

Thursday, 14 November 2024

(10.00 am)

**LADY JUSTICE THIRLWALL:** Mr De La Poer.

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

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

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

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

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

Second, there are no records available of any of

1

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

3

the core interviews with senior managers during the inspection.

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

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

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

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

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

**LADY JUSTICE THIRLWALL:** Very well.

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

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

MS HELEN CAIN (sworn)

Questions by MR CARR

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

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

**A.** Helen Cain.

2

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

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

4

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

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

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

25           **A.** Yes.

5

1 apart from an inspection?

2           **A.** Yes, yes.

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

5           **A.** Yes.

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

9           **A.** Yes.

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

14           **A.** Yes.

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

19           **A.** Yes.

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

22           **A.** Yes.

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

25           **A.** Yes.

7

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

3           **A.** Yes, and their clinical expertise.

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

8           **A.** Yes.

9           **Q.** The other being monitoring?

10           **A.** Yes.

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

13           **A.** Yes.

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

16           **A.** Yes.

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

19           **A.** Yes.

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

23           **A.** Yes.

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

6

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

3           **A.** Yes.

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

6           **A.** Yes.

7           **Q.** Returning to the 2016 inspection. I want to  
 8 look at the information gathered ahead of the  
 9 inspection.

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

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

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

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

8

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

4 A. (Nods)

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

7 A. For the core service, yes.

8 Q. For the core service?

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

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

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

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

9

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

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

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

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

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

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

24 A. Yes.

25 Q. -- you think there were more documents

11

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

3 A. Yes.

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

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

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

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

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

10

1 obtained by the Trust for the purposes of this  
2 inspection?

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

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

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

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

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

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

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

12

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

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

13 Q. If we can have on screen, please, INQ0103249,  
14 if we turn, please, to page 3 of that document. The  
15 email in the bottom half of that page dated  
16 15 February 2016 from John Cunningham to Ruth Millward  
17 at the Trust.

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

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

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

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

13

1 the first visit.

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

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

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

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

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

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

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

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

15

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

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

6 A. Yes.

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

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

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

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

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

14

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

3 A. Before we were actually on site.

4 LADY JUSTICE THIRLWALL: Yes, yes, thank you.

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

10 A. Yes.

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

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

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

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

16

1 and learning from them.

2 Every Trust should have a mortality and morbidity  
3 process. Part of the inspection process is to identify  
4 how the Trust assure themselves they are learning from  
5 that, they are following the process and learning from  
6 deaths and subsequently assure the CQC that the process  
7 is in place and it's being followed.

8 **Q.** Page 5 of this document, please. The first  
9 entry.

10 "Incidents relating to neonates and paediatrics,  
11 last 12 months"?

12 **A.** Yes.

13 **Q.** So you are asking there for incidents leading  
14 right up to the time of the inspection?

15 **A.** Yes.

16 **Q.** Again that is presumably because you want the  
17 most up-to-date information as to what's going on in the  
18 hospital?

19 **A.** Yes.

20 **Q.** Did you receive all of the documents that you  
21 requested?

22 **A.** No.

23 **Q.** Which documents did you not receive?

24 **A.** The only one that I can remember specifically  
25 is the Mortality and Morbidity Meeting minutes from

17

1 practice, I -- I would take although the day before the  
2 on-site inspection it is part of the inspection period  
3 which is I think where my confusion has come between  
4 making them months before or weeks before and the day  
5 before. If it was the week of the on-site inspection  
6 that I would -- my interpretation is that that is part  
7 of the inspection week.

8 Those documents that we had asked for would come  
9 through in tranches, either myself or any of the other  
10 core services leads, it could be the next day, it could  
11 be with -- on the inspection time, we were on site, it  
12 could be subsequent to the site visit.

13 **MR CARR:** What was the nature of the further  
14 documents that you requested after 15 February?

15 **A.** I am sure -- I would have to have a look to  
16 see what I have requested.

17 **Q.** The other page is page 4.

18 **A.** There would definitely be staffing information  
19 because during the on-site inspection, nurse staffing on  
20 both the paediatric unit and the neonatal unit was  
21 identified as a cause of concern.

22 **Q.** In circumstances where a data request is not  
23 made until the day before the inspection visit starts,  
24 and may not be responded to until after the inspection  
25 visit occurs, any documents received afterwards can't be

19

1 10 December.

2 **Q.** When did you receive the documents that you  
3 had requested?

4 **A.** It could -- it was -- it could be immediately,  
5 it could be during the period of the inspection. It  
6 could be subsequently following the on-site visit.

7 **Q.** Do you know which of those applied here?

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

9 **Q.** Do you know which of those timeframes applied  
10 on this inspection, did you --

11 **A.** It was that -- it would -- it could be any  
12 time. The Trust -- during the inspection the Trust were  
13 questioning, we were -- the CQC requested a lot of  
14 documents from the Trust and it was quite an undertaking  
15 for the Trust to provide all the documents for all the  
16 core services as they were required.

17 **LADY JUSTICE THIRLWALL:** Sorry, just so that  
18 I understand this, so you made the request for all the  
19 documents that we are looking at now before you got  
20 there but then did you make more requests for more  
21 documents while you were there?

22 **A.** It is possible.

23 **LADY JUSTICE THIRLWALL:** Well, can you help  
24 a little bit more than that?

25 **A.** Sorry, yes, yes, I would have done. Normal

18

1 discussed with the people you are interviewing?

2 **A.** Usually the request for a document has come as  
3 a result of an observation or a discussion on site.

4 **Q.** Well, this request is dated 15 February, so it  
5 can't have come as a result of an observation or  
6 a discussion?

7 **A.** I'm sorry, I think -- there were -- you  
8 would -- there would be a normal number of documents  
9 that you would request as a matter of course to support  
10 the judgment making. And this -- you would -- these are  
11 part of those requests.

12 **Q.** Wouldn't you want to see up-to-date  
13 information and to receive it prior to conducting  
14 interviews?

15 **A.** It -- it would depend on the information.  
16 Some of it is information that you require to -- to  
17 support the judgment. Some of it is to provide  
18 assurance of what, of the service that's been provided.  
19 So not every piece of evidence requested would require  
20 a conversation. You wouldn't need to ask about every  
21 piece of evidence.

22 **Q.** Yes, but you wouldn't know what you need to  
23 ask questions about or not until you have received it  
24 and assessed it?

25 **A.** Not necessarily. Because some of the  
20

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

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

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

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

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

11 **A.** Yes.

12 **Q.** At paragraph 22, you say:

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

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

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

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

25 **A.** Can you repeat the question again, please?

21

1 **Q.** At paragraph 24 you state:

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

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

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

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

18 **A.** Yes.

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

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

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

23

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

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

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

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

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

19 **Q.** Not every Trust would meet your expectation --

20 **A.** Possibly.

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

23 **A.** That.

24 **Q.** -- you would want to see it?

25 **A.** Absolutely.

22

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

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

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

19 **A.** No.

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

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

24

1 Now we are about to look at some of the  
 2 documentation. But from who and how would you expect  
 3 that information to be provided?  
 4 **A.** Through the Provider Information Return.  
 5 **Q.** When you considered the Provider Information  
 6 Return did you find anywhere in there clear  
 7 documentation setting out details regarding unexpected  
 8 or unexplained deaths at the neonatal unit?  
 9 **A.** Not that I remember.  
 10 **Q.** Again, did you raise with the Trust or the CQC  
 11 the absence of that information?  
 12 **A.** No.  
 13 **Q.** I asked you earlier about the two NHS England  
 14 reporting systems: the National Reporting and Learning  
 15 System and the Strategic Executive Information System,  
 16 so the systems for reporting serious incidents and  
 17 patient harm incidents?  
 18 **A.** Yes.  
 19 **Q.** You explained that the CQC tracks those  
 20 systems as part of its monitoring. For the purposes of  
 21 preparing your evidence, you have been provided the  
 22 spreadsheets, haven't you, showing entries on those two  
 23 systems --  
 24 **A.** Yes.  
 25 **Q.** -- containing reporting made by the Trust.

25

1 information for the core service ahead of the  
 2 inspection.  
 3 I don't remember from the intelligence pack those  
 4 being highlighted.  
 5 **Q.** We will look at some of the documents relevant  
 6 to the inspection in a few moments. But they don't  
 7 identify, do they, the report of the Serious Incident of  
 8 Child D?  
 9 **A.** No.  
 10 **Q.** And they don't make any mention at all, do  
 11 they, of the entries that I have described, to the  
 12 National Reporting and Learning System, in respect of  
 13 Child A, Child C, Child D, Child E and Child I?  
 14 **A.** No.  
 15 **Q.** Had you been given access to this information  
 16 would it have changed your approach in preparing for or  
 17 conducting the inspection?  
 18 **A.** Yes.  
 19 **Q.** How so?  
 20 **A.** Because it would have been more of a focus of  
 21 the inspection. There would have been more direct  
 22 questions asked about mortality and morbidity.  
 23 **Q.** And something that you would have  
 24 investigated?  
 25 **A.** Absolutely.

27

1 Now, I am not going to put that document on screen  
 2 because it contains sensitive third party information  
 3 but you will have seen from those spreadsheets that on  
 4 3 July 2015, the Trust reported to the Strategic  
 5 Executive Information System for Serious Incidents and  
 6 Never Events the inspected potentially avoidable death  
 7 of Child D?  
 8 **A.** Yes.  
 9 **Q.** It was reported as a Serious Incident, due to  
 10 what was reported as a delay recognising sepsis.  
 11 Were you made aware of that report in the course of  
 12 your preparations for the inspection?  
 13 **A.** Not that I can remember.  
 14 **Q.** The deaths of Child A, Child C, Child D,  
 15 Child E and Child I were reported to the National  
 16 Reporting and Learning System in the months prior to  
 17 your inspection. Were you aware of the reports made to  
 18 the National Reporting and Learning System?  
 19 **A.** No, not that I remember.  
 20 **Q.** Given the CQC has access to that information  
 21 and tracks those systems, should it have been provided  
 22 to you?  
 23 **A.** My -- my understanding is that the  
 24 intelligence report provided by the CQC data analysts  
 25 reviews Serious Incidents Never Events and provides that

26

1 **Q.** A document that you did receive, and again  
 2 I am not going to put it on screen because of the  
 3 sensitive third party information it contains, is one  
 4 that I understand was prepared by the Trust, it is  
 5 a spreadsheet titled "NNU Paediatric Incidents  
 6 1 December 2015 to 31 January 2016".  
 7 **A.** Yes.  
 8 **Q.** You know the spreadsheet that I am referring  
 9 to?  
 10 **A.** Yes.  
 11 **Q.** It contains in total some 377 entries?  
 12 **A.** Yes.  
 13 **Q.** It's arranged over six columns with a column  
 14 for an ID number?  
 15 **A.** Yes.  
 16 **Q.** A column for the date of the incident?  
 17 **A.** Yes.  
 18 **Q.** A column for the location of the incident?  
 19 **A.** Yes.  
 20 **Q.** And then there is a column which is colour  
 21 coded for actual harm with green for none, yellow for  
 22 low, so low harm, orange for moderate harm and red for  
 23 severe harm?  
 24 **A.** Yes.  
 25 **Q.** Then there is a description of the incident in

28

1 question?

2 **A.** Yes.

3 **Q.** What was your understanding as to the basis  
4 for that document, how it had been prepared?

5 **A.** It was a list, with detail, of all the  
6 incidents that had been reported in the Children and  
7 Young People's Service within that timeframe.

8 **Q.** The presentation of that document, is that  
9 a standard document that you would see for most  
10 inspections?

11 **A.** Yes.

12 **Q.** It's quite a substantial document, isn't it?

13 **A.** Yes.

14 **Q.** It runs to some 25 pages with as I said what  
15 appears to be 377 entries. Are you confident that you  
16 would have read each and every entry or is it likely  
17 that you would focus only on those coloured red for  
18 severe or orange for moderate?

19 **A.** I would have looked at every incident.

20 **Q.** Eight entries in that table include in the  
21 description death, don't they?

22 **A.** Yes.

23 **Q.** Now the first query. Would you expect all  
24 neonatal deaths on a unit to be included in a table such  
25 as that?

29

1 **A.** I think incidents would have been discussed.  
2 I can't remember exactly the detail of, of the  
3 conversation.

4 **Q.** Dr Odeka, one of the Specialist Advisories and  
5 we are going to be hearing evidence from him later  
6 today, but in his statement when looking at this table  
7 he reviewed it for the purposes of his statement. He  
8 says that the categorisation struck him as inaccurate  
9 and he wondered if the data was being inputted into the  
10 Datix system incorrectly.

11 Now, if you had had a discussion with him about  
12 this table, at the inspection, and he told you that he  
13 considered the categorisations to be inaccurate, how  
14 would that have affected your conduct of the inspection?

15 **A.** It would have been one of the questions asked  
16 with the service leads.

17 **Q.** If you can turn to your paragraph 57, please.  
18 It's the first sentence. When dealing with this table  
19 you say:

20 "Overall, nothing from the table of incidents  
21 appeared immediately concerning when I reviewed it in  
22 advance of the inspection."

23 That would suggest, then, when looking at the  
24 table, reading all of the entries, you weren't concerned  
25 as to whether the categorisation, particularly of events

31

1 **A.** Yes.

2 **Q.** And those eight entries, they are all marked  
3 green for none, aren't they, in the "Actual harm"  
4 column?

5 **A.** Yes.

6 **Q.** Can you explain your understanding of the "no  
7 harm" categorisation? It's paragraph 58 if you want to  
8 see what you said in your statement.

9 **A.** My understanding was the clinician completing  
10 the incident form made the assessment that no harm had  
11 occurred as a result -- direct result of the clinical  
12 care provided.

13 So not that the death in itself wasn't harmful but  
14 in their opinion when they were completing the incident  
15 form, that no harm had occurred as a result of the  
16 treatment or care.

17 **Q.** Did it strike you as odd that cases involving  
18 death were marked "no harm"?

19 **A.** No, for the reasons I have just mentioned.

20 **Q.** Did you share or discuss this table or the  
21 entries in the table with the Specialist Advisers?

22 **A.** I can't remember.

23 **Q.** Do you think this is a document that you  
24 should have shared or discussed with the Specialist  
25 Advisers?

30

1 involving child death, was or might be incorrect?

2 **A.** No.

3 **Q.** Going back in your statement to paragraph 51,  
4 and again this is a reference to one of the entries in  
5 that table, it's one concerning Child A and it's entry  
6 188 in the table, the spreadsheet.

7 You describe the entry there, what the entry in the  
8 table says is:

9 "Sudden and unexpected deterioration and death of  
10 a patient on the neonatal unit after full resuscitation.  
11 Requiring postmortem."

12 So within the description in the table you have  
13 a reference, don't you, to a Sudden and Unexpected  
14 Death?

15 **A.** Yes.

16 **Q.** There is a suggestion -- well, it's clear, not  
17 a suggestion -- that the cause of death is yet to be  
18 ascertained?

19 **A.** Yes.

20 **Q.** It is awaiting postmortem.

21 Now whilst this has been marked "no harm" in the  
22 table, there's nothing in the description that explains  
23 or seeks to justify why it's been marked "no harm"?

24 **A.** But there was no evidence, there was no --  
25 nothing in the description to suggest that there was any

32



1 harm caused.

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

9 **A.** Yes.

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

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

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

33

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

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

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

14 **Q.** You say the process was tested. How was it  
15 tested?

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

35

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

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

10 **A.** Yes.

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

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

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

25 Again a similar question: wouldn't that warrant

34

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

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

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

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

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

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

23 **A.** Yes.

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

36

1 will see that what Alison Kelly writes is:

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

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

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

16 **A.** Yes.

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

22 **A.** Could you clarify which reviews you mean?

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

24 **A.** Yes.

25 **Q.** November 2015, forgive me. And the Thematic

37

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

6 The February 2016 Thematic Review starts by saying:

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

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

12 **A.** Absolutely.

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

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

39

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

3 **A.** Yes.

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

6 **A.** At the time of the inspection?

7 **Q.** Yes.

8 **A.** No.

9 **Q.** At paragraph 62 of your statement you say:

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

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

17 **A.** No.

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

20 **A.** No.

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

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

38

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

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

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

8 **A.** If -- if a review of this nature had taken

9 place, I would have expected it. However, not all  
10 Trusts are as open and transparent as you would hope  
11 that they would be in the inspection process.

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

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

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

40

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

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

13 **A.** Yes, I did.

14 **Q.** 4 March.

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

17 **A.** Yes.

18 **Q.** -- isn't it?

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

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

41

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

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

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

14 **A.** Yes.

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

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

24 **A.** Yes.

25 **Q.** For services for children and young people,

43

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

3 So clearly identifying there unexpected and  
4 unexplained deaths.

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

10 **A.** Yes.

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

18 **A.** Yes.

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

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

42

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

3 **A.** Yes.

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

6 **A.** Yes.

7 **Q.** Three good, two outstanding.

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

10 **A.** It wouldn't have any impact.

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

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

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

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

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

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

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

10 What is the purpose of this document?

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

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

16 **A.** This and the intelligence document, the  
17 subsequent intelligence document that was used in the  
18 presentation.

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

21 **A.** To my recollection, yes.

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

45

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

3 **A.** Yes.

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

7 **A.** Yes.

8 **Q.** In particular for preparing the report?

9 **A.** Yes.

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

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

14 **A.** Yes.

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

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

19 The box underneath that requires further  
20 investigation:

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

24 **A.** Yes.

25 **Q.** And so that is identifying all the categories

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1 **A.** Available to the CQC analysts, yes.

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

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

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

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

15 **A.** Now -- now, yes.

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

18 **A.** No.

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

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

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

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

4 **A.** Yes.

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

8 The first bullet point:

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

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

15 **A.** Yes.

16 **Q.** Bullet point 2:

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

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

21 **A.** Yes.

22 **Q.** 3:

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

48

1 externally?"

2 Now, the reference to reporting externally safety  
3 incidents, that would be reporting externally to whom?

4 **A.** NRLS, STEIS. At the time the Clinical  
5 Commissioning Group; those sorts of people.

6 **Q.** Now, in respect of those first two entries:

7 "Safety performance over time, how does safety  
8 performance compare?"

9 Did you obtain evidence as to the safety  
10 performance over time or the comparison with like units?

11 **A.** That was the intelligence that the CQC  
12 analysts provided.

13 **Q.** At page 19 of this document, please, under the  
14 heading "Effective":

15 "Requires further investigation ..."

16 Sorry, two boxes down, in bullet points "NRLS  
17 incident" and that is not restricted, is it, it doesn't  
18 say "only moderate"? That has an NRLS incident and then  
19 secondly STEIS -- Serious Incident, STEIS, Never Events.

20 So in order to assess in the "effective" category  
21 this document is suggesting that you look at the entries  
22 on those reporting systems or you obtain evidence of the  
23 entries?

24 **A.** But all those incidents that would be going to  
25 NRLS and STEIS would be part of the multiple incidents

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1 (11.40 am)

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

3 **MR CARR:** Thank you. I asked you about the  
4 document dated December 2015, the pre-inspection  
5 document and I took you to what you said about  
6 Never Events being reported and you mentioned that there  
7 had been an update from the December document to the  
8 intelligence briefing. I just want to get that  
9 intelligence briefing back up, it's INQ0103620.

10 So that we can understand the purpose of this  
11 document, it appears to be a PowerPoint presentation  
12 for, a presentation on 16 February, the first day of the  
13 inspection visit?

14 **A.** Yes.

15 **Q.** It would be a presentation to who?

16 **A.** To all the inspection teams.

17 **Q.** And so the Specialist Advisers would see this?

18 **A.** Yes.

19 **Q.** Would they be given a copy of it as well or  
20 would it just be on the screen?

21 **A.** I don't know, to be honest.

22 **Q.** If we go to the section dealing with Children  
23 and Young People's Services the summary of intelligence  
24 is takes up only two pages. Page 27. We see the first  
25 bullet point there:

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1 that were reviewed as part of the spreadsheet.

2 So they would be on the incident spreadsheet, they  
3 would then be reported -- those that required reporting  
4 would then be reported up to NRLS or STEIS.

5 So they should have already been part of the  
6 incident spreadsheet.

7 **Q.** Yes, you reviewed the incident spreadsheet.

8 It doesn't identify does it whether any of the entries  
9 were reported to NRLS or STEIS?

10 **A.** Not that I am aware of, that I can remember.

11 **Q.** When I was asking you earlier about the STEIS  
12 report in respect of Child D, your recollection was that  
13 you were unaware that there had been a report to STEIS  
14 in respect of Child D?

15 **A.** Yes.

16 **Q.** You were unaware of the reports in respect of  
17 several children to NRLS?

18 **A.** Yes.

19 **MR CARR:** My Lady, that would be a convenient  
20 moment for a break, if it pleases you?

21 **LADY JUSTICE THIRLWALL:** Thank you very much  
22 indeed. So we will take a break now and we will come  
23 back in at 20 to.

24 (11.21 am)

(A short break)

50

1 "No Never Events or Serious Incidents reported up  
2 to January 2016."

3 So although it is right to say that the  
4 December 2015 document was updated to January 2016 --

5 **A.** Yes.

6 **Q.** -- it still has the same omission, doesn't it?

7 **A.** Yes.

8 **Q.** The summary of intelligence doesn't include,  
9 does it, any entries from the National Reporting and  
10 Learning System?

11 **A.** No.

12 **Q.** Thank you. We can take that document down.  
13 There is a pre-inspection briefing pack which presumably  
14 was provided to you and Specialist Advisers which set  
15 out the key lines of inquiry to explore?

16 **A.** Yes.

17 **Q.** I am not going to take you to that, I am going  
18 to move forward, please, to the inspection itself. Now,  
19 ahead of the inspection, a week before, there was  
20 a listening event for patients on 9 February 2016, but  
21 as I understand it you didn't attend that?

22 **A.** No.

23 **Q.** Did you receive any feedback of any issues  
24 raised at that meeting?

25 **A.** Not that I remember.

52

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

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

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

9 A. I can't remember but my usual practice was to  
10 telephone the Special Advisers just to introduce myself.

11 That was my usual practice. I can't say for sure  
12 whether this happened at the Countess of Chester.

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

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

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

24 A. Yes.

25 Q. You also did a walk through the paediatric

53

1 mortality?

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

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

10 A. Nothing, no, nothing like that.

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

15 A. No.

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

19 A. Not specifically.

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

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

25 So --

55

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

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

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

12 A. Yes.

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

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

17 Paragraph 114:

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

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

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

25 Q. So there's no discussion of neonatal

54

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

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

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

9 **LADY JUSTICE THIRLWALL:** Yes, sorry do go ahead.

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

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

15 A. Yes.

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

21 A. Yes.

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

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

56

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

4 A. Yes.

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

11 Can you help us with that section?

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

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

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

57

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

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

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

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

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

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

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

25 A. Yes, that is right.

59

1 text.

2 Yes. Can you tell us what that says?

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

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

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

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

19 A. For the neonatal unit.

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

22 A. No.

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

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

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

3 A. No.

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

6 A. No.

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

10 A. No.

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

13 A. No.

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

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

18 Q. So is the answer to the question no?

19 A. No.

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

25 A. I think by discussing the process and how the

60

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

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

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

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

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

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

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1 **A.** On some occasions.

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

11 **A.** (Nods)

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

18 **A.** Yes.

19 **Q.** Did you ask that question?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65

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

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

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

17 A. No.

18 Q. -- written documents --

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

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

25 A. Yes.

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1 relevant part might be the second half of the page.

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

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

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

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

24 A. No.

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

66

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

3 A. Yes.

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

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

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

11 Q. It's INQ0017295, at page 10.

12 The fifth column "High level ratings indicators".

13 We see "panel" --

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

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

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1 particularly with staffing in both the neonatal unit and  
 2 the children's and paediatric services.  
 3 However, risks were mitigated, managers were aware  
 4 of the risks, and were actively -- had actively  
 5 described scenarios and experiences that they had moved  
 6 to to mitigate that risk. They could describe actions  
 7 that were being taken.

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

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

14 **A.** Yes.

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

17 **A.** Yes.

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

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

22 **A.** I'm, sorry say that again?

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

24 **A.** Yes.

25 **Q.** Everything else has been graded "good"?

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

4 **A.** Yes.

5 **Q.** -- and determining that their categorisations  
 6 were correct?

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

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

13 **A.** Yes.

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

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

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

25 **A.** Not specifically. There's obviously

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1 **A.** Yes.

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

3 **A.** Yes.

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

9 **A.** Yes.

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

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

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

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

25 I have asked you many questions on that, that

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

3 **Q.** We can take that document down.

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

8 **A.** Yes.

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

11 **A.** Relationship owner.

12 **Q.** Relationship owner, sorry, forgive me.

13 **A.** Yes.

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

17 **A.** Yes.

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

20 **A.** Yes.

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

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

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1 staff as at November 2017?

2 **A.** I think possibly then, yes, I think.

3 **Q.** Dealing finally, then, with some reflections.

4 Dealing finally with some reflections, looking back  
5 particularly on the inspection.

6 The CQC inspection did not detect the concerns that  
7 we know existed at the neonatal unit. What is your  
8 explanation for the failure to detect those concerns?

9 **A.** I think some of it is the -- the data, the --  
10 the there is always a lag with data and sources of data  
11 so I think that is -- is an issue is a consideration.

12 And I think very much the on-site inspection you can ask  
13 a lot of open questions, a lot of general questions but  
14 you are very much reliant on -- on people's responses.

15 **MR CARR:** Thank you, my Lady, I have no further  
16 questions for this witness.

17 **LADY JUSTICE THIRLWALL:** Thank you. Mr Deakin, do  
18 you have any questions? No, thank you.

19 Ms Cain, just one or two from me.

20 Questions by LADY JUSTICE THIRLWALL

21 **LADY JUSTICE THIRLWALL:** You have mentioned  
22 a number of times the intelligence and that comes to you  
23 from the data analysts?

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** Just so I have understood

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1 **A.** Again, I'm sorry, I can't answer, I don't  
2 know.

3 **LADY JUSTICE THIRLWALL:** Do you know anything about  
4 their background, what actually their qualifications  
5 are, what their instructions are.

6 **A.** No, I'm sorry, I don't. I'm sorry.

7 **LADY JUSTICE THIRLWALL:** So you are just -- I don't  
8 mean "just", but you are the passive recipient of what  
9 they tell you?

10 **A.** Yes, of the data they provide, yes.

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

12 On a second related point, we looked at a slide  
13 with colours of the Countess of Chester's own  
14 self-assessment of how they were doing and I know  
15 earlier in the evidence I think from someone working in  
16 risk in the hospital, we saw a form that had been filled  
17 in in some detail, a sort of self-assessment.

18 This is obviously a different thing. I want to  
19 know whether you know that whether the document with all  
20 the colours on came from the Countess or again was  
21 something that was produced by the data analysts having  
22 analysed the data from the Countess?

23 **A.** The self-assessment?

24 **LADY JUSTICE THIRLWALL:** Yes, the one with all the  
25 colours on, yes.

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1 this: it's they who should have picked up the reports to  
2 the NRLS?

3 **A.** My understanding is that they, they review,  
4 yes, and they bring that data together ahead of  
5 an inspection to provide to the core service leads.

6 **LADY JUSTICE THIRLWALL:** And so the purpose of the  
7 data analysts really is to save the team the effort of  
8 looking for that information, I don't mean that in  
9 a disparaging way.

10 **A.** No.

11 **LADY JUSTICE THIRLWALL:** But that is their role?

12 **A.** Yes.

13 **LADY JUSTICE THIRLWALL:** Then they then present it  
14 to you?

15 **A.** Yes.

16 **LADY JUSTICE THIRLWALL:** But they are still part of  
17 the CQC process?

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** What explanation is there  
20 for the fact that there was no reference to the NRLS in  
21 the intelligence pack?

22 **A.** I'm sorry, I don't know, I can't answer,  
23 I don't know what the explanation would be.

24 **LADY JUSTICE THIRLWALL:** What's the process for  
25 quality assuring the data analysts, do you know?

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1 **A.** That would have come from the Countess of  
2 Chester.

3 **LADY JUSTICE THIRLWALL:** In the colours?

4 **A.** That was their self-assessment as part of the  
5 Provider Information Return, as far as I am aware.

6 **LADY JUSTICE THIRLWALL:** That is what you would  
7 have assumed it was?

8 **A.** That was their self-assessment, yes.

9 **LADY JUSTICE THIRLWALL:** Yes, certainly, I just  
10 wanted to make sure that it wasn't a sort of a  
11 restatement of it in a slightly different form by a data  
12 analyst?

13 **A.** No, my understanding is each Trust prior to  
14 inspection rated themselves, assessed themselves against  
15 the domains.

16 **LADY JUSTICE THIRLWALL:** I see, thank you, that is  
17 helpful.

18 Mr Carr asked you a number of times about the  
19 difference between what you would expect and what you  
20 would hope. Can I just check that my understanding is  
21 correct?

22 So your professional expectation would be that the  
23 information that you were then being asked about would  
24 be and should be provided?

25 **A.** Yes.

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1 **LADY JUSTICE THIRLWALL:** And the reason you  
2 expressed it, sometimes as hope, is because experience  
3 has shown you that people do not always provide the  
4 information that you would expect as a matter of  
5 professionalism?  
6 **A.** Yes.  
7 **LADY JUSTICE THIRLWALL:** Why do you think they do  
8 that? Why do they hold back?  
9 **A.** Pardon?  
10 **LADY JUSTICE THIRLWALL:** Why do you think they hold  
11 back?  
12 **A.** I think some Trusts would rather you find  
13 out -- find it for yourself. I think some, as with  
14 perhaps the self-assessment here, they want to show  
15 themselves in the best light possible. And some Trusts  
16 are better than others at acknowledging their risks and  
17 challenges.  
18 My experience was certainly as a relationship owner  
19 for other Trusts you would have one Trust who every time  
20 there was something significant rather than waiting  
21 to -- for me to detect it on NRLS or STEIS, they would  
22 phone up and say: we are declaring a Serious Incident,  
23 this is what's happened, this is what we are doing about  
24 it immediately, as soon as we have our Serious Incident  
25 report, we will pass it to you. Others --

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1 **MR CARR:** My Lady, the next witness is Dr Odeka,  
2 may I call him.  
3 **LADY JUSTICE THIRLWALL:** Sorry, Dr Odeka, I didn't  
4 see that you had arrived. Do come forward.  
5 **DR BENJAMIN ODEKA (sworn)**  
6 **Questions by MR CARR**  
7 **LADY JUSTICE THIRLWALL:** Do sit down.  
8 **MR CARR:** Can you provide your full name, please?  
9 **A.** Dr Benjamin Odeka.  
10 **Q.** You have prepared a witness statement for this  
11 Inquiry, haven't you, and it's signed and it is dated  
12 10 June 2024?  
13 **A.** Yes, yes.  
14 **Q.** The contents of that witness statement, are  
15 they true to the best of your knowledge and belief?  
16 **A.** Yes.  
17 **Q.** You give evidence in that statement, don't  
18 you, of your professional background, you have been  
19 a Consultant in paediatrics and gastroenterology since  
20 1994?  
21 **A.** That's correct, yes.  
22 **Q.** You describe at your paragraphs 3 and 4  
23 a variety of academic posts and positions of  
24 responsibility?  
25 **A.** Yes.

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1 **LADY JUSTICE THIRLWALL:** Would that be between  
2 inspections?  
3 **A.** Yes, and that would be the relationship owner.  
4 **LADY JUSTICE THIRLWALL:** I see.  
5 **A.** So if I was a relationship owner for a Trust,  
6 I actually had one Trust who would pick up the phone,  
7 very transparent, this has happened, this is what we are  
8 doing about it immediately, the rapid review or the  
9 SBAR, the investigation report, and these are the  
10 measures we have put in place immediately.  
11 Other Trusts you would wait, it would wait and you  
12 would find it on NRLS or STEIS.  
13 So two very different approaches in the  
14 relationship with the Care Quality Commission.  
15 **LADY JUSTICE THIRLWALL:** Just to go back to my  
16 earlier question, would the relationship owner as  
17 a matter of course be checking NRLS in respect of the  
18 hospital with whom they had the relationship?  
19 **A.** Yes.  
20 **LADY JUSTICE THIRLWALL:** Thank you. Those are my  
21 questions. Mr Carr, do you have anything else?  
22 **MR CARR:** No I don't, thank you very much.  
23 **LADY JUSTICE THIRLWALL:** Thank you very much, you  
24 are free to go.  
25 **A.** Thank you.

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1 **Q.** That includes being a tutor at the University  
2 of Manchester from 1994 to 1996, a Clinical Director of  
3 paediatrics for eight years, a clinical area lead for  
4 paediatrics for two years, a Divisional Medical Director  
5 and Associate Medical Director for Women's and Children  
6 2006 to 2009?  
7 **A.** Yes.  
8 **Q.** And you have particular experience in  
9 safeguarding, having chaired the Safeguarding Group for  
10 the Child Health Division?  
11 **A.** Yes.  
12 **Q.** So far as your role with the CQC you explain  
13 at paragraph 5 of your statement that you have assisted  
14 with CQC inspections since June 2014?  
15 **A.** Yes.  
16 **Q.** The 2016 inspection at the Countess of Chester  
17 Hospital with which we are concerned, you think was your  
18 fourth such inspection?  
19 **A.** Yes.  
20 **Q.** You were a Specialist Adviser --  
21 **A.** Yes.  
22 **Q.** -- on that inspection and that's distinct from  
23 a CQC inspector, isn't it?  
24 **A.** Yes.  
25 **Q.** Do you want to explain the difference in the

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1 roles, as you understood it?

2 **A.** As a professional adviser, we or for myself  
3 were meant to give a professional slant and support to  
4 the CQC interpreting medical issues that they might  
5 encounter during inspections and to make the inspections  
6 more clearer in terms of interpreting medical issues  
7 they encounter during inspections.

8 So in short it's just to advise them on medical  
9 issues picked up at inspection using their templates of  
10 inspection but to put a medical angle to it.

11 **Q.** The role isn't simply advisory, is it, you are  
12 an active participant, you partake in interviews during  
13 the inspection?

14 **A.** Yes.

15 **Q.** There were some interviews, judging from the  
16 notes, that you undertook alone, so without the other  
17 two?

18 **A.** Yes.

19 **Q.** Specialist Adviser and CQC Inspector?

20 **A.** Yes.

21 **Q.** And the division appears to have been you  
22 focused more on interviewing doctors, whereas the other  
23 Specialist Adviser, who was a nurse, she did more of the  
24 interviews with nurses?

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

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1 statement is:

2 "As a Specialist Adviser I would ordinarily expect  
3 to receive the following information in advance of  
4 an inspection: information regarding the venue, the  
5 reason for the inspection, the focus of the inspection  
6 from CQC, any particular areas of concern or red flags  
7 to be aware of."

8 **A.** That's correct.

9 **Q.** You are aware that the CQC will gather a lot  
10 of documentation for the purposes of an inspection?

11 **A.** Yes.

12 **Q.** Also as part of their ongoing monitoring?

13 **A.** Yes.

14 **Q.** But that doesn't get provided to you as  
15 a Specialist Adviser?

16 **A.** No.

17 **Q.** At paragraph 13 you say:

18 "Provider Information Returns and data requests  
19 were matters for the CQC Inspectors. I would only  
20 receive information which CQC and in particular the CYP  
21 inspection lead ..."

22 And that is Children and Young Person's Services  
23 inspection lead --

24 **A.** Correct.

25 **Q.** -- Helen Cain "consider to be relevant."

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1 **Q.** Was there any training that you received from  
2 the CQC or elsewhere for the Specialist Adviser role or  
3 was it unnecessary?

4 **A.** There was a brief training. It's -- it wasn't  
5 a detailed training as such but you had introductory  
6 training of induction and explained to us what the role  
7 was and I think what they did was they looked at our  
8 background to match what they expected from us to the  
9 role and that formed the basis of the short training  
10 that they gave us.

11 **Q.** I wanted to turn now to the documentation that  
12 you receive ahead of and for the purposes of  
13 an inspection visit and you explain in your statement  
14 the information you receive is quite limited, isn't it?

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

16 **Q.** You don't receive the Provider Information  
17 Return?

18 **A.** No.

19 **Q.** Or the documents submitted as part of  
20 a Provider Information Return and you don't receive the  
21 response to data requests --

22 **A.** No.

23 **Q.** -- from a Trust?

24 **A.** No.

25 **Q.** And what you say at paragraph 10 of your

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1 So you did understand there to be a process that if  
2 there were particular documents which were a cause of  
3 concern or which called for specialist advice then you  
4 would see those?

5 **A.** I would -- I would be informed of such and  
6 subsequently I will be provided with such information if  
7 they deemed relevant and necessary.

8 **Q.** Can I try to understand, please, what it was  
9 that you were sent. So paragraph 42 of your statement,  
10 you describe, if you find it, receiving the information  
11 pack in advance of the inspection. You say it was  
12 received by email and you understand searches are  
13 ongoing within CQC to locate this email and its  
14 attachments.

15 Now, I want to see if we can identify that  
16 document. Have you subsequently seen a copy of the pack  
17 that you think you were sent?

18 **A.** I think I have seen a copy of it.

19 **Q.** Is it the intelligence briefing pack?

20 **A.** Yes.

21 **Q.** If we can get that document up, it is  
22 INQ0103620. So this is the document?

23 **A.** Yes.

24 **Q.** As I understand it, it was a PowerPoint  
25 presentation. Are you saying you would have been sent

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1 it by email as well?

2 **A.** Sorry, this is not the -- this is not the one  
3 that is sent which is which contains the -- for the  
4 Women and Children's Division. It's not this one. This  
5 was -- this was a presentation at the -- on the day of  
6 the inspection itself, this was the intelligence  
7 presentation on the day.

8 **Q.** Okay, we can take that down. INQ0101422.

9 Now we have this document. It's labelled "Draft  
10 Pre-Inspection Document, 22 December 2015", the document  
11 that you are describing, is it --

12 **A.** This, yes.

13 **Q.** It's like this?

14 **A.** Yes.

15 **Q.** If we go forward, please, to page 5, we have  
16 a summary of analysis on this page into the next page --  
17 I will go to the next page in a moment -- against the  
18 five domains of regulation: "Safe", "effective", "care"  
19 and "responsive" and "well led".

20 Now, this version of the document is dated  
21 December 2015. Do you believe that you received  
22 an updated version of this document or was this the one  
23 that you received for the inspection?

24 **A.** I can't -- I can't be very specific here, but  
25 it looked familiar but I am not, I am not very clear

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1 performance?

2 **A.** Yes. Can I -- okay, I think the answer is  
3 yes, but when we look at our inspection templates we are  
4 looking at -- looking at governance issues. So even if  
5 the information given not as robust as it should be, we  
6 have the -- I do have -- we do have a template where we  
7 look at the overall picture using the key lines of  
8 inquiries to try and expand on that because we have the  
9 scope that we need to examine.

10 So even with limited information like this, we  
11 still have to go through the whole gamut of it.

12 **Q.** I have seen the inspection briefing pack --  
13 and you can take this down now -- we can go to it if we  
14 need to, but that is a document which sets out the areas  
15 for the inspectors to probe at inspection, doesn't it?

16 **A.** Yes.

17 **Q.** It doesn't contain information about the  
18 actual Trust?

19 **A.** No.

20 **Q.** So for you as a Specialist Adviser you are not  
21 given access to the wealth of information that the CQC  
22 has and you are going into a hospital, you are given the  
23 analysis at the level which I have just taken you to, so  
24 a summary of four bullet points, one of which is  
25 a survey, one of which is staff skill mix.

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1 about it. It's a long time now.

2 **Q.** And is it -- would it be typical for you as  
3 a Specialist Adviser for the information that you  
4 receive to be limited to this kind of document?

5 **A.** Yes.

6 **Q.** Would the extent of the information contained  
7 in such a document be similar in its scope to what's  
8 contained in this version?

9 **A.** Yes, maybe not as detailed but similar, yes.

10 **Q.** If, for instance, we take the "safe" section.

11 Nothing in positive analysis, nothing in negative  
12 analysis. Then neutral analysis it says:

13 "No Never Events or Serious Incidents have been  
14 reported."

15 And we will come back to that.

16 There's another bullet point dealing with pressure  
17 ulcers and falls.

18 Bullet point 3 deals with questions in the  
19 children's survey. Now, the children's survey, is that  
20 a survey that goes out to patients?

21 **A.** Yes.

22 **Q.** Then bullet point 4, a comment on the staff  
23 skill mix. It seems quite light in terms of evidence  
24 that's been given to you as a Specialist Adviser ahead  
25 of going into inspecting a hospital to assess its

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1 There doesn't seem to be much that you can provide  
2 specialist advice on in terms of data prior to the  
3 inspection?

4 **A.** Correct, yes. It's not -- not detailed, not  
5 robust enough for inspection, yes.

6 **Q.** Now, you weren't given ahead of the  
7 inspection, were you, any information relating to  
8 neonatal mortality at this unit?

9 **A.** No.

10 **Q.** At paragraph 14 of your statement, you say:

11 "In my role as a Specialist Adviser I would not  
12 necessarily expect to receive information concerning  
13 neonatal deaths directly in advance of an inspection but  
14 would have such information if this was available to the  
15 CQC inspector."

16 And just so that I can make sure I am understanding  
17 that, is the point that you are making there: well, if  
18 the information has gone to the inspector then you would  
19 expect it to be shared to you but if the inspector  
20 doesn't have it, so if Helen Cain doesn't have that  
21 information, then she can't share it with you?

22 **A.** No.

23 **Q.** Is that the point you are making?

24 **A.** The point I am making is they might receive  
25 the details of neonatal deaths. That may not be given

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

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

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

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

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

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1 **A.** Yes.

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

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

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

15 **A.** Yes.

16 **Q.** At paragraph 17, you say:

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

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

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

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

13 **A.** Yes.

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

16 **A.** Yes.

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

20 **A.** Yes.

21 **Q.** If the doctors themselves had concerns about  
 22 the increase?

23 **A.** Yes, that is useful information.

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

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

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

8 **A.** Yes, it will be, yes.

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

12 **A.** Yes, please.

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

19 **A.** Yes.

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

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

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1 on screen. But you are familiar, aren't you, with the  
 2 document that I am referring to?  
 3 **A.** Yes.  
 4 **Q.** It is a table with some entries marked and  
 5 colour coded by the degree of harm?  
 6 **A.** Yes.  
 7 **Q.** Green for no harm. Yellow for low harm?  
 8 **A.** Yes.  
 9 **Q.** That is a document that you did not see prior  
 10 to preparing the evidence here?  
 11 **A.** Yes.  
 12 **Q.** It wasn't shown to you by the CQC or by  
 13 Helen Cain?  
 14 **A.** No, it wasn't shown.  
 15 **Q.** There was no discussion with you by anybody at  
 16 the CQC about that table?  
 17 **A.** No, no discussion.  
 18 **Q.** Or the contents of it?  
 19 **A.** No.  
 20 **Q.** You have reviewed it to prepare your  
 21 statement.  
 22 Now the first question is this: would you expect  
 23 all neonatal deaths at the unit to be included on  
 24 a table like that?  
 25 **A.** Yes.

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1 it in that fashion.  
 2 **Q.** So had you received the table it's something  
 3 that you would want to investigate and test the  
 4 categorisation of?  
 5 **A.** Yes, yes.  
 6 **Q.** Is that something that you would explore at  
 7 the interviews?  
 8 **A.** The interviews was -- excuse me, was to  
 9 confirm that the entries --  
 10 **Q.** Yes.  
 11 **A.** -- and also to speak to the -- the managers --  
 12 when I mean the managers, those who actually lead in  
 13 governance, produce that document. Then I would explore  
 14 what they have done about it and to see if the actions  
 15 they have taken, if it's in line with good practice and  
 16 if it also addresses the issue and if there are any  
 17 lessons to be learnt from those.  
 18 So it's the process I would be interested in  
 19 looking at and that would be something that CQC would be  
 20 interested in in terms of making a decision.  
 21 **Q.** But the point is because it strikes you as  
 22 inaccurate, that would be something that you would want  
 23 to look into to --  
 24 **A.** Yes.  
 25 **Q.** -- find out what's happened --

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

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

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1 what the postmortem said and whether a cause of death  
2 had been established?

3 **A.** Yes, I would and obviously most of the deaths  
4 would have been referred to the Child's Death Inquiries  
5 so I would want to know the outcome of such inquiries.

6 **Q.** What would you explore based on that  
7 description? For instance, whether the SUDIC guidelines  
8 were complied with, would that be appropriate to your  
9 regulatory investigations?

10 **A.** Yes.

11 **Q.** But in the event of course you didn't see this  
12 table?

13 **A.** No.

14 **Q.** And there was no discussion of those events at  
15 inspection?

16 **A.** No.

17 **Q.** Now, there are two reporting systems which the  
18 Care Quality Commission track.

19 So there's the National Reporting and Learning  
20 System to which patient harm events are reported and  
21 there is the Strategic Executive Information System for  
22 Serious Incidents and the CQC has access to reports to  
23 those systems, doesn't it?

24 **A.** I can't answer to that because I don't know.

25 **Q.** You have seen, again as part of your  
97

1 my reading of the notes, you interviewed Dr Brearey?

2 **A.** Yes.

3 **Q.** Dr V, Dr Lowe, Dr Gibbs, Dr Cooke?

4 **A.** Yes.

5 **Q.** Sorry. You also took part in the large  
6 interview with the team leads with both of the other  
7 members of your inspection team?

8 **A.** Yes.

9 **Q.** When I said you interviewed Dr Brearey, that  
10 was an additional interview to the interview as part of  
11 the team.

12 So you would have seen him as part of the large  
13 interview, but you also had a separate interview with  
14 him?

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

16 **Q.** Turning to your statement, paragraphs 87 and  
17 88 please. Paragraph 87, are you there?

18 "I do not recall discussing concerns about  
19 an increase in neonatal deaths with any of the  
20 interviewees. If this had been discussed I would expect  
21 it to be recorded in the notes."

22 Paragraph 88:

23 "I do not recall discussing concerns about  
24 unexplained or unexpected deaths. Again I would expect  
25 any discussion of this nature to have been recorded."  
99

1 preparation for giving evidence to this Inquiry, you  
2 have seen spreadsheets showing reports by the Trust to  
3 those two systems, haven't you --

4 **A.** Yes.

5 **Q.** -- in the period --

6 **A.** Yes.

7 **Q.** -- covering that prior to your inspection?

8 Were you, for the purposes of the inspection or  
9 during the inspection, informed by the CQC of the  
10 reports in those table concerning children?

11 **A.** No.

12 **Q.** Do you think you should have been?

13 **A.** Yes.

14 **Q.** Were you aware, did it come up during the  
15 inspection that the death of Child D had been reported  
16 to the Strategic Information System for Serious  
17 Incidents and other events as an unexpected potentially  
18 avoidable death and as a Serious Incident due to a delay  
19 recognising sepsis?

20 **A.** No.

21 **Q.** Turning to the visit itself. You were  
22 involved in a number of interviews, weren't you?

23 **A.** Yes.

24 **Q.** As you have explained already, your focus was  
25 mainly on interviewing the doctors. You interviewed, on  
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1 Just looking at both of those sentences. It's  
2 correct, isn't it, that it's not only that concerns  
3 about an increase in deaths or concerns about  
4 unexplained or unexpected deaths was not discussed.  
5 Those topics weren't discussed at all?

6 **A.** Not at all.

7 **Q.** We have already seen there was a discussion in  
8 the team leads' interview as to Morbidity and Mortality  
9 Meetings but not a discussion as to neonatal rates on  
10 the unit.

11 **A.** No.

12 **Q.** Sorry, neonatal mortality rates on the unit.

13 Wouldn't discussion of outcomes at the neonatal  
14 unit, including for instance mortality rates, instances  
15 of unexpected or unexplained deaths, wouldn't that be  
16 an important topic to explore for the purposes of  
17 assessing safety of the unit?

18 **A.** Yes.

19 **Q.** Why wasn't it explored?

20 **A.** I -- the -- the incidents reports is what  
21 triggers such discussions because we will get the  
22 reports of incidents, you look at -- we look at the way  
23 it's been investigated, the outcome and the processes  
24 involved in that. But since those information were not  
25 available to myself, it wasn't -- so all we will do it  
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1 in that instance would be to look at processes. So that  
2 discussion did not take place and that's the reason for  
3 that. That wasn't --

4 **Q.** So in the interviews that you attended --

5 **A.** Yes.

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

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

9 Can I just explain a bit there? Can I?

10 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

25 **A.** Yes.

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1 the unit.

2 Now, you weren't aware of that.

3 **A.** No.

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

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

9 **Q.** Such as?

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

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

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

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

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

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

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1 **Q.** -- as to issues of neonatal mortality?

2 **A.** Yes.

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

5 **A.** Correct, yes.

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

8 **A.** None of them.

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

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

21 So, yes, some of them do.

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

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

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

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

8 **A.** Yes, yes.

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

11 **MR CARR:** Thank you.

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

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

20 **A.** No.

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

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

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

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

7 A. That's right, yes.

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

11 A. That's right, yes.

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

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

18 Q. Do you recall what your feedback was?

19 A. Sorry, can you repeat that again?

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

23 What were the issues that you raised with her?

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

25 Q. It's paragraph 100.

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1 the CQC to investigate individual incidents of concern  
2 or processes?

3 A. Not individual concerns, but processes.

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

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

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

16 A. Yes.

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

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

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

22 Q. Please.

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

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1 A. Yes. Please.

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

4 A. Yes.

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

7 A. Just the findings.

8 Q. Which were?

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

11 Q. The interview notes that we have?

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

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

18 LADY JUSTICE THIRLWALL: Thank you. Mr Deakin.

19 MR DEAKIN: My Lady, if I may.

20 LADY JUSTICE THIRLWALL: Yes, of course.

#### 21 Questions by MR DEAKIN

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

24 A. Okay.

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

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

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

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

11 A. Please.

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

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

18 A. Yes.

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

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

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1 would be expected to be informed.  
 2 **MR DEAKIN:** Thank you very much.  
 3 Thank you very much, my Lady.  
 4 **LADY JUSTICE THIRLWALL:** Thank you very much,  
 5 Mr Deakin.  
 6 Have you got anything arising out of that, Mr Carr?  
 7 **MR CARR:** No, I don't. Thank you very much.  
 8 **LADY JUSTICE THIRLWALL:** Thank you very much  
 9 indeed, Dr Odeka.  
 10 **A.** Thank you.  
 11 **LADY JUSTICE THIRLWALL:** We will rise now until  
 12 10 past 2.  
 13 (1.08 pm)  
 14 (The luncheon adjournment)  
 15 (2.10 pm)  
 16 **LADY JUSTICE THIRLWALL:** Mr Carr.  
 17 **MR CARR:** May I call Mary Potter, please.  
 18 **LADY JUSTICE THIRLWALL:** Ms Potter, would you like  
 19 to come forward.  
 20 MS MARY POTTER (sworn)  
 21 **LADY JUSTICE THIRLWALL:** Thank you very much, do  
 22 sit down.  
 23 Questions by MR CARR  
 24 **MR CARR:** Can we start with your full name, please.  
 25 **A.** Mary Potter.

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

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1 **Q.** You have prepared a witness statement for this  
 2 Inquiry dated 21 June 2024, haven't you?  
 3 **A.** Yes.  
 4 **Q.** Are the contents of that statement true to the  
 5 best of your knowledge and belief?  
 6 **A.** Sorry?  
 7 **Q.** Are the contents of the witness statement true  
 8 to your best knowledge and belief?  
 9 **A.** Yes.  
 10 **Q.** So far as your professional background, you  
 11 are a nurse, aren't you, you qualified in 1973 and  
 12 you've worked as a Registered Sick Children's Nurse in  
 13 the past?  
 14 **A.** Yes.  
 15 **Q.** In 2004 you trained to become  
 16 a RCN representative, a Royal College of Nursing  
 17 representative?  
 18 **A.** (Nods)  
 19 **Q.** You became a Specialist Adviser in Children's  
 20 Services for the CQC in July 2014?  
 21 **A.** I think it was 2012, but it might have been  
 22 2014.  
 23 **Q.** At paragraph 6 of your statement, you state  
 24 your recollection to be that you completed three or four  
 25 inspections, the last of which was the inspection for

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1 **A.** Sorry, could you expand on that?  
 2 **Q.** So you visited for three days?  
 3 **A.** Yes.  
 4 **Q.** Three days' worth of inspection, and we are  
 5 going to come on to that in a few moments. But putting  
 6 that to one side, what was the role of a Specialist  
 7 Advisor either running up to the actual visit or in the  
 8 period following the visit?  
 9 **A.** As a Specialist Adviser I wasn't involved in  
 10 anything prior to the actual inspection of the clinical  
 11 areas.  
 12 **Q.** So --  
 13 **A.** Sorry.  
 14 **Q.** Forgive me.  
 15 **A.** Post the inspection, we may have been called  
 16 to do an unexpected visit, but on this occasion I never  
 17 was, so my only involvement was the actual three days of  
 18 the inspection.  
 19 **Q.** Did you ever receive any training for the role  
 20 of Specialist Adviser?  
 21 **A.** Yes.  
 22 **Q.** Where was the training, who provided the  
 23 training?  
 24 **A.** The CQC provided the training and it was to my  
 25 recollection because this is eight years ago, so longer

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1 than that since I did any training, I think it was all  
 2 done remotely.  
 3 **LADY JUSTICE THIRLWALL:** Eight years ago, it was  
 4 done remotely?  
 5 **A.** Sorry?  
 6 **LADY JUSTICE THIRLWALL:** All done remotely eight  
 7 years ago, did you say?  
 8 **A.** Probably -- now that you have questioned that,  
 9 no, probably not. But it was a long time ago and  
 10 I don't remember what was involved in my actual  
 11 training. But I had some training about the role of the  
 12 Specialist Adviser.  
 13 **LADY JUSTICE THIRLWALL:** But you can't remember  
 14 what, what it was?  
 15 **A.** No, it -- it was around how we would be  
 16 expected, what we would be expected to look for.  
 17 **MR CARR:** You were a Specialist Adviser with  
 18 a nursing background?  
 19 **A.** Yes.  
 20 **Q.** We have heard evidence from the other  
 21 Specialist Adviser who was a doctor. So between the two  
 22 of you, Specialist Adviser doctor, Specialist Adviser in  
 23 nursing, were there different issues that you would  
 24 provide specialist advice on?  
 25 **A.** Yes.

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1 pack which was given to you on the first day of the  
 2 inspection?  
 3 **A.** On the inspection, yes.  
 4 **Q.** So prior to arriving at the hospital, you  
 5 received no document containing any detail about the  
 6 service at all?  
 7 **A.** No.  
 8 **Q.** So you arrive on day one and you receive an  
 9 information pack. Now, there's a few different  
 10 documents and I want to see if we can work out quite  
 11 what the data pack was. If we can look, please, at  
 12 INQ0101422, does this look like the data pack that you  
 13 are describing?  
 14 **A.** Yes, to my recollection.  
 15 **Q.** Now, this version has draft marked on it, it's  
 16 titled "Pre-inspection document 22 December 2015".  
 17 **A.** I don't recall seeing a pre-inspection  
 18 document.  
 19 **Q.** That was the point of my question. So the  
 20 draft pack that you described receiving on the first day  
 21 --  
 22 **A.** The draft pack on -- on the day would have  
 23 included the service provision of the Trust or  
 24 organisation we were inspecting. What provisions they,  
 25 they had, what services they provided I do not recall

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1 **Q.** How was the division of work or advice  
 2 arranged between the two of you?  
 3 **A.** As a Specialist Adviser from a nursing  
 4 background my main role was to look at the clinical  
 5 areas and observe the service provision of, from that  
 6 area.  
 7 **Q.** When it came to interviews looking at the  
 8 notes, it appears that you focused on interviewing  
 9 nurses, most of the nurses and Dr Odeka did more of the  
 10 doctors?  
 11 **A.** Yes, I don't recall interviewing anybody other  
 12 than nurses or care providers, healthcare assistants.  
 13 **Q.** If I can turn to documentation provided to you  
 14 ahead of the inspection. For the purposes of you  
 15 preparing your statement to this Inquiry, you have seen,  
 16 haven't you, the Provider Information Returns, and the  
 17 responses to data requests that the hospital sent to the  
 18 CQC?  
 19 **A.** This was sent to me in preparation for  
 20 making -- preparing my statement.  
 21 **Q.** Yes. About at the time of the inspection the  
 22 point that you make in your evidence is you wouldn't  
 23 have seen those documents?  
 24 **A.** No.  
 25 **Q.** What you describe is receiving an information

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1 seeing anything prior to that, that included  
 2 a pre-inspection document.  
 3 **Q.** So this document was not part of the  
 4 information pack and is not the information pack?  
 5 **A.** Not that I recall.  
 6 **Q.** If we can look at INQ0017286, this is the  
 7 inspection team briefing pack. Now, is this the  
 8 document that you say you received on day one?  
 9 **A.** From my recollection this would have been the  
 10 document.  
 11 **Q.** Now, what this document does is, there is  
 12 a few introductory pages, we can look at page 11,  
 13 please. Now, part of this pack there is an agenda for  
 14 an inspection briefing section, 10 February at 2.  
 15 Did you attend that briefing section?  
 16 **A.** Not to my knowledge or recollection.  
 17 **Q.** Your recollection is that in fact you didn't  
 18 receive this document until day one --  
 19 **A.** Yes.  
 20 **Q.** -- of the inspection which was on the 16th.  
 21 Now, I have skipped over a few introductory pages  
 22 that have individual's contact details. If we go to  
 23 page 14, a section dealing with the services to be  
 24 inspected, we can see the penultimate heading "Services  
 25 for Children and Young People" and that's the service

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1 that you were inspecting?

2 **A.** Yes.

3 **Q.** But there is nothing in there which is  
4 specific to the Countess of Chester, is there? This is  
5 generic information about services for children and  
6 young people?

7 **A.** (Nods)

8 **Q.** Then if we go forward, please, to page 16,  
9 this is a section of the document that deals with the  
10 key lines of inquiry, which contains the prompts for you  
11 to use when conducting interviews?

12 **A.** Yes.

13 **Q.** It's aimed at obtaining evidence for the  
14 purposes of the inspection report?

15 **A.** (Nods)

16 **Q.** Now, again this runs over several pages, it's  
17 split into the different domains that you were  
18 inspecting "safe", "effective", "responsive", "well  
19 led".

20 But there's nothing in these key lines of inquiry  
21 which is specific to the Countess of Chester, is there?

22 **A.** No, this is a general, a general document for  
23 how we -- we would -- the things we would look for  
24 during an inspection.

25 **Q.** So in fact these are the same key lines of  
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1 receive anything specific.

2 **Q.** The next document please, INQ0103620. Now,  
3 this appears to be a PowerPoint presentation, slides  
4 from a PowerPoint presentation. You see there  
5 "Intelligence presentation 16 February 2016". Do you  
6 recall if you went to this presentation?

7 **A.** I think this was, yes, yes, to that. This  
8 would have been the first discussion we had on the  
9 morning of the first day of the inspection.

10 **Q.** If we go to page 7 of this document, please.

11 So when you are going through these slides, the  
12 first few slides deal with Trust-wide issues and once  
13 you got to slide 7, there is information as to Children  
14 and Young People's Services', which of course you are  
15 most directly concerned with?

16 **A.** Yes.

17 **Q.** So the first thing that you -- the first bit  
18 of data that is specifically relevant to Children and  
19 Young People's Services that you would have seen would  
20 have been this slide?

21 **A.** I believe so.

22 **Q.** We can see the title, can we not,  
23 "Self-assessment from PIR" so it's Provider Information  
24 Return. So it's clear this is how the Trust is  
25 assessing their own performance?  
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1 inquiry that you would see on other inspections?

2 **A.** Yes.

3 **Q.** Then there are some concluding pages, page 32,  
4 which has procedures for the visit. And finally within  
5 this document, page 35, which deals with escalation  
6 procedures "Where an issue of concern arises". This is  
7 the bit in bold in the middle of the page "Where  
8 an issue of concern arise during an inspection", but  
9 again that is all generic, isn't it, nothing specific?

10 **A.** Yes, it's a generic one.

11 **Q.** So going into the inspection, you receive this  
12 document which tells you nothing about the service you  
13 are about to inspect. Did you receive anything else  
14 which did contain information about the Countess of  
15 Chester?

16 **A.** Not to my recollection.

17 **Q.** Was that usual for a CQC inspection that you  
18 as a Specialist Adviser turn up on day one --

19 **A.** Yes.

20 **Q.** -- and you don't know anything about -- you  
21 don't have any advance information about what you are  
22 inspecting?

23 **A.** No.

24 **Q.** That was usual or --

25 **A.** Sorry, yes, this was usual that we wouldn't  
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1 **A.** (Nods)

2 **Q.** But for Services for Children and Young People  
3 we can see it is a positive assessment, isn't it, three  
4 "goods" and two "outstandings"?

5 **A.** Yes.

6 **Q.** When you see an assessment like that, "good"  
7 for safe "good" for effective, "outstanding" for caring,  
8 "outstanding" for responsive and "good" for well-led,  
9 how does that shape your approach to the inspection in  
10 the upcoming days?

11 **A.** Seeing this document wouldn't have shaped my  
12 approach to an inspection. My approach would be that  
13 I go in and comment on what I personally am seeing of  
14 the service provision during the inspection.

15 **Q.** So your approach would be the same even if it  
16 was "requires improvement across the board"?

17 **A.** Sorry.

18 **Q.** Your approach to the inspection would have  
19 been the same even if the self-assessment was "requires  
20 improvement"?

21 **A.** Yes.

22 **Q.** If we go forward, please, to page 27 and here  
23 we have what is described as a summary of intelligence  
24 findings. So this is the first real data that you would  
25 have seen about the service that you were about to  
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1 inspect?  
 2 **A.** (Nods)  
 3 **Q.** "No Never Events or Serious Incidents reported  
 4 up to January 2016."  
 5 What conclusion would you draw from seeing that  
 6 entry?  
 7 **A.** Again, I would try not to allow any of this to  
 8 influence how I approached the inspection and I would be  
 9 asking to look at their data recording myself.  
 10 **Q.** Looking at this page, the data contained on  
 11 this page, and thinking particularly about the domains  
 12 of safety and effectiveness, are there any other entries  
 13 on that page which are relevant to the assessment of  
 14 safety or of effectiveness?  
 15 **A.** Sorry, can you expand on that? I am not  
 16 really sure what you are asking.  
 17 **Q.** Yes. The inspection is according to the key  
 18 lines of inquiry?  
 19 **A.** Yes, yes.  
 20 **Q.** The key lines of inquiry are in five different  
 21 domains?  
 22 **A.** Yes.  
 23 **Q.** One of those domains is safety?  
 24 **A.** Yes.  
 25 **Q.** We looked at the document briefly before, but  
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1 **MR CARR:** Up a page, I think.  
 2 **LADY JUSTICE THIRLWALL:** The next.  
 3 **MR CARR:** It is page 27.  
 4 **LADY JUSTICE THIRLWALL:** Thank you. Do you see the  
 5 second last bullet paediatrics is "2.19 WTE over  
 6 establishment". What does that mean?  
 7 **A.** The over establishment so "WTE" is whole time  
 8 equivalent, so they are saying that they have more staff  
 9 than their establishment calls for.  
 10 **LADY JUSTICE THIRLWALL:** So that is more staff than  
 11 they would expect to have?  
 12 **A.** Than they would expect to have.  
 13 **LADY JUSTICE THIRLWALL:** Thank you.  
 14 Is that something that you would have explored?  
 15 **A.** I would have explored it with the nursing  
 16 establishment in general with the staff on the ward and  
 17 the manager of the ward.  
 18 **LADY JUSTICE THIRLWALL:** Which ward?  
 19 **A.** Sorry?  
 20 **LADY JUSTICE THIRLWALL:** Which ward?  
 21 **A.** The areas -- the clinical areas I was  
 22 inspecting, so the neonatal unit and the children's  
 23 wards.  
 24 **LADY JUSTICE THIRLWALL:** Thank you. Sorry,  
 25 Mr Carr.  
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1 within those key lines of inquiry there are prompts for  
 2 safety, so the evidence that you are looking for or  
 3 looking at in determining safety. Another is  
 4 "effective", one of the prompts looking at effective.  
 5 So what I am asking is when you look at these  
 6 bullet points this is the first bit of information you  
 7 have about the Trust, are there entries on that slide  
 8 which are relevant to either of those two domains?  
 9 **A.** No. Again I'm not sure what you are actually  
 10 asking me.  
 11 **LADY JUSTICE THIRLWALL:** Perhaps we will move on,  
 12 Mr Carr.  
 13 **MR CARR:** We can take that document down.  
 14 **LADY JUSTICE THIRLWALL:** Actually, just before you  
 15 do that, could I just ask a question.  
 16 **MR CARR:** Yes, of course.  
 17 **LADY JUSTICE THIRLWALL:** The second last bullet  
 18 says paediatrics is -- and then it's something WTE.  
 19 **A.** Sorry, it's gone off my screen.  
 20 **LADY JUSTICE THIRLWALL:** I know, it's coming back.  
 21 **A.** Sorry.  
 22 **LADY JUSTICE THIRLWALL:** Can you just -- I'm sorry  
 23 Mr Carr, could you remind us of the page?  
 24 **MR CARR:** Yes -- no.  
 25 **LADY JUSTICE THIRLWALL:** Here it is.  
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1 **MR CARR:** Thank you.  
 2 One of the documents that was provided to the CQC  
 3 by the hospital was a spreadsheet titled "NNU paediatric  
 4 incidents 1 January 2015 to 31" -- sorry, forgive me,  
 5 1 February 2015 to 31 January 2016. It is a document  
 6 that you wouldn't have seen at the time of the  
 7 inspection but you have seen it for the purposes of  
 8 providing your statement for this Inquiry, haven't you?  
 9 **A.** (Nods)  
 10 **Q.** It is a table that has the coloured column to  
 11 the left marking incidents or categorising incidents  
 12 according to harm, with the majority of them being in  
 13 green.  
 14 Now, having looked at that document, what you say  
 15 in your statement, and I am considering your  
 16 paragraph 34, you say:  
 17 "Unless specific concerns relating to this document  
 18 were identified by the lead inspector, I would not have  
 19 expected to receive this document in my role as  
 20 Specialist Adviser."  
 21 Is the process then that you are describing: lead  
 22 inspector looks at this document and would only come to  
 23 you if the lead inspector identified concerns that she  
 24 wanted your input on?  
 25 **A.** Yes.  
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1 Q. On a document such as this, and in particular  
2 issues as to categorisation of incidents, would that be  
3 something that you would give specialist advice on or  
4 would you expect Dr Odeka to be the appropriate person  
5 to give specialist advice or would it be both of you?

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

10 Q. You say at paragraph 35 of your statement:  
11 "Having not had access to this document at the time  
12 of the inspection, I am unable to comment on why these  
13 incidents have been categorised as they have been."

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

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

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

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

5 A. (Nods)

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

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

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

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

16 A. No.

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

20 A. (Nods)

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

25 A. I don't recall it.

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

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

5 A. Certainly.

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

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

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

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

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

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

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

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

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

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

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

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

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1 handwriting, isn't it?  
 2 **A.** This is my handwriting, yes.  
 3 **Q.** So this is your note of the same meeting. The  
 4 third line down:  
 5 "Mortality and Morbidity Meetings equals five last  
 6 year. Planned four this year -- CS."  
 7 What does CS refer to?  
 8 **A.** Sorry, I didn't hear that question.  
 9 **Q.** The CS that is highlighted on the screen,  
 10 what, what is that a reference to? Or is it C-5 caring  
 11 5, is it one of the prompts?  
 12 **A.** I think it's C-5 but as I say, this was eight  
 13 years ago and I can't fully recall.  
 14 **Q.** The next sentence:  
 15 "Neonatal depend on number of cases to be  
 16 discussed."  
 17 What's your recollection as to what was said at  
 18 this meeting as to Neonatal Mortality and Morbidity  
 19 Meetings?  
 20 **A.** My recollection is that all the cases would  
 21 have been discussed. It's very difficult, as I said,  
 22 eight years on, to really recall what that sentence  
 23 means.  
 24 **Q.** Now, you have considered your notes of the  
 25 interviews that you conducted, you have also seen the

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

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1 notes of others. Based on those notes and based on your  
 2 recollection, did you discuss -- we can take this down,  
 3 did you discuss directly with any of the interviewees  
 4 neonatal mortality?  
 5 **A.** No.  
 6 **Q.** You didn't discuss therefore concerns about  
 7 neonatal mortality?  
 8 **A.** No.  
 9 **Q.** Instances of unexpected and unexplained  
 10 deaths?  
 11 **A.** No, because we weren't given information  
 12 around that on, during the inspection.  
 13 **Q.** When you say you weren't given information,  
 14 did you directly ask any -- did you directly ask anybody  
 15 that you interviewed about neonatal mortality?  
 16 **A.** No.  
 17 **Q.** You didn't ask and it wasn't volunteered by  
 18 anybody who you interviewed?  
 19 **A.** It wasn't.  
 20 **Q.** Did you ask any question that you think should  
 21 have elicited an answer describing concerns about  
 22 neonatal mortality given that there were concerns on the  
 23 unit?  
 24 **A.** To my recollection, I didn't ask any specific  
 25 questions.

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

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1 You say in the first sentence that:  
 2 "The provision of the Thematic Review or peer  
 3 review ahead of an inspection would not have changed my  
 4 approach to the inspection insofar as there was a CQC  
 5 process for inspections and for inspectors and  
 6 Specialist Advisers to follow."

7 But you go on, don't you, in the rest of that  
 8 paragraph to explain how receiving that information  
 9 would have shaped your approach to the inspection and  
 10 would have changed the areas of focus and the areas of  
 11 questioning?

12 **A.** (Nods) I believe that it would have done had  
 13 I had that information prior to my inspecting the  
 14 clinical areas and interviewing staff. I may have asked  
 15 different questions but I was -- I did not have that  
 16 information.

17 **Q.** During interviews when you are asking staff  
 18 about safeguarding policies, safeguarding practice and  
 19 safeguarding knowledge, how do you go about testing the  
 20 safeguarding knowledge of the people you are  
 21 interviewing?

22 **A.** I wouldn't say that we tested the knowledge.  
 23 I would have a conversation with them just to see if  
 24 they were aware of the safeguarding processes within the  
 25 Trust.

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1 which is described at paragraph 85, you say:  
 2 "To the best of my recollection some staff  
 3 expressed concerns during interviews that staffing was  
 4 not adequate and there were times when the ward unit was  
 5 short-staffed".

6 Aside from that, were there any concerns that  
 7 emerged during your participation in this inspection?

8 **A.** Not that I can recall now.

9 **Q.** In terms of providing feedback because you  
 10 were not involved at all, were you, in the writing of  
 11 the report?

12 **A.** No.

13 **Q.** You have explained you were there for  
 14 three days and that's it and then the report is written  
 15 by Helen Cain.

16 At the end of the three-day inspection, did you  
 17 provide feedback to Helen Cain?

18 **A.** At the end of each day of the inspection, we  
 19 provided feedback on that day's inspection.

20 **MR CARR:** Thank you, my Lady, subject to any  
 21 questions Mr Deakin may have, those are my questions.

22 **LADY JUSTICE THIRLWALL:** Thank you, Mr Carr. Mr  
 23 Deakin?

24 Thank you very much indeed, Mrs Potter, you are  
 25 free to go.

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1 **Q.** In the course of that conversation would  
 2 you -- would you ask them, for instance, what the  
 3 safeguarding processes were?

4 **A.** Yes.

5 **Q.** Rather than just saying: have you had  
 6 safeguarding training, and they say yes, would you seek  
 7 evidence that demonstrates the person before you did  
 8 actually and could articulate what safeguarding  
 9 processes were?

10 **A.** Yes.

11 **Q.** You were not at the Consultants' focus group;  
 12 that was conducted by another member of staff.

13 As you will be aware as part of your -- part of the  
 14 preparation of your evidence for this Inquiry, there  
 15 were some concerns or concerns noted at the Consultants'  
 16 group of a culture of bullying.

17 In the course of your interviews with staff members  
 18 predominantly nurses did you hear any evidence were you  
 19 told of any culture or bullying at the hospital?

20 **A.** No, I asked a number of staff how they felt  
 21 they were supported in their clinical areas and by their  
 22 senior staff and I -- nobody said to me they had  
 23 concerns about how they were supported. Nobody voiced  
 24 any concerns about bullying with me.

25 **Q.** And beyond the concerns about staff numbers

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1 **A.** Thank you.

2 **LADY JUSTICE THIRLWALL:** Would you take the oath  
 3 please.

4 MS ELIZABETH CHILDS (sworn)

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

6 **A.** Thank you.

7 Questions by MR DE LA POER

8 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.

9 **MR DE LA POER:** Please could you state your full  
 10 name?

11 **A.** Elizabeth Childs.

12 **Q.** Ms Childs, is it correct that on 22 June of  
 13 this year you provided the Inquiry with a witness  
 14 statement?

15 **A.** Yes.

16 **Q.** Is the content of that witness statement true,  
 17 to the best of your knowledge and belief?

18 **A.** Yes.

19 **Q.** We will begin briefly with your background.  
 20 Did you qualify as a nurse in 1977?

21 **A.** Yes.

22 **Q.** Did you subsequently work in a management role  
 23 within Women and Children's Services?

24 **A.** Yes.

25 **Q.** Did you obtain a Master's in Healthcare

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1 Management in 1999?  
 2 **A.** Yes.  
 3 **Q.** In 2000, did you become the Executive Director  
 4 of Nursing at an NHS Foundation Trust?  
 5 **A.** Yes.  
 6 **Q.** And was the role of Deputy Chief Executive  
 7 added to your portfolio in 2009 for the same Trust?  
 8 **A.** Yes, yes, it was.  
 9 **Q.** In 2011, did you qualify as an Executive  
 10 coach?  
 11 **A.** I did.  
 12 **Q.** Did you subsequently become a Non-Executive  
 13 Director at a different NHS Trust, in 2013?  
 14 **A.** Yes.  
 15 **Q.** I think you retired from that Non-Executive  
 16 role in 2019?  
 17 **A.** Yes, I did.  
 18 **Q.** If we deal with your experience of the CQC.  
 19 In 2014, did you start acting as a Specialist  
 20 Adviser on an ad hoc basis for CQC inspections?  
 21 **A.** Yes.  
 22 **Q.** And did you undertake that special advisory  
 23 role during the period 2014 to 2016?  
 24 **A.** Yes, I did.  
 25 **Q.** You estimate in your witness statement, is

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1 **Q.** Can you tell us please in your own words what  
 2 the role of chair of a CQC inspection involves?  
 3 **A.** It involves supporting the head of hospital  
 4 inspection who's a CQC employee, it involves making sure  
 5 that the team that you have in front of you particularly  
 6 the specialist professional advisers are used to the  
 7 best advantage. It involves ensuring that you have  
 8 a thorough but a fair and respectful inspection because  
 9 you are working through a hospital that's engaged in its  
 10 duties.  
 11 You help to lead or you lead with the head of  
 12 hospital inspection the -- the briefing sessions and the  
 13 corroboration sessions when people come together and you  
 14 listen to the evidence that's been provided and if there  
 15 are issues, any issues that are raised, you deal with  
 16 those areas of concern which we probably discussed with  
 17 the head of hospital inspection. And my experience is  
 18 that as a chair you would usually be involved in the  
 19 interviews of senior people in the organisation, such as  
 20 the chairperson, the Chief Executive, the Director of  
 21 Nursing.  
 22 **Q.** In that list of responsibilities, you identify  
 23 that the role of the chair was to ensure a thorough  
 24 investigation?  
 25 **A.** Yes.

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1 this correct, that you did between five and six  
 2 inspections in that role?  
 3 **A.** Yes, that is an estimation, yes.  
 4 **Q.** And of those five or six, you say that you  
 5 were the chair for two of them?  
 6 **A.** Yes, that's right.  
 7 **Q.** Of course as we know you were the Chair for  
 8 the inspection of the Countess of Chester in  
 9 February 2016?  
 10 **A.** That's right.  
 11 **Q.** Can you help us. Do you think that was the  
 12 first time you acted as chair or the second time?  
 13 **A.** I think it was the second time I acted as  
 14 chair.  
 15 **Q.** And was the Countess of Chester the final  
 16 inspection you were involved in or did you have  
 17 subsequent inspections in 2016?  
 18 **A.** I think that was the final inspection that  
 19 I was involved in.  
 20 **Q.** So in this sense, you were the most  
 21 experienced that you ever became of acting as an  
 22 inspector and chair --  
 23 **A.** Yes.  
 24 **Q.** -- at that inspection?  
 25 **A.** Yes.

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1 **Q.** Does it follow from that that if it transpires  
 2 that the investigation -- or the inspection, rather --  
 3 was not thorough, that the person who bears  
 4 responsibility for that overall would be the Chair?  
 5 **A.** I think that would -- let me think.  
 6 Alongside the head of hospital inspection because  
 7 as a chair you only have responsibility for those days  
 8 you are actually in the on-site inspection, not prior to  
 9 the inspection or following the inspection.  
 10 I suspect you would have some responsibility for  
 11 ensuring it was thorough. But you would hope that also  
 12 the head of hospital inspection who does this full time  
 13 actually would work closely with you to ensure that that  
 14 was the case.  
 15 **Q.** One of the things I am sure you will  
 16 appreciate is that an important principle is  
 17 accountability?  
 18 **A.** Yes.  
 19 **Q.** And if I have understood your last answer,  
 20 that if it is objectively determined that a particular  
 21 inspection was insufficiently thorough, the person who  
 22 would be accountable for that would be the Chair and  
 23 also the head of hospital at the CQC.  
 24 **A.** I think that's --  
 25 **Q.** Is that a fair way of characterising it?

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1 A. I think that is probably a fair assessment,  
 2 yes.  
 3 Q. At least that was your view at the time?  
 4 A. Yes. I only hesitate because the role of the  
 5 chair is quite a minimal role in just those few days  
 6 that you are on site in the organisation.  
 7 Q. That being the case, just to explore this with  
 8 you further, is it a surprising statement you have made  
 9 then that you are on the one hand accountable for the  
 10 thoroughness of the investigation but on the other have  
 11 only a very limited role within it? Just help us to  
 12 understand that apparent tension?  
 13 A. In gathering the statement, putting the  
 14 statement together for this Inquiry, and you can look at  
 15 information that you may not have had sight of, that was  
 16 prepared ahead or seen ahead of the inspection and how  
 17 the detail following the inspection, it allows you to  
 18 realise that your role is actually quite limited.  
 19 It's not exactly as a chairperson would normally  
 20 carry a role where you may have a clear overview from  
 21 start to finish of a process.  
 22 Q. So the idea that you may be one of the two  
 23 people accountable is that simply your interpretation or  
 24 is that something that was part of any training or  
 25 information given to you by the CQC when telling you:

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1 seniority?  
 2 A. I think that's exactly right, yes.  
 3 Q. And so part of your function was to do exactly  
 4 that?  
 5 A. Yes. Yes.  
 6 Q. But I think you have described your  
 7 understanding of the remit as being broader than just  
 8 being an appropriately senior person for those  
 9 interviews because you have talked about liaising with  
 10 the head of hospitals and ensuring that the whole  
 11 process worked?  
 12 A. Well, yes, you didn't just interview the  
 13 senior people in the organisation. You actually were,  
 14 I suppose, overseeing the Specialist Advisers who were  
 15 there. I was a Specialist Adviser, they were Specialist  
 16 Advisers making sure that actually they were supported  
 17 if they needed support and they were used to the best of  
 18 their advantage along with the head of hospital  
 19 inspection, who of course is much more used to  
 20 inspections than I was.  
 21 Q. That person, so we are all clear, is a person  
 22 called Ann Ford at the time?  
 23 A. That's right yes.  
 24 Q. We will be hearing from Ms Ford tomorrow.  
 25 A. Yes.

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

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1 Q. At the time, did you think that the culture of  
 2 inspectors should be one of curiosity?  
 3 A. The culture of inspectors?  
 4 Q. Yes, should -- should the inspectors be  
 5 curious?  
 6 A. Yes.  
 7 Q. Was it part of your role to encourage that  
 8 curiosity?  
 9 A. Yes, it would have been part of the role  
 10 although it was quite a strict format that people  
 11 followed. But you would expect that people would ask  
 12 questions and if that might lead to further questions  
 13 and they would look for evidence to support what they  
 14 were asking the questions about.  
 15 Q. You have talked about a role as in a way  
 16 managing the Special Advisers and how they operated, was  
 17 there an opportunity for you to say: Right, well this  
 18 is the inspection that I am the chair of, this is what  
 19 I am hoping we are all going to achieve? Did you have  
 20 that sort of leadership role where you spoke to the  
 21 team and told them how you wanted it all to run or how  
 22 you thought it should run?  
 23 A. There was a format at the pre-inspection  
 24 briefing that you would just welcome everybody -- that  
 25 was a Zoom call. You would welcome everybody and say

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1 that, you know, the culture is that we are polite, we  
2 are respectful, so you just go through those headings.  
3 There was no further -- I don't recall there being  
4 a further sort of opportunity to really engage fully  
5 with people. At the start of the inspection, you would  
6 again reiterate the behaviours you expected of people.

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

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

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

14 **A.** Okay.

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

16 **A.** Yes.

17 **Q.** -- and the position at the Countess.

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

23 Her murders had caused an unexpected increase in  
24 the neonatal mortality rate for the neonatal unit in  
25 that nine-month period previously. We know now that

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1 common theme for the unexpected increase and that that  
2 draft report was sent to the Medical Director and the  
3 Director of Nursing the day before you attended and I am  
4 just going to bring up an email that you won't have seen  
5 before --

6 **A.** No.

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

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

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

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

23 **A.** Yes.

24 **Q.** The final thing we know -- and I promise that  
25 there is a question coming at the end of this -- that

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1 staff at the hospital had identified that unexpected  
2 increase in mortality?

3 **A.** (Nods)

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

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

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

23 In the week before your inspection, we know that  
24 there was a Thematic Review meeting which brought  
25 together all of the deaths and said that there was no

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1 over and above all of that, over the nine months prior  
2 to your inspection, four Consultants at least, two  
3 nursing managers, and one Risk and Safety Lead had  
4 identified or were otherwise told that Letby was  
5 associated with the unexplained spike. And that in the  
6 case of the four Consultants they had varying degrees of  
7 concern that that association may suggest causation.

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

11 **A.** That's right.

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

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

16 **Q.** Overall "good"?

17 **A.** -- it was "good".

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

20 **A.** (Nods)

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

25 What I am hoping you might be able to assist us

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1 with, reflecting on all of that information, much of  
2 which I daresay you knew already --  
3 **A.** No.  
4 **Q.** Well, reflecting upon that information, was  
5 there anything about the CQC inspection that you think  
6 failed to draw that out in some way?

7 **A.** I was able to look through the transcripts of  
8 the interviews that had been held with the  
9 paediatricians and the nurses and the unit managers of  
10 the Children's and Young People's Services and the  
11 neonatal service.

12 I wasn't involved in those interviews, but I did  
13 have a chance to look through them and make a comment  
14 and I -- nowhere could I find a comment or the words  
15 "Concern", "unexplained", "unexpected" in those notes.

16 The Mortality Morbidity Meetings were mentioned in  
17 three of those notes, briefly in a couple, but no  
18 transcripts that would say that actually this was raised  
19 with a level of concern. That's all I can say, I wasn't  
20 in those interviews but I did look through those records  
21 and that's, I could not find evidence of that being  
22 written down.

23 **Q.** So it wasn't volunteered, you can't see  
24 evidence of it being volunteered?

25 **A.** I don't -- I would have to say I could not see  
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1 **Q.** Well, one way to pick it up is to say as part  
2 of a standard meeting, "Is there anything that you think  
3 I should be aware of or anything that you are concerned  
4 about that we haven't talked about yet?"

5 **A.** And quite often at the end of a session, you  
6 would finish with, "Is there anything else you want to  
7 tell me that we haven't discussed?" And also you would  
8 probably say, you know, we'd hope that people would say,  
9 "There's opportunity if you wish to raise something  
10 individually to a CQC member of staff" and it would be  
11 anonymised.

12 And throughout the organisation there was  
13 opportunities, you know, posters that would allow staff  
14 to use what they might see as the whistleblowing policy  
15 but to come forward if they had a concern that they  
16 didn't wish to discuss in a -- in a forum where other  
17 people were with them.

18 **Q.** Now, you didn't yourself, because it wasn't  
19 your role, speak to anybody in the children services  
20 area?

21 **A.** No.

22 **Q.** But you did speak to Ian Harvey and to  
23 Alison Kelly?

24 **A.** Yes.

25 **Q.** And you have seen the email that --  
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1 evidence that it was volunteered.

2 **Q.** If inspectors are operating and the Special  
3 Advisers are operating curiously, would you expect them  
4 to be asking questions that might draw that out?

5 **A.** Well, you would expect that they would be  
6 discussing them, mortality and morbidity meetings, and  
7 you would depend on the answer in a sense to lead you to  
8 where the next question is.

9 If there's a discussion that we have Morbidity and  
10 Mortality Meetings and we know that we look at the  
11 actions taken and the learning from that and we haven't  
12 yet found any common themes but there hasn't been  
13 a mention of a rise in deaths, then actually you would  
14 see that as good practice; that each neonate that dies  
15 has a review of the care that's undertaken with junior  
16 staff engaged in that, actions are identified, lessons  
17 are learnt.

18 There was evidence from those notes that actually  
19 action from incidents was passed through staff on safety  
20 briefings, et cetera. So you would be following that  
21 lead.

22 I think without somebody giving you information  
23 that it's an unexpected number or a rise in our number,  
24 using those terms, it may be difficult to think that you  
25 would pick that up.  
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1 **A.** Yes.

2 **Q.** -- chain the day before.

3 Did you ask either of them, "We have talked about  
4 all of that. Is there anything else that you think  
5 I should be aware of or that I need to know or that you  
6 are worried about?"

7 Did you ask that question to either of them?

8 **A.** I can only say I may have asked. I can't  
9 absolutely remember, but I would have asked, "What are  
10 the serious concerns or risks you have around patient  
11 safety?" That's usually one of the questions I would  
12 ask. "Tell me what those serious risks are. Where are  
13 you most concerned? What are you doing to mitigate  
14 against that?"

15 So that would be one of the regular sort of  
16 questions that I would ask around the safety and quality  
17 of patient care generally. You know, not asking about  
18 a particular -- neonates because I wouldn't have  
19 considered that to be something to ask but generally,  
20 "What are the serious risks? Are there any concerns you  
21 have about care? What are you doing about those  
22 concerns? What are you doing to mitigate those  
23 concerns."

24 That would be a question that I would ask.

25 **Q.** Drawing on your experience as a Executive  
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1 Director of Nursing and as a non-executive director, if  
2 you had an unexpected increase in a mortality rate in  
3 any department, and that there was a Thematic Review  
4 done of those cases and that review came back and said,  
5 "We cannot identify a common theme that explains this",  
6 is that something that a Director of Nursing or  
7 a non-executive director should regard as an area of  
8 concern?

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

15 **Q.** So --

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

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

23 **A.** What you would probably want to do is follow  
24 on with that. So, you know, "Okay, there's no common  
25 threads. Where do we go from here? Where are you going  
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1 Well, if that's sort of information coming in just  
2 before the inspection, I really ought to raise it with  
3 the inspector, or the special adviser or do you think:  
4 Well, it might not need to be raised?

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

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

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

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

24 **A.** No, no.

25 **Q.** You have never heard anybody say, "Don't tell  
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1 to go next? What are you going to do?"

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

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

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

13 **Q.** Of course.

14 **A.** I'm not sure --

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

17 **A.** Okay.

18 **Q.** -- or Medical Director?

19 **A.** Yes.

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

25 I'm just trying to understand whether your view is:  
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1 the CQC" or "We don't need to quite let them know yet,  
2 this may turn out to be nothing. We don't want them  
3 worrying about this or putting it on our rating."

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

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

10 **A.** No.

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

14 **A.** Yes.

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

17 **A.** Yes.

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

20 **A.** Yes.

21 **Q.** You are satisfied you did?

22 **A.** Yes.

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

25 **A.** That's right.  
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1 Q. One part of -- well, let's have a look at  
2 a document. It's the children's pack, INQ0101422.  
3 That's termed a pre-inspection document, it's dated  
4 22 December 2015. Do you recall whether this was within  
5 your pre-inspection pack?  
6 A. Yes, this was. Yes, this was part of the  
7 pre-inspection pack.  
8 Q. Now, you had a background in children's  
9 services as a clinician, didn't you?  
10 A. Yes.  
11 Q. But that wasn't your function at this  
12 particular inspection. Is this something that you will  
13 have read before you went to the inspection?  
14 A. Yes. This would have come out prior to the  
15 pre-inspection briefing, which was held on the  
16 10th February. So there would have been an expectation  
17 that anybody who was attending the pre-inspection  
18 briefing would have looked at the -- the pre-inspection  
19 pack.  
20 Q. Now, just one query as to whether you noticed  
21 it at the time and if so whether it was in any way  
22 a problem. If we look at page 6, we can see there is  
23 a summary of analysis presumably provided by people at  
24 the CQC based on information that they were --  
25 A. I have got page 5 up on my screen.

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

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1 Q. It's page 6, it's document page 6.  
2 A. Sorry. Okay, yes.  
3 Q. No trouble at all. But this, this appears to  
4 be information gathered by the CQC and prepared for the  
5 inspectors?  
6 A. Yes.  
7 Q. Now, "Well-led" is blank.  
8 A. Yes.  
9 Q. Is that something that was common, that there  
10 would be a blank field about an important area that you  
11 were looking at?  
12 A. I can't remember if it would be common in the  
13 pre-inspection briefing pack or not to be quite honest.  
14 Q. And if you were reading that, would you be  
15 sufficiently concerned about that absence to say, "We  
16 need to know that before we come along", or would you  
17 just say, "Well, I am sure we will find that out when we  
18 get there."  
19 I mean, how important is this?  
20 A. I think I would assume that that would be  
21 found out when you get there, when you start talking to  
22 staff and asking them about their role, the way they  
23 work within the organisation, et cetera.  
24 Q. Thank you. We can take that down. The next  
25 document I want to ask you about is a table of neonatal

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1 advance or as part of your inspection?  
2 A. No, no, I had not seen that table.  
3 Q. You had not seen --  
4 A. I had not seen that table until I had it sent  
5 to me in readiness to put the statement together.  
6 Q. And the third and final pre-inspection  
7 document, INQ0103620. This is the intelligence  
8 presentation?  
9 A. Yes.  
10 Q. Was this something that you will have seen  
11 before the inspection or on the day of the inspection?  
12 A. This is on the day of the inspection.  
13 Q. And was this a presentation to the Trust or  
14 was it just within the inspectors that this presentation  
15 was --  
16 A. I think it was just to the inspectors in the  
17 presentation -- in the inspection team.  
18 Q. So it's a way of preparing you for what you  
19 were about --  
20 A. It is a way of preparing everybody for the  
21 inspection which was about to -- which had started that  
22 day.  
23 Q. Others have been asked about this. We can go  
24 to page 7 and see the self-assessment where we can see  
25 for services for children and young people that the

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1 hospital has rated itself as "good", "good",  
2 "outstanding", "outstanding" and "good" across the  
3 five domains?

4 **A.** Yes.

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

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

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

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

22 **A.** Phew.

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

24 But if it wasn't going to make any difference, why  
25 do you think you are being told this on the morning of

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1 Do you recall whether that was something that you  
2 actively investigated or tried to get to the bottom of  
3 with the interviews that you conducted?

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

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

10 **A.** Yes.

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

13 **A.** No, no, I don't.

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

17 **A.** Vaguely.

18 **Q.** What did you understand that was?

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

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

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

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1 your inspection? What's the value of that information  
2 if all you are going to do is say, "Well, that's what  
3 they think. I am now going to get on with what I think  
4 I need to do"?

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

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

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

16 **A.** Yes, it is. Yes, it is.

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

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

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

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

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1 **Q.** Is it fair to characterise your reaction that  
2 from the fact you only knew it vaguely that this wasn't  
3 a big part of what you understood was going to be  
4 important for the inspection process?

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

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

11 **A.** Yes.

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

15 **A.** Before I ... ?

16 **Q.** Attended the inspection?

17 **A.** No.

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

22 **A.** No.

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

25 **A.** Yes.

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1 Q. -- do you have any recollection of having seen  
2 a Thematic Review of neonatal mortality?  
3 A. I did not see a Thematic Review, no.  
4 Q. I have characterised that document to you now.  
5 It's about 10 pages long or so and it goes through each  
6 of the deaths, looks at different factors --  
7 A. Yes, yes.  
8 Q. -- identifies some areas for improvement but  
9 says ultimately no common theme. Is that a document  
10 that should have been provided to you and the inspection  
11 team beforehand, do you think? Is it a document that  
12 would have been valuable to your inspection?  
13 A. I think it would have been, as we said  
14 earlier, giving CQC a heads up that there had been  
15 a concern raised and this is the work that had been  
16 undertaken to try and identify a little bit more about  
17 that concern.  
18 Q. So does it all come to this: that your  
19 position is that you should have been told about  
20 whatever concerns existed certainly about the increase  
21 in mortality rate?  
22 A. Yes.  
23 Q. And that that should have come before you  
24 started?  
25 A. Or as we started discussing with the

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1 A. Oh, absolutely.  
2 Q. Who kept those notes, who was the scribe or  
3 was everybody writing their own notes?  
4 A. Well, you could write yourself and there would  
5 be a second person with you, a CQC person, who would  
6 also be transcribing.  
7 All of the records would be handed in at the end of  
8 any inspection. It was really important that every  
9 record you had was handed in to CQC, which obviously  
10 became part of the process of taking the report writing  
11 forward.  
12 Q. Was it your practice to make notes?  
13 A. It was my practice to make notes, yes.  
14 Q. So do you think for each of these interviews  
15 there existed, at one time, your record of what was  
16 said?  
17 A. Yes. And there was a, you know, a table that  
18 you would use from CQC that you could write them down  
19 on, yes.  
20 Q. Now, you have told us your recollection is  
21 extremely limited.  
22 A. Yes, I'm afraid so.  
23 Q. You do have a recollection of Alison Kelly  
24 becoming distressed in your meeting with her?  
25 A. Yes.

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1 paediatric team or the Medical Director or the Director  
2 of Nursing.  
3 Q. We will just identify the people that you  
4 interviewed. I can bring a document up but I'm sure you  
5 can take it from me you interviewed the non-executive  
6 Director for Quality and Safety, Mr Higgins?  
7 A. Yes.  
8 Q. The Chair, Sir Duncan Nichol?  
9 A. Yes.  
10 Q. The Director of Nursing, Alison Kelly?  
11 A. Yes.  
12 Q. The Senior Information and Risk Owner, also  
13 Alison Kelly?  
14 A. Yes.  
15 Q. The chief operating officer, Lorraine Burnett?  
16 A. Yes.  
17 Q. That was all on the 17th. And then on the  
18 18th, the Senior Lead for HR Sue Hodgkinson, the  
19 Chief Executive Tony Chambers and the Medical Director  
20 Ian Harvey?  
21 A. Yes.  
22 Q. As you have told us you have got no notes  
23 available to you to refresh your memory from that?  
24 A. No, I haven't.  
25 Q. Were notes kept of those meetings?

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

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1 A. Yes, yes.  
 2 Q. In terms of other things that you have  
 3 recorded in your witness statement that were or weren't  
 4 said, you say that you can't recall discussing  
 5 a situation of any unexpected or unexplained increase in  
 6 neonatal deaths and that you can say, with absolute  
 7 certainty, that there was no mention of any suspicion or  
 8 correlation with a member of staff and neonatal deaths?  
 9 A. Yes.  
 10 Q. And had that, had either of those things been  
 11 raised, would they have provoked a reaction from you?  
 12 A. Yes, I would have discussed those with --  
 13 well, you might have asked more questions in the actual  
 14 interview itself. But I think I would have discussed  
 15 those with the Head of Hospital Inspection, that  
 16 concerns had been raised that maybe we hadn't been made  
 17 aware of before the inspection, particularly  
 18 correlations between staff members and, you know,  
 19 patient deaths. That's a serious issue.  
 20 Q. You record in your statement that staff were  
 21 generally positive about the culture of the  
 22 organisation?  
 23 A. Yes.  
 24 Q. And that they spoke positively about the  
 25 visibility of the CEO and Director of Nursing?

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1 Q. You say that staff shortages were most  
 2 frequently mentioned?  
 3 A. Yes.  
 4 Q. And that there was real concern about that?  
 5 A. Yes.  
 6 Q. But that the nursing shortages in particular  
 7 were long-standing?  
 8 A. Yes.  
 9 Q. Your involvement as you have told us was  
 10 effectively for three days?  
 11 A. Yes.  
 12 Q. That's the 16th, 17th and 18th.  
 13 The inspection continued on the 19th?  
 14 A. Yes.  
 15 Q. But even though you were Chair, that wasn't  
 16 your function to be present for that?  
 17 A. No. That was I think a CQC wrap-up meeting.  
 18 I'm not quite sure how that was addressed.  
 19 But no, we stayed for the three days that we were  
 20 conducting the inspection in the hospital itself.  
 21 Q. And it would appear there was some sort of  
 22 connected visit in very early March, but I don't  
 23 think --  
 24 A. An unexpected -- an unexpected?  
 25 Q. I'm not sure I would go that far but it

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1 A. That wasn't necessarily just the Children's  
 2 Unit. I think that was when I was asked to give an  
 3 account of the interviews that had taken place with  
 4 other staff groups, yes.  
 5 Q. Yes. So this is you giving your overview as  
 6 Chair effectively?  
 7 A. Yes. I wasn't involved in any of those but  
 8 I looked through all of the transcripts and I was trying  
 9 to get an overview for the purposes of the statement and  
 10 the Rule 9.  
 11 Q. You say your review caused you to find that  
 12 generally interviewees gave positive accounts of the  
 13 care they delivered to children and young people?  
 14 A. Yes.  
 15 Q. That in two interviews the issue of the  
 16 Children's Unit not having a voice at board level was  
 17 raised?  
 18 A. Yes.  
 19 Q. However, you say the neonatal unit department  
 20 manager gave a slightly different impression?  
 21 A. Yes.  
 22 Q. That person is Eirian Powell. I think you say  
 23 that she described the board as being visible and  
 24 supportive?  
 25 A. Yes.

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1 appears to be connected with -- the follow-up is  
 2 connected with the February visit.  
 3 For my purpose, what's important is you didn't go  
 4 back in March?  
 5 A. No. No, I didn't, I didn't go back.  
 6 Q. And you say in your witness statement you  
 7 don't believe you went to any post-inspection meetings?  
 8 A. No, that was the quality summit and my name  
 9 was on the template and I wasn't present at the quality  
 10 summit.  
 11 Q. And you weren't involved in the drafting of  
 12 the report?  
 13 A. No, no, I wasn't.  
 14 Q. Or provided with the email sent by  
 15 Alison Kelly on 30 June?  
 16 A. No, no.  
 17 Q. So I would just like to invite you to reflect  
 18 and you have had a little bit of processing time,  
 19 although I have been asking you questions about it; if  
 20 it is thought that something's gone wrong with this  
 21 inspection --  
 22 A. Yes.  
 23 Q. -- the process overall and everybody involved  
 24 in it, where do you think improvements might be made to  
 25 try and prevent that in the future? And when I say

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1 something gone wrong, an important piece of information  
2 does not appear to have made it to the CQC and as  
3 a result the CQC has given a report that suggests that  
4 effectively there isn't a big problem when there is?

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

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

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

22 Or if you do want somebody to do that role who's  
23 external to the CQC, it needs to be thought through  
24 differently so they can give more time to it and they  
25 are not somebody who's, you know, already working and

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1 say that we haven't yet covered?"

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

7 **Q.** And --

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

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

18 **A.** Yes.

19 **Q.** You know --

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

23 Yes, I think that's a better word.

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

25 Those are my questions, my Lady.

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1 just doing this as another issue.

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

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

7 **A.** Yes.

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

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

19 **A.** Yes, I do.

20 **Q.** Sorry.

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

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1 **LADY JUSTICE THIRLWALL:** Any questions, Mr Deakin?

2 **MR DEAKIN:** No questions.

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

6 **A.** Thank you.

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

11 **LADY JUSTICE THIRLWALL:** Very good. Thank you very  
12 much, Mr De La Poer. So we will rise now until  
13 10 o'clock tomorrow morning.

14 **(3.44 pm)**

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

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