IN THE THIRLWALL INQUIRY
BEFORE LADY JUSTICE THIRLWALL

Witness name: CLAIRE RAGGETT
Witness statement number: 3
Exhibits: None
Dated: 2 August 2024

THIRD DISCLOSURE STATEMENT OF CLAIRE RAGGETT ON BEHALF OF THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

I, Claire Elizabeth Raggett, of the Countess of Chester Hospital NHS Foundation Trust ("the Trust") say as follows:

Introduction

1. The facts in this witness statement are true, complete and accurate to the best of my knowledge and belief. Where I refer to my beliefs, those beliefs, and my knowledge contained in this statement, are informed by colleagues, current and former, who I have spoken with in an attempt to identify and collate relevant documentation, and colleagues within the Trust's IT department, in particular Paul Keith, who has assisted with the searches for and collation of relevant electronic documentation. Hill Dickinson, the firm of solicitors instructed by the Trust as its Recognised Legal Representative in this Inquiry, have assisted me in identifying, collating and disclosing relevant documentation to the Inquiry and thus in the preparation of this statement.

2. This disclosure statement is a third disclosure statement provided by the Trust and supplemental to the first and second disclosure statements prepared by me on behalf of the Trust and dated 8 May 2024 and 9 July 2024 respectively.

3. I remain the appropriate person to give this witness statement on behalf of the Trust in view of my role as Trust Thirlwall Inquiry lead in respect of the Trust's disclosure process and my role as Trust contact for Operation Hummingbird. I was appointed to these roles

in light of my previous Trust role (Executive Assistant) and corporate memory, being one of the few employees who were employed by the Trust in the corporate team during 2015/2016 and who remain employed at the present time. My roles within corporate governance at the Trust and my knowledge of data protection issues also led to me being deemed the most appropriate person to lead on the disclosure process. I have been the custodian of all documents held by the Trust relevant to this Inquiry or the indictment that proceeded it or, where the documents have been shared with third parties, I have been the person in charge of coordinating and sharing information requested on behalf of the Trust.

Notebooks of executive directors

4. The Trust has been asked by the Inquiry to provide information on the retention and disclosure of hard copy notebooks belonging to former executive directors of the Trust and former members of senior staff. It should be noted that hard copy notebooks were only held by the Trust due to the on-going Police investigation and the Facere Melius 'Hidden in Plain Sight' report potentially needing the information. The Trust retained the notebooks of executive directors on their departure from the Trust.

5. On 9 July 2024, the Inquiry emailed Hill Dickinson to advise that it had been made aware that Stephen Cross's legal representatives had been provided with scanned copies of his notebooks on 4 July 2024. The Trust held scanned copies of Mr Cross's notebooks, the hard copy notebooks having previously been seized by the Police. Mr Cross had been provided with his H drive and mailbox material recovered by the Trust (as described in my previous disclosure statements) to support him to respond to his Rule 9 request. Hill Dickinson had asked Mr Cross's legal representatives if Mr Cross needed access to any other material the Trust might hold in order to respond to his Rule 9 request (over and above the material the Inquiry might have provided with Mr Cross's Rule 9 statement request). On 1 July 2024 Mr Cross's legal representatives confirmed that it was their understanding from Mr Cross that he had left six notebooks containing his handwritten notes at the Trust when he left the employment of the Trust, extracts of which they had already been provided with. They asked if he could be provided with full copies of each notebook. We explained that the Trust held scanned copies of fifteen notebooks of Mr Cross's (the Police being in possession of the hard copies) and the scanned copies were subsequently provided on 4 July. On 24 July 2024, following a further request, we provided

to Mr Cross's legal representatives a pdf document of all the extracts from Mr Cross's notebooks that we had previously disclosed to the Inquiry.

6. In their email of 9 July 2024 the Inquiry asked for confirmation of whether handwritten notes disclosed to the Inquiry previously by the Trust were extracts of Mr Cross's notebooks. Hill Dickinson responded on behalf of the Trust to advise that the handwritten notes provided to the Inquiry were extracts from the notebooks of former members of Trust staff. Many of these were scanned from the notebooks by Facere Melius for the purposes of their Hidden in Plain Sight report. My understanding was that Mr Cross had personally reviewed his notebooks and identified those extracts relevant to the Police investigation and Facere Melius review and that those extracts were scanned by the Trust and provided to the Police and Facere Melius. I also understood that the same process had been undertaken by Alison Kelly in respect of her notebooks. All such scanned extracts were retained by Facere Melius for the purposes of their review and had previously been disclosed to the Inquiry (albeit they were retained in a way which did not easily identify the extracts as pertaining from each individuals' notebooks).

7. Hill Dickinson discussed this with Mr Cross's legal representatives via email and Mr Cross has subsequently confirmed that he did not identify or highlight any notebooks for the purpose of his Police interview or for the Facere Melius interviews. He has confirmed however that when he left the Trust, he took copies of certain date ranges of his notebooks for his own records and he therefore identified the dates on copies of 'post it' notes provided by the Trust, which he seemingly identified for his own purposes only. He has also confirmed that he is not aware of which pages/books were identified to or handed to the Police by the Trust. He has confirmed that the Facere Melius interviews with him took place virtually, during which the review team put extracts from his notebooks on the screen and Mr Cross was asked to comment on them. It seems therefore that there is no clarity about how all the extracts from the notebooks were identified and tabbed, but I can confirm that the tabbed extracts from notebooks or copies of notebooks held by the Trust have been previously disclosed by the Trust to the Inquiry.

8. We have therefore confirmed to the Inquiry that only extracts from the notebooks have previously been disclosed to the Inquiry. These would have been extracts either identified by the individual members of staff themselves or identified by Facere Melius as being of relevance at the time of the Police investigation and Facere Melius review. As a result,

the remainder of the notebooks was deemed unlikely to contain relevant material for the purposes of the Inquiry and full copies of the notebooks were not therefore disclosed.

9. Many of the notebooks are not held by the Trust and are held by Cheshire Police having been previously seized as part of on-going investigations. The Trust did until very recently hold a number of Ms Kelly's notebooks (32). The Police seized Ms Kelly's notebooks on the 12 July 2024 after I advised them that Ms Kelly had requested copies of her notebooks on 9 July 2024, as the Police required the notebooks for the purposes of the ongoing investigation. As such, the Trust now only holds a scanned copy of those notebooks. This was confirmed to the Inquiry with confirmation that the Trust held a scanned copy of Mr Cross's 15 notebooks and a scanned copy of the extracts provided from Sue Hodkinson's notebooks. Ms Hodkinson's legal representatives had previously confirmed that Ms Hodkinson holds her own hard copy notebooks.

10. We have since provided to the Inquiry a scanned copy of all of Mr Cross's 15 notebooks, a scanned copy of the extracts previously provided from Ms Hodkinson's notebooks (which were held by the Trust) and a scanned copy of all of Ms Kelly's 32 notebooks, which were provided by the Police subsequent to them seizing the notebooks. The Inquiry has also been provided with a pdf of the extracts from Mr Cross's and Ms Kelly's notebooks previously provided to the Inquiry (one pdf of the extracts for ease of reference). [Extracts from Tony Chambers' notebooks which were held by the Trust have previously been disclosed to the Inquiry and provided to Mr Chambers' legal representatives].

11. We confirmed to the Inquiry that we would liaise with the legal representatives of the former executive directors and Mr Cross about the notebooks to ensure that they were provided with copies of the notebooks the Trust held and that we would create and provide them with a pdf of the extracts already provided to the Inquiry from each individual's notebooks so that the individuals could then review their own notebooks and provide any further material identified as relevant to the Inquiry. Copies of these notebooks and extracts have now been provided to the legal representatives of the former executive directors and Mr Cross.

12. The Trust has subsequently found 2 notebooks which are understood to be Ms Hodkinson's notebooks (covering the period June 2017-September 2017 and December 2016-April 2017) and some loose hard copy documents (15 documents), some of which are believed to have Ms Hodkinson's handwriting on them. We informed the Inquiry of this

on 22 July 2024 and also Ms Hodkinson's legal representatives. We have since provided Ms Hodkinson's legal representatives with scanned copies of the two notebooks and they have confirmed that they belong to Ms Hodkinson. We have also provided them with the loose documents found and are currently reviewing the documents to confirm if copies of them have previously been disclosed to the Inquiry. Any documents that haven't been previously disclosed to the Inquiry, together with the two notebooks, will be disclosed.

13. These notebooks and documents were found during the recent move of the Trust executive team offices. An unnamed box file containing the records of a disciplinary matter from 2011 (relating to a non-NNU member of staff) was found in the corporate secure cupboard (not NNU related information). I reviewed the contents of the box file and noticed at the bottom of the box there were two notebooks which did not relate to the disciplinary matter. There were also a small number of paper copies of emails and documents, again unrelated to the disciplinary matter. I do not know who the owner of the box was or why it had been stored in the cupboard and it is not clear why there were documents in the box belonging to or relating to Ms Hodkinson. I confirm that for completeness a full review of all the documents found in the corporate secure cupboard was undertaken for any other potentially relevant documents and no further documents were found.

14. On 17 July 2024 the legal representatives for Dee Appleton-Cairnes enquired as to whether the Trust held any notebooks relating to Ms Appleton-Cairnes, as she thought that there may be some of her notebooks at the Trust, but she was not sure. I was not aware of any of Ms Appleton-Cairnes' notebooks being held by the Trust, but on making enquiries, I was made aware of a HR investigation in which Ms Appleton-Cairnes was involved and consideration was then given by HR as to whether the notebooks may have been retained as part of that investigation. A review of the material held in the Trust's off-site data storage, Dataspace, was undertaken. A box of material relating to the HR investigation was identified and I requested that this be retrieved from Dataspace. On 26 July 2024 I received the box and a number of notebooks belonging to Ms Appleton-Cairnes (11) were contained in the box. We have since scanned a number of these and copies have been provided to Ms Appleton-Cairnes' legal representatives. The remainder will be copied, and copies will be provided to Ms Appleton-Cairnes' legal representatives and to the Inquiry.

15. Following further discussions with the Police and a review of the material provided to the Police/seized by the Police, the availability of further notebooks has come to light as at the date of this statement. It is understood that tabbed extracts from the books have

already been disclosed to the Inquiry, but the Trust is now obtaining scanned copies of all the notebooks to be able to provide these to the Inquiry, as has been done with other notebooks. The further notebooks are as follows:

(a) Alison Kelly – it is understood the Police hold a further 8 notebooks belonging to Ms Kelly from pre-2015 and from June 2020, with one from March-July 2018.

(b) Sue Hodkinson - whilst it was understood that Ms Hodkinson had retained her own notebooks, it is understood that the Police have a further 10 of Ms Hodkinson's notebooks up to March 2016.

16. The Trust holds 4 notebooks of Julie Fogarty's. Extracts from the books have already been disclosed to the Inquiry as these were deemed relevant. However, the Trust is now copying the whole of the notebooks so that copies can be provided to the Inquiry.

17. Scanned copies of Simon Holden's notebooks (7 in total) were provided to him for the purposes of his Rule 9 request and Mr Holden has attached all copies as an exhibit to his Rule 9 statement, which has been provided to the Inquiry.

18. For completeness, I confirm that I hold scanned copies of 5 of my own notebooks. I have previously reviewed these for relevance. Full copies of these have not previously been disclosed as they were not deemed relevant, but I now intend to re-review the notebooks to undertake a further check.

Perinatal mortality surveillance reports

19. The Trust has been asked to provide information in relation to its disclosure of perinatal mortality surveillance reports. In my second disclosure statement, I explained that these reports provide information on the annual figures for neonatal deaths. They are reports prepared by MBRRACE and they record the perinatal mortality data (nationally) collated by MBRRACE each year (previously CEMACH, The Confidential Enquiry into Maternal & Child Health) and produced by them in an annual report. I explained in my second disclosure statement that the Trust had previously provided to the Inquiry a number of these MBRRACE annual reports (where they were held in material retained by the Trust and identified as a result of the Trust's searches for relevant material).

20. I also explained in my second disclosure statement that searches for relevant material by the Trust had identified a number of Trust executive summaries of the MBRRACE

data/reports, which had been disclosed to the Inquiry. Summaries of the 2013 and 2015 data had previously been provided. These were the documents located from initial searches. Summaries of the 2014 and 2016 data were located within H drive and/or mailbox material and were subsequently provided to the Inquiry. I indicated in my second disclosure statement that we had not been able to locate an executive summary document in respect of the 2017 data. We have since located this document, as explained below.

21. The Inquiry emailed Hill Dickinson on 10 July 2024 in the following terms:

To further assist with our work on the neonatal death statistics……..we should be grateful if you would:

Confirm if the CoCH has Perinatal Mortality Surveillance Reports (which the CoCH prepared and submitted to MBRRACE) from 2009, 2010, 2011, 2012, 2018, 2019 and 2020. If so, please provide these by Monday next week. Please see attached INQ0097999 which we provided recently by way of example (2016 deaths reported March 2019).

22. On 15 July 2024 Hill Dickinson responded to the Inquiry in the following terms:

The Trust have located the attached summaries for 2017, 2019, 2020 and 2021. The Trust had previously advised that they were unable to locate the summary for 2017 but have now located this in Dr Jo Davies' h-drive. They have been unable to locate the summaries for 2009, 2010, 2011, 2012 and 2018 and will ask Dr Davies to review for these documents on her working days I&S *as she appears to be the author of attached summaries. They are also confirming with Dr Davies where the reports were presented to as it is not clear if they went to MBRRACE or went to the clinical audit committee……..*

23. On 19 July 2024 we were able to provide further information to the Inquiry, noting the following:

As the Inquiry is aware, Dr Jo Davies I&S
She has not therefore so far been included in internal Trust discussions around preparation for the Inquiry and identifying any documents that may be relevant to the Inquiry's terms of reference (until now on her return from I&S *. She has not therefore produced any documents of relevance thus far and her H drive was not searched in her absence* I&S *as it was not felt that it would contain any further documents of*

relevance to the Inquiry over and above the material initially collated by the Trust for the purposes of the Police and Facere Melius investigations (and already disclosed to the Inquiry). It is only on identifying her as the author of the executive summary reports that the Trust has now searched within her H drive and identified further reports. These reports would not have been considered relevant for the purposes of the Police and Facere Melius investigations as they fell outside of the relevant timeframe under investigation. Following Dr Davies' **I&S** *the Trust has been able to seek further information from her about the summary reports.*

The executive summaries of the perinatal mortality data that we have produced to the Inquiry are summaries which were produced by Dr Jo Davies. The summaries are a summary of the perinatal mortality data collated by MBRRACE each year (previously CEMACH, The Confidential Enquiry into Maternal & Child Health) and produced by them in an annual report. The summaries were provided by Dr Davies to the Trust's audit team and then presented to the Trust's CAG (Clinical Audit Group). Dr Davies recalls that the summary reports may also have been produced to the Women and Children's Governance Board at some point, but not in 2015/16. Dr Davies believes that the purpose of the reports was to demonstrate that the Trust had received and read the MBRRACE reports and, if necessary (eg. if the reports indicated that the Trust was an outlier), had acted on them.

As it would have taken some time for the relevant data for each year to be collated and presented by MBRRACE by way of its reports (usually up to a 2 year process), the executive summaries produced by Dr Davies were produced with a time delay eg. the 2017 data was presented in a summary report in 2019 once the MBRRACE report was available. The data is therefore not contemporaneous and does not provide an immediate alert or trend in mortality cases.

Dr Davies recalls that she was first asked by the Trust to produce an executive summary report in September 2015 – this was a summary of the 2013 data. She believes that this was the first time the Trust had asked for such a report, as she remembers having to ask how to draft the report as there was no template available. No reports in respect of data from 2009, 2010, 2011, or 2012 can be located. Dr Davies recalls that prior to 2015 the annual MBRRACE report was received into the Trust and Dr Jim McCormack would share the information at an annual perinatal statistics joint meeting with the paediatricians. Dr Jim McCormack led on perinatal reporting and education prior to Dr Davies. [Dr Davies

provided an example of a powerpoint from 2011 that Dr Jim McCormack gave on the 2008 data (published 2010) as an example of what she believes was the practice prior to 2015].

We have made contact with Dr Jim McCormack who has advised that annual perinatal mortality reports from MBRRACE and predecessor organisations (Regional Perinatal Audit Group, CMACE, CEMACH, MBRRACE) have been available in some form for many years and that it is likely that all obstetric units would have delivered a presentation internally on the annual perinatal statistics for education and learning purposes. These presentations would likely have included, for example, normal delivery rates, caesarean section rates, multiple pregnancy rates and outcomes, breech pregnancy rates and outcomes, maternal deaths and neonatal and stillbirth rates. Dr Jim McCormack has confirmed that he was the lead consultant for organising these annual meetings in the Trust, that a consultant paediatrician would have contributed with the preparation of the neonatal data and that most obstetric, neonatal and midwifery staff would have attended. He has no recollection of the 2011 presentation. However, he has confirmed that such presentations would have been the Trust's usual method of disseminating the data from MBRRACE reports to relevant staff.

Dr McCormack cannot recall when he stopped being the lead in this area, but thinks this was probably 2015, which would seem to fit with the date that Dr Davies was first asked to produce the executive summary report. Dr McCormack has confirmed that he was not involved in preparing summary reports of MBRRACE perinatal mortality data for the Trust, and does not recall ever seeing one of the reports prepared by Dr Jo Davies.

An executive summary report in respect of the 2018 data cannot be located. The Trust has discussed with Dr Davies why this might be the case. It is thought that, as a report on this data would have been produced in or around 2020, a report may not in fact have been produced at this time in view of the Covid period. The Trust cannot locate Clinical Audit Group agendas for 2020 and therefore believes meetings of this group may not have taken place during this time.

24. To summarise therefore, the Trust located executive summaries of the 2017, 2019, 2020 and 2021 MBRRACE data in Dr Davies's H drive. Summaries of the 2013, 2014, 2015 and 2016 data had been previously located within other material held by the Trust (the dataset of material provided to Facere Melius and/or the H drive/mailbox material of former employees). It is not known why the executive summaries were held in various different locations, but it is an example of where material was not held in a collated form in a named

S drive (as I have explained in my previous disclosure statements), making searches for this material at this point in time very challenging. As previously explained, the 'H' drive is a drive personal to an individual member of staff, and the member of staff can manage their H drive as they wish, setting up a number of unmanaged folders. Ordinarily only the individual user can access documents saved in their H drive and no other users can access the folders/documents.

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: **2 August 2024**