THE MORECAMBE BAY INVESTIGATION

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)
Maternity and Neonatal Services Investigation

PANEL MEETING

held on

Thursday, 28th November 2013

at

Park Hotel (Council Building)
East Cliff, Preston, PR1 3EA

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Before:

The Panel

Dr Bill Kirkup CBE - Chair
Dr Geraldine Walters - Expert Advisor, Nursing
Mr Julian Brookes - Expert Advisor, Governance
Professor Stewart Forsyth - Expert Advisor, Paediatrics
Dr Catherine Calderwood - Expert Advisor, Obstetrics
Professor Jonathan Montgomery - Expert Advisor, Ethics

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Ms Oonagh McIntosh - Secretary to the Investigation
Hannah Wright - Analyst

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1 CHAIR: I will start the meeting by saying welcome.

2 Thank you to colleagues and to families for coming this
3 morning. This is the first meeting of the Morecambe Bay
4 Investigation Panel. It is good to see that we have such
5 a good turnout. Thank you.

6 There are a couple of bits of housekeeping that we
7 usually need to do to start off with. The first we are
8 not expecting any fire alarms to go off, but, if any fire
9 alarms do go off, then we have people on hand from the
10 secretariat to make sure that we all go in the right
11 direction and congregate in the right place.

12 As you know, the meeting is open to family members
13 and thank you for coming. Paul and Jenny are on hand to
14 make sure that everybody who is here has the proper
15 credentials for being here. We want to make sure that in
16 this process you are not subject to people trying to
17 gatecrash. That is what they are doing here.

18 We will aim to break for lunch around about 12.30 and
19 we will draw to a close by about 3 or 3.30 at the very
20 latest. It may well be that we do not go on for as long as
21 that, but we will truncate things at that point.

22 If the discussions are still going on, these are
23 important things, obviously, we have another meeting
24 coming up in a couple of weeks time when we will be able
25 to pick them up again. I am not going to try to constrain
26 any discussions to hit an artificial timetable like that,
27 but, for domestic purposes, we will aim to be out of here
28 around about 3 o'clock.

29 This is the first meeting of the Panel. We have only
30 just had the chance to meet each other. I think,

1 therefore, it is important that we spend the first bit of
2 this meeting going through some of the processes and
3 procedures that we are going to work to as a Panel.
4 Therefore, I have asked that we put those items on the
5 agenda first and then, if you are still willing,
6 individually to come and talk to us about your
7 experiences, I think that that is a very, very valuable
8 part of the process and we would very much appreciate it.
9 We will manage that so that you can come in one at a time
10 and make it informal, but then we hope that you will come
11 back again and listen to the discussion after we have done
12 that.
13 Is that acceptable to you? [Yes] That is great, thank
14 you.
15 I should explain before we go any further that Anne
16 Thomas, who was going to be our expert advisor on
17 midwifery, has had to withdraw because of pressure of work
18 at the Trust that she works in. We have replaced her with
19 Jackie Featherstone, who is head of midwifery in Harlow,
20 but, unfortunately, she could not make this meeting. She
21 is going to come along to the next meeting. I think that
22 that is almost enough from me for the moment, because I
23 really want to get everybody on the Panel just to
24 introduce themselves to you briefly, starting in a moment
25 with Catherine and then working around, but I will kick
26 the process off.
27 I am Bill Kirkup, for those of you who I have not had
28 the pleasure of meeting yet. I actually started out
29 training in obstetrics, but that is an awful long time ago
30 and I do not think that it is relevant for the purposes of

1 this. I then moved into public health and worked in
2 Newcastle and London, ending up as associate chief medical
3 officer in London, with Liam Donaldson. I retired there at
4 the end of 2009. Since the end of 2009 I have been
5 involved in various investigations into failures in
6 services of one sort or another, including the Oxford
7 Children's Heart Surgery Service, the Hillsborough
8 Independent Panel and still just finishing off, actually,
9 the involvement of Jimmy Saville at Broadmoor and the
10 Department of Health. However, the Jimmy Saville one is
11 nearly finished now, so I will be devoting 100 per cent of
12 my time to this. Catherine.
13 DR CALDERWOOD: Hello. I am Catherine Calderwood, I am an
14 obstetrician, I work in Edinburgh and I have recently been
15 medical advisor for the Scottish Government for women and
16 children's health. As part of that role, I chair the
17 confidential enquiry panel into maternal deaths which is
18 the investigation that we do for all maternal deaths in
19 the UK. Also as part of my work with the Scottish
20 Government I have been involved in a still birth working
21 group that we have set up there and, as part of that I
22 have become involved with SANDS, the parent support
23 charity that you probably know about, and we are doing a
24 lot of work with lots of other organisations to look at a
25 standardised review process for perinatal deaths or still
26 births and neo-natal deaths, when these happen in
27 maternity services, so I am very involved in that Panel as
28 well.
29 Very recently, I have taken up a new position working
30 as the national clinical director for maternity and

1 women's health for NHS England. And I am also a mum of
2 three children, which I probably should have said first.
3 DR WALTERS: I am Geraldine Walters, I am executive director of
4 nursing at King's College Hospital in South London, which
5 is a big acute teaching hospital. I have been a director
6 of nursing for about 15 or 16 years, so have worked at
7 smaller DGHs and specialist hospitals as well. About the
8 turn of the century, I was working in London introducing
9 clinical governance when it was first introduced across
10 London. That is the sort clinical quality system that we
11 have in the NHS. I am not a midwife, but I am executive
12 director for midwifery in our organisation. That is why it
13 is important that we have a midwife on the panel, as well.
14 I have never worked in this part of the country, but I am
15 from Mansfield in Nottinghamshire. I am a cardiac nurse by
16 background.
17 PROFESSOR FORSYTH: Good morning. My name is Stewart Forsyth, I
18 am a consultant paediatrician and professor of paediatrics
19 from Dundee in Scotland. For over 25 years I ran our
20 neonatal intensive service for the area of Tayside. I
21 retired from my full-time NHS post nearly four years ago.
22 For the last three years or so I chaired a Scottish
23 Government committee which was set up to look at standards
24 of neonatal care within Scotland, so that was completed in
25 the early part of this year, and the publication came out
26 in April/May of this year. I have also undertaken a number
27 of reviews of maternity and neonatal services across
28 Scotland and also in England as well on behalf of the
29 Scottish Government, the Colleges of Paediatrics and Child
30 Health and also the College of Obstetricians and

1 Gynaecologists.

2 MS McINTOSH: I am Oonagh McIntosh. I have met some of you

3 previously. I am the Secretary of the Investigation. I am

4 a civil servant by background but I am seconded to the

5 independent investigation and, therefore, I am accountable

6 to the chair and the chair only. I have had the

7 privilege of previously working on pubic inquiries, so I

8 hope that I can contribute to the process in making it run

9 as smoothly as possible for everybody.

10 MR BROOKES: I am Julian Brookes. I have worked in health-

11 related services for nearly 30 years now. Geraldine and I worked together

12 around the turn of the century when I was head of clinical quality at

13 the Department of Health responsible for the introduction

14 of clinical governance, the creation of the National

15 Patient Safety Agency and the Healthcare Quality

16 Commission, as it was known in those days. I have spent a

17 lot of my most recent years involved in investigations

18 around governance in organisations in the South West. I

19 have never worked in this area or have any real links to

20 this area at all. Unfortunately, I am a Midlander and then

21 a Southerner. In my private life I am a magistrate and a

22 father of two sons.

23 PROFESSOR MONTGOMERY: I am Jonathan Montgomery. I am a father

24 of two daughters. [redacted] so I

25 have my ear bent on maternity issues quite often. I am a

26 law professor by main career and I have a longstanding

27 interest in how we try to improve the ethics of

28 professions and services, which mostly has been around

29 trying to help identify guidance for what good practice

1 looks like, which has included genetic testing of
2 children, work on pandemic flu. This is my first
3 experience of something a bit like this, but I also have
4 experience in terms of bodies responsible for trying to
5 govern ethics. I chair something called the Nuffield
6 Panel for Bioethics which deals with ethical issues in
7 relation to emerging technologies, new health service issues;
8 and I chair the Health Research Authority which is
9 responsible for protecting and promoting the interests of
10 patients, the public and participants in research. Up
11 until the latest NHS reorganisation I also had local NHS
12 involvement chairing various bodies in Hampshire and the
13 Isle of Wight where I live, but I opted out of that when
14 other things became more pressing, and it will be a
15 privilege to hear from you later on and understand better
16 what has been going on.
17 MS KNIGHT: My name is Hannah Knight and I am the analyst for
18 the investigation, and seconded from the Royal College of
19 Obstetricians and Gynaecologists where I am a Research
20 Fellow, so my work is in the analysis of maternity data.
21 CHAIR: Thank you. I think it is clear that we have
22 a strong team here, which I think is reassuring to me.
23 Most of you have been appointed to the Panel because of
24 your particular experience and current knowledge,
25 including all of the relevant areas that we have heard
26 about. What I have said previously about the
27 Investigation and the direction I would like to set for it
28 is that it is founded on three principles. The first is
29 thoroughness and we have to be sure that we get to the
30 bottom of all of the events that you are concerned about,

1 and actually we have to understand what exactly those
2 things are before we embark on that.
3 Secondly we need to do it transparently and that is
4 part of the reason why you are here today, so that you can
5 see that we are doing this transparently and we are not
6 hiding anything.
7 And thirdly independence. We are not beholden to
8 anybody, this is an independent investigation and we
9 report to the Secretary of State whose responsibility it
10 then is to ensure that whatever recommendations we come up
11 with are implemented.
12 By the way before I go any further I should have
13 mentioned previously, and it was remiss of me not to say
14 so, that the reason we have the microphones and people sat
15 at the back of the room is that we are recording
16 proceedings and will process that appropriately. You will
17 also see somebody coming in and out from time to time when
18 the tape runs out to change the tape.
19 As well as the specialist knowledge I think it is
20 particularly important to stress that we are all of us
21 here to challenge, we are here to challenge the evidence,
22 we are here to challenge what people tell us and we are
23 here to challenge each other, because if we do that then
24 we will I think end up with not just a robust process, but
25 also an outcome that we can all sign up to and that
26 everybody will have confidence in.
27 I just want to briefly highlight Jonathan's role in
28 bringing an external ethical perspective to bear on that.
29 We all have a challenging role and Jonathan is a key part
30 of that.

1 Perhaps I can pause there and ask for reflections on
2 how we see this process unfolding.
3 MS McINTOSH: We have a huge job of work to do and I would
4 like to draw the Panel's attention to the papers that they
5 have been given, and there is a paper there called MBIPM1.
6 It is Morecambe Bay Investigation Panel Meeting and this
7 is the first meeting, and point 1 simply because it is the
8 first paper we are looking at.
9 I have set out there the scope of the Investigation
10 and the terms of reference which are obviously in the
11 public domain. But what I am quite concerned that we have
12 a discussion about today and we reach some agreement about
13 is actually looking at how we structure ourselves and how
14 we use the resources that we have as a team, as a team of
15 experts, to actually assess the evidence that we will be
16 collecting, are collecting and will be collecting, and how
17 we take that forward so you can then decide as chair
18 who we might need to take evidence from and how we go
19 about planning and structuring that. What I have set out
20 there is a list of organisations, many of which you
21 mentioned on the 1st November when you delivered your
22 method statement. The organisations that we have
23 identified thus far, which is 1 to 15, organisations that
24 we will be going to or already have been in touch with to
25 actually secure evidence from. And then finally on that
26 list, because it leads into the next discussion, is
27 families and relatives and maybe later on in the day we
28 can talk about how any material that families want to
29 share with the Investigation is provided. I think that we
30 need to look at the terms of reference and the list of

1 organisations. We will look at the next paper, which is
2 1.2. That is a draft letter to the Trust. The reason that
3 it is draft is because I am trying to work through the
4 Terms of Reference in a structured way to list the
5 evidence that the Investigation will require. I have
6 obviously discussed this with the chair and it is a
7 very long letter and sets out very specific requirements
8 that the Investigation needs. The reason that I have
9 structured it in that way is because there is no point in
10 just saying, "Here are our terms of reference, send us
11 anything that you have got", because then Paul, as the
12 documents and evidence manager, would then just receive a
13 massive amount of material in a very unstructured way and
14 also we could not guarantee that, in this example, any of
15 the other 14 organisations had gone through their records
16 in a structured manner to actually ensure that they had
17 provided us with all the documentation that we require.
18 The difficulty for some of these organisations is that
19 they have been subject to the NHS reforms that came in on
20 1st April, which means that some of the organisations that
21 we require information from, for example, the historic
22 records from the Primary Care Trust who commissioned the
23 services, from the Strategic Health Authority, who had a
24 sort of governance and assurance role and responsibility,
25 and the Health Protection Unit and Public Health
26 Observatories, organisations that will have had an
27 oversight or material that we want to investigate, either
28 ceased to exist or have been corralled into the new bodies.
29 For example, the public health organisations have gone
30 into Public Health England. Actually, just starting the

1 discussions with those organisations, all of whom
2 have taken very seriously the commitment that the
3 Secretary of State has given, and that you reiterated
4 on 1st November, that they would cooperate fully with
5 the Investigation, nevertheless, have people in post
6 who do not understand what the feeder body is ...
7 where the archived material from those feeder bodies
8 has gone. For example, the Health Protection Agency
9 was abolished on 31st March, so the health protection
10 units who would have looked after the Cumbria area do
11 not exist and the files for that are stored
12 somewhere. Now, they are not lost, but, actually,
13 Public Health England do not currently hold them. The
14 legacy bodies hold them and there are legacy
15 arrangements for each of the bodies. For example, it
16 is very clear in the case of the Primary Care Trusts
17 and the Strategic Health Authorities because when
18 they were abolished the evidence went to the legacy
19 body. The only body that was still existing was the
20 Department of Health, so it holds half a million
21 files from Primary Care Trusts and Strategic Health
22 Authorities that no longer exist and they are in a
23 process - which is part of the transition to the new
24 structure - of sorting out those files to determine
25 if it relates to a function that moved from a Primary
26 Care Trust or a Strategic Health Authority to NHS
27 England, and most of the functions logically flowed
28 that way, but not all. Then those files will be
29 transferred to NHS England. Some functions, of
30 course, from Primary Care Trusts went to local

1 authorities, including some of the public health
2 functions. We have a job of work to do to extrapolate
3 the files that this Investigation needs, to be
4 specific about our requirements, and actually give
5 clear direction to the new bodies, who then have a
6 job of work to do to find those files and give them
7 to us. We have obviously started that process. I do
8 not want you to think that today's discussion is the
9 first that we have thought about it, because we are
10 incredibly advanced with some of the organisations.
11 We have discussions, we have had meetings, and this
12 approach - the one letter that you have in front of
13 you is the sort of template letter, because we
14 imagine that University Hospitals Morecambe Bay NHS
15 Foundation Trust, will have the significant volume of
16 material that the Investigation needs to gather and
17 they are fully aware of that and are working on that
18 to give us as much of it as is ready to provide. It
19 is not a difficulty with them. This is the sort of
20 template approach that you have agreed. But what I
21 need from the panel is their quick view, not today,
22 but in the next few days, if possible - and at the
23 moment I have given you a hard copy, I will email you
24 the letter - if you think there is anything that I
25 have missed ... I have explained that I am a jobbing
26 civil servant. I do not understand the intricacies of
27 the systems or the professions. That is why you are
28 here to keep us on the straight and narrow and make
29 sure that we do not miss anything. But, actually, for
30 you to say, "You have not thought of this, you have

1 not thought of that".

2 PROFESSOR MONTGOMERY: Obviously, we will look at it in greater

3 detail when we have had a chance to do it, but what I do

4 not see either in the letter or in the list of bodies is

5 access to the voices of patients, service users and there

6 are various places where we should be able to find that,

7 so the Maternity Services Liaison Committee, the whole

8 train of public involve mechanisms through from the old

9 CHCs up to Health Watch and the various iterations in

10 between. We have concentrated, I think, on seeking things

11 around maternal deaths, but I do not see about the

12 complaints records and those sort of things which come

13 through quite strongly in some of the reports that we

14 should be seeing.

15 MS McINTOSH: OK. That is very valuable. This is exactly what I

16 wanted to do. Thank you. We have made it abundantly

17 clear to the Trust in discussions that our Terms of

18 Reference, whilst the Investigation is maternity and

19 neonatal services, the chair has a responsibility to

20 report on serious untoward incidents and that does not

21 ring fence just those that happened in maternity and

22 neonatal services.

23 CHAIR: Or those that resulted in a death.

24 MS McINTOSH: No, exactly so. We have broadened the

25 understanding with the communities that we are talking to.

26 The reason that I wanted to give you that sort of

27 background was to explain in some sort of umbrella way the

28 complexity of the job in hand, not just the complexity for

29 us ... we need the material sent in in as structured a

30 manner as possible so that we can then put it into our

1 database and you will be able to look at it and review it
2 and comment on it. If it is correspondence between the
3 Trust and the PCT about a certain issue and then
4 correspondence with the SHA, we can actually say that we
5 have the full chain of correspondence. We already know
6 that by going through this process we are going to receive
7 a volume of duplicate material, but, actually, that is the
8 safest way of ensuring that we have the whole of the
9 conversation that has taken place. There is a complexity
10 for us in how we receive and manage, which, hopefully,
11 will be made simpler by what appears to be an
12 indeterminable list going to every body to locate and
13 submit evidence, but there is also a complexity - and I
14 think that we need to recognise it. I am not making
15 excuses for anybody, but I think that we have talked
16 within the Investigation about the complexity for our
17 understanding of the new bodies and which functions have
18 gone where and who would have the records and the papers,
19 but for staff in those new bodies, who may have only been
20 recruited to senior posts since 1st April, for them
21 actually to gain an understanding of where records are, it
22 is not about their cooperation, but it is about them
23 having to do backtracking. I just wanted to bring that to
24 people's attention initially because I consider - and I
25 have already explained this to the chairman - this will
26 have an impact on the speed with which we can progress to
27 the next stage of the process which is identifying who you
28 want to interview and who you might want to hear evidence
29 from. I think that it is important that you know that as
30 well. If we go quiet for a while, it is because there is a

1 hell of a lot of work happening to gather evidence and
2 collate it and assign it to the appropriate term of
3 reference and the appropriate expert. We will talk about
4 that in a moment. I just wanted to bring that to your
5 attention before I move to how is this expert Panel going
6 to work, because there is going to be a significant volume
7 of material. You said earlier, for example, that you are a
8 nurse not a midwife, but, actually, nurses and midwifery
9 from what we have found out from the hospitals we have
10 been talking to, the nursing and midwifery, you can
11 separate them because they are specialist skills and
12 involve specialist training, but, actually, they work in
13 conjunction, and the paediatricians. There is such a lot
14 of overlap. We have to work out how as a Panel each of
15 the Terms of Reference are going to be addressed.
16 CHAIR: Before we get on to that, though, I think that
17 it would be worth just pausing to see if anybody else has
18 any comments on the letter setting out the approach. It is
19 not a letter that I would normally aim to send. It is much
20 too long and much too complicated, but I think that the
21 thing is that we have to send something that is that long
22 and complicated at this stage. I would be very glad of
23 any views from you.
24 DR CALDERWOOD: This is obviously the first time I have seen it.
25 There is one comment from me as a clinician who is wanting
26 to find out what has happened. We have asked for a list of
27 cases of maternal and neonatal deaths and then we have
28 asked for a list of sudden unexplained/unexpected
29 incidents. My understanding is that sometimes maternal
30 death or a neonatal death will not be an SUI. I am making

1 no further comment. But that would not be my opinion, but
2 that is apparently sometimes what happens. Actually, what
3 I would like to have is a list of the maternal deaths,
4 still births and the neonatal deaths and what the
5 responses to those were, because, if it has not been an
6 SUI, we will not get any information. We have also talked
7 about maternal and neonatal deaths and not still birth, so
8 there is a definition there. I think that, maybe, to help
9 with the complexity, if there has been a response by the
10 hospital, that should be in the case notes, so to have all
11 of these things you have said, name and date of birth, of
12 course, and then what actually happened and then what did
13 the hospital do about that, but all of that as one piece
14 of information would make it much more easy for us to
15 review it rather than then having to go to a big
16 investigation box and match the two together. I think that
17 it is very important that, first of all, the criteria for
18 any investigation, because it will have changed between
19 2004 and 2013, what was the hospital using as their pro
20 forma - I use the term loosely - for investigation of
21 these sorts of incidents, because it would not be the
22 correct thing to measure something ten years later if that
23 has not been the way that it has been done. We need to see
24 what they did do, though, and what the response was and
25 whether there was family input to that or there was any
26 feedback at the time and that should be the hare. I do
27 not think that that is an extra burden for them.
28 MS McINTOSH: It is more of a process per case.
29 DR CALDERWOOD: Yes. In a way, the other SUIs would be a
30 reflection of what is going on but what these people here

1 want to know is what happened to me and what did you do
2 about it and maybe less important for them, as families,
3 but for us in the health service is what did you do to
4 stop it happening again. That is what I would like to see
5 for each case.
6 CHAIR: Sure.
7 DR CALDERWOOD: Then we may comment on whether that is the
8 correct thing or not, but, unfortunately, and I do not
9 know about this Trust, the SUIs will not necessarily pick
10 up maternal and still births and neonatal deaths in all
11 hospitals. It may do here, but I do not know.
12 MS McINTOSH: That is helpful.
13 CHAIR: That is very valuable. Thank you. I can just
14 about see on a good day how you could say that not every
15 single still birth might result in an SUI, but I cannot
16 imagine how anybody could say that a maternal death was
17 not an SUI. It would be extraordinary.
18 DR CALDERWOOD: We might still have been able to do better,
19 Bill.
20 CHAIR: Yes.
21 MR BROOKES: I have just two quick points. There is one to
22 follow up on that. I absolutely agree that it is
23 difficult in terms of the team in terms of getting data
24 from different sources and things and there will be
25 duplicates, but can we not lose in collection of that
26 where those duplicates are, because it actually tells you
27 quite a lot about what different organisations have. That
28 was one of the things. Also in terms of information,
29 because a lot of this is about what the board saw, and
30 that is absolutely right, but I would also be interested

1 at divisional level, assuming they have got divisional
2 level, about what happened there and what discussions the
3 were, because that is where a lot of the action should
4 have been taken. I do not want us to see just the high-
5 level things. That is really, really important. We do
6 need, actually, to get down into the nitty-gritty of what was
7 happening within there, so clarity about what was
8 happening operationally as well as what was happening at
9 board level is really important. It may be in there, I
10 have only just scanned it, but it would be really
11 important as well.
12 MS McINTOSH: OK. Maybe we can speak about that, because what I
13 have done is I have said, when we refer to "the Trust",
14 because, obviously, when you say, "who at the Trust dealt
15 with", I thought that it was quite important that we
16 actually listed who we meant by that. There is quite a
17 long list going from the Chair of the Trust right down to
18 people who were on wards. Actually, I think that I need to
19 review that and, maybe, you could comment on it for me.
20 MR BROOKES: Yes.
21 MS McINTOSH: That would be grand. Thank you.
22 PROFESSOR MONTGOMERY: I have only skimmed it and it may already
23 be in there, and apologies if I have not picked it up, but
24 I get a sense from this that we will get quite detailed
25 information about how particular things were tracked
26 through. I do not get a sense that we will learn about
27 what connections might have been identified and might have
28 been missed. I think that we would need to see the quality
29 reports going through so that we can see what is flagged
30 up and, reading what is already available from the various

1 investigations, there are clearly questions around the
2 possible correlations between sickness and staffing levels
3 in parts of the organisation, the possible connection
4 between complaints information and the sort of things we
5 have picked up from this and various suggestions that the
6 clinical governance processes were not connected with each
7 other, they were in different sorts of silos. I think that
8 we need to get an account of what the Trust thought it was
9 doing in terms of what was put where and how it was
10 brought together or not brought together. I think that we
11 just need to see a complete set of documentation going
12 through to those committees and I could not immediately
13 see it there in that form.
14 MS McINTOSH: Yes. I do think that this is kind of the best stab
15 so far, but definitely needs input and ...
16 PROFESSOR MONTGOMERY: I think that we want to be able to
17 triangulate what will come out in this sort of format with
18 what was delivered to whatever committees or people that
19 were dealing with it, so part of our question is were
20 those things managed then in a way that would have enabled
21 them to pick up the patterns.
22 CHAIR: Yes, and how did practice match with theory.
23 PROFESSOR FORSYTH: I have just a general point. There is always
24 a risk that we become overwhelmed with information and we
25 lose the focus of what this is all about and this is
26 actually trying to answer the questions that these
27 families have as to what happened to them. I think that
28 that should be the starting point. I am very keen to get
29 clarity of what are the real questions that you have and
30 that is the first driver of this and we then go back to go

1 through your case, go through what we see is the standard
2 of care, was it good, bad, indifferent or whatever, and
3 then what were the mechanisms, why did that happen and try
4 to pull all that together, but the real focus is answering
5 your questions. I think that, if we have not answered your
6 questions in this review, then there would be an appeal
7 and therefore I think it is really important at the outset
8 to have a clear understanding of what your specific
9 questions are so that we can always have these side by
10 side with the information we receive, and that may
11 determine what other information we require. Rather than
12 here is all the information, now try and sort out what is
13 going on. I think we really need to keep a very clear
14 focus of where all this started and where we want to go
15 with it.
16 CHAIR: Absolutely. We will go into that little bit more
17 when we have the sessions when we hear from you. But
18 you are absolutely right, we need to have a clear view of
19 that before we finalise this.
20 DR WALTERS: I think the only thing I would add is that to
21 get a little bit of a picture of what the view of the
22 Trust looked like from the Monitor and the SHA respective.
23 I think things like HSMR, patient and staff survey
24 results, and the sort of ratings they were given for
25 things like performance and finance and quality to see
26 where the perception was that the problems were external
27 as opposed to where they appeared to be coming from
28 internally.
29 CHAIR: And presumably we would want to include any kind
30 of assessment that was done, whatever the source of it

1 was.

2 DR WALTERS: Yes. If I was sitting at the SHA I am just

3 wondering what sort of picture I could see from the high

4 level.

5 CHAIR: I think that is very good question.

6 MS McINTOSH: Thank you, that is exactly what I wanted.

7 CHAIR: Can I ask that you communicate your concrete

8 suggestions for that within the next, how long shall we

9 give?

10 MS McINTOSH: It is Thursday, if we say by close of play next

11 Wednesday, simply because we have to maintain the

12 momentum for the 11th and want to keep the pressure -

13 perhaps that is unfair, but keep the momentum with the

14 organisation as we are nowhere in this process really. I

15 will email this after this meeting to colleagues so they

16 have it to work on and if you send back - I do not mind

17 whether you send manuscript or track changes, I do not

18 care how you send it back to me, but I would appreciate

19 that as it will help us no end.

20 CHAIR: Thank you all for that. If you could move us on

21 to the next section, please.

22 MS McINTOSH: The next section really is going back to paper

23 1.1 and the penultimate bold heading which is options for

24 considering the evidence. I think just from the flavour

25 of that discussion people are beginning to draw down into

26 their area, but also can understand the overlap with other

27 people's specialties as well. It is how on earth we work

28 as a team and you work as a team of expert advisers

29 looking at the evidence. I have put down here three

30 options. The first option is that all of you individually

1 review all of the evidence and come up with your summaries
2 and reports. The second option is that you work
3 individually on specific areas of our terms of reference,
4 to contribute towards the work of the Investigation. Or
5 thirdly an option that experts work in sub-groups and
6 maybe play to the overlaps between the areas of care that
7 you have experience of, and actually work through evidence
8 in that way. There are just three options and I put down
9 their strengths and weaknesses, and I think it would be my
10 role to do this, would it not, but we have to get this
11 work done and we want to get it done properly but not
12 taking for ever, and also bearing in mind you are all
13 extremely busy people it seems bonkers to make a poor use
14 of your time and contributions. So I really would welcome
15 your views on how this might work and pull that together.
16 DR WALTERS: If I could pitch in first I would go for a
17 modification of 2 in which I think it would be good for
18 expert advisers to take a lead on something that is their
19 expertise, but the rest of us should look over it because
20 I think sub-groups do not work very well. Perhaps that is
21 just my personal preference, and I agree with the
22 weaknesses of No. 1. That would be my preference but I am
23 happy top negotiate.
24 MS McINTOSH: A sort of slightly tweaked option 2.
25 PROFESSOR MONTGOMERY: I think this is going to be a
26 challenge for me because I am going to have to try and
27 span everything to see what are the ethical issues, but I
28 think I am supporting of the idea that perhaps it is not
29 so much areas about particular questions and we might need
30 to span everything with a view to which things might throw

1 up stuff in our particular areas of interest, and then
2 share that so that we have the chance to say "Actually I
3 spotted this as relevant to the question you are raising".
4 So maybe we could think about identifying some of the core
5 questions for which we took responsibility for looking
6 for. We will all have access to everything but we are not
7 necessarily expected to look at it all in the same depth.
8 The trick there would be to make sure that everything is
9 looked at by somebody because otherwise we will miss
10 something that does not appear to fit anybody's individual
11 expertise and could turn out to be crucially important.
12 MR BROOKES: I would support that. I think we need to make
13 sure that we have looked at it, so we cannot miss things.
14 But evidence maybe relevant to more than one panel member.
15 But it is also important that we have as full a picture
16 as we can going forward, so we just need to have that
17 balance between where we are going to be driven down
18 because of our expertise and keeping an overall
19 understanding of what the picture looks like.
20 PROFESSOR FORSYTH: I think it is complicated, and there are
21 always going to be overlap. But I would support the view
22 that Oonagh is quite keen on, clear areas of
23 responsibility of items in this work to make sure it
24 happens on time; and I would go along with No. 2 in that
25 we all have our specialist areas to look at but clearly we
26 are going to be sharing information. But you know who is
27 responsible for it, the work is going to be done, but
28 there are going to be good communication across the group
29 and overlapped discussion in clearly common areas.
30 DR CALDERWOOD: I agree. I think what I would like is

1 obviously I would understand what I have asked for about
2 the evidence around what has happened and what the
3 organisation did in response to that, but then what I
4 might need is for Julian to say I would have thought this
5 might happen, and he then would say from my perspective
6 what did happen was correct or not, because I could not
7 comment on board response being appropriate, I could not
8 do the medical side. So I think almost pulling in
9 specifics before I would make any comment to check on
10 things, but we can do that as needed. I agree with
11 somebody taking the lead for particular areas then, and
12 pulling people in individually but perhaps then also the
13 whole panel has a look at a summary level.
14 CHAIR: Yes. So everybody has access to everything and
15 we expect people to scrutinise everything to pick up
16 things they particularly want to see, but also we have
17 individual leads identified for each particular area. I
18 do not think the areas fit very neatly into the Terms of
19 Reference. I think it will be specialist expertise areas.
20 And the person who takes the lead on that is responsible
21 for making sure that they have consulted with the people
22 who they think are relevant, but they are also open to
23 people like Jonathan or whoever saying "Hang on a minute,
24 you might need to consider this". That way we try and get
25 at it from both directions. Does that make sense. Are
26 you content with that, Oonagh?
27 MS McINTOSH: Yes. I am going to be a bit dragon-like and
28 convert that into a proposal and an agreement that we will
29 sign up to, and again I will circulate that. I know we
30 have a record but people's understanding if I convert

1 that into how we will work, and then also if I talk to you
2 about Yes, we are looking at specialist expertise but
3 actually there are areas that might not fit neatly, where
4 the obvious overlaps are, and then where some of the less
5 obvious overlaps are where you would expect another member
6 of the Panel to comment on. It will not be set in stone
7 and obviously it is quite organic in a way, but just to
8 have some clarity for the team.
9 PROFESSOR MONTGOMERY: I think that may need to include us
10 being able to log who has looked at what so that you can
11 be assured that everything is being covered by somebody,
12 because what we must not do is find that there is a key
13 piece of information that everybody thought somebody else
14 was going to deal with.
15 CHAIR: Absolutely right, it is not the overlaps that
16 concern me so much as the potential gaps, and I think that
17 you and I need to play the sweeper role.
18 MS McINTOSH: Yes, keep reviewing it. We will come to this
19 on the 11th when we are more familiar with the system, but
20 we are going to, and I refer to it here just so that you
21 know, the evidence for the Investigation we are going to
22 use a data base called Huddle which is something that the
23 Department of Health has never actually accessed before.
24 It has been used in the Foreign Office for people who are
25 distantly located to actually work on pieces of work. So
26 it is a very secure data base and we will put the evidence
27 into it as we receive it and we will give it some data so
28 that there are research terms there and we will share
29 those in draft with you. That is at a very early stage
30 because we are working through practicalities in the

1 office, but also going through the search terms, we have
2 just come up with a proposed list thus far and we will
3 need to share that with you. That database gives the
4 facility for someone to actually say I have looked at
5 this, Catherine would you now look at, or whatever. We
6 will be giving guidance on that. I am hopeless at IT and
7 if I can see that it can work and can do it then there is
8 hope for everybody. But it does give us that chance and
9 us as a Secretariat the chance to do the sweep up, so when
10 you and I are talking we can say there needs to be more
11 focus on this, who can we count on.
12 CHAIR: It might be worth mentioning that access is
13 restricted to named and cleared individuals as well. You
14 mentioned the Department of Health but it is not open to
15 the Department of Health.
16 MS McINTOSH: They are just paying.
17 PROFESSOR MONTGOMERY: This ought to be a non-question but
18 can we check whether it works on iPads or not?
19 MS McINTOSH: We will definitely check.
20 PROFESSOR MONTGOMERY: You can work on either but if you try
21 and do it on one and it does not work as smoothly
22 sometimes you do not see things looking quite the same.
23 CHAIR: Some of these systems restrict access to anything
24 using wireless as well.
25 MS McINTOSH: There is a session tomorrow morning with Huddle
26 about it at 9 o'clock so it is very relevant that we get
27 this kind of question answered and we will try and think
28 of other questions.
29 DR WALTERS: Can you print things off?
30 MS McINTOSH: We will ask, I do not know. I am pretty sure

1 there must be a facility but if not we are putting stuff
2 in and we will be able to print within the Investigation
3 from our source. We can work with that.
4 DR WALTERS: There is confidentiality. You might leave
5 it on the train or I might. I am thinking of some of the
6 wider documents.
7 MS McINTOSH: And the reports which are pages and pages.
8 CHAIR: You are right to remind us that we are going
9 to be dealing with a lot of very sensitive information and
10 we absolutely must follow the proper protocols. But when
11 you are talking about documents and policies and reports
12 and so on I actually think Huddle will allow you to print
13 those off. It will be our responsibility to make sure
14 that we do not print off anything inappropriate.
15 PROFESSOR MONTGOMERY: Just on that it would be really
16 helpful for us to understand the protocols we are working
17 to, because we will be working from remote places and
18 different places, and there is always the danger of
19 patient information. Just reminding us all of some of
20 those rules under which we need to operate is important.
21 It is not just the printing off, it is information being
22 secure. So some rules around that, just to remind us
23 would be helpful. In terms of retaining our notes and so
24 on. It can be done in different ways but we need to know
25 which is the way it should be done.
26 DR CALDERWOOD: It will be interesting to hear what the
27 families think of that. A way around would be to allocate
28 a case, a number, and we would know who was No. or letter
29 A or B, but that would be mean that the data is then
30 anonymised and so that allows much more. So only we would

1 have access to the list of individuals. The difficulty
2 would be I suppose it comes into your secure database and
3 then has to be anonymised before we can have it back out
4 again as it were.
5 MS McINTOSH: It would have to be redacted before it went in.
6 DR CALDERWOOD: Yes, and the way they will send it will have
7 identifiable information on.
8 DR WALTERS: Our SUI reports do not have any identifiable
9 information.
10 CHAIR: We also have to be able to link records, we have
11 to be able to link the SUI report with a clinical record
12 DR CALDERWOOD: And that reminds me of another thing I
13 should have said and which you may not be aware of;
14 mothers and baby records are not instantly identifiable,
15 sometimes the baby has a different name, but also the
16 hospital system does not recognise a still birth as having
17 a unique or does not get an NHS number, so we need to be
18 careful of matching, of somehow being able to link that if
19 you do not know the patient identifiable information.
20 MS McINTOSH: That is really helpful because it is something
21 I was struggling with, so I need to turn to you again.
22 DR CALDERWOOD: And in danger of bringing the DoH right
23 into the 21st century, what I found very helpful recently
24 is Webex, a sort of virtual so you have the papers in
25 front of you wherever you are but we are all talking on
26 the phone at the same time, and it is very easy to set up
27 the software for that, but something equivalent again if
28 things are redacted, we can put specific documents on.
29 MS McINTOSH: I had my Huddle initiation discussion and
30 walked through by Webex but it is something we need to

1 talk about within the Investigation because we have not
2 got it at the moment.
3 PROFESSOR MONTGOMERY: Something that emerged in my mind
4 from the discussion is that it would be helpful to be
5 clear up front as we gather information about what will or
6 will not become public domain information when we publish
7 our report, because some stuff clearly could not be put in
8 the public domain because it is confidential, and we might
9 need to think about what should be said about stuff that
10 we have relied on but because it is confidential and
11 identifiable we could not put into the public domain. A
12 lot of this material would be disclosable under FOI and
13 therefore I am not suggesting we should be resistant to it
14 but I think being clear about how we handle it, what would
15 be made public alongside the Panel report at the end,
16 because some inquiries make all the information available
17 through a website and I do not know what the plan is here.
18 It would be good to sort that out at the beginning rather
19 than have to ask later on when you have asked for
20 information and they have not known on what basis it is
21 being made available.
22 CHAIR: I think we might ask if we can come back with
23 a proposal on that, I think that would be a good idea.
24 There is an inevitable tension between wanting to put as
25 much as possible into the public domain to ensure that
26 transparency I was talking about earlier and not
27 disclosing anything which makes somebody identifiable. It
28 is not simply a question of not having a name and so on or
29 numbers on, there is a lot of information that is already
30 in the public domain that will enable people to identify

1 individuals. We have to be careful about that. Can we
2 come back on that one?
3 MS McINTOSH: Yes.
4 CHAIR: We will sort something out. Shall we move on
5 to the next section, and you were going to update us on
6 recovery of evidence I think.
7 MS McINTOSH: We have got this letter, the letter you are
8 going to comment on, is going to be sent to all of the
9 organisations. We have spoken too and have met about half
10 of the organisations thus far and we have made our
11 timeline very clear to them. We have received material
12 already, we have received material from Cumbria
13 Constabulary who have given us a significant amount of
14 material that is required for some of our work, but not
15 all. The Trust have got it virtually all ready. We have
16 seen the cupboards (plural) of papers that we have asked
17 them to get together. The Department of Health are
18 working on the legacy material for SHAs and PCTS. There is
19 some urgency around that, not just from our perspective,
20 but because they are working to handing those files over
21 to NHS England. I have suggested to them that they have a
22 discussion with NHS England that those files, whilst legally
23 transferred to NHS England, might remain with the
24 Department of Health with NHS England having access to
25 them should they require it for anything other than the
26 work of the Morecambe Bay Investigation. That is something
27 that they have gone away to do. I have also had an
28 informal discussion with NHS England about it in the
29 spirit of them being able to see that that is a logical
30 way forward. Obviously, there just have to be arrangements

1 put in place. We obviously have a memorandum of
2 understanding in place with Cumbria Constabulary and we
3 are talking to some organisations who have concerns around
4 data protection, so we are taking some legal advice about
5 whether they can provide us information. It is not that
6 they do not want to, it is just that they have a duty and
7 responsibility for some of the data and can they give it
8 to us. They will probably take their own legal advice,
9 too, which, as employers, is an appropriate course of
10 action, but, similarly, we will have legal advice which
11 will come to you and then it will be hopefully received in
12 time to be woven into the letter explaining why we, the
13 Morecambe Bay Investigation, consider they, employer X or
14 organisation Y, can provide us with the material. That is
15 about protection. The Investigation is looking at
16 potential poor practices. It is not fair if we put them
17 under pressure to compromise arrangements that are in
18 place now.
19 There are several methods of receiving the evidence,
20 ranging from on disc ... I am just going to talk a bit
21 informally now, if you bear with me. On disc we have
22 computers that do not have disc readers. If it comes in
23 hard copy, our photocopier and scanner is not compatible
24 with ... There are some sort of practical issues that I
25 can assure you we are beavering away to try and sort out,
26 but there are several different ways. If we get pen
27 drives, our system is very secure and we cannot put pen
28 drives in to our system and it is secure for a specific
29 reason. If we bring it in off a Cloud and it is put into
30 a secure IT Cloud by the sending organisation and it comes

1 to us, it cannot necessarily be read in our database.
2 There are some real practical issues that we are trying to
3 sort out, so that everybody can have access in a smooth as
4 possible a way. They are not pertinent and relevant to
5 the Terms of Reference, but, actually, it is very
6 important about getting the procedure as smooth as
7 possible, bearing in mind what I said earlier about the
8 fact that it is taking us longer than we had anticipated
9 because of the complexity and the opportunity we have had
10 to fine tune our requirements. There are issues for us to
11 resolve - for me to resolve, sorry, it is my
12 responsibility to resolve them - so that we can then work
13 as swiftly and as efficiently and effectively as possible
14 as a Panel, but there are challenges. If you write to an
15 organisation, they will send you a hard copy or they will
16 email you documents and, if you have made, say, an FOI
17 request, then that is an agreed method of communication
18 from them to your. Ours are just very different types of
19 requests. They are just some sort of administrative issues
20 that have to be resolved, really. The organisations that
21 we have been dealing with are very clear that they will be
22 receiving a letter in the next couple of weeks.
23 CHAIR: Which is the draft that we have been talking
24 about.
25 MS McINTOSH: Yes, something from the draft, that they will
26 receive something. I think that we have to be reasonable
27 about the turnaround times and we also have to be
28 reasonable in understanding that they might be able to
29 provide the first half of it or one, three, five and nine
30 very quickly, but, actually, the remaining questions we

1 are asking might just take us a bit longer. Obviously, we
2 cannot go on forever, but I think that we have to be
3 reasonable, because, if we want to maintain the goodwill
4 that you have been striving to achieve, and we need to
5 maintain that.
6 CHAIR: Fine, but I think that we need to make sure
7 that we do keep the impetus up. I think that that
8 underlines the fact that this is not a sequential process.
9 We are not going to do all the documentary analysis and
10 then take the verbal evidence. We have to start
11 overlapping that. Catherine.
12 DR CALDERWOOD: I am sorry to take us back to the patient
13 confidentiality part. If we are asking the Trust for
14 named data, can we do that?
15 MS McINTOSH: That is what we are taking legal advice about.
16 CHAIR: Yes, we can. I am absolutely clear that we can.
17 I am slightly cynical about legal advice. If the Trust are
18 paying a lawyer to say that they cannot disclose it, then
19 the lawyer will tell them that they cannot disclose it.
20 You know that is how the legal system works. I am
21 absolutely sure that there is provision in the relevant
22 Act for independent investigations to be given this data.
23 DR CALDERWOOD: It was just to be clear, because ... well, the
24 medics are bound by a very clear code of conduct and this
25 then is data being seen by non-doctors, but, of course, I
26 am not these people's doctor, so, as a doctor, I am not
27 entitled to see data of patients unless it is clearly said
28 where we are using it.
29 CHAIR: And one of those is in an investigation which is
30 clearly directed at improving the quality or safety of

1 services.

2 PROFESSOR MONTGOMERY: I do not think that that is going to be a

3 problem, but it just needs to be bottomed out. It does

4 relate to the question that I asked earlier about what we

5 are going to do with it, because part of the answer to

6 that is that we will be able to guarantee that our usage

7 will only be within the scope of that purpose and that is

8 why we need to be clear how we are keeping it

9 confidential, other than for our purposes, and our usage

10 of it is only in the capacities that we render the Panel

11 to.

12 CHAIR: Absolutely.

13 MR BROOKES: And, Bill, there is no question of there needing to

14 be individual patient consent for their data to be looked

15 at?

16 CHAIR: No, not under those circumstances.

17 MR BROOKES: I have one slightly askew point that went through

18 my mind when Oonagh was talking. There will be

19 information that we have requested which potentially they

20 cannot find, so it is really important to understand what

21 has been found and what has been asked for. That tells

22 you something as well.

23 MS McINTOSH: Yes, absolutely. Just following up that point,

24 Julian, I was talking to one organisation who said that it

25 is our policy that after seven years we destroy those

26 records and that is their policy. They showed me the

27 policy. Therefore, they said that, if our policy has been

28 operated properly, they may not exist now, but that is

29 again a proper application of a policy and a procedure and

30 they will need to explain that to us.

1 PROFESSOR MONTGOMERY: We also need to test that ...
2 MS McINTOSH: Absolutely.
3 PROFESSOR MONTGOMERY: They may say that they have destroyed
4 them, but that they have not always done so.
5 MS McINTOSH: Absolutely. I need to cover that in the letter as
6 well.
7 PROFESSOR MONTGOMERY: I think there are specific exceptions
8 for maternity records as well.
9 PROFESSOR FORSYTH: Yes, I would be surprised if the information
10 we want has been destroyed because most policies say until
11 they reach the age of 21 or something.
12 PROFESSOR MONTGOMERY: And board papers as well.
13 MS McINTOSH: But in there we might ask for some HR staff
14 information and those records may not exist. Thank you.
15 CHAIR: Are we content with that update on progress?
16 [Yes] Shall we move on to item 4? This one is about
17 glossary of terms and chronology of events in two halves.
18 I think that one of the fascinating features of working
19 around the health service over the last 40 years has been
20 the fact that everybody has different terms for the same
21 things, different locations, different professions,
22 different time periods, things are changing over time. I
23 thought that I knew what "PID" meant as a gynaecologist
24 and then I met an orthopaedic surgeon who said it meant
25 something completely different. That is just one very
26 small example. To avoid confusion, I think that we need
27 to have an agreed set of terms and definitions and we need
28 to understand how they have changed over time. An example
29 more pertinent to us, I think, is that I am reliably
30 informed that what I knew as serious untoward incidents

1 are now called serious incidents requiring investigation,
2 so they are not SUIs any more, they are SIRIs. I am
3 proposing that we do some work and that you will be able
4 to help me out in your particular area to identify what
5 the relevant terms are to start with and then come to a
6 standardised version. Are you content with that? [Yes]
7 At paper 1.3 you have the beginnings of a chronology
8 of events. Do you want to say a brief word about that,
9 Oonagh?
10 MS McINTOSH: Yes. It is by no means complete, because,
11 obviously, we have not got the evidence in and, obviously,
12 it is the period in our Terms of Reference which is 1
13 January 2004 to 30 June 2013. What I have included in here
14 are those individual cases that we, the Investigation,
15 have been made aware of, anonymised, obviously. Key
16 appointments within the Trust, within regulatory
17 authorities, key reports, included in our Terms of
18 Reference, some of which we were unaware of until we
19 started gathering some evidence and some material. There
20 is a lot of information there about serious untoward
21 incidents and the process, Julian, that they went through
22 by way of risk assessments and the governance procedures
23 and gold command and things. There are several references
24 to visits and investigations that have taken place
25 primarily at the Trust. It is more Trust focused than what
26 happened in the other organisations that had a governance
27 role. That is a sort of gap on proceedings. Some of this
28 information will need to be validated through the evidence
29 that the Investigation gathers. I have also recorded in
30 the key meetings between Department of Health Ministers

1 and regulators or local MPs and the process about granting
2 University Hospitals Morecambe Bay Trust Foundation Trust
3 status and the timeline for that and the process that it
4 went through. Obviously, it concludes with the
5 establishment of the Investigation. Again, it is a first
6 stab at something and I see it as something that will need
7 to be strengthened. It will need to be standardised in its
8 approach. Within the Investigation we have decided only
9 yesterday that the hospital has so many different names
10 and people call it different things. We would call it what
11 it is now which is University Hospitals of Morecambe Bay
12 NHS Foundation Trust (the Trust) and thereafter it will be
13 "the Trust". And, when we are talking about "the Trust",
14 we are only talking about University Hospitals Trust,
15 because, actually, it is called so many different things.
16 It is just about getting a level of consistency and a
17 level of detail.
18 Again, I would appreciate two things, please, one
19 would be people's comments on it, good, bad or
20 indifferent, but mostly what else would you like to see in
21 it, because I think that, without trying to pre-empt your
22 role and your work, I think that this is an important
23 document for us to contribute maybe towards the report to
24 present to the readers and recipients of the events that
25 took place and just to be able to give people a sort of
26 overview. I will just take comments.
27 CHAIR: I think that establishing a good solid
28 chronology is absolutely fundamental to do this. You
29 cannot put everything into its proper context until you
30 understand the chronology. I have only got two very brief

1 comments and then I will ask for other people's views. One
2 is that we have anonymised as far as we can all of the
3 cases except one. I know that that one is already in the
4 public domain because of the activities of his father, but
5 I think for the consistency we ought to treat them all in
6 the same way. The second is that in or two places we have
7 people standing down, but we do not have a record of when
8 they started, so we need to do starting and finishing.
9 PROFESSOR MONTGOMERY: One of the points was very similar to
10 that one. We have quite a lot of names and identification
11 of roles outside of the Trust. We do not have much sense
12 of who the leadership was to start with and then a bit
13 later on we discover when some people step down, but that
14 would be a really helpful thing to pick up.
15 MS McINTOSH: Apologies, it is something that I meant to mention
16 earlier. Every time we go out and talk to any of the
17 organisations, I am asking them to start work now - and
18 they have already started work - on organigrams. I should
19 have said that earlier. That hopefully will be very
20 helpful, because, when we get an email from Jonathan
21 Montgomery to Oonagh McIntosh, we will not actually know
22 what Jonathan Montgomery's role was and what Oonagh
23 McIntosh's role was, but, actually, if we know that you
24 were the medical director and I was the - I don't know Joe
25 Bloggs, whatever. I am asking for that which is,
26 actually, background information for Panel members. I am
27 sorry, I should have said that.
28 PROFESSOR MONTGOMERY: I picked that up from the letter. I could
29 see you were doing that. There is something around looking
30 at those together, because we do not want the Panel to

1 become so cluttered that you lose the sense of chronology.
2 MS McINTOSH: Absolutely.
3 PROFESSOR MONTGOMERY: On the other hand, we need a way of
4 saying, "Hang on a minute, in 2005 who was doing what?"
5 If we can find a way of ...
6 MS McINTOSH: It is almost two chronologies.
7 PROFESSOR MONTGOMERY: Yes.
8 MS McINTOSH: There is a chronology of roles and
9 responsibilities within all the organisations that
10 actually shows the arriving and the departure and then
11 there is a chronology of events. Is that a way of doing
12 it?
13 PROFESSOR MONTGOMERY: With web technology it should be possible
14 to open them both us and look at them alongside each
15 other. I would not be in favour of cluttering this up by
16 putting everything into it, but I would be in favour of us
17 thinking about how would it become possible to say, if I
18 am looking at March 2008, who was it who was the medical
19 director or whatever at that stage, because sometimes you
20 need that to make sense of the documentation.
21 I think there is something around the anonymity which
22 I wonder whether we might consider which is I will find it
23 very difficult to think about these as letters or numbers,
24 I would rather have a name. I wonder whether we might
25 invite the families, whether they would like to pick a
26 pseudonym, so that, actually, when we are talking about
27 it, it is something that feels like a real person not a 1,
28 A2 or whatever. That is in a research context, because I
29 think that otherwise we will lose sight of what this is
30 actually about.

1 CHAIR: It becomes depersonalised.

2 PROFESSOR MONTGOMERY: Yes, absolutely. That may be one of the
3 problems that we uncover because things became
4 depersonalised. I do not think that we should fall into
5 that trap. I think that we need a mechanism for us
6 flagging up. If we spot something in documents that we
7 feel deserved to be on the chronology, I do not think that
8 we should just put it in, because it will become too
9 cluttered, but I think that we need a way of flagging up
10 that this might be a significant thing that does deserve
11 to be there.

12 MS McINTOSH: It is almost kind of a set of house rules. That
13 sounds a bit awful, but it is all part of how we
14 will work, but there is some sort of administrative
15 aspects to it.

16 PROFESSOR MONTGOMERY: It is almost a house style. If you want
17 to say something, if you do it in this way, we will use it
18 the way that you expect us to use it, whereas, if you
19 describe it something differently ...

20 CHAIR: I agree.

21 MR BROOKES: Just as someone who has done this, it is incredibly
22 complicated and you never get it quite right, so accepting
23 that. My experience was building it from the bottom
24 upwards is the way to be. We will need to be clear in
25 terms of where we are looking at specific cases of the
26 chronology of that particular case. I think that the
27 overall chronology sort of flows out of those individual
28 component parts. As you said, there is an organisational
29 chronology of what happened, who was responsible, what
30 positions at particular times. That overlaps with the

1 individual cases and what happened around those individual
2 cases. I think that it is difficult to start at the top
3 and work downwards. It is much easier to work from the
4 bottom upwards as you get specific information, and, yes,
5 the trick then is what is actually relevant in terms of
6 that overall chronology.
7 DR WALTERS: There is absolutely nothing here about consultant
8 medical staff either.
9 CHAIR: That is true.
10 PROFESSOR FORSYTH: Just in relation to chronology, I am a great
11 supporter of chronologies as well. I can see that this
12 chronology is already getting slightly mixed with babies
13 and Care Quality Commission etc. I can see, in fact, that
14 we will probably build up a number of different
15 chronologies and, in particular, clinical chronologies,
16 which, as you have suggested, would break down almost to
17 individual babies or mothers or whatever, so we can have a
18 sort of clinical chronology. You say that you are looking
19 at March 2008 and then you can look at the chronology of,
20 well, what was the local management chronology and what
21 was the sort of strategic health, Care Quality Commission.
22 PROFESSOR MONTGOMERY: If this is on an Excel spreadsheet,
23 actually, to be able to filter it would be really useful
24 if we thought that we would just like to see the medical
25 chronology or the paediatric chronology or the maternity,
26 actually, it should be possible to have one document that
27 we can look at in different ways.
28 PROFESSOR FORSYTH: I think that that would be much more helpful
29 on a practical basis and would help us again to keep us
30 focused and have some organisation to our thinking and

1 also our elections.

2 DR CALDERWOOD: I see you have listed in April the commissioning

3 of the trust maternity and new born services.

4 MS McINTOSH: Which year?

5 DR CALDERWOOD: It is this year. It has been commissioned in

6 April and what you have called it is "The Trust Review

7 Report Maternity and New Born Services Gold Command". Do

8 we have a timeline for that?

9 MS McINTOSH: I do not know at the moment. I will have to find

10 out.

11 DR CALDERWOOD: And how do we interact with it.

12 MS McINTOSH: Right. I will find out.

13 DR CALDERWOOD: I do not know, but is that what has to come out

14 when there is a gold command, a level of concern ...

15 CHAIR: I actually have a feeling that that was last

16 year and not this year.

17 PROFESSOR MONTGOMERY: I think there were two. There is one in

18 April 2012 and there is one in April 2013.

19 CHAIR: We will have to clarify that. Is there anything

20 else on that item? [No] Shall we move on? It is half-

21 past-12. Do we need to break now or can we take Hannah

22 before?

23 MS McINTOSH: I think there is some logic in actually taking

24 Hannah now if we can.

25 CHAIR: I agree, in terms of the logic, as long as

26 people can hold on for however long it takes. Can I ask

27 Hannah to introduce item 5 on analytic work.

28 MS KNIGHT: I have a couple of slides. There is also a paper

29 1.4 in the packs that the panel has access to. I thought

30 that it would just be worth saying a few words about the

1 approach that is being developed and how we are in the
2 very early stages of developing the approach for the
3 analytical part of the work, the investigation. I am very
4 happy to take advice and suggestions from those present
5 today. I am going to be focusing on quantitative data
6 really and data we hope to gain from various sources, both
7 from the Trust itself and from the national sources of
8 data, so we can make comparisons. Please stop me at any
9 point if I get too technical.
10 The first is in relation to the first Term of
11 Reference, through the outcomes, mothers and babies, that
12 occurred during the period of investigation, including
13 maternal and neonatal deaths. I have just documented a
14 few of the possible lines of inquiry that I have come up
15 with so far that I think will be important to address and
16 I am very happy to take advice now or when I finish this
17 short presentation. The first two possible lines of
18 inquiry are related to mortality and looking at whether
19 the Trust was a nation outlier for maternal neonatal
20 mortality - one might extend that to perinatal mortality
21 rather than just neonatal mortality during the period of
22 investigation, and was mortality at the Trust higher than
23 expected for particular causes of death.
24 The third possible line of inquiry is related not to
25 mortality but to the general quality of care. We know
26 that mortality can sometimes be the tip of an iceberg and
27 so morbidity and other complications will be important for
28 us to look at some questions about maternal complications,
29 neonatal complications and other things such as infections
30 and maternity service user experience about which there is

1 some national data available. So the types of maternal
2 complications that we might be able to look at include
3 admissions to intensive care and postpartum haemorrhage
4 and other severe septic complications and readmission to
5 hospital within 30 days and VTE, which is venus thrombo
6 embolism.
7 Neonatal complications which I think there is data
8 available, include injury to the neonate, Apgar score
9 which is a measure that is taken normally at one minute
10 after birth, five minutes and then ten minutes. That is a
11 score out of 10. If the Apgar score is less than 7 at
12 five minutes that is one quality indicator that has been
13 used in some cases. Percentage of term babies admitted to
14 neonatal care and readmission of babies to hospital within
15 30 days, that is unplanned readmission. These are some of
16 the possible quality indicators which perhaps we can talk
17 a bit more in detail about later.
18 These are some of the considerations and I think it
19 is quite important for us to think about in relation to
20 both the availability and the quality of data at the Trust
21 itself and on a national level. We also need to consider
22 the availability of data on patients in the Trust who are
23 then transferred to other institutions, we need to be able
24 to link data so it will therefore be important to have
25 identifiers. And also we will require patient level data,
26 if we want to case mix adjust which means taking into
27 account the characteristics of the population treated at
28 this hospital. If we want to make national level
29 comparisons it is important to take into account the types
30 of patients treated at each hospital.

1 DR CALDERWOOD: Just in relation to the maternity data,
2 Hannah, or is this everything?
3 MS KNIGHT: This is everything, I am used to working with
4 maternity data but there are sources of data available,
5 neonatal care, which I will talk about in a moment.
6 So far my work has involved scoping out potential
7 sources of data that we may wish to request. Some of
8 these are more readily available than others, so it will
9 be a case of going to the organisations that hold this
10 data and requesting it. We have begun to do that with the
11 Trust already, so in terms of maternity records the
12 majority of Trusts now use an electronic maternity
13 information system to capture detailed information about
14 the patients under their care. We are in discussion with
15 the Trust to determine whether they have an electronic
16 maternity information system and at what point that was
17 introduced and to look at whether we can get extracts of
18 that data covering the period of the Investigation.
19 Maternity data is also recorded on hand held notes. That
20 might be more complicated to analyse in bulk because it
21 would require somebody actually transferring the data from
22 the notes into a database of some kind. It might be
23 possible from a statistical point of view to look at a
24 sample of handheld notes for the period if the electronic
25 data is not available.
26 Maternity dashboards, these are a clinical governance
27 tool that was recommended by the Chief Medical Officer
28 back in 2008 and now I think the majority of maternity
29 units use such a dashboard. It is usually produced on a
30 monthly basis and it is a sort of overview of some key

1 statistics focusing on activity in the unit, workforce and
2 clinical outcomes. So we have asked the head of midwifery
3 at the Trust whether maternity dashboards were used and
4 when they were introduced and if we can have access to
5 that data. Some Trusts also purchase benchmarking
6 services from commercial companies, so Dr Foster and CHKS
7 were the two main companies that provide this service. We
8 were also asking head of midwifery whether and when they
9 had access to this benchmarking data and if we could have
10 access to that.
11 Then finally in terms of the source of data held by
12 the Trust longstanding maternal and perinatal confidential
13 inquiries programme began sending out Trust level reports
14 and I think there are different dates for maternal and
15 perinatal mortality respectively, but the Trust does hold
16 some. When they were sent Trust level reports identifying
17 the Trust on national data plots. They do hold those so
18 we will be asking for them.
19 Then in terms of national sources of data we could
20 use to compare the Trust performance with other Trusts in
21 the region or other similar trusts throughout England, and
22 the first that comes to mind is hospital episode
23 statistics. This is a record of every single admission to
24 the English NHS and it goes back to 1989. It is at the
25 patient level so you have a record of any procedures or
26 diagnoses that were made during that patient's hospital
27 admission and for admissions that included the delivery of
28 a baby there should be supplementary data items available
29 which could be of interest to the Investigation and also
30 mode of delivery and how the labour was started, what then

1 happened, what was the birth weight of the baby,
2 gestational age etc, and this data from hospital episodes
3 statistics can be linked with the Office for National
4 Statistics to identify cause of death, if the death
5 happened after hospital discharge.
6 I have already mentioned briefly the confidential
7 inquiries data and there is a bit more about this in the
8 document, but CMACE was disbanded in 2011 and has now been
9 reincarnated as MBRACE but it does mean there is a gap of
10 a couple of years in the confidential inquiries programme,
11 so CMACE collected data up until 2009 and MBRACE then
12 started in 2012 and looking back one year retrospectively,
13 but every maternal death that happens in England and in
14 the UK I think is subjected to confidential inquiry and
15 for perinatal deaths I believe there is a sample of
16 perinatal death that is reviewed confidentially by some
17 expert.
18 DR CALDERWOOD: We know all the numbers, but yes, a sample is
19 looked into in detail.
20 MS KNIGHT: So that is an important source of data that you
21 may wish to consider. The national neonatal audit
22 programme is run by Neena Modi's team at Imperial College,
23 London, I think it was 2006 that that started, and it
24 collects detailed information on every baby that is
25 admitted to neonatal care. It seeks to address 11
26 questions. I have not worked with that data before but
27 maybe it is an organisation that we would wish to approach
28 and see if data is available for the institutions to which
29 babies were transferred from the Trust.
30 The National Reporting and Learning Service, this

1 came under the wings of the National Patients Safety
2 Organisation but as of 1st April that function has
3 transferred to NHS England. This is the body that monitors
4 events and SUIs should be reported to, and again that
5 data is available in free text which makes it slightly
6 more difficult to analyses. You can look at overall
7 numbers but if you want to look at what is actually going
8 on in each dated incident it is possible to analyze it but
9 it is a bit more time consuming because it is free text.
10 PROFESSOR MONTGOMERY: But there is something which would
11 come out of that which I would be quite interested to see,
12 which is when you report snapshot, organisation by
13 organisation, it gives you a sense of reporting rates and
14 also incident rates.
15 MS KNIGHT: Yes, those are available on line. I think those
16 would be useful.
17 PROFESSOR MONTGOMERY: I think that they would be useful for us
18 to see, because we would get a sense of what was available
19 to the Trust as a picture coming out of that as well as
20 the individual data that you are talking about.
21 MS KNIGHT: Yes. The NHS Litigation Authority. They administer
22 a database of all claims made by patients and families
23 against the NHS. We have not had sight of the precise
24 content of this database, but it would likely contain a
25 detailed report of each claim, including maternity and
26 neonatal claims. Finally, on this slide is the Care
27 Quality Commission's maternity experience survey, which
28 has been carried out three times, every three years since
29 2007. The 2013 report is due in December. This takes in
30 about 25,000 maternity records and also gives a Trust

1 level summary to each maternity unit.

2 PROFESSOR MONTGOMERY: I think that we will get these already

3 from the enquiries that Oonagh is making of the Trust, but

4 the clinical negligence scheme for Trust's assessments

5 would be really important for us to see. I think that we

6 will get those from the Trust enquiry. I do not think that

7 we need to go directly to the Care Quality Commission.

8 MS KNIGHT: There are a couple of other sources of data that are

9 not national but may be useful for comparison. The West

10 Midlands Perinatal Institute hosts the peer database which

11 holds approximately 150,000 maternity records and it is

12 very detailed. I think that there are about 100 data items

13 available per delivery. Then the Royal College of

14 Obstetricians and Gynaecologists, which I work for, is

15 developing a database again at patient level holding very

16 detailed clinical information of 100,000 deliveries from

17 15 Trusts throughout the UK, so those are two other

18 potential sources of quite detailed clinical information

19 that could be used to make comparisons.

20 There are just a couple of other data sources to

21 consider. Workforce. I know we will be getting a lot of

22 information from the trust and from the HR department

23 there. There is also data available about the workforce

24 from various sources, including the Health and Social Care

25 Information Centre. The Royal College of Obstetricians

26 and Gynaecologists conducts an annual census which asks

27 for information about consultants and consultant presence

28 on the labour ward policy. Then the Local Supervising

29 Authorities hold data on the number of midwives registered

30 in each Trust. So we should be able to look at things

1 like the midwife to birth ratio and the consultant
2 presence on the labour ward. Also staff satisfaction is
3 captured by the General Medical Council in its staff
4 survey and in its trainee survey. Clinical negligence
5 claims and payments, I have already covered. Finally, bed
6 occupancy rates. That data is also available at a national
7 level.
8 I would like to ask if there are additional sources
9 of data that the Panel is aware of which we want to feed
10 into this scoping exercise and then other potential lines
11 of enquiry which you may be able to address using the data
12 that is available.
13 CHAIR: Thanks, Hannah. I would ask for some comment.
14 I think that we will give you the opportunity to feed back
15 subsequently as well, if you would like to do that.
16 Jonathan, would you like to start?
17 PROFESSOR MONTGOMERY: Yes. There are a couple of things that
18 struck me. One is around the handheld records. I think
19 that we should come back to this after we have heard from
20 the families about what really is important, because if we
21 try and find everything that could be there we might hold
22 the whole thing up and it may not add very much to what we
23 need to find out about. I am not keen that we wait too
24 long before we get into things. I think that that is quite
25 important.
26 The other thing that I am not sure that we can pick
27 up from this, but came up in one of the reports, it was
28 around the degree of choice that women had about where to
29 have birth and the suggestion that there were people who
30 were quite high risk signing disclaimer forms as opposed

1 to having proper discussions about what their choices are.
2 I just wonder whether we could get some data on where it
3 was planned for people to have babies and where they
4 actually had their babies to get a pattern, because you
5 will get transfers from that.
6 MS KNIGHT: Yes.
7 PROFESSOR MONTGOMERY: Something about whether or not it was
8 going as people expected would be quite interesting for me
9 to know.
10 MS KNIGHT: The data field is there and is asking for intended
11 place of birth and actual place of birth, but whether that
12 data is actually submitted is another thing that I will
13 have to look into.
14 MR BROOKES: Just a very quick one. I am not an expert on the
15 data sources, so I am not going to comment, but I would
16 quite like to be able to understand the answer to the
17 question of what data sources were they using, because
18 there is a difference between what might have been
19 available and what they were actually using and what were
20 they doing with that information. It is a slightly
21 different question. It is not about what data sources were
22 available, it is what was being actually used to analyse
23 and give them confidence in terms of their governance that
24 they were providing safe and secure and effective
25 services.
26 PROFESSOR FORSYTH: I think that it appears to me, listening to
27 your presentation, that there are two aspects to this, one
28 is the maternity and neonatal services and the data
29 related to that particularly. Of course, that is the main
30 focus. But also clearly there is the wider data which

1 gives a feel for performance across the Trust as well. I
2 think that what we probably need to do, as the discussion
3 goes on, is identify questions that we feel are really
4 important and have the questions driving the analysis of
5 the data rather than just a whole lot of figures which
6 probably might not be terribly relevant. I think that one
7 thing from my perspective that I am keen to learn fairly
8 quickly - and I do not know if we have got information -
9 is how maternity and paediatrics are delivered across the
10 Trust. I do not have a feel for that yet in terms of the
11 number of beds, the number of deliveries, transferred,
12 where they transfer to, where are the critically ill
13 babies transferred to for subsequent care. So the whole
14 sort of arrangements for maternity and paediatric services
15 in this region would be really helpful information for me.
16 CHAIR: Are there any other comments? Do feel free to
17 submit any more comments to Hannah subsequent to the
18 meeting. I am going to draw to a close temporarily for
19 lunch now, because I am concerned that we have enough time
20 to talk to you folks after lunch. We will be fairly
21 disciplined. We will come back here in no more than half
22 an hour.
23 MS McINTOSH: We will reconvene at 20-past-one.
24 (Short Adjournment)
25 CHAIR: I am sorry, we have missed our deadline by a
26 few minutes, that is not a very good start, is it? I do
27 apologise. What I am very keen to do now is for us to
28 hear from you individually, because I have had the
29 privilege of talking to some of you individually over the
30 summer and I know that it was a very important part of

1 forming my early thought processes about all of this.
2 Nevertheless, I think that in view of the time we do need
3 to crack on. I think that it would not be appropriate to
4 do this with everyone here en mass. I think that it would
5 be much preferable if we could ask each individual family
6 group to come in individually. I am going to ask if you
7 would all do me the favour of stepping out briefly -
8 hopefully fairly briefly - and we will ask you to come
9 back in one at a time. What I would like you to do when
10 you do come in is just to come and sit here and just talk
11 to us about what happened to you and what your particular
12 expectations and hopes are of the review, if there are any
13 questions that you want to ask us and then, when we have
14 concluded that part of the meeting, I will ask everybody
15 who is still here to come back in and we will continue
16 with the meeting at that point. Is that all right? Thank
17 you.
18 (All families left the room and returned one family at a time to talk to the Panel)

Later

19 (All families came back into the hearing)
20 CHAIR: Thanks for waiting. I appreciate that. Can I
21 just say on behalf of all us, I am sure, how immensely
22 valuable we found that. I know that it was difficult for
23 all of you, but it was really very much appreciated and I
24 think it impossible for us to properly understand the
25 context of all this without what you have done previously
26 and today, so thank you.

1 Having hoped otherwise, we have now bust our time schedule
2 comprehensively. A quick consultation with Oonagh says
3 that we can hold over items 7, 8 and 9 until the next
4 meeting, so I am going to go straight to item 10 and ask
5 whether anybody has any other business. If not, then I am
6 going to let you know that the date and venue of the next
7 meeting is Wednesday, 11th December at 11 o'clock in this
8 room. Thank you again for coming. Thanks for the Panel for
9 coming and see you in a fortnight.
10 - - - - - - -

Morecambe Bay Investigation – Panel Meeting

Action Points

28th November 2013

The Park Hotel, East Cliff, Preston PR1 3EA

Present:

Families

Panel Members
Bill Kirkup - Chairman
Catherine Calderwood – Expert Adviser, Obstetrics
Geraldine Walters – Expert Adviser, Nursing
Jonathan Montgomery – Expert Adviser, Ethics
Julian Brookes – Expert Adviser, Quality and Governance
Stewart Forsyth – Expert Adviser, Paediatrics
Oonagh McIntosh - Secretary

Jacqui Featherstone – Expert Adviser, Midwifery

Agenda item no.	Action point	To be actioned by	Date for completion	Progress
1.2	Oonagh to circulate draft letter to panel members	Oonagh	29/11/2013	Completed
1.2	Panel members to comment on the draft letter	All Panel members	4/12/2013	Completed
1.2	Draw up a protocol of working arrangements between the Panel & Secretariat	Oonagh	January 2014	Outstanding
1.2	Produce a log of what evidence has been distributed to Panel members. Ensure a process of cross referencing to ensure nothing is missed	Paul	January 2014	Outstanding
1.2	Check if Huddle works with iPad	Paul	29/11/2013	Completed
1.2	Protocols for using Huddle	Paul	11/12/2013	Completed
1.2	Share search terms with Panel and seek views for additional terms	Paul	11/12/2013	Outstanding
1.2	Explore options for Webex	[redacted]	January 2014	Outstanding
1.2	Draft a proposal for what information will be in the public domain both now and later in the investigation	Oonagh	January 2014	Outstanding
1.2	Comments to be sought on timeline	Panel	11/12/2013	Draft for comment
1.3	Obtain relatives views on using pseudonyms	Oonagh	20/12/2013	Outstanding
	Identify additional search terms from Panel meeting	Paul	11/12/2013	
6	Obtain PALS (Patients Advice Liaison Service) reports (as raised by Mr & Mrs Tooze)	Paul [redacted]	January 2014	Outstanding
6	Obtain relevant evidence from families discussed during Mrs Bennett's evidence	Paul/[redacted]	January 2014	Outstanding

Brief paper for Bill Kirkup following first panel meeting on 28/11/13

1. The discussions with the families were very helpful however raised questions for me as an obstetrician of very serious issues in protocols, following recognised national guidelines, quality of intrapartum care, professionalism, professional relationships, risk reporting, governance , learning and culture. One example is the fact that a maternal and neonatal death, 2 intrapartum stillbirths, a neonatal death and an intrapartum birth injury were not reported within the Trust as SUIs.

2. We urgently need to ask the Trust to allow us to see any reviews of clinical cases which took place either internally or by external bodies as there will be no SUI reports to examine. We also need to see any actions which arose out of these reviews.

2.I believe that the number of the events we have been reported makes Furness General Hospital an outlier in relation to numbers of intrapartum stillbirths and early neonatal deaths due to intrapartum issues. Data is not collected separately for intrapartum stillbirths. We expect intrapartum stillbirths to be 5-10% of all stillbirths. We would therefore expect an intrapartum stillbirth 1 in 2000 to 1 in 4000 births . However it is my feeling (corroborated by data from a unit of similar size) that this rate would be considerably lower in a small unit although this may be difficult to find more formally.
I have asked the team at MBRRACE-UK the current provider of the new confidential enquiry data into maternal and perinatal deaths to examine the legacy data they have from CMACE perinatal mortality report which last collected data from 2009 to examine the data from FGH or from the Trust depending on what was collected. They also inform me that the unit will have been sent their own data and the funnel plots which are produced and we can request these if they do not have them. They will also look at the incomplete dataset from 2010-2012 and inform us about the data from the Trust which they received.
The director of the NPEU which hosts MBRRACE-UK is Prof Jenny Kurinczuk
Jenny.kurinczuk@npeu.ox.ac.uk

3.The gap in the inspections and reviews which have already occurred is that of clinical case note review- pending result of trust response at point 2.
I believe we should ask a respected and experienced team to perform a review of case notes of perinatal deaths. The extend of which would need to be scoped out
Eg FGH or whole Trust, all stillbirths or intrapartum stillbirths and early neonatal deaths. At the present time the families have information regarding their babies deaths obtained through negligence cases in court which have a very specific focus and have not received answers regarding clinical care from the NHS.
I believe we should also ask for a review process by a respected and experienced multidisciplinary group into the maternal deaths which have occurred. These will have been reviewed as part of the confidential enquiry process however it is not possible to de-anonymise this process and access this review for learning specifically for the Trust and for information for the family subject to response from the Trust to point 2.

4. The inspections have not examined the working of the unit 'at the coal face'. There appears to have been little interaction with medical staff, in particular the clinical lead for obstetrics and the medical director. We should consider an inspection of the sort which the RCOG performs or the new CQC process (if this has not already been done) which examine protocols and guidelines and if these are being followed rather than merely seeing that they are present. They also interview staff.

Additional concerns

5. The Trust most recent application for CNST was at level 1- this was achieved in Sept 2013. Previously CNST level 2.

6.MBRRACE the new confidential enquiry process has required the identification of a contact person to co ordinate the return of information on maternal and perinatal deaths through a secure web portal. There were 6 trusts who were very slow in engaging in this process. The Trust of one of these 6 but have now engaged however they have not yet appointed a lead user which is also expected. There has been one perinatal death in the Trust in Q1 of 2013 according to ONS data- this has not been reported to MBRRACE-UK. Data for Q2 will be available on 11/12/13.

7. an FOI request by [redacted] has given the data that there are currently 34 open claims in obstetrics from the Trust with the NHSLA.