Tuesday, 7 January 2025

(10.00 am)

LADY JUSTICE THIRLWALL: Welcome back. Ms Brown.

MS BROWN: My Lady, the Inquiry has adopted a proportionate approach to the calling of witnesses to give oral evidence. Witnesses were selected to give evidence following consultation with all Core Participants. With a very few exceptions, the Inquiry has now finished hearing from witnesses whose evidence is relevant to Part B of the Terms of Reference.

Part B is concerned with the conduct of those working at the Countess of Chester during the period June 2015 to May 2017. As the evidence relevant to Part B was heard, documents or sections of documents to which the witness was referred were uploaded to the Inquiry on a daily basis.

In addition, a summary of the evidence from all doctors and a further summary of the evidence of all nurses who had provided witness statements to the Inquiry but were not called to give oral evidence was read into the transcript.

In order to complete the evidence in relation to Part B, the Inquiry will also upload to the website a number of written statements provided to the Inquiry

by the following individuals. I will read out the names of these individuals with their role at the relevant period.

Jane Evans, Head of Nursing for Urgent Care, Countess of Chester Hospital, to September 2015.

Mr David Semple, Divisional Leader for Planned Care and Consultant obstetrician at the Countess of Chester Hospital.

Karen Milne, named midwife and Safeguarding Children Lead at the Countess of Chester Hospital.

Sarah Harper-Lea, head of Legal Services at the Countess of Chester Hospital.

Claire Raggett, Executive Office Manager and Executive Assistant to the Chairman and Director of Corporate and Legal Services.

Gill Golt, the head of Communication and Engagement at the Countess of Chester Hospital.

Dr Martin Sedgwick, Divisional Medical Director for Urgent Care and Consultant Physician and Cardiologist at the Countess of Chester Hospital.

Stephen Cross, Director of Corporate and Legal Services at the Countess of Chester Hospital.

Dr Bill Yoxall, Consultant Neonatologist, Liverpool Women's Hospital, and a member of the Cheshire and Mersey Neonatal Network Steering Group.

Heather Wilshaw-Jones, Senior Clinical Scientist at Liverpool Clinical Laboratories.

Sarah Davies, Senior Clinical Scientist at Liverpool Clinical Laboratories.

Emma Taylor, Director of Children's Services for the Cheshire West and Chester Council.

Helen Brackenbury, Director of Early Help and Prevention, Cheshire West and Chester Council.

Paul Jenkins, the Local Authority Designated Officer for Cheshire West and Cheshire Council.

Sian Jones, business manager for the Local Safeguarding Children Board for Cheshire West and Cheshire Council.

Dr Lawrence Andrew Dickson, Chair of Child Death Review Panel.

David Hunter, interim Chair of Merseyside Child Death Overview Panel.

Mike Leaf, Chair of Lancashire Child Death Overview Panel.

David Milligan, reviewer for the Royal College of Paediatrics and Child Health.

Graham Stewart, reviewer for the Royal College of Paediatrics and Child Health.

Margaret Kitching, Regional Chief Nurse North.

Christine Hurst, Coroner's Officer.

Stephanie Davies, Coroner's Officer.

Andrew Bibby, Assistant Regional Director of Specialised Commissioning North.

Erica Saunders, Director of Corporate Affairs Alder Hey Children's NHS Foundation Trust.

Julie McCabe, Director of North West Neonatal Operational Delivery Network.

Kristian Garsed, Regulation Adviser for the NMC, Nursing & Midwifery Council.

Michael Gregory, NHS North Commissioner.

Robert Cornall, NHS North Commissioner and Regional Director for Specialised Commissioning in the north region.

Kirstin Hannaford, Senior Media Adviser to the CQC.

Turning to the coming two weeks, the focus of all evidence which will be called will be on Part C; that is to say on the wider NHS. Given that this evidence deals with NHS structures outside of the Countess of Chester Hospital, and is substantially forward-looking, it is the Inquiry legal team's intention to publish these statements in full unless there is good reason not to.

Such reasons may include matters such as personal sensitive information concerning individuals and material irrelevant to the Inquiry's Term of Reference.

I will now hand over to Ms Langdale KC.

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

MS LANGDALE: My Lady, may I call Professor Knight, please.

PROFESSOR MARIAN KNIGHT (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you, Professor Knight, do have a seat.

MS LANGDALE: Professor, can you give us your qualifications, please?

A. An MA from the University of Cambridge, MBChB from University of Edinburgh, DPhil from the University of Oxford and Fellowship of the Faculty of Public Health.

Q. And your current employment?

A. I am Professor of Maternal and Child Population Health at the University of Oxford.

Q. You kindly provided a statement, Professor, dated 10 January 2024 and I am going to ask that that statement is on the screen so people can follow the questions and answers this morning. INQ0006757 beginning at page 1. Perhaps while that's being put on the screen, Professor, that was obviously written a year ago now, this statement, and we will go to parts of that.

A. Yes.

Q. Is there any overview or update you would like to give us before we begin? Events that happened since then?

A. Yes. So just -- in my statement I refer to the introduction of statistical process control functions in the real-time data monitoring tool that we provide to Trusts, just to say that's all been included now. So, for example, some of the -- I provided a screenshot of the viewer back in January last year. That's been superseded by some of the new functions.

So in addition to the evidence that I provided at the time, I have provided you with the current version of the user guide which has some more detail of those new functions which enable looking at variation unusual variation in -- in events.

Q. We can go to that when we look at the screenshot. In fact, you can set those out. Anything else in the broader canvas that you want to comment on at the outset?

A. So the other additional information guidance for Trusts that's been introduced since my statement is further guidance and templates for interaction with parents who have been bereaved, who have -- whose child has died with regards to the Perinatal Mortality Review

Tool. So we have much more detailed guidance, we have worked with parents to develop that guidance further and that is also new since my statement was written.

Q. We will come to that as well in a moment, thank you.

So if we look then at your statement on the screen, page 1, can you tell us firstly please about the Maternal Newborn and Infant Clinical Outcome Review Programme, what is that intended to do?

A. So it is -- it is one of I think about 40 national audits commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the devolved nations.

Our remit is to conduct surveillance of all perinatal deaths, so that's stillbirth and neonatal deaths up to 28 days of age, as well as maternal deaths, as well as confidential Inquiries into maternal deaths and selected neonatal deaths or morbidities.

Q. If we go to the next page of your statement, we see at paragraph 3 you set out the surveillance that MBRRACE undertakes. Where do you obtain the data from and how is the data obtained?

A. So we obtain the data in several ways. So the initial reports of a death come from the hospital where the death occurred and that's notified to us through

our -- in case of a perinatal death through our online notification system.

We will then cross-check notifications of deaths with routinely available statistics. So we get information for England and Wales from the Office for National Statistics and from the equivalents in Northern Ireland and Scotland.

Q. Is it mandatory or not for information about deaths to be provided to MBRRACE?

A. It is part of Quality Accounts and also in the case of perinatal deaths, part of the Maternity Incentive Scheme, one of the requirements is that all deaths are notified within seven days to MBRRACE.

Q. What level of compliance do you find you have in respect of that?

A. Compliance is good. So in terms particularly since the Maternity Incentive Scheme requirement came into place, which is since the events of 2015 and 2016, we now see nearly 100% of deaths notified within that time.

Q. Would you attribute that to the Maternity Incentive Scheme?

A. That's certainly made a difference, yes.

Q. If we look at paragraph 4(b), you refer to the active communication with parents to ensure they are

told that a review of their care and that of their baby will be carried out. This is -- how is that done, you have said you have updated that but how do you have that communication?

A. So that is not our remit.

Q. Sure.

A. So this paragraph refers to the Perinatal Mortality Review Tool which is a comprehensive tool for hospitals to use. It includes prompts to consider all aspects of the mother's care and the baby's care, to determine issues underlying the deaths and areas where care can be improved but also to give parents an understanding of -- of why their baby has died.

Parent contribution to that process obviously is absolutely essential and -- and yet we were aware that that engagement was not always happening and -- and indeed parents were not always told that a review was even taking place.

So beginning from a study conducted called the Parent Study we have developed a succession of materials to enable the hospitals to engage with parents to ensure parents have a named contact, to keep them informed about review processes, to enable them to input questions into the review process and to ensure that they get an output from the review in lay language that

is understandable that they can -- that they will have but can also ask questions about.

Q. And when was that study undertaken?

A. So the PMRT started in 2018, so the study that was that has informed that took place then but as I said we have also been taking undertaken further engagement in 2024 to update those materials with further interviews with bereaved parents.

Q. Are you able to measure how effective any improvements have been?

A. So we have certainly seen improvements in the -- in the numbers, in the proportions of parents who are informed about a review and who have been able to input into their review. So those proportions have increased when we look at the statistics from the Perinatal Mortality Review Tool.

There's actually a piece of research funded by the National Institute for Health and Care Research being undertaken at the moment interviewing parents about their experiences of the review process which will give us some more qualitative understanding of whether that has improved experiences for parents. We can -- it's really important we have both a qualitative, so parents' actual reports of their experiences as well as the numbers. We need both to be able to tell whether we are

having -- you know, whether those improvements are genuinely effective.

Q. Paragraph 7, the next page of your statement. You set out what deaths are reported to MBRRACE. Can you just tell us what deaths are reported and the rationale for those deaths being included?

A. So our -- our remit is to conduct reviews to conduct surveillance of stillbirths as well as neonatal deaths. Stillbirth is a legal definition, that a stillbirth is a baby born without sign of life -- signs of life after 24 weeks of gestation. For a neonatal death the -- the guidance is obviously a baby born with signs of life. There's no gestational age cut-off for that and we know that between 22 and -- well, 22 to 24 weeks there is variable responses to the birth of a baby in terms of whether that baby has signs of life and is offered supportive care or offered resuscitation and neonatal intensive care. So we therefore collect information on all births with signs of life from 20 weeks' gestation onwards as well as fetal losses so babies that are born without signs of life at 22 and 23 weeks to make sure we have -- we have got all of the information about -- about all babies because of some of the variations in practice.

Q. So unlike MOSS, you actually take data in

relation to premature babies, don't you?

A. We do.

Q. We will come --

A. Yes.

Q. -- to MOSS later but what is your understanding about what that system does or analyses?

A. So MOSS only takes information about term babies who are either stillborn or died in the neonatal period. Also it includes information about babies who have had brain injury. So a relatively small proportion of babies that die in the perinatal period.

Q. If we go to the bottom paragraph 9 of this page, and then on to the next paragraph, you tell us about your online reporting system. How does it work? What are the timings of reports that you get from hospitals, who is completing the data? How does it work in practice?

A. So in each hospital we have a lead reporter. There are usually -- there will be more than one nominated reporter who is able to enter the data but we have a lead neonatal reporter and a lead maternal reporter. They have to complete a notification as I mentioned within seven days, that is part of the Maternity Incentive Scheme and then we have more detailed surveillance data and the requirement for that

is 30 days to complete those data.

The additional surveillance data is important to get more understanding around the characteristics of -- of the mum and the baby as well as her pregnancy. So we can -- it helps give more nuanced understanding of the characteristics of the babies that are dying. It also helps to make the real-time data monitoring tool more helpful to hospitals to be able to look at the patterns of baby deaths that are occurring.

Q. We see at paragraph 10 information collected. You set out there that the data has you have just said consists of information about mother and baby. How much information do you get about the death itself? For example, would you expect to receive information about whether the death was sudden, unexpected, or that there was suspicion around a member of staff, would that kind of material be guaranteed through this system?

A. So we do get basic information about the cause of death as -- as it has been classified by -- by the hospital. We in the MBRRACE surveillance system would not get information about suspicion of a member of staff. We use coded data, it's a code called CODAC which has I think nine broad categories of which one is unknown and indeed other.

The -- the data which might have more of the type

of information you are talking about would be in the Perinatal Mortality Review Tool -- although, you know, I have to say because the actions of a member of staff in -- in -- you know, when we are thinking about murder is not something that we encounter commonly. The Perinatal Mortality Review Tool has been developed to go through the most -- the care pathways and the most common causes of death that you would expect in the perinatal period. So it does not have a substantial section about homicide, for example.

Q. Are you aware to what extent unknown features in the coding? Would that trigger anything of any concern, I mean that covers a broad category, doesn't it, of itself?

A. It is a very broad category and -- and unfortunately we do come to the -- at the end of the day even after a very detailed and thorough review and a postmortem, it is not uncommon particularly for stillborn babies for the cause of death to be unknown. I can't give you a percentage off the top of my head, it's certainly been improving over recent years as -- as postmortem rates have improved.

But it is -- the fact that a cause of death might be unknown on its own would not be a trigger for concern in the absence of any other concerning --

Q. Or clinical information?

A. Exactly, yes.

Q. I am going to ask that we scroll slowly through the statement so people can read it and then we stop at paragraph 19.

(Pause)

You tell us at paragraph 19:

"Three mortality outcomes are calculated by the MBRRACE UK perinatal team based at the University of Leicester and reported for each organisation: stillbirth, neonatal death and extended perinatal death. These mortality rates are presented in several different ways as a crude mortality rate and as either a stabilised mortality rate or a stabilised and adjusted mortality rate."

Can you explain those three terms for us, please: the crude mortality rate, stabilised, and stabilised and adjusted?

A. So the crude mortality rate is very simply the number of deaths as the numerator over the total number of births in the denominator, so for any one year, that -- that would be the crude mortality rate.

We know perinatal deaths are fortunately relatively rare and that does mean that there is some random fluctuation in the data that can make it appear as if

there are very big changes in rates which are partly explained -- could partly be explained by random variation on the basis of small numbers.

So the stabilised rate takes into account that that random variation or common cause variation is the terminology used in the NHS Making Data Count guidance.

Stabilised and adjusted rate takes into account differences in the population of women giving birth and the population of babies cared for by different hospitals. We know, for example, that large hospitals with a neonatal intensive care unit and a surgical unit will be caring for women who are at higher risk of poor perinatal outcomes more likely to have babies who are sadly more likely to die because, for example, they have congenital anomalies or are born prematurely.

So they -- the adjustment we do takes into account some of those characteristics and I have to say only some of those characteristics because we can only adjust for things where we have national information. So we can adjust for maternal age, we can adjust for maternal deprivation and we can adjust for gestational age at birth, but it's a relatively limited number of things we can adjust for.

For example, we can't adjust for maternal health conditions which we know will impact on the health of

her baby because we don't have national information that would allow us to do that.

Q. Obviously you wouldn't be able to adjust for unknown conditions for the mother or the baby?

A. No. No, exactly.

Q. Presumably it's more difficult to make risk adjustments for a newborn infant than it is for a mother where you have got at least the data or more data from her?

A. Exactly, for a newborn infant we have very limited information other than the gestational age and the sex of the baby which are the two main things.

Q. If we scroll through, please, the statement to section 2 at paragraph 28.

If we continue to scroll down, please to section 2. You tell us here that the report with data for trends up to and including 2015 was released to the Trust on 15 June 2017 and the report with trends up to and including 2016 was released on 8 June 2018. So before we look at what signals were or were not generated, can you tell us about that lapse in time, if you like, between the signals themselves and when they are reported?

A. So as I mentioned we get data from different sources and cross-checking data with the routine sources

means that we can't start any of that cross-checking until we get data from those routine sources. So we -- and I should say that timeliness has improved slightly since -- since the dates here, so if -- if events were to happen now, the -- the Trust reports -- the Trusts would be getting their reports in February.

Q. February, which month are you talking about there?

A. So February of the -- so for deaths of babies in 2015, we would -- let me. So for deaths of babies that occurred in 2023, for example, we will be giving the Trusts their report in February 2025. If I explain the -- so we don't get information from the Office for National Statistics final information until the end of June which we then have to cross-check process and give it back to the Hospital Trusts for them to cross-check their data. So they get data to cross-check in August/September.

I am -- if I use current years to make at least --

Q. Please do?

A. So -- so I am talking about deaths of babies that were born in 2023. We receive the final data from the Office for National Statistics in June. In fact, we didn't get the Scottish data until a bit later than that.

Q. In June 2024?

A. 2024.

Q. Mm-hm.

A. So we then processed the data, gave it back to the Trusts to cross-check that they were, that the data were correct in August and gave them all of September to do that. That cross-checking process has several purposes: one of the purposes is checking the gestational age of those babies that I mentioned that are born between 20 and 24 weeks, some of whom would be included in the statistics, some of whom wouldn't.

The information we get from the Office for National Statistics also includes terminations of pregnancy which we would exclude from mortality statistics, so that's also part of the cross-checking that goes on.

Once we have the cross-checked data, we can then produce the stabilised and adjusted rates which we can then -- which we then publish as I say February the following year. So that is about a 14-month -- 14 months from the end of the year in which the babies were born who then subsequently died bearing in mind that some of them will have died in January of 2024 because we use a birth year because the only denominator we have is births and so we use births that occur in the calendar year.

So that is the delay for -- for publishing that, that single number. But obviously hospitals have, have access. They -- they know how much deaths are occurring, they have access to the online viewer which shows them how many deaths there have been the characteristics of the deaths that have been reported live time, so there is other information beyond that single report. Now, that was not the case when these -- the deaths of these babies occurred.

Q. Let's look at what was reported and then look at what people could access online now. So if you go to page 9 of your statement. Figures 2 and 3.

So tell us what these represent in terms of the data from the Countess of Chester, the death data in 2015 and 2016.

A. So if we look at figure 2, you will see at the bottom the year of birth. So if we look at year of birth 2015, what this presents are the crude rates that I described, so the simple number of deaths occurring as the numerator with the denominator total number of births occurring at that hospital.

The top line is extended perinatal deaths which is very simply the total number of stillbirths and the total number of neonatal deaths, so deaths of babies up to 28 days of age.

The -- the second line in 2015 is the stillbirths so the orange dot there is the -- is the rate of stillbirths and then the red dot below that is the rate of neonatal deaths.

For 2016, you can see the rate of stillbirths is apparently much lower whereas the rate of neonatal deaths has overtaken that and remains as a red dot.

Figure 3 is the stabilised and adjusted rate that I mentioned so that takes into account random variation as well as some adjustment for the characteristics of mothers and babies that we know about.

So you will see that that when you look at the stillbirth line that has removed that apparently big decrease because that -- there is obviously a substantial element of random variation to that and indeed has identified that the stillbirth rate is -- is we categorised it as yellow rather than being green, yellow in this instance being between 5% and 15% lower than the national average.

The neonatal death rates although the rates are -- don't appear as extreme you will still see that they are both still classified as red, which means that they are more -- in the time this was done 10% more than the average for the group of hospitals which the Countess of Chester belonged to.

We -- we don't compare hospitals against a national rate. We actually compare hospitals against an average rate for the group to which they belong because we know as I mentioned at the beginning that if -- if you are a large hospital with a neonatal intensive care unit where you have lots of extremely preterm babies and a surgical unit those babies will have a higher death rate than babies born at a smaller unit which doesn't have those intensive care facilities.

So we compare in -- in five different groups against hospitals of similar characteristics. So the red dot in this instance shows that the rate at the Countess of Chester for neonatal deaths is more than 10% higher than the average for hospitals with similar characteristics in terms of the neonatal care and their birth population.

Q. Do you classify that as a signal?

A. It is a signal. The advice we give to hospitals is that they should be reviewing in detail the deaths of the babies that occurred in their care, although that is a recommendation that all deaths should be reviewed.

Just worth bearing in mind that the number of hospitals that will have that signal is quite substantial. I think it was 55 for example last year in

the last -- last set of data that had a red signal.

Q. Was that within Tier 2s or the same level or generally across?

A. No, that was across -- across all hospitals.

Q. So it needs a human to evaluate whatever it means?

A. It is, exactly. And we can only do -- we can only do a limited number with numbers. What we really need for anything is more information and the review of each baby's care and actually understanding the story of what happened to the baby is essential to actually understand, you know, how we can make a difference, how we can improve care to change what we are doing and -- and reduce the -- the death rate.

Q. If we look, you have also helpfully attached this if we go to INQ0006749, page 91, we see the Countess of Chester red, we see another hospital further down, Kettering General as red. As you say, the red requires evaluation as to what it represents?

A. Exactly. Yes.

Q. And if we look at 2016, it's page 96, 00067500096.

LADY JUSTICE THIRLWALL: 6750. We have got --

MS LANGDALE: So INQ0006750, page 96.

Still saying 6749 at the bottom, so it will catch

up, won't it?

There we have the 2016 position with the orange.

A. Worth pointing out that that orange is the overall extended perinatal mortality rate in -- in this page that you have noted. At the time these reports were published we didn't do the -- the red/amber/yellow/green colour coding for stillbirths and neonatal deaths separately which we now do.

Q. Right.

A. You can see from my statement that it was a red for neonatal deaths in 2016 as well as 2015.

Q. That can come down if we go back to your statement, which was 0006757, page 10, if we go to paragraph 32. You point out at paragraph 32 that MBRRACE reports neonatal mortality based on place of birth, not place of death.

Why is it done in that way? What's useful when collating deaths around place of birth?

A. So the simple reason is that that is the only straightforward denominator we have. To calculate any rate we need a denominator total number of babies at risk and the only easy easily available denominator rate we have is the number of babies born in a Trust.

And we know that babies that are born that become unwell will be transferred elsewhere and because of

neonatal networks and pathways of transfers of care, we don't have any easy denominator that would allow us to calculate a rate for deaths occurring in a Trust and again this brings me back to statistics can tell us something but they can't tell us everything and actually more understanding of the circumstances around each individual death, whether it occurred at your Trust or whether it occurred -- whether the mother was cared for in your Trust but her baby died elsewhere, that's what's going to give us more information than -- than a simple rate.

But -- but fundamentally the reason we use babies that were born at your Trust is because we don't have another denominator to allow us to calculate the rate.

Q. You mentioned the input of families and mothers earlier. Do you think the input of parents is really important in understanding the story?

A. It's absolutely crucial. You know, listening to parents, parents have a unique perspective on the events that surrounded the woman's pregnancy, the baby's birth as well as the baby's subsequent care. You know, we -- we need all aspects of care to be assessed and reviewed and parents' perspectives is absolutely critical to that.

Q. If we go to section 3 of your statement, "More

effective use of neonatal data", you tell us since May 2019 MBRRACE has provided all Trusts and health boards with a real-time data view which enables immediate and ongoing monitoring of all still are births and neonatal deaths reported to MBRRACE UK and the document you attached was INQ0006755, page 1. If we can go to that, please, 0006755, page 1.

You say this has been updated since. But can you talk us through, please, what clinicians might be able to access at the time?

A. So this is obviously a still screenshot from what is a live tool --

Q. Yes, sure.

A. -- that -- that clinicians and staff can interact with.

If I talk you through very basically what it -- what it is.

So you can see a large graph in the middle. What we present in this graph are the number of days between deaths. So perhaps counterintuitively a high number, so a graph that is -- that is presenting a big number is -- is a good thing in this instance because it means there is a much longer gap between deaths occurring and so a low number means more deaths are occurring, more frequently.

On the left-hand side are a range of filters that can be used to look at different groups of babies to help potentially look at where there are clusters of deaths occurring together, the characteristics of those babies. On this screenshot I have -- I have filtered the data so it's just showing neonatal deaths but for the whole of the Trust data it -- it would show, it would show stillbirths as well.

We can look at the next category down, it is around the timing of death so that will show us whether it is an early neonatal death or a late neonatal death, whether the baby was admitted to the neonatal unit and again I have filtered on this for this example.

We can look at how long the baby survived, that is the next category but perhaps the other one relevant to thinking about the events at Countess of Chester is that one can also filter to look at the gestational age at birth of the babies that had died, which is the next category. I won't read through all the rest but you can see all of the other characteristics that we can potentially use that the hospital can potentially use to -- to look further at the patterns of deaths that are occurring in their -- in their hospital.

Just going back to reference to our discussion around causes of death, you will see here what is listed

as CODAC Level 1 and CODAC Level 2. Those are the different levels of the classification of causes of death, so Level 1 is the nine broad groups and then Level 2 are sub categories of those groups. So again it may enable you to see that actually there is a group of babies who are dying at a particular gestational age who were born at a particular gestational age and from a particular cause by using that tool.

Q. There is some reference to cause then? From what you are saying, there is some reference to cause very specific --

A. Some reference -- exactly, it is based on that CODAC classification so bearing in mind the events in question may not be specific enough to be able to, to pick up the -- the -- these events as being murder. But would certainly, if it was unclear/unknown, you know, that would come out from -- you could look at that from the data viewer.

As I mentioned, this -- this has now been modified and I provided some supplementary information in that we have now got statistical process control functions built into this so that the hospital will be able to look at, to give an indication whether there is any of the variation that they are seeing is common cause variation, random variation, or whether it might be

special cause variation where there is a more imperative to actually go and -- and look at what is -- what is happening around the pattern of deaths.

Although, you know, as I -- and I am sure you will hear this from Professor Spiegelhalter, with relatively uncommon events there is a limit to what you can actually do with statistics. So actually having somebody at the hospital who has an understanding of their data is really important but also that review process for every death, so that actually you are looking because the Perinatal Mortality Review Tool will produce a summary report around all of the issues that have been identified with -- after review of each individual death, that's got the parents' input into it, it's got the clinician's input into it, we also recommend that it has an external review member so there is an external perspective from another unit included in the review of all the deaths.

And you need that as well. We would never be able to just use this tool to identify where we need to make a change, where we need to improve care.

Q. So when you say somebody at a Trust who understands their data, so somebody who may say: well look, we have three, four, now I have got 10 ... they have a perspective of a unit and understanding their

data, is that relevant to understanding significance of data?

A. It is relevant. As I said, we, we can, we can -- because, because perinatal deaths are trivial rare, we know that statistics are limited. So you know, we, we -- in a statistical process control chart, typically and the Making Data Count guidance is that you know, it doesn't trigger a signal until six events have occurred, because by random chance you will get four events occurring in a row, not uncommonly. And it's always a balance between the sort of cry wolf, you know, expecting hospitals to investigate apparent clusters frequently with picking up a signal of, of when there really is a concern and we will never be able to have just one or the other.

I -- I don't think hospitals can ever rely solely on a statistical process control chart, no matter what it -- what is included and how it's done. And we say this all the time: all baby deaths need to be reviewed, need to be reviewed thoroughly and only with that additional information can we interpret what we see in a statistical process control chart. If you as a clinician are in a hospital where you know that one baby dies maybe you have three, four baby deaths in a year and then you have three deaths in a month, that

will trigger something in your mind that actually I don't think any of us would -- would look past. You know, we would all want to understand what is -- what is happening and that review process will be what will help us do that.

Q. We will be hearing from Professor Spiegelhalter next week but he makes the observation in his statement that had data been collected and properly analysed, Dr Shipman could have been detected as unusual after only around 40 deaths. But in terms of numbers for individuals, each number is huge, isn't it, each death is so significant and the effect of your evidence is that you can't rely on numbers alone to know what a move from two to three to seven to nine to 10 means; you need someone who understands the unit and the babies?

A. Exactly. We can't rely on numbers alone. I mean, I -- we talk a lot about evidence-based medicine and that tends to be numbers but I think we should also talk about narrative-based medicine and for me there was an editorial in the -- some years ago now which talked about narrative-based medicine and not or, for me we have to have both the statistics and the stories.

So I lead the maternal death confidential inquiries which is globally regarded as the gold standard. There

are 16 maternal deaths per year in the UK. We are never really going to be able to show a major statistical change in those deaths but by reviewing every death telling the women's stories, identifying common areas of care where we can improve, we have made a huge difference to the care of women giving birth and we need the same sort of approach for perinatal deaths.

Q. If we can take that document from the screen and go back to your statement please, which is 6757, page 11, so 0006757, page 11, paragraph 37, you raise the point that you consider individuals within each unit should be given responsibility for regulator monitoring of the data.

Can you expand on this for us, please, how do you think this real-time viewing is that the same as continuous viewing? Being able to see it as you go along, if you like?

A. So I mean at its simplest it is having a person with the responsibility to actually be looking constantly at those data. So we know -- so we know how often the tool is accessed, so we know that there are some hospitals where it's accessed once every couple of months. There are some hospitals where it is accessed several times a week. So that -- but up until now there's been -- there is nothing that mandates use of

the tool.

I think -- I don't know whether I have confused everybody listening but, you know, I think even -- even in my simple description of the tool I suspect many of you are slightly perplexed and actually to use it properly to be able to look at it, to understand the -- the nuance of, you know, the filtering that you can use to get a better understanding of your data, it -- it needs somebody who -- that is part of their role, they have had some of that training and it is not something that can be done as a sideline on top of, you know, full-time clinical shifts. It does need to be somebody with that responsibility.

Q. And a clinician or not?

A. It doesn't need to be a clinician. It -- clinicians will undoubtedly need to be involved. You know, the -- but it could be a person with a quality improvement background, with analytical expertise but who would need to be able to explain what the data was showing to the clinicians in the unit.

One of the advances that -- that I think the -- that you will maybe come to later, that the MOSS group has, is developing with us is the governance process around use of the tool so as MBRRACE we have no, we can't -- we have no power to ensure recommendations we

make are implemented. We have no power to mandate that organisations use the tool. We obviously have some basic training materials but there's really good training materials from NHS England in the Making Data Count guidelines.

And part of the what's been developed with the MOSS group is that that governance process would be put in such that hospitals use the data and that there is somebody whose remit it is who is trained to use the data, but they still have to be listened to. So it still -- all of these processes require, you know, the Board to take things seriously when -- when it is being flagged by a person who is looking in detail at the data.

Q. And you say at paragraph 38 of your statement:

"I consider there should be an established escalation route to senior management level to ensure that any concerns are taken seriously and an appropriate action plan put in place."

So that's a matter for each Trust managing data as far as you see it --

A. Yes.

Q. -- that they can access as they go along?

A. Yes, exactly.

Q. That concludes your statement,

Professor Knight.

I would like you also, please, if we can have on the screen to read the second statement of Dr Murdoch which is INQ0108744, page 1. You have touched upon MOSS which we know is primarily aimed at identifying potential critical safety issues in maternity care and it is still in its development stage. So broadly speaking different from your position at MBRRACE in terms of looking at deaths or neonatal deaths and premature deaths.

You nod, but how do they differ, the two tools?

A. So I think it's important that, that I -- I reserve judgment on, on MOSS at the moment and I should say that I am speaking as an individual. I don't have any legal advice and I am not presenting on behalf of an organisation.

It is still in development. It is reliant on some routine data and routine data is not always high quality, so I don't know how good it will be. It is reliant on a new notification system which is also still in development and it is relatively limited in terms of the number of deaths included, but the difference from the deaths that we -- from what we have is that it also includes babies who have had a severe brain injury.

My understanding of MOSS is that it is designed to

look at events occurring on a labour ward. So for the purposes of this Inquiry, it's largely irrelevant in terms of, you know, one wouldn't expect it to be generating a signal in response to events occurring because of a member of staff action on a neonatal unit.

On the other hand, we would expect the MBRRACE tool with the statistical process control charts it has now to be able to show where there is that unusual special cause variation which we would expect to trigger further investigation.

Q. And equally MOSS is developing maternity care signals, that is a good thing too, isn't it, we are comparing apples and pears here --

A. Exactly, and I think --

Q. In terms of this Inquiry and a broad range of maternity services?

A. I think the point that Dr Murdoch makes in her statement, you know, we would never expect one complex organisation to have one single signalling system. I think she likens it to car mechanics; you would expect more than one signalling system.

There always has to be a balance, you know, if we have got signals going off, here, there and everywhere, sorry, we are not going to be able to see the -- the most important signals amongst the noise and that's, you

know, some of the reasons for the statistical process control chart.

So I think recognising that the two things are different and doing -- doing different things is, is important. What is a really positive development for me is as I have already said around the governance process because it's no use having signalling systems if nobody knows they are there, nobody uses them but more importantly nobody responds to them so that governance process is -- is essential and that's where, you know, I refer to that in my statement a year ago and I do think that's a positive development if -- if that happens as anticipated from -- from what the MOSS group are proposing.

Q. Can we just then scroll through this statement and see if you agree with it. If we go -- we have read the first page, second page sets out what's the safety signal system. You have seen this before, Professor Murdoch(sic) --

A. Yes.

Q. -- so we can go at a reasonable pace.

LADY JUSTICE THIRLWALL: Professor Knight.

MS LANGDALE: Professor Knight, sorry. We have seen Dr Murdoch's statement before. If we go to figure 1, what she sets out at paragraphs 15 to 17,

would you agree with that?

A. I guess I -- I don't quite understand why the real-time data monitoring tool isn't a safety signal system because it is to me.

So I think, I think I -- I wouldn't say that MOS is the first system of this nature. It is a system.

Q. For maternity care I suppose it is saying to be developed for maternity care in a broader context?

A. So I think for labour ward care which is where it is designed, but obviously the real-time data monitoring tool is looking at perinatal deaths the majority of which will be deaths in relation to pregnancy and subsequent maternity care. Obviously the majority of deaths that occur are amongst preterm babies.

Q. She does refer at paragraph 17 to the MBRRACE real-time data monitoring tool providing real-time monitoring of perinatal deaths et cetera. So -- and then there is a summary of differences between MOSS and MBRRACE.

A. And the key -- well, I mean, it sets it out, that -- that that is exactly correct, those are the key differences in terms of the different groups that MOSS is planning to include versus the real-time data monitoring tool.

Q. And if we continue and scroll to paragraph 27. Dr Murdoch makes the points that MOSS deliberately doesn't measure preterm deaths or stillbirths because it was designed to support the improvement of maternity and neonatal outcomes at term.

So MBRRACE will remain the only analysis of that preterm data?

A. Yes, exactly.

Q. If we continue to paragraphs 29 and 30. She says:

"It is common in other sectors to have a number of signalling systems and data monitoring tools operating concurrently."

Would you agree with that?

A. So as I said, I think I mean it is -- it is often a criticism in maternity that there are multiple organisations inspecting, providing grades, providing red, amber, green ratings and I think it is always a balance between -- between signal and noise.

I -- I have not been involved in development of the MOSS, I am not party to the thinking around it. It does add in the babies with brain injury.

But the real-time data monitoring tool could include those if they were reported to MBRRACE, it could indeed include deaths beyond 28 days if they were

included. I -- I don't know how confusing it's going to be to hospitals to have two different signalling systems and I think that that's an important consideration.

As I say I haven't seen the training materials. It will -- it will depend.

If it's very different groups of people responding to the two, then -- then there is potential. But it is a worry I have of having more than one system in maternity.

Q. Dr Camilla Kingdon from the RCPCH told us there are a number of places where data has to be provided in neonatal care and she told us that the new electronic patient healthcare records don't talk to the BadgerNet system that's used for NNAP, for example. Are you aware how easy it is for data to be entered in relation to the MBRRACE system or not?

A. So we, we still -- so we have our own system. So the data are entered directly into the surveillance system we have and it's a regular discussion. You know, could we get that information from any other source?

So we know that there is information in there that we can't get from other routinely available national sources of data, say, for example, hospital statistics or the maternity services dataset. Either the data items are not all there or they are not well completed,

so we know we can't get it from that.
In theory, we might be able to get the data directly extracted from hospital systems and this is probably where Dr Kingdon's advice comes in -- her evidence came in. All of those systems are different. There are I don't know how many different systems but although there are some different electronic patient record systems that are used across quite a number of hospitals, there's no one system that covers all of them and the way to extract data from each of those individual systems to -- to feed into a surveillance system is -- is very complex.
Just to give you an example from a totally different area, I run a national system of surveillance of outcomes following paediatric surgery and we have got a pilot research project funded by the NIHR and it's taken us nearly three years to get to the point of having six hospitals where we have been able to extract data from. Four of them are using the same electronic patient record system to different systems, one of them is having to rely on manual data entry from the -- from the clinicians because they just cannot extract the data from their -- from their electronic system.
So -- so it is, it is quite complex to get information from different systems. Not everybody uses

BadgerNet any more. People are moving away from -- from BadgerNet.
I -- everybody has heard many stories of NHS IT and the challenges around it but I think we should, we should -- shouldn't under-estimate how difficult it is to get information out of systems. And that's one reason why we have a data entry system of our own so that the data is -- are entered manually.
But we have to be conscious of the burden that places on -- on reporters to have to enter that data.
Q. Thank you. Can we have on the screen please INQ0102043, page 1, and it's an email to you, Professor Knight, from Dr Murdoch. I don't know if it is an email, it is an exhibit to her statement and it is the proposal to work in partnership with MBRRACE on developing procedures.
The partnership or discussions. As far as you are concerned, what discussions have you been having this extends to four pages. But what's the position as far as you are concerned?
A. So there is a joint group which I am not a part of so that -- the -- my colleagues from the University of Leicester are part of the MBRRACE collaboration, are part of that group. And that is largely around the joint governance, the joint training,

the joint use of the tools. We don't have any input into developing the MOSS tool.
We have provided data for the MOSS group to input into their tool to test it because obviously we do have the perinatal deaths data and the MOSS tool can't go live until they have got data flowing into it which I understand is coming from the single perinatal event notification system which again is still in development, it's not got an anticipated go live date yet.
So we -- we definitely worked jointly together and this proposed joint working was sent to me and clearly anything that strengthens the governance around use of the real-time data monitoring tool responding to it is a positive from my point of view. So obviously, you know, I would agree with that.
Q. So good discussion around governance and joint tools is happening?
A. Yes. I haven't, as I said, I -- where I slightly hesitate is I don't know how confusing it will be for people to be looking at two different systems.
I think probably with -- with regard to and I obviously don't want to -- to teach you your job but with regard to neonatal units and neonatal deaths, particularly of preterm babies, the MOSS system is not

going to be relevant because those babies would not be -- their deaths would not be included in that safety signalling system tool.
So the -- there shouldn't be that confusion if we were -- if we were talking about events like those that occurred at the Countess of Chester.
MS LANGDALE: Understood. Thank you, Professor Knight.
My Lady, that might be a good time to take a short break.
LADY JUSTICE THIRLWALL: Very good. We are going to take a 15-minute break and we will start again at 11.30.
(11.12 am)
(A short break)
(11.30 am)
LADY JUSTICE THIRLWALL: Ms Langdale.
MS LANGDALE: My Lady, Professor Knight, can we have on the screen please INQ0018029. Professor Knight, you have been sent this already. It's a document from NHS England Specialised Commissioning titled "Schedule 2 -- The Services."
"Service Specifications: Neonatal Critical Care" regarding categories of neonatal critical care and neonatal unit dated March 2024.

If we can move slowly through that document, just so people can see broad headings. Then when we get to page 14 of the document, we see there "Standards for Family Experience, Communication and Facilities."

If we could highlight that and scroll down through to the following page. I will give people a chance to see that.

(Pause)

We see reference to a number of matters including parents, carers must be kept informed, must receive regular updates from all health professionals involved in the care of their baby.

And at the bottom:

"Family Involvement and Feedback."

Third bullet point:

"A range of tools must be in place to measure parent experience which balances real-time and retrospective feedback. This must be in a form which can be nationally and regionally benchmarked."

You touched upon earlier when you were doing your reviews and speaking of earlier work the need to communicate with parents. You have seen this document. How important do you think this is and do you think this is a very helpful plan setting it out in this way?

A. So I guess I can only speak from the

perspective of the work I do which is around reviewing the care of babies who have died. Parent involvement is absolutely crucial and I think there are elements of this that -- that absolutely echo what, what we have in our guidance, a named lead who is responsible to -- for receiving and responding to concerns.

Communication is obviously at the heart of everything we do as health professionals and making sure that parents are at the heart of the care of their baby through that very basic communication is absolutely going to be central to us providing the best quality care. You know, we know that parents provide elements of care to their babies on the neonatal unit as well as -- as well as staff. So absolutely it is central.

What role this guidance will have in terms of changing any culture where that communication is not optimal, I'm not sure. I'm not in the best position to answer that.

You know, party -- the discussion we had earlier is that we -- we have undoubtedly seen improvements in involvement of parents in the review processes after they have had a bereavement after they have lost their baby, still work ongoing to see whether that whether their experiences have improved with that. But we do know that more proportionately parents are involved.

I'm not sure if that really helps answer your question.

Q. No, no. MBRRACE has been collecting data on maternity and neonatal care over a number of years. Has it noticed any trends in neonatal mortality and, if so, what are they?

A. So neonatal mortality has gradually decreased over the past few years. Obviously things change, changed slightly with the -- with the pandemic but overall neonatal mortality has gradually decreased. It is a slow decrease that the previous government had a target which I can't remember exactly but we are obviously not on -- not on track to meet that target.

And we know that with both neonatal mortality and stillbirths, so perinatal mortality overall, we are, have higher rates than similarly developed nations, so there's always more we can do. The important thing for me, I am a public health physician, so we have to recognise that we can't do everything within neonatal units, we do have to think much more widely than that and think about population health, deprivation other aspects of care which are probably not within the remit of this Inquiry.

I think it's perhaps been, we have assumed we can do everything in the hospital and we can't. We do have

to think wider than that but we can still undoubtedly improve care in the hospital and continue to improve care in the hospital.

Q. Do you think it would be helpful if MBRRACE was able to send information to integrated care boards or share continuous or real-time viewing with integrated care boards?

A. Yes, absolutely. So we the permissions we have to receive identifiable information come from the Confidentiality Advisory Group of the Health Research Authority and you will forgive my -- I think it's an exemption under section 251 of the Health and Social Care Act. That may have changed so don't -- don't take my word on that.

But that, that information can only be used by us for the purposes of producing the mortality rates and the real-time data viewer for Hospital Trusts. When you interact with that real-time viewer, you will see that if you hover over any of the dots on that graph you will see quite a lot of details about individual babies who have died which may enable you to identify that baby and so that means that information can only be used under the terms of our permissions by people in the direct clinical care team, so that's by people in the Trusts.

And at the moment, people with oversight either in

integrated care boards or NHS England are not considered part of the direct clinical care team. So in order for the viewer to be accessed or usable by them, we either have to monitor it, we either have to modify it to make it perhaps less useful and there are -- we would have to remove any dates. So there are -- there are challenges in making it usable, but with no potential identification of individuals. But it's possible.

So we could -- we could have a limited version which could be used by integrated care boards or other commissioning organisations or --

Q. So -- sorry.

A. Or we need a directive from the Secretary of State which says that it should be used by them. And that is my understanding of the legal position. I am not a lawyer, so I will obviously defer to legal teams on that. But at the moment, because of the governance, because of the permissions that we have to receive the data we can't -- the viewer can't be used at -- at an Integrated Care Board or NHS England level.

I think that would be a good thing if it could be with the caveat that those individuals would need to be trained to understand the data as well because we -- it's that balance between regularly investigation -- investigating what may be random variation versus

targeted investigation where there's real concern on the background of that we should be reviewing and learning from every death of every baby that happens in all of our hospitals.

Q. And why do you say it would be a good thing leaving aside the modifications and confidentiality issues and the legislative issues?

A. ICBs obviously have the remit for commissioning care and oversight for their whole population, so need information about the care that is being -- that is received by their population and therefore you know and the outcomes of that care for their population which is why it ... and the real-time data viewer as I hope it's become clear in the evidence this morning is much more informative than a single dot once a year in a report, although we have, you know, interactive maps, it -- it gives -- and, you know, the clue is in the name: real-time. So, you know, the lag is not there in the same way as it is with us publishing single mortality rates once a year.

Q. Professor, you may or may not have any comments to make on my last two questions but I am going to ask you them in any event.

Do you think Hospital Trusts and the Integrated Care Board should have a children's champion to

incorporate neonatal care on to the board and would be responsible for oversight for all matters relating to neonates, including for example looking at MBRRACE data?

A. Yes, I -- I'm not sure I have an immediate answer. I guess my -- my immediate thoughts are that that person needs to involve maternity as well. So for me, it should be a maternity and children's champion because the care of babies starts before they are born and just including neonatal care and care of children may be -- may miss some of the vital aspects of care that we need to ensure are continuing to improve.

I think -- I mean, when we are thinking about the care of children and the care of neonates it is very different so whether a single individual should cover all of that -- you know, there is a big difference between a one-week old and an 18 year old or even 14, 15 year old when -- when children are moving to adult services.

So I -- I think it's challenging to have a single children's champion, whether it should be a maternity and early years champion might be perhaps more useful. I don't know.

Q. Finally from your perspective, what difference has it made having a National Clinical Director for Neonatology?

A. The National Clinical Directors are an important voice for patient care and at the moment my understanding is that there is a single Clinical Director for effectively Children and Young People throughout years nought to 18 and it -- back to my previous answer, neonatal care and the care of premature babies for me is very different from other aspects of children's care.

I have heard the analogy, you know, there is a -- there's a National Clinical Director for every body part and one single clinical director for all of Children and Young People, so I think it is an important consideration and when we know that the majority of deaths occur in the neonatal period and in infancy, having an individual with that remit, with that responsibility, I can see that could add value.

Q. There is one, there is a director, a National Clinical Director for Neonatology.

A. For neonatology --

Q. Yes?

A. -- as opposed to Children and Young People.

Q. But that is not something -- you wouldn't have dealt with that person or that office?

A. I think I know -- I now know who you are talking about but it's not -- it is not a person that

I have had any interaction with.

But as I mentioned my -- my -- I lead the maternal side and although I lead the overall programme, the focus of my work is on maternal. So my main interaction as a Clinical Director is for obstetrics.

MS LANGDALE: Thank you. Those are my questions and I think, my Lady, Mr Baker King's Counsel may have a few more.

Questions by MR BAKER

MR BAKER: Thank you, my Lady. Professor Knight, I ask questions on behalf of two of the Family groups.

MBRRACE as an organisation is about reducing risk through audit through the interpretation of data that's provided to it by other people. And so I understand it's not an organisation that carries out its own independent investigations into specific deaths.

But what role does it have in identifying patient safety issues and seeking to have those redressed?

A. So I mean the point of what we do is to improve patient safety in its broadest sense to make sure as I hope has been clear from what I -- from my evidence that we learn from every death of any mother or any baby. As you quite rightly say, we don't have a remit for individual investigations in individual hospitals, but we do have a remit for providing the

tools to both hospitals and Trusts to ensure that they can do that in a robust way and that the data that we produce and that are produced through the use of that tool are escalated appropriately to organisations such as NHS England where we have identified concerns.

So that is a very important part of what we do.

Q. So the Perinatal Mortality Review Tool, which is the device that's been used since 2018?

A. Yes.

Q. For this purpose, does it serve a dual purpose does it serve a purpose in causing the person collating the data or the organisation collating the data to look at it in a particular way and to interpret its own actions as well as being the conduit by which information is produced to you?

A. So I think it's important to recognise that the Perinatal Mortality Review Tool is not to collect data and is actually separate from the surveillance data that MBRRACE use but your point is exactly correct, the Perinatal Mortality Review Tool was developed based on a group led by SANDS, the Stillbirths And Neonatal Death charity with the Department of Health to -- to provide a logical and complete set of questions for each Trust to go through around the care of every baby to make sure that they have looked at every aspect of that baby's

care as well as bereavement care after a baby's death to work out where -- where care can be improved as well as to provide the parents with an understanding of why their baby died and that, that for, that's the most important part of the Perinatal Mortality Review Tool.

It does produce data by its very nature. The importance, we have -- the -- of the data for Trusts is that there is a -- hospitals can download a report which brings together all of the issues they have identified so that they can report up to the hospital board, so it has that -- that function as well.

It is not a tool for us in MBRRACE to collect data. We can analyse some of the data from it, but by and large it is -- it is exactly as you said: for the Trusts to ensure that they are doing a comprehensive review.

Q. It is a template for investigation?

A. Exactly, yes.

Q. Yes. Does MBRRACE receive and analyse though information from Trusts regarding self-identified patient safety issues contributing towards death?

A. So the Perinatal Mortality Review Tool we produce a report annually, which looks at -- which does look at some of the information about what issues have been identified across all hospitals. So not -- we -- we don't look at what has been identified in individual

hospitals but we will look at where there are broad things, the purpose of that annual report being more for the -- the organisations that are commissioning care to look at where there could be system level improvements that are needed on the basis of the issues that have been identified.

Q. So in terms of publishing of information, you would obviously publish the crude and adjusted data?

A. So the -- the Perinatal Mortality Review Tool doesn't produce numbers in that way, so crudely.

Q. Forgive me --

A. That is the MBRRACE surveillance data.

Q. It was the way that I put the question, I am sure.

But obviously you have the crude and adjusted mortality data --

A. Yes.

Q. -- which is provided to you and as was discussed when Ms Langdale was asking you questions, but also you are provided with information through the Perinatal Mortality Review Tool which enables you to identify broad patient safety trends. So for example if Trusts were reporting a rise in stillbirths due to issues in interpreting CTG traces then that might be something that you would regard as a broad trend but you

wouldn't publish information relating to individual cases and individual Trusts?

A. That is exactly right, yes, so we don't publish individual -- and I think probably we -- we, you can't interpret PMRT data in terms of trends quite in the same way. But we do certainly summarise the issues that have been identified by Trusts and that has been used to generate national actions, national training.

Q. So for example you may see that the most common cause self-identified of stillbirth in a particular Trust is the interpretation of CTG traces but again how would you act upon that or how would you seek to address that as a patient safety issue?

A. So I think we are probably conflating. So the PMRT I go back to, its primary aim is as a tool for Trusts to identify their learning. Thinking about the type of learning that you are talking about, we would be more likely to get that type of learning from confidential Inquiries, where we have undertaken an in-depth investigation of a sample of cases. So, for example, the perinatal -- recent perinatal enquiry report into intrapartum stillbirths identified exactly the point that you have you've identified and the there is a programme, ABC programme which is -- which is now focusing much more on training around CTG

interpretation.

Q. Yes. Coming back to I think what may be an important point though is that the effectiveness of the templates for investigation, does it not rely inherently upon the Trust's own reflectiveness and indeed willingness to accept patient safety issues?

A. Your point is a very well made one. One of the recommendations that we make around use of the tool is that there should always be external involvement in the Review Team for exactly that -- that reason that you give: that external perspective brings some of that reflection gets away from sometimes some of the group think that we have when we are in an environment that -- that we are used to.

And -- and we have seen an increase in the proportion of reviews that involve an external person but that's not 100%.

Some good examples of where Trusts in completely different parts of the country have sort of partnered with each other and exchanged external reviewers to enable that -- that external perspective to be there. But that's not mandated and I think it is an important thing, a really important part of the review process.

Q. Yes. So a Trust that is particularly switched on and geared towards patient safety --

A. Yes.

Q. -- will have somebody carrying out the investigation who is particularly switched on and geared towards patient safety or indeed will bring somebody else in from another Trust to do that?

A. Yes, exactly, so, so I -- we -- an external perspective, a different eye on things will always be valuable. Even in, you know if -- if one has the best reflective practice, actually having that, that second -- you know, we often talk about fresh eyes that second view, it can only add value. If, if there's nothing that, that they have identified that's different, great. But I -- I think, I don't think, no I think that should always be part of the process.

Q. Of course, during the time MBRRACE has been around there have been a number of very high profile maternity scandals that have involved a lack of reflectiveness, a lack of proper investigation into issues and have led to Inquiries being undertaken on a more formal basis. I mean, isn't one of the inherent problems with the self-investigation process is that it requires the individual or organisation to be reflective, to have a proper eye towards patient safety and I don't want to say to take those things seriously because I am sure that would be putting it the wrong way

but to actually understand patient safety and the role of their own organisation in effecting it?

A. Again your point is very well made. It -- to actually understand patient safety and that -- that, you know, picks up on many of the things we have talked about, you can be provided with all -- as many tools, numbers, that you like but unless you understand it, you know how to interpret it, you know your own data, you know when and who to escalate and your concerns are taken seriously, all of the tools in the world won't have any effect.

Q. And no amount of templates will change a culture?

A. No, no amount of templates will change a culture. So there has to be, there has to be other mechanisms to change culture and governance processes and that again is one of the positive developments for me over the last year because we -- I have, you know, feel as MBRRACE we have no power to -- to mandate use or use in the right way and indeed making sure that parents are listened to although that's part of the tool, it -- you know, it actually takes people at the Trust level to -- to do that.

So that is a positive I think of the -- of the development with MOSS that's occurred over the last

year.
Q. The reporting is incentivised through -- effectively it counts as credit towards additional funding if you have proper reporting. Do you think finding out that an organisation was being misreporting or has been withholding information from organisations like MBRRACE should lead to penalties being placed upon that Trust?
A. So we always cross-check all deaths that occur, so I -- I don't think we could say that -- that information about individual deaths that occurred has been withheld because if we find a death that hasn't been reported, we will include it in the statistics and -- and the hospitals we get the hospitals to check the data so it's -- all deaths are included in MBRRACE statistics.
I -- I am assuming that you are referring to where it -- more around the quality of reviews and whether reviews have identified all of the issues.
Q. Yes.
A. And we definitely find when we -- when we undertake a confidential inquiry, which is an entirely external process, so all of the reviewers of mothers and babies' care will be external to the organisation where the mother or baby died, we definitely identify more

issues than are identified by the Trust themselves. So there is still undoubtedly an important -- lots of improvements to the review processes that need to go on locally which is part of the culture that you talked about.
MR BAKER: Thank you, my Lady I have no more questions.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Baker.
Questions by LADY JUSTICE THIRLWALL
LADY JUSTICE THIRLWALL: I just want to be clear about something that you said just recently. So you are confident I think from what you said that because of the system of cross-checking, and it may be goodwill from people in the first place, that the death data that you have on MBRRACE is accurate?
A. Yes. I am going to put a small caveat on that. So the death data that are accurate are stillbirths from 24 weeks onwards and neonatal deaths from 22 weeks onwards.
LADY JUSTICE THIRLWALL: Yes.
A. The late fetal losses, so deaths at 22 and 23 weeks of babies who are stillborn at 22 and 23 weeks which are not statutorily registrable as stillbirths we have no means of cross-checking the hospital data so

there may be small numbers of those babies whose deaths we miss.
But they are not -- not in the stillbirth and perinatal death statistics.
LADY JUSTICE THIRLWALL: Thank you. I think you did say something about that much earlier in your evidence.
A. Much earlier, yes.
LADY JUSTICE THIRLWALL: Thank you for reminding me about that.
Just one other question really arising out of some of what you have said in respect of sort of real-time monitoring and the fact that clearly you need people who are trained to first of all operate and input the appropriate data but also to understand and analyse so there is an interesting question there about who ought to be doing it.
Do you know at the moment who does it in the hospitals?
A. No is the short answer and -- and highly variable between, between hospitals. I mean, I think it does relate a little bit to culture.
LADY JUSTICE THIRLWALL: Yes.
A. There are clearly some Trusts where actually it's considered very important, it is a funded role,

somebody who is used to looking at safety signalling systems has, has done a lot of training, has a voice at board level, not the same for all -- all hospitals and all Trusts.
The question was asked: does it have to be a clinician? I don't think it does have to be a clinician. There does need to be -- all of the multi professional team need to be involved when looking at review processes so there needs to be that multi professional team involved but not necessarily just in the -- in terms of having the responsibility for making sure that they are looking at the viewer on a regular basis and interpreting any signals.
LADY JUSTICE THIRLWALL: So clearly if you have got a culture which says this really matters and money is made available, one can see that that's a real clear commitment --
A. Yes.
LADY JUSTICE THIRLWALL: -- to looking at this very carefully.
A. (Nods)
LADY JUSTICE THIRLWALL: Where there isn't that same commitment, and we see that I think from what you said earlier, you know, some people don't really look at it from one year's end to the next, it suggests that it

hasn't been accorded any importance by those who are making decisions about the money as a minimum?

A. (Nods)

LADY JUSTICE THIRLWALL: Is there anything in the point that when you are dealing with small numbers, in relatively small units, that actually what matters is what happened, the narrative as you were talking about and actually what are the statistics going to add and I am just wondering if that might be the way some people think. Firstly, is that a possibility and if it is, what do you think could or should be done about it, assuming that it's not necessarily a valid approach to take?

A. Yes, also a very valid point and I think it goes back to my "and not or". Reviewing every baby death to learn and to prevent in any way we can deaths occurring in the future has to be fundamental to the care we are providing whether we have got lots of deaths occurring or few deaths occurring.

Your point about there is a limitation to what we can do with statistics is -- is, is valid and I guess I had never thought before about whether people think "well, we won't bother" then it goes back to the "and not or" and, you know, I was going to say in response to your comment about if people aren't using it may be it

shows they don't care, I guess we have to -- we have to accept some responsibility ourselves. Do people know, you know, are we telling the right people that the tool exists? Are we providing the training? And that again is where I think it's a positive of the involvement with the MOSS group and the added governance.

LADY JUSTICE THIRLWALL: Yes.

A. So -- so I think we have to -- we have to take both of those in -- in mind and maybe with that, it will then begin to get over the "oh well, statistics can't tell us anything". Well, they can tell us something and actually just looking at them will on its own familiarise us with the patterns that we are normally seeing so that if something unusual, three deaths in three weeks, occurs it makes us much more likely to -- to jump and respond and -- and look in much more, much greater depth much more quickly.

LADY JUSTICE THIRLWALL: Thank you. Anybody want to ask anything arising out of that?

MS LANGDALE: No thank you.

LADY JUSTICE THIRLWALL: Professor Knight, thank you very much indeed for coming along and providing such illuminating and helpful evidence. I am happy to tell you you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you.

MS LANGDALE: My Lady, I hand over to Mr De La Poer for the next witness.

LADY JUSTICE THIRLWALL: Thank you.

Mr De La Poer.

MR DE LA POER: My Lady, the next witness is Mr Ken Jarrold CBE. He has been kind enough to join us in the hearing room before we got to this point and I wonder if he might come forward, please.

LADY JUSTICE THIRLWALL: Yes, would you come forward, please, Mr Jarrold.

MR KEN JARROLD (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Thank you, do sit down.

A. Thank you.

MR DE LA POER: Please could you give us your full name.

A. I'm sorry?

Q. Please could you give us your full name?

A. Indeed. It's Kenneth Wesley Jarrold.

Q. Mr Jarrold, is it correct that you provided to the Inquiry a witness statement dated 6 March of this year?

A. I did.

Q. Is the content of that witness statement true

to the best of your knowledge and belief?

A. It is.

Q. Now, before we come to the substance of your evidence I understand there is something that you would like to say.

A. Thank you. Just as a father and a grandfather, I would like to express my deep sadness about the events that occurred and offer my profound condolences to the Families.

Q. Now, Mr Jarrold, although not dealt with in your statement, and no criticism is implied by that, you have had a lengthy career involved in the NHS, is that correct?

A. It is.

Q. Open-source research tends to suggest that you began life in the NHS in 1969; is that right?

A. Correct.

Q. We won't cover the entirety of your career, but no doubt there came a point when you became what is described as a senior manager within the NHS?

A. Yes.

Q. At what point was that, please?

A. Terms vary over the years of course. I would regard it as when I was appointed as the hospital secretary of the Derbyshire Royal Infirmary in 1974.

Others might place it later when I became a district administrator for the Gloucester Health Authority in 1982.

Q. Following the dates you have just given us, did you continue your career in the NHS undertaking a variety of posts at that level or above?

A. I did. I retired from full time work at the end of 2005 early for both personal and work reasons. I had had a very difficult three years.

Q. Well, before we reach the point of your retirement, and we will come to the detail of this in a moment, is it right that you were in 2002 asked to write a Code of Conduct for senior managers?

A. I was.

Q. Just help us in terms of the position you were in in your career at that time. What role did you have?

A. Right. I had just been appointed as the Chief Executive of the County Durham and Tees Valley Strategic Health Authority.

Q. We will come back to more of the circumstances surrounding that. You have told us that you took early retirement in 2005.

A. I did.

Q. Have you continued to work though within the NHS?

A. I have, it's been my great privilege to continue to serve both as a management consultant but perhaps more importantly as the Chair of two Trusts.

Q. Are you still working within the NHS as at today's date?

A. I am not. I felt that when my 75th birthday came it was time for me to stop.

Q. But is it fair to say that you have had the opportunity over the course of your long and distinguished career to observe the role of the senior manager up close and personal both as a senior manager yourself and as somebody who was working closely with senior managers?

A. Yes, indeed and I have been, I have lived through the transition from administration to the coming of general management after the Griffiths Inquiry in the mid-80s and then all the changes that have occurred since then.

Q. Now, towards the start of your statement at your paragraphs 2 and 3 you recount a personal experience which as you make clear in your statement was something that stuck with you throughout your career and if I can summarise it in this way and you add the detail that is particularly important to you: is it right that it was drawn to your attention by a doctor that you

ought not to have your wife treated at the hospital that you were working at because of another doctor; is that right?

A. That -- that is correct.

Q. That when you went to speak to the doctor in relation to whom there was a concern, you were treated with contempt and disdain?

A. Yes.

LADY JUSTICE THIRLWALL: Was it a surgeon?

A. I'm sorry?

LADY JUSTICE THIRLWALL: Was it a surgeon?

A. Yes, it was.

LADY JUSTICE THIRLWALL: I just think that is probably important.

A. The person who drew my attention to the problem was a surgeon and he drew attention to the fact that he had concerns about one of his colleagues and that was the person he didn't want me to have my wife referred to.

In those days, and we are talking about the 1980s now, it would have been very difficult even for a senior person as such as a district administrator or manager to directly challenge a surgeon. So what I did was to set up an inquiry into the service which I thought might lead us into the right territory, because having checked

the legal files in the district office there clearly was cause for concern and the surgeon who was the object of my attention replied to me and I still have his note to say that he wasn't going to respond to a letter from a "snivelling clerk".

MR DE LA POER: That was put in writing?

A. (Nods)

Q. How did you seek to resolve that situation and what lessons did you draw from it?

A. Well, it was very difficult. A, the surgeon who had drawn my attention to the problem originally asked me a few weeks later how the inquiry was getting on and I said that I wasn't getting very far and he sympathised, he was a good man, and he said that it really was very difficult and I almost let it go. I remember the -- the moment of thinking: have I got the courage to challenge this? And fortunately I did. And I just said to him, and he was a very senior man, that I wanted him to go home and look in the mirror and ask himself if he could live with what he knew and he never forgave me for that challenge and it affected my relationship with the Consultants as a whole.

But three days later, a few days later, the three wise men, which was a mechanism we had in those days for three senior doctors who would be -- take an interest in

the conduct of their colleagues, went to see the person concerned and shortly after he retired on grounds of ill health and his successor transformed the service.

Q. What did you take away from that experience that so powerfully shaped what you did in the NHS after that?

A. Well, as I said right at the beginning of my statement I am very fortunate that my first boss, Jack Newton at the Royal Hospital in Sheffield, taught me everything I needed to know. First, that patients come first always; and secondly, that everyone should be treated with the greatest of respect, whether they were a porter or a professor. So I had those basic values right from the start in 1974 -- 1971.

What then happened in the story that we have just been talking about absolutely imprinted on my heart and in my mind that patient safety is -- has to be the first responsibility of everyone in the NHS, including the managers, and that we need to act and that's the crucial word, we need to act to protect patients from harm.

Q. Now, if we just step out of your personal career and just acknowledge wider events. The Kennedy report --

A. Yes.

Q. -- by Professor Ian Kennedy into the Bristol

Royal Infirmary produced a number of recommendations, one of which was Recommendation 91 and I would like just to bring it up on to the screen now, please, it is INQ0017990 and we are going to go to page 458, please.

A. Yes.

Q. We see it there.

A. Thank you.

Q. "Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals including being subject to a regulatory body and professional code of practice."

The Government responded to Professor Kennedy's report and we will bring up the response to that and in particular the response to Recommendation 91. This is INQ0012447, please and we will go to page 164.

At the top there, I am sure you will acknowledge, Mr Jarrold, there appear to be two parts to this Recommendation?

A. Yes.

Q. One is the regulatory regime, the other is the code and the Government's response:

"We agree in part. We do not think it is practical to establish self-regulation for senior managers. We do agree that the standards expected of senior NHS managers should be explicit. We favour a Code of Conduct,

stronger performance management and tighter contracts rather than regulation."

A. Yes.

Q. That I think is where you intersect with what was going on arising from Bristol because the Chief Executive then of the NHS, Nigel Crisp, asked you to write the code?

A. Yes, he asked me to chair a working group to produce the code and that was a great privilege and I ended up writing it as well as chairing the group.

Q. Thank you, we can take that document down.

In your witness statement you mention a number of those organisations that were involved in the working group. I just wanted to ask you about one of them, the British Association of Medical Managers.

Is that an organisation which still exists so far as you are aware?

A. I don't think so which is sad because it was a very effective organisation led by Jenny Simpson and did a great deal of good work.

Q. In summary, what was the purpose of that organisation, who were its members and what did it do?

A. The Griffiths report in the mid-80s that created general management was very keen, and Roy Griffiths was very keen, to bring clinicians into

management and therefore a large number of doctors had by this time become clinical directors and managers and the new pattern in most NHS Trusts was to have a series of clinical directors managed by a clinician and that still endures in most places today and BAMM's role was it support the doctors in their new management career. Because although there had always been managers in the sense of being people who control resources, they hadn't had specific managerial roles. So that was the purpose of BAMM and they did an excellent job.

Q. Do you know why that organisation ceased to exist, as you believe?

A. I'm sorry, I don't.

Q. Returning to Nigel Crisp. He launched the code, if that is right word?

A. He did.

Q. Is that correct?

A. Yes, it is.

Q. You tell us in your witness statement that it was launched on 9 October 2002?

A. Yes.

Q. And issued to the NHS on 21 October and I am here looking at your paragraph 6?

A. Yes.

Q. I would just like to draw attention to what

was said at that time as you record it in your witness statement.

A. Yes.

Q. So it's at the bottom of page 2.

A. Yes.

Q. I will just read to you what we can see you have reproduced there:

"The Code sets out the core standards of conduct expected of all senior managers and should be incorporated into the employment contracts of all senior managers at the earliest opportunity. Employers should also begin to identify other managers in their organisation who should also be subject to the Code, look at their organisational culture to ensure they are providing a supportive environment to managers and ensure systems are in place to fairly investigate any breaches of the Code."

So we will park that for a moment and we will come back to it when we review what in fact happened. But we ought to acknowledge that at the same time that this code was launched, there was a wider piece produced by Mr Crisp; is that right?

A. (Nods)

Q. Was that called Managing for Excellence in the NHS?

A. (Nods)

Q. Could you just tell us please in summary what Managing for Excellence in the NHS was about and how it fitted with the code that was launched at the same time?

A. Yes, thank you and my apologies for not mentioning Managing for Excellence in my statement. I had just not remembered it when I was writing the statement.

It was a very good document and it set out not just that -- not just very strong support for the code which obviously I was very grateful for, but priorities for the service because new priorities were being developed in the light of the very substantial resources that were being allocated to the NHS at that time.

It talked about management development, it talked about management standards. It was a very wide-ranging document and interestingly enough, and you may wish to come back to this, the content is very similar to what Amanda Pritchard has recently announced she is proposing to do.

Q. Well, we will come back to the position as at today at the end of my questions.

So we are going to look now, please, Mr Jarrold, at the code itself. This is the document that you wrote chairing that working group, INQ0107810. We see there

the first page dated October 2002 if we move forward to page 7, please, we will see the principles as they are described.

I am just going to read these into the record, so please bear with me:

"As an NHS manager I will observe the following principles:

"Make the care and safety of patients my first concern and act to protect them from risk.

"Respect the public, patients, relatives, carers, NHS staff and partners in other agencies.

"Be honest and act with integrity.

Accept responsibility for my own work and the proper performance of the people I manage.

"Share my commitment to working as a team member by working with all my colleagues in the NHS and the wider community and take responsibility for my own learning and development."

A. (Nods)

Q. Excuse me. Mr Jarrold, you have distilled from what no doubt was a very wide number of possibilities down to that and I am not seeking a justification for each and every one of them but what was the philosophy or the mentality that was driving the selection of those when you created this?

A. Personally, it was the values that I had learnt at the beginning of my career and subsequently and I think the final version of the code was much better than my first draft, due to the input from both the working group and the external reference group which had some very distinguished and helpful people on it. And one of the key changes was making this a personal statement that I hoped each NHS manager would make.

So you know as you see it talks about "I" will observe the principles and I thought that was very powerful and that came through my colleagues' wisdom and the wisdom of those we worked with and we did also work with the Plain English Society who were very helpful in making it understandable and brief, which is something that is sadly lacking from some of the other documents we may be going to talk about.

Q. Was it chance or design that led to "Make the care and safety of patients my first concern and act to protect them from risk" was first in the list that you created?

A. I think that's the only bit of wording which survived from my first draft in the exact form in the code. And that was because of the issues we have discussed, the values I had learnt, my own personal experience but also the terrible tragedy of what

happened in Bristol. And I thought well if, if we are going to help managers to behave differently and better, then we have to address the fundamental issue from the Kennedy Report and I felt the right way to do that was to make it very clear that each manager should be able to say: I will make the care and safety of patients my first concern and act to protect them from risk and to put that ahead of personal interest, the reputation of the organisation, or protecting colleagues. That, that was the reason for it.

Q. Thank you, we can take that document down. So returning to what Mr Crisp said he expected to happen in terms of this being integrated into employment contracts, you continued to work in the NHS full time for another three years after this. Did you see that happen?

A. No, I did not. And it was clear to -- I mean, there were three difficult years for me workwise and personally, but it didn't happen and when I left full time work and subsequently I was really sad that the code simply didn't seem to be being implemented. I can't think of -- and I am very open to correction of course but I can't think of a single investigation of a breach of the code that I was made aware of and let's not forget that the terrible events in Stafford

investigated by the Francis Report occurred between 2005 and 2008.

So we can be sure that at least in one Trust the code was not having any impact and that was a great sadness to me at that time and in subsequent years.

Q. Have you formed any view about why despite the clear terms should --

A. Yes.

Q. -- from the NHS Chief Executive that it wasn't taken up immediately even when all of the terrible features of the Bristol Inquiry were still fresh in the memory of everybody who was working in the NHS at that time?

A. Yes, I have. If we think back to the NHS into which the code was born, paradoxically it was in my view the best time in NHS history in terms of resources. From 2001 onwards we had an injection of resources greater than we had ever had before or since and there was a massive programme of work at national level to reduce waiting lists, to set up the wonderful National Service Frameworks which did guide a great deal of service improvement, the appointment of the National Clinical Directors and we have heard a little about them earlier and it -- I think what happened was that the whole world seemed positive and hopeful and developments

were taking place and people were busy getting those waiting lists down which they did and let's remember that by 2010 public satisfaction was at its highest in the history of the NHS.

So it was a good time in many ways. But sadly I think this fell out of -- of favour. You will know that Lord Crisp as he is now stood down as the Chief Executive of the NHS early in 2006, I don't know whether that had any bearing on it. And the service was then immediately consumed with the awfulness of Stafford.

So I think those are all contributory factors.

I think there were some managers who were never very keen on it to begin with. Out of the 64 responses, six were critical, hostile, one said that the code should apply to clinical staff and not to managers which I thought was very interesting, in other words they didn't see patients as being what managers were about and another accused us -- accused the code of "medical evangelism" which was clearly a very bad thing in the commentators' eyes.

Q. Now, one of the matters that you deal with in your statement, and I am here looking at paragraph 8, is your concern about how the general management reforms, if that is the right way of describing them --

A. Yes.

Q. -- may impact upon a desire to promote patient safety and you identify a possible risk of those reforms being that of reputation. Could you just explain to us please why you think that reputation might become more important under the general management reforms which in one form or another subsist to this day and whether in fact that concern was more imagined than real?

A. Yes. I think the reason why I saw the risk and I mean I -- I wasn't in favour initially of Roy Griffiths' proposal to appoint general managers because I felt that the appointment of a Chief Executive would undermine the consensus management of the NHS and I was a bit old-fashioned in that way.

However, I -- I got to know Roy Griffiths, I got to understand where he came from his commitment to patient care and I became a convert to what he was doing. But there was a risk and that risk was that the creation of NHS Trusts in the early '90s established a very strong identity for a local organisation, much stronger than there had been in the past because the whole point was to have an independent Trust, I mean, the independence is long gone but that was the original idea.

And I think because of that, there was a great focus on the Trust protecting its reputation. And you had to go through all sorts of stages to become a Trust

and later with the Foundation Trust movement as well.
So that -- that I think is why the risk occurred. But I was reassured because I -- I did understand that both Roy Griffiths and indeed Ken Clarke, a very able Secretary of State, did care deeply about patient care.
Q. If we continue through a timeline and just pause at 2012 and we are going to hear from Dr Clamp this afternoon who is the current Chief Executive of the PSA, the Council for Healthcare Regulatory Excellence, as it was, in 2012 and he will tell us about the introduction of the standards for members of NHS boards and clinical governing groups that that organisation published in 2012.
Were you aware of that taking place at the time?
A. I -- I wasn't, no. And that's, that's interesting because I had taken up my first chair's role in 2011. Could I just mention 2010?
Q. Yes, of course.
A. Would that be all right? I think it is relevant.
In the course of preparing for today I discovered that there had been an official national review of the code in 2010. I hadn't been aware of it until preparing for today. And the conclusion of the group was that the values set out in the code were out of date, which seems

to me to be quite shocking, and -- and also -- and also their second criticism has just gone from ... oh, yes, the code was described as "aspirational" which clearly again was not regarded as a good thing.
So there had been an official review of the code in 2010 which I wasn't aware of that had said we needed a new code and a new system and all that and made all sorts of recommendations which didn't happen because of the election of 2010 and the change of government and then being plunged into yet another reorganisation. And I wasn't aware of the 2012 work.
Q. Well, you have as part of your statement to bring us very much up-to-date had the opportunity to consider the leadership competency framework?
A. Yes, yes.
Q. Published on 28 February of last year.
You have looked at the detail of that as part of your preparation for today?
A. Yes.
Q. You raise three concerns as you characterise them --
A. Yes.
Q. -- that you have about the document. I am looking here at paragraph 12. Let's just first understand in headline form what concerns you have about

this document.
A. The first is that it does not specifically refer to the care and safety of patients being the first concern of managers. And I think that's unfortunate.
The second is that it appears to depend on self-assessment and that is obviously limited and, you know, any, any proper appraisal system needs to involve 360 feedback from colleagues and so on.
The third is that appraisal is often not done well, I mean it should be a meaningful discussion where you really come out understanding what you have done right and being commended for it and understanding where you need to learn and I have to say that in all my years I only had six decent appraisals, all of which were carried out by chairs and none of which were carried out by managers. So to rely so heavily on appraisal worries me and again there is so much here, the wordiness of it and we may go on to the fitness for practice work which is also incredibly wordy. But, you know, how much of this can people really take into their hearts and minds and do something about? That's the problem with a lot of this.
Q. Now, given those concerns, I am just going to draw your attention to some aspects of it to see whether they meet your concerns or whether your concerns subsist

even having considered them?
A. Sure.
Q. So if we bring up the leadership competency framework, INQ0108668. If we have a look at page 2, we see at the top that the competency domains reflect the NHS values and a hyperlink is given to them.
So in one sense it may be thought that the NHS values are imported into this document, so that is the first point I will ask for your comment in a moment I will just draw your attention to these factors.
If we go over the page we will also see reference to the Nolan Principles under a link to them, so in terms of the concerns you have about patient safety, does that meet your concerns about this document and if not, why not?
A. Well, unless I have misread it, there is no specific reference to the care and safety of patients being the first concern of managers and the need to act to protect them from risk. I cannot find that. If I have missed it, I apologise.
Q. No, no, that wording is not there?
A. It's not there.
Q. So does it follow from your answer that you regarded as essential that that wording or something equivalent is written in the document for everybody to

see when they look at the document?

A. I -- I do. And also that it, it we should have a limited number of things in any code or approach that people have some chance of understanding and remembering. And if you look at this -- this -- this diagram we have in front of us, the competency framework itself with no less than six domains and lots of words around them, "the leadership way" I am not entirely sure what that is, the NHS values, which are six set out previously, another six, "the people promise" which is a whole other thing, and the seven principles of public life.

I mean this is all excellent stuff, the Nolan stuff, but, you know, the numbers of things that you are expecting people to understand and observe and take into their lives and change their practice, and behaviour, it's just too complicated.

Q. I also just draw your attention, please, on page 13 to domain 4, which speaks about providing robust governance and assurance.

Forgive me. I wonder if -- I think I have lost my reference there. Could we just scroll down, please. Thank you, if you keep going, please. No, that's ...

My mistake. If we stop, thank you very much indeed.

I think the point -- and we can take the document down -- I think the point I am inviting you to consider is that within domain 4, which deals with providing robust governance and assurance, there is a requirement, presumably inherent in the idea of governance, that you are ensuring that systems, including systems of patient safety, are properly implemented.

Again, do you feel that addressing the concerns that you have through that route is sufficient or is more required in terms of being express?

A. No, I -- I don't think it's sufficient.

Let's bear in mind that human nature in any organisation, and I try to be realistic about human nature, but hopeful about it, but if we are realistic about human nature there is a very strong temptation in any organisation if something goes wrong for people to try and conceal what's happened, to protect colleagues, to protect the reputation of the organisation. And there needs -- in order to counterbalance that, there needs to be a very specific, clearly-worded commitment to something that is strong enough to stand some chance of counterbalancing it and I don't see it here.

Q. Now, the document itself appears to be a list of competencies against which you can benchmark --

A. Yes.

Q. -- a senior manager. Again, just considering how that document might sit as part of a wider set of documents supplying to managers, is it possible to create a competency, which is what the document is seeking to do, which addresses the need to keep patients safe which is a way of behaving as opposed to perhaps a competency? Again, I would just invite you to consider that and how you would phrase within the terms of the document as it exists?

A. I think it's possible, but you need to start from the point we have been discussing and then build on that, but again not build too much on it because again you will lose people.

The more complex and wordy you make it, you will lose people.

So the simpler you can make it the better.

People need simple things to guide them.

Q. Just two more topics for us to deal with please, Mr Jarrold. The first is -- and we said we would come back to this -- the current position. You have referred to Amanda Pritchard --

A. Yes.

Q. -- and what she's seeking to do.

What do you understand the current position to be and do you consider that it is adequate?

A. Yes. I -- I support everything in Amanda's statement. I would just respectfully offer her a number of pieces of advice.

The first is that in drafting the code, I would hope she would use the wording that we used in the original code and which we have both mentioned several times. That's my first request, and it remains to be seen if that's going to happen, but I will be disappointed if it doesn't.

Secondly, that the code should apply to all managers because let's remember that all this stuff about board managers is, is just one aspect. The people who actually manage the NHS are the ward sisters and team leaders; they are the real managers of the NHS, and it's those team leaders and ward leaders who need to be included in any version of the code and indeed you will remember that Nigel Crisp specifically referred to ward sisters and similar roles.

So the second thing is it must apply to all managers.

The third is that of course it must be implemented, and not like the last one.

The fourth, and forgive me if I run out of numbers, but the fourth is that we could take on board some of the aspects of the current wider debate about the

regulation of managers and there are three in particular, two of which I think have come from the Infected Blood Inquiry.

The first is that I think that there does need to be proper investigation of breaches of the code and -- which never happened before, and there needs to be a disbarring list that somebody could be placed on if the breach of the code had been judged to be sufficiently serious for that to happen.

Then I think it would be very useful to pursue the idea of the statutory duty of candour for individual managers and, thirdly, the duty -- again from I think the Infected Blood Inquiry -- to require, to have a formal duty for people to respond to concerns about safety.

So I think if you put all of that together with what Amanda has proposed we would be getting somewhere, crucially, if of course it is then implemented. And if we could in five years' time we could say that the code was lived in every Trust and everywhere else that NHS managers work, that it, it was, you know, if we walked into a manager's office we could ask them what the key aspects of the code were and they could stand some chance of telling us -- and I would like to come back to the nursing code if I may which offers some good

practice -- and that there had been investigations and people had been disbarred and people had become more alive to the duty of candour and more alive to the duty to respond.

And one of the aspects of the NMC code, which I am very familiar with because my son is a staff nurse, is that if something happens that people think you can learn from the nurse is required to prepare what's called a reflective account and then the last question, as I recall it, in the reflective account form is to link it back to the code. So: which aspect of the code does this learning relate to?

Now, if we could get managers into that position where they had a code they understood, where when that code -- when something went wrong, they were required to write reflective accounts, these are not long documents, they are short documents, and they were required to think about how what had happened went back to their code that would be powerful.

Q. Now, in the suggestions you have made for future improvement, you didn't, unless I misunderstood, expressly endorse the statutory regulation of senior managers and very often we see a code such as good medical practice which sits in the context of statutory regulation.

Do you have a view about whether statutory regulation is a good thing or a bad thing?

A. I -- I do. The aspects that are in the current consultation that I support are the ones I have just mentioned.

I don't support the regulation of managers in the formal way because management is not a profession. I mean, people talk about "professional management" but the fact of the matter is that management is an occupation, it's not a profession. It does not have an entry standard, it does not have all the other things which medicine or the law or nursing or other, other professions have.

So if you are going to do this, you are creating an entirely new profession and the consultation document itself, to be fair, refers to many of the difficulties. So for example, where are you going to define the entry standard to management? You know which of the zillions of management degrees are you going to accept as entry to the register of management? There's a very big task, task there.

And there isn't the same agreement on the body of knowledge that you have in other professions. There would be, again as the document recalls, there might be problems for people who didn't have management

qualifications taking up management roles.

And as I have said, you know, the managers who really matter in the NHS are not the chief exec and the boards -- and having been a chief exec myself I feel entitled to say that -- the managers who really matter are these first-line managers. You ask somebody on a ward or on a team, "Who is your manager?" they are not going to say the chief exec or the director of this, or that or the other. They are going to say, "The ward manager" or "The team manager." Those are the key people.

And many of those people are of course from clinical backgrounds. They do not have management qualifications, formal management qualifications many of them, and to require every one of them to reach some standard simply in order to create a new profession, academic standard, I just think would be wrong and much -- and it's going to be expensive if you apply it to all, all the managers I have talked about.

So I would much rather focus on Amanda Pritchard's package, which I think is excellent, reinforced by the points I have made.

Q. Within that system, how do you understand, absent a statutory regulatory scheme that has a fitness to practise element to it, that managers who fail to

adhere to the code are -- or rather the public are protected from such managers?

A. Well, I think, it's -- I mean, I am not an expert in these things and no doubt there are legal difficulties that I am not aware of.

But I would have thought it was possible to have a code, to have investigations of breaches of the code and to have then a disbarring list based on those investigations. It would no doubt need proper basis and all the rest of it. I would have thought it was possible to do that without creating the full panoply of professional regulation.

Q. The final topic to ask you about is in relation to a document which was drawn to your attention recently as far as your preparation for today was concerned. It's INQ0108022.

We will just have a look at the first page and introduce the document.

A. Yes.

Q. This is a document which started life as a document created by the Thirlwall Inquiry legal team, but which has had additions made to it, quite properly, by, as I understand it, the Department for Health and Social Care and NHS England. I may be wrong about the latter of those.

But the point is that the underlying data is from the Inquiry and then we can see some additions and we will see in the table that we'll look at what the additions are in relation to Recommendation 91.

So if we could go to page 45. We are coming back to where we started, Mr Jarrold, which is with the Bristol Royal Infirmary Inquiry and Recommendation 91.

Just so you understand what "superseded" is intended to convey. That is intended to convey the fact that there is a firm Government commitment to carrying out this Recommendation in terms of the code as opposed to an assertion that it has already been done. So that's what "superseded" means.

But the second column from the right which provides some detail around it, I think you have had an opportunity to consider as part of your preparation for today and, as I understand it, you have an observation to make about it and in particular what it does or doesn't say about the work that you did?

A. I was simply astonished that a document of this kind made no reference to the code of 2002. It seemed to me very odd indeed that a code that had been commissioned by the Chief Executive of the NHS, issued to the NHS by him with very specific instructions, you know, there were formal statutory backing to it as well

in one of those orders that you get, past -- none of that is reflected here and I couldn't understand that.

It seemed to me odd that you should simply -- that they should simply refer to the January 2002 response saying that they favoured a Code of Conduct with absolutely no information, no indication in this document that a code was ever produced.

And that just worries me slightly because when I tried to find the code, I mean I had my own copies, but when I tried to find the code a few years ago, I think three or four years ago, I discovered that it had been archived by the Department of Health which I think was interesting.

Q. I mean, is it your understanding that that is still a document available for use by NHS Trusts if they wish to or is it your understanding that that document is now considered withdrawn or are you in a position of being unsure?

A. I -- I don't know what their view of it is, but it does seem odd to me that it's not mentioned here.

MR DE LA POER: Mr Jarrold, thank you very much indeed. Those are the questions that I have for you.

I see indications from Core Participants that although permission was granted that there are no questions, so I am pleased that I have covered what

needed to be covered.

My Lady, that therefore concludes the questions that I have.

LADY JUSTICE THIRLWALL: Yes. Actually there are one or two things I would quite like to think about over lunch. Would you mind coming back at 2 o'clock --

A. Of course.

LADY JUSTICE THIRLWALL: -- Mr Jarrold? It may be it will take five minutes, but I would like to think that I have properly reflected on some of the information which is, to me at least, relatively new.

A. Of course.

LADY JUSTICE THIRLWALL: Thank you very much. We will rise and we will start again at 2 o'clock.

(12.56 pm)

(The luncheon adjournment)

(1.58 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer, I think there was something else you wanted to ask.

MR DE LA POER: There is a point. Thank you, Mr Jarrold, for coming back. I should have asked you about the fit and proper person test. I understand there are two views that you have that you would like to share about that, please.

A. Thank you. I have two problems with it. The

first is that it says that its aim is to prioritise safety but I can find nothing in it that would be towards that end. And when you come to the end of the document and it -- the document itself says what its core recommendations are, they are good character, qualifications and finance. All important, but nothing about safety. So I don't know why the document says it is about prioritising safety when it hardly mentions it and then when it defines its own core, it fails to mention it.

My second problem is as we discussed earlier, its complexity and its length. If I have counted correctly there are 64 criteria. Now, how anybody is supposed to make any sense of that, I just -- I just don't know. And there are some very complicated diagrams I think on pages 15 to 17 or something like that and you just wonder who is going to make this work, busy people trying to do the right thing, if this is supposed to help them with that, how is it going to help?

Q. So as to the first concern that you have, how would you address the latter part of it that you observed that were three particular core characteristics that are mentioned at the end. Would you add to those in terms of -- and if so, what language would you use to make it clear that patient safety is to be prioritised?

A. I mean clearly, when you are recruiting somebody, you need to check their background and all those sort of things so there's nothing wrong with any of that. But I think it should make it clear that this test is about background checks. It's about those issues. Its primary purpose shouldn't be stated as being prioritising safety because that's not what it's doing.

And unfortunately people do tend to use these slogans and then not follow through on them because it's the fashion of the day or perceived to be the priority.

So I have nothing wrong with, nothing -- no problems with a fit for purpose test that is what it says it is and checks background and all the rest of it. But if you are going to influence behaviour, you can't have as this document has -- and forgive me if I get the numbers wrong -- but you know, six NHS core values, seven Nolan recommendations, six something else and it just adds up and up and up.

So, fine, as if its purpose was different. But to state that its purpose is to prioritise safety and then not to do so is not helpful.

Q. So how would you change it, practically speaking what would you do to it?

A. I would say that it wasn't about prioritising

safety. I would say that it was about recruitment checks and that is fine. Nothing wrong with that every organisation needs to do that. You need to know whether somebody is an undischarged bankrupt or a conviction that hasn't been spent and all those sort of things. But just tell it -- call it what it is and don't pretend it is something else and deal with the safety issues through the Code of Conduct and I -- a point I meant to make this morning is I do believe that it's possible if we got the right code that it might be a code not just for managers but for the NHS as a whole. And that would actually be a unifying thing.

I mean, there's a lot of in common between the GMC code, the nursing code, and what I would hope the managers code would be.

So could we have an NHS code and that would almost bring people together and that's badly needed because, you know, the whole of the NHS needs to work together and when lay managers -- and I have been a lay manager -- ask me how I made good relationships with clinicians, I said that it was because I thought the clinicians could hand even though I was only a history graduate who knew nothing about anything that they understood two things: first that I was interested in their work, and secondly, that I cared very deeply about

patient care and safety.

And if we could have a code that spelt that out, it would be a unifying force in the NHS because we don't want to have doctors and nurses and managers in different camps and other professions and occupations, we want to have everybody understanding what we are here for and committed to it in clear and unequivocal terms.

MR DE LA POER: Mr Jarrold, thank you very much indeed.

My Lady those were the only supplementary questions I wished to ask.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much, Mr de la Poer.

Just picking up on how you made good relationships after and perhaps before the incident that you told us about.

I understand you read history from what you have just said?

A. I did.

LADY JUSTICE THIRLWALL: I think you had a first class degree from Cambridge.

A. I did.

LADY JUSTICE THIRLWALL: So if I may, you were intellectually equal to the people that you were seeking

to make relationships with at all levels obviously?
A. Well ...
LADY JUSTICE THIRLWALL: You may not have had any clinical or medical knowledge but in terms of your intellect.
A. Thank you, my Lady.
I mean, that's obviously for them to judge. Yes, I think intellect is important in managers and that managers should be able to deal on terms with the incredibly bright people that we have working in the NHS, the doctors, the nurses, the physios, all of these people.
So yes, intellectual ability is important. But it's not as important as the values and commitments.
LADY JUSTICE THIRLWALL: Yes.
A. Because that is what brings us together and you could be -- without wishing in any way to assume this -- somebody who wasn't as gifted intellectually as a neurosurgery professor but you could still share the common commitment to values.
LADY JUSTICE THIRLWALL: Yes, absolutely. I think I was trying to get into the shoes of the person on the other side of the relationship.
A. Right.
LADY JUSTICE THIRLWALL: So whilst one thoroughly

ignorant person would have described you as he did, anyone who actually knew that would have an effect wouldn't it, on how they treated you, you might think?
A. I have -- I mean I have been very fortunate, my Lady, in my relationships and have worked with many wonderful people over 54 years, but, you know, there were a number of people who loathed me and whatever intellectual ability I may or may not have made no difference at all.
LADY JUSTICE THIRLWALL: I understand that.
A. Their views of me.
LADY JUSTICE THIRLWALL: Indeed that is one of the things that one can pick up and perhaps shift and I would ask your view about this and I appreciate you left about 20 years ago. But in terms of the relationships my impression is, and it is only so far that impression, that there has been a shift from doctors or certain members of the medical profession, certain parts of it, sort of asserting themselves very-- well, let's just say being very assertive as to who was in charge in their view to a situation where the managers particularly at board level would consider themselves in charge, if you like. There just seems to have been that shift and it may be that it's an ongoing situation.

Is that something you have been aware of or is it very patchy? Does it just depend on the hospital?
A. I -- I was closely involved until last September, September of 23, rather, as a chairman so --
LADY JUSTICE THIRLWALL: Of course you were yes, of course.
A. I have been involved very, very recently and for many years.
LADY JUSTICE THIRLWALL: Yes.
A. This is an interesting one. There are those who think that the most important people in the Trust are the chairman and the chief exec and the board, there is that view and I think it might be quite a common one in some quarters. It's never been my view, because again of the fundamental values that I was taught and the fact the way I always explain this is what would happen if a chairman couldn't come to work, it would be a minor inconvenience, somebody else would have to pick up at the odd meeting. But if a staff nurse doesn't turn up on a ward shift where you only have one or two staff nurses on, you know all about it and there is an immediate problem, there is an immediate safety problem, there is an immediate staffing problem.
So we know who the most important people are and they are not the chairman and the chief exec of the

board. And their job, and this is how I tried to do my job as a chair in two very good Trusts or one that became good thanks to other people and one that was good before I got there, what I tried to always give the impression, the real impression, was that I understood that we were there as a board to serve the staff at the front line. That was our job.
That's why in the book that I had the privilege of writing about leadership and management, I talked a lot about servant leadership as developed by Robert Greenleaf because it does seem to me that that's -- the right tone of leadership for the NHS is for the people who have the titles and the salaries and all the rest of it to feel that they are servants of the organisation and of the frontline staff, hence it is their job to support the frontline staff as they do the very challenging job of caring for patients and families.
LADY JUSTICE THIRLWALL: Thank you. And you mentioned in the course of your last answer 52 years or so in the NHS one way or another. One of the things that has emerged in the course of the Inquiry is the absence of a corporate memory in the NHS, a number of people have commented on that.
So you might be the closest we can get apart from

one other witness to someone who does have that long memory of over many decades. You have pointed to on a number of occasions something which you have called the incredible wordiness of the documents.

Is that something which is worse now than it was in the 1980s?

A. Yes. Two things, my Lady. I mean the first is that I think the NHS is very poor at learning from its own mistakes and looking back, saying: why didn't the code work in 2002? And I hope that Amanda Pritchard will do that because unless she understands why it failed last time she won't get it right this time. But we are just not good at that and it is partly because we have had so many reorganisations that have destroyed corporate memory, that has been a major factor and I have lived through every reorganisation of the NHS because the first was in 1974 when a whole group of senior people were swept aside and then again in 1982 and that resulted in me getting my first chief officer job at a very young age but that was because so many of the experienced and wise people were swept out and that's happened time and time again so corporate memory is not something where we are strong at all.

And in terms of the wordiness I -- I think it has got worse and I think sometimes there is a tendency to

believe that it's clever to write long documents. I think it's very hard to write short documents.

It's easy to splurge the whole thing out over 64 criteria. There is no control, there is no analysis, there's no intellectual rigour there, but to write something short, and I am sure you will know that some of the most powerful documents in history have been very, very short documents, the Gettysburg Address, the Ten Commandments, you don't have to have 50 or 60 pages. You can write things simply and powerfully and people like the Plain English Society are useful in doing that because that is their trade.

LADY JUSTICE THIRLWALL: Thank you.

Then going to a particular incident in history. You will remember, I imagine, the Beverley Allitt case?

A. I do.

LADY JUSTICE THIRLWALL: Back in the late 1980s/early 1990s, I don't know if you remember the Clothier Report, which Sir Cecil Clothier wrote in the early 1990s and we know that that was distributed by the NHS, Sir Duncan Nichol was then the Chair, I think he was about to leave or to step down from that role, and that went to all hospitals.

Do you know was there any follow-up to what was said there which was that everyone must be open to the

possibility of malevolent action by a member of staff?

A. Sadly not. And I mean I was very much involved in the management of the NHS at that time.

LADY JUSTICE THIRLWALL: Yes.

A. And I just don't remember that being a major factor and again there isn't an implementation issue in the NHS.

LADY JUSTICE THIRLWALL: Yes.

A. We are much better at coming up with new reports and new recommendations than we are at implementing what we have already got. And that is a weakness.

Because, you know, the job of providing healthcare is a very challenging job in terms of finite resources even in the good years, the massive demand for services, public expectations which quite rightly are greater and it's just very difficult for people who are trying to do their best day-to-day to provide services to really check on these things and again if you, you know, there are just not many mechanisms for checking on implementation and really checking on it.

So I regret to say that although I was very much involved when Duncan was around and when he left, I -- I just don't remember it being a key factor in my thinking or those of my colleagues.

LADY JUSTICE THIRLWALL: No, thank you.

You mentioned in the course of your evidence reflective practice and you were struck by the way that was inculcated in nursing training --

A. Yes.

LADY JUSTICE THIRLWALL: -- in those circumstances of your son and we know from the evidence that the doctors from a very early stage --

A. Yes.

LADY JUSTICE THIRLWALL: -- are reflecting --

A. Indeed.

LADY JUSTICE THIRLWALL: -- almost constantly on what they have done and how they might have done it better.

A. Yes.

LADY JUSTICE THIRLWALL: And I think that you thought that would be a good approach for managers also. Do you have any experience of that happening amongst managers and I suppose those who are doctors and nurses may do it anyway, but is that something that gets talked about at management training or anything like that?

A. Not -- not to my knowledge. I have had the privilege of working with managers who were naturally reflective.

LADY JUSTICE THIRLWALL: Yes.

A. And who therefore did it for themselves and I hope I was one of those. But that's for others to judge.

But there's -- there's almost a sense in which that sort of reflection doesn't fit the model of a somewhat macho management culture which is sometimes thought to be the right way to manage things. You know, their doubts or self doubt or reflection are seen as weaknesses. To me they are strengths. But to some schools of management, the sort of heroic schools of management which has long been discredited in most management academic circles, in those days anything like reflective practice would have been seen as an admission of weakness and that still I'm afraid persists in some places.

And the other factor of course is that one of the things I have enjoyed about the NHS is that it is -- I forget the exact figures but there must be 75, 80% of the staff of NHS are women and yet the bias in senior management is still towards men. And in my experience of life, and I can only offer it, men tend to be less reflective than women.

LADY JUSTICE THIRLWALL: Yes, an interesting observation.

How would you compare just really in short form

management, we have been talking about management with leadership, because the two can go together but they don't always?

A. I think they are very, very different things and I sought to define them in my book. For me, leadership is about showing the way and that comes directly from Robert Greenleaf and his work on servant leadership and that means that leadership can come from anywhere in the organisation, anybody who has a good idea regardless of their position can show the way to the organisation and often it's the most junior people, the most inexperienced people who can show the way if the organisation allows them to do that.

The problem is that management is quite different to that, in my view, if it is defined in the Thwaites Report many years ago as the control of resources. That is what management is according to Thwaites and I agree with that.

So to be a manager you have to have a position that gives you formal control of resources. To be a leader you don't have to have that.

The problem is that the managers have often been burdened with the expectation of leadership and they think they have got to show all the leadership whereas the most successful managers are often those who don't

have the ideas themselves, but create in their teams an atmosphere where leadership can come from anyone and all you have to have is a junior member of staff making a suggestion in a team meeting and if the manager comes down hard on that and ridicules them or makes fun of them in front of their colleagues they will stop making suggestions.

If the manager says "I think that is worth looking at", then flow -- you will get a flow of ideas coming from the people.

So that's my difference between management and leadership and both are important. But if managers can't show leadership themselves, and many can't, because they don't know how to show the way, they do in my view have a very solemn responsibility to encourage leadership in others and to respond to the ideas when they come forward.

LADY JUSTICE THIRLWALL: Yes. Thank you.

We have looked with some care at the Code of Conduct for managers which you drafted and we didn't look at but we know that there is a section straight after the code itself on implementing it and in fairness it does remind everyone of the Nolan Principles, it is just that there isn't a hyperlink to it, probably we couldn't do that in those days.

But I just wondered what -- you have mentioned you know that there weren't any -- there was no investigation of breaches of the code?

A. No.

LADY JUSTICE THIRLWALL: And what sort of thing would you have envisaged and you and the working group would have envisaged would have constituted a breach of the code at that time or even now? Is there certain behaviour that would be caught in your view by the code?

A. Well, absolutely. And sadly we saw -- as I mentioned earlier, my Lady, we saw that in Stafford. It is one of the most shameful episodes in the history of the NHS.

LADY JUSTICE THIRLWALL: Yes.

A. And, you know, had the code been enforced, the people there should have been investigated for the breach of the code because what they were doing was clearly in breach of its fundamental principles and that could and should have been investigated and something done but it but, you know, I may be wrong and I absolutely am happy to be corrected but I am not aware of a single investigation of a breach of the code.

LADY JUSTICE THIRLWALL: No, okay. Thank you very much. Those are all my questions. I had better just see if anybody else wants to ask anything.

No. Well, thank you. It has certainly been very enlightening for me and I hope you don't mind the extra hour that you have been here over lunchtime?

A. Of course not.

LADY JUSTICE THIRLWALL: Thank you very much indeed, you are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady our final witness for today is Dr Alan Clamp and I wonder if Dr Clamp could come forward please.

LADY JUSTICE THIRLWALL: Yes, please come forward, Dr Clamp.

DR ALAN CLAMP (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

MR DE LA POER: Please could you give us your full name?

A. My name is Alan Clamp.

Q. Dr Clamp, is it right that you provided to the Inquiry a witness statement dated 5 April of last year?

A. I did.

Q. Is the content of that witness statement true to the best of your knowledge and belief?

A. It is.

Q. Before we go any further, I understand there is something that you would like to say?

A. I would. Thank you.

I am very aware that this Inquiry is about babies who have been murdered or suffered significant injuries. It's about their families, very importantly it is about their parents. I can think of nothing worse than the death or serious harm of a vulnerable child.

The Inquiry is about finding out what happened and doing everything humanly possible to make sure it doesn't happen again.

I have worked in regulation for over 25 years. I am conscious that for some regulation might appear technical, bureaucratic, possibly a bit remote from our every day lives. But I am also very aware I understand that but I am very aware that regulation in this context has a primary function of mitigating the risk of harm in healthcare and that's why I perform this role.

So I hope that the evidence that I give to the Inquiry can help us to learn from the dreadful events at the Countess of Chester Hospital and to make the changes that are necessary to avoid such tragedies in the future.

Thank you.

Q. Dr Clamp, I will begin my questions of you by

just introducing you briefly. You are and have been since 2018 the Chief Executive of the Professional Standards Authority for Health and Social Care; is that right?

A. That's correct.

Q. We will come to who that organisation is in a moment. But before you had that role, is it right that you were the Chief Executive of the Security Industry Authority?

A. I was.

Q. That role was I think between 2015 up to 2018, so a three-year period?

A. Yes.

Q. Then if we just take a further step back into your career, between 2011 and 2015 were you the Chief Executive at the Human Tissue Authority?

A. That's correct.

Q. As you have told us in the statement you made at the start, in fact your experience and your career extends some time before that particular role and it has been in the regulatory sphere?

A. It has essentially for the whole of this century and before that in regulation in education primarily with OFSTED.

Q. Are you also a Non-Executive Director at the

Parole Board?

A. I am.

Q. And at the Intellectual Property Regulation Board?

A. That's right.

Q. Are you a trustee of the Institute of Regulation?

A. I am.

Q. So as we turn to the substance of your evidence now, just telegraph to you that they are going to be in two parts: we are going to begin by just introducing who the PSA are, then we will look at the issue of the accountability of senior managers and we will look at that in some detail.

So let's start with the PSA, the Professional Standards Authority, and as the full name suggests it is responsible for the regulation of health and social care; is that right?

A. That's right, yes. So the professional Standards Authority for Health and Social Care -- it is a bit long-winded, so from now on I will refer to it as the PSA -- we have a role to oversee the function of the 10 regulators of people who work in health and social care.

So doctors, nurse, pharmacists, dentists, social

workers and our role is to oversee the performance of their regulators.

Q. You do that through a number of mechanisms, is that right? Firstly do you undertake a performance review process of those regulators?

A. That's correct. So each year a regulator will have a performance review by the PSA which fulfils our obligation to report to Parliament on their performance. We have a number of standards of good regulation which they either meet or don't meet.

We also review their final fitness to practise cases to ensure that they are sufficient to protect the public and if we decide that they are not, we have the ability to appeal those to the High Court. There are very few of those but typically maybe around 25 to 30 a year out of the 2,500 cases that are referred to us and we also have a role to try to improve professional regulation through research and policy work.

Q. I think separate from those 10 regulators, do you also operate an accreditation process for organisations holding voluntary registers?

A. That's right, there are currently around I think it is 29 such registers of people who work in professional healthcare related roles but who are not regulated under statute. That accounts for about

130,000 people, compared to the near 2 million who are regulated under statute, many of whom actually work in mental health roles but in a wide range of areas, yes.

Q. So if you could just give us one or two examples of the sort of organisations you are talking about that are unregulated?

A. So counsellors, psychotherapists, sports rehabilitation people, and many other organisations it is quite a broad field but all related to health and social care because that is one of the criteria for accreditation.

Q. In terms of the PSA's involvement in regulatory policy and improvement, would it be right to describe the concept of right-touch regulation as being absolutely central to that?

A. It would. So right-touch regulation builds upon the better regulatory principles from the latter half of the last century about being proportionate and accountable and consistent and targeted and it builds upon that by adding agility because one of the problems that regulators have is that they are usually operating in an environment which wasn't the one they were set up in and they need to be agile they need to be able to adapt their approaches. So right-touch regulation is a core tenet of our work but also should be of all

regulators.

Q. Just so we are clear about it. You would expect that the regulators who you oversee would be exhibiting exactly the same principles of right-touch as you apply to them?

A. Yes. We would. I think it is something that they themselves would say as well. I think the most probably common referral to right-touch regulation tends to talk about being proportionate to the risk of harm so that regulation isn't overly burdensome but it still provides the necessary protections.

Q. I am sure we will come back to those principles when we look in detail at the accountability of senior managers. But just considering the key themes as you describe them in your witness statement of the regulatory improvement work that the PSA undertakes, and here if it's helpful to you I am looking at paragraph 15 of your witness statement, you make a number of points, bullet points on page 5 about the themes which run through the policy statements and written work that the PSA undertake and I just want to look at a number of these.

The first you say is this: the arrangements for ensuring the safety of health and care in the UK are too complicated, fragmented and difficult to navigate in

particular for patients and the public when they try to raise concerns and it perhaps won't be any surprise to you, Dr Clamp, that in fact Sir Robert Francis, who gave evidence at the start of this Inquiry, made a not dissimilar point about quite how complicated the NHS is, including in relation to its regulation side.

So as to that first bullet point, does the PSA have a view on how that can be improved?

A. Yes. There has been work undertaken looking at the number of bodies that oversee processes in hospitals and one estimate of that has been put I think at 126 different organisations if you take all the different types of regulation into account.

And I have already mentioned for example that there are 10 regulators of professionals rather than 1, 2 or 3 and therefore I think if taking opportunities to point out that simple regulation is often more effective, but also I think a key point in this statement is at the end. For those people who want to engage with the system where something has gone wrong or they want to make a complaint would find it very complicated to know where to go to.

Do you go to the professional regulators? Do you go to the hospital itself? Do you go to the system regulators like the Care Quality Commission? And often

when care is being delivered by a team of professionals, some of whom are regulated, some of whom are not and by different regulators, it does get very complicated and very difficult to actually get things achieved. And I think one of the points that we make about right-touch regulation is to embrace simplicity so we have in the past called for fewer professional regulators and even in the absence of structural change, better co-ordination of the work of regulators and better communication between them.

Q. Might an example be that we heard from Mr Jarrold just a few moments ago, the idea that there is a common code or a common standard that people are working towards, is that the sort of simplification which obviously needs a lot of detailed work to make it work, that the PSA would be in favour of in principle?

A. I think there is a lot of merit in that. We recently undertook -- we commissioned some research into the benefits and drawbacks of a common code across the professional regulators, which came to the conclusion that there were a lot of positive points about that, whilst at the same time needing to recognise that different professions sometimes have different requirements but I certainly think there is scope for a -- a core within that and the previous evidence was

talking about management. I don't see any good reason why managers in a hospital would have a different Code of Conduct which is very much about how we behave to doctors and nurses. And the one thing that came to mind when I was hearing the end of the previous evidence was in fact that the Patient Safety Commissioner for England has recently published a set of Patient Safety Principles which build on the Nolan Principles and I think would be a really good starting point for those conversations.

Q. So the PSA identifies a problem, it's done some research, concludes that the problem is real, concludes that there is a solution which no doubt needs further work. How is it then taken to the next stage, what is -- what takes that first recognition of a problem through to a solution that is implemented?

A. I think there are two routes in this context, the first is, for example, for a common code against the current statutory regulators. That would be our advice to the Department of Health and Social Care and the equivalent bodies within the devolved administrations as policy advice from the PSA on the basis of the work that we have done to inform future judgments.

When it comes to the possible regulation of NHS managers, there's an opportunity through the current

consultation which is open, but also we are working with NHS England on the development of their leadership and management framework which would also include a Code of Conduct so we have another opportunity there to make those points.

Q. And in that second sphere, which is just focused upon the senior managers, and we will come to the detail of it --

A. Yes.

Q. -- but is there an opportunity there to make sure that it is aligning with the other professions for the reason that you have given, namely that there is no good reason why managers should not be in a core sense acting to the same standards as doctors, nurses and physios?

A. I think that opportunity definitely exists. It is highly desirable and given that if managers and senior leaders in the NHS were regulated it's likely that a number of them would be regulated both by their professional body say as a doctor or a nurse as well as managers. So the more consistent those models, the more effective they are likely to be.

Q. So turning to your second bullet point, which has elements in common with the first, there are too many organisations involved creating difficulties in

determining where remits overlap and where there are gaps and in managing these.

You identify the challenge of working out where the gaps are. Is it the PSA's role to be investigating that and identifying that for the benefit of the department, is that work that the PSA does or is it simply confined find to identifying the problem and leaving it to others to investigate it further?

A. Identifying the problem would be the first step and where the solutions are within our remit looking at that as broadly as possible, looking at professional regulation, it would be our responsibility, I would argue, to make recommendations as to how that could be brought about.

Q. And certainly so far as a code is concerned, is there a substantial gap at the moment in relation to senior managers?

A. One of the things that probably I should have mentioned in the context of my previous responses is that all or virtually all of the statutory regulators we oversee have a unifying aim to protect the public which is -- I think it's an interesting area because they will have a statutory basis which says what they have got to do but then over and above that you must protect the public because sometimes they feel constrained by their

own legislation in terms of what they can and they can't do.

And I think that flexibility to take steps to do work in that broader context without ultimately stepping outside a remit is there.

But in terms of senior managers, I think actually in many ways not only is this an opportunity to introduce greater accountability and support and development for senior managers, it's actually also an opportunity to introduce a highly effective regulatory model learning from the current regulatory models.

Q. Let's turn now to the accountability of managers and I think it's probably important and you are undoubtedly very well placed to assist us with this to understand what we mean by regulation, in other words a professional group of people who are regulated because as I understand it, it can mean a number of different things. You have got statutory regulation in the way that we see classically with the General Medical Council but there are other forms of what might be described as regulation; is that right?

A. That's correct. I think it might be helpful to reflect I am very conscious as well, being a regulator, I don't want to lapse into jargon, with

where responsibilities lie for patient safety. So primarily in what is often called a first line of defence it's with the professionals themselves, the people who are giving the care. And that's where professional regulation has most influence.

But the next layer out, the second layer of defence, is very much about local controls and governance, clinical governance which are protecting them but also which have the checks and balances on the individual behaviour. And then regulation, the external scrutiny of regulation is the third, the outside layer of that, and that is where regulation can have the maximum impact and it's about checking both that that second line is there that the governance is there, the key role in hospitals being for the Care Quality Commission but also that the professional regulation is working as effectively as possible.

Q. And so we need to be careful if we talk about the concept of regulating senior managers as to exactly what we mean by that?

A. Yes.

Q. And not just assume that it is the existing model of the General Medical Council --

A. That's right.

Q. -- for example?

A. I apologise. In my enthusiasm I didn't fully answer your question there. So yes. When it comes to regulation, I have to be mindful it doesn't just mean one thing or one model. We sometimes talk about a continuum of assurance so if you have low risk professions, there may not be any regulation there, there may be some sorts of checks and balances that are happening locally.

Somewhere in the middle which might cover the professions I talked about before around psychotherapy and counselling, you could have a register which would be a voluntary register and that register then might be accredited by the PSA which actually introduces an extra level of quality.

And then for the more high risk professions you would probably have a statutory regulator such as the GMC or NMC, those are sort of the three main parts.

But even within that, you can have regulation which is based on disbarring, so an unfit to practise or people being on the list who shouldn't be allowed to do that job, or you could have a fit for practice register which is essential what the accredited registers do.

So I think it's useful when thinking about regulation of managers to think about different models and it's positive to see in the current consultation

which is out by the Department of Health and Social Care that these various models are set out with their pros and cons to enable people to respond accordingly.

Q. So if we perhaps take it back to what some may view as its origin point of the Bristol Royal Infirmary report and the Recommendation there, we looked at with Mr Jarrold just before lunch that there were two parts of that Recommendation. We don't need to go over the detail of it. But one was that senior managers be regulated and the other that there be a code which is obviously part of the process of achieving regulation and we know that a code was produced and circulated in 2002 by the Chief Executive of the NHS, Lord Crisp as he is now.

In terms of what then happened to it, Mr Jarrold, who wrote it, is of the view that it wasn't widely implemented and even now he isn't sure whether it is current practice or not.

What is your understanding of that code and its current status?

A. I think I would largely agree with - with Mr Jarrold because over time there have been various iterations of this so following that 2002 code the PSA itself which was also set up on the back of the Bristol Inquiry did some work in 2011 and 2012 which

subsequently became a code which was part of the Fit and Proper Person Test following the Mid Staffordshire Report.

That then was looked at again by Tom Kark in 2019 who recommended a sort of a more robust approach but also a barring list and then a revised version of that was introduced in 2023. But some of the work we have done over time is to look back -- there are various inconsistent references to codes, they may not all be talking about the same code even though they use the same language.

So although I have little doubt that there are codes of conduct that are applying in these contexts including things like versions of the Nolan Principles and so on, a central universally recognised and understood Code of Conduct which is consistent across the NHS and as consistent as possible across groups of professionals and ultimately where managers as well doesn't appear to be there.

Q. You have mentioned the 2012 code which was created by effectively the PSA's predecessor organisation, the Council for Healthcare Regulatory Excellence.

Just help us so far as you can about what the origin of that was, why was that needed given that only

a decade earlier Mr Jarrold had produced the code and the NHS had circulated it?

A. Well, this -- this definitely predates me but the actual origin of the work was a commission by the Department of Health at the time to ask us to do that work on the basis of that decade and I think of reports and other Inquiries which still suggested that whatever needed to improve in that sphere of leadership and management and organisational culture wasn't doing what it should.

I think the other problem in this space is that if a code is in place but never formally revoked or replaced people aren't quite sure which code they are applying and it comes back to that point of inconsistency and that was followed up very quickly by the Mid Staffordshire Inquiry which further supported the need for work in this area.

Q. One of the things that Mr Jarrold spoke about is the problem with the lack of corporate memory and the fact that new things come along and old things get forgotten even if they hadn't been implemented; that is me paraphrasing part of his evidence.

Do you know for example whether in 2012 just looking at the process of producing that code, whether anybody looked at the one that was produced a decade

earlier and decided it wasn't good enough or whether that wasn't looked at and people were just starting from scratch and trying to invent the wheel for the first time?

A. I'm afraid I -- I don't know to what extent that was done but do I think that in the context of what you describe as organisational memory, the NHS -- the multiple changes in the structure of the NHS that Mr Jarrold spoke about, that one of the benefits of regulation of NHS managers might be the centralisation and the universality of such a code so that such things are much less likely to happen as we go forward.

Q. I am just going to bring up one part of the code that was -- or rather the standard as it's described -- produced by your predecessor organisation in 2012. It's INQ0017175 and it's page 4 that we are going to look at. I think it may in fact be internal page 4, so that will be my mistake.

So we can see here that the Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England. If we just pause there to take stock of the title, this standard is aimed at those who sit on NHS Trust -- Foundation Trust as it subsequently came to be and also the Clinical Commissioning Group.

Just help us to understand a little bit there

because this is moving perhaps outside the group of people who are often thought about in this sphere as needing regulation or needing a code, the Clinical Commissioning Group, what is the thinking behind including them at this stage?

A. I think fundamentally when developing standards such as this, you are looking at those people who have the most influence on the organisational culture and the performance of organisations within the NHS and following the Lansley Reforms that were set out in the 2012 Act, the huge changes really that were made to the NHS, including commissioning, warranted a powerful group which sat outside of NHS boards also being held to account for an appropriate Code of Conduct.

But I am conscious as well when looking at this that this and in fact iterations after this still focused very much on the top level within the NHS rather than necessarily Executive Leaders and other managers.

Q. If we go over the page we will see paragraph 4.1, which appears under the wider heading of "Technical Competence" and it speaks about how the previous three subparagraphs will be achieved and I just want to draw attention to the wording here:

"I will do this by always putting the safety of

patients and service users, the quality of care and patient experience first and enabling colleagues to do the same."

Obviously this is the language of 2012. But is that language that the PSA in 2024 regards as important?

A. Not just important but I think absolutely critical. I mean, I have mentioned the Nolan Principles which I think are laudable and the Patient Safety Principles which actually do emphasise this very point and have been published recently.

But the point about the Nolan Principles is that they are not context specific and I think decisions when you are making decisions about people's health and well-being, life or death decisions in effect, this should be coming right at the start of any Code of Conduct.

Q. So in any new code that may emerge from the current consultation, would you expect language of that type to be right at the very heart of it?

A. I would. And it's part of the world that I know well in regulation I think it is always important to emphasise that the primary purpose of regulation is public protection, patient protection and therefore this would be absolutely critical for a future code and to influence the work and the decision-making of leaders

and managers across the NHS.

Q. Now, one of the matters that Mr Jarrold regarded as extremely helpful to him when he was drafting his code was input from the Plain English Society and he went on to comment about the fact as I think you may have heard when you were in the room that guidance documents and policy seem to be getting longer in his view and obviously there is a question about the accessibility of the language and that a simple principle should be stated simply.

Is that something that the PSA recognises and associates itself with or is that something you would disagree with?

A. No, I would definitely agree with it because it comes back to that point about simple regulation being more effective. People know what the rules are, what the guidance is, it's easier to comply. It's also something that we have reflected on ourselves. I think some of our documents up to even as recently as sort of 2019/2020 were I think a little verbose, not always plain English and we have taken conscious steps to do that in our own work and to encourage others to do it as well. I think that the simpler and more straightforward the better and apart from anything else, if you have multiple points in codes it can dilute the nature of

some of the important messages such as 4.1 on this page.

Q. Thank you. We can take that down. So we are going to turn now and I am -- at page 9 of your witness statement under the heading "Right-touch regulation and its potential application to regulating NHS managers".

Here we are just going to talk about a few principles, if we may, as to the purpose of regulation.

The first question is really this: is the purpose to punish or is it to protect?

A. It's a phrase which crops up in regulation a lot in various guises but essentially I think regulation is there to both promote goods and control bads. So it is both.

I think the more that regulation can work in what I often describe as a positive way, which is preventative, it's based on information, advice and guidance, it's supporting people to meet standards, then obviously that's highly desirable because apart from anything else, it is likely to avoid the harm occurring in the first place.

The punishment, technically it's -- it's not punishment, it's about ensuring that people are fit to practise. It might be about supervision or conditions to get them back on track again. But it does need to be there in the face of people who are showing significant

competence or conduct issues who make conscious violations of the rules of the regulations or behave in a reckless manner. So you need that part of regulation to support it but the more that regulation can work on the positive side, to prevent harm in the first place, the more effective it is.

Q. Now, when you consider as you do at paragraph 26 the principles of right-touch regulation and how there might be they might be applied, you use a phrase I just wanted you to explain to us because it may not be immediately apparently as to what you mean.

You say at your second sentence:

"A right-touch regulation approach involves understanding both the nature and scale of unmanaged risk in order to identify the most effective regulatory measures for mitigating that risk."

Just explain to us why you focus upon unmanaged risk as opposed to identifying what the risks are, whether they be managed or not?

A. Well, it would start with having to identify the risks but it's making a comparison of an intervention versus a "do nothing" approach. You could have an extra step in there which might be the scale of poorly managed risk because you could have something which looks as if it's addressing a risk but it may not

be effective. So essentially it is about what additional intervention is needed to manage the risk down as low as possible to an acceptable level.

Q. So although you are mentioning there unmanaged risk you are not suggesting that you are only looking for risks that don't have any mitigations, regulation also involves looking at what the existing mitigations are and whether they are adequate?

A. Exactly, yes.

Q. You then propose using the right-touch assurance methodology an assessment of three different types of risk and I just want to see if we can tease out what the differences are between them.

So you have intervention and complexity which is your first. Just in simple terms what are you looking for there when you are acting under that heading?

A. Well, perhaps as well there is a sort of a personal note to self there about the plain English point from earlier but essentially the intervention is the nature of the interactions between in this case I think the patient and the professional. So for example, a liver transplant would be high intervention because it involves, you know, somebody being unconscious, opening them up, complicated procedure, it comes with a lot of risks, whereas there may be other

forms of interaction such as an example I used earlier such as counselling which doesn't involve that sort of life or death risk.

So it is nature of the intervention between the professional and the patient.

Q. Context?

A. The context is essentially where it happens. So if I stick with my example, with the liver surgeon, you could argue in fact that the context there is very controlled. It will often be a group of people in an operating theatre, there may be cameras, may be lots of checks and balances and other professionals whereas the counselling or the psychotherapy could take place in someone's own home and there are different types of risks there because it just be on an individual basis without the clinical governance arrangements.

So you could argue in some ways in that case that the context of the individual's home, private home, there are some higher risks involved in that individual interaction.

Q. Finally agency and vulnerability.

A. Yes, I think vulnerability is more useful than agency but essentially it is about the nature of the patient. Are they young, old, have they got other health conditions? So how vulnerable are they because

that will affect the impact of both context and intervention and although we haven't got it in here because it is a typed document, often what we look at with these is a triangle with these three points at each of the apex and trying to identify where the risks sits within that. And it is a development of right-touch regulation.

Q. So in practical terms can that model of thinking be applied to the question of whether senior managers should be regulated?

A. It could. Because the idea is that whatever that triangle looks like from a particular occupation will give you an assessment of overall risk and therefore the nature of the regulation that's needed on that continuum of assurance from sort of light touch through to heavy touch.

I think the challenge with managers as opposed to some of the healthcare regulated professions that were probably set out back with the Bristol Inquiry is to what extent are they directly responsible for patient safety rather than indirectly using this context, and the fact that management doesn't have a defined set of qualifications or scope of practice like some of the other professions and that some of them may appear very distant, such as if you are a manager of IT systems or

finance or HR, is that really about patient safety? So I think some of those challenges still exist but they are essentially practical challenges and I don't see any reason why you don't apply this model to the regulation of managers.

Q. Because one thing that might be said to an attempt to simplify things that one could identify perhaps the Board of Directors, that is a defined group of people and we know that there is an expectation that the board will be a unitary board; in other words they have collective responsibility for their decision-making, they control a very substantial budget and ultimately bear responsibility for ensuring that the frontline care is delivered.

So if you analyse it in that context in terms of the individuals, might it be said that there is a very good case for the fact that there are considerable risks that need to be controlled there?

A. Yes. And that would take me back to my point about that key line of defence being governance of which I would make the board a key part. But also there is the point about culture, where the board will also carry, and senior executives, a lot of responsibility for driving the culture of an organisation. Having said that, there will also be other leaders and managers who

in an operational sense are making day-to-day decisions which can affect patient care.

So I think what you described as a unitary board would definitely be in scope for regulation but I also think there is a good argument for that extending beyond that to those who have a significant influence on patient safety matters.

Q. Just one question before we turn to the advantages and disadvantages that you outline in terms of the regulation of senior managers.

You mention in paragraph 29 that:

"In January 2022 the DHSC published a consultation on criteria for which professional groups should be regulated."

You see that's a consultation stage. What has come of the output of that consultation as far as you are aware?

A. As far as I'm aware to date, so that is now three years on, the Department for Health and Social Care are still considering the consultation responses.

Largely that consultation mirrored possibly more accessible language, our own right-touch assurance model and I am conscious that it got, you know, a good amount of feedback, but it hasn't yet been used to make any decisions that I am aware of about when statutory

regulation is needed. So the consultation is still under consideration and an outcome hasn't been published.

Q. So let's turn now to what you describe as the key considerations, which begin at page 11, and I will just read to you if I may what you say at paragraph 32. It may be thought by some to be quite powerful:

"The advantage of introducing regulation in any form for NHS managers would be the potential to prevent or reduce of harm to patients. This would be achieved through better management of the risks that arise to patients through the work of managers and its impact on care."

So straight out of the gates, an advantage is patient safety?

A. Yes. I, on looking through this evidence more recently, I do want to take the opportunity to emphasise that paragraph as I think being key and I think it's paragraph 54, where I am slightly more explicit to say that steps should be taken to enhance the professional development and accountability of NHS managers; essentially taking both of those together as support for developing regulation for managers.

Q. So, you correct me if I'm reflecting this back to you incorrectly, senior managers, in your view, do

need to be regulated and whatever is in place at the moment now needs to be strengthened. The question then is just to what extent?

A. That's correct, and the analysis that follows on from paragraph 32 of my evidence is very much a sort of, you know: here are the pros and cons of doing this, and that runs throughout the document. But so that's why I wanted to put the emphasis on those two paragraphs which essentially says, you know: We need to move forward now after -- 25 years since the Bristol Inquiry, has shown us that whatever we put in place still needs improvements.

Now, I should be conscious here about saying that there are two parts to what I want to say. One is there is definitely scope to improve what's there already, but this is the new thing to introduce and I think the current consultation that the Department for Health has out on regulation of managers sets out the different models, which I think closes next month, and I would hope can come to a fairly quick conclusion on an optimal model going forward.

Q. So let's look at some of the barriers as you describe them. We have substantial cost as being the first, although you acknowledge that that's usually met by the registrants.

Now, plainly in relation to relatively low-paid professions, a levy to pay for the regulator may present a very substantial barrier to people wishing to enter that profession because taking any amount of a modest salary can impact very substantially upon quality of life. But here we are talking about well-paid people if we are going to be frank about it, aren't we?

A. Well, it depends on how far you extend the model --

Q. Yes.

A. -- of, of management. But in general, that is true. The introduction of regulation is actually often borne by government, the set-up costs. When it's actually up and running then usually there is a cost to the registrant and that's certainly how it works with statutory regulation for doctors and nurses.

And I think given the importance of the decision-making by leaders and managers in these contexts then that, that accountability and that cost -- and again if there are significant numbers of people here you do get economies of scale, it doesn't necessarily have to be a prohibitive cost -- the average registration cost for those we oversee is probably around £250 to £300 a year, but for -- I mean, for social workers it's only £90; that's partially

subsidised by the Government. But for nurses for example I think it's around £120 a year.

So, yes, I mean, it would be naive not to have the costs in there and they are included in the Government consultation, but I don't think that should be a barrier.

Q. And of course there is always the option to make the costs reflective of your stage of experience, your banding or your salary depending on what model is ultimately adopted?

A. That's correct.

Q. The next barrier you identify is a barrier to mobility. Just explain to us what you mean, in simple terms, how the fact that for example to become a board member you will need to pay a levy, that you will need to subscribe to a code, that you may be subject to disbarment and so on and so forth. Why might that be a barrier to mobility?

A. Well, I think as with many other sectors the NHS can benefit from people with good leadership and management skills coming from other sectors into the NHS.

And if they do so, and they look at this now being -- they would become regulated and there would be enhanced accountability and additional costs. It's

important to consider that as part of the model that is introduced that you wouldn't want to deter people from doing that.

Now, you made a point about, you know, the cost of it. Obviously that would be a factor. I think that's within the scope of the employee organisation to take that into account. So it's just to try to make sure that in regulating a number of people who aren't currently regulated you don't deter people from wanting those jobs.

Q. So one just has to be thoughtful about it as one does it?

A. Yes.

Q. Is that what it comes to?

A. As I say, I think making point that I think there is a lot of merit in the regulation of leaders and managers within the NHS, we need to acknowledge that there are challenges, which is probably partly why we are where we are, we are having that regulation at the moment. But I think the importance of the influence that they can have on culture and quality and safety means that these barriers can be overcome.

Q. Now, an issue that you have touched upon already which you deal with at paragraph 38 is defining who is included.

Now, is a solution to this particular problem, which undoubtedly where the margins are is difficult to define and different people have different views about it, but is a solution to this problem simply to focus upon those people who obviously should be regulated, get that up and running and then look to perhaps more marginal roles in the future rather than trying to achieve it in one fell swoop particularly if this is one of the most controversial areas?

A. Yes, I think there are a number of things to consider here. You could, for example, look at individual roles or clusters of roles which have a direct or more of a direct influence on patient safety and say they should be regulated, or you could look at a level within the NHS management structure. I am not overly familiar with the pay and grading scales, but they are there and therefore you could say everybody above level X should be regulated.

But I think that the point that you make around that there are some obvious candidates for regulation as a starting point is -- would be a good approach. And in fact one of the advantages of one of the models proposed in the current consultation, that being a voluntary register that the NHS may then choose to essentially mandate because you can't get a job unless you are on

the register, has the advantage that you could introduce it quickly, that it may feel more proportionate, but also that it would have that agility to be able to grow if you felt the need to do that and -- but I think the key point in all of that is the pace.

In other words, you could introduce something quite quickly for a defined group of people, which you described as being, you know, necessary to have regulated, but you could then keep under review whether that group needed to grow or whether you needed to change parts of the model as you went forward.

Q. Now, when it comes to a specific group of people the public's focus is very often on the Board of Directors when this discussion is taking place outside of Public Inquiries. But there is another group who are sometimes seen as sitting above boards of directors -- whether that is a correct description or not that is the perception sometimes -- namely, those who sit at the regional level within the NHS England and above and the Inquiry has heard evidence about whether such people have given an instruction or given advice and how that has been interpreted.

Is that a group of people, in other words, who are not directly managing a hospital but who are outside of that structure or outside a primary care setting also

a group of people who should be subject to regulation?
A. Assuming those people -- and I think this is the case -- are influencing the governance, the management structures of let's say in this case hospitals, then I think the same arguments would apply to that group as well and potentially, although the NHS obviously is an enormous and very varied organisation, to some extent the culture, I think the same points would apply; that if you had a Code of Conduct and, as I say, notionally I suspect these people will be following what is in their own minds, set out on paper a Code of Conduct that might be the Nolan principles or something more equivalent, an NHS Code of Conduct, I would argue that the same should apply and the same code.
Q. So same code, but that would also mean the same register, whether voluntary or otherwise, it would involve the same background checks whatever they may be, the possibility of disbarment for breach of the code, all of those things that we have been discussing, depending on where you draw the line, would apply equally to those who are sitting in that context, is that what your view is?
A. Following the argument that those who have an influence, certainly a significant influence on patient safety outcomes should be regulated, then that would

make sense.
Q. The next issue which appears in a number of the objections is the dual registration issue, namely the fact that a doctor may reach a managerial position, a nurse may reach a managerial position, falling wherever the line is drawn, within the sphere of senior manager and that they have their own obligations already.
Now, what's your view as Chief Executive of the PSA in terms of whether this is a real objection to regulation or whether it's just something that needs to be carefully managed so that people are not stepping on each other's toes and that everybody is pulling in the same direction?
A. Well, there are examples that exist at the moment. A small number of people, but not an insignificant number, who are dually regulated by different regulators and largely those regulators are able to work with each other to decide in the event of a complaint as to how it might be managed.
Issues around conduct typically would probably invoke procedures from both regulators. If it was competence, it might be very specific one to the other.
The point that I often make in this context is that I think you could have an example you used, a very good

doctor whose leadership and management skills may not be particularly strong or the other way round and I think that there is a lot of merit in thinking about having a leadership and management regulator separate from a clinical regulator.
Having said that, there is another model whereby the process that already exists let's say within the GMC for developing leadership and management skills could be enhanced so that the professional regulators could have that remit as well. The challenge there would be trying to ensure that what is required of leaders and managers is consistent across all the regulators because they would all have potentially slightly different codes going back to an earlier point.
So, again, I think dual registration is a challenge, but it's certainly not insurmountable.
Q. And in and of itself is not a reason why senior managers should not be regulated?
A. No.
Q. I would just like to move through your list just to highlight one of the matters that you draw attention to. At your paragraph 44 under your heading, "Drawing on a wider range of views and evidence", it might seem striking to some but it is a point that you make:

"The arguments being put forth for the regulation of managers appear to be coming from other groups and do not appear to have taken account of the views or insights from managers themselves."
I would just like you to amplify that for us, please, in terms of what your understanding is about the extent to which managers have been asked for a view and what you understand the general consensus to be?
A. I think the point that I am trying to make there is in fact now being addressed through the Department of Health consultation, which is that over a course of, if we just take the last 25 years there's been a number of Inquiries and other investigations which have talked about culture, they have talked about leaders, they have talked about managers and some of them have called for greater accountability.
But what we haven't had is a national public consultation on the pros and cons of managers also of which has been informed by having a relative amount of detail on different regulatory models because it is not an area that is familiar to a lot of people. If they think regulation, they probably tend to think about this is -- you know, it's a GMC model or nothing.
So I think that is something which hasn't taken place to date but is happening now and I think the

outcomes of the consultation will address that point.
Q. Moving forward in what you have told us in your witness statement, you provide us with the heading, "Distinguishing between issues of competence and accountability." This I think is a point which you regard as important and I wonder if you could just tell us what you mean by that.
A. Yes. This, this takes me back to a point I made earlier about what I often call positive and negative regulation or the question that you asked me about punishment.
Primarily, regulators should be concerned about ensuring that those that they regulate meet the required standards. But in order to meet standards, people need to know what those standards are, they need to be given opportunities, training and development and support to meet those standards. Some that have will come from professional bodies or qualifications and so on but some of it will also come from the regulator.
So this is something about -- and it also is reflected in the work that NHS England are doing on the leadership and management framework. So it's very much about developing people and giving them opportunities to meet standards so they can do a really good job as leaders and managers.

The accountability bit first. I mean, it's part of a job role anyway being accountable but the accountability bit in terms of regulation comes when that conduct or that competence is called into question by behaviour or by mistakes or by referrals from an employer or a patient and that needs to be taken into account as well. So they are different things, but they are complementary and regulation should be addressing both of them.
But the more preventative model is to make sure you don't just be thinking about that punishment or that accountability angle because ultimately what you are doing there is commonly waiting for something to go wrong and then taking action. What we really want to do is to stop things going wrong in the first place by having much better quality leadership and management going, again going back to the earlier point in the document that you showed me, with a strong emphasis on the primacy of patient safety.
Q. How important do you think it is that members of staff who may themselves be regulated have confidence in the accountability of the senior staff?
A. I suppose from my own professional experience, you talked about the regulators that I have been the Chief Executive of. I am the accounting officer,

I would expect people to think that I am being held to account by my own board, by in previous lives, by the Home Office or the Department of Health. I think that's absolutely critical.
I mean one of the things I try to talk about a lot in regulation is that whether it's the regulators themselves or the PSA or other parts of the system is essentially we are all part of the same team, we all want the same outcomes, we want positive outcomes for patients. The same is true within a hospital of the clinicians and the managers; they should all be wanting the same thing and I can understand that if one group thought the others weren't being held to account for their actions that that would certainly be very difficult for that team work ethos, but why not if you are all there to ensure safety and effective care?
Q. You indicate though that accountability can drive negative behaviours, that's something you say at paragraph 52. Are you able to give any examples of how in real life circumstances accountability might drive negative behaviour?
A. I think if either there is an excessive fear of that accountability or that accountability is enforced in too draconian a fashion, it might lead to more defensive practices. It might even lead to

clinicians not wanting to get involved in certain aspects of healthcare because they are high risk. It might lead to excessive work to cover one's back to use a phrase and, therefore, I think it is important that the accountability exists, that regulators are good at explaining what they do and what they don't do to try to manage that fear, but also I think that the professionals will look at that accountability and say that that is fair and they see fairness in that.
And I think if you have got those things in place it's less likely to drive unwanted behaviour of which there may be other examples, such as whether you define something as a critical safety incident or not and therefore don't have to go through certain reporting change.
So I do think it's something to be thoughtful of when introducing a model.
Q. We have talked around the central advantage of regulation, we have talked about the various challenges and barriers. You address this head on in your statement.
I would like you to put it in your own words.
Where do you stand on what needs to be done now?
A. So I think if I -- if I come back to the point about the professional duty of candour which exists now

for regulated professionals, I think there are further opportunities for regulators to promote that using the positive side of regulation, the information, the advice and guidance on how important it is and how to do it as well as the compliance part which is if you are not candid there will be repercussions and within professional regulation I think there's a job there for the PSA to oversee the work of the regulators in doing this.

In terms of the statutory duty of organisations to be candid, I think the NHS and the hospitals themselves that there is scope there for further improvement, but also the Care Quality Commission in terms of holding these organisations to account, again in terms of advice and guidance the CQC can provide but also potentially sanctions.

The third part of what's already there that needs to develop further I think is around governance and leadership and culture. So all of that is there, but can be enhanced.

The thing that's new is the regulation of leaders and managers but introducing that I think will produce the benefits that I have described in here, in particular I think it was under paragraph 32 at the start, but also will drive the improvements that I have

been talking about in candour.

So I think those are the critical changes that are needed.

Q. In terms of what that regulation looks like, you say in terms that at this stage you are minded to discount the option of full statutory regulation such as the GMC, and you say that you have not yet seen evidence that this is required and further work will need to be done to establish if it is necessary.

You go on to say:

"I am also reluctant to suggest a statutory regulatory solution to what appears to be primarily an employment issue."

And I just want to just explore with you a little about why you characterise this as primarily an employment issue?

A. I think if you -- reflecting back on the idea about the fit and proper persons test and the idea about barring senior leaders and managers who have been shown to be either lacking competence or having conduct issues, a lot of those things in other sectors would be seen as the employer themselves dealing with that and removing them from that employment context.

In the I suppose now it is kind of eight months since writing/submitting this, this evidence statement

I just want to elaborate a little bit on that full statutory regulation point because I think the first thing to bear in mind here is that full statutory regulation may be particularly a strong response on the limited evidence base we have got, but that evidence base grows over time as to whether it's needed or not.

But the key thing with it is the amount of time it would take to put in place and bearing in mind the purpose of this Inquiry and generally in terms of safety across the NHS, something that we could put in place that would be quicker, because it wouldn't require legislation and public consultation, would be more agile, as I referred to earlier in terms of expanding the remit of the managers, leaders and managers that were covered if that was needed and would feel suitably proportionate on the evidence base we have got, would be to actually start with the idea of having a voluntary register, which the NHS could then choose to mandate for possibly all managerial positions or managerial positions in certain clusters or above a certain level and that would have all of those advantages.

That does not rule out, in parallel, developing the work on statutory regulation or even using that voluntary register as a stepping stone to statutory regulation.

So of the models that are presented in the current consultation I think the voluntary register, possibly with accreditation by the PSA if that was required, and probably with the support of the NHS to use the register would be the best model for now primarily because you could put that into place much quicker and it could start to have an effect much quicker and then in parallel considering whether that should over time evolve into full statutory regulation.

Just -- just to cover one of the other key points that's in that document which is a barring regime, I think the issue there is that again would require legislation, so it wouldn't be quick, and what you have with the barring regime is you produce a list of people who shouldn't be employed by the NHS. Now, yes, that might get rid of a few people who shouldn't be doing that job, but it does very little to enhance the standards in all the people that are doing the job.

So it addresses that accountability point, but it doesn't address the competency point. So although the PSA hasn't yet finalised its response to the Government consultation, it's likely to essentially say that the voluntary register with all of its benefits would be the best way forward at this point in time whilst, at the same time, you can be doing either the evidence

gathering or the further consultation that might be required for statutory regulation.

Q. You will tell me if I have got this wrong, but have you softened in the eight months since you wrote this statement in terms of your attitude towards statutory regulation being the end point even if it isn't appropriate because of the time for now?

A. I -- I would -- I certainly would not rule it out and I think, I mean, maybe if I were to -- I don't know if I have softened or maybe I over-emphasised the words "at this stage". But either way round, I think the important thing in the context of this Inquiry is to enhance that professional development such as is happening with NHS England and the leadership and management framework, but also to enhance the accountability through a regulatory model as soon as possible and, at the same time, use that time when you have got those extra safeguards in place or you are putting those in place to develop the thinking around whether this needs to evolve to the full statutory regulatory model.

Q. In terms of the voluntary list that you envisage, who is going to administer that in the sense that they will determine whether an individual needs to be removed from that list or that the individual will

not be permitted to join that list?

A. Well, that could for example be a register that was being run by an entirely new organisation such as one of our accredited registers that I mentioned earlier. It could, subject to constraints and legislation, become part of one of the statutory regulators, the Healthcare Professions Council for example is a multi-professional regulator. I am not an expert on its legislation, whether it could do that.

But essentially it would have to be independent of the NHS, but there are a number of models that could be introduced, a number of organisations and again I think that probably comes down to one of those practical points whether you set up something new or you add something to something that's already there.

As long as the model works I think it's quite -- relatively easy to deliver and, as I say, that pace of change also would be quicker with a voluntary register.

MR DE LA POER: My Lady, I am conscious of the time. I have probably got about another 15 minutes with Dr Clamp and we have been going I think an hour and a half since lunch, an hour and a half with Dr Clamp.

I am entirely in my Lady's hands whether I -- and no doubt the shorthand writer will have a view.

LADY JUSTICE THIRLWALL: We are all right to

continue, but no more than 15 minutes.

MR DE LA POER: It won't be any more than 15 minutes.

Just to deal with one or two further points surrounding how this might be implemented practically.

When talking about this external registration body, which I think is what we are talking about, your view is that they might assure training programmes, so going towards the competency side rather than the accountability side.

From where is the impetus to come to create that body? In other words, that requires people to agree that it's necessary, the PSA isn't going to run that. The PSA might accredit it, but it's not going to run it. Many of these other bodies in the past have developed organically. They've often started life as trade organisations, I think, or common interest organisations that then start to impose requirements on the members.

Where would you expect the impetus for that to come from?

A. I think the starting point would be the government's response to the current consultation, the outcomes of that. So whether a decision is made that managers should be regulated, which I think is certainly government policy in some form as to what the model

would be.

In terms of who would then essentially pick up the mantle with starting to look at the qualifications, the complaints processes, the registration processes and anything that might be needed to deregister somebody, it would be a decision for government.

I think potentially they could look at something that already exists to see if they could expand the remit of that organisation to take this on, or an alternative would be essentially -- a second alternative would be an invitation to tender for an organisation that wanted to do this and the third actually might be to set up a new body which, as I say, with most regulatory models they are often set up by government and become self-funding. So that would be an option as well.

So I -- I don't -- I think as long as it was effective in what it did, and there are a lot of parallels between that sort of model anyway and statutory regulation in terms of what's required, I think there would be a number of options.

Q. I would like to turn just to deal with the final section of your witness statement which deals with candour and workplace culture and you have already spoken to this in your evidence so far.

Firstly, it is right that this is an area which the PSA has published in relation to, is that right?

A. That's correct, yes.

Q. I just want to ask you, please, about one of the items -- the rest will speak for itself on the website -- is the fear of the regulator and litigation as being a barrier to candour and speaking up. How important is the culture at NHS Resolution to promoting candour?

A. I think similar to the description that I gave about having a common Code of Conduct, I think the approach of NHS Resolution should be supportive of candour in exactly the same way as the NHS Trusts themselves and the associated bodies. In other words, you should have a consistent approach to do this.

Fear of regulation, for example, would be difficult to eliminate, but I do think that regulators can do more in that space to avoid excessive fear of regulation, even only just by explaining what they do and how they do it and how unlikely it is under certain circumstances for people to end up in fitness to practise hearings and fear of litigation, which obviously is more the remit of NHS Resolution should also be addressed by that organisation.

And although I am not an expert on its work,

I certainly pick up over the last couple of years that the work of NHS Resolution has, you know, is generally positive about the importance of doing this and about saying sorry when things go wrong.

Q. Turning to the final part of what you say in your witness statement. You seek to draw attention at paragraphs 77 and 78 to two factors which you regard as significant when we are considering this overall theme of candour. Just to headline them for you, they are the effect of the pandemic and the current workforce and demand crisis in the NHS and I wonder if you could just briefly amplify how each of those two factors are in your view relevant to this sphere?

A. I think these, these two factors are essentially contextual in terms of the operating environment of people.

I talked about the second-line checks, the second line of defence ensuring patient safety in hospitals around being governance and so on. But actually a very important informal second-line checks is working in an environment where you are surrounded by professionals who will speak up if they think that something is amiss and actually to follow that up they will speak up if they feel that someone will listen and if they feel that someone will act.

So I think what we attempted to do in setting out the statements were to consider all of these factors so whether it is fear of regulation or litigation, whether it is time pressure, culture being absolutely critical through this, but then reflecting in those last two paragraphs on the challenges of working through the pandemic and some of the things that people were asked to do under very difficult circumstances and also the current workforce pressures and probably workforce issues are one the biggest risks in the system at the moment need to be taken into account when you are considering the difficulties that people have in being candid. Which takes me back to one of my earlier points, which is in recognising and acknowledging those and being very clear, let's say, with professional regulatory advice and guidance that this is recognised but candour is still so important that you need to be able to see beyond these.

So I think it is trying not to essentially say, you know: here is a rule, write it on the wall, you must be candid. It is to recognise the operating context of these professionals and say: we are aware of all these things, this is how you can work round it. In fact, we can provide some further advice and training and development in how to speak up, how to get listened to.

But quite critically one of the key things is how the organisation itself responds when somebody speaks up. And I am paraphrasing the Patient Safety Commissioner when I talk about Speak Up, Listen Up, Act Up, but it is something she says all the time and I think this is just two more key points that have been -- well, the pandemic, the effects of the pandemic are still with us, the workforce pressures are definitely there, that need to be taken into account rather than just say: there's the rule, follow it. It is about acknowledging that there are numerous barriers to doing that and try to dismantle those barriers.

MR DE LA POER: Dr Clamp, thank you very much indeed. Those are my questions.

My Lady, there were two permissions granted I think Mr Baker has five minutes which will bring us in I hope under the time that we indicated for the shorthand writer but I don't think Mr Sharghy -- no, he has no questions, so just Mr Baker.

Questions by MR BAKER

MR BAKER: I ask questions on behalf of two of the Family groups. You have heard I only have five minutes so forgive me if I am a little direct?

A. Okay.

Q. In relation to paragraph 57 of your witness

statement, you say there it is a point Mr De La Poer took you to a moment ago that NHS managers are employed under NHS contracts and the Inquiry should explore whether the NHS itself should perform the roles that statutory regulation might be expected to play.

Now, of course the NHS could have done that at any point, couldn't it, under the existing contracts or under its existing powers?

A. The point here I think it comes back to my -- the point I made about teamwork, is that regulation isn't the only answer to patient safety. There are a number of levers and to really keep people safe they should all be working as effectively as possible and the employer being on site and local and there 24/7 has got a key role to play in the effectiveness and the quality of leadership and management and the culture within individual establishments.

So I think it's just trying to make sure that we are not looking at just one place for the answers to the problems. But that the process that already exists within the NHS inevitably can be enhanced.

Q. Yes, but of course this isn't the first circumstance or incident where managers and their role in patient safety issues has been brought to the attention of an Inquiry or indeed to the world in a more

broad sense.

Would it not suggest that if these powers are not being used effectively and given that the role of managers was highlighted as long ago as 2001 by Sir Ian Kennedy that leaving it to the NHS to do it itself through its existing mechanisms probably isn't robust enough?

A. And that is why regulation of managers in some form as being explored in the current consultation is required to support that and in fact provide I think additional frameworks and guidance that the NHS can use, without it, there's always a risk under this situation that then such matters are deferred only to the regulators rather than being dealt with locally. So I do think it is a combined effort but the regulation of managers would enhance that.

Q. Yes, so a combined approach between internal structures and external regulation?

A. Exactly, yes.

MR BAKER: Thank you, I am grateful. My Lady, I think I kept within my five minutes.

LADY JUSTICE THIRLWALL: You did, thank you very much indeed, Mr Baker.

Dr Clamp I have got no questions for you, thank you very much indeed for your interesting evidence --

A. Thank you.

LADY JUSTICE THIRLWALL: -- which is now completed and you are free to go. Thank you.

A. Thank you.

LADY JUSTICE THIRLWALL: Does that conclude the evidence for today, Mr De La Poer?

MR DE LA POER: It does.

LADY JUSTICE THIRLWALL: We are starting tomorrow at 10 tomorrow, are we, as usual?

MR DE LA POER: We are, thank you.

LADY JUSTICE THIRLWALL: In that case, we will rise now and reconvene at 10 o'clock tomorrow morning.

(3.44 pm)

(The Inquiry adjourned until 10.00 am, on Wednesday, 8 January 2025)

I N D E X