Tuesday, 14 January 2025

(10.00 am)

(Proceedings delayed)

(10.03 am)

LADY JUSTICE THIRLWALL: Mr Bershadski.

Evidence read by MR BERSHADSKI

MR BERSHADSKI: Yes, good morning, my Lady.

My Lady, the Inquiry has received a number of witness statements which contain evidence relating to whistleblowing and the Freedom to Speak Up system in the NHS and related issues.

The following is a summary of some of that evidence:

Dr Jayne Chidgey-Clark is the current National Guardian. This is an appointment by the CQC. The role was created as a result of recommendations made by Sir Robert Francis KC's Freedom to Speak Up Review.

Dr Chidgey-Clarke has provided the Inquiry with a statement dated 21 February 2024. She is unfortunately not able to give evidence today. The Inquiry will be asking Dr Chidgey-Clarke to produce a further short statement.

Dr Chidgey-Clarke explains that the National Guardian's Office is an independent office hosted by the Care Quality Commission. It leads, trains

supports and reviews a network of Freedom to Speak Up Guardians, hereinafter referred to simply as "guardians", throughout England.

It does not investigate individual whistleblowing cases but may signpost individuals to alternative sources of advice and support. She explains that there is a national Freedom to Speak Up policy which sets minimum standards across the NHS and that NHS Trusts and providers of NHS services are required under the NHS Standard Contract and other rules to appoint a guardian and follow the NGO's guidance.

The NGO has developed documents including Freedom to Speak Up guidance, tools to be used by boards, e-learning modules to be used by those working in healthcare and a universal job description for the guardian role.

Dr Chidgey-Clarke explains that the role of a guardian is to ensure that all staff have the capability to speak up and to engage the board in all Freedom to Speak Up matters. The guardian's role is complementary to traditional routes of speaking up, such as through line management, patient safety reporting and HR processes.

The National Guardian's Office itself does not employ guardians. Dr Chidgey-Clarke notes that the

implementation of the role does not always accord with the NGO's guidance and guardians are not always sufficiently well resourced.

The NGO provides mandatory training to guardians and offers support calls.

The NGO maintains a directory of guardians: as of December 2023, there were 1,165 guardians appointed and since 2017 they have managed more than 100,000 cases.

In 2022 to 2023, nearly a third of cases involved alleged inappropriate behaviours; 21.7% involved bullying and harassment; over 25% involved worker safety and well-being; and 19% related to patient safety and quality.

The NGO does not have authority to ensure compliance but it works in partnership with the CQC and NHS England to support this. According to the NGO's 2023 survey of guardians, 86% of respondents felt supported by their Chief Executive and 77% by senior management. However, only 66% felt supported by managers.

The proportion of respondents who felt Speak Up was taken seriously in their organisation 78%, was down 6 percentage points compared to results in 2020. Almost two-thirds of respondents, 66%, identified the belief that "nothing will be done" was a barrier to workers in

their organisation speaking up.

Dr Chidgey-Clarke considers implementation of recommendations of reviews such as Kark and Messenger to be vital to support improvement in Speak Up culture.

She notes that the NGO's annual surveys demonstrate that a significant number of guardians consider protected characteristics, such as ethnicity, act as barriers to speaking up.

The Inquiry has received a statement from Bernadette Rochford, she is former whistleblower, commissioner, manager and nurse and is currently a principal Freedom to Speak Up Guardian at Essex Partnership University NHS Foundation Trust.

Ms Rochford notes a number of barriers to effective Freedom to Speak Up processes, including the following: the remit of the guardian role is now very wide. It encompasses "Anything that gets in the way of someone coming to work and doing their job".

Accordingly, the time and resources of the job have widened and there is a need to introduce prioritisation to the work.

The implementation of the guardian role in terms of pay banding and the number of guardians is variable. There is insufficient training within the NHS regarding how to speak up. Managers are often so overloaded that

they struggle to respond appropriately to concerns, ostracisation by peers can act as a barrier and the organisational complexity of the NHS.

She notes that some guardians feel they have suffered "detriment for just doing their role", and "some have resigned because of this".

She makes a number of suggestions. Guardians should be fully supported, receive regular supervision and be linked to a region network and buddy system. The question of whether guardians should be employed directly by the organisations in which they work should be reviewed. Organisations should have greater guidance on what local Freedom to Speak Up metrics should be reported and how casework should be documented and retained. Management lines should be clearly communicated so that members of staff know who to escalate concerns to.

It should be made clear to staff that they should "report suspicions rather than wait for evidence". There should be one organisation which has responsibility for enforcing Speak Up concerns and an independent review of whistleblowing and the role of Employment Tribunals in the NHS should be carried out.

Professor Narinder Kapur is currently a visiting professor of neuropsychology at

University College London and an honorary Consultant neuropsychologist at Imperial College NHS Trust.

He raised concerns while a Consultant at Addenbrooke's Hospital Cambridge and is the Human Factors Advisor to CORESS, the confidential reporting system for surgery.

Professor Kapur considers that there are currently significant failings in how whistleblowers are treated in the NHS. He highlights the case of nurse Amin Abdullah who died in 2016 after setting himself alight following his dismissal while working at Charing Cross Hospital in London.

Professor Kapur says that since guardians are employees of the organisations in which they work, they "face a clear conflict of interest if they try to stand up to management". Accordingly, he suggests that guardians should be employed by an external body which can then ensure that any investigations or disciplinary procedures are carried out fairly.

He supports regulation of managers in the NHS and suggests training regarding whistleblowing and fairness of investigatory and disciplinary procedures. Professor Kapur also suggests a review of the role of the legal system in whistleblowing cases involving the NHS.

Nick Hulme has over 40 years experience in health and social care and over 13 years experience as a Chief Executive. He is currently the Chief Executive Officer of East Suffolk and North Essex NHS Foundation Trust. Mr Hulme notes, as do many other witnesses that key barriers to speaking up are fear, "staff may also feel that it is too risky to challenge the status quo" and futility, "nothing will happen so it is just not worth it".

He notes that leadership roles are often undertaken by clinicians with little to no formal leadership training or preparation, including as regards speaking up.

Mr Hulme observes that improving relationships amongst staff increases confidence to speak up. To this end he recommends that staff undertake apprenticeships within different departments and the use of coaching and organisational development he notes that a:

"... culture of openness and honesty in which all colleagues are able to raise concerns will not be achieved through one simple speak up message, campaign or policy. It needs to be embedded within the culture... truly listening is to hear the concern, take the relevant action and then, where appropriate, communicating about it."

His own Trust has taken measures including holding a board development session with the National Guardian, revising their Freedom to Speak Up policy, introducing training for managers, creating new posters for staff, increasing the number of Freedom to Speak Up Guardian assistance and delivering town hall events. Mr Hulme supports the introduction of professional regulation for managers with associated training and development and access to expertise and support.

Professor David Oliver is a Consultant physician in geriatrics and general internal medicine. He is a visiting professor at City University of London and is also a columnist for the British Medical Journal.

He notes that since many managers in the NHS are already registered with a clinical regulator and are therefore already professionally bound to raise and act on concerns, the regulation of managers may not be a "panacea for some the problems identified in the Letby case".

His view is that if there is to be regulation of managers then any manager found to have suppressed or ignored the concerns of a whistleblower should be barred from employment in the NHS.

He notes that whilst professionals are obligated by their regulator to raise concerns, failures to do so

rarely lead to regulatory action and whilst he welcomes the Freedom To Speak Up Guardian system he notes that whether it has been successful or not is inconclusive.

Sir Andrew Morris is a Non-Executive Director on the board of NHS England and was previously chair of NHS Improvement. He has worked in the NHS for over 45 years and has been a Chief Executive at Trust level for over 25 years.

He believes that the Freedom to Speak Up system has improved the culture in the NHS and is making a difference, although "in some organisations further improvement and refinement is required."

He notes that each Trust has a Freedom to Speak Up Non-Executive Director champion on its board. His experience is that the Chief Executive of a Trust is particularly influential in setting the tone of speaking up and that it is important that the board should send a clear signal that "no detriment will result from speaking up".

Sir Andrew makes a number of recommendations in relation to Freedom to Speak Up.

"Better communication to staff of what to do in exceptional circumstances if they have a very serious concern regarding safety and they feel that their organisation is not addressing the issue adequately."

Currently not every Freedom to Speak Up Guardian has an open invite to the board through the Freedom to Speak Up Non-Executive Director champion. More training for managers regarding speaking up and Freedom to Speak Up should be incorporated into appraisals at all levels.

Regarding the regulation of managers, he considers that the Fit and Proper Person Framework in place since August 2023 should be allowed to "bed in and then be reviewed before a final decision on whether full regulation is required."

Sir Stephen Moss has held managerial posts in the NHS at board level for over 30 years and was Director of Nursing and then Chief Executive at Queen's Medical Centre in Nottingham. In 2009 he was asked to take on the role of chairman at Mid Staffordshire NHS Foundation Trust. He was a trustees of a charity, Patient Safety Learning, between 2018 and 2024 he notes that:

"It is vital that NHS staff feel able to raise, report and discuss safety concerns and opportunities for improvement. This is not simply a principle at that applies to healthcare but is vital across all safety critical industries. When organisations have a culture that seeks to assign blame when things go wrong, harm is more likely to happen."

However, he considers that:

"There is substantial evidence that in significant parts of the NHS there remains a culture that inhibits members of staff from raising concerns about patient safety."

Sir Stephen makes a number of recommendations. Each NHS organisation board should create a culture which is seen to be:

"... welcoming and supportive of those that speak out and explicitly seeks to learn rather than punish. This culture needs to be accompanied by the organisation being committed not only to listen to staff but act on their insights."

The message needs to be reinforced to all healthcare staff as part of education systems that one of their core responsibilities is speaking out when they see poor practice or behaviours. And staff should have a "menu of options for speaking out", such as regular surgeries, run with a Freedom to Speak Up Guardian where staff can raise concerns.

The Inquiry has received a statement from Dr Henrietta Hughes. Dr Hughes has been the Patient Safety Commissioner for England since September 2022 and was previously the National Guardian for a period of five years from 2016. She explains that the Patient Safety Commissioner's role is to promote the safety of

patients and promote the views of patients of and other members the public with regard to the use of medicines and medical devices.

In that role, she has made a number of recommendations in relation to the implementation of Martha's Rule which empowers patients and their families to seek an urgent review from a critical care outreach team. She chairs the Martha's Rule Working Group meetings.

Dr Hughes notes that the patient safety landscape is complex with over 100 organisations holding some relevant responsibility and that there are many different channels that patients and their relatives and carers can turn to. She notes that complaint systems can feel formalised.

Dr Hughes says that leaders and managers are not held to account for patient safety and the patient voice in the same way as they are on finance.

Inductions training for Non-Executive Directors provided by NHS Providers does not currently include patient safety. There is no system of national learning from patient complaints.

Dr Hughes concludes by saying that a cultural shift of listening to patient and staff voices when speaking up about patient safety and care is needed throughout

the healthcare system.

Ms Georgina Halford-Hall is the Chief Executive of WhistleblowersUK. This provides a confidential reporting platform for whistleblowers. Over 50% of reports to WhistleblowersUK come from the NHS. WhistleblowersUK has been contacted by Freedom to Speak Up Guardians who have raised their own concerns after trying to represent whistleblowers and who have been undermined and targeted. Some have felt bullied and forced out of their roles.

Ms Halford-Hall also says that many whistleblowers have reported receiving little more than generic information and a "shoulder to cry on" from their Freedom to Speak Up Guardians. She therefore considers there are failures and inadequacies in the Freedom to Speak Up system.

WhistleblowersUK supports the creation of an office of the whistleblower with the statutory power to be able to intervene in whistleblowing cases, protect the public, support the whistleblower, oversee regulatory investigations into whistleblowing cases and direct the prosecution of any individual or organisation seeking to illegally punish or silence a whistleblower.

Ms Halford-Hall notes the particular problem of vexatious referrals to regulators. She is highly

critical of the Public Interest Disclosure Act and the fact that whistleblowing is dealt with primarily via Employment Tribunal proceedings.

Ann Paul is the Chief Executive of Doctors in Distress, a charity which promotes and protects the mental health of all healthcare workers and aims to prevent suicide in the medical profession.

Ms Paul notes that the risk of suicide among mental health professionals is elevated compared to the national average. Nurses in particular are four times more likely to take their own lives than people working in other professions. She notes that the key occupational factors behind this are a culture of self-sacrifice, bullying, the pressure to toughen up, staff shortages and workplace violence and abuse.

Ms Paul suggests that a more positive culture where the well-being of staff members is prioritised will lead to better retention and a happier workforce.

Dr Zaid Al-Najjar is the Medical Director at NHS Practitioner Health. This is a mental health service established in 2008. It provides mental health treatment to medical practitioners who are at increased risk of mental health conditions compared with the general population. It sees some 600 self referrals per month. 30,000 people have accessed treatment services

since 2008. Treatments provided include talking therapy, cognitive behavioural therapy and treatment for addiction.

All staff at NHS Practitioner Health undergo safeguarding training.

It is NHS Practitioner Health's view that medical errors or significant untoward incidents should be dealt with as learning events and that the blame culture in the NHS is hugely detrimental.

Peter Duffy was a whistleblower at University Hospitals of Morecambe Bay NHS Trust whilst working there as a Consultant urological surgeon in 2015. His experiences there are outside the Terms of Reference of this Inquiry. He is currently the Chair of WhistleblowersUK.

He notes a number of barriers to speaking out: fear of being ostracised by peers; the gradual normalisation of poor practice; a feeling of loyalty to one's employer; and fear of detriment. Mr Duffy notes that regulators rarely sanction professionals for not whistleblowing and safeguarding and suggests greater regulatory support for whistleblowers. He too suggests a review of the role of the legal system in whistleblowing cases.

The Inquiry has received a statement from

Mr Phillip Brear, who was a police officer from 1973 until retiring in 2005. He was then appointed the deputy head of the Gaming Board of Great Britain and in 2007 the Head of Regulation and then the Gaming Commissioner for the Government of Gibraltar.

Mr Brear currents his experience of being a governor of a NHS Foundation Trust for a period of time in 2022.

Mr Brear states that there is an ongoing dispute between him and an NHS Foundation Trust which is addressed throughout his statement. This issue is not relevant to the Terms of Reference of the Inquiry.

Mr Brear is highly critical of the conduct of board meetings within NHS Foundation Trusts. He considers that board papers are unnecessarily long and deprecates a practice he says is prevalent whereby publicised board meetings are held which are designed to overwhelm the average reader, followed by private meetings from which the public and governors are excluded.

He considers that governors are regularly prevented by Foundation Trusts from playing a meaningful role. He is highly critical of NHS Providers, which he describes as a "pressure and lobby group" for Foundation Trusts and of alleged failures by NHS England and the CQC to intervene in his case.

The Inquiry has also received a witness statement from Mr St John Brown. Mr Brown was a senior vice president at Philips Medical Systems until 2001 and was chairman of Medical Imaging Partnership, a private diagnostic imaging provider between 2016 and 2019.

He was a governor of a hospital in West Sussex between 2017 and 2023. Like Mr Brear, Mr Brown details significant problems during his tenure as a governor. He is highly critical of NHS England which he considers was "pulling the strings" behind a planned merger with another Trust. Mr Brown considers that the current Foundation Trust and Council of Governors structure is "not fit for purpose".

These issues fall outside the Terms of Reference of the Inquiry.

Dr McLean is a retired police officer. He was appointed as Chair of Bradford Teaching Hospitals NHS Foundation Trust on 1 May 2019 and held that role until he resigned on 3 October 2023.

He has provided the Inquiry with a statement in which he details his experiences whilst Chair. Dr McLean, like Mr Brear and Mr Brown, sets out the poor responses to his raising of concerns.

He says that he raised nine issues about the performance of the Chief Executive Officer who was

accountable to him. One of the issues raised concerned significantly protracted investigation relating to serious neonatal incidents.

These issues fall outside the Terms of Reference of the Inquiry. Accordingly, the decision has been taken only to publish this summary of Mr Duffy, Mr Brear, Mr Brown and Dr McLean's evidence.

My Lady, that concludes a summary of Freedom to Speak Up witness statements and I think Mr Carr is taking the next witness.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Bershadski.

Mr Carr.

MR CARR: My Lady, thank you. My Lady, if I may call Mr Chris Dzikiti, please.

LADY JUSTICE THIRLWALL: Mr Dzikiti.

MR CHRIS DZIKITI (sworn)

Questions by MR CARR

MR CARR: Do sit down.

A. Thank you.

MR CARR: If we can start, please, with your full name.

A. My name is Chris Dzikiti and, my Lady, if possible, if I can say a few words at the start?

LADY JUSTICE THIRLWALL: If you want to.

A. On behalf of CQC and myself I want to express our deepest and sincere condolences and sympathies to the Families for their loss and for the grief they have been through and what they are still going through.

Thank you, my Lady.

MR CARR: Mr Dzikiti, you are the Interim Chief Inspector of Healthcare at the Care Quality Commission, the CQC.

A. Yes, that's correct.

Q. You have prepared, haven't you, a statement dated 9 December 2024?

A. Yes, that's correct.

Q. Are the contents of that statement true to your best knowledge and belief?

A. That's correct.

Q. By way of your professional background, you explain at paragraph 2 of that statement that you have a background in healthcare?

A. Yes.

Q. You qualified as a registered mental health nurse in 2002?

A. That's correct.

Q. You've worked in and managed mental health services in London?

A. Yes.

Q. You've worked for a commissioning team at NHS England?

A. Yes.

Q. You've worked at an Integrated Care System --

A. Yes, that is correct.

Q. -- prior to the role at the CQC.

Now, in addition to your statement you refer to the two witness statements that had been provided to the Inquiry from Ian Trenholm?

A. That's correct.

Q. Statements dated 12 February 2024 and 4 April 2024.

A. Yes, that's correct.

Q. At the time of signing those statements, Mr Trenholm was the CQC's Chief Executive?

A. That's correct.

Q. But he has since stepped down from that role?

A. That's correct.

Q. You state that you have been briefed on those statements by Mr Trenholm?

A. I have -- I've looked at the statements that has been provided by Mr Trenholm but I haven't spoken to Mr Trenholm.

Q. And in your statement you say you are able to adopt the statements of Mr Trenholm?

A. That's correct.
Q. Paragraph 9 of your statement.
A. That's correct.
Q. And you are here to speak to the matters raised by Mr Trenholm?
A. That's correct.
Q. Now, by way of overview, the CQC, it's the independent regulator of healthcare in this country?
A. That's correct.
Q. And it regulates providers of healthcare such as NHS Foundation Trusts?
A. Yes.
Q. Like the Countess of Chester?
A. That's correct.
Q. And the CQC has the power to take civil or criminal enforcement action where regulatory standards are not being met?
A. That's correct.
Q. And as Mr Trenholm explains in his statement, we will be going to various parts of his statement, but the regulatory standards are those set out in the 2014 regulations?
A. That's correct.
Q. Those regulations include Regulation 12 which is concerned with providing care and treatment in a safe

way?
A. That's correct.
Q. Regulation 13 which is concerned with safeguarding service users from abuse and improper treatment?
A. That's correct.
Q. The intention of Regulation 13, protecting patients from abuse or improper treatment, that would extend, wouldn't it, to deliberate harm?
A. That's correct.
Q. And if we can look at Mr Trenholm's first statement, it's INQ0012634. My Lady, it's your tab 2.
LADY JUSTICE THIRLWALL: Thank you.
MR CARR: If we go to page 26 of that statement. It's paragraph 26, Mr Dzikiti, I am going to highlight here.
Here Mr Trenholm is describing the guidance on Regulation 13.
LADY JUSTICE THIRLWALL: That is paragraph 126.
MR CARR: Yes, 126, yes 126.
And if we look at the second sentence of paragraph 126:
"The guidance also states that where a provider becomes aware of any allegation or evidence of abuse they must take appropriate action without delay which

must include investigation and may also include referral to an appropriate body."
Now, in line with your previous answer about Regulation 13 extending to deliberate harm, that section I have just read out would also apply to allegations of deliberate harm, wouldn't it?
A. Yes, that's correct.
Q. Okay we can take the statement down for now.
More broadly, Mr Dzikiti, how was Regulation 13 assessed and regulated in the context of neonatal and paediatric care in hospitals in 2016?
A. So as, as part of the planning of the inspection, my understanding from the information I have accessed and the staff I have managed to speak to within CQC, so there would be a plan, that plan would include looking at the data which was available. That data would have come through from NHS England because NHS England are responsible for collecting data from providers in terms of STEIS, the National Reporting and Learning System also so that information would be collected by our analysts.
In 2016, our analyst will create a data pack, in that data pack that will include information, for example if there was any instances of harm or avoidable harm it would be included in that data pack which would

then be shared with inspectors or the inspection team. Also they would highlight if there were any issues to focus in, in those data packs and as part of that planning, the inspection teams would go through the data packs. Also there was an opportunity as well for inspectors, for example the lead inspector could request for information from, from the Trust which they could Provider Information Request, or PIR.
And as part of the inspection process the providers are required to submit that information to the inspection team and so using all that intelligence they would look and see if there were any, any issues in terms of safety for patients or safety for especially in that area.
During that time we are doing comprehensive assessments, which meant we were doing more core services. From my memory I think we were doing nine core services of Countess of Chester Hospital. As part of those services Children and Young People were part of those services and also maternity services were part of those services and they would look at the data to look at if there were any issues of concern prior to going to an inspection.
Q. Thank you. We are going to spend some time looking at the approach to data and what data was

available.
A. Yes.
Q. And we will get to that in a few moments, but thank you for the full answer.
Is a summary of the answers to the question as to how Regulation 13 was assessed in the context of neonatal care that it is essentially data led, so assessing Regulation 13 starts with the data?
A. Yes so data is the starting point because then it informs what key lines of enquiries the team would then focus on. So data was the starting point because it would give you, you know, the focus of which areas you should focus on and we had key lines of enquiries, or some people would call them KLOEs, which then the team would use to further discuss with the team. There was also an opportunity to observe care when you are doing inspections to see how practitioners, nurses or doctors carried themselves out in terms of delivering care.
There was also an opportunity to speak to staff and to speak to people who had used services to understand their experience of care during their admissions. So there were so many other areas to focus on to try and understand whether Regulation 13 was being complied on.
Q. The answer there focused on inspections. If

we just take a few steps back and consider the way in which the CQC regulates, inspection is one element of regulation?
A. Yes.
Q. The other is monitoring, isn't it?
A. Yes.
Q. And by monitoring, that involves the CQC having a relationship --
A. Yes.
Q. -- with a Trust and keeping their performance under review?
A. Yes, that -- that's correct.
Q. And it also involves engagement meetings where CQC Inspectors will meet with representatives from the Trust?
A. Yes.
Q. And management review meetings which are internal?
A. Internal.
Q. CQC meetings where decisions are made as to --
A. Yes.
Q. -- enforcement or any issues for investigation?
A. That's correct.
Q. And the analysis and receipt of data feeds

into both aspects?
A. It does.
Q. Both inspection and monitoring?
A. Monitoring, yes.
Q. There will be national data returns which are received by the CQC on a regular basis?
A. That's correct.
Q. And notifiable safety incidents which we will come to and you have already mentioned it, STEIS and RLS which the CQC has an ongoing access to?
A. (Nods)
Q. Now, as for inspections, how effective are they as a means of discovering failings by members of staff at a healthcare institution?
A. So like I said at the start, data is the starting point and inspections give the team of inspectors and Specialist Advisors an opportunity to go into a service, spending time observing care, observing interactions between staff and patients or service users, it also give inspection teams an opportunity to speak to the staff about their experience in terms of either working in an organisation, experience of what's going on in that service.
So, for example, when we attend a hospital you can talk to people about -- staffing levels, for example, is

a big issue and most services will express concerns around you know staffing issues.
In some services, where we have gone in and found some concerns around for example an area where there has been restrictive practice which is not about this incident we are talking about today but just giving an example of what's available in other sectors we regulate for example in mental health, if we are not clear about what has happened and we want to look at more detail because most mental health services has got CCTV camera, we can request for example to look at CCTV to see an episode of an incident that has happened.
Also then when you think about, for example, talking to people use services, their families, giving feedback of what has happened in those services.
So I believe if the question is whether inspections help to identify (a), the poor practice or any issues or areas of improvement, I believe inspections do so.
Q. If we can turn then to the Countess of Chester Hospital and specifics --
A. Yes.
Q. -- relating to that.
I want to start with the CQC's position as to its knowledge of events at the hospital and again we will go to Mr Trenholm's evidence, this time his second witness

statement. My Lady, your tab 3.

INQ0017809. If we go forward, please, to page 16, it is paragraph 73. It reads:

"We first became aware of concerns regarding deaths on the neonatal unit on 29 June 2016, the day our inspection report was published. At the CQC, Inspector Deborah Lindley received a call from Alison Kelly, Director of Nursing and Quality at Countess of Chester NHS Foundation Trust informing her the Trust had identified an increase in the number of deaths of newborn babies ... differing levels of prematurity on the neonatal unit in 2015 to 2016 and now 2016/17 compared to previous years."

There has obviously been extra disclosure that the CQC has found since Mr Trenholm's witness statements. Does paragraph 17, the section I have just read out, still represent the CQC's position as to when it became aware of this issue?

A. Yes, from my understanding, yes.

Q. And is it the case that it's not simply that this is a date that the CQC first became aware of concerns, it was the date they first became aware that there was an increase in deaths on the neonatal unit at all?

A. From my understanding, this is the date we

knew about an increase into neonatal mortality rate.

Q. And up until that date, 29 June, the monitoring conducted by the Care Quality Commission, so the meetings, the relationship, the data analysis, the inspection visit, the report writing and publication had not detected the increase in neonatal mortality, let alone concerns about it?

A. Yes, from my understanding, no.

Q. And staying in that statement, if we go forward to paragraph 94, it's page 20, please. I will be coming back to this paragraph, but it is the first sentence I want deal with now:

"Review of available records indicate that CQC first became aware of a criminal investigation on 15 May 2017 following an engagement call with the Trust."

And again, the question is: does that remain the CQC's position notwithstanding the additional documentation that has been discovered?

A. Yes, that's correct, Mr Carr.

Q. Thank you, we can take that statement down for now.

Part of the reason I asked you the questions that I just did about state of knowledge and whether Mr Trenholm's statement still represents the CQC's

position is because and as you will have seen, there have been serious shortcomings in the CQC's disclosure to this Inquiry, hasn't there?

A. Yes.

Q. You will have seen the transcript of the evidence that Ann Ford gave to this Inquiry?

A. (Nods)

Q. The position is, so far as disclosure is concerned, in light of the policy adopted by the CQC, following the directive from the IICSA Inquiry, all records relating to the 2016 inspection ought to have been retained?

A. That's correct.

Q. And they weren't, were they, there's documents that have not been found?

A. (Nods)

Q. The CQC originally provided disclosure to the Inquiry in February and April 2024, but the Inquiry had to make a further Rule 9 request after that initial disclosure which led to around 4,000 documents being provided in July 2024?

A. (Nods)

Q. Just shortly before the oral hearing started; that's correct, isn't it?

A. Yes.

Q. The explanation given was that the CQC interpreted the Inquiry's original request too narrowly.

Do you adopt on behalf of the CQC Ms Ford's evidence that the delay was -- delay in providing full disclosure was unacceptable?

A. That's correct.

Q. And that from as early as 2017, when the CQC became aware of the police investigation it would have been sensible for the CQC to turn its mind then to the preservation of documents?

A. That's correct.

Q. And it remains the case up until now that there are a significant number of documents which have not been found or provided, including notes of the pre-inspection meeting with the Countess of Chester --

A. Yes.

Q. -- in February 2016?

A. Yes, that's correct.

Q. Notes of the listening event on 9 February 2016?

A. That's correct.

Q. Notes of any of the core interviews with senior members of staff at the hospital as part of the inspection in 2016?

A. That's correct.

Q. Full notes of the Consultants' focus group meeting?
A. That's correct.
Q. And notes of the quality summit meeting in February 2016 and the quality surveillance group meeting in July 2016?
A. That's correct.
Q. Ms Ford accepted in her oral evidence that the CQC needed to have a discussion, internally have a discussion about whether or not the Information Commissioner should be formally notified of the loss of a significant quantity of records.
Are you able to update us as to whether that discussion has been held and the CQC's position?
A. Yes. So our data protection officer has reviewed those information which we are currently no longer able to find and concluded that there was no requirement to -- to refer to -- to the IOC -- ICO, sorry, the Information Commissioners Office, in terms of the missing documents.
But also managed to have a conversation with ICO to explain our position and ICO did agree that most likely because our data protection officer felt that there was no personal information which was missing in those documents or included in those documents; there was no

requirement to make an official referral to ICO which ICO agreed with.
Q. Can we turn now to the issue of data.
A. Yes.
LADY JUSTICE THIRLWALL: Sorry, Mr Carr, just before we leave that, is there a note of that somewhere?
A. Yes, we can -- I can make sure that's provided to the Inquiry if it's needed, yes, I will take that back.
LADY JUSTICE THIRLWALL: Thank you very much, just for completeness. Thank you.
A. Thank you.
MR CARR: Yes, turning to the issue of data.
A. Yes.
Q. You have already explained that it's the starting point for assessing for instance Regulation 13 --
A. Yes.
Q. -- in respect of neonates and paediatric care and it is obviously important to both effective monitoring --
A. Yes.
Q. -- inspection regulation as a whole?
A. Yes, that's correct.
Q. If we can begin the exploration of this issue

by going again to Mr Trenholm's statement, his first statement, INQ0012634. If we turn to page 37 of the statement, and this is where the section on data starts.
It's 193. I want you to look at where Mr Trenholm describes CQC Insight. He states:
"We use CQC Insight to monitor potential changes to the quality of care. CQC Insight brings together in one place the information we hold about services and analyses it to monitor services that provide a location or core service at level."
And then at paragraph 194:
"Our inspectors and assessors regularly check CQC Insight."
And what he is describing here it is an electronic system, isn't it?
A. Yes.
Q. Which analyses and explains various data sources available to the CQC?
A. That's correct.
Q. And it would follow, wouldn't it, from the fact that at the inspection in 2016 the CQC were unaware of increased mortality at the Countess of Chester, CQC Insight had not identified that increased mortality?
A. Yes, that's -- that's correct. And my understanding being the Insight report in 2016, some of

the information there, there was a data lag in some of the information. So for example if you look at some of the information we use there will always be a three or six months data lag sometimes into the information.
Q. Yes, I have looked through both of Mr Trenholm's statements and I know there are some data statements we are going to go to in a few moments --
A. Yes.
Q. -- to try to understand the extent of the data lag.
What Mr Trenholm explains in his second statement is, for instance, the MBRRACE data for 2015, 2016 didn't come through until -- wasn't available to the CQC until November 2017?
A. Yes, a year later, that's correct.
Q. So on MBRRACE there is a significant lag?
A. Yes.
Q. And it's about two years, isn't it?
A. Yes.
Q. So MBRRACE is not going to provide, as it were, up-to-date data?
A. No, it doesn't provide real monitoring like on a regular basis or current real monitoring data you need.
Q. Thank you, we can take that statement down.

Another source of data and analysis is the Hospital Episodes Statistics, HES?

A. Yes.

Q. Now, Ann Ford gave oral evidence on this topic, it was also covered in her witness statements, her second and third witness statements, but there was a degree of confusion between the two statements.

In her oral evidence the position reached was that HES data was not in real-time either. There was also a lag on HES data?

A. Yes, that's -- that's correct. That's my understanding.

Q. More recently, the CQC has provided two statements dealing with data and if we can look at the statement from Lisa Annaly first, please, it is INQ0108742. My Lady, it is your tab 5. This is a statement dated 18 December 2024.

And Ms Annaly, she is a Deputy Director of Analytical Content for the CQC.

A. That's correct.

Q. And she sets out in this statement a number of different data sources available to the CQC. If we turn to page 3 of her statement, please, at the bottom of the page, paragraph 2.1.4.1, she describes the outliers programme that the CQC ran between 2009 and 2020.

It appears to have stopped because of Covid.

A. Yes, can I just --

Q. Yes.

A. -- read that section if that's okay?

Q. Yes.

(Pause)

A. Thank you, Mr Carr.

Q. Yes, the question that I have for you about the outliers programme is whether you could help us to understand the time lag, if any, on the outliers programme, so what period would the outliers programme cover at any one time?

A. So, so my -- my understanding is the outliers programme used different sources of data, so it didn't use just one source of data. So it used for example the hospital, hospital episode statistics data, it also used other sort of published data from any reviews around mortality data and all those data sources, they were different there were different lags to when those statistics were provided to CQC.

I can't clearly cover each part of the data sources, how long the data lag was but my understanding was there was never a data source which didn't have a lag, but I am not able to give you exactly in terms of how long the lag was on each data source but happy to --

to bring that at a later stage if that's helpful to the Inquiry.

Q. Ms Annaly goes on to deal with the use of Hospital Episodes Statistics, HES.

If we look further down on page 4, paragraph 2.1.6.1, she describes it as, second line of the paragraph:

"A key data source for the analysis of mortality for services provided in NHS hospitals."

A. Yes.

Q. But then if we go forward to page 13 of her statement, at the bottom of that page into the next page, paragraphs 3.6 and 3.7, she makes a similar point to the one I think you make where she says:

"I would not myself describe the tools that CQC use as typically employing data available to CQC at the point of data collection.

"Although CQC has processes in place to bring in new data and keep data sources up to date, there is often a lag between the point of data collection and its availability to CQC for analysis so I would not characterise our tools as operating in real-time."

Then the next paragraph, 3.7:

"As such I am unable to identify a CQC prospective mortality monitoring tool of the sort Sir David defines."

And gives us an example of real-time monitoring systems.

She is referring in paragraph 3.7 to the statement to the Inquiry from Professor Spiegelhalter, isn't she?

A. Yes.

Q. He states that the CQC had a prospective mortality monitoring tool that he helped to set up. But is it the CQC's position that there was no real-time monitoring in 2016?

A. No, there was never a real-time monitoring of data in 2016.

LADY JUSTICE THIRLWALL: You say there was never one?

A. No. Yes, we didn't have it.

MR CARR: Does that remain the case today?

A. Yes, that, that remains the case.

Q. And are you able to help us with what the time lag on data is currently?

A. So majority of the patient safety data we use, it, it comes through NHS England, which is through STEIS and AOS which is now being replaced by Learn from Patient Safety Events. Because the data is submitted by providers to NHS England and then NHS England has to do its own processes of managing the data before it's then shared with us on a weekly basis. So we get a count on

a weekly basis, that's my understanding. But, so you are looking at possibility from my understanding three to six months' lag but some information may come to us quicker in the sense of depending when it has been submitted by the provider to NHS England and how long NHS England take to process the data and then when it comes to us but at least because we are getting it on a weekly basis that might improve the data lag.

So my understand is it varies depending on when the information is being submitted by the provider to NHS England.

We -- we don't have a means in terms of getting the same data that goes to NHS England because the understanding is trying to make sure there is not too much data requests being asked of providers to be sent to us as well to be sent to NHS England. That is why STEIS and Learning from Patient Safety Incidents data goes via NHS England.

LADY JUSTICE THIRLWALL: So what is the lag within NHS England?

A. It depends. Normally it's a few days they need to process the data before it comes to us.

LADY JUSTICE THIRLWALL: Right. So the three to six months lag derives from what? A failure of the hospitals to send the information to NHS England?

A. It depends on how long it has taken them to send that information to NHS England --

LADY JUSTICE THIRLWALL: I'm sorry to cut across you, but how soon, what are they required to do? What is required of the hospital? How soon after an incident are they expected to report it?

A. Our expectation from my understanding from talking to analysts is as soon as there has been an incident they should be able to update or report that incident to NHS England and my understanding being that actually if anything more comes into light they are also able to update those records they have submitted to STEIS for example.

LADY JUSTICE THIRLWALL: So what's the explanation for the three to six month lag, as far as you know?

A. This is my understanding, and I might have to get more information from the analysts to submit to the Inquiry, but my understanding is the whole time between submission to NHS England, the process in NHS England then to be submitted to us, that may take that time.

But in some --

LADY JUSTICE THIRLWALL: Sorry, I think I misunderstood you again.

A. Yes.

LADY JUSTICE THIRLWALL: I thought you said that it

just takes a few days for NHS England to sort it out.

A. For some of the data, yes, for some of the data, my understanding being there is no standard approach in terms of how long it takes for each data to be submitted. So the lag it's, it's a variation between different organisational data which has been submitted.

So an example is some organisations from my understanding from our analysts is some data might come to us as quickly as less than a month. But some might take three to six months but more --

LADY JUSTICE THIRLWALL: So the source of your information is the people in your organisation. So you have asked them?

A. Yes.

LADY JUSTICE THIRLWALL: But it sounds as though the delay, if there is one, which I am assuming there is --

A. Yes.

LADY JUSTICE THIRLWALL: -- occurs either at NHS England or before it gets to NHS England.

A. That would be my understanding.

LADY JUSTICE THIRLWALL: But somebody must know the answer to those questions?

A. Yes, I can -- I can take that back, my Lady, if that's okay to get the specifics.

LADY JUSTICE THIRLWALL: Well, I am just wondering what the point of that would be because the people in your organisation have told you what they think.

A. Yes.

LADY JUSTICE THIRLWALL: What we want to know is what actually is the answer, which presumably NHS England can help about?

A. Yes.

LADY JUSTICE THIRLWALL: So that might be where we need to direct the questions.

A. Yes.

LADY JUSTICE THIRLWALL: Have I understood that correctly?

A. Yes, that's correct.

LADY JUSTICE THIRLWALL: All right. Well, we will do that, thank you.

Sorry, Mr Carr.

MR CARR: Thank you. It would be beneficial, wouldn't it, mainly to inspections and to monitoring, to have information as soon as possible, to have as close to real-time data as possible?

A. Yes, yes that would be really helpful, yes.

Q. In respect of the 2016 inspection, the position of the inspection team considering Child and Young People's services is that they were unaware of the

increase in neonatal mortality and it was not discussed at the inspection. And Helen Cain's evidence, she was the CQC Inspector leading that team, is that she was also unaware of neonatal mortality and did not know how many deaths would be usual for the neonatal unit.

Now, does CQC consider that that is information that inspectors ought to be armed with on an inspection?

A. Yes, if -- if that information was available, yes, I would expect that that information would serve a purpose and be helpful in informing our key lines of enquiries if it had been made available.

LADY JUSTICE THIRLWALL: So just to unpack that answer a little bit.

A. Yes.

LADY JUSTICE THIRLWALL: Making it available, I understand that.

A. Yes.

LADY JUSTICE THIRLWALL: You say if that information were available. But are there any circumstances in which the information wouldn't be available to the hospital about the number of babies who had died on their neonatal unit?

A. Yes, so my understanding being, you know, that information you would expect it to be available to the hospital.

LADY JUSTICE THIRLWALL: It is difficult to see how it wouldn't be.

A. Yes, it would be, it would be available to the hospital.

LADY JUSTICE THIRLWALL: Yes.

A. So what I was trying to say is then if it had been shared with us.

LADY JUSTICE THIRLWALL: No, I understand that part --

A. Yes.

LADY JUSTICE THIRLWALL: Yes, thank you. So it should have been shared with you?

A. Yes, yes.

MR CARR: Staying within data but turning now to notifiable safety incidents. One of the datasets that the CQC has access to are reports to NHS England's National Reporting and Learning Systems, NRLS; that's correct, isn't it?

A. Yes.

Q. And that is a system used to report patient safety incidents and there is a duty on healthcare providers to notify the CQC of those incidents?

A. Yes, that's correct.

Q. And the way that -- one the ways they can do that is by reporting to NRLS because the CQC has access

to it?

A. Yes, yes, that's correct.

Q. And the CQC also has access to the Strategic Executive Information System, so that is STEIS, and that's a system for reporting Serious Incidents or Never Events?

A. Yes, that's correct.

Q. Now, we know, and you will have seen from the transcripts of the evidence of the CQC Inspectors, that on 3 July 2015 the Trust reported to STEIS the unexpected, potentially avoidable death of Child D.

A. Yes.

Q. That was reported as a Serious Incident due to a recorded as a delay in recognising sepsis?

A. Yes.

Q. And the deaths of Child A, Child C, Child D, Child E and Child I were all reported to the National Reporting and Learning System in the months prior to the CQC's inspection in February 2016?

A. Yes.

Q. Does the CQC accept that the members of the Children and Young People's services inspection team should have been aware of those reports?

A. So my understanding was when that information was, was shared and unfortunately, when it had been

submitted to NHS England those had been rated as "low", low harm or low instances, because the definition of "high" or "moderate to high" instances from NHS England was based on the organisation of the provider who would have accepted that they had contributed to the incident taking place.

If they felt that that was due to their contribution or poor practice, or part of their staff contributing to those deaths, they would then rate themselves as "low" and that's my understanding that's actually possibly why this had been missed because people would have looked at instances which were rated as "moderate" to "high"?

Q. We will come on to the categorisation --

A. Yes.

Q. -- and how, if at all, that is interrogated by the CQC. You will have seen the evidence of, in particular, Mr Odeka but also Ms Potter?

A. Yes.

Q. And of course the report of the death of Child D was to the STEIS system as a Serious Incident.

So my question is, putting aside the fact that they were marked as "low"?

A. Yes.

Q. Does the CQC, looking at those reports, both

the STEIS report and the NRLS reports, accept that those reports should have been seen by the inspection -- the entirety of the inspection team?

A. Yes, I would want that information to have been seen because it would have then informed our key lines of enquiries.

Q. Because the Inquiry heard evidence from all three members of that inspection team Helen Cain, Benjamin Odeka and Mary Potter, that they were unaware of the report to STEIS in respect of Child D?

A. (Nods)

Q. Unaware of reports to NRLS and the Specialist Advisors did not see that table of neonatal incidents?

A. Yes.

Q. And in light of the evidence that they gave, which is that it would have affected their approach to the inspection, clearly they should have seen them?

A. Yes. From -- from looking at the practice during 2016 inspection, my understanding being the data packs which had been created, yes, the Specialist Advisors could have benefited from seeing that information, but unfortunately they were not able to see that information because the practice then was that information would be shared with them in terms of the data packs I had of the inspection.

LADY JUSTICE THIRLWALL: In relation to STEIS, to the STEIS report, what's the explanation there?

A. Yes. So the information would have been submitted to -- my understanding is the information would have been submitted to STEIS by the providers. But in that process of submitting the information they would have categorised those instances --

LADY JUSTICE THIRLWALL: The same answer?

A. Yes, as low. Hence then, by the time the information would come to CQC, those instances wouldn't have been categorised as moderate to high, they would have been categorised as low because providers then would have assessed and think because they had not contributed to the harm happening, they wouldn't then rate that as moderate to high.

LADY JUSTICE THIRLWALL: But earlier you were saying that the number of deaths should have been made available to you. But in fact there was the system for collecting information about deaths, which the hospital did comply with.

But that information didn't get to the inspection team because of a categorisation issue?

A. Yes, so what I have said, my Lady, is that is -- I would prefer that information to be available to inspectors.

And also then, you know, there was an analyst who would present the data to the inspection team on the day, what they called Day Zero, for example, just before the inspection and unfortunately the Specialist Advisors did not see the whole data which had come through like my explanation before possibly from my understanding from talking to analysts it was because of the categorisation of the data, hence they didn't see it because it had been categorised as low harm.

LADY JUSTICE THIRLWALL: So the error -- firstly, was there an error by the data analysts?

A. No. From my understanding there was no error because they what they would do, because of the amount of data they receive, they would then categorise the data by looking at moderate to high risks instances, unfortunately from my understanding is these instances were not part of the moderate to high, hence they wouldn't have looked at them because that was the process they would follow in terms of looking at analysing data.

LADY JUSTICE THIRLWALL: So that is information about deaths that was not going to be passed on to the inspection team?

A. Yes, it wouldn't have been passed to the inspection team.

LADY JUSTICE THIRLWALL: As a general proposition so get rid of that filter by the analysts?

A. Yes, so my expectation would be if there was an unexpected death or avoidable harm, that information should be considered as part of an inspection process.

LADY JUSTICE THIRLWALL: Thank you.

Sorry, Mr Carr.

MR CARR: Thank you, my Lady. If we take it in stages, I am going to deal with the STEIS record first and then the NRLS because the issue of categorisation and no harm/low harm, that refers to the NRLS entries --

A. Yes.

Q. -- not to STEIS.

Now, if we look at the intelligence presentation for the inspectors, it's INQ0103620, my Lady, it is your tab 10, if we go forward to page 27, and this is a slide dealing with the Children and Young People core service, a summary of intelligence findings.

We see bullet point 1:

"No Never Events or Serious Incidents reported up to January 2016."

And in light of the report to STEIS in respect of Child D, that is incorrect, isn't it?

A. Yes, I -- I would want to take that back and have a further review. But if the --

LADY JUSTICE THIRLWALL: This is something that's been seen before in the Inquiry.

A. Yes, yes.

LADY JUSTICE THIRLWALL: So it is something that should have been drawn to your attention?

A. Yes, it should, it should have been included, yes. If that is the question, Mr Carr, yes.

MR CARR: We can take it in stages, because following the exploration of this issue with the CQC Inspectors, as I have indicated further witness statements have been provided dealing with data and if we take that down and look at the statement of Lynn Andrews this time, it's INQ0108743.

That is your tab 6, my Lady.

LADY JUSTICE THIRLWALL: Yes, thank you.

MR CARR: A statement dated 20 December 2024.

Now, Ms Andrews, she is a senior analyst at the CQC and she was responsible for putting together --

A. Yes.

Q. -- that presentation document I just took you to?

A. That's correct.

Q. And what she explains, if we go forward, please, to page 11, paragraph 43, she states:

"CQC's data packs and intelligence presentation

report that no Serious Incidents were reported in the Children and Young People's core service, this was due to neonatology being considered under the maternity core service for the purposes of data collection and analysis. This was standard for all inspections. The intelligence presentation and the maternity and gynaecology data pack both refer to seven Serious Incidents which include the death of Child D."

And the point that is being made here is that while the CQC didn't miss, as it were, the report to STEIS in respect of Child D, the analysts were aware of it and it was in the data packs put in the maternity section?

A. Yes.

Q. Now, with that in mind, we can go back to the intelligence presentation. So we can take that statement down, please, and bring back up INQ0103620. And this time if we look at page 26, this is the slide dealing with the maternity core service and to be clear maternity would be being dealt with by a completely different inspection team?

A. Inspection team, yes.

Q. The third bullet point on the slide refers to:

"A further seven Serious Incidents between February 2015 and January 2016 in addition to seven in the reporting period. No themes identified."

So there is nothing in that description which would alert the Child and Young People's Services inspectors that this is data which is relevant to their inspection?

A. Yes, that's correct.

Q. As for the maternity and gynaecology pack that Ms Andrews refers to, we see that at INQ0103668, my Lady that is your tab 9, page 7. And in the neutral analysis section, in the middle of the page at the top, again, we have reference to seven Serious Incidents were reported between November 14 to October 2015.

And if we can go forward two pages, please, to page 9, we see a breakdown there of STEIS incidents.

Now, having looked at those three pages from the presentation slides and from this maternity and gynaecology pack, there is nothing that would alert the members of the Children and Young People's services in either document to the fact that this is a serious incident in neonatology, is there?

A. Yes.

Q. And you have considered the transcripts of the oral evidence of the CQC Inspectors and there is nothing in their evidence to suggest that they were aware of any need to consider maternity data as part of their inspection?

A. Yes, that's correct.

Q. In circumstances where the neonatal unit is being inspected by the Child and Young People's Services team, wouldn't -- or shouldn't rather -- neonatology data be considered under that core service?

A. It -- it should have, it should have been considered under that service, you know, it should have gone under the Children and Young People service. But one could also consider the fact that this was a whole team which was doing different core services. The -- my understanding being when for example the presentation of the intelligence was being done, it wasn't done to individual teams for those core teams or core services; it was done to the whole inspection team.

So -- so if there was any information which possibly needed further clarification, I would hope or expect that teams would share that information if that information was available because they were all working together even though they were focusing on different core services. But actually the starting point is it was one team but then divided to look at different core services.

Q. So your expectation would be that the members of the maternity team, having dived beyond what's in the documentation and seen the STEIS report they should have flagged that to the Child and Young People's Services

team?
A. That's -- that's what I would expect.
Q. I return to my question. Wouldn't it make more sense for neonatology data to be contained in the core service that is inspecting the neonatal unit?
A. Yes, it, it would -- it would help because that's where it should have been and that was the expectation -- I suspect that was the expectation because that's where the data was supposed to have been presented in Children and Young People.
Q. Does it remain the case?
A. No, now currently neonatal data or information or services are now looked at as an additional service. So they are now a standalone service. So in our new assessment framework, they would sit in its own assessment service group, even though the teams that might end up assessing might be the same teams like Children and Young People and maternity services but it would be looked specifically on its own as a service line.
Q. So is the position at present that those inspecting a neonatal unit will be provided with the neonatal data?
A. Yes, because it would be in its own assessment service group.

MR CARR: My Lady, that might be an appropriate time.
LADY JUSTICE THIRLWALL: Yes. Thank you, Mr Carr.
So we will take a break now for just over a quarter of an hour and we will start again at quarter to 12.
(11.29 am)
(A short break)
(11.46 am)
LADY JUSTICE THIRLWALL: Mr Carr.
MR CARR: My Lady, thank you.
Mr Dzikiti, we are still looking at the approach to data. I want to move now from STEIS, please, to NRLS entries and you touched upon this earlier in your evidence. This is where there's different categorisations of harm.
Now, this statement from Ms Andrews also deals with the analysis of NRLS entries. If we can it up on screen it's INQ0108743, my Lady it's your tab 6. If we go forward, please, to page 12 and look at paragraph 48.
In that paragraph Ms Andrews describes the type of analysis undertaken on NRLS entries and it's the sort of entries we see in that table titled "NNU Paediatric Incidents" that you have already alluded to with the different categorisations of harm.
Now, I am not going to put that table on screen

because it contains sensitive third party information but you have seen it.
A. Yes.
Q. It's a substantial document, isn't it; it's got some 377 entries --
A. Yes.
Q. -- in it on my calculation?
They are not date ordered, are they, it is not chronological, the table?
A. No.
Q. And within that table, there are eight entries in which the description involves death, but each of those entries has been marked green for no harm.
A. (Nods)
Q. Now, what Ms Andrews says in her statement at paragraph 48 is that it is standard practice when completing analysis of NRLS incidents, particularly when the datasets are large, for analysts to begin with reviewing the level of harm focusing on those reported as "moderate", "severe" and "death". Given the volume of reports made on NRLS it was not viable for analysts to read detailed descriptions of every report. The CQC data analyst team would have first filtered out the incidents marked "no harm" and "low harm".
And it appears to follow from that, doesn't it,

that so far as the data analysts are concerned, this is a spreadsheet, they have simply removed the low harm so they wouldn't be considering these entries at all?
A. Yes.
Q. Is that correct?
A. Yes, that's correct, yes.
Q. She goes on to make the point in the final sentence of that paragraph:
"The raw data includes the full list of incidents with all detail were available to the inspection team to access. It was standard practice for the CQC inspection team to access on our system the SPA did not have access to the CQC systems and it would be for the core service lead to share the raw data with them if they needed to."
Now, that reflects, doesn't it, the oral evidence that was given by Helen Cain, the lead of the inspection team, and the two Specialist Advisors from the Countess of Chester inspection in 2016, that the Specialist Advisors did not have access to that table, did they?
A. Yes, that's correct.
Q. So it was left to the non-specialist, the service lead, Ms Cain, to determine the significance of those entries and to decide whether or not to share it with the more specialist members of the team?
A. Yes, that's -- that's correct.

Q. Is that a weakness in the inspection system or the data analysis system?

A. I think if, if you are looking I think the starting point I suspect is the definition. You know, you know defining death of a baby is low or no harm I think that is where the challenge is because then that definition means for the analyst in CQC they were looking for moderate to severe harm and then they missed out those entries because of the categorisation of actually making it green.

So I think that's the, that is starting point.

And then the second point I suppose is the lead inspector would have had to access the system, right, but you would then need a reason to access the system, you know, instead of relying on the data packs. I would assume during that time, that with everything that was going on, preparing for inspection, managing, you know, the team, getting the Specialist Advisors on board, I would find it may be unlikely for the lead inspector again to use the data packs one and after using the data packs go back to the CQC system to look for more information, especially knowing that actually analysts had already done the analysis, I would find that I suppose challenging for, for the lead inspector.

But my point being I think the starting point is

how harm or death are defined and from the provider point of view submitting information and categorising that it's low harm.

Q. Just on your point about what the lead inspector would look at. Is what you are saying that you would expect the lead inspector to rely on the analysis carried out by the data team?

A. And, and if there were any concerns I suspect to be flagged to give them the reason to go into more detail in terms of what more to look at on the system.

Q. But in that scenario, the data analysts wouldn't be flagging issues about the entries marked "low harm" or "no harm", because they had filtered them out and not considered them at all?

A. Yes.

Q. So if the position is as you have described it, the lead inspector relies on the data analysts then those low and no harm entries are just not being considered at all?

A. (Nods)

Q. And in the event in the Countess of Chester inspection, we know that not only did those entries not get shared with Dr Odeka and Mary Potter, the Specialist Advisors, both confirmed in evidence they didn't see them -- Mr Odeka explained that having looked at the

table for the purposes of giving evidence to the Inquiry, the categorisation of incidents struck him as inaccurate and it is something that he would have wanted to look into at the inspection had he been made aware of it?

A. Yes, and, and I can see why that point because like I said you know looking at a baby's death, you know, you wouldn't really classify that as no harm. But that's the issue I am saying the root cause if I was looking at the root cause is that definition that enables people to classify a baby's death as no harm or low harm.

Q. Well, there are two issues, aren't there? Firstly there is the question of the adequacy of reporting, categorisation of death.

Now, as the regulator, is it the CQC's role to ensure that incidents are being properly reported?

A. My understanding from talking to analysts is the definition I suspect from I would need maybe to double-check this, is the definition given I think by NHS England as part of the organisation submitting data to NHS England.

Q. There is a question of the definition and the categorisations but my question is about regulation. Is it the role of the CQC to consider whether or not

a healthcare organisation is properly categorising patient safety incidents?

A. Yes. I would want to think so, yes.

Q. Would it not be difficult to carry out the function of regulating reports without consideration being given to all the categorisations rather than simply filtering out low and no harm reports?

A. Yes, I think, I think there is in hindsight looking back, part of the learning I suppose is thinking about -- when like I said at the start that this data is coming to us, there is a question I suppose thinking in the future and working with other stakeholders to think about, you know, how the data one is submitted and whether there is room for us to go back and consider as a regulator should we be receiving data directly to us as a regulator of health and social care rather than actually relying for the data to go somewhere else and then come to us.

Whereas if it's coming to us then I suppose we have got more control to quickly look at that data, you know, over a period of time instead of actually relying on the data coming via other means.

So I suppose what I am saying is there's more work I supposed to consider going back thinking about going forward in terms of how data is shared with us because

it's not directly coming to us.
Q. But the issue that we are considering now is not one about whether or not you had the data. The data was there. The issue is the analysts don't consider at all, they filter out the low and the no harm?
A. Yes.
Q. And on your interpretation, the inspection lead may not be considering what has been filtered out by the analysts and on the evidence we know that the specialists were never given access to that information. So it's not an issue of the CQC getting the information, it's a question of who, if anybody, at the inspection is looking at it?
A. Yes, and my understanding from talking to analysts being because of the volume of data they are processing, on a regular basis and considering my understanding being at any given time, we are doing several assessments or inspections of organisations, so our analysts are constantly, maybe during that time my understanding is Lynn was looking at five other organisations in terms of data packs.
So I think because of the volume my understanding is they would then have to filter in order for them to go through all the necessary information and thinking about as well, you don't want to miss "moderate" to

"severe harm" being recorded in that volume of data. Hence the need for them to filter the data.
That is my understanding of their position.
Q. Does the approach remain, does it remain the position today that data analysts will not look at reports which are categorised "low" or "no harm"?
A. I think from, from learning I think over years now, this is nearly eight years, there's a bit about professional curiosity as well in terms of when you are looking at things because now I am looking at hindsight that actually you know you want to test, you know, over period of time that actually by filtering you test that methodology, is it working by actually taking random samples of looking at that information to make sure actually there's nothing being missed?
But in terms of the definition it's true from my understanding it still remains the same definition of actually how providers would report data to NHS England.
Q. Specifically in light of the evidence that was given by the CQC Inspectors to this Inquiry to the effect that had that information -- it is the Specialist Advisors, had the NRLS data been provided to them, they would have wanted to ask more questions. Dr Odeka's evidence that the categorisation of incidents that struck him as inaccurate, wasn't that a missed

opportunity for the CQC inspection team in February 2016 possibly to explore the issues of death?
A. I mean, when you -- obviously in hindsight when you look at then what happened and transpired, you know, you would want to think: actually, yes, there should have been more there done to a certain extent. But if the question is: did the inspectors and the people working then follow the process which was in place during that time, my understanding is yes, they followed the process which was in place at that time.
But in hindsight now when you look back, actually I think possibly more could have been considered.
Q. So what learning or changes have the -- well, what has the CQC learned and what changes, if any, have they made as a result of that hindsight?
A. So now all the information which comes from my understanding is all the information we get through NHS England, it's uploaded on our dashboards, right. So because all the information is loaded on our dashboards at any given time, people have got access to that information. So, for example, relationship owners inspectors, even outside of the inspection time they have got access to look at those services, to consider if there is anything they feel actually warrants more investigation or more time to look at it.

So I am hoping where we are using data now has improved in the sense that all the information is now going into our dashboards, that is my understanding from analysts that all the information that's coming from the STEIS, it is all going straight into the dashboard, so there is someone who is constantly looking at that information and if there's anything they read or they see that gives them some concern, they will refer that to the inspectors. But also the whole point of actually gathering intelligence in terms of how we are using intelligence from different sources, either from people who are raising concerns, giving feedback of care to us who are calling our customer centres, you know, other organisation data we are picking up from either research or data being built up by other organisations like NHSE, for example, all that information is now being put in one place in those dashboards to inform what we do going forward.
Q. Do Specialist Advisors have access to that?
A. Specialist Advisors, my understanding is they can see the information. We, since 2016 we started using the CQC Insight which brought all the data into one place and the inspector, the lead inspector can get that lead information to Specialist Advisors, I am not aware that Specialist Advisors can access CQC systems

but the lead inspector can provide that information to -- to CQC Specialist Advisors.

Q. If we can move now to a connected topic, please, which is information gathering ahead of an inspection more broadly. There are, we have heard evidence, two forms of information provided ahead of an inspection, a Provider Information Return --

A. Yes.

Q. -- which would be provided several months before an inspection and so might be out of date by the time of the inspection?

A. Yes.

Q. And then data requests which are made just before an inspection which will bring the data up to speed?

A. Yes.

Q. And should paint a picture of the current state of affairs.

Now, in the 2016 inspection at the Countess of Chester Hospital, the data requests for Children and Young People Services was made a day before the visit so in the same, in the inspection week is what Helen Cain explained, but a day before the actual inspection visit commenced. And the response to the data request she explained would not necessarily come in before the

visit, it's only made the day before so data could come in during or after the inspection visit.

Now, is that a weakness in the inspection system, the fact that documentation and potentially substantial documentation, we have already dealt with the table of neonatal incidents, doesn't come in in time for the inspectors to consider it thoroughly?

A. From, from what I have seen in terms of it's a process we go through when you are doing an inspection, you are going to request information before the inspection, you are going to request information sometimes during the inspection in the sense that you might speak to a member of staff or you might speak to a service user that actually triggers something that you want to explore more. So you would for example request maybe an incident report that hasn't been included and then even after the inspection you can still request information because I always -- we always look at data as a process as part of the process of inspection and sometimes you might have to request that information at different points of time.

Whether it is -- it is a weakness, it depends on whether you have got that data you need to go through your key lines of enquiries. But what I am saying you can get that data even after the inspection itself

because you have identified some gaps in terms of the intelligence we -- we have gathered.

So whether it was a weakness then, I wouldn't comment on that. But my understanding being, you know, they had information and unfortunately the information they had didn't give them the concerns around the mortality increasing.

Q. Thank you. I understand the point that you make about the ongoing ability to request data and the need to be able to request data as issues arise.

The question really is this: should that process of requesting data after a Provider Information Return months before an inspection, should that start prior to inspection week?

A. And, and I guess from experience of seeing inspections going on, information is requested from the provider. Some comes a week before. Some comes a few days before depending on how the volume of the information we are requesting.

If it's quite straightforward information then it can come earlier, so your point about can you get it a week before, yes, you can depending on the volume and the complexities of the information you are requesting. I wouldn't sit here and say more time is better. You know, if you could get more time with the data before

you do the inspection, yes, then you can review the information.

But our way of working, and I have been part of inspections, is every data that comes in, you know, because you are requesting data for a specific information, you are trying to clarify, so you know what you are looking for, that is why you are requesting that data for, and it does work. You know, you can actually get the intelligence you need but definitely yes, if we could get more time with the data, the better, because then it will inform much better questions to ask as part of the inspection.

Q. If we can deal now, please, with the internal review, so the Thematic Review and the Brigham Review. The Inquiry has received a fourth witness statement from Ann Ford, it's INQ0108674. It is dated 11 December 2024, so it follows the oral evidence she gave to this Inquiry.

At paragraph 5 of the statement on that page, under the heading "Provision of documents from the Countess of Chester Hospital to the CQC" she refers to oral evidence given by Ian Harvey in which he stated that he would have forwarded the Thematic Review to whoever was responsible for sending the documentation through to the CQC.

The purpose of this statement was to respond to that suggestion, isn't it, and to set out the CQC's position on receipt of the Thematic Review and the Brigham Report?

A. My understanding this was never received before the inspection and everyone I have spoken to are quite clear about that position.

Q. If we look at the second page of the statement, we see what is set out about both the Thematic Review at paragraph 7, that it was never received from the Countess of Chester, and in respect of the Brigham Review, dealt with at paragraphs 8 and 9, that that was provided to the CQC but not until April 2018?

A. That's correct.

Q. So more than two years after the inspection.

What is the CQC's position on, dealing first with the Thematic Review, whether those reviews should have been provided to the CQC?

A. I think the fact that there was a Thematic Review taking place it concludes that there were concerns about the mortality rates going up and I think I strongly believe that information should have been shared with the CQC before or immediately when I suspect Terms of Reference were being drawn to have that

Thematic Review completed. As part of the engagement with CQC, I would expect the Trust or the provider to share that information, that's being transparent, that is being open and also from my experience of attending inspections, one thing we are quite clear about is asking the team, especially the senior leaders, in terms of "is there anything else you are concerned about, is there anything you are worried about, is there anything that keeps you wide awake at night, or anything you just feel possibly at this point in time you don't have the evidence and you just wanted to share with CQC?" And that has been my experience of all the inspections I have been to.

So if the question you are asking about the Thematic Review or even the Brigham Report, if this information was available to the Trust, I would strongly expect them -- it is an expectation really that they would have shared that with CQC before the inspection.

Q. And to be clear, what you are saying should have been shared, one you indicated that if they are carrying out a review then there is some concern, so it is a concern that should be shared?

A. Yes.

Q. And once the reports are finalised, there are two Thematic Reviews: there was a draft investors and

a final version?

A. Yes.

Q. Are you saying that the final version should be provided to the CQC?

A. Yes.

Q. And what about the draft version?

A. I mean, if -- if there is any -- my expectation will be if there is any learning coming through, if there is anything they are discovering in that, during the draft report they should be sharing with CQC and they are welcome to say it is a draft, you know, because the whole point of having a draft is to start informing if there is anything that needs to happen in terms of improvement around patient safety. So you can't wait until you have got a final report. Draft reports are welcome because that is the starting point in terms of patient safety.

Q. Now, I will read a section of Mr Trenholm's first statement rather than put it up on screen. It's a short extract but what he says at paragraph 60 of his first statement is: if a Trust has any significant concerns about quality we expect those to be raised with the relationship holder, together with the action the Trust is taking to address them. If the Trust has commissioned any external reviews, those should be

disclosed -- it says "these as a matter of course", but the "these" is superfluous, so should be disclosed as a matter of course.

Now, in light of the evidence you just gave a few moments ago, is it the case that that also applies to internal reviews, internal reports, those should also be disclosed as a matter of course?

A. Yes, that's correct.

Q. Turning now to the inspection itself and you have considered the transcripts of the inspectors and I am not going to go through in any detail what was discussed at individual interviews.

The evidence from the inspectors is that they were not told during their inspection about increase in neonatal mortality or incidents of unexpected and unexplained deaths --

A. Yes.

Q. -- or any concerns relating to it.

Is the CQC's position that they should have been told that by staff at the Countess of Chester Hospital?

A. Yes, because if it was well known within the Trust and the Thematic Review appears to have already started during our inspection, yes, that information should have been shared with the inspectors.

Q. And does it follow then that the CQC considers

that there was a failure by staff at the Countess of Chester to volunteer that information to the CQC Inspectors?

A. Yes.

Q. Does the CQC recognise that there can at inspections be a reluctance by staff to volunteer information of concern?

A. There is a possibility, yes.

Q. You indicated a few moments ago that during inspections, one of the things that you would raise at interviews are questions like: "is there anything that's concerning you, anything that keeps you awake at night?" Is that a standard requirement of inspectors to ask those sorts of questions?

A. I -- I would expect -- I mean, like I am saying the inspections I have observed and I have been to that line of questioning, it takes place and in a more collaborative way really in terms of just trying to understand where an organisation is because our expectation is we work with organisations and providers around patient safety that actually we all can learn from instances.

So if there is anything to share, there is an expectation that they should be sharing and internally we talk about some of the areas in terms of

asking questions around what areas to focus on.

Q. Is there a requirement either as part of training of inspectors or elsewhere, is there a requirement that inspectors ask hospital staff explicitly whether they have any issues of concern in addition to anything that has been discussed at a visit?

A. I mean, in terms of support inspectors one thing I am clear about is around questions around: is there anything else you want to add, is there anything else, you know, you feel CQC need to be aware of? And that's -- that's common practice and we talk about that all the time, there is some pointers in during that inspection time in terms of questions you might ask.

So yes, I -- I will be surprised if there is an inspector in CQC who is not aware of that.

Q. In respect of the 2016 inspection of the Countess of Chester we have already looked at issues to do with monitoring and data but in respect of the inspection specifically, what is the CQC's position on the reason for the failure to detect the concerns about the increase in neonatal mortality or neonatal mortality itself?

A. I think there's something around -- and we have touched on this earlier in terms of the staff, whatever reasons behind staff not being able to express

those concerns, my understanding from, from some of the team members who attended that inspection is there was information around, there were some posters around the hospital, for example, which said: CQC are here, if you have got anything you want to share with us, please do come and talk to us.

There are some instances where staff have expressed to me that they have even arranged, you know, to go outside of the hospital to meet people to talk about any concerns that they might have.

There were some boxes in place for people to put in feedback if there was anything they wanted to raise. So in terms of what the inspection team did on that day to try and facilitate an environment or an opportunity for people to express any concerns or any other feedback they wanted to give back, unfortunately that didn't happen.

I'm not sure why that didn't happen from a point of staff telling us. Obviously there's an issue around the data in terms of actually, you know, just professional curiosity I suppose in terms of what else could have been asked during that time.

But my hope is people should be free to speak up and should not feel that if they speak up, something would happen to them.

So we try by all means, the CQC we have provided guidance around that, around whistleblowing, around Freedom to Speak Up, and trying to encourage staff to speak up and we are seeing it now, we get more people, whistleblowers, we get more people speaking up and we use some of that information to inform our intelligence for where do we go to in terms of inspections

Q. The failure -- it appears so far as the CQC is concerned from the answer you just gave, the failure to detect the concerns was due to the fact that staff did not disclose their concerns to the CQC Inspectors?

A. That, that's one but one can also argue that the leadership as well of the Trust, like from what we know I am saying -- obviously in hindsight from what we know it appears as if, you know, the review or the Thematic Review might have already possibly started or been considered during that time and my question in my head is: why was that information not shared because it was the previous year as well. I think if I am not mistaken it was, if my memory serves me right, between 14/15 and 15/16 financial years.

Q. The Brigham Report was 2015.

A. Yes.

Q. The Thematic Review was 2016.

A. Yes.

Q. February and March.
A. Yes, exactly.
Q. The Inquiry has heard evidence that for members of staff at an institution that is being inspected it can be difficult to express views in a group setting and so the question that follows from that is whether there is a need for more private one-to-one interviews between inspectors and members of staff or at least giving all members of staff, whether it's by way of email, an opportunity for private meetings with inspectors rather than large group meetings?
A. Yes, and -- and as part of the inspection process, my understanding during that time as well that there will be contact information for CQC. We have got now additional contact centre so if people are not feeling comfortable to talk they can, you know, contact privately, contact us.
Obviously now time has moved on, we now know, understand more about Freedom to Speak Up, whistleblowing, and we always give those opportunities for staff to speak -- to speak to us even to the extent of we have had staff have come asking us to speak to us as a group of staff, instead of one person although sometimes it can be a lot for one person to -- to

speak up about a concern.
Now we see sometimes groups of staff and of nurses or doctors coming and wanting to have a conversation with CQC in private to talk about concerns.
So we try by all means and my understanding during that time as well those opportunities were available for, for people to express any concerns. But what I am, what I am now saying is even with all that available, you know, we know that sometimes the culture and the leadership in an organisation can still hinder people from expressing their concerns, despite everything I have spoken about in terms of trying to facilitate those conversations.
Q. Since 2016, the CQC moved to a different framework of assessment, the single assessment framework. And is it likely that the single assessment framework would be better able to elicit concerns than the position in 2016 at the Countess of Chester and if so, how?
A. There's -- the whole point I suppose moving into the single assessment framework, which will be changing to assessment framework, was because it gives CQC the opportunity to go into services on a regular basis that was the aim. And it also focused on certain aspects in terms of the quality of services, also

focusing on outcomes for patients and part of our strategy in 21/22 was around people and communities and it was more about thinking about people's experience of care, you know, talking to people who use services to understand their experience of care also making sure we speak to their families to understand the experience of their relative being looked after in a service.
So, yes, the single assessment framework, the main aim was one, to make sure we focused on patient outcomes, we focused on people's experience of care, also gave us the opportunity to go into service on a more regular basis because sometimes it would take a long time before we went back in but the single assessment would enable us to go back in on a more regular basis.
Q. There is of course the recent Dash Report, which was a review of the single assessment framework rather than the form of assessment in 2016 at the Countess of Chester Hospital. One of the concerns identified in that review was the lack of focus on outcomes and insufficient evidence of assessments and inspections that considered the outcomes of care. Are you able to update us with the CQC's response, if any, to that report and any work that is being done to improve focusing on outcomes of care?

A. Yes. In terms of that review, we, we accepted the recommendations from talking to Penny Dash in full and now work is ongoing in terms of one, thinking about how best, because I think the challenge was more about the implementation of that new framework rather than the framework itself. Like I said, for example the main reason why the framework was brought in was one, we needed to go into service on a regular basis, we needed to focus on patient experience of care and outcomes of care and so we have looked at that actually how best do we implement the single assessment framework? And as part of that work we asked Sir Mike Richards to look at the implementation of that work and we are now starting to focus on how best we focus on implementation of that work.
For example, we are looking at for example we have got a new Chief Executive Officer, Sir Julian Hartley, and are in the process of now recruiting more chief inspectors for each sector we regulate. So thinking about mental health, thinking about secondary specialist care, primary community care and other social care.
The focus being those leaders in as chief inspectors who focus more on their areas of expertise and think about the outcomes of patient care and think about the experience of care within CQC. So that's the

work we are starting to undertake now as we reset our position in terms of how we work with our providers.

But mainly also to think about one area we are really keen on working on with and we have started working on and we have been doing some work in the last year is how we work with experts by experience and people who have used services before thinking you about how they become part and parcel of our inspection methodology, because they understand the experience of being in a service so we want their input in describing what good care looks like and the whole feedback that will help us to focus mainly on outcomes going forward.

Q. It sounds like there is ongoing work?

A. It is, it is ongoing work. And our Chief Executive just started on, on the 2 December and our previous interim Chief Executive had already started looking at those recommendations going forward.

Q. I was going to ask you about leadership of the CQC. There was obviously Mr Trenholm, who was Chief Executive?

A. Yes.

Q. And he stepped down and was replaced and I think you are now on to perhaps the third or fourth Chief Executive since Mr Trenholm. So it sounds like there's been a period of flux at the CQC.

How -- well, what would your observation be on the leadership of the CQC in that time?

A. So there has been -- like I said there has been changes. We have had several Chief Executives during this time and obviously, you know, leadership is key in ... and it's been challenging to say the least but when I look around at what we, we now have, in terms of the focus we have, in terms of improving ourselves as a regulator for health and social care and when I also look at the people who work in CQC, the staff who work in CQC, their commitment to patient safety, their commitment to improving and, and making sure people are safe in services, I am really, really inspired and reassured that actually we are starting to take the steps forward to think about how best we can improve as an organisation.

Like I said, you know, changing Chief Executives can destabilise an organisation but now we are in a position where we have got a permanent Chief Executive Officer in place, we are recruiting chief inspectors to support the work we need going forward. We are quite clear about where we need to go to in terms of the work we need to do with other key stakeholders, the work we need to do with providers in Trusts and social care services in terms of actually the work we need to

improve services going forward, including the maternity services and including neonatal services as well as part of that work going forward. And definitely learning from this process from this Inquiry as we go along.

Q. So a period of flux at the senior level at Chief Executive level has been destabilising but with the new Chief Executive and the plan that you have outlined, you feel more confident that stability will return, is that a --

A. Yes, I am, I am really confident and like I said, you know, the staff who work in CQC some of them who have been in CQC for a very, very long time, I talk to them I am a chief inspector now, I am also the Exec Director of Operations and I can see, you know, the deep commitment and wanting to improve what we do as a regulator and, and the standards we, we have set for ourselves going forward should be higher than the standards we set for the services that we regulate.

So that is our ambition going forward.

Q. Staying with the theme of leadership and Well-Led, but turning back now to regulation and in particular the inspection of the Countess of Chester Trust. The report following the inspection in 2016 rated the hospital as "good" in the Well-Led campaign and you have raised in your evidence, albeit with the

benefit of hindsight some concerns about leadership at the Trust at the time.

So can you help us with how the Well-Led category is assessed and how the good categorisation can be arrived at?

A. Yes, so, so for, for Well-Led, really, you are looking at leadership and the culture of the organisation in terms of how that organisation is led. But the majority of that information of gathering the information also comes from -- as part of the inspection of doing Well-Led you would have reviewed some core services so you would have spoken to service users or patients before you would have spoken to the staff who work in that organisation ahead of doing the Well-Led which was always and still announced because you want to make sure people you want to interview are present to be interviewed.

So there is an element of using the information you have gathered from the inspection you have already undertaken and spoken to staff, spoken to patients.

Then you need to look around governance, how governance is being addressed within the organisation in terms of, for example, you know, risk. How is risk assessed and managed, are there policies in place that help staff to understand risk assessment and risk

management, how are instances, for example, managed in terms of, you know, is there a learning culture in this organisation? For example, if there is an incident are they learning from it? On top of that there is an expectation as well to think about the board itself, how sighted is the board in terms of those instances in terms of the learning that needs to happen?

In some organisations you have got multiple lines of service lines, for example, so you can have six service lines or five service lines. How is that information cascaded across the organisation in terms of learning? Are there audits taking place to understand where the services are at in terms of their practice? And how is that information used to -- to inform practice? Is there anything else happening in terms of complaints? What kind of complaints are being received and how are complaints being managed by organisations going forward and are they learning from those complaints? For example the Patient Advice Liaison Service, how is it being used? People call it PALS.

And the other information you sort of need to look in terms of anything else that the -- that the leadership is doing to improve itself going forward, in terms of things like Speak Up, how is Speak Up being managed, you know and are there any data and records to

show how it's being managed, how is the organisation learning from Speak Up or whistleblowing?

All that information, that is the information we look as part of considering whether an organisation is well-led or not, but as part of the inspection then you speak to the chairperson of the organisation, you will speak to the Chief Exec to the Medical Director, you also speak to the Chief Nurse to try and understand how the Executive Team works together and also thinking about the Non-Executive Directors, how they also work within that organisation.

So it's quite a comprehensive assessment in areas we pick to really determine how well-led that organisation is.

Q. Sticking with the 2016 report. In the "Safe" category, the rating in Children and Young People's services at the Countess of Chester Hospital was "requires improvement" and one of the issues identified in the report was staffing levels, nurse staffing levels?

A. Yes.

Q. What regulatory action, if any, can the CQC take where there are concerns about staffing levels; is there anything that the CQC can do about that?

A. There is an expectation, obviously if there

are any issues around, you know, staffing levels is to, you know, ask the organisation in terms of what are their plans, you know, is there an action plan to address staffing levels and -- and we know over years, you know, staffing levels has been an issue in the NHS in social care especially when you look at nurses. You know, there has been a challenge over years in terms of vacancies in most organisations.

So at CQC we totally appreciate the context in which organisations are operating in. But still we expect because you need the staff to in order for you to provide safe care. So what we would expect is an organisation to have an action plan in terms of how they are addressing those gaps. What else are they doing in terms of recruitment, you know, other organisations, they would look at international recruitment, for example, thinking about other roles that could be introduced into the organisation.

So there are other action that is an organisation can take, so we would be expecting that the organisations are taking those into, into consideration.

Q. If we can move away from the inspection and to the monitoring of the Trust following the inspection. And I am not going to go through every single element of the chronology. But if we can start with the disclosure

to the CQC of the increase in neonatal mortality and we can look at the email, it's INQ0017411.

Now you will have seen this email, this is an email dated 30 June 2016 from Alison Kelly and it follows a telephone conversation the day before on 29 June, same day the CQC report was published.

And in this email, details of the increase in mortality or some details of the increase in mortality are given. Now, what we see under the heading "Context", we can see there reference to the internal reviews, actually that is the Brigham Report and the Thematic Report and we have already addressed that.

And we see in the next paragraph reference to the fact that an independent review from the RCPCH has been commissioned. Now, what this email does not say anywhere, does it, is that there were concerns of potential deliberate harm?

A. (Nods) Yes, yes.

Q. Now, given the CQC's position is that they had not in fact received the Thematic -- well, what's described here as the in-depth Thematic Medical Review, which I think is the Brigham Report or the subsequent peer review, which is the Thematic Review, should the CQC have requested those documents from the Trust?

A. Yes, I -- I would yes, that is the

professional curiosity I was talking about earlier.
Yes, because that information had not been, you know, submitted to us or forwarded to us, I would see the value of us requesting for that information to be sent through.
Q. Well, the position is we have an assertion and Alison Kelly has dealt with this in --
A. Yes.
Q. -- her evidence and doesn't contend that those reviews were sent?
A. Yes.
Q. But on the basis of the email there is an assertion to the CQC that two reviews have been sent to the CQC.
Now, we have as of that December statement from Ms Ford that I have taken you to, the position of the CQC is we were never sent the Thematic Review, we were only sent the Brigham Review in 2018?
A. Yes.
Q. So in light of that, in response to the assertion that "there are these reviews and we have provided you with them", is there evidence that the CQC took any steps to determine whether they had those reviews and, if not, to request them?
A. Yes, and my understanding from talking to --

to the team obviously I do get that when, during this time, I think the focus my understanding is the focus of the team or the relationship owner Ms Ann Ford was now about the safety of those babies in, in the unit and that was the focus in terms of: actually are babies safe? What is the Trust doing? So they didn't focus on actually -- you know, these documents haven't been sent to us.
Their focus was more on: actually, let's make sure, you know, the babies are safe, let's make sure the Trust is doing all it can and get some assurance. On -- obviously on hindsight you look back and think: actually, because we didn't have all the details about what had transpired in terms of the reviews taking place yes, it would have been helpful very, very helpful to request for that information to be sent to us, then it would have then informed our monitoring process going forward.
Q. Well, do you know what steps, if any, were taken by the CQC on the back of this email as a result of this email?
A. Like I said, I think the starting point was actually making sure that the service was safe and asking the Trust to reassure CQC in terms of the steps they were taking to address the issues within the

service. From my understanding, the Trust obviously then downgraded the service to Level 1. They closed some, some beds which meant then the service could manage in terms of staffing levels because some of those services, some of those beds had been closed so that's what the Trust was doing and also informing CQC in terms of the Royal College of Paediatricians and Child Health, its review which was taking place as an external review of what was going on, and also making sure actually that all the other external people were being contacted, for example, NHSE in terms of what was happening and letting them know about the instances.
I think that was the position of CQC in terms of making sure all those things were taking place and my understanding the follow-ups in terms of the engagement which was taking place, there was then an expectation that actually in the follow-up of the conversation they were having with CQC with the Trust they were looking at, for example, the action plans which were in place going forward and thinking about what else the Trust was doing to okay make sure the service remained safe.
Q. We will look at some of the subsequent engagement meetings, but the question really is following receipt of this email, it raises an increase in neonatal mortality which CQC were not previously

aware of.
And the question is: should the CQC have taken steps to obtain or at least request information as to why there had been an increase in deaths?
A. I mean on hindsight, definitely yes. You need to understand a bit more in terms of what has happened. Like I am saying I think the focus during this time was safety for, for the babies. But I do get your question, Mr Carr, in terms of actually I think that also comes to the point I am saying about the professional curiosity of actually a bit more of wanting to understand a bit more in terms of actually we were not given this information during the inspection. And then consideration should have been -- unfortunately I wasn't there, but in my head these considerations possibly should have been given in terms of: actually can, we have more information?
But from what I have spoken to the team my understanding is was the Trust at that point in time doing everything it needed to do, they were downgrading the service, they have asked for an external review to take place. There was a Thematic Review then taking place. So it seems as if the Trust was doing everything at that point in time, in terms of making sure babies were safe, and also making sure there was an external

review to look at why this was happening in terms of the increase in mortality rate.

Q. That was the review being undertaken by the RCPCH?

A. Yes.

Q. But so far as the CQC is concerned, that's the regulator. Shouldn't the CQC have taken steps to try and discover more about the increase in neonatal deaths, you have reference there to two different reviews. They could have been requested for instance?

A. Yes, that's, and that point I have, I've accepted that point in terms of consideration should have been, that is the professional curiosity, you know like I wasn't there but I am looking in hindsight thinking about that professional curiosity of: actually this information wasn't shared with us during the, the inspection time and we didn't have access to that. Then that was maybe a good point to consider actually getting that information being shared when we were informed about the incidences.

Q. As for the review by the RCPCH which is referred to here, did the CQC ever ask to see the Terms of Reference for that review?

A. My memory doesn't serve me right. I wouldn't -- we can come back to you on that, but

I can't recall anything about that. But my expectation will be that if a Trust is requesting an external review, those Terms of Reference should be shared with the relationship owner because the fact that you are going externally it means you are concerned, you are worried and it would be my expectation that actually the Terms of Reference are shared with CQC.

Q. But there is two sides of that coin, isn't there? On the one hand you say the Terms of Reference should be shared by the Countess of Chester with the CQC. If the Countess of Chester fails to share them, then shouldn't the CQC request them?

A. Yes. That -- that would be but on this occasion I am not so sure whether this had been requested. It is something I can come back to the Inquiry about.

Q. I want to move forward in the chronology, if we can, to the engagement meeting in December. There was one in August but I am going to look to at the one in December. INQ0017298. Yes, that is an engagement meeting at the Countess of Chester on 22 December 2016.

And we can see item 2, areas for discussion, action plan, neonatal review, Never Events and Serious Incident and the reference to neonatal review is to the RCPCH review, isn't it?

A. Yes.

Q. Now, what Mr Trenholm says about this meeting in his second statement it's a short section. I will read it out. On describing this appointment he says -- this meeting, sorry:

"We were informed that the RCPCH report was at the draft factual accuracy stage and we requested a copy of the final report."

Now, given the date, 22 December, if Mr Trenholm is right, given what we know now, that was incorrect, wasn't it, because the final RCPCH report was with the Countess of Chester?

A. Yes.

Q. In circumstances where the hospital had the final report, should they have been provided at, if not by, the time of this meeting?

A. Yes. It should have informed the discussion of the meeting, so the expectation is, you know, if the discussion is going to be helpful, is to provide the report in advance of that meeting.

Q. If we go forward to what appears to be the next engagement meeting, it's INQ0017300 and this is a meeting on 17 February 2017. And we see item 3 under strategic update from the Trust, (i), key risk areas. Neonatal services.

IH, reference to Ian Harvey:

"... explained that following the publication of the external review by the Royal College Paediatrics and Child Health this month, the parents of children that were contactable were informed and the report has been shared with them and key stakeholders."

So this postdates the publication of the RCPCH report and that was, as we know, the redacted version of the report. Did the CQC receive the redacted or confidential report?

A. Unfortunately, I'm not aware of the -- whether CQC received the redacted report or not and apologies on that. I can come back on you on that.

Q. In circumstances where there are two versions of the report, so one that included references to the concerns and allegations in respect of Letby, is it the CQC's position that both versions of the report should be provided to them?

A. Yes. That's -- that's the open and transparency that we hope that every organisation, every Trust would work with us on that.

That would have been, yes, our expectation.

Q. Should there, in the CQC's view, be an obligation that service reviews or external reviews are required to be shared with them?

A. Yes.
Q. How would that be facilitated? Would it be an obligation on the hospital to provide copies once they received them?
A. Yes, because -- because there is an ongoing -- and the whole point during that time of having a relationship on as a single point of contact was building relationships with people. And at CQC we believe having a relationship with providers or with Trusts it's really helpful because you build those relationships based on honest transparency and being open that actually when issues do arise then people have got a point of contact of someone to talk to or to share information with, which would be the expectation for, for any provider we regulate.
But they use that mechanism of communication to share anything they -- which needs to be shared, especially something as serious as this.
Q. Now, is it the case that at this stage, so February 2017 and following the publication of a version of the RCPCH report, were the CQC still unaware that there were concerns of deliberate harm?
A. I'm not clear on the dates really in terms of when the issue of deliberate harm came into effect and I will need to, to double-check that.

LADY JUSTICE THIRLWALL: Would you expect a record to have been made of that?
A. Yes. Yes, I would expect a record to have been made when we were contacted or informed of that.
LADY JUSTICE THIRLWALL: So on the face of it, there is no reference to it in this meeting.
A. Yes, no, I can't see it referenced in the ...
MR CARR: There was the section of Mr Trenholm's statement --
A. Yes.
Q. -- I took you to at the beginning of my questions when he referred to an email in May 2017 as being the first point that the CQC was aware of a criminal investigation. Now, that email is INQ0017303.
Now, I understand from what Mr Trenholm says in his statement that this email follows a engagement call the day before on 15 May 2017 and it describes, in the third paragraph in the middle of the page, the paragraph that starts, "However, the neonatologists were still concerned ..."
And this letter reports of a Child Death Overview Panel which requested the Trust seek assurance from the police regarding any unnatural causes for the deaths.
It goes on to describe the CEO writing to the

police and ultimately, in the last line of that paragraph:
"The police have indicated that a further review of the deaths may be undertaken by a relevant specialist."
So whilst Mr Trenholm identifies this as being the point at which the CQC became aware of a criminal investigation, it's still not clear on the face of this email that the CQC were aware that there were concerns of deliberate harm by a staff member?
A. Yes. I mean, when -- when I reviewed the email yesterday the email is quite clear in terms of police involvement. But, yes, it doesn't make it clear that there was deliberate harm to -- to the babies, yes.
Q. And you can't help us with when the CQC became aware of concerns about deliberate harm?
A. My memory doesn't serve me right. I will -- I'll -- it's something I am more than happy to go back and double-check because I would expect that to have been documented.
Q. Now, in terms of the monitoring, so following the disclosure in June 2016 and in the period that followed, are you able to identify any action taken by the CQC in light of the concerns and the investigations that were being -- the concerns that were had and the investigations that were being carried out, both by the

RCPCH and then by the police? What was the CQC's role?
A. I think from, from everything I have reviewed and the conversations I have had with some of the staff involved I think CQC's position was they continued having the engagement meetings with, with the Trust and at some point, like I said, there was an action plan.
They continued, you know, talking about that action plan, asking updates in terms of progress of some of the reviews that had taken place, and what also was happening in terms of monitoring that service, making sure that service was still safe for babies who required Level 1. And, there's -- there's a point about actually when the police were involved whether there was a point for, on reflection, for CQC to think about what was our role.
My understanding during that time police will always take primacy in terms of those criminal investigations that police were taking.
We, we were maturing as an organisation. I think it wasn't long before we had got our -- some of our criminal enforcement powers and as an organisation we were maturing.
So looking back and reflecting, I think especially if you look at the timeline and the events that took place since 29 June onwards, could we have considered at

some point, especially when even the police were involved in May 2017, could we have considered our position of, of CQC in terms of what we could have been doing during that time whilst police were carrying out their investigation, considering that police investigations normally takes -- take time anyway?

So in hindsight, on reflection, we think possibly a consideration should have been. But my understanding is then police would always take primacy during that time.

If that incident was to happen again now, would we wait for police to complete their investigation? Absolutely not. When you consider as well that we have got a statute limit of three years in terms of what we can do as CQC. So when you put everything in consideration on reflection, then possibly consideration should have been made on our position at CQC.

Q. Well, the danger is that if the CQC does await the police investigation, you have just identified there is a statutory limitation of taking enforcement action?

A. Yes.

Q. So if you don't investigate, then you can lose ability to take any enforcement action at all?

A. Yes.

Q. Is it your understanding that it was the

police investigation that led to the CQC effectively to take something of a backseat in terms of its monitoring because there wasn't an inspection of Child and Young People's services in 2018 either, was there?

A. Yes, and, and also the -- I suspect it was also during the time that we sort of changed the methodology as well from comprehensive to, in my understanding, to risk-based inspections towards 2018/2019.

And from what I have seen, I wouldn't necessarily say whether it was taking a backseat or not, Mr Carr. I would think, at that point, I suppose the focus was more of my understanding was the engagement with the Trust, thinking about what was being done to -- to make sure, you know, babies were safe in those services and what the organisation was doing and monitoring that.

But I am saying -- obviously I wasn't there -- but when I look back now, I think that that the point of professional curiosity of thinking about what else is happening and also thinking about focusing on possibly safeguarding, you know, thinking about, you know, looking at it from a lens of safeguarding and thinking about what else could be done and I suppose thinking about, you know, what else could other organisations, you know, between ourselves, NHS England,

NHS Improvement.

So what I am saying, on reflection, there are so many areas that I could think of possibly, you know, one could have considered during that time to try by all means to make sure we build a case in terms of what was happening during that time in, in Countess of Chester Hospital.

Q. In summary and in respect of the monitoring, does the CQC consider that it should have done more to interrogate what was going on because if we -- the chronology we have just looked at, the CQC was told it had been sent the Thematic Review and the Brigham Report.

Its position is it hadn't; it never requested clarification or those documents. It only received the redacted RCPCH report and then when it was published to the entire world and it appears to have been unaware of the suspicions of deliberate harm for an undefined period but at least a year.

Now in light of those factors, does the CQC as regulator accept that it should have known, it should have done more to know what was going on at this hospital?

A. I mean, questions should have been asked. I mean, I think that's -- it all comes down like I said

to the professional curiosity of just asking questions in terms of like if you follow the timelines like you have articulated, Mr Carr, you know, were there points where possibly one could have actually as a regulator think about asking more questions and, you know, requesting the documents to be submitted to us.

Like I said, I am not aware or can say yes or no whether those documents were requested during that time. But I would expect that, you know, if someone is saying to you, you know, we are carrying out a review, you would want to know more about the review if, if, if what is going on the Terms of Reference. Yes, there will be that expectation, especially now if something would happen now, those are the questions I will be asking in terms of wanting to know more.

Q. Just to close this topic, Mr Dzikiti, you started your previous answer with a qualification "possibly" and just reflecting on, for instance, the email referring to the Thematic Review and the Brigham Report we don't need to qualify that with: it would have been possible to request.

If you are being told by an entity that you regulate there has been an increase in neonatal mortality, we have done two reports on it, that is something that the regulator should be asking for, isn't

it?
A. Yes. Yes. Now I would.
MR CARR: My Lady, is that a suitable time?
LADY JUSTICE THIRLWALL: Very good. So we will rise now and we will start again at 10 past 2.
(1.09 pm)
(The luncheon adjournment)
(2.10 pm)
LADY JUSTICE THIRLWALL: Yes.
MR CARR: My Lady, thank you.
Mr Dzikiti, if we can consider, please, the duty of candour. I am going to take you to two sections of Mr Trenholm's first witness statement, INQ0012634.
If we turn to page 10, please, you will see there a section, Mr Dzikiti, titled "Duty of Candour" and at paragraph 43, Mr Trenholm describes what that duty is.
Have you considered that bit?
A. Yes.
Q. And if we go forward, please, to page 30 of the statement -- sorry 3-0, forgive me -- and we see another section titled "Duty of candour".
Paragraph 151, Mr Trenholm describes two types of duty of candour notifications, statutory and professional and he states that in the following sentence:

"CQC's guidance relates to the statutory duty which we regulate as opposed to the professional."
Is it the position then that the CQC in terms of regulation regulates the organisation rather than the individual?
A. Yes, that's correct.
Q. The Inquiry has heard evidence from Sir Robert Behrens, and I think you have been directed to a section of the transcript of evidence where he deals with the duty of candour and one of the criticisms that he made was that the duty of candour does not work because it doesn't apply to individuals; and, secondly, that the fines are too small to impact the behaviour of leaders.
What's the CQC's position in respect of the duty of candour as it applies to organisations?
A. For -- for organisations? So, I mean for organisations we are quite clear of our expectations as set out in, in the statement in terms of what we expect organisations to do when it comes to being open and transparent. There is something about when, for example harm is happened, you know, we expect that to be open, the organisation, and also make sure there is support to the people who are the victims of that harm happening.
I think over the years, I think since 2020, if my

memory serves me right, we have successfully prosecuted organisations around duty of candour, I think seven of them.
Q. Seven?
A. Seven I am aware of, we have prosecuted in terms of duty of candour.
So it is an expectation, you know, as time moves on I suppose we are getting better as we mature as an organisation in terms of how we deal with that, but our expectation is quite clear, our guidance is quite clear of what we expect organisations to be in terms of openness and in terms of being transparent.
Q. Insofar as the duty is concerned, do you accept that the regulator duty by the CQC is a duty on an organisation rather than --
A. Yes, it is to the organisation, yes.
Q. And so far as successful prosecutions, are you able to help us with what the fine was or the result of a successful prosecution was?
A. I mean, I can't, I cannot recall the exact fine but I think one I can remember I suppose because it is public knowledge, it is Plymouth NHS it was around the issues of being transparent when harm has happened to a service user, to a patient, and we felt that actually they were not being open and transparent

throughout the process of dealing with that Serious Incident and -- and we successfully prosecuted them.
In terms of what was the fine, I can always come back, my Lady, if that's okay, in terms of the exact but we can provide more details on those seven which I've referred in terms of more details if required.
LADY JUSTICE THIRLWALL: Thank you.
MR CARR: If we go forward, please, to page 32 of the statement. At paragraphs 164 and 165, under the heading "CCTV", and we can see that Mr Trenholm addresses the issue of CCTV here stating that there's not information held by the CQC on the number of Trusts with CCTV and at paragraph 165 he addresses a potential basis to impose conditions of registration in respect of CCTV.
Has the CQC done any more work in relation to the potential benefits of CCTV specifically on neonatal wards?
A. Not that I am aware of.
Q. Is there anything that you can add to these two paragraphs on CCTV?
A. I mean, I do, do I agree with, with what Mr Trenholm was referring in terms of the complexities when it comes to CCTV? Hence, we don't have a position as such on what organisations can do. But what we have

tried to do is to provide some guidance on those organisations who decide to -- to use CCTV camera on areas they should consider of things like if you use CCTV, how do you use it? Where do you store the information? Who's got access to the information? And then consider in the right to respect for private and family life.

So what I am saying is some organisations not in neonatal services but for example in mental health CCTV is more regularly used by, by providers and like I said earlier, it has to a certain extent informed some of our inspections, especially when we are trying to gather more information about an incident.

Q. Did you say -- sorry, I may not have caught it correctly, did you say the CQC does provide guidance to healthcare providers?

A. Yes, for those who want to -- to use CCTV in terms of what areas some -- to consider.

Q. The issue of medication is addressed in both of Mr Trenholm's statements. If we go forward, please, to page 35 of this statement, and if we look at paragraph 184, Mr Trenholm states:

"The vast majority of cupboards, including controlled drug cupboards, are not electronic and would be open with a key or using a coded keypad. Ordinarily

therefore there would be no record of someone accessing the cupboard unless they removed an item where there was a legal requirement for it to be recorded, such as certain and controlled drugs."

Is the CQC's view that this needs to change and that there should be an electronic system for accessing any drugs?

A. I suppose this, this sits with providers. So we, we haven't issued in terms of guidance on how providers should look after medicines or, you know, controlled drugs. What we are quite clear is there has to be a process of managing medicines and controlled drugs.

If your question is about what we think in terms of whether there has to be an electronic way of managing medicines I suppose it's for providers to consider the best way which it safely can be, you know, implemented and managed within a provider to make actually you are quite clear in terms of who is accessing medicines, especially controlled drugs and I do appreciate the point Mr Trenholm was making of actually it's hard to tell who has accessed those medicines if you are using a key to lock and unlock a cupboard, whereas possibly an electronic way of accessing might help in giving that information going forward.

Q. So it would be beneficial?

A. It would be beneficial, yes, but we don't have a position at CQC.

Q. And I asked the question broadly in respect of medications. Has the CQC, in light of the events that we are concerned with at this Inquiry, has it done any work or has it reached any view in respect specifically of insulin and whether extra steps need to be taken for the secure storage of insulin or access to it?

A. Not, not that I am aware of.

Q. And if you stay on this -- sorry, in fact if you go back to page 32, thank you, and paragraph 162, this is Mr Trenholm's first statement, it states:

"CQC's guidance on how providers can meet the regulations has not been revised in light of the Letby case and nor have the regulations that underpin our work."

Now, this is the first statement, the statement from February 2024. In light of the evidence that has been heard at this Inquiry, have any changes now been made to guidance or the regulations underpinning the CQC's work?

A. Obviously we are going through changes in CQC. And, and as part of those changes I think one thing I can sort of reflect on thinking about, about is

discussions around the statute limitation of three years where it's a challenge in terms of trying to -- to investigate, to address concerns, investigate, bring a prosecution or enforcement within those three years.

And my understanding from talking to -- to colleagues and legal colleagues is previously I think that they have attempted to -- to request considerations of that statute of limit to be considered whether it can be taken or not, but I do appreciate there is some concerns around, you know, how long can it be, you know, you make it, once you take the, those limitations, then the providers don't know how long it would take for something to come as a case towards them.

But I think for us it is one area we have been reflecting on in terms of just the limitations of those three years.

But I suppose some of the work in terms of just actually learning from the issues I discussed earlier around professional curiosity, thinking about, you know, how we use our data and definitely. But one which comes to mind is that limitation of three years.

MR CARR: My Lady, those are my questions for Mr Dzikiti. I know that Mr Sharghy has some questions.

LADY JUSTICE THIRLWALL: Mr Sharghy. Thank you, Mr Carr.

Questions by MR SHARGHY

MR SHARGHY: Good afternoon, Mr Dzikiti. I ask questions on behalf of one of the Family groups involved within this Inquiry.

Can I just ask you briefly on a matter that Mr Carr asked some questions with you a few moments ago and that was in relation to the duty of candour and I listened to your answer very carefully in regards to what the CQC expects or expected of Trusts in particular in relation to the provision of information to service users and also indeed to the CQC.

If, however, the Trust are less than forthcoming, as the Countess of Chester the Inquiry has heard was over the relevant period, that makes it less likely, for example, that the service users or their family are informed of any issues regarding care; that's right, isn't it?

A. Yes.

Q. And if the Trust are less than forthcoming with clear information as to what has happened, what may have gone wrong, or indeed investigations, they are likely to also keep that information from the CQC, the GMC, the NMC and other regulating bodies; is that right?

A. There's a likelihood, yes, there is a likelihood.

Q. Yes, and so therefore the Trust or Trusts sit right at the heart and centre of information provision regarding notifiable incidences, concerns, issues regarding safeguarding?

A. Yes.

Q. The position the Inquiry has heard a lot of evidence on in relation to 2015 over to 2017/2018 was one where the Trust was less than forthcoming and in some cases deliberately withheld information, not just from the CQC but other regulators and other external bodies.

What steps can the CQC take to ensure that where Trusts are less than forthcoming, the CQC can elicit and indeed in some respects require key information that would set about further assessment and Inquiry regarding safeguarding?

A. Yes, I mean, when it comes to safeguarding, safeguarding is everyone's responsibility. You know we are quite clear about that. And, and we have got enforcement powers and we can use those powers to request for information and ask a provider to provide that information. Like I said at the start, our expectation and we are quite clear about duty of candour is that transparency, that openness and if an organisation is not, you know, we will require it to, if

they don't follow those instructions, then we will use our powers to -- to make sure we prosecute for that. Like I gave an example we have successfully prosecuted seven organisations for some of those reasons for not one being open and transparent. So we have got means and mechanisms to make sure we get providers to understand that. And we have been quite clear in terms of what we expect from providers in terms of duty of candour.

Q. Is the CQC and its inspectors now routinely asking the sort of questions you have just indicated? In other words is that part of the training for the inspectors, is that part of any guidance that they have provided are rather than expecting information to simply voluntarily be provided, that they will proactively curiously ask those questions?

A. Yes, because we have got those regulations now. You know, we have got Regulation 12, we have got it, it is clear, it is clearly articulated in terms of that expectation. So every organisation we inspect, we assess, we are following the regulations we have got to make sure actually they are compliant of the regulations and as part of looking at Well-Led, for example, we are looking at that in terms of the leadership, in terms of the culture of that organisation about being open, about

being transparent, in the event that as we gather intelligence, and we have improved our work in terms of how we work with other organisations, with other bodies. For example, you know, on a regular basis every fortnight I meet with the National Medical Director at NHSE, you know, Professor Powis, to talk about what's happening across healthcare and shared intelligence. Every month I meet with NHSE to look at their recovery support work they do for organisations plus the HSE to talk about what is happening and sharing information. And if we get to know some information that we should have been told by the provider from other intelligence gathering, then we will make sure that we follow it through with that provider to make sure we understand why that information has not been shared with CQC, for example.

Q. Thank you.

Moving on to the final question on duty of candour. What role does the CQC play in the monitoring of those that it then does enquire into, either write letters of notices to or indeed prosecute, to ensure that they actually are learning from what has befallen them before?

A. Yes, and that's -- you know, part of the engagement meetings and follow-up meetings is actually

having those conversations, understanding about actually is there learning taking place and internally as well, the conversations we have about actually in terms of those organisations my expectation would be that, you know, engagement lead who's the single point of contact in those regular touchpoints with providers understanding how is the organisation learning? How are they moving on from what has happened?

So if you have been prosecuted for an offence, what is the learning? And when we go back in, for example, to look at Well-Led is thinking about we look at the learning from previous instances, how has that learning been shared across the organisation to make sure everyone is fully aware about what is expected?

Q. Thank you.

Can I move on to another topic now and that is in relation to the culture the CQC is routinely finding within various Trusts in the NHS more generally. And for this it might be helpful if I put in front of you the first witness statement of Mr Trenholm and what he has said in relation to this factor and it is INQ0012634, internal page 51. And it's paragraphs 267, 269 and 270 in particular.

If I start with paragraph 267, Mr Trenholm refers to a question the Inquiry has asked regarding

recommendations from previous Inquiries.

What he says is:

"Our maternity inspection programme has however shown that despite multiple recommendations for maternity services, we have found shortfalls in the quality and safety of care including concerns about the identification and management of risk to women and babies and strong safety narrative where quality and safety is well understood and embedded throughout the service."

He then goes on at paragraph 269 to specifically refer to the state of care annual assessment that a report on this carried out 2021, 2022 and 2023 and says this:

"In our latest report published on 29 October 2023, we set out that many people are not receiving the safe, good quality maternity care that they deserve. Our report notes issues around leadership, staffing, and communications."

The following paragraph just specifically picking up on this says, last sentence:

"We also have concerns about problematic working relationships between service level managers, neonatal, midwifery and obstetric leaders."

All of what Mr Trenholm has said here chimes very

much with the majority of the evidence that this Inquiry has heard as to what was occurring at the Countess of Chester between 2015 and 2017.

If these problems have been existing for that length of time, what is the CQC capable or able to do to help Trusts and the NHS nor widely to address them?

A. So -- so some of the reflections from Mr Trenholm is the work we do at CQC. So the National Maternity Programme, for example, we do that work as a response to what was happening at Shrewsbury and Telford review and we, we undertook all the services we had not inspected, for example before 2021 to look at what is happening in maternity care and came up with some recommendations. We published a report last year on the work we had done in 2023, for example, highlighting some of the challenges in maternity care but we did not just highlight the issues or the challenges. We also -- as part of the publication we published a programme of work or some recommendations, a programme of work to offer to providers in terms of tools they can use to improve maternity care and also our expectation of what we are expecting from maternity services.

On top of that we have had continuous discussions with NHS England, for example, to think about actually

some of the work they are doing in NHS England to provide the maternity services with the requirement of improvement tools they need to improve maternity services.

One issue we keep on picking up and it comes on-coming out in almost every review we do, it is around workforce, for example. There is a challenge around having enough workforce. So having those conversations and talking with NHS England in terms of what can be done to make sure there is enough workforce in terms of midwives in those services.

So instead of just us highlighting the gaps in maternity services like I said we are also highlighting improvement tools to support those organisations in terms of the work that they need to do but on top of that, we are also using our enforcement powers. It's public knowledge we have prosecuted some organisations for failure. In Nottingham for example we have successfully prosecuted them for two, for failure in terms of the care expected to be given to mothers and babies in those services.

So that's for me what we are saying to providers is: our expectation is we expect high quality of care in terms of maternity services. Where we find shortfalls and gaps, where we require enforcement powers to be used

we are using those and successfully prosecuting those services.

Q. I understand the enforcement powers, I understand the actions taken once you identify an issue, but this particular matter in terms of relationship cultural problems that exist and have -- continued to exist, is that something that the CQC is able to also provide recommendations on other than the number of nurses, the number of midwives et cetera? Or is this for another organisation?

A. I mean, I mean I know definitely in terms of, you know, cultural issues, I know NHS England has got a programme which looks at culture, you know, helping an organisation to think about their culture and to develop their culture and think about the practice in that culture. But also for us I think, I think for CQC when we look at Well-Led of that organisation we are also looking at the leadership in that organisation in terms of what the leadership is like, things like for example you know Freedom to Speak Up, whistleblowing, especially Freedom to Speak Up, you know, the psychological safety and emotional safety for staff to be able to highlight within they see poor practice or even just an element of a likelihood of poor practice; that people are able to raise it before it becomes a big problem within those

organisations.

So that's part of what we do and we do our Well-Led to make sure we are assessing those services to make sure actually, you know, in terms of Freedom to Speak Up, like I said, how well is it working? Because we know that when it is working, people are able to raise some concerns with us and we have used that intelligence to go in to check for ourselves what's happening in the service before actually we get to a point where we have got high instances happening.

Q. Thank you.

Final question. Having reflected not just on the evidence that the Inquiry has heard to date but also indeed the self-reflection that the CQC has carried out, in your view, what more does the CQC need, whether it's funding, whether it's additional resources or inspectors, or what does it need to be able to do more effectively to do what Mr Trenholm indicated, which is actually allow Trusts to provide the safe and good quality maternity care that they deserve?

A. Well, I think on, on reflection you know there are so many points to focus on. Something about what we do as a healthcare system and all of us, I mean in terms of CQC including other stakeholders, in terms of system working, when I look back and think I mentioned early on

about safeguarding, about how important safeguarding is, how important organisations should be working together especially regulators, ourselves, you know, NHS England thinking about professional bodies, how best can we work together to try and support maternity services and system working as well.

I think in 2022 the Health and Social Care Act 2022 gave us some powers as CQC to look at system working which we have not started using but we are hoping very soon to be using, to look at system working about how are actually organisations within the system working together to make sure, for example, they are providing safe care and for example they are addressing issues in maternity services because some of those things need to be a system-wide approach.

And there's more in terms of learning as well, in terms of seeing, you know, is there more we can do in terms of keep on encouraging our staff. Like I said earlier the professional curiosity of thinking about actually what more can you ask, what more can you even just trusting your instinct and also keep on promoting Freedom to Speak Up, keep on promoting whistleblowing, to make sure actually people feel safe to identify that.

I think earlier on there was some reflections around whether there is, you know, regulation for, for

senior managers. I think, yes, serious consideration should be, should be made to think about whether it's something as a healthcare system we should consider regulating managers especially within the NHS, I think it's something to take back to -- to discuss and reflect on.

MR SHARGHY: My Lady, thank you, those are my questions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much, Mr Sharghy. Presumably that has already been thought about, given the consultation at the moment?

A. Yes.

LADY JUSTICE THIRLWALL: Is there a view from CQC about it?

A. Yes. I mean, for us I think it's -- we would contemplate it and say it's something seriously to consider from our part.

LADY JUSTICE THIRLWALL: Yes, I appreciate it is something to consider. But is the review about whether it should be done or not?

A. At the moment we, we haven't referred ourselves per se to say should we be doing it, but if I was talking about a position, it is something we will need to seriously consider who does it.

LADY JUSTICE THIRLWALL: Right.
A. I think that would be the question who does it and I think for CQC we have had some conversations about is that something possibly we could do because we do it for other sectors, we do it for social care, for example, and independent health where they have got registered managers, so we do that.
So it's something we would think possibly we might be able to help going forward.
LADY JUSTICE THIRLWALL: So in principle you think regulation is a good idea and the issue is by whom it should be done; is that a fair summary?
A. Yes, I think it is, it is a good, a good idea but more will need to be discussed in terms of the process of doing it. Yes.
LADY JUSTICE THIRLWALL: You mentioned the response to the Dash Report and I just want to make sure I have properly understood this. You talked a lot earlier in your evidence about process and not at all about outcome but then when you were talking about the response to Dash, my understanding is that this is a shift to processes which are much more outcome focused; is that right?
A. Yes, that's correct, yes.
LADY JUSTICE THIRLWALL: Yes, thank you.

Looking at the position of analysts, obviously we have only looked at part of what they do in the context of a particular inspection of a particular hospital. But just so that I understand it, the analysts are not clinically trained; is that right?
A. No.
LADY JUSTICE THIRLWALL: And so their job is to look at the information that comes in, the numbers and then to draw something from the numbers to analyse them and see if there's something to be said; is that what their role is?
A. Yes, and what I would hope, my Lady, is over a period of time talking to the analysts, for example, I was talking to who have been looking at healthcare records for nearly two decades. Over time some of them have gained that expertise because it's something they do on a daily basis, but their background --
LADY JUSTICE THIRLWALL: Well, what expertise?
A. No, what I mean is of looking at medical records.
LADY JUSTICE THIRLWALL: How to look at -- do they look at medical records?
A. No, sorry, I am talking about the information we receive we, especially safety data. Sorry, pardon me.

LADY JUSTICE THIRLWALL: Yes, that is all right, we are just slightly at cross-purposes.
Thank you. One of the points that was made in the statement, and I think you have also picked it up, is that there's too much information for the analysts to look at the detail and so they have devised a way of just reducing the amount of information by taking out certain levels, so the low harm/no harm sections?
A. Yes.
LADY JUSTICE THIRLWALL: The other way of doing it I suppose would have been to have more analysts so that's a resources issue, presumably?
A. Yes.
LADY JUSTICE THIRLWALL: Yes. Okay. Thank you.
Going back to the 2016 inspection. The outcome was that under the Well-Led section, the Countess was rated as "good".
A. Yes.
LADY JUSTICE THIRLWALL: And we don't have the notes for the reasons that we have already gone through. But we do have some evidence which you will have read from one of the advisors that she held a focus group with a large group of Consultants, not just paediatricians, but Consultants generally.
A. Yes.

LADY JUSTICE THIRLWALL: And that the only note that there is is to the effect that they were raising the fact that senior medical management were bullying or some such phrase.
A. Yes.
LADY JUSTICE THIRLWALL: Now, is that not something that perhaps ought to have featured somewhere in the consideration of whether the hospital was Well-Led? What should have happened to that information?
A. I think my expectations would have been, you know, further conversations. So I would --
LADY JUSTICE THIRLWALL: Further conversation with whom?
A. With, for example, the Chief Executive or the Chair. Because it's quite serious, you know, in terms of -- if you have got a team saying there are some issues around bullying or harassment. So I would have -- my expectation would have been further conversations to really clarify, to go under the skin of what was really happening with the most senior people within the organisation and the Chief Executive and the Chairperson would have an ideal person to have those conversations with.
LADY JUSTICE THIRLWALL: Yes, thank you. I think we know that the advisor believed she may have raised it

with the Medical Director but she wasn't sure and he didn't have any recollection of it having been raised with him. But I think your point is the question should have been raised at a higher level with the Chief Executive.

A. Yes.

LADY JUSTICE THIRLWALL: And the Chair.

A. Yes.

LADY JUSTICE THIRLWALL: I mean, is it fair to say that it's quite surprising that that information didn't find its way to the right people?

A. Yes, and -- and we did apologise obviously some of that information we don't have access to.

LADY JUSTICE THIRLWALL: No, no but what we have got?

A. But, yes, it is when I look back now on reflection, yes, you know, it was right to raise it with the Medical Director but it was also very, very important to raise it with the Chief Exec and the Chairperson.

LADY JUSTICE THIRLWALL: Yes, and then something, presumably the Consultants would have had some expectation having said something --

A. Yes.

LADY JUSTICE THIRLWALL: -- in the interests of

being open and transparent and actually nothing happened?

A. No.

LADY JUSTICE THIRLWALL: That is the reality, isn't it?

A. (Nods)

LADY JUSTICE THIRLWALL: Then going back to what wasn't said. So June 2016 you get the email which we have gone through in detail, but you know the one I mean?

A. Yes.

LADY JUSTICE THIRLWALL: Which says you have already had our Thematic Review and then it says quite a lot else following up on a telephone conversation?

A. Yes.

LADY JUSTICE THIRLWALL: Which coincided with the publication of the report, that was probably the prompt I think for the call?

A. Yes.

LADY JUSTICE THIRLWALL: But again, I mean, just briefly. You don't need hindsight I don't think for this. We have got a team of inspectors or an inspector and advisors who have not been told anything about mortality in the neonatal unit.

Then some months later they are told that which

appears in the email. Was there not, do you think, an expectation that the person receiving that information and the CQC more generally would have gone back immediately to say: well, hold on a minute. Where is the report? We haven't got it. You know, whether or not there was a mistake about whether it had been sent is not the issue.

The point is you didn't have it so far as anyone can tell and there seems to have been no challenge of all the people that you spoke to, not you personally but CQC spoke to to say: well, this is important information, why were we not told where is the openness and where is the honesty in relation to that? Would you not have expected that?

A. Yes, I would have -- my Lady, I would have expected that because I suppose when I look back and think how the events transpired, we published a report and then we were then informed immediately after publishing the report about the reviews which had taken place.

LADY JUSTICE THIRLWALL: We have been through that, I don't want to cut you off, you have explained all of that.

A. Yes.

LADY JUSTICE THIRLWALL: What there isn't is any

challenge of the hospital for the absence of that information before 30 June. There's just no challenge at all.

A. Yes, no, I would have expected a challenge.

LADY JUSTICE THIRLWALL: Yes. Well, there should have been a challenge, should there not?

A. Yes.

LADY JUSTICE THIRLWALL: And the reason I am so interested in this is because it may indicate the extent to which there was any effective probing of the information that was being given during the course of the inspection, given its total absence when this information, which on any view was pretty startling, was received.

Is that a fair inference to draw, do you think?

A. I think, yes, one could conclude that and one thing I -- I totally agree with you is, you know, yes you know we should have, we should have probed a bit more, that professional curiosity I was talking about earlier, we should have asked more questions --

LADY JUSTICE THIRLWALL: You must be a bit cross apart from being curious?

A. Yes, but asking the question.

LADY JUSTICE THIRLWALL: Yes.

A. And, and to a certain extent holding people to

account in terms of actually, you know, we didn't see this information, can we see the information? So it is no longer just a question of: we did not see the information, it's now you have got the information can we have the information?

LADY JUSTICE THIRLWALL: And "why didn't you tell us about it before"?

A. Before, exactly. So those questions, I would have expected them to be part of the conversations. Even in the follow-up conversations we had, I would have expected those conversation.

LADY JUSTICE THIRLWALL: Yes, thank you very much indeed.

Ms Richards, I'm sorry, I didn't ask if you have any questions.

MS RICHARDS: No, it's okay.

LADY JUSTICE THIRLWALL: I am sorry to ask at a later stage. Anyone else want to ask anything else?

No. Good, thank you very much for coming to give your evidence. You are now free to go.

A. Thank you, my Lady, Mr Carr, thank you.

MR CARR: Thank you.

My Lady, I am going to hand over to Ms Brown who is dealing with the next witness.

LADY JUSTICE THIRLWALL: Thank you very much

indeed, Mr Carr, and I think we have got Ms Murphy coming to give evidence, haven't we?

Do come forward. Sorry to have kept you waiting so long, we are just going to wait for everyone to settle down with the change of counsel and then it will be your turn, I know there is nothing worse than waiting all day so I am very grateful to you for being here.

MS FIONA MURPHY (sworn)

LADY JUSTICE THIRLWALL: Do have a seat.

Questions by MS BROWN

MS BROWN: Could you please give your full name?

A. I am Fiona Doune Murphy.

Q. And you provided a statement to the Inquiry dated 1 August 2024 and is that statement true to the best of your knowledge and belief?

A. It is indeed.

Q. If I can start by dealing with your qualifications, expertise and some of the roles and experience you have in relation to bereavement, you are a Registered Nurse and have worked in a number of hospitals in critical care; is that correct?

A. It is.

Q. Have you ever worked in a neonatal unit as part of that?

A. So I haven't specifically had a role in

a neonatal unit but I have cared for patients in neonatal units as part of my role as a bereavement nurse, yes.

Q. And in 2004, you were involved in setting up the bereavement and donor support service?

A. I was indeed.

Q. In 2016, you were awarded an MBE in recognition of your work within nursing and specifically in the area of bereavement?

A. Yes.

Q. Also in 2016 you became a patron of the Good Grief Trust, the umbrella charity for over 1,000 charities for bereavement support?

A. Yes.

Q. In 2017, you led the immediate support and aftercare of the Families of the deceased victims from the Manchester Arena bombing?

A. I did.

Q. And in 2022 you commenced role as A corporate Director of Nursing at the Royal Liverpool University Hospital and you retired from that post last year in June 2024?

A. I did indeed.

Q. Could you just briefly outline what that last post encompassed, your most recent post?

A. So my final post in my nursing career of 40 years gave me the responsibilities of looking after three hospitals, so I looked after the Royal Liverpool, I looked after Aintree Hospital and I looked after -- my responsibilities were quality improvement, my responsibilities were end of life care and bereavement and my responsibilities were the ward accreditation systems across the organisation. I looked after the Chaplaincy teams, I looked after all patient experience responsibilities across each of the hospital sites and everything to do with that. And had major input into the international collaborative for end of life care with Liverpool University to pursue the SWAN model of end of life care, which was one of the reasons that I came over to Liverpool.

Q. Thank you. And your current situation, are you now retired or do you still have a role within the NHS as your current role?

A. So I have retired but I still do work with the Good Grief Trust and I still do a little bit of work outside of the NHS.

Q. Thank you. Turning to first of all look at the SWAN model that you discuss in your statement, if we could just have up INQ0108720. And that should be the front page of the booklet setting out the SWAN system.

We see there at the bottom of that heading page:
"To promote dignity, respect and compassion at the end of life and after death."
Which I think is self-explanatory.
But the next phrase:
"Permission to act and break the rules that don't exist."
Could you just explain that a little, please?
A. Of course I can. So historically, when nurses in particular look after end of life care patients or patients that are dying immediately have died, often healthcare professionals, particularly nurses, are often fearful of either distressing a family more than they are already distressed because the person that they love has just died, so we are frightened of upsetting them more but doing something with their deceased relative, their dead baby or the person that they care for, or we are frightened of getting something wrong because we are frightened of going outside of process.
So often, we can make a situation worse because we are fearful of getting something wrong.
So we often -- and the majority of NHS staff, don't have advanced communication education or training and so our generalists are not specialists in end of life care in whatever field of nursing they work in. So whether

you work in a neonatal unit, whether you work in a critical care unit, whether you work in any aspect of healthcare, we are not skilled particularly unless we have chosen to do an advanced communication skills course or a bereavement end of life care course where we are equipped with a skillset to be able to have a difficult conversation, or we are really attuned to our end of life care bereavement policies within our organisation which are usually pages and pages long.
And the pressures on the nursing staff, so I am going to say nursing staff because it's usually nursing staff that look after these families that are in acute bereavement phase, that is one of hundreds of policies, and do not go and read those pages and pages of policies so they don't know the minutiae of what's in that information.
So often staff don't understand all the things that they can go and do. So --
Q. Can I just stop you there by going on to the policy because I think if we look at that, that will help us go through that.
A. So I am just trying to describe permission to act. So the SWAN model is about it's okay to have conversations that matter with families and we are not always breaking policy by having a conversation and

asking a family what matters to them right in this moment in time because we are not breaching anything and nobody is going to get into trouble by asking somebody: what really matters to you right now?
Q. Thank you. And if we could go then to page 6 of this policy, I think that probably illustrates -- and this policy is not too full of words, it sets it out very clearly, if we can go to page 6. Sorry, it's INQ -- 005 is the reference, one back. Yes.
So Ms Murphy, could you just -- obviously we have got the acronym SWAN there, but just set out briefly what those four steps are and how that helps the nurses to break the rules when necessary and give the care under the SWAN principles.
A. So we have tried to simplify it. The SWAN model, when I and others -- when we created the SWAN model it was just to make it as simple -- and one-page "read it, understand it" -- as possible.
Private space: really, really important. The use of language: really sensitive, communicate with the family. Step out the box. We really need to know what's important to a family and those walking alongside that journey with them to make sure that we can facilitate it and not just talking the talk. Are the needs of the family being met, are they documented? Are

we reviewing them?
You might ask a family something of what they want in one moment and half an hour later they may have changed their mind because you might have planted a seed, they might have had a conversation and actually maybe the sibling that they didn't want bringing in because they didn't think it was right, they have thought about it had a chat and maybe they do want to bring that sibling in half an hour. So it's really, really important that we go back and we have that conversation again and often repeated and making sure we are reviewing and having those conversations again.
So I just think it's really simplistic; the more simple we make things the more chance people are going to adhere and do what we need them to do.
Q. And the page we are looking at here is the SWAN model care for individuals who have Sudden Unexpected Death. Obviously the Inquiry are looking specifically at neonatal death.
A. Yes.
Q. Are there things that you would like to add in terms of that best practice that would be specific to neonatal care where there's been a Sudden and Unexpected Death?
A. So I think, you know, it can be adapted to any

setting and I think a group of neonatal specialists could sit and tweak that accordingly. But actually that could be -- in my opinion that could be picked up and tweaked up to the neonatal setting in exactly the same way.

A Sudden and Unexpected Death in any setting is a Sudden and Unexpected Death and actually the processes are very, very similar. So actually the specialists in each of those areas, a Sudden and Unexpected Death in the community would be tweaked in a very similar way so I actually think the specialists in those particular areas could have a look at it and see how they could tweak that themselves, if it needed tweaking.

Q. Thank you. And if we could just go over to the next page, then, page 0006. We will see there again very briefly but clearly set out some of the actual practical examples we see in terms of under "Good for the dying patient, dignity and respect, well-informed and prepared, compassionate care". And then probably relevant to the neonatal context in terms of family and friends, "Informed and prepared, practical support" and examples are given of the practical support in terms of drinks and food provided, car parking, "Supported moments and memory-making".

Is there anything you would like to expand upon

there in terms of those very sort of practical points in terms specifically with a neonatal death?

A. So I think those conversations with families for supported moments, memory-making are really, really important and neonatal unit, as in any other death, I think those conversations to ask what is important to those family members really, really matter.

And that takes me to families, sometimes they want to take their babies home after death, and that's okay. That can be done. But unless we have those conversations, after death we don't know that until we speak to those families, but we don't want to miss that opportunity.

That -- that's okay but we need to have those conversations so that we can ensure that we can make those memories happen because they may want to put their deceased baby in their Moses basket in the nursery that they had prepared at home, but we can facilitate those things. That's really, really important.

So I think it's those conversations that really, really matter. They are really, really important.

Neonatal donation is really, really rare but it's still really important and it may be possible. Those conversations are also really, really important and you don't want to miss that opportunity because that's also

a really practical moment. So that liaison, collaboration with the Consultants, with the specialist nurses for donation, that you are working with collaboratively, these relationships I cannot stress enough how important they are with the people that we are working with.

And I think a benefit of the SWAN model is that these things are prompts so that we are not missing anything and often all of these things that we are discussing here today are things that nursing staff are often really frightened to raise because they are difficult conversations because we are also fearful that we don't want to distress the family further. But actually, we are not distressing the family further; we are actually giving the family some control in a really uncontrolled situation and I think that's really important at this really awful time.

Q. And the SWAN model, you referred to this in your statement, was created and developed in 2012. It's since been rolled out across 70 care organisations you say in your statement. Are you able to give an indication of the number of hospitals that are now using the SWAN model?

A. So all of the time more organisations, not just in the UK but abroad, are taking on the SWAN model.

Just in the last month, a hospital in Portugal have implemented the SWAN model. They are coming from everywhere and that's because the model is out there as part of the International Collaborative for Best Care for the Dying.

Many organisations across the UK, and I am not sure since I have left work in June last year, how many. When I left in June last year, we had an International SWAN Summit in June and there were 55 organisations in the UK that had adopted the SWAN model of care. And we had done a research study, which was funded by the Burdett Trust, who had looked at all sorts of indicators and I think the paper actually is in the pack as evidence and actually the organisations where there had been Executive support through the CQC outputs were doing really well with the SWAN model and their outputs were really, really good but the ones where there wasn't senior leadership support, the implementation was proving to be really, really difficult.

So my advice and my advice would be we need really senior leadership within the organisations for the SWAN model to work.

Q. And with those organisations that are adopting or have adopted the SWAN model, that would include neonatal units with it?

A. Yes.
Q. That includes hospitals with neonatal units.
What is it that leads to a hospital to adopting the SWAN model? How is that --
A. The organisations that I have personally worked with or the jurisdictions have been under the Coroners' jurisdictions and it's been really, really -- the catalyst for implementation of the SWAN, my Lady, has been because we have worked really closely with the Coroners' jurisdictions and I think that's because the Coroners have seen particularly the benefits of having a bereavement nurse and that was definitely part of the catalyst of me moving to Liverpool from Greater Manchester because our, the Coroner in Liverpool wanted to have a bereavement nurse within his Coroners' Office. And that had really helped.
I am also aware in Newcastle that was exactly the same way that the hospital took over the SWAN model, was because their Coroners' office up there wanted a bereavement nurse. So I think the support of the Coronial service has been really, really helpful in ensuring the SWAN model within those organisations.
Q. Is it your view that the SWAN model should in fact be rolled out entirely across the NHS?
A. I think the benefits and the reduction in

complaints in the organisations where the SWAN model is -- speaks volumes and that actually speaks for itself because you can see complaints drop quite dramatically and I think the fact that you can see complaints within organisations in regard to bereavement and end of life care reduce is a quite a clear indicator.
Q. And you spoke there about training bereavement nurses. How does the training work, would it be that all nurses working would have some training of the SWAN or would there be specific nurses who would be the champions, so to speak?
A. So the -- I think the SWAN model could work in many ways. My fundamental belief is I think that every single nurse, midwife who works in healthcare should be trained in the SWAN model, should be trained in end of life care or bereavement. Some organisations don't call it the SWAN model. The principles are exactly the same.
But I think everybody should be trained in end of life care and specifically bereavement care to take some of the fear away and I think that is definitely sporadic around the country, that is -- it needs to be a core part of our training. Particularly in Liverpool we did something new: we start the educating staff at postgrad level which was really, really important. We educated 24 staff on a postgrad SWAN scholarship and that was

really, really important and that was all levels of staff from Band 6 upwards in all aspects of end of life care and bereavement.
And so when something specific in regard to end of life care and bereavement happened in their specialist area they were equipped with the skillset to be able to have the advanced communication skills to be able to look after patients and families. Death happens 24 hours a day and we need the staff on site 24 hours a day to be able to have those conversations that matter, to be able to support our Consultant colleagues is that we are having compassionate conversations with families seven days a week, 24 hours a day to provide a better service.
Q. And when you say a postgraduate course, that would be a continuation at the end of their studies or that would be something they would -- a course they go to having worked?
A. We did it as modules, we did it as standalone modules.
Q. Moving to a slightly different but related topic, memory boxes, you refer in your statement to hand and footprints memory-making. Could you explain a little bit more about that in the context of a neonatal unit?

A. So I think, so the idea of memory-making in adults from -- for the SWAN model was taken from the work that was done on neonatal units, that wasn't something that was created for neonatal units from the work that we were doing on the SWAN model, that was something that had always historically happened on neonatal units that was something that neonatal units have been outstanding at offering to families, certainly in the neonatal units that I worked in when I did any bereavement care. And actually that's how it transferred to our adult community families of which get offered and have all of the mementos that we offer that came from neonatal units.
So that's really, really important to stress and say that is nothing new in a neonatal unit. But I think memory-making is really, really important for it to be offered to everybody and I think, I hope that the memory-making happens in all neonatal units and that is a normal part of practice and there are so many charities out there that provide memory boxes for free to neonatal units and, and I would like to think that is something that we would be accessing because it's so easy to do because so many families who have lived through the tragedy of losing a baby from a neonatal unit want to so much give back.

And these are the most precious resources that families hold on to and it is really important that -- that memories are offered to families.

Q. And just picking up then on what you were saying in terms of the numbers of charities that are involved in this area. We have, the Inquiry have had statements from SANDS who have hospital liaison advisors from Bliss who have a Baby Charter and also local charities who work in specific geographical areas.

Obviously as patron of the Good Grief Trust, you are aware of the extent of the bereavement charities. How does the SWAN model work so that there is a consistent approach over what is a large body of different charities working the sector?

A. So the Good Grief Trust is purely the umbrella and the charities are registered with their contact details and number. With the Good Grief Trust, you put in your postcode where you live, anybody can put in their postcode where you live and it will take, tell you what charities are available in your postcode area and the waiting times and what the access is for you to get support from that particular charity from whatever your need is, for whatever type of death and bereavement your family has experienced, so that you have got immediate access and I think that is what's really, really

important and the Good Grief Trust is an overarching bereavement charity, it is not a specific type of bereavement charity, it is an all-encompassing bereavement charity.

Q. And how does the SWAN model engage with all those different charities, is there --

A. So we refer to -- so depending on our families that we are working with, we will refer them to any of the charities that is needed for that particular family and we work with all the charities.

Q. Thank you.

If we could pull up now INQ0108773. This is a policy, Ms Murphy, that came in a framework after you had retired --

A. Yes.

Q. -- but I think you have been shown a copy of it in preparation for giving evidence today, and this is a framework from the British Association for Perinatal Medicine. And if we could just go to page 6 first of all, we will see there in the paragraph just below the last two lines:

"The framework for practice has been developed by consensus."

It goes on to say:

"BAPM is grateful for input from parent

representative organisations including Bliss, SANDS, Child Bereavement UK and Together for Short Lives".

So there would appear to be when drawing up these frameworks good collaboration with the charity sector, would that be your experience?

A. Yes.

Q. And if we could then turn to page 14, and that's the section of this framework that deals with loss, grief and bereavement care and we see there just going down, I am just going to pick out a few sentence:

"After the death of a baby, parents and the extended family will require bereavement support."

Going on to the next paragraph:

"Care of the baby after death is an important element of bereavement care and parents may wish to participate in the physical care of their baby's body after death as well as memory-making activities."

And then going down again it talks about the situation of the loss of a twin or triplet, noting there may be additional complexity of needing to care and support surviving siblings."

And then in the last paragraph talking about the issue of a subsequent pregnancy and the need for tailored care and support which takes their previous loss into account.

Would you agree with all those principles in relation to bereavement care, where there's been a neonatal death?

A. Absolutely I would, yes.

Q. And looking at that policy and we are going to come on to the neonatal and the bereavement pathway. Do you think there is any risk of confusion or overburdening of the NHS with the fact there are a number of different schemes? We have looked at the SWAN scheme, this is the BAPM, we are going to look at the Pathway scheme in a moment. There is the Bliss Charter, the SANDS liaison advisors. Is there any risk that there is confusion or is there sort of a cohesive approach despite the different schemes that exist?

A. So I have read -- and I have just recently this week read this because this is the first time I have seen this one that's currently in front of us and I have read them all. And when you read them, so this is in more depth than the others, they are all saying the same thing.

There's very little difference in each of the policies. For staff on the shopfloor doing the doing, I alluded to when I first started speaking in my opinion staff need simple, staff need quick, and staff need something that's really, really concise.

We need something that we can just pick up and we can just really, really concisely understand that we, we know what we need to do and because the workload is massive and we don't want to get it wrong.

So all of this is absolutely, this is a fantastic piece of work written by really well-articulated academics who have got a brilliant reputation and the people that have written this document have been really great at writing the document.

But it needs to be consolidated. For me as a nurse on the shopfloor, before I had got into a really senior position I needed a pocket card that I could pull out of my pocket because I have got hundreds of policies that I need to follow, so that I know that I am not going to get it wrong.

Q. And that probably flows into the next topic I was going to turn to which is something you stress in your statement about clear communication. And you say that one of the things bereaved parents appreciate is good clear communication by someone who's providing immediate support so they have one point of contact.

A. (Nods)

Q. What is the best way of ensuring that happens in a neonatal setting?

A. So I honestly believe the Consultant that is

looking after the family needs to articulate the immediate -- the death -- the futility of the baby's death and I think they need to be supported with the nurse that's looking after them. If there is a bereavement nurse on that unit, that needs to be with that person, ideally a trained neonatal nurse that's had an advanced communication skills training session education package. That would be in the ideal world. I don't know how normal it is for neonatal nurses to have advanced communication skills, I don't know how normal that is.

That would be the ideal because then when the Consultant's gone to do his/her work, then the neonatal nurse can go over what the Consultant has said and reiterate what has said because the chances are the family will not be able to be able to absorb everything that's been said and they can just go over it nice and gently in really clear gentle language because you won't take it in. And they can write it down so the families can understand exactly what's saying and that's not for any other reason than they have just been given the worst news possible and I think that's really, really important that that happens.

For me, in an ideal world there would be a bereavement specialist, midwife, bereavement nurse

within the organisation that could co-ordinate that care. Because when that family go home, if we say we are going to ring them because we are always in whatever organisation you are in heavily criticised if we say we are going to give them a call in a week or in a couple of days just to see how they are, once we have talked them through what the next steps are of picking up the MCCD or: you need to do this to organise the funeral, and we say we are going to ring them on Thursday and then we don't ring them until the Monday; that's horrific for a family and feedback and lots of hospital complaints is that's horrendous.

If we say we are going to ring a family on the Thursday, we must ring them on the Thursday. And if we have got somebody that's coordinating that diary of our families that we are going to ring at 2 o'clock on a Thursday, we need to make sure we are coordinated and we ring that family at 2 o'clock on a Thursday and we maintain that. That is absolutely vitally important because that's our first part of maintaining our trust and our relationship with that family.

And for me, that is a real basic and that is a starting point of us increasing our reputation and our trust and our pride in what we do. That's really important and that's simple.

Q. Thank you.

Turning to a slightly different topic, that of Medical Examiners. As I am sure you are aware that became a statutory scheme from September 2024 having existed previously.

A key aspect of course of the Medical Examiner system is that the bereaved family are able to speak to the Medical Examiner in the immediate period following the death and I just wondered your observations on how that is working in practice from the perspective of the bereaved family?

A. So I retired in June last year and it came in September, so actually my lived working experience it hadn't come in to statute before I had finished. However, we had started working with that model across Liverpool before I had finished work and we were really fortunate because we had got bereavement nurses in our organisations across the city footprint.

So I was really used to working with Medical Examiners and bereavement nurses and certainly across Greater Manchester we were used to working with bereavement nurses across all my Hospital Trusts and bereavement nurses and we were very used to working with bereavement nurses in the Coroners'.

So we didn't know how it was going to work. So in

Manchester we modelled the bereavement nurses and the Medical Examiners in exactly the same way that we did with the Coroners that the Coroners' Officers would speak to the bereaved families for the Sudden and Unexpected Deaths and then the Coroners' Officers, once they had done their formalities, would refer -- offer the option to the bereaved families of: we have a bereavement nurse here, would you like us to pass on your details?

Inevitably the families would say yes, please, and the bereavement nurses would pick up Coroner's referral. So we decided to do exactly that with the Medical Examiners in Greater Manchester. And it didn't for some reason it didn't work in exactly the same way.

So we tried something different, we didn't want the families to be bombarded with phone calls, so we didn't want them to get a Medical Officer to ring them and then a Medical Examiner to ring them and then a bereavement nurse to ring them. So we decided that either a medical examiner or a bereavement -- or a bereavement nurse would ring them, or a Medical Officer or a bereavement nurse, so they would get two phone calls rather than three and that seemed to work really well.

Whereas in Liverpool we got a Medical Examiner and a bereavement nurse would make the phone calls so the

Medical Examiner would make the phone call, offer them a bereavement follow-up phone call and then the bereavement nurse would make the phone call and usually go and do a home visit if it was something complicated and offer them one of the three levels of bereavement support and that seemed to work really, really well.

Q. So if we could maybe go to INQ0012363, this is the Good Practice Series that the National Medical Examiner's Office produces a number of Good Practice models and this is the one that relates to child deaths. And we see there if we can then go to page 4 of that policy, 004, we see at 3, paragraph 3:

"Recognise that while all deaths require sensitive interactions with bereaved people, the death of a child is likely to be particularly traumatic. Medical Examiners and Medical Examiner Officers should ensure that bereaved families are informed clearly that participation is entirely voluntary."

Then it goes on:

"Take advice from childhood neonate bereavement leads on their approach to bereaved parents and participate in training opportunities."

So I presume you would agree with that, that advice? And I suppose the question is: in order for the Medical Examiners' system to work in the particularly

sensitive situation of a neonatal death, is it your view that there should be a bereavement nurse who is there to facilitate that rather than a direct contact, although obviously parents may have a direct contact if they wish, but they should have the ability to have the assistance of a bereavement nurse?

A. Absolutely and that, that was always the case particularly more so in Manchester than Liverpool because obviously Alder Hey and that wasn't part of my remit in Liverpool, but in Greater Manchester that was very different.

We dealt with a lot of child deaths, particularly in, in Greater Manchester. But just to say the joint education of Medical Officers and Examiners routinely happened in Liverpool, all our training was together and also the bereavement nurses were always invited to the Medical Examiners' training. We were just a team.

Q. Clearly you have got very specialist experience in relation to the learning from the Manchester Arena which was a different and particular situation. But in terms of what this Inquiry is looking at and where there could in a situation be police involvement, is there anything you feel were learnings from Manchester Arena that have a crossover to a situation where there's a neonatal death and there is

cause for concern about what has happened with a situation of possible deliberate harm?

A. So, so I think just, just to say that you know unfortunately if, if you do need to refer to the police from any area that you work in in a healthcare setting, which will happen, does happen, drug error, mistake, whatever that may be, and we have to call our police colleagues, that open and honest conversation with the SIO, I have learnt so much particularly through the Manchester Arena -- you know, it was amazing what we learn.

It was really prickly at first okay, the FLOs in Greater Manchester felt the bereavement nurses were going to step on their toes, what their job was, but actually once we sat in a room and we knew our remits and our roles were really, really different, we had a totally different skillset. When we looked after all of the victims we learned so much from each other and, yes, process was followed the whole way through. Every bit of legal process had been followed caring for those families bar none.

We were able to teach the FLOs lots of things that we could do with those families in regard to memory-making without absolutely causing anything that would impede or cause any issues to the care that they

needed to provide for their process and policies and they were able to teach us so much for a disaster that was happening because we really didn't know, we just wanted to care for these deceased victims.

And if you are in a hospital setting and we need to get police involvement because of a Sudden and Unexpected Death, there are still things -- so we couldn't necessarily take memories, handprints or footprints in the moment because of a crime scene as being because of a baby but we can sit with a family and we can be really, really open and honest and say: today we can't create memories and handprints and footprints of your baby but what we can do is we can speak to the police and they are going to be able to tell us when we can do that and we will tell you immediately and we will be able to go and do those tomorrow evening because that's when they have said that we can ...

So actually really, really importantly by keeping families informed every step of the way and we are not saying: no, you can't have any of those things, and that blanket that they want to have wrapped round their baby, that the police don't want us to wrap round that baby because they don't want us to hinder process. We can say but it's okay because we can put the blanket at the bottom of the baby and when the police's postmortem has

finished, they have promised that they are going to wrap that blanket around your baby. And that might not be what they want to hear, but do you know what, those families will respect and cope far better than thinking: What's going to happen, I don't know, because they know something and that's a far better place to be.

And I think by building relationships with our police colleagues and our Coroners, that is a much better place to work.

So for me enhancing our relationships with our SIOs and our Coroners and our Medical Examiners can only be of massive benefits to our patients and our families that we are caring for. That has got to be a good thing.

Q. And at paragraph 15 of your statement you set out some of the principles in the particular context of death of a baby on a neonatal unit in terms of best practice and you have covered some of those already.

But what you say is the anticipated death or fact of death should be articulated by the Consultant with responsibility for the baby that that should be with a bereavement midwife or nurse available for immediate follow-up that the conversation should be face to face in an area of privacy and parents should be given as much or as little time as they wish with their baby.

The question is: is that something that you think is happening on neonatal units at the moment?

A. So I can't honestly sit here and say "yes, it is" or "no, it isn't" because I truly don't know. I haven't been in a neonatal unit for the last four, three and a half years, so I don't know.

I would like to think it was happening but I really, really don't know. My last experience in a neonatal unit was absolutely it happened and it was a -- it was a tragic but a beautiful experience that was my last experience, but I really don't know.

Q. If we could just turn now to the National Bereavement Care Pathway and if we could call that up, it's INQ0108675 and as you are aware, Ms Murphy, the National Bereavement Care Pathway covers different types of loss and this is a specific document, the one we are looking at, the guidance document specifically for neonatal death.

If we could just turn to page 5 first of all. So this is one of the very long policies, 43 pages of detailed guidance. But this page sets out the principles and just glancing through those, they are the things you have already been speaking about: parent led bereavement care, bereavement care training to all staff, bereaved parents are informed about support,

there is a bereavement lead in every healthcare setting. Going down, the preferences of bereaved families are sought, bereaved parents are offered opportunities to make memories and there is a little bit more detail there but that is the essence of it.

So those are the standards set out in this pathway and presumably that would be again something that you would endorse?

A. 100%.

Q. And if we could just go through what else is covered in this pathway just to have your views. If we could go to page 7, please, we see there "Communication":

"All communication with parents ... the experience of pregnancy loss or the death of a baby must be empathic, sensitive, non-judgemental and parent-led."

And that chimes with the SWAN principles, would you agree?

A. Yes.

Q. And then if we can turn on to page 18, this is a section that deals with multiple births and I just wanted your views on whether you think that is something that is covered in training on bereavement. It sets out here in the middle of the main paragraph:

"Parents should be offered specialist bereavement

support if one baby has died and another baby is still being cared for in the neonatal ward."

Is that an area that you think is being addressed?

A. So again, it's three and a half years since I have been on a neonatal unit and I don't think it was addressed enough. I don't think education is addressed enough around the country. I think it's sporadic, I think in some areas it's fantastic and in other areas it's ad hoc. That's where I was at three and a half years ago.

I think -- but I am not a neonatal nurse specialist, I am a bereavement nurse, so I want to be really, really clear on that. But I think education and more education is absolutely key.

Q. Thank you. If we can just look very briefly then at page 19, I think we can, we have talked but this pathway emphasises memory making which we have discussed.

Then if we could go on to page 27 and you have referred to this slightly when talking about the Manchester Arena situation, but discussing a postmortem examination with parents, is there anything you feel the Inquiry should be aware of with that specific situation, the difficulties and the sensitivity of discussing a postmortem?

A. I think that perhaps discussing postmortem is definitely an area that there is fear, is fear of having those conversations. But actually that's again another area that we perceive it to be really, really difficult. If a family don't want to talk about postmortems, obviously it's very different. If it's a Coroner's-led postmortem it is an option. But if it's a hospital-led postmortem and we are having that conversation it's an area of perceived difficulty.

A family have just been given the worst news possible. Their child is dead and actually any subsequent conversation that we have they will say "yes" or "no" to. We are not going to make their grief worse because we are having a conversation with them.

Even in the faith arena, they will say "yes" or "no". And the way we have that conversation in a gentle manner it's the right thing to do. We have to have these conversations. It's all part of having the family having some control and we can't second-guess what they are going to say. It's often really, really important for them to be given a choice so that they can have a benchmark because all of this is often part of their future and that's really, really important. So that again comes down to education.

Q. If we could go on to page 33, something we

haven't discussed quite so much, but that looks at care and support for parents in the community and the issue of ongoing care and support. What are your views in relation to that? We've been talking quite a lot about memory making within the hospital and communicating within the hospital, but clearly when the parents go home, I wonder what your thoughts would be about that, the ongoing care?

A. So the SWAN model when implemented in the organisations those bereavement nurses will support families out in the community for as long, up to an inquest if they are under the care of the Coroner, and will slowly provide an exit strategy with those parents and refer to different support groups and needs for whatever that family may or may not need.

There is also SWAN services out there in the community, so in district nursing services, et cetera, in some areas and care home settings, et cetera. So it's not just for NHS Trusts per se.

So if they are in neonatal, in hospitals where there are neonatal units those bereavement nurses would support out into the community when those families go home. So that's really important to say that. Or if there's a bereavement midwife within the neonatal unit and there's SWAN service within the organisation those

two teams could link up because they could provide support for each other and that would be a quick win for an organisation. So that also would be really useful to know.

I worry a little bit here about care and support from GP services because of the current situation within our wonderful NHS and the difficulties that we are currently having within our GP services out there in the community. And I don't know how much support is out there in regard to bereavement care.

And I think particularly at the moment I think support per se for anybody is really, really difficult and I couldn't put my hand on my heart and say to you, "I think there's great bereavement support out there in our community" because I truly don't know. But I would challenge that in the current situation that we have got across the UK.

Q. Finally, Ms Murphy, in terms of questions that I will be asking you, having all your experience of 40 years-plus, a lot of that work in the bereavement sector, what would you see if you were able to give one piece of advice in terms of improving the bereavement care to those parents who find themselves in the situation of having a baby who's died on a neonatal unit? What do you think is the one thing that would

improve that service most, would be the most effective change that could be made?

A. I am truly sorry for any parent who has been through the loss of a baby or a child. It's not written that way, we're not supposed to lose our children and I am genuinely truly, truly sorry for anybody that's experienced that. And that's not just for our Families that you are here to do this Inquiry for today and I am sure that's for some people that are sat in this room or people that are listening because it is really, really common. So I am genuinely sorry.

If there was one thing that I would change is when there's a baby loss, remember, when we are looking after these families we are dealing with adults. We are speaking and caring for adults, to help adults get through their next tomorrow and help them with their new normal, and their new normal is life without their baby or their child.

So all we can do to make their new normal is we absolutely have got to prioritise education and make every single generalist in healthcare a specialist in bereavement care. Because all of us that work in healthcare work 24/7 and somebody will die on our watch and we have got to be equipped. It is not a specialist role; it's a generalist role and it's our

responsibility.

So our job is to fix it through education and empower the workforce to take responsibility. So look after each other and let's educate the workforce.

MS BROWN: Thank you very much, Ms Murphy. There will be a few more questions from Mr Baker.

A. Thanks.

LADY JUSTICE THIRLWALL: Mr Baker.

Questions by MR BAKER

MR BAKER: My Lady. Mrs Murphy, I ask questions on behalf of two of the Family groups. I would like to ask some very brief questions about the role of a bereavement nurse or midwife and then go on to a couple of examples from two of the families who I represent.

So in terms of the limits on what the bereavement nurse or midwife can do when providing bereavement care, rather than end of life care, if a family member requires counselling or psychological therapy, is it correct to say that the bereavement midwife or bereavement nurse isn't trained to provide that themselves but they will provide support in signposting or referring the family member through to a different service?

A. So it would depend where you worked.

So some of the bereavement nurses definitely are trained counsellors without a doubt -- so I was a trained counsellor -- but we didn't practice as counsellors because obviously if you counsel somebody too soon into their bereavement you can potentially cause harm. So there it's, you know -- we, we band it around the term "counselling" when people are bereaved.

But actually, evidence suggests if we offer counselling within, you know, six months -- so I am just being generic here, some people need counselling immediately because they might have experienced three or four losses quite close together of people, so they might need counselling immediately -- but most people we would potentially cause them harm if we, if they had formal counselling too soon.

So we wouldn't recommend somebody have formal psychological counselling until six months after their bereavement. So you would provide immediate support, and immediate support can be quite complex. It's not just sitting and patting somebody's hand. It can be quite complex taking them through the next steps.

So some organisations when they advertise for the role of bereavement midwife or a bereavement nurse, they require a counselling qualification as part of the job interview process. So it's very, very different

depending where you go for that role.

Q. So the qualification of a bereavement midwife or nurse may be different in different places?

A. Yes.

Q. But there will be cases where there is a need for immediate referral into adult mental health services?

A. Yes, yes.

Q. Is there any -- and I'm sorry to use this term -- but is there any "priority lane" for referral via bereavement services into mental health services?

A. Yes, sometimes there is. So in Manchester we could refer through Saint Mary's Hospital and so it didn't mean to say you would get in tomorrow, but obviously relationships. You could, you could refer into Saint Mary's and quite often you could get a referral in rather than go through -- the bereavement nurses could do a referral in rather than having to send the patient via their GP.

Q. Yes.

A. We could do it that way. We could fast-track a referral.

Q. Do you think that that --

A. But that was only in Manchester.

Q. Yes.

A. I couldn't speak about what happened in Liverpool or in other areas.
Q. Do you think that should be a mechanism --
A. Yes, I do. Yes, I do.
Q. -- that's in place because otherwise adult mental health services are under pressure --
A. Absolutely.
Q. -- and if referrals are coming through GPs for counselling or even psychological therapy --
A. Agreed, yes.
Q. -- it may not be provided or it may not be provided for a long time?
A. Yes.
Q. So you would think it of benefit if --
A. Yes, I do.
Q. -- the bereavement midwife or bereavement nurse --
A. Yes.
Q. -- or the bereavement service could make a fast-track referral?
A. And -- and bereavement midwives and bereavement nurses are senior nurses. They are not junior nurses within an organisation. They are senior nurses within an organisation with lots of lived experiences. They're the equivalent to a ward manager

or sister. Their banding is that of a senior nurse.
Q. Yes, and I am going to come on to two examples, one involving Mother C and one involving Mother E. Now, these are given examples amongst my client group not because they are the only examples but because --
A. Yes, yes.
Q. -- because they provide an indication of some common features.
Now, Mother C described that whilst her son was dying that Letby would intrude into, into the room and impose herself on that process, the process of them spending time with their son.
Again, if we had in place formal, trained bereavement nurses or a bereavement midwife in this case, would you expect them to take carriage of providing the end of life care and controlling who had access to the room in the circumstances in which that access took place?
A. I would.
Q. In terms of more long-term interactions with Mother C, she gives an account how in July 2016, so about a year or so following death of her son, her husband became aware, through WhatsApp messages from a friend, of articles in the Chester Chronicle that

referred to investigations being carried out by the Trust into an increased rate of neonatal death in the unit.
Now this is occurring a year later. Would you expect the bereavement services, a bereavement nurse to retain contact with a family over that length of time so as to facilitate interactions between families in hospitals when it comes to issues such as that: There is now going to be an investigation relating to the circumstances of your child's death?
A. I think that's quite hard for me to comment on because I'm not sure of what the interaction would have been.
Q. Well, there was no interaction at all from the hospital.
A. So --
Q. There may be a variety of reasons for that obviously --
A. Yes.
Q. -- which have been explored by the Inquiry. But in the general sense, would it provide a point of contact between the hospital and the bereaved parent if, if something like that had happened in the future?
A. So I am going to say not necessarily. It would be very dependent on the level of interaction that

there had been from the, the identification of the baby being in the dying phase of his life, dying, and what the interaction had been from that point and the communication between the family and the bereavement nurse.
Only around 14% of families want -- all families want next steps, Level 1 bereavement support. Every family want: I don't know what I'm doing. Where do I need to go? I want to make memories. All families want some level of Level 1 bereavement support.
About 35-40% of families want Level 2, which is a follow-up phone call, maybe a home visit, "How are you doing? Where are you up to with the funeral? Do the siblings need some support? How's your husband?" A cup of tea, chat, you know a little bit more intense.
But only around 14% of families want more intense -- because the family units are brilliant --
Q. But in terms of the hospital announcing that it is doing something, I mean, you would expect, wouldn't you, if that was going to be handled sensitively, that the bereavement service would play a part in interacting with families?
A. So, in my experience, if there had been a complaint raised, I don't know whether there had -- I don't know because I wasn't involved in anything,

I wasn't involved in the family -- in my experience if a complaint had been raised and maybe the governance Complaints Team from the organisation rather than a bereavement person may have contacted the family.

But it's quite hard for me to answer because I genuinely don't know.

Q. Would you see a benefit though in everybody who has an interactive role of bereaved people having some form of bereavement training?

A. Oh, I think absolutely having a key worker and a bereavement nurse. But I think it is really dependent on what that relationship's been like in the beginning.

A bereavement nurse making contact when there's been no contact after 12 months, I think would be rather difficult.

Q. Okay. The final point, because you have already given some evidence about postmortem interaction, so interaction surrounding postmortems, which is relevant to Mother E. It's in relation to her experiences when it came to the memory box and this shows another side to the memory box in relation to her experiences. But it may be something that is replicated in other cases which I will come to.

So she said that the memory box for her son was put together by Letby and so all the memories she has are

the things that are in the box, photographs, the hair being cut, involve Letby, the person who murdered her child.

Now, that's going to be a rare occurrence but one might foresee circumstances where a nurse carries out that service, creates a memory box, who is later implicated in some form of negligence relating to the death which taints the memory box for the family because it was put together by somebody that they feel is responsible, at least in part, for the death.

How do you get round that sort of problem?

A. So hopefully I can give you a little bit of insight. I would never allow our practice to be that -- not just for a neonatal unit, so I am not saying this just for a neonatal unit.

Q. Yes.

A. I am saying for any person that comes into my organisations that I have worked in, I wouldn't allow them to come into the hospital with a relative and go home, on the same day, with a box instead of their beautiful relative. To me that's horrific.

I love memory boxes. They're a really positive thing but for me it's a fantastic way of a bereavement nurse -- going round to knock on the door and seeing them is a lovely way to go round to their home and knock

on the door and take a box of memories to that family. It's a really great way of breaking down a communication with that family and saying, "Hiya, it's Fiona. I am just coming in to check how you're doing" and taking the memory box with you.

So that would get round that. That's what I can say to you, and that's always been my practice. I would never allow a family to walk out of a hospital having taken a relative in to get well --

Q. But should there be -- should one avoid the treating nurses being involved in that process because of the potential --

A. Often, often families have a brilliant relationship with their nurse and they adore their nurse that's been looking after their relative, and they have a great experience with their nurse that's been looking after them. And, you know, that nurse that's been looking after them that's delivered beautiful care and has done their end of life care, mouth care with Prosecco because that was their mum's favourite flavour, or their child on the paediatric ward's favourite flavour was Ribena and so they have done mouth care with Ribena, you would want that standard of care from your nurse that was looking after you.

So you wouldn't want to stop that practice, would

you?

Q. No. But you may have a situation where it's imposed upon the family, which is what it was in the case of Mother E?

A. Okay.

Q. She imposed it.

A. So I think that's a little bit of a dilemma that we need to be really, really mindful of.

I absolutely concur with you and agree. I don't like memory boxes being given to families at a bedside. I think it's a not nice thing to do and I think we need to think about that really, really carefully. However, I do love memory boxes and I think they are a really important part of a bereavement journey.

MR BAKER: Thank you.

Thank you, my Lady, those are my questions.

LADY JUSTICE THIRLWALL: Thank you, Mr Baker.

Are there any other questions for Mrs Murphy? No.

Well, Mrs Murphy, thank you very much indeed for an enlightening evidence session and you will be glad to know you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you very much indeed.

A. Thank you very much.

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: My Lady, there is a summary of some evidence of bereavement that was going to be read in but I am conscious that we haven't had a break.

LADY JUSTICE THIRLWALL: Yes, quite. Yes, I had forgotten that.

MS BROWN: I don't imagine it will take more than 20 minutes, if that, to read in. But we could either do that another time or after a break.

LADY JUSTICE THIRLWALL: Shall we just take 10 minutes and come back in at quarter past 4. I hope that's not inconvenient. Thanks, Ms Brown.

(4.03 pm)

(A short break)

(4.17 pm)

LADY JUSTICE THIRLWALL: Ms Brown.

Evidence read by MS BROWN

MS BROWN: My Lady, the Inquiry has heard the evidence from parents of the babies named on the indictment. This included evidence of their experience at the hospital after the death of their babies.

Jane Tomkinson, the current Chief Executive Officer of the Countess of Chester Hospital NHS Foundation Trust, deals with the issues of support from bereaved parents at paragraphs 25-42 of a statement to the

Inquiry.

She notes that in 2015 and 2016:

"The expectation would have been that families of a baby who died on the neonatal ward would meet with their named often obstetrician and, if requested, the paediatrician who had treated their baby.

"The normal practice was for the Consultant paediatrician to write to the mother's GP to inform them of the baby's death. The hospital would notify the Cheshire West and Cheshire Child Health Department of the death and the child's medical record would be updated by the Trust so that no inappropriate correspondence was sent out to the bereaved parents."

Jane Tomkinson refers in her statement to a neonatal standards review dated July 2016, which she states:

"... records that counselling services were on offer with leaflets and a contact number outside the neonatal unit door, information in the parents' accommodation and in the SANDS bag. This bag would contain information, cards, a teddy and information on where to go and seek support on return home."

Jane Tomkinson also notes in terms of any future pregnancy:

"The mother would be allocated high-risk maternity

care which is shared with paediatricians and given access to counselling."

Turning to the present day. Sir Stephen Powis, the National Medical Director of NHS England, in his statement to the Inquiry refers to bereavement care. He says:

"In 2022-23, NHS England provided 2.26 million of national funding to support Trusts to expand the number of staff being trained in bereavement care and increase access to specialist bereavement services.

"In 2023-2024, NHS England are investing 5.9 million in bereavement care to enable all Trusts to implement a seven-day provision and increase the number of staff trained in bereavement care".

The Inquiry has sought evidence on support for families for babies being treated in neonatal units including evidence on bereavement support from leading charities in this sector.

Bliss was founded in 1979 and works with all neonatal units in the UK and describes itself as existing to give every baby born premature or sick in the UK the best chance of survival and quality of life. Bliss offers emotional support and information to families, provided online support and in 19 neonatal units offers in person meetings with Bliss-trained

volunteers. Bliss have their own information for bereaved families but also refer families to specialist bereavement organisations.

Caroline Lee-Davey, the Chief Executive of Bliss in her statement to the Inquiry notes:

"Across each of Bliss's services we aim to support parents and carers to be more involved in their baby's care on the neonatal unit. This means helping them to provide hands-on care, such as skin to skin, to be partners in decision-making about their baby's care plan and to be advocates for their and their baby's needs. Our support for parents or carers aligns to our work with healthcare professionals who we encourage to make sure parents, carers and families are integrated into care for babies by removing barriers to participation; for example, in emphasising the importance of psychological support on neonatal units so that parents can access the support which helps them to feel comfortable in that role."

The Bliss Baby Charter is a nationally recognised quality improvement programme which supports neonatal units to deliver high-quality family-centred care where families' needs, views and experiences are explicitly prioritised within care planning and delivery.

Bliss note in their statement to the Inquiry that

whilst they are a national neonatal charity, some charities supporting families and babies in neonatal care are more localised, working in particular hospitals or geographical areas. One such charity is Spoons, a neonatal family support charity, operating in Greater Manchester, registered as a charity in 2016.

The statement to the Inquiry of Rebecca Lowe, a trustee of Spoons Neonatal Charity notes:

"Our role is to ensure that the neonatal voice is heard."

SANDS is a UK charity that exists to reduce the number of babies dying and to support anyone affected by the death of a baby before, during or shortly after birth. The full statement of Clea Harmer, the Chief Executive of SANDS, will be uploaded to the Inquiry website.

SANDS has existed for more than 40 years and provides a range of bereavement support, including a helpline and an online community in addition to having approximately 100 regional support groups.

SANDS also produces memory-making resources, a bereavement support book and has a network of football clubs which provide peer support for men through sport.

SANDS leads the National Bereavement Care Pathway project which commenced in 2019 and 2020 and is

currently being implemented across NHS Trusts.

The project aims to improve the quality and consistency of bereavement care received by parents after pregnancy loss or following the death of a baby. The pathway offers guidance, workshops and access to training and resources for NHS Trusts. The pathway addresses different types of loss including specific guidance related to neonatal death.

The SANDS statement to the Inquiry also describes the role of their liaison volunteers stating:

SANDS hospital liaison volunteers provide a link between hospitals, SANDS local support groups and SANDS national services. These specially trained local volunteers signpost NHS staff working within the hospital to SANDS resources, support services, training and bereavement care guidance for NHS staff. Thus they enable parents and families to access support after pregnancy loss and baby death. There are currently 114 SANDS hospital liaison volunteers throughout England and Scotland. SANDS' long-term aim is tone sure that every hospital in the UK has access to a hospital liaison volunteer.

Clea Harmer notes in her statement to the Inquiry that the Countess of Chester Hospital has had a SANDS hospital liaison volunteer since September 2023 and

signed up to the National Bereavement Care Pathway in January 2024.

SANDS also works with Tommy's, a charity carrying out research into pregnancy loss and premature birth in the UK in a joint policy unit to raise concerns about maternity and neonatal care with policy makers. This work includes identifying key recurring themes from previous reviews and reports into maternity and neonatal services.

The joint policy unit has also looked at NHS board oversight of maternity and neonatal services. This review identified issues regarding the quality and content of reports and data presented to NHS boards, noting that reports to boards frequently have large quantities of hard to digest information with data spread across multiple reports and little analysis to draw attention to trends that might suggest that there is an issue with the care.

The review noted that few board papers include external data to contextualise local performance against national trends and targets. The statement from SANDS notes that the review of NHS board oversight highlighted the need for:

A) further guidance on the minimum metrics to be submitted to boards to provide an early warning of

service quality and safety declining;

B) better ward to board communication to contextualise data, more analysis from clinical service leaders to interpret metrics and more board member engagement with wards and staff;

C) reports which reflect on and contextualise metrics and trends over longer timeframes and regular service monitoring dashboards;

D) a review of current systems and processes in each Trust as to whether boards have meaningful oversight over the quality and safety of services;

E) transparent reporting of issues discussed outside of public board meetings;

F) a review of whether financial certainty and reputation management is prioritised over a culture of learning and improvement; and.

G) clarity over the role of local maternity and neonatal systems in oversight of quality and safety and the implications for Trust board responsibilities.

The SANDS statement to the Inquiry comments:

"Recent reviews and investigations of maternity and neonatal services have identified the lack of a culture of safety within organisations as a key recurring problem. Staff working within services must feel more able to escalate concerns about care whenever necessary

without fear of repercussions. We fear that too often reputation management is prioritised over a culture of learning and improvement. We must focus on systems change including the support NHS Trusts need to embed and sustain improvements to move away from a culture of denial and blame and instead to incentivise candour, support improvements and systematically revisit recommendations to ensure sustained change.

"Without a just culture of openness and without blame, mistakes and system errors will continue to be downplayed or even covered up by Trusts that incentivised to demonstrate infallibility. This needs to be tackled at every level from clinical training to management ethos to resource allocation. We need a system that applauds honesty and transparency highlighting what needs to change."

The statement from SANDS concludes by saying:

"Listening to the voices and experience of bereaved parents will help to drive a change in culture and must be at the heart of all policies developed to save babies' lives and improve future care."

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Brown.

So that concludes the evidence for today. We will start again tomorrow morning at -- is it 10 o'clock

tomorrow?

MS BROWN: I believe so, yes.

LADY JUSTICE THIRLWALL: Thank you very much indeed. Tomorrow at 10.

(4.29 pm)

(The Inquiry adjourned until 10.00 am, on Wednesday, 15 January 2025)

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