96. On 11th January 2017 Specialised Commissioning North received an email from Vince Connolly stating that he had a discussion with Ian Harvey who said that the issues were complex and that they would provide a copy of the RCPCH report when available. At that stage I was not aware of what the complex issues referred to. However, I inferred that something must have been going on internally at the Hospital which meant that the RCPCH report could not be published.

97. On 10th January 2017 an Extraordinary Meeting of the Board of Directors at the Hospital was held that supported the nurse going back on the unit **[Exhibit MG/36, INQ0003237]**. I did not know about this meeting at the time any my understanding is that the board papers were not made public or shared with NHS England.

98. I do not believe that the board papers for the meeting were public. At that stage I was not aware that an individual was involved or that a nurse had ever been taken off the unit. Had Specialised Commissioning North been told that an individual had been moved off the Neonatal Unit due to concerns from clinicians, we would also have expected to have been informed of the decision to reinstate her onto the unit. However, we were never informed that there were concerns with regard to an individual nurse. In my role, I had experiences with other Medical Directors and hospitals who have rung me up to inform me about concerns with particular individuals. Informing us of these concerns and decisions is part of having an open and transparent culture of patient safety, which I came to believe was lacking at the Hospital.

99. On 23rd February 2017 I met with Ian Harvey, Andrew Bibby and Lesley Patel. The meeting arose as Lesley Patel was raising concerns about the Hospital's response to the review and their failure to share the recommendations of the external report. It was at this point my concerns around the failure of the Hospital to volunteer information and its reluctance to share the RCPCH report first arose. At the meeting Ian Harvey discussed progress to date following the external review, recommendations and the neonatal units continued status as a special care baby level 1 unit. Ian Harvey confirmed that the Hospital had completed the external review of babies who had died from January 2015 to July 2016. It was at this meeting Ian Harvey first referred to the external review being more in depth than the previous high level thematic review that was undertaken by the Hospital. **[Exhibit MG/37, INQ0006081]**.

100. The notes prepared for the meeting do not refer to the completion of Dr Jane Hawdon's review. At that time the assumption was that the external review referred to

individual on the unit having involvement. The Inquiry have provided me with a copy of Ian Harvey's handwritten notes of the meeting which accord with my recollection of the discussion. **[MG/39, INQ0003246]**.

104. When I pushed Ian Harvey on the involvement of an individual staff member, he stated that he did not want to go into any more detail until the Hospital had made a significant announcement about the decision they had taken to speak to an "appropriate body" on the following Monday. He did not indicate what that announcement was, nor what "appropriate body" he was referring to. I do not believe that an announcement was ever made on the Monday. Ian Harvey told me that he was handling a very difficult situation and was asking for more time so that he could handle matters within the Hospital. When I pressed Ian Harvey as to what this difficult situation was, he indicated that the Hospital were having some issues with the paediatricians.

105. It was at this meeting that I first learnt about a clinician that raised concerns about the babies that had died or needed resuscitation in the Hospital or other units. My understanding was that the clinicians were picking up signs and symptoms that they didn't understand. Ian Harvey mentioned that the clinicians were confused about the signs that they were seeing and that they had observed mottling of skin, which they had not seen before. However, Ian Harvey also seemed to suggest that one clinician had some other sort of agenda. I got the impression that there was a complex situation going on and Ian Harvey was trying to piece together a consistent thread in the unexpected mortalities and illnesses. At no point during my involvement was I informed by the Hospital that two clinicians were concerned about an individual nurse, and I was not aware that this individual was LL until her arrest in 2018.

106. At this time it felt like we were going to the Hospital repeatedly and having to ask questions, rather than them volunteering the information and giving us updates. This lack of co-operation from the Hospital meant that I did not feel as though Specialised Commissioning North was able to fulfil its assurance role. Every time that we went to the Hospital we were met with obscure terminology and a lack of explanations. As Ian Harvey was the Medical Director of a Hospital, I did not feel that I had the clear lines of escalation which I would if I was regional Medical Director. I escalated my concerns within NHS England who could escalate to NHS Improvement, who had the power to take regulatory action.

Culture and atmosphere

134. I first became aware that the Hospital was having issues with the Consultant Paediatricians in my call with Ian Harvey on 29th March 2017 where he suggested that a clinician had some sort of agenda. However, I was not aware of a deterioration in the relationship between Hospital executives, senior management and the Consultant Paediatricians. As a result, I have no insight into whether the quality of professional relationships between the Consultant Paediatricians and the executive team affected how the concerns raised by the Consultants were reported to NHS England North.

135. I did not approach the Consultant Paediatricians directly to discuss their concerns. It would not be the role for a commissioner to go to clinicians on the frontline about a service. Bypassing the Medical Director and the Hospital Board would have been highly inappropriate and speaking directly to consultants would have been an unusual step, outside of our normal remit. Given the evasive responses we were getting from the Hospital, if Specialised Commissioning knew at the time that the Consultant Paediatricians were pointing the finger at an individual, then within the NHS England regional team we would have had a discussion internally about how to approach them directly. However, we were never informed by the Hospital of the nature of the Consultant Paediatrician's concerns and so would not have known which individuals to have contacted had we been in a position to do so.

Reflections

136. If the Hospital been more open with us and disclosed the clinician's concerns about the involvement of an individual, then I believe NHS England North and Specialised Commissioning would have taken further action with regard to the Hospital. However, at the time, we could only work with the information we had and, in the case of Specialised Commissioning, act within the powers that we had as Commissioners.

137. I personally first became aware of the increased mortality rate at the Hospital in February 2017 and escalated my mounting concerns in the following months to Robert Cornall, who was the Regional Director for Specialised Commissioning. During

this time NHS England North and the Specialised Commissioning team used what powers it had to subject the Hospital to scrutiny and monitoring. However, we had to be conscious about respecting the normal Hospital governance processes.

138. Specialised Commissioning was not informed that the Consultant Paediatrician's concerns related to one individual. If I knew this, in hindsight, I could have pressed the hospital further, however it is difficult to press on something that I was not informed about and I had limited authority in my role when dealing with a Hospital Medical Director. When I raised the possibility of an individual have disproportionate involvement, this was dismissed by Ian Harvey who informed me that they had undertaken multiple reviews and discounted this as a possibility.

139. From February to April 2017 we pressed the Hospital with calls and emails and I am not sure what much else we could have done in the context of our role in Specialised Commissioning, given the information we were receiving from the Hospital. We were not kept sufficiently informed about the Neonatal Unit's mortality rate, nor the Hospital's subsequent internal and external investigations. As Specialised Commissioning we had limited powers to compel the Hospital to do anything and we certainly had no mechanism to directly intervene in the running of the Hospital.

140. Throughout the relevant period, Specialised Commissioning was willing to offer the Hospital support, however what support we did offer was not being taken. By April 2017 I was growing increasingly frustrated. The Royal College report had a section missing and did not contain the individual case reviews that I thought Ian Harvey had agreed to provide. I felt that there was a lack of transparency from the Hospital, avoidance of answers and wanting to defer the issues we raised. We were still in email contact with the Hospital in April 2017 but when we asked questions, we did not receive straight answers. My sense was that the Hospital was intent on conducting its own process through their board and were evasive in response to our questions. The message that kept coming from the Hospital was that we had to wait until they had done things internally, however what that involved was not relayed to us.

141. Following the merger of NHS England and NHS Improvement, the region was split into the North West and North East and Yorkshire regions. The merger of NHS England and NHS Improvement was to use NHS England and NHS Improvement's collective resources more effectively and efficiently and remove unnecessary duplication and allowing the new region to have combined oversight of Trusts. The replacement of clinical commissioning groups with integrated care boards relationships