Witness Name: Ann Ford
Statement No.: 2
Exhibits: 4 [AF/22 - AF/38]
Dated: 8 August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF ANN FORD

I, Ann Ford, of the Care Quality Commission ("CQC"), Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA, will say as follows:

1. Introduction

1.1 I am the Director of Operations Network North within the CQC. The Countess of Chester Hospital ("CoCH") sits under Network North, the area for which I am responsible. The team responsible for the monitoring and inspection of the Countess of Chester NHS Hospital Trust ("the Trust"), as well as the Operations team responsible for identifying and reviewing materials of relevance for the Inquiry all sit under my leadership.

1.2 As CQC's Head of Hospital Inspection I led the work of the inspection team throughout the 2016 inspection of CoCH and provided support, advice and guidance to the Inspection Chair on CQC regulatory requirements. I attended on site for the inspection visit. This included leading the planning stage of the inspection, ensuring that all intelligence available was used in the most effective way and development of the areas on which to focus. I coordinated the input of the CQC Analytical Support including document review and management of the CQC Inspection Planner. I oversaw the logging and analysis of evidence and made regulatory judgements based on all evidence presented to determine provisional ratings. I also contributed to briefing and corroboration meetings and deputised for the Inspection Chair as required. I am duly authorised to make this statement on behalf of the CQC.

1.3 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,

are informed by the CQC Operations team, supported by CQC's Inquiries and Investigations team, Records and Data Management team, the Knowledge and Information team, the Workplace and Facilities team and our technology partners Little Fish.

1.4 Exhibits to this statement are referred to by reference to the accompanying index (eg. [AF2/1]). When referring to documents already disclosed to the Inquiry the relevant reference is given where available (eg. [INQ000000])

1.5 The purpose of this statement is to update the Inquiry on a number of matters addressed in my first statement dated 24 June 2024 and to respond to the Rule 9 Request issued by the Thirlwall Inquiry on 23 July 2024 (I&S I&S).

1.6 My first statement addressed how CQC responded to previous Rule 9 requests for potentially relevant documents; relevant retention policy and practice; our methodology in relation to search and disclosure of material; the processes under which material has been identified as potentially relevant to the Inquiry; and oversight and quality assurance of disclosure.

2. Provision of documents to the Inquiry

2.1 In order to ensure that CQC's searches capture and disclose all material within its custody and control that is relevant or of potential relevance to the Inquiry's terms of reference (and to avoid a narrow focus on specific Rule 9 requests) we have developed and expanded our approach since the Inquiry's work began. I described our activities, intentions and commitment in relation to this in my previous statement (at paragraphs 3.75 to 3.92).

Paper records

2.2 As explained (at paragraphs 3.68-3.74 of my first statement) further searches and enquiries have continued in order to locate, among other things, any inspection notes for Children and Young People services within our paper records.

2.3 Facilities staff at our Newcastle Office with assistance from colleagues in our Operations and Inquiries and Investigation teams completed reviewing 591 boxes of previously scanned documents returned from Iron Mountain on 19 July 2024.

2.4 Three of these boxes contained six bundles of documents including records relating to CoCH. This material has been rescanned at a higher resolution than the originally available and was provided to the Inquiry on 19 July 2024.

2.5 Our own understanding, from an initial review by members of CQC's Inquiries and Investigations Team, is that these records largely, if not wholly, comprise:

(i) documents that we have shared previously with the Inquiry, including the inspection notes from the Children and Young People's service; or

(ii) documents that relate to other core services subjected to CQC's inspection in 2016, subsequent inspection dates, or other CoCH documentation.

2.6 Legal review of this tranche of scanned material is underway, and an index to the disclosure provided on 19 July will be provided to the Inquiry on 9 August 2024.

Electronic records

2.7 In relation to electronic records, a second review of the CoCH area within our Customer Relationship Management system ("CRM") and Y Drive has been completed by a team of 46 Operation team colleagues with knowledge and experience of Operations and inspections. A total of 3,101 items identified have been reviewed for relevance and all attachments in CRM relating to CoCH have been reviewed resulting in the disclosure of 849 CRM enquiry attachments being disclosed to the Inquiry on 15 July 2024.

2.8 As previously explained in my evidence, CRM is where CQC would expect staff to record any information received about CoCH. Until November 2023 CQC used CRM

in order to manage our relationship with registered providers. Outside of CRM the Y Drive, a file share server, was used to house all non-regulatory information and inspection related information too large to be uploaded to CRM during 2015-2019. From 2019 all Y Drive data modified on or after 1 April 2018, was transferred to SharePoint Online. (See paragraphs 3.23, 3.38 and 3.39 of my first statement in particular.)

2.9 Two Y Drive folders ("2015 2016 Q4" and "General") were identified as relevant. Their entire contents have been reviewed and items marked as relevant following review were disclosed to the Inquiry on 15 July 2024. This amounts to 1,134 documents and 91 items, respectively.

2.10 Searches within M365 eDiscovery for my own Outlook Mailbox and OneDrive were undertaken by the Inquiries and Investigations Team Records Manager on 5 July 2024. The search date range spanned 1 January 2015 to 19 October 2023 and the following key words:

- "CoCH"
- "COCH"
- "COOH"
- "Countess"
- "Countess of Chester Hospital"
- "Chester"
- "RJR"
- "RJR05"

2.11 After deduplication the search returned 942 items, which were then exported from M365 eDiscovery to the Inquiries Team's secure SharePoint area. Manual review of those items for relevancy was undertaken and 614 identified as relevant and disclosed to the Inquiry on 15 July 2024. An index to that disclosed material was provided to the Inquiry on 7 August 2024.

2.12 Additional searches within M365 eDiscovery were undertaken by Little Fish, CQC's external IT providers, on 26 July 2024. These were run against those CQC staff members within or supporting the 2016 Inspection Team identified as likely to hold

relevant material[1]. A date range of 1 January 2015 to 1 January 2017 and using the key words listed above was applied to the Outlook Mailbox and OneDrive data sources. The search returned 983 items which have been exported to the Inquiries Team secure SharePoint area and the subject of review since 26 July 2024. Disclosure of relevant material was made to the Inquiry on 7 August 2024.

2.13 Members of the Inquiries and Investigations Team met with internal Customer Computing colleagues and external Little Fish colleagues on 19 July 2024 to discuss gaining access to the Outlook calendars of relevant diaries. It was found that Outlook calendars for staff who have left the organisation could not be accessed within Outlook but were retained within Microsoft Purview and accessed via M365 eDiscovery. It was decided to review calendar entries as part of the eDiscovery review exercises.

2.14 Calendar entries relating to myself were reviewed as part of the review of the eDiscovery search for Microsoft data sources, and all relevant items from this have been disclosed to the Inquiry.

2.15 Items within the Outlook mailboxes including calendar entries for the members of the 2016 CoCH inspection team review was completed on 2 August 2024 . We have found that, following transfer of IT Service Providers in April 2020, the accounts of inspectors Bridget Lees and Caroline Williams were not put on hold and retained, and therefore inaccessible via Microsoft Purview and M365 eDiscovery. At the time of my last statement this was thought to apply only to Bridget Lees (see paragraph 5.18).

2.16 As I explained in my first statement (at paragraph 5.2 in particular) CQC became aware during the preparation of Ian Trenholm's evidence to the Inquiry that records and material generated in relation to a number of meetings which were known or believed to have taken place in connection with the inspection of CoCH had not been found, if they ever existed.

2.17 Discussion with the Operations Team during March/April 2024 together with available records suggested that meetings of this kind were considered likely to have occurred and so were mentioned within Ian Trenholm's evidence. We have been able to locate

[1] Deborah Lindley, Julie Hughes, Daniel Watson, Nicola Everitt, Michelle Haller, Cara Taylor, Joanne McManus, Helen Cain, Katherine Williams, Vivienne Mitchel, Karen Knapton, Angie Brown

large numbers of engagement meeting notes, which appear to have been taken routinely. However, it has become apparent that we do not hold such records for certain meetings prompting queries as to whether in fact they were recorded at all or were scheduled but did not take place. As such we can only say with certainty that the consultants' focus group meeting took place on 17 February 2016.

2.18 Although CQC considers that the following meetings could have taken place its searches and inquiries so far have not revealed any corroborative evidence of the fact that they did or as to anything that was discussed:

- A pre-inspection engagement meeting with the CoCH NHS Trust during February 2016.
- A meeting between the CQC and CoCH NHS Trust during February 2016.
- A Quality Summit meeting dated 29 February 2016.
- A Quality Surveillance Group meeting dated 28 July 2016.

2.19 In terms of the consultants' focus group meeting specifically, CQC understood that the inspection team would have generated paper (rather than electronic) notes as this was the practice at that time. Any such notes, like other 2016 inspection notes discovered as part of the disclosure process, were expected to be held within paper record archives.

2.20 For that reason the search strategy in relation to evidence of these meetings has prioritised paper records. However, searches conducted by colleagues in Newcastle (already mentioned above) have produced no results in relation to any of these meetings. We have contacted all members of the 2016 inspection team again to ascertain if they hold any records, specifically referencing the focus group. But none has been identified. Nor has any documentation relating to any of these meetings been found so far as part of our additional reviews of electronic documents or e-discovery searches.

2.21 We have also continued to make further enquiries in relation to any additional documents that we would have expected to have been generated by the inspection process but which we have not encountered. We are not able to say that such

documents definitely existed but there remains a possibility that some items were created but because of human factors, such as documents not being stored in CRM or the Y Drive as suspected or because original papers were not kept or were destroyed, that any information contained in them is no longer within CQC's possession. As already mentioned we have been carefully searching locations where we would expect to find such material (or evidence of its creation or existence). We have continued to make enquiries of the inspection team in order to locate any items they might have retained or to establish additional intelligence that might inform further searches and enquiries.

Requests for specific documentation

2.22 In its Rule 9 Request of 24 July 2024 the Inquiry expressly asked to be provided with:

- Complete copies of all Data Requests made to the Countess of Chester Hospital for the purposes of the 2016 inspection.
- The complete PIRs, insofar as these have not already been provided.
- Any index or indices that has/have been prepared of all of the documents provided by the Countess of Chester Hospital for the 2016 inspection.
- Materials relating to the "Listening Event" on 9 February 2016.
- Minutes or notes of briefing meeting took place with Tony Chambers on 11 February 2016.

Data Requests

2.23 We disclosed to the Inquiry a list of all of the Data Requests made to the CoCH for the purposes of the 2016 inspection found following our searches of the CRM and Y Drive on 15 July 2024. On the same date we also disclosed the "Inspection Evidence request log" recovered from the Y Drive. This records all the evidence logged as part of the inspection process, including Data Requests sent and received.

Provider Information Returns

2.24 We have provided the Inquiry with complete copies of all the likely relevant Provider Information Returns ("PIRs") relating to each core service. These are contained within the inspection folder and evidenced in the "Inspection Evidence request log", which was disclosed to the Inquiry on 15 July 2024. (I discuss the Provider Information Return process and Data Requests relating to the CoCH inspection further at paragraphs 4.2-4.4 below.)

2.25 There are a number of PIR related documents that have not been disclosed. These were not disclosed as they were either assessed as not likely to be relevant in line with the guidance provided to our operational colleagues, were duplicate documents, contained only blank templates, or the file had been corrupted and was unopenable. (AF/35,AF/22 [INQ0102664]) There were a total of 315 items that fell into these categories.

Index/indices to documents provided by the CoCH for the 2016 inspection

2.26 We are not aware of any index or indices having been prepared of all of the documents provided by the CoCH for the 2016 inspection. The "Inspection Evidence request log" records all the material received by the inspection team and reflects a master list of inspection evidence material. A PDF of this log was disclosed to the Inquiry on 15 July 2024. AF/36 provides the log in an Excel file format. (AF/36) Spreadsheets relating to the PIRs completed and returned to the inspection team have also been identified; "COCH Stage 1 PIR" and "COCH PIR2 Evidence Submission". (AF/37, AF/38)

Materials relating to the "Listening Event"

2.27 We have not found any notes from the Listening Event on 9 February 2016. As for other materials, our understanding is that there were posters/flyers advertising the event together with press releases give to local press and organisations. These were disclosed to the Inquiry on 15 July 2024.

Briefing meeting with Tony Chambers

2.28 In terms of a meeting with Tony Chambers in February 2016, we have found no minutes or other notes relating to it or any discussion. If this was a courtesy meeting to discuss the practicalities of the inspection process then this might explain why no material was generated or has been retained.

2.28 The Inquiry has also asked CQC to confirm whether any parts of Mr Trenholm's evidence are inaccurate in light of subsequent disclosure investigations. In particular:

- Paragraph 16 of Mr Trenholm's second statement [INQ0017809] setting out the PIRs returned by the CoCH in relation to Children and Young People's services.
- Paragraphs 18 and 19 of Mr Trenholm's second statement [INQ0017809] as to the various sources of feedback obtained in advance of the inspection.
- Paragraph 20 of Mr Trenholm's second statement [INQ0017809] referring to data provided by the CoCH in relation to Children and Young People's services.

2.29 CQC initially exhibited the PIRs, Data Requests and feedback that were most relevant to the specific questions posed in the Rule 9 requests relating to Ian Trenholm's second statement. Subsequent disclosure searches and reviews identified further PIRs and data requests spanning the whole Trust and we disclosed that material to the Inquiry on 15 July 2024. To the best of our knowledge the CQC believes that at this time it has disclosed all of the available records relating to PIRs, data and various sources of feedback within these three categories. We also believe that paragraphs 16,18-19 and 20 of Ian Trenholm's second statement are accurate.

2.30 Having carefully reviewed the position and following comments from the Inspection Chair (Liz Childs) we should clarify that the performance of her role in the CoCH inspection did not involve approving the draft or final report (as suggested by paragraph 26 of Ian Trenholm's second statement). The Deputy Chief Inspector chaired the National Quality Assurance Group which had overall responsibility for moderation and approval of the inspection rating and report (see paragraph 146 of Ian Trenholm's second statement).

2.31 As part of Ian Trenholm's second statement we listed at paragraphs 26 to 51 a list of colleagues who attended the 2016 inspection, along with their roles on the inspection visit. This information was gathered via our HR records, and pre-existing descriptions

of the various inspection roles. Since this statement, we have undertaken a further quality assurance check with those inspection team members to ensure the accuracy of the information provided. As a result of this activity, I wish to clarify the following roles:

- Cara Taylor attended the planning day only and did not have interactions with the clinical staff or attend any of the clinical areas.

- Michelle Haller was registered with the NMC on parts 1 and 5 of the register at the tine of the inspection. She reported directly to the Inspection Manager and was responsible for the Obstetrics/ Maternity and Gynaecology core services inspection, including escalation of any immediate risks identified during the on-site inspection, and drafting the inspection report.

- Peter Quick also holds the following qualifications: Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN), Registered Mental Nurse (RMN) and Dip HE (Specialised nursing, Accident & Emergency).

- Laurence Solomon holds the following qualifications: MA, MB ChB, MD, FRCP.

- Helen Cain was a qualified general nurse, paediatric nurse and health visitor and spent the 20 years prior to joining the CQC in a health visitor role.

3. Concerns raised before, during and after inspection of Countess of Chester Hospital in February 2016

3.1 The Inquiry has asked CQC to state the information it had in its possession, or which was otherwise communicated to it and/or the inspectors as to:
(a) Increased neonatal mortality at the hospital.
(b) Any concern about increased neonatal mortality at the hospital.
(c) Concerns in relation to Letby (whether identified specifically by name or not).

Before inspection

3.2 All CQC inspectors of NHS Trusts were provided with a data pack by our Intelligence Unit before any inspection visit. Typically this was supplied 2-4 weeks prior to an inspection.

3.3 In relation to CoCH's inspection in 2016 the final version of the data pack was supplied to the relevant inspectors and the Trust on 2 February 2016. (Draft data packs were previously shared with the Trust on 21 January 2016. This was to allow the opportunity for them to carry out their own factual accuracy checks and respond to CQC by 27 January 2016.) The intelligence data packs relating to the CoCH inspection were disclosed to the Inquiry on 15 July 2024.

3.4 In 2016 data packs were based on an 'exception reporting' approach, so included data and metrics showing either above average or below average data of note, comparative analysis of a trust's performance and other contextual data relating to the service. It included available metrics on mortality and concerning statistical 'outliers', where applicable.

3.5 The pre-inspection data pack for the Trust included reports of any active mortality 'outlier' alerts, correct as of 7 December 2015. This disclosed a single outlier for puerperal sepsis and other puerperal infections. It included no data showing increased neonatal mortality risks at CoCH. Data packs were disclosed to the Inquiry on 15 July as part of the disclosure for 2015 2016 Q4 Intelligence Pack Final folder.

3.6 To be clear, prior to the inspection in February 2016 CQC had no information in its possession, or which was otherwise communicated to it, as to:
(a) Increased neonatal mortality at the hospital.
(b) Any concern about increased neonatal mortality at the hospital.
(c) Concerns in relation to Letby (whether identified specifically by name or not).

<u>During inspection</u>

3.7 On the first day of every inspection an Analyst Team Leader would present the data to the inspection team offering them an opportunity to ask any questions. This was true for the inspection of CoCH.

3.8 Our Analyst Team also remained on site throughout the inspection to respond to any intelligence or process queries that arose.

3.9 Analysis of Healthcare Episode Statistics ("HES") by CQC during the course of the inspection did not flag the Trust as an outlier for higher-than-expected rates of perinatal or late neonatal mortality for the period April 2015 to December 2016.

3.10 I should explain that HES provides data to monitor a range of maternity indicators which include perinatal mortality and late neonatal mortality rates. Statistical 'outliers' are identified using Cumulative Sum (CUSUM) methodology. (CUSUM involves analysis of the cumulative sum of differences between data points in order to identify trends in data over time.)

3.11 For the period April 2015 to December 2016, CoCH did not register as an outlier for higher-than-expected rates of perinatal or late neonatal mortality.

3.12 The number of perinatal deaths during 2015/16 quarters 2 and 4 (8 and 7 deaths respectively) were higher than most other quarters (<6). But to register as a statistical outlier over this period the data would have had to include at least three standard deviations from "observed" and "expected" indicator values. Applied to the data for this period the Trust was not flagged as an outlier and the data was not examined further during this time.

3.13 In summary, during the inspection of CoCH CQC, had no information in its possession, or which was otherwise communicated to it, as to:

(a) Increased neonatal mortality at the hospital. Other than that contained within the inspection data packs and HES statistics as outlined above.
(b) Any concern about increased neonatal mortality at the hospital.
(c) Concerns in relation to Letby (whether identified specifically by name or not).

<u>After inspection</u>

Increased mortality rates

3.14 Perinatal Mortality Surveillance reports from Mothers and Babies Reducing Risk through Audits and Confidential Enquiries UK ("MBRRACE-UK") for the period 2015 and 2016 were not available at the time of the inspection. These reports were published during 2017 and 2018 respectively and showed perinatal mortality rates at the Trust to be higher than average for births in 2015 and 2016 (calendar years).

3.15 MBRRACE-UK reported that extended perinatal morality rates and neonatal mortality rates at CoCH were higher than average (for comparator trusts) for births in 2015 (more than 10% higher) and 2016 (up to 10% higher). But that data was not available at the time of the inspection in 2016 or during the planning and preparation for it.

3.16 CQC's Inspection Analyst teams were first informed that the MBRRACE-UK data results had been refreshed in CQC Insight on 11 August 2017. (The information and analysis CQC Insight provides and how it is used as part of inspection, monitoring and ongoing review of hospitals is described at paragraphs 193 to 195 of Ian Trenholm's first witness statement.)

Concerns about increased neonatal mortality rates at CoCH

3.17 The first time concerns were raised with CQC about mortality and increased numbers of death in the Neonatal Unit was on 29 June 2016, as described in Ian Trenholm's second statement to this Inquiry dated 4 April 2024 (paragraph 73) [INQ0017809].

Concerns raised in relation to Letby

3.18 The first time CQC became aware of concerns of a criminal nature was on 15 May 2017, as described in Ian Trenholm's second statement to this Inquiry dated 4 April 2024 (paragraph 94) [INQ0017809].

3.19 To summarise, CQC first became aware of increased neonatal mortality rates at the hospital on 29 June 2016 (paragraph 73) [INQ0017809]. This was followed by information about a criminal investigation on 17 May 2017 (paragraph 94) [INQ0017809]. The data from MBRRACE-UK data for that period was received on 11 August 2017.

4. CQC confidence in relation to its knowledge of what documents, data and feedback were sought and provided in relation to the 2016 CoCH inspection

4.1 The Inquiry has asked whether CQC is confident that it knows:

- what documents were provided as part of the Provider Information Return process for the inspection;
- what data was requested and provided in relation to Children and Young People's services for this inspection; and
- what feedback was sought and received from third parties for this inspection.

Documents provided as part of the Provider Information Return process for the inspection

4.2 As described by Ian Trenholm in his second statement [INQ0017809] (at paragraph 16), CQC received a PIR from the Countess of Chester NHS Hospital Trust during the lead up to the planned inspection in February 2016. The purpose of the information requests (as for all inspections) was to help and inform the inspection plan and visit.

4.3 Initially, and as was routine, the PIR returned by the Trust gave basic data and general information relating to all core services (see "COCH Stage 1 PIR (071015)" and paragraph 2.25 above).

4.4 This was followed by a further, fuller PIR supplying more detailed information and additional returns in response to specific data requests made by CQC and/or information, data, documentation and narrative by the Hospital relating to its core services. CQC's Inspection Team maintained a log of data requests and receipts relating to the inspection: the "Inspection Evidence Request Log". This Log and its entries – comprising the evidence base for the inspection - have been preserved and (as mentioned above at paragraph 2.23) was disclosed to the Inquiry on 15 July 2024. (To be clear, the Log and all the logged material relates to all those services subject to inspection not just those corresponding to Children and Young People and/or maternity services. This includes all neonatal data and documentation received by CQC during the inspection process.)

Data requested and provided in relation to Children and Young People's services

4.5 We made a data request to the Trust on 15 February 2016, one of which related specifically to Paediatric Incidents. The data provided in response included information on incidents occurring in the neonatal unit, including deaths. (See paragraph 20 of Ian Trenholm's second statement [INQ0017809] and the documents referred to: **INQ0017331** INQ0017355]; [INQ0017356]; [INQ0017357]; [INQ0017358]; [INQ0017345]; [INQ0017352]; [INQ0017353]; [INQ0017354]; [INQ0017801].) Data requests relating to Children and Young People's services which were issued to the CoCH inspection were standard for any Trust in relation to which no specific concerns had been raised ahead of inspection.

Feedback sought and received from third parties for this inspection

4.6 In terms of feedback sought and received from third parties in relation to a planned inspection, potential sources would range from the provider themself, people who used the service, health professionals and their professional bodies; other regulators (such as the Nursing and Midwifery Council and the General Medical Council); and bodies such as NHS England and Health Education England. The mode of engagement, and whether it would happen at all, would vary from inspection to inspection and depend on the unique circumstances of each setting.

4.7 As already mentioned the Trust itself was engaged both during the lead up and during the CoCH inspection: through provision of information, documentation and data and interaction with the inspection team during the course of the inspection visit itself. There were also opportunities for those who used the service to share their experience and views with CQC and for health professionals and other stakeholders to do so.

4.8 In his second statement Ian Trenholm describes (at paragraph 18) [INQ0017809] how on 16 December 2015, in advance of the 2016 inspection CQC received feedback about CoCH from the Royal College of Nursing [INQ0017429]. This included concerns raised generally about adequate staffing levels, engagement between Trust management, staff and staff representatives, and a perception that feedback from

nursing staff to managers is not acted on. However, it should be emphasised that this was not raised specifically in relation Children and Young People's services or the Neonatal Unit.

4.9 Also in his second statement Ian Trenholm states (at paragraph 17) [INQ0017809] that an engagement meeting with the Trust took place. As already mentioned, we have not found any records of what (if anything) was discussed or noted during that meeting and, as he suggests, it was most likely focused on the logistics of the inspection visit, including planning of interviews. That would be typical of a meeting of that kind. We believe that meeting with Tony Chambers took place on 11 February 2016 (and that the email confirmation mentioned at paragraph 2.27 above related to its scheduling).

4.10 We also received feedback from the Health and Care Professionals Council (see paragraph 19, Ian Trenholm's Second Statement [INQ0017809] /IT92 [INQ0017329]).

4.11 CQC held a listening event on 9 February 2016 for people who had received care and treatment at either CoCH or Ellesmere Port Hospital (paragraph 22, Ian Trenholm's second statement [INQ0017809]). In relation to this limited records relating to publicity for the event have been found (see paragraph 2.26 above). Typically any feedback from a forum of this kind would have been shared with the lead inspector for each service and used for inspection planning and reporting purposes. It is possible that any contemporaneous paper notes relating to these discussions and feedback, if they ever existed, may have been subject to routine destruction within six months in accordance with CQC's retention and destruction policy at the time or otherwise destroyed.

4.12 As part of the inspection process for this hospital the inspection team spoke with patients and carers, conducted observations and inspected records. Staff members were interviewed across a range of disciplines and grades, including those within Children and Young People's service and the neonatal unit (see paragraphs 63-66 of Ian Trenholm's Second Statement [INQ0017809]; IT/113 [INQ0017322]; IT103/[INQ0017339]).

4.13 On 17 February 2016 the inspection team held a focus group attended by a number of consultants working at the Trust, including those working in the neonatal unit (paragraph 67-68 of Ian Trenholm's Second Statement [INQ0017809]; (IT/114

[INQ0017287]; IT/115 [INQ0017289; IT/116 [INQ0017292]; IT/117 [INQ0017324]; IT/118 [INQ0017398]; IT/119 [INQ0017427]; IT/120 [INQ0017431]). Contemporaneous notes from this focus group have not been found but images of a member of the inspection team's notes have (see paragraph 58; IT/121 [INQ0017319].

4.14 The same afternoon a meeting was held between the inspection team and the Medical Director of the Trust, Ian Harvey and a record of this discussion exists (paragraph 69 of Ian Trenholm's Second Statement [INQ0017809]; IT/121 [INQ0017319]).

4.15 The various sources of feedback summarised above (at paragraphs 4.7- 4.14 above) are the full extent of those which informed the 2016 inspection of CoCH.

4.16 Following the extensive searches and reviews undertaken by colleagues across the organisation for materials of relevance, I can confirm;

4.17 We hold a log of all data requests made to CoCH as part of the 2016 inspection. This is exhibited as AF/36. We believe we have now located and disclosed all relevant data requests as of 16 July 2024.

4.18 We hold a list of PIR's requested and received back to us from CoCH as part of the 2016 inspection in relation to Children and Young People's services. This is exhibited as AF/37 and AF/38. We believe we have now located and disclosed all relevant PIR's as of 16 July 2024, with the exception of those documents outlined at paragraph 2.25.

4.19 We do not have a record of the feedback sought and received back as part of the 2016 inspection to confirm with confidence that all feedback has been shared with the Inquiry. However, our teams have now undertaken full searches of all areas where these records are likely to be kept. Any feedback located as a result of those searches have been disclosed to the Inquiry via Ian Trenholm's second statement [INQ0017809].

4.20 We acknowledge there remains items relating to the 2016 inspection that we believe to have existed but have been unable to locate at the time of this statement. This includes the Consultant's focus group of February 2016. As a result of this, we

cannot say confidently that all relevant materials have now been disclosed. We wish to emphasise that colleagues across the organisation have manually reviewed all documents and areas where we would reasonably believe those records to be held and will continue to explore options in relation to this. However, as I noted in my first statement at paragraph 5.4, there remains a possibility, because of human factors such as documents not being stored in CRM or the Y Drive as expected, that these documents may no longer be in CQC's possession.

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.

Name: Ann Ford

Signed: Personal Data

Dated: 8 August 2024