19 **A.** So I mean the point of what we do is to
20 improve patient safety in its broadest sense to make
21 sure as I hope has been clear from what I -- from my
22 evidence that we learn from every death of any mother or
23 any baby. As you quite rightly say, we don't have
24 a remit for individual investigations in individual
25 hospitals, but we do have a remit for providing the

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1 care as well as bereavement care after a baby's death to
2 work out where -- where care can be improved as well as
3 to provide the parents with an understanding of why
4 their baby died and that, that for, that's the most
5 important part of the Perinatal Mortality Review Tool.

6 It does produce data by its very nature. The
7 importance, we have -- the -- of the data for Trusts is
8 that there is a -- hospitals can download a report which
9 brings together all of the issues they have identified
10 so that they can report up to the hospital board, so it
11 has that -- that function as well.

12 It is not a tool for us in MBRRACE to collect data.
13 We can analyse some of the data from it, but by and
14 large it is -- it is exactly as you said: for the Trusts
15 to ensure that they are doing a comprehensive review.

16 **Q.** It is a template for investigation?

17 **A.** Exactly, yes.

18 **Q.** Yes. Does MBRRACE receive and analyse though
19 information from Trusts regarding self-identified
20 patient safety issues contributing towards death?

21 **A.** So the Perinatal Mortality Review Tool we
22 produce a report annually, which looks at -- which does
23 look at some of the information about what issues have
24 been identified across all hospitals. So not -- we --
25 we don't look at what has been identified in individual

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1 tools to both hospitals and Trusts to ensure that they
2 can do that in a robust way and that the data that we
3 produce and that are produced through the use of that
4 tool are escalated appropriately to organisations such
5 as NHS England where we have identified concerns.

6 So that is a very important part of what we do.

7 **Q.** So the Perinatal Mortality Review Tool, which
8 is the device that's been used since 2018?

9 **A.** Yes.

10 **Q.** For this purpose, does it serve a dual purpose
11 does it serve a purpose in causing the person collating
12 the data or the organisation collating the data to look
13 at it in a particular way and to interpret its own
14 actions as well as being the conduit by which
15 information is produced to you?

16 **A.** So I think it's important to recognise that
17 the Perinatal Mortality Review Tool is not to collect
18 data and is actually separate from the surveillance data
19 that MBRRACE use but your point is exactly correct, the
20 Perinatal Mortality Review Tool was developed based on
21 a group led by SANDS, the Stillbirths And Neonatal Death
22 charity with the Department of Health to -- to provide
23 a logical and complete set of questions for each Trust
24 to go through around the care of every baby to make sure
25 that they have looked at every aspect of that baby's

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1 hospitals but we will look at where there are broad
2 things, the purpose of that annual report being more for
3 the -- the organisations that are commissioning care to
4 look at where there could be system level improvements
5 that are needed on the basis of the issues that have
6 been identified.

7 **Q.** So in terms of publishing of information, you
8 would obviously publish the crude and adjusted data?

9 **A.** So the -- the Perinatal Mortality Review Tool
10 doesn't produce numbers in that way, so crudely.

11 **Q.** Forgive me --

12 **A.** That is the MBRRACE surveillance data.

13 **Q.** It was the way that I put the question, I am
14 sure.

15 But obviously you have the crude and adjusted
16 mortality data --

17 **A.** Yes.

18 **Q.** -- which is provided to you and as was
19 discussed when Ms Langdale was asking you questions, but
20 also you are provided with information through the
21 Perinatal Mortality Review Tool which enables you to
22 identify broad patient safety trends. So for example if
23 Trusts were reporting a rise in stillbirths due to
24 issues in interpreting CTG traces then that might be
25 something that you would regard as a broad trend but you

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1 wouldn't publish information relating to individual
2 cases and individual Trusts?

3 **A.** That is exactly right, yes, so we don't
4 publish individual -- and I think probably we -- we, you
5 can't interpret PMRT data in terms of trends quite in
6 the same way. But we do certainly summarise the issues
7 that have been identified by Trusts and that has been
8 used to generate national actions, national training.

9 **Q.** So for example you may see that the most
10 common cause self-identified of stillbirth in
11 a particular Trust is the interpretation of CTG traces
12 but again how would you act upon that or how would you
13 seek to address that as a patient safety issue?

14 **A.** So I think we are probably conflating. So the
15 PMRT I go back to, its primary aim is as a tool for
16 Trusts to identify their learning. Thinking about the
17 type of learning that you are talking about, we would be
18 more likely to get that type of learning from
19 confidential Inquiries, where we have undertaken an
20 in-depth investigation of a sample of cases. So, for
21 example, the perinatal -- recent perinatal enquiry
22 report into intrapartum stillbirths identified exactly
23 the point that you have you've identified and the there
24 is a programme, ABC programme which is -- which is now
25 focusing much more on training around CTG

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1 **A.** Yes.

2 **Q.** -- will have somebody carrying out the
3 investigation who is particularly switched on and geared
4 towards patient safety or indeed will bring somebody
5 else in from another Trust to do that?

6 **A.** Yes, exactly, so, so I -- we -- an external
7 perspective, a different eye on things will always be
8 valuable. Even in, you know if -- if one has the best
9 reflective practice, actually having that, that
10 second -- you know, we often talk about fresh eyes that
11 second view, it can only add value. If, if there's
12 nothing that, that they have identified that's
13 different, great. But I -- I think, I don't think, no
14 I think that should always be part of the process.

15 **Q.** Of course, during the time MBRRACE has been
16 around there have been a number of very high profile
17 maternity scandals that have involved a lack of
18 reflectiveness, a lack of proper investigation into
19 issues and have led to Inquiries being undertaken on
20 a more formal basis. I mean, isn't one of the inherent
21 problems with the self-investigation process is that it
22 requires the individual or organisation to be
23 reflective, to have a proper eye towards patient safety
24 and I don't want to say to take those things seriously
25 because I am sure that would be putting it the wrong way

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1 interpretation.

2 **Q.** Yes. Coming back to I think what may be
3 an important point though is that the effectiveness of
4 the templates for investigation, does it not rely
5 inherently upon the Trust's own reflectiveness and
6 indeed willingness to accept patient safety issues?

7 **A.** Your point is a very well made one. One of
8 the recommendations that we make around use of the tool
9 is that there should always be external involvement in
10 the Review Team for exactly that -- that reason that you
11 give: that external perspective brings some of that
12 reflection gets away from sometimes some of the group
13 think that we have when we are in an environment that --
14 that we are used to.

15 And -- and we have seen an increase in the
16 proportion of reviews that involve an external person
17 but that's not 100%.

18 Some good examples of where Trusts in completely
19 different parts of the country have sort of partnered
20 with each other and exchanged external reviewers to
21 enable that -- that external perspective to be there.
22 But that's not mandated and I think it is an important
23 thing, a really important part of the review process.

24 **Q.** Yes. So a Trust that is particularly switched
25 on and geared towards patient safety --

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1 but to actually understand patient safety and the role
2 of their own organisation in effecting it?

3 **A.** Again your point is very well made. It -- to
4 actually understand patient safety and that -- that, you
5 know, picks up on many of the things we have talked
6 about, you can be provided with all -- as many tools,
7 numbers, that you like but unless you understand it, you
8 know how to interpret it, you know your own data, you
9 know when and who to escalate and your concerns are
10 taken seriously, all of the tools in the world won't
11 have any effect.

12 **Q.** And no amount of templates will change
13 a culture?

14 **A.** No, no amount of templates will change
15 a culture. So there has to be, there has to be other
16 mechanisms to change culture and governance processes
17 and that again is one of the positive developments for
18 me over the last year because we -- I have, you know,
19 feel as MBRRACE we have no power to -- to mandate use or
20 use in the right way and indeed making sure that parents
21 are listened to although that's part of the tool, it --
22 you know, it actually takes people at the Trust level
23 to -- to do that.

24 So that is a positive I think of the -- of the
25 development with MOSS that's occurred over the last

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1 year.

2 **Q.** The reporting is incentivised through --
3 effectively it counts as credit towards additional
4 funding if you have proper reporting. Do you think
5 finding out that an organisation was being misreporting
6 or has been withholding information from organisations
7 like MBRRACE should lead to penalties being placed upon
8 that Trust?

9 **A.** So we always cross-check all deaths that
10 occur, so I -- I don't think we could say that -- that
11 information about individual deaths that occurred has
12 been withheld because if we find a death that hasn't
13 been reported, we will include it in the statistics
14 and -- and the hospitals we get the hospitals to check
15 the data so it's -- all deaths are included in MBRRACE
16 statistics.

17 I -- I am assuming that you are referring to where
18 it -- more around the quality of reviews and whether
19 reviews have identified all of the issues.

20 **Q.** Yes.

21 **A.** And we definitely find when we -- when we
22 undertake a confidential inquiry, which is an entirely
23 external process, so all of the reviewers of mothers and
24 babies' care will be external to the organisation where
25 the mother or baby died, we definitely identify more

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1 there may be small numbers of those babies whose deaths
2 we miss.

3 But they are not -- not in the stillbirth and
4 perinatal death statistics.

5 **LADY JUSTICE THIRLWALL:** Thank you. I think you
6 did say something about that much earlier in your
7 evidence.

8 **A.** Much earlier, yes.

9 **LADY JUSTICE THIRLWALL:** Thank you for reminding me
10 about that.

11 Just one other question really arising out of some
12 of what you have said in respect of sort of real-time
13 monitoring and the fact that clearly you need people who
14 are trained to first of all operate and input the
15 appropriate data but also to understand and analyse so
16 there is an interesting question there about who ought
17 to be doing it.

18 Do you know at the moment who does it in the
19 hospitals?

20 **A.** No is the short answer and -- and highly
21 variable between, between hospitals. I mean, I think it
22 does relate a little bit to culture.

23 **LADY JUSTICE THIRLWALL:** Yes.

24 **A.** There are clearly some Trusts where actually
25 it's considered very important, it is a funded role,

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1 issues than are identified by the Trust themselves. So
2 there is still undoubtedly an important -- lots of
3 improvements to the review processes that need to go on
4 locally which is part of the culture that you talked
5 about.

6 **MR BAKER:** Thank you, my Lady I have no more
7 questions.

8 **LADY JUSTICE THIRLWALL:** Thank you very much
9 indeed, Mr Baker.

10 Questions by LADY JUSTICE THIRLWALL

11 **LADY JUSTICE THIRLWALL:** I just want to be clear
12 about something that you said just recently. So you are
13 confident I think from what you said that because of the
14 system of cross-checking, and it may be goodwill from
15 people in the first place, that the death data that you
16 have on MBRRACE is accurate?

17 **A.** Yes. I am going to put a small caveat on
18 that. So the death data that are accurate are
19 stillbirths from 24 weeks onwards and neonatal deaths
20 from 22 weeks onwards.

21 **LADY JUSTICE THIRLWALL:** Yes.

22 **A.** The late fetal losses, so deaths at 22 and 23
23 weeks of babies who are stillborn at 22 and 23 weeks
24 which are not statutorily registrable as stillbirths we
25 have no means of cross-checking the hospital data so

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1 somebody who is used to looking at safety signalling
2 systems has, has done a lot of training, has a voice at
3 board level, not the same for all -- all hospitals and
4 all Trusts.

5 The question was asked: does it have to be
6 a clinician? I don't think it does have to be
7 a clinician. There does need to be -- all of the multi
8 professional team need to be involved when looking at
9 review processes so there needs to be that multi
10 professional team involved but not necessarily just in
11 the -- in terms of having the responsibility for making
12 sure that they are looking at the viewer on a regular
13 basis and interpreting any signals.

14 **LADY JUSTICE THIRLWALL:** So clearly if you have got
15 a culture which says this really matters and money is
16 made available, one can see that that's a real clear
17 commitment --

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** -- to looking at this very
20 carefully.

21 **A.** (Nods)

22 **LADY JUSTICE THIRLWALL:** Where there isn't that
23 same commitment, and we see that I think from what you
24 said earlier, you know, some people don't really look at
25 it from one year's end to the next, it suggests that it

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1 hasn't been accorded any importance by those who are
2 making decisions about the money as a minimum?

3 **A.** (Nods)

4 **LADY JUSTICE THIRLWALL:** Is there anything in the
5 point that when you are dealing with small numbers, in
6 relatively small units, that actually what matters is
7 what happened, the narrative as you were talking about
8 and actually what are the statistics going to add and
9 I am just wondering if that might be the way some people
10 think. Firstly, is that a possibility and if it is,
11 what do you think could or should be done about it,
12 assuming that it's not necessarily a valid approach to
13 take?

14 **A.** Yes, also a very valid point and I think it
15 goes back to my "and not or". Reviewing every baby
16 death to learn and to prevent in any way we can deaths
17 occurring in the future has to be fundamental to the
18 care we are providing whether we have got lots of deaths
19 occurring or few deaths occurring.

20 Your point about there is a limitation to what we
21 can do with statistics is -- is, is valid and I guess
22 I had never thought before about whether people think
23 "well, we won't bother" then it goes back to the "and
24 not or" and, you know, I was going to say in response to
25 your comment about if people aren't using it may be it

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

2 **MS LANGDALE:** My Lady, I hand over to Mr De La Poer
3 for the next witness.

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

5 Mr De La Poer.

6 **MR DE LA POER:** My Lady, the next witness is
7 Mr Ken Jarrold CBE. He has been kind enough to join us
8 in the hearing room before we got to this point and
9 I wonder if he might come forward, please.

10 **LADY JUSTICE THIRLWALL:** Yes, would you come
11 forward, please, Mr Jarrold.

12 MR KEN JARROLD (affirmed)

13 Questions by MR DE LA POER

14 **LADY JUSTICE THIRLWALL:** Thank you, do sit down.

15 **A.** Thank you.

16 **MR DE LA POER:** Please could you give us your full
17 name.

18 **A.** I'm sorry?

19 **Q.** Please could you give us your full name?

20 **A.** Indeed. It's Kenneth Wesley Jarrold.

21 **Q.** Mr Jarrold, is it correct that you provided to
22 the Inquiry a witness statement dated 6 March of this
23 year?

24 **A.** I did.

25 **Q.** Is the content of that witness statement true

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1 shows they don't care, I guess we have to -- we have to
2 accept some responsibility ourselves. Do people know,
3 you know, are we telling the right people that the tool
4 exists? Are we providing the training? And that again
5 is where I think it's a positive of the involvement with
6 the MOSS group and the added governance.

7 **LADY JUSTICE THIRLWALL:** Yes.

8 **A.** So -- so I think we have to -- we have to take
9 both of those in -- in mind and maybe with that, it will
10 then begin to get over the "oh well, statistics can't
11 tell us anything". Well, they can tell us something and
12 actually just looking at them will on its own
13 familiarise us with the patterns that we are normally
14 seeing so that if something unusual, three deaths in
15 three weeks, occurs it makes us much more likely to --
16 to jump and respond and -- and look in much more, much
17 greater depth much more quickly.

18 **LADY JUSTICE THIRLWALL:** Thank you. Anybody want
19 to ask anything arising out of that?

20 **MS LANGDALE:** No thank you.

21 **LADY JUSTICE THIRLWALL:** Professor Knight, thank
22 you very much indeed for coming along and providing such
23 illuminating and helpful evidence. I am happy to tell
24 you you are now free to go.

25 **A.** Thank you.

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1 to the best of your knowledge and belief?

2 **A.** It is.

3 **Q.** Now, before we come to the substance of your
4 evidence I understand there is something that you would
5 like to say.

6 **A.** Thank you. Just as a father and
7 a grandfather, I would like to express my deep sadness
8 about the events that occurred and offer my profound
9 condolences to the Families.

10 **Q.** Now, Mr Jarrold, although not dealt with in
11 your statement, and no criticism is implied by that, you
12 have had a lengthy career involved in the NHS, is that
13 correct?

14 **A.** It is.

15 **Q.** Open-source research tends to suggest that you
16 began life in the NHS in 1969; is that right?

17 **A.** Correct.

18 **Q.** We won't cover the entirety of your career,
19 but no doubt there came a point when you became what is
20 described as a senior manager within the NHS?

21 **A.** Yes.

22 **Q.** At what point was that, please?

23 **A.** Terms vary over the years of course. I would
24 regard it as when I was appointed as the hospital
25 secretary of the Derbyshire Royal Infirmary in 1974.

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1 Others might place it later when I became a district
 2 administrator for the Gloucester Health Authority in
 3 1982.

4 **Q.** Following the dates you have just given us,
 5 did you continue your career in the NHS undertaking
 6 a variety of posts at that level or above?

7 **A.** I did. I retired from full time work at the
 8 end of 2005 early for both personal and work reasons.
 9 I had had a very difficult three years.

10 **Q.** Well, before we reach the point of your
 11 retirement, and we will come to the detail of this in
 12 a moment, is it right that you were in 2002 asked to
 13 write a Code of Conduct for senior managers?

14 **A.** I was.

15 **Q.** Just help us in terms of the position you were
 16 in in your career at that time. What role did you have?

17 **A.** Right. I had just been appointed as the Chief
 18 Executive of the County Durham and Tees Valley Strategic
 19 Health Authority.

20 **Q.** We will come back to more of the circumstances
 21 surrounding that. You have told us that you took early
 22 retirement in 2005.

23 **A.** I did.

24 **Q.** Have you continued to work though within the
 25 NHS?

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1 ought not to have your wife treated at the hospital that
 2 you were working at because of another doctor; is that
 3 right?

4 **A.** That -- that is correct.

5 **Q.** That when you went to speak to the doctor in
 6 relation to whom there was a concern, you were treated
 7 with contempt and disdain?

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** Was it a surgeon?

10 **A.** I'm sorry?

11 **LADY JUSTICE THIRLWALL:** Was it a surgeon?

12 **A.** Yes, it was.

13 **LADY JUSTICE THIRLWALL:** I just think that is
 14 probably important.

15 **A.** The person who drew my attention to the
 16 problem was a surgeon and he drew attention to the fact
 17 that he had concerns about one of his colleagues and
 18 that was the person he didn't want me to have my wife
 19 referred to.

20 In those days, and we are talking about the 1980s
 21 now, it would have been very difficult even for a senior
 22 person as such as a district administrator or manager to
 23 directly challenge a surgeon. So what I did was to set
 24 up an inquiry into the service which I thought might
 25 lead us into the right territory, because having checked

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1 **A.** I have, it's been my great privilege to
 2 continue to serve both as a management consultant but
 3 perhaps more importantly as the Chair of two Trusts.

4 **Q.** Are you still working within the NHS as at
 5 today's date?

6 **A.** I am not. I felt that when my 75th birthday
 7 came it was time for me to stop.

8 **Q.** But is it fair to say that you have had the
 9 opportunity over the course of your long and
 10 distinguished career to observe the role of the senior
 11 manager up close and personal both as a senior manager
 12 yourself and as somebody who was working closely with
 13 senior managers?

14 **A.** Yes, indeed and I have been, I have lived
 15 through the transition from administration to the coming
 16 of general management after the Griffiths Inquiry in the
 17 mid-80s and then all the changes that have occurred
 18 since then.

19 **Q.** Now, towards the start of your statement at
 20 your paragraphs 2 and 3 you recount a personal
 21 experience which as you make clear in your statement was
 22 something that stuck with you throughout your career and
 23 if I can summarise it in this way and you add the detail
 24 that is particularly important to you: is it right that
 25 it was drawn to your attention by a doctor that you

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1 the legal files in the district office there clearly was
 2 cause for concern and the surgeon who was the object of
 3 my attention replied to me and I still have his note to
 4 say that he wasn't going to respond to a letter from
 5 a "snivelling clerk".

6 **MR DE LA POER:** That was put in writing?

7 **A.** (Nods)

8 **Q.** How did you seek to resolve that situation and
 9 what lessons did you draw from it?

10 **A.** Well, it was very difficult. A, the surgeon
 11 who had drawn my attention to the problem originally
 12 asked me a few weeks later how the inquiry was getting
 13 on and I said that I wasn't getting very far and he
 14 sympathised, he was a good man, and he said that it
 15 really was very difficult and I almost let it go.
 16 I remember the -- the moment of thinking: have I got the
 17 courage to challenge this? And fortunately I did. And
 18 I just said to him, and he was a very senior man, that
 19 I wanted him to go home and look in the mirror and ask
 20 himself if he could live with what he knew and he never
 21 forgave me for that challenge and it affected my
 22 relationship with the Consultants as a whole.

23 But three days later, a few days later, the three
 24 wise men, which was a mechanism we had in those days for
 25 three senior doctors who would be -- take an interest in

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1 the conduct of their colleagues, went to see the person
2 concerned and shortly after he retired on grounds of ill
3 health and his successor transformed the service.

4 **Q.** What did you take away from that experience
5 that so powerfully shaped what you did in the NHS after
6 that?

7 **A.** Well, as I said right at the beginning of my
8 statement I am very fortunate that my first boss,
9 Jack Newton at the Royal Hospital in Sheffield, taught
10 me everything I needed to know. First, that patients
11 come first always; and secondly, that everyone should be
12 treated with the greatest of respect, whether they were
13 a porter or a professor. So I had those basic values
14 right from the start in 1974 -- 1971.

15 What then happened in the story that we have just
16 been talking about absolutely imprinted on my heart and
17 in my mind that patient safety is -- has to be the first
18 responsibility of everyone in the NHS, including the
19 managers, and that we need to act and that's the crucial
20 word, we need to act to protect patients from harm.

21 **Q.** Now, if we just step out of your personal
22 career and just acknowledge wider events. The Kennedy
23 report --

24 **A.** Yes.

25 **Q.** -- by Professor Ian Kennedy into the Bristol

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1 stronger performance management and tighter contracts
2 rather than regulation."

3 **A.** Yes.

4 **Q.** That I think is where you intersect with what
5 was going on arising from Bristol because the Chief
6 Executive then of the NHS, Nigel Crisp, asked you to
7 write the code?

8 **A.** Yes, he asked me to chair a working group to
9 produce the code and that was a great privilege and
10 I ended up writing it as well as chairing the group.

11 **Q.** Thank you, we can take that document down.

12 In your witness statement you mention a number of
13 those organisations that were involved in the working
14 group. I just wanted to ask you about one of them, the
15 British Association of Medical Managers.

16 Is that an organisation which still exists so far
17 as you are aware?

18 **A.** I don't think so which is sad because it was
19 a very effective organisation led by Jenny Simpson and
20 did a great deal of good work.

21 **Q.** In summary, what was the purpose of that
22 organisation, who were its members and what did it do?

23 **A.** The Griffiths report in the mid-80s that
24 created general management was very keen, and
25 Roy Griffiths was very keen, to bring clinicians into

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1 Royal Infirmary produced a number of recommendations,
2 one of which was Recommendation 91 and I would like just
3 to bring it up on to the screen now, please, it is
4 INQ0017990 and we are going to go to page 458, please.

5 **A.** Yes.

6 **Q.** We see it there.

7 **A.** Thank you.

8 **Q.** "Managers as healthcare professionals should
9 be subject to the same obligations as other healthcare
10 professionals including being subject to a regulatory
11 body and professional code of practice."

12 The Government responded to Professor Kennedy's
13 report and we will bring up the response to that and in
14 particular the response to Recommendation 91. This is
15 INQ0012447, please and we will go to page 164.

16 At the top there, I am sure you will acknowledge,
17 Mr Jarrold, there appear to be two parts to this
18 Recommendation?

19 **A.** Yes.

20 **Q.** One is the regulatory regime, the other is the
21 code and the Government's response:

22 "We agree in part. We do not think it is practical
23 to establish self-regulation for senior managers. We do
24 agree that the standards expected of senior NHS managers
25 should be explicit. We favour a Code of Conduct,

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1 management and therefore a large number of doctors had
2 by this time become clinical directors and managers and
3 the new pattern in most NHS Trusts was to have a series
4 of clinical directors managed by a clinician and that
5 still endures in most places today and BAMM's role was
6 it support the doctors in their new management career.
7 Because although there had always been managers in the
8 sense of being people who control resources, they hadn't
9 had specific managerial roles. So that was the purpose
10 of BAMM and they did an excellent job.

11 **Q.** Do you know why that organisation ceased to
12 exist, as you believe?

13 **A.** I'm sorry, I don't.

14 **Q.** Returning to Nigel Crisp. He launched the
15 code, if that is right word?

16 **A.** He did.

17 **Q.** Is that correct?

18 **A.** Yes, it is.

19 **Q.** You tell us in your witness statement that it
20 was launched on 9 October 2002?

21 **A.** Yes.

22 **Q.** And issued to the NHS on 21 October and I am
23 here looking at your paragraph 6?

24 **A.** Yes.

25 **Q.** I would just like to draw attention to what

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1 was said at that time as you record it in your witness
2 statement.

3 **A.** Yes.

4 **Q.** So it's at the bottom of page 2.

5 **A.** Yes.

6 **Q.** I will just read to you what we can see you
7 have reproduced there:

8 "The Code sets out the core standards of conduct
9 expected of all senior managers and should be
10 incorporated into the employment contracts of all senior
11 managers at the earliest opportunity. Employers should
12 also begin to identify other managers in their
13 organisation who should also be subject to the Code,
14 look at their organisational culture to ensure they are
15 providing a supportive environment to managers and
16 ensure systems are in place to fairly investigate any
17 breaches of the Code."

18 So we will park that for a moment and we will come
19 back to it when we review what in fact happened. But we
20 ought to acknowledge that at the same time that this
21 code was launched, there was a wider piece produced by
22 Mr Crisp; is that right?

23 **A.** (Nods)

24 **Q.** Was that called Managing for Excellence in the
25 NHS?

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1 the first page dated October 2002 if we move forward to
2 page 7, please, we will see the principles as they are
3 described.

4 I am just going to read these into the record, so
5 please bear with me:

6 "As an NHS manager I will observe the following
7 principles:

8 "Make the care and safety of patients my first
9 concern and act to protect them from risk.

10 "Respect the public, patients, relatives, carers,
11 NHS staff and partners in other agencies.

12 "Be honest and act with integrity.

13 Accept responsibility for my own work and the
14 proper performance of the people I manage.

15 "Share my commitment to working as a team member by
16 working with all my colleagues in the NHS and the wider
17 community and take responsibility for my own learning
18 and development."

19 **A.** (Nods)

20 **Q.** Excuse me. Mr Jarrold, you have distilled
21 from what no doubt was a very wide number of
22 possibilities down to that and I am not seeking
23 a justification for each and every one of them but what
24 was the philosophy or the mentality that was driving the
25 selection of those when you created this?

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1 **A.** (Nods)

2 **Q.** Could you just tell us please in summary what
3 Managing for Excellence in the NHS was about and how it
4 fitted with the code that was launched at the same time?

5 **A.** Yes, thank you and my apologies for not
6 mentioning Managing for Excellence in my statement.
7 I had just not remembered it when I was writing the
8 statement.

9 It was a very good document and it set out not just
10 that -- not just very strong support for the code which
11 obviously I was very grateful for, but priorities for
12 the service because new priorities were being developed
13 in the light of the very substantial resources that were
14 being allocated to the NHS at that time.

15 It talked about management development, it talked
16 about management standards. It was a very wide-ranging
17 document and interestingly enough, and you may wish to
18 come back to this, the content is very similar to what
19 Amanda Pritchard has recently announced she is proposing
20 to do.

21 **Q.** Well, we will come back to the position as at
22 today at the end of my questions.

23 So we are going to look now, please, Mr Jarrold, at
24 the code itself. This is the document that you wrote
25 chairing that working group, INQ0107810. We see there

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1 **A.** Personally, it was the values that I had
2 learnt at the beginning of my career and subsequently
3 and I think the final version of the code was much
4 better than my first draft, due to the input from both
5 the working group and the external reference group which
6 had some very distinguished and helpful people on it.
7 And one of the key changes was making this a personal
8 statement that I hoped each NHS manager would make.

9 So you know as you see it talks about "I" will
10 observe the principles and I thought that was very
11 powerful and that came through my colleagues' wisdom and
12 the wisdom of those we worked with and we did also work
13 with the Plain English Society who were very helpful in
14 making it understandable and brief, which is something
15 that is sadly lacking from some of the other documents
16 we may be going to talk about.

17 **Q.** Was it chance or design that led to "Make the
18 care and safety of patients my first concern and act to
19 protect them from risk" was first in the list that you
20 created?

21 **A.** I think that's the only bit of wording which
22 survived from my first draft in the exact form in the
23 code. And that was because of the issues we have
24 discussed, the values I had learnt, my own personal
25 experience but also the terrible tragedy of what

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1 happened in Bristol. And I thought well if, if we are
2 going to help managers to behave differently and better,
3 then we have to address the fundamental issue from the
4 Kennedy Report and I felt the right way to do that was
5 to make it very clear that each manager should be able
6 to say: I will make the care and safety of patients my
7 first concern and act to protect them from risk and to
8 put that ahead of personal interest, the reputation of
9 the organisation, or protecting colleagues. That, that
10 was the reason for it.

11 **Q.** Thank you, we can take that document down. So
12 returning to what Mr Crisp said he expected to happen in
13 terms of this being integrated into employment
14 contracts, you continued to work in the NHS full time
15 for another three years after this. Did you see that
16 happen?

17 **A.** No, I did not. And it was clear to -- I mean,
18 there were three difficult years for me workwise and
19 personally, but it didn't happen and when I left full
20 time work and subsequently I was really sad that the
21 code simply didn't seem to be being implemented.
22 I can't think of -- and I am very open to correction of
23 course but I can't think of a single investigation of
24 a breach of the code that I was made aware of and let's
25 not forget that the terrible events in Stafford

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1 were taking place and people were busy getting those
2 waiting lists down which they did and let's remember
3 that by 2010 public satisfaction was at its highest in
4 the history of the NHS.

5 So it was a good time in many ways. But sadly
6 I think this fell out of -- of favour. You will know
7 that Lord Crisp as he is now stood down as the Chief
8 Executive of the NHS early in 2006, I don't know whether
9 that had any bearing on it. And the service was then
10 immediately consumed with the awfulness of Stafford.

11 So I think those are all contributory factors.

12 I think there were some managers who were never
13 very keen on it to begin with. Out of the 64 responses,
14 six were critical, hostile, one said that the code
15 should apply to clinical staff and not to managers which
16 I thought was very interesting, in other words they
17 didn't see patients as being what managers were about
18 and another accused us -- accused the code of "medical
19 evangelism" which was clearly a very bad thing in the
20 commentators' eyes.

21 **Q.** Now, one of the matters that you deal with in
22 your statement, and I am here looking at paragraph 8, is
23 your concern about how the general management reforms,
24 if that is the right way of describing them --

25 **A.** Yes.

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1 investigated by the Francis Report occurred between 2005
2 and 2008.

3 So we can be sure that at least in one Trust the
4 code was not having any impact and that was a great
5 sadness to me at that time and in subsequent years.

6 **Q.** Have you formed any view about why despite the
7 clear terms should --

8 **A.** Yes.

9 **Q.** -- from the NHS Chief Executive that it wasn't
10 taken up immediately even when all of the terrible
11 features of the Bristol Inquiry were still fresh in the
12 memory of everybody who was working in the NHS at that
13 time?

14 **A.** Yes, I have. If we think back to the NHS into
15 which the code was born, paradoxically it was in my view
16 the best time in NHS history in terms of resources.
17 From 2001 onwards we had an injection of resources
18 greater than we had ever had before or since and there
19 was a massive programme of work at national level to
20 reduce waiting lists, to set up the wonderful National
21 Service Frameworks which did guide a great deal of
22 service improvement, the appointment of the National
23 Clinical Directors and we have heard a little about them
24 earlier and it -- I think what happened was that the
25 whole world seemed positive and hopeful and developments

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1 **Q.** -- may impact upon a desire to promote patient
2 safety and you identify a possible risk of those reforms
3 being that of reputation. Could you just explain to us
4 please why you think that reputation might become more
5 important under the general management reforms which in
6 one form or another subsist to this day and whether in
7 fact that concern was more imagined than real?

8 **A.** Yes. I think the reason why I saw the risk
9 and I mean I -- I wasn't in favour initially of
10 Roy Griffiths' proposal to appoint general managers
11 because I felt that the appointment of a Chief Executive
12 would undermine the consensus management of the NHS and
13 I was a bit old-fashioned in that way.

14 However, I -- I got to know Roy Griffiths, I got to
15 understand where he came from his commitment to patient
16 care and I became a convert to what he was doing. But
17 there was a risk and that risk was that the creation of
18 NHS Trusts in the early '90s established a very strong
19 identity for a local organisation, much stronger than
20 there had been in the past because the whole point was
21 to have an independent Trust, I mean, the independence
22 is long gone but that was the original idea.

23 And I think because of that, there was a great
24 focus on the Trust protecting its reputation. And you
25 had to go through all sorts of stages to become a Trust

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1 and later with the Foundation Trust movement as well.

2 So that -- that I think is why the risk occurred.
3 But I was reassured because I -- I did understand that
4 both Roy Griffiths and indeed Ken Clarke, a very able
5 Secretary of State, did care deeply about patient care.

6 **Q.** If we continue through a timeline and just
7 pause at 2012 and we are going to hear from Dr Clamp
8 this afternoon who is the current Chief Executive of the
9 PSA, the Council for Healthcare Regulatory Excellence,
10 as it was, in 2012 and he will tell us about the
11 introduction of the standards for members of NHS boards
12 and clinical governing groups that that organisation
13 published in 2012.

14 Were you aware of that taking place at the time?

15 **A.** I -- I wasn't, no. And that's, that's
16 interesting because I had taken up my first chair's role
17 in 2011. Could I just mention 2010?

18 **Q.** Yes, of course.

19 **A.** Would that be all right? I think it is
20 relevant.

21 In the course of preparing for today I discovered
22 that there had been an official national review of the
23 code in 2010. I hadn't been aware of it until preparing
24 for today. And the conclusion of the group was that the
25 values set out in the code were out of date, which seems

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1 this document.

2 **A.** The first is that it does not specifically
3 refer to the care and safety of patients being the first
4 concern of managers. And I think that's unfortunate.

5 The second is that it appears to depend on
6 self-assessment and that is obviously limited and, you
7 know, any, any proper appraisal system needs to involve
8 360 feedback from colleagues and so on.

9 The third is that appraisal is often not done well,
10 I mean it should be a meaningful discussion where you
11 really come out understanding what you have done right
12 and being commended for it and understanding where you
13 need to learn and I have to say that in all my years
14 I only had six decent appraisals, all of which were
15 carried out by chairs and none of which were carried out
16 by managers. So to rely so heavily on appraisal worries
17 me and again there is so much here, the wordiness of it
18 and we may go on to the fitness for practice work which
19 is also incredibly wordy. But, you know, how much of
20 this can people really take into their hearts and minds
21 and do something about? That's the problem with a lot
22 of this.

23 **Q.** Now, given those concerns, I am just going to
24 draw your attention to some aspects of it to see whether
25 they meet your concerns or whether your concerns subsist

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1 to me to be quite shocking, and -- and also -- and also
2 their second criticism has just gone from ... oh, yes,
3 the code was described as "aspirational" which clearly
4 again was not regarded as a good thing.

5 So there had been an official review of the code in
6 2010 which I wasn't aware of that had said we needed
7 a new code and a new system and all that and made all
8 sorts of recommendations which didn't happen because of
9 the election of 2010 and the change of government and
10 then being plunged into yet another reorganisation. And
11 I wasn't aware of the 2012 work.

12 **Q.** Well, you have as part of your statement to
13 bring us very much up-to-date had the opportunity to
14 consider the leadership competency framework?

15 **A.** Yes, yes.

16 **Q.** Published on 28 February of last year.

17 You have looked at the detail of that as part of
18 your preparation for today?

19 **A.** Yes.

20 **Q.** You raise three concerns as you characterise
21 them --

22 **A.** Yes.

23 **Q.** -- that you have about the document. I am
24 looking here at paragraph 12. Let's just first

25 understand in headline form what concerns you have about

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1 even having considered them?

2 **A.** Sure.

3 **Q.** So if we bring up the leadership competency
4 framework, INQ0108668. If we have a look at page 2, we
5 see at the top that the competency domains reflect the
6 NHS values and a hyperlink is given to them.

7 So in one sense it may be thought that the NHS
8 values are imported into this document, so that is the
9 first point I will ask for your comment in a moment
10 I will just draw your attention to these factors.

11 If we go over the page we will also see reference
12 to the Nolan Principles under a link to them, so in
13 terms of the concerns you have about patient safety,
14 does that meet your concerns about this document and if
15 not, why not?

16 **A.** Well, unless I have misread it, there is no
17 specific reference to the care and safety of patients
18 being the first concern of managers and the need to act
19 to protect them from risk. I cannot find that. If
20 I have missed it, I apologise.

21 **Q.** No, no, that wording is not there?

22 **A.** It's not there.

23 **Q.** So does it follow from your answer that you
24 regarded as essential that that wording or something
25 equivalent is written in the document for everybody to

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1 see when they look at the document?

2 **A.** I -- I do. And also that it, if we should
3 have a limited number of things in any code or approach
4 that people have some chance of understanding and
5 remembering. And if you look at this -- this -- this
6 diagram we have in front of us, the competency framework
7 itself with no less than six domains and lots of words
8 around them, "the leadership way" I am not entirely sure
9 what that is, the NHS values, which are six set out
10 previously, another six, "the people promise" which is
11 a whole other thing, and the seven principles of public
12 life.

13 I mean this is all excellent stuff, the Nolan
14 stuff, but, you know, the numbers of things that you are
15 expecting people to understand and observe and take into
16 their lives and change their practice, and behaviour,
17 it's just too complicated.

18 **Q.** I also just draw your attention, please, on
19 page 13 to domain 4, which speaks about providing robust
20 governance and assurance.

21 Forgive me. I wonder if -- I think I have lost my
22 reference there. Could we just scroll down, please.
23 Thank you, if you keep going, please. No, that's ...

24 My mistake. If we stop, thank you very much
25 indeed.

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1 **Q.** -- a senior manager. Again, just considering
2 how that document might sit as part of a wider set of
3 documents supplying to managers, is it possible to
4 create a competency, which is what the document is
5 seeking to do, which addresses the need to keep patients
6 safe which is a way of behaving as opposed to perhaps
7 a competency? Again, I would just invite you to
8 consider that and how you would phrase within the terms
9 of the document as it exists?

10 **A.** I think it's possible, but you need to start
11 from the point we have been discussing and then build on
12 that, but again not build too much on it because again
13 you will lose people.

14 The more complex and wordy you make it, you will
15 lose people.

16 So the simpler you can make it the better.

17 People need simple things to guide them.

18 **Q.** Just two more topics for us to deal with
19 please, Mr Jarrold. The first is -- and we said we
20 would come back to this -- the current position. You
21 have referred to Amanda Pritchard --

22 **A.** Yes.

23 **Q.** -- and what she's seeking to do.

24 What do you understand the current position to be
25 and do you consider that it is adequate?

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1 I think the point -- and we can take the document
2 down -- I think the point I am inviting you to consider
3 is that within domain 4, which deals with providing
4 robust governance and assurance, there is a requirement,
5 presumably inherent in the idea of governance, that you
6 are ensuring that systems, including systems of patient
7 safety, are properly implemented.

8 Again, do you feel that addressing the concerns
9 that you have through that route is sufficient or is
10 more required in terms of being express?

11 **A.** No, I -- I don't think it's sufficient.

12 Let's bear in mind that human nature in any
13 organisation, and I try to be realistic about human
14 nature, but hopeful about it, but if we are realistic
15 about human nature there is a very strong temptation in
16 any organisation if something goes wrong for people to
17 try and conceal what's happened, to protect colleagues,
18 to protect the reputation of the organisation. And
19 there needs -- in order to counterbalance that, there
20 needs to be a very specific, clearly-worded commitment
21 to something that is strong enough to stand some chance
22 of counterbalancing it and I don't see it here.

23 **Q.** Now, the document itself appears to be a list
24 of competencies against which you can benchmark --

25 **A.** Yes.

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1 **A.** Yes. I -- I support everything in Amanda's
2 statement. I would just respectfully offer her a number
3 of pieces of advice.

4 The first is that in drafting the code, I would
5 hope she would use the wording that we used in the
6 original code and which we have both mentioned several
7 times. That's my first request, and it remains to be
8 seen if that's going to happen, but I will be
9 disappointed if it doesn't.

10 Secondly, that the code should apply to all
11 managers because let's remember that all this stuff
12 about board managers is, is just one aspect. The people
13 who actually manage the NHS are the ward sisters and
14 team leaders; they are the real managers of the NHS, and
15 it's those team leaders and ward leaders who need to be
16 included in any version of the code and indeed you will
17 remember that Nigel Crisp specifically referred to ward
18 sisters and similar roles.

19 So the second thing is it must apply to all
20 managers.

21 The third is that of course it must be implemented,
22 and not like the last one.

23 The fourth, and forgive me if I run out of numbers,
24 but the fourth is that we could take on board some of
25 the aspects of the current wider debate about the

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1 regulation of managers and there are three in
2 particular, two of which I think have come from the
3 Infected Blood Inquiry.

4 The first is that I think that there does need to
5 be proper investigation of breaches of the code and --
6 which never happened before, and there needs to be
7 a disbaring list that somebody could be placed on if
8 the breach of the code had been judged to be
9 sufficiently serious for that to happen.

10 Then I think it would be very useful to pursue the
11 idea of the statutory duty of candour for individual
12 managers and, thirdly, the duty -- again from I think
13 the Infected Blood Inquiry -- to require, to have a
14 formal duty for people to respond to concerns about
15 safety.

16 So I think if you put all of that together with
17 what Amanda has proposed we would be getting somewhere,
18 crucially, if of course it is then implemented. And if
19 we could in five years' time we could say that the code
20 was lived in every Trust and everywhere else that NHS
21 managers work, that it, it was, you know, if we walked
22 into a manager's office we could ask them what the key
23 aspects of the code were and they could stand some
24 chance of telling us -- and I would like to come back to
25 the nursing code if I may which offers some good

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1 Do you have a view about whether statutory
2 regulation is a good thing or a bad thing?

3 **A.** I -- I do. The aspects that are in the
4 current consultation that I support are the ones I have
5 just mentioned.

6 I don't support the regulation of managers in the
7 formal way because management is not a profession.
8 I mean, people talk about "professional management" but
9 the fact of the matter is that management is an
10 occupation, it's not a profession. It does not have an
11 entry standard, it does not have all the other things
12 which medicine or the law or nursing or other, other
13 professions have.

14 So if you are going to do this, you are creating an
15 entirely new profession and the consultation document
16 itself, to be fair, refers to many of the difficulties.
17 So for example, where are you going to define the entry
18 standard to management? You know which of the zillions
19 of management degrees are you going to accept as entry
20 to the register of management? There's a very big task,
21 task there.

22 And there isn't the same agreement on the body of
23 knowledge that you have in other professions. There
24 would be, again as the document recalls, there might be
25 problems for people who didn't have management

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1 practice -- and that there had been investigations and
2 people had been disbarred and people had become more
3 alive to the duty of candour and more alive to the duty
4 to respond.

5 And one of the aspects of the NMC code, which I am
6 very familiar with because my son is a staff nurse, is
7 that if something happens that people think you can
8 learn from the nurse is required to prepare what's
9 called a reflective account and then the last question,
10 as I recall it, in the reflective account form is to
11 link it back to the code. So: which aspect of the code
12 does this learning relate to?

13 Now, if we could get managers into that position
14 where they had a code they understood, where when that
15 code -- when something went wrong, they were required to
16 write reflective accounts, these are not long documents,
17 they are short documents, and they were required to
18 think about how what had happened went back to their
19 code that would be powerful.

20 **Q.** Now, in the suggestions you have made for
21 future improvement, you didn't, unless I misunderstood,
22 expressly endorse the statutory regulation of senior
23 managers and very often we see a code such as good
24 medical practice which sits in the context of statutory
25 regulation.

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1 qualifications taking up management roles.

2 And as I have said, you know, the managers who
3 really matter in the NHS are not the chief exec and the
4 boards -- and having been a chief exec myself I feel
5 entitled to say that -- the managers who really matter
6 are these first-line managers. You ask somebody on
7 a ward or on a team, "Who is your manager?" they are not
8 going to say the chief exec or the director of this, or
9 that or the other. They are going to say, "The ward
10 manager" or "The team manager." Those are the key
11 people.

12 And many of those people are of course from
13 clinical backgrounds. They do not have management
14 qualifications, formal management qualifications many of
15 them, and to require every one of them to reach some
16 standard simply in order to create a new profession,
17 academic standard, I just think would be wrong and
18 much -- and it's going to be expensive if you apply it
19 to all, all the managers I have talked about.

20 So I would much rather focus on Amanda Pritchard's
21 package, which I think is excellent, reinforced by the
22 points I have made.

23 **Q.** Within that system, how do you understand,
24 absent a statutory regulatory scheme that has a fitness
25 to practise element to it, that managers who fail to

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1 adhere to the code are -- or rather the public are
2 protected from such managers?

3 **A.** Well, I think, it's -- I mean, I am not
4 an expert in these things and no doubt there are legal
5 difficulties that I am not aware of.

6 But I would have thought it was possible to have
7 a code, to have investigations of breaches of the code
8 and to have then a disbarring list based on those
9 investigations. It would no doubt need proper basis and
10 all the rest of it. I would have thought it was
11 possible to do that without creating the full panoply of
12 professional regulation.

13 **Q.** The final topic to ask you about is in
14 relation to a document which was drawn to your attention
15 recently as far as your preparation for today was
16 concerned. It's INQ0108022.

17 We will just have a look at the first page and
18 introduce the document.

19 **A.** Yes.

20 **Q.** This is a document which started life as
21 a document created by the Thirlwall Inquiry legal team,
22 but which has had additions made to it, quite properly,
23 by, as I understand it, the Department for Health and
24 Social Care and NHS England. I may be wrong about the
25 latter of those.

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1 in one of those orders that you get, past -- none of
2 that is reflected here and I couldn't understand that.

3 It seemed to me odd that you should simply -- that
4 they should simply refer to the January 2002 response
5 saying that they favoured a Code of Conduct with
6 absolutely no information, no indication in this
7 document that a code was ever produced.

8 And that just worries me slightly because when
9 I tried to find the code, I mean I had my own copies,
10 but when I tried to find the code a few years ago,
11 I think three or four years ago, I discovered that it
12 had been archived by the Department of Health which
13 I think was interesting.

14 **Q.** I mean, is it your understanding that that is
15 still a document available for use by NHS Trusts if they
16 wish to or is it your understanding that that document
17 is now considered withdrawn or are you in a position of
18 being unsure?

19 **A.** I -- I don't know what their view of it is,
20 but it does seem odd to me that it's not mentioned here.

21 **MR DE LA POER:** Mr Jarrold, thank you very much
22 indeed. Those are the questions that I have for you.

23 I see indications from Core Participants that
24 although permission was granted that there are no
25 questions, so I am pleased that I have covered what

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1 But the point is that the underlying data is from
2 the Inquiry and then we can see some additions and we
3 will see in the table that we'll look at what the
4 additions are in relation to Recommendation 91.

5 So if we could go to page 45. We are coming back
6 to where we started, Mr Jarrold, which is with the
7 Bristol Royal Infirmary Inquiry and Recommendation 91.

8 Just so you understand what "superseded" is
9 intended to convey. That is intended to convey the fact
10 that there is a firm Government commitment to carrying
11 out this Recommendation in terms of the code as opposed
12 to an assertion that it has already been done. So
13 that's what "superseded" means.

14 But the second column from the right which provides
15 some detail around it, I think you have had
16 an opportunity to consider as part of your preparation
17 for today and, as I understand it, you have
18 an observation to make about it and in particular what
19 it does or doesn't say about the work that you did?

20 **A.** I was simply astonished that a document of
21 this kind made no reference to the code of 2002. It
22 seemed to me very odd indeed that a code that had been
23 commissioned by the Chief Executive of the NHS, issued
24 to the NHS by him with very specific instructions, you
25 know, there were formal statutory backing to it as well

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1 needed to be covered.

2 My Lady, that therefore concludes the questions
3 that I have.

4 **LADY JUSTICE THIRLWALL:** Yes. Actually there are
5 one or two things I would quite like to think about over
6 lunch. Would you mind coming back at 2 o'clock --

7 **A.** Of course.

8 **LADY JUSTICE THIRLWALL:** -- Mr Jarrold? It may be
9 it will take five minutes, but I would like to think
10 that I have properly reflected on some of the
11 information which is, to me at least, relatively new.

12 **A.** Of course.

13 **LADY JUSTICE THIRLWALL:** Thank you very much. We
14 will rise and we will start again at 2 o'clock.

15 (12.56 pm)

(The luncheon adjournment)

17 (1.58 pm)

18 **LADY JUSTICE THIRLWALL:** Mr De La Poer, I think
19 there was something else you wanted to ask.

20 **MR DE LA POER:** There is a point. Thank you,
21 Mr Jarrold, for coming back. I should have asked you
22 about the fit and proper person test. I understand
23 there are two views that you have that you would like to
24 share about that, please.

25 **A.** Thank you. I have two problems with it. The

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1 first is that it says that its aim is to prioritise
 2 safety but I can find nothing in it that would be
 3 towards that end. And when you come to the end of the
 4 document and it -- the document itself says what its
 5 core recommendations are, they are good character,
 6 qualifications and finance. All important, but nothing
 7 about safety. So I don't know why the document says it
 8 is about prioritising safety when it hardly mentions it
 9 and then when it defines its own core, it fails to
 10 mention it.

11 My second problem is as we discussed earlier, its
 12 complexity and its length. If I have counted correctly
 13 there are 64 criteria. Now, how anybody is supposed to
 14 make any sense of that, I just -- I just don't know.
 15 And there are some very complicated diagrams I think on
 16 pages 15 to 17 or something like that and you just
 17 wonder who is going to make this work, busy people
 18 trying to do the right thing, if this is supposed to
 19 help them with that, how is it going to help?

20 **Q.** So as to the first concern that you have, how
 21 would you address the latter part of it that you
 22 observed that were three particular core characteristics
 23 that are mentioned at the end. Would you add to those
 24 in terms of -- and if so, what language would you use to
 25 make it clear that patient safety is to be prioritised?

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1 safety. I would say that it was about recruitment
 2 checks and that is fine. Nothing wrong with that every
 3 organisation needs to do that. You need to know whether
 4 somebody is an undischarged bankrupt or a conviction
 5 that hasn't been spent and all those sort of things.
 6 But just tell it -- call it what it is and don't pretend
 7 it is something else and deal with the safety issues
 8 through the Code of Conduct and I -- a point I meant to
 9 make this morning is I do believe that it's possible if
 10 we got the right code that it might be a code not just
 11 for managers but for the NHS as a whole. And that would
 12 actually be a unifying thing.

13 I mean, there's a lot of in common between the GMC
 14 code, the nursing code, and what I would hope the
 15 managers code would be.

16 So could we have an NHS code and that would almost
 17 bring people together and that's badly needed because,
 18 you know, the whole of the NHS needs to work together
 19 and when lay managers -- and I have been a lay
 20 manager -- ask me how I made good relationships with
 21 clinicians, I said that it was because I thought the
 22 clinicians could hand even though I was only a history
 23 graduate who knew nothing about anything that they
 24 understood two things: first that I was interested in
 25 their work, and secondly, that I cared very deeply about

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1 **A.** I mean clearly, when you are recruiting
 2 somebody, you need to check their background and all
 3 those sort of things so there's nothing wrong with any
 4 of that. But I think it should make it clear that this
 5 test is about background checks. It's about those
 6 issues. Its primary purpose shouldn't be stated as
 7 being prioritising safety because that's not what it's
 8 doing.

9 And unfortunately people do tend to use these
 10 slogans and then not follow through on them because it's
 11 the fashion of the day or perceived to be the priority.

12 So I have nothing wrong with, nothing -- no
 13 problems with a fit for purpose test that is what it
 14 says it is and checks background and all the rest of it.
 15 But if you are going to influence behaviour, you can't
 16 have as this document has -- and forgive me if I get the
 17 numbers wrong -- but you know, six NHS core values,
 18 seven Nolan recommendations, six something else and it
 19 just adds up and up and up.

20 So, fine, as if its purpose was different. But to
 21 state that its purpose is to prioritise safety and then
 22 not to do so is not helpful.

23 **Q.** So how would you change it, practically
 24 speaking what would you do to it?

25 **A.** I would say that it wasn't about prioritising

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1 patient care and safety.

2 And if we could have a code that spelt that out, it
 3 would be a unifying force in the NHS because we don't
 4 want to have doctors and nurses and managers in
 5 different camps and other professions and occupations,
 6 we want to have everybody understanding what we are here
 7 for and committed to it in clear and unequivocal terms.

8 **MR DE LA POER:** Mr Jarrold, thank you very much
 9 indeed.

10 My Lady those were the only supplementary questions
 11 I wished to ask.

12 Questions by LADY JUSTICE THIRLWALL

13 **LADY JUSTICE THIRLWALL:** Thank you very much,
 14 Mr de la Poer.

15 Just picking up on how you made good relationships
 16 after and perhaps before the incident that you told us
 17 about.

18 I understand you read history from what you have
 19 just said?

20 **A.** I did.

21 **LADY JUSTICE THIRLWALL:** I think you had a first
 22 class degree from Cambridge.

23 **A.** I did.

24 **LADY JUSTICE THIRLWALL:** So if I may, you were
 25 intellectually equal to the people that you were seeking

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1 to make relationships with at all levels obviously?

2 **A.** Well ...

3 **LADY JUSTICE THIRLWALL:** You may not have had any
4 clinical or medical knowledge but in terms of your
5 intellect.

6 **A.** Thank you, my Lady.

7 I mean, that's obviously for them to judge. Yes,
8 I think intellect is important in managers and that
9 managers should be able to deal on terms with the
10 incredibly bright people that we have working in the
11 NHS, the doctors, the nurses, the physios, all of these
12 people.

13 So yes, intellectual ability is important. But
14 it's not as important as the values and commitments.

15 **LADY JUSTICE THIRLWALL:** Yes.

16 **A.** Because that is what brings us together and
17 you could be -- without wishing in any way to assume
18 this -- somebody who wasn't as gifted intellectually as
19 a neurosurgery professor but you could still share the
20 common commitment to values.

21 **LADY JUSTICE THIRLWALL:** Yes, absolutely. I think
22 I was trying to get into the shoes of the person on the
23 other side of the relationship.

24 **A.** Right.

25 **LADY JUSTICE THIRLWALL:** So whilst one thoroughly

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1 Is that something you have been aware of or is it
2 very patchy? Does it just depend on the hospital?

3 **A.** I -- I was closely involved until last
4 September, September of 23, rather, as a chairman so --

5 **LADY JUSTICE THIRLWALL:** Of course you were yes, of
6 course.

7 **A.** I have been involved very, very recently and
8 for many years.

9 **LADY JUSTICE THIRLWALL:** Yes.

10 **A.** This is an interesting one. There are those
11 who think that the most important people in the Trust
12 are the chairman and the chief exec and the board, there
13 is that view and I think it might be quite a common one
14 in some quarters. It's never been my view, because
15 again of the fundamental values that I was taught and
16 the fact the way I always explain this is what would
17 happen if a chairman couldn't come to work, it would be
18 a minor inconvenience, somebody else would have to pick
19 up at the odd meeting. But if a staff nurse doesn't
20 turn up on a ward shift where you only have one or two
21 staff nurses on, you know all about it and there is
22 an immediate problem, there is an immediate safety
23 problem, there is an immediate staffing problem.

24 So we know who the most important people are and
25 they are not the chairman and the chief exec of the

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1 ignorant person would have described you as he did,
2 anyone who actually knew that would have an effect
3 wouldn't it, on how they treated you, you might think?

4 **A.** I have -- I mean I have been very fortunate,
5 my Lady, in my relationships and have worked with many
6 wonderful people over 54 years, but, you know, there
7 were a number of people who loathed me and whatever
8 intellectual ability I may or may not have made no
9 difference at all.

10 **LADY JUSTICE THIRLWALL:** I understand that.

11 **A.** Their views of me.

12 **LADY JUSTICE THIRLWALL:** Indeed that is one of the
13 things that one can pick up and perhaps shift and
14 I would ask your view about this and I appreciate you
15 left about 20 years ago. But in terms of the
16 relationships my impression is, and it is only so far
17 that impression, that there has been a shift from
18 doctors or certain members of the medical profession,
19 certain parts of it, sort of asserting themselves very--
20 well, let's just say being very assertive as to who was
21 in charge in their view to a situation where the
22 managers particularly at board level would consider
23 themselves in charge, if you like. There just seems to
24 have been that shift and it may be that it's an ongoing
25 situation.

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1 board. And their job, and this is how I tried to do my
2 job as a chair in two very good Trusts or one that
3 became good thanks to other people and one that was good
4 before I got there, what I tried to always give the
5 impression, the real impression, was that I understood
6 that we were there as a board to serve the staff at the
7 front line. That was our job.

8 That's why in the book that I had the privilege of
9 writing about leadership and management, I talked a lot
10 about servant leadership as developed by
11 Robert Greenleaf because it does seem to me that
12 that's -- the right tone of leadership for the NHS is
13 for the people who have the titles and the salaries and
14 all the rest of it to feel that they are servants of the
15 organisation and of the frontline staff, hence it is
16 their job to support the frontline staff as they do the
17 very challenging job of caring for patients and
18 families.

19 **LADY JUSTICE THIRLWALL:** Thank you. And you
20 mentioned in the course of your last answer 52 years or
21 so in the NHS one way or another. One of the things
22 that has emerged in the course of the Inquiry is the
23 absence of a corporate memory in the NHS, a number of
24 people have commented on that.

25 So you might be the closest we can get apart from

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1 one other witness to someone who does have that long
2 memory of over many decades. You have pointed to on
3 a number of occasions something which you have called
4 the incredible wordiness of the documents.

5 Is that something which is worse now than it was in
6 the 1980s?

7 **A.** Yes. Two things, my Lady. I mean the first
8 is that I think the NHS is very poor at learning from
9 its own mistakes and looking back, saying: why didn't
10 the code work in 2002? And I hope that Amanda Pritchard
11 will do that because unless she understands why it
12 failed last time she won't get it right this time. But
13 we are just not good at that and it is partly because we
14 have had so many reorganisations that have destroyed
15 corporate memory, that has been a major factor and
16 I have lived through every reorganisation of the NHS
17 because the first was in 1974 when a whole group of
18 senior people were swept aside and then again in 1982
19 and that resulted in me getting my first chief officer
20 job at a very young age but that was because so many of
21 the experienced and wise people were swept out and
22 that's happened time and time again so corporate memory
23 is not something where we are strong at all.

24 And in terms of the wordiness I -- I think it has
25 got worse and I think sometimes there is a tendency to

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1 possibility of malevolent action by a member of staff?

2 **A.** Sadly not. And I mean I was very much
3 involved in the management of the NHS at that time.

4 **LADY JUSTICE THIRLWALL:** Yes.

5 **A.** And I just don't remember that being a major
6 factor and again there isn't an implementation issue in
7 the NHS.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **A.** We are much better at coming up with new
10 reports and new recommendations than we are at
11 implementing what we have already got. And that is
12 a weakness.

13 Because, you know, the job of providing healthcare
14 is a very challenging job in terms of finite resources
15 even in the good years, the massive demand for services,
16 public expectations which quite rightly are greater and
17 it's just very difficult for people who are trying to do
18 their best day-to-day to provide services to really
19 check on these things and again if you, you know, there
20 are just not many mechanisms for checking on
21 implementation and really checking on it.

22 So I regret to say that although I was very much
23 involved when Duncan was around and when he left, I -- I
24 just don't remember it being a key factor in my thinking
25 or those of my colleagues.

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1 believe that it's clever to write long documents.

2 I think it's very hard to write short documents.

3 It's easy to splurge the whole thing out over 64
4 criteria. There is no control, there is no analysis,
5 there's no intellectual rigour there, but to write
6 something short, and I am sure you will know that some
7 of the most powerful documents in history have been
8 very, very short documents, the Gettysburg Address, the
9 Ten Commandments, you don't have to have 50 or 60 pages.
10 You can write things simply and powerfully and people
11 like the Plain English Society are useful in doing that
12 because that is their trade.

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

14 Then going to a particular incident in history.
15 You will remember, I imagine, the Beverley Allitt case?

16 **A.** I do.

17 **LADY JUSTICE THIRLWALL:** Back in the late
18 1980s/early 1990s, I don't know if you remember the
19 Clothier Report, which Sir Cecil Clothier wrote in the
20 early 1990s and we know that that was distributed by the
21 NHS, Sir Duncan Nichol was then the Chair, I think he
22 was about to leave or to step down from that role, and
23 that went to all hospitals.

24 Do you know was there any follow-up to what was
25 said there which was that everyone must be open to the

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1 **LADY JUSTICE THIRLWALL:** No, thank you.

2 You mentioned in the course of your evidence
3 reflective practice and you were struck by the way that
4 was inculcated in nursing training --

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** -- in those circumstances
7 of your son and we know from the evidence that the
8 doctors from a very early stage --

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** -- are reflecting --

11 **A.** Indeed.

12 **LADY JUSTICE THIRLWALL:** -- almost constantly on
13 what they have done and how they might have done it
14 better.

15 **A.** Yes.

16 **LADY JUSTICE THIRLWALL:** And I think that you
17 thought that would be a good approach for managers also.
18 Do you have any experience of that happening amongst
19 managers and I suppose those who are doctors and nurses
20 may do it anyway, but is that something that gets talked
21 about at management training or anything like that?

22 **A.** Not -- not to my knowledge. I have had the
23 privilege of working with managers who were naturally
24 reflective.

25 **LADY JUSTICE THIRLWALL:** Yes.

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1 **A.** And who therefore did it for themselves and
2 I hope I was one of those. But that's for others to
3 judge.

4 But there's -- there's almost a sense in which that
5 sort of reflection doesn't fit the model of a somewhat
6 macho management culture which is sometimes thought to
7 be the right way to manage things. You know, their
8 doubts or self doubt or reflection are seen as
9 weaknesses. To me they are strengths. But to some
10 schools of management, the sort of heroic schools of
11 management which has long been discredited in most
12 management academic circles, in those days anything like
13 reflective practice would have been seen as an admission
14 of weakness and that still I'm afraid persists in some
15 places.

16 And the other factor of course is that one of the
17 things I have enjoyed about the NHS is that it is --
18 I forget the exact figures but there must be 75, 80% of
19 the staff of NHS are women and yet the bias in senior
20 management is still towards men. And in my experience
21 of life, and I can only offer it, men tend to be less
22 reflective than women.

23 **LADY JUSTICE THIRLWALL:** Yes, an interesting
24 observation.

25 How would you compare just really in short form
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1 have the ideas themselves, but create in their teams an
2 atmosphere where leadership can come from anyone and all
3 you have to have is a junior member of staff making
4 a suggestion in a team meeting and if the manager comes
5 down hard on that and ridicules them or makes fun of
6 them in front of their colleagues they will stop making
7 suggestions.

8 If the manager says "I think that is worth looking
9 at", then flow -- you will get a flow of ideas coming
10 from the people.

11 So that's my difference between management and
12 leadership and both are important. But if managers
13 can't show leadership themselves, and many can't,
14 because they don't know how to show the way, they do in
15 my view have a very solemn responsibility to encourage
16 leadership in others and to respond to the ideas when
17 they come forward.

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

19 We have looked with some care at the Code of
20 Conduct for managers which you drafted and we didn't
21 look at but we know that there is a section straight
22 after the code itself on implementing it and in fairness
23 it does remind everyone of the Nolan Principles, it is
24 just that there isn't a hyperlink to it, probably we
25 couldn't do that in those days.
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1 management, we have been talking about management with
2 leadership, because the two can go together but they
3 don't always?

4 **A.** I think they are very, very different things
5 and I sought to define them in my book. For me,
6 leadership is about showing the way and that comes
7 directly from Robert Greenleaf and his work on servant
8 leadership and that means that leadership can come from
9 anywhere in the organisation, anybody who has a good
10 idea regardless of their position can show the way to
11 the organisation and often it's the most junior people,
12 the most inexperienced people who can show the way if
13 the organisation allows them to do that.

14 The problem is that management is quite different
15 to that, in my view, if it is defined in the Thwaites
16 Report many years ago as the control of resources. That
17 is what management is according to Thwaites and I agree
18 with that.

19 So to be a manager you have to have a position that
20 gives you formal control of resources. To be a leader
21 you don't have to have that.

22 The problem is that the managers have often been
23 burdened with the expectation of leadership and they
24 think they have got to show all the leadership whereas
25 the most successful managers are often those who don't
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1 But I just wondered what -- you have mentioned you
2 know that there weren't any -- there was no
3 investigation of breaches of the code?

4 **A.** No.

5 **LADY JUSTICE THIRLWALL:** And what sort of thing
6 would you have envisaged and you and the working group
7 would have envisaged would have constituted a breach of
8 the code at that time or even now? Is there certain
9 behaviour that would be caught in your view by the code?

10 **A.** Well, absolutely. And sadly we saw -- as
11 I mentioned earlier, my Lady, we saw that in Stafford.
12 It is one of the most shameful episodes in the history
13 of the NHS.

14 **LADY JUSTICE THIRLWALL:** Yes.

15 **A.** And, you know, had the code been enforced, the
16 people there should have been investigated for the
17 breach of the code because what they were doing was
18 clearly in breach of its fundamental principles and that
19 could and should have been investigated and something
20 done but it but, you know, I may be wrong and
21 I absolutely am happy to be corrected but I am not aware
22 of a single investigation of a breach of the code.

23 **LADY JUSTICE THIRLWALL:** No, okay. Thank you very
24 much. Those are all my questions. I had better just
25 see if anybody else wants to ask anything.
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1 No. Well, thank you. It has certainly been very
 2 enlightening for me and I hope you don't mind the extra
 3 hour that you have been here over lunchtime?
 4 **A.** Of course not.
 5 **LADY JUSTICE THIRLWALL:** Thank you very much
 6 indeed, you are free to go.
 7 **A.** Thank you.
 8 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
 9 **MR DE LA POER:** My Lady our final witness for today
 10 is Dr Alan Clamp and I wonder if Dr Clamp could come
 11 forward please.
 12 **LADY JUSTICE THIRLWALL:** Yes, please come forward,
 13 Dr Clamp.
 14 DR ALAN CLAMP (affirmed)
 15 Questions by MR DE LA POER
 16 **LADY JUSTICE THIRLWALL:** Do sit down.
 17 **MR DE LA POER:** Please could you give us your full
 18 name?
 19 **A.** My name is Alan Clamp.
 20 **Q.** Dr Clamp, is it right that you provided to the
 21 Inquiry a witness statement dated 5 April of last year?
 22 **A.** I did.
 23 **Q.** Is the content of that witness statement true
 24 to the best of your knowledge and belief?
 25 **A.** It is.

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1 just introducing you briefly. You are and have been
 2 since 2018 the Chief Executive of the Professional
 3 Standards Authority for Health and Social Care; is that
 4 right?
 5 **A.** That's correct.
 6 **Q.** We will come to who that organisation is in
 7 a moment. But before you had that role, is it right
 8 that you were the Chief Executive of the Security
 9 Industry Authority?
 10 **A.** I was.
 11 **Q.** That role was I think between 2015 up to 2018,
 12 so a three-year period?
 13 **A.** Yes.
 14 **Q.** Then if we just take a further step back into
 15 your career, between 2011 and 2015 were you the Chief
 16 Executive at the Human Tissue Authority?
 17 **A.** That's correct.
 18 **Q.** As you have told us in the statement you made
 19 at the start, in fact your experience and your career
 20 extends some time before that particular role and it has
 21 been in the regulatory sphere?
 22 **A.** It has essentially for the whole of this
 23 century and before that in regulation in education
 24 primarily with OFSTED.
 25 **Q.** Are you also a Non-Executive Director at the

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1 **Q.** Before we go any further, I understand there
 2 is something that you would like to say?
 3 **A.** I would. Thank you.
 4 I am very aware that this Inquiry is about babies
 5 who have been murdered or suffered significant injuries.
 6 It's about their families, very importantly it is about
 7 their parents. I can think of nothing worse than the
 8 death or serious harm of a vulnerable child.
 9 The Inquiry is about finding out what happened and
 10 doing everything humanly possible to make sure it
 11 doesn't happen again.
 12 I have worked in regulation for over 25 years.
 13 I am conscious that for some regulation might appear
 14 technical, bureaucratic, possibly a bit remote from our
 15 every day lives. But I am also very aware I understand
 16 that but I am very aware that regulation in this context
 17 has a primary function of mitigating the risk of harm in
 18 healthcare and that's why I perform this role.
 19 So I hope that the evidence that I give to the
 20 Inquiry can help us to learn from the dreadful events at
 21 the Countess of Chester Hospital and to make the changes
 22 that are necessary to avoid such tragedies in the
 23 future.
 24 Thank you.
 25 **Q.** Dr Clamp, I will begin my questions of you by

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1 Parole Board?
 2 **A.** I am.
 3 **Q.** And at the Intellectual Property Regulation
 4 Board?
 5 **A.** That's right.
 6 **Q.** Are you a trustee of the Institute of
 7 Regulation?
 8 **A.** I am.
 9 **Q.** So as we turn to the substance of your
 10 evidence now, just telegraph to you that they are going
 11 to be in two parts: we are going to begin by just
 12 introducing who the PSA are, then we will look at the
 13 issue of the accountability of senior managers and we
 14 will look at that in some detail.
 15 So let's start with the PSA, the Professional
 16 Standards Authority, and as the full name suggests it is
 17 responsible for the regulation of health and social
 18 care; is that right?
 19 **A.** That's right, yes. So the professional
 20 Standards Authority for Health and Social Care -- it is
 21 a bit long-winded, so from now on I will refer to it as
 22 the PSA -- we have a role to oversee the function of the
 23 10 regulators of people who work in health and social
 24 care.
 25 So doctors, nurse, pharmacists, dentists, social

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1 workers and our role is to oversee the performance of
2 their regulators.

3 **Q.** You do that through a number of mechanisms, is
4 that right? Firstly do you undertake a performance
5 review process of those regulators?

6 **A.** That's correct. So each year a regulator will
7 have a performance review by the PSA which fulfils our
8 obligation to report to Parliament on their performance.
9 We have a number of standards of good regulation which
10 they either meet or don't meet.

11 We also review their final fitness to practise
12 cases to ensure that they are sufficient to protect the
13 public and if we decide that they are not, we have the
14 ability to appeal those to the High Court. There are
15 very few of those but typically maybe around 25 to 30
16 a year out of the 2,500 cases that are referred to us
17 and we also have a role to try to improve professional
18 regulation through research and policy work.

19 **Q.** I think separate from those 10 regulators, do
20 you also operate an accreditation process for
21 organisations holding voluntary registers?

22 **A.** That's right, there are currently around
23 I think it is 29 such registers of people who work in
24 professional healthcare related roles but who are not
25 regulated under statute. That accounts for about

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1 regulators.

2 **Q.** Just so we are clear about it. You would
3 expect that the regulators who you oversee would be
4 exhibiting exactly the same principles of right-touch as
5 you apply to them?

6 **A.** Yes. We would. I think it is something that
7 they themselves would say as well. I think the most
8 probably common referral to right-touch regulation tends
9 to talk about being proportionate to the risk of harm so
10 that regulation isn't overly burdensome but it still
11 provides the necessary protections.

12 **Q.** I am sure we will come back to those
13 principles when we look in detail at the accountability
14 of senior managers. But just considering the key themes
15 as you describe them in your witness statement of the
16 regulatory improvement work that the PSA undertakes, and
17 here if it's helpful to you I am looking at paragraph 15
18 of your witness statement, you make a number of points,
19 bullet points on page 5 about the themes which run
20 through the policy statements and written work that the
21 PSA undertake and I just want to look at a number of
22 these.

23 The first you say is this: the arrangements for
24 ensuring the safety of health and care in the UK are too
25 complicated, fragmented and difficult to navigate in

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1 130,000 people, compared to the near 2 million who are
2 regulated under statute, many of whom actually work in
3 mental health roles but in a wide range of areas, yes.

4 **Q.** So if you could just give us one or two
5 examples of the sort of organisations you are talking
6 about that are unregulated?

7 **A.** So counsellors, psychotherapists, sports
8 rehabilitation people, and many other organisations it
9 is quite a broad field but all related to health and
10 social care because that is one of the criteria for
11 accreditation.

12 **Q.** In terms of the PSA's involvement in
13 regulatory policy and improvement, would it be right to
14 describe the concept of right-touch regulation as being
15 absolutely central to that?

16 **A.** It would. So right-touch regulation builds
17 upon the better regulatory principles from the latter
18 half of the last century about being proportionate and
19 accountable and consistent and targeted and it builds
20 upon that by adding agility because one of the problems
21 that regulators have is that they are usually operating
22 in an environment which wasn't the one they were set up
23 in and they need to be agile they need to be able to
24 adapt their approaches. So right-touch regulation is
25 a core tenet of our work but also should be of all

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1 particular for patients and the public when they try to
2 raise concerns and it perhaps won't be any surprise to
3 you, Dr Clamp, that in fact Sir Robert Francis, who gave
4 evidence at the start of this Inquiry, made a not
5 dissimilar point about quite how complicated the NHS is,
6 including in relation to its regulation side.

7 So as to that first bullet point, does the PSA have
8 a view on how that can be improved?

9 **A.** Yes. There has been work undertaken looking
10 at the number of bodies that oversee processes in
11 hospitals and one estimate of that has been put I think
12 at 126 different organisations if you take all the
13 different types of regulation into account.

14 And I have already mentioned for example that there
15 are 10 regulators of professionals rather than 1, 2 or 3
16 and therefore I think if taking opportunities to point
17 out that simple regulation is often more effective, but
18 also I think a key point in this statement is at the
19 end. For those people who want to engage with the
20 system where something has gone wrong or they want to
21 make a complaint would find it very complicated to know
22 where to go to.

23 Do you go to the professional regulators? Do you
24 go to the hospital itself? Do you go to the system
25 regulators like the Care Quality Commission? And often

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1 when care is being delivered by a team of professionals,
 2 some of whom are regulated, some of whom are not and by
 3 different regulators, it does get very complicated and
 4 very difficult to actually get things achieved. And
 5 I think one of the points that we make about right-touch
 6 regulation is to embrace simplicity so we have in the
 7 past called for fewer professional regulators and even
 8 in the absence of structural change, better
 9 co-ordination of the work of regulators and better
 10 communication between them.

11 **Q.** Might an example be that we heard from
 12 Mr Jarrold just a few moments ago, the idea that there
 13 is a common code or a common standard that people are
 14 working towards, is that the sort of simplification
 15 which obviously needs a lot of detailed work to make it
 16 work, that the PSA would be in favour of in principle?

17 **A.** I think there is a lot of merit in that. We
 18 recently undertook -- we commissioned some research into
 19 the benefits and drawbacks of a common code across the
 20 professional regulators, which came to the conclusion
 21 that there were a lot of positive points about that,
 22 whilst at the same time needing to recognise that
 23 different professions sometimes have different
 24 requirements but I certainly think there is scope for
 25 a -- a core within that and the previous evidence was

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1 consultation which is open, but also we are working with
 2 NHS England on the development of their leadership and
 3 management framework which would also include a Code of
 4 Conduct so we have another opportunity there to make
 5 those points.

6 **Q.** And in that second sphere, which is just
 7 focused upon the senior managers, and we will come to
 8 the detail of it --

9 **A.** Yes.

10 **Q.** -- but is there an opportunity there to make
 11 sure that it is aligning with the other professions for
 12 the reason that you have given, namely that there is no
 13 good reason why managers should not be in a core sense
 14 acting to the same standards as doctors, nurses and
 15 physios?

16 **A.** I think that opportunity definitely exists.
 17 It is highly desirable and given that if managers and
 18 senior leaders in the NHS were regulated it's likely
 19 that a number of them would be regulated both by their
 20 professional body say as a doctor or a nurse as well as
 21 managers. So the more consistent those models, the more
 22 effective they are likely to be.

23 **Q.** So turning to your second bullet point, which
 24 has elements in common with the first, there are too
 25 many organisations involved creating difficulties in

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1 talking about management. I don't see any good reason
 2 why managers in a hospital would have a different Code
 3 of Conduct which is very much about how we behave to
 4 doctors and nurses. And the one thing that came to mind
 5 when I was hearing the end of the previous evidence was
 6 in fact that the Patient Safety Commissioner for England
 7 has recently published a set of Patient Safety
 8 Principles which build on the Nolan Principles and
 9 I think would be a really good starting point for those
 10 conversations.

11 **Q.** So the PSA identifies a problem, it's done
 12 some research, concludes that the problem is real,
 13 concludes that there is a solution which no doubt needs
 14 further work. How is it then taken to the next stage,
 15 what is -- what takes that first recognition of
 16 a problem through to a solution that is implemented?

17 **A.** I think there are two routes in this context,
 18 the first is, for example, for a common code against the
 19 current statutory regulators. That would be our advice
 20 to the Department of Health and Social Care and the
 21 equivalent bodies within the devolved administrations as
 22 policy advice from the PSA on the basis of the work that
 23 we have done to inform future judgments.

24 When it comes to the possible regulation of NHS
 25 managers, there's an opportunity through the current

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1 determining where remits overlap and where there are
 2 gaps and in managing these.

3 You identify the challenge of working out where the
 4 gaps are. Is it the PSA's role to be investigating that
 5 and identifying that for the benefit of the department,
 6 is that work that the PSA does or is it simply confined
 7 find to identifying the problem and leaving it to others
 8 to investigate it further?

9 **A.** Identifying the problem would be the first
 10 step and where the solutions are within our remit
 11 looking at that as broadly as possible, looking at
 12 professional regulation, it would be our responsibility,
 13 I would argue, to make recommendations as to how that
 14 could be brought about.

15 **Q.** And certainly so far as a code is concerned,
 16 is there a substantial gap at the moment in relation to
 17 senior managers?

18 **A.** One of the things that probably I should have
 19 mentioned in the context of my previous responses is
 20 that all or virtually all of the statutory regulators we
 21 oversee have a unifying aim to protect the public which
 22 is -- I think it's an interesting area because they will
 23 have a statutory basis which says what they have got to
 24 do but then over and above that you must protect the
 25 public because sometimes they feel constrained by their

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1 own legislation in terms of what they can and they can't
2 do.

3 And I think that flexibility to take steps to do
4 work in that broader context without ultimately stepping
5 outside a remit is there.

6 But in terms of senior managers, I think actually
7 in many ways not only is this an opportunity to
8 introduce greater accountability and support and
9 development for senior managers, it's actually also
10 an opportunity to introduce a highly effective
11 regulatory model learning from the current regulatory
12 models.

13 **Q.** Let's turn now to the accountability of
14 managers and I think it's probably important and you are
15 undoubtedly very well placed to assist us with this to
16 understand what we mean by regulation, in other words
17 a professional group of people who are regulated because
18 as I understand it, it can mean a number of different
19 things. You have got statutory regulation in the way
20 that we see classically with the General Medical Council
21 but there are other forms of what might be described as
22 regulation; is that right?

23 **A.** That's correct. I think it might be helpful
24 to reflect I am very conscious as well, being
25 a regulator, I don't want to lapse into jargon, with

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1 **A.** I apologise. In my enthusiasm I didn't fully
2 answer your question there. So yes. When it comes to
3 regulation, I have to be mindful it doesn't just mean
4 one thing or one model. We sometimes talk about
5 a continuum of assurance so if you have low risk
6 professions, there may not be any regulation there,
7 there may be some sorts of checks and balances that are
8 happening locally.

9 Somewhere in the middle which might cover the
10 professions I talked about before around psychotherapy
11 and counselling, you could have a register which would
12 be a voluntary register and that register then might be
13 accredited by the PSA which actually introduces an extra
14 level of quality.

15 And then for the more high risk professions you
16 would probably have a statutory regulator such as the
17 GMC or NMC, those are sort of the three main parts.

18 But even within that, you can have regulation which
19 is based on disbarring, so an unfit to practise or
20 people being on the list who shouldn't be allowed to do
21 that job, or you could have a fit for practice register
22 which is essential what the accredited registers do.

23 So I think it's useful when thinking about
24 regulation of managers to think about different models
25 and it's positive to see in the current consultation

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1 where responsibilities lie for patient safety. So
2 primarily in what is often called a first line of
3 defence it's with the professionals themselves, the
4 people who are giving the care. And that's where
5 professional regulation has most influence.

6 But the next layer out, the second layer of
7 defence, is very much about local controls and
8 governance, clinical governance which are protecting
9 them but also which have the checks and balances on the
10 individual behaviour. And then regulation, the external
11 scrutiny of regulation is the third, the outside layer
12 of that, and that is where regulation can have the
13 maximum impact and it's about checking both that that
14 second line is there that the governance is there, the
15 key role in hospitals being for the Care Quality
16 Commission but also that the professional regulation is
17 working as effectively as possible.

18 **Q.** And so we need to be careful if we talk about
19 the concept of regulating senior managers as to exactly
20 what we mean by that?

21 **A.** Yes.

22 **Q.** And not just assume that it is the existing
23 model of the General Medical Council --

24 **A.** That's right.

25 **Q.** -- for example?

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1 which is out by the Department of Health and Social Care
2 that these various models are set out with their pros
3 and cons to enable people to respond accordingly.

4 **Q.** So if we perhaps take it back to what some may
5 view as its origin point of the Bristol Royal Infirmary
6 report and the Recommendation there, we looked at with
7 Mr Jarrold just before lunch that there were two parts
8 of that Recommendation. We don't need to go over the
9 detail of it. But one was that senior managers be
10 regulated and the other that there be a code which is
11 obviously part of the process of achieving regulation
12 and we know that a code was produced and circulated
13 in 2002 by the Chief Executive of the NHS, Lord Crisp as
14 he is now.

15 In terms of what then happened to it, Mr Jarrold,
16 who wrote it, is of the view that it wasn't widely
17 implemented and even now he isn't sure whether it is
18 current practice or not.

19 What is your understanding of that code and its
20 current status?

21 **A.** I think I would largely agree with - with
22 Mr Jarrold because over time there have been various
23 iterations of this so following that 2002 code the PSA
24 itself which was also set up on the back of the Bristol
25 Inquiry did some work in 2011 and 2012 which

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1 subsequently became a code which was part of the Fit and
2 Proper Person Test following the Mid Staffordshire
3 Report.

4 That then was looked at again by Tom Kark in 2019
5 who recommended a sort of a more robust approach but
6 also a barring list and then a revised version of that
7 was introduced in 2023. But some of the work we have
8 done over time is to look back -- there are various
9 inconsistent references to codes, they may not all be
10 talking about the same code even though they use the
11 same language.

12 So although I have little doubt that there are
13 codes of conduct that are applying in these contexts
14 including things like versions of the Nolan Principles
15 and so on, a central universally recognised and
16 understood Code of Conduct which is consistent across
17 the NHS and as consistent as possible across groups of
18 professionals and ultimately where managers as well
19 doesn't appear to be there.

20 **Q.** You have mentioned the 2012 code which was
21 created by effectively the PSA's predecessor
22 organisation, the Council for Healthcare Regulatory
23 Excellence.

24 Just help us so far as you can about what the
25 origin of that was, why was that needed given that only

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1 earlier and decided it wasn't good enough or whether
2 that wasn't looked at and people were just starting from
3 scratch and trying to invent the wheel for the first
4 time?

5 **A.** I'm afraid I -- I don't know to what extent
6 that was done but do I think that in the context of what
7 you describe as organisational memory, the NHS -- the
8 multiple changes in the structure of the NHS that
9 Mr Jarrold spoke about, that one of the benefits of
10 regulation of NHS managers might be the centralisation
11 and the universality of such a code so that such things
12 are much less likely to happen as we go forward.

13 **Q.** I am just going to bring up one part of the
14 code that was -- or rather the standard as it's
15 described -- produced by your predecessor organisation
16 in 2012. It's INQ0017175 and it's page 4 that we are
17 going to look at. I think it may in fact be internal
18 page 4, so that will be my mistake.

19 So we can see here that the Standards for Members
20 of NHS Boards and Clinical Commissioning Group Governing
21 Bodies in England. If we just pause there to take stock
22 of the title, this standard is aimed at those who sit on
23 NHS Trust -- Foundation Trust as it subsequently came to
24 be and also the Clinical Commissioning Group.

25 Just help us to understand a little bit there

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1 a decade earlier Mr Jarrold had produced the code and
2 the NHS had circulated it?

3 **A.** Well, this -- this definitely predates me but
4 the actual origin of the work was a commission by the
5 Department of Health at the time to ask us to do that
6 work on the basis of that decade and I think of reports
7 and other inquiries which still suggested that whatever
8 needed to improve in that sphere of leadership and
9 management and organisational culture wasn't doing what
10 it should.

11 I think the other problem in this space is that if
12 a code is in place but never formally revoked or
13 replaced people aren't quite sure which code they are
14 applying and it comes back to that point of
15 inconsistency and that was followed up very quickly by
16 the Mid Staffordshire Inquiry which further supported
17 the need for work in this area.

18 **Q.** One of the things that Mr Jarrold spoke about
19 is the problem with the lack of corporate memory and the
20 fact that new things come along and old things get
21 forgotten even if they hadn't been implemented; that is
22 me paraphrasing part of his evidence.

23 Do you know for example whether in 2012 just
24 looking at the process of producing that code, whether
25 anybody looked at the one that was produced a decade

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1 because this is moving perhaps outside the group of
2 people who are often thought about in this sphere as
3 needing regulation or needing a code, the Clinical
4 Commissioning Group, what is the thinking behind
5 including them at this stage?

6 **A.** I think fundamentally when developing
7 standards such as this, you are looking at those people
8 who have the most influence on the organisational
9 culture and the performance of organisations within the
10 NHS and following the Lansley Reforms that were set out
11 in the 2012 Act, the huge changes really that were made
12 to the NHS, including commissioning, warranted
13 a powerful group which sat outside of NHS boards also
14 being held to account for an appropriate Code of
15 Conduct.

16 But I am conscious as well when looking at this
17 that this and in fact iterations after this still
18 focused very much on the top level within the NHS rather
19 than necessarily Executive Leaders and other managers.

20 **Q.** If we go over the page we will see paragraph
21 4.1, which appears under the wider heading of "Technical
22 Competence" and it speaks about how the previous three
23 subparagraphs will be achieved and I just want to draw
24 attention to the wording here:

25 "I will do this by always putting the safety of

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1 patients and service users, the quality of care and
2 patient experience first and enabling colleagues to do
3 the same."

4 Obviously this is the language of 2012. But is
5 that language that the PSA in 2024 regards as important?

6 **A.** Not just important but I think absolutely
7 critical. I mean, I have mentioned the Nolan Principles
8 which I think are laudable and the Patient Safety
9 Principles which actually do emphasise this very point
10 and have been published recently.

11 But the point about the Nolan Principles is that
12 they are not context specific and I think decisions when
13 you are making decisions about people's health and
14 well-being, life or death decisions in effect, this
15 should be coming right at the start of any Code of
16 Conduct.

17 **Q.** So in any new code that may emerge from the
18 current consultation, would you expect language of that
19 type to be right at the very heart of it?

20 **A.** I would. And it's part of the world that
21 I know well in regulation I think it is always important
22 to emphasise that the primary purpose of regulation is
23 public protection, patient protection and therefore this
24 would be absolutely critical for a future code and to
25 influence the work and the decision-making of leaders

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1 some of the important messages such as 4.1 on this page.

2 **Q.** Thank you. We can take that down. So we are
3 going to turn now and I am -- at page 9 of your witness
4 statement under the heading "Right-touch regulation and
5 its potential application to regulating NHS managers".

6 Here we are just going to talk about a few
7 principles, if we may, as to the purpose of regulation.

8 The first question is really this: is the purpose
9 to punish or is it to protect?

10 **A.** It's a phrase which crops up in regulation
11 a lot in various guises but essentially I think
12 regulation is there to both promote goods and control
13 bads. So it is both.

14 I think the more that regulation can work in what
15 I often describe as a positive way, which is
16 preventative, it's based on information, advice and
17 guidance, it's supporting people to meet standards, then
18 obviously that's highly desirable because apart from
19 anything else, it is likely to avoid the harm occurring
20 in the first place.

21 The punishment, technically it's -- it's not
22 punishment, it's about ensuring that people are fit to
23 practise. It might be about supervision or conditions
24 to get them back on track again. But it does need to be
25 there in the face of people who are showing significant

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1 and managers across the NHS.

2 **Q.** Now, one of the matters that Mr Jarrold
3 regarded as extremely helpful to him when he was
4 drafting his code was input from the Plain English
5 Society and he went on to comment about the fact as
6 I think you may have heard when you were in the room
7 that guidance documents and policy seem to be getting
8 longer in his view and obviously there is a question
9 about the accessibility of the language and that
10 a simple principle should be stated simply.

11 Is that something that the PSA recognises and
12 associates itself with or is that something you would
13 disagree with?

14 **A.** No, I would definitely agree with it because
15 it comes back to that point about simple regulation
16 being more effective. People know what the rules are,
17 what the guidance is, it's easier to comply. It's also
18 something that we have reflected on ourselves. I think
19 some of our documents up to even as recently as sort of
20 2019/2020 were I think a little verbose, not always
21 plain English and we have taken conscious steps to do
22 that in our own work and to encourage others to do it as
23 well. I think that the simpler and more straightforward
24 the better and apart from anything else, if you have
25 multiple points in codes it can dilute the nature of

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1 competence or conduct issues who make conscious
2 violations of the rules of the regulations or behave in
3 a reckless manner. So you need that part of regulation
4 to support it but the more that regulation can work on
5 the positive side, to prevent harm in the first place,
6 the more effective it is.

7 **Q.** Now, when you consider as you do at
8 paragraph 26 the principles of right-touch regulation
9 and how there might be they might be applied, you use
10 a phrase I just wanted you to explain to us because it
11 may not be immediately apparent as to what you mean.

12 You say at your second sentence:

13 "A right-touch regulation approach involves
14 understanding both the nature and scale of unmanaged
15 risk in order to identify the most effective regulatory
16 measures for mitigating that risk."

17 Just explain to us why you focus upon unmanaged
18 risk as opposed to identifying what the risks are,
19 whether they be managed or not?

20 **A.** Well, it would start with having to identify
21 the risks but it's making a comparison of an
22 intervention versus a "do nothing" approach. You could
23 have an extra step in there which might be the scale of
24 poorly managed risk because you could have something
25 which looks as if it's addressing a risk but it may not

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1 be effective. So essentially it is about what
2 additional intervention is needed to manage the risk
3 down as low as possible to an acceptable level.

4 **Q.** So although you are mentioning there unmanaged
5 risk you are not suggesting that you are only looking
6 for risks that don't have any mitigations, regulation
7 also involves looking at what the existing mitigations
8 are and whether they are adequate?

9 **A.** Exactly, yes.

10 **Q.** You then propose using the right-touch
11 assurance methodology an assessment of three different
12 types of risk and I just want to see if we can tease out
13 what the differences are between them.

14 So you have intervention and complexity which is
15 your first. Just in simple terms what are you looking
16 for there when you are acting under that heading?

17 **A.** Well, perhaps as well there is a sort of
18 a personal note to self there about the plain English
19 point from earlier but essentially the intervention is
20 the nature of the interactions between in this case
21 I think the patient and the professional. So for
22 example, a liver transplant would be high intervention
23 because it involves, you know, somebody being
24 unconscious, opening them up, complicated procedure, it
25 comes with a lot of risks, whereas there may be other

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1 that will affect the impact of both context and
2 intervention and although we haven't got it in here
3 because it is a typed document, often what we look at
4 with these is a triangle with these three points at each
5 of the apex and trying to identify where the risks sits
6 within that. And it is a development of right-touch
7 regulation.

8 **Q.** So in practical terms can that model of
9 thinking be applied to the question of whether senior
10 managers should be regulated?

11 **A.** It could. Because the idea is that whatever
12 that triangle looks like from a particular occupation
13 will give you an assessment of overall risk and
14 therefore the nature of the regulation that's needed on
15 that continuum of assurance from sort of light touch
16 through to heavy touch.

17 I think the challenge with managers as opposed to
18 some of the healthcare regulated professions that were
19 probably set out back with the Bristol Inquiry is to
20 what extent are they directly responsible for patient
21 safety rather than indirectly using this context, and
22 the fact that management doesn't have a defined set of
23 qualifications or scope of practice like some of the
24 other professions and that some of them may appear very
25 distant, such as if you are a manager of IT systems or

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1 forms of interaction such as an example I used earlier
2 such as counselling which doesn't involve that sort of
3 life or death risk.

4 So it is nature of the intervention between the
5 professional and the patient.

6 **Q.** Context?

7 **A.** The context is essentially where it happens.
8 So if I stick with my example, with the liver surgeon,
9 you could argue in fact that the context there is very
10 controlled. It will often be a group of people in an
11 operating theatre, there may be cameras, may be lots of
12 checks and balances and other professionals whereas the
13 counselling or the psychotherapy could take place in
14 someone's own home and there are different types of
15 risks there because it just be on an individual basis
16 without the clinical governance arrangements.

17 So you could argue in some ways in that case that
18 the context of the individual's home, private home,
19 there are some higher risks involved in that individual
20 interaction.

21 **Q.** Finally agency and vulnerability.

22 **A.** Yes, I think vulnerability is more useful than
23 agency but essentially it is about the nature of the
24 patient. Are they young, old, have they got other
25 health conditions? So how vulnerable are they because

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1 finance or HR, is that really about patient safety? So
2 I think some of those challenges still exist but they
3 are essentially practical challenges and I don't see any
4 reason why you don't apply this model to the regulation
5 of managers.

6 **Q.** Because one thing that might be said to an
7 attempt to simplify things that one could identify
8 perhaps the Board of Directors, that is a defined group
9 of people and we know that there is an expectation that
10 the board will be a unitary board; in other words they
11 have collective responsibility for their
12 decision-making, they control a very substantial budget
13 and ultimately bear responsibility for ensuring that the
14 frontline care is delivered.

15 So if you analyse it in that context in terms of
16 the individuals, might it be said that there is a very
17 good case for the fact that there are considerable risks
18 that need to be controlled there?

19 **A.** Yes. And that would take me back to my point
20 about that key line of defence being governance of which
21 I would make the board a key part. But also there is
22 the point about culture, where the board will also
23 carry, and senior executives, a lot of responsibility
24 for driving the culture of an organisation. Having said
25 that, there will also be other leaders and managers who

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1 in an operational sense are making day-to-day decisions
2 which can affect patient care.

3 So I think what you described as a unitary board
4 would definitely be in scope for regulation but I also
5 think there is a good argument for that extending beyond
6 that to those who have a significant influence on
7 patient safety matters.

8 **Q.** Just one question before we turn to the
9 advantages and disadvantages that you outline in terms
10 of the regulation of senior managers.

11 You mention in paragraph 29 that:

12 "In January 2022 the DHSC published a consultation
13 on criteria for which professional groups should be
14 regulated."

15 You see that's a consultation stage. What has come
16 of the output of that consultation as far as you are
17 aware?

18 **A.** As far as I'm aware to date, so that is now
19 three years on, the Department for Health and Social
20 Care are still considering the consultation responses.

21 Largely that consultation mirrored possibly more
22 accessible language, our own right-touch assurance model
23 and I am conscious that it got, you know, a good amount
24 of feedback, but it hasn't yet been used to make any
25 decisions that I am aware of about when statutory

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1 need to be regulated and whatever is in place at the
2 moment now needs to be strengthened. The question then
3 is just to what extent?

4 **A.** That's correct, and the analysis that follows
5 on from paragraph 32 of my evidence is very much a sort
6 of, you know: here are the pros and cons of doing this,
7 and that runs throughout the document. But so that's
8 why I wanted to put the emphasis on those two paragraphs
9 which essentially says, you know: We need to move
10 forward now after -- 25 years since the Bristol Inquiry,
11 has shown us that whatever we put in place still needs
12 improvements.

13 Now, I should be conscious here about saying that
14 there are two parts to what I want to say. One is there
15 is definitely scope to improve what's there already, but
16 this is the new thing to introduce and I think the
17 current consultation that the Department for Health has
18 out on regulation of managers sets out the different
19 models, which I think closes next month, and I would
20 hope can come to a fairly quick conclusion on an optimal
21 model going forward.

22 **Q.** So let's look at some of the barriers as you
23 describe them. We have substantial cost as being the
24 first, although you acknowledge that that's usually met
25 by the registrants.

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1 regulation is needed. So the consultation is still
2 under consideration and an outcome hasn't been
3 published.

4 **Q.** So let's turn now to what you describe as the
5 key considerations, which begin at page 11, and I will
6 just read to you if I may what you say at paragraph 32.
7 It may be thought by some to be quite powerful:

8 "The advantage of introducing regulation in any
9 form for NHS managers would be the potential to prevent
10 or reduce of harm to patients. This would be achieved
11 through better management of the risks that arise to
12 patients through the work of managers and its impact on
13 care."

14 So straight out of the gates, an advantage is
15 patient safety?

16 **A.** Yes. I, on looking through this evidence more
17 recently, I do want to take the opportunity to emphasise
18 that paragraph as I think being key and I think it's
19 paragraph 54, where I am slightly more explicit to say
20 that steps should be taken to enhance the professional
21 development and accountability of NHS managers;
22 essentially taking both of those together as support for
23 developing regulation for managers.

24 **Q.** So, you correct me if I'm reflecting this back
25 to you incorrectly, senior managers, in your view, do

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1 Now, plainly in relation to relatively low-paid
2 professions, a levy to pay for the regulator may present
3 a very substantial barrier to people wishing to enter
4 that profession because taking any amount of a modest
5 salary can impact very substantially upon quality of
6 life. But here we are talking about well-paid people if
7 we are going to be frank about it, aren't we?

8 **A.** Well, it depends on how far you extend the
9 model --

10 **Q.** Yes.

11 **A.** -- of, of management. But in general, that is
12 true. The introduction of regulation is actually often
13 borne by government, the set-up costs. When it's
14 actually up and running then usually there is a cost to
15 the registrant and that's certainly how it works with
16 statutory regulation for doctors and nurses.

17 And I think given the importance of the
18 decision-making by leaders and managers in these
19 contexts then that, that accountability and that cost --
20 and again if there are significant numbers of people
21 here you do get economies of scale, it doesn't
22 necessarily have to be a prohibitive cost -- the average
23 registration cost for those we oversee is probably
24 around £250 to £300 a year, but for -- I mean,
25 for social workers it's only £90; that's partially

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1 subsidised by the Government. But for nurses for
2 example I think it's around £120 a year.

3 So, yes, I mean, it would be naive not to have the
4 costs in there and they are included in the Government
5 consultation, but I don't think that should be
6 a barrier.

7 **Q.** And of course there is always the option to
8 make the costs reflective of your stage of experience,
9 your banding or your salary depending on what model is
10 ultimately adopted?

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

12 **Q.** The next barrier you identify is a barrier to
13 mobility. Just explain to us what you mean, in simple
14 terms, how the fact that for example to become a board
15 member you will need to pay a levy, that you will need
16 to subscribe to a code, that you may be subject to
17 disbarment and so on and so forth. Why might that be
18 a barrier to mobility?

19 **A.** Well, I think as with many other sectors the
20 NHS can benefit from people with good leadership and
21 management skills coming from other sectors into the
22 NHS.

23 And if they do so, and they look at this now
24 being -- they would become regulated and there would be
25 enhanced accountability and additional costs. It's

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1 Now, is a solution to this particular problem,
2 which undoubtedly where the margins are is difficult to
3 define and different people have different views about
4 it, but is a solution to this problem simply to focus
5 upon those people who obviously should be regulated, get
6 that up and running and then look to perhaps more
7 marginal roles in the future rather than trying to
8 achieve it in one fell swoop particularly if this is one
9 of the most controversial areas?

10 **A.** Yes, I think there are a number of things to
11 consider here. You could, for example, look at
12 individual roles or clusters of roles which have
13 a direct or more of a direct influence on patient safety
14 and say they should be regulated, or you could look at
15 a level within the NHS management structure. I am not
16 overly familiar with the pay and grading scales, but
17 they are there and therefore you could say everybody
18 above level X should be regulated.

19 But I think that the point that you make around
20 that there are some obvious candidates for regulation as
21 a starting point is -- would be a good approach. And in
22 fact one of the advantages of one of the models proposed
23 in the current consultation, that being a voluntary
24 register that the NHS may then choose to essentially
25 mandate because you can't get a job unless you are on

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1 important to consider that as part of the model that is
2 introduced that you wouldn't want to deter people from
3 doing that.

4 Now, you made a point about, you know, the cost of
5 it. Obviously that would be a factor. I think that's
6 within the scope of the employee organisation to take
7 that into account. So it's just to try to make sure
8 that in regulating a number of people who aren't
9 currently regulated you don't deter people from wanting
10 those jobs.

11 **Q.** So one just has to be thoughtful about it as
12 one does it?

13 **A.** Yes.

14 **Q.** Is that what it comes to?

15 **A.** As I say, I think making point that I think
16 there is a lot of merit in the regulation of leaders and
17 managers within the NHS, we need to acknowledge that
18 there are challenges, which is probably partly why we
19 are where we are, we are having that regulation at the
20 moment. But I think the importance of the influence
21 that they can have on culture and quality and safety
22 means that these barriers can be overcome.

23 **Q.** Now, an issue that you have touched upon
24 already which you deal with at paragraph 38 is defining
25 who is included.

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1 the register, has the advantage that you could introduce
2 it quickly, that it may feel more proportionate, but
3 also that it would have that agility to be able to grow
4 if you felt the need to do that and -- but I think the
5 key point in all of that is the pace.

6 In other words, you could introduce something quite
7 quickly for a defined group of people, which you
8 described as being, you know, necessary to have
9 regulated, but you could then keep under review whether
10 that group needed to grow or whether you needed to
11 change parts of the model as you went forward.

12 **Q.** Now, when it comes to a specific group of
13 people the public's focus is very often on the
14 Board of Directors when this discussion is taking place
15 outside of Public Inquiries. But there is another group
16 who are sometimes seen as sitting above boards of
17 directors -- whether that is a correct description or
18 not that is the perception sometimes -- namely, those
19 who sit at the regional level within the NHS England and
20 above and the Inquiry has heard evidence about whether
21 such people have given an instruction or given advice
22 and how that has been interpreted.

23 Is that a group of people, in other words, who are
24 not directly managing a hospital but who are outside of
25 that structure or outside a primary care setting also

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1 a group of people who should be subject to regulation?

2 **A.** Assuming those people -- and I think this is
3 the case -- are influencing the governance, the
4 management structures of let's say in this case
5 hospitals, then I think the same arguments would apply
6 to that group as well and potentially, although the NHS
7 obviously is an enormous and very varied organisation,
8 to some extent the culture, I think the same points
9 would apply; that if you had a Code of Conduct and, as I
10 say, notionally I suspect these people will be following
11 what is in their own minds, set out on paper a Code of
12 Conduct that might be the Nolan principles or something
13 more equivalent, an NHS Code of Conduct, I would argue
14 that the same should apply and the same code.

15 **Q.** So same code, but that would also mean the
16 same register, whether voluntary or otherwise, it would
17 involve the same background checks whatever they may be,
18 the possibility of disbarment for breach of the code,
19 all of those things that we have been discussing,
20 depending on where you draw the line, would apply
21 equally to those who are sitting in that context, is
22 that what your view is?

23 **A.** Following the argument that those who have an
24 influence, certainly a significant influence on patient
25 safety outcomes should be regulated, then that would

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1 doctor whose leadership and management skills may not be
2 particularly strong or the other way round and I think
3 that there is a lot of merit in thinking about having
4 a leadership and management regulator separate from
5 a clinical regulator.

6 Having said that, there is another model whereby
7 the process that already exists let's say within the GMC
8 for developing leadership and management skills could be
9 enhanced so that the professional regulators could have
10 that remit as well. The challenge there would be trying
11 to ensure that what is required of leaders and managers
12 is consistent across all the regulators because they
13 would all have potentially slightly different codes
14 going back to an earlier point.

15 So, again, I think dual registration is
16 a challenge, but it's certainly not insurmountable.

17 **Q.** And in and of itself is not a reason why
18 senior managers should not be regulated?

19 **A.** No.

20 **Q.** I would just like to move through your list
21 just to highlight one of the matters that you draw
22 attention to. At your paragraph 44 under your heading,
23 "Drawing on a wider range of views and evidence", it
24 might seem striking to some but it is a point that you
25 make:

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1 make sense.

2 **Q.** The next issue which appears in a number of
3 the objections is the dual registration issue, namely
4 the fact that a doctor may reach a managerial position,
5 a nurse may reach a managerial position, falling
6 wherever the line is drawn, within the sphere of senior
7 manager and that they have their own obligations
8 already.

9 Now, what's your view as Chief Executive of the PSA
10 in terms of whether this is a real objection to
11 regulation or whether it's just something that needs to
12 be carefully managed so that people are not stepping on
13 each other's toes and that everybody is pulling in the
14 same direction?

15 **A.** Well, there are examples that exist at the
16 moment. A small number of people, but not an
17 insignificant number, who are dually regulated by
18 different regulators and largely those regulators are
19 able to work with each other to decide in the event of
20 a complaint as to how it might be managed.

21 Issues around conduct typically would probably
22 invoke procedures from both regulators. If it was
23 competence, it might be very specific one to the other.

24 The point that I often make in this context is that
25 I think you could have an example you used, a very good

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1 "The arguments being put forth for the regulation
2 of managers appear to be coming from other groups and do
3 not appear to have taken account of the views or
4 insights from managers themselves."

5 I would just like you to amplify that for us,
6 please, in terms of what your understanding is about the
7 extent to which managers have been asked for a view and
8 what you understand the general consensus to be?

9 **A.** I think the point that I am trying to make
10 there is in fact now being addressed through the
11 Department of Health consultation, which is that over
12 a course of, if we just take the last 25 years there's
13 been a number of Inquiries and other investigations
14 which have talked about culture, they have talked about
15 leaders, they have talked about managers and some of
16 them have called for greater accountability.

17 But what we haven't had is a national public
18 consultation on the pros and cons of managers also of
19 which has been informed by having a relative amount of
20 detail on different regulatory models because it is not
21 an area that is familiar to a lot of people. If they
22 think regulation, they probably tend to think about this
23 is -- you know, it's a GMC model or nothing.

24 So I think that is something which hasn't taken
25 place to date but is happening now and I think the

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1 outcomes of the consultation will address that point.

2 **Q.** Moving forward in what you have told us in
3 your witness statement, you provide us with the heading,
4 "Distinguishing between issues of competence and
5 accountability." This I think is a point which you
6 regard as important and I wonder if you could just tell
7 us what you mean by that.

8 **A.** Yes. This, this takes me back to a point
9 I made earlier about what I often call positive and
10 negative regulation or the question that you asked me
11 about punishment.

12 Primarily, regulators should be concerned about
13 ensuring that those that they regulate meet the required
14 standards. But in order to meet standards, people need
15 to know what those standards are, they need to be given
16 opportunities, training and development and support to
17 meet those standards. Some that have will come from
18 professional bodies or qualifications and so on but some
19 of it will also come from the regulator.

20 So this is something about -- and it also is
21 reflected in the work that NHS England are doing on the
22 leadership and management framework. So it's very much
23 about developing people and giving them opportunities to
24 meet standards so they can do a really good job as
25 leaders and managers.

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1 I would expect people to think that I am being held to
2 account by my own board, by in previous lives, by the
3 Home Office or the Department of Health. I think that's
4 absolutely critical.

5 I mean one of the things I try to talk about a lot
6 in regulation is that whether it's the regulators
7 themselves or the PSA or other parts of the system is
8 essentially we are all part of the same team, we all
9 want the same outcomes, we want positive outcomes for
10 patients. The same is true within a hospital of the
11 clinicians and the managers; they should all be wanting
12 the same thing and I can understand that if one group
13 thought the others weren't being held to account for
14 their actions that that would certainly be very
15 difficult for that team work ethos, but why not if you
16 are all there to ensure safety and effective care?

17 **Q.** You indicate though that accountability can
18 drive negative behaviours, that's something you say at
19 paragraph 52. Are you able to give any examples of how
20 in real life circumstances accountability might drive
21 negative behaviour?

22 **A.** I think if either there is an excessive fear
23 of that accountability or that accountability is
24 enforced in too draconian a fashion, it might lead to
25 more defensive practices. It might even lead to

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1 The accountability bit first. I mean, it's part of
2 a job role anyway being accountable but the
3 accountability bit in terms of regulation comes when
4 that conduct or that competence is called into question
5 by behaviour or by mistakes or by referrals from
6 an employer or a patient and that needs to be taken into
7 account as well. So they are different things, but they
8 are complementary and regulation should be addressing
9 both of them.

10 But the more preventative model is to make sure you
11 don't just be thinking about that punishment or that
12 accountability angle because ultimately what you are
13 doing there is commonly waiting for something to go
14 wrong and then taking action. What we really want to do
15 is to stop things going wrong in the first place by
16 having much better quality leadership and management
17 going, again going back to the earlier point in the
18 document that you showed me, with a strong emphasis on
19 the primacy of patient safety.

20 **Q.** How important do you think it is that members
21 of staff who may themselves be regulated have confidence
22 in the accountability of the senior staff?

23 **A.** I suppose from my own professional experience,
24 you talked about the regulators that I have been the
25 Chief Executive of. I am the accounting officer,

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1 clinicians not wanting to get involved in certain
2 aspects of healthcare because they are high risk. It
3 might lead to excessive work to cover one's back to use
4 a phrase and, therefore, I think it is important that
5 the accountability exists, that regulators are good at
6 explaining what they do and what they don't do to try to
7 manage that fear, but also I think that the
8 professionals will look at that accountability and say
9 that that is fair and they see fairness in that.

10 And I think if you have got those things in place
11 it's less likely to drive unwanted behaviour of which
12 there may be other examples, such as whether you define
13 something as a critical safety incident or not and
14 therefore don't have to go through certain reporting
15 change.

16 So I do think it's something to be thoughtful of
17 when introducing a model.

18 **Q.** We have talked around the central advantage of
19 regulation, we have talked about the various challenges
20 and barriers. You address this head on in your
21 statement.

22 I would like you to put it in your own words.

23 Where do you stand on what needs to be done now?

24 **A.** So I think if I -- if I come back to the point
25 about the professional duty of candour which exists now

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1 for regulated professionals, I think there are further
 2 opportunities for regulators to promote that using the
 3 positive side of regulation, the information, the advice
 4 and guidance on how important it is and how to do it as
 5 well as the compliance part which is if you are not
 6 candid there will be repercussions and within
 7 professional regulation I think there's a job there for
 8 the PSA to oversee the work of the regulators in doing
 9 this.

10 In terms of the statutory duty of organisations to
 11 be candid, I think the NHS and the hospitals themselves
 12 that there is scope there for further improvement, but
 13 also the Care Quality Commission in terms of holding
 14 these organisations to account, again in terms of advice
 15 and guidance the CQC can provide but also potentially
 16 sanctions.

17 The third part of what's already there that needs
 18 to develop further I think is around governance and
 19 leadership and culture. So all of that is there, but
 20 can be enhanced.

21 The thing that's new is the regulation of leaders
 22 and managers but introducing that I think will produce
 23 the benefits that I have described in here, in
 24 particular I think it was under paragraph 32 at the
 25 start, but also will drive the improvements that I have

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1 I just want to elaborate a little bit on that full
 2 statutory regulation point because I think the first
 3 thing to bear in mind here is that full statutory
 4 regulation may be particularly a strong response on the
 5 limited evidence base we have got, but that evidence
 6 base grows over time as to whether it's needed or not.

7 But the key thing with it is the amount of time it
 8 would take to put in place and bearing in mind the
 9 purpose of this Inquiry and generally in terms of safety
 10 across the NHS, something that we could put in place
 11 that would be quicker, because it wouldn't require
 12 legislation and public consultation, would be more
 13 agile, as I referred to earlier in terms of expanding
 14 the remit of the managers, leaders and managers that
 15 were covered if that was needed and would feel suitably
 16 proportionate on the evidence base we have got, would be
 17 to actually start with the idea of having a voluntary
 18 register, which the NHS could then choose to mandate for
 19 possibly all managerial positions or managerial
 20 positions in certain clusters or above a certain level
 21 and that would have all of those advantages.

22 That does not rule out, in parallel, developing the
 23 work on statutory regulation or even using that
 24 voluntary register as a stepping stone to statutory
 25 regulation.

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1 been talking about in candour.

2 So I think those are the critical changes that are
 3 needed.

4 **Q.** In terms of what that regulation looks like,
 5 you say in terms that at this stage you are minded to
 6 discount the option of full statutory regulation such as
 7 the GMC, and you say that you have not yet seen evidence
 8 that this is required and further work will need to be
 9 done to establish if it is necessary.

10 You go on to say:

11 "I am also reluctant to suggest a statutory
 12 regulatory solution to what appears to be primarily an
 13 employment issue."

14 And I just want to just explore with you a little
 15 about why you characterise this as primarily an
 16 employment issue?

17 **A.** I think if you -- reflecting back on the idea
 18 about the fit and proper persons test and the idea about
 19 barring senior leaders and managers who have been shown
 20 to be either lacking competence or having conduct
 21 issues, a lot of those things in other sectors would be
 22 seen as the employer themselves dealing with that and
 23 removing them from that employment context.

24 In the I suppose now it is kind of eight months
 25 since writing/submitting this, this evidence statement

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1 So of the models that are presented in the current
 2 consultation I think the voluntary register, possibly
 3 with accreditation by the PSA if that was required, and
 4 probably with the support of the NHS to use the register
 5 would be the best model for now primarily because you
 6 could put that into place much quicker and it could
 7 start to have an effect much quicker and then in
 8 parallel considering whether that should over time
 9 evolve into full statutory regulation.

10 Just -- just to cover one of the other key points
 11 that's in that document which is a barring regime,
 12 I think the issue there is that again would require
 13 legislation, so it wouldn't be quick, and what you have
 14 with the barring regime is you produce a list of people
 15 who shouldn't be employed by the NHS. Now, yes, that
 16 might get rid of a few people who shouldn't be doing
 17 that job, but it does very little to enhance the
 18 standards in all the people that are doing the job.

19 So it addresses that accountability point, but it
 20 doesn't address the competency point. So although the
 21 PSA hasn't yet finalised its response to the Government
 22 consultation, it's likely to essentially say that the
 23 voluntary register with all of its benefits would be the
 24 best way forward at this point in time whilst, at the
 25 same time, you can be doing either the evidence

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1 gathering or the further consultation that might be
2 required for statutory regulation.

3 **Q.** You will tell me if I have got this wrong, but
4 have you softened in the eight months since you wrote
5 this statement in terms of your attitude towards
6 statutory regulation being the end point even if it
7 isn't appropriate because of the time for now?

8 **A.** I -- I would -- I certainly would not rule it
9 out and I think, I mean, maybe if I were to -- I don't
10 know if I have softened or maybe I over-emphasised the
11 words "at this stage". But either way round, I think
12 the important thing in the context of this Inquiry is to
13 enhance that professional development such as is
14 happening with NHS England and the leadership and
15 management framework, but also to enhance the
16 accountability through a regulatory model as soon as
17 possible and, at the same time, use that time when you
18 have got those extra safeguards in place or you are
19 putting those in place to develop the thinking around
20 whether this needs to evolve to the full statutory
21 regulatory model.

22 **Q.** In terms of the voluntary list that you
23 envisage, who is going to administer that in the sense
24 that they will determine whether an individual needs to
25 be removed from that list or that the individual will

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1 continue, but no more than 15 minutes.

2 **MR DE LA POER:** It won't be any more than
3 15 minutes.

4 Just to deal with one or two further points
5 surrounding how this might be implemented practically.

6 When talking about this external registration body,
7 which I think is what we are talking about, your view is
8 that they might assure training programmes, so going
9 towards the competency side rather than the
10 accountability side.

11 From where is the impetus to come to create that
12 body? In other words, that requires people to agree
13 that it's necessary, the PSA isn't going to run that.
14 The PSA might accredit it, but it's not going to run it.
15 Many of these other bodies in the past have developed
16 organically. They've often started life as trade
17 organisations, I think, or common interest organisations
18 that then start to impose requirements on the members.

19 Where would you expect the impetus for that to come
20 from?

21 **A.** I think the starting point would be the
22 government's response to the current consultation, the
23 outcomes of that. So whether a decision is made that
24 managers should be regulated, which I think is certainly
25 government policy in some form as to what the model

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1 not be permitted to join that list?

2 **A.** Well, that could for example be a register
3 that was being run by an entirely new organisation such
4 as one of our accredited registers that I mentioned
5 earlier. It could, subject to constraints and
6 legislation, become part of one of the statutory
7 regulators, the Healthcare Professions Council for
8 example is a multi-professional regulator. I am not
9 an expert on its legislation, whether it could do that.

10 But essentially it would have to be independent of
11 the NHS, but there are a number of models that could be
12 introduced, a number of organisations and again I think
13 that probably comes down to one of those practical
14 points whether you set up something new or you add
15 something to something that's already there.

16 As long as the model works I think it's quite --
17 relatively easy to deliver and, as I say, that pace of
18 change also would be quicker with a voluntary register.

19 **MR DE LA POER:** My Lady, I am conscious of the
20 time. I have probably got about another 15 minutes with
21 Dr Clamp and we have been going I think an hour and a
22 half since lunch, an hour and a half with Dr Clamp.

23 I am entirely in my Lady's hands whether I -- and
24 no doubt the shorthand writer will have a view.

25 **LADY JUSTICE THIRLWALL:** We are all right to

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1 would be.

2 In terms of who would then essentially pick up the
3 mantle with starting to look at the qualifications, the
4 complaints processes, the registration processes and
5 anything that might be needed to deregister somebody, it
6 would be a decision for government.

7 I think potentially they could look at something
8 that already exists to see if they could expand the
9 remit of that organisation to take this on, or
10 an alternative would be essentially -- a second
11 alternative would be an invitation to tender for an
12 organisation that wanted to do this and the third
13 actually might be to set up a new body which, as I say,
14 with most regulatory models they are often set up by
15 government and become self-funding. So that would be
16 an option as well.

17 So I -- I don't -- I think as long as it was
18 effective in what it did, and there are a lot of
19 parallels between that sort of model anyway and
20 statutory regulation in terms of what's required,
21 I think there would be a number of options.

22 **Q.** I would like to turn just to deal with the
23 final section of your witness statement which deals with
24 candour and workplace culture and you have already
25 spoken to this in your evidence so far.

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1 Firstly, it is right that this is an area which the
2 PSA has published in relation to, is that right?
3 **A.** That's correct, yes.
4 **Q.** I just want to ask you, please, about one of
5 the items -- the rest will speak for itself on the
6 website -- is the fear of the regulator and litigation
7 as being a barrier to candour and speaking up. How
8 important is the culture at NHS Resolution to promoting
9 candour?

10 **A.** I think similar to the description that I gave
11 about having a common Code of Conduct, I think the
12 approach of NHS Resolution should be supportive of
13 candour in exactly the same way as the NHS Trusts
14 themselves and the associated bodies. In other words,
15 you should have a consistent approach to do this.

16 Fear of regulation, for example, would be difficult
17 to eliminate, but I do think that regulators can do more
18 in that space to avoid excessive fear of regulation,
19 even only just by explaining what they do and how they
20 do it and how unlikely it is under certain circumstances
21 for people to end up in fitness to practise hearings and
22 fear of litigation, which obviously is more the remit of
23 NHS Resolution should also be addressed by that
24 organisation.

25 And although I am not an expert on its work,
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1 So I think what we attempted to do in setting out
2 the statements were to consider all of these factors so
3 whether it is fear of regulation or litigation, whether
4 it is time pressure, culture being absolutely critical
5 through this, but then reflecting in those last two
6 paragraphs on the challenges of working through the
7 pandemic and some of the things that people were asked
8 to do under very difficult circumstances and also the
9 current workforce pressures and probably workforce
10 issues are one the biggest risks in the system at the
11 moment need to be taken into account when you are
12 considering the difficulties that people have in being
13 candid. Which takes me back to one of my earlier
14 points, which is in recognising and acknowledging those
15 and being very clear, let's say, with professional
16 regulatory advice and guidance that this is recognised
17 but candour is still so important that you need to be
18 able to see beyond these.

19 So I think it is trying not to essentially say, you
20 know: here is a rule, write it on the wall, you must be
21 candid. It is to recognise the operating context of
22 these professionals and say: we are aware of all these
23 things, this is how you can work round it. In fact, we
24 can provide some further advice and training and
25 development in how to speak up, how to get listened to.
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1 I certainly pick up over the last couple of years that
2 the work of NHS Resolution has, you know, is generally
3 positive about the importance of doing this and about
4 saying sorry when things go wrong.

5 **Q.** Turning to the final part of what you say in
6 your witness statement. You seek to draw attention at
7 paragraphs 77 and 78 to two factors which you regard as
8 significant when we are considering this overall theme
9 of candour. Just to headline them for you, they are the
10 effect of the pandemic and the current workforce and
11 demand crisis in the NHS and I wonder if you could just
12 briefly amplify how each of those two factors are in
13 your view relevant to this sphere?

14 **A.** I think these, these two factors are
15 essentially contextual in terms of the operating
16 environment of people.

17 I talked about the second-line checks, the second
18 line of defence ensuring patient safety in hospitals
19 around being governance and so on. But actually a very
20 important informal second-line checks is working in an
21 environment where you are surrounded by professionals
22 who will speak up if they think that something is amiss
23 and actually to follow that up they will speak up if
24 they feel that someone will listen and if they feel that
25 someone will act.

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1 But quite critically one of the key things is how
2 the organisation itself responds when somebody speaks
3 up. And I am paraphrasing the Patient Safety
4 Commissioner when I talk about Speak Up, Listen Up, Act
5 Up, but it is something she says all the time and
6 I think this is just two more key points that have
7 been -- well, the pandemic, the effects of the pandemic
8 are still with us, the workforce pressures are
9 definitely there, that need to be taken into account
10 rather than just say: there's the rule, follow it. It
11 is about acknowledging that there are numerous barriers
12 to doing that and try to dismantle those barriers.

13 **MR DE LA POER:** Dr Clamp, thank you very much
14 indeed. Those are my questions.

15 My Lady, there were two permissions granted I think
16 Mr Baker has five minutes which will bring us in I hope
17 under the time that we indicated for the shorthand
18 writer but I don't think Mr Sharghy -- no, he has no
19 questions, so just Mr Baker.

20 Questions by MR BAKER

21 **MR BAKER:** I ask questions on behalf of two of the
22 Family groups. You have heard I only have five minutes
23 so forgive me if I am a little direct?

24 **A.** Okay.

25 **Q.** In relation to paragraph 57 of your witness
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1 statement, you say there it is a point Mr De La Poer
 2 took you to a moment ago that NHS managers are employed
 3 under NHS contracts and the Inquiry should explore
 4 whether the NHS itself should perform the roles that
 5 statutory regulation might be expected to play.

6 Now, of course the NHS could have done that at any
 7 point, couldn't it, under the existing contracts or
 8 under its existing powers?

9 **A.** The point here I think it comes back to my --
 10 the point I made about teamwork, is that regulation
 11 isn't the only answer to patient safety. There are
 12 a number of levers and to really keep people safe they
 13 should all be working as effectively as possible and the
 14 employer being on site and local and there 24/7 has got
 15 a key role to play in the effectiveness and the quality
 16 of leadership and management and the culture within
 17 individual establishments.

18 So I think it's just trying to make sure that we
 19 are not looking at just one place for the answers to the
 20 problems. But that the process that already exists
 21 within the NHS inevitably can be enhanced.

22 **Q.** Yes, but of course this isn't the first
 23 circumstance or incident where managers and their role
 24 in patient safety issues has been brought to the
 25 attention of an Inquiry or indeed to the world in a more

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1 **A.** Thank you.
 2 **LADY JUSTICE THIRLWALL:** -- which is now completed
 3 and you are free to go. Thank you.

4 **A.** Thank you.

5 **LADY JUSTICE THIRLWALL:** Does that conclude the
 6 evidence for today, Mr De La Poer?

7 **MR DE LA POER:** It does.

8 **LADY JUSTICE THIRLWALL:** We are starting tomorrow
 9 at 10 tomorrow, are we, as usual?

10 **MR DE LA POER:** We are, thank you.

11 **LADY JUSTICE THIRLWALL:** In that case, we will rise
 12 now and reconvene at 10 o'clock tomorrow morning.

13 (3.44 pm)

14 (The Inquiry adjourned until 10.00 am,
 15 on Wednesday, 8 January 2025)

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1 broad sense.

2 Would it not suggest that if these powers are not
 3 being used effectively and given that the role of
 4 managers was highlighted as long ago as 2001 by Sir Ian
 5 Kennedy that leaving it to the NHS to do it itself
 6 through its existing mechanisms probably isn't robust
 7 enough?

8 **A.** And that is why regulation of managers in some
 9 form as being explored in the current consultation is
 10 required to support that and in fact provide I think
 11 additional frameworks and guidance that the NHS can use,
 12 without it, there's always a risk under this situation
 13 that then such matters are deferred only to the
 14 regulators rather than being dealt with locally. So
 15 I do think it is a combined effort but the regulation of
 16 managers would enhance that.

17 **Q.** Yes, so a combined approach between internal
 18 structures and external regulation?

19 **A.** Exactly, yes.

20 **MR BAKER:** Thank you, I am grateful. My Lady,
 21 I think I kept within my five minutes.

22 **LADY JUSTICE THIRLWALL:** You did, thank you very
 23 much indeed, Mr Baker.

24 Dr Clamp I have got no questions for you, thank you
 25 very much indeed for your interesting evidence --

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