An independent investigation into potential missed opportunities for identification and avoidance of possible harm to paediatric orthopaedic patients at Cambridge University Hospitals NHS Foundation Trust

A report for
Cambridge University Hospitals NHS Foundation Trust

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1. Executive summary

Introduction and background

Scope and context

1.1 Verita conducted this independent investigation commissioned by Cambridge University Hospitals NHS Foundation Trust (CUH) into potential missed opportunities to identify and avoid harm to paediatric orthopaedic patients under the care of Ms Kuldeep Stohr, Consultant Paediatric Orthopaedic Surgeon.

1.2 Concerns were raised in 2024 about patient outcomes and aspects of Ms Stohr's decision-making. An external review confirmed issues with her operative technique and judgment in complex hip surgeries. Ms Stohr has not practised since she began a leave of absence in March 2024. The Trust formally excluded her from work in February 2025.

1.3 This report sets out to show what was known about Ms Stohr's practice, when it was known, and whether earlier intervention could have prevented harm. This investigation does not review individual patient care (covered by a separate clinical review).

1.4 CUH is one of the largest hospital trusts in the UK, providing specialist services regionally and nationally. Paediatric orthopaedics at CUH deals with complex musculoskeletal conditions in children, characterised as 'low volume – high complexity' work where outcomes focus on improvements to quality-of-life.

Part one: Concerns raised in 2015/16

Concerns raised about Ms Stohr's practice in 2015 - 2016

1.5 Ms Stohr joined the Trust in 2012, in her first consultant post. In December 2015, her colleague, Consultant A, raised formal concerns with Trust management about Ms Stohr's surgical technique and decision-making.

1.6 To investigate these concerns the Trust's Deputy Medical Director A commissioned an external review so that the concerns could be evaluated. This was a proportionate response to the concerns.

1.7 The Trust identified Mr Robert Hill, an experienced and senior paediatric orthopaedic surgeon as the external reviewer. Mr Hill's desktop review of ten cases confirmed technical and judgmental concerns about Ms Stohr's surgical practice.

1.8 In our view the advice and the recommendations made by Mr Hill comprised a package of practicable steps that Mr Hill believed would help the Trust, and Ms Stohr, to make improvements across a range of measurable activities.

The Trust's handling of Mr Hill's review and report

1.9 We consider that Deputy Medical Director A, and his colleagues only partially understood Mr Hill's report and concluded that Ms Stohr's clinical competence was not in question. They appear to have interpreted Mr Hill's report as evidence that Ms Stohr could safely carry on practising. The result was that she was not restricted from practising surgery or placed under closer supervision from then on.

1.10 Apart from the small number of staff who were involved in the commissioning and immediate handling of the Hill report, we found no-one else who knew about the report, or its findings from 2016 until early 2025.

1.11 We consider that Deputy Medical Director A's summary of Mr Hill's report - as communicated to Ms Stohr, Consultant A, and the Director of their Division was inconsistent with its findings, advice, and recommendations. We believe that Deputy Medical Director A's summary diluted the messages that needed to be sent to Ms Stohr about her practice.

1.12 The Trust missed an opportunity in 2016 to address deficiencies in Ms Stohr's clinical performance.

1.13 This presentation of the Hill report led to inadequate managerial follow-up of the recommendations it contained. There was inadequate planning for what actions needed to be taken by management and Ms Stohr to deliver improvements to her practice. This was

compounded by a lack of clarity about who would be responsible for ensuring any actions were taken, beyond the establishment of a paediatric orthopaedics multi-disciplinary team (MDT) meeting.

Actions taken following the Hill review

1.14 We believe that nothing substantial was done by the Trust to address any of Ms Stohr's clinical practice shortcomings. We saw no sign that anyone in management had set out a plan of activities she should undertake to improve her performance. Other organisational improvements advised by Mr Hill were not enacted.

1.15 We found no evidence that Datix incident reports or duty of candour notifications were made for patients identified as harmed in the review, and no entries were added to the divisional risk register. The Trust therefore failed to learn from these issues at the time.

1.16 Ms Stohr set about to address what she interpreted from the Hill review as organisational governance failures by setting up a weekly MDT for paediatric orthopaedics.

1.17 In respect of her own practice, she sought peer feedback and learning opportunities independently, attending the paediatric orthopaedic MDT meeting at a nearby hospital. Her actions demonstrated recognition of the review's criticism and an effort to improve.

1.18 We found no evidence that anyone from the Trust facilitated or provided any support for her in these endeavours. We believe that senior management had simply not recognised a need to provide her with this kind of help, and they lacked the impetus to do so because they considered that her practice was safe.

Part two: management and governance 2012 - 2025

Ms Stohr's practice 2016 – 2024

1.19 After 2016, Ms Stohr continued practising without effective managerial oversight and had limited engagement with divisional management. Common to many surgeons in the Trust, there were limited oversight mechanisms in place to give feedback on the quality of

Ms Stohr's surgical work. Leadership within the Trust apparently took comfort from the fact that members of the department were no longer raising concerns and issues.

1.20 Most colleagues who worked closely with Ms Stohr were unaware that concerns had been raised about her clinical practice. With the exception of Consultant A in 2015/ 2016, none of Ms Stohr's fellow surgeons had concerns about the safety of her practice until 2024, when they assumed responsibility for her patients during her leave of absence.

1.21 There were no indications from patient safety incidents reported that there was any problem with Ms Stohr's practice. Trust systems that generate hard data about patient safety issues had not indicated the incidence of any 'red flag' concerns about Ms Stohr's clinical practice.

1.22 Ms Stohr carried a disproportionately high surgical workload and got involved in waiting list initiatives that were managed within the service. Her willingness to volunteer to take on extra responsibilities was well known to her colleagues, but its impact on her was less obvious to her management, who seemed satisfied with her contribution to reducing waiting lists and increasing departmental throughput.

1.23 Occupational Health referrals in 2015 and 2024 cited work-related stress and unsustainable demands on her. However, no adjustments were made to her workload or supervision.

1.24 We found no-one in the management of the paediatric orthopaedics service, or in the workforce directorate who held a complete picture of all the factors affecting Ms Stohr and, potentially, the quality and safety of her work.

Management and governance of paediatric orthopaedics

1.25 There is evidence to suggest underdeveloped clinical governance in paediatric orthopaedics in 2015. Like the rest of the Trust, the governance arrangements in the service evolved significantly in recent years. Ms Stohr made efforts to improve governance by setting up the MDT, but much of the positive change in recent years has been led by Consultant C, who joined the Trust in 2019.

1.26 Consultant C has developed clinical governance significantly, recognising where the gaps in effectiveness were, and has brought improvements to participation and teamwork, and improved the hard data flows into the service.

1.27 There is, however, still a lack of engagement from service and operational management and links between service, divisional, and Trust-wide governance remain incomplete.

Governance arrangements across the Trust

1.28 Since a critical CQC inspection report in 2015, the Trust has worked to strengthen clinical governance systems and leadership across the board. A wide-ranging governance review, supported by NHS England, is underway to improve quality and safety.

1.29 Failures in recording and escalation meant that concerns about Ms Stohr's practice were not visible in Trust systems in 2016 and only emerged in 2024 when her patients were reviewed by colleagues. This has highlighted the need for improved local reporting and oversight.

1.30 The Trust remains on a long-term journey to ensure its clinical governance framework and practices are fit for purpose. The review now underway aims to strengthen clinical governance, quality, and safety, with specific focus on specialty and departmental levels. Early learning from this investigation showed that the Trust already knew much about Ms Stohr's practice before 2024 but lacked joined-up information to act on that knowledge.

1.31 Finally, cultural factors, such as a perception of blame and lack of trust between key parts of the organisation need to be acknowledged and resolved as part of the current clinical governance review.

Concerns raised in 2024

1.32 When further concerns about Ms Stohr's practice came to light in 2024 Dr Shaw, then Medical Director of the Trust, acted promptly to commission a second external review. Staff

in the service were shocked to learn, in early 2025, that the Hill report, produced eight years earlier, had highlighted similar issues but had not been widely shared or acted upon.

Part three: Overall findings, conclusions, and recommendations

Overall findings and conclusions

1.33 This investigation highlights a series of missed opportunities in how the Trust addressed concerns about Ms Stohr's clinical practice. Had these opportunities been recognised, appropriate actions could have been taken to reduce harm to patients.

1.34 The investigation concludes that while the Trust acted correctly in commissioning an external review, the pivotal missed opportunity was the Trust's failure to interpret and act on the 2016 Hill report. The report identified shortcomings in Ms Stohr's surgery and proposed remedial steps. The report was misunderstood, miscommunicated, and its findings reduced to a matter of interpersonal conflict rather than surgical concerns. As a result, deficiencies in Ms Stohr's practice persisted for years as her caseload and patient complexity grew. Collectively, these failings resulted in prolonged risk to patients.

1.35 The investigation illustrates the importance of clear governance structures, managerial accountability, and continuous learning to safeguard patient safety. Weak MDT structures, poor clinical governance, and lack of consultant oversight meant continuing clinical issues went undetected. The Trust failed to connect data with "soft signals" of risk. That Ms Stohr's difficulties remained unaddressed for so long exposes a serious gap in the Trust's ability to identify and act on concerns about doctors' practice.

1.36 In the report that follows, we make twenty-three recommendations for the Trust to act on.

2. Introduction

2.1 Ms Kuldeep Stohr has been employed as a paediatric orthopaedic surgeon at Cambridge University Hospitals NHS Foundation Trust (CUH) since 2012.

2.2 In March 2024, Ms Stohr began a period of sick leave, and her work was undertaken by colleagues. These colleagues subsequently raised concerns with the Medical Director's (MD) office regarding the outcomes of the paediatric surgery and some of the decision making by Ms Stohr.

2.3 In October 2024 the Medical Director's office engaged Mr James Hunter, an external surgeon from Nottingham University Hospitals NHS Trust, who evaluated a number of paediatric elective cases from all surgeons in the team and concluded that there were concerns with Ms Stohr's practice. Mr Hunter's interim report was received on 16 December 2024, with further reports received on 14 January 2025 and 17 February 2025.

2.4 The reports concluded that a number of Ms Stohr's patients who had complex surgery for dysplastic hips over a two-year period had experienced significant harm. The reports found evidence of poor operative technique and issues with Ms Stohr's decision making.

2.5 Due to these findings, Ms Stohr was excluded from work by the Trust on 12 February 2025. The Chief Medical Officer reviews the exclusion every four weeks. Ms Stohr has not practised clinically since the start of her sick leave in March 2024.

2.6 As a result of Mr Hunter's findings, the Trust has contacted all patients and families where harm has been identified to arrange follow-up appointments and to exercise duty of candour. A further external clinical review has been commissioned of Ms Stohr's clinical practice during her employment with CUH and the quality of care received by patients. This review is chaired by Andrew Kennedy KC.

2.7 The Trust's Director of Strategy and Major Projects has commissioned Verita, a specialist investigations company, to carry out an independent investigation into what was known and when about the practice of Ms Stohr and whether there were opportunities to have identified these issues sooner.

2.8 Ed Marsden, founder, David Scott, company director, and Nicola Salmon, senior consultant have conducted the work. In the report below we refer to the Verita investigation team as 'we'. Biographies of the investigation team appear at Appendix A.

2.9 Ian Walker, the Trust's director of corporate affairs and latterly Beth Hughes, interim chief governance and performance officer have provided day-to-day senior support to the investigation. Alexis Jagne, executive assistant, has assisted. We are grateful to these staff for their professionalism and for the help they have given us.

2.10 Our report has been peer reviewed by Lucy Scott-Moncrieff, CBE and Peter Killwick. Lucy Scott-Moncrieff is a Verita senior associate, senior solicitor and judge, former president of the Law Society of England and Wales, and former commissioner for standards of the House of Lords. Peter Killwick is a director of Verita.

3. Terms of reference

3.1 The Trust's director of strategy and major projects has commissioned Verita to carry out an independent investigation into what was known when about the practice of Ms Stohr and whether there were opportunities to have identified these issues sooner.

3.2 Verita will report on any gaps in systems, processes and governance arrangements in the paediatric orthopaedics department and the wider Trust and make appropriate recommendations for learning and improvement.

3.3 Verita will not examine the clinical care and treatment of individual patients of Ms Stohr which is the subject of the separate external retrospective clinical review. Verita will liaise as necessary with those conducting the external clinical review.

3.4 For clarity, information from this investigation may lead to further inquiries or action being undertaken.

3.5 The investigation will comprise two parts. This phasing will allow Verita to highlight any concerns that require immediate corrective action by the Trust to maintain patient safety, without waiting for the full investigation to be completed.

3.6 Part one covers the period 2015-2016. Verita will:

- Investigate the appropriateness, proportionality and effectiveness of the actions taken by the Trust in response to concerns raised in 2015 regarding Ms Stohr's practice. This will include the commissioning of an external clinical review in 2016 and the Trust's response to the findings and recommendations of that review.

3.7 Part two of the terms of reference cover the time period 2012-2024 and has the following remit:

- Assess the effectiveness of the management and governance arrangements (including policies, procedures and processes) within the paediatric orthopaedic department governing the clinical activities of Ms Stohr, and report on the extent to which they were complied with.

- Identify any gaps in these arrangements which may have prevented identification and/or addressing of concerns about Ms Stohr's practice.

- Assess the effectiveness of the management and governance arrangements (including policies, procedures and processes) at a divisional and Trust-wide level relating to oversight and assurance on the clinical activities of Ms Stohr and the paediatric orthopaedic department more widely, and report on the extent to which they were complied with.

- Identify any gaps in these arrangements which may have prevented identification and/or addressing of concerns about Ms Stohr's practice.

- Identify any concerns raised by Trust colleagues about Ms Stohr (in addition to the specific concerns covered in Part 1 of the investigation), including concerns raised in 2024, and comment on the appropriateness of any action taken in response to such concerns.

- Identify any 'hard data', such as complaints and patient safety incidents, or 'soft signals' relating to Ms Stohr and comment on the appropriateness of any action taken in response to these.

3.8 If, through its conduct of this investigation, Verita identifies any broader issues or concerns about the Trust's policies, processes and practices which might require separate investigation or review, it will draw these to the attention of the commissioner.

3.9 The full terms of reference appear at Appendix B.

4. Approach and methodology

4.1 Our terms of reference are in two parts. Part one requires us to report on the Trust's response to the concerns about Ms Stohr's practice as identified by Consultant A in late December 2015. Part two concerns the governance of paediatric orthopaedics and arrangements for governance in the wider Trust across the years 2012 to 2024. It also describes how further concerns about Ms Stohr's practice came to light in 2024 and contains our reflections on the safety culture of the Trust.

4.2 Although the terms of reference originally envisaged that the work would be phased, and reported on in two separate reports, the commissioner subsequently asked us to produce one report that covered both parts of the investigation.

4.3 The investigation has been undertaken in private. We have interviewed 40 people and examined all available documents. Interviewees include consultant members of the paediatric orthopaedic department, including Ms Stohr. We interviewed divisional management team members and staff, managers from the former Medical Director's office and from the workforce directorate. We have also interviewed a number of the Trust's executive directors. We interviewed some participants in part one, and again in part two of the investigation.

4.4 A list of those interviewed appears at Appendix C. In some cases, at the request of individuals who came forward to give evidence about wider governance issues, we have not identified them.

4.5 The majority of those we initially interviewed were suggested to us by the Trust. As the investigation progressed, we contacted other individuals whose contribution we considered might be material. In addition, a number of other people contacted us direct to offer their inputs, predominantly in respect of wider governance concerns at CUH.

4.6 We recorded and transcribed our interviews with participants. We offered all interviewees the opportunity to comment on the factual accuracy of their transcripts or to add to them. Where amendments were proposed, we incorporated them into the final versions of the transcripts. In some cases, we also provided links for individuals to their audio or Teams recording. The transcripts remain confidential between Verita and each

interviewee. They have not been shared with the Trust. The guidance we provided to interviewees appears at Appendix D.

4.7 We requested documents from the Trust, including policies and specific documents and information about Ms Stohr and paediatric orthopaedics. Some interviewees provided us with written information in addition to their testimony. Ms Stohr provided us with written material at and after her interviews. This included her response to the 2016 report by Mr Hill, information about paediatric orthopaedic activity, and the names of work colleagues who could assist our work. We are grateful for her contribution.

4.8 A small number of interviewees said that they no longer had email correspondence available to share with us. We were told by some staff that their emails had been lost in the switch-over from Addenbrooke's email addresses to NHS.net email addresses. Others told us that historical emails had been deleted.

4.9 We asked the Trust's information governance lead/ data protection officer, about the Trust's data retention policy. They explained:

> *"[We] retain emails for a task or piece of work until that has been resolved and then delete the emails*
>
> *Emails should not be retained once read/actioned unless the email needs to be retained as evidence of a decision/action, where possible if that is the case save the email in the appropriate network folder*
>
> *Patient identifiable emails that need to be retained as a record of advice or clinical update should be copied into Epic[1] as soon as possible. Delete email once this has been filed.*
>
> *It is down to each staff member to manage their emails in compliance with this statement, it is down to each individual to decide how long they need to retain emails for."*

4.10 We investigated events and organisational arrangements from nearly a decade ago. Most of our evidence came from the interviews we conducted. We assumed that everyone

[1] Epic is an electronic patient record system

tried their best to tell the truth as they recalled it. Given the time that has passed, people's recollections were sometimes incomplete or unreliable, and in some cases inconsistent with reliable records. This is apparent in some of the narrative where we are not able to be precise about time periods.

4.11 Consultant A, a paediatric orthopaedic surgeon and colleague of Ms Stohr's, had initially raised concerns about her practice in 2015. On 10 April 2025, as the investigation got underway, we wrote to them to share the terms of reference and to invite them to interview.

4.12 We considered that Consultant A's testimony would be important to the investigation and, in line with good practice, we contacted them, on three subsequent occasions, to encourage them to be interviewed. We discussed their continuing lack of involvement on several occasions, initially with our commissioner, Ian Walker, director of corporate affairs at the Trust, and latterly with Beth Hughes. We suggested ways of supporting the Consultant to give their evidence.

4.13 The Trust funded legal support to enable Consultant A to participate in the investigation and, on 27 August 2025, they provided, via a legal adviser, a written statement and a bundle of documents for us to consider. This comprises their own account of events, but we were unable to ask direct questions of them to give context to the testimony. Where relevant, we include their evidence throughout our report, and comment on it where necessary.

4.14 Since the investigation was commissioned, the Trust has appointed a Chief Medical Officer (CMO) to replace the former Medical Director (MD). In this report we refer to the former Medical Director, and the former Medical Director's office when considering how concerns about clinical practice have been handled in the past.

4.15 We make findings and comments based on our interviews and the information available to us to the best of our knowledge and belief. Where we have made criticisms of individuals in this report, we offered them the opportunity to address those criticisms before the report was concluded. Where appropriate, we amended the report in light of comments or new evidence we gathered in this process.

Structure of this report

4.16 Part one of this report covers discussion of matters covered within part one of the terms of reference. Section 6 is a chronology of the events as they relate to the terms of reference. Sections 7 to 11 set out the narrative of events in 2015 - 2017 in the form of our interview evidence and material gathered from documents.

4.17 Part two explores matters contained within part two of the terms of reference. This section of the report examines whether the organisational systems at the Trust identified any concerns about Ms Stohr's clinical practice over the twelve years of her time as a consultant orthopaedic surgeon. Section 12 explores the management of Ms Stohr and the governance of her practice. Section 13 discusses the effectiveness of management and governance systems more generally as they relate to paediatric orthopaedics. Section 14 explores the effectiveness of management and governance systems in the wider Trust as they relate to Ms Stohr's practice. Section 15 includes an assessment of the medical safety culture at the Trust. Section 16 sets out how the concerns about Ms Stohr's clinical practice in 2024 arose.

4.18 Part three draws together our overall findings, conclusions and recommendations.

4.19 Our comments below are in ***bold italics***. We have included quotes from transcripts and other written evidence throughout this report in *italics*.

4.20 The terms of reference require us to identify missed opportunities for identifying and avoiding of possible harm to paediatric orthopaedic patients. The term "missed opportunities" suggests situations where a person, team, or organisation could have taken action that might have led to a better outcome, but did not - whether due to inattention, hesitation, anxiety, lack of awareness, or competing priorities.

4.21 We sought to identify opportunities that were not recognised at the time by the Trust, and to describe actions that could have been taken based on the information that was available. We also sought to capture the reflections of participants in the investigation on their recognition, with the benefit of hindsight, of missed opportunities.

4.22 We have used this interpretation in our analysis. We label specific missed opportunities as **MO1, 2, 3 etc.**

4.23 We also make recommendations for further action. These are labelled in the style of **RX**

5. Background

Cambridge University Hospitals NHS Foundation Trust

5.1 Cambridge University Hospitals NHS Foundation Trust (CUH) is one of the largest hospital trusts in the United Kingdom. It comprises Addenbrooke's Hospital and The Rosie Hospital, both situated on the Cambridge Biomedical Campus. CUH serves the local population of Cambridge and eastern England and provides specialist services to patients regionally, nationally, and internationally.

5.2 The Trust employs some 1,400 NHS consultants and academic doctors on honorary contracts. There are some 500 to 600 doctors in training working in the Trust.

5.3 The Trust has five clinical divisions, each led by a divisional director (DD). Adult orthopaedics is in Division A and paediatric orthopaedics is in Division E.

Paediatric orthopaedics

5.4 Paediatric orthopaedic surgery is the care and treatment of children and young people who have problems with their bones, joints, or muscles. As part of its portfolio of services the Trust has a paediatric orthopaedics service that provides specialised care for children, many of whom will have complex, often multiple and serious conditions. Patients require a referral from a primary or secondary care provider. Patients are drawn from a broad geography. Paediatric orthopaedics is a sub-speciality of orthopaedics.

5.5 The department's consultants and staff play a vital role in helping children achieve a better quality of life in the context of a serious condition and/ or disability. This includes conditions they are born with, such as hip dysplasia[2] or clubfoot[3], as well as injuries from accidents, or problems that develop as they grow.

[2] Hip dysplasia means that a baby's hip joint has not developed properly. It is not usually painful for babies but, if it's not treated, it can cause problems with walking later and lead to arthritis in early adulthood.
[3] Clubfoot is a condition where the baby is born with one or both feet turned inwards and downwards.

5.6 Children's bones are still developing, so they need different treatment from adults. Paediatric orthopaedic surgeons are specially trained to understand how growing bones behave and how best to treat them to give children the best chance of a healthy future.

5.7 Common procedures include correcting bone deformities, treating fractures, and helping children with conditions like scoliosis (curved spine) or cerebral palsy that affect movement.

5.8 The work of the department at CUH is commonly described as "low volume – high complexity". The former Director of Division E (in post from around 2012 until 2019) is an experienced paediatric consultant and medical manager at the Trust. He leads the development of the new children's hospital at CUH. He told us:

> *"In paediatrics, broadly, all of us are low volume specialties compared to adults. Paediatric orthopaedics, paediatric surgery, both are low volume with high variation specialties"*

5.9 He added:

> *"In many of the paediatric sub-specialties, we very often deal with children with multiple complex conditions. They are very often chronically unwell, survivors of perinatal events, intensive care and neonatal units, and so they have complicated medical and surgical problems that are difficult to assess, even before you get involved with a surgical procedure."*

5.10 The former Director of Division E told us that the clinical outcomes from these surgeries might be subtle and aimed at delivering improvements to quality of life rather than 'cure'. In describing surgical outcomes for the children cared for he said:

> *"It's likely not just about getting the bone in the right place. It's about functional outcomes and often it is about managing pain. It is about managing the whole patient and there probably are limits to the bony correction that is available.*
>
> *I can also see that a decision to operate is not just on where the bone is sitting, but it is about how we improve function i.e. ability to comfortably move the child around from a wheelchair or hoist."*

5.11 When Ms Stohr joined the paediatric orthopaedics department at the Trust in 2012, she became the second of two consultant surgeons in the service, the first being Consultant A who was, by some years, the more experienced consultant. Ms Stohr was in her first consultant post, following completion of her specialist training. Between 2012 and 2016 the service was led by these two consultants.

5.12 The service subsequently grew further with the recruitment of additional staff, and it now has five consultant surgeons in the team, including Ms Stohr.

Part one

6. Chronology of key events

Date	Event
2012	
January	Ms Stohr offered appointment as consultant orthopaedic consultant
2 April	CUH becomes the designated major trauma centre (MTC) for the East of England
1 August	Ms Stohr joins CUH working in Division A
17 December	Ms Stohr commences maternity leave
2013	
29 July	Ms Stohr returns to work following maternity leave
2014	
April	Management of paediatric orthopaedics moves from Division A to Division E
2015	
13 February	Ms Stohr is referred to occupational health (OH) citing concerns about her workload
23 February	Ms Stohr is confirmed fit to work with advice about managing her workload
5 March	OH refers Ms Stohr for specialist advice
24 March	Ms Stohr's case is reviewed by OH and she is confirmed fit to work
5 August	Consultant A raised a grievance against a clinical nurse specialist (CNS).
10 August	Grievance raised against Consultant A by the CNS. Ms Stohr gives evidence in support of the CNS.
14 October	Ms Stohr has her annual appraisal meeting
29 December	Consultant A emails the then Director of Division E (in post 2012 – 2019) citing concerns about Ms Stohr's clinical practice
30 December	The Director of Division E responds to Consultant A's email of 29 December

Date	Event
2016	
20 January	Consultant A and the Director of Division E meet to discuss the concerns raised
27 January	Medical Director's casework meeting log contains a new entry for Ms Stohr
28 February	Consultant A sends a more detailed email to the Director of Division E citing specific cases
3 March	The Director of Division E writes to a colleague at Great Ormond Street Hospital about the need for an experienced paediatric orthopaedic surgeon to review Ms Stohr's cases as identified by Consultant A
23 March	Casework meeting log confirms that review will be undertaken by a consultant from GOSH. "*No current restrictions on practice.*" Deputy Medical Director A (lead for professional governance) to chase consultant.
20 April	Deputy Medical Director A engages Mr Robert Hill to conduct the review and communicates plans to the Director of Division E. Casework meeting log reports that Deputy Medical Director A and the Associate Director of Workforce will meet Ms Stohr
3 May	The Associate Director of Workforce writes separately to Consultant A and Ms Stohr informing them about the upcoming review
4 May	Casework meeting log records "*lead at GOSH to do case review*" Deputy Medical Director A and the Associate Director of Workforce plan to meet Ms Stohr and Consultant A
10 May	Deputy Medical Director A and the Associate Director of Workforce meet Ms Stohr to explain which cases will be reviewed and by whom.
May, date unknown	Deputy Medical Director A and the Associate Director of Workforce meet with Consultant A to discuss the concerns raised and outline the proposed external review
26 May	Deputy Medical Director A and Mr Hill confirm the arrangements for the review
1 June	Casework meeting log records "*Robert Hill coming on 13 June to undertake case review*".
13 June	Mr Hill conducts his review of a selection of Ms Stohr's cases as raised by Consultant A

Date	Event
22 June	Ms Stohr has her annual appraisal meeting
29 June	Casework meeting log records "*initial thoughts were [Ms Stohr] was not incompetent*". Mr Hill sends his report of the completed review to Deputy Medical Director A.
4 July	Deputy Medical Director A meets Ms Stohr to share the Hill report with her
4 July	Deputy Medical Director A emails the Director of Division E Mr Hill's report, covering it with a summary of the report and a request for the Director of Division E to establish a multidisciplinary team (MDT) meeting in the paediatric orthopaedics department
13 July	Casework meeting log records "*[Ms Stohr] does feel unsupported*".
July	Ms Stohr begins attending the MDT at Norfolk and Norwich University Hospital
27July	Casework meeting log records that "*[Ms Stohr] has made a grievance against [Consultant A]*".
3 August	Ms Stohr writes to Deputy Medical Director A and the Associate Director of Workforce to withdraw the grievance but suggests she remains open to mediation. Consultant A is copied into this message
4 August	Deputy Medical Director A responds to Ms Stohr (copying Consultant A) inviting her to consider an exploratory meeting with Consultant A, the Associate Director of Workforce and himself
10 August	Casework meeting log records "*[The Director of Division E] present at meeting. [Ms Stohr] submitted grievance against [Consultant A]. [The Associate Director of Workforce] /[Deputy Medical Director A]/ [Ms Stohr] met to discuss process and likely outcomes. [Ms Stohr has] withdrawn grievance but requested mediation with [Consultant A]. [Ms Stohr] requested external review of dept. Not appropriate at this time.*"
15 August	Deputy Medical Director A writes to Consultant A informing them that the cases he had identified have been reviewed by Mr Hill and that the Trust has received his report. His letter says Mr Hill "*made no findings to lead the Trust to be concerned about Kuldeep's practice*".
August, date unknown	Ms Stohr meets with the Director of Division E to receive feedback about the Hill report's findings

Date	Event
August	Investigation of the grievance complaint against Consultant A from the CNS concludes
7 September	Casework meeting log records Deputy Medical Director A, the Associate Director of Workforce, Ms Stohr and Consultant A to meet to discuss 'future mediation and /MDT issues".
21 September	Casework meeting log records that the Associate Director of Workforce and Deputy Medical Director A "*met with [Ms Stohr] and discussed behaviour going forward*"
September	Ms Stohr becomes clinical lead for paediatric orthopaedics Ms Stohr sets up the MDT in paediatric orthopaedics
5 October	Casework meeting log records "*Service, behaviour and reputation was discussed*"
October	Division E managers (the Director of Division E and the Divisional Director of Operations), Ms Stohr and Consultant A (and latterly Consultant B) meet monthly to discuss moving forwards with relationships within paediatric orthopaedics
30 November	Casework meeting log records "*[The Service Lead for Trauma and Orthopaedic Surgery] chaired MDT with [Consultant A] and [Ms Stohr] – all went well*"
December	Consultant B joins paediatric orthopaedics substantively
14 December	Casework meeting log records "*MDT meeting progressing well. No further action at this time. Close*"
2017	
17 May	Ms Stohr has her annual appraisal meeting
20 June	Ms Stohr writes to Deputy Medical Director A and the Associate Director of Workforce asking for a written reply from the Trust to Consultant A's complaint of the previous year to include in her appraisal Deputy Medical Director A responds confirming there are no concerns about her clinical practice
Autumn	Ms Stohr stops attending MDT at Norfolk and Norwich University Hospital due to clinical commitments at CUH
Late 2017	End of monthly meetings between paediatric orthopaedics team and Division E management
1 November	Deputy Medical Director A takes on the role of Responsible Officer

Date	Event
2018	
2019	
April	Consultant C joins paediatric orthopaedics substantively
2020	
March	Consultant C becomes clinical lead for paediatric orthopaedics
2021	
2022	
Mid 2022 – March 2024	Ms Stohr's behaviour towards colleagues starts to deteriorate leading to ongoing intermittent complaints
2023	
Spring 2023	Ms Stohr stops attending MDT meetings
May 2023	Ms Stohr begins meeting regularly with the Deputy Medical Director B, the lead for patient safety and clinical quality to receive support and manage her wellbeing and welfare concerns
2024	
March – October	Ms Stohr on sick leave Colleagues in paediatric orthopaedics take over Ms Stohr's patient caseload
21 August	Consultant A raises concerns by email to Deputy Medical Director B and the current Divisional Director for Division E (in post since late 2019)
11 September	Paediatric orthopaedics team meet with Deputy Medical Director B to discuss their concerns
October	The MD's office engages Mr James Hunter to review paediatric orthopaedics' cases
16 December	Mr Hunter sends an interim report to the Trust highlighting problems with Ms Stohr's surgical cases
2025	
14 January	Mr Hunter sends a second interim report to the Trust
12 February	Ms Stohr is formally excluded from working at the Trust

Date	Event
17 February	Mr Hunter sends a third interim report to the Trust
20 February	Consultant A writes to the Trust's CEO and senior executives and managers
April	Consultant C and Consultant A receive the Hill report for the first time
7 March – 10 April	Trust commissions Verita's independent missed opportunities review
10 April	Verita sends first invitations to participants
24 April	First interview takes place

7. Ms Stohr's appointment and working arrangements 2012 – 2015

Background, training, and specialty interests

7.1 Before joining the Trust Ms Stohr completed her registrar training at University College Hospital, London. She then specialised in paediatric orthopaedics and did fellowships in New Zealand, at the Royal National Orthopaedic Hospital in Stanmore, and at Great Ormond Street Hospital. While a locum consultant at Chelsea and Westminster she applied for the Consultant Paediatric Orthopaedic Surgeon position at CUH because she understood that CUH was about to become a Level 1 trauma centre, which was where her interest in paediatric trauma would best fit. Ms Stohr describes herself as "*a paediatric orthopaedic surgeon, but I also do trauma*".

Ms Stohr's arrival at CUH as a consultant

7.2 Ms Stohr was appointed as a full-time Consultant Orthopaedic Surgeon in the Trust in January 2012 and started in her role on 1 August 2012. It was her first substantive consultant appointment since finishing her specialist training. She joined Division A. Ms Stohr went on maternity leave on 17 December 2012. She returned from maternity leave on 29 July 2013.

7.3 Ms Stohr said that there appeared to have been little preparation for her appointment and that her induction to the role and to the Trust was perfunctory. She told us:

> *"I arrived with no clinics and no operating and that was a bit of a struggle when I started, but I didn't know any different then, this was my first consultant job. Things were disorganised here. Having said that, with the orthopaedic surgeons, we had a very quick introduction to each other, extremely quick, I was on-call within days of me starting."*

7.4 She said that she did not have a line manager although a colleague suggested that she find herself a mentor. Ms Stohr found that there was no process for assessing and

monitoring the quality of her clinical work and there were no multidisciplinary team (MDT) meetings taking place in paediatric orthopaedics at the time.

7.5 Ms Stohr told us that, when she took up post, she did not have any patients or operating sessions for some months. Her only other consultant colleague in the service was Consultant A. Consultant A had joined the Trust in March 2003 and was working in Division A when Ms Stohr was appointed. Consultant A had a long waiting list of patients and Ms Stohr says that she felt pressured by service management in her first month to take on some of his work. We were unable to verify who this person was.

7.6 She said:

> *"Looking back, only because I have now been directly responsible for the appointment of two other consultants, [Consultant B] and [Consultant C], I can see that [Consultant A] did not do a lot that would be expected, setting up clinics, organising lists, the sort of introduction to a department that a consultant might expect and I now know to be routine, but that wasn't done for me."*

Ms Stohr's role in the paediatric orthopaedics department

7.7 Ms Stohr says that from 2013 the bulk of emergency work managed in the service – both paediatric trauma and musculoskeletal – fell to her to do. She explained this in her written evidence saying that she "*worked much harder and did not demarcate the boundaries of my role as sharply as [Consultant A].*"

7.8 In 2014 the service moved from Division A – where the adult orthopaedic service is located – to Division E to be a part of the women and children's service. The then Director of Division E (in post from 2012 to 2019) and the clinical director assumed responsibility for the paediatric orthopaedics department. Ms Stohr told us that children's fractures and governance remained the responsibility of trauma and orthopaedics in Division A after this move.

Relationships between people in the department

7.9 The GMC's 'Good Medical Practice' guidance (the 2013 version in place at the time) requires doctors to work with colleagues to maintain or improve patient care. Paragraph 35 says:

> *"You must work collaboratively with colleagues, respecting their skills and contributions."*

7.10 Both Ms Stohr and Consultant A reported that they operated together and, initially, had a good personal and professional relationship after she joined the Trust. Ms Stohr said:

> *"He's actually a very pleasant person when he wants to be, he really is, you must have met him, he is very convivial. He is German, my husband is German, and he invited us round before I even started, so we had a real social start. He is that friendly sort of person when he wants to be, certainly that's how it was when I started."*

7.11 Consultant A wrote:

> *"Ms Stohr and I had a good working relationship when she started at the Trust until the end of 2015: we would do surgeries together on a Friday afternoon so that she could gain experience in performing certain surgeries, and we discussed difficult cases together as well as issues with the wider orthopaedic team which we sometimes then raised with senior management. Ms Stohr and I were also social outside of work. Our families would visit one another, and I considered us to be friends."*

7.12 However, in the following years, their relationship soured. Several people we interviewed were aware of the difficult relationship between Ms Stohr and Consultant A, and they spoke of the impact that had on teamwork within the department. One person said:

> *"I knew they didn't get on. [Consultant A], his culture is very 'as it should be' and I think Kuldeep, her background was in some of the rougher hospitals when she came*

in. She had to fight for her positioning, and she was quite a strong character as well, so the two of them didn't really mesh that well."

7.13 A long-serving member of the team said that the relationship between Ms Stohr and Consultant A had a significant impact on team dynamics. The interviewee said:

"Both have very strong opinions of what things should be and I think sometimes those opinions differ. How they then collaborate together to move forwards was probably where that challenge originally sat. I've been at the sharp end of when one of them has got cross and started shouting."

7.14 They added that such frustrations were evident from both Ms Stohr and Consultant A:

"Probably both, at various points. It is not necessarily at me, but both tend to become frustrated at systems generally – and I think we all do at some points – which they feel probably does block."

7.15 Ms Stohr and Consultant A were also known to other departments of the Trust on account of their behaviour with colleagues and for their relationship difficulties. The Associate Director of Workforce told us:

"Broadly speaking, both of them [Consultant A and Ms Stohr] have been much more frequent visitors to this office than is the case for pretty much any other consultant, I would say both of them as individuals and, I suppose, with regard to their relationship with each other. Yes, they have been involved in fallings-out and disputes between the two of them and they have both been involved in issues with others."

7.16 Deputy Medical Director A, then the lead for professional governance described frequent interactions they had with Consultant A before Ms Stohr joined the paediatric orthopaedic team and said that Ms Stohr:

"Did not come to formal attention in the way that [Consultant A] did so often, but she was known to be incredibly hardworking, sometimes had a short fuse, but she hadn't attracted the [Medical Director's] office attention that [Consultant A] did."

7.17 We asked Deputy Medical Director A if he had ever dealt with conflict between Ms Stohr and Consultant A before 2016. He said that:

> *"I had not been involved in any attempt to get them to work together. They were both seen as being difficult individuals. It is no surprise at all that they did not have a well-functioning relationship, and they were the only consultants in the paediatric orthopaedic 'team'."*

7.18 The then Director of Division E told us about his experience of handling Consultant A and Ms Stohr and their professional relationship as the two consultants in the paediatric orthopaedic service between 2012 and 2016. He said that Consultant A is:

> *"Very committed to his service and his patients but, in the main, focused on his own issues and priorities, not at all committed to anyone else's. Managing him and involving him in shared decision-making, or shared efforts to develop the service was very challenging."*

7.19 The Director of Division E said of Ms Stohr:

> *"I knew that she could be a bit prickly and difficult, but I am of the view that you have to tolerate a bit of that if you want people to excel in other areas."*

7.20 A member of staff who worked with Ms Stohr told of us about her patient numbers and approach to her work:

> *"[Ms Stohr] did take on a lot of patients, and she would take on any of the patients. If a complexity was there and she thought she could help, she would take it on. On-call, she would take all of the paediatrics into her service, rather than putting them into other people's service. I couldn't fault her commitment to it, she was always here, even on her birthday she was still writing up patients at six o'clock in the evening."*

Management and oversight of consultants in paediatric orthopaedics

7.21 The Director of Division E also told us that the management and oversight arrangements between Divisions A and E were "*very fragmented*". In essence, job planning for Consultant A and Ms Stohr and other professional matters i.e. how they structured their working week, rested with Division A, while development of the paediatric orthopaedic service rested with the Director of Division E and colleagues in Division E.

7.22 The Director of Division E also said that he played a greater role with paediatric orthopaedics when relations broke down between Ms Stohr and the then clinical director:

> *"I was involved in regular service meetings to try and help manage behaviours and expand this service in 2014-16 – this was perhaps unusual as [Divisional Director], as more usually the paediatric surgical clinical director would have led this work. I took this on as the relationship between the [clinical director] and the orthopaedic surgeons had broken down."*

Comment

Ms Stohr's arrival in the Trust was disorganised and, when she began taking on cases, she quickly inherited a large workload which she managed with little guidance from her Clinical Director or the Divisional Director.

Management and clinical supervision appeared to be fragmented and remote. We believe that Ms Stohr was under-managed in the early years of her career at CUH.

Ms Stohr's expectations of Consultant A in facilitating her introduction to the department were not met. We could see no reason why Consultant A would have had any formal responsibility for doing so, since they had no role in managing their colleague.

Missed opportunities

MO1 Ms Stohr's induction to the Trust failed to equip her adequately for her first consultant appointment. The lack of clarity about her clinical governance and line management structure, combined with inadequate resource provision put her immediately under workload pressure without sufficient support.

MO2 Although their colleagues and managers alike knew that relationships between Ms Stohr and Consultant A were strained there was no determined attempt to resolve them to prevent any impact on patient safety.

Recommendations

R1 The Trust should consider implementing a more organised approach to the initial job and role planning process for new consultants. This should include clear identification of the consultant's line management arrangements, and the responsibility for their clinical supervision.

R2 The workplace induction process for new consultants should be reviewed to ensure that appropriate mentoring and/or buddying arrangements are in place to enable consultants joining the Trust to have a resource to assist them to integrate quickly to their role and their division.

8. Concerns raised about Ms Stohr's practice in 2015 - 2016

Doctors' responsibility for raising concerns

8.1 Doctors have a responsibility to raise concerns about patient safety. These responsibilities are set out in detail in the Trust's own policies and in guidance from the General Medical Council (GMC) published then in 'Good medical practice 2013'. The relevant extracts from the GMC guidance state:

> *"You must follow the procedure where you work for reporting adverse incidents and near misses. This is because routinely identifying adverse incidents or near misses at an early stage, can allow issues to be tackled, problems to be put right and lessons to be learnt.*
>
> *If you have reason to believe that patients are, or may be, at risk of death or serious harm for any reason, you should report your concern to the appropriate person or organisation immediately. Do not delay doing so because you yourself are not in a position to put the matter right.*
>
> *Wherever possible, you should first raise your concern with your manager or an appropriate officer of the organisation you have a contract with, or which employs you.*
>
> *You must be clear, honest and objective about the reason for your concern. You should acknowledge any personal grievance that may arise from the situation but focus on the issue of patient safety.*
>
> *You should also keep a record of your concern and any steps that you have taken to deal with it."*

How the Trust handles concerns about doctors

8.2 Dr Jag Ahluwalia, the Medical Director (MD) at CUH until 2017 described the usual routes through which concerns about consultants came to his attention:

It might come through a complaint that named an individual… The routes were complaints which may, for example, have come out of a critical incident - a procedure or an intervention that had gone wrong. Sometimes the General Medical Council would contact us directly, because a member of public had complained to them, or sometimes it was a result of the consultant raising concerns [about themselves]. For example, if you are stopped for drink-driving and accept a caution as a consultant, that triggers a report by the police to the GMC automatically and the wiser ones might have come to their Medical Director and let me know first! Sometimes it's fellow consultants raising concerns about their colleagues. On occasion, it was nursing other colleagues who were at the receiving end of poor behaviour often. I would say that was as much about behaviour as it was competence."

8.3 We also asked the Director of Division E how, in his experience, concerns about a consultant's practice typically come to light:

"Mostly, consultants go to clinic and make a decision there themselves – operation or not, investigation or not – and they continue to do that until someone tells them to stop or there are incidents, complaints, concerns raised within the service governance. This decision making will be either with or without an MDT; but all surgical specialties should also include an M&M [mortality and morbidity] meeting; where incidents start being filed and discussed; or outcomes are challenged."

8.4 We learned that the systems for handling and resolving concerns about doctors involved a number of different people and departments in the Trust. In 2015 Deputy Medical Director A was the lead for professional governance, reporting – along with two other Deputy Medical Directors - to the Medical Director, Dr Jag Ahluwalia who was also the Trust's Responsible Officer (RO)[4]. Deputy Medical Director A and colleagues in the Medical Director's office worked closely with the Associate Director of Workforce and their team. Deputy Medical Director A became the Trust's RO on 1 November 2017 and relinquished this role on 30 April 2025.

[4] In the NHS, a responsible officer (RO) is an individual with statutory responsibility for monitoring and evaluating the fitness to practice of doctors in their organisation. They play a key role in ensuring high standards of medical practice and patient safety. ROs make recommendations to the General Medical Council (GMC) about revalidation and the investigation of concerns about a doctor's performance.

8.5 Deputy Medical Director A told us that their role is demanding, and it is common for Medical Directors, Deputy Medical Directors and others responsible for managing professional disciplinary processes to be challenged.

8.6 We asked Dr Ashley Shaw, the Trust's Medical Director until April 2025 about the incidence of serious concerns being raised about doctors. He said that:

> *"I would say that any one time we are looking at perhaps two or three at the serious end of large investigations. At the moment, there are probably two or three that I am aware of, not clinical concerns but breakdown of relationships is probably the biggest thing – a complete breakdown of relationships within a team."*

Consultant A's history of raising concerns within the Trust

8.7 Deputy Medical Director A told us that Consultant A had a history of raising clinical concerns about colleagues and about other matters. Ms Stohr told us she knew of four other consultants about whom Consultant A had complained. Deputy Medical Director A was concerned that Consultant A had sometimes raised such concerns outside of established Trust processes. He told us he had several discussions with Consultant A about the need for them to report concerns using existing systems and in line with GMC guidance. For example, this would include using Trust systems first and recording concerns in writing.

8.8 Deputy Medical Director A said:

> *"I am sure [Consultant A] will tell you that [Deputy Medical Director A] has tried to bully him over the years. I know that because he's told lots of other people that and he has suggested to me that I've done that. It is true I have tried to get him to modify his approach, which he has taken as being bullying. I have tried to say, as I do to many people, that yes, we do want to know if you have concerns, but please would you raise them in an appropriate manner and not as in [Consultant A's] case, involve external bodies before you have let us know."*

8.9 We asked if Consultant A reacted positively to that advice:

"Not at all, no. I don't think his behaviour has modified in any way and he talks about [Deputy Medical Director A] bullying him, which reflects the fact that I have asked him in relation to these events to try to say, 'you are entitled to raise your concerns, anybody is and in fact it's dangerous in a place if people can't raise concerns, but can you please do it in a proportionate way and can you please use Trust mechanisms before you go external'. Do I think he has modified his approach to life in any significant way? The answer is no, not really."

8.10 Of the previous concerns they raised, Consultant A wrote:

"At this point I should provide important context that this was not the first time I had raised formal concerns about colleagues' practices with the Trust's senior management which were not dealt with as they should have been (though it was the last concern I raised until 2024). The details of those concerns (prior to the issues I raised about Ms Stohr in 2015) are set out in schedule 1 to this witness statement… I continue to regard each of them as a serious incident that I was right to raise."

8.11 Consultant A explained that they had raised six previous concerns in the period 2008 to 2014. Consultant A's concerns included issues around surgical practices, clinical outcomes, poor behaviours of colleagues across the Trust and one concern about an annual leave dispute. None of these issues related to paediatric orthopaedics. They wrote:

"I believe that the Trust's senior management team was not happy that I had raised multiple issues over a seven-year period and the various meetings that were held to discuss these incidents were very stressful. The Trust's senior management also criticised me for not raising concerns in what they considered to be the proper manner and for using the Trust's whistleblowing procedure, rather than the complaints procedure."

8.12 Consultant A explained their approach:

"I started to use the whistleblowing route and formal procedures when I raised concerns as it was my experience that, if I raised an issue through an incident report, nothing would happen, and if I discussed something by 'phone or face to face', there would be no record of my raising the point which I did not think was satisfactory when serious issues were being discussed. I was also told in a call from [Deputy

Medical Director A] on 23 November 2011 that I was the only individual at the Trust who raised issues like this and that [Deputy Medical Director A] saw it as there being a problem with me raising issues."

8.13 Consultant A described their experience of these processes as follows:

"The various meetings left me feeling bullied, intimidated and threatened by [Deputy Medical Director A] and [the Associate Director of Workforce] and I always had the impression that [Deputy Medical Director A] and [the Associate Director of Workforce] were never concerned about improving patient care."

Comment

Consultant A had a history of raising concerns outside of the preferred mechanisms within the governance arrangements that exist in the Trust.

We infer from this that Consultant A did not Trust that the existing mechanisms were fit for purpose and that they failed to produce the resolution of his concerns.

In principle, concerns should be addressed thoroughly, no matter how they are raised, but we can understand why Consultant A's approach caused difficulties in resolving these matters.

We did not interpret Deputy Medical Director A's behaviour towards Consultant A as bullying. However, we were unable to discuss Consultant A's perception of this because they did not agree to be interviewed in the investigation.

Concerns raised by Consultant A in 2015 and 2016

8.14 Consultant A recounted that, in late 2015, they began to have concerns about Ms Stohr's practice:

"Towards the end of 2015, I started to become concerned by shortcomings in Ms Stohr's practice. I cannot remember now if there was a specific trigger or a

particular patient incident that led me to act but I recall noticing a number of things that gave me cause for concern. These were:

(a) services that had been running well under me, such as the baby hip service, were no longer operating as they should have been, having been taken over by Ms Stohr;

(b) Ms Stohr came late to our joint Friday afternoon surgery sessions (which were intended to help build up her experience) and then stopped coming altogether;

(c) I came across cases that troubled me. This included cases that trainees raised with me where Ms Stohr had been the lead surgeon and the trainees were not comfortable with Ms Stohr's practice. It also included some of my patients who, probably due to the length of my waiting list, had been operated on by Ms Stohr but then returned to me for their follow-up appointments in clinic where they presented with issues that should not have been there; and

(d) where I had concerns about patient outcomes and tried to discuss them with Ms Stohr, she was defensive and difficult such that there could be no constructive discussion. It eventually reached the point where I felt I could no longer help improve Ms Stohr's practice through raising my concerns on specific cases directly with Ms Stohr and she was not interested to continue with dual surgery.

I began to fear that Ms Stohr's practice was leading to poor surgical outcomes causing harm to children."

8.15 We found no records of the conversations Consultant A says they had with Ms Stohr about her surgical practice. Consultant A said that they also raised these issues verbally with the Director of Division E on two occasions in late 2015. They wrote:

"I recall that [the Director of Division E] did not follow up on those conversations so, on 29 December 2015, I emailed him to set out my concerns in writing."

8.16 We have removed patient identifiable data from the text of the email that Consultant A sent to the Director of Division E, and we identify the patients by number in square brackets.

8.17 Consultant A's email to the Director of Division E says:

"I have patient safety concerns regarding patients whom I listed for surgery to be operated on by Ms Stohr because I have concerns that she does not have the experience to perform certain surgeries. When Ms Stohr started, I thought that it would be good for us to do some operating together. We agreed for her to join me Friday afternoons after her trauma list. She usually came late and after not long she stopped coming and started running a clinic instead.

I give you two examples:

1) [Patient 1]. This is a patient whom I listed for surgery but was operated on by Ms Stohr. She performed a tibial and fibula osteotomy but performed these at the same level. To the best of my knowledge, it is wrong to do the cuts at the same level because there is a risk of cross union between the two bones. The level of the fibula osteotomy is also high with there being an increased risk to damage the peroneal nerve. If you do the osteotomies at different levels, you do not have the risk of synostosis formation. The patient would probably develop a problem with ankle function if he would develop a synostosis and the bones look very close. I think that it is unnecessary risk taking to do this and my thoughts stretch as far as me thinking that maybe the surgeon has not done this surgery before. If it happens it is purely the result of how the surgery was performed. I cannot imagine that anyone else would do it like this.

2) This is a patient [Patient 2] I came across on the medicolegal side and was not my patient. He presented with Perthes disease of his right hip for which he underwent a femoral and pelvic osteotomy. The aim will have been to improve femoral head coverage to reduce the risk of femoral head extrusion. The femoral head coverage after surgery looks Stohr worse compared to before. On the x-rays you can see that the bones have been cut but it looks as if the bones have not been moved much and the femoral head looks more extruded about one year after surgery compared to before. The metal has been removed since. Now the patient had two surgeries of which one was major surgery without an improvement of femoral head coverage, still being left with a laterally uncovered femoral head. I would probably offer the patient to do another pelvic osteotomy.

I have specific discussions about surgeries with parents and children which I then perform in a way I think is the best for the patient based on the patient's problems, clinical and radiological findings, my training and experience. I understand that there are frequently ranges of opinions and experiences."

8.18 The Director of Division E replied by email to Consultant A on 30 December 2015, saying:

"Hi [Consultant A], we need to discuss this in person – you know how this works… if this is a clinical concern you have about just these 2 cases, then this is a discussion we need to have with Kuldeep about the outcomes of these procedures and act accordingly.

If you are concerned/have evidence that this is outside acceptable practice and is a more widespread problem, then this is something we will need to take forward with Jag's office [Dr Jag Ahluwalia, then Medical Director of the Trust]. It would almost certainly then require an external review of practice / outcomes across the service to ensure that we are being fair and doing the best for all our patients.

I am around this week and next to meet up."

8.19 Consultant A and the Director of Division E met to discuss these concerns on Wednesday 20 January 2016. We have found no written record of that discussion, and neither Consultant A nor the Director of Division E can recall the exact details of the conversation. Consultant A sent the Director of Division E a further email on 28 February 2016 listing twelve cases about which they had concerns. We assume that Consultant A compiled the list by reviewing Ms Stohr's patient case records. Again, we have removed patient identifiable data from the text below.

8.20 Consultant A wrote:

"Thank you for discussing the issue raised below with me in person on Wednesday 20th January 2016. I asked on 29.12.2015 for Ms Stohr not to operate on any of my patients anymore because I do not think that she has the necessary skills to perform a number of surgeries in a safe and adequate manner. I also think that she lacks insight into her limitations with her having performed surgeries over a longer period

with what I call inadequate radiological outcomes. Since then, major surgery was performed on one patient whom I had referred to myself from Luton … However, Ms Stohr decided to operate on this patient. I would describe the surgery on the right femur as unnecessary and on the other side as inadequate. The left femoral head should have been fully covered but was left about 30% uncovered.

I explained three cases to you in detail, showing you on the x-rays why the surgery has been done inappropriately in my opinion giving an inadequate results and potentially harming patients. One patient I came across on the medicolegal side, one patient was on my waiting list for surgery and the third I had referred from Luton to myself here for surgery.

You wanted to ask [a colleague] for an opinion. May I point out that he performed Salter pelvic osteotomies in patients with cerebral palsy. Salter himself stated when he was alive that his osteotomy should not be used in patients with cerebral palsy. Despite this [the colleague] performed this osteotomy on these patients for years. There is a good reason for that. I am not aware that [the colleague] has done any pelvic osteotomy other than the Salter and would therefore have limited expertise

Here is a list of multiple cases which I think are concerning."

8.21 Consultant A goes on to detail the cases in which they identified potential issues with Ms Stohr's surgery. They concluded:

"In my opinion the… cases indicate that multiple inadequate major surgeries were performed on multiple patients resulting in more procedures and/or harm to the patients. Complications can occur but are more likely to occur if surgeries are performed without the adequate skills and knowledge… there is possibly also a problem with adequate patient assessments…

Parents/patients as listed above need to know about the problems with their surgeries and that these can affect the outcome."

Comment

This is the first time Consultant A raised concerns about clinical practice within their own service. Consultant A, in common with all doctors, has a responsibility to raise patient safety concerns as they arise. Their raising of the concerns with the Director of Division E was an appropriate step to take. They did this in writing as Deputy Medical Director A had previously suggested they should, and it prompted the Trust to take the necessary steps to investigate his concerns.

We consider that the Director of Division E, after being approached informally by Consultant A, rightly recognised the potential seriousness of the issues being described and encouraged Consultant A to formalise the concerns so that they could be investigated further.

Consultant A described in significant detail in emails to the Director of Division E the specific concerns they had about procedures Ms Stohr had carried out on individual children.

We consider that Consultant A could not have been more explicit in their criticisms of Ms Stohr's surgical technique, and they were clear that they did not want her to operate anymore on Consultant A's patients.

Ms Stohr's view of the concerns

8.22 Ms Stohr told us that Consultant A had not previously discussed their concerns with her. It was her view that they had raised these concerns with the Director of Division E in retaliation against her because she had supported a nursing colleague who raised a complaint about Consultant A's behaviour in August 2015. Ms Stohr said that she had been interviewed as part of an internal investigation of the nurse's grievance. She said:

> *"In that grievance I was interviewed, and I was very supportive of [the nurse]. I made remarks, I remember saying that [Consultant A] can be difficult to talk to, because he can and at that time, he was very hands-off with me, and he would criticise me."*

8.23 Ms Stohr told us that, around the end of 2015, she had the first inkling that Consultant A had concerns about her clinical practice. She told us that she met Consultant A to propose that they should travel together to a meeting outside the Trust. Ms Stohr recalled that, at the end of this conversation, Consultant A:

> *"Put on the screen one of my cases, one of his cases that I had done and said, 'why would you do this? Why would you do the tibia and fibula osteotomy at the same site, because that can cause a stinocosis, no one would do that?' I said, 'oh, seriously, is that bad?' And he said, 'yeah' and I said, 'well do you have concerns about my practice?' And he just stayed quiet. So, I did have an inkling that there was something."*

Comment

Consultant A and Ms Stohr have different views as to whether any perceived shortcomings in her surgical practice were discussed before Consultant A raised them with the Director of Division E. Ms Stohr recalls only one case being briefly discussed. We have no record of the discussions that Consultant A says they had with Ms Stohr about any other cases.

Consultant A acted correctly to raise the concerns they had about Ms Stohr's practice with Trust management. However, we believe that this placed further strain on the relationship between the two consultants.

Missed opportunities

MO3 Divisional management could have anticipated that a poor relationship might have led to a lack of collaboration between the only two consultants in the service and failed to recognise the signs that the relationship was at risk of worsening after Consultant A raised concerns about Ms Stohr's practice.

MO4 Convening an internal, facilitated discussion at the point of Consultant A's complaints may have given the two surgeons the chance to work together sooner to support one another more constructively.

MO5 Because this did not happen, Ms Stohr went on practising unaware of any concerns about her practice until May 2016. There was a clear risk that any poor practice from December 2015 until then would persist.

Recommendations

R3 Line managers should intervene with clinicians more promptly to address and resolve relationship problems where they might adversely affect patient safety (especially in small specialties). Line managers should consider whether informal approaches to resolve any problems, such as encouraging colleagues to talk through issues are needed. Support may also be considered for more explicit conflict resolution or mediation if problems persist.

9. Mr Hill's external review

Medical Director's office involvement

9.1 Dr Ahluwalia was Medical Director at CUH from April 2008 until the end of October 2017.

9.2 Dr Ahluwalia recalled little about the concerns raised about Ms Stohr in 2016 and the external review that followed. He told us:

> *"I can remember very little about this case and I can barely remember Kuldeep [Ms Stohr]. If it hadn't been put into the papers and in an email exchange from my successor asking about any retained information, I wouldn't have remembered her surname even."*

9.3 Dr Ahluwalia described the casework demands on the Medical Director's office at the time:

> *"There were probably, at any one time, 20 or 30 on our casework list on a regular basis and over a decade, that is quite a lot of people. I bear the scars of Myles Bradbury who was in the public domain vividly because I was daily involved with him for the entire period and others whom we ended up dismissing.[5] However, on this one, I can't. That is not to make a commentary on the importance or otherwise of this case but, simply put, I just don't have a memory of this one."*

9.4 The Medical Director's office has a bi-weekly meeting for the discussion of concerns and other matters about medical staff referred to them. The meeting is chaired by the Medical Director. Deputy Medical Directors and colleagues from medical workforce also attend. Dr Ahluwalia told us that he met with Deputy Medical Directors and colleagues from the workforce directorate on a fortnightly basis to discuss the cases being managed by his office. He added:

[5] Myles Bradbury was a former consultant paediatric haematologist at Cambridge University Hospitals NHS Foundation Trust, who was convicted in 2014 of serious sexual offences against child patients under his care.

"The more serious cases, and I am not trying to undervalue the index case here, that had been referred to the GMC or where the consultant was suspended or excluded, or placed on a formal retraining programmes, took up the bulk of the casework time but also the separate meetings outside that often on a one-to-one basis."

9.5 Deputy Medical Director A said that:

"During that time the membership of the casework group comprised Dr Jag Ahluwalia (MD/RO and chair), myself, … [two other Deputy MDs] … [the Associate Director of Workforce], … Deputy Head of Medical Staffing and … Senior Medical Staffing Adviser."

9.6 Then, as now, the Medical Director was supported by a number of deputies, each with a specific area of focus. Deputy Medical Director A is experienced and held the remit in the Medical Director's office to deal with concerns about the performance of doctors. We asked Deputy Medical Director A how he had come to learn about the concerns raised by Consultant A:

"[Consultant A] had raised concerns about Kuldeep by submitting a number of case names. Clearly this wasn't something that was going to be possible to resolve just internally. It was clearly a serious thing. My style is not to brush things under the carpet, which has held me back quite a lot here, people wish I did that a bit more. We were thinking okay, if we have these cases where concerns have been raised, what we are going to do?"

9.7 We asked Deputy Medical Director A for his assessment of the matters raised by Consultant A:

"It's important for perspective to recognise that the concerns that were expressed by [Consultant A] about Kuldeep are not unusual at all. I have been thinking about this and reflecting on it. In the last two years there are 11 consultants in Addenbrookes who other people have expressed concerns about, either about their behaviour or their clinical performance, equivalent to or more significant concerns than those that were expressed about Kuldeep in 2015/16.

I think that is important, because it's always easy to be wise after the event and say, 'well it was blindingly obvious that this was going wrong', or 'this or that should have been done'. It's important to realise the amount of traffic through the MD's office and how difficult it is to deal with."

9.8 We asked Deputy Medical Director A if he knew that Ms Stohr and Consultant A had a difficult relationship at work. He said:

"The answer is yes, they had been at loggerheads, but I had not been involved in any attempt to get them to work together. They were both seen as being difficult individuals. It is no surprise at all that they did not have a well-functioning relationship, and they were the only consultants in the paediatric orthopaedic 'team'."

9.9 The Associate Director of Workforce said the following about the commissioning of the external review:

"When [Consultant A] raised concerns about clinical cases, Jag and [Deputy Medical Director A] did not consider them to be trivial and did not sweep them under the carpet. They commissioned an external review."

9.10 We asked the Associate Director of Workforce how such external reviews were commissioned and conducted. They said:

"I am not aware of any formal guidance. External reviews are commissioned by a number of different people and, depending on the nature of the concern and how it comes forward, that will determine who commissions the review. If it is a clinical concern about a doctor, then that is a discussion that happens between the Medical Director and his deputies in that team. I am sure that the Execs talk to each other as well, and the Workforce Director is often, but not always, involved in those conversations. So no, I do not think there is a hard and fast rule, and it would just depend on the nature of the complaint."

9.11 Dr Ahluwalia told us that, in his experience, external reviews were invariably commissioned through the Medical Director's office:

"I would say that in my near decade there, I was not aware of any external reviews that were commissioned without our involvement, so I am sure I was involved with that or would have been aware of it."

Comment

Deputy Medical Director A and the Associate Director of Workforce are both experienced in dealing with concerns about doctors in the Trust. We are satisfied that they recognised the potential seriousness of the concerns raised by Consultant A.

We accept that Dr Ahluwalia, Deputy Medical Director A and colleagues in the Medical Director's office had, over some years, dealt with a number of other serious cases in the Trust. In our view, they did not initially see the issues raised by Consultant A as being significantly more serious than others that had been raised in the past.

They did, however, go on to ensure they were properly investigated. We consider that Deputy Medical Director A's decision to commission the external review was a proportionate and appropriate response to enable the Trust to have the concerns raised by Consultant A independently evaluated.

Commissioning of the external review of cases

Identification of the clinical reviewer

9.12 On 3 March 2016 the Director of Division E wrote to a colleague at Great Ormond Street Hospital for Children (GOSH) about the need to identify an experienced orthopaedic surgeon to review Ms Stohr's cases as identified by Consultant A.

"We met briefly at GOSH a few weeks back when I was there about your gastro service.

I wonder whether I could ask your advice on recommending an experienced and expert paediatric orthopaedic surgeon, who might have time to help our MD's office with a review of our paediatric orthopaedic service!?

Happy to discuss on the phone if that would help."

9.13 The Director of Division E's GOSH colleague replied and suggested the name of Mr Robert Hill, senior consultant paediatric orthopaedic surgeon at GOSH and now recently retired Medical Director at The Portland Hospital.

9.14 Deputy Medical Director A added:

"Obviously I spoke about this with Jag, the then Medical Director, and [the Associate Director of Workforce]. Jag was a neonatologist by clinical background; he knew the Medical Director of Great Ormond Street via his neonatology connections. There was a conversation between Jag, and I don't know who that was, saying that a man called Robert Hill was their senior paediatric orthopaedic surgeon and a sensible person, so Jag gave me that name and I sent an email."

Comment

The Trust identified Mr Hill as the external reviewer based on a recommendation from a colleague at Great Ormond Street Hospital. There appeared to be no other reviewer considered. We do not consider this to be inappropriate. In our experience, independent experts can be difficult to source, and it is not unusual for senior doctors to use their networks in this way.

We believe that this approach was a tried and reliable way for the Trust to secure an expert analysis of Ms Stohr's practice.

Scope of the review

9.15 On 15 April 2016 Deputy Medical Director A emailed Mr Hill:

"This email, which comes out of the blue, follows a call to [a colleague] this morning. I write as Deputy Medical Director in Cambridge…, to ask if you could help us with a problem …

In confidence, and in brief: we have two paediatric orthopaedic surgeons in Addenbrookes. Relationships between them are not comfortable, and it's fair to say that they are not easy colleagues to work with. One has complained to the Divisional Director that the surgical outcomes of the other are poor, hence I think we need to have an external review. I think that this would, in the first instance, involve interviewing both consultants and looking at clinical outcomes of the whole service, i.e. both consultants, by review of an appropriate number of case notes. Whether anything else was needed would depend on the outcome of the initial interviews and case reviews.

Could you help us with this? We would, of course, pay you for doing this for us. Please give me a call… if you'd like to discuss."

9.16 Deputy Medical Director A and Mr Hill subsequently spoke. Mr Hill recalled the conversation:

"He [Deputy Medical Director A] explained that concerns had been raised by another consultant and, specifically, 10 cases had been presented to him where the other consultant felt that the wrong treatment, or inappropriate treatment, had been given. I was requested to review the records of those 10 patients and give a view as to whether I thought their treatment was appropriate."

9.17 Deputy Medical Director A confirmed that Mr Hill agreed to conduct this review. There was no evidence that either the Director of Division E or Deputy Medical Director A had considered any other potential reviewers. Similarly, neither doctor said that they consulted Consultant A or Ms Stohr about their choice of reviewer before Mr Hill was engaged.

9.18 The Director of Division E appeared to think up until this point that the external review would cover the work of both Ms Stohr and Consultant A and consider both their clinical outcomes. However, Deputy Medical Director A commissioned Mr Hill to look solely at the clinical cases of Ms Stohr as identified by Consultant A. This change appears to have happened after his first conversation with Mr Hill.

9.19 Deputy Medical Director A told us that, after speaking with Mr Hill, they agreed that he would review only those patients of Ms Stohr that Consultant A had reported to the Director of Division E.

Comment

Mr Hill's terms of reference were set out in Deputy Medical Director A's email of 15 April 2016. They were brief, but we believe they were adequate for Mr Hill to understand what he had been asked to do. It appears that in the conversation between Deputy Medical Director A and Mr Hill it was agreed that the review would focus solely on Ms Stohr's cases as raised by Consultant A.

The Trust did not provide any specific written guidance to Mr Hill about how to conduct and present his review, and he was left to decide how best to evaluate the evidence and to present his findings and advice.

The suggestion that Mr Hill might speak to Ms Stohr and Consultant A in the review was not followed through. It is not clear why this did not happen, and Mr Hill ultimately conducted a desktop review of clinical notes and documents about a number of Ms Stohr's cases that were provided to him by CUH.

Consideration of potential conflicts of interest

9.20 Deputy Medical Director A updated the Director of Division E on 18 April 2016 after he had spoken to Mr Hill, writing:

> *"I've now tracked Robert Hill down and had a chat with him. He's willing to help us with a review of cases, hence a few queries:*
>
> *Can you send me the list of cases about which [Consultant A] has raised concerns?*
>
> *Now that Robert [Hill] has agreed to investigate, I need to explain this to [Consultant A] and Kuldeep so that they (a) know about it, and (b) don't have any reason to object to [Mr Hill] giving an external opinion (the paediatric orthopaedic*

world is a small one: Kuldeep trained at GOSH, and he's met [Consultant A] before). Does Kuldeep know that [Consultant A] has made specific complaint about her practice? How much, if anything, do they both know about our plans for review?

I have agreed with Robert H that the investigation will initially consist simply of review of the clinical records of the particular cases about which concern has been raised. If problems are identified, or there are matters which can't be established simply by record review, then we will consider how to proceed."

9.21 In a written statement Consultant A questioned whether Mr Hill had been an appropriate person to conduct the review due to concerns about his expertise in hip dysplasia surgery and their belief that Mr Hill and Ms Stohr were friends having worked together at GOSH, with Mr Hill possibly having trained Ms Stohr. We understand that they did not have the opportunity to discuss these reservations with Deputy Medical Director A before Mr Hill was invited to conduct the review.

9.22 We asked Deputy Medical Director A whether he had discussed with Mr Hill if he knew Ms Stohr sufficiently well to have a conflict of interest. He told us that he had:

"The standard thing that we always talk about is, are there conflicts of interest? Obviously in specialities, particularly small specialities, if somebody said 'actually, I don't know somebody' you might begin to wonder whether they are in fact the right person. So, he said that he knew that Kuldeep had done a period at GOSH of about a year, when she wasn't working directly with him, she was working a post-CCT[6] fellowship with another paediatric orthopaedic consultant at GOSH, so he knew of her.

***Q**. He wasn't her trainer?*

***A**. No, he wasn't her trainer. He said that he had never had any conflict or significant interaction with her and so he felt that he was not conflicted in providing an opinion. I know that [Consultant A] takes a different view…*

But what I would say is in a thing like paediatric orthopaedics, at that time, I suspect that there were probably only 40 or 50 of them in the whole country. It's unlikely

[6] Certificate of Completion of Training (CCT) is a certificate that confirms a doctor has finished an approved training program in the UK and is eligible for entry onto the Specialist or GP Register.

that somebody would be both very knowledgeable of the subject and not know somebody who had worked at Great Ormond Street."

9.23 We asked Mr Hill about his prior knowledge of Ms Stohr:

"As I recall, we had a letter from [Deputy Medical Director A], who I believe to be the Deputy Medical Director, sent to me here, asking whether I would do a report. He gave some details, and I explained that Ms Stohr had been one of the trainees at Great Ormond Street where I was working at the time and potentially there was a conflict of interest. However, my recollection is that he said, 'that's fine. Please still do the report.'"

9.24 Mr Hill confirmed to Deputy Medical Director A that he did not consider his previous interactions with Ms Stohr to be a conflict of interest. Deputy Medical Director A agrees that Mr Hill gave such a confirmation.

Comment

It is important in an external review that those involved should have confidence in the qualifications, experience and the independence of the reviewer. Deputy Medical Director A anticipated the potential for a conflict of interest and explored the issue with Mr Hill before his appointment. We believe that Deputy Medical Director A properly satisfied himself that there was no conflict of interest that prevented Mr Hill from carrying out a thorough and impartial review.

There was an opportunity for Deputy Medical Director A and others in the Medical Director's office to anticipate how to reassure Consultant A and Ms Stohr about Mr Hill's suitability for the task, but it was not taken. This meant that Consultant A could not have been satisfied, before the review started, that their concerns about a possible conflict of interest had been considered by Deputy Medical Director A and colleagues.

Communicating the next steps

9.25 On 3 May 2016 the Associate Director of Workforce wrote to Consultant A to invite them to a meeting with Deputy Medical Director A to discuss the concerns they had raised and to outline the proposed process for reviewing the cases.

9.26 On the same date, the Associate Director of Workforce emailed and spoke to Ms Stohr to inform her of the concerns raised by Consultant A and the proposed external review. They wrote to Deputy Medical Director A after this conversation:

> *"I have just spoken to Kuldeep. She says that she didn't know about this and certainly not that [Consultant A] has formally raised concerns about 9 of her cases – she is very (understandably) upset. I have pretty much told her our plan (except I couldn't recall the name of the reviewer) as I didn't feel that I had an option. I will make a file note of my conversation with her, and we can see her next Tuesday."*

9.27 On 10 May 2016 Deputy Medical Director A and the Associate Director of Workforce met Ms Stohr to explain which cases would be reviewed and by whom. Ms Stohr agreed to this. She told us:

> *"I asked [Deputy Medical Director A] and [the Associate Director of Workforce] at the time, could we not review the whole department? It's only two of us, could we not review all our cases? They said no."*

9.28 On 11 May 2016 Deputy Medical Director A emailed Ms Stohr in response to questions she had asked following a meeting they had the previous day:

> *"A brief note following our meeting yesterday. You asked for dates of when various things happened, and I was not able to provide them from memory. I've now looked at emails. To my knowledge, the first email that [Consultant A] sent to [the Director of Division E] raising concerns was on 29 December 2015. Following a meeting with [the Director of Division E] he sent a more detailed email on 28 February 2016. My conversation on the phone with Robert Hill was on Monday or Tuesday, 18 or 19 April. Since our discussion yesterday I have sent an email to him asking if he can give us a date to review the cases.*
>
> *Please let me know if you have any queries or would otherwise like to talk things over."*

9.29 On 19 May 2016 Mr Hill proposed to Deputy Medical Director A that he visit Addenbrooke's on 13 June 2016 to carry out the review. Deputy Medical Director A confirmed the arrangements by email on 26 May 2016.

Comment

Ms Stohr was only told about Consultant A's concerns about her clinical practice some five months after he had first written to the Director of Division E. No-one had spoken to her until 3 May 2016 when she was advised by the Associate Director of Workforce about the concerns that had been raised and the external review.

When the Trust first learned about the concerns raised by Consultant A there appeared to be little attempt made to get the two surgeons together to share their understanding of what the concerns were, and whether they could be addressed locally in the service. This meant that Ms Stohr remained unaware for many months that these concerns had been raised by her only consultant colleague.

Process of the review

9.30 We spoke to Mr Hill about:

- What he was asked to do by Deputy Medical Director A
- How he went about his review
- What he found and advised
- Subsequent communication and correspondence he exchanged with the Trust

9.31 Mr Hill described his review to us:

> *"He [Deputy Medical Director A] explained that concerns had been raised by another consultant and, specifically, 10 cases had been presented to him where the other consultant felt that the wrong treatment, or inappropriate treatment, had been given. I was requested to review the records of those 10 patients and give a view as to whether I thought their treatment was appropriate.*

They set out the problem, in that they had these allegations which had been raised about these 10 or 11 cases, and they asked me to look at the notes and the allegations. I was left to report in whatever format I felt was appropriate."

9.32 On 13 June 2016 Mr Hill reviewed the cases of Ms Stohr that were identified by Consultant A in his email of 28 February 2016. Deputy Medical Director A had taken steps to ensure that the necessary documents and images were available for the review.

9.33 Mr Hill explained how he had conducted the review:

"I went for a day to Addenbrookes, and they sat me down in a room at the front of the building, overlooking the car park, and I was given either paper and/or electronic notes on the 10 cases. When I wrote my report, I set it out case by case, as I remember. In one of the 10 cases they didn't provide me with the notes, so I did 10 but there were 11.

Q. *Was the material sufficient for you to form an opinion?*

A. *Yes, it was sufficient to form an opinion. In some cases, there was what I considered to be relevant documentation missing. When you go through my report, you will see that sometimes I said, 'x-ray not available', or something like that. Nevertheless, I felt on the 10 where there were records, which were mainly complete, they were sufficient for me to give an opinion, particularly as I was being asked to address a specific concern. [Consultant A] says, 'she shouldn't have done this, this and this', and I was able to answer and say that this, this and this were okay or not okay, as the case may be. The report was very much orientated towards the specific complaints or allegations on each case.*

Q. *You didn't talk to Kuldeep or [Consultant A]?*

A. *I did not talk to either of them."*

9.34 Consultant A confirmed:

"I cannot now recall whether I was aware that he [Mr Hill] was the consultant appointed to conduct the review prior to being told of his findings by the Trust. I

was not involved in Mr Hill's review. I was not asked to speak with him about my concerns, and I am not aware whether he asked to speak to me."

Comment

We are satisfied with Mr Hill's reassurance that he had sufficient information to review the majority of the cases he considered. Any reservations he had about the availability of information in the cases were clearly explained to the commissioner in his report.

Mr Hill's summary findings and advice to CUH

9.35 Mr Hill's written report is sixteen pages long with one appendix (Consultant A's concerns as expressed in an email to the Director of Division E of 28 February 2016). Mr Hill comments on eleven of Ms Stohr's cases but was unable to review one of the cases because the documents were not available to him.

9.36 Mr Hill sent his report of the completed review to Deputy Medical Director A on 29 June 2016. He believes that it was sent by email and post.

9.37 Mr Hill includes the following words in the methodology section of his report:

> *"I have concluded with some general remarks and specific advice. I am prepared to meet with representatives of the Trust to discuss further if this would be helpful or to deal with further enquiries."*

9.38 We asked Mr Hill what his review revealed about Ms Stohr's practice:

> ***"Q.*** *In terms of what you found, and the scale of seriousness, where would you have put what you found?*
> ***A.*** *It sounds like a simple question to answer but, in a way, it is not. When I went through each individual case, there were some that I had no concerns about and some where I had concerns. My level of concern was as written on each individual case. Some things should not have happened, and I said that. My concerns – which we can go through in more detail if you want to – extended beyond the care of individual patients."*

9.39 He said:

"I made comments about the relationship between the two consultants, and I made comments about what they might do to improve the governance around paediatric orthopaedics. If you averaged it out, you could probably say I had just the good side of moderate concerns about it. There were things that were definitely wrong but, … the way in which I wrote the report was intended to be constructive rather than being pejorative in every sentence, which would have made it difficult for the Trust to do something about it. I tried to write the report in a constructive way…

There were some definite actions that I wrote, and there were some which should have been easy enough for the reader to identify as being appropriate to take. That is the interpretation."

9.40 Mr Hill talked us through his 2016 report when we interviewed him in 2025. We use Mr Hill's words to summarise each case:

"Case 1 - My conclusions were, 'unwise to carry out bilateral surgery. Decision-making correct. A technical error'. I also noted, because this came up later on, that there was no post-operative CT scan[7] to assess results.

Case 2 - This was a dislocated hip. I made some comment about this because Ms Stohr continued with a form of treatment. She got one hip back in the socket and the other hip not. It was unwise to continue with the treatment if the hip was still dislocated.

Q. *This is the Pavlic harness?*

A. *The Pavlic harness, yes. So, a little confusion crept in here, and it was almost like we didn't quite know what to do: we had got one right, but one wasn't right. What were we to do under those circumstances? I didn't get the impression that there was a clear plan, or a clear direction, and there was a delay in treatment. Then a procedure was done and again there was an issue about scanning afterwards to check on the position.*

Q. *That seems a very significant -*

[7] A CT (computed tomography) scan is a medical imaging procedure that uses X-rays and a computer to create detailed, cross-sectional images of the inside of the body.

A. *Well, I'm not the only person to have said that. Even I can see what Mr Hunter has - according to the - so, yes. There was a little bit of an issue about the arthrogram, there was a technical point about it and then an operation was done. I said, 'I have some anxiety about the intra-operative images and the adequacy of the reduction and quality of the Salter' I raised concerns about technical -*

Case 3 - there is not much there, it is reasonable and there are a few minor comments.

Case 4 - I didn't understand the decision-making. The left hip was not properly reduced: 'sub-lux' means half in, half out. It is another case where bilateral surgery has been done, six and a half hours this one took. That is a long time.

Q. *Yes, and you clearly say there that it wasn't required.*
A. *Yes. I made some technical points about the pelvic osteotomy*

Case 5 – In my view surgery was reasonably advised and the result is very satisfactory but the patient needs continued follow up.

Case 6 - is another hip dislocation, and I will skip to the comments. Again, I said the suggestions are a bit uncharitable – we have all had problems and these are difficult cases. Again, I am trying to write a report in a way which is conducive to the Trust sorting something out, without me being excessively pejorative, which is not helpful. However, I did not shy away from making comments when I thought they were appropriate. 'Some thought might be given to the technique of the Salter'. Okay, that was probably a bit mild, but this is where the interpretation comes in.

Case 7 - there was a complication, which is a known complication and it does not necessarily indicate poor care but, again, I said, 'maybe you need to think about how you are doing your pelvic osteotomies.', but I did not substantiate the complaint that was made against her.

Case 8 - Yes, 'there would been a case of transferring this patient out. This is not a case for an occasional operator.'

Case 9 – no clinical concerns

Case 10 – missed a fractured humerus.

Q. This is the secondary trauma, secondary survey, isn't it?

A. Yes, in somebody with multiple injuries, it is common practice to go back and do a secondary survey and re-examine them for this very reason.

Case 11 – clinical notes not available

Case 12 - The Trust should have had a process for the introduction of new procedures or new implants. I didn't know whether it did, and I do not know whether they followed it in this case.

***Q**. Should this case have been investigated subsequently?*

***A**. Well, I think so. I said this was a matter for the Trust, inside of its own protocols that were not followed. The complaint is that this was a procedure new to the Trust and protocol authorisation had not been followed. This was a matter for the Trust to decide whether its own protocols were not followed.*

***Q**. I put in my notes that this should have been looked into further.*

***A**. I think if I had been the recipient of this report, I would have said, 'well we need to check whether we authorised that.'"*

9.41 Ms Stohr told us at interview she had since reviewed the cases that had been considered by Mr Hill and noted that:

"Twelve patients were referred by [Consultant A] to review. Of these, three attracted criticisms. All three did well clinically. In my opinion, I think that there have been cases where I could definitely have done better, and it could have been better for the patients if I hadn't operated. Those cases are few and I have been candid with the patients throughout. Those outcomes when presented in the reports were not a surprise to me, but I haven't had an opportunity to state that."

9.42 Ms Stohr went off sick in March 2024, so this was her clinical assessment before that date.

Comment

Although the terms of reference provided for the review were brief, we consider that Mr Hill was thorough and diligent in his approach to the task, in his analysis of the cases and in producing his report.

We are satisfied that Mr Hill did what was asked of him in the review, met the terms of reference and delivered a report to the commissioner that, from our lay perspective, was comprehensive in its analysis of the individual cases and of the organisational issues it covered.

Mr Hill had been told by Deputy Medical Director A that there were problems in the relationship between Ms Stohr and Consultant A. However, he did not have direct evidence of this as neither of them was spoken to by Mr Hill in the review. He was not asked to examine these relationship difficulties or their impact during his review. We believe Mr Hill worded his report carefully as he did not want to trigger further difficulties between them.

Mr Hill provided advice addressed to the Trust that would be relevant to Ms Stohr and that would have informed Consultant A about what the review had found. In his report Mr Hill focused his advice to the Trust on practical improvements that could be made in paediatric orthopaedics.

Missed opportunities

MO6 Ms Stohr and Consultant A were not consulted about the choice of the external reviewer, had no say in the terms of reference for the review and were not interviewed or involved in the evidence-gathering phase of the review. This may have been a missed opportunity for the Trust to have involved them both more extensively in the process.

MO7 Mr Hill was not asked to explore the relationship difficulties between Ms Stohr and Consultant A that he had been briefed about by Deputy Medical Director A. There was no opportunity for Mr Hill to objectively assess the impact that poor relationships had on the clinical outcomes of the paediatric orthopaedics department.

Recommendations

R4 The Chief Medical Officer's team should develop written guidance on the commissioning of external reviews to ensure they are properly specified, that their findings and recommendations are actioned, and that appropriate monitoring arrangements are established to track progress with any improvement plans. This guidance should be developed in collaboration with line management. The agreed guidance should be set out in a standard operating procedure (SOP).

10. Trust handling of Mr Hill's review and report

Deputy Medical Director A's interpretation of Mr Hill's report

10.1 Deputy Medical Director A has dealt with many concerns about the performance of doctors. He told us what he concluded from reading Mr Hill's report:

> *"That report, did it say everything was perfect? No. It did raise some issues; it made a specific point about a surprise that postoperative imaging wasn't done as frequently as would be expected.*
>
> *It made the obvious point that in managing difficult cases a good MDT would be a good idea. The language I use when I am asking people to do reports, is 'can you please imagine this is a medico-legal enquiry. Do you think there is a breach of duty of care here? If so, do you think it's below, or seriously below?' Because that's language people are familiar with. That report from Robert Hill did not say that there are lots of things that are seriously below.*
>
> *Reading his concluding comments which I have read again since all this blew up, it made recommendations about trying to establish an MDT, about imaging and so that report was shared with Kuldeep and also with [the Director of Division E]."*

10.2 We asked Deputy Medical Director A if he considered that his conclusions about the Hill report were merited by what it contained. He said:

> *"The narrative talks about a number of reservations about the quality of decision-making, but the conclusion says there is not a problem about decision-making.*
>
> *Again, I have read the thing again recently and yes, looking back retrospectively, I can see that there was that tension between some of the comments on individual cases and the final summary."*

10.3 Deputy Medical Director A explained why he had considered whether the report presented any 'red flags' that suggested there was a need to restrict Ms Stohr's practice:

"Those were the questions, that is the way I phrased them, is there anything here, do we need to stop this person, etc? So that conversation was certainly had [with Mr Hill] but in terms of the comment you made about the concluding page, not picking up all the things that had been put on the individual cases, yes, I would accept that. I suppose in retrospect it might have been good for me to go back and push that point a bit more."

10.4 Deputy Medical Director A says that he had a phone call with Mr Hill to discuss his findings and advice.

"Yes, we did have a chat. As I say, his final summary paragraph, this is my recollection of the conversation, was, 'is there somebody here who is a complete menace that you ought to stop operating?' 'No'. 'Are there learning points here?' 'Yes'. 'These are they -', was very much the flavour of it, although I didn't record the conversation."

10.5 Deputy Medical Director A goes on to say:

"Following this discussion with Mr Hill the matter was discussed at the casework meeting, following which Dr Ahluwalia spoke with… an experienced consultant adult orthopaedic surgeon and the Service Lead for Trauma and Orthopaedic Surgery, and asked him to join the paediatric orthopaedic MDT to support the paediatric surgeons. I cannot imagine that he will have done this without having received a thorough briefing from Dr Ahluwalia. Records of the casework meeting show that feedback from him was received."

10.6 Mr Hill accepts that a brief conversation with Deputy Medical Director A may have occurred in the course of his review, but he told us that the first time he had explained his findings at length to anyone was when we met him in May 2025 as part of this investigation. We asked him what, in his experience, such a conversation with Deputy Medical Director A might have covered:

"I don't know what would have happened, had this hypothetical conversation taken place. In the generality, an opportunity to sit down with the author of a report allows you to go through things which you do not quite understand, or where you

require clarification. You may ask for specific suggestions as to how to deal with certain situations. That is what the opportunity would have been."

Comment

Neither Deputy Medical Director A nor Mr Hill can recall any substantial conversation about the findings of the report, and this is understandable, given the passage of time since then.

We consider that it would have been good practice for Deputy Medical Director A to have spoken to Mr Hill in detail about the report before he summarised its findings and shared the report with key colleagues.

Not having this detailed conversation is likely to have deprived Deputy Medical Director A of the opportunity to test with Mr Hill his understanding of the whole of the report, and to resolve any of his concerns about "tensions" and conflicts in the evidence and analysis. Deputy Medical Director A also missed the chance to share with Mr Hill how he would use the report as part of his feedback to Ms Stohr and to others in the Trust.

Deputy Medical Director A and his colleagues in the casework group appear to have interpreted Mr Hill's report as evidence that Ms Stohr could safely carry on practising, but we believe that they did not sufficiently recognise that Mr Hill had identified that she needed help to improve her clinical practice.

Other interpretations of the report findings

10.7 We considered what opportunities the report presented to help the Trust take appropriate actions to address any concerns identified in Ms Stohr's practice. We also sought to understand what advice the report contained about any actions that might be taken to improve the overall effectiveness of the paediatric orthopaedics department.

A lay perspective

10.8 We considered, from a lay perspective, Mr Hill's report and sought to understand the findings about Ms Stohr's practice.

10.9 Mr Hill's report contained the following summary of the recommended steps or actions:

- Newly appointed consultants should not work in isolation
- Establishing an MDT that covers pre-operative discussions as well as mortality and morbidity in which complications can be discussed.
- Given the small size of the team and the complexity of the work, having meetings and case conferences with other Trusts
- Making outward referrals i.e. sending patients to other providers where the CUH clinical team lacks the requisite experience
- Having a development plan for paediatric orthopaedics.
- Ensuring post-operative imaging for all cases of developmental dysplasia of the hip (DDH) - either CT or MRI[8]
- Ms Stohr discussing with consultant colleagues some of her cases
- Ms Stohr getting extra experience with pelvic osteotomies (Mr Hill observes the need for technical improvements)
- Better explanations from Ms Stohr in her case notes
- The Trust ensuring that it has trauma secondary survey protocol and using CT in trauma assessment
- The Trust's new treatment protocol should be followed for appropriate cases.

Mr Hill's perspective

10.10 Mr Hill provided us with a summary of his recommendations and comments for improvement which he anticipated would be understood and considered for action.

"General for Hospital.

[8] MRI, or magnetic resonance imaging, is a medical scan that uses powerful magnets and radio waves to create detailed images of the inside of the body.

Look at organisation of MDT meetings and M & M meetings. 'I would advise the Trust to look at…'
Consider referring cases out if there is inadequate experience.
Vision and development of Department recommended.

Specific for Hospital.
New Procedure Protocol case 12.
Secondary survey protocol for polytrauma

Specific to Miss Stohr and these cases.
As noted, there was a summary, but I stated "for each case I have made some comments and given an overall opinion on management" to emphasise I was expecting the comments under individual cases to be noted. Overall, the first area considered - the decision making – that is what treatment or operation to be carried out I considered reasonable but there were some exceptions as noted.

The second area considered was technical execution of procedures which was commented on under each individual patient is so far as it could be deduced from the imaging and notes.

The third area related to peri operative management of individual cases – that is not the actual conduct of the operation but the pre-operative management and post operative management including follow up.

The fourth area related to note keeping with a better explanation for rationale of treatment.

Taken from my report on individual cases the comments that I expected to be noted and considered were:

1. *Cerebral palsy hip subluxation. Difficult case. Technical error with pelvic osteotomy. No post operative CT scan*

2. *Bilateral DDH. Unacceptable delay in arranging admission. Question about post procedure imaging. I wrote almost a page of comments about management that ought to have led to reflections on part of Miss Stohr.*

3. *Club foot de-rotational osteotomy. No significant concerns.*

4. *Cerebral palsy dislocated hip. Technical errors – hip not fully reduced, pelvic osteotomy. Bilateral surgery not required. Kindly intended comments about experience – referenced at end of report for Trust attention "it is important Consultants do not feel they have to take on a complex case when in reality the Department is not big or experienced enough"*

5. *Perthes disease. No significant concerns*

6. *Late DDH. Issues considered to be known complications and not specific technical error although some comments, including about pelvic osteotomy, intended to be helpful were made.*

7. *Bilateral DDH. Issues known complications. "May need to look at technique of pelvic osteotomy"*

8. *Severe SUFE.[9] Very difficult case with serious but known complication. Consideration should have been given to transferring out.*

9. *Persistent femoral anteversion. Not operated (by Miss Stohr) No comments.*

10. *Poly trauma. Missed humeral fracture. "Should not have been missed" Comments made about organisation.*

11. *Patient details not supplied*

12. *Mobile flat feet. The issue here related to a new procedure and whether Trust had a protocol for new procedures which is outside the remit of the review. The actual operation was in use in UK and elsewhere, but exact role not established at time."*

[9] Slipped Upper Femoral Epiphysis (SUFE) is a hip condition that occurs when the ball at the top of the thigh bone slips backward at the growth plate. It is most common in adolescents during periods of rapid growth.

Comment

We believe that the advice given by Mr Hill was clear and concise, and that it would require significant organisational focus and individual commitment if it was to be successfully implemented.

Although we are not qualified to comment on the quality of Mr Hill's analysis, nor on his clinical expertise, we had identified from the report – to his satisfaction – a number of observations about Ms Stohr's practice that pointed to issues of clinical competence that she needed to address.

The completion and delivery of Mr Hill's review and report was an obvious opportunity for the Trust to deal with important organisational deficiencies in paediatric orthopaedics. It also presented an opportunity for Ms Stohr to acknowledge and to build up her clinical capabilities by addressing the shortfalls identified by Mr Hill.

This ought to have created the impetus for the Trust, and Ms Stohr, to take the necessary actions to address these shortcomings and to improve her clinical practice. We believe this opportunity was not fully recognised or sufficiently actioned at the time.

The impression gained by Mr Hill was of a divided department in which discussion of difficult cases and mutual support did not exist. His observation that newly appointed consultants should not work in isolation provided a clear reason for management to address the problems caused by the difficult relationships between the two consultants.

Resolving these issues would be a challenging task. The Director of Division E and Deputy Medical Director A needed to take account of the fact that Consultant A was the complainant in this matter and that relations between them and Ms Stohr were already difficult. It was unlikely that they would both readily work together in future to make improvements in the service.

It would have been extremely difficult for management to ensure that complex surgery was undertaken by these two consultants as British Society for Children's Orthopaedic Surgery (BSCOS) recommends.[10]

[10] https://www.bscos.org.uk/Portals/0/downloads/resources/BSCOS%20GPS%201%20Low%20Vol.pdf?ver=ggZHSK4duwr2nnV9HbcRIg%3D%3D

Consultant A's perspective

10.11 Consultant A did not have an opportunity to read Mr Hill's report until April 2025. They set out their views on its content in a written statement:

> *"The body of the Hill Report is disconnected from the conclusions in the Hill Report: it is clear from the body, particularly the 'commentary' sections of the Hill Report, that Mr Hill generally shared my concerns about Ms Stohr's surgical technique and, where relevant, decision-making…*
>
> *However, the severity of the findings in the body of the Hill Report are not reflected in the conclusions to the Hill Report which did not go far enough. Mr Hill only recommended that Ms Stohr (i) increase her use of postoperative imaging; (ii) gain more experience with pelvic osteotomies; and (iii) better record her decision-making in patient notes."*

10.12 Consultant A was also concerned that Mr Hill did not have all the available information to complete the review:

> *"I calculate that in three places in the Hill Report, Mr Hill notes that he needed copies of 'old paper notes'. In relation to two further cases, Mr Hill was unable to identify the relevant patient and so unable to comment on the cases. If the Trust did not provide Mr Hill with this missing information, then Mr Hill's review was incomplete, and the Trust should have followed up with Mr Hill on these points. I do not know whether it did."*

10.13 Consultant A also challenged Mr Hill's analysis:

> *"The irrelevance of the 'complexity of the operations' point: on a number of occasions throughout the Hill Report, Mr Hill notes that the surgery under consideration was a difficult or challenging procedure and suggests that it is therefore reasonable and/or not unexpected that there was a sub-optimal outcome. I disagree strongly with that. A complex surgery should not result in a bad outcome, and a surgeon should only conduct complex surgery if they are capable of doing so in a way that means they would expect a good outcome. Ms Stohr frequently had poor outcomes from challenging surgery not because the surgery was complex but*

because she lacked the knowledge and skills to perform such surgeries resulting in permanent damage or failure to correct a deformity. This is an important difference."

10.14 Finally, Consultant A also commented on the basis for Mr Hill's conclusions about poor working relationships within the department:

"Mr Hill was not qualified to comment on working relationships within the paediatric orthopaedic department: one of Mr Hill's general comments was that the 'way in which this issue has arisen gives rise to the impression of a divided department of paediatric orthopaedics in which discussion of difficult cases and mutual support does not exist'…

I do not understand how Mr Hill was able to draw this conclusion in circumstances where his review was, in his own words, based solely on 'available notes and imaging' and did not include interviewing Ms Stohr or I. Mr Hill therefore had nothing to base this comment on beyond the fact that I had raised (rightly as it turned out) concerns about Ms Stohr's practice. I also need to point out that I understand that MDT meetings did not exist at GOSH. It is also surprising where, as I explained … above, Ms Stohr and I had been friendly until the point at which I raised my concerns."

10.15 Consultant A concluded:

"I would like to stress that whilst I believe there are issues with the Hill Report in places, the clear conclusion from reading the Hill Report in detail is that there were serious issues with Ms Stohr's practice."

Comment

Consultant A had reservations about the choice of the external reviewer, about Mr Hill's experience and the possibility that there could be a conflict of interest arising from his prior knowledge of Ms Stohr. Despite these reservations, Consultant A's statement recognises that Mr Hill's report endorsed the concerns they had raised about Ms Stohr's practice

Communication of the Hill report findings by Deputy Medical Director A

10.16 Deputy Medical Director A has no record of his correspondence from 2016 because of problems arising for all Trust staff from the migration of CUH email to NHS.net addresses. He said:

> *"I and everybody else lost about three years of emails and the only emails that remained saved were the ones I had dragged into a separate folder. I gave all of those to [the Head of Delivery] as soon as all this happened, so I don't have all the emails. In retrospect, it would have been good if I had saved every email relating to that into a separate folder, because just by accident those ones didn't seem to get deleted when things were wiped out. As I say, everything I have, I have shared."*

10.17 Deputy Medical Director A said that, as a result, he could not recall who had received the report in its entirety. We understand that, in 2016, after he had received Mr Hill's report, Deputy Medical Director A shared it with Dr Jag Ahluwalia (then Medical Director of the Trust), with the Director of Division E, the Associate Director of Workforce and a colleague from the workforce directorate and also with Ms Stohr. We believe those individuals are likely, at some stage, to have received the whole report. There is no evidence that Deputy Medical Director A shared the report with Consultant A during this process.

10.18 We asked Dr Ahluwalia if he knew that an external review was conducted by Mr Hill in 2016. Dr Ahluwalia had no access to historical emails or correspondence from his time at the Trust. He told us that he had learned about the review in hindsight, and only as a result of being prompted by exchanges with CUH after he left the Trust.

10.19 He told us that it was likely all the serious cases involving doctors would have appeared on his desk at the time, but that he could not recall ever seeing the report produced by Mr Hill. He added:

> *"I don't recall Ms Stohr figuring in those conversations that I held."*

10.20 We asked Ms Stohr how she had learned about Mr Hill's report. Ms Stohr confirmed that she had been sent the report by email from Deputy Medical Director A. We understand

that Ms Stohr met with Deputy Medical Director A and the Associate Director of Workforce on 4 July 2016 to discuss the findings.

10.21 Ms Stohr also had a one-to-one meeting with the Director of Division E. She said:

> *"This was a meeting arranged by him, but it was very informal, it was just the two of us. I remember him having the report, he said, 'there's no real concerns here'."*

10.22 We have been unable to find any written record of either of these meetings.

10.23 We asked Deputy Medical Director A how he thought Ms Stohr had reacted to the findings and advice of Mr Hill's review. He said:

> *"I would be very surprised if she did anything other than say that she was exonerated"*

10.24 Ms Stohr told us that, after the meetings with Deputy Medical Director A and the Director of Division E she was left with the impression that there were no significant concerns about her practice:

> *"The two senior people said, 'this is okay this report, it's not that bad' so I took that on, I took that message on and indeed Mr Hill's review, as I said, I've gone through them again, the criticisms, although they don't seem mild now in 2025, I get that, they pertain to three patients out of all of these. The criticisms aren't that harsh, 'could have been done better, may need to pay attention to this, I would have augmented this, but nevertheless it's okay'."*

10.25 However, despite this, Ms Stohr accepted that she had issues to address in her practice:

> *"I still didn't quite believe them [the reassurances of the Director of Division E and Deputy Medical Director A], one is a GI [gastro-intestinal] paediatrician, and [Deputy Medical Director A] is a nephrologist, I think. They wouldn't even know how to spell osteotomy, so actually it's up to me to sort out getting this better, is the message I took."*

10.26 Ms Stohr told us that she felt she had been unfairly criticised by Consultant A:

> *"I was very aware then that the relationship between [Consultant A] and I had deteriorated and… was dangerous for me."*

10.27 Ms Stohr told us that she subsequently lobbied colleagues in hopes of getting support to lodge a joint grievance against Consultant A. She said this was unsuccessful and that, in her words, all of them had said:

> *"'Do you know it was a really tough year, but it's done now, I don't want to go there again', so I was on my own."*

10.28 Ms Stohr then submitted her own grievance against Consultant A in late July 2016. She said that she was subsequently contacted by Deputy Medical Director A who encouraged her to re-consider this course of action. She said:

> *"[Deputy Medical Director A] communicated to me by email saying that in that meeting [in July 2016], … I'd said that I do want to work harmoniously towards a better paediatric orthopaedic department, and he said by submitting this grievance you are not fostering that. And so, I withdrew it."*

10.29 Ms Stohr wrote to Deputy Medical Director A and the Associate Director of Workforce on 3 August 2016 to withdraw her grievance. Consultant A was copied into this email. Ms Stohr told us that she inferred from Deputy Medical Director A's approach that he wanted her and Consultant A to:

> *"Just get on with it, you two are as bad as each other, you are on your own."*

10.30 Deputy Medical Director A wrote to Ms Stohr on 4 August 2016 (copied to Consultant A) confirming the withdrawal of her grievance. Consultant A confirmed that they were made aware of the grievance but has never received any details about its content.

10.31 Ms Stohr's view that both she and Consultant A were, in the opinion of Deputy Medical Director A and colleagues, to blame for their relationship difficulties, is further confirmed by a letter from Deputy Medical Director A to Consultant A on 15 August 2016. It read:

"Re: Your concern about patient safety and quality of care

On 20 January 2016 you spoke with [the Director of Division E] to express concern about the clinical practice of your colleague, Ms Kuldeep Stohr. You followed this up on 28 February 2016 by sending him a list of particular patients in whom you thought that care had been sub-optimal. The matter was discussed with Dr Jag Ahluwalia (Medical Director), and the outcome was that I was charged with explaining to Kuldeep that a concern had been raised and organising for confidential external review of the cases in question by an appropriate person. I am now writing to you to explain the findings of the external review.

On 29 June 2016, Mr Robert Hill (Consultant Orthopaedic surgeon at the Hospital for Sick Children, Great Ormond Street, and The Portland Hospital, London) came to Addenbrookes. He reviewed the clinical records of all of the cases that you had identified, and subsequently provided me with a report, which I have shared with Kuldeep. He commented that many of the cases involved were complex, but he did not consider decision making to have been an area of concern and made no findings to lead the Trust to be concerned about Kuldeep's practice. He also made a general comment that the way in which this issue had arisen gave him the impression of a divided department in which discussion of difficult cases and mutual support did not exist.

On behalf of the Trust, I consider that these cases have been properly investigated and am reassured that there is no concern about Kuldeep's practice. However, I do recognise that there is truth in Mr Hill's general observation about the department, and hope that I can work with you, Kuldeep and relevant Service Leads / Clinical Directors / Divisional Directors to develop a cohesive paediatric orthopaedic department, where colleagues support each other in providing good care for our patients.

Please let me know if you would like to meet to discuss this letter."

10.32 Consultant A confirmed that Mr Hill's report was not shared with them at this time and described their reaction to the letter from Deputy Medical Director A:

"My reaction to the letter at the time was one of disbelief and shock. The Trust's letter implied that Mr Hill had dismissed all of my concerns, and I could not understand how this could be the case. It felt as though everything I had learnt throughout my career had been thrown out. I had learned from some of the best surgeons in the world and I thought that I knew very well what good and bad surgical practice looked like. I thought Mr Hill must have got it wrong and/ or that something very wrong had happened.

10.33 However, Consultant A recounted that they did not feel able to raise these concerns or challenge the letter or summary of the report's findings:

"Despite this, I decided I could not challenge the Trust's letter, or the apparent findings in the Hill Report it referred to. I did not even ask to see a copy of the Hill Report. By this point, I really feared [the Associate Director of Workforce] and [Deputy Medical Director A] and was extremely stressed by the whole situation. I thought that if I continued to push when there had been an external review, I risked serious sanctions."

10.34 Consultant A explained that, in August 2016, they were also under disciplinary investigation following a complaint made against them for the alleged bullying and harassment of a clinical nurse specialist (CNS). They described the impact on them of this disciplinary investigation, and their reaction and response to what they were told about the findings of Mr Hill's report:

"I was then disciplined by [Deputy Medical Director A] in August 2016 i.e. at the same time as I was informed that my concerns about Ms Stohr's practice had not been recognised. I do not know if the CNS was disciplined.

"I did not believe that I was being treated fairly by the Trust but, by this stage and combined with the Trust's letter to me regarding the Hill Report, I felt like there was a witch hunt to silence me and to stop me from raising concerns and that I had no choice but to cooperate."

10.35 Consultant A concluded:

"I felt so harassed and bullied by this point that I considered resigning. I decided that resigning was not an option as I did not want to up-root my young family. I therefore decided to instead take a 'step back' and stop raising incidents even where I witnessed something I thought was wrong."

10.36 Deputy Medical Director A said of this matter:

"It is important, because it is material to the way in which [Consultant A] was behaving at the time, to record the fact that the clinical nurse specialist made a formal complaint that [Consultant A] had bullied and harassed her. Following an investigation ordered by the casework committee [Consultant A] decided to accept the written warning."

10.37 Ms Stohr told us that Deputy Medical Director A and the Associate Director of Workforce had met her and Consultant A in September 2016 to discuss how the paediatric orthopaedics department could move forward. She recalled the nature of the discussion at the meeting:

"So, [Deputy Medical Director A] and [the Associate Director of Workforce], what [Deputy Medical Director A] said was, 'there are no significant concerns from the Hill report'. Then he went on to say other things. He went on to say that he regarded that [Consultant A] and I had real similarities and that we were as bad as each other. There was no support, but I do remember that remark…

He said, 'I detect a friction within the team, you are very similar, and you are as bad as each other,' which I found really difficult."

10.38 Consultant A confirmed that this discussion took place:

"I attended a meeting in September 2016 with Ms Stohr, [Deputy Medical Director A] and [the Associate Director of Workforce] in which Ms Stohr and I were told by [Deputy Medical Director A] and [the Associate Director of Workforce] to 'get along' and that the Trust did not want to hear any more complaints. I felt I had no choice but to go along with this since I felt threatened and bullied by [Deputy Medical Director A] and [the Associate Director of Workforce]."

10.39 Consultant A gave us their perspective on the feedback that their relationship with Ms Stohr was at the root of the issues:

> *"I also do not understand the Trust's focus, post-Hill Report, on addressing what they described as Mr Hill's 'impression' and 'general observation' that the paediatric orthopaedic department was 'divided' where it was clear that Mr Hill was not in a position to make these comments."*

10.40 Ms Stohr described her reaction to the discussion in the meeting:

> *"During this meeting I became really upset, because in this meeting when [Deputy Medical Director A] said there were no significant concerns, I said that this process had been really damaging to me, it had been very, very upsetting. I put on 20kg of weight, it was awful, having lost it, and the room went silent as I said that. I was upset, I was crying and [the Associate Director of Workforce] said, '[Consultant A]?' To ask him to sort of respond and [Consultant A] paused, big uncomfortable silences, and he said he wanted to thank the Trust for the review and the opportunity to come and talk about it. Then [the Associate Director of Workforce] and [Deputy Medical Director A] made some sort of noncommittal remark, 'you're welcome' that sort of thing, I cannot remember what they said. I became so upset at that I just thanked them, and I left, I just left the meeting. So, there may have been remarks and conclusions that weren't given to me, because I abruptly thanked them and left."*

10.41 Ms Stohr confirmed that there was no follow-up with her from the meetings:

> *"[There was] no formal follow-up - that I would absolutely remember, and the nature of the correspondence was not memorable and my impression then as I left this meeting was that there were no significant concerns. That [Consultant A] and I are regarded as a problem and as bad as each other and there's no help, there's no support, and I now have to watch my back as far as [Consultant A] is concerned. Those were my take home messages."*

10.42 In 2017 Ms Stohr had an annual appraisal and emailed Deputy Medical Director A and the Associate Director of Workforce on 20 June 2017 to ask if she:

"Should have something in writing that the Trust has considered the complaint and review and that I am considered safe to work."

10.43 Deputy Medical Director A replied to her that day saying:

"The external review was conducted by Mr Robert Hill, Consultant Orthopaedic Surgeon at Great Ormond Street Hospital, London. It considered all of the cases about which concern had been raised. He made a number of observations about the nature of the Cambridge paediatric orthopaedic service in general but did not express any significant concerns about your clinical practice in the cases examined.

At the conclusion of the investigation, the report of which was shared with you at the time, I thanked you for your engagement and help throughout the process and confirmed that the Trust had no concerns about your practice, which should continue."

10.44 When we spoke to the Associate Director of Workforce about what happened after the review, they remained convinced that commissioning the review was the correct thing for the Trust to do to investigate the concerns that were raised by Consultant A:

"People have different opinions on the findings of the review and what should have happened next, but they didn't say, 'Go away, [Consultant A] – we don't want to hear that.' They said, 'Send us the cases and we will get someone to look into it', and they did. It found what it found, and they acted in good faith on the findings."

Comment

Deputy Medical Director A and casework meeting colleagues kept the circulation of Mr Hill's report to a small group of people – none of whom was an orthopaedic surgeon other than Ms Stohr.

Deputy Medical Director A's discussion with Ms Stohr after receiving Mr Hill's report is highly likely to have led her to conclude that there were no specific problems with her surgery and that she could continue to practise. His email to the Director of Division E and his letter to Ms Stohr of 20 June 2017 after her appraisal would have served to

strengthen that view. However, Ms Stohr did recognise that there were areas for her to improve, and she subsequently took steps to address them.

Deputy Medical Director A's positioning of Mr Hill's report with Ms Stohr and Consultant A was in large part to make the focus of his feedback on their relationship difficulties. This placed the responsibility to improve on the two doctors and less of a responsibility on the Trust to organise and support the changes needed in paediatric orthopaedics.

We think he should not have written to Consultant A in the terms that he did in August 2016 or provided the written assurance to Ms Stohr after her appraisal in June 2017. We believe he gave them both the wrong impression of the Hill report, its findings and the improvements required in the department.

Ms Stohr went on working alongside Consultant A, knowing that her colleague had raised concerns about her. It was inconceivable that Ms Stohr would, in the circumstances, have gone on to seek advice or support from Consultant A to address any shortcomings identified in her clinical practice.

The fact that they rarely operated together deprived Ms Stohr of any opportunity to receive direct, real-time feedback from a senior colleague about the quality and safety of her work.

Assessment of the interpretation of Mr Hill's report

10.45 We considered whether Deputy Medical Director A's summaries of the report, as communicated to Ms Stohr, Consultant A and the Director of Division E were consistent with the findings it contained. We asked the key people involved in the review and in handling the report what they inferred from it, and what it led them to do about the matters arising from it.

10.46 We shared the correspondence from Deputy Medical Director A to Consultant A on 15 August 2016 with Mr Hill. We also shared an email sent by Deputy Medical Director A to Ms Stohr in 2017. Both of these messages contained a summary of Mr Hill's report.

10.47 Mr Hill told us:

"I am extremely surprised by this interpretation of my report which I believe to be wrong and a misrepresentation of my views. It is as if my report has not been fully read and [Deputy Medical Director A] has just skipped to the final page and even then, has been selective.

I appreciated that this was a difficult situation for the Trust with a poor relationship between the two Paediatric Orthopaedic Consultants and little evidence of supportive and consensual working. I endeavoured to write a diplomatic and helpful report which had it been studied diligently would have assisted the Trust in dealing with both the relationship issues and the technical/management issue with Miss Stohr's practice.

There were clear technical and management issues which were apparent to Verita and listed by them even though by their own admission they do not have clinical expertise. In the document I provided I have drawn out these issues. The management of the Trust includes clinicians and if [Deputy Medical Director A] did not have the surgical expertise to enable full understanding of the report he should either have taken up my invitation to discuss further, (in the report), or sought the advice of a senior surgical – orthopaedic colleague.

His actions may have had the benefit of expediency but lacked any insight or understanding of the issues that confronted the Trust."

10.48 Mr Hill also reviewed the letter sent from Deputy Medical Director A to Ms Stohr on 20 June 2017 following her appraisal. Mr Hill wrote:

"The response is consistent with the first letter but does raise further questions:
If the report was shared with Ms Stohr, it would have been appropriate to have had a discussion with her and gone through the report to see if there was any learning or actions…

There is nothing in the correspondence from [Deputy Medical Director A] to indicate anything was done even about the concerns they did manage to identify from my report. [Consultant A] was just asked to be in contact if he wanted to discuss

further. Did the Trust not convene a meeting to discuss organisation, MDTs, joint working etc?"

10.49 Mr Hill added:

"I regret to conclude, on the information I have – and I would be happy to be wrong – that the Trust failed to draw the correct conclusions from my report, made no effort to check with me that their conclusions were correct and demonstrated little if any insight into the issues confronting them."

10.50 Consultant A saw Mr Hill's report for the first time in April 2025. They set out in thier statement their comments on the Trust's interpretation of the report:

"Whilst I recognise that the Trust's senior management team were not paediatric orthopaedic surgeons, they should have been able to fully grasp the implications of the Hill Report and recognise that it raised serious questions about Ms Stohr's practice. Indeed, I think that it is written in such a way that a layperson without any medical training could quickly identify that the Hill Report raised issues about Ms Stohr's practice that needed addressing urgently. Furthermore, had the Trust's senior management team required any assistance with the Hill Report or had any questions, there would have been plenty of people who could help them with those questions, not least Mr Hill himself who says on the first page of the Hill Report 'I am prepared to meet with representatives of the Trust to discuss further if this would be helpful or to deal with further enquiries'."

10.51 Consultant A added:

"The Trust's senior management team should also have engaged critically with the Hill Report and taken appropriate action. Despite the disconnect between the body and the conclusions of the Hill Report, a critical reader would have been able to discern that the conclusions in the Hill Report did not reflect the gravity of Mr Hill's findings and that more drastic action needed to be taken in relation to Ms Stohr."

10.52 Consultant A outlined how they believe the Trust should have responded:

"In my opinion, the only appropriate immediate course of action was for the Trust to suspend Ms Stohr, pending a broader investigation to identify the extent of the problem and it is telling that the Trust suspended Ms Stohr on 12 February 2025 after the Hunter Report made similar findings to the Hill Report. The Trust should also have commissioned a further and wider review into Ms Stohr's other patients. Doing so would have also given the Trust the opportunity to address any concerns they may have had over the issues with the Hill Report.

10.53 Consultant A wrote:

"Having now seen the Hill Report, I cannot understand the Trust's summary of the Hill Report in their letter to me dated 15 August 2016 and I feel that the Trust lied to me…

I simply cannot understand how the Trust was able to reach that view and write to me in those terms."

10.54 In respect of Ms Stohr's continuing practice after the Hill review in 2016 Deputy Medical Director A said:

"The casework meetings did consider whether or not Ms Stohr's practice should be restricted, kept this under review, and decided that this would not be a necessary and proportionate action."

10.55 He added:

"My actions were all based on discussions and decisions made at the casework MDT."

Comment

We do not consider Deputy Medical Director A's summary of Mr Hill's report to be consistent with its findings, advice, and recommendations for the Trust to consider. In producing and covering Mr Hill's report with this summary, we believe that Deputy Medical Director A diluted the messages that needed to be sent to Ms Stohr about her practice.

Had Deputy Medical Director A discussed with Mr Hill the detail of the findings and his understanding and summary of the report before he shared it with colleagues, it is unlikely that he would have presented it as he did to Ms Stohr and to Consultant A. We consider that Deputy Medical Director A should have taken this opportunity to pause and reflect on the report and to test with Mr Hill his understanding of what it contained and his proposed handling of it.

On the evidence, it seems that Deputy Medical Director A and his casework group colleagues had only partially understood Mr Hill's report and concluded that Ms Stohr's clinical competence was not in question. The result was that she was not restricted from practising surgery or placed under closer supervision from then on.

The way in which the outcomes of the review were communicated to Consultant A left them feeling as though they had been silenced and their concerns dismissed. As a result, they chose not to further challenge the findings of the review and Deputy Medical Director A's interpretation of them. We believe that this inhibited Consultant A from raising any other concerns within the Trust from then on.

Planning for action: handover from the Medical Director's office to Division E

10.56 The Medical Director's office at CUH supports the work and responsibilities of the Medical Director across the organisation. However, it has no executive authority over the five divisions and relies on them to plan and implement organisational change. Deputy Medical Director A expressed the organisational challenge facing the organisation:

> *"There is a tension in the Trust… about the operational lines of command and the Medical Director's office side of things. The operational lines of command go from doctors to service leads, to clinical directors, to divisional directors, who report to the Chief Operating Officer. They don't report to the Medical Director.*
>
> *I don't think there is a perfect way to structure a hospital, if there was, everybody would just do it, but that does create a tension. From the Medical Director's Office, I don't and never have had an operational brief. I can try to influence things, and some divisional directors will actually welcome help and influence from me, but at*

times others would very much say, 'this is our patch, you keep your nose out', sort of thing. I think those tensions arise in any system."

10.57 Dr Shaw, the former Medical Director from late 2017 told us that there was a split between the work of his office and the divisional leadership:

"If it was much less significant as far as the recommendations, if it was really operational matters, it would have been left to the divisions. If it had been matters raised of clinical competence and patient harm, then I would expect the Medical Director's office to take a more active role in that."

10.58 In practical terms, this meant that the Medical Director's office would have needed the attention and commitment of senior staff in Division E – including the Director of Division E, Ms Stohr and Consultant A - to implement the advice and recommendations of Mr Hill's review.

10.59 Deputy Medical Director A told us about sharing the report with the Director of Division E:

"What we did was to ask… the Divisional Director for Paediatrics [Division E], 'these are the recommendations, this is the report which has been shared with Kuldeep, these are the conclusions, can you within the divisional and service structure try to implement those?'"

10.60 On 4 July 2016 Deputy Medical Director A emailed the Director of Division E with an update about the review. In this message he told the Director of Division E that the review had revealed no significant concerns about Ms Stohr's practice. He proposed several actions, the most notable of which was the formation of an MDT chaired by an adult orthopaedic surgeon. He wrote:

"In response to [Consultant A's] concerns we commissioned an external review of the cases he identified. Robert Hill from GOS undertook this for us and has now sent his report. I have shared this with Kuldeep, and [a colleague from the Workforce directorate] and I met with her today.

My perspective is that there is nothing in the report that raises significant concern about Kuldeep's practice, but circumstances mean that she has tackled difficult cases without opportunity for discussion or support. I have told her this, and we moved the discussion onto where we should go from here.

I think that it is stating the obvious to say that what is required is a proper MDT meeting. This needs to be held at a time that is possible for all relevant parties to attend, in the job plans of all relevant parties, and all should be required to attend. It needs to be chaired by someone suitable, proper records must be made of decisions, and there will need to be an 'escalation strategy' in the event that the MDT cannot agree on a course of action. So, my starter for ten (on the basis that a blank sheet of paper isn't helpful) after discussion with Kuldeep is as follows:

Who? – Kuldeep, [Consultant A], Physio, ?Radiologist
Chair? – adult orthopod (?[the Service Lead for Trauma and Orthopaedic Surgery]) … (I do think that moving paed ortho back into ortho would be helpful and reduce Kuldeep's isolation)
When? – ?Wednesday morning
Escalation? – ?do we need to cultivate communication with colleagues at GOS

As regards the report, I have told Kuldeep that I am sharing it with you, but not yet with anyone else. I have said that we will let her know if we do want to share it with others, and I would be grateful if you would do so if you do decide to show it to anyone else. She has told me that she may show it to 'senior orthopaedic colleagues', but that's her call.

I am away from now for the next 2 ½ weeks, hence this rather long email setting out where I've got to."

10.61 It is clear from Deputy Medical Director A's email that, by this time, he had:

- Shared the report with Ms Stohr and workforce colleagues (but not with Consultant A)
- Informed Ms Stohr that there were no significant concerns about her practice
- Decided that setting up an MDT meeting was the priority task arising from the Hill report

10.62 Deputy Medical Director A told us that he expected that the Director of Division E should have read the report carefully and considered the implications for the service within his directorate. In writing to the Director of Division E, Deputy Medical Director A told us that he was expecting the Director of Division E and Division E colleagues to take action to implement the conclusions set out in Mr Hill's report.

Comment

Deputy Medical Director A's attention appears to have been drawn to the summary paragraph in Mr Hill's report, and he conveyed the substance of this to the Director of Division E in his email to him of 4 July 2016. Deputy Medical Director A's email to the Director of Division E does not say what is to happen to all of advice the offered by Mr Hill, some of which required responses from the organisation, Ms Stohr and Consultant A.

We would have expected the Director of Division E, and any other recipient of the Hill report, to have read it carefully and to consider its implications. However, it is more likely than not that the Director of Division E had read the report and been drawn to the conclusion from Deputy Medical Director A's email that the main task for him and colleagues in Division E was to set up an MDT.

Similarly, even if the Director of Division E had noted other issues in the report, it is not clear that Deputy Medical Director A was asking him to take any action to address them, except to facilitate setting up the MDT.

We believe that his approach also failed to create the necessary clarity and impetus to divisional management about what needed to be done to address Mr Hill's recommendations. In our view, this led to little or no planned and appropriate action being taken by the Trust after Mr Hill's review was completed.

While we acknowledge that the Medical Director's office has no operational remit - and no responsibility to implement changes arising from this review - we consider that the handover of the report to the Director of Division E left him believing that no urgent action was required to address Ms Stohr's clinical practice.

This reassurance from the Medical Director's office is likely to have conditioned how the Director of Division E responded to the need to develop and implement the necessary plans to address the findings and advice from Mr Hill's review. We believe this was an opportunity missed to alert divisional management to the shortcomings in Ms Stohr's clinical practice that were revealed in Mr Hill's review.

We consider that a lack of clarity about the day-to-day management of paediatric orthopaedics and responsibility for organisational and clinical improvement played a significant part in the aftermath of the 2016 Hill review about Ms Stohr's surgery.

A more comprehensive and carefully organised handover from the Medical Director's office was needed to ensure that the implementation all of Mr Hill's advice was properly planned and delivered. This could have included Deputy Medical Director A, Mr Hill, representatives of Divisions A and E, Ms Stohr, and Consultant A.

We believe that one individual should have been clearly identified as being accountable for implementation of the advice. Mr Hill could have been invited to support the development of Ms Stohr's technical skills e.g. in pelvic osteotomies. Ms Stohr could have been signposted to other ways in which she could address shortcomings in her practice.

The Medical Director's office and the management of Division E should have worked in concert to facilitate the means by which Ms Stohr could have improved her practice. This should not have been left to Ms Stohr alone to sort out.

Mechanisms to ensure action was taken to implement recommendations from the review

10.63 We asked staff if there were processes or mechanisms in place that might be used to monitor and track progress on actions being taken to address the findings and advice from this review. The evidence suggests that there were no such mechanisms.

10.64 We asked the Associate Director of Workforce in the workforce team about this, and they said:

"Assuming it wasn't closed, I think closing the loop in relation to the recommendations in the 2016 report would have been helpful. I don't know that it wasn't closed but, in the event that it wasn't, then I think it would have been good if it had been, or in future if it could be."

Comment

Planning for the implementation of the Hill review findings and advice was, at the time, inadequate. It was not clear as to how the advice would be turned into practical actions. We saw little sign that Deputy Medical Director A and the Director of Division E worked together to understand the import of Mr Hill's report. We also saw little evidence that they considered collaborating on developing a plan to ensure that actions would be taken.

Deputy Medical Director A's view that it would be exclusively the division's responsibility to implement the advice and the recommendations from the Hill report left the Director of Division E and his senior colleagues to work out for themselves what needed to be done about the individual and organisational issues identified by Mr Hill.

It was assumed by Deputy Medical Director A that the Director of Division E would take on responsibility to implement the advice and findings of the Hill report, but we believe that this should have been explicitly agreed and recorded to prevent it from drifting without clear ownership.

We believe no-one stepped forward at that point to take lead responsibility for ensuring that improvements to Ms Stohr's practice were achieved and maintained.

There was no monitoring mechanism put in place to track whether any plan would deliver its actions and outcomes. There seemed to be no expectation that there would be any systematic reporting or follow-up between Division E's management and the Medical Director's office.

Availability of the Hill report to other Trust staff

10.65 We spoke to a range of staff about when they became aware of the Hill report and its content. These included the other surgeons in paediatric orthopaedics. We also spoke to senior members of the divisional management team, and to executive directors of the Trust.

10.66 Apart from the small number of staff who were involved in the commissioning and immediate handling of the Hill report, we found no-one else who knew about the report, or its findings from 2016 until early 2024.

Paediatric orthopaedics department

10.67 Consultant B joined the paediatric orthopaedics department at the Trust in December 2016, having worked there in a locum capacity before accepting his current appointment. We asked what their early impressions were of the team:

> *"I was aware that there had been an external review commissioned prior to me joining the Trust, so I was aware that there had been a background of perhaps tensions or poor outcomes or something… I did actually ask, 'what was the outcome?'. It was largely dismissed, I was told it was absolutely fine, nothing to see here, move on."*

10.68 They added:

> *"It was only vaguely mentioned in pre-interview discussions, you know, 'I'm applying for a job in your department, you've had an external report, what was the conclusion?', 'Oh, there was nothing to see here'."*

10.69 We asked if Consultant B knew who had seen the Hill report and what had happened as a result, and they said:

> *"I don't know who did see that report, I don't know who took responsibility for implementing the recommendations of that report, but in my experience of working in this department shortly after that report, I didn't see any of those recommendations being implemented."*

10.70 Consultant B confirmed that they had not discussed Ms Stohr's involvement in the Hill review in 2016. They told us that**:**

> *"I think in ten years, I probably did two or three joint cases with her. I have done joint cases with her, and I was only too happy to work with her. I think together we had successful outcomes. She and I have discussed a couple of tricky cases, but no, we never spoke about the 2016 report."*

10.71 Consultant C joined the Trust in April 2019 as a paediatric orthopaedic surgeon working alongside Ms Stohr, Consultant A and Consultant B. They are the last of the current consultant surgeons to join the team. Consultant C took over from Ms Stohr as clinical lead for paediatric orthopaedics in March 2020.

10.72 We asked Consultant C when they had first received the Hill report. They told us:

> *"I was given the report at the end of March [2025], having asked for it for several months."*

10.73 Consultant C was aware that Ms Stohr's practice had been reviewed in the past. They confirmed that they were friendly with Ms Stohr and had known her before she arrived at CUH in 2019 and, since then, had worked with her on quite a few occasions:

> *"She would tell me that there was an investigation happening, so I did know that an investigation had happened. At the end of that investigation, she just said that no clinical concerns were found, and it was just 'get on with everything as normal' … I heard that many times."*

10.74 We asked Consultant C if they were aware of any actions that had stemmed from the Hill report, and they said that:

> *"One thing she told me was that the report recommended that an MDT meeting be started every week and that she had done that, and that was all I knew."*

10.75 Consultant C confirmed that Ms Stohr's approach to imaging was deficient:

"It's standard practice to get 3D post-operative imaging. All the other three of us get it, and she was asked time and time again to get it, and refused and she would say, 'I've had an external review of my work, and my practice is fine. I know that from my X-ray [2D] imaging it is fine.'"

10.76 Consultant C told us they believe that:

"By the Trust saying that there were no clinical concerns, that standard of care was taken by the team to be normal. Therefore, when there were any concerns in the future, the reply was, 'I have had an external investigation. I have been cleared', and so substandard care was normalised."

Comment

All three of Ms Stohr's consultant colleagues in the paediatric orthopaedic service knew that her clinical work had been subject to an external review at an earlier period. However, none of them had access to the Hill report before further concerns about Ms Stohr's practice came to light in 2024.

Ms Stohr's response to any questions from colleagues about her clinical practice - for example about imaging - was to reference the 'clean bill of health' she believed that she had from the Hill review.

This made it difficult to challenge or influence the quality of Ms Stohr's clinical work. Consultant B carried out dual operating with Ms Stohr on a small number of occasions and followed up one or two of her patients and had no concerns.

Alleged cover-up

10.77 In a statement to this investigation Consultant A wrote:

> *"I am shocked, desperately saddened and very angry by the Trust's seemingly wilful and deliberate mischaracterisation of the Hill Report in their August 2016 letter to me and their total inaction in relation to Ms Stohr's surgical practice in 2016. Only now is it becoming clear that this missed opportunity and cover-up by the Trust has led to calamitous consequences for a currently unknown number of children. I believe that the Trust senior management bear responsibility for the tragic events that have unfolded."*

10.78 Cover-up claims have also been reported in the press.

10.79 We have examined in detail the events of 2016:

- Consultant A raised concerns about Ms Stohr with the Director of Division E in late December 2015 by email
- The Director of Division E replied to Consultant A the next day

- The Director of Division E and Consultant A further discussed the concerns in January 2016
- Consultant A supplied more evidence to the Director of Division E in February 2016
- The Director of Division E discussed the matter with Deputy Medical Director A and wrote to a colleague at GOSH about a suitable reviewer. We think it is likely that Deputy Medical Director A will have discussed the matter with colleagues including Dr Jag Ahluwalia, then Medical Director
- Deputy Medical Director A contacted Mr Hill and appointed him to carry out the external review
- Mr Hill visited the Trust in June 2016 and carried out a desk-top review of 12 of Ms Stohr's cases
- Mr Hill delivered his report to Deputy Medical Director A at the end of June 2016
- Deputy Medical Director A read and then circulated the report to a small group of colleagues including the Associate Director of Workforce, a colleague from the workforce directorate, the Director of Division E and Ms Stohr. We think it is likely that Dr Ahluwalia also saw the report.
- Deputy Medical Director A met Ms Stohr in July 2016 to tell her the outcome of the Hill review.
- Deputy Medical Director A explained his understanding of the report at the time (which has subsequently been challenged) to Ms Stohr and Consultant A.
- Deputy Medical Director A and the Associate Director of Workforce met with Ms Stohr and Consultant A in September 2016 to discuss moving forward with their relationship difficulties.

Comment

The Trust commissioned an external review from an experienced and senior paediatric orthopaedic surgeon from a world-class children's hospital in response to Consultant A's concerns.

For there to be evidence of a cover-up, we would have expected to find that Consultant A's concerns had been ignored or suppressed when they raised them. We would have expected that they would not have been investigated, internally or externally, and no report would therefore have been produced about them.

Had the Trust wished to cover up Consultant A's concerns then commissioning and paying for an external review by a senior consultant from Great Ormond Street Hospital was an unlikely way to go about doing so.

Deputy Medical Director A did share the report with a small number of colleagues in the casework group at the time. As we have seen since, the report has been discoverable, but it was not shared with colleagues in paediatric orthopaedics until April 2025

Our view is that Deputy Medical Director A and colleagues had failed to understand fully the findings, conclusions and recommendations of the Hill review when presenting the outcome to Consultant A and Ms Stohr. This happened because he had not taken up Mr Hill's offer to discuss his detailed findings at a meeting. Mr Hill confirms this to be the case.

Deputy Medical Director A compounded this misunderstanding of the report in letters he then wrote to Consultant A in 2016 and to Ms Stohr after her appraisal in 2017 in which he summarised the Hill report findings in an inaccurate and misleading way. In doing so, he gave incorrect assurance to Ms Stohr about her clinical practice.

We have found no evidence to support the allegation that Deputy Medical Director A wilfully and deliberately mischaracterised the Hill report.

In our culture section (section 15 below) we report on conversations we have had with senior medical staff in the Trust. They speak of an organisational culture that is reluctant to learn from others and that tends to minimise or neutralise the findings of external investigations and reviews. We believe that this factor was at play in this case.

Missed opportunities

MO8 Deputy Medical Director A's presentation of the Hill report's conclusions to Ms Stohr and to the Director of Division E meant that a major opportunity was missed to address the shortcomings in her surgical practice identified in the report.

MO9 The lack of any detailed conversation between Deputy Medical Director A and Mr Hill after the report was completed meant that Deputy Medical Director A was unable to test his understanding of the report and its conclusions with the reviewer.

MO10 Similarly, this prevented Deputy Medical Director A from rehearsing with Mr Hill how he planned to summarise and position the report with Ms Stohr and the divisional management.

MO11 The limited circulation of the Hill report within the Trust was an opportunity missed for the Medical Director's office, divisional management and Ms Stohr to work together to plan for implementation of its findings.

MO12 The incorrect reassurance given to Ms Stohr and the management of Division E meant that she, and her managers and colleagues, assumed that she was fit to practise with no restrictions on what work she could do in future.

MO13 There was a lack of open and candid sharing of the report with clinicians and managers in paediatric orthopaedics who could have supported Ms Stohr to improve her practice.

MO14 The organisational failure to understand the findings of the report meant that there was insufficient recognition of the need to help Ms Stohr achieve an acceptable standard of clinical practice.

MO15 As a result, the opportunity was lost to develop and implement an improvement plan for Ms Stohr to address the practice shortcomings that had been identified.

MO16 Divisional management, in consultation with the Medical Director's office, could have agreed what such a plan would comprise, and how its implementation would be monitored.

MO17 Divisional management could have assigned responsibility to one person to ensure that any action plan was delivered. This person could have been the conduit for Ms Stohr to access help and support from the Trust to return to an acceptable standard of performance.

Recommendations

R5 To ensure that reliable records are available in any further investigation or review, we recommend that the Trust should maintain more comprehensive written records or file notes of meetings and important conversations with people involved in patient safety issues and their investigation.

R6 In evaluating reports produced by external reviewers we recommend that the commissioner, or the manager responsible for interpreting the report, should always speak with the reviewer to test understanding of the findings and any recommendations flowing from the report.

R7 Outcomes, findings and recommendations from an external review should be shared with a senior clinician in the specialty for the purpose of understanding the findings, conclusions, and recommendations.

R8 The Chief Medical Officer (CMO) should develop a protocol for ensuring that the handover from their office of an external report for action is managed in concert with the specialty or divisional manager.

R9 We recommend that a named individual should be held responsible for ensuring that actions are taken consequent upon a review. That individual should be responsible for ensuring any improvement plan for a clinician whose practice has been reviewed is properly resourced and enabled by the Trust.

R10 The Chief Medical Officer's office and the named individual should agree what monitoring and reporting mechanisms are needed to track progress, and to ensure key steps and outcomes are accurately recorded.

R11 We recommend the CMO's office, and the named individual should sign off and record the closure of any actions arising from the review.

11. Actions taken following the Hill review

11.1 We set out below our summary of the advice given and the recommendations Mr Hill made in his report and describe what actions were taken by the Trust to address them.

11.2 He highlighted, in respect of Ms Stohr's practice, potential learning opportunities around her:

- decision making – that is what treatment, or surgery should be carried out in each case
- technical execution of some surgical procedures
- peri-operative management of individual cases, including pre-and post-operative management and follow up
- note-keeping with the aim of better explaining her rationale of treatment
- improved imaging

11.3 He advised the Trust to consider:

- Better organisation of MDT meetings and morbidity and mortality meetings
- Referring complex cases out of CUH if there is inadequate experience in-house
- The vision for and development of the paediatric orthopaedics department
- Implementing the new procedure protocol in respect of case 12 in the review
- Implementing the secondary survey protocol for polytrauma

Comment

In our view this advice and the recommendations comprised a package of practicable steps that Mr Hill believed would help the Trust, and Ms Stohr, to make improvements across a range of measurable activities.

They presented opportunities for the management of paediatric orthopaedics, and its practitioners to acknowledge organisational and individual shortcomings. They also gave the Trust a clear sense of what its priorities should be arising from the review.

We consider that the successful delivery of all these steps would have required coordination between divisional and departmental management, the workforce directorate and Ms Stohr herself. To achieve the necessary improvements, Ms Stohr needed, in our view, the support of the Trust to create the opportunities for her to augment her surgical skills and performance.

Action plan

11.4 In speaking to the Director of Division E about what actions he put in place after he had received Mr Hill's report, we found no evidence of there being a clear, documented plan to follow up on the findings and advice it contained.

11.5 We asked the Director of Division E about his recollections of the Hill review and whether he had acted on the outcome:

> *"Did I ever have an action plan that came out of that for me to enact? I would hope that I would remember that, but I have no memory at all of me having to enforce something, or to deliver something. There was never any, 'Here are your actions. Come back to us on a monthly or quarterly basis to give us an update'. I don't remember if and how and I involved in any of that. Might they have shared something? I guess that is possible, but I don't have any memory of reading something that says, 'this is what happened'.*
>
> *I think it is likely that I would have been involved in the follow up given my preceding involvement with the team and the service development - I have no written documentation of the actions that were taken, although we continued to push for additional surgeons to increase the critical mass in paediatrics and help dilute the personal issues in such a small team."*

11.6 He recalled that, arising from the report of the review:

> *"There were no actions tied to me. I remember that, broadly speaking, there were no actions for me. Kuldeep didn't disappear, or there wasn't suddenly a whole bunch of extra things that changed how the team worked. I did have quite a lot of contact with the Division A orthopaedic leadership – perhaps around service issues and MDT*

arrangements, but I cannot really remember whether this was before / after the Hill report. [Consultant A] essentially had to get back in his box and carry on. The relationship didn't improve as a result of that, but Kuldeep was essentially off the hook and the service carried on."

11.7 In speaking to staff from the Medical Director's office we learned that they had no expectation that they would have been involved in the development and delivery of such a plan. The Associate Director of Workforce was unaware of any plan being implemented in Division E to address the recommendations from the report.

11.8 The Associate Director of Workforce considered that proper weight had been given to the concerns raised by Consultant A, and that they had been investigated thoroughly, irrespective of any actions that should have followed the review, saying:

"The bit about closing the loop is important. So, even with all the noise, there was and remains a concerted effort to try to distinguish between what was just noise and what was properly serious. However, it takes up an inordinate amount of time, and they are two consultants out of 900"

Comment

A better and more carefully organised handover from the Medical Director's office was needed to ensure the rigorous planning for, and implementation of actions arising from Mr Hill's advice. This could have included Deputy Medical Director A, Mr Hill, representatives of Divisions A and E, the workforce directorate, Ms Stohr and Consultant A.

An individual needed to be accountable for ensuring implementation of the advice and recommendations.

It is unsurprising that divisional management did not set up and deliver a coordinated plan to address the advice and recommendations that flowed from Mr Hill's review. It is more likely than not that management willingly accepted the view, reinforced by the Deputy Medical Director's summary of the Hill report, that Ms Stohr remained safe to practise.

Actions taken by divisional management after the review

11.9 Following receipt of the Hill report in 2016 the Director of Division E, together with the Divisional Director of Operations – who were then responsible for the management of Division E - met Consultant A and Ms Stohr on a monthly basis until around late 2017. We have found no records of what the meetings comprised.

11.10 Ms Stohr described these meetings:

> *"What did happen, and this actually was useful, is that [the Director of Division E] and… [the Divisional] Director of Operations… would have monthly meetings with us. This lasted for quite a while actually, that would have been 2016, let's say August and then it lasted until [the Head of Paediatric Surgery] took over and that lasted a long time.*
>
> *Even after [Consultant B] started, cynically the three of us would say that 'we have this really good meeting every month with very senior management where we feel like we are being heard, and things can happen'. That's only because [Consultant A] and I were perceived to be this big problem that we get this big meeting with [the Director of Division E] and [the Divisional Director of Operations]."*

Comment

After Mr Hill's report was shared with him, the Director of Division E and the Divisional Director of Operations did continue to meet with Ms Stohr and Consultant A on a regular basis until late 2017. Ms Stohr saw these meetings as being focused on relationships and behaviours and not on her clinical work. Aside from this engagement with Ms Stohr, we believe the Director of Division E effectively left her to carry on in her clinical role, having taken comfort from the way in which the findings of Mr Hill's review had been presented to him.

Beyond these monthly meetings, we believe that nothing substantial was done by the Trust to address any of Ms Stohr's clinical practice shortcomings. We saw no sign that

anyone in management had set out a plan of activities she should undertake to improve her performance.

For example, Mr Hill could have been invited to support the development of Ms Stohr's technical skills e.g. pelvic osteotomies. The Medical Director's office and the management of Division E could have worked in concert to address the corrective actions that were required.

Follow-up activities

11.11 Due to the poor interpretation and handling of the Hill report and its findings a number of actions that would be expected in such circumstances did not take place.

11.12 None of the cases in which Mr Hill identified harm to patients were reported in Datix QSIS[11] as patient safety incidents. Doing so would have triggered further review into the causes of the incidents and possibly the development of measures to be put into place to address these failures in future.

11.13 Similarly, none of the patients, or their families, who had experienced harm were notified at the time in line with the Trust's duty of candour requirements in place since 2014. The duty of candour is a statutory and professional requirement for NHS organisations and healthcare professionals to be open and honest with patients and their families when care or treatment goes wrong and results in moderate harm or worse. It obliges providers to inform patients about safety incidents, to provide explanations, to offer apologies, and to communicate what will happen next, fostering a culture of learning and transparency.

11.14 We understand that these patients and their families have now been contacted as part of the Trust's response in 2025. They are now aware that their cases formed part of the 2016 review. All those patients whose cases were reviewed in 2016 have been re-reviewed as part of the Trust's 2025 review.

11.15 Consultant A wrote:

[11] Datix Quality Surveillance Information System is a web-based management information system used in many UK healthcare settings, including the NHS, for incident reporting and learning.

"I learnt that the Trust also covered up the Hill Report externally at the time in 2016. In around June 2025, Dr Broster informed [Consultant C] and I that the Trust had only in 2025 contacted the parents of the children (now adults) who were severely harmed and listed in my February 2016 email and the Hill Report, to inform them that they had been harmed. Based on the mandatory training I have received from the Trust, I believe that this is a breach of the Trust's duty of candour."

11.16 Exercising the duty of candour at the time would have allowed for much earlier identification and rectification of any ongoing complications associated with surgery.

11.17 Finally, we found no evidence that the concerns about Ms Stohr's practice were added to the local paediatric risk register and, therefore, would not have appeared in the Trust's risk register.

Comment

Had the findings of the Hill review resulted in a set of actions to address Ms Stohr's practice issues it is likely that this would have contributed to mitigating further risk of harm to patients.

Recording of the findings and recommendation from the report, together with the actions planned or taken would have kept the risks it identified on the radar of divisional managers and, if necessary, the Trust as a whole. This would have enabled surgeons in the service, and their managers, to anticipate and take more timely action in any future cases where concerns about the care of patients became apparent.

MDT in paediatric orthopaedics

11.18 A key recommendation was that the paediatric orthopaedics department would benefit from having a well-functioning MDT.

Role and importance of MDTs

11.19 Multidisciplinary team (MDT) meetings are a cornerstone of effective surgical practice across NHS trusts, enabling high-quality, patient-centred care through collaborative clinical decision-making. These meetings bring together professionals from a range of disciplines - including surgeons, anaesthetists, radiologists, specialist nurses, physiotherapists, and, where relevant, safeguarding, mental health, and social care professionals - to ensure that surgical care is informed, safe, and aligned with the individual needs of each patient.

11.20 In practice MDTs provide a structured forum to:

- Confirm diagnosis and consider differential diagnoses
- Agree on the need for surgery and explore non-operative options
- Assess patient readiness for surgery, including anaesthetic and rehabilitation risks
- Identify safeguarding, mental health, or social vulnerabilities that may impact recovery
- Promote standardised approaches through shared protocols and learning
- Ensure that complex or rare cases are reviewed by the most appropriate experts

11.21 Ultimately, MDTs strengthen clinical governance by creating an auditable, transparent record of decision-making. Their role is not merely advisory but integral to ensuring that surgical interventions are safe, justified, and patient centred. MDT meetings need to be regular, inclusive, well-documented, and supported by appropriate administrative and digital infrastructure. As the demands on surgical services increase, particularly in elective recovery and paediatric care, high-functioning MDTs will be essential to delivering safe, effective, and equitable surgical care.

11.22 One interviewee suggested what he thought made for a successful MDT meeting:

> *"Openness and transparency, and a willingness to learn. A willingness to be wrong, and a willingness to listen to the quiet voice… Listening to the HCA who happens to have popped in and given their opinion – that is important in an MDT."*

11.23 Mr Hill has experience of establishing MDTs. He told us what is required:

"An MDT is a multidisciplinary team meeting and, if you have an MDT, first of all you have to choose which cases are going to be put into the MDT. It would be uncommon to put every single case into an MDT and that is simply not practical or necessary. First of all you have to have selection criteria for the cases you think should go to an MDT. Then you have to constitute an MDT: you have to have a chairman, and you have to decide which people are going to attend the MDT. It may not be the same people for each case, but you need to have people there.

You then have to set the terms of reference for the MDT, and you have to have a written outcome. You have to have the minutes signed off by the chairman as a record, and the chairman's job is to make sure that there is agreement amongst the participants that the chosen or recommended treatment is appropriate for that patient – there has to be consensus. The membership of the MDT would have to include other surgeons who would have a view.

The second part of an MDT is to make sure that the hospital has everything prepared and resourced to tackle that individual patient. That would mean that you might have representatives from theatres – have we got the kit? Or physiotherapy? Is it the right treatment for this given patient? If it is, do we have the right equipment and resources to do it? Are there any special precautions or things we need take into account? That is what an MDT is there to do."

Comment

In our experience MDTs are, across the whole healthcare system, a common and key enabler of effective team working, raising and resolution of concerns, feedback and constructive challenge to practitioners, and improving patient safety.

Mr Hill's experience suggests that building an effective MDT in paediatric orthopaedics was to be a significant undertaking to deliver.

Establishment of the MDT

11.24 Deputy Medical Director A told us that, as a consequence of receiving the Hill report, the MD's casework group asked the Service Lead for Trauma and Orthopaedics to join and support the paediatric orthopaedic MDT. He told us that this indicated that the MDs' office recognised the seriousness of the concerns raised about Ms Stohr's practice.

11.25 Deputy Medical Director A and his colleagues recognised the need for Ms Stohr to improve her practice and intended that the Service Lead for Trauma and Orthopaedic Surgery's chairing of the MDT would provide support for Ms Stohr and for the other surgeons in the paediatric orthopaedics service.

11.26 In speaking to a range of people in the department we learned that Ms Stohr was instrumental in setting up the department's MDT after the Hill report had been given to her. She told us that she discussed Mr Hill's advice and recommendations with the Service Lead for Trauma and Orthopaedic Surgery. This included Mr Hill's suggestion of setting up an MDT. The Service Lead for Trauma and Orthopaedic Surgery advised Ms Stohr to make herself the clinical lead for paediatric orthopaedics and to establish the MDT. She did both after a discussion with the Director of Division E. This was not a promotion, but an unpaid addition to her duties as a consultant, and one that did not attract any additional time (PAs).

11.27 Membership of the first paediatric orthopaedic MDT at CUH included the Service Lead for Trauma and Orthopaedic Surgery chair, Ms Stohr, Consultant A, physiotherapists, and a specialist nurse. We were told that an Operations Manager for Division E also attended. The initial agenda was to discuss pre-operative patients, post-operative patients, and any problems. There was no MDT coordinator, so a secretary kept the minutes. Patient records were not routinely updated with the outcome of the MDT discussion.

11.28 A participant in an early paediatric orthopaedic MDT told us about the nature of team relationships:

> *"It felt to me that Kuldeep would probably – and this may be me just reading into the situation – I think she would have liked a strong MDT there around her. However, at their core, they [Ms Stohr and Consultant A] were individual practitioners. What I did not see in that, which is what I have seen in other teams, is that if I had had a problem with [Consultant A's] patient, or if I had had a problem with Kuldeep's patient, I could have gone to [Consultant A] and said, 'Kuldeep isn't around – she's in a meeting. Could you just give me an opinion on this?'. That wasn't the level of*

interaction that was there, if that makes sense. I would have needed to ask about Kuldeep about Kuldeep's patients, and [Consultant A] about [Consultant A's] patients. I could have asked Kuldeep about [Consultant A's] patients, and she probably would have given an opinion, but I know that would probably have caused an argument at some point down the line."

11.29 They gave us their view of the quality of the MDT meetings:

"Was the MDT that was existing – it wasn't awful, but was it the pinnacle of MDTs? No."

11.30 They explained the reasons for the perceived sub-optimal functioning of the MDT:

"I think buy-in from probably [Consultant A] and Kuldeep – I don't know where in that. You have to be vulnerable to take your patients that you are struggling with, and you need the other person to be supportive."

11.31 According to this participant, a service manager attended some of the paediatric orthopaedic MDT meetings. This was unusual as the purpose of the meeting is for clinicians to meet to discuss the care and treatment of patients. They thought they were there to troubleshoot and solve problems.

11.32 Deputy Medical Director A said that the contemporaneous notes recorded at the MD's casework meeting indicate that feedback was received from these MDT meetings, following which the MD's casework meeting closed their regular review of matters, with further supervision reverting to the usual service, directorate and divisional processes.

11.33 Consultant A explained that to their knowledge no other actions were put in place following the Hill review.

11.34 Ms Stohr recalls that the Service Lead for Trauma and Orthopaedic Surgery's tenure as chair of the paediatric orthopaedic MDT was brief:

"I think the MDT is something I am really proud of, for having started it. [The Service Lead for Trauma and Orthopaedic Surgery] came at the beginning and didn't last long – he disappeared after a few weeks."

Comment

The key organisational recommendation in Mr Hill's report was the establishment of a paediatric orthopaedic MDT. This was likely to be a significant undertaking as Mr Hill's experience of doing this suggests. His evidence points to the organisational effort needed. This should not have been left for Ms Stohr to deliver on her own.

The establishment of the paediatric orthopaedics MDT was an important first step in re-setting the processes, practice and culture to deliver effective clinical governance across the department.

It is to Ms Stohr's credit that she set about, of her own volition, to address what she interpreted from the Hill review as organisational governance failures by setting up a weekly MDT for paediatric orthopaedics.

While the MD's office designated a consultant orthopaedic surgeon to chair the new MDT it appears that the initial good progress in setting up and running the MDT was not maintained, and the Service Lead for Trauma and Orthopaedic Surgery's departure left the MDT without his guidance and the hoped for support for Ms Stohr.

Other actions taken by Ms Stohr following the Hill review

11.35 Ms Stohr took it upon herself to take other actions after considering Mr Hill's report. She told us that she took the outcome of the review as an opportunity to improve her clinical practice. She explained why, after the findings of the Hill report had been shared with her, she did this:

> *"To be clear, I wasn't happy. I could see the criticisms in the report. I also knew about the issues that Mr Hill described in all the patients that were criticised."*

Discussion of cases raised of clinical concern

11.36 Ms Stohr told us that she discussed all the cases in Mr Hill's review with her paediatric orthopaedic colleagues at their MDT at Norfolk and Norwich Hospital. She did this because she believed that Mr Hill was raising concerns about her clinical practice:

> *"I thought there were concerns and I discussed the report with my colleagues at Norfolk and Norwich Hospital, and I started to attend… - I think my first one was in June [2016] - their monthly MDT meetings… I went through the cases with them as well. I presented them, I took the x-rays with me, and I presented them there."*

11.37 Ms Stohr confirmed that she did not share the Hill report with colleagues at Norfolk and Norwich but did discuss the cases identified therein. She told us her intention in doing this was:

> *"Just getting more feedback, what could have I done? How could I recognise that that Salter osteotomy wasn't deeper? How do you do it? What do you do on the table? To work that out, because afterwards it's too late, your time is actually on the operating table."*

11.38 Ms Stohr described the feedback she received from colleagues at Norfolk and Norwich:

> *"That one of my Salter osteotomies wasn't adequate, wasn't big enough, but it was probably going to be alright. Again, one of my Dega osteotomies, another pelvic osteotomy, I could have gone bigger, but actually the result was okay. I followed most of those patients up and I can now see that they were right, almost all the patients are still okay and in fact the Salter osteotomy one, she is fine, she is 10 now and I have not had to re-operate. Basically, they are growing children and so if you are lucky and if the osteotomy isn't adequate, it's still good enough and then their socket grows and that's what happened to a lot of those children."*

11.39 Ms Stohr offered us evidence of her discussions with colleagues at the Norfolk and Norwich.

Attendance at Norfolk and Norwich MDT meetings

11.40 Ms Stohr told us that she went on to regularly attend the MDT at the Norfolk and Norwich. She provided us with the contact details of a senior consultant colleague in that Trust who told us about her participation in their MDT:

> *"She [Ms Stohr] spoke to me personally; I know there had always been, from day one, relationship issues between her and [Consultant A] and not feeling supported by her colleagues within her Trust. She had always fallen back on people she felt she could approach, so she had often contacted us to ask something in a more informal way at meetings. She would talk about the difficulties she was having and how isolated she felt.*
>
> *Around 2016 she contacted us specifically, it probably was me, but again, I can't remember exactly but I can't see why it wouldn't have been, to say, 'I'm reaching a point where I haven't got anyone to talk through some of my more difficult cases with. I know you have'… We were up to three people at the Norfolk and Norwich, and we had started having our own either x-ray meeting or teaching MDT-type meeting. Could she start coming to ours because she felt we were more approachable? We said, 'yes, of course'."*

11.41 We asked this colleague what Ms Stohr had said about her reasons for joining their MDT. We were told that Ms Stohr had explained that she was experiencing difficult relationships with a colleague at CUH that made teamworking difficult. Ms Stohr had also spoken of workload issues:

> *"She felt very heavily overloaded for a long period of time. She felt that she had all the complex work and when she tried to offload it no-one was listening to her. That is not just from colleagues, that is at a higher level as well."*

11.42 We asked if the colleague was aware that Mr Hill had recently completed an external review into Ms Stohr's practice:

> *"I don't remember whether she actually said, 'I have had a formal external review and I need to do this because of that'. I don't think that particular conversation ever happened. It was more along the lines of, 'I need to have more'. She mentioned*

the Trust had spoken to her and she had some meetings and one of the things suggested was that she had more colleague support. She felt she wasn't in a position that she could get that at Addenbrooke's, so could she come and get it with us? We had then grown to three specialists. What were we doing? Could she join in with what we were doing?"

11.43 We asked whether it was CUH or Ms Stohr who had initiated her participation in the Norfolk and Norwich MDT. We were told that Ms Stohr had initiated this contact:

"What definitely didn't happen was no-one from the Trust, for example, said, 'we have an employee who needs some CPD [Continuing Professional Development] support, please can you provide it?'. It was very much off her own back that she did it… She initiated it, 100 per cent. I know that for definite."

11.44 The colleague also confirmed that Ms Stohr played a key role in organising and participating in the East Anglian Paediatric Orthopaedic Group (EPOG) MDT.

11.45 We asked the colleague what they thought Ms Stohr wanted to gain by attending the Norfolk and Norwich MDT:

She tried to get some extra support, feedback and reassurance with her cases and could she come to us, look at what we were doing? Obviously, she did bring cases, but we also had cases, so there was a very open discussion between the four specialists.

11.46 We asked if staff at the Norfolk and Norwich had ever had reason to question Ms Stohr's clinical capabilities. We were told:

"Never."

11.47 We asked this colleague if they believed that Ms Stohr was concerned about her own practice:

"Certainly, there was a period of time where she lacked a lot of confidence because of where she was at. I know she felt very isolated, and she felt concerned that she was isolated, if that makes sense. She definitely understood the severity of the fact

that she felt she was a sole practitioner with no-one. She said to me several times, 'when I get stuck, all that happens is people have a go at me. There isn't anyone I can go to'.

I know that she had concerns that she would be doing something and what would happen as and when. Some of the time that didn't relate to kids because she was still on the adult on-call rota at that time and that was one of her big worries. She said, 'I'm not trained to do this, and the next day people are not taking these cases off me, I don't know what to do with them and they are saying they are my problem'. There was an awful lot of that that was clear, and we did what we did.

She never said to me she was worried about her actual surgical competence, but some of the cases, and I know this, are extremely difficult and stressful to deal with. Not just the actual surgery but the medical complications of the person and the families and everyone around them. They are incredibly difficult families to manage, especially if you haven't got someone to offload to once you have had a 45-minute consultation with them. I have been there; I know how hard that is."

11.48 Ms Stohr travelled 90 minutes each way to attend the Norfolk and Norwich MDT meeting. This was before the advent of meetings held over the web.

11.49 Ms Stohr continued her monthly attendance for a year or so until her CUH clinical commitments required her to stop.

Comment

Ms Stohr took Mr Hill's advice seriously despite the organisational reaction to his review. The evidence for that is her seeking professional support and help from consultant colleagues in the paediatric orthopaedic service at the Norfolk and Norwich Trust.

She appears to have acknowledged that the Hill report was critical of her clinical practice, and that she recognised the need to seek out ways in which she might improve.

We found no evidence that anyone from the Trust facilitated or provided any support for her in these endeavours.

We believe that Ms Stohr took time and made significant personal efforts to improve her practice. She took these actions when she could have simply used the Trust's response to the findings of the review to justify claiming that there were no concerns about her clinical practice.

Ms Stohr's plan to improve her clinical skills

11.50 We asked Ms Stohr what she did to improve her pelvic osteotomy practice:

> *"Yes, osteotomies, I found it hard to find someone to follow-up, so what I did do was to go to Norfolk and Norwich regularly, but that fizzled out after about six months."*

11.51 Ms Stohr described how she learned from colleagues at the Norfolk and Norwich and elsewhere:

> *"To discuss cases, 'how would you do it? What would you do?' That sort of stuff. I went back to original articles, and I used to discuss things ad hoc with consultants that I know, that are in my contact list. 'I am about to do this'. That is people in Stanmore, people in Great Ormond Street; I would then refer the odd patient out to Stanmore, because actually that process of discussing things with these old contacts made them friends of mine and it was quite good."*

11.52 Ms Stohr explained that she had found it difficult to get additional experience:

> *"I didn't get hands-on operating experience with people. It's quite hard to organise."*

11.53 We asked her if she had sought help from her own Trust in this respect and she said:

> *"There is no management help, there is none. I cannot tell you how hands-off management is."*

Comment

By July 2016, in the wake of the Hill report, we believe the accepted managerial and organisational view was that there were no issues with Ms Stohr's clinical practice. This view was, however, only shared by the limited number of people who knew about the report. Most colleagues would not have known about the review or what it had found and recommended.

Ms Stohr could have been forgiven for not challenging this view since admitting to her own failings would come at potentially great personal and professional risk. Despite being relieved at the outcome of the review, Ms Stohr accepted that there were some practice issues for her to address.

Ms Stohr attempted to tackle three of the matters arising from the Hill report with little or no support from the organisation. She pursued these in isolation and without direction from senior divisional management. The facilitation, support and oversight that might have helped her to achieve the necessary improvements were not forthcoming from the organisation.

Ms Stohr made a significant effort to discuss the cases in Mr Hill's review with colleagues and to learn more about her practice by discussion with them. However, what she also needed was the guiding hand of an experienced paediatric orthopaedic surgeon to work alongside her in theatre.

For Ms Stohr to have learned and improved she needed hands-on practical help, and this needed to be facilitated, organised, and paid for by the Trust. By not understanding what Mr Hill's review had found, the Trust denied itself the opportunity to provide this support to Ms Stohr.

We believe that senior management had simply not recognised a need to provide her with this kind of help, and they lacked the impetus to do so because they considered that her practice was safe.

Missed opportunities

MO18 There was no discussion between Ms Stohr and Mr Hill about the specific comments he made on her practice, the need for technical improvements and how to achieve them. Mr Hill could have been drafted in by the Trust to help Ms Stohr improve her technique.

MO19 The organisational failure to understand that action was needed to improve Ms Stohr's practice meant that no plans were made to help her improve her practice.

MO20 Had the division, the Medical Director's office, the workforce directorate and Ms Stohr met to develop such a plan, it would have created the impetus for her to improve. No-one was given responsibility to coordinate the development and implementation of a personal improvement plan for Ms Stohr.

MO21 To the best of our knowledge, the cases reviewed by Mr Hill were not recorded in Trust governance data streams as incidents, nor were they identified on a risk register.

MO22 Had the Trust considered, at that time, the need to exercise duty of candour to the families, this obligation would have required greater emphasis on the harm caused, if any, to Ms Stohr's patients up to 2016.

MO23 There was no opportunity created for the Medical Director's office and the division to co-manage any actions aimed at improving Ms Stohr's practice. No opportunity was taken to consider what financial, practical or personal support she might need to achieve the improvements.

MO24 There appeared to be no opportunity to support Ms Stohr in her personal attempts to work with colleagues at the Norfolk and Norwich, nor in her efforts to identify how she might augment her skills in pelvic osteotomy.

MO25 Either divisional management or the Medical Director's office could have arranged a follow-up review of her practice after, say, six months of the Hill review to check on progress. Had this been done, there would have been an earlier opportunity to report back to the Trust on whether Ms Stohr's practice had improved, or not.

Recommendations

R12 The CMO's team should ensure that the findings and conclusions of any external review are shared with the management team involved and that an appropriate plan is developed and implemented that sets out the actions to be taken and by whom.

R13 The CMO's team should satisfy itself in the commissioning and delivery of an external review that any information and/ or findings are recorded in the appropriate Trust data streams and risk registers. Any completed review should be assessed by the CMO's team to identify any need to exercise the Trust's duty of candour.

Part two

12. Ms Stohr's practice 2016 – 2024

12.1 We review below how Ms Stohr was managed in paediatric orthopaedics, and consider what evidence was available to the Trust about her performance, her wellbeing and her workload.

Ms Stohr's management and supervision in Division E

12.2 During our investigation, we did not find anybody who took overall responsibility for Ms Stohr's line management or for the supervision of her clinical practice.

12.3 We asked the Director of Division E what he knew about how Ms Stohr was managed. The Director of Division E told us that he held this role from around 2012 until 2019. He told us:

> *"I certainly had contact with [Ms Stohr] during the time when I was Divisional Director – not a great deal, but contact. She 'lives' in the same portacabin as I've been in for 15 years, so we have bumped into each other on occasion."*

12.4 The Director of Division E described his priorities as divisional director (DD):

> *"I was involved in regular service meetings to try and help manage behaviours and expand [the paediatric orthopaedics] service in 2014-16 – this was perhaps unusual as DD, as more usually the Paediatric Surgical Clinical Director would have led this work. I took my role as largely protecting the Medical Director's Office from all that divisional stuff. But these two surgeons [Ms Stohr and Consultant A] were between divisions and hence whatever issues of competence there was were between them and whoever their professional service lead was."*

12.5 He also knew of the long-term difficulties between Ms Stohr and Consultant A.

> *"I was peripherally aware of the mostly personal fallout between the two of them but was involved in holding them to account for some of their behaviours."*

12.6 He said:

> *"My view, rightly or wrongly, was that managing consultants within Division E… was a biggish chunk of what I saw as my responsibility. In this case, it was a shared Division A issue and much of it was ultimately around professional opinions of competence."*

12.7 We asked how much he was involved in resolving these relationship issues and he said:

> *"I don't remember how much I pushed, to be honest… Certainly, I don't remember there being an expectation on me to monitor anything."*

12.8 The then Director of Division E told us that he saw no real change in Ms Stohr's behaviour, or her relationship with Consultant A, after her practice was reviewed by Mr Hill. We asked him whether he went on to engage with Ms Stohr and Consultant A after the Hill report was shared with him and he said:

> *"One place I didn't want to go diving around in was orthopaedics. If they are doing their job, coming to work and not causing too much mayhem – that was enough."*

12.9 He added:

> *"One of the challenges for the organisation with these services was that oversight was very fragmented. The accountability and governance arrangements were fragmented, as is often the case when these types of situations arise. As these conflicts ramped up, the arrangements with [the surgeons] and whatever complaints or professional issues went on within orthopaedics, I believe was largely handled by Division A and the Medical Director's Office."*

12.10 Deputy Medical Director A told us:

> *"With [Consultant B] being appointed in 2017 and [Consultant C] in 2019… neither of them came back to the Medical Director's Office, which is a trigger for us. And this system does work, there are some things that recurrently have kept coming*

back to the MD's Office, because it has not been possible to resolve them within the operational service or division, and those, yes, you do get involved in again."

Comment

Ms Stohr was not closely managed at any point. There was no real day-to-day oversight of her clinical work, as is confirmed by the evidence we heard from another, long-standing service/ operations manager in Division E.

Ms Stohr appeared to have little engagement with the clinical director of her service. The Director of Division E was not involved in monitoring Ms Stohr's clinical practice. Although he was the closest manager who was aware of the findings and recommendations from Mr Hill's review, he appeared to keep some distance between himself, Ms Stohr and the relationship difficulties she had with Consultant A.

Leadership within the Trust apparently took comfort from the fact that members of the department were no longer raising concerns and issues.

Ms Stohr's relationship with Consultant A

12.11 Despite a promising start, the evidence suggests that the working relationship between Ms Stohr and Consultant A became more distant after Consultant A raised concerns about her clinical practice in 2016, resulting in Mr Hill's review.

12.12 Consultant A reported that, after this time, they no longer dual-operated with Ms Stohr out of concern that her practice was unsafe. They said:

"I also would not have wanted to operate with Ms Stohr because I knew that she had severe surgical deficiencies and that it would have been potentially dangerous to operate with her."

12.13 We were told by both senior and junior staff who worked in paediatric orthopaedics that Consultant A and Ms Stohr did not have a cooperative working relationship as the two consultants in the service. As one member of staff told us:

"It had become obvious they didn't get on, because Kuldeep had pushed to get clinical nurse specialists to help out with her clinics.

… [Consultant A] didn't agree with that. I knew that there were issues and you know what it's like within any kind of area as big as a hospital, Chinese whispers start and things like that and it just increases into a thing, it's because [Consultant A] and Kuldeep don't get on and things like that and I didn't really take any notice of it."

12.14 They added:

"It was common knowledge that they didn't want to work together, and [Consultant A] didn't want these clinical nurse specialists that Kuldeep wanted. Even now he still only occasionally works with them, but most of the time he just won't have them in his clinics or anything."

12.15 Ms Stohr told us that she made efforts to improve her relationship with Consultant A after the Hill review:

"We shared an office, I would try to be friendly and one the best things was because it was hard, I am not an actress and it's hard and certainly forget about socialising and going to see comedians and things, that's not happening, but what I really did was if he had any issues with a patient and an MDT I would volunteer to take over and that was my more authentic way of trying to smooth things over. I cannot be your friend, but I can be a good colleague.

That's what I tried and actually geography was a real part of that. He does a fracture clinic on a Monday, I do a fracture clinic on a Wednesday, and I operate on a Friday. If he had an issue in the fracture clinic with a complex patient, I would then operate on the Friday, and he would be delighted if I took it on and I did on many occasions. And that geography of that timing was what really made that happen."

12.16 We asked the Director of Division E if he had sensed that Ms Stohr was becoming increasingly isolated from the rest of the department. He said:

"There are a few clinicians who I think are in that boat. It is a combination of personal behaviour and their character traits, together with people not wanting to get involved with someone who is challenging and difficult. Mostly, at least in my experience, those people find a few individuals with whom they have some common ground. I think it is quite clear that, if something then goes wrong or there is an allegation made, there are then not many people who will come out of the woodwork to stand up for that individual."

Comment

Ms Stohr and Consultant A had a distant working relationship. Neither of them was keen to work together in surgery, and there appeared to be no explicit managerial imperative that they should do so. They both preferred to operate on patients independently of each other.

There was little chance of their relationship improving after the Hill review in 2016 and it seems unlikely that they would have settled easily into the MDT Mr Hill advised was needed. This was at a time when the paediatric orthopaedic workload was becoming more onerous and complex.

Ms Stohr's relationships with others in the Trust

12.17 Consultant colleagues in adult orthopaedics were positive about their experience of working with Ms Stohr. The former Trauma Lead, told us:

"[She was] very helpful. Certainly, on the trauma side, if there were any queries she was usually the first to step-up and say she would help, but also the management of paediatric infection too, which can be quite challenging, because there are a number of teams that need to be coordinated and she would take that on, so she is usually very forthcoming to support and help."

12.18 A Consultant Anaesthetist who regularly operated with Ms Stohr told us:

"It was always fine. Kuldeep and I have always got on very well, our children are of similar ages, so we have a lot in common. She has perhaps been a consultant a couple of years longer than I have, but we were fairly new consultants at the time we first worked together. I have never seen, and I know because I have spoken to others that she has lost her temper with other things, but I have never seen her lose her temper in theatre. The working environment was always really nice - a little bit fun, a little bit jolly and it was always very pleasant. I have never seen her be unpleasant to theatre staff and I have never seen her be unpleasant to registrars. Actually, I used to look forward to my Fridays!"

12.19 They added:

"I think that among her consultant colleagues, she was very well liked; the anaesthetists would always say she was really nice, a nice person to get on with.

When I was coming here today, I was thinking I don't really have very much to say because we have always had an excellent, excellent working relationship, and I can't judge her on whether she is a good surgeon or not. While we all work together as a team, I don't see whether her patients have good outcomes because they go away."

12.20 However, a nurse working in the paediatric orthopaedics service told us:

"There are two Ms Stohrs. There's the really kind, really compassionate, going the extra mile, holding a baby for a mum to get the bottle-feed ready and then there's the overworked, overstressed who could be abrupt. She could be abrupt to the child or the parent or even staff."

12.21 We asked the nurse what triggered this "abrupt" behaviour:

"I can't comment but, in my opinion, I believe it's down to stress and overwork because I could see, if she was coming from theatre, she's got a clinic that started but theatre was overrunning. I made sure I got her lunch so that she came into clinic and there was a water bottle, there's some lunch, and there was calm. I can't really comment on her opinions really.

… It's random, it's not all that often but then sometimes more memorable. I don't know, 10% of the time. I couldn't really quantify it, I'm afraid."

12.22 An orthopaedic practitioner said that they had personally enjoyed a positive working relationship with Ms Stohr:

"To me, all of this is really quite hard to accept because I've worked so closely with her. We're colleagues, we've gone to conferences, Christmas meal out. I know what she needs. I'm not in theatre with her, I'm not a surgeon but I was kind of like her assistant, and we'd talk, like 'did you watch this TV?'. We had a really good working relationship so for me to see this, half of me doesn't believe it, but I'm involved in it, so I see it. That's quite hard to accept, and it's hard because this is a colleague who I trusted and respected, and now I've lost them.

… I really did enjoy working with her and that's why, to me, this is quite challenging because I'm trying to process all the harm that I'm seeing."

12.23 We spoke to a senior nurse who is responsible for quality across the Trust for children and young people. They had been the ward manager on a children's ward and had worked closely with the paediatric orthopaedics team when it comprised Ms Stohr and Consultant A. They told us it was:

"A very small team, and I had a very good working relationship with Kuldeep, incredibly positive feedback, worked incredibly well with patients. I will be honest, one of the best consultants I've worked with in surgery; really listened to the Nursing Team, valued their information and valued their input."

Comment

We heard that Ms Stohr enjoyed largely positive relationships with most colleagues in the Trust. Since her absence, some colleagues have reported missing working with her.

Some colleagues noted that Ms Stohr could be ill-tempered with colleagues and patients but attributed this to stress.

It is notable that colleagues who worked closely with Ms Stohr had no awareness that there were problems with her clinical practice. But they were also not able to make an informed judgement on this matter due to differences in their areas of expertise and exposure to patients.

Ms Stohr's appraisals

12.24 Trust documents show that Ms Stohr had an appraisal annually from 2015 to 2023. There is no appraisal in 2020, presumably because of the Covid-19 pandemic response.

12.25 Annual medical appraisals are a requirement of the General Medical Council for consultants to demonstrate compliance with fitness to practise and revalidation of their licence to practise. Appraisals are completed using a standardised NHS England-designed pro forma. The appraisal content is the responsibility of the appraised doctor. The appraiser is usually a senior consultant colleague from a different specialty. Ms Stohr had four different appraisers between 2015 and her last appraisal in 2023. While the appraisal is 'signed off' by the RO, this process is not designed to be a management intervention or performance monitoring tool.

12.26 Deputy Medical Director A, the responsible officer at CUH described how the appraisal system for doctors might not explicitly address concerns about an individual's clinical practice:

> *"The obligation in medical appraisal as set up by the GMC – which is not the standard form of performance management appraisal - is for the doctor to make a statement about their practice over the previous year, reflection on issues and planning for the following year.*
>
> *The appraiser is informed by the doctor: it is not their role to conduct an investigation into the doctor's practice; the expectation is on the doctor to make a declaration of it."*

12.27 We have read all Ms Stohr's appraisals, and some general themes emerge, including

- Her increasing clinical workload and associated stress

- Reports of inadequate administrative support in paediatric orthopaedics
- The increase in consultant numbers in the service by two additional consultant surgeons during the period 2016 -2019
- Her not taking her annual leave entitlement (2015 and 2018 appraisals)
- Her taking on clinical leadership responsibilities for the paediatric orthopaedic service
- Her undertaking service development work in addition to clinical work
- Her taking on educational responsibilities
- Her participating in MDTs with other professionals outside the Trust

12.28 We have captured below extracts from some of the appraisals. They provide a contemporaneous account of Ms Stohr's work, with commentary by an impartial senior colleague.

12.29 This is the entry from her 2016/17 appraisal, conducted on 22 June 2016:

"My paediatric orthopaedic colleague has cited some concerns about my patient management - he has listed a few cases. This is currently being examined by an external consultant from Great Ormond Street."

12.30 The appraiser's comment is:

"The issues raised were discussed and noted. There is evidence of much good practice, and the additional item discussed is still under review, and should be raised in next year's appraisal."

12.31 An entry in her 2017/18 appraisal following the Hill review includes:

"The regular multidisciplinary meetings with Norfolk and Norwich provide a good journal review forum - this involves a lot of pre-reading and preparation.

The (East Anglia Paediatric Orthopaedic) regional meetings allow for immediate peer review of actual clinical work."

12.32 The appraiser's comments in the 2017/18 appraisal include

"Busy clinical, managerial and educational responsibilities."

"Has an appropriate range of Continuing Professional Development (CPD) activity to support her clinical practice."

"Many of Kuldeep's QI (quality improvement) activities have been self-initiated and are at an early stage of development."

"No SUIs [serious untoward incidents] to report."

"All complaints reflect the enormous pressures on the elective services at CUHFT and not Kuldeep's clinical practice. Evidence that she is very highly regarded by her patients and clinical colleagues as evidenced by her nomination for 'Making a difference award'."

"Kuldeep has had significant educational and academic achievements this year. She has also had to deal with major interpersonal relationship issues with a close colleague which have been resolved with no concerns after independent review about her clinical practice."

"Mandatory training record complete. I note the email from the Deputy MD confirming that following an external review the Trust have no concerns about Kuldeep's practice"

12.33 The 2018/19 appraisal reveals, for the first time, written concerns about Ms Stohr's workload. Her comment at the beginning of the appraisal in the section *Scope of Work* says:

"I have spent a lot of time in service provision and development over the last twelve months. A consultant colleague was on sick leave for three months and I picked up lists during his absence. Furthermore, I have been doing an extra operating list per week for the last six months. However, my cases for another consultant and physiotherapist appointments have been approved and I continue to work on creating another nurse specialist post. I have helped successfully develop the nurse specialist role in Paediatric Orthopaedics from it commencing in January 2017.

Events of 2017 - namely the sick leave of a colleague, the sudden retirement of a consultant at Chelmsford (and the urgent provision of a service there) and then obtaining extra theatre capacity during the winter bed crisis, has meant I have focused primarily on service provision. My operative waiting list has reduced from eight months down to eight weeks.

I have had very little leave since August 2017. As a consequence, I have not had an opportunity to attend the courses that I had planned. However, the service has improved in terms of waiting list times, team development and development (such as the Cerebral Palsy Integrated Programme, helping start Paediatric Musculoskeletal Radiology meeting, successfully obtaining a charitable grant to purchase a special wheelchair for complex cerebral palsy patients).”

12.34 The appraiser comments about Ms Stohr’s workload:

“A very busy clinical and managerial scope of practice that Kuldeep enjoys. However, the current workload and intensity is unsustainable. Professional relationships within her dept have improved considerably over the past 12 months due to efforts from herself and others.”

12.35 He also adds under the Continuing Professional Development (CPD) section:

“Good range of CPD relevant to her paediatric practice but we have agreed that next year Kuldeep should give more emphasis on her adult practice learning needs particularly as she maintains an adult on call commitment.”

12.36 The summary of this appraisal discussion includes the following comment:

“Kuldeep has had an exceptionally busy year compounded by the extra workload she had to pick up due to the absence of a sick colleague in a very small clinical group in paediatric orthopaedics. She should be congratulated on the amount of non-clinical research and teaching activity she has managed to engage in despite these pressures which have been acknowledged by the award of local CEA points.[12]*“*

[12] CEA points are used to score applications for Clinical Excellence Awards in the NHS, with scores ranging from 0 to 10 based on the level of impact beyond a consultant’s contract. A score of 10 indicates an excellent application with clear national impact, while a score of 2 means the applicant

Comment

Ms Stohr was regularly and frequently appraised, albeit by several different appraisers. There is evidence dating back to 2016 that she shared information with her appraiser about the external review of her clinical practice but, at that time, she had yet to hear about the outcomes of the review.

Successive appraisals acknowledged efforts she was making to address clinical practice improvements at her own initiative, and the 2017/18 appraisal confirms her view that the Trust has no concerns about her practice.

Later appraisals mention her concerns about the impact of carrying unsustainable workloads while dealing with difficult relationships in the department.

Regrettably, none of this intelligence appears to have been apparent to anyone bar Ms Stohr and her appraisers. We saw no evidence that Ms Stohr shared the content of her appraisals with anyone in her division.

We discerned no mechanism that could have been used to inform her line management of these matters, and we infer that they remained unaware of them.

Workload and activity levels

12.37 Ms Stohr described the scope of her own clinical practice:

> *"The caseload here is a bit tertiary, but Addenbrookes… still does everything from children falling off swings and trampolines and babies born with club feet and that sort of stuff, like any other place and we still get plenty of patients with fractured legs and femur. I do adult trauma as well and when I started, I was doing adult on-calls. So that sort of bog-standard stuff comes here as well and then on top of that we accommodate the more specialised stuff."*

has met contractual obligations locally. These points are used by awards committees to determine if a consultant receives an award and at what level.

"Gradually, over the 12 years, very quickly actually, by about 2014, people started referring to me specifically, complex paediatric elective cases, but that's not how I started, as some big tertiary referral person, that sort of happened semi-organically."

12.38 A nursing colleague described the complexity of Ms Stohr's patients:

"Ms Stohr's were very much disabled children in wheelchairs, who needed to be hoisted out to be weighed. She definitely took an interest in the more complex disabled patients that [Consultant A] wouldn't operate on. I remember saying to her… 'Why do you do these surgeries on these complex, disabled children, who are never going to walk? What will be the benefit?'. As a nurse, I didn't understand, but she said to me that when the disabled children are in wheelchairs and their hips are out, it is really uncomfortable, and they can't tell you. If they can stand in a walking frame, a standing frame, just to be changed, just to get some strength, then it transforms their lives.

[Consultant A] didn't operate on those children at all. I took that to be because that was her interest… Their workload was very different."

12.39 A senior colleague in the Trust's workforce team who had had dealings with Ms Stohr described her approach to work in the following terms:

"She [Ms Stohr] is absolutely committed to her patients, and she works really hard. I think she struggles to say no to things, but she also seems unable to manage any anger or frustration that she feels for situations or individuals.

In the same way as there have been about [Consultant A], there have been many complaints over the years about Kuldeep which can be summarised as her being extremely rude to people. Whereas [Consultant A] tends to go to a formal complaint process, Kuldeep loses her temper, shouts at people and can be extremely rude… She [Ms Stohr] talked a great deal about her workload which was extremely high and her inability to say 'no'"

12.40 They told us they had been very surprised to hear that Ms Stohr had experienced clinical practice problems and spoke of her approach to work:

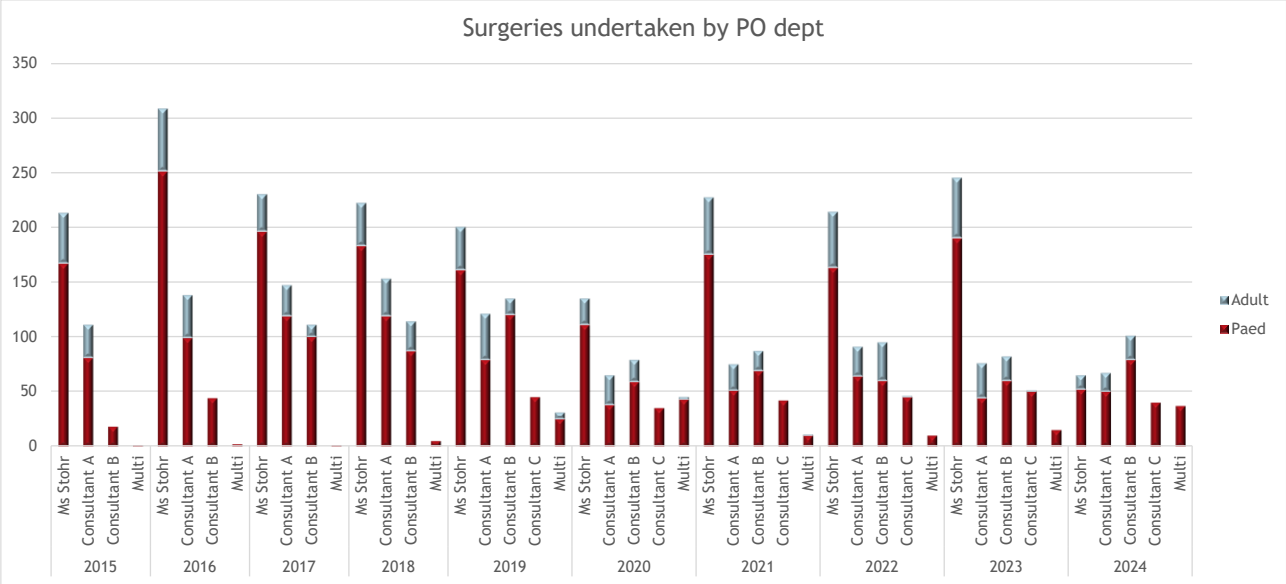
> *"Kuldeep was always a person who would do those extra waiting lists, stay late and do those extra clinics. Even up until before she was sick, she was always the person who stepped forward to say, 'I will cover that clinic, I will do that waiting list over weekend', and she was working huge amounts of time."*

12.41 The Trust provided us with data about the surgical activity of the consultants in the paediatric orthopaedic service. The data begins on 10 January 2015 using data from the Epic system which was implemented at that time. Data before this date was unavailable.

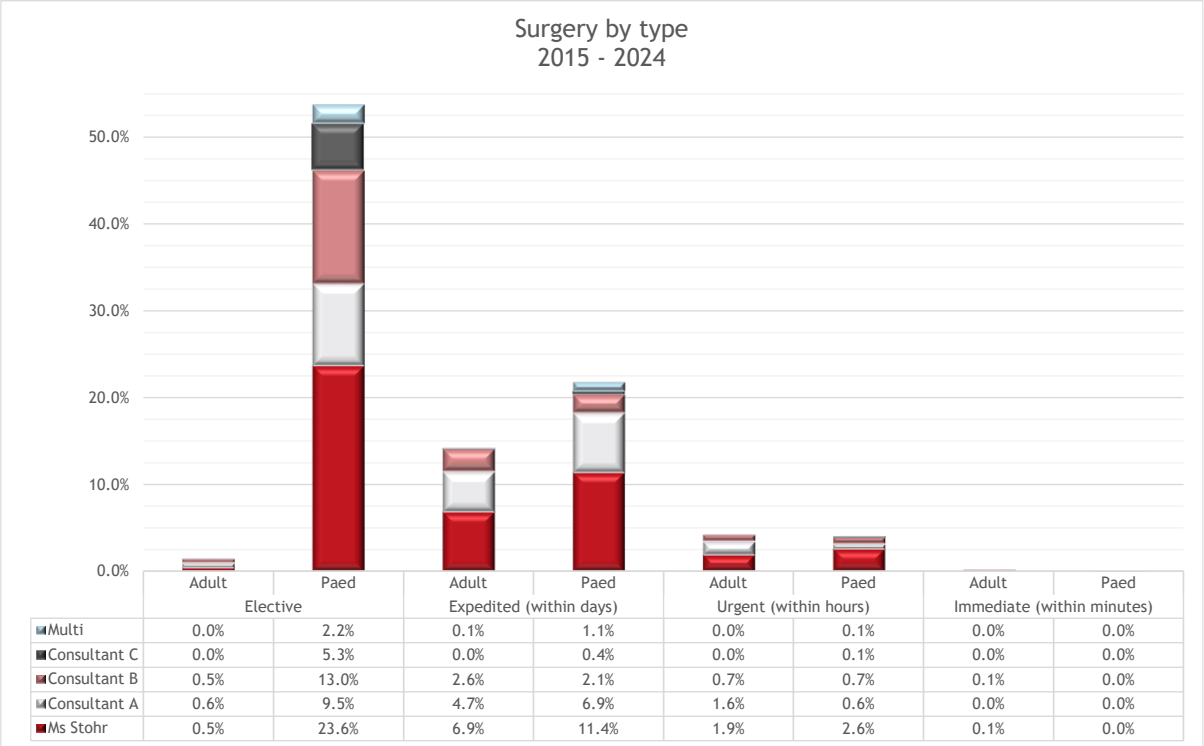
12.42 The information shows that between 10 January 2015 and 4 July 2025, Ms Stohr individually performed around 45 per cent of all the surgery done in paediatric orthopaedics.

Year	Consultant A		Consultant B		Consultant C		Ms Stohr		Dual Surgery		Grand Total	
	Num	%	Num	%	Num	%	Num	%	Num	%	Num	%
2015	81	30.3	18	6.7	0 (not in post)	0.0	167	62.5	1	0.4	267	100
2016	99	25.0	44	11.1		0.0	251	63.4	2	0.5	396	100
2017	119	28.6	100	24.0		0.0	196	47.1	1	0.2	416	100
2018	119	30.2	87	22.1		0.0	183	46.4	5	1.3	394	100
2019	79	18.4	120	27.9	45	10.5	161	37.4	25	5.8	430	100
2020	38	13.3	59	20.6	35	12.2	111	38.8	43	15.0	286	100
2021	51	14.7	69	19.9	42	12.1	175	50.4	10	2.9	347	100
2022	64	18.7	60	17.5	45	13.2	163	47.7	10	2.9	342	100
2023	44	12.3	60	16.7	50	13.9	190	52.9	15	4.2	359	100
2024	50	19.4	79	30.6	40	15.5	52	20.2	37	14.3	258	100
2025	12	11.8	39	38.2	38	37.3	0	0.0	13	12.7	102	100
Grand Total	**756**	**21.0 %**	**735**	**20.4 %**	**295**	**8.2%**	**1649**	**45.8 %**	**162**	**4.5%**	**3597**	**100 %**

12.43 In addition to her activity in paediatrics, Ms Stohr also undertook a heavier load of adult surgery than her paediatric orthopaedic peers.



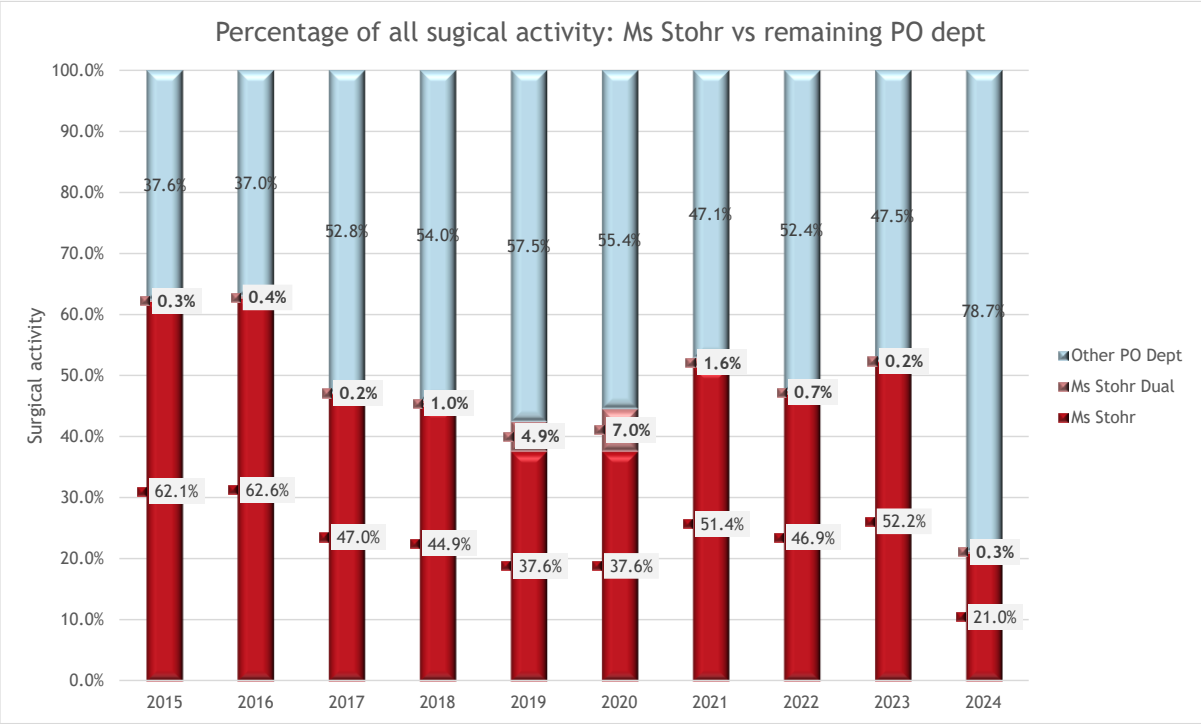
12.44 While elective paediatric surgery is the most common type of surgery undertaken by members of the team, Ms Stohr also carried out a greater proportion of paediatric unplanned or emergency procedures and adult orthopaedic surgery than her colleagues.



	Elective		Expedited (within days)		Urgent (within hours)		Immediate (within minutes)	
	Adult	Paed	Adult	Paed	Adult	Paed	Adult	Paed
Multi	0.0%	2.2%	0.1%	1.1%	0.0%	0.1%	0.0%	0.0%
Consultant C	0.0%	5.3%	0.0%	0.4%	0.0%	0.1%	0.0%	0.0%
Consultant B	0.5%	13.0%	2.6%	2.1%	0.7%	0.7%	0.1%	0.0%
Consultant A	0.6%	9.5%	4.7%	6.9%	1.6%	0.6%	0.0%	0.0%
Ms Stohr	0.5%	23.6%	6.9%	11.4%	1.9%	2.6%	0.1%	0.0%

12.45 Including adult orthopaedic surgery, Ms Stohr was responsible for close to half of the all the surgery carried out by consultants in the paediatric orthopaedics team, and in some

years did more surgery than the rest of the team combined (excluding 2024, when Ms Stohr was only in work for three months).



12.46 We would expect that Ms Stohr's higher level of surgical activity would result in similarly higher demands for outpatient consultations in paediatrics, with all elective patients requiring, at minimum, a pre-operative and a follow-up consultation, and emergency cases invariably being seen in clinic post-operatively.

12.47 A member of staff who worked with Consultant A and Ms Stohr told of us about their different patient numbers and approach to their work:

> *"[Consultant A] put it out there and it was known that he would see 12 [outpatients per day] and that was it … whereas Kuldeep would see anything up to about 30."*

12.48 The member of staff described the perceived impact this had on Ms Stohr:

> *"She did take on a lot, and it used to show, she used to get quite anxious, not anxious, but you could see she was ready to take on the world."*

12.49 They added:

"There were other issues. She did used to get quite angry, I think everyone is aware of that.

The Wednesday afternoon fracture clinics, which was hers was always mayhem, absolute chaos, because there was just so many children coming through and her pre-op clinics on a Thursday afternoon, because she really did take on all the children that were needed, or as she saw as needed."

12.50 Another member of staff who had participated in the paediatric orthopaedics MDT commented on the perceived imbalance in consultant workloads in the service:

"She was probably the more approachable of the two, when it came to that, so then you probably find that your workload increases. [Consultant A] was very good at setting boundaries for what he felt was a safe amount, or the amount of work he wanted to do at any one point in time."

12.51 The same interviewee also confirmed that they thought the complexity of the referrals was increasing:

"It definitely was growing and growing and growing, and the more consultants you bring into a team, the more they draw in work. [Consultant B] famously brings in complex stuff from around the country, that look him up, and then he brings that in. Kuldeep (Ms Stohr) tended to bring in more complex hip stuff whereas, when I was just working with [Consultant A], it was busy – I am sure the waiting list was horrendous, but we got through it…"

"… We only have the same amount of kids but the more complex work seems to have come at higher frequency. I am not sure exactly where it was coming from – whether it is drawn in more from the region as smaller units close."

12.52 Another colleague disagreed, but believed that the volume of work was increasing:

"I don't think the complexities increased; I think the volume… Because we're a regional service we take the complex needs children, the children needing intensive care, the children that the local hospitals can't operate on, so they need the Complex Team to deal with it."

12.53 Consultant B was aware that Ms Stohr sometimes felt the pressure of managing a heavy surgical workload:

> *"She was often stressed and under pressure, and she worked very hard. Kuldeep did an awful lot of out-of-hours trauma operating in, again, a very commendable way. If you were to ask the on-call trauma team who they would call in a crisis, it would be Kuldeep."*

12.54 We asked the Deputy Operations Manager for children's services how management viewed Ms Stohr's workload. They said:

> *"She was going to burn herself [out], wasn't she? She was doing a lot, a lot."*

12.55 He confirmed it would be a shared responsibility to highlight this risk, but that:

> *"I am sure in passing I would say 'she is doing a hell of a lot', but … we have so much pressure on the recovery side of things and with a small team I would leap too if someone is saying 'I am happy to do this list'."*

12.56 Ms Stohr gave us her account of how she tried to manage her workload:

> *"I became aware that the amount of work that I was doing was disproportionately more and increasingly complex. This was especially true for trauma, tumour and infection work. I had done so much that consultants in other specialties would contact me directly. This was even when I was not meant to be doing clinical work.*
>
> *I tried to bring about a system that teams would contact the clinical nurse specialist first (they got given a mobile phone), and the nurses would contact one of the [paediatric orthopaedic] consultants as the nurses would be best placed to know which consultant was available on which day…*
>
> *This worked for a bit, but not really for long. I don't know why - I suspected that our own CNSs were disinclined, and I didn't really want to have that conversation with referring clinicians. Also, old habits die hard and consultants would continue to approach me directly. Then COVID happened, and because of my position on the trauma rota, and fracture clinics and hip ultrasound – I was just in hospital more.*

The trauma room got moved to the basement for two years… and this system just got eroded."

12.57 Ms Stohr described the working practices of her colleagues in the service:

"[Consultant C] did not have a trauma presence, no trauma theatre and was the newest member of the team as a result many consultants in other specialties were not even aware of her. [Consultant B] effectively worked 2.5 days of the week and out of the building from Wednesday lunchtime to Monday morning. [Consultant A] says 'no' –so I continued to be the 'go-to' paediatric orthopaedic contact."

12.58 She concluded:

"As I have shown before, I did the most. Work was not evenly shared out. No one challenged how any consultant is able to cap their clinics… Nobody seems to have an oversight on consultant activity."

12.59 Ms Stohr explained that she reported her workload to management as a concern in 2023:

"[Deputy Medical Director B, the lead for patient safety and quality] was aware of the disproportionate work I was doing; I presented graphs and statistics of the work distribution back in 2023. She could have stepped in and recognised that it is hard for someone to say 'no' to sick children (I had stated this to her), and that for some individuals and some departments it takes a more senior approach to distribute work. This is just as true for [the Director of Division E] and [Deputy Medical Director A], but [Deputy Medical Director B] knew this directly.

Issues like – who takes referrals from other hospitals, what do we need to be able to deal with the numbers of external referrals - This could have been addressed better by the Trust. [The current] divisional director for Division E knew. I had copied her on an email exchange about an emergency referral regarding a patient from Stevenage or Harlow (I cannot quite remember which hospital now). She chastised me for giving [Consultant A] the wrong impression of a conversation we had about how we have an obligation as we are the regional centre for referrals.

I think this was an opportunity for [the current Director of Division E] to come to us as a department and discuss acute external referrals. I attended regional meetings for a while which were an attempt to distribute work and have agreed pathways across the region. I stopped going as I felt my absence might actually be more effective in forcing improvements in CUH – it was clear that other hospitals in the region (quite rightly) wanted to have clearer and more automatic methods of referral to CUH.

Unfortunately, there was no engagement from management, both clinical and administrative, to engage in a conversation about how this could be best delivered. It was left to the medical team, which inevitably meant – me."

Comment

Ms Stohr consistently carried a heavy workload that comprised complex cases and additional commitments as part of her on-call work in trauma. At her own initiative she also took on clinical lead responsibilities in the service, prior to Consultant C's assuming that role in March 2020.

She also got involved in waiting list initiatives that were managed within the service. Her willingness to step up and to volunteer to take on waiting list and on-call responsibilities was well known to her colleagues, but its impact on her was less obvious to her management, who seemed satisfied with her contribution to reducing waiting lists and increasing departmental throughput.

Ms Stohr's consultant and management colleagues knew that she worked hard and took on a lot of additional work if asked to do so. This included regular operating initiatives to reduce waiting lists.

Impact of waiting list pressures

12.60 Waiting lists in paediatric orthopaedics at CUH appear to have been a long-standing operational issue. Consultant A had a waiting list when Ms Stohr arrived as a consultant in 2012. She said:

"In my first few months at Addenbrooke's (before I left for maternity leave), I did not do much elective operating. What I did, were almost all [Consultant A's] patients (from [Consultant A's] waiting list)."

12.61 Ms Stohr told us that she felt under pressure to take on work that she did not consider that she was able to do as a new consultant:

"I remember very early on, literally within the first few days, the manager then and I cannot remember his name, he was quite officious… I now can see what his strategy was that 'your waiting list is out of control [Consultant A], at last we have a new consultant, what are we going to do about it?' None of that was spoken, it's just that I now know that that's how management works.

So, we had a meeting, I went, and [Consultant A] was there, and we went through a spreadsheet of the cases and what could I do? I do remember that gentleman making a remark, 'well, I thought you were a trained orthopaedic surgeon?' Because I would say, 'I am not sure I could do that, because that's a case that has been with you for a very long time', or that and this manager wanted that patient to be done because they had been waiting for so long and I remember that being a bit upsetting when he said that."

12.62 The Deputy Operations Manager for children's services has been involved in the management of paediatric orthopaedics for many years and has a detailed understanding of waiting lists:

"When we inherited Paediatric Orthopaedics, they were our worst performing surgical speciality in terms of waits and everything. So up until definitely Covid time they were the ones with the biggest waiting list…

… Where we had no 52 week breaches back then, they had 10 or 12 a year and it was the priority service for the Division to be giving WLI (waiting list initiatives) [to] paeds surgery and urology was a little bit lower but it was recognised it was a limited service, because there were only two of them. I believe as part of the business case and everything in terms of moving the service forward obviously we had the additional consultants in a stage process throughout the period. [Consultant A] would do the big, massive cases, Kuldeep wasn't always the big, massive cases."

12.63 They also observed the consequences of the changed relationship between Consultant A and Ms Stohr as they worked independently of each other and the impact that had on waiting lists:

> *"I think there was a period where they just - [Consultant A] would refuse - there was a reason he wouldn't take Kuldeep's patients, so he wouldn't pool, he would have his own waiting list, he would not pool anything."*

12.64 They told us about the regular waiting list initiatives in paediatric orthopaedics and the importance to Trust management of reducing the size of the list and avoiding patient breaches. They also confirmed that Ms Stohr willingly volunteered to tackle waiting lists by working extra hours:

> *"Kuldeep would just do everything, she would be, 'yes, yes I want to do this, I want to do that, I will do this weekend, I will do that weekend,' because she was really keen, she had the biggest waiting list and she was really keen to try and clear it as much as possible. This was all the way up to when she went off."*

12.65 We heard some evidence to suggest that optimal clinical outcomes in paediatric orthopaedics can be compromised by delays in surgery being undertaken. For example, a child may go through a growth spurt, and this could make surgery more complex and the outcome less predictable. A paediatric orthopaedic surgeon from another Trust told us:

> *"Ms Stohr definitely had concerns that she had kids whose hips were dislocating that the Trust were telling her she could not prioritise. They were going to be waiting 12/18 months, and she knew by then that it would be harder to manage and the problem would be worse. She felt no-one was understanding that…*
>
> *As soon as you realise a hip is at X point you need to do it, because otherwise you are going to be doing acetabular osteotomies, you will be doing so much more clinically if it waits another 12/18 months, especially if they have a growth spurt in that time. So, you have made your operation bigger, more complex, your outcomes are not going to be as good, 100 per cent, and there is plenty of evidence for that."*

12.66 We were told that this need for timely surgery sometimes conflicted with Trust-wide priorities to reduce waiting lists:

"Neuro-disability cases need to be prioritised, pretty much every single one of them. You can't predict when they are next going to grow or something that makes that situation 100 times worse and you are starting again with a more complicated problem. You need to be fast. The other thing with long waits like that, especially with complex families who have so many other things to deal with, you lose the patients' confidence as well, because they think it is your fault."

Comment

The CUH paediatric orthopaedic service has had waiting times for care and treatment for many years. From the start of her consultant career Ms Stohr has been involved in initiatives to reduce waiting times. She describes pressure from Trust management at the start of her career to take on complex cases and she resisted this. Nevertheless, she consistently carried the biggest caseload in the service.

The pressure to reduce waiting lists has been an ever-present feature of paediatric orthopaedics. It is likely that children with complex conditions were on the waiting list.

Ms Stohr's health and wellbeing

12.67 Ms Stohr was referred by Trust management to Occupational Health (OH) once in early 2015 and a second time in March 2024. She has given us permission to access her OH records and has shared with us the reports that were made by OH clinicians at the time.

12.68 With Ms Stohr's permission, her legal adviser provided us with the correspondence Ms Stohr had about her referrals to OH in 2015 and 2024. However, we do not have the occupational health physician's (OHP) report to the Trust following a specialist's report in 2015 and we are unsure whether the OHP saw the specialist's report in 2024. We think it is likely that they did.

12.69 We do not therefore know what action the OHP advised management to take on either occasion. However, we do have sufficient information to know and understand the

basis for the referrals. We believe that the information is directly relevant to our terms of reference and an understanding of Ms Stohr's work as a paediatric orthopaedic surgeon, and the effects it had on her health and wellbeing.

12.70 We learned that Ms Stohr returned to work after maternity leave in November 2013 and found work to be quite stressful while having a new baby and another young child at home. She consulted her GP around September/ October 2014.

12.71 The OHP's referral of Ms Stohr to a specialist in March 2015 highlighted the following difficulties at work:

- difficult work relationships
- high work demands from the clinical director. Ms Stohr found it difficult to say no to these demands and proceeded to undertake tasks but then later expressed anger about the situation
- restructure at work with temporary loss of administrative support (we believe that this refers to the 2014 move by paediatric orthopaedics to Division E)

12.72 The reports from OH clinicians refer, in 2015, to the impact of work factors on her mental health, citing organisational restructuring, workload and relationship problems.

12.73 We asked the Director of Division E if he had ever known about any concerns around Ms Stohr's health and wellbeing, and if he knew that she had been referred to Occupational Health. He said:

> *"I don't think I was involved in any of that. I have some sort of vague memory about her absences and to be honest I can't remember any detail of why that would have been."*

12.74 Ms Stohr told us that she did not modify her working practices following the assessment and advice from OH. She also told us that the Trust did not take responsibility for reducing her work-related stress. She said:

> *"If anything, the organisation put more and more work at my door."*

12.75 A specialist's report to Ms Stohr's general practitioner in April 2024 highlighted work demands on her and that the orthopaedic surgery workload in the service was not evenly distributed or supported. The specialist advised that Ms Stohr needed help with creating a role and workload that were sustainable for the longer term.

12.76 In 2024 an OH report says that Ms Stohr's mental health had improved, and that she is under a treatment plan with a therapist. A provisional return to work date of early October 2024 was indicated, on a phased basis, beginning with her working at around 50% of her normal commitment, but this was overtaken by events.

12.77 The OHP report to the Associate Director of Workforce in April 2024 highlighted some recurring themes:

- difficulty with work relationships
- increased work demands with an unsustainable and disproportionate workload. *"Work factors have been the cause of or a significant contributor to K's persistent low mood".*
- changes in work practices

12.78 Using the categorisation of the Health and Safety Executive (HSE) Management Standards framework, the main work stress factors which affected Ms Stohr were high, unsustainable, and disproportionate work demands, difficult work relationships and change/ restructuring at work. These factors were highlighted by the OHP in the March 2015 referral to the specialist and again in the management referral report to the Associate Director of Workforce in April 2024.

12.79 We infer that the intention of the OHP, as set out in his letter, was that these factors should be discussed with Ms Stohr and addressed by the organisation prior to her return to work, to avoid the risk of recurrence.

12.80 To date, this has not happened as Ms Stohr's return to work has been delayed by the current clinical review of her work and this management investigation.

Comment

Occupational health reports are confidential and the details they contain are not normally shared with an employee's line management. There is no likelihood that her line management or her colleagues in the department would have known, at the time, of her engagement with OH, or of the advice and guidance she was given.

We believe the amount of work that Ms Stohr carried had a negative impact on her health and wellbeing that was aggravated by the relationship difficulties in her department. We saw no evidence that line management was aware of any health or wellbeing issues that Ms Stohr was experiencing.

It would have been appropriate, without revealing the details of her medical condition, for line management to have been advised that her workload was becoming unsustainable and that it might need to be adjusted.

We saw no evidence that occupational health advice on this issue reached her line management. There was also no connection made between her appraisals and her line management about whether anything needed to be done to alleviate her workload.

We consider that much of the stress that Ms Stohr was experiencing came from obvious factors such as the complexity and volume of work that the service was handling. We believe that her willingness to take on more work outside her specialty was laudable but also contributed to the stress she felt at work.

Ms Stohr also found it difficult to manage the relationship between her and Consultant A and she felt that she was not supported by her management in resolving these difficulties.

Similar factors are common in many jobs and can produce significant work-related stress if they are not managed properly.

Feedback to Ms Stohr on her clinical practice

Sources of feedback

12.81 We asked Ms Stohr how her clinical performance was measured and assessed. She said:

> *"It isn't, nobody's is."*

12.82 We asked where she would get feedback on the quality of her surgical work. She said:

> *"It would be when I would bring up a case to somebody else, so it was consultant-reported…*
>
> *[Consultant C] is an old friend of mine. We would also be in the offices until late Wednesdays, Thursdays and sometimes Friday. We'd often be there until about 7pm finishing our admin, and I would show her my x-rays, and she'd show me hers. It would be that sort of 'no blame', friendly discussion between the two of us."*

12.83 Ms Stohr confirmed that there were no other formal sources to get feedback on the quality of her work:

> *"It's not so much about quality of work… as 'am I as good as other people?'. The only way I know that is by looking at my own work critically and benchmarking in the things I can benchmark against, so that was things like DDH, Club Foot and infection. You can't really benchmark easily anywhere else.*
>
> *I know that I would email my contacts at the Royal National Orthopaedic Hospital, Chelsea and Westminster, and say, 'what do you think of this' and send them x-rays and stuff. There's that sort of ad hoc advice, and then the East Anglian Paediatric Orthopaedic Group (EPOG) people, would be a bit more formalised but again, it's not often enough. You're wary of the audience so you're not bringing up everything, and that is not the environment to bring up complications and quality stuff."*

12.84 She added:

"Every consultant surgeon, who is not dealing with oncology, is in the same boat, so any surgical specialty that has oncology as part of their remit has proper data analysis."

12.85 We asked Ms Stohr how she could find out if she was doing something that was unsafe. She told us:

"You don't. The only thing you have to go on is other people telling you and I mean the anaesthetists, plaster technicians, saying things - after surgery."

12.86 Ms Stohr told us that she did "occasionally" get feedback from colleagues but that:

"I have had angry incidents with people, and I do wonder whether that puts people off then from talking to me, but then enough people talk to me that I think - I'm not an ogre, I don't think."

12.87 Ms Stohr told us that she had reflected on her practice and sought to make some changes:

"Yes, sometimes… and my figures seem to improve, but actually my statistics are too small to know that for certain, but it seemed to improve. Yes, I do check on things."

12.88 Recognising that managing the performance of consultants is a key part of clinical governance we asked Consultant C - as we had asked others – what metrics are used to ensure surgeons are performing safely.

12.89 They told us that, in adult orthopaedics:

"90% of your practice is doing knee replacements. All your results go onto the National Joint Registry, and you're told if you're an outlier."

12.90 By contrast, in paediatric orthopaedics, they said:

"We are high complexity/ low volume and for a lot of what we do there is a complication rate. Even in the best hands, there is a complication rate, and if you're doing very few, you do three a year, and you have a complication on one, do you have a 33% complication rate or is it, if you've done it for 10 years, that would be your only complication?

When you have such a low volume, it is harder and what makes it even harder is we don't have that – well, it's evolving, but traditionally we have not had set outcomes. We don't say that for the success of doing a clubfoot operation, this is a success and this is not a success, because again, if you have a really gnarled clubfoot, maybe the child has been born in a different country, they move here when they are six, you are never going to get the same outcome.

Because there is such a range, and in DDH you can have a mild dislocation, you can have a really high dislocation and you are going to have different outcomes, so it's really difficult."

12.91 Consultant C described the efforts they are making to improve this aspect of care:

"As a specialty, even globally, never mind nationally, we are trying. We now have core outcome sets (COSs) for clubfeet. We have collected the core outcome set for the last five years, so if anyone says to me, 'do you run a good clubfoot service', I can show them all our data, I can give them patient satisfaction data, I can give them anatomical data, I can give them x-ray results, so I can tell you absolutely what the outcomes of my clubfoot service are."

12.92 However, Consultant C told us that there may be:

"At a guess, 200 to 250 different pathologies in Paediatric Orthopaedics - I saw a child yesterday, I have never seen it before this particular problem and I may never see it again, how will you know if my treatment of that child is any good? It is difficult."

12.93 They said:

"Actually, there's no set outcomes for DDH, so that's difficult. For cerebral palsy, we are getting some outcomes now and, for instance, for cerebral palsy you can put children through a gait lab, you can watch how they walk, you can do it before and after. The East of England don't have a gait lab, we are the only region, and I have been trying to set one up for the last three and half years."

12.94 We asked Consultant C how their work as a surgeon is overseen. They said:

"Well, it's presented every week now at the MDT, so my colleagues, we have peer review of all of us. Every single case I do is peer reviewed by my colleagues, but if I do an Achilles tendon lengthening, that's just soft tissue, I will say to them, 'it went well', and that's what I do say, it's a very bog standard procedure but there is nothing I can show them. I have a registrar in theatre with me, hopefully if I was rubbish, they might say something, I don't know. Again, it's not foolproof."

12.95 Consultant C said that they also have a mentor from whom they can seek advice in difficult cases, and, at the Norwich and Norfolk Hospital, there are colleagues who can advise them on request. Consultant C said that they aims to set up a formal agreement with Great Ormond Street Hospital to help ensure they not become isolated and that they have support from other colleagues outside CUH.

12.96 They described what this means in practice, saying it is:

"Support from others who do complex surgery, so hopefully that formal relationship can be set up. We have the ODN [Operational Delivery Network], and with the clubfoot we have an audit regionally, so we collect those core outcome sets, so actually the region sees my results. With DDH now, every x-ray once a year is presented, so at this regional meeting, so actually the whole region will see my DDH, the whole region will see all my clubfeet and my colleagues will see all of my operating where you can see an x-ray. Some of the more minor operating, they will have no idea."

12.97 We asked Consultant C how confident they are that, with improved local governance in paediatric orthopaedics and with improved audit, peer review and better external relationships, the problems that were experienced in respect of Ms Stohr's practice would not recur. They said:

"Ninety eight percent. I think with a hip operation I could give you almost 100 percent for hips, because you would see it on the x-rays, you do see it on the x-rays. There are some surgeries that don't have x-rays, how you going to monitor that? I don't know, that's going to be a bit more tricky."

12.98 They added:

"I think with what's in place, I am not going to say 100 percent, I don't think anything is 100 percent, but I think the set-up we have now will be as good as anyone in the country. I am not saying it cannot be improved, of course it probably can, and I will keep trying to."

12.99 The Director of Division E told us:

"Broadly speaking, consultants still make a decision and carry on until apprehended.

There are national fora where people can get together and share difficult cases in advance of decision-making, and perhaps even regional fora where more complex patients can be discussed. Broadly speaking, however, you make your decision if you are appointed as a consultant and you carry on, seeking advice only when you, or one of your colleagues, feel this is necessary."

12.100 We asked Dr Shaw, the former Medical Director, how a surgeon's clinical practice is assessed. He said:

"In surgery, you would be amazed at how few outcomes are routinely collected and measured nationally. Broadly, they collect mortality rates and orthopaedic surgeons look at joints – there is a National Joint Registry. However, there is not much more beyond that. If you wanted to find out who is a good surgeon, I suspect that probably the best thing to do would be to ask someone else who works in the hospital."

Comment

Common to many surgeons in the Trust, there are limited oversight mechanisms in place to give feedback on the quality of their surgical work. Consultants are autonomous and entrusted to maintain the quality of their practice themselves. For some surgeons it is possible that their patients will only be reviewed if something goes wrong.

Clinical practice concerns

12.101 The General Medical Council (GMC) guidance, 'Raising and acting on concerns about patient safety' came into effect 12 March 2012.

12.102 It states:

> *"All medical professionals have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work."*

12.103 The guidance requires that a doctor:

> *"Must take prompt action if you think patient safety, dignity or comfort is being compromised."*

12.104 The guidance also states:

> *"You may be reluctant to report a concern for a number of reasons. For example, because you fear that nothing will be done or that raising your concern may cause problems for colleagues; have a negative effect on working relationships; have a negative effect on your career; or result in a complaint about you."*

12.105 It goes on:

"If you are hesitating about reporting a concern for these reasons, you should bear the following in mind. You have a duty to put patients' interests first and act to protect them, which overrides personal and professional loyalties."

12.106 Consultant A had raised significant concerns about Ms Stohr's clinical practice in 2015/ 2016 and did so again with colleagues in 2024. Our account of Consultant A's concerns is discussed in Part one of this report. We have sought to identify whether any other concerns than these came to light during the period between 2016 and 2024.

12.107 Consultant A wrote in a statement to us that in the period after August 2016 until 2024 they continued to believe there were issues with Ms Stohr's clinical practice:

"After 2016, I saw further cases operated on by Ms Stohr that gave me cause for concern. I did not feel, however, that I could challenge them in light of what the Trust had told me the Hill Report had concluded and the Trust's treatment of me in relation to raising complaints. I was still very concerned that I would face serious sanctions if I sought to re-open concerns about Ms Stohr's practice or, indeed, about any other issue in the hospital."

12.108 Consultant A wrote:

"I felt my hands were further tied when the Trust promoted Ms Stohr to Clinical Lead for the Paediatric Orthopaedic department."

12.109 Consultant A also confirmed in the written statement that they:

"… Decided to instead take a 'step back' and stop raising incidents even where I witnessed something I thought was wrong."

12.110 We asked Deputy Medical Director A if any issues had been raised about Ms Stohr's clinical practice between 2016 and 2024. He confirmed that:

"There were no clinical performance issues that were flagged up that I was aware of, nothing via the incident reporting. In terms of Datix reports and incidents forms of various sorts, no flags to that. Nothing coming from her colleagues within the service before the most recent events, so it had been quiet for that time."

12.111 A consultant in the Trust who received Ms Stohr's patients as adults told us:

> *"I look after a lot of people who have cerebral palsy, who have complex difficulties in their musculoskeletal systems of various kinds, and transition their care from paediatrics to me. I'm an adult bone physician, I don't do any operating, I'm not a surgeon. I get people from Kuldeep's care and her operations, and I don't think she's come across as someone who is an outlier.*
>
> *… We do diagnostic bone biopsies… I'm reporting them, and there's a variation in the quality of those, and we're talking to one another and saying, 'how do we get this better?'. There are things where it's not done perfectly and you want to make everything good, but she's never come up as someone with hips, or the adult hips, or anyone who she's transitioned care to me or asked my opinion, I've not thought, this is someone I'm worried about."*

12.112 We also learned that Ms Stohr was nominated for a 'You Made a Difference Award' for clinical excellence in December 2017 but was not successful.

Comment

With the exception of Consultant A, none of Ms Stohr's fellow surgeons had concerns about the safety of her practice until 2024, when they assumed responsibility for her patients during her leave of absence.

Despite their previously cited concerns, Consultant A did not raise any further concerns about Ms Stohr's practice in this period. Although this is understandable, given what they were told about the outcomes of the Hill review, it did not comply with the 'raising concerns' guidance.

This was an opportunity missed for any further concerns to be identified, although, if they had also disclosed their understanding of the outcome of the Hill review, it might have made little difference.

Patients' and families' satisfaction measures

12.113 The parent of a former patient of Ms Stohr offered the following feedback about the care she provided:

> *"I would say Kuldeep is an extraordinarily dedicated and conscientious doctor, first and foremost, not unusually so, there are hundreds of different Addenbrookes you will come across but the one that she works in is high quality, high throughput, but highly specialised, so when you are flailing around, trying to find out if this is a cancer or not – it turned out not to be cancer – you really need someone like this on your side."*

12.114 This parent is also a consultant in another specialty in the Trust and has seen patients from Ms Stohr's caseload. They told us that they had no concerns about her clinical practice.

Complaints about Ms Stohr

12.115 Since 2015 the Trust has recorded complaints received on Datix QSIS. The PALS and Complaints Manager manages the Patient Advice and Liaison Service (PALS) at CUH. Complaints received by the Trust are dealt with centrally by this team. They told us this is a well-established practice across the organisation, and the team has good processes to support the management of complaints. The Trust currently receives between 50 and 70 complaints a month. The annual total is between 800 and 900 complaints and 5,000 PALS cases.

12.116 Clinical complaints are shared with the responsible clinical director, and it is their decision as to whether the consultant is involved in the response. All responses to complaints – be they about operational, clinical, or nursing matters – are reviewed by an executive director before they are sent to the complainant.

12.117 The PALS and Complaints Manager reviewed previous complaints about Ms Stohr when the most recent concerns about her clinical practice came to light in 2024. These covered twelve years of her clinical practice:

"We did a look back and there were 13 related to [Ms Stohr] since 2013. One was directly related to a surgical procedure, two related to hip dysplasia diagnosis, and a mix of emergency care and elective, but nothing that we would have highlighted."

12.118 The PALS and Complaints Manager confirmed that there is no discernible difference in complaints about Ms Stohr in 2016 or in 2017 and beyond when she became clinical lead for paediatric orthopaedics.

12.119 We have reviewed the PALS data and analysis of complaints involving Ms Stohr. We have read the original complaint, the investigation report, and the Trust's response. The first complaint was made in 2014 and the last in 2024.

12.120 The complaints include five emergency cases and eight elective or outpatient cases. Ms Stohr was not named in four of the complaints. Four of the complaints concern her attitude and behaviour and fall in the period 2019 to 2024.

12.121 The main themes arising from the complaints include:

- Ms Stohr's attitude during the patient/ family consultation (inpatient and outpatient)
- One relates directly to a surgical procedure carried out by an adult orthopaedic surgeon that Ms Stohr then reviewed (2024)
- Two relate to missed hip dysplasia diagnoses
- Others concern post-operative care / follow up

12.122 We received written evidence from one family whose child had been cared for by Ms Stohr. The care and treatment received from Ms Stohr and team covered late 2023 through to February 2024. The concerns include:

- Ms Stohr's clinical decision-making and surgical technique
- Her consultation style with a teenage patient
- The clinical outcome of the surgery

12.123 We believe that this case was one that the paediatric orthopaedic team brought to the attention of Trust management, and it was reviewed by Mr Hunter in 2025.

Comment

There are low numbers of complaints recorded by PALS about Ms Stohr during the period 2012 to 2024. According to the Trust, those complaints that were made do not suggest serious concerns about her clinical practice. Ms Stohr is not described as an 'outlier' amongst her peers for complaints.

None of these complaints prompted any management intervention in Ms Stohr's clinical practice.

Patient safety incidents

12.124 None of Ms Stohr's colleagues reported that she had been involved in any serious patient safety incidents.

12.125 We received a spreadsheet from the Trust detailing 27 incidents raised in the Datix system that were "linked" to Ms Stohr between October 2015 and March 2024. None of the cases of identified harm in 2016 or 2024 are included as reported incidents.

12.126 The report descriptions are anonymised, so it is not immediately clear which staff were involved and therefore, their roles in each incident. We reviewed the data to ascertain which of these incidents involved issues relating to Ms Stohr's behaviour, conduct or clinical practice.

12.127 Overall, we found that, of these incidents, 17 related to issues around short staffing and clerical errors within the wider paediatric or adult orthopaedics services.

12.128 There are four incidents where it is not clear if Ms Stohr is involved in the incident nor is it obvious that she was at the centre of the issues which arose, or that she had direct responsibility for the area of clinical failing. These are:

- 18/08/2016 – delayed treatment/ cannulation. Possibly unresponsive to bleep
- 05/06/2017 – patient slips on ward with the implication of incorrect surgery or post-operative support

- 30/11/2018 – poorly managed discharge resulting in delayed follow-up
- 23/11/2020 – delayed clinical notes/ failure to note PICC (Peripherally Inserted Central Catheter) line safety

12.129 There are five incidents which appear to definitively involve Ms Stohr:

- 27/02/2016 - retained surgical equipment (k-wire)
- 20/07/2016 – wrong site cast on a child
- 13/02/2019 – Ms Stohr shouting at a health care assistant
- 03/07/2019 – Ms Stohr being rude to patient's mother
- 13/06/2022 – Ms Stohr being rude to a colleague during surgery

12.130 Two of these incidents related to clinical outcomes. Notably, the only reported incident relating to Ms Stohr's surgical performance (k-wire retention) occurred in early 2016, before the Hill review had got underway. The second clinical incident came about through poor communication and inaccurate records between the emergency department, plaster technicians, Ms Stohr and radiographers in the x-ray department.

12.131 Similar to the evidence gather through complaints, three of these incidents relate to Ms Stohr's behaviour towards colleagues and patients.

Comment

There are a relatively small number of incidents which could be directly or indirectly linked to Ms Stohr throughout her twelve years at the Trust. Moreover, none of these incidents relate to poor clinical outcomes for patients or highlight any deficiencies in Ms Stohr's surgical techniques such as those revealed in 2016 and 2024.

As we have described earlier in this report, it is unfortunate that none of the cases of identified harm were raised as patient safety incidents.

Overall, there were no indications from patient safety incidents reported that there was any problem with Ms Stohr's practice.

Joining the dots: what did the Trust know, and what did it do?

12.132 The Trust knew the following from 2016:

- The two consultant surgeons in the service (Ms Stohr and Consultant A) did not get on and had a distant working relationship. They did not work as a team. The Medical Director's office recognises relationship breakdown as the most significant problem it deals with. Patient safety literature makes it plain that such poor relationships are likely to impinge negatively on patient care and treatment.[13]

- This poor relationship suffered further damage after Consultant A correctly complained to the Director of Division E about the quality of Ms Stohr's clinical work.

- From June 2016 there were independently documented concerns from the Hill review about some of the cases raised by Consultant A.

- The paediatric orthopaedics service did not then have functioning MDT meetings.

- The service was handling an increasing volume of referrals to CUH as a tertiary centre, adding to a growing waiting list.

- Ms Stohr's workload became increasingly heavy.

- There were concerns about the impact of Ms Stohr's onerous workload as is evident from her occupational health report in 2015 and as expressed by her appraiser in writing in her 2017/2018 appraisal.

- Dual operating was not commonplace in paediatric orthopaedics before 2019 and there were limited opportunities and mechanisms for monitoring surgical performance, meaning that detailed feedback on individuals' clinical performance was not readily available

[13] https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/

- There was little feedback to Ms Stohr about her clinical practice.

- Ms Stohr was a well-liked and respected colleague within the wider Trust, although there were occasional behavioural issues that arose with colleagues and patients' families.

- Other members of the paediatric orthopaedic team were not raising concerns about her surgical techniques, or about her patient outcomes.

- There was little hard data about Ms Stohr's clinical practice and the quality of her work, as was the case with her consultant colleagues. The data streams that might have indicated problems with Ms Stohr's practice revealed nothing of concern to warrant pro-active intervention into her surgical technique.

- The incidence of patient/ family complaints about Ms Stohr's practice was considered by the PALS team to be unremarkable, and the incidence of concerns about her behaviour with families and colleagues were not felt to be out of the ordinary.

Comment

We found no-one in the management of the paediatric service, or in the workforce directorate who held a complete picture of all the factors affecting Ms Stohr and, potentially, the quality and safety of her work.

We believe that, at the time, it was not clear how the management of the Trust should or could have 'joined the dots' to compile a comprehensive view of how to anticipate and mitigate the effect of all these factors on Ms Stohr. There did not appear to be any mechanism by which a complete picture of her workload, wellbeing and the quality of her clinical practice could be brought together.

We saw no evidence of any attempts to address the poor/ uncollaborative working practices within the paediatric orthopaedics service, despite the possibility that they would adversely affect the delivery of safe patient care.

Trust systems that generate hard data about patient safety issues had not indicated the incidence of any 'red flag' concerns about Ms Stohr's clinical practice.

Missed opportunities

MO26 Had there been greater clarity about Ms Stohr's line management and clinical supervision (including 360° feedback about her performance) the Trust would have been able to see more quickly when her practice was becoming potentially unsafe.

MO27 The lack of connection between Ms Stohr's appraisal process and day-to-day management meant that issues of concern about her practice were left to her to bring up in her annual appraisals, meaning that action to address them might be delayed or not taken.

MO28 The information available from Ms Stohr's OH referrals was not shared with her line management and gave them no opportunity to address the factors affecting her health and wellbeing.

MO29 Numerous opportunities were missed to consider whether Ms Stohr's workload was sustainable, and to assess whether the workload presented a risk to the quality and safety of her practice.

MO30 There was an opportunity missed by Consultant A to flag up any further concerns they had about Ms Stohr's practice in the period between 2016 and 2024.

Recommendations

R14 We recommend that the Chief Medical Officer and the Chief People Officer should produce guidance that clearly sets out the respective roles of appraisers and line managers in the management of consultants. This guidance should also clarify who is responsible for clinical supervision of consultants and how that supervision should operate.

R15 To improve the confidence that the Trust has in the competence of its surgeons we recommend that the Chief Medical Officer should consider developing appropriate mechanisms to ensure surgical practice is routinely observed by qualified colleagues.

R16 The Trust should consider whether to develop a more formal mechanism to share outputs from appraisals with line management. Any concerns about a clinician's practice, or factors that might affect it, need to be routed, with the clinician's agreement, into the management of the Trust so that they can be considered and acted upon.

R17 While the personal and medical content of Occupational Health referrals and reports are private to the individual, the Trust should assure itself that appropriate arrangements are in place for line management to understand whether any reasonable adjustments need to be made to support the individual to maintain good health and performance.

R18 Line managers should be encouraged to be proactive in identifying and correcting excessive workload for their team members. Managers should be alert to the possible effect that staff carrying excessive workloads may have on patient safety and quality of care.

13. Management and governance of paediatric orthopaedics

13.1 The Trust's paediatric orthopaedic service during the time covered by this investigation grew from two consultant surgeons – Ms Stohr and Consultant A - in 2012 to four today, by adding Consultant B and Consultant C.

13.2 We describe below the development and journey of governance within the department during the period of Ms Stohr's tenure (2012 – 2024)

Governance in Division A 2012 - 2014

13.3 Paediatric orthopaedics is a small specialty, caring for children with challenging conditions from the locality and wider geography. Until 2014 paediatric orthopaedics was a part of adult trauma and orthopaedics in Division A.

13.4 Ms Stohr described the governance in place when she arrived in the Trust as comprising a quarterly meeting where the consultant team discussed cases:

> *"Governance, when I arrived… We were under Division A, Trauma and Orthopaedics, and governance was basically a quarterly meeting that lasted about 90 minutes to two hours, chaired by a revolving set of consultants for a while until [the Service Lead for Trauma and Orthopaedic Surgery] took over. He became Governance Lead and did it in a really thorough way that opened up my eyes a bit to how it could be done.*
>
> *At that time, it was, just as it has been in most of the other Trusts I've ever worked in in the UK, mortality and morbidity. Mortality in Trauma and Orthopaedics, there's an awful lot of it. People did discuss complications but a big flaw, in my belief in the NHS, is that it is consultant reported. Consultants report their own complications; they're not gathered centrally anywhere that I know."*

13.5 Consultant A described the MDT that was in place at that time:

> *"The 'MDT' meetings that took place before this time were not like the MDTs we then started running. Those earlier MDT meetings were people meeting to chat*

about the service, general issues and obstacles that people came across. I do not remember patients being discussed at those earlier meetings. I remember that we started to discuss cases in MDT meetings from October 2016."

Comment

The comments we received from those people who were in paediatric orthopaedics at the time suggest that it was a lower priority service in Division A's governance structure. Its governance needs were dominated by those of the trauma and adult orthopaedics service.

Ms Stohr and Consultant A both observed that the MDT in Division A was not well developed and lacked focus on patients and the effective management of complicated cases.

Move from Division A to Division E in 2014 - 2016

13.6 In April 2014 the paediatric orthopaedics service moved from Division A to be a part of the women and children's service in Division E.

13.7 The Director of Division E was the divisional director and explained the thinking behind his drive to have paediatric orthopaedics in Division E:

"We felt it was appropriate that a service dealing with children should be managed by people who primarily care for children."

13.8 However, paediatric orthopaedics continued to share management and governance arrangements with Division A, even after the service moved to Division E. Ms Stohr told us that children's fractures and overall governance remained the responsibility of the trauma and orthopaedics service in Division A for some time after this move.

13.9 In reflecting on this organisational change, Ms Stohr told us that she and Consultant A were both, at the time, opposed to paediatric orthopaedic services being under the management of Division E.

13.10 In a written statement Ms Stohr outlined what she saw as the advantages of continuing to work alongside colleagues in Division A:

- *"Closer working arrangements with T&O consultants leading to, e.g., better approach to trauma and musculoskeletal infection*
- *Easy access to T&O resources – plaster room, traction equipment, operating nurses, musculoskeletal radiologists*
- *Governance was under T&O which meant that matters were discussed with a wider range of colleagues (all the other orthopaedic surgeons)*
- *Adequate secretarial support*
- *General sense of being able to 'get things done' – possibly because of smaller department with relatively more management."*

13.11 She set out some disadvantages, saying that paediatric services were a:

- *"Cinderella-like service competing with the other demands of T&O*
- *Governance was effectively a two-hour meeting every three months that was not responsive and arguably not effective."*

13.12 Ms Stohr described some perceived advantages of working in Division E:

- *"Separate office in the paediatric portacabin, meaning more interactions with the paediatric team*
- *Use of nurse specialists was successful in delivering care that used to be performed by doctors.*
- *More direct involvement with other Division E senior managers and,*
- *Less contact with [Consultant A] and the clinical director."*

13.13 She described the disadvantages:

- *"Slower pace of work*
- *Smaller admin and management team.*
- *Paediatric orthopaedics still a Cinderella-service"*

13.14 The Director of Division E gave us his view of the success of the transition:

"I pushed hard to get as many paediatric clinicians [as possible] into Division E, although I was not completely successful in the end, for all sorts of appropriate reasons. We ended up with orthopaedics having a split situation, where new consultants would be appointed in Division E and established consultants were organisationally/ professionally still in Division A."

13.15 Some interviewees suggested that, after its move to Division E, the service continued to participate in and share the governance of Division A. However, our impression is that the governance and management of paediatric orthopaedics – a small service – was a second order priority in the organisational changes that were made in 2014.

13.16 Interviewees told us that the paediatric orthopaedic service's management and governance - that is the means for overseeing the control and direction of the service - were minimal and poorly developed after it moved to Division E. Members of the team described other significant governance deficiencies at that time. They reported that there were few standard operating procedures or care pathways, no multidisciplinary team meetings, limited dual operating by the two consultants and, because there were only two of them, little sub-specialisation. This meant that opportunities were limited for the consultants to become expert in the care and treatment of a small number of conditions.

13.17 We were told that these problems were exacerbated by the fact that Ms Stohr and Consultant A did not get on with one another, resulting in a lack of consultant teamwork that is considered essential for excellent patient care.

13.18 Ms Stohr confirmed the absence of governance in the 2014 - 2016 period and said that seeking the clinical advice and help of Consultant A had been difficult in the absence of an MDT. She said that she and Consultant A had become reluctant to discuss cases constructively and that this made it difficult for them to work effectively together:

"The way that I work with [Consultant C] or [Consultant B] now, more collaboratively. That wasn't happening, and so that was in the back of my mind that this Hill Report is an opportunity to call this out."

13.19 We have been told that the service had lengthy waiting lists during these years and that delays over many months to surgery for a growing child could affect the outcome of their care and treatment.

Comment

The paediatric orthopaedic service became a part of Division E in April 2014. This move appeared to result in considerable organisational disruption for the service. There was some ongoing ambiguity about who was ultimately responsible for governance of the service after it moved from Division A, and team members were dissatisfied with the effectiveness of the governance arrangements.

There was not a clean break in the transition of paediatric orthopaedics from Division A to Division E. Although it seems that governance in Division A had not been strong, and that paediatric orthopaedics had been somewhat marginalised, the move to Division E did not immediately improve governance in the service.

Example of the effectiveness of paediatric orthopaedics governance in 2015

13.20 Our terms of reference invite us to comment on the governance of the paediatric orthopaedic service a decade or so ago. We have found little written material from this period, but we have interviewed a clinical nurse specialist (CNS) who worked in the service for six months in 2015. They resigned from paediatric orthopaedics in the summer of that year and went to another job in a related specialty. We have had access to a seventeen-page complaint they wrote under the Trust's Dignity at Work policy. The complaint describes the governance of the paediatric orthopaedic service at that time. We note that period of time described was before the raising of concerns resulting in the Hill review and Ms Stohr's role as clinical lead in the paediatric orthopaedics department.

13.21 The CNS had worked at CUH for fifteen years when they joined the paediatric orthopaedic team in January 2015. Their complaint was about the breakdown in their working relationship with Consultant A. The concerns were investigated by another consultant in the Trust. The CNS told us that the investigation took a year to complete.

13.22 The complaint provides detailed written evidence from 2015 about the state of governance in paediatric orthopaedics. The nurse's concerns are summarised below:

- No structured ward rounds or team meetings making it difficult for her to identify paediatric orthopaedic inpatients
- Ms Stohr initiated a team meeting at the CNS's suggestion. Her complaint reports that Consultant A rarely attended.
- The CNS created a neuro-disability pathway for the service. Her complaint says that Ms Stohr supported this idea, but Consultant A did not.
- Both consultants were taking annual leave at the same time, and on several occasions during her six months in post
- Patients were not being booked onto Epic, so the CNS suggested a referral pathway for DDH patients to Consultant A and to Ms Stohr. She records that this was only welcomed by Ms Stohr.

13.23 The CNS left the paediatric orthopaedic service in June 2015 and joined the paediatric rheumatology team. They described the difference in governance between the two services at her interview:

> *"First of all, there were incident forms – Datixes done. There should have been some sort of meeting where we could go through those. In Rheumatology, we had a two-hour weekly meeting, once a week. We discussed the patients that were of concern. There would be physios there – all the MDT – and you could bring an issue to that meeting. I could say things in Rheumatology like, if a patient had rung me on Tuesday – I would say to the patient, 'I know I'm meeting the consultants on Thursday. I'll get back to you after that and let you know.' I had none of that in Orthopaedics. There was just no joined-up thinking, there was nothing. It felt like they were independent practitioners who were not supervised and not managed. The service wasn't looked at as a whole."*

13.24 In October 2015 the CNS gave an exit interview to senior colleagues in Division E consisting of the head of HR for paediatrics, the matron and clinical director:

> *"I knew that it wasn't a safe service. I went to my matron, and I went to the Clinical Director for Paediatrics, to the Head of HR, to the Head of Medical Staff, and I felt that I was dismissed 10 years ago. I knew it wasn't right.*

Q. *"If you put that against our Terms of Reference, would you say that that was a missed opportunity?*

A. *Absolutely, yes."*

13.25 The Trust has not retained a copy of the exit interview, and it is not clear what, if any action, was taken in response to it.

Comment

This CNS's complaint provides direct and detailed evidence of the underdeveloped state of governance in paediatric orthopaedics in 2015. They contrast this nurse's experience there with the nature of the governance being practised in a closely linked paediatric service. This suggests that governance of paediatric orthopaedics was out of line with the standards of the day.

Governance of paediatric orthopaedics under Ms Stohr, 2016 - 2019

13.26 The Director of Division E shared with us a presentation that outlined the governance structure of Division E in 2016.

13.27 It showed that Ms Stohr was clinical lead for paediatric orthopaedics in the structure. At the time, this was an unpaid additional role that she took on with no additional time to do it.

13.28 The division also had an assistant director of operations, a quality and safety lead, a lead for patient safety, a lead nurse and lead midwife.

13.29 A divisional patient safety sub-committee, and a governance sub-committee met monthly and reported its outputs to the divisional board.

13.30 The divisional clinical governance committee met every three months and reported to the divisional board.

13.31 Key matters in the remit of the committee were:

- Minutes from service meetings
- Minutes from sub-committees
- Clinical governance newsletter
- Risk register
- Nursing quality metrics
- Datix incident data – serious incident action plans
- National datasets/dashboards
- Independent / peer reviews
- Quarterly PALS complaints/compliments data

13.32 Specialty MDTs were also in place and were required to meet at least every three months and to maintain local records of meetings.

13.33 The divisional board was the conduit for reporting to the Trust executive.

13.34 After the Hill review in late 2016 Ms Stohr became the clinical lead for paediatric orthopaedics. She told us that she held the role for four years.

13.35 Consultant A was disappointed with the fact that Ms Stohr had become clinical lead in the service:

> *"I felt my hands were further tied when the Trust promoted Ms Stohr to Clinical Lead for the Paediatric Orthopaedic department. I believe Ms Stohr was promoted in around October 2016 and that she remained Clinical Lead for about five years."*

13.36 We asked Ms Stohr who she was accountable to for patient safety and quality as the clinical lead:

> *"The honest answer is I don't know, because nobody is checking or asking. In terms of patient safety, I really couldn't tell you and nobody was asking."*

13.37 Ms Stohr described her experience of managing patient complaints as clinical lead in the paediatric orthopaedics department:

"These were brought up by consultants if they wanted to. We would advise and offer to see patients on each other's behalf. I think that [Consultant A] were the most likely to bring complaints to the MDT meeting, although I think we all got a similar number of complaints.

When I was clinical lead, I did not have oversight into patient complaints for the department. I now know (from when I was briefly Governance Lead of Trauma and Orthopaedics) that retrospective general data can be obtained from the PALs office, but it not specific or detailed."

13.38 Ms Stohr told us that, in her time as clinical lead, she was responsible for management/ oversight of patient safety incidents and saw any reports generated about patient safety issues. She told us that her experience in this area was gained gradually:

"When I was clinical lead, I might escalate some issues to the Patient Safety meeting by filling in a Datix form and marking it as 'harm'. This prompted a review at the Tuesday meeting. I learnt this gradually and eventually.

I did not even know what the Risk Register was until [a paediatric nurse] complained to her matron about an issue that had arisen, and the matron then mentioned it to me. This reflects not just my lack of awareness but also the Trust's approach to emphasising governance."

13.39 Ms Stohr reported some difficulties she had in this role in getting support from other managers with governance and safety responsibilities. She said that she was unclear about what data were available to inform the service about how it was performing. She said:

"I got an idea of the patient safety team when a Paediatric Surgical Governance meeting started, and a lady… started contributing statistics.

That was the first time I became aware that there are figures available somewhere. [Consultant C] managed to get a hold on this better as she started immediately working with the coding department to improve the income brought in by coding. This opened my eyes.

As individuals, management are nice. Some of them very nice. However, they seem to be over-stretched and just want us to 'get on with it'. They seem to be tackling crisis after crisis."

Comment

Although Ms Stohr made efforts to establish more organised clinical governance in Division E, we believe that it was some time – probably around the time when Consultant C arrived - before governance of the service in Division E reached a high standard.

It is to Ms Stohr's credit that she took on the clinical lead role in Division E. This created additional work for her on top of a patient caseload that was already large. Ms Stohr was learning about the role of clinical lead as she went, and it is understandable that some areas of the work were not fully explored. Nevertheless, it was a commendable effort on her part given that she discharged the role with little support from colleagues.

Her taking the role as clinical lead was not welcomed by Consultant A and this appears to have been another factor in the cooling of their relationship with Ms Stohr.

Early paediatric orthopaedics MDT

13.40 Interviewees told us that CUH has many forms of MDT with no standard model.

13.41 We learned that the paediatric orthopaedics MDT was, until Consultant C's arrival in 2020, less structured with consultants and other team members opting to identify only those patients whose care and treatment they wanted to discuss. There was also no separate clinical governance meeting.

13.42 Ms Stohr told us that she was the mainspring behind setting up the paediatric orthopaedics MDT meetings in August/ September 2016, and that this was triggered by her reaction to the Hill report. Consultant A wrote about the development of the MDT after the Hill review:

"I believe that the MDT was put in place by the Trust with a view to addressing what the Trust's letter to me described as Mr Hill's 'impression' and 'general observation' that the paediatric orthopaedic department was 'divided' and the Trust's desire for [Deputy Medical Director A], Ms Stohr, 'relevant Service Leads / Clinical Directors / Divisional Directors' and I to work together to 'develop a cohesive paediatric orthopaedic department, where colleagues support each other in providing good care of our patients'."

13.43 Ms Stohr described how the MDT meetings worked:

"It would be [Consultant A] and I and, I have to say, he was good. He attended and he was engaged. This is what I wanted, but the presence of all the physiotherapists and the nurse specialists meant that the conversations weren't quite as combative as they were when we were one-to-one.

The physiotherapists, initially, were reluctant and considered it a bit of a chore, and I had to force them a bit to come. However, when the Physiotherapy Department expanded, with the consultants' expansion, with [Consultant B] arriving and then later [Consultant C] arriving, the newer physiotherapists, and the fact that their duties were divided between Adults and Paediatrics, meant that they started to use that meeting as a very important communication forum, so that changed."

13.44 Ms Stohr told us that the MDT meetings were exclusively attended by clinicians and there were no managers present, either from the service operations team or divisional management. She told us that the focus of the MDT was, as in many other MDTs in which she had worked, on mortality and morbidity rather than on discussing with colleagues complications in surgery.

13.45 In her view the MDT was essentially isolated from the rest of the service and any concerns or actions that needed to be taken were not monitored or followed up by anyone outside the team.

13.46 Ms Stohr described what data were available to the MDT:

"In theory, there's Datix and then there's the mortality data as well. Datix is about somebody having the time, effort and inclination to fill that in, and that just doesn't apply for the sort of thing I'm talking about, post-operative infections, pressure sores, pneumonias."

13.47 She said the biggest failing for the MDT was around the lack of objective data collection. Ms Stohr recalled that:

"Apart from the consultants bringing cases to discuss at the MDTs, there were no data streams about patient safety and patient quality issues."

13.48 She told us that Datix reports in the service would come to her as clinical lead, but complaints went to individual consultants, meaning she would not necessarily be aware of another consultant getting a direct patient complaint.

13.49 We asked Ms Stohr what she had done to increase her access to data. She said that she believed a governance colleague had data:

"I was aware of her existence before, but I didn't know what she did. I did try to contact her once or twice, but she doesn't answer her phone."

13.50 She added:

"This is a fault of mine; when I can't engage with someone I give up and try and find someone else."

13.51 Ms Stohr, on looking back on her experience of the MDT meetings said:

"Honestly, I didn't realise it then, this is all retrospect and reflection, that this is all a big talking shop."

13.52 Ms Stohr believes that the effectiveness of earlier approaches to MDT meetings was compromised by consultants and other staff selecting the cases to discuss, the lack of basic data and the potential for a combative rather than supportive atmosphere.

13.53 Ms Stohr offered further reflections about the MDT she set up in a written statement she sent us:

> *"With the physiotherapists bringing issues and discussion points to the MDT. Historically there were two less than half-time physiotherapists and one had a defensive practice (also commented on by a couple of hospitals elsewhere). However, with the expansion of staff in physiotherapy this began to change. And therapists began to bring patients up for discussion.*
>
> *Complex and difficult cases – where parents were unhappy, could be discussed and we often took over each other's patients.*
> *In COVID, I set up the hip dysplasia, one-stop clinic. I was able to liaise with midwifery and the radiographers to produce annual data of ultrasound findings, and hip outcomes that I presented.*
>
> *With expansion of consultant numbers and physiotherapy numbers, the physiotherapy team was able to organise club foot care into dedicated clinics. This move preceded the eventual club foot clinic. So, the physiotherapy team was able to provide good, organised data about their club foot statistics.*
>
> *One of the physiotherapists, under the guidance/mentorship of [Consultant A], did a patella dislocation audit. This identified that the majority of children (~85%) did not return to sports after a patella dislocation. The outcome was the beginning of the 'Adolescent Knee Service', with its own monthly MDT, adult knee surgeons joined in from the region and seemed to result in excellent service and outcomes to our patients.*
>
> *I have never seen such data produced routinely and well in other MDTs. [A physiotherapist] started it, and I contributed data (hip dysplasia in particular) which brought about improvements."*

13.54 However, she also notes that there were some failures:

> *"The MDT failed to resolve combative situations.*

Where work problems were identified – there were no volunteers for solutions. So, this created more work for myself, and later also for [Consultant C]

Failure to organise proper admin support. This led to conflict.

I think with a larger department, there are issues that should be 'consultant only' and that we should have a separate consultant meeting, perhaps an additional thirty minutes where we can speak freely and co-operatively."

13.55 One interviewee who attended the MDT said that Consultant B's presence at the MDT had helped *"calm"* discussions and that the meeting changed again with the arrival of Consultant C. They also said that they had not seen anything as a practitioner that caused them to have concerns about Ms Stohr's clinical practice.

Comment

Paediatric orthopaedics lacked a properly functioning multidisciplinary team meeting until it was set up following Mr Hill's review in 2016.

It may have been, in its transition to the management of Division E, that the paediatric orthopaedics department lost focus on the importance of the MDT as part of effective clinical governance. The Hill report was a timely reminder to divisional management that it should be set up.

Ms Stohr set one up in 2016 but at least one participant thinks that the relationship challenges between Ms Stohr and Consultant A made for a difficult meeting. The meeting improved with the addition of Consultant B.

Participation in the paediatric orthopaedic MDT was voluntary before Consultant C's arrival. The consultant members would have brought to the meeting those cases that they wanted to discuss and would not have been obliged to follow the MDT advice about care and treatment. As we understand it, there were difficulties in recording the meeting minutes and entries following the MDT meetings, and discussions were not necessarily entered into patient records.

The Trust has no set template for creation of an MDT nor any 'rules' for how it should operate. The fact that only clinicians attended paediatric orthopaedics MDT meetings, and not service or operations managers, meant that a 'whole team' approach was difficult to achieve.

Had an effective MDT been in place from 2016 it is possible that its members could have debated the handling of future complex cases more openly, encouraged more dual operating between Ms Stohr and Consultant A, and ensured appropriate outgoing referral of complex cases.

Views about effectiveness of current clinical governance in paediatric orthopaedics 2019 - 2025

13.56 Like the rest of the Trust, the governance arrangements in paediatric orthopaedics have evolved significantly in recent years. Much of the change has been led by Consultant C, who joined the Trust in 2019 with a strong interest in governance gained from their experience working at the Evelina Children's Hospital. Consultant C became clinical lead for paediatric orthopaedics when Ms Stohr relinquished the role.

13.57 They said:

> *"I became Clinical Lead in 2020 and my direct line manager, [the Clinical Director] at the time asked me, as one of my first tasks if I could introduce a regular clinical governance meeting within paediatric orthopaedics because there wasn't one, and so I did."*

13.58 Consultant C described their role as clinical lead:

> *"I chair the MDT. I look at how to develop the department… I have developed the clubfoot service, the DDH service, and I'm now developing cerebral palsy… Before I started as clinical lead in 2020, there was no regular clinical governance meeting, and I have set that up."*

13.59 They added:

"I organise and do my own minutes, and I report back – we have an MDT meeting every week, but there is a formal clinical governance meeting four times a year, and I set that up and oversee it."

13.60 In addition, Consultant C told us:

"I look after audits within the department. I look after annual leave and check that it is spread out and taken appropriately. I look at the mandatory training, which comes to me to chase it up."

13.61 They added:

"When there are problems with any of my colleagues, that comes to me, for me to sort out. Whenever there are problems with clinics, that comes to me. When there are problems with other people's patients, that comes to me."

13.62 Consultant C told us that they chair this new governance meeting and that it takes place every three months, following a protocol and structure given to them by their line manager:

"It has about 24 different parts, like including looking at our waiting lists, looking at morbidity, mortality. We've never had a mortality but it's a list that we go through, and so every three months I would collect all that data. Some of the data I would get from the Ops Team."

13.63 Ms Stohr gave us her views on how well governance was managed in the service before she was excluded. She said that that the production of regular audit data – including about complaints - and contribution to research is probably *"better than other units in the United Kingdom"* and paediatric governance is now amongst the best she had seen. She said that the MDT style of working had improved communication. She also thought that good teamwork is necessary to resolve and prevent further issues, particularly to do with patient safety.

Comment

Consultant C has developed the governance in paediatric orthopaedics significantly in recent years. They have brought to bear their experience from elsewhere in the NHS to achieve this.

Having acknowledged that Ms Stohr made a start on good governance, Consultant C has built on it, recognised where the gaps in effectiveness were, has brought improvements to participation and teamwork, and improved the hard data flows into the service.

The MDT meeting 'as was' and the MDT in 2025

13.64 Consultant C now chairs the weekly MDT meetings. They gave credit to Ms Stohr for setting these up:

> *"To give Kuldeep absolute credit, she set the MDT meetings up after the 2016 report; In that meeting… basically everyone brought any cases to that meeting that they wanted to discuss."*

13.65 They said that the MDT meeting that they inherited consisted of the following staff:

> *"Physios, nurses, admin team, consultants, registrars; there's the entire team. It is a very worthwhile and good meeting, but people would bring just cases, if it was difficult and they didn't quite know what to do, if something hadn't gone as expected. They just wanted other people's input, but it was self-brought."*

13.66 Consultant C confirmed that consultants had a choice about which cases, if any, to bring to the MDT meetings but:

> *"Also nurses and physios could bring it. Our patients are seen by other members of the team, so if the physio was worried about a patient, they would bring it and, similarly, if a nurse in a post-op clinic saw a wound infection and the consultant wasn't there, they would bring it. It wasn't only self-reporting, if that makes sense, there were other avenues in but that was the structure that I took over."*

13.67 Consultant C recognised that, in the early days, they had needed to encourage greater participation:

> *"One of the first changes I made was - I wasn't sure, in that meeting, that everyone felt able to speak up, so now our meeting runs from 9:00 officially to 10:30 but normally runs to about 10:45. Now, from about 9:00 until 9:10, I literally just go around the room to our physio group and give everyone just a general chitchat about what's happening, a bit informal but everyone speaks. I just wanted to make clear that everyone can speak up, so hopefully that helps."*

13.68 Consultant C has worked hard to get everyone in the team to participate and not feel intimidated:

> *"I just wanted to get rid of those aspects and just make it clear that everyone was welcome. I wanted to just make sure it was a truly inclusive experience, and I think now it is."*

13.69 Consultant C described the current allocation of time across the team members in the meetings:

> *"From 9:10 until 10:00 we still look at cases that everyone brings. I would say, of that 50 minutes, probably half an hour is from consultants, but the other 20 minutes will be from physios, nurses. In fact, even more, it might be half consultants, but the nurses, physios and registrars bring cases along, and it's very much an open floor and if it takes a bit longer than the 10 o'clock, it does."*

13.70 They added:

> *"From 10 o'clock until 10.30 we discuss all the post-ops from the week before… and then we look at the pre-ops for the week ahead, so assessing, 'is this the right thing for this patient?'."*

13.71 We asked Consultant C if the Trust has a set protocol for the establishment and running of MDT meetings. They said:

"If you look around there's very little documented evidence. We're creating a SOP (Standard Operating Procedure) for this. I've worked at lots of big centres. I think the Evelina had an excellent MDT, and I've brought lots of the ideas from there."

13.72 Consultant C said that, in setting up the MDT, they had looked at arrangements in other specialities, but:

"Paediatric orthopaedics is a bit unusual. We are sort of low volume/high complexity. In many ways we are unique, so we have to have unique features. To the best of my knowledge, there's no ideal MDT. We now incorporate everything that the Evelina had, adding this extra layer of doing the week before. I'm sure we can get better or keep talking to other hospitals."

13.73 We asked Consultant C how confident they are that the MDT plays a more crucial role than the quarterly governance meeting and they told us:

"I think the Quality meeting is important, because obviously it's all minuted, and that gives you an overall view, so you get the figures from the Ops Team, you know how many wound infections you've had for the last three months, and you can see a trend. It gives you that broader aspect, that broader look, but I think the weekly MDT provides a much more on the ground 'is what we're doing right now the best thing'. They're different aspects of clinical governance."

13.74 We asked people in the team to describe their experiences of how the current MDT works. Consultant B told us that the operation of the MDT has improved greatly under Consultant C's leadership. They told us that, in 2025, the paediatric orthopaedic meeting has the following features:

- Mandatory for staff to attend
- Publishes in advance all operating lists
- Discusses all pre-operative and post-operative patients
- Reviews images
- Identifies concerns from intra-operative imaging and reviews the imaging at the MDT or follow-up clinic
- Requires dual operating for such conditions as developmental dysplasia of the hip or hip reconstruction

13.75 Consultant B explained how the operation of today's MDT contrasts with their experience of it in 2016:

> *"We did have a weekly MDT when I joined the department in 2016, but it wasn't mandatory. We didn't have the same process exactly for all cases. The way it works now is that everybody's operating lists are published and we go through every single pre-op case, every single post-op case –*
>
> *We deal with consultants, operate, we have a weekly MDT in which every single paediatric orthopaedic case going to theatre is discussed pre-operatively, and the outcomes are discussed post-operatively, every single case, which are largely joyful experiences, and experiences of actually sharing with your colleagues things which you feel have been challenging and have gone well. We have three-dimensional cross-sectional imaging of every appropriate pelvic case."*

13.76 Consultant B also emphasised the importance of imaging in the work of the MDT:

> *"If there are concerns about a post-op case on the intraoperative imaging, then it's flagged up as a review case to be then brought back to the MDT in six weeks at the follow-up clinic or whatever. That process is now robust. I think everybody secretly quite enjoys it.*
>
> ***Q.*** *If you thought back to 2016 when you joined, and you compared the MDT today –*
> ***A.*** *It's more robust.*
> ***Q.*** *In what way is it more robust?*
> ***A.*** *There is a mandatory review of all cases whereas it was previously a more voluntary review of cases."*

13.77 We learned that there was no operational or service management presence at the MDT. We asked a Service Operations Manager if they would normally be a member of an MDT and they said:

> *"Typically, should they be? - yes. It depends on what the scope of the MDT is and things. I don't go each day when the surgeons are talking through their current*

workload and things from overnight. The MDT has always been discussions about patients."

Comment

The MDT meeting has become more inclusive, organised, and structured under Consultant C's leadership. Efforts have been made to ensure that all staff participate in discussions and are able to bring patients' care to discuss. The approach they have taken to leading the MDT has encouraged more effective teamwork and that is supportive of good quality care to patients.

Cases are no longer self-selected by consultants. They are managed in a more organised way, with the MDT ensuring that there is appropriate consideration of pre- as well as post-operative planning, and review of cases. There is, however, still a lack of engagement from service and operational management.

The governance connection between paediatric orthopaedics, the division, and the Trust

13.78 Consultant C explained how local governance in paediatric orthopaedics fits into divisional and Trust-wide governance. They said that, unlike their experience before joining the Trust, CUH operations managers do not routinely join local governance meetings. They said that, prior to the arrival of her current operations manager their predecessor had simply been spread too thinly across services to give close support to paediatric orthopaedics.

13.79 Consultant C said that clinical governance responsibilities impose a significant, additional burden on them as clinical lead:

"I collate the information for the clinical governance, I write the slides, I write the minutes, I put things on there for escalation, and I then write an email. I include my Line Manager, and I include the lead for Division E in that. If there are things that are urgent, I just do them myself, but you can't do everything yourself."

13.80 We asked Consultant C where they get management support, and theysaid:

"For the last year and a half - the support that I've gained is from my own team. It's from the CNS and it's from my physio."

13.81 Consultant C told us that they currently meet the Chief Medical Officer every week:

"Which I really appreciate, so I must say that, but the in-between bits, there's basically none".

13.82 Consultant C told us that, since joining the Trust, neither the CEO nor the deputy CEO had spoken directly to them. We asked if they believed that there is visible leadership around safety and quality, and they replied:

"I wouldn't know, because they have never spoken to me. I don't know any of them. I have met David Wherrett once ages ago, I have never met the rest, so I actually wouldn't even know them. I wouldn't have a clue."

13.83 Consultant C told us how they perceived the flow of information to and from the top of the organisation – the ward-to-board connection. They said:

"My impression is the flow of information up to the top gets altered as it gets to the top. I don't think what gets to the top is what I say.

I have sent emails to the top with very serious queries on; I received no reply. I spoke to one of the management executive team of NHS England two weeks ago and she was quite surprised that I hadn't spoken to the CEO, I hadn't spoken to the Deputy CEO. I didn't speak to anyone of the Executive team. They hear it through another three layers before it gets to the top."

13.84 We asked Consultant C how confident they are that if an issue arose in paediatric orthopaedics, they could swiftly escalate it to the right level of the Trust and that action would be taken. They said:

"I now know people I wished I had known before where I have this level of trust, and I have no qualms at all now of going straight to them."

13.85 In practice, Consultant C told us that any serious safety concern would now go straight to the Chief Medical Officer, Dr Sue Broster. They told us that they would not routinely escalate such concerns via any other divisional manager as they had direct access to Dr Broster.

13.86 They added:

> *"There are some extraordinary things happening at the moment which I just go straight to Sue [Broster], and it will get sorted. Above me there's a Clinical Director and above that is the Divisional Director. There's a new Clinical Director… then there's all the Deputy Medical Directors and then there's Sue."*

13.87 We interviewed an experienced, senior paediatric nurse who gave us their assessment of governance in the aftermath of the concerns about Ms Stohr's clinical practice. They told us:

- They had thought divisional/ specialty governance to be good until six months ago
- Paediatrics had lots of meetings and followed Trust processes and guidance
- Meetings focused on documents
- Often oversight was practised without *'the detail'*
- There was lots of information

13.88 As they put it:

> *"Within Women's and Children's – bearing in mind that's Maternity, Gynae, Children's surgery, Medicine, and we have three ITUs [Intensive Therapy Units] as well – that's a lot of information to get up to our meeting, so I'm not sure we've got it right, are we discussing the right things? Do we give ourselves time to discuss important things that keep us awake at night?"*

13.89 The reflected on more general concerns about governance:

- The issue that keeps them awake at night is high vacancy rates particularly for senior nurses in ITU
- Nursing staff are more open than other staff in raising concerns

- Consultants are not taking governance seriously
- Is paediatrics escalating matters to the right people?

13.90 They added:

"The way I look at it is that we have a meeting within Children's that feeds into a meeting of the Trust. It goes into my Trust full team performance meeting with the Executive Team, so I think we have a meeting for everything, maybe too many meetings, and that's a problem: maybe we have too many meetings and then we don't actually do the detail."

13.91 They also commented on the effort and commitment that the Trust puts into governance and safe care:

"It is an industry. What is effective governance, what is good governance? I think we can all pick our basics of what is good governance, but I think when you go down to the granular detail, what is good governance

***Q**. Would you expect to see any commonality of approach between specialties and sub-specialties?*

"I think I would, between Medicine and Surgery, I expect Surgery to be looking at their RAC measures, a lot of the focus is on targets, on theatre utilisation, how much time you're wasting between your turnovers from your surgeries. I suppose for me it's picking up the harm, and that's the thing of Friday meeting, it's only as good as the person who's recognising the harm, and if I'm honest, nearly all of the incident forms are filled in by nursing, I've very rarely seen them filled in by consultants."

13.92 We asked a paediatric safety and governance nurse for their views about the effectiveness of the Trust's approach to governance. Their job is about ensuring safe care, and they work at service/ ward level. They said:

"PSIRF[14] has changed the horizon in terms of how we manage safety events. There is a great deal more about closing the loop, and we use the evidence that you have closed the loop, and what your actions are and tracking it. A lot of the work that we do within our team is trying to make sure that those loops are closed.

13.93 This nurse spoke of the difficulty of making progress and achieving consistency of approach across the Trust:

It's getting better but it is really hard in an organisation like this, with so many specialties.

It depends on who your teams are, but there is definitely a move towards having actions and responses, and workable solutions to things. I think doctors are definitely on board with that."

13.94 We asked if these positive changes were in evidence everywhere in the Trust and they said:

"Across the board, definitely a change has come in during the last five years. I think we are definitely driving to that: people are concerned and they are proactive. It is much more that, when we relay concerns now through Datix, we are trying to get the learning out there and we want people to know that we take them seriously and we do look at them."

13.95 They added:

"Datix is definitely different since we have moved from just your incident form to Datix. There is so much more accountability, and you have to respond to them appropriately."

13.96 Asked about the prevalence of governance meetings and their effectiveness they said:

[14] The Patient Safety Incident Response Framework (PSIRF) is now mandatory for NHS Trusts investigating patient safety incidents.

"There are a lot of meetings and there is a great deal of overlap of meetings. I am not sure whether we will ever completely sort that out."

Comment

While side-stepping established management structures may be an indication that the current reporting arrangements are not functioning well, we understand why Consultant C felt the need to establish a direct link to the Chief Medical Officer. Such a relationship should not be necessary if leaders have trust in one another, and governance based on personal relationships may not be sufficiently resilient if people change roles.

Managing work responsibilities through personal relationships also creates a risk of excluding people from those relationships, even if they have a legitimate reason to be involved.

The nurse's perspective illustrates the progress that has been made in the Trust on governance in recent years, and the change in focus to more active learning from safety incidents. However, the nurse points to the continuing proliferation of meetings, and the potential for them to overlap. We believe this is a view shared by many people across the organisation.

Future plans to improve governance in paediatric orthopaedics

13.97 Consultant C described the quarterly governance meeting and the weekly MDT meetings as part of their plan to further improve clinical governance and the care of children with cerebral palsy. They said:

"I have lots of plans and lots of ideas, and we have a plan how to work through them step-by-step, and we'll get as much done as possible."

13.98 They reflected on the value of the support the Trust has recently provided in this respect:

"I have been given a very capable and very enthusiastic Ops Manager for the next 18 months and she is helping with this QIP [quality improvement project]".

13.99 We asked Consultant C what further improvements they could achieve in governance in the paediatric orthopaedics service. They said that they aim to integrate the service operations manager role more closely into the departmental team but acknowledged that the current support available is time limited to 18 months.

13.100 However, they also told us that the increased workload on them is considerable:

"When [Ms Stohr] left there was a lot of work to do, and I took on a lot of that. I increased my workload. Obviously, from a leadership role, a lot had to happen and then, on top of that, there's all this investigation. At times it has been overwhelming, there is absolutely no doubt."

13.101 Looking forward, Consultant C plans to implement a local QIP to help the MDT focus on looking at all the patients that are listed for surgery. They said:

"We have good buy-in from senior members of the hospital to support this, and we have buy-in in better documentation."

13.102 Consultant C added that work is underway on:

"An Epic rebuild, especially for our MDT, to get some better documentation of the outcomes of each discussion we have. In terms of clinical governance, although we have this meeting quarterly, which is very important, actually the weekly meeting probably adds more to clinical governance than the actual official … clinical governance meeting."

Comment

The direction of travel for governance in paediatric orthopaedics is correct. Consultant C has a good grip on the key enablers of effective governance and enjoys the support of the paediatric orthopaedics team. We believe Consultant C will need

continuing support and resources to sustain this progress and embed longer term improvements in the service.

While Consultant C is now compensated for the clinical lead role, it has added to their overall workload, and the Trust will need to ensure that they are adequately supported, in resource terms, to strike a healthy balance between their commitments as a surgeon, and their management responsibilities.

Dual consultant operating in paediatric orthopaedic surgery

13.103 Dual operating in the NHS refers to two senior surgeons – usually consultants – operating on a patient. In paediatric orthopaedic surgery, this means two experienced surgeons collaborating on complex procedures particularly for procedures that are technically demanding, high risk, or rare in practice. The benefits to patient care can include:

- Increased safety
- Better decision making
- Reduced operating time
- Higher surgical precision
- Improved outcomes

13.104 As we understand it, dual operating is not mandatory practice for surgeons at CUH. Dual operating is increasingly seen as good practice for challenging and complex paediatric orthopaedic procedures, where teamwork between two consultants helps ensure the best possible outcome for the child.

13.105 'Paediatric Trauma and Orthopaedic Surgery GIRFT (Getting It Right First Time) Programme National Specialty Report' (April 2022) describes the benefits of dual-surgeon operating for complex cases on page 29:

> *"University Hospitals of North Midlands NHS Trust has a long-established principle that complex paediatric orthopaedic cases would be undertaken by at least two consultant orthopaedic surgeons. These cases include mostly complex or long procedures.*

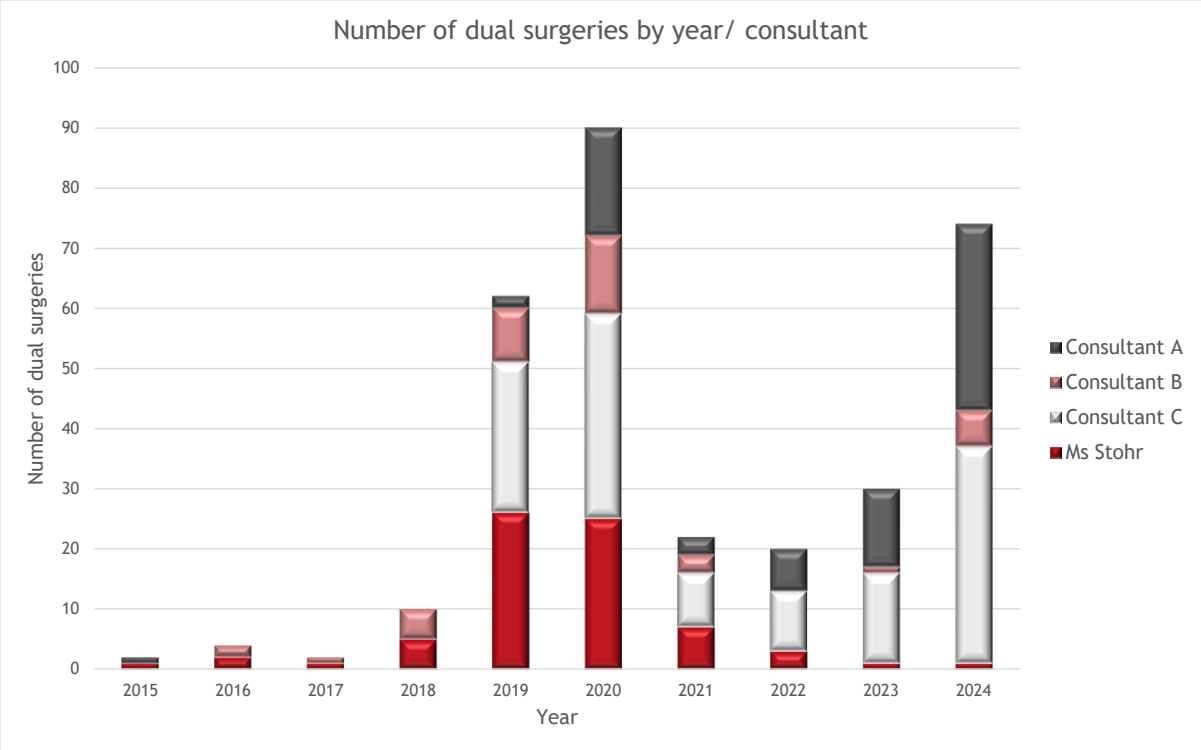
This was initially started in 2003 on an ad hoc basis as an assistance to newly joined consultants. It has since developed into normal practice with the aim of improving outcomes in complex patients, but also to support colleagues, and extend experience as surgeons."

13.106 Dual consultant operating aligns with NHS-wide commitments to multidisciplinary care and robust clinical governance. It provides a safeguard for rare or complex cases, ensures greater consistency in outcomes, and supports reflective practice through real-time peer review.

13.107 In speaking to consultant surgeons and senior managers in the Trust we were told that the practice of dual operating is an important element in maintaining high professional standards, given that it presents regular opportunities for colleagues to work together and to give one another constructive feedback aimed at improving performance and delivering safe care. We noted that, for many surgeons, feedback from colleagues was one of the few ways in which they could learn if they were doing a good job.

Dual operating in paediatric orthopaedics at CUH

13.108 Dual consultant operating has developed at CUH in the last few years but was not commonplace when Ms Stohr started at the Trust. We asked the Trust for data to illustrate the extent of dual operating in paediatric orthopaedics at CUH. It should be noted that that the information supplied, and analysed below, covers only the period from 2015 to 2024.



13.109 However, dual operating surgery is still a less customary practice within the paediatric orthopaedic team's surgical work.

Consultant	Number of dual surgeries	Number total surgery	Percentage of Dual-operated surgery
Ms Stohr	72	2,131	3.4%
Consultant C	143	440	32.5%
Consultant B	41	963	4.3%
Consultant A	88	1,150	7.7%
TOTAL	344	4,684	7.3%

13.110 As the only two surgeons in the service until Consultant B was recruited, Ms Stohr and Consultant A did not undertake much surgery together, though Ms Stohr recalled one case in around 2013/14 where she suggested they perform a bilateral surgery in patient with cerebral palsy together:

> *"I was really keen to do that and I persuaded [Consultant A] to help me… he is risk averse and he is averse to taking on responsibility, so he wanted me to specify exactly what operation was needed to the angle of the plate and I thought, 'you do what you feel right'. So that was a moment of tension.*

"The patient had an infection on my side of the procedure on the hip, and it took a while to correct and it was corrected. The patient eventually did quite nicely, but later on, that was one of the patients that was criticised in the 2016 report. He knew the patient had an infection, I told him about it and discussed it, and he didn't really bring it up as an issue with me before."

13.111 Ms Stohr described her experience of dual operating with Consultant A:

"I do not like operating with [Consultant A]. This is a personal feeling. I did it when I was new, I wanted to use two operating teams in single-event multi-level surgery, again this was an innovative approach from the United States and Australia that I had participated in in New Zealand. [Consultant A] and I did a few cases together – I found him to be critical, questioning but not in a constructive way, he seemed reluctant to take any responsibility, and he wanted to hold a retractor and watch me. I did not find this to be useful; in fact, it put me off. I know that he and [Consultant C] seem to enjoy working together, so I can see that there is an element of personality clash between [Consultant A] and I."

13.112 Consultant A wrote:

"*I did not conduct joint surgery with Ms Stohr as I was sufficiently experienced that I could operate with a trainee, rather than a fellow consultant. I also would not have wanted to operate with Ms Stohr because I knew that she had severe surgical deficiencies and that it would have been potentially dangerous to operate with her. I do not believe that Ms Stohr would have wanted to operate with me had that been suggested.*"

13.113 Consultant A had told us that, until the end of 2015, they and Ms Stohr operated together and had a good working relationship, but they had stopped dual operating with her because she had ceased to attend their joint surgeries, and they were concerned about her clinical practice.

13.114 We asked Consultant C if Consultant A's decision not to go on operating with Ms Stohr had an impact on her ability to learn or get feedback on her practice. They said:

"I don't know. The one thing I would say is I do think it's a shame that happened, because [Consultant A] is a very, very good surgeon and Kuldeep could have learnt a lot from him. Now what I don't know, and I will never know because I wasn't there, is how much Kuldeep was unwilling to follow instruction, or how much [Consultant A] was unwilling to instruct. That I do not know, because I wasn't there and I can see a scenario where both could happen, but I think only they can tell you that. It's a great shame anyway."

13.115 Ms Stohr described her approach to dual operating in later years:

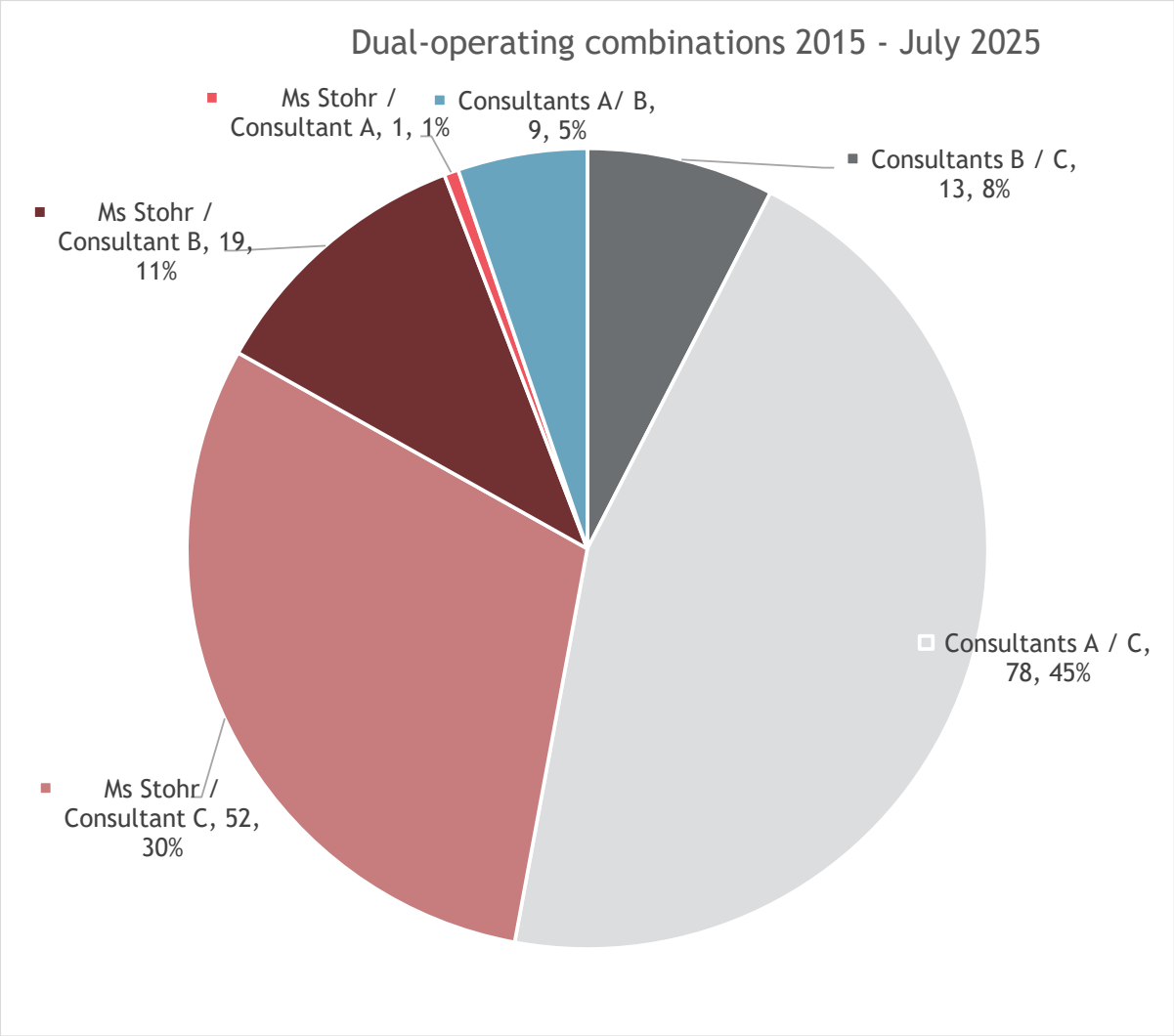
"With [Consultant C] I've done two or three, and with [Consultant B] I've probably done about three or four. Then there was a surgeon here for a while… with whom I did, I couldn't tell you, 30-odd. It's not that I don't like it as a principle, but I don't like it with [Consultant A]"

13.116 Ms Stohr described her experience of dual operating with Consultant C and Consultant B:

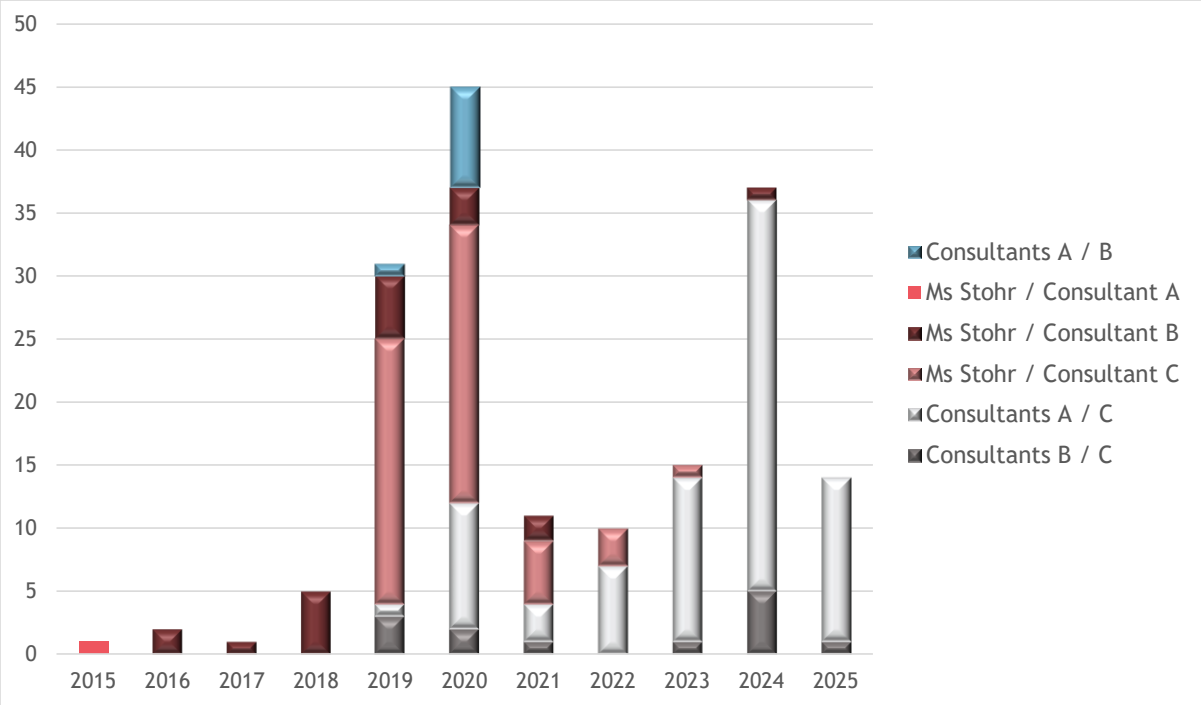
"I enjoy working with [Consultant C]. This seems to be genuinely collaborative work.

For rota reasons, I have dual operated with [Consultant B] most often (in paediatric orthopaedic terms) as we operate on alternate Mondays. I find him to be disorganised but technically excellent. It is an administrative hassle to organise dual operating as it either means I come in on my non-clinical workdays or [Consultant B] cancels a clinic which is a huge administrative burden to him. But on at least two occasions it was worth it. On other occasions I have genuinely felt that I would have been just as good working with a registrar. By 2024, I had accepted that for some cases, working with [Consultant B] could work well. I accepted that although he organises his work differently to me, I could make it work."

13.117 Some set combinations of dual-operating partners emerged within the paediatric orthopaedics team. Consultant C took the lead in partnering with colleagues within the department, but most frequently worked alongside Consultant A.



13.118 The chart below shows how these dual-operating partnerships developed over time in the department.



13.119 Consultant C had some experience of dual operating with Ms Stohr prior to March 2024, and we asked if they had noted any concerns about her clinical practice. They said:

> *"She was a quicker surgeon than I am, but that is not right or wrong. It might mean that she is a better surgeon than I am, but she was a quicker surgeon. I like to go pace by pace, and some people might criticise me for being too slow. I am not saying that one way is the right way or the wrong way, but the way that Kuldeep operated was different from the way that I operated. At times, I didn't feel entirely comfortable with that."*

13.120 They added:

> *"With a lot of what we do, there's more than one way to do it. It is not that one way is right, or one way is wrong. If I ever thought that there was harm coming, I would stop – but let me just say that I never had to do that. But yes, it was different."*

13.121 Asked if they had ever raised concerns directly with Ms Stohr about her technique, Consultant C said:

"No, it was never at that stage. I never thought it was dangerous."

13.122 They also said that she had never raised concerns formally, for example via a Datix incident report:

"Because when operating, I can genuinely say that every single time I operated with her, never did I think that anything dangerous happened."

13.123 Consultant B had also done some dual operating (described below as "joint cases") with Ms Stohr and said that they had never expressed concerns about her practice:

"I think in ten years, I probably did two or three joint cases with her. I have done joint cases with her, and I was only too happy to work with her. I think together we had successful outcomes. She and I have discussed a couple of tricky cases…"

"… I haven't myself actually flagged up anything. It may be that we did have slightly different specialty interests. I don't remember seeing very many of her cases. I have seen one or two which were fine actually."

13.124 They confirmed that they had been asked by Ms Stohr to operate together on a few occasions and that they went along willingly with her in those cases:

"I never actually had a case which I thought needed revision surgery or needed any formal review process."

13.125 Ms Stohr also explained that she had "*usefully and happily*" dual operated with trauma surgeons in complex orthopaedic trauma cases as well as with consultants in other specialties, although in these circumstances:

"I accept in these examples of where I have successfully and even joyfully worked with other surgeons, the operations mean that each surgeon has a clearly defined contribution."

13.126 Ms Stohr offered the following reflections on her approach to dual operating:

"I am of a generation where I rarely encountered dual operating. It was discussed in a BSCOS meeting (British Society Children's Orthopaedic Surgery) as a way to train up junior consultants and maintain numbers in low volume units. I did not feel this really applied to me or to CUH and I now recognise this supported my natural reticence. I used to think that dual operating was a way to 'share the blame' rather than change the outcome. In hindsight, I'd like to share the blame that is being directed to me now. But I can see that occasionally it does change the outcome, as I say – there are at least two dual operating procedures I have participated in where this was the case.

I had some bad experiences as a registrar. I'm a woman in my 50's in one of the most male-dominated of surgical specialties. When I was training, two registrars used to frequently operate together because the consultants would often be absent. What often happened was that I was often jostled out of the way unless I spoke up aggressively. I believe that this was reflective of the casual misogyny of the times 15-20 years ago. I have not encountered such a hostile operating environment since 2010. Things have overtly improved, but I suspect that my old memories are hard to truly eradicate.

I feel differently now, of the cases where Mr Hunter criticised me for not dual operating, I think the outcome could conceivably be different for two of these patients (that is 2/9 patients)."

Comment

Ms Stohr has undertaken a small amount of dual operating and appears to have been an early adopter of this emerging practice in paediatric orthopaedics. Overall, however, it seems from the data and testimonial evidence that Ms Stohr elected to operate on most of her complex cases by herself without the support and help of another senior surgeon.

The Trust did manage to support some dual operating e.g. Ms Stohr and Consultant B but it became more firmly established when Consultant C arrived and worked with Consultant A. Given that it was not mandatory at that time for surgeons to operate

together, the practice of voluntary dual operating was never likely to take hold with Consultant A and Ms Stohr as partners.

We are satisfied that Consultant A had no specific responsibility to dual operate with Ms Stohr and that any decision to do so would have been voluntary for both surgeons. However, we consider that Consultant A's decision not to operate with Ms Stohr after 2015 prevented her from learning from a more experienced surgeon.

Ms Stohr was unable to get feedback about her surgical technique from anyone else in the clinical team. Whether she could have worked well with Consultant A, in view of their poor relationship, is a moot point. Whether she could have improved her surgical practice as a result of dual operating with Consultant A is also moot.

Differences in style or approach may be more or less acceptable to a fellow surgeon but neither Consultant C nor Consultant B had concerns about Ms Stohr's surgical practice while dual operating with her.

Consultant C has led the development and successfully partnered with Consultant A, and with other surgeons.

Deciding to dual-operate

13.127 Consultant C told us:

> *"BSCOS, our national body… has recommended that for any complex case, such as putting a baby's hip back into joint, or for any case that is done very, very rarely – a case you only do once a year, and there are many of those in children's orthopaedics – we should be dual-operating."*

13.128 Asked if the MDT makes decisions about when to deploy dual operating for complex surgery Consultant C said:

> *"Yes, we have dual surgeon operating for all complex cases now; that is just standard."*

13.129 We asked how this decision-making operates in practice:

> *"There always has to be an element of self-awareness and what you are able to do yourself. I'm a surgeon, I'm a professional but if I say to a colleague, 'are you happy, it's a two-hour case, it's a small case', and he said to me 'I've never done it before, [Consultant C], would you join me', of course I will. If he said 'I've done 40 of them before and they've all been perfect and it's my bread and butter' he doesn't need me there. You can never have a definitive list, but it will be slightly different for everyone.*
>
> *There are some cases that are absolute, and I think, nationally, they would agree that for all DDH cases, open cases, dual operating. All big multilevel complex cerebral palsy cases, dual operating."*

13.130 Since arriving at CUH Consultant C has expanded the practice of dual operating with Consultant A. They described to us what is required for two surgeons to work together successfully:

> *"When you dual-operate with someone, you have to have a good rapport with them. You have to have a very high level of trust because you are doing highly complex cases which can have catastrophic outcomes."*

Comment

Dual consultant operating is now an established practice in complex paediatric orthopaedic surgery. Consultant C's appointment as clinical lead from 2020 appears to have given the practice a boost at CUH.

Decisions about when dual operating is required are now made via the MDT. There are now more developed processes in place to ensure all complex and infrequent surgery in paediatric orthopaedics is conducted by two consultant surgeons.

From our lay perspective dual operating is good practice. It helps achieve better outcomes for patients in complex cases. It enables surgeons working together to identify any technical concerns about themselves or colleagues in real time. It also

creates an environment in which surgeons can give and receive feedback aimed at improving their performance and maintaining a safe service.

The need for more widespread dual operating and a standardised approach to post-operative imaging were issues highlighted in the Hill report.

Post-operative imaging

13.131 Mr Hill suggested in his report into Ms Stohr's cases in 2016 that the lack of post-operative 3D imaging was of concern. Consultant C explained that this was not a 'built-in' part of ordering a surgery:

> *"We have to go and order it. There's always an argument because the radiology department still don't want to do them, but they do it."*

13.132 Consultant C told us that the standardisation of the use of post-operative imaging is now delivered through the MDT:

> *"In our MDT every week, we discuss pre-op and post-op imaging, so if there was a case without 3D post-op imaging, we would know. We all get it, and it is reviewed by the entire team."*

13.133 Consultant C also explained that the team is now routinely doing post-operative imaging in all hip cases. They said:

> *"3D post-op imaging for all hips in this hospital is standard."*

13.134 They explained that CUH is 'ahead of the curve nationally' in this respect having discussed how other hospitals practice at the Operational Delivery Network (ODN) for Paediatric Orthopaedics. They had discovered, at a recent meeting of the ODN:

> *"Half the people there did not do post-operative 3D imaging. I was quite surprised at that, but it did show that Kuldeep wasn't different to half the surgeons in the region."*

13.135 Consultant C noted that this practice was also, in Ms Stohr's case:

> *"A recommendation on the 2016 report that I only saw at the beginning of this year… but it was standard practice for me for my whole career."*

Comment

Post-operative imaging is best practice but, as Consultant C confirms, not universally adopted. This is a matter that CUH may want to consider discussing with BSCOS, the ODN and the university to identify best practice in 2025 and supporting research.

Impact of sub-specialisation

13.136 The paediatric orthopaedic service at CUH provides specialised care for children with serious, often multiple and complex conditions. One way in which medicine deals with clinical complexity is for consultants to sub-specialise in their chosen field. Sub-specialisation is when a doctor develops expert knowledge and skills in a narrower field within their specialty. Paediatric orthopaedics is a sub-speciality of orthopaedics.

13.137 NHS consultants are senior doctors who have completed all their specialist training. Most consultants are trained in a broad specialty. Ms Stohr is an orthopaedic surgeon who sub-specialises in paediatric orthopaedic surgery. However, some consultants develop even more specific skills (e.g., to focus on hips, feet or specific conditions) but this depends on consultant numbers and the nature of the clinical work needing to be done. It is increasingly necessary for surgeons to sub-specialise.

13.138 Sub-specialisation has the potential to improve patient care by:

- Ensuring that complex or rare conditions are managed by clinicians with specific expertise
- Increasing accuracy in diagnosis and appropriateness of treatment
- Supporting better outcomes and fewer complications
- Facilitating use of the latest techniques and evidence-based practices
- Enhancing teamwork through clearly defined roles and focused training

13.139 It appears that the volume of work ruled out any significant degree of consultant sub-specialisation at CUH.

13.140 A consultant adult orthopaedic surgeon provided us with a helpful insight into their own clinical work compared with the surgical work of a paediatric orthopaedic surgeon:

> *"I have spoken to my paediatric colleagues about it too and I suppose my speciality is hip and knee, so I compare it to what I do. I think the surgery that I do, particularly the primary, bog standard hip replacement or knee replacement are high volume surgery and relatively low complexity, whereas in paediatrics, their breadth of surgery is huge. It's pretty much all limbs, they may have a particular sub-specialist interest, but they will potentially operate on all and they can be quite complex surgeries, so it's almost the reverse. So, it's high complexity and low volume as you say, and that seems to be the nature of the beast in paediatric orthopaedics and that's not specific to here, I think that's paediatric orthopaedics. For some that obviously attracts people into it, but I would agree there is probably more complexity and certainly lower volume for sure."*

13.141 Ms Stohr's clinical practice included adult and children's orthopaedic surgery. Ms Stohr told us:

> *"I didn't see it then, but I am seeing it now, as I said there are opportunities for reflection, but that ability to sub-specialise wasn't a luxury that was afforded to us for some time.*
>
> *"… Volume is a tricky one actually, because when you look at our data on e-Hospital which we did for GIRFT, the Getting It Right First Time Review, we are actually doing more cerebral palsy surgery here than most centres, but it is still low volume, it's still six patients a year or whatever."*

Comment

Further sub-specialisation was not possible with just two consultants in the service, one of whom already curtailed his patient numbers. This left Ms Stohr with the task of either referring patients to other providers – and CUH was the specialist centre – or doing the procedure needed by herself.

As consultant numbers have increased in paediatric orthopaedics there has been further opportunity for sub-specialisation. For example, Consultant C is dedicated exclusively to paediatric orthopaedics and does not carry out trauma surgery. As clinical lead they continue to develop specialist services. A new consultant has been appointed this summer, and a further consultant appointment is planned. Increased consultant numbers will assist sub-specialisation.

Trust management seemed unaware of the changing clinical expectations and standards in a small specialty.

Recommendations

R19 We recommend that the Trust should develop a more consistent approach to the establishment and management of MDTs. The aim should be to standardise, where appropriate, those common elements that apply to MDTs across the Trust. Such an approach could be set out in a Standard Operating Procedure (SOP).

R20 The Trust should consider an audit of all existing MDTs to consider their effectiveness in enabling the consistent delivery of safe care. Such an audit should consider; clarity of the MDT's aims; team working; use of data and information for decision-making, and regularity/inclusiveness of meetings.

14. Governance arrangements across the Trust

14.1 In this section we describe the context in which clinical governance operates across the Trust as a whole. We explore the roles played by divisions, the Medical Director's office and the workforce directorate in ensuring good governance. We set out the changes that have been made by the Trust in recent years and describe plans that are in place to improve and maintain quality and the safety of patient care in future.

14.2 Where appropriate we comment on the effectiveness of the Trust's clinical governance in anticipating and resolving concerns about the safe care of patients. We consider whether there were any governance deficiencies that may have prevented identification and/or addressing of concerns about Ms Stohr's practice.

14.3 This work does not constitute a full-scale governance review but concentrates on those safety and quality issues arising from this investigation. We asked participants, where the opportunity arose, to share their understanding of the structures and processes the Trust has for governance. Care should be taken in extrapolating from this small sample of views any conclusions that would apply everywhere in CUH.

14.4 With the assistance of NHS England, the Trust is conducting a wide-ranging review of clinical governance across all areas of its service to patients. We expect the report of this investigation to form part of the consideration of how improvements to quality and safety can be delivered in future.

Defining clinical governance

14.5 Department of Health guidance defines clinical governance as:

> *"The system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish."*

14.6 NHS organisations have a statutory duty to embed quality of care. It is a basic responsibility.

14.7 In everyday language, clinical governance is the system that helps the NHS to deliver its promise to ensure that:

- Patient care keeps getting better
- Patient care is safe and trustworthy
- Staff are supported to do great work
- Families are kept in mind

14.8 Experience shows that governance in NHS organisations can easily become a 'paper exercise' and does not always translate into visible, practical improvements in patient care. Organisations frequently get caught up in the process of governance – reporting incidents, collecting data, attending meetings, and making records – rather than taking action to make improvements to benefit patient care.

2015: a turning point for governance at CUH

14.9 The Care Quality Commission (CQC) inspected CUH in 2015 and rated it 'Inadequate'. The report summary describes what the inspectorate found:

> *"We have rated this location as inadequate overall due to significant concerns in safety, responsiveness and the disconnect between ward staff and the divisional leaders. We found that the staff were exceptionally caring and that they went the extra mile for their patients."*

14.10 Among the CQC's findings relevant to this investigation were:

- *"There was a significant shortfall of staff in a number of areas, including critical care services and those caring for unwell patients*

- *Services often had staff with an inappropriate skills mix, and patients were being cared for by staff without training relating to their health needs*

- *Pressure on surgical services meant routine operations were frequently cancelled*

- *Disconnected governance arrangements meant that important messages from the clinical divisions were not highlighted at Trust board level.*

- *Introducing the new Epic IT system for clinical records had affected the Trust's ability to report, highlight and take action on data collected on the system."*

14.11 The CQC report also made two other findings relevant to this report:

- Caring staff who did everything they could for patients in their care
- Effective and robust multidisciplinary working across the Trust.

14.12 As a result of the CQC report the Trust was placed in special measures and its Chief Executive Officer was dismissed, along with other executives. Mr Sinker was appointed Acting Chief Executive Officer, along with a new chair. Mr Sinker told us about his arrival in the Trust:

> *"What I would say about 2015/16 is that we had gone into special measures, we had an inadequate rating from the CQC. We had a £80-£90 million deficit on £850 million. The organisation had been shamed. We lost our Chief Executive, our Chief Finance Officer and a number of members of the Board, and we had a Chair who was slowly exiting. Ron Kerr and I were sent in as, in effect, an interim Chief Executive and a shadow Chair, to try to make sense of this really difficult set of circumstances.*
>
> *I arrived in November 2015 into an organisation that was in a state of profound anxiety and crisis. The relationships within the organisation were very damaged; doctors' confidence in the organisation; the confidence of our partners in CUH and then, within the leadership community, the divisions and the Executive and the Board. What I am saying to you is that it was a pretty testing period."*

14.13 The CQC inspected the Trust again in September 2016 and extracts from their report say:

> *"We carried out a full follow up inspection between 20th and 22nd September with an unannounced inspection on 29th September 2016.*

At this inspection we saw significant improvement across most of the areas we inspected.

There were similar improvements in medical care, surgery and urgent and emergency services with all services now rated as good overall. The improvement was in line with the Trust's improvement plan and was assisted by constructive challenge from stakeholders at regular meetings

***Division E**: Medical Paediatrics; Paediatric Critical Care and Paediatric Surgery; Obstetrics and Gynaecology*

The Trust was continuing progress against an overarching improvement plan in response to concerns found at our previous inspections.

The revised governance systems were sufficient to ensure that the senior team had robust information on which to make decisions.

The electronic patient record (Epic) had now been in place for some two years. Many of the concerns we had identified at previous inspections had been addressed and staff were more familiar with the system though care planning was not always individualised and personalised.

Staff were very caring and, on some occasions, went to great lengths to support and care for patients.

There was an open culture. Staff reported incidents and there was increased evidence of learning from incidents.

Staff spoke positively of local (divisional) management. Managers in all areas were well sighted on risks as well as developing new pathways and delivering care

On the basis of this inspection, I am recommending that Cambridge University Hospitals NHS Foundation Trust is removed from special measures"

14.14 The CEO has steered much of the change in governance that aimed to address the findings of the CQC. We asked Mr Sinker about the criticism CQC made of CUH in its 2015

inspection report that 'disconnected governance arrangements meant that important messages from the clinical divisions were not highlighted at Trust board level'. Mr Sinker gave us his assessment of the situation in 2025:

> *"Every week at Management Executive, you have a Quality item. It is documented by Lorraine [the Chief Nurse] and everybody can add in anything they have heard, and we pick up a great deal there, from 'never' events in theatres through to 'somebody has put a rubber glove down a sluice and flooded level four', every single week.*
>
> *We then have all of the infrastructure reporting into Management Executive, with a refreshed Deloitte enabled accountability framework for the Quality and Performance meetings. All of the reports that come from patient safety, patient experience, clinical effectiveness, are coming through. We have the Risk Oversight Committee and then, at Board, we are summarising this for the Quality Committee and so on."*

Comment

In the early part of the period under review in this investigation there were significant organisational challenges that undoubtedly had an impact on leadership and governance of the Trust.

The CQC inspection and rating in 2015 highlighted significant shortcomings in the governance of the Trust, which the organisation worked hard to remedy in the subsequent year. It appears that since 2015 the Trust has been on a journey to strengthen its governance systems, structures and improve effectiveness.

That journey is still underway, and the events discovered in 2024 have lent additional urgency and impetus to the task of ensuring clinical governance delivers safer practice in future.

Governance in the Trust now

Structures and processes

14.15 We sought to discover whether the Trust has appropriate processes and structures in place that are recognised and used throughout the organisation. We looked for evidence from participants that they take opportunities to identify risks to safety and quality, and that they were confident that concerns raised or escalated would be resolved.

14.16 We have read the Trust's draft 2025 guidance *Quality Governance Good Practice Policy and Guide* and considered the extensive committee structure. The clinical quality governance remit of all groups is described as follows:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

14.17 The draft guidance sets out the expectations for divisional quality governance and includes:

> *"Divisions must confirm that all directorates and specialties hold a quality governance meeting on a regular basis at which clinical safety and quality issues are discussed and that any items escalated have been dealt with."*

14.18 Divisions are also expected to have arrangements in place for local rapid incident review meetings to review new incidents, ensure correct grading of incidents and to agree next steps.

14.19 The draft guidance provides sample template documents – including terms of reference, core/wider topics and sample agendas - to help standardise discussions about quality governance.

Comment

The Trust has recognised the need to review its guidance for the development and maintenance of effective governance practice. The test of the new guidance will be in the extent to which changes to policies, processes and practices are embedded in a culture that encourages openness and transparency in identifying and resolving safety and quality issues.

Executive oversight

14.20 Mr Sinker told us that the management executive of the Trust considers, on a weekly basis, whether there are any quality concerns relating to patients or staff that would require an immediate response.

14.21 He told us that information on such quality and safety performance is derived from a number of data streams and processes that feed into the executive's consideration and management of issues affecting patient safety. He added that 'soft' data are also collected and considered, most notably from feedback presented by the Trust's freedom to speak up guardian about concerns raised by staff.

14.22 Mr Sinker told us that key data from the Trust's information systems and these meetings are collated, summarised and presented regularly to the management executive team and the board and to its risk oversight committee. He told us that these data were the main inputs to senior management about quality and safety performance.

14.23 We asked Mr Sinker what was done with this information, and he said:

> *"I look at the outputs: what is that showing us? It is never complete, but it enables us to see increasing reporting rates. In Freedom to Speak Up, we don't have enough from medical, but we are doing a lot of work to try to get more response from medical staff, the Resident Doctors' Forum and so on. I look at the Guardian of Safe Working, and I see the big increase we have seen in incidents being raised, rotas, and we are able to triangulate it into service areas."*

14.24 He told us that this information enabled him and his executive team to identify more promptly:

> *"What outputs or reporting rates are going up and then I'm able to say, 'in these areas we are doing really well but, in those areas, we have anxiety'. We are then intervening in the areas where we have anxiety."*

14.25 In addition to the data flowing from Trust systems Mr Sinker told us that:

> *"We then have audit looking at things. We have CQC. I am out and about in the hospital with Lorraine and others. You have all of that going on, and you are seeing good and bad things happening."*

14.26 We spoke to Ms Szeremeta, the Trust's Chief Nurse, who told us that these governance arrangements have been developed over time following the principles set out in the Trust's guide to good governance, that is currently being reviewed. Ms Szeremeta said that the guide:

> *"Was being updated following some observations which have been done into the governance meetings that are taking place. I have paused it currently until we've done the governance review."*

14.27 She told us that, in addition to the processes for reporting to the executive through patient experience, clinical effectiveness and patient safety groups the Trust also runs a range of key committee meetings under the management executive meetings, including the:

> *"Performance Committee, Quality Committee, Workforce Education Committee.*
>
> *Then there are some Operational Boards, Surgery Board, Medicine Board, Cancer Board and Children's Board, that are cross-divisional. They should be looking at any cross-divisional issues that are coming up from Performance or Quality, etc."*

14.28 We learned that the key committees are chaired by executive directors and have a reporting line to the whole management executive. The reporting line is fulfilled through a 'Chair's Key Issues' exception report to the management executive following each meeting.

This offers the opportunity to escalate any issues requiring executive awareness and/ or action.

14.29 Asked how confident she was that the data reported through the governance structures were properly understood and acted on Ms Szeremeta said:

> *"The other thing we're really conscious of is at the top level we have the Performance Committee, Quality Committee, and the Workforce Education Committee. We have the Management Executive but there's almost something that we need to pull together to triangulate in a much better way.*
>
> *We're hoping that the governance review might help us find a way through best practice, that we can get some recommendations on how we pull all that together, so what's the triangulation of data – that kind of thing."*

14.30 Ms Szeremeta pointed to recent organisational changes aimed at improving the Trust's approach to managing quality and safety. She told us that the formerly discrete role of director of clinical quality had been dissolved and that she now has:

> *"Two deputies that report to me. One who is responsible for professional standards practice, safe staffing. Then my second deputy has just taken over quality, safety, risk."*

14.31 This split of responsibilities is also replicated in the new CMO's office where Dr Broster has:

> *"A Quality and Safety Deputy Medical Director and they work very closely together."*

Comment

The Trust has a comprehensive architecture of governance with a wide range of data collection streams, quality, performance and safety meetings. It collects a wealth of data about patient safety incidents and involves multiple clinicians and managers in producing inputs to the system.

The executive team sees a high volume of data through Trust reporting systems, and there is close focus on what trends the data reveal in safety and quality terms. However, the risk remains that the outputs of these systems are only as good as the inputs that are generated from wards, departments, services and divisions across the Trust.

It is evident that these systems have failed, in the past, to identify serious issues that were simply never recorded in Trust systems.

The connection between ward and board

14.32 Mr Sinker told us that he regularly visited services across the Trust and that he encourages executive directors to do likewise.

14.33 Ms Szeremeta said that she works every Friday alongside clinical colleagues:

> *"I have time clinically on a Friday. Predominantly I go in and shadow people, trying to see what it feels like working in different areas, and I encourage all of my Heads of Nursing – the Heads of Nursing in the divisions. They don't report directly to me, they report to the Divisional Directors, but professionally to me, so we have quite a close relationship. But with my own team, my expectation is that they do some of the same clinical shadowing or clinical audits on a Friday morning. They are all out today doing a peer review of children and young people services."*

14.34 We asked staff at various levels of the organisation about communication between frontline services and executives. We received some examples of good practice with frontline staff and managers feeling supported. One or two questioned the authenticity of senior staff visiting services and had ideas about how to better acquaint executives and non-executives with the reality of frontline services.

14.35 The head of nursing for paediatrics commented positively on the visibility and support they get from the Chief Nurse and other senior colleagues, including the recent chair:

"I can guarantee, any difficult place, Lorraine will be there. I don't know how she finds it, but she does. Children and young people with mental health have caused a lot of distress, and Lorraine is there, she'll be there, she'll be engaging.

The Deputy Chief Nurse is absolutely brilliant, will always be involved in all the different cases…. Our previous Chairman, was the children's champion, we saw him all the time, he would absolutely be visible, he'd know everyone by name, he wrote us a lovely letter when he left, he was brilliant."

14.36 One senior doctor suggested that executives should consider longer visits to services and should dress as other staff in that service do and work alongside them for an hour or two. They also thought that problems they observed should be discussed and tackled rather than simply acknowledged. The purpose of this would be to make the executive input as meaningful as possible.

"Perceived differences between consultants/nursing staff when it comes to reporting concerns"

14.37 Several interviewees said that nurses are better at reporting concerns about patient care than medical staff are. As one senior nurse put it:

"If I'm honest, nearly all of the incident forms are filled in by nursing, I've very rarely seen them filled in by consultants."

Comment

There is some concern that reporting of concerns is not consistent across all groups of staff. The existence of a comprehensive governance structure and reporting framework is no guarantee that it will be used effectively at all levels of the organisation.

We have no objective evidence to support this, but we think it is worth the Trust establishing whether this is true and, if so, what is preventing some medical staff from reporting concerns.

It would also be an opportunity to find out whether lack of reporting applies to other grades of medical staff. Our impression is that what interviewees may be describing is medical staff not completing written reports via Datix.

Failure of governance systems to identify issues with Ms Stohr's clinical practice

14.38 We asked Mr Sinker why he believed that this infrastructure of governance, and the comprehensive reporting of data had not signalled the problems discovered in paediatric orthopaedics. He said:

> *"I look at all of the outputs and what I see is that we have been on a really significant journey. That is not to say that it is all right, but I think we have done a huge amount, and I have seen output from it and yet, clearly, we have sat through nine years of meetings when nobody has raised this as a concern. I look at that, and then that has driven us to think immediately, where else is there?"*

14.39 We asked Ms Szeremeta if, through this large number of meetings and reporting channels, we could, in practice, trace any issues arising from paediatric orthopaedics governance all the way to the Trust board. She said:

> *"You should be able to, yes."*

14.40 Ms Szeremeta, when asked about how serious patient safety concerns might be missed, said:

> *"We have a quality governance structure as you would expect. We have a specialty governance feeding into the directorate governance, feeding up to the divisional, and the divisions feeding into us as Execs. We have that whole structure, and then the corporate structure feeding into the Board. But, even with that structure, this bit could have been missed. Well, it has been missed and potentially could be missed again."*

14.41 We explored with Ms Szeremeta if it was possible, at this top level, for executives to 'join the dots' on trends in the incidence of safety issues. She said:

"At a macro level, that's a challenge. At the micro level of Kuldeep Stohr and her practice, that was the problem as well. No-one thought to join any of the dots together with the end result that she became isolated from her colleagues, she went on practising. A review was done that was positioned with her in a way that didn't give her the impetus to change her practice, so no-one really picked up the whole picture and said, 'these things combined to give us concern' before concerns became much more acute in the autumn of 2024."

14.42 In speaking to Dr Broster, the current Chief Medical Officer, we asked how she would know if a surgeon, like Ms Stohr, is actually doing a really good job. She said:

"Even looking at some of the national data that is available which, as a CMO I can look at, Kuldeep was not a particular outlier comparing her practice to others locally and even nationally. This is even though the clinical review itself is highlighting areas of concern as her case load is being reviewed. I think this shows sometimes how hard this can be."

14.43 Dr Broster also reflected on the lack of input to the reporting processes when the initial concerns about Ms Stohr's practice were first investigated. She was surprised that:

"In this particular case there were nurses, physios, [operating department practitioners], anaesthetists - and nobody apart from one individual, a doctor, raised concerns. That is really sobering for us in the Trust."

Comment

We are not completely confident that everything that needs to be recorded actually enters the Trust's quality and safety systems. If safety issues are not input at the departmental level, then there is no prospect of them featuring on the executive or board radar. This limits the Trust's ability to identify quality and safety issues before they become concerns or before they result in serious adverse outcomes for patients.

None of the data that were available in 2016 about Ms Stohr's practice problems appeared to be reported in Trust systems at the time. Ms Stohr did not stand out in the datasets that were available to the Trust.

It is not clear that the problems that were subsequently identified in 2024 about her practice would have appeared in these systems but for the fact that, in her absence, other surgeons took on her patients and recognised the clinical concerns.

There is recognition at the most senior levels of the Trust that they were not sighted on the most recent issues in paediatric orthopaedics until Ms Stohr went on leave in 2024. We recognise that this has galvanised the current wide-ranging review of governance across the Trust.

It is important for executives to acknowledge that what they see through the Trust's reporting systems and data streams may not be a comprehensive and accurate picture of the reality on the ground.

It is inevitable that patient safety incidents will continue to occur in future. Improving the connection between ward and board and building confidence that all staff can contribute to reporting concerns should help to reduce the risk of harm to patients.

Role of the Medical Director's office in governance

14.44 The Medical Director (and now the Chief Medical Officer) is a member of the Trust board. Dr Jag Ahluwalia and Dr Ashley Shaw were the Medical Directors covering the period 2012 to 2024. The Medical Director's office included four Deputy Medical Directors with defined responsibilities.

14.45 Dr Shaw explained the role his office played in governance:

> *"Basically, the Medical Director's Office gets assurance. Just like the rest of the Board, we are looking for assurance and reassurance. We get that through the day-to-day soft data, soft intelligence, and we look at the integrated performance reports."*

14.46 He said that divisions are largely autonomous and tend to report issues 'by exception' to the executive leadership:

"The divisions run their divisions, and they are running a £200-£400 million business in each division. Every month, they have a meeting with the executives at which point they raise things. They have their own risk registers, and they raise things that are of concern. I guess you could argue that actually there is an infrastructure in place for people to raise concerns clinically. Effectively, when a division is given a job to do, the organisation generally assumes that it is being done, unless it is getting raised back to you by the division, to say 'We are unable to deliver this, that or the other.'"

14.47 Dr Shaw explained that the Medical Director's office plays a key role in patient safety which, "*has always been the most important aspect".*

Concerns about doctor's professional practice

14.48 A key responsibility of the Medical Director's office is to manage concerns raised about doctors across the Trust, whether about performance, conduct or health. Dr Shaw told us that his office was responsible for the professional activities and professional behaviours of all consultants. We asked him where concerns about the performance of doctors could be raised, and he said:

"At the level of the clinical directorate and the divisional directors - morbidity and mortality meetings, the routine run-of-the-mill stuff, would happen within the clinical directorates and the divisional directorates. Things might then be flagged up from there, from their routine monitoring."

14.49 He explained that his office would become involved in such concerns:

"If, for example, someone had done something really egregiously wrong, or where there were probity issues. I can only think of a handful of cases over my seven and a half years where there were concerns over the quality of someone's practice."

14.50 Deputy Medical Director A explained how the governance and reporting systems alerted his office to quality and safety issues. He told us:

"There are other things that we do use for instance, there are complaints, there are incident reports submitted in the Trust, and those are the things that the Medical Director's Office track.

If there are flags that come up through that route that we are getting a lot of complaints, or a particular complaint about x, then obviously the Trust would pick that up centrally and lead us to then go back and look. Those mechanisms have operated throughout, so one question aside the very fair question to us of these recommendations that were made, what assurance was there, or was there any mechanism for following them up to check that they have been done? The answer is I cannot tell you the detail of that.

When problems do arise, the first line should be that problems are sorted out locally within services, within divisions if possible. They get escalated by people coming along to the Medical Staffing and Medical Director's Office. It's either somebody from within a division who says, 'I have tried to raise this within division they have done nothing', or somebody who is trying to run a service and said, 'I can't deal with this [Deputy Medical Director A], can you help?' The question for me is about how we go back into the divisions together, the assurance that things are done.

There are so-called divisional quality meetings with Board level people once every so often, which I sit in periodically in place of the Medical Director, and broadly they're of very little value. There's a lot of data presented; there's no time for discussion."

14.51 Dr Shaw told us that he and the Deputy Medical Directors and the senior medical staffing team held casework meetings once a fortnight, in addition to meetings he held with his direct reports every week. He said that, at these meetings:

"We would discuss all cases that had been referred to us for whatever reason. We would keep them on the list, and we would plot a way forward."

14.52 Depending on the concerns raised Dr Shaw said they would initially be reviewed or investigated, either internally or externally to gather evidence about the concerns. Any such investigation or review would be conducted under terms of reference determined by the

Medical Director's office, which would assume stewardship of the handling of the concerns from then on. He said:

> *"This is similar for a patient safety concern – if you raise something for them, the Patient Safety Team or the Medical Director's Office will do the investigation. If there are findings that come out of that, which need to be delivered, then those would be passed back to the local team to deliver."*

14.53 Dr Shaw said that the fortnightly case conferences would deal with something in the region of 15-20 individuals, not all of whom were involved in the most serious of concerns:

> *"I would say that any one time we are looking at perhaps two or three at the serious end of large investigations. At the moment, there are probably two or three that I am aware of, not clinical concerns but breakdown of relationships is probably the biggest thing – a complete breakdown of relationships within a team - this seems to be the biggest concern and how we can help the teams to fix that."*

14.54 The Associate Director of Workforce described the nature of many of the concerns about doctors that are dealt with by the Medical Director's office:

> *"The prevalence is significantly conduct. At consultant level, I would say that 90% of the casework load relates to conduct, if not more. It is also important to note the potential negative impact of poor conduct and behaviour on team working and patient safety."*

> *"The common theme is that something has triggered the fact that longstanding poor behaviour is no longer being tolerated. Someone or something has snapped and the nuances for each circumstance are different but, broadly speaking, someone has had enough."*

Organisational tensions

14.55 We considered the relationship between paediatric orthopaedics, divisional leadership and the Medical Director's office was a key component of the governance arrangements affecting doctors in that part of the organisation.

14.56 On 1 November 2017 Deputy Medical Director A became the Trust's responsible officer (RO). He spent half his working week on his deputy medical officer responsibilities and worked in his medical specialty the rest of the time. Deputy Medical Director A announced his intention to step down from his role in the Medical Director's office in August 2024 and return to his consultant role. He relinquished his Deputy Medical Director duties on 30 April 2025.

14.57 We asked Deputy Medical Director A to describe how the Medical Director's office worked with divisions to maintain quality and safety of care for patients. He said:

> *"There is a tension in the Trust about the operational lines of command and the Medical Director's Office side of things. The operational lines of command go from doctors to service leads, to clinical directors, to divisional directors, who report to the Chief Operating Officer. They don't report to the Medical Director.*
>
> *From the Medical Director's Office, I don't and never have had an operational brief. I can try to influence things, and some divisional directors will actually welcome help and influence from me, but at times others would very much say, 'this is our patch, you keep your nose out'.*
>
> *I have found this difficult at times, the tension between what the Medical Director's office does and what's done within the divisions. A number of the divisional directors over time have actually made it very clear that they don't want what they see as Medical Director's office interference with things. They see their job as managing their division as it were. I don't think that tension is resolved. It's not helped by the Board level approach to these things."*

14.58 The Director of Division E, the former divisional director for paediatric orthopaedics, thought that the handling of challenges concerning doctors had become overly centralised and that had its disadvantages:

> *"Devolution, with adequate leverage and organisational support, and advice and skills, is preferable to me, I believe you have to make the local people accountable and hold them to account. I think HR issues have become more centralised now. The*

Deputy Medical Directors are dealing with a number of hotspots and little responsibility is delegated to the division, as far as I can see."

14.59 Mr Wherrett, Chief People Officer, made the same point:

"Just to say, cases aren't handled further down the organisation, this case [Ms Stohr] hasn't been handled further down the organisation, it has been handled at my level, and in the Medical Director's office. Staff capability/ conduct all come to the Medical Director's office and, again, coming back to CUH 11 years ago, there was some surprise that - everything sort of magnetises to the centre. Where is the Clinical Director, the Specialty Lead, where is the Divisional Director in all of this?"

14.60 He also told us that in his experience CUH's management of concerns about doctors has been held tightly by a small group of people in the Medical Director's office. He considered that this approach brought many benefits but also meant that issues were not always discussed more widely by senior management or subjected to different thinking and challenge. He compared it with his experience of other NHS organisations and said that CUH was out of step with current practice.

14.61 He added that some of the processes associated with managing concerns about doctors were not formalised in meeting structures and organisational policies and that they should be. He was aware that the Medical Director's office ran regular:

"Case management meetings… as the place where the plurality in decision making happens. I'm not convinced. This is not a formally constituted group. It does not document its decision-making, but it does get together to look at all cases. We did a review a while back on how we handle cases and the upside of that was a consistency and a coherence about managing medical cases. The downside was a feeling of sort of groupthink and lack of formality / governance."

14.62 Mr Wherrett said that there were examples of the Medical Director's office handing back the outcome of an external review to a relatively inexperienced and junior medical manager e.g. a clinical director in a service, without more senior colleagues knowing. The individual then struggled to implement complex and demanding recommendations.

"For complex stuff, the same people deal with it; I have a report here from a couple of years ago on interpersonal issues between clinical services – an investigation is commissioned by the centre to look into issues. As a result, the central team receive a significant report with 37 recommendations.

There has been little involvement by the clinical division in the report or its findings, (in this case they haven't seen the report, despite asking) and whilst the MD's office may deal with some of the recommendations, the bulk are handed back to the clinical team to deal with, and often it is complex things that need to be addressed.

The recommendations are about culture, about ways of working, about forming new relationships, so handling this is quite complex."

14.63 Deputy Medical Director A disagreed with Mr Wherrett. He told us that the Medical Director's casework group is formally constituted and chaired by the Medical Director. During Deputy Medical Director A's time the membership included the Deputy Medical Directors, the Associate Director of Workforce, other senior members of the medical staffing teams and, more recently, cultural ambassadors. The group met regularly every two weeks; an agenda was circulated; notes of actions taken and to be taken were recorded. He provided us with documentary evidence showing the concerns about Ms Stohr in 2015 and 2016 being discussed and recorded.

14.64 Deputy Medical Director A explained what happened to concern that had been reviewed or investigated by the Medical Director's office:

"If things are done through the auspices of the Medical Director's Office, the operationalisation very often sits within services and the responsibility for them sits within the divisional structure."

14.65 Deputy Medical Director A told us that there is no system in place in the Trust to assure the delivery of any changes that might stem from an investigation or review of concerns about a doctor. He confirmed that he had never had responsibility for taking such action himself:

"No, it's never been, because the roles I've had have never had an operational remit."

14.66 He added:

"The only circumstance would be is if recurrent issues come back to the MD's office, so it's not uncommon to have a situation where something is handed back to the service and then returns."

14.67 We asked Deputy Medical Director A what improvements he would expect to see in this area. He said:

"In terms of learning points for me from this, they would be around what assurance is there that reports and recommendations are followed through."

14.68 We asked Deputy Medical Director A what broader lessons the Trust should take from the handling of the concerns about Ms Stohr's practice. He said:

"I do intend to write to Roland [Sinker] and Sally [Morgan, chief executive and chair, respectively of the Trust] about this, because I think it is important, and I found dealing with these things tricky. They are tricky, because I have worked in the certain knowledge that the Board don't want to be involved. When I have asked individuals for guidance, they have not wanted to give it, but what they have wanted to do is to reserve the right to criticise in retrospect and that's what I fully expect to happen here.

I shall be very pleased if it doesn't, but if you ask what I am expecting, I am expecting that they will. They are in a very difficult position, and I think there's a whole lot of societal changes that play into things, even the Archbishop of Canterbury hasn't been protected from a difficult issue, and it is a really hard thing for them not wanting to get involved in the dirt because they need all to keep sparkly clean.

There's a failure to acknowledge that difficult things often can't be sorted easily and an overwhelming desire to find someone to blame if they're not."

Comment

While the organisational structures in the Trust are relatively stable, there are long-standing frictions and lack of role clarity between some parts of the organisation. They have manifested themselves particularly between the Medical Director's office and the divisions centred around how concerns about doctors are investigated and actioned.

The CUH Medical Director's office has operated a highly centralised practice when it has come to the management of concerns about doctors. This approach has had great advantages to the organisation but also significant weaknesses.

The appointment of the Trust's new Chief Medical Officer and responsible officer presents an opportunity for her to clarify the roles and responsibilities for her, and of those in her team responsible for the management of concerns about doctors. She has told us that she is doing so.

Such clarification should aim to confirm who is responsible for decision-making in such cases, and how checks and balances can operate to ensure cases are managed fairly and consistently.

We believe this should also help to eliminate ambiguity about who is responsible for taking any actions to address shortcomings in the performance of doctors. We expect that clarity in this area will prevent any future cases from 'falling between the cracks' in the organisation.

Deputy Medical Director A has personal concerns about what he perceives to be the lack of engagement by the board of the Trust and a culture of seeking to assign blame to individuals if things go wrong.

Acknowledgement of these organisational frictions, lack of clarity and trust between parts of the organisation needs to be factored into the current review of governance. We believe a robust plan needs to be developed in this review to address potential cultural blockages that could hinder the implementation of sustainable improvements in governance.

We reflect further on some of the cultural issues facing the Trust in section 15 below.

Concerns about nurses' professional practice

14.69 Ms Szeremeta, as Chief Nurse, is responsible for around 4,000 nurses and around 250 midwives in the Trust. She told us how concerns about nurses are raised and addressed. We include this here as an alternative model to the way in which concerns about doctors are handled within the Trust.

14.70 Ms Szeremeta told us:

> *"If there is an issue within a division or anywhere corporately with a nurse professionally, that issue would come up through to my Deputy who would then obviously alert me, and then there is a professional panel that's held which includes the Division, ER [Employee Relations] and any other relevant individuals. That panel would feed back into me so that I would have oversight of that, and any actions would be tracked through the ER process and through their Head of Nursing."*

14.71 Ms Szeremeta confirmed that a robust approach was taken to investigate thoroughly any significant concerns, and that such investigations take place internally or, where appropriate outside the Trust.

14.72 Ms Szeremeta said that only the most serious cases involving nurses would gravitate towards her office. She told us that there are, at any given time, about fifteen cases that her office would track through until the issues or concerns were dealt with. She said:

> *"It will fluctuate. It's not huge numbers. You can have a panel meeting and there'll be no action, or it will go back into the division to manage, in which case we wouldn't track it."*

14.73 She said:

> *"The route that we have is really transparent. It's worked up with the divisions and they're part of it."*

14.74 Ms Szeremeta told us that these professional panels meet weekly, and address concerns about nurses' conduct, behaviour and clinical competence:

"It's all done in a just culture; we are trying to be proportionate. Sometimes we do have to remove individuals and stop them working, other times we can remove them from a clinical area, other times we can keep them working while we investigate, and that's all done in a professional conversation, and then followed up."

14.75 She added:

"I also oversee what we have referred to the NMC (The Nursing and Midwifery Council) and the HCPC (The Health and Care Professions Council)."

14.76 She told us that the handling of such cases is done in real time, and does not await meetings if need be:

"If an incident happened today, we would make a decision today. Even on a Friday afternoon we would have a conversation around what actions we need to take immediately, and then we might hold a full panel on Monday, but we would always address it in real time. It wouldn't be a monthly review."

Comment

Nursing at CUH appears to have well established mechanisms for managing concerns about staff, with only the most serious matters coming to the attention of the Chief Nurse and her team. Dr Sue Broster and Ms Szeremeta have a close working relationship, and it may be that there are lessons to be learned from CUH nursing for the oversight and management of medical staff by divisions and services.

15. Reflections on medical safety culture at the Trust

15.1 This section of our report deals with additional evidence we received about wider aspects of the safety culture in the medical community at CUH. These issues were not the prime focus of our investigation, but we report on them here so that senior management of the Trust is aware that they have been raised with us.

15.2 In the early stages of this investigation, we spoke to those people who had been identified by the Trust as having been involved in the issues described in Part one of our report. As our work progressed, other senior consultants contacted us directly and asked to give us evidence. The Trust had published the terms of reference for the investigation on its intranet, and nine people approached us, seeking to link their intended contributions to paragraph 2.7 in the terms of reference, which says:

> *"If, through its conduct of this investigation, Verita identifies any broader issues of concern about the Trust's policies, processes and practices which might require separate investigation or review, it will draw these to the attention of the commissioner."*

15.3 These individuals did not have specific evidence to give us about paediatric orthopaedics, or about the specific matters covered in Part one, but they had a broader insight and understanding of CUH that they wanted to share. Much of their feedback centred on the ways in which the culture of the Trust in respect of patient safety was, in their experience, at odds with what the Trust's approach to governance meant it to be.

15.4 We include these comments and observations on the culture of the organisation on the basis that culture is a key enabler of effective clinical governance. However, we have not sought to substantiate or corroborate them further in the context of our investigation.

15.5 All these interviewees were senior consultants, some of whom had worked in the Trust for many years. Many hold, or had held, senior clinical roles in the organisation and knew the Trust well. We believe they all gave their evidence in good faith with the improvement and further development of the organisation in mind.

15.6 One interviewee asked for their evidence to be treated as a public interest disclosure. We confirmed with the individual that this was a parallel disclosure and that the Trust had already been informed of the concerns.

15.7 Two participants were involved in protracted cases with the Trust as their employer. We advised them that it was not within our remit to comment on, or to influence the handling of personal issues in this investigation.

15.8 While some were content to be identified in the report, others were less inclined to be named, fearing adverse consequences for their reputation and job security. In the interests of consistency, we have decided not to identify any of these contributors.

CUH and Cambridge University – cultural impact

15.9 We have had great difficulty during our work establishing who had ultimate responsibility in paediatric orthopaedics for managing the team and individual consultants. We have encountered staff with responsibility for parts of the service but not its entirety. Similarly, paediatric orthopaedic service staff have had a clear understanding of some of the service challenges but have not felt able/ been enabled to speak about them and find solutions.

15.10 One of our interviewees told us that in their experience CUH suffers from the following challenges that we believe help explain some of these difficulties:

> *"No one is in charge: The Trust operates like a collegiate federation, with each division functioning as an autonomous state. This fragments services, duplicates effort, and creates inconsistency. Cross-divisional problems—such as those faced by trauma and emergency care—are extremely difficult to resolve because there is no single line of authority or accountability.*
>
> *Paralysis by analysis: The organisation is full of very bright and analytical people. Yet this often leads to delay and inertia: decisions are over-analysed, deferred through fear of criticism, or postponed in pursuit of a "perfect" solution. Proven approaches from elsewhere are rarely adopted. Instead, CUH repeatedly "reinvents*

the wheel," producing lengthy documents or pathways that consume time but rarely lead to timely change.

Basking in reflected glory: Pride in Cambridge's global reputation fosters complacency. Staff and services within CUH often assume that it is 'the best', even when objective measures show otherwise. External reviews and commissioner concerns are frequently neutralised or ignored, rather than acted upon."

15.11 They went on to say that the consequences of this are serious with governance systems fragmented, inconsistent, and largely ineffective:

"Reporting is mistrusted: Datix has been weaponised, staff fear repercussions, and many see little point in raising concerns.

My perspective comes from direct involvement in the governance machinery.

CUH could be outstanding, but its entrenched culture (fragmented, paralysed, complacent, and punitive) actively resists accountability and organisational learning."

15.12 These quotes come from a senior, experienced consultant with considerable understanding of the Trust and the services it manages.

15.13 This consultant considers that the culture of the medical community in CUH is heavily influenced by that of the university which is made up of independent colleges and the culture of *'a body of scholars of equal rank'*. Some consultants are NHS employees while others are employed by the university. The university's federated structure is replicated in the hospital in the form of five divisions; an organisational model that, in the experience of some consultants, tends to divide rather than unite the Trust in achieving its patient safety goals.

15.14 Another interviewee said that, inevitably, some of the consultants who are university employees are powerful personalities, highly thought of and with strong academic links:

"Sometimes these people lead the department, and they are too focused on their own agenda. They are too focused on getting the money in, perhaps, and getting the next grant. They hold quite a lot of power over people."

15.15 The consultant observes that divisions see themselves as independent entities within the whole, which presents considerable difficulty for those specialties whose patients require the care and treatment of several services across divisional boundaries:

"We've had huge problems, we continue to have huge problems, in co-ordinating care as well as enforcing some of the internal professional standards, in getting people from other services and other divisions to actually do their job, if I'm blunt."

15.16 The culture is also perceived to be resistant to learning from the outside, so the outputs and recommendations from external reviews and /or investigations are prone to being neutralised if they present unpalatable feedback to the Trust.

Comment

Consultants, especially those employed through the university, operate with little effective management. Yet every employee, however senior, must be managed. Without accountability, there can be no consistent or reliable safety.

Patient care that needs to be delivered across divisional boundaries lacks consistent focus. Much time and effort are spent on resolving frictions between divisions. The divisional structure and splits between Trust and university-employed consultants work against joined-up care. Patients who need care and treatment from multiple services - for example, along a single care pathway, do not always get this in a timely way

What the hospital needs in future is clear: a culture where everyone acts as one team, however large or complex, united by the interests of patients and families. Achieving these demands visible leadership and unwavering commitment from the board, the executive, the consultant body - and the full engagement of the university.

Openness, transparency and speaking up

15.17 We heard evidence from one senior consultant who said that raising concerns carried considerable personal risk:

> *"CUH tends to oscillate between tolerance of unsafe behaviour and disproportionate punitive action. Long-standing risks or poor practices are ignored until suddenly an individual is targeted as a 'bad egg'. At that point, system failings and cultural contributors are not considered. Staff understandably learn that raising concerns, or even engaging honestly in investigations, carries personal risk.*
>
> *For myself, years of frustration have led to disengagement… My focus has become [my service]."*

15.18 The same consultant told us that they had carried out a patient safety incident investigation some while ago that they believe was then *"suppressed"* because it did not come to the 'right' conclusions:

> *"I was involved in an investigation around another consultant, and I was asked to do a whole [serious incident] report, this is a few years ago now. I did my report, it took me quite a long time and, fundamentally, I determined that some of the allegations were not substantiated by the evidence presented to me. That actually there were more complex issues at play.*
>
> *I submitted my report, which I later found out didn't get to the Disciplinary Panel at all."*

15.19 Another told us that they would no longer consider reporting a patient safety incident, given their own treatment by the Trust for having done so. They said:

> *"I should have been able to weather this storm, and I haven't, so I wouldn't let anyone else do it. I would never let a junior colleague raise a patient safety issue. I would never let anyone raise patient safety concerns in this organisation."*

15.20 By contrast, a senior nurse told us that they felt more than able to raise concerns with her manager, did so frequently and had a positive, supportive response including by phone and the manager seeking her out to discuss the matter.

15.21 Another interviewee said that reporting by the nursing workforce was partly dependent on ethnicity with some groups of nursing staff reporting less than others did.

15.22 This difference, in their view, could be accounted for by the history of a more punitive culture towards medical staff. We did not seek, within the scope of our work, to verify this assertion.

15.23 One interviewee expressed their concern at how clinical staff at the centre of incidents are treated by the organisation. This service has developed its own local approach to supporting those at the centre of an incident:

> *"I worry sometimes about how these individuals under investigation are isolated, and how a story around them is created. One of the things I have said to someone I have known a long time – since we were [senior registrars] together – is that I wonder if someone is looking after Kuldeep (Ms Stohr). That is something the organisation is not great at. We ended up writing our own policy here around what would happen if one of us was involved in a serious incident and how we would manage that in terms of their wellbeing and looking after them. We call it the 'second victim' policy – other people do not like that term, but there is no better term, and we know what it means. I worry about how these individuals are cared for and supported."*

15.24 People told us of perceived differences between consultants and other clinicians in terms of being prepared to flag up safety concerns. We were also told that often concerns are not fully addressed and that those who raise them get little feedback on outcomes/ changes.

15.25 We heard of 'battle fatigue' amongst people who had tried to address long-term concerns about the organisation, engagement, and poor behaviours. At least one individual – who has been a regular patient safety incident investigator and conductor of After-Action Reviews (AARs) – told us that they were no longer prepared to participate in such work because they believed it to be pointless.

15.26 When Consultant A spoke up to report concerns about Ms Stohr's clinical practice in 2015/2016 they tested the 'ward to board' mantra of safety. The concerns prompted the correct initial response from the Trust's systems. While the concerns did not reach the Trust board then, they did get to the office of a senior executive on the Trust board and action was taken to review them. However, it was the human response to the outcome of the Hill review that resulted in inaction. Furthermore, Consultant A reports feeling bullied and silenced by their experience of raising concerns and thereafter retreated from doing so in future.

15.27 If speaking up is to be made a reality of life in CUH then this legacy of organisational and individual inertia needs to be overcome.

15.28 Dr Broster appreciates the need to tackle the sense of distrust, withdrawal, and disconnection amongst some of the consultant community that is part of the legacy of the paediatric orthopaedic incident. She reported that in her early days in post consultants and others have come to see her to discuss concerns. In turn, she hopes that she has demonstrated to them the importance of clinical governance and delivering safe and high-quality care to patients. As she put it to us:

> *"I actually hope that we are slightly resetting some of that trust, which is not easily gained, and it is more than conversations."*

15.29 Dr Broster recognises that this wider re-establishment of trust and confidence is going to take time and requires tangible commitment from the senior leaders and real improvement. She told us that she is regularly:

> *"Out and about, listening to people and getting a feel for their perspectives and what they think. I go to team meetings and join sessions that they have organised…I want to hear and have a relatively broad view… of what is happening and what people think. I want to know what people are thinking and be sighted on what people want me to know, because that is helpful in this piece."*

Comment

The Trust is undertaking a major governance review and a refresh of its over-arching approach to ensuring quality and patient safety. To make this succeed, it must win back the confidence of its senior consultants, some of whom have developed doubts about the effectiveness of clinical governance in the past.

New structures and processes alone will not deliver safe patient care if inertia, distrust, and resignation are allowed to persist – or worse, to spread. By recognising the problem, opening and maintaining constructive dialogue with consultants, and backing the clinical lead in paediatric orthopaedics, Dr Broster has taken an important step forward.

Successful and sustainable delivery of improvements to governance will require executives to be highly visible and accessible to people at all levels in the organisation. Executives will need to show consistently that they are receptive to feedback from the organisation, and that they are prepared to act on it.

Learning culture

15.30 One interviewee said that the Trust was *'stuck in safety 1'*.[15] Patient safety remains underdeveloped and, in the views of some, largely performative. The impression given is that quality, safety, and the associated culture remain big challenges for the Trust.

15.31 We were told that, amongst some senior staff, there is reluctance to learn from other NHS organisations as CUH assumes that it is *'the best'*. One interviewee said:

> *"Even going and visiting them, saying, 'let's go and see how Nottingham do this', is met with resistance. There are X services in the country that have the same demographic as we do and just going to them and seeing how they run, and adopting best practice, we are very reluctant to do that as an organisation."*

[15] Safety 1 and Safety 2 are different approaches to safety management. Safety 1 is a reactive approach that focuses on preventing incidents. Safety 2 is a proactive approach that emphasises system resilience.

15.32 We asked an experienced Deputy Medical Director about whether the Medical Director's office normally followed up the outcome and recommendations of investigations. They said:

> *"In a way, you should, but that is a whole other piece of work. I have repeatedly seen no real oversight or holding oneself or others to account for ensuring that actions are delivered, or, where they can't be delivered, it's noted – why can't it be, what is stopping us and what, if anything do we need to do?"*

15.33 Several participants described a culture in which senior management take too much comfort from the data they receive about patient safety, without understanding what goes on 'behind the numbers'. This extended to a lack of curiosity about what is reported, and a lack of awareness about what might not be declared by clinicians about safety issues.

15.34 It is believed that these factors combine to produce and sustain a corporate mindset that leads to a low impetus to change practice until disaster strikes.

15.35 One interviewee told us that, when safety incidents occur:

> *"More attention is paid to closing incident forms within the timeframe to achieve the reporting standard, than implementing the actions of the report."*

Clinical standards and behaviour

15.36 We were told that the Medical Director's office has not consistently led and challenged the medical community in dealing with serious operational issues. These could be organisational and practical issue producing delays and blockages in admissions, non-conformance to operational requirements e.g. use of Epic or NHS rather than university email. This suggests the need for the Trust to appoint a more operationally focused Deputy Medical Director who can lead and challenge the day-to-day behaviour of consultant colleagues and ensure conformance to Trust policies and procedures

15.37 We heard that allegations about the behaviour of consultants can become exaggerated and can lead to them being investigated under MHPS processes[16], sometimes with disproportionate terms of reference. Several interviewees remarked on a strong sense that individuals can become isolated and victimised by an unfair application of such processes and in turn becoming the 'marked man/woman'.

15.38 The impression people gave us is that MHPS investigations are sometimes conducted to produce a desired result for those individuals subjected to the process. Doubts have been expressed to us about the independence and open-mindedness of some of the investigators, and about the proportionality of decisions taken after investigations are concluded. There is perceived to be an over-attention in the investigations to behavioural issues, with competence rarely subject to investigation. Several people told us that MHPS processes take too long to complete.

15.39 We were told that 'second chances' are rare for a consultant under MHPS investigation and that the focus is on punishment rather than rehabilitation or correction of any behaviour issues. There is also a perception that the Trust does not take care of the wellbeing of people under investigation.

15.40 One interviewee said in respect of the concerns about Ms Stohr:

> *"Here we go again, there's someone who's potentially struggling to do the right things and not had the resources' or not necessarily had the skills developed or the technical skills or something's gone a bit wrong and, before we know it, we've gone from zero to hero or vice versa."*

15.41 Several interviewees told us that the divisional structure had not been the success that people perhaps hoped it would be. One said**:**

> *"I think it is divisive, and everyone is out for themselves. They are quite protectionist and so there is no alignment along certain pathways where everybody has a responsibility, such as the [urgent and emergency care] pathway. I am sure there are elective pathways within a specialty, or groups of specialties within that*

[16] A Maintaining High Professional Standards (MHPS) investigation is the formal procedure used by NHS organisations when concerns are raised about a doctor's conduct, capability, or health. It is based on the Department of Health's MHPS (2003) guidance.

division, which work very well, but where there is cross-divisional working, where there are standards required across a pathway, the organisation is not aligned."

15.42 There is a strong sense that the accountability for performance improvement of doctors is unclear between divisional management and the Medical Director's office.

15.43 One person described their frustrations with how allowances are made for some people around their behaviour with colleagues depending on which specialty they are in, or on their reputation outside the Trust. Some such individuals were also seen to have wide scope to ignore accepted policy and practice in CUH. One said:

"For me, that is a real problem in this organisation, in that the culture is such that many people feel that they can do their own thing, depending on which specialty they are. Some people talk about the 'favoured few', because there are definitely the favoured few."

15.44 This participant observed an historical reluctance to challenge some surgeons in some specialties:

"Superimposed on that is a lack of discipline. I used to joke and say, 'the fundamental problem is that consultants don't behave like employees'. Then I realised that it's not that they don't behave like employees, it's that they're not managed as employees. Then I realised a few years later that half of them are not employees, they are employed by the university.

15.45 The same person saw the negative impact of this differential treatment on other colleagues:

"Some of their behaviours are unbelievable. We have lost two really good females – and I'm not talking about the one who was investigated, but I am talking about two relatively young people, really good clinicians, who were their trainees and then, eventually, they just walked because they couldn't cope with the behaviours. They are very good at being divisive and they will not listen. They don't change their behaviours, and they don't work together."

15.46 We asked if these issues were widely known, and the person said:

"If you talk to people who are involved with neurosurgery, you will understand. It is almost as though they are untouchable.

The problem with neurosurgery… we did investigate, and we tried to hold to account. It's easy for us but, unless you have leaders within your own organisation who say, 'No, this is not acceptable behaviour', or say 'Why would we want this individual to come and join our team if he's going to behave like this?'."

15.47 The interviewee added:

"The way teams behave is very different in terms of holding their own to account. If I'm honest, some of these academics are too busy looking after themselves and not actually managing their service. That is my view."

Improvement vs process reliance

15.48 Evidence from a few interviewees suggests that governance and safe care has focused more on systems and processes rather than on actual frontline improvements. The paediatric senior nurse interview summary (from paragraph 13.87, p.186) reveals this.

15.49 There is a growing awareness that data does not tell the whole story of the quality of patient care. It is a striking feature in this investigation that hard data about paediatric orthopaedics and Ms Stohr did not flag the concerns about her surgery that have since come to light.

15.50 The Trust still faces a risk that some serious issues simply do not enter the reporting system, and opportunities for making lasting improvements are lost as a result.

Comment

These insights come from a small, self-selecting, group of interviewees, not the whole CUH consultant body. Care should, therefore, be taken not to extrapolate these views

too widely. But every one of them is a senior, experienced clinician with deep knowledge of their service and of how the Trust works – or not – to deliver safe care.

Despite CUH's heavy investment in governance, quality and safety, things continue to go wrong. Interviewees point to an overload of process and a lack of real focus on service improvement. Put bluntly: CUH has, in parts of the medical community, a weak culture of learning and improvement in patient safety.

The seriousness of the problem is clear. Some consultants now avoid raising concerns or engaging with improvement efforts because they see it as futile. Instead, they withdraw into their own services, doing what they can for their patients in isolation. The potential effect of this is that people in their teams may follow suit. What leadership ignores becomes the new standard.

Given the importance of culture in the delivery of safe care for patients, we believe that the Trust needs to understand better the extent to which these insights are prevalent across the whole consultant community.

In the context of the revision of the Trust's approach to clinical governance it is essential that the Trust understands these concerns and enlists key clinical leaders in developing implementation plans to ensure new clinical governance structures and processes are effective.

Recommendation

R21 The CMO and the Chief People Officer should establish an implementation working group to ensure that changes to clinical governance structures, processes and practice are embedded effectively across the Trust. The group should include corporate management, and staff from a 'deep slice' of the organisation to ensure representation from all the key groups responsible for patient safety.

16. Concerns raised in 2024

Emerging issues in 2023 and 2024

16.1 Ms Stohr stopped attending the paediatric orthopaedics MDT in 2023. She explained:

> *"I stopped attending [paediatric orthopaedics] MDT meetings in May 2023, after I had been rude to a registrar and the matter was escalated so swiftly. I felt the MDT was not a safe environment for me, I was resentful that I was doing most of the work, certainly the acute work and yet I was more likely to be reported and punished."*

16.2 Consultant C said that they had been managing intermittent complaints from staff about Ms Stohr's behaviours towards colleagues since early 2023. In the wake of one such incident Consultant C said:

> *"I escalated it to my line manager, [the Clinical Director] who escalated it straight up to [the] Deputy Medical Director. [Deputy Medical Director B] took over, so that was about two years ago, and that was about behavioural concerns. There was evidence to see, and so [Deputy Medical Director B] took over at that time. At that time, Kuldeep said she couldn't control her temper, and she would no longer be attending MDT meetings: from that time, therefore, she no longer came to any MDT meetings. I don't know whether that was from March or April, but I think it was March 2023."*

16.3 Ms Stohr reflected on the handling of her non-attendance at the MDT:

> *"I now think I should have been made to attend MDTs in 2023 by [Deputy Medical Director B] with measures that respected my reservations. My reservations should have been brought up by line managers – [Deputy Medical Director B] knew I was not attending; I had also told her why. [The Clinical Director] or [Deputy Medical Director B] could have chaired a few meetings themselves. There could have been mediation."*

16.4 Consultant C understood that, in the months after this escalation Ms Stohr was having regular meetings with Deputy Medical Director B, who leads on patient safety and clinical

quality, and was receiving appropriate support to help with anger management issues. However, we understand that there were further instances of Ms Stohr behaving poorly towards colleagues through to early 2024.

16.5 Consultant A wrote:

> *"I am aware that complaints had been made by trainees around this time [March/ April 2024] which alleged that Ms Stohr had bullied trainees… I do not know the details of these complaints, but they were common knowledge, and I personally witnessed an instance of Ms Stohr bullying a trainee in an MDT meeting in March 2024. I intervened in that meeting following which she was reported to the Trust by [Consultant C]"*

16.6 Consultant C told us that in March 2024 they raised with Deputy Medical Director B another behavioural incident involving Ms Stohr.

16.7 The Associate Director of Workforce told us that in early 2024 it became clear that Ms Stohr was having increasing difficulties at work. They provided support during this period to Ms Stohr and gave advice to her line management about actions that might help her to cope with her workload. The Associate Director of Workforce told us that staff were increasingly raising concerns in the service about Ms Stohr's behaviour:

> *"They were giving lots of examples about very curt, inappropriate rude emails or outbursts in clinic, on the wards, or towards secretaries or ward clerks."*

16.8 They added:

> *"There were much more frequent outbursts, with shouting and crying. I think she had unilaterally withdrawn from the MDT… because she didn't feel able to control her anger in that environment."*

16.9 The Associate Director of Workforce liaised with Deputy Medical Director B to consider what action might need to be taken to support Ms Stohr and to address the behavioural concerns. They told us that, with Deputy Medical Director B, they met Ms Stohr in:

"Two or three meetings in quick succession where we were encouraging her to take some time to look after herself, re-group, and get some Occupational Health support, and perhaps access the Doctors for Doctors service."

16.10 Following these discussions The Associate Director of Workforce said:

"The long and the short of it is that she eventually agreed that she would take some time off."

16.11 Consultant C said that, in concert with Deputy Medical Director B, they agreed that Ms Stohr should take some time off from work:

"That was when it was recommended to her that she took voluntary leave. I think it was recorded as sick leave… this was in March last year. Kuldeep was advised to have some time off, which she accepted and took."

16.12 Deputy Medical Director A told us that Ms Stohr:

"Has always been known as being incredibly hardworking, doing lots and lots of things -short fuse etc., people managing around her - but it was when further concerns arose about her behaviour that she ended up having further discussions, not with me on this occasion, but with [the Associate Director of Workforce] and others.

It was agreed that Kuldeep, from the history that I had with her in 2015/16 and 2017 over her behaviour in theatres, when she wouldn't accept any form of mediation or meetings, she acquired, if she didn't have it before, the view that I was not a good person and was unreasonable. So, we agreed in the MD's Office that I wouldn't be involved in the most recent thing to try to avoid inflaming the situation.

Anyway, as a result of that discussion, Kuldeep went off duty, under the auspices of Occupational Health, and that's when her colleagues then started to pick up her patients and that is when this whole story that you know started."

Comment

We found no evidence that action was taken to encourage or to require Ms Stohr to return to the paediatric orthopaedic meetings after she stopped attending them in May 2023. There is no evidence that anyone in the team, or in divisional management, intervened with Ms Stohr to address her concerns about how she was treated by colleagues in the MDT.

By May 2023 attendance at MDT meetings was meant to be mandatory. The MDT meetings remain the main mechanism by which surgeons shared their cases with colleagues. Every meeting that Ms Stohr missed from May 2023 onwards was an opportunity missed for her cases to be discussed.

Ms Stohr had an obligation to attend these meetings that she did not/was not able to fulfil. Ms Stohr's non-attendance was a warning flag to service and divisional management to address the reasons why she was not attending. We know that senior medical colleagues became increasingly concerned about Ms Stohr's isolation, withdrawal, and behaviour in 2023 and provided considerable support to her on a regular basis until she eventually went off sick in March 2024.

Ms Stohr believes that she should have been made by management to attend the MDTs, but with appropriate arrangements in place to prevent her from being further affected by the behaviours of other colleagues in the MDT. This did not happen, and we believe this resulted in Ms Stohr becoming further withdrawn and isolated from the paediatric orthopaedic team.

Ms Stohr's behaviour towards colleagues deteriorated significantly from mid-2023 resulting in her taking a leave of absence from work. Given the impacts on her mental health and stress that Ms Stohr reported, this appears to have been a pragmatic decision that balanced the needs of the Trust while offering a supportive solution to Ms Stohr's health and wellbeing problems.

During this period the Trust should have considered changes to the working arrangements for the MDT and developed other ways for the team to maintain visibility of Ms Stohr's clinical work, particularly as instructing her to attend the meeting was unlikely to be successful and would have caused her increased distress.

Discovery of further clinical practice concerns

16.13 In Ms Stohr's absence, the remaining members of the paediatric service took over the care of her patients. In doing so, colleagues began to identify problems with Ms Stohr's clinical practice. Consultant A wrote in their statement:

> *"This included follow-up appointments with patients who had been operated on by Ms Stohr. It became clear quickly from these follow-up appointments that a large number of Ms Stohr's patients had problems, some of a severe nature, that they should not have had. I was very concerned by this, and those concerns were shared by [Consultant C]. For example, one patient had 14 general anaesthetics over a seven-year period during which Ms Stohr had performed at least four pelvic and four femoral osteotomies, resulting in irreversible damage to the hip. Another patient had at least five general anaesthetics and six femoral osteotomies and a fracture fixation in relation to one of these osteotomies over about six years. Ms Stohr had converted one severe bilateral lower limb deformity into a different severe lower limb deformity."*

16.14 Consultant C told us that they and colleagues had concluded, after taking on Ms Stohr's patient caseload:

> *"That the volume of cases coming from Kuldeep, and the severity of the cases, could not be normal. I always knew that she had had this review before, but that it had found that she was normal or that her practice was acceptable and there were no concerns, and so it was difficult to raise those concerns again.*
>
> *I know the personal impact that that can have, and it is awful for anyone to have these allegations put against them, but I just thought to myself that this could not be right. It was just too much."*

16.15 Consultant A raised their concerns with Deputy Medical Director B and the current Divisional Director for Division E (who has held this post since 2019) on 21 August 2024.

16.16 Consultant A, Consultant C, and Consultant B met with Deputy Medical Director B on 11 September 2024 to discuss their concerns. Consultant A recalled:

> *"[Deputy Medical Director B] led us to believe that there had been no concerns made by Mr Hill in 2016 and made out that there had been no problem with Ms Stohr's surgeries before. I could not understand this as our 2024 concerns were in line with my 2015/2016 concerns: I had specifically pointed out in 2015 and 2016 that Ms Stohr did not have the skills to perform femoral and pelvic osteotomies adequately and in 2024, we could see that Ms Stohr had carried on performing pelvic and femoral osteotomies with poor results."*

16.17 Consultant C said they were initially told by Deputy Medical Director B:

> *"That there was a normal curve of surgeons and 'We don't sack the bottom 10 per cent, and we don't sack the bottom five per cent – we don't even sack the bottom one per cent. It's only if there are recurrent, very major problems that happen."*

16.18 Consultant C told us that concerns about Ms Stohr's patients had not been brought to the MDT because Ms Stohr:

> *"Hadn't been going [to the MDT] for a year, but some of these patients had been operated on in 2016, 2015, 2018. They were before [Consultant B] started at the hospital and before I started at the hospital. They were long-term patients."*

Comment

It is unclear why the extent of these concerns had not become apparent to the Trust before colleagues began to care for Ms Stohr's patients. Her withdrawal from attending the MDT from May 2023 should have been addressed more assertively. Instead, her absence meant that there was probably no visibility at the MDT of any of her casework for around 15 months before she went on leave.

Her colleagues' concerns about the volume and severity of the issues revealed amongst Ms Stohr's patients were promptly and properly raised by her colleagues with senior management and with the hospital director.

Although some of those colleagues had known that Ms Stohr's practice had been reviewed in 2016 none of them knew, in 2024, what the Hill report had said about the specific shortcomings that had been identified. Their discovery of the concerns in 2024 also revealed that some of them dated back to the time when her practice had already been reviewed.

The Trust's response to these concerns – the Hunter review

16.19 The Associate Director of Workforce was responsible for managing Ms Stohr's extended sick leave during this time. They told us:

> *"She was off sick for about six months or so, and she was not ready to return. There were then discussions about a phased return and what it might look like; what would be necessary in terms of adjustments to her job plan, because if she was working too hard, was too much being expected of her? All of those conversations were happening and when it began… we were having those initial discussions and receiving advice from Occupational Health, the concerns about her clinical practice were not known."*

16.20 The Associate Director of Workforce said that, in this period, they became aware that colleagues were surfacing concerns about Ms Stohr's patients. They told us that in the early autumn Ms Stohr was signalling an improvement in her health, saying:

> *"She had then reached a place where she was definitely feeling better and wanted to start talking about a phased return to work. The advice from the Occupational Health consultant was, 'Yes, I think she is ready now. We need to take it gradually, step by step, but I think it is appropriate to start thinking about that.'"*

16.21 The Associate Director of Workforce said:

> *"That was almost exactly the moment when [Consultant C] was saying to [Deputy Medical Director B], 'Actually, I don't think we can let her come back because I'm really worried about all of these things.'"*

16.22 Dr Shaw described how he responded to the reports of Ms Stohr's poor clinical practice in autumn 2024.

> *"Subsequent to Kuldeep going off we then started to receive concerns from [Consultant A] and [Consultant C] about the outcomes as they started to see patients in their clinics. We saw the reports, and we decided that we knew that there was no ongoing harm because she was off. We knew that we had had an external review before and so we tried to get in an expert to look at the cases that had been explicitly raised by [Consultant C] and [Consultant A]. I think there were a small number of cases – I forget exactly how many.*
>
> *We looked around and identified James Hunter from Nottingham as a national expert in the field. He had previously been the GIRFT lead and was a well-respected paediatric surgeon.[17] I think we checked with [Consultant A] and/or [Consultant C] that this was someone whose opinion was valid, and we organised for him to look at the cases. That is what we did. We thought that that would be the best first step in establishing whether there was an issue, and then, obviously, James then came back with his opinions, which you will have seen.*
>
> *They are much more explicit than Rob Hill's in their viewpoints and, at that point, that was when we came to January/February time. I escalated that to the rest of the Executive Board, and we then moved into the current phase, which was to seek support from the British Orthopaedic Association in establishing a wider review.*
>
> *We knew that we had a little time to do that and then we moved to the formal exclusion of Kuldeep Stohr."*

16.23 Consultant A wrote:

> *"I do not know when the Trust appointed Mr James Hunter to investigate us. It might have been September or October 2024. I wanted to be sure that the Trust were providing Mr Hunter with relevant information and so I sent a detailed email on 21 October 2024 to Roland Sinker (Chief Executive of the Trust), Dr Ashley Shaw (Medical Director), [Deputy Medical Director B] and [the current Director of Division*

[17] Mr Hunter is still the GIRFT clinical lead for paediatric orthopaedics in 2025. He authored the GIRFT paediatric trauma and orthopaedic report.

E] which set out a number of cases that I thought should be investigated by Mr Hunter… I also referred to the concerns I had raised in 2015/2016 and attached relevant documents. I wanted to remind Mr Sinker / for him to know that I had contacted the Trust in 2015 and 2016 with serious concerns about Ms Stohr (even though Mr Sinker had been the Chief Executive of the Trust in 2016) and that all this could have been prevented from 2016 onwards."

16.24 Consultant A described their response to the Hunter report in February 2025:

"I was shocked when I read the Hunter Report as, to my mind, it clearly demonstrated that the concerns I had raised in 2015/2016 were valid and that there were very serious problems with Ms Stohr's operative technique and decision-making…

"… The 2025 Hunter report mirrors my concerns by highlighting that there are multiple cases of poorly performed pelvic osteotomies… I could not believe what I was seeing all these years later and it seemed to me that the 2016 review must have been completely inadequate particularly where it was apparent from what we were also seeing from clinic follow-ups in 2024 and 2025 that Ms Stohr had caused serious harm to many patients and we were already carrying out procedures to try to rectify problems caused by Ms Stohr."

16.25 Consultant A added:

"At this point, I had still not seen a copy of the 2016 Hill Report and so I felt compelled to make sure that the Trust's senior management was fully aware and/or reminded that (i) I had raised similar concerns in 2015/2016; (ii) that I was told by the Trust that Mr Hill had not found Ms Stohr's decision making to be a concern; and (iii) that the Trust told me that the Hill Report did not lead them to be concerned about Ms Stohr's practice.

I therefore sent a detailed email to Mr Sinker, [Deputy Medical Director B], Ms Nicola Ayton (Deputy Chief Executive Officer), Dr Susan Broster (Chief Medical Officer),[18] Mr David Wherrett (Director of Workforce), and Dr Shaw on 20 February 2025 to raise concerns about the findings of the Hill Report and the actions of Trust's

[18] Dr Shaw was still the CUH Medical Director in February 2025.

senior management involved at the time… To be frank, I thought that Mr Hill needed to be investigated, and I said so. His findings had apparently allowed this situation to develop.

My email was acknowledged by Ms Nicola Ayton on the same day who informed me via email about the Trust's plan to perform an internal and external investigation. She stated 'We are clear that we must be open to any learning and findings, even where that is uncomfortable or painful for us as a leadership team'… I now interpret that statement as Ms Ayton alluding to the position the Trust's senior management had taken in 2015/2016 in response to my concerns and the Hill Report.

I am very angry that all the senior management on that email chain (being Ms Ayton, Mr Sinker, Dr Broster, [Deputy Medical Director B], Mr Wherrett and Dr Shaw) continued to leave me and [Consultant C] in the belief that my 2015/2016 concerns were wrong and that the Hill Report had not identified any issues with Ms Stohr's practice."

16.26 We asked how the decision to exclude Ms Stohr came about, and the Associate Director of Workforce explained:

"There were a number of steps. We were trying to buy ourselves some time and the first one was that 'We should take this step by step, gently, Kuldeep – perhaps you could come back to admin first.' That was still under the health banner. Then there was the first interim report from James Hunter – I think there were three in the end. The first one was quite worrying and so the decision was made to restrict her practice: not full exclusion, but to restrict her practice."

16.27 They said:

"We restricted her to non-clinical duties, which was essentially a kind of re-badging of her phased return to work. She was already on non-clinical duties but was looking to start to build that up again."

16.28 Following discussions with the Medical Director the decision was taken to formally restrict Ms Stohr's practice under the provisions of the Maintaining High Professional Standards (MHPS) framework. Ms Stohr was notified about this decision in a meeting with

the Medical Director and her exclusion was confirmed in February 2025. She has not practised in the Trust since being unwell in March 2024.

Comment

Dr Shaw recognised the seriousness of the new concerns that had been raised about patients under Ms Stohr's care. He moved quickly to formalise Ms Stohr's exclusion from practice.

This was a proportionate response to the situation and also meant that Ms Stohr would be prevented from operating on any more patients, thus limiting any future risk of harm.

Wider sharing of the Hill report in 2024/ 2025

The paediatric orthopaedics department

16.29 Consultant C was particularly concerned that it had taken the discovery of wider concerns about Ms Stohr's practice in 2024 to reveal that the Hill report had not been shared earlier with them as clinical lead of paediatric orthopaedics. Consultant C told us that:

> *"The contents of that report were leaked to me over time."*

16.30 Consultant C told us that they had met Mr Hunter on 13 or 14 March 2025 at a BSCOS conference in Brighton. She said:

> *"He mentioned Rob Hill's report, and I said that I had not seen it, and he said, 'You do know, [Consultant C], that it said Kuldeep needed some help?'. That was the first time I had heard that, and it was James Hunter at a national meeting. The Trust had had this from 2016 and the first time I heard about it was from a Nottingham consultant at a meeting in Brighton. Understandably, I came back after that quite upset."*

16.31 Consultant A recalls a similar interaction with Mr Hunter at the BSCOS conference:

"[Consultant C] and I separately bumped into Mr Hunter and independently commented to him that we had concerns about the Hill Report having seen a copy of Mr Hunter's third interim report as we were under the impression, at that point in time, that the Hunter Report had found issues with Ms Stohr's practice but that the Hill Report had not. I went as far as to suggest to Mr Hunter that Mr Hill shared some responsibility for subsequent events. I was not present to [Consultant C's] conversation with Mr Hunter but, in my interaction with him, Mr Hunter gave me the impression that the Hill Report was not the problem."

16.32 Consultant C was uncertain whether Deputy Medical Director B had read the Hill report by the time the team raised their concerns with them:

"I assumed she had not at that point but she did read it afterwards, because she told me a couple of months later what it had said in the report – and I asked to see it at this point, but kept being told, 'Oh, we'll get it to you. We'll get it to you.'

I started asking last summer [2024] and I received it in March this year [2025]. [Deputy Medical Director B] told me to my face that it had said in the report categorically that all hip reconstructions – that is, her cerebral palsy and her DDH work – should have post-operative 3D imaging, and that is a CT or MRI. That alone would have stopped many of the problems that have come to light from the James Hunter report.

I was quite shocked when [Deputy Medical Director B] told me that and I therefore asked her if I could please see the report. On top of that, I was cross, because I had asked Kuldeep myself, on many occasions, to do post-op 3D imaging and she had refused. She insisted to me that her imaging in theatre, her X-ray (which is 2D imaging) … was good enough and that she had had an external review which had said that her practice was fine, and she was not changing it. It frustrated me because I had asked her on many occasions. We had had difficult conversations on that matter and there had been a report in 2016 which said it."

16.33 Consultant A explained that they and Consultant C eventually received a copy of the Hill report in April 2025. Consultant A described their reaction to reading the report for the first time nine years after it was written:

"It became clear to me on seeing the Hill Report, that Mr Hill's assessment of Ms Stohr's practice in 2016 was not incorrect and that it was the Trust which got things wrong when it inaccurately (and, I can only assume, intentionally) told me in their letter dated 15 August 2016 that Mr Hill had 'made no findings to lead the Trust to be concerned about Kuldeep's practice'… I was utterly shocked and deeply distressed by what I saw in the Hill Report, and at the Trust for the very limited action it took after Hill concluded his review in 2016. Had the Trust acted on mine and Mr Hill's concerns as they should have done, I believe that considerable harm could have been prevented."

Comment

The surgeons in the paediatric orthopaedics service were understandably surprised and distressed on learning that the Hill report had anticipated, by eight years, similar concerns to those identified by Mr Hunter in 2024.

By the time they learned about the Hill report – from Mr Hunter rather than from the Trust - they had already identified a significant number of further concerns about the care and treatment of Ms Stohr's patients. They recognised that their lack of knowledge about the Hill report had given them no insight into what had been discovered about her practice in 2016.

Response to the Hill report from the paediatric orthopaedics team

16.34 Consultant A wrote that they believe that Mr Hill had upheld the concerns about Ms Stohr's practice and raised further concerns himself around the use of post-operative imaging.

16.35 We asked Consultant C about their interpretation of the Hill report. They said:

"Rob Hill says that there are some issues to address and then, from a technical point of view, he puts categorically all cases of DDH post-surgery should have an MRI – it

is categorical. He says, Secondly, I detect some issues with pelvic osteotomies. It is not, 'I detect some issues, but in the cases clear' - issues are described."

16.36 In considering Mr Hill's advice and recommendations Consultant C referred to the phrase, *"and Ms Stohr might like to consider this and, if necessary, look for some extra experience"*. They said:

"In my opinion, that could have been worded a little differently, should we say, but also it is up to the Trust to look at this and act appropriately. There are some categorical things that are said, about sub-specialisation, 3D post-op imaging. There are some that you could say are more woolly and more open to interpretation, and you can make of that what you will."

16.37 Consultant C also referred to the letter sent to Consultant A by Deputy Medical Director A on 16 August 2016, in which Deputy Medical Director A:

"States twice, categorically, that there are no clinical concerns, and he twice raises the issue about a divided department. One aspect, which Rob Hill says may not be true, is picked out and highlighted twice in this letter, and none of the other issues. Then, when there are clinical issues, it has stated the opposite – that there are no clinical issues."

16.38 We asked Consultant C who else, to their knowledge, had seen the Hill report before they became aware of it. They named Deputy Medical Director B, Dr Shaw, and Mr Wherrett, director of workforce. Consultant C told us that they had asked several times for sight of the report without success.

"The only inkling I had was about the CT, and the fact that they would not show me – I wondered why they would not show me this report from 2016? I had asked and asked and asked.

All I have is a letter to [Consultant A], saying there were no clinical concerns but, on any other aspect, did anyone acknowledge that there were any? And was anything ever done about it? I would like to know that. Or was it literally, there was nothing, and who else knew about it? It would be unusual to have an external review and then only one person read it, act and do everything. There must have been more

people who read it – so who else read it and did they think the same? Did they think that this raised no clinical concerns and required no action?"

16.39 Consultant C, in response to a question about whether these issues meant that an opportunity to identify Ms Stohr's practice concerns sooner was missed said:

"I think we could answer: not only could it have been, but it was. It was identified sooner – it was identified in 2016."

16.40 Consultant C described the way in which they learned of the Hill report as an example of the poor connection between frontline services and Trust leadership:

"In April [2025], when I first saw the review from 2016, to say I was flabbergasted doesn't come close. Never did I think that you would have an external review that raised concerns and listed actions that should be taken where none would be done and where no-one would have any oversight.

I was literally floored and the way I found out about that was from James Hunter at a national meeting in Brighton. I had been asking to see it here. So, following that, I sent a very strong email to Roland Sinker, David Wherrett, the Medical Director at the time, I think it probably was Ashley… I got a one-line reply from Roland saying, '[Dr Broster] will speak to you about this', and when I spoke to [Dr Broster], she said, 'oh, the Verita report will answer it.'"

16.41 Consultant B told us that they had only seen the Hill report two or three weeks before we interviewed them on 23 May 2025. They said that:

"Until then, I had never seen it, nobody I know had ever given me any detail, and I don't think anybody I know had ever seen it."

16.42 We asked Consultant B for their views on the report, and they said:

"I think the report would have provided the Trust with an opportunity to actually, with appropriate governance structures, to support and guide Kuldeep's trajectory in a way that I don't think happened. I think Kuldeep is the victim of a lack of

appropriate Trust governance, if I'm honest. I have operated with Kuldeep. I don't have any significant concerns."

16.43 Consultant B added:

"I actually feel that everything that I was told about that report in retrospect was wrong."

16.44 Consultant B was concerned about the fact that the report had identified issues about Ms Stohr's surgical practice, saying the report was:

"A bolt from the blue, to be honest. As I say, I think if Rob Hill's report had been implemented, she'd still be here. She's not a deeply flawed person, and it wasn't an irredeemable situation in 2016. It could have been managed, and it was not."

16.45 Consultant B explained how they had come to receive the report:

"[Deputy Medical Director B] told us about the existence of the report. The only reason that we were given a copy of the report was that [Consultant C] challenged James Hunter, face-to-face. I don't think we'd have it now – I don't know, that's speculation – but nobody shared that report with me. Nobody told me about anything inside it. It was horrifying, to be honest, to know that somebody had made a decision either not to share that report, or even to suppress that report and not to provide Kuldeep and her colleagues with the support and a strategy to implement the report."

Comment

The surgeons in the paediatric orthopaedics service were stunned by the fact that they had only learned about the Hill report in 2024. We believe this led them to question whether the report had been suppressed after it had been received by the Trust.

The team was extremely surprised to learn that no discernible action had been taken by anyone in the Trust on the findings and recommendations stemming from the Hill report.

They recognised that such action would have had a significant impact on Ms Stohr at the time but believed she had not been given enough incentive or support to effect any changes in her practice.

Roland Sinker, CEO since November 2015

16.46 Roland Sinker has been the Chief Executive Officer of the Trust since November 2015. We asked if the paediatric orthopaedics department had come to his attention for quality or governance concerns during his tenure. He said:

> *"The first time I heard about paediatric orthopaedics in that context was when [Consultant A] wrote to Ashley [Shaw] and me in September/October 2024. That was the very first time I heard about it. Ashley came to see me and said, 'I'm immediately commissioning an external review'… I let the [now former] Chairman,,, know. I recall that we let [the] Chair of Quality Committee know, although I can't quite remember. Then Ashley went away and did the work on the second review and in January [2025] he said that it was looking pretty serious – it looked as though it was substantiated."*

16.47 Mr Sinker said that the James Hunter review led to the Hill report first being surfaced in the Trust:

> *"When we got the '24/25 review, that was the point when there was a wider circulation for the first time of the 2015/16 report, and that was the first time I saw the 2016 report."*

Comment

We believe Mr Sinker responded appropriately to the discovery of concerns in 2024 and accept that he had not been made aware of any issues arising in the paediatric orthopaedics service before then.

Dr Ashley Shaw, former Medical Director

16.48 Dr Shaw was the Trust's Medical Director from November 2017 until the end of March 2025. He told us:

> *"In the time when I was Medical Director, I wasn't aware of the Rob Hill thing until the end of July last year [2024]. Whenever Kuldeep's name came up, it was because she had lost her temper in clinic, or something, and shouted at a nurse or HCA [health care assistant], or there had been a bad interaction, and she had lost her temper in clinic or something.*
>
> *Up until [Consultant A] raised these issues last spring [2024], if you had said to me that there was a problem with Kuldeep and asked me what it was, the only thing I would have said to you would be anger management. In fact, we had organised previously help for her to manage anger and outbursts, so she had popped up a few times but always with regard to anger management.*
>
> *I can think of one occasion when [Consultant A] wrote to us complaining about a couple of surgeons and the outcomes of some elbow surgery, I think it was. I think it was a couple of surgeons, and I can't remember whether Kuldeep was one of them – she might have been – and then there was a locum consultant. There were two or three cases that he sent us and said this was terrible. We asked Lee van Rensburg, who is one of the country's best elbow surgeons, to have a look at the three cases and tell us about them, and Lee's response was along the lines of 'Well, they're not perfect, but they are not a problem. This is within the range of normal behaviour'. If the bar is that everything has to be perfect, then we will struggle.*
>
> *That was the only time I was ever aware of anyone raising any clinical concern, and Lee said that they were within the range.*
>
> *That would have been up until last spring and, if we had had that conversation then, that is what I would have been telling you. No-one before that had ever raised concerns to me.*
>
> *I checked my emails on this one yesterday, just so that I was clear. I think it was sent to me on 31 July last year [2024] for the first time."*

16.49 Dr Shaw reflected on the findings of the Hill report:

"It did not appear to be something I could look at and say, 'My goodness – this person needs to be retrained, or it didn't read to me as if to say, 'You should have done a full investigation.' It didn't say, 'My God, you need to do a full investigation of everyone this person has ever touched!' It didn't say that we needed to go and do a wide review in some way, shape or form, and it didn't say 'I think this person needs formal retraining, or you might want to consider that.' It basically said to double-up dual operating and better MDT working."

16.50 We asked Dr Shaw where he believed the responsibility lay to act on the findings and advice from the report. He said:

"I guess there is a combination of personal responsibility to look at and think 'where are my outcomes?'. And there is an organisational responsibility to ask whether those things have been done. It is tricky."

16.51 Dr Shaw told us, in looking back at what might have been done differently:

"First of all, it is about ensuring that people were comfortable that the right experts had been engaged in the first instance. That is probably the first point, so that everyone would have assurance as to whether you have someone who is genuinely an expert.

The second point would be to have some clarity at the end of the report as to what they thought might be needed in terms of being a little more explicit.

And then thirdly, probably, a meeting with everyone involved at the time, to discuss the outcomes of that report and the way forward."

Comment

Dr Shaw had a balanced view of the findings of Mr Hill's review, and he believed that it fell short of suggesting that Ms Stohr was unfit to practise. He acknowledged that

his opinion was one formed in hindsight but told us that previous concerns raised by Consultant A about three cases of elbow surgery had not demonstrated to him that a serious problem existed in paediatric orthopaedics.

It is a matter of conjecture whether Dr Shaw would have reacted differently to the Hill report had he seen it in 2016, but he did not have that opportunity.

David Wherrett, Director of Workforce (now Chief People Officer)

16.52 Mr Wherrett has been Director of Workforce/ Chief People Officer since 2014.

16.53 He told us the first time he found out about this case was from Dr Shaw who had, in mid-February 2025, just received the third interim report of Mr James Hunter's review. He said:

> *"A little while after that, the Hill report came out, because I think [Consultant A] had emailed a number of us referring to the earlier Robert Hill report. Then I asked, 'where is this report?' It was almost like Ashley didn't know at that point. I am not sure what he did or did not know about the earlier report."*

16.54 Mr Wherrett confirmed that he had now seen the whole Hill report, and he recalled his immediate reaction:

> *"I remember calling colleagues late into the evening saying: 'have you read this report?' Next day, Roland [Sinker] was appearing in front of the Press saying, 'we will look into whether there were any missed opportunities to spot this sooner'. I thought it seemed pretty clear on the face of it, there were."*

16.55 We asked Mr Wherrett if, on reading the report, it indicated the need for Ms Stohr to address any quality issues in her work. He said:

> *"Even I understood that the report recommendations necessitated improvement in her practice"*

16.56 Mr Wherrett told us that he was unaware who had seen the report when it appeared in 2016.

Deputy Medical Director B

16.57 Deputy Medical Director B, who is the lead for patient safety and clinical quality told us that, when Consultant C and colleagues began raising concerns about Ms Stohr's practice in 2024 they had not seen the Hill report:

> *"I had been told that it had explored a number of cases which [Consultant A] had highlighted and that there was some learning from it but nothing that reached the threshold of concern at the level at which [he] was reporting concerns."*

16.58 Deputy Medical Director B went on to say that, by this time:

> *"We had already made the decision that we would need to investigate. I remember reading the summary [of the Hill report] and thinking, 'Oh, there are a few bits here', but I think the report was slightly counter-intuitive in retrospect. It said 'I have no concerns. Then, when I received James Hunter's first interim report, and read it – I am a neurologist, so I don't know much about paediatric orthopaedics, but I suddenly realised I was reading some bits which sounded similar to the Hill report. I re-read the Hill report and thought, okay, there's something here – these sound similar."*

16.59 Deputy Medical Director B, with the permission of Ashley Shaw and Deputy Medical Director A, shared the Hill report with Mr Hunter with the aim of ensuring that his review would not be compromised in any way. Deputy Medical Director B noted that, in the Hill report:

> *"When you went through the detail of the case descriptions, there were clearly concerns with her decision-making. But I don't think I had read that at the time.*
>
> *I read that, and I read the bit about the MDT – I remember reading that, about the MDT and the lack of imaging, because that was something that [Consultant C] had commented to me about, saying that she was really surprised that these scans were*

still not being done. I assumed that the other bits had been addressed back in the day. I think I read it, thinking that whatever this thing says, we need to re-investigate anyway, because this was nine years or so ago."

16.60 Deputy Medical Director B said that they and Mr Hunter arranged to meet to talk through his report, and for him to share his concerns about how serious the issues were. They said:

"I understood how concerned he was. I got it, that there were really fundamental problems here. The moment when I then felt sick was when I sent him Rob Hill's report and he said, 'It's all the same stuff.' At that point, I escalated it straight, of course, to [Deputy Medical Director A and Ashley Shaw] again."

Dr Sue Broster, current Chief Medical Officer

16.61 Dr Broster shared her reflections on the handling of the Hill report and its findings:

"It is important how people interpreted the report: they focused on the relationship part, rather than other aspects in that. However, in an ideal situation, how that is all managed collectively together (MD's office, Division etc) might have kept the focus on the patient element. It should not ignore the relationship element, because that is important, but not at the cost of the other aspects."

16.62 She added:

"They particularly use the word 'exoneration' a great deal. I am sure people who have talked to you will have described that, that that word was used in conversations with them and therefore they rightly or wrongly felt unable to challenge, or not willing to challenge.

The feedback to them had been that it had been reviewed, and Kuldeep was exonerated. I recognise Kuldeep may have been thinking about this report and its implications more, but the communication as a whole was, I think, inadequate."

Comment

None of these people knew about the findings and recommendations of the Hill review until at least 2024. It would have been extremely unlikely that they could have anticipated or prevented the events that occurred until 2024 when Ms Stohr's cases were reviewed by Mr Hunter.

Feedback about Ms Stohr from patients and families contacted by the Trust

16.63 Following the discovery of further concerns in 2024 the Trust set up arrangements to contact patients and their families about the care and treatment they had received from Ms Stohr. The PALS and Complaints Manager and their manager, the Head of Nursing, Patient Experience and Engagement carried out the first set of conversations with families whose children had suffered harm while receiving care and treatment from Ms Stohr. These were patients whose cases were reviewed by Mr Hunter in 2024 and early 2025. The Trust also set up a Helpline that was contacted by 156 families as of early July 2025.

16.64 The PALS and Complaints Manager told us about the reaction of families to being contacted:

> *"Initially, because these calls were 'cold', they came out of the blue, and then we arranged the (duty of candour) meetings, and we arranged those meetings very quickly. Some of them happened the next day, some were within a few days. Due to medical complications, one has taken a longer time. There were some who were absolutely shocked at the calls, some were positive about [Ms Stohr], obviously really surprised. There were some who had always had concerns around care and follow-up, so there was quite a variety just from those initial phone calls."*

16.65 We asked whether any families told the helpline that they had raised concerns at the time of their care and treatment:

> ***The PALS and Complaints Manager:*** *Some did.*
> ***The Head of Nursing, Patient Experience and Engagement:*** *Some raised it with her direct. Some just accepted. We were really mindful that this is a patient group that we very rarely hear from anyway. Their lifestyles are quite complex,*

difficult and challenging, and for some, they just accepted that this was going to be the outcome. Then some who had asked for a second opinion and had been referred on.

16.66 The PALS and Complaints Manager told us that few of the families contacted by the helpline had ever raised a complaint with the Trust. They think the explanation for this is that families caring for a child with a disability did not have the time and capacity to raise formal complaints and that they may not have had high expectations about care and treatment. They added that the paediatric orthopaedic service was not one that they had ever raised concerns about to senior colleagues.

16.67 The Head of Nursing, Patient Experience and Engagement told us that they had several families on the helpline say positive things about Ms Stohr:

"We've heard some really positive things about this individual (Ms Stohr), about how she did care and how she did go above and beyond, and I think that shouldn't be forgotten."

16.68 The PALS and Complaints Manager added:

"She was caring, she did go the extra mile. We've actually had five letters of compliments in while we've been doing this because parents have been absolutely thrilled with the outcome for their children. It's important that we do log those as well."

Comment

There was a range of feedback from families about Ms Stohr after they had been contacted by the Trust, and some were complimentary about her. At the time of writing, it is likely that more information is available to the Trust about how families now feel about the way in which their children were treated.

Ms Stohr's practice outside the Trust

16.69 Ms Stohr carried out private practice at the Nuffield Hospital in Cambridge. We spoke to senior colleagues at Nuffield about how a doctor is accepted to work for them. They explained the process which is common to all independent healthcare providers:

> *"They [consultants] are all contracted under practising privileges, but they are not employed. They are fully accountable and responsible for their work – they are the admitting consultant – and so under the healthcare regulation we have a shared duty of care for those patients. They are shared patients, but it is very clear with practising privileges that they are not employed in terms of HR law. However, if you look at the CQC regulation and the IHPN [Independent Healthcare Provider Network], we manage them in the same way and we expect the same as them being an employee: teamwork, sharing, being part of the workforce and sharing patient accountability."*

16.70 Nuffield colleagues told us that they inform NHS trusts when a new consultant is contracted. This includes setting out the scope of their clinical practice. A Trust will be told annually that a consultant has been reapproved to practise. This annual contact is an opportunity for an NHS organisation to alert an independent provider like Nuffield to any concerns about the doctor's practice. Nuffield work on the principle of *'no news is good news'*.

16.71 They told us that they are provided with a consultant's annual NHS appraisal each year. The registered manager at the Nuffield hospital reads the appraisal and would discuss the matter with the consultant and the local medical advisory committee chair if they needed to do so.

16.72 We asked whether CUH had alerted them to any concerns they had about Ms Stohr:

> *"From a responsible officer to responsible officer… information-sharing - absolutely not. We do not have anything on file."*

16.73 They told us that they had had to ask CUH to provide further information to them when concerns about Ms Stohr became public knowledge in 2025 and that they had asked the CUH responsible officer for a copy of the Hill report in June 2025.

16.74 We were told that Nuffield had initiated their own investigation into Ms Stohr's practice. This includes reviewing their information about Ms Stohr's practising privileges and

appraisals to see whether there was any information that should have prompted concerns. At the time of our interview the investigation had just started. So far, they had found one complaint from a patient about Ms Stohr's behaviour in outpatients. The patient had brought this to the attention of the media.

16.75 We have since been advised by CUH that Ms Stohr's Nuffield patients will be reviewed as part of the clinical review led by Andrew Kennedy KC. At the time of writing, the review of these Nuffield patients had yet to begin.

16.76 The Independent Healthcare Provider Network (IHPN) is the membership network for independent providers. In September 2022 it published its refreshed version of the Medical Practitioners Assurance Framework (MPAF) which was first released in 2018. The purpose of the framework is to:

> *"Help foster a more standardised approach to medical governance in the independent sector and ultimately drive up the quality and safety of care for patients."*

16.77 Section 4 of the framework Raising and Responding to Concerns says:

> *"Responsible Officers should take appropriate action in response to any information of note they receive about the practice of a medical practitioner who works at their organisation. This includes information received from outside the organisation. Where a Responsible Officer (NHS or independent sector) becomes aware of information about a medical practitioner that could affect the safety or confidence of patients, they should share that information with the relevant Responsible Officer in all places where the medical practitioner is known to be working in an effective and timely manner. Responsible Officer training and participation in Responsible Officer Networks should encourage collaboration between the NHS and independent sector as part of a community of care where there can potentially be sharing of specialist resources such as case investigator."*

Comment

Nuffield knew nothing about the outcome of Mr Hill 's external review in 2016. This is not surprising given CUH's own assessment of the review and how it was handled.

However, since the Ian Paterson case, expectations have changed considerably about how NHS trusts and independent healthcare providers work together. These expectations are set out in the IHPN framework. CUH had good reason to inform Nuffield formally of their concerns about Ms Stohr in 2023/2024 and did not do so, though there appears to have been an informal conversation in late 2024. They had an even more compelling reason to provide formal notification in early 2025.

Performance of the paediatric orthopaedics department in 2025

16.78 During the period since the surfacing of the concerns about Ms Stohr's practice and the investigation of them, staff in the department have been closely involved in the organisational response to the review of patients who had experienced harm.

16.79 Consultant C said that in responding to the current clinical review of Ms Stohr's patients the Trust has:

> *"Put a lot of resource and energy into contacting the patients and going out for external review and that is good. I don't feel they've given anywhere near as much resource to the team on the ground dealing with this day-to-day as we are a small team, and this is a big investigation. I have found it tough, but so have my colleagues found it tough."*

16.80 We asked how visible to paediatric orthopaedics the executive management team has been in this time. Consultant C said:

> *"Once, when I first started seeing the patients who had come to harm there was one family who were so furious, so angry, so upset, and David Wherrett had come to clinic but the family wouldn't let him in and I was so cross because it would have been really good for him just to see the level of grief in these families and when they are asking me 'why wasn't this raised earlier? Why haven't you done something sooner? How did your team allow this to go on so long?'.*

Seeing patient after patient after patient asking these questions, it's hard and it would have been nice for him to see the reality of having a crying mother in front of him, but the family wouldn't let him in, so he is the only one who tried."

16.81 Consultant C said that the Chief Medical Officer is an exception to this rule:

"I don't often give people credit, but [Dr Broster] will come, she hasn't been for a little while, but maybe once every month, once every six weeks, she will come to our Wednesday meeting just to give a little update to the team as well because it's nice. I give a little update, but it's nice for someone a bit more senior to come along and just give an update, but no-one else does."

16.82 They said:

"The situation this service is in is extraordinary. For Roland Sinker to have maybe pencilled in a half hour meeting with me at some point over the last year and a half would have maybe been nice."

16.83 They hope, in the exceptional circumstances for the service they manage, to see more from the leadership of the Trust:

"I do think that the Executive Management team, it would be nice for me to know that at least one of them has any interest whatsoever, as in will come and speak to me, or actually, even better, we have a meeting once a week, come along and just speak to the team."

16.84 They thought that an executive visiting the MDT meeting should:

"Just come for half an hour and make them see a bit of what we do, listen to us for 15 minutes and then talk to us for 15 minutes. I know they're busy, I know they have an awful lot on, but I think this is probably one of the hospital's priorities at the moment, so surely, they could give a little bit of time."

16.85 They told us:

"NHS England visited us about eight weeks ago, and I brought this up then, and since then there's been a little more action. It took a year and a half of really quite struggling, but there have been some changes since then. So, give credit where it's due, they did listen. So that NHS England visit helped, so that's good I suppose. But yes, it would have been nicer if they had maybe thought about the team a bit earlier."

Comment

The events in paediatric orthopaedics in 2024, and the current handling of them by the Trust are a significant challenge for the leadership of the organisation. A perception has developed in paediatric orthopaedics that staff in the service have been left to handle the aftermath of those events without adequate, visible support from executive management.

While some executives received positive feedback about their visibility in the service, others were seen to be remote, if not invisible to the paediatric orthopaedics team.

Missed opportunities

MO31 Failure to address and mitigate the effects of Ms Stohr's continuing absence from MDT meetings from May 2023 led to reduced oversight of her clinical work at a time when she was becoming increasingly distressed, isolated from colleagues and possibly unwell.

MO32 The Trust missed the opportunity to tell the Nuffield RO about their concerns about Ms Stohr in early 2025.

Recommendation

R22 The Trust should establish a structured process for supporting clinicians whose participation in MDT meetings is affected by health or interpersonal difficulties. The aim should be to ensure that safe, collaborative clinical practice is maintained. This process should comprise early discussion of reasons for withdrawal; assessment of any risk to

clinician or patients; mitigation of such risk; alternative mechanisms for peer review and monitoring of safe practice.

R23 The CMO's team should ensure that the Trust has the necessary procedures in place to meet the expectations of the IHPN Medical Practitioners Assurance Framework.

17. The current review of governance in the Trust

17.1 We have noted that the Trust is still on a long-term journey to ensure its governance framework, policies, processes, and practices are fit for purpose. In this section we set out the actions the Trust is currently taking to review and improve its approach to clinical governance, quality and safety. Dr Broster described the current review as:

> *"An over-arching piece around what does the governance look like now and does it meet the needs of the hospital today in light of the current requirements of us nationally, but also in terms of meeting our patients' needs?"*

17.2 As part of that review, we learned that specific attention would be focused on governance at specialty and department levels. Dr Broster reflected that the early learning from the events that precipitated this investigation had revealed to her that the Trust knew a lot about Ms Stohr's practice before the events of 2024. She said:

> *"Quite a lot of that information was available to us, so it is not all new information that has suddenly come to light at the end of October/November 2024. Although the reviews of the cases have provided new clinical detail, quite a lot of the information around team-working, MDTs and behaviours was known to us but sat in different and disparate areas so was difficult to triangulate and bring together."*

17.3 She added, in the context of the governance review:

> *"I am asking - is what we think is happening, actually happening?"*

17.4 Dr Broster told us that the governance review would also consider organisational structures and roles and responsibilities across the Trust in respect of quality and safety. The structure and role of the CMO's office in governance would be reviewed. The relationships between her office and the workforce directorate would also be examined, given that there is significant overlap between the two functions in governance and in the maintenance of high professional standards for doctors.

17.5 Dr Broster believes that senior management cannot yet have confidence that issues and concerns around quality and patient safety are consistently raised and addressed across the Trust. We asked how well the channels for raising such concerns are used. She said:

"I don't think it's consistent. I think it happens really well in some areas. I think it is probably less consistent in others, and I think that's what we'll probably find. The one area where we may or may not want to strengthen might be that 'horizontal' flow across specialties and divisions."

17.6 She explained that the current review will consider this key question:

"What does the structure need to look like so that we work really well and effectively together across the divisions from divisional directors to specialty leads and the CMO's office?"

17.7 In anticipation of this work Dr Broster has already taken steps to improve some of these relationships:

"Previously we weren't meeting with the speciality leads, I have put in an alternate month regular meeting with this group in addition to the regular consultant forums."

17.8 Dr Broster intends that the review will help the Trust understand better how the activity and outcomes in small specialties and teams might be better assessed.

"There is quite a lot to do here and, talking about this with colleagues who are CMOs in other similar size Trusts, we are all grappling with exactly the same issues. It's the smaller teams or single-handed teams and/or the high complexity/low volume procedures, that I think is the area that most of us have concerns about because the data isn't there to provide the assurance that we would want to see"

17.9 Dr Broster will examine how the Trust can provide better peer support for clinicians in smaller services, including from outside CUH. She said:

"One of the ambitions is to have a more standardised approach as to how we manage/support teams/individuals; from support that is provided locally up to cases that might benefit from more central oversight."

17.10 We discussed with Dr Broster and Ms Szeremeta, Chief Nurse, the risks associated with small specialties such as paediatric orthopaedics when it transferred to Division E in 2014. They told us that they are currently carrying out a piece of work to identify how many small specialties are operating in the Trust. They are investigating two issues:

- Specialties with fewer than three consultants
- Small specialities where an individual consultant carries out low volume but high-risk surgery

17.11 Dr Broster said:

"Where the small teams are within the hospital is relatively more straightforward for us to work out, we would define that locally as where there are maybe only one, two or three people working in that service. To map that is relatively straightforward. I think the area that is perhaps harder, and they both need to be fully understood, is the high complexity/low volume procedures that we are doing here, and how many people are doing those and in which particular areas. We are actively looking at all of this."

17.12 We asked how many small specialties she estimated the Trust to have:

"In terms of very small teams where there is only one or two people working, less than 20 in total across the hospital and possibly less than that.

17.13 She told us that there were more teams across the hospital managing a high complexity/low volume patient cohort, saying this number:

"Will be considerably higher because, as a specialist hospital, taking referrals from right around, not just the region, but around the country, I think that is going to be a much more difficult area to unpick."

17.14 The degree of freedom or autonomy that MDTs might have in the broader governance framework is an issue to be examined:

"It's how do we start to build our own expectations for what good looks like. We might say for example, 'if you're in segment 1, (high performing) we're not worried

about you, you have relative autonomy, but as a hospital we want to see this data and information on a regular to be determined basis. If you're in segment 2 (more challenged) you have this level of oversight/support, and you're expected to work/submit data in a more specific way'."

17.15 She added:

"I think there is also something around what are the agreed principles of how you need to operate to work here as a clinician, and I use that word advisedly because it is right across the clinical workforce, and then beyond that, and depending on the risk to the service and how it's functioning, there will be different expectations. We need to be much clearer on that for people."

17.16 The effectiveness of MDTs is also a matter for the review to consider. Dr Broster recognises the increased number of MDTs in the Trust and the fact that, with the exception of cancer MDTs, there is no national guidance that sets out how they should be run. She also believes benefit can be derived in future from collaborative working with other organisations:

"Some of those MDTs may be very effective delivered locally, but some of them you might find would be better set up at a regional level. The neurosurgeons for example are looking at some pan-regional MDTs. Thinking about future models some of the MDTs may be with other centres, which is what already happens in some of the cancer fields, for example, which quite often involve a number of centres coming together. I think we need to start being more proactive in that beyond cancer."

17.17 The role of leadership in governance across the Trust will be examined, and the review will seek to identify:

"What is the skillset that we need and what does that mean for divisional directors, clinical directors, specialty leads? What skillsets do we want clinical leaders to have and how do we make sure that they have the right training, experience and skills to do that?"

17.18 Ms Szeremeta told us that the governance review will be managed in a six-month programme and will be supported by colleagues from NHS England. The diagnostic phase, of around four months, will be followed by two months writing the review report, producing recommendations and developing an action plan to implement the changes required.

17.19 She told us that the review has Trust board and executive management's endorsement and that she and Dr Broster, as joint senior responsible officers, meet with the review team on a weekly basis to ensure the programme is effectively managed.

Comment

CUH is a large and complex teaching hospital. The current quality and safety structures reflect this. The Trust has recovered from a highly critical CQC report a decade ago and has restored some confidence within the Trust about its ability to keep patients safe and to provide high quality care.

There is much good intention in the plans and guidance we have read and been told about. However, the challenge for the Trust is to get all disciplines at all levels focused on safe care and all that comes with it. Process is no substitute for action and improvement.

In the paediatric orthopaedic service, a great deal was knowable about the potential risks that the service was facing – everything from the poor relationships between the two consultants to the lack of a functioning local MDT. Staff spoke openly about these issues to us and told us that such issues had been clear for a long time.

The Trust did not have a close focus on the paediatric orthopaedic service and lacked the means to build a picture of its overall effectiveness, to identify the risks to patients in the service and to take action to prevent harm.

CUH requires a significant cultural change if the Trust is to reorient itself around the principles of a patient-safe future. The Trust may benefit from using the Patient Safety Learning framework, A Blueprint for Action, as a structured means of assessing progress.

We see evidence that the Trust has already taken early learning from the issues stemming from the events in this investigation, and from the reviews conducted by Mr Hill and Mr Hunter into Ms Stohr's clinical practice. This learning has given significant impetus to the current review of governance.

Several key issues being considered in the governance review have been evident in paediatric orthopaedics for more than a decade. The leaders of the governance review are acutely conscious of the impetus that the events in paediatric orthopaedics have generated to develop better systems and processes for clinical governance across the Trust.

We believe that Dr Broster and Ms Szeremeta share a sound grasp of the organisational, structural, attitudinal and process improvements that need to be made to improve governance across the Trust. They also recognise the need to address the role of leadership in developing the culture needed to ensure new systems and processes deliver better governance.

The Trust will need to develop a climate in which concerns are surfaced and addressed in a non-punitive way if staff at all levels are supported in learning from poor practice.

The review that is underway will present an opportunity for the Trust to learn the lessons from the events of 2016 and 2024 and to develop governance that is fit for purpose, and that consistently ensures the delivery of high quality and safe care for patients.

We welcome both the broad sweep of the governance review and the inclusion of a range of specific issues that are directly linked to the findings of this investigation.

Challenge of the review

17.20 We asked Dr Broster and Ms Szeremeta what they hoped the governance review would achieve. Ms Szeremeta said:

> *"What we want to test with this governance review, because there is a lot of meetings, but we do want to test 'the ward to Board', is that truly working, and is*

it up and down? That is what we're really trying to test with this governance review."

17.21 Dr Broster added that the legacy of how the Hill report had been handled was significant for the prospects of achieving improvements via the review. She said it:

"Has had some significant ramifications for the Trust and confidence in the MD's office and Executive team from the wider consultant body, not just the consultant body but more widely."

17.22 She told us that the reaction from people now that they are more aware of those issues is to question the ability of Trust leadership to deliver change. She said:

"What has been played back to me is, 'You're saying you are taking it seriously now but how can we trust you that you really are, because this report came in in 2016?'. I have had this played back from both the adult team and the Paeds orthopaedic teams: 'This was known in 2016 and there was a report which identified potential areas that were important to be aware of. How can we trust that you are really going to respond properly this time to any concerns?' It is the transparency issue, I think."

17.23 She added:

"The ripples from this are right across the hospital, as you will know and, if people don't have Trust, they won't want to raise other things that are important that we need to be aware of."

17.24 Finally, Dr Broster expressed concern about one of the inferences she has drawn from the handling of the concerns around Ms Stohr's practice:

"What we have is different groups of people often wanting someone else to be responsible for managing an individual or team in difficulty rather than resolving this themselves and that is really unhelpful for the individual who is in the midst of it, or the team in the midst of it."

Comment

The review gives the Trust a chance to make governance significantly better in future. A key challenge will be to ensure that the culture and behaviour of people in the system changes so that any new systems and processes work effectively to maintain quality and safety for patients.

We consider that there is growing recognition across the Trust that installing the best structures and processes will not guarantee that issues will be raised and addressed if the culture of the organisation gets in the way.

Part three

18. Summary of missed opportunities to identify and avoid harm to paediatric orthopaedic patients

MO1 Ms Stohr's induction to the Trust failed to equip her adequately for her first consultant appointment. The lack of clarity about her clinical governance and line management structure, combined with inadequate resource provision put her immediately under workload pressure without sufficient support.

MO2 Although their colleagues and managers alike knew that relationships between Ms Stohr and Consultant A were strained there was no determined attempt to resolve them to prevent any impact on patient safety.

MO3 Divisional management could have anticipated that a poor relationship might have led to a lack of collaboration between the only two consultants in the service and failed to recognise the signs that the relationship was at risk of worsening after Consultant A raised concerns about Ms Stohr's practice.

MO4 Convening an internal, facilitated discussion at the point of Consultant A's complaints may have given the two surgeons the chance to work together sooner to support one another more constructively.

MO5 Because this did not happen, Ms Stohr went on practising unaware of any concerns about her practice until May 2016. There was a clear risk that any poor practice from December 2015 until then would persist.

MO6 Ms Stohr and Consultant A were not consulted about the choice of the external reviewer, had no say in the terms of reference for the review and were not interviewed or involved in the evidence-gathering phase of the review. This may have been a missed opportunity for the Trust to have involved them both more extensively in the process.

MO7 Mr Hill was not asked to explore the relationship difficulties between Ms Stohr and Consultant A that he had been briefed about by Deputy Medical Director A. There was no opportunity for Mr Hill to objectively assess the impact that poor relationships had on the clinical outcomes of the paediatric orthopaedics department.

MO8 Deputy Medical Director A's presentation of the Hill report's conclusions to Ms Stohr and to the Director of Division E meant that a major opportunity was missed to address the shortcomings in her surgical practice identified in the report.

MO9 The lack of any detailed conversation between Deputy Medical Director A and Mr Hill after the report was completed meant that Deputy Medical Director A was unable to test his understanding of the report and its conclusions with the reviewer.

MO10 Similarly, this prevented Deputy Medical Director A from rehearsing with Mr Hill how he planned to summarise and position the report with Ms Stohr and the divisional management.

MO11 The limited circulation of the Hill report within the Trust was an opportunity missed for the Medical Director's office, divisional management and Ms Stohr to work together to plan for implementation of its findings.

MO12 The incorrect reassurance given to Ms Stohr and the management of Division E meant that she, and her managers and colleagues, assumed that she was fit to practise with no restrictions on what work she could do in future.

MO13 There was a lack of open and candid sharing of the report with clinicians and managers in paediatric orthopaedics who could have supported Ms Stohr to improve her practice.

MO14 The organisational failure to understand the findings of the report meant that there was insufficient recognition of the need to help Ms Stohr achieve an acceptable standard of clinical practice.

MO15 As a result, the opportunity was lost to develop and implement an improvement plan for Ms Stohr to address the practice shortcomings that had been identified.

MO16 Divisional management, in consultation with the Medical Director's office, could have agreed what such a plan would comprise, and how its implementation would be monitored.

MO17 Divisional management could have assigned responsibility to one person to ensure that any action plan was delivered. This person could have been the conduit for Ms Stohr to access help and support from the Trust to return to an acceptable standard of performance.

MO18 There was no discussion between Ms Stohr and Mr Hill about the specific comments he made on her practice, the need for technical improvements and how to achieve them. Mr Hill could have been drafted in by the Trust to help Ms Stohr improve her technique.

MO19 The organisational failure to understand that action was needed to improve Ms Stohr's practice meant that no plans were made to help her improve her practice.

MO20 Had the division, the Medical Director's office, the workforce directorate and Ms Stohr met to develop such a plan, it would have created the impetus for her to improve. No-one was given responsibility to coordinate the development and implementation of a personal improvement plan for Ms Stohr.

MO21 To the best of our knowledge, the cases reviewed by Mr Hill were not recorded in Trust governance data streams as incidents, nor were they identified on a risk register.

MO22 Had the Trust considered, at that time, the need to exercise duty of candour to the families, this obligation would have required greater emphasis on the harm caused, if any, to Ms Stohr's patients up to 2016.

MO23 There was no opportunity created for the Medical Director's office and the division to co-manage any actions aimed at improving Ms Stohr's practice. No opportunity was taken to consider what financial, practical or personal support she might need to achieve the improvements.

MO24 There appeared to be no opportunity to support Ms Stohr in her personal attempts to work with colleagues at the Norfolk and Norwich, nor in her efforts to identify how she might augment her skills in pelvic osteotomy.

MO25 Either divisional management or the Medical Director's office could have arranged a follow-up review of her practice after, say, six months of the Hill review to check on progress. Had this been done, there would have been an earlier opportunity to report back to the Trust on whether Ms Stohr's practice had improved, or not.

MO26 Had there been greater clarity about Ms Stohr's line management and clinical supervision (including 360° feedback about her performance) the Trust would have been able to see more quickly when her practice was becoming potentially unsafe.

MO27 The lack of connection between Ms Stohr's appraisal process and day-to-day management meant that issues of concern about her practice were left to her to bring up in her annual appraisals, meaning that action to address them might be delayed or not taken.

MO28 The information available from Ms Stohr's OH referrals was not shared with her line management and gave them no opportunity to address the factors affecting her health and wellbeing.

MO29 Numerous opportunities were missed to consider whether Ms Stohr's workload was sustainable, and to assess whether the workload presented a risk to the quality and safety of her practice.

MO30 There was an opportunity missed by Consultant A to flag up any further concerns they had about Ms Stohr's practice in the period between 2016 and 2024.

MO31 Failure to address and mitigate the effects of Ms Stohr's continuing absence from MDT meetings from May 2023 led to reduced oversight of her clinical work at a time when she was becoming increasingly distressed, isolated from colleagues and possibly unwell.

MO32 The Trust missed the opportunity to tell the Nuffield RO about their concerns about Ms Stohr in early 2025.

19. Overall findings and conclusions

19.1 This independent investigation highlights a series of missed opportunities, both major and minor, in how CUH and its leadership addressed concerns about the clinical practice of Ms Stohr, a consultant paediatric orthopaedic surgeon. If these opportunities had been recognised at the time, appropriate actions could have been taken. Those actions would have likely reduced harm to paediatric orthopaedic patients.

19.2 The pivotal missed opportunity was for the Trust to have correctly interpreted the findings, conclusions and recommendations set out in an external report written by Mr Hill, senior consultant paediatric orthopaedic surgeon in 2016. The external report had been commissioned after Consultant A, Ms Stohr's senior colleague, had raised concerns about the quality of her surgical practice.

19.3 Mr Hill's report identified a series of shortcomings in Ms Stohr's surgery and proposed steps to address them, which the Trust failed to understand and act upon. The Hill report was not adequately interpreted and discussed with the author, clinical peers, and other senior colleagues in the Trust. This led to the findings and outcome being miscommunicated both to Ms Stohr, her colleague Consultant A, and the wider staff group in paediatric orthopaedics.

19.4 The two surgeons were led to believe that the principal problem was their poor relationship. It is to the credit of Ms Stohr that she understood the findings of the Hill report and made her own efforts to improve her clinical practice. She did this without the help and support of the Trust.

19.5 Consultant A stopped raising concerns from then on because they believed Mr Hill had exonerated Ms Stohr and had characterised the difficulties as being about their relationship, rather than about her surgery. Consultant A was also concerned that they would face serious sanctions from the Trust if they sought to re-open concerns about Ms Stohr's practice.

19.6 The combination of these factors meant that any deficiencies in Ms Stohr's practice persisted for the next seven/eight years during which, coincidentally, her patient population grew and presented with ever more complex conditions.

19.7 We believe that the paediatric orthopaedic MDT meetings, before Consultant C's time, were not sufficiently well structured to allow the identification of concerns about a surgeon's clinical practice relying, as it did for long periods, on surgeons selecting their own cases for discussion at the meetings. Furthermore, the governance and management systems in place in the years after the Hill report were not able to detect Ms Stohr's continuing clinical practice difficulties. This is of serious concern.

19.8 Management and oversight of the consultant population in paediatric orthopaedics was largely non-existent for many years and therefore, until there were serious failings, it was close to impossible for the Trust to identify deficiencies in the quality of care provided. Moreover, there were weak systems and processes for 'joining the dots' between the data and the 'soft signals' which might indicate that a clinician is under strain or might be at risk of clinical failure.

19.9 That Ms Stohr's clinical difficulties went unaddressed for so long highlights a significant gap in the Trust's capacity to identify and address concerns about doctors' practice before things go wrong.

20. Summary of recommendations

R1 The Trust should consider implementing a more organised approach to the initial job and role planning process for new consultants. This should include clear identification of the consultant's line management arrangements, and the responsibility for their clinical supervision.

R2 The workplace induction process for new consultants should be reviewed to ensure that appropriate mentoring and/or buddying arrangements are in place to enable consultants joining the Trust to have a resource to assist them to integrate quickly to their role and their division.

R3 Line managers should intervene with clinicians more promptly to address and resolve relationship problems where they might adversely affect patient safety (especially in small specialties). Line managers should consider whether informal approaches to resolve any problems, such as encouraging colleagues to talk through issues are needed. Support may also be considered for more explicit conflict resolution or mediation if problems persist.

R4 The Chief Medical Officer's team should develop written guidance on the commissioning of external reviews to ensure they are properly specified, that their findings and recommendations are actioned, and that appropriate monitoring arrangements are established to track progress with any improvement plans. This guidance should be developed in collaboration with line management. The agreed guidance should be set out in a standard operating procedure (SOP).

R5 To ensure that reliable records are available in any further investigation or review, we recommend that the Trust should maintain more comprehensive written records or file notes of meetings and important conversations with people involved in patient safety issues and their investigation.

R6 In evaluating reports produced by external reviewers we recommend that the commissioner, or the manager responsible for interpreting the report, should always speak with the reviewer to test understanding of the findings and any recommendations flowing from the report.

R7 Outcomes, findings and recommendations from an external review should be shared with a senior clinician in the specialty for the purpose of understanding the findings, conclusions, and recommendations.

R8 The Chief Medical Officer (CMO) should develop a protocol for ensuring that the handover from their office of an external report for action is managed in concert with the specialty or divisional manager.

R9 We recommend that a named individual should be held responsible for ensuring that actions are taken consequent upon a review. That individual should be responsible for ensuring any improvement plan for a clinician whose practice has been reviewed is properly resourced and enabled by the Trust.

R10 The Chief Medical Officer's office and the named individual should agree what monitoring and reporting mechanisms are needed to track progress, and to ensure key steps and outcomes are accurately recorded.

R11 We recommend the CMO's office, and the named individual should sign off and record the closure of any actions arising from the review.

R12 The CMO's team should ensure that the findings and conclusions of any external review are shared with the management team involved and that an appropriate plan is developed and implemented that sets out the actions to be taken and by whom.

R13 The CMO's team should satisfy itself in the commissioning and delivery of an external review that any information and/ or findings are recorded in the appropriate Trust data streams and risk registers. Any completed review should be assessed by the CMO's team to identify any need to exercise the Trust's duty of candour.

R14 We recommend that the Chief Medical Officer and the Chief People Officer should produce guidance that clearly sets out the respective roles of appraisers and line managers in the management of consultants. This guidance should also clarify who is responsible for clinical supervision of consultants and how that supervision should operate.

R15 To improve the confidence that the Trust has in the competence of its surgeons we recommend that the Chief Medical Officer should consider developing appropriate mechanisms to ensure surgical practice is routinely observed by qualified colleagues.

R16 The Trust should consider whether to develop a more formal mechanism to share outputs from appraisals with line management. Any concerns about a clinician's practice, or factors that might affect it, need to be routed, with the clinician's agreement, into the management of the Trust so that they can be considered and acted upon.

R17 While the personal and medical content of Occupational Health referrals and reports are private to the individual, the Trust should assure itself that appropriate arrangements are in place for line management to understand whether any reasonable adjustments need to be made to support the individual to maintain good health and performance.

R18 Line managers should be encouraged to be proactive in identifying and correcting excessive workload for their team members. Managers should be alert to the possible effect that staff carrying excessive workloads may have on patient safety and quality of care.

R19 We recommend that the Trust should develop a more consistent approach to the establishment and management of MDTs. The aim should be to standardise, where appropriate, those common elements that apply to MDTs across the Trust. Such an approach could be set out in a Standard Operating Procedure (SOP).

R20 The Trust should consider an audit of all existing MDTs to consider their effectiveness in enabling the consistent delivery of safe care. Such an audit should consider; clarity of the MDT's aims; team working; use of data and information for decision-making, and regularity/inclusiveness of meetings.

R21 The CMO and the Chief People Officer should establish an implementation working group to ensure that changes to clinical governance structures, processes and practice are embedded effectively across the Trust. The group should include corporate management, and staff from a 'deep slice' of the organisation to ensure representation from all the key groups responsible for patient safety.

R22 The Trust should establish a structured process for supporting clinicians whose participation in MDT meetings is affected by health or interpersonal difficulties. The aim

should be to ensure that safe, collaborative clinical practice is maintained. This process should comprise early discussion of reasons for withdrawal; assessment of any risk to clinician or patients; mitigation of such risk; alternative mechanisms for peer review and monitoring of safe practice.

R23 The CMO's team should ensure that the Trust has the necessary procedures in place to meet the expectations of the IHPN Medical Practitioners Assurance Framework.

Appendices

Appendix A

Team biographies

Ed Marsden

Ed Marsden has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's founder with an active role in leading complex consultancy. He worked with Kate Lampard to provide independent oversight of the 40 or so investigations carried out by the NHS into allegations about Jimmy Savile. He and Kate wrote a 'lessons learnt' report for the Secretary of State for Health arising from the publication of the Savile investigations.

Ed was appointed by the global board of G4S PLC to investigate the concerns raised by BBC Panorama in their programme about Brook House immigration removal centre at Gatwick airport. The report was published in December 2018. Ed has advised the Jersey government about the inquiry into historical child abuse. He is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

David Scott

David is an experienced human resources director, having worked at board/executive level for more than 30 years, including senior positions at British Telecommunications plc, HM Prison Service and United Utilities plc. He has been interim HR director of First Group, the Strategic Rail Authority and was interim Director of Workforce and Strategic HR at Kent and Medway Strategic Health Authority.

David has wide-ranging experience in workplace investigations, organisation development, industrial relations and training and development. He is a fellow of the CIPD, a certificated practitioner on psychometric testing and an experienced leader. He is a trained MHPS Case Investigator and designed and delivers our CPD-accredited training courses for Case Managers in MHPS investigations, and for Workplace Investigations. David has managed our

most recent assignments including organisational culture reviews, HR governance, disciplinary and whistleblowing investigations.

Nicola Salmon

Nicola is a senior consultant having worked at Verita for eight years. Nicola has conducted patient care reviews for acute and mental health NHS trusts. More recently, Nicola has specialised in the investigation of human resources and governance issues for clients such as UKHSA (formerly Public Health England), NHS England, Barts Health NHS Trust and The Open University. Nicola has also been part of investigation teams reviewing governance concerns including conflicts of interest between officers and whistleblowing complaints. She has also carried out complaint audits for the GMC and the CAA. She has worked with Ed Marsden and Kate Lampard on a review of an immigration removal centre for G4S. She has a first-class degree in history from the University of Essex. Nicola is a qualified 'Professional Safety Investigator' having received a Level 3 award in 2022.

Peter Killwick

After graduating from Cambridge University, Peter Killwick worked in the IT industry for three years before spending the next two years travelling in Asia, Oceania, North America and Africa. For the subsequent 25 years, Peter has worked in consulting covering a variety of strategic and operational issues in a wide range of sectors including healthcare, automotive, financial services, manufacturing, retail, telecommunications and government. At Verita, Peter has a particular focus on the development and evolution of our diagnostic tools including the Organisational Resilience Assessment and Complaints diagnostic. Peter has extensive experience of conducting complex investigations within the NHS, both at operational and commissioner level, including several cases involving allegations raised by whistle-blowers.

Lucy Scott-Moncrieff CBE

Lucy Scott-Moncrieff CBE is a mental health and human rights solicitor, a Mental Health Tribunal and Court of Protection judge and a long-standing Verita associate. She is Chair of

the Administrative Justice Council's working group on addressing disadvantage in the administrative justice system. Her previous roles include President of the Law Society of England and Wales, Commissioner for Standards at the House of Lords, commissioner at the Mental Health Act Commission, member of the QC Appointments Panel, and commissioner on the Judicial Appointments Commission. Lucy led the International Bar Association's work to develop good practice guidance for legal aid systems across the world.

Lucy has carried out a number of complex and high profile reviews with Verita including a report into the death of a patient during routine day surgery for the States of Jersey, an investigation into paediatric cardiac surgery in Leeds, and a governance review commissioned by Cambridge University Hospitals NHS Foundation Trust following the conviction of Myles Bradbury. Lucy worked with Verita to produce work for the Secretary of State for Education: a quality assurance review into allegations about Jimmy Savile and a report on current risks of sexual abuse and exploitation in schools and children's homes.

More recent work Lucy has completed for Verita includes an investigation, published by NHS Improvement, at the request of the Secretary of State for Health into the handling of whistleblowing allegations at a hospital trust in the West Midlands.

Terms of reference

NHS
Cambridge
University Hospitals
NHS Foundation Trust

An independent investigation into potential missed opportunities for identification and avoidance of possible harm to paediatric orthopaedic patients at Cambridge University Hospitals NHS Foundation Trust

1. Background and introduction

1.1 Ms Kuldeep Stohr (KS) has been employed as a paediatric orthopaedic surgeon at Cambridge University Hospitals (CUH) since 2012 and is currently suspended.

1.2 In March 2024, KS took a period of absence and her work was picked up by colleagues. These colleagues subsequently raised concerns with the Medical Director's office regarding the outcomes of the paediatric surgery and some of the decision making by KS.

1.3 To investigate further, the Medical Director's office engaged an external surgeon from Nottingham University Hospitals NHS Trust, Mr James Hunter, in October 2024 who evaluated a number of paediatric elective cases from all surgeons in the team and concluded that there was an issue with KS's practice. The external expert's interim report was received on 16 December 2024, with further reports received on 14 January 2025 and 17 February 2025.

1.4 The reports concluded that a number of KS's patients who had complex surgery for dysplastic hips over a two-year period had experienced significant harm. The reports found evidence of poor operative technique and issues with KS's decision making.

1.5 KS has not undertaken any clinical practice at CUH since March 2024.

1.6 As a result of Mr Hunter's findings, the Trust has contacted all patients and families where harm has been identified to arrange follow-up appointments and to exercise Duty of Candour. A further external clinical review has been commissioned of KS's clinical practice during their employment with CUH and the quality of care received by patients. This will be chaired by Andrew Kennedy KC.

1.7 The Trust's Director of Strategy and Major Projects has commissioned Verita, a specialist investigations company, to carry out an independent investigation into what was known when about the practice of KS and whether there were opportunities to have identified these issues sooner.

2. Terms of reference

2.1 Verita will report on any gaps in systems, processes and governance arrangements in the paediatric orthopaedics department and the wider Trust and make appropriate recommendations for learning and improvement.

2.2 Verita will not examine the clinical care and treatment of individual patients of KS which is the subject of the separate external retrospective clinical review. Verita will liaise as necessary with those conducting the external clinical review.

2.3 For clarity, information from this investigation may lead to further inquiries or action being undertaken.

2.4 The investigation will comprise two parts. This phasing will allow Verita to highlight any concerns that require immediate corrective action by the Trust to maintain patient safety, without waiting for the full investigation to be completed.

Part 1: 2015-2016

2.5 Verita will:

- Investigate the appropriateness, proportionality and effectiveness of the actions taken by the Trust in response to concerns raised in 2015 regarding KS's practice. This will include the commissioning of an external clinical review in 2016 and the Trust's response to the findings and recommendations of that review.

Part 2: 2012-2024

2.6 Verita will:

- Assess the effectiveness of the management and governance arrangements (including policies, procedures and processes) within the paediatric orthopaedic department governing the clinical activities of KS, and report on the extent to which they were complied with.
- Identify any gaps in these arrangements which may have prevented identification and/or addressing of concerns about KS's practice.
- Assess the effectiveness of the management and governance arrangements (including policies, procedures and processes) at a divisional and Trust-wide level relating to oversight and assurance on the clinical activities of KS and the paediatric orthopaedic department more widely, and report on the extent to which they were complied with.
- Identify any gaps in these arrangements which may have prevented identification and/or addressing of concerns about KS's practice.
- Identify any concerns raised by Trust colleagues about KS (in addition to the specific concerns covered in Part 1 of the investigation),

including concerns raised in 2024, and comment on the appropriateness of any action taken in response to such concerns.
- Identify any 'hard data', such as complaints and patient safety incidents, or 'soft signals' relating to KS and comment on the appropriateness of any action taken in response to these.

2.7 If, through its conduct of this investigation, Verita identifies any broader issues or concerns about the Trust's policies, processes and practices which might require separate investigation or review, it will draw these to the attention of the commissioner.

3. Methodology and engagement with participants

3.1 Verita will conduct the investigation in the spirit of the Trust's just and learning culture. The team will ensure that all participants have the opportunity to contribute to the learning from the investigation. Verita will, at all times, follow best practice in the conduct of the investigation.

3.2 The investigation has no explicit performance management or disciplinary remit. However, if Verita identifies evidence of specific shortcomings in the handling of any of the matters under investigation, the investigation team will flag them to the commissioner to consider any further action.

3.3 Verita will gather and evaluate all relevant documentation and written evidence held by the Trust concerning the clinical activities of KS and all relevant governance arrangements.

3.4 Verita will also gather and evaluate testimonial evidence from a range of Trust staff and others as required. All potential interviewees will be notified in writing and invited to speak to the investigation team. Participants will be given written guidance on what to expect in the process and all interviewees will be offered the opportunity to be accompanied to interview by a union representative or work colleague. Verita will make any necessary adjustments to the interview process to allow staff to participate fully.

3.5 Interviews may be held remotely or face-to-face. With the permission of the interviewee, interviews will be recorded. Interviewees will be offered the opportunity to see and correct a transcript of their evidence.

3.6 The investigation will be conducted in private. Participants will be required to maintain confidentiality about the investigation and any evidence they give. Interviewees must not divulge any information about the investigation to anyone apart from their companion (if this option is exercised), who must similarly maintain this confidentiality.

3.7 The Trust will provide an initial list of interviewees. Verita will be free to interview any other people, inside or outside the Trust, who may have relevant evidence to contribute to the terms of reference. Any additional interviews will be conducted at the sole discretion of the investigation team.

4. Outputs of the investigation

4.1 Verita will provide a written report incorporating both parts of the investigation to the Trust. The report will contain clear recommendations aimed at learning any lessons from these events.

4.2 An initial draft will be provided to the commissioner to allow for fact checking before it is finalised.

4.3 If any individual may be criticised in the report they will have the opportunity to see and comment on the potential criticism before the report is finalised.

4.4 After fact checking is complete, Verita will provide the final report as a full, frank and detailed written account to the Trust's Board of Directors. The final report will be published at the Trust's discretion.

5. Timescales

5.1 Verita has begun preparations for the investigation and the team expects to conclude its work by the end of July 2025.

5.2 The investigation will be conducted in a timely manner, subject to the availability of witnesses and evidence. Verita will report any undue delays to the commissioner.

Appendix C

List of interviewees

External reviewers

- Mr Robert Hill, Chief Medical Advisor for International Business, Portland Hospital, London. Formerly Consultant Orthopaedic Surgeon, Great Ormond Street Hospital and Medical Director, Portland Hospital.

- Mr James Hunter, Paediatric Trauma and Orthopaedic Surgeon, the Queen's Medical Centre, Nottingham

Current CUH staff

- Dr Sue Broster – Chief Medical Officer
- Dr Ashley Shaw – former Medical Director
- Roland Sinker – Chief Executive Officer
- Ms Kuldeep Stohr – Paediatric Orthopaedic Surgeon
- Ms Lorraine Szeremeta – Chief Nurse
- David Wherrett – Chief People Officer

Others

In the course of the investigation, we also interviewed 31 current and former managers, clinicians and other staff.

Guidance for interviewees

Confidential

An independent investigation into potential missed opportunities for identification and avoidance of possible harm to paediatric orthopaedic patients at Cambridge University Hospitals NHS Foundation Trust

Guidance for interviewees

Thank you for agreeing to take part in this investigation. We look forward to speaking to you. Your interview will be conducted by two members of the Verita team.

I am writing to give you some information about the process we will follow for this phase of the work and to explain how we will conduct our interview with you.

Our role is to discover the facts about the matters set out in the terms of reference and to report our findings to the Trust. We aim to find and evaluate all the evidence that is available to us. This may be documentary evidence or testimonial evidence from you and from any other people we speak to in the course of this work.

We have shared with you the agreed terms of reference for the investigation. We would be happy to talk you through them when we meet if you have any questions about the scope of the investigation.

Our aim is to conduct this investigation, and your interview, in the spirit of the Trust's just and learning culture. We value the opportunity to speak to you personally and will do everything we can to help you to participate fully in the process. If you have a disability or you need us to make any adjustments to enable your participation, please let me know and we will manage any changes to meet your needs.

You may, if you wish, bring a companion to this meeting for support, but we expect you to speak for yourself during the interview. Your companion should be a work colleague or a union representative.

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Place of registration: England • Registered number: 10504456

VERITA

When we meet, we will ask you to confirm that you will keep confidential anything that we discuss. We will also ask you not to share any written statements or documents that you may give us, or that might be disclosed to you during the interview. You must not divulge your participation or the matters we discuss with anyone apart from your companion, who must also maintain this confidentiality.

With your permission we will audio record the interview to ensure that we, and you, have a record of what we discuss. We will send you a full transcript of the recording and you will have the opportunity to correct or amend anything in that record. It is in your interest to have a comprehensive and accurate account of what we discuss with you. We will, once any changes have been made, ask you to sign the agreed record. We will keep the record of your interview confidential and will not share it with anyone outside the Verita team unless we are legally obliged to disclose it.

We will securely retain all the evidence collected for as long as necessary after the investigation is completed. We will ask you, when we meet, to give us your permission to retain your personal information on file accordingly.

On completion of the investigation, we will provide a written report to the commissioner that will set out our findings on the matters covered by the terms of reference. In our report we will, if necessary, quote from the evidence you and others share with us.

You should be aware that the Trust may publish the final report, given the level of public interest in the matters under investigation here, and in other reviews underway.

I realise there is a lot of information for you to consider before we meet, and some of it may seem a little formal. However, if you have any questions about the investigation or our approach, please do not hesitate to contact me on Phone number [redacted].

David Scott
Company director

Introductory remarks for the interviews

- Thank you for meeting us today
- If you agree, we will record the interview. It is in your interest to have the interview accurately recorded
- It helps us focus better on the conversation
- We have been asked by your Trust to conduct this investigation into the possible missed opportunities associated with Ms Stohr's clinical practice
- While we are independent investigators, the investigation and our report will form part of the Trust's suite of activity into this matter
- You should assume that our report is likely to enter the public domain
- Ian Walker, director of corporate affairs/ Beth Hughes, interim chief governance and performance officer, is our day-to-day commissioner
- Following the interview, we will send you a full transcript of our conversation
- Once you have reviewed the transcript, please suggest any changes or sign it as a true record of our discussion
- We will not share your evidence, including the testimony from this interview, with the Trust. We are required to write a report of the investigation, and we may well quote directly from your evidence.
- Please ask to pause at any time if you would like to do so. This is a voluntary process.
- Please keep this confidential, out of fairness Ms Stohr and to protect the integrity of the investigation
- Would you like to ask us anything before we start?