Witness Name: Margaret Kitching

Statement No.: 1

Exhibits: MK/1-MK/33

Dated: 25 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF

MARGARET KITCHING

I, Margaret Kitching, will say as follows:

My statement

1. 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. It is the product of drafting after communications between those external solicitors in writing and by video conference.

2. I also contributed to the process through which section 2 of NHSE/1 (the section of NHS England's Corporate Witness Statement which focused on what it knew about the events that took place at the Countess of Chester Hospital ("the Hospital")). I have explained below where evidence overlaps what is contained within NHSE/1.

3. During the preparation of NHSE/1 and this statement I have searched my records and provided the Inquiry with all documents and information that are relevant to its terms of reference. I have also sought to set out below any additional evidence that I am able to provide from my knowledge and experience generally. I have not given any interviews or otherwise made any public comments about the actions of LL or the matters of investigation by the Inquiry.

4. I have structured my statement as follows:

   A. My career and background
   B. An explanation of how the NHS England North regional team operated and my role in the team
   C. Concerns about the Hospital
   D. Escalation to me in March-April 2017
   E. Operation Hummingbird
   F. My reflections on these events
   G. Other reflections

5. Before I continue with these matters, I wish to express at the outset my sorrow for the parents and families of the babies who have lost their lives or been injured as a result of the crimes committed by LL. These were unthinkable acts on innocent babies and I appreciate that it may have been difficult for those working at the Hospital to believe initially that a nurse was responsible. However, it also my view that the Hospital should have involved NHS England and the regulators much sooner and been more transparent regarding the concerns that had been raised by clinicians at the Hospital about their suspicions of LL. This would have enabled NHS England being able to offer much better support and guidance to the Hospital and steered it towards involving the police at a much earlier stage.

A. Career / background

6. I qualified as a registered nurse in 1978 and then as a Certified Midwife in 1981 before choosing to work in the community as a District Nurse and then a Specialist Nurse.

7. In 1994 I became a hospital manager at Mount Vernon Hospital Barnsley, and I gained senior management experience over the following five years before I took up the Director of Nursing role in 1999 for Barnsley Primary Care Trust, which had a dual role of commissioner and provider, providing hospital, community and mental health services. Further information about Primary Care Trusts can be found in NHSE/1 paragraphs 34 to 35.

8. In 2013 I moved to NHS England as Director of Nursing for the South Yorkshire locality before being promoted to Interim Regional Chief Nurse in 2015. I set out below a summary of my roles at NHS England.

1 April 2013 – 30 March 2015	Area Team Director of Nursing and Quality for the South Yorkshire and Bassetlaw area.
31 March 2015	Appointed to Director of Nursing for the Yorkshire and Humber locality, but did not take up this position as I was seconded to the role of Regional Chief Nurse (North).
31 March 2015 – 31 March 2019	Regional Chief Nurse (North), initially on a secondment basis, then permanent from 1 January 2016.
1 April 2019	Joint Regional Chief Nurse for NHS England and NHS Improvement. At this point, the North Region split into two and I moved to the Northeast and Yorkshire Region. This was initially an interim position, then became permanent.
31 October 2020	Retired. I briefly returned to the same role on 1 November 2020 to assist with the response to the Covid-19 pandemic and continued to work 4 days per week until fully retiring on 31 December 2023.

B. <u>NHS England North Region</u>

<u>The regional team</u>

9. NHS England is divided into various regional teams, as set out in NHSE/1 paragraphs 80 to 86. NHS England North was one of four regional teams in operation at this time and was responsible for oversight of Clinical Commissioning Groups and responsible for NHS England's direct commissioning function which included Specialised Commissioning.

10. The members of the North Regional Team are set out at Annex 7 to NHSE/1. The North Regional Team had an executive team led by the Regional Director, Richard Barker, which included several directors. Up until 2015 the North regional team was additionally supported by nine Area Teams each comprising of a Director of Commissioning Operations, and they were supported by a full management team including a Director of Nursing and Medical Director. By 2016 the Area Teams were restructured into 4 sub-regional teams (for the purpose of this statement I will refer to the sub-regional teams as locality teams) with each having the Director of Commissioning Operations and a full management team in place.

11. The Director of Commissioning Operations reported directly to the Regional Director. On behalf of NHS England's North Region, the Area Teams and its successor Locality Teams provided local oversight of Clinical Commissioning Groups, delivered a direct commissioning function of some services. The Director of Commissioning Operations did not oversee specialised commissioning as this function reported through to the national Specialised Commissioning Team. Specialised commissioning was a national function with its own regional structures. The regional Specialised Commissioning director was supported by a management team, but they worked closely with the Regional Team, Area/Locality Teams and the Clinical Commissioning Groups.

12. NHS England North worked closely with regional, national and Area/locality Teams operating within NHS England. NHS England operated using a matrix approach which enabled sharing of expertise and access to specialist skills as and when required. National and regional directorates were very flexible in supporting teams and individuals outside of their own directorate, for example, access to the National Medical Director or Chief Nursing Officer for advice was welcomed.

13. NHS England's relationship with hospitals was primarily through our regional specialised commissioning team as they would be involved in agreeing contracts and overseeing the commissioning functions that related to each hospital. NHS England North Area/Locality Teams would support oversight and assurance of all providers in their patch as part of the quality surveillance structures in place.

14. The Regional Management Team had a weekly regional internal operational meeting that was normally chaired by our regional director Richard Barker. All the directors in the regional team attended which included myself, the medical director, the specialised commissioning director, HR director, Director of Finance, the Directors of Commissioning Operations from the four localities and the regional support team who took notes and organised the meetings. Discussions were wide ranging considering details around performance, finance and quality. A specialised commissioning hot spot report was tabled, and other reports would be put onto the agenda as and when required.

My role as Chief Nurse

15. Each NHS England regional team has a regional Chief Nurse. From 31 March 2015 – 31 March 2019 I was Chief Nurse of the North region.

16. This role involved no management of nurses and midwives employed by hospitals in the region or routine assurance of what provider chief nurses were doing. Rather, it was in a wider local NHS sense to ensure there was an individual who could provide identifiable professional leadership, for example when circumstances required effective clinical engagement, coordination, assurance and improvement.

17. Internally, a key role for the Regional Chief Nurse was to provide support and advice to their regional colleagues and to support the Chief Nursing Officer for England in executing their professional duties. This involved matrix working as I have described further below.

18. I was delegated several key operational areas of responsibility from the Regional Director (North), which included oversight of maternity services, learning disabilities and autism, infection control, patient safety, mental health homicides oversight, safeguarding, complaints and workforce developments.

19. There were four localities within the North region: Yorkshire and Humber, Lancashire and Manchester, Cheshire and Merseyside, and the Northeast. Each locality had its own director of nursing, medical director, operations personnel, and commissioning personnel all reporting to the Director of Commissioning Operations. The Director of nursing for the Cheshire and Merseyside locality team (Hazel Richards) was managed by the Director of Commissioning Operations, although she also had (as a nurse in NHS England) a professional reporting line into me.

20. My line manager was the North Regional Director, Richard Barker. I also had a professional dotted reporting line to the Chief Nursing Officer for England.

21. As part of the Regional Management Team I would review risk reports which were escalated to the Regional Team to ensure any particular concerns within the region remained on the agenda for the regional management team to discuss. Risk reports would highlight any areas of concern that would need support for example pressures in the system, timelines going off target, supporting staff shortages in my direct team, and considering priorities delegated from my manager or the Chief Nursing Officer.

22. I would also work collaboratively with the North Regional Medical Director, Dr Mike Prentice, as patient safety issues arose in the region. One of us would take the lead depending on what the issue concerned and our capacity at the time depending on other work priorities.

23. I would chair meetings for areas of work I was responsible for, joined regional and national meetings relating to putting NHS England policy into practice, and provided a source of professional support to the nursing and midwifery staff in the region. I encouraged good relationships. The kinds of queries I might support I cover at para [56] below. I exhibit to this statement the job description for Regional Chief Nurse (North) **[Exhibit MK/01, INQ0106984]**.

The North Regional Quality Surveillance Group

24. The North Regional Quality Surveillance Group had overall responsibility for quality surveillance in the North region. The core membership of the Regional Quality Surveillance Group was the Regional Director, Richard Barker, who chaired the group, myself as Regional Nursing Director and Mike Prentice as Regional Medical Director. Either Dr Prentice or I would chair the group if Mr Barker was absent. The chairs from the local quality surveillance groups also attended as well as representatives from regulators such as the Care Quality Commission ("CQC"), NHS Improvement, Public Health England, the GMC and the NMC. The Regional Quality Surveillance Group would meet quarterly. The Terms of Reference are exhibited **[Exhibit MK/02, INQ0106981]**.

25. The Regional Quality Surveillance Group brought together the different parts of the system to share information and provided a proactive forum for collaboration. It allowed for the sharing of intelligence and was an 'early warning' mechanism of risk about poor quality before other data (such as MBRACCE reporting) was available. Sharing local intelligence is key to ensure intelligence is triangulated from several stakeholders and sources to provide a single view of risks to quality across the region. It also provided support and assurance to local Quality Surveillance Groups.

26. Each of the four Locality teams had a Local Quality Surveillance Group that would scrutinise and share intelligence about their providers and take actions to coordinate quality improvements. It was at local level where the detailed analysis and oversight of providers would take place. The Regional Quality Surveillance Group acted as an escalation mechanism for Local Quality Surveillance Groups, as they could assimilate risks and concerns from the local groups across the region and identify common or recurring issues requiring regional or national response. Part of the regional meeting would involve presentations and discussions about themes or learnings from published reports or investigations.

27. The Local Quality Surveillance Groups would share their reports and flag by exception any issues or concerns for discussion at the regional group. The local groups produced a report about their providers and would present their written report and highlight risks and decisions around surveillance levels. Stakeholders such as the CQC and Local Authority representatives would then give verbal updates as appropriate to the discussions. This prevented a duplication of information and highlighted gaps where further investigation was needed. Providers were not involved in the Regional Quality Surveillance Group and therefore did not have access to the information that was being shared.

28. The Local Quality Surveillance Groups would determine the surveillance levels according to the risks to quality that they were seeing. These were categorised as routine, further information required, enhanced and Risk Summit. These levels would be influenced by factors such as CQC inspection reports, NHS Improvement Strategic Oversight Framework ratings, Health Education risks associated with staff in training. In addition, patient safety indicators such as increased mortality, Serious Incident reporting, near miss events, mental health homicides, whistle blowing incidents and complaints would also be considered in determining surveillance level.

29. The consequence of an enhanced surveillance level was that commissioners and regulators would apply more scrutiny in the areas of concern. This could include increased frequency of visits, requiring regular updates on improvement work, increased monitoring on patient safety indicators and attending the hospital's governance and patient safety meetings. If there was demonstrable improvement in the issue of concern, then the surveillance level would be discussed at the Local Quality Surveillance Group and an agreement to downgrade it could be taken. Equally, if concerns were heightening, then further escalation to a Risk Summit would be decided.

30. When a hospital was put on Risk Summit, that indicated a serious, specific risk to quality and a need to act rapidly to protect patients or staff. A Risk Summit was only considered as a last resort, where there were no other mechanisms more appropriate to deal with an issue. As part of the Risk Summit process, collective support and actions would be agreed. This could be support with staffing, communications, investigations or, in extreme circumstances, decommissioning a service.

31. There were various intelligence routes through which local concerns could be dealt with outside of the Regional Quality Surveillance Group. I would have professional relationships with senior nurses in hospitals and within Specialised Commissioning and through this professional network, I would sometimes get intelligence on individual hospitals and units. In addition, the CQC might sometimes approach me and share intelligence outside of the Regional Quality Surveillance Group forum. These avenues of intelligence sharing were important to escalate issues to the Regional Management Team as, if there were local concerns, we would want to act before they got brought to the quarterly Regional Quality Surveillance Group.

Specialised Commissioning North

32. The role of Specialised Commissioning within NHS England is set out in NHSE/1 at paragraphs 79 and 93 – 112. Within the North of England, Specialised Commissioning had oversight of the specialised services directly commissioned by NHS England. Robert Cornall was the Regional Director of Specialised Commissioning. Under him sat a team which included three Assistant Directors, a Director of Finance, the Clinical Director (Michael Gregory) and a Nursing Director (Lesley Patel). It is my understanding that the Regional Specialised Commissioning Director line managed the Clinical and Nurse Director and they all professionally reported to their national colleagues.

33. As Regional Chief Nurse I was not directly involved in Specialised Commissioning decisions nationally or regionally. However, as a regional colleague I did support the regional Specialised Commissioning team, specifically the Nursing Director by ensuring that she was included in professional support meetings and had access to me for advice. Although Specialised Commissioning regional teams and other Regional Teams have separate responsibilities, NHS England promotes matrix working, which means that colleagues can work across the organisation as a whole to seek advice, share intelligence, and avoid siloed working. Matrix working has been a core principle of NHS England since its establishment.

34. Specialised Commissioning teams had the knowledge of the areas that they commissioned (including Neonatal) but might come to their Regional Team for more general advice and share information, escalate concerns and ensure the region was appraised on any specialised commissioning developments with their regional colleagues.

Policies, guidance and training

35. The North Regional Team would not produce its own guidance; rather its role would be to contribute to guidance being developed nationally by NHS England. This was to avoid duplication in issuing policies and guidance. Once guidance was published, the Regional Team would assist providers with implementation.

36. To support the implementation of national guidance and policy, the Regional Team would provide training and support to hospitals on areas such as safeguarding, Freedom to Speak Up and Serious Incident Reporting. The Regional Team would run awareness sessions for new patient safety systems or if there were learning points from national Inquiries. For example, the North Region hosted a national event on child exploitation following the Saville Inquiry.

Investigating child deaths

37. In the event of a sudden unexpected death of a child, I would expect a hospital to correctly log it as an unexpected child death, and then flag it as a Serious Incident and initiate their internal investigation and review process. Hospitals may have their own policies on the mechanics of reporting a serious incident, but it will be based on the NHS England patient strategy and national guidance. I understand that with neonatal deaths, some clinicians might not flag a death as "unexpected" if the baby was born not conducive to life. This is a clinical judgement, made on a case by case basis.

38. Being flagged as a Serious Incident would mean that the incident was shared widely, beyond the hospital. Serious Incident reporting is immediate and would have been notified directly to the NHS England, relevant Clinical Commissioning Group ("CCG") and the Care Quality Commission, via the StEIS reporting tool.

39. The Specialised Commissioning and applicable Clinical Commissioning Group would scrutinise any incidents and work with the hospital to monitor and gain assurance regarding any mitigating actions and investigation as they progressed. I believe that the Quality Lead for the Specialised Commissioning North West Hub, Sue McGorry, was one of the lead individuals in the Specialised Commissioning team that reviewed serious incident reports. She contributed to the Regional Specialised Commissioning Team's Hotspot reports and the local surveillance reports which were presented at the quarterly meetings of the Regional Quality Surveillance Group.

40. While mortality increases can indicate a particular issue with a service, it may be the case the heightened mortality is due to factors such as increased admissions of babies born with immaturity, congenital abnormalities, antepartum infections and staffing levels. It is therefore important that incidents are reported, statistics are collated and the appropriate investigations undertaken to determine the cause of increased mortality rates.

41. An unexpected death should be reported by the hospital to the coroner, and where it concerns a child, should be reported by the hospital to Child Death Overview Panel. As the police are part of Child Death Overview Panel, they will be alerted to any unexpected child death through this route. However, if there is any indication that a potential criminal act was suspected or reported, the hospital should also refer the matter directly to the police so their concerns can be raised and dealt with immediately.

42. Prior to the events at the Countess of Chester Hospital described further below in this statement, I already had experience of police investigations as I had been the NHS England incident co-ordinator for incidents in Doncaster and in Barnsley. It was primarily due to this experience that I believe I was asked to take a lead role in liaising with the Countess of Chester Hospital in April 2017 when the Specialised Commissioning Team escalated their concerns to the RMT about the Countess of Chester Hospital.

43. In relation to each of these incidents I relied on the historic Memorandum of Understanding [**Exhibit MK/03 INQ0014686]** which was a useful toolkit to assist with communications with stakeholders, the police, media, and safety of the service. This Memorandum of Understanding had been archived in 2013, and so was technically outdated, but a new model had not yet come into place and I nevertheless regarded it as a useful guide for coordinating with other bodies.

The collection and analysis of data

44. The Regional Team would receive information about individual hospitals through the Regional Quality Surveillance Group which would analyse trends. Mortality, safeguarding and risk factors would be flagged into the group. As the group covered all services in the North, which included thousands of providers, it could only focus on matters that had been escalated to it. As outlined above in paragraphs 26-28, the Local Quality Surveillance Groups would assimilate risks and concerns from their localities and identify common or recurring issues requiring a regional or national response. If a hospital or unit was of particular concern, it could be escalated as a single item for a focus meeting of the Local Quality Surveillance Group.

45. Once mortality outliers were picked up through national analytics, this data was pulled into a dashboard summary which was also circulated in advance of the Regional Quality Surveillance Group Meetings. The dashboard was also available for the Local Quality Surveillance Groups to use. However, the mortality statistics provided by the analytics team was not in real time, so we were relying on hospitals being open and transparent.

46. Data related to post-mortems, referrals to the Coroner and Coroners' Inquests were fed through our medical directorate and also shared as part of the Regional Quality Surveillance Group process.

47. I emphasise at this point that the quality processes described above typically look at deterioration and known problems and their escalation. Many elements of it rely on hospital data entry and reporting.

48. Following a Serious Incident, a Hospital has the responsibility to inform the regulators and Commissioners within 24 hours. A report would then be produced within 72 hours. Regional teams could access Serious Incident initial reports and our Specialised Commissioning team would have access to the full reports as part of their commissioning role. Serious incidents would be monitored by the commissioners (namely, the applicable Clinical Commissioning Group and Specialised Commissioning team). Escalation would be via the Local and Regional Quality Surveillance Groups and the Regional Patient Safety Team.

Whistleblowing and Freedom to Speak Up

49. I cannot recall when provider Freedom to Speak Up data became available to us in the region. During the early period covered by this statement, Freedom to Speak Up was in its infancy and there was not a high level of awareness of it among staff. At that time, many hospitals were not fully operating it or have a Freedom to Speak Up Guardian as when legislation comes it takes time before it becomes operational on the ground. Freedom to Speak Up is now much more embedded and sophisticated. In 2015/16 Freedom to Speak Up data from hospitals was not shared with the Regional Team and I believe that is still the case in the present day. We would therefore not have access to individual provider Freedom to Speak Up reports unless the whistle blower came to us directly.

50. As the CQC is the body responsible for the operation of the duty of candour, staff were more likely to flag concerns to the CQC, of whom they had a greater awareness of. Occasionally, individual whistle blowers in a hospital would come directly to the Regional Team. To my knowledge, staff on the unit at the Hospital never did.

51. NHS England had a national contact centre where complaints would be reported into, and these would be passed onto our regional complaints team where these were managed regionally. However, these were predominantly in relation to Primary care complaints. Hospital complaints would be dealt with in hospitals, occasionally some complainants would go through our contact centre. We would not routinely see hospital complaints and responses unless they had come through to us directly.

52. NHS England regions would usually only see hospital board papers when they were published on the hospital's website, and we would not routinely have access to minutes of meetings unless they were also put in the public domain. Commissioners and regulators could request access as and when they may be scrutinising a service or concern, but I do not recall this being routinely done.

How the regional team would raise concerns

53. If the Regional Team had concerns about a hospital, it would bring together stakeholders to share intelligence and establish assurance about the services that hospital was providing. If we were not assured, a quality review would jointly be undertaken. We referred to this as a rapid quality review and it would be a single item at the Local Quality Surveillance Group where all appropriate organisations would share intelligence and identify risks and issues. A rapid meeting would be arranged with the hospital to seek assurance and actions. The hospital would go into enhanced monitoring (the level of surveillance was something done by local quality surveillance groups) and if the risks are significant and not mitigated then a Risk Summit would be called, which at this point would involve the Regional Quality Surveillance Group. The CQC could undertake a rapid unannounced inspection and NHS Improvement could apply some regulatory sanctions depending on the issues of concern.

Concerns raised with NHS England North from within hospitals

54. I have been contacted on occasions by Hospital Chief Nurses directly seeking advice. All Chief Nurses in the North of England had my contact details, and they could choose to phone or email me direct or book an appointment via my office. I would not (and should not) be the first line of contact as there are numerous routes

for raising concerns and seeking advice within a Hospital locally and beyond. For example, Hospitals would routinely contact the CQC, the Clinical Commissioning Group Executive Nurse, NHS Improvement Director of Nursing, or the Director of Nursing within the NHS England Specialised Commissioning Team as their first port of call for concerns they may want to discuss.

55. If and when I have been contacted by a hospital Chief Nurse it would be to keep me informed, to seek advice or to help raise an issue in a confidential manner. I would advise accordingly and ensure that they have involved the nursing executives/directors in their patch and the regulators to ensure they have escalated appropriately and gained local support and supervision to aid them in determining the appropriate steps.

56. I have been contacted about someone within a hospital raising concerns about a nurse. The Chief Nurse of a hospital contacted me initially via telephone to ask advice about some whistleblowing information regarding individual nurses who had been accused of giving unprescribed medications to vulnerable adults in the hospital. My advice was to involve the police immediately and to escalate to their regulators (CQC and NHS Improvement) and commissioners, which was duly done. I also suggested that a rapid response meeting would need to be held to determine the full facts in reference to patient care and service delivery. This case resulted in setting up an incident coordination meeting with key stakeholders involved to help mitigate patient safety and service risks and a single point of contact for the police. It is of course the police's role to decide whether a matter is criminal, but once referred to the police, the Regional Team can assist the hospital with matters as to how to keep the service running and best protect patients.

C. Concerns about the Hospital

Events in July 2016

57. I set out below my knowledge and involvement in the concerns around the Neonatal Unit at the Hospital, up to the point of the police investigation in May 2017, to the best of my knowledge and recollection, and with the assistance of contemporaneous emails and notes where available (as referenced in the statement). I would like to note that the events referred to within this statement are in a working environment

that was much more office-based than it is today. At that time, I would have been in the office at Quarry House every day unless I was visiting a Trust. The office was open plan and shared with colleagues from Regional Specialised Commissioning. My own personal working style is also more verbal than email based. Whilst I have used the contemporaneous emails and notes to assist me in my recollections, there will have been many more in-person and telephone conversations with colleagues that I now have difficulty recollecting some eight years later.

58. As explained at paragraph 42, I believe my primary involvement in the escalation of concerns with the Hospital was due to colleagues seeking my input because of my previous experience with safeguarding, Child Death Overview Panels and other matters where there had been police investigations into incidents at hospitals.

59. I first became aware of concerns about the neonatal mortality rate at the Hospital on 5 July 2016 when I was informed by the Specialised Commissioning Director of Nursing, Lesley Patel, of two serious incidents relating to the death of two triplets. **[Exhibit MK/04, INQ0102984]**.

60. The email was sent to directors from within the NHS England locality, senior clinicians within the NHS England North Regional Team, and Senior Directors of Operations within NHS England, plus the CCG which worked with Specialised Commissioning on commissioning the service, and NHS Improvement as the regulator. The Regional Specialised Commissioning Team are also copied into the email. The email was flagging concerns regarding the nature of the two serious incidents and the increased mortality in the unit to the appropriate commissioners and regulators.

61. It was not unusual for me to be copied into emails regarding serious concerns. Our regional medical director and I would routinely be copied into emails raising serious concerns across our region. Mostly it would be for information but also as a route to escalate to our regional and national colleagues, if need be. In this case it was being flagged to the national specialised commissioning team already.

62. Ms Patel's email refers to the Unit being under some local scrutiny earlier in the year following an infection concern, and that a thematic review was undertaken of 10 cases reviewed with no clinical issues identified. I would not necessarily have read that information as an indication of 10 deaths that were being reviewed, but a review of 10 cases involving an infection concern that had been investigated.

63. It is routine practice that a thematic review approach is adopted when infections are rising, this is to determine if there are any themes that could be causative in the rise of infections. The themes will look to see the type of organisms causing the infections are they the same and if so, are they spreading due to contact or care issues. This will enable preventative actions that would need to be taken such as isolation facilities, hand hygiene etc. I don't recall seeing the thematic review or this being flagged to me or the region before 5 July 2016.

64. One of the actions said to be considered by the Hospital was an "*external review of all aspects of the unit to include staff/ equipment/ pathways/ competency […]".* It was my understanding that all information would be considered by people conducting such a review. My reading of that would have been that "staff" includes the numbers of staff on duty, whereas competency would be more about skill mix. For example, 10 auxiliary staff plus one nurse would be a very different competency mix than five auxiliary staff and 5 nurses. I would expect such a review of "*all aspects of the unit*" to be looking at all potential causative factors, and the email stating that it was "*to include staff/ equipment/ pathways/ competency*" is a non-exhaustive list of some of the areas they would explore.

65. The email also stated "*The Countess also has some work to do in order for the system to be assured regarding their internal governance within this speciality*." I understood this to be a concern that the Hospital was not reporting matters on StEIS. My understanding is that when a serious incident occurs, such as the unexpected death of a baby, a unit should report on StEIS within 72 hours. That triggers a rapid review, and commissioners are alerted. The serious incident gets investigated internally, is inputted into the national StEIS system and therefore available for local and regional review, and it becomes part of the mortality statistics available. From this email chain, it was established that the incidents had been reported on StEIS, but not within the timeframe we would have expected this to be completed. Furthermore, it was not until the two triplet incidents had been reported that the Hospital then notified the commissioners regarding the increased mortality rates from the past year, it is this lack of timely reporting that raised serious concerns about the Hospital's governance processes as referred to in the email.

66. I did not have any reason to think that the Hospital would be unable to investigate effectively the concerns raised. From the email chain, I could see that there was an assurance process in place with close involvement from specialised commissioners and the CCG. At the end of the email chain both Ms Patel and Ms Wedd (the Director of Quality and Safeguarding at West Cheshire Clinical Commissioning Group) were concerned about the Hospital not reporting the incidents in a timely manner and now it was evident that there was a collaborative approach being adopted by the local system specialists overseeing and reviewing the Hospital, which was normal practice.

67. Ms Patel's email of 5 July 2016 concluded by saying "*I have discussed this with Margaret Kitching who has suggested that the DCO team coordinate an incident review meeting to look at the impact across Cheshire and Merseyside*." My recollection of the conversation is vague, but the key area of concern was delivering a continued service to babies requiring a level two service now that a decision to downgrade the unit had been made. The review would check and ensure that there were enough level two cots to provide an effective sustainable service whilst the Hospital was undergoing the investigation and where need be other providers would be asked to step up and increase their cots to accommodate the needs assessment.

68. Ms Wedd replied to the email noting that the deaths referred to by Ms Patel had actually been reported on StEIS. Ms Wedd noted that she had not been sighted on the wider context of earlier concerns at the Hospital in relation to the neonatal service so she had not been in a position to share these concerns with NHS England through her local QSG report which is how escalations were managed. In order to avoid any duplication of effort, Ms Wedd stated that her focus would be on Ms Patel's point in the previous email that "*The Countess also has some work to do in order for the system to be assured regarding their internal governance within this speciality*" as Ms Wedd described this as of significant concern. Ms Wedd concluded by noting that "*My Serious Incident policy is clear in terms of what I expect to be reported to me but this will only work if the specialty is reporting internally to begin with. So this internal failure must be my starting point*."

69. Ms Patel then replied to Ms Wedd's email "*To clarify I discussed the neonatal service with Alison a week last Monday as part of an assurance process and was given a*

fairly clean bill of health. It was only Friday that these new issues were discussed, we also have another incident which is outstanding which doesn't appear to have been reported which I raised with Alison. So likewise I think we were unaware"

70. In the Hotspot report, the Specialised Commissioning Team detailed the actions of the internal and planned external review into the Neonatal Unit. The decision to downgrade the Unit was explained, which was seen as good practise after a Serious Incident. At this stage, nothing was raised about the concerns of the Consultant Paediatricians or concerns about an individual member of staff being associated with the deaths or collapses. The report was also discussed at the next Regional Quality Surveillance Group meeting, which took place in September 2016 **[Exhibit MK/05, INQ0014760]**.

71. It was clear to me at the time that the appropriate actions were being taken and I remain of this view. In response to the Inquiry's specific question about whether I considered contacting the police at this stage, I did not. As regional chief nurse I was not directly involved in the day-to-day oversight of the Hospital, and I did not consider the information provided to me in the email chain discussed above would be a sufficient reason to do so. Premature triplets is clearly high risk and I did not have the details regarding their circumstances or any background expertise in neonatal care. My first thought would have been that an investigation was necessary, which is something the Hospital indicated was being done. The usual process would then have been to involve the Child Death Overview Panel (which has police representation) and the coroner – but it was not my role to facilitate these matters.

72. I was also not aware that the finger was being pointed at any particular individual at this time and I don't believe anyone else in the North Regional team were aware either. As a matter of good practice, if clinicians had raised concerns about an individual in relation to increased mortality, then the Hospital should have informed NHS England's Specialised Commissioning team, as well as the CQC and NHS Improvement would be made aware.

<u>Events between July 2016 and March 2017</u>

73. On 12 August 2016, Andrew Bibby, Assistant Regional Director of Specialised Commissioning (North) emailed NHS Improvement and West Cheshire Clinical Commissioning Group, updating them on a call he had with the Hospital. Ms Patel,

forwarded this email on to me for information. My understanding was that Andrew's team worked on the operational side of things and would be routinely in contact with the Hospital. In forwarding this email to me, Ms Patel noted "no further concerns at this time". **[Exhibit MK/06, INQ0014679]**

74. This email noted that the Royal Colleges' review had been delayed (due to the Colleges' needing to reschedule) but was due to take place on 1–2 September; that the weekly data reports had not shown any further issues or trends; and a face-to- face meeting between NHS England and the Hospital would be arranged once the Royal Colleges' review was available. I do not recall the Terms of Reference for this review being shared with me, and I would not expect this to have been done as this was the remit of the Specialised Commissioning team. In my experience, sharing such terms of reference with commissioners is something normally done as a point of good practice.

75. Mr Bibby's email also referred to a briefing paper going to the "Trust Quality and Safety Committee". I was not provided with a copy of this and would not have expected to see it. It would be more appropriate for Specialised Commissioning, the Clinical Commissioning Group, CQC and/or NHS Improvement to request access. Then, if there were some concerns this could have been flagged with me or any of my regional colleagues if needed. I would expect the service commissioners and regulators to be involved at a local level, but not necessarily regional level.

76. On the same day, I was also received an email by Lisa Cooper, Deputy Director Quality & Safeguarding (Cheshire & Merseyside) and Regional Lead Safeguarding (NHS England North), also setting out a summary of the call between the Hospital and Specialised Commissioning. **[Exhibit MK/07, INQ0106997]** I replied to both emails, acknowledging receipt. Neither required any action on my part. It was in the hands of the experts reviewing the cases. The Hospital was responsible for that. I would expect specialised commissioning to have face to face meetings to scrutinise the review.

77. As I have mentioned above at paragraph 70, the North Regional Quality and Surveillance Group met on 16 September 2016, which I chaired. The Deputy Director Quality and Safeguarding for Cheshire and Merseyside provided the Group with an update on the Countess of Chester Hospital, as set out in the minutes of the meeting.

[Exhibit MK/08, INQ0014687] The minutes of this meeting refer to "Cheshire and Merseyside summary (Item 5b) covering the Cheshire, Warrington and Wirral QSG and the Merseyside QSG", which I exhibit to this statement. **[Exhibit MK/09, INQ0014760]** The meeting minutes noted that the Royal Colleges' review had been carried out from 1–2 September 2016 had gone "well" and that it had therefore been agreed that the level of surveillance should be "downgraded to routine".

78. I understood the comment that the review "went well" to mean that there were no urgent patient safety issues being identified and the review had happened with full cooperation from the Hospital, and I recollect that it was reported that no single issue or individual was identified as a causal factor. My recollection is that Specialised Commissioning only had a verbal update and reassurance from the Hospital at this time.

79. As I was not involved in decision making around this review, so it is difficult to comment on whether I thought that a two-day review was sufficient to investigate the issues raised about the neonatal unit. The Hospital and the external reviewers would determine the approximate time frame needed to undertake the review. However, it is usual that a review is determined by factors such as the scope of the review and the number of clinicians undertaking the review. Initial reviews will often extend in time once case notes are examined which often lead to further information and reviews needed. In my experience, it is not unusual that the external body may also do a scoping exercise initially, followed by a more specialist or forensic deep dive.

80. I was never given a copy of the Royal Colleges' report, but I was aware that a redacted copy was shared by the Hospital with our regional Specialised Commissioning team after it had been leaked to the press in February 2017. I had no contact with the Royal Colleges. This was not unusual as I was not directly involved in commissioning or oversight of the Hospital, and so would not be involved in such a process. It is relevant to note here that it was not uncommon for Hospitals to be reluctant to share information around external college reviews with commissioners, as this was not mandated at that time even though it was good practice to do so.

81. The Inquiry has referred me to the Dr Jane Hawdon review commissioned by the Hospital into individual cases **[INQ0009428]** and Dr Jane Hawdon's letter dated 29th October 2016. **[INQ0002771]**. I do not recall having been provided with either of these documents.

82. On 2 December 2016, I chaired the North Regional Quality Surveillance Group quarterly meeting. The minutes record that in relation to the Countess of Chester Hospital, "The hospital has been closed to Level 3 neonatal services. The provider is currently on 'Enhanced' surveillance, but a report is being published which may change this." **[Exhibit MK/10, INQ0106992]**.

83. The local surveillance report covering the period August – October 2016 was included in the papers for this meeting. This report set out that in relation to The Countess of Chester Hospital:

> "*The Trust alerted commissioners to concerns raised by members of the Neonatal Team, which included higher than expected mortality. Commissioners, NHS Improvement (NHSI) and the Neonatal Network agreed a plan to downgrade three neonatal cots to Level 1, whilst a comprehensive investigation is carried out. In addition the Trust has commissioned an independent review of their neonatal service from the Royal College of Paediatrics and Child Health and the Royal College of Nursing. The initial feedback is that no immediate risks to patient safety have been identified, however the reviewers have recommended a forensic deep dive into a number of identified incidents, to be undertaken by an independent external consultant and this is currently being arranged. There are ongoing discussions locally as to whether the Neonatal Unit should be placed on enhanced surveillance".* **[Exhibit MK/11, INQ0106988]**

84. The Inquiry has referred me to an Extraordinary Meeting of the Board of Directors of the Hospital that was held on 10 January 2017. I was not aware of this meeting at the time and would not routinely have access to Board reports from any hospital unless they were in the public domain, or the Hospital decided to share them voluntarily.

85. On 3 March 2017, I chaired the next quarterly Regional Quality Surveillance Group meeting. The minutes record that:

"MG noted that Countess of Chester is under review by Specialised Commissioning. There was a meeting to discuss a paper by the Royal College of Paediatricians last week. Specialised Commissioning have asked for sight of the report. Another issue at the Countess of Chester is the level of training of an interventional radiologist. A meeting of three Chief Executives is to take place regarding the vascular rota. Specialised Commissioning will have a presence at this meeting" [**Exhibit MK/12, INQ0106993]**.

86. The local surveillance report included in the papers for this meeting, covering the period November 2016 – February 2017, contained an update in relation to the Countess of Chester Neonatal unit. It noted that the unit remained in enhanced surveillance, that an external review by the Royal Colleges had attracted national media attention and the main areas of concern related to:

- *"Medical and Nurse Staffing levels*
- *An apparent disconnect between the Neonatal leadership and the Trust Risk Management and governance processes*
- *Lack of transfer protocols for neonates to tertiary centres"*

87. The report also noted that this review had included the following recommendations:

- *"A review of neonatal deaths*
- *Development of robust processes for equitable investigation of concerns/allegations*
- *Appointment of two additional consultants*
- *Strengthen guidance on when to seek medical advice and consultant involvement*
- *Strengthen incident reporting relating to inadequate staffing*
- *Develop a recruitment strategy*
- *Review the nurse involvement in decision making, guideline development and transport arrangements*
- *Development of a children's champion on the trust board*
- *Strengthen the response and review of neonatal deaths*
- *A review of transport protocols"*

[Exhibit MK/13, INQ0106991].

88. The Inquiry has referred me to a meeting that took place on 23 February 2017 between Ian Harvey, Lesley Patel and Andrew Bibby. I do not recall having been aware of this meeting at the time, but this is not unusual I would not expect to be informed as part of my role in the region. This was normal practice for how Specialised commissioners operate. I became aware of the meeting after being copied into the email Michael Gregory sent on 5th April 2017, which is discussed below.

D. Escalation to me in March-April 2017

89. On 29 March 2017, Robert Cornall forwarded to me an email that Michael Gregory had sent to him, Andrew Bibby and Lesley Patel. The email was summarising a conversation Michael had with Ian Harvey, the Medical Director at the Hospital, that same day. Robert asked me to give him a ring regarding this email **[Exhibit MK/14, INQ0014651]**

90. In the email, Michael said he had spoken to Ian Harvey and told him "*that we had mounting concerns about what we had heard*". I believe that this was because Michael felt that the Hospital was refusing to share the external report. My understanding of concerns at this point was that Specialised Commissioning didn't feel as though the Hospital were acting in an open and transparent manner.

91. At this time, I had not had any direct contact with the Hospital, and when Michael Gregory referred to "*mounting concerns*", I believe that he would have been referring to the Specialised Commissioning team to whom the email was being sent. It was my understanding that Michael was becoming concerned that the Hospital was being evasive which I believe he had briefed his manager Robert Cornall about. Robert was keeping the Regional Management Team briefed at our weekly meetings. I cannot comment on what he had heard specifically as I was not present at any of these meetings with the Hospital.

92. Michael's email, which was forwarded to me set out that:

    a. "*Ian had said at the start that they intend to make a significant announcement on Monday and that we bear with them until this announcement was made.*
    b. *There are the 13 known deaths which have been investigated.*

c. *There had been some concerns about another 5 babies that had collapsed and were resuscitated but the review raised no issues about these babies.*

d. *A clinician (who Ian gave the impression may had another agenda) on Monday night brought up a list of babies names that he or she was concerned about[…]*

e. *There is a member of staff whose presence has been seemingly disproportionate but (as was discussed when we met) this was originally accounted for by rotas and skill level. However when pushed about staff members Ian stated that this matter was best dealt with when they make the significant announcement about the decision they have taken to speak to an "appropriate body" on Monday."*

93. Michael noted that *"Clearly something very serious is going on and they must have their hands tied somewhere — but it would be speculation to guess what."*

94. This was the first time anything was raised regarding rotas and individuals, at any of our briefings. On my return from leave on 4 April 2017 I replied to Robert's email and asked if he still needed a call. I did not get an email response back from Robert but it is likely we spoke at some point. However, I do not now recall what steps had been taken whilst I was on leave.

95. However, on 5 April 2017, Michael Gregory, copied me into an email to Ian Harvey, referring to a meeting that had been held between Specialised Commissioning (Michael Gregory, Andrew Bibby, and Lesley Patel) and Ian Harvey on 23 February 2017 [**Exhibit MK/15, INQ0003126]**. Michael's email was following up on actions that had been agreed at that meeting on 23 February 2017, and he provided a copy of action notes from that meeting **[Exhibit MK/16, INQ0014656]**. The action notes refer to an "external review" which had been completed in relation to 13 babies who had died between January 2015 and July 2016, which had been more in-depth than the previous high level thematic review undertaken by the Hospital. The notes record that Ian Harvey had confirmed that the completed review would be shared with families and then with Specialised Commissioning. It also noted that Ian Harvey had confirmed that learning had been identified in relation to the care pathway and an action plan would be developed by the end of March, to share with commissioners. Michael Gregory's email of 5 April 2017 requested a copy of the external review.

96. Michael's email went on to say that *"As you are aware, we have discussed the current issues within the senior members in NHS England Specialised Commissioning, NHS England North Region and Director of Commissioning Operations Teams"*. I could not say who Michael was referring to here, but I set out above my involvement prior to 5 April 2017 and note that as above, Robert Cornall of Specialised Commissioning had been briefing the Regional team via the Regional Management Team, but I was not involved in any meetings with the senior members of NHS England Specialised Commissioning team directly.

97. The email concluded with three further requests:

    a. "*Is it possible to have a copy of the brief that was given to the independent QC for the work that he (or she) was asked to do for the Trust?*
    b. *Is there a written record of the concerns expressed by the two paediatricians so that we can understand the precise nature of their concerns?*
    c. *Is there a proposed timeline of events? For example, do you know when the legal advisor is due to meet with the clinicians and when the outcome of that meeting is to be reviewed?"*.

98. This was the first time I knew of the independent QC's input, and concerns raised by two paediatricians.

99. NHS England has provided me with a copy of the minutes from the Regional Management Team meeting on 18 April 2017. I do not specifically recall this meeting but these notes indicate that I provided the group with an update on the Hospital, including that there were "*still concerns in relation to the neo-natal service following a review into the number of deaths*". **[Exhibit MK/17, INQ0103001]**

100. On 19 April 2017, Michael Gregory forwarded to Robert Cornall, Lesley Patel and myself an email chain between him and Ian Harvey earlier that day **[Exhibit MK/18, INQ0014667]**. The email chain between Michael and Ian started with Michael asking for an update following the Board meeting. Ian replied noting that "*having completed the College review and the further case review – we have consulted further with the external, independent case reviewer and since we have 4 cases which, in the reviewer's opinion, the death is unexplained we are following the process that would be the case in the event of an unexplained death out of hospital and are consulting with the CDOP*". He said he had a call scheduled with the chair of the Child Death Overview Panel and would feed back after this.

101. Michael responded to Ian, asking whether the clinicians that were concerned about the report have changed their view, and when the report of the external reviewer would be available to commissioners. Ian replied, noting that the hospital was going through this process because there "*isn't yet a complete and definitive answer in all cases*" and that "*I don't think that there was ever an agreement that the individual case report would be shared — this contains identifiable data — this would need a conversation*" [**Exhibit MK/18, INQ0014667]**

102. In forwarding this email chain to myself, Robert Cornall and Lesley Patel, Michael noted that there was still no response as to whether the clinicians have had their concerns addressed. Robert Cornall noted that "*it all feels a little evasive again*" and he asked for my views regarding escalation. I responded to note that I would be happy to pick this up directly with the Hospital, if the Specialised Commissioning team wanted me to do so. However, in the meantime, Michael Gregory had pressed Ian Harvey in relation to the clinicians' concerns, and relayed a further response from Ian Harvey, which said "*They still don't feel that we have completed what the external reviewer described as a "broad forensic review". The reviewer was asked to define what they meant by this term and, in essence, said it was what we wanted it to be and wasn't implying a legal connotation that might have been put on it. They did, however, suggest further CDOP involvement (we have had prior conversations with the Chair of the CDOP) and given the make-up of the CDOP they might well fulfil this remit*". I therefore asked if Michael was happy to await the response from the Hospital **[Exhibit MK/18, INQ0014667]**.

103. My view is that Child Death Overview Panels play a crucial role. If the panel is working effectively each baby should have been reviewed to identify any causal links and modifiable factors to pick up. They have access to clinicians who can do that. In addition they have representation from the police who can offer appropriate guidance.

104. I have exhibited to this statement some of our further discussions during this period. [**Exhibit MK/19 INQ0014660] [Exhibit MK/20 INQ0014664] [Exhibit MK/21, INQ0014665].**

105. On 26 April 2017, I was copied into an email chain which was originally an email from Ian Harvey to Michael Gregory, noting that the Hospital would be "happy to meet once we have completed our process", followed by emails between the Specialised Commissioning Team (North) (Michael Gregory, Robert Cornall, Lesley Patel, and Andrew Bibby). In that email Michael stated that: "*At RMT yesterday Margaret said she was prepared to give them a bit more time to respond*." **[Exhibit MK/22, INQ0014673]**.

106. I recall the RMT meeting that took place on the 25 April 2017 mentioned by Michael in this email (who was standing in for Robert Cornall). Michael briefed us on the position and his frustration regarding the lack of progress in sharing the full report. He indicated that further case reviews were being undertaken and the Hospital was taking advice from the Child Death Overview Panel. Michael was imminently expecting a further update from the Hospital. I recollect advising Michael that we should give the hospital a bit more time (by this I meant a week or so) to respond and this was supported by those present. I also offered to speak to the Hospital later that week if they had not responded. I have exhibited to this statement the notes from this meeting, although these notes do not go into the detail described above. **[Exhibit MK/23, INQ0103004]**

107. I also recollect having a conversation with the Hospital at some point between 19 and 25 April, although I do not recall whether I spoke with Tony Chambers or Ian Harvey). At this stage, I was not aware that an individual had been implicated, just that two consultants had concerns that the external investigation didn't go far enough, and they hadn't received sufficient assurance. That of itself was not uncommon; it was one clinician looking at another's work and sometimes views are challenged. I understood from this call that the Hospital was going back to the chair of the Child Death Overview Panel to look at the cluster of neonatal deaths as the panel normally look at individual cases as they occurred. I was told by the Hospital that they were having conversations with the police officer who was a member of the panel.

108. The day following the Regional Team meeting mentioned above, Robert Cornall queried with me whether NHS England should refer the matter to the police directly. **[Exhibit MK/22, INQ0014673]** I was unsure what had changed since the meeting, so I had several phone calls to try and clarify the facts. I believe I spoke with Robert,

Teresa Fenech, Richard Barker Vince Connoly and Michael Gregory. I was also conscious that Richard Barker and Lyn Simpson, the two regional directors within the North, had not been copied into this email train and I did not have the authority to refer a hospital to the police without going through our leadership team to seek their advice.

109. I replied to Robert, copying Richard Barker, and noted that I believed that there should be a call with the Hospital's chief executive to clarify NHS England's position and to give the Hospital opportunity to seek advice from the police, if we remained concerned. I also noted that in my experience, Child Death Overview Process processes are not lengthy, so I had suggested we should give the Hospital until the end of the week if we had not received further assurance.

110. I recall speaking with Tony Chambers around this time but do not recall the precise time. It was clear from this conversation that the Hospital had engaged several people to review the neonatal deaths including an internal and external investigation, a pathology case review and a legal view from a Queens Council. He explained that there was no evidence to suggest any criminality or unnatural causes had occurred. He also explained that they were also speaking with the chair of the Child Death Overview Panel and the police officer who attended that group for further advice around the cluster of neonatal deaths which was one of the recommendations arising from the Royal Colleges' review.

111. Mr Chambers expressed that it was his view that the two consultants were the problem as they were not happy with the findings of the investigations. The Hospital was engaging with the police as part of their internal processes, which is why they were asking for this process to be concluded first. It was at the point when I learnt that the consultant paediatricians were pointing the finger at a member of staff, and I pressed Mr Chambers to engage the police immediately for advice as I was not sure how long their internal process would take. He stated that there was no evidence to support the consultants view but I explained that just the accusation alone was sufficient to seek police advice as they are the experts in this field. Mr Chambers assured me he would do it that day.

112. In addition, Tony Chambers disclosed that they were assured internally that there was no single causal factor. He explained that the staff member was full time and that there were a lot of part time staff so she might have been on duty. The internal or

external review didn't pick up a single person or factor. The QC didn't see any criminality. Mr Chambers did not disclose that it was a nurse, just a member of staff. I said Specialised Commissioning were really concerned about the Hospital's lack of transparency. He was upset by that as they believed that they were being open and transparent. I recall thinking that there must have been breakdown in the relationship between the Hospital and Specialised Commissioning. Mr Chambers agreed to expedite his conversation with the police, and I agreed to set up an urgent meeting the following day with the Hospital so we could be briefed fully and determine appropriate actions and escalations. He told me that Ian Harvey was leading on this, so I agreed to meet with him the next day.

113. I appraised Richard Barker, my manager and Vince Connolly the medical director for NHS Improvement, who in turn he appraised his manager (Lyn Simpson). They were both supportive of us meeting with the Hospital the next day.

114. Later on 26 April, at 18:46, I replied on the email chain, noting that:

> "*When I last spoke with Tony, he explained that the independent investigation's did not identify any criminality, two of their paediatricians are disputing and casting doubt on the findings*
> *Hence them taking further steps, we did discuss involving the police which they intend to do if full assurance is not gained, the two paeds could be the problem but we need to be sure Tony and the team want to exhaust internal processes first as they recognise that involving the police could cause further signifant distress to the families*
> *I spoke with Vince and Michael and we agreed that I would speak to the Trust at that time Michael is worried that he believes they are being evasive hence escalation to the national leads, Tony is not happy at this accusation as he believes that they have been fully transparent,*
> *I don't think we should involve the police without appraising the Trust and giving them the opportunity to explain and contact the police if needed*
> *The unit is safe as it has continued to stop admitting complex cases*
> *Let me know id you need me to do anything*") **[Exhibit MK/22, INQ0014673]**

115. Whilst the bulk of the emails I was party to are contained within the email chain at **[Exhibit MK/22, INQ0014673],** there are some further short emails which I exhibit by way of completeness. [**Exhibit MK/24, INQ0014672**].

116. On 27 April 2017, Vince Connolly and I had a teleconference with Ian Harvey and Stephen Cross (the Hospital's Legal Director). The purpose of the meeting was to follow up with the Hospital and key stakeholders as I did share the same view that the Hospital had not shared the full facts with anyone up until now. It was important that we understood the Hospital's actions the impact on the service and patient care and be supportive of any pending police investigation going forward. I shared my notes of this meeting with Ian Harvey and Vincent Connolly by email on 28 April. **[Exhibit MK/25, INQ0003193]** Ian replied, agreeing the contents of my note. **[Exhibit MK/26, INQ0005077]**.

117. As recorded in the notes, I set out the concerns of the Specialised Commissioning team that they did not understand the full picture of the deaths and felt that they had not had full access to the detail of the investigations. I noted that senior clinicians in Specialised Commissioning believed that the police should now be involved, for their opinion.

118. Ian Harvey felt that he had been updating Specialised Commissioning appropriately. Mr Harvey also set out the background to the matter, as recorded in my notes which I summarise as follows:

a. A paediatrician and neonatologist had raised an alert regarding the number of deaths on the unit.

b. This resulted in an investigation by the Royal Colleges into all of the deaths, which identified no single factor. It was recommended that there be an investigation into each of the deaths, which was completed by an independent expert who did not identify any significant additional issues.

c. A single member of the nursing staff was on duty and attended to most of the cases, but not all, and her full time status meant that this was probably not unusual.

d. The Hospital had sought an independent legal opinion which did not find any evidence of criminality.

e. The independent reviewer identified that four deaths were unexplained and needed a broader forensic review.

f. The Hospital clarified the broader forensic review with the reviewer and it was determined that involving the Child Death Overview Panel would enable a further consideration which would involve the police (who had a representative on the panel).

g. The Hospital had shared everything with the Coroner.

h. The Hospital had kept families involved.

119. Mr Harvey also updated us on the Child Death Over Panel meeting that had taken place earlier that day. I recorded in the notes that the purpose of that meeting had been to consider if there was any possibility that there could be unnatural causes. Mr Harvey reported that the Police representative had advised that there may be a need to seek their support / advice, which could be done via a scoping type meeting. The police representative had agreed to speak to his Chief Constable and would get back to Mr Harvey on this. At the end of the meeting, Mr Harvey agreed to let us know the outcome of discussions with the police.

120. My notes record that I "*raised communications and the media risks around this.*". My concerns regarding media risks would be based on my previous experience of assisting with police investigations; when a police investigation is underway the media will swamp the hospital of concern, park media vans outside the hospital, door stop staff and visitors and make it very difficult to maintain a safe service and ensure we protect the confidentiality around the police investigation. It can be very difficult for staff who are being accused by association and for patients and families who are reading very difficult social media posts. The hospital in question often comes under significant media pressure to respond to requests from media and other stakeholders. It is best practice to set up a media and communication cell which includes experts from the hospital, commissioners, regulators and it is guided by the police

communications teams to ensure any proactive or reactive statements have police approval.

121. My notes record that I "*thanked IH for his time and briefing and recognised that the Trust was doing all they could to resolve this*", and that I welcomed the involvement of CDOP and the police. It is my natural style to thank people for their effort especially when they were asked at short notice to attend the meeting and provide a comprehensive brief, such as had occurred here. It was a difficult meeting for the Hospital as they were questioned intensely about their previous evasiveness regarding the accusations from the two consultants and their stance of dealing with this internally.

122. The actions for myself and Vince Connolly following this meeting were around determining a single point of contact for the Hospital and identifying communications leads. I appraised Michael Gregory and Richard Barker of the outcome of this meeting. Vince also appraised Lyn Simpson.

123. On 28 April 2017, Hazel Richards, Director of Nursing NHS England (Cheshire & Merseyside) emailed me and Paula Wedd, to note that Ms Wedd had been briefed by Ian Harvey. I replied on 4 May 2017, to say that I would brief Paula and Hazel as information comes in, and as it had been agreed that I would act alongside Vince Connolly as the single point of contact for the Hospital. The Hospital was to meet with police on Friday and I stated that I would "*brief all key people including yourself on a need to know basis, clearly if this becomes a police investigation we may need to be restrictive in terms of information sharing in order not to compromise the investigation.*" Paula Wedd replied to note that "*Ian rang me straight after his call to you. He values the single point of contact as it has been a challenge for him to keep Spec comm and 2 regulators briefed.*" [**Exhibit MK/27, INQ0106994**].

124. Having a single point of contact was important and the reason why we agreed that the police investigation was on a "need-to-know basis". The Hospital had multiple commissioners, regulators and clinical networks all wanting information about the police investigation and to seek assurance about the safety of the service. This level of pressure on the Hospital was a risk but it was important that the police had a single of point of contact to help coordinate their investigation. This is why we refer to this on a need-to-know basis. All other issues would go through normal communications channels.

E. Operation Hummingbird

125. On 4 May 2017, I wrote to Ian Harvey to enquire whether he had received any updates from the police, as I was aware that he had been hoping that the police would have come back to him the previous week. Ian Harvey replied to say that he had a scoping meeting scheduled with some of the neonatologists for 15 May 2017 but the Assistant Chief Constable and the Detective Chief Inspector (who would be the Senior Investigating Officer) wanted first to meet with Ian, Tony chambers and Stephen Cross. That meeting was scheduled for Friday afternoon (which was the following day) and Ian said that he would update me following that meeting with the police. **[Exhibit MK/26, INQ0005077]**

126. On the evening of 5 May 2017, Ian Harvey emailed with the update as follows:

> "*Further to previous correspondence Tony, Stephen and I met with the ACC, Det Supt and DCS Wenham (who is on the CDOP). In short:*
> *There will be an investigation, but it will be described as an invited police investigation to investigate unexplained deaths, not a criminal process.*
> *They are drawing up TORs to share with us and agree next week.*
> *We are forwarding details of the 13 babies and parents and the nurse.*
> *They will be advising the Coroner(s) and then jointly with us discussing with all the parents before it gets out by other routes i.e. the Coroner adjourning a forthcoming inquest.*
> *They will then liaise re the investigation and analysis- they already have an SIO, analyst and Liaison Officer identified.*
> *They have advised us to discuss the nurse with the LADO* Irrelevant & Sensitive
> *They have you as the point of contact for NHSE.*
> *Think that's the major points- I will keep you updated.*
> *Let me know if there are any queries.* **[Exhibit MK/26, INQ0005077]**

127. I replied later that evening to thank Ian for the update, and said that if he needed any support, to let me know.

128. On 9 May 2017, I emailed colleagues including CQC, Spec Comm, NHS Improvement, and West Cheshire CCG with a confidential briefing update in relation

to the Hospital, including the information I had received from Ian Harvey on 5 May 2017. **[Exhibit MK/28, INQ0012683]** I set out that:

> *a. "The Trust has met with the Police and it has been agreed that there will be an investigation but it will be described as an invited police investigation to investigate unexplained deaths, not a criminal process.*
> *b. The police are drawing up TORs to share with the Trust and agree by next week.*
> *c. The Trust are forwarding details of the 13 babies and parents and the nurse to the police.*
> *d. The Trust will be advising the Coroner(s) and then jointly with the Trust discussing with all the parents before it gets out by other routes i.e. the Coroner adjourning a forthcoming inquest.*
> *e. The Police will then liaise re the investigation and analysis- they already have an SIO, analyst and Liaison Officer identified.*
> *f. The police have advised the Trust to discuss the nurse with the LADO* **Irrelevant & Sensitive**
> *g. The have me as the point of contact for NHSE and the external system"*

129. On 12 May 2017, I received a further update from Ian Harvey which stated:

> *"[The police] are minded not to hold an investigation - firstly they don't feel that there is evidence of criminal activity and secondly they are mindful of the effects on families. However, our Paediatricians sent a document to them that was a listing of their concerns which was a very prejudiced view, effectively pointing the finger at one nurse. The police noted that it hadn't been forwarded to us also and requested that they do so. It does not contain anything new that multiple people and agencies haven't heard despite the Paediatricians assertion that they haven't been listened to. The police feel that they need to speak to our Paediatric Lead as the sender of the email and report, to give an opportunity to raise anything else that hasn't featured and will, based on this give us an indication by COP on Monday whether they will or won't be proceeding. The timing is important because I am due to meet the parents of one of the babies on Tuesday.*

My own feeling is that unless there is something that the Paediatricians haven't disclosed previously that evidences criminal activity there will not *be an investigation and the police will assist us in a message that will allow us to close down the speculation here and deal with the issues of culture etc. The Coroner has been kept fully informed by the police*
Perhaps a phone conversation next week might be helpful to fully cover the detail and anything that comes out of Monday?" **[Exhibit MK/29, INQ0014678]**

130. I was very concerned with this email; clearly the Hospital was still focused on the two consultants being the problem. I was worried that the police may be listening to the Hospital view without looking at all the facts and speaking with the two consultants. I recollect speaking to Ian and asking him to make sure the police did speak to the two consultants before any decisions were made.

131. I replied, agreeing that a call after Monday would be good, and Ian Harvey suggested 8:30am the following Tuesday [**Exhibit MK/30, INQ0106995**].

132. On Monday, 15 May 2017, Ian Harvey emailed me to defer our call because the police were going to be investigating the matter. He advised that he would be meeting AAC Maryland at 8:30am the following day (when our call had been scheduled) and advised that "*Having met with some of our paediatricians they are now going to investigate. We are sorting TORs with them tomorrow- I'll keep you updated. Because the coroner will almost certainly be adjourning an inquest it is likely to be in the public domain tomorrow."* **[Exhibit MK/31, INQ0106996]**. In my role as the Single Point of Contact, I emailed the CQC, Specialised Commissioning team, NHS Improvement, and West Cheshire CCG with this update, and asked one of the Communication leads in the North West locality team to liaise with the Hospital's Comms team and NHS Improvement **[Exhibit MK/32, INQ0101349]**.

133. I continued to liaise with the police as the Single Point of Contact, as summarised in section 2 of NHSE/1. When LL was first charged with murder in 2018 the police informed me of this so we could be prepared as part of the single point of contact and significant media attention this would bring. As part of their initial investigation, it became apparent that the police investigation extended to two other Trusts where LL had worked, and it would involve interviewing large numbers of witnesses. The impact on the ability of these hospitals to deliver a service, as well as the impact on staff, patients and the public, could be significant and risk causing further harm to services and patient care.

134. The incident coordination group was a tried and tested approach that can aid in handling these situations which not only protects the primacy of the police investigation but also enables the NHS and others to provide a coordinated approach to supporting staff, media and communication enquiries. It allows commissioners to be prepared to consider alternative providers if need be, to ensure a continuation of safe services. I was nominated as chair because I had previous experience of using this approach in other police investigations. As chair I was able to continue to provide a single point of contact for the police and Hospital and help coordinate key stakeholders to support the Hospital in key areas for example communication support and psychological support to families and staff. I believe that the first meeting of this group was an Incident coordination Call on 4 June 2018, to ensure that the appropriate governance processes and support were in place for the Hospital **[Exhibit MK/33, INQ0003194]**.

F. My reflections on the events that took place at the Hospital

135. Having reflected again recently on the events that took place at the Hospital, I do believe that the Hospital was being evasive and uncooperative with NHS England and NHS Improvement, particularly in early 2017. I do not understand why the Hospital didn't just give the information requested and do not consider that concerns around confidentiality were justified; these concerns are standard and can be addressed by redacting any identifiable patient information if necessary.

136. It is my firm view that the Hospital should have informed NHS England much sooner regarding the suspicions held by clinicians that an individual (LL) was the reason for the increased mortality rate within the neonatal unit. A referral should also have been to the police shortly after this allegation was made. This would have allowed the Hospital to seek proper advice and to demonstrate full transparency.

137. The Hospital did alert the specialised commissioning team and neonatal network to the increased mortality rate in July 2016. I do not know personally when the Hospital was first aware of the increased mortality rate. National mortality data was not available in real time, so no external bodies were alerted to the increased mortality until the Hospital raised it following the deaths of the two Triplets at the end of June 2016. In addition, the Hospital had not reported any of the other deaths as serious incidents which would have alerted external commissioners and regulators sooner to the developing mortality increased rates. With the benefit of hindsight, I can now see how the lack of real time data was a key reason for the delay in NHS England becoming aware of the crimes committed by LL at the Hospital.

138. Following the reporting of these two serious incidents and the increase in the mortality rate within the neonatal unit, the unit was downgraded as a safety measure to enable the investigations to happen, reduce the risk on the unit and to prevent further deaths or harm to babies. The Hospital also arranged for the Royal Colleges to conduct the investigation. This was the appropriate action for it to take, As indicated above, as I do not believe anyone at NHS England or NHS Improvement was appraised of the concerns regarding LL, it was right that we did not consider that any additional action was warranted at the time. The Specialised Commissioning team continued to scrutinise the Hospital during this period, having regard to its role and the powers available to it. There were clearly further steps that the Specialised Commissioning team could have taken had it been provided with the full picture.

139. Whilst delays in making the reports of the external investigations available to the NHS England and regulators is not itself unusual, as hospitals often want to conclude all investigations to establish a complete picture before sharing the outcome, the approach taken by the Countess of Chester Hospital in this case was wrong and was of deep concern to the Specialised Commissioning team during the early months of 2017 in particular as the correspondence I have described above demonstrates.

140. My role was to support the Specialised Commissioning team in their interactions with the Hospital. As explained above, I only became directly involved at the end of March 2017 due to my previous role in the Regional Management team and experience in dealing with Child Death Overview Panels and police investigations. It was only a matter of around 4-5 weeks between then and when the police launched Operation Hummingbird. I therefore believe that, even with the benefit of hindsight, there were not any different steps I personally should have taken at the time.

141. I had no knowledge of any culture issues at the Hospital or the reasons why the two consultants who suspected LL of committing these crimes did not take further steps at the time to bring their concerns to the attention of any external organisations. I did not speak with any of the clinicians at the Hospital and would not usually do so unless someone approached me as a whistle-blower or a nurse needed professional guidance. However, I believe the relationship between the executive team at the Hospital and the two consultants did appear to impact on the decisions made by the Hospital. This is reflected in the correspondence I have set out above from Mr Harvey, which repeatedly focused on the issues they were having with the clinicians being his key concern.

142. Similarly, I had no knowledge of the grievance raised by LL or how this was dealt with by the Hospital. Again, this is not something that was within my remit as Regional Chief Nurse.

143. I also cannot comment on whether the Hospital was being candid with the families. The principal guardian of this duty is CQC.

G. Other Reflections

Allitt and Clothier inquiries

144. The Inquiry has asked me specifically whether I was aware of the Allitt and Clothier public inquiries. I do not recall having ever read the report from the Allitt Inquiry. However, I was aware of the issues around missed chances to stop Beverley Allitt sooner, as well as staffing and skill mix, and weakness in whistle blowing.

145. At the time of the Clothier Inquiry, I was working as a District Nurse in Barnsley, and so did not have any involvement in the implementations of its recommendations. I do remember the case mostly because of the media reporting and I recollect the Trust I worked in raising the outcome and recommendations from the inquiry. I did not read the full report at the time, but I do recollect the issue of recruitment of people with mental health and personality disorders being a significant area of concern from the school of nursing and the hospital itself.

146. I am of the opinion that as the events underpinning public inquiries such as Allitt and Clothier are extra-ordinary they are therefore not often considered as a causative possibility to explain harm to patients. As a general point, and key learning for me is the need to learn that the worst-case scenario, of intentional harm being perpetrated, should always be considered as a potential cause to explain events.

Factors that may inhibit or encourage concerns being raised about patient safety

147. The Inquiry has asked me what factors may inhibit or encourage concerns being raised about patient safety. In my experience, inhibiting factors include:

- a disbelief that colleagues could be causing harm to patients
- closed cultures
- organisational conflicts, conflicts with line managers, fear of reprisals, a lack of trust and fear of persecution from colleagues or managers, and
- a lack of understanding how to raise issues.

148. Factors that encourage staff to raise concerns include:

- an open culture
- access to effective Freedom to Speak Up guardians so whistle-blowers know they are protected, and confidentiality will be maintained
- good communication of processes so everyone knows where and how to raise issues.
- Good information on how to raise issues to other regulatory agencies such as the CQC.

Impact of national / system reform

149. Whilst commissioning is not my area of expertise, I believe that the structural changes made to the NHS since 2016 have improved integration and accountability at local system level. I understand that the intention is to delegate specialised commissioning to Integrated Care Boards which will ensure all commissioning is done at a local level and there will be a single point of oversight and assurance is created. I consider this to be a positive change.

150. Overall, I think that there have been improvements and those are continuing to be made. For example, there is better and more timely access to mortality data, the Patient Safety Incident Reporting Framework means that the reporting and oversight of incidents should be more effective, and the introduction of medical examiners will also bring better scrutiny. However, I can't say whether any of these changes would have stopped LL.

Training and regulation of nurses

151. I think nurse training could be strengthened by adding training and insights into the unthinkable acts that *some* people can do to patients. Professional curiosity is to be welcomed and encouraged especially when untoward events occur. Safeguarding training covers abuse and neglect but the rare instances of the likes of LL means healthcare staff will not even contemplate that colleagues could do such evil things to patients. Learning about personality traits and mental ill health for everyone could help to keep staff aware even in the unlikely event that happened. Being aware of the possibility and how to raise suspicions is a key element of training.

152. Nurses are already professionally regulated by the NMC which is largely effective in ensuring nurses adhere to standards of practice within a framework of duty of care to patients. I believe the duty to report concerns could be strengthened for situations where staff feel they are intimidated by their internal peers, managers or the organisation. This could be done by specifically stipulating such a duty in the NMC's code of practice as this would provide a regulatory safety net if nurses are too scared of internal reprisals.

Manager accountability

153. I believe any serious allegation made against staff who is suspected of harming anyone should be routinely referred to the police irrespective of whether the allegations are malicious or not so the police can advise accordingly.

154. I also believe senior managers should be held accountable for taking these actions and reporting them to the appropriate regulators. Given that all healthcare clinical staff are regulated by their professional bodies, I do not see a good reason why managers should not have the same scrutiny applied to their professional behaviours. This would mean having a regulator for all senior managers. I recognise this might be difficult to implement as we do not have any existing infrastructures in place, and this could be a costly approach at a time when the NHS is under so much pressure. However, this would be an important step to apply common standards to the highly professional managers who do not come from a clinical background.

Keeping babies safe

155. There are already so many different types of scrutiny in place for seeking to reduce instances of harm to babies, such as coroners, safeguarding processes including the Child Death Overview Panel, safe recruitment practices, Serious Incident reporting, Freedom to Speak Up, and regulator/commissioner oversight. In particular, reporting deaths should be timely and scrutinised by external clinicians.

156. As I have mentioned above, training and education is also key to make staff and managers aware of the prompt actions they need to take when concerns arise. This includes close monitoring and professional curiosity when patients suddenly deteriorate.

CCTV and access to drugs

157. I am not sure if LL's crimes could have been prevented by additional CCTV monitoring, but I do support CCTV as an aid to monitor vulnerable adults, children and babies who cannot speak out for themselves. The benefit of CCTV is that it can be reviewed at a later point to establish any potential causal acts. In the LL case it may have alerted the Hospital a lot quicker to look at her as a single causal factor.

158. I am not convinced that increasing security systems around monitoring drugs could make a huge difference. It is not necessary to use drugs to inflict potentially fatal harm to a baby

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: 25 July 2024