Witness Name: Robert Cornall
Statement No.: RC/1
Exhibits: [XXXX]
Dated: [XXXX]

THIRLWALL INQUIRY

WITNESS STATEMENT OF ROBERT CORNALL

I, Robert Cornall, will say as follows: -

Introductory comments

1. For the last eleven years I have worked for NHS England, either in the North Region or North East and Yorkshire Region. My roles during this time have been in finance and commissioning, all of which included responsibilities relating to aspects of specialised commissioning. I understand that the Inquiry is particularly interested in the role I held in the period November 2015 to March 2019 when I was Regional Director for Specialised Commissioning in the North Region. In my statement, I have explained what commissioning involves and, specifically, what my role as Regional Director for Specialised Commissioning involved. In doing to, I understand that explaining what is meant by commissioning can sometimes be difficult. It captures a wide range of responsibilities and activities that, together, help us ensure that the healthcare services we are arranging are safe, high quality, efficient and economic. In order to do this, we used a collaborative team based approach.

2. However, in terms of safety and quality, this work was largely led by those within the North Region Specialised Commissioning team who were quality experts, under the leadership of the Clinical Leads (the North Region Specialised Commissioning Clinical Director and the North Region Specialised Commissioning Director of Nursing). Safety and quality more broadly involve other key stakeholders, including in particular the Care Quality Commission. During the period 2015-2017 NHS Improvement also played a regulatory role in relation to overall provider performance.

3. The way in which the commissioning relationship operates has changed over time and continues to evolve, reflecting wider changes in working. It is not a static process and will also adapt to suit specific circumstances, taking into account any issues arising in relation to a service; the provider's overall operating environment and wider issues that have an impact on service delivery.

4. This context is important in understanding how I performed my role as Regional Director for Specialised Commissioning. I am also not a clinician and so I drew on the expertise of those within my team who were, to ensure that decision-making was appropriately informed by clinical views. As Regional Director for Specialised Commissioning, my role was essentially one of coordination; bringing together the national priorities of the National Specialised Commissioning Team, translating these to the regional level, and working with the Regional Specialised Commissioning Team to implement them. All of this work was informed by the needs of patients and our regional population, as well as by the views shared by our stakeholders, including providers.

5. The national publication Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16 emphasises NHS England's commitment to ensuring that "patients are the priority in every decision that NHS England makes" and it describes the way in which this is enabled in a specialised commissioning context, including through the role of what was at the time regional NHS England teams. As Regional Director of Specialised Commissioning for the North Region, one of my responsibilities was to support the Regional implementation of these nationally-set Commissioning Intentions **[Exhibit RC/0001 INQ0102968]**.

6. In my statement I have also answered the Inquiry's specific questions and provided my comments on the documents that I have been asked to consider in the Rule 9 Request.

7. I would also like to say that from my experience this was a dreadful series of crimes which I have had no other similar experience of in my working life and I cannot begin to imagine how difficult and traumatising this has been for the parents, families and friends directly involved. Events like these are unexpected and rare and consequently often difficult to identify and process. I have reflected on how our review and investigations process could be different from then and also the fact that they are based on statistical analysis of variance and dependant on open and transparent reporting of incidents and the need to flag where there may be areas of concern. I think that in general terms our

quality reporting and risk approach works well but it is harder to identify things where deceit and criminology are involved.

8. What we have tried to improve since 2017 learning from these terrible events and other investigations and reviews is enabling incidents to be flagged as potentially serious without certainty that this is the case, rather than waiting until we are certain that there is a problem. This is generally needed to be done by those closest to the events and the patients concerned but all parts of the NHS can reflect on this. The seriousness of an incident can always be downgraded when the true facts are known.

9. In this case, there were no more deaths once the unit had been downgraded in July 2016. At the time, this gave us as the Specialised Commissioning Team some reassurance. However, we now know that the fact there were no more deaths was because of the Countess of Chester Hospital's decision to remove LL from the neonatal unit, a fact we did not know at the time. In July 2016, when the downgrade decision was made, and as described below in my statement, we did not know that there were concerns about an individual's involvement in the increased mortality; the identity of LL; or the fact that she was removed from duty. It is important to understand that the steps we took in the period from July 2016 to late March 2017 were on the basis of what was known at the time. While we had increasing concerns through this period about the Hospital's transparency and openness and about what was going on, we did not know until 29 March 2017 that there were concerns about an individual's involvement in the deaths.

10. While these thoughts do not help the families of those impacted by these dreadful events I hope what I have described below helps people understand what the thinking was at the time, how actions were taken and why, what the impact of these actions was and how we look to try and improve things moving forward.

Approach to my statement

11. In this statement, I have set out my response to the questions that the Inquiry has asked me in the Rule 9 Request it sent dated 1 May 2024. Before turning to address those issues, I would like to explain the process through which I have drafted this statement and my involvement to date in responding to the Rule 9 Requests made to NHS England.

12. This statement has been drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. This statement is the product of drafting after communications between myself and those external solicitors in writing, by telephone, video conference and in-person meetings.

13. Prior to giving this statement, I had contributed to the process through which NHSE/1 (the NHS England Corporate Witness Statement that provided an overview of NHS England's role; the applicable statutory frameworks; its knowledge and involvement in events relating to LL; and its views on a range of issues relating to culture, management and governance within the NHS) was drafted. This included attending several meetings with NHS England's solicitors to assist with responding to the questions relating to the North regional arrangements; the governance of specialised commissioning; and the North region's involvement and knowledge of events involving LL. As part of this process, I also provided relevant documents and other materials to NHS England's solicitors, which were then disclosed as exhibits to NHSE/1. As a result, I have few additional exhibits to disclose with this statement.

Background

14. I exhibit a copy of my CV to this statement **[Exhibit RC/0002 INQ0103054]**. I qualified as a Chartered Accountant (Institute of Chartered Accountants in England and Wales) in 1990. I joined NHS England in February 2013, just prior to its formal legal establishment. Before joining the NHS I held a variety of commercial roles from 1986 to 1998, and then worked in the public sector at the BBC, Durham County Council, Croydon Council and Business & Enterprise North East.

15. My first role in NHS England was as the Area Team Finance Director for the Cumbria, Northumberland and Tyne & Wear Area Team joining in 2013. At the time, and as described in paragraph 80 of NHSE/1, NHS England was organised into 4 regions, becoming five when NHS England was first established, and 27 areas. After that, in January 2015, I became Finance Director for Specialised Commissioning across the North Region. From November 2015 to March 2019 I was the Regional Director for Specialised Commissioning, again across the North Region. Since April 2019 to the current date I have held the role of the Regional Director of Commissioning North East and Yorkshire. I have concentrated in this statement in describing in more detail below what my NHS England role as Regional Director for Specialised Commissioning involved, as I have understood this to be the primary focus of the Inquiry's Rule 9

Request. I have exhibited a copy of my job description for this role to this statement **[Exhibit RC/0003 INQ0103038]**.

16. I would also like to explain how I have structured my statement. I have covered the following:

    a) Part A: An overview of the role and function of the Specialised Commissioning Team in the North Region, including the structure of the Team; my role within the Team; how decisions were made; how we interacted with the Regional Team as a whole; and how we interacted with the NHS England national specialised commissioning team;

    b) Part B: How the Specialised Commissioning Team operated as a commissioner of the services set out in the service specification for Neonatal Critical Care (Intensive Care, HDU and Special Care); how we monitored and managed providers, including the Countess of Chester Hospital;

    c) Part C: My knowledge of and involvement in the events at the Countess of Chester Hospital, including responding to the specific questions that the Inquiry has asked me and my comments on the documents that the Inquiry has referred me to in my Rule 9 Request;

    d) Part D: My reflections on the matters that the Inquiry is considering, including on the role of the Regional Specialised Commissioning Team in managing the events at the Countess of Chester Hospital.

Part A: Specialised Commissioning in the North Region

17. In this Part A of my statement, I have described the following:
    a) An overview of the role and function of the Specialised Commissioning Team in the North Region;
    b) The structure of the Specialised Commissioning Team;
    c) How we operated, including how decisions were made;
    d) My role within the Team;
    e) Regional quality arrangements; and
    f) How we interacted with the NHS England national specialised commissioning team.

18. NHSE/1 provides an overview, from paragraph 99, of the way in which Specialised Commissioning was structured in the period 2015-2016 and the way in which the NHS England Regional Teams worked with the NHS England national Specialised Commissioning team. I have not repeated that content here but have set out below key points relevant to explaining how we worked as a Regional Team. I have exhibited the Specialised Commissioning Business plan for 2016 – 17 at **Exhibit RC/0004 INQ0103071**

19. Specialised services are legally defined and NHS England is the responsible statutory body for commissioning these services. Each NHS England Region had a Specialised Commissioning Team. Regional Specialised Commissioning Teams were responsible for commissioning most of the Specialised Services that NHS England had responsibility for. However, the service specifications for these Specialised Services were set nationally. The relevant specification for the neonatal services provided by the Countess of Chester was the Neonatal Critical Care (Intensive Care, HDU and Special Care) specification (E08/S/a) **[Exhibit RC/0005 INQ0009232]**. The copy exhibited is undated but the content is as per my memory of what the specification was in the period 2015-2017. I have referred to these services as 'Neonatal Critical Care Services' throughout the rest of my statement.

20. In order to commission healthcare services from a provider, like the Countess of Chester, we enter into a contract. This is the position today and was the position in the period 2015-2017. This contract governs the provision of services but I would describe it as the back-stop if problems arise in the relationship with the provider in question. Day-to-day, the contract is not the primary mechanism that is used to monitor and manage the provider's performance or the safety, quality and effectiveness of the services we are commissioning them to provide. On a day-to-day basis, performance by our providers was monitored and managed through the collation, analysis and triangulation of data and information, as well as through regular meetings with them. I have described how this worked in practice later in my statement at paragraphs 47-49 but I was not at the forefront of this process because it was largely managed by the Assistant Regional Directors within the Regional Specialised Commissioning Team and their teams.

21. The North Specialised Commissioning Regional Team held the contract with the Countess of Chester Hospital for the provision of Neonatal Critical Care Services. As is required, the contract we used was the national NHS Standard Contract. The NHS Standard Contract is described in NHSE/1 at paragraph 56.

22. I have explained the team structure and my role within the team in more detail below but I would like to first explain that the Regional Specialised Commissioning Team formed part of the wider North Regional Team. On matters relating to quality, for instance, Specialised Commissioning did not have its own separate processes. We worked to the same core structure as was used within the Region as a whole. We also worked closely with Clinical Commissioning Group colleagues, recognising that for all providers, most of the services that they were commissioned to provide were ones where it was the Clinical Commissioning Group and not NHS England that was the commissioner.

23. The NHS England Regional Team as a whole operated on a multi-disciplinary approach, with different parts of the Regional Team having specific responsibilities. These parts were organised as directorates, with a director heading each one. While the directorate structures have evolved over time during the period 2013 to date, they have broadly been organised to cover the areas that are described by reference to the arrangements in place in 2016.

24. In 2016, for example, and as illustrated in the organograms exhibited to this statement as **[Exhibit RC/0006 INQ0102980]**, there were the following directorates within the Regional Team as a whole:

    a) Medical;
    b) Nursing;
    c) Commissioning;
    d) Operations;
    e) Finance;
    f) Assurance and delivery;
    g) Patients and information;
    h) Specialised Commissioning;
    i) Human Resources and Organisation Development.

25. There was also a dedicated part of the Regional Team that led on intervention and support. In the period prior to 2019, when NHS England and NHS Improvement came together, this intervention and support was for Clinical Commissioning Groups who the Regional Team had identified as requiring this. In the period to 2019 NHS Improvement was responsible for provider intervention and support as described at NHSE/1 paragraph 192.

26. The North Region Specialised Commissioning Team operated in a similar way to the Regional Team. However, as a commissioning team, the role of Assistant Directors encompassed commissioning operations, assurance and delivery. They were supported in this by dedicated teams, each one led by a director:

    a) Medical;
    b) Nursing;
    c) Finance.

27. The North Region Specialised Commissioning Team was organised into sub-regional hubs. This reflected NHS England policy that the commissioner/provider relationship was best managed as locally as possible. Each hub was organised around patient flows.

28. In the period 2015-2017, the hubs were as follows:

    a) North East and North Cumbria;
    b) Yorkshire and Humber;
    c) North West.

29. Each hub team was led by an Assistant Director of Specialised Commissioning, each of whom reported to me. I have described my role and my responsibilities, including in relation to the individuals who reported to me, in more detail below at paragraphs 39-46.

30. Each area was self-sufficient in terms of having a full team of the disciplines mentioned above (Finance, Clinical, Quality) and these areas were supported by the Assistant Directors who reported to me. In addition, each discipline had clear joint responsibilities to their regional function leads, such as the regional Chief Nurse, Medical Director, or Finance Director, and also to their functional equivalents in the National Specialised Commissioning Team.

31. The Regional Team as a whole had seven Director of Commissioning Operations teams. The Director of Commissioning Operations teams were responsible for working with Clinical Commissioning Groups and Trusts on their patch, providing medical, nursing and finance support and also running the complaints function and being the direct commissioner for Primary Care.

32. The North Regional Director had ultimate responsibility for the Region and associated responsibilities, which are described in NHSE/1 and in the NHS England Scheme of Reservation and Delegation **[Exhibit RC/0007 INQ0103007]**. I reported to the North Regional Director.

33. The diagram below illustrates the North Specialised Commissioning Regional Team structure as it was in 2016:

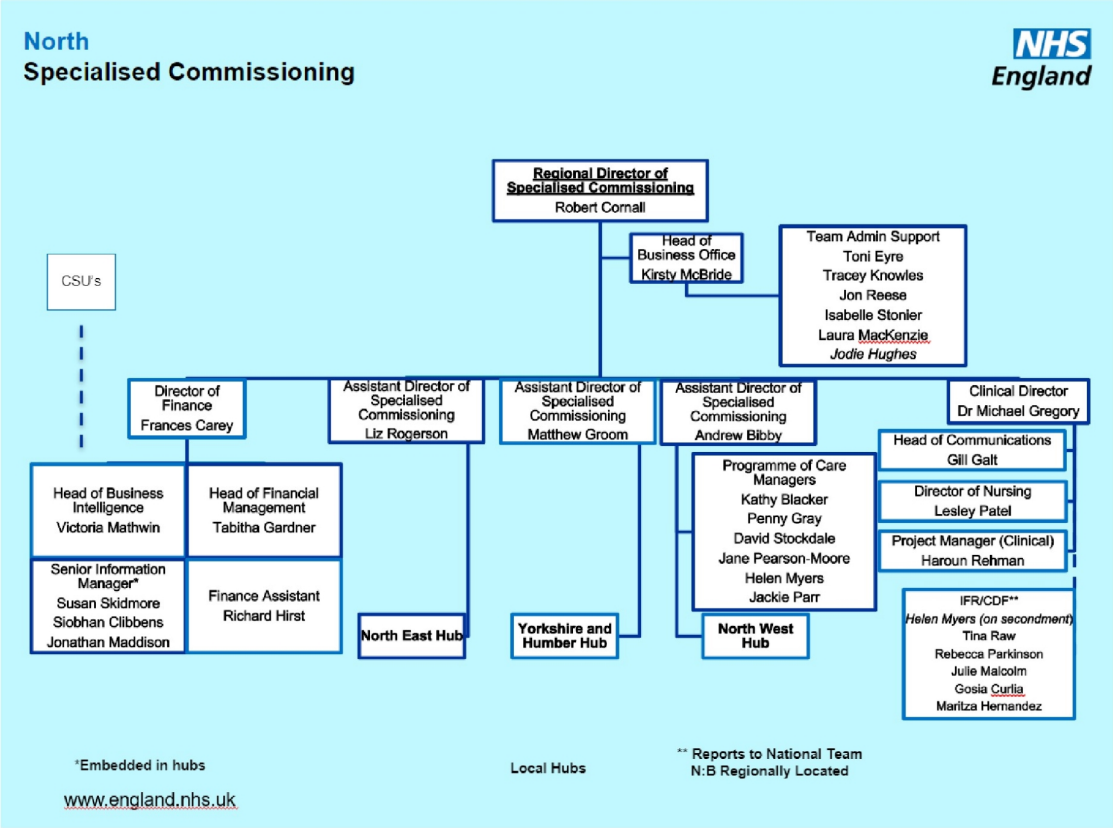

Figure 1 NHS England - North Structure

How the North Region Specialised Commissioning Team operated

34. The North Region Specialised Commissioning Team worked to the governance arrangements set out in the North Region Specialised Commissioning Team Governance Arrangements guidance (first published June 2015 and updated in December 2015) **[Exhibit RC/0008 INQ0103034]**.

35. As part of NHS England, we also operated in accordance with corporate governance processes and frameworks, including the NHS England Scheme of Delegation; Standing Financial Instructions; and applicable policies.

36. The diagram below sets out what the governance structures were in the period 2015-2016:

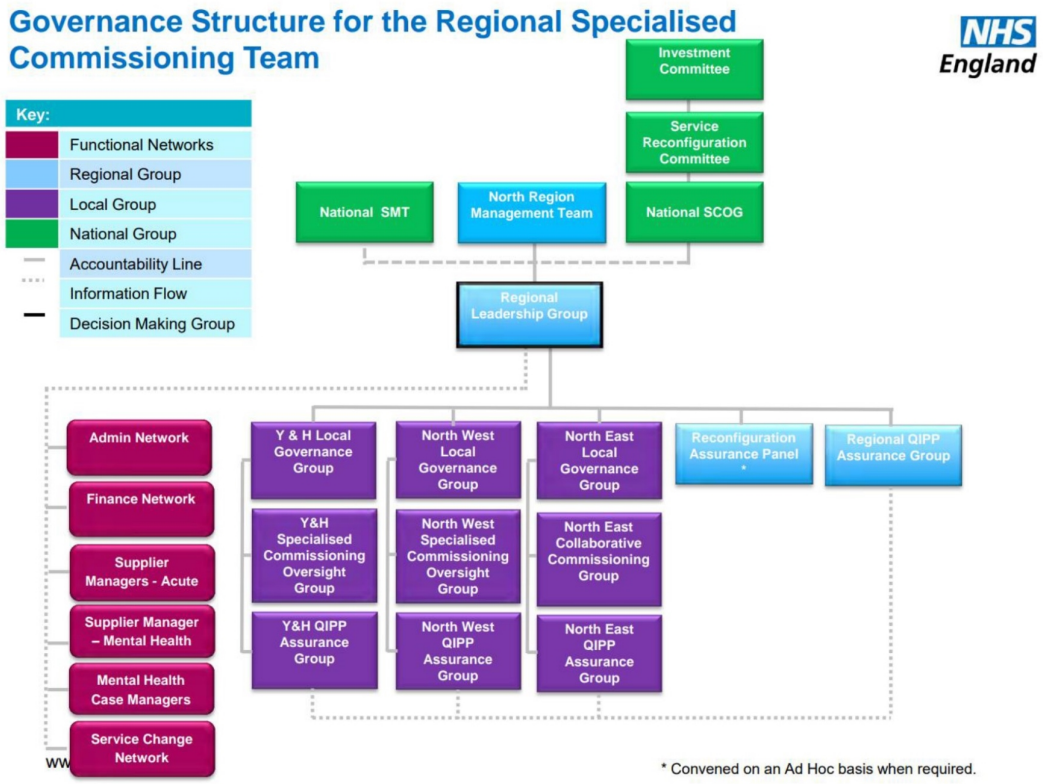

Figure 2 - Governance Structure for the Regional Specialised Commissioning Team from North Region Specialised Commissioning Team Governance Arrangements.

37. As described in this Governance Arrangements guidance, the North Region Specialised Commissioning governance arrangements were as follows:

a) The default position for decision making was as per the latest agreed Standing Financial Instructions, Standing Orders and Scheme of Delegation, as agreed by the NHS England Board. Relevant extracts were enclosed at Appendix B of the Governance Arrangements guidance **[Exhibit RC/008 INQ0103034]**. A copy of the full Scheme of Delegation in force at the time in 2015 and 2016 has not been able to be located but I have exhibited the 2013 and 2017 versions **[Exhibit RC/0009**

INQ0102967 and Exhibit RC/0007], which contains similar provisions to those in Appendix B of the Governance Arrangements guidance.

b) A Regional Leadership Group, formally established with Terms of Reference **[Exhibit RC/0010 INQ0103033]**, met weekly. I chaired the Regional Leadership Group.

c) Once a month the Regional Leadership Group took the form of a Regional Governance Group. Any matters requiring a decision by me as the Regional Director of Specialised Commissioning were taken to the Regional Leadership Group or, if urgent, taken outside of the meeting cycle.

d) Equivalent arrangements were established at hub level, with each hub holding monthly Local Governance Group meetings. Notes of Local Governance Groups were reported to the Regional Leadership Group on a monthly basis.

e) A structured Assurance Process was in place for the Team. This formed the basis against which the Team's performance in ensuring operational delivery of the Operational Plan for Specialised Services was assessed and assured. The guiding objective of this Assurance Process was to ensure that the Team were "commissioning the best patient care which is delivered in the right place and right time" **[Exhibit RC/0008 INQ0103034]**.

38. The Inquiry has referred me to the Direct Commissioning Assurance Framework **[INQ0009226]**. I was aware of this Framework and I can see that it was referenced in the contracts from that period and our commissioning approach would have been based around what the Framework described. I have described the way we operated as a Team in more detail below.

<u>My role as North Region Director of Specialised Commissioning</u>

39. I have exhibited the Job Description for my role as Regional Director of Specialised Commissioning (North) at **[Exhibit RC/0004 INQ0103038]**.

40. My role as Regional Director of Specialised Commissioning North was essentially one of coordination. I brought together the national priorities outlined by the National Specialised Commissioning Team, translating these to a regional level and working through the three hub teams. I also facilitated the sharing of local or provider/population specific implementation issues back through to the National Team. In my role, I managed a cross disciplinary team that included individuals in Finance, Medical, Nursing, Communications and Commissioning roles.

41. As a whole, the Specialised Commissioning Team for the North Region numbered around 210 people in total, spread across the disciplines mentioned. I was responsible for managing 6 people directly in a line management sense. The Assistant Directors of Specialised Commissioning for the three hubs, the Director of Finance for Specialised Commissioning North Region, the Clinical Director for Specialised Commissioning North Region, and the Team Business Manager all reported directly to me. The Director of Nursing reported to the Clinical Director.

    In all that we did, the most critical part was that the decision making should be clinically led. I was not a clinician and so I was reliant on the clinical members of my team in helping me ensure that this was the case. The Specialised Commissioning Clinical and Nursing Directors had a prominent role, therefore, within the Team in helping to ensure that services we were commissioning were safe, secure and of high quality across the region.

42. The emphasis in my role was on ensuring proper commissioning and procurement process, financial control, service change through agreement and consensus where possible. I oversaw the implementation of the annual operating plan that was agreed for the Specialised Commissioning in the North Region. I have exhibited to this statement the Operating Plan for 2016/17 as an illustration of what this looked like **[Exhibit RC/0011 INQ0102988]**.

43. However, while I am not a clinician, I was always closely involved in both regional and local decision-making, including through attending Local Government Health Overview and Scrutiny panels; Local Council meetings; and patient engagement meetings in the context of potential service change. Around the time of the events involving LL, I was actively involved in the reconfiguration of Learning Disability services in the North Region; the reconfiguration of Congenital Heart Disease Services, as part of a national review; the reorganisation of vascular surgery in the North East; and various issues relating to prison healthcare in the Region.

44. The Clinical Director for Specialised Commissioning and the Director of Nursing for Specialised Commissioning also worked closely with others within the wider Regional Team who had equivalent clinical responsibilities. For example, the Specialised Commissioning Director of Nursing worked with the Regional Chief Nurse. Similarly, the Clinical Director for Specialised Commissioning worked with the Regional Medical Director. These professional relationships were especially important on quality and

safety issues. The simplified diagram below illustrates these line management and professional reporting arrangements:

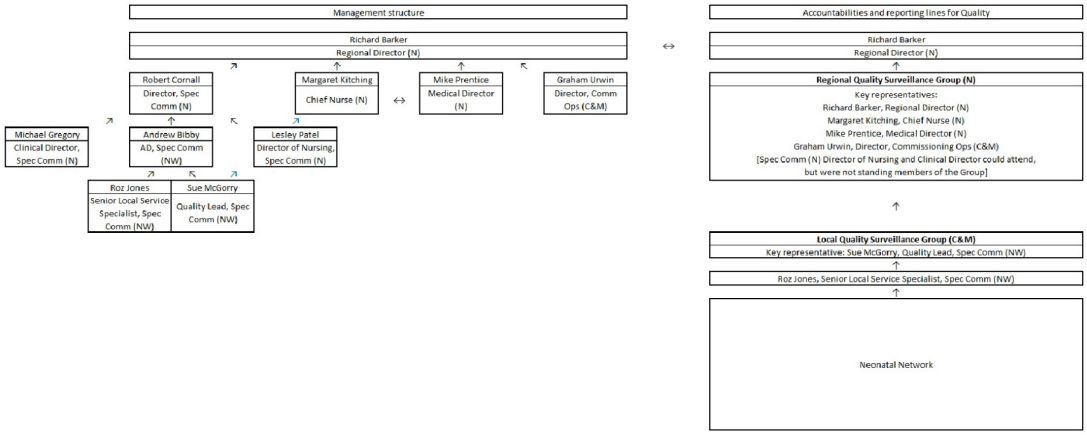

Figure 3 – Management and professional reporting arrangements

45. Each of the sub-regional hubs was supported by its own team, working to the Assistant Directors. The hub relevant to the events at the Countess of Chester Hospital was the North West Hub and the Assistant Director of the North West Hub during the period 2015-2017 was Andrew Bibby. Each of the Hubs would provide a detailed monthly performance report to me, one part of which contained a summary report from the Specialised Services Quality Dashboards (which were used by the Quality team to log and manage quality issues arising in our services [**Exhibit RC/0012 INQ0102981, Exhibit RC/0013 INQ0103091, Exhibit RC/0014 INQ0103097, Exhibit RC/0015 INQ0103093, Exhibit RC/0016 INQ0103095, Exhibit RC/0017 INQ0103010]**). I have exhibited to this statement the Months 3, 4 and 5 reports for 2016, which provide monthly briefings on the concerns around an increased pattern of mortality at the Countess of Chester Hospital; the downgrade of the unit; and the external review **[Exhibit RC/0018 INQ0102987], [Exhibit RC/0019 INQ0102989] [Exhibit RC/0020 INQ0103070]**. I have also exhibited the Month 12 performance report, which covers the 12 Months to end of March 2017 and which describes the quality risk profile that was undertaken in February 2017 in relation to the Countess of Chester Hospital "following concerns re responsiveness of the trust in request for information. A surgical related never event and lack of partnership working." **[Exhibit RC/0021 INQ0103002]** I have described further below how I used the information contained in these monthly performance reports to brief the Regional Management Group and my National Specialised Commissioning colleagues. For completeness I have exhibited the other performance reports for the

period 2016 – 2017 **[RC/0022 INQ0102972, RC/0023 INQ0102974, RC/0024 INQ0102976, RC/0025 INQ0103069, RC/0026 INQ0102991, RC/0027 INQ0102993, RC/0028 INQ0103072, RC/0029 INQ0102995, RC/0030 INQ0102999, RC/0031 INQ0103000, RC/0032 INQ0103006]**

46. The diagram below sets out the North West Hub structure during the period 2015-2017:

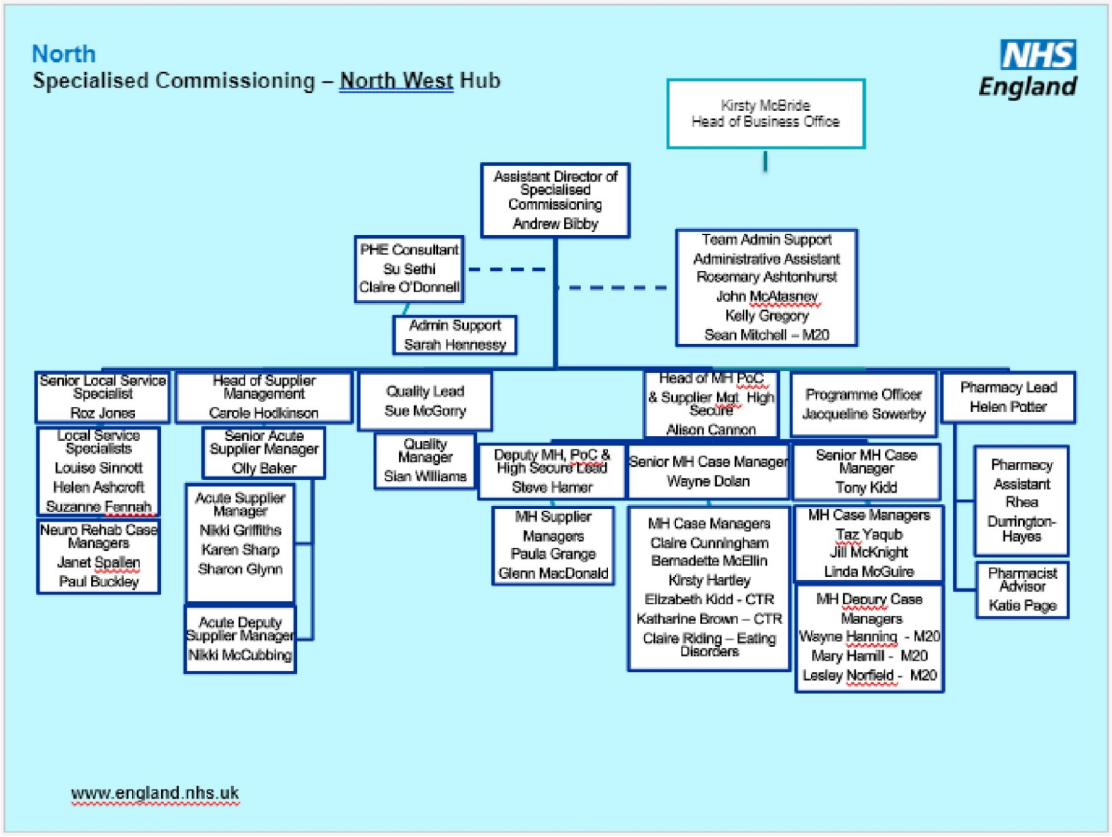

Figure 4 – North Structure v0.6

Part B: How the Specialised Commissioning Team operated

Governance of the North Regional Specialised Commissioning Team

47. As Regional Director for Specialised Commissioning I chaired the meetings of the NHS England North Specialised Commissioning Regional Leadership Group. Terms of reference are exhibited **[Exhibit RC/0008 INQ0103033]**. The Group included the following members:
    a) Regional Director Specialised commissioning;
    b) Assistant Regional Director Specialised Commissioning for each of the three Hubs;

c) Regional Specialised Commissioning Clinical Director;
d) Regional Specialised Commissioning Director of Nursing;
e) Regional Specialised Commissioning Finance Director;
f) Regional Specialised Commissioning Head of Financial Management; and
g) The Communications and Engagement Manager and Business Manager also attended.

48. The Regional Leadership Group enabled a formalised way for the Regional team to feed into the National Specialised Commissioning governance structure. Reports from the Regional Leadership Group formed part of the reporting into the Specialised Commissioning Oversight Group (whose role is described at 102 in NHSE/1). It was also the primary decision-making body within the Region for decisions on Specialised Commissioning matters. I generally attended each of the Regional Leadership Group meetings, unless I was on leave.

49. At the end of every month, there was a log of decisions taken and a summary report of what had happened in the month prior. This formed the basis of my report to the Regional Director. In between this formal meeting cycle, we used "Hotspot reports" to provide snapshot updates on issues arising in a specialised commissioning context and again, these were provided to the Regional Director for his awareness and information. I approved these reports before they were issued.

50. An example of these "Hotspot reports" is below:

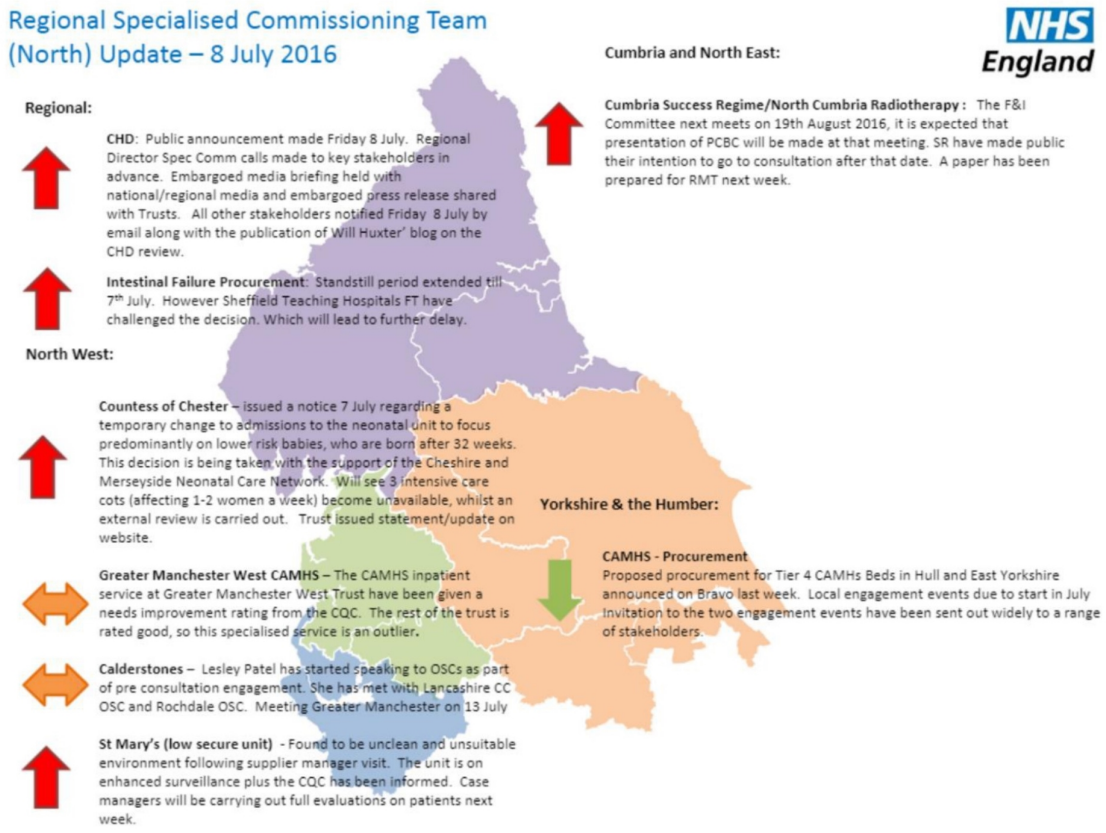

Figure 5 – Hotspot report from 8 July 2016

51. I have described above the monthly performance reports that each of the Hubs provided to me. I used the information contained within these to produce my reports, which formed part of the pack of papers provided to the Regional Management Team for our meetings, which generally took place on a weekly basis. I have exhibited to this statement the Regional Management Team Meeting Packs for the period March 2016-July 2017, all of which contain reference to events involving the neonatal unit at the Countess of Chester Hospital **[Exhibit RC/0033 INQ0103076] [Exhibit RC/0034 INQ0103073] [Exhibit RC/0035 INQ0103089] [Exhibit RC/0036 INQ0103075] [Exhibit RC/0037 INQ0103082] [Exhibit RC/0038 INQ0103074] [Exhibit RC/0039 INQ0103083] [Exhibit RC/0040 INQ0103081] [Exhibit RC/0041 INQ0107007] [Exhibit RC/0042 INQ0103084] [Exhibit RC/0043 INQ0103077] [Exhibit RC/0044 INQ0103085] [Exhibit RC/0045 INQ0103078] [Exhibit RC/0046 INQ0103086] [Exhibit RC/0047 INQ0103087] [Exhibit RC/0048 INQ0103088] [Exhibit RC/0049 INQ0103079].** I also have exhibited the Regional Management Teams minutes that mention neonatal mortality at the Countess of Chester Hospital **[Exhibit RC/0050 INQ0102970] [Exhibit RC/0051 INQ0102973] [Exhibit**

RC/0052 INQ0102975] [Exhibit RC/0053 INQ0102986] [Exhibit RC/0054 INQ0102998] [Exhibit RC/0055 INQ0103001] [Exhibit RC/0056 INQ0103004].

Quality and safety

52. As I have explained above, all decision-making needed to be clinically led and I drew on the expertise of the Regional Specialised Commissioning Clinical Director and the Regional Specialised Commissioning Director of Nursing to help me ensure that this was the case. In the period 2015-2017, these roles were performed by Michael Gregory (Regional Specialised Commissioning Clinical Director) and Lesley Patel (Regional Specialised Commissioning Director of Nursing). The team structure, and the processes we worked to, ensured that I was able to draw on appropriate clinical and quality expertise and information, which informed the decisions I took as Regional Director for Specialised Commissioning.

53. There was a dedicated team within the Specialised Commissioning Regional Team that was responsible for quality matters. They worked to a structure and processes that were part of the overarching Regional Quality arrangements. These in turn reflected national guidance. The general position regarding how quality arrangements were structured, nationally, regionally and locally, is described in NHSE/1 at from paragraph 333.

54. In summary, the arrangements in place at the time were as follows:

    a) Specialised Commissioning had a dedicated quality team. This was led by the Specialised Commissioning Director of Nursing. In the period 2015-2017, Lesley Patel was the Specialised Commissioning Director of Nursing. Michael Gregory worked closely with Lesley on quality matters and together they submitted a dedicated monthly Clinical and Quality Report to the Regional Leadership Group.
    b) Each hub had a Quality Lead who supported the Specialised Commissioning Director of Nursing in the exercise of her responsibilities and who provided local leadership for quality matters. The North West Hub Quality Lead during the period 2015-2017 was Sue McGorry.
    c) The Specialised Commissioning arrangements worked as part of the overall quality arrangements in place within the Region. This included peer professional support for those in the Specialised Commissioning Team performing clinical roles.
    d) Each NHS England Region had a Regional Quality Surveillance Group. For the North Region, this was the Regional North Quality Surveillance Group. This Group was

chaired by the Regional Chief Nurse. I did not routinely attend meetings of the Regional North Quality Surveillance Group but if there were agenda items relating to Specialised Commissioning, either the Specialised Commissioning Clinical Director, the Specialised Commissioning Director of Nursing or myself would attend. I exhibit example papers from the Regional Quality Surveillance Group at **Exhibit RC/0057 INQ0103009.**

e) In addition to these Regional arrangements, there were also Local Quality Surveillance Groups. These were arranged on the same geographical footprint as the 7 Director of Commissioning Operations area footprints. The Cheshire and Merseyside Local Quality Surveillance Group was the relevant local group for the Countess of Chester Hospital. My understanding is that the North West Quality Lead attended this Group.

55. Within the North Region Team, the Regional Chief Nurse was the overall responsible lead for quality and safety issues. Similarly, the quality lead for Specialised Commissioning was the Specialised Commissioning Director of Nursing. I worked closely with both in the course of performing my role, but particularly with the Specialised Commissioning Director of Nursing, whose expertise I valued.

56. Quality and safety were central aspects of all decisions we took and were considered at every one of our meetings, whether Regional or Specialised Commissioning Team. Our focus in such meetings was on understanding what issues had arisen and what actions needed to be taken to address these issues. At meetings, whether of the Specialised Commissioning Team or the Regional Team, we would receive reports that covered clinical safety, quality matters and finance. In addition, we would also receive specific issue papers (such as on procurement) as needed. Attendees routinely raised issues of concern or significance as part of these meetings and we recognised the distinction between current known issues around quality, as well as anticipated / potential risks, which we worked to avoid occurring. An example set of papers is attached **[Exhibit RC/0058 INQ0103005]**.

57. My way of working was for me to coordinate and manage key stakeholders and I would rely on others within my Team to get the detail and tell me about it. I was not personally gathering that information, nor did I visit all the providers we had contracts with, but we did run regular update communications calls with providers and issue email updates to all providers. Reflecting on my way of working in responding to this Rule 9, I think that

this is the only way to manage the breadth of providers and geography I was responsible for in my role at the time.

58. The Inquiry has asked me about my experience of concerns being raised with me, by clinicians, patients or family members. I do not recall that anyone from these groups has ever raised issues directly with me relating to quality or patient safety. However, in the course of my role I have met with patients and their families (particularly relating to mental health services). These meetings will often be facilitated by their local Member of Parliament and would be to hear their concerns. Patient and public input into the development and update of service specifications and related specialised commissioning products also provided a way in which concerns could be shared. In general, though, on a routine basis the issues that were directly raised with us by our providers related to the commissioning or contractual process, or the service specifications.

59. I am also aware that each provider would have had processes in place through which concerns could be raised, whether in the form of a complaint (perhaps by a service user or a family member) or in the form of a whistleblowing concern.

60. Staff members or Boards of directors of Trusts could escalate issues directly to the specialised commissioning team. We were open and transparent with Trusts as the commissioner of services and the wider team at various levels interacted with all commissioned providers on a regular basis. The Regional Leadership Group as a team or individually met with the major providers of specialised services at least annually and peer-to-peer meetings took place between the Regional Medical Director and Trust Medical Directors more regularly. For a provider of the size of the Countess of Chester, regular contact would have been with members of the Specialised Commissioning Hub Team (the North West Hub). The regular contract and quality meetings provided a forum for issues to be raised.

61. I do not recall an example of an individual coming to me to express a quality or patient safety concern directly. This would have been much more likely to have happened through professional routes (to the Specialised Commissioning North Director of Nursing, for example) and I am sure that conversations of this nature took place in that context.

62. In the course of providing this statement, I have reviewed relevant Quality Reports **[RC/0059 INQ0103041, RC/0060 INQ0103040, RC/0061 INQ0103042, RC/0062 INQ0103044, RC/0063 INQ0103045, RC/0064 INQ0103046, RC/0065 INQ0103047, RC/0066 INQ0103048, RC/0067 INQ0103043]** that were provided to the Regional

Leadership Group in the time period I am particularly considering for this statement and I can see by way of example that information obtained through whistleblowing made to the Care Quality Commission is referenced in the July 2016 report **[Exhibit RC/0068 INQ0014640]** (these concerns did not relate to the Countess of Chester Hospital). This is one way in which such information might be brought to our attention, within the Specialised Commissioning Team.

63. As part of our ongoing and active performance monitoring of our providers, the Specialised Commissioning Team were able to (and did) ask for information. There was also information that was submitted on a regular basis, as part of each provider's monitoring returns. This information included information on mortality statistics, data related to post mortems, referrals to the coroner and coroners' inquests, serious incident reports or data. We could request to see more specific information, where there was a reason for doing so. This could include copies of reviews into individual incidents, Whistleblowing / Freedom to Speak Up data and complaints data. In my experience, it would be more unusual for us to ask to see copies of individual complaints responses or to review minutes of Board of Directors meetings and/or internal committee meetings. However, if there had been a reasonable basis for doing so, I am sure that we would have asked to see this type of information. This would, however, be in the context of the risk-based approach to provider monitoring that I have described earlier and so there would need to be a sufficient risk-based rationale for such a request.

64. The quality reports that were provided to the Regional Leadership Group were, in my view, detailed and wide ranging. The July 2016 report, exhibited above as **[Exhibit RC/0068 INQ0014640]**, explains at paragraph 2 that the report is based on "triangulation of a number of information sources available to us working closely with the Quality Surveillance team and local partners". However, it goes on to state that "Soft intelligence is also utilised from collaboration and involvement with local quality surveillance groups" and that "Additional information from complaints, incidents, peer review, dashboards and performance against national service specifications has supported the production of the report". As Regional Director for Specialised Commissioning I therefore found these reports comprehensive, informative and they guided the decision-making I made, working closely with my clinical colleagues. I have also exhibited an example report from July 2018 [**Exhibit RC/0069 INQ0103012**]

65. The general process that would have been used in the case of a provider like the Countess of Chester [**see Exhibit RC/0070 INQ0103013** for the provider's policy for the management of incidents] at the time was as follows:

    a. Each Clinical Commissioning Group ran a quality review process with all their providers. This contributed to the Local Quality and Surveillance Group process, which the Hub Teams contributed to, through the Hub Quality Leads. In the case of the Countess of Chester Hospital, this would have been the North West Hub.
    b. The Specialised Commissioning Director of Nursing would also have contributed to the Local Quality and Surveillance Group process and her input into each of these was then consolidated into a single report.
    c. This consolidated report was shared with members of the Regional Leadership Group, which I led and which is described in more detail below.
    d. My understanding is that the consolidated report was also shared with the Regional Quality and Surveillance Group, led by the Regional Chief Nurse, and with the National Specialised Commissioning Team (through the papers provided to the national quality review meetings, which were led by the National Director of Nursing for Specialised Commissioning), although I was not responsible for doing this as this process was managed by the North Region Specialised Commissioning Director of Nursing.
    e. The Regional Management Team met monthly and issues relating to quality and safety would be raised through these meetings. I attended these meetings and one of the routine items on the agenda for these meetings as an update from the Regional Specialised Commissioning Team, which was usually provided by me. Relevant papers and minutes of the Regional Management Team are exhibited to my statement, where referenced in the context of my involvement in and knowledge of the events involving LL.

66. Overall, I do consider that the quality arrangements we had in place were robust; that the team who supported me, including those with clinical roles, were thorough, diligent and raised issues with me in a timely manner. There was a structured process in place; issues were appropriately and promptly brought to my attention, either through the Specialised Commissioning Director of Nursing's routine reports or through ad-hoc reports, discussions and meetings.

The annual contracting round

67. As I have explained, the contract used to commission providers like the Countess of Chester was the National Standard Contract. I have attached as exhibits copies of the contracts for the periods 2019-2021, 2017-2019, 2016-2017 and 2015-2016 that we held in relation to the Countess of Chester **[Exhibit RC/0071 INQ0103050] [Exhibit RC/0072 INQ0103049] [Exhibit RC/0073 INQ0102979] [Exhibit RC/0074 INQ0103019]**. I have also exhibited some documents that are embedded within the 2019 – 2021 contract, **INQ0103019** [**RC/0075 INQ0103015, RC/0076 INQ0103016, RC/0077 INQ0103018, RC/0078 INQ0103011, RC/0079 INQ0103014**

68. The annual contract agreement process was managed by each of the Hub Assistant Directors. They would meet with each of the providers in their Hub area and agree all the contract details. I would expect the Hub teams to check all the particulars in the contract were in place. If there were any areas of dispute these would be raised with first the Assistant Directors and then me if necessary, for resolution and discussion. I do not recall any such issues being raised with me in relation to the contract with the Countess of Chester for the 2015-2016 or the 2016-2017 periods. Each contract manager would prepare a checklist, which was provided to me and which I would check before I signed the contract [an example is provided at **Exhibit RC/0080 INQ0102971]**. This ensured that I knew key actions had been taken. I would then review and sign the contract, once the provider and the North Region Finance Director for Specialised Commissioning had signed the document. Signing was done remotely and there was no "signing" meeting at either the provider or NHS England's regional offices at which all parties attended. (Some high value contracts were signed nationally but the process above is accurate for a provider like the Countess of Chester).

The service specification

69. The Service Specification for Neonatal Critical Care is exhibited to my statement **[RC/0005 INQ0009232]**. While it is undated, I have reviewed the contents again in the course of providing this statement and it appears to accurately describe the services that we had commissioned the Countess of Chester Hospital to provide. The Service Specification incorporated NHS England's expectations around each provider's compliance with the Outcomes Framework in use at the time, and the domains and indicators contained within the Outcomes Framework. NHSE/1 describes the approach in relation to the Outcomes Framework and how this was used in the context of NHS England's role as a commissioner. The Outcomes Framework formed part of the overall

accountability framework against which the Government measured NHS England's performance.

70. The Service Specification lists the five Domains at the time as follows:

    a) Domain 1: preventing people from dying prematurely;
    b) Domain 2: enhancing quality of life for people; and
    c) Domain 3: helping people to recover from episodes of ill-heath or following injury.
    d) Domain 4: ensuring people have a positive experience of care.
    e) Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm.

71. Taken together, the Service Specification (incorporating the Outcomes Framework content above) and the Commissioning Intentions for 2014-2017 emphasise high quality and safe care as key areas of focus for NHS England as a commissioner. This emphasis was key to our operational as a commissioning team.

72. Then and now, all staff undertake mandatory training in relation to key areas such as safeguarding and the importance of safeguarding was regularly emphasised, particularly by the Director of Nursing for Specialised Commissioning and her team. My view is that safeguarding, and quality more broadly, were always at the forefront of all the meetings.

73. In my experience, the main reason that we as commissioners intervened in any of our commissioned services was because of concerns about quality. We did this through the serious incident reporting process and the Quality and Surveillance Group structures described earlier in my statement, but also through the regular review of quality dashboards related to our services and through information obtained during meetings with providers and other stakeholder colleagues. The Director of Nursing would also highlight issues from these processes to our regular Regional Leadership Group meetings, to share learning and ensure risks were noted and actioned accordingly.

74. For both our smallest and largest Trusts, I was satisfied that the team supporting me were absolutely dealing with any quality/patient safety and safeguarding issues and processes. Because the Countess of Chester was a small provider of specialised services, it was generally supported by the North West Hub team. We took a risk based approach to engagement with providers, meaning that our contact with them and the

tools used to monitor their performance would intensify if we had concerns about the quality or safety of the services they were providing.

The relationship between national and regional specialised commissioning teams

75. The Inquiry has asked me to explain the relationship between the Regional and National Specialised Commissioning structures. As a reminder, specialised services are specific types of healthcare services that are legally defined as being 'specialised'. This is explained in more detail in NHSE/1 and, as noted there, although these services are legally defined, they are still largely locally commissioned. This was the case in 2015-2017 and remains the case today, with further arrangements being developed for Integrated Care Boards to take on greater responsibility for this.

76. As described in NHSE/1, and in particular at paragraph 105, in the period 2015-2017 the national governance of Specialised Services included:

    a) The Specialised Services Commissioning Committee, which was a Committee of the (national) NHS England Board. Regional teams did not directly interact with the Committee and I had no role in relation to it or any experience of directly interfacing with it. The role of managing the Committee was performed by the National Director for Specialised Commissioning.

    b) The Specialised Commissioning Oversight Group, which supported the work of the Committee and whose role is described in NHSE/1 at paragraph 102. In brief, the Specialised Commissioning Oversight Group reported to the Committee through the National Director for Specialised Commissioning. I, along with the other Regional Directors for Specialised Commissioning, was a member of the Specialised Commissioning Oversight Group. Full membership of the Specialised Commissioning Oversight Group is set out in the Terms of Reference **[Exhibit RC/0081 INQ0102969]** and I have exhibited example papers **[Exhibit RC/0082 INQ0102992** and **Exhibit RC/0083 INQ0102990]**. The role of the Specialised Commissioning Oversight Group, as I understood it, was to agree and approve commissioning policies and service specifications for specialised commissioning and to ensure that the overall specialised commissioning function was managed effectively with regards to quality, patient access, finance, procurement and scope of services, including the need to evaluate and introduce new service developments. I reported to the Regional

Leadership Team on key matters arising from meetings of the Specialised Commissioning Oversight Group.

77. The Inquiry has referred me to the legal duties that NHS England was subject to, including those under NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the Children Act 2004 (as amended by the Health and Social Care Act 2012), as well as the NHS Mandate. In describing the Service Specification; Commissioning Intentions; and the way in which quality was central to our way of commissioning, I have sought to illustrate in practice how these various duties and requirements were implemented day-to-day. In addition, and as described in NHSE/1, it is important to reiterate that NHS Foundation Trusts, like the Countess of Chester, were subject to their own statutory responsibilities in relation to safeguarding. As a commissioner, we actively monitored and sought assurance around each provider's performance using a range of tools, including self-assessment; review of data (including mortality data and incident reports); triangulation with other regulatory information (such as information contained in inspection reports produced by the Care Quality Commission) but we also operated on a risk-based approach, with our baseline expectation being that providers were responsible statutory bodies.

78. The Inquiry has also asked me about whether the Regional Specialised Commissioning Team produced guidance for Trusts or provided training to such providers on the following topics:

    a) Safeguarding of babies and children in hospitals;
    b) Forensic investigation following unexpected baby deaths in hospital;
    c) Speaking up and raising concerns (including Freedom to Speak Up); and
    d) The management of grievance procedures.

79. As far as I am aware, we did not do either. The reason for this is that any guidance produced specifically for providers of specialised services would have been developed and published by the National Specialised Commissioning Team, with implementation being led by Regional Teams. This reflects the strong drive by the National Team to ensure consistent access to specialised services across England, with nationally developed and determined clinical service specifications, as reflected in the Commissioning Intentions. A key feature of the design of the specialised commissioning structure in the period from 2013 when NHS England was established was to avoid the

"post code lottery" of different services being provided to different standards in different geographies and so these types of policies were not for regional discretion.

80. In the event that a need for such policy or guidance had been identified, this work would have been taken forward by the National Specialised Commissioning Team, with implementation being managed on a regional basis. Regional teams were able to raise issues such as this through the Specialised Commissioning Oversight Group.

81. Similarly, we did not provide training to Trusts on these types of topics. If we identified concerns around a Trust's processes in relation to safeguarding, for example, we would discuss with the Trust how they intended to address the concerns and seek assurance around the measures proposed being appropriate and suitably actioned. This could include the Trust arranging for training on a particular topic but this would not be provided by the Regional Specialised Commissioning Team.

82. Finally, the Inquiry has asked me what knowledge I had about the Child Death Overview Panel process in the period 2015-2016. I can confirm that I had no specific knowledge of the Child Death Overview Panel, its role or process prior to the events involving LL. I was, however, aware that there were a range of external scrutiny functions in relation to child deaths and my expectation would have been that any patient death, including that of a child, was subject to appropriate review, including by the coroner or other structures as appropriate. This is evidenced by the emails shared with the Inquiry as part of NHSE/1 [**Exhibit RC/0084 INQ0014661]**.

Part C – My knowledge and involvement in the events at the Countess of Chester Hospital

Concerns about the Neonatal Unit Mortality Rate

83. I do not recall any concerns about a pattern of increased mortality at the Neonatal Unit at the Hospital being raised as an issue before July 2016.

84. For completeness, I would like to explain that I was, however, aware of a neonatal death in March 2016. In early 2016 we were aware of issues relating to the Neonatal Transport service in the North West generally and we were concerned about deaths associated with capacity issues within this service. One of these deaths occurred in relation to a baby at the Countess of Chester Hospital who was due to be transferred but sadly died before this could happen. This information was brought to a Regional Management

Team meeting on 14 March 2016 and resulted from a briefing made by the then Director of Commissioning Operations for Cheshire and Merseyside.

85. The Action Log from this meeting is exhibited to this statement **[Exhibit RC/0085 INQ0103073]**. The relevant entry reads "SUIs – GU updated on a baby death in Furness, RCA underway…CD also updated on another death at Countess of Chester. RC to ensure implications for neonatal transport are identified and addressed." In the course of providing this statement, I have reviewed the papers and the wording quoted above about "another death". My recollection is that this does not suggest earlier knowledge about the pattern of raised mortality at the Countess of Chester Hospital that we subsequently became aware of in July 2016. Instead, it is in the context of a discussion about two separate baby deaths in the Region, so the minute records an update about the first death, at Furness, and another, at Countess of Chester Hospital.

86. In terms of the pattern of raised mortality at the Countess of Chester, while I cannot recall exactly when or how I was informed about raised mortality on the Neonatal Unit, I do recall that sometime in early July 2016 I was briefed by the North Region Specialised Commissioning Director of Nursing, Lesley Patel on what was, at the time, understood to be an unexpected and unexplained increase in mortality. The Trust reported two serious incidents through the Strategic Executive Information System on 30 June 2016 and I understand my team became aware of these cases then.

87. The Inquiry has referred me to an email from Lesley Patel of 5 July 2016. I can also see that the increase in mortality is recorded as an issue on our hotspots report on 8 July 2016 shown above at Figure 5. I imagine, therefore, that I was briefed sometime around these dates, most probably in our weekly Regional Leadership Group meeting.

88. In any event, I know that I briefed the Regional Management Team on 11 July 2016 about the issues. The relevant entry, which is recorded in the Action Log for the meeting **[Exhibit RC/0086 INQ0102986]** notes that I highlighted a number of points from the "Hotspots report" (of 8 July), one of which was "Countess of Chester maternity".

89. I did not know at this stage that the Consultant Paediatricians had raised concerns about a particular nurse and indeed there was no indication of concern over an individual member of staff at that time or at any point until 29th March 2017, following a call between Michael Gregory and Ian Harvey. I return to this later in my statement.

90. In the period from when we became aware of the issues in July 2016, our normal process was followed, and as the concerns were of a clinical nature, the process was to first to seek to understand and address the issues through the medical/quality route. The role of discussing concerns with the Hospital was taken by Lesley Patel, Michael Gregory and by Andrew Bibby. They reported back to me regularly through this period as and when there were any updates to be provided. Some of these updates and discussions are documented through our meeting papers and action logs but we would often informally discuss issues arising in relation to a provider and these were not always recorded. This is because the minutes of our meetings were taken as action logs, not a verbatim record of the full discussion

91. Initially I was happy that the right process was being followed. The bringing in of external reviewers seemed logical and explanations around needing to test findings and to take these through the Hospital's Board structures seemed appropriate. Over time, the concerns expressed by the North Region Specialised Commissioning Clinical and Nursing Directors about the lack of sharing of information led me to worry that the Trust was becoming evasive in its response to questioning. This led to us involving the regulator, NHS Improvement, and then escalating to the Regional Chief Nurse. I describe these later developments in my statement.

92. Lesley Patel's email of 5 July 2016 **[Exhibit RC/0087** INQ0102984 **]**, makes reference to a thematic review. The Inquiry has asked me what "thematic review" I understood this to be referring to. As far as I am aware, the quality team would have reviewed the data in conjunction with the Trust to see if any trends or issues could be determined. This is, I think, how I would have read that email at the time. I did not see the review and nor would I ordinarily expect to see such a review, given Lesley's email states that "no clinical issues [had been] identified". I am not a clinician and would defer to the clinical expertise within the Specialised Commissioning Team. If they had considered any escalation necessary at that point, they would have made me aware of this and I would have actioned accordingly.

93. At the time all I knew was what was covered in Lesley's email. At this point we knew that mortality was higher than expected; that incident reporting was maybe not as expected and the unit was downgraded as a result. These steps are described in detail in Section 2 of NHSE/1. My expectation was that a quality led exercise between NHS England, the Clinical Commissioning Group and the Trust would uncover any issues and agree an

action plan to remedy any issues found. I was not anticipating or expecting criminal acts to be the cause. Given the nature of what we understood to be the issues at this point in time, and the assurance we had that the Hospital seemed to be taking appropriate steps to obtain an external review of the deaths, we did not consider contacting the police at this stage as there was no evidence to suggest any criminal activity.

94. The Inquiry has referred me to a timeline **[INQ0002926]**, which I understand was prepared by Sue Hodkinson. I am not aware that I have seen this timeline before but I can see, as the Inquiry has noted, that this suggests that members of the Trust's executive team met with the West Cheshire Clinical Commissioning Group and the Specialised Commissioning Team on 7th July 2016. The Inquiry has asked me whether I attended this meeting or was otherwise involved. I can confirm that I did not attend but I would have been briefed after the event and that briefing would have informed the Hotspot report I provided on 8 July and subsequently to the Regional Management Team, as described above at paragraph 51.

95. The Inquiry has asked me whether the spreadsheet with reference **INQ0006455** is correct in stating that the attendees at the meeting on 7 July 2016 were provided with a "Tabular Chronology of Events" and, if so, whether it was the chronology with reference **INQ0005216**. I am not able to comment on this given I was not in attendance at the meeting.

96. I was not aware at the time that because of concerns raised about LL she was moved from the Neonatal Unit to the risk team in July 2016. Reflecting on this, I do not think I would expect to be told of this type of decision by a Trust if it was a routine staff transfer. However, given what now seems to be the case in terms of when suspicions were first raised within the Countess of Chester Hospital about LL's involvement, and our involvement in exploring what had led to the increased mortality, it is reasonable to consider that the Trust should have made us aware of these concerns and the steps they were taking as a result at a much earlier stage.

97. The Inquiry has asked me whether I was aware of a call I understand that Andrew Bibby had on 12 August 2016 with someone at the Hospital. It is likely that I was aware, but equally, Andrew did not need my permission to have such discussions and would only have briefed or reported back if there was a relevant update to provide. If this was the case, he would have reported back via the Regional Leadership Group but I have been unable to find any documentary evidence to support that this did happen. It is helpful to

reiterate that Andrew was, generally, in regular contact with the Trust, as the local lead for specialised commissioning dealing with the Trust. The North Region Specialised Commissioning Team Governance Arrangements **[Exhibit RC/0008 INQ0103034]** emphasises that "As a principle the Assistant Directors of Specialised Commissioning…will be responsible for the day-to-day management within the delegated areas of responsibility".

98. The Inquiry has referred me to a timeline prepared by the North West Hub Head of Quality, Sue McGorry, and Lesley Patel **[INQ0014692]**. The timeline suggests updates were requested from the Hospital on 14th September 2016 and in November 2016 but to the best of my knowledge I was not involved with these requests. I would have been told they were going to be made and would have agreed that this seemed appropriate but I can find no documentary record of such discussion. This is not surprising because this type of discussion would likely have been an informal one, with colleagues leading on liaising with the Countess of Chester, as part of what I considered to be routine steps to understand what had happened and to ensure appropriately regular follow-up. While we did have concerns that we were not getting information in a timely manner from the Trust, we were still at this stage operating on the understanding that there was no malicious reason for the increased mortality. The information we had did not raise any suspicions of the scale that we now know to be the case. I would say that at this stage I at least thought that the Trust was just being rather irritating in not providing us with information more promptly rather than avoiding providing us with information.

99. In November 2016 the Specialised Commissioners agreed that the neonatal unit should be placed on enhanced surveillance. I believe that this was noted at the Regional Leadership Group but the actual decision would have been taken at a quality and surveillance group meeting, which I did not attend. While I had no involvement with the decision, I recall being informed about it and was in agreement with it. My recollection is that the Hospital as a whole had been on a period of enhanced surveillance, most likely as a result of concerns raised by the Care Quality Commission in their 2016 inspection of the Hospital. However, while progress had been made in addressing these wider concerns, there were ongoing concerns about the neonatal unit, which was why the decision would have been taken to keep the surveillance level for this specific unit at enhanced.

100. The Inquiry has referred me to a letter written by Andrew Bibby on 16 December 2016 and which was sent to the Trust **[Exhibit RC/0088 INQ0102994]**. In this letter,

Andrew requests again a copy of the Royal College of Paediatrics and Child Health Report. I recall that we had discussed the fact that the Report had not been provided at a meeting of the Regional Leadership Group and agreed the approach. I have not been able to find any relevant papers evidencing this discussion. I have also been referred by the Inquiry to the Hospital's response to the Andrew's letter, which is dated 21 December 2016 **[INQ00008077]**. The Hospital's response, sent by Alison Kelly, was to the effect that they did not feel comfortable in sharing the report at this stage, in light of a further review that the Royal College had recommended was carried out.

101. The Inquiry has referred me to a timeline prepared by Sue McGorry and Lesley Patel **[INQ0014692]**. This states that on the same day as we received the Hospital's response (21 December 2016), we decided as a Specialised Commissioning Team to request support from NHS Improvement regarding the response from the Trust. I believe that I was updated verbally on this at the Regional Leadership Group and that this is where we agreed that the correct regulatory approach was to involve NHS Improvement (who were, at the time, the regulator of Foundation Trusts). It would have been normal for us to involve NHS Improvement where there were issues that went beyond a commissioning one and had potential implications for the provider's regulatory compliance. On occasion, we also found that contact from NHS Improvement could have more impact in conveying the seriousness of an issue because they could ultimately take regulatory action if they considered this necessary, including placing an organisation in special measures.

102. As a result of this request for support, the North Regional Medical Director of NHS Improvement, Vince Connolley spoke with the Hospital Medical Director, Ian Harvey in early January 2017. I can confirm that the reference in the timeline to "NHSI MD" is the North Regional Medical Director of NHS Improvement. I recall being updated on the meeting that had taken place and I understand that Vince's note of the meeting has been provided to the Inquiry as part of NHS England's NHSE/1 statement **[INQ0014771]**. NHS England's solicitors have provided a copy of this note to me, in the course of providing this statement and to inform my response to the Inquiry's questions. I had not seen this note prior to being provided a copy in the context of giving this statement.

103. I did not speak to Vince at the time personally and, as explained above, did not see his verbatim note at the time. I do not specifically recall the words Vince uses in his note around "complex issues" but it would not have surprised me at the time if he had

described it in this way. I also felt that the issues were complex and this would not have caused me concern that he felt this way.

104. I do not recall seeing a copy of either the Royal College Review Report or the Hawdon Report **[INQ0009428]** myself.

105. In terms of the Royal College Review Report, my recollection is that Michael Gregory and Lesley Patel reviewed it and then they explained its content to me. This would have been my standard practice where there had been a clinical review, recognising the clinical expertise and input that they could bring to such matters. I cannot comment, therefore, on whether the Report was redacted in any way. I do not recall seeing or being briefed about the Hawdon Report, although I can see that in her December letter to Andrew Bibby Alison Kelly refers to a further independent case review so I would have known that a further review was taking place.

106. The Inquiry has asked me whether I contacted the Royal College review team. As the review was commissioned by the Trust, I do not consider that such a step would at that point in time (and again on the basis of what we knew at the time) would have been appropriate.

107. The Inquiry has also asked me whether I was aware of discussions at the Trust private board meeting on 10 January 2017 **[INQ0003237]** and I can confirm that I was not.

108. I was, however, aware that Ian Harvey, Andrew Bibby, Lesley Patel and Michael Gregory met on 23rd February 2017 following receipt of the Royal College's report on 3 February. My understanding is that the purpose of this meeting, from the Specialised Commissioning Team's perspective, was that we were trying to understand what the issues were at the Countess of Chester and what action the Hospital was taking.

109. However, in light of our growing concerns, a quality risk profile was undertaken 25 February 2017 to understand the risk profile given everything that was known at that point **[Exhibit RC/0089 INQ0014647]**. This was a step we would take where we were managing a situation of this nature, as a way of bringing together known risks and ensuring we had an agreed approach to managing them. I was not directly involved in this process but would have been aware it was taking place and what the conclusions were. In refreshing my memory around the contents of the quality risk profile I can see

that its contents reflect what our understanding was at the time and so I do not think that this would have raised any additional red flags for me at the time.

110. A further meeting took place on 10 March 2017. I did not attend the meeting but I understand that we were told that the Consultant Paediatricians were not content with the investigations and reviews undertaken so far. I believe that the adequacy of information provided and the way things were being handled was challenged at the meeting by those who attended on behalf of Specialised Commissioning, but I was not at the meeting myself and so cannot comment authoritatively on what was discussed.

111. However, the Michael Gregory emailed me after the meeting **[Exhibit RC/0090 INQ0014651]**. In the email, he referred to concerns about what we had heard, this was in regards to the evidence referred to above and the lack of clear answers that concerned us. My recollection was that we discussed the meeting at Regional Leadership Group and that we all considered that due to the lack of disclosure from the Trust we needed to force the issue to require them to share more fully information about the concerns. We agreed that I would raise our concerns with the Regional Chief Nurse, Margaret Kitching and I forwarded Michael's email to the Margaret Kitching and asked her to call me. I have exhibited to this statement an action log dated 4 April 2017 [**Exhibit RC/0091 INQ0103068]** from a meeting of the Regional Leadership Group, at which we discussed how to involve Margaret. The agreement was that a briefing would be prepared for her but this was superseded by my meeting with her.

112. I believe I met with Margaret at NHS England's Leeds office (in person) on Monday 4th April and relayed our collective concerns. I recall that we discussed the concerns we had about unanswered questions and that this may need escalating it was an informal meeting and so I do not have a note of the meeting.

113. On 4 April, I attended a meeting of the Regional Specialised Leadership group. This was the meeting referred to by Michael Gregory in his email on 5 April **[INQ0003126]** At the meeting we discussed the concern was that we were feeling the Trust was not sharing all their concerns, that the possibility of more serious allegations to be investigated and the need to potentially involve the police **[Exhibit RC/0092 INQ0103098]**.

114. On 19 April I was involved in an email **[INQ00114667]** discussion with Margaret Kitching, Lesley Patel and Michael Gregory regarding the inadequacy of the Trust's

response. I asked Margaret whether she had a view on escalation, as she was the responsible Director in this area for NHS England and we did not feel we had received satisfactory answers or assurance from the Trust as to what was happening.

115. I felt that Ian Harvey's response was evasive, because we did not get straight answers to questions and he was still unwilling to share information. I did not consider that Ian Harvey and other directors at the Hospital were candid with us about what was going on and I felt that the timeframe suggested by Ian Harvey was still frustrating the process.

116. A Regional Management Team Meeting was held on 25 April 2017. I did not attend this and Michael Gregory attended in my place. I am not therefore able to comment on what discussed at that meeting in detail, although I have seen the action log and Michael updated by email after the meeting. This is the email that the Inquiry has referred me to dated 26 April 2017, in which MG refers to the Regional Management Team meeting **[INQ0014667]**. I understood that at this meeting Margaret said she was prepared to give the Hospital a bit more time to respond. I can confirm that "RMT" stands for Regional Management Team. Membership of the Regional Management Team is described at paragraph 51and the minutes of this meeting are exhibited with this statement showing who attended this specific meeting. On reviewing the minutes, I can see that they do not contain any reference to this discussion, but as already explained this does not mean that discussion did not take place because of the use of an Action Log format, rather than a verbatim record of the full meeting **[Exhibit RC/0093 INQ0103036]**. On reading Michael's email I was not entirely happy with the suggestion they should be given more time to respond but understood the complexity of the issue. It must be remembered that there had been no new deaths and the downgrading and surveillance of the unit had given us some assurance that neonatal care could continue at the unit.

117. In light of our concerns within the Specialised Commissioning Team, on that same day, 26 April 2017, I can confirm I spoke to the Nursing Director for the National Specialised Commissioning Team, Teresa Fenech, and the National Specialised Commissioning Medical Director, James Palmer. We discussed the concerns and our view within the Regional Specialised Commissioning Team that we needed to involve the police. Although I had specifically arranged this meeting, it was a routine step for me to brief the National Team on an issue of this nature, where we had concerns about what was happening, to ensure they were aware and could provide any views about actions needed or support those underway. For the reasons above, we were concerned that the

trust was not disclosing full information and that there may have been a criminal element to the baby deaths. My conversation with Teresa and James was another example of us using our escalation routes to facilitate this happening. I wanted to discuss the concerns we had been discussing within the Regional Specialised Commissioning team with the responsible directors from a National Specialised Commissioning viewpoint. The outcome of this conversation was that the National Nursing Director and the National Medical Director for Specialised Commissioning agreed with our view that the Police should be involved.

118. Also on 26 April, Margaret informed me that she had briefed the North Regional Director, Richard Barker and was awaiting his response **[Exhibit RC/0094 INQ0103003]**.

119. On 27 April 2017, I was informed by the Michael Gregory that the Child Death Overview Panel team had met with the representatives from the Trust and that a police officer was on the panel **[Exhibit RC/0095 INQ0014674]**.

120. I took some reassurance from the police involvement in the Child Death Overview Panel process, especially because we by now understood that that there was potentially a person or persons of concern, that babies may have been harmed and so the police needed to review the situation and evidence.

121. I became aware that the Hospital had formally contacted the police and that they would be commencing an investigation from the email from Margaret Kitching on 9 May 2017 **[Exhibit RC/0096** INQ0012683 **]**. It is my understanding that Margaret gave the Trust an ultimatum to the effect that either they called in the police or we (NHS England) would. The Inquiry have asked me to explain what I understood when Margaret explained that she and Vince Connolly were "liaising closely on this on a need to know basis". I understood from this that communications were kept confidential so that the police could be brought in and do their work effectively, without the criminal investigation being compromised.

122. The Inquiry has also asked me to explain why there was no reference to LL in any of the above discussions or correspondence. The reason for this is that at this time we did not know who the person they were concerned about was. I had no information on LL, or that murder was an issue and so we felt this was a matter for the police and the Trust.

123. The Inquiry has also asked me to comment on whether I felt that the Hospital was sufficiently candid with the parents of the babies named on the indictment but I do not feel that I am able to comment on this. While I have described the concerns we had about the Trust's candour with us, as their commissioner, I did not know then in any detail what they had told the parents and I still do not know today the details of this aspect.

124. Finally, the Inquiry has asked me to comment on whether I considered that Ian Harvey and other directors at the Hospital were sufficiently candid with us. I hope that for the reasons set out above it is clear that I did not feel this to be the case.

Concerns around LL

125. Our fundamental approach was that having identified a risk with the service not operating successfully once the issues were flagged to us, but being uncertain what that risk was, we downgraded the service. Because we downgraded the service, babies of that clinical risk were not dealt with at the Hospital. In hindsight, it is possible that this gave us an initial degree of reassurance because there were no further deaths following the downgrade.

126. I have subsequently reflected whether this escalation could have been made sooner, working closely with my clinical leads I could see their frustration, but I believe we agreed and were happy collectively on the approach we made. We made the senior clinical leaders within the Regional Specialised Commissioning Team aware of our concerns individually and collectively and then ultimately involved Margaret Kitching, then Richard Barker and also Michael Gregory and Lesley Patel.

127. I was however wanting to be certain of facts before escalating and am also of the view that had an escalation happened a month or two earlier the events of this case would not have materially changed given our scrutiny of the service addressed the risks but I am also aware that this view may not be shared by those parents and people impacted by the crimes.

128. An area I think continues to develop is around whistleblowing and freedom to speak-up processes, which at the time were largely ringfenced to individual organisations. We

now recognise the need to share this information more widely, so all stakeholders are aware of the concerns.

129. I do not know if Lesley Patel (or others closely working with the Hospital) directly asked the Trust if there was person of concern in this process. I can confirm that I did not ask this question of anyone within my Team as it was not a risk that occurred to me at the time but I can see this would be a reasonable question to ask and would learn from this in future situations and should be incorporated into our training for all staff. At the point that this conclusion was being reached (that there was an individual of concern) escalation did occur.

130. We monitored the situation going forward but there were no further incidents from the point that we downgraded the service. We had perhaps inadvertently taken away a risk factor, along with LL being taken off the ward (which I did not know about), as she did not have access to vulnerable babies. As there were no other incidents, further action was not taken.

131. At the time, we did not know there were any concerns about an individual, and since we did not know about an individual we were not able to approach the Trust about this, we only knew about clinical concerns that had been raised and therefore we addressed the concerns through our usual processes.

132. I am not sure I was fully aware of the deterioration of the relationship between Trust executives/senior management and the Consultant Paediatricians. While I did know there were concerns I did not know that they had concerns specifically about LL. I did not take any action partly as my view was that the independent reviews would highlight issues and that the quality process would also highlight any concerns but also because, as we did not know about LL and their concerns about her, we could not have approached the clinicians directly to discuss any concerns.

133. Overall, I think the Trust executive team controlled the narrative so that it was hard to unravel the issues.

134. I was not aware of the grievance submitted by LL in September 2016 as I was not informed at the time. Reflecting on this now, my view is that we probably should have been aware of the issue in the round, as it would have explained the basis of the

concerns the Trust had with the process, but I can understand that they might not have felt able to have disclosed any of the details or the name without prejudicing the process.

Part D - my reflections

135. The Inquiry has asked me a number of reflective questions. In this section of my statement I have provided my views on them, informed by my knowledge and awareness of events as described above and on the basis of my experience.

136. In my view, NHS England North and the specialised commissioning team did subject the Hospital to sufficient scrutiny and monitoring. While mortality is reported, the analysis is somewhat behind events but when the clear outlier status was recognised appropriate action was taken which was intended to make babies safe from that point (July 2016). We did not know at the time about LL; concerns about her role in the deaths or the fact she had been removed from duty.

137. On the increase in mortality rate, I do think we were kept sufficiently informed but again because we are the commissioner of services monitoring quality and not involved in day to day care, that analysis lags behind events. We were not informed about LL until the very end and as discussed above the Trust executive were not forthcoming on the investigations and reviews.

138. We pressed the Trust for information as hard as we could within the regulatory framework and our role within it. With hindsight, knowing a mass murderer was involved we could have been more direct and called in the police but at the time this was not known and we thought we were dealing with a poorly managed, under staffed, and poorly run unit.

139. It was not generally our role as commissioner to intervene with the running of the hospital. My view remains, therefore, that our interventions were entirely appropriate given what we knew and had been shared with us, as we did not know about the role of LL. This included ensuring that NHS Improvement were involved and briefed through the Regional Chief Nurse, Margaret Kitching, and or Michael Gregory and were able to take any regulatory action they considered appropriate.

140. I think our approach is always collaborative and supportive, aiming to improve quality and safety working with the Trust and all stakeholders. However, this approach does require cooperation form the Trust to succeed.

141. I think the quality and surveillance process involved local authority and all health stakeholders, but as we did not know about LL calling the police was not an appropriate action at that stage.

142. The split of NHS North into two, and the replacement of Clinical Commissioning Groups with Integrated Care Boards has meant there have been marginally different approaches with their own strengths and weaknesses but I don't think either would have impacted on the LL case positively or negatively.

143. I struggle to comment on what improvements could be made in a clinical sense to keep babies safe, as I am not a clinician. Therefore I do not feel best placed to provide a view on how national and regional commissioning of healthcare services could be improved in relation to LL.

144. The whole point of being a doctor or nurse is that you are trusted to carry out your role, the professions are regulated and it is not easy to spot criminal acts where processes are deliberately concealed or manipulated. Additional staffing and supervision would always make it harder for rogue individuals to operate and in my view would be a good thing to consider further.

145. In relation to CCTV, it might be beneficial but for me it raises issues around confidentiality, privacy and dignity, particularly as if it is something that is going to be implemented for babies then it maybe should it be done for everyone. This may make others uncomfortable about seeking health care which would be detrimental too. However again as I am not a clinician I feel that I am not able to comment on the clinical impact.

146. In conclusion, this is clearly a tragic case that should never have happened. However, to some extent health care with limited resources always relies on trust. Cost and the need for staffing would be much greater if someone always checked and signed off on another's work and actions. If an individual abuses that trust it is consequently hard to detect. The analytics and review processes highlighted in this case worked in the

way they were intended and drove actions that put focus on the unit as they were intended to ensure that babies were safe and not being harmed going forward.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Dated: 24 July 2024