Witness Name: Chris Dzikiti
Statement No.: 2
Exhibits: CD2/01
Dated: 5 February 2025

THIRLWALL INQUIRY

WITNESS STATEMENT OF CHRIS DZIKITI

I, Chris Dzikiti, will say as follows: -

1. I am employed by the Care Quality Commission (CQC) as Interim Chief Inspector of Healthcare, a post I started in May 2024. Prior to this I was CQC's Director of Mental Health, joining CQC in October 2022.

2. I have a background in Health Care, having qualified as a registered mental health nurse in 2002. Between 2002 and 2013 I worked and managed mental health services in London followed by working for a commissioning team at NHS England. In 2017 I joined an Integrated Care System in London leading on mental health transformation and returned to NHS England in 2019 as Deputy Director of national retention programme. Between 2017 and 2021 I also worked as a global healthcare consultant for Health Education England in India.

3. This statement is provided in response in response to the request from the Thirlwall Inquiry (the Inquiry) dated 22 January 2025, made under Rule 9 of the Inquiry Rules 2006.

Provision of Information to the Information Commissioner's Office (ICO)

4. In Ann Ford's evidence to the Inquiry on 15 November 2024, Counsel to the Inquiry asked whether there should be "*careful and thoughtful discussion about whether or not the Information Commissioner's office should be notified*" about the loss of records by CQC relating to the 2016 Inspection of the Countess of Chester Hospital.

5. I have been asked by the Inquiry to provide further information on CQC's engagement with the ICO.

6. On 21 November 2024, CQC's Information Security Team were asked by CQC's Data Protection Officer to look into whether a specific ICO reportable data breach had been established in light of the missing CQC records.

7. The information security team completed their review using a self assessment tool provided by the ICO. They took the view that a notifiable breach was unlikely. The Data Protection Officer asked for more information about the likelihood of: (i) the missing records containing personal data and (ii) if they were likely to contain personal data, whether its loss would have presented a risk to data subjects. Based on the information provided, the Data Protection Officer agreed there was no ICO reportable data breach but advised that it would be prudent to engage with the ICO in the circumstances.

8. On 9 December 2024, a senior information access officer in CQC emailed the ICO requesting advice and guidance. The ICO provided the following advice:

> *The key element here is that if there's no evidence of personal data being involved then there wouldn't be anything to report at this time. Without any such evidence it's not possible, as you say, to consider the other elements in relation to what may have happened to the data or any risks to the rights and freedoms of data subjects.*
> *However it's important you keen* [sic] *an open mind, and should any further information come to light which suggest that personal data was involved, you should revisit this assessment (using the self-assessment tool should help again here).*

9. The full communication trail with the ICO, CQC's information security team and CQC's Data Protection Officer is exhibited at CD2/01. **[INQ0108864]**

10. CQC will, in accordance with the advice provided by the ICO, revisit this matter should information come to light that personal data was involved in the missing documentation.

Time lags in data sources available to CQC

11. I have been asked by the Inquiry to provide further information regarding the time length of the data lags in the data sources available to CQC.

12. Lisa Annaly, CQC's Deputy Director of Analytical content provided a statement to the Inquiry dated 18 December 2024 that outlined the various sources of data available to

CQC in 2016 and currently. What is set out below has been confirmed by Ms Annaly in the course of preparing this statement.

Hospital Episode Statistics (HES) data

13. Hospital Episode Statistics (HES) data was used by CQC in 2016 and continues to be used. As Lisa Annaly explains at paragraph 2.1.6.1 of her statement, HES "*is a dataset about admissions, outpatient appointments and historical accident and emergency attendances at NHS hospitals in England*". CQC has arranged access to the HES dataset through a data sharing arrangement with NHS England (previously arranged with the Health and Social Care Information Centre/ NHS Digital (up until February 2023)).

14. There is a lag between the events being recorded and the data being available to CQC for analysis. On average this lag is typically between 3 and 6 months. This lag can be explained by a series of data cleaning processes to the central dataset before it is available to organisations like CQC. In addition, CQC has to undertake a number of data processing activities to prepare the data for analysis, once it has access to the dataset. There have been periods where this lag has been longer: for example, as set out in Lisa Annaly's statement (paragraph 2.7.1) several challenges led to CQC not being able to run analysis from HES from May 2022 to June 2023. These issues have now been resolved.

Data lags in 2016

15. In 2016, we used HES as our source data for the outliers programme outlined in Lisa Annaly's statement (section 2.4). Looking at the year 2016, the average time between the data being recorded (e.g. a spell in hospital being recorded as discharged) and the data being ready for analysis by the CQC team was 4 months.

16. Lisa Annaly's statement also refers to data received from the MBRRACE-UK Programme, which focusses on an earlier period of mortality for their analysis (typically for two years prior to the year of publication of results). Analytical results from MBBRACE-UK's programme relating to 2015-2016 were available in 2017. This is explained in more detail at paragraph 4.2.1.1 of Lisa Annaly's witness statement.

Patient safety reporting systems (NRLS/STEIS and LFPSE)

National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS)

17. Data received from NHS England's National Reporting and Learning System ("NRLS") and the Strategic Executive Information System ("STEIS") in 2016 came to CQC via a weekly data feed of reported incidents via NHSE. In her statement to the Inquiry dated 20 December 2024, Lyn Andrews, a Senior Analyst at CQC, explains (paragraph 35a) that "*it typically took a few days for the information to be manually transferred from the Excel csv files received from NHSE to CQC's internal system*".

18. Lyn also explains that the length of time between an incident occurring and this data being available to CQC via NRLS or STEIS was dependent on how long it took for an incident to be reported to NRLS or STEIS. She explains at paragraph 35c that this reporting was not always timely: "*just 66% of NRLS incidents were reported to NHSE within 0-14 days of the date of the incident across all core services*". This would have increased the time lag in the data being made available to CQC.

Learn from Patient Safety Events Service (LFPSE)

19. CQC now receives data about incidents reported to the new Learn from Patient Safety Events service (LFPSE). All NHS Trusts transitioned to LFPSE at the end of June 2024 when the previous NRLS was decommissioned. The vast majority of NHS Trusts submit safety event data through LFPSE within two weeks of the incident being reported. CQC receives a weekly copy of the data on the Wednesday following the incident having been reported to LFPSE. CQC therefore receives a reported incident between one and eight days from when it is available on LFPSE depending on the day that the incident is reported.

20. CQC does periodically undertake system maintenance, particularly to adapt our systems to changes in the LFPSE dataset. This can increase the lag time between the date of reporting to the receipt of the data by CQC. CQC tries to plan any system maintenance to minimise the impact of these changes on the availability of data.

Provision of Terms of Reference from the Royal College of Paediatric and Child Health (RCPCH) Review

21. I have been asked to clarify the extent to which CQC requested the Terms of Reference for the Royal College of Paediatric and Child Health ("RCPCH") review.

22. From the records available and from speaking to relevant members of CQC staff, CQC has not been able to identify any evidence of CQC having requested or received the Terms of Reference for the RCPCH review in advance of the publication of the report. Deborah Lindley, the Relationship Owner for Countess of Chester at the time, has confirmed she cannot recall reviewing any Terms of Reference prior to those included in the RCPCH report. Ann Ford, who was the recipient of the 30 June 2016 email from Alison Kelly (INQ0017411), has also confirmed she cannot recall receiving the Terms of Reference. The email from Alison Kelly to Ann Ford on 30 June 2016 indicates that the Terms of Reference were not yet finalised at this stage: "*RCPCH review terms of reference being developed via our Medical Director*".

23. During the preparation of this statement the following passage of paragraph 74 of Ian Trenholm's second witness statement (INQ0017809) has been brought to my attention: "*On 30 June 2016, Alison Kelly emailed CQC Head of Inspection Ann Ford, detailing the actions the Trust were taking following the concerns raised on 29 June 2016. This included... a terms of reference to support the Royal College of Paediatrics and Child Health (RCPCH) review…*". This could be read as suggesting that CQC received the Terms of Reference alongside this email. However, having carried out further research, including discussion with Ann Ford, CQC are now confident that we did not receive the Terms of Reference on 30 June 2016.

24. The records we have do show that CQC was actively involved in the monitoring of the Countess of Chester Hospital during this period. This involvement is set out in detail at paragraphs 75-84 of Ian Trenholm's second witness statement (INQ0017809). In particular, the RCPCH review was discussed at an engagement meeting on 24 August 2016 (INQ0017296) ("*external review planned for next week*"), and a "*copy of [the] report*" was "*requested once available*". The review was again discussed at a further engagement meeting on 22 December 2016 (INQ0017298).

25. When asked about this in oral evidence, I agreed that CQC ought to have requested a copy of the Terms of Reference of the RCPCH review and this remains my view. However, I think it is important to be clear that the Terms of Reference for the RCPCH review would

have been a matter from the Trust and the RCPCH to agree between themselves. As Ian Trenholm explains in his second witness statement (INQ0017809, paragraph 84), CQC's "*non-involvement* [with the RCPCH report] *was usual in these circumstances as we did not commission the report and would not have had access to it until it was completed*".

26. As explained at paragraphs 27-32 below, CQC were not aware of concerns about deliberate harm at COCH until much later. Given the information available to CQC at the time I think it was appropriate for the Terms of Reference to have been agreed between the Trust and the RCPCH without CQC's involvement. As noted above, the records demonstrate that CQC's ongoing monitoring of the Countess of Chester Hospital included discussion of the Trust's response to the increase in neonatal mortality, and its commissioning of the RCPCH review.

Clarification on CQC's knowledge of concerns of 'deliberate harm'

27. I have been asked to provide the Inquiry with any further details on when the CQC became aware of concerns of deliberate harm on the neonatal unit at the Countess of Chester Hospital, including any records or documentation of this issue.

28. An email sent by Lorraine Bolam, who was at that time CQC's Acting Head of Hospital Inspection, on 16 May 2017 (INQ0017303) notes that the continued concerns of the neonatologists regarding the increased neonatal mortality rate "*led to a report to the Child Death Overview Panel which requested the trust seek assurance from the police regarding any un-natural causes for the deaths*", and that "*Police have reviewed information supplied by the trust and spoken with medical staff and deemed further investigation is warranted*". However, this email is not explicit as to whether CQC was aware at this point that the involvement of the police was due to concerns about deliberate harm by an individual.

29. An internal CQC briefing, also dated 16 May 2017 (INQ0105678), goes into more detail:

"9 May 2017 we received the following update:

- *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.*
- *The police are drawing up TORs to share with the Trust and agree by next week.*

- *The Trust is forwarding details of the 13 babies and parents and the nurse to the police.*
- *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.*
- *The Police will then liaise re the investigation and analysis- they already have an SIO, analyst and Liaison Officer identified.*
- *The police have advised the Trust to discuss the nurse with the LADO (she has a child).*
- *The have me as the point of contact for NHSE and the external system.*

I sort [sic] *clarification around the nurse that was mentioned as this had not been highlighted previously. I was informed that a nurse, who was one of a few fulltime nurses on the unit, was involved in some of the cases but not all and the Police would follow this up in their invited investigation."*

30. Again, this is not explicit about whether CQC was aware that concerns about deliberate harm were being investigated. Deborah Lindley, who was the Relationship Owner for Countess of Chester at the time and was copied into the 16 May 2017 email (INQ0017303) and briefing (INQ0105678), has been asked about this for the purpose of this witness statement but is unable to recall specifically when CQC was made aware of concerns of deliberate harm.

31. However, the extract from the 16 May briefing (INQ0105678) set out at paragraph 29 does demonstrate that CQC was aware in May 2017 that there was *"an invited police investigation to investigate unexplained deaths"* and that a particular nurse was being "*followed up*" as part of that investigation. It is therefore likely that CQC was aware at this point that there were concerns about deliberate harm on the neonatal unit at the Countess of Chester Hospital.

32. The briefing also indicates that this was the first time CQC had been made aware of concerns about a particular nurse: "*I sort* [sic] *clarification around the nurse that was mentioned as this had not been highlighted previously*".

33. There is no documentary record of CQC having been made aware prior to May 2017 of concerns about deliberate harm. I understand that NHS England's evidence to the Inquiry is that NHS England was given some information regarding these concerns in a telephone call from Ian Harvey in late March 2017. The possibility that this information was

subsequently passed on from NHS England to CQC, perhaps by telephone, cannot be ruled out; however, there is no documentary evidence to suggest this took place.

Duty of Candour Prosecutions

34. During my oral evidence on 14 January 2025, the Inquiry chair asked if I could assist the Inquiry with details of the fines issued following successful prosecutions for breaches of the duty of candour.

35. If a duty of candour matter is prosecuted in court, the maximum fine a Court can issue for each individual breach charged is £2,500. There is no discretion to issue a higher penalty, however the court can issue a lower penalty taking into account an early guilty plea, mitigation or ability to pay.

36. Since 2020, CQC has prosecuted five providers for failing to meet the requirements of the duty of candour. This includes:

    a. In September 2020 Plymouth Hospitals NHS Trust was fined after admitting it failed to disclose details relating to a surgical procedure or apologise, following the death of a person. The total amount payable was £I&S comprising a fine of £I&S £I&S victim surcharge, and costs of £I&S

    b. In April 2021 Spire Healthcare Limited was fined after admitting it failed to apologise or disclose details of failures in their treatment, to four patients in a timely manner. . The total amount payable was £I&S comprising a fine of £I&S, £I&S victim surcharge, and costs of £I&S

    c. In July 2022, Premiere Care (Southern) Limited was fined after admitting it failed to inform and apologise to the appropriate person following the death of a person living in one of its care homes. The total amount payable was £I&S comprising a fine of £I&S £I&S victim surcharge and costs of £I&S

    d. In June 2023, DM Care Limited was prosecuted for breaches of Regulation 12 and 20. In relation to the duty of candour (Regulation 20) breach, it was found that the provider failed to be open and honest with a person's family following an incident in which the person had suffered harm. . The total amount payable (including costs) was £I&S

comprising a total fine across both offences of £ I&S , victim surcharge of £ I&S and costs of £ I&S I am not able to specify how much of this fine was for the specific duty of candour breach.

e. In May 2024 Claremont Care Services was prosecuted for breaches of Regulation 12 and 20. In relation to the duty of candour (Regulation 20) breach, it was found that the provider failed to inform and apologise to a person's family soon enough after the incident and the person's death. The total amount payable was £ I&S which included an £ I&S fine for Regulation 20 breach and £ I&S victim surcharge.

37. In addition to prosecutions, CQC have also issued fixed penalty notices to a further two providers for failing to comply with their duty of candour. Fixed Penalty Notices for duty of candour offences are set at £ I&S

38. CQC continue to investigate and take criminal enforcement action against registered providers / persons where breaches of the duty of candour occur. Information from CQC's national enforcement team indicate there are a further seven cases currently under investigation.

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: 5 February 2025