Witness Name: Kirstin Hannaford
Statement No.: 1
Exhibits: N/A
Dated: 30 October 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF KIRSTIN HANNAFORD

I, Kirstin Hannaford, will say as follows: -

Background

1. My name is Kirstin Hannaford. My current role is Senior Media Adviser with the Care Quality Commission Engagement directorate. I have held my current role since January 2016.

Emails relating to Ann Ford's Media Statement following the Lucy Letby trial verdict

2. I am providing this statement to the Inquiry to provide additional contextual information and clarification relating to a document CQC has previously disclosed to the Inquiry reference – *INQ0105344*.

3. *INQ0105344* contains an email trail consisting of twenty-six emails between 3 and 27 July 2023. These are mostly internal to CQC, but begin with correspondence received from a reporter from 'The i' newspaper dated 3 July 2023 15:53 PM asking a number of questions about CQC's oversight of the Trust for use on a story to publish on conclusion of the ongoing Lucy Letby trial. In the subsequent email trail there is a discussion between me, Ann Ford, and colleagues from CQC media and operational teams regarding two pieces of drafted text.

4. As the trial of Lucy Letby came towards its conclusion CQC were aware that it would be important to provide a public response to the verdict, and be ready to respond to questions from the media as the regulator of health and social care services in England. The first piece of text was a draft media briefing and Q&A document, the second was some suggested wording that could help form the basis of a reactive statement responding to a potential guilty verdict. This statement was attributed to Ann.

5. The draft reactive statement was included in my email dated 6 July 2023 09:56 AM to operational colleagues to seek their feedback on the content and to confirm accuracy so that any necessary amendments could be made. This early draft included the text:

   "…*The team identified some concerns about staffing levels and skill mix on the neonatal unit and paediatric wards and made clear to the trust that action was needed to ensure sufficient numbers of staff - including those trained in advanced paediatric life support. Inspectors also received some concerns from hospital staff about an increase in the number of new born baby deaths and followed up directly with trust management*…"

6. In my later email dated 7 July 14:42 PM and also included in the chain, I included an updated draft of the reactive statement, asking for further feedback and amendments as needed. This version incorporated a number of amendments which had been made to the initial version in the intervening period, including to the above quoted section to the effect that:

   "…*The team identified some concerns about staffing levels and skill mix on the neonatal unit and paediatric wards and made clear to the trust that action was needed to ensure sufficient numbers of staff – including those trained in advanced paediatric life support. Inspectors also received some concerns from hospital staff about a lack of support from management when they tried to speak up which we highlighted directly to senior trust staff as an issue that they needed to address.*

   In July 2016 as part of our regular engagement with the trust, we were alerted to some concerns that an internal trust audit had revealed regarding an apparent increase in the number of new born baby deaths. The trust went on to suspend the provision of neonatal intensive care at the hospital, and commissioned an external review by the Royal College of Paediatrics and Child Health (RCPCH) to look at neonatal mortality in more detail…"

7. The above amendments were made in response to further clarifications received from the former CQC Relationship Owner of the Countess of Chester Trust, Julie Hughes, who had attended CQC's 2016 inspection.

8. I spoke to Julie on 7 July 2023 to confirm some of the details to be included in the statement. Julie provided clarification that the concerns raised by hospital staff related to "*a lack of support from management when [staff] tried to speak up*" rather than concerns about "*an increase in the number of new born baby deaths".* This change was highlighted in yellow in the revised version of the draft text included in the above referenced 7 July email.

9. The reference to concerns about deaths was originally included in the initial suggested draft text in error. It had been based on a misunderstanding following an earlier conversation with Ann Ford who had shared her vague recollection of the feedback received regarding the Trust in 2016, with the caveat that this was a vague recollection and would need to be confirmed by Julie as the Relationship Owner. In conversation with Julie she further clarified that we "*were alerted to some concerns that an internal trust audit had revealed regarding an apparent increase in the number of new born baby deaths*" in July 2016, rather than during the February 2016 inspection itself.

10. The revised text reflecting the correct sequence of events remained in its amended form through the remainder of the email chain and formed part of CQC's final reactive statement.

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: _____Kirstin Hannaford_____

Dated: _____30th October 2024_____