

Monday, 24 February 2025

1
2 (9.59 am)
3 **LADY JUSTICE THIRLWALL:** Good morning. Ms Langdale.
4 **MS LANGDALE:** May I call Dr Gilby, please.
5 **LADY JUSTICE THIRLWALL:** Dr Gilby, would you like to come
6 forward, please, and take the oath?
7 **DR SUSAN GILBY (sworn)**
8 **Questions by MS LANGDALE**
9 **MS LANGDALE:** Dr Gilby, you have prepared two statements for
10 the Inquiry, the first dated 29 May 2024 and the second
11 14 January 2025. Can you confirm the contents are true
12 and accurate as far as you're concerned?
13 **A.** Yes, I can.
14 **Q.** And do you have them in front of you?
15 **A.** I do. Thank you.
16 **Q.** You tell us in your statement that you were working at
17 the Countess of Chester from 1 August 2018, can you
18 briefly tell us your various roles and the date that you
19 submitted your resignation?
20 **A.** Do you mean my roles at the Countess of Chester?
21 **Q.** Yes, at the Countess of Chester.
22 **A.** When I commenced working at the Countess of Chester on
23 1 August 2018 it was as the Executive Medical Director,
24 the Deputy Chief Executive, and the Strategic Medical
25 Director for the Cheshire West Integrated Care

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1 at the University of Manchester and achieved
2 Bachelor of Medicine and Bachelor of Surgery in 1992.
3 I then went on to -- I'd studied and practised in
4 a number of specialties. In those days it was possible
5 to try out specialties in -- at a junior level before
6 deciding on a final commitment, and I chose to train as
7 a consultant in critical care.
8 In those days, you also had to train in anaesthesia
9 so I became a Fellow of the Royal College of
10 Anaesthesia, and later, a Fellow of the Faculty of
11 Intensive Care Medicine and that led to, after a long
12 period of time training, to becoming a consultant with
13 specialist accreditation in critical care and
14 anaesthesia in 2005, and I specialised at that time in
15 cardiothoracic anaesthesia and intensive care.
16 **Q.** And you moved into leadership roles, didn't you; by
17 about 2012 you were clinical lead for theatre and
18 critical care new build projects?
19 **A.** Yes, that's right. My initial roles in leadership were
20 very much in education and leading junior medical staff.
21 So when I was a consultant at the Liverpool Heart and
22 Chest Hospital, I think only three months after taking
23 up my post, I became the college tutor for training in
24 anaesthesia there. After the birth of my third child,
25 when he was around two years old, I decided to move to

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1 Partnership. I fulfilled that role for a mere seven
2 weeks until Mr Tony Chambers, who was the Chief
3 Executive Officer, left the Trust, and I was asked to
4 act up into the post of Chief Executive Officer, pending
5 the appointment of a substantive replacement for
6 Mr Chambers.
7 I did that from September, I think September 18,
8 thereabouts, 2018, until 1 April 2019, when I became the
9 substantive -- I took up the post of substantive Chief
10 Executive Officer and relinquished the post of Medical
11 Director.
12 **Q.** And subsequent to that?
13 **A.** Subsequent to that, I continued in that role until,
14 well, I was employed in that role until 5 June 2023, but
15 in practice, I relinquished, had to step down from the
16 role on 2 December 2022 when I was unlawfully excluded
17 from the organisation.
18 **Q.** We'll come to that briefly soon enough.
19 **A.** Thank you.
20 **Q.** You also provided the Inquiry with your CV. Can I ask
21 you about some of your earlier appointments and your
22 qualifications?
23 **A.** Yes.
24 **Q.** So, firstly, your qualifications.
25 **A.** Well, my medical qualifications are: I studied medicine

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1 a hospital more locally to me, and I went to Mid
2 Cheshire Trust. When I got to Mid Cheshire Trust
3 I found that there were lots of issues with professional
4 leadership and professional standards, and also with
5 best practice in terms of patient safety and outcomes,
6 and therefore took it upon myself to help to improve
7 those things, and that led to being asked to take on the
8 clinical director role for anaesthesia and critical
9 care.
10 And then, when the Trust was successful in getting
11 funding for a new critical care unit and surgical
12 theatres and assessment unit, they asked me to be the
13 clinical lead for that programme.
14 **Q.** And you, between November 2013 and March 2015, were the
15 Associate Medical Director, division of medicine and
16 emergency care at Mid Cheshire?
17 **A.** Yes.
18 **Q.** What was the culture like? The Inquiry is investigating
19 culture in the NHS widely and specifically within the
20 Countess, so how would you have described the culture
21 there?
22 **A.** I would say that the culture at Mid Cheshire Trust at
23 that time was the most open and positive that I've seen
24 in my career. It was in stark contrast to other
25 experiences I've had. When I first raised concerns,

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1 I would put that at its lowest, sort of questioned the
2 management of patients presenting with sepsis, for
3 example, or the deteriorating patient, I found that the
4 leadership of the Trust were very open to understanding
5 what was best practice and how that different from what
6 was happening in the Trust and looking to learn lessons
7 from perhaps poor outcomes. There was very strong
8 collaborative leadership and a very visible Executive
9 team.

10 I was invited, as a relatively junior consultant, to
11 attend board meetings, to -- so that Non-Executive
12 Directors could understand from the perspective of the
13 shop floor, if you like, how we could improve services
14 and outcomes for patients. It was very patient focused,
15 and there was an understanding that staff had to be
16 listened to and included in decision-making and that was
17 very much a day-to-day experience in that organisation.

18 **Q.** How does patient focus fit with targets? The Inquiry
19 has heard some evidence that leaders in the NHS may be
20 under pressure to deal with targets, and whether that
21 impacts or not on being patient focused. What's your
22 view about that?

23 **A.** My view is that most targets are, with perhaps the
24 exception of financial targets, seen in isolation, most
25 targets are patient safety measures. And that is

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1 the way in which the targets are pursued that differs
2 from one organisation to another. And it's the
3 meaningful and honest reporting of how you're achieving
4 those targets is also important.

5 There's been quite a lot of work during the pandemic
6 on how to risk stratify patients who are either on the
7 elective or urgent waiting lists, and I think for the
8 joint Royal Colleges, that's been an incredibly helpful
9 piece of work for providers to acknowledge and adopt,
10 because that patient focused.

11 And I think that clinical leadership, in terms of
12 the approach to targets, is definitely the way forward:
13 As opposed to just looking at numbers, we're looking at
14 people and those situations that they find themselves
15 in.

16 **Q.** You moved on to be the full time Executive Medical
17 Director at Wye Valley NHS Trust, that's between
18 March 2015 and January 2017. How did you find it within
19 that organisation?

20 **A.** Well, that was an extremely challenged organisation.
21 I was approached to apply for that role whilst I was --
22 after I'd undergone quite a long period of training for
23 prospective Medical Directors, and I had no intentions
24 of taking up a role that was so far away from home.
25 However, my parents and other members of my family lived

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1 particularly the case, particularly the case with the
2 urgent and emergency care standard, which most people
3 will know as the A&E wait target, which officially is
4 a four-hour wait target but hasn't been achieved in the
5 NHS for some time.

6 And the reason for that is that focusing on that,
7 achieving that target, is about patient focus, is
8 because ultimately, if an ambulance is sitting outside
9 an A&E department, unable to leave because there is
10 a queue, and they are therefore unable to get to the
11 undifferentiated patient in the community who may be
12 lying on the floor having had a bad fall or a heart
13 attack or a stroke, and there are time critical
14 interventions that really improve the outcome for
15 patients in that situation, and that's just one small
16 example of how timeliness in treatment is
17 a patient-safety issue.

18 And it's the same with elective care. Whilst the
19 consequences for a long wait for elective care may not
20 be as physically consequential as a long wait for
21 treatment for a heart attack or stroke, it does mean
22 that patients are having a very poor experience, it's
23 often psychologically distressing and symptoms will
24 worsen as they endure that wait.

25 I think it's not the targets in itself, it's more

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1 in that area, and the CQC report was published which
2 shows that the Trust was rated as "Inadequate", and
3 particularly in areas which gave me great concern around
4 patient safety. So I felt that having grown up in that
5 area, it would be something worth doing to try to help
6 them to turn that around.

7 I went to the organisation and found, again,
8 a very -- a group of colleagues who were very open to
9 understanding how they'd found themselves in this
10 position, but they were very culturally isolated. It
11 serves the population of Herefordshire and East Powys,
12 so geographically it is quite an isolated area but very
13 good clinicians and very good managers had made
14 lifestyle decisions to go and work there. Often,
15 I found that they were people who could have worked in
16 any organisation, including big teaching hospitals, but
17 they chose for their own quality of life, and that of
18 their family, to work there.

19 But over time, they had become disconnected with the
20 cultural changes and the practice changes within the
21 NHS, and had become out of touch with what was best
22 practice. I found that particularly the case in
23 learning from mortality, for example. And in terms of
24 governance and particularly quality governance, it was
25 difficult for them to know what "good" looked like

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1 because they didn't have interactions with other
 2 organisations who were doing well.
 3 So I found a very open and willing workforce who
 4 absolutely embraced the changes that we needed to make.
 5 We did need to bring in quite a lot of external support
 6 to bring new ways of working and new governance and
 7 I think most of all to develop the sort of safety
 8 culture that I had seen at Mid Cheshire Trust and the
 9 examples I'd seen at Mid Cheshire had been incredibly
 10 useful in taking those to Wye Valley and turning around
 11 the safety culture and governance and professional
 12 standards in that organisation.
 13 **Q.** Do you think that the safety culture and governance did
 14 strengthen in the periods you were there between 2015 to
 15 2017?
 16 **A.** Oh, absolutely, yes. And I wouldn't have moved back to
 17 the north west had we not managed to achieve that.
 18 There was a further inspection by the CQC, which rated
 19 the Trust as "requires improvement"; they were moved out
 20 of special measures relatively quickly and there was
 21 a new structure put around the organisation which has
 22 helped them. I've followed the progress of the Trust
 23 quite closely since. It became part of a group which
 24 meant that they had connections with other
 25 organisations, which geographically were relatively

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1 listening events, lots of presentations, both from
 2 internal and external individuals and bodies.
 3 I think also, celebrating and rewarding people who
 4 were brave enough to stand up and say, "An incident
 5 happened in my practice and I want you all to know about
 6 it", because it could happen in you similar way in your
 7 practice, and there's lots of shared learning that we
 8 can have here. There are many -- I mean, an incident in
 9 maternity can -- learning from that can be useful for
 10 a whole organisation because a similar type of incident
 11 around, particularly human factors, could happen in,
 12 say, orthopaedics or ophthalmology. People were working
 13 in silos and bringing them together to learn and share
 14 their experiences was probably the most effective first
 15 step. And then listening to people in terms of how they
 16 want to develop what their motivations are for the roles
 17 they're in, and what their fears are as well is also
 18 very important. The role of the leader in that is to
 19 engender trust in order to make them feel safe and to
 20 speak up when something has gone wrong, and we put
 21 a huge amount of work into that safety culture at
 22 Wye Valley.

23 We got to the point where people had been afraid to
 24 speak up, it hadn't been a natural thing to do, not that
 25 anybody -- I had any evidence of people suffering

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1 distant, but one of them, South Warwickshire Trust, led
 2 by Glen Burley, who is an extremely experienced Chief
 3 Executive Officer and his team, meant that they were
 4 able to continue to develop and improve practice in
 5 governance and leadership and leaders had others to whom
 6 they could turn whom were more experienced who would
 7 help them in their development and that was a very
 8 positive outcome for that Trust, and I believe it
 9 continues to this day.
 10 **Q.** And it presumably takes more than one or two leaders,
 11 doesn't it, to influence and make that change? How do
 12 you think a culture can change in a hospital? What are
 13 the key planks to achieve that?
 14 **A.** I think it's a mistake to feel that you can go in to an
 15 organisation and make an intervention to change the
 16 culture or improve the culture. First of all, you have
 17 to understand the -- where the current cultural views
 18 and behaviours have stemmed from and they were different
 19 in different organisations.
 20 As I said I think at Wye Valley it stemmed most only
 21 from the fact that they were geographically and
 22 culturally isolated, and so opening the whole
 23 workforce's eyes to the possibilities of how to improve
 24 outcomes for patients, and also the experience of
 25 working in the organisation was key. So lots of

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1 detriment as a result of that; it just wasn't a natural
 2 part of the ways of working there. We got to the point
 3 where they were coming to a weekly meeting in droves and
 4 somebody, often a very junior member of staff, would
 5 stand up in front of senior clinicians, managers,
 6 Executives, and would maybe describe a drug error that
 7 had happened in their practice and what they'd learnt
 8 from it. They would be supported by a senior manager
 9 and an Executive. I would usually run the presentation,
 10 and then as a collective we would discuss how this might
 11 happen in a different way and in different parts of the
 12 organisation.

13 And for those who weren't able to attend, we
 14 would -- within 24 hours, we committed to sharing
 15 a written account of the narrative, again with some
 16 additional, we called them "safety bites", pieces of
 17 information that people might find helpful in their
 18 practice, and that just grew and grew to the point where
 19 we ran out of space to hold these events.

20 I did actually try to do this at the Countess and
 21 successfully did it also at Wirral University
 22 Hospitals --

23 **Q.** Just pausing there, so before we move to the Countess,
 24 that was your next role, wasn't it, Wirral University
 25 Teaching Hospitals?

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1 A. Yes.

2 Q. Executive Medical Director, January 2017 to July 2018.

3 And again, as a snapshot, what did you find there with

4 the culture?

5 A. I found that quite a challenging organisation. I didn't

6 perhaps do the levels of due diligence that I would

7 normally do but I had my youngest child at this point,

8 well, he was eight when I went to Wye Valley and I was

9 working away from home, and it wasn't ideal so when we

10 came out of special measures at Wye Valley, this was the

11 first Medical Director role that came up that would

12 allow me to live at home during the week and I was

13 successfully appointed. But even during the interview

14 process, there was a stakeholder panel which consisted

15 of consultants across different specialties in the

16 organisation and I found their approach to discussion in

17 the stakeholder panel to be very aggressive and it did

18 make me question, when I was successful and offered the

19 role, whether I actually wanted to go to that

20 organisation but I felt that it was perhaps just

21 a one-off. Unfortunately I did find that relationships

22 were very tense there between Executives and the

23 consultant body, in particular, but the standards of

24 care were very high and I don't think people were as

25 open as they had been in Wye Valley to learning. I felt

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1 a visible, values-driven leader of the organisation in

2 terms of the workforce. There were 5,500 employees at

3 the time, many of whom were part-time, but a large

4 workforce spread over two main sites.

5 Q. And who encouraged you to apply for that role, if you

6 were encouraged to apply for it?

7 A. I was. Sir Duncan Nichol and the other Non-Executive

8 Directors of the board encouraged me to apply for the

9 CEO role, but actually going back to my application for

10 the Medical Director role, it was Sir Duncan who had

11 approached me in March 2018 when Ian Harvey announced

12 his intention to retire that summer.

13 As you said I was working at Wirral Hospitals,

14 Sir Duncan lived in the area that we served, had seen

15 some of the work that I had done there, and was

16 interested in my thoughts on the vacancy that was coming

17 up. I was in the process for a bigger organisation at

18 the time and wasn't terribly interested, I have to say,

19 but he was quite persuasive and when it became apparent

20 that there was a system role within this potential

21 appointment, and the fact that it was -- it fitted very

22 well with my geographical location and family

23 commitments, I decided to look at it, and it was a very

24 exciting opportunity. I applied and was appointed.

25 The Deputy Chief Executive element of that was

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1 that they were very confident that what they were doing

2 was excellent and that sharing mistakes was perhaps

3 a risky thing to do, and it took some time, but even in

4 that organisation they did eventually start to reap the

5 benefits of sharing learning from incidents and issues.

6 But it didn't feel like a collaborative organisation

7 in the way that Mid Cheshire and Wye Valley had done.

8 Q. Moving to your first statement then now, please, at

9 paragraph 10, you tell us, as you just have, in oral

10 evidence that you were appointed as Chief Executive

11 Officer in 2019. What were your duties and

12 responsibilities in that role?

13 A. Well, they are quite considerable. So first of all, to

14 develop and to develop the strategy for the organisation

15 in collaboration with partners across the system,

16 stakeholders, patient groups, and the local authority,

17 and then to deliver that strategy and to deliver the

18 Trust's strategic objectives, obviously to appoint and

19 lead the Executive team in the delivery of the Trust's

20 objectives, to advise the board around working in the --

21 the integrated care systems that we were developing at

22 the time so in working in those systems. As the

23 accountable officer, to be responsible for the legal

24 obligations of the Trust, including those of finance,

25 those -- but the most important thing was to be

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1 something that I didn't think too closely about. It was

2 quite common for the Medical Director to be a Deputy

3 Chief Executive because it shows that there is

4 a commitment to clinical leadership in the organisation.

5 It was something of a shock to find myself having to

6 therefore act up after only seven weeks in the role, and

7 when Sir Duncan asked me to do so, I did say to him

8 that I felt that my time in the organisation hadn't been

9 long enough to act into the role, and I didn't feel

10 confident that in such a challenged organisation,

11 I would be able to deliver what they needed.

12 However, it was pointed out to me that when you're

13 the Deputy Chief Executive it is expected that you act

14 up if that's what is required.

15 But also, more importantly, Sir Duncan and the other

16 Non-Executives gave me their full support and assurance

17 that they would support me during this time. I expected

18 it to be for potentially a matter of weeks until they

19 found somebody perhaps more experienced. As it turned

20 out, it was five months before the process for the

21 substantive role was fully commenced, by which time I'd

22 obviously had to do quite a lot in the role to move

23 things forward. And I was encouraged at that point to

24 apply almost having undergone a five-month assessment

25 and interview process. So it was a difficult

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1 decision --

2 **Q.** Your employment was three weeks, wasn't it, that you
3 started after Lucy Letby had been arrested?

4 **A.** Yes.

5 **Q.** How did that impact? We'll go into some of the details
6 later, but how did that impact the organisation and the
7 role that you were taking on?

8 **A.** The arrest took place when I was -- I think I was out of
9 the country at the time. So in the -- the weeks in
10 between the arrest and the -- my taking up the role,
11 I didn't -- wasn't sighted on how this was being
12 received, how this news was received in the
13 organisation. But I did prepare myself to arrive and
14 find colleagues reeling from this news. I know you'll
15 go into the detail later, so there had been discussions
16 leading up to this of what I might expect from Operation
17 Hummingbird.

18 What I found was not what I expected at all. It was
19 almost a -- well, there were individuals who were
20 shocked, but there was a denial that this meant that it
21 needed to be taken really seriously. I don't know
22 whether that's because people didn't understand that
23 when an arrest is made, it's because the investigating
24 officers have evidence that they wish to put to the
25 person who has been arrested, and that's not something

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1 **Q.** Very briefly, what period of time, what documents were
2 you unable to find or retrieve?

3 **A.** Well, for a very long time, until this Inquiry enabled
4 me to access -- well, order the Trust to enable me to
5 access my emails and the copious numbers of files that
6 were saved on my personal drive, I wasn't allowed to
7 look at anything at all. So when I was looking for
8 documents relevant to this Inquiry, I found that there
9 were emails over periods of time which were entirely
10 missing. So there were chunks of emails -- no emails at
11 all, sorry. And as you can imagine how many emails
12 a Chief Executive might get in a day, there were weeks
13 and weeks of emails just not there. They also weren't
14 in the deleted folders and there was nothing in the sent
15 folders.

16 For the period from two years prior to this, so in
17 2022, all of my emails had been deleted and were
18 unretrievable. There were also many documents,
19 including my own appraisals, which had been done by
20 Sir Duncan and by Mrs Chris Hannah, his successor, and
21 also by Mr Haythornthwaite, that were missing, and many
22 documents that related to governance failings, the work
23 that was done around the governance improvement and
24 documents that had previously been in the ownership of
25 Mr Harvey where I was unable to find them or retrieve

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1 that is done lightly. But it certainly seemed to me
2 that even at that point, it was believed that nothing
3 would come of this, and the focus continued to be on the
4 people who had raised concerns.

5 So that was a surprise.

6 **Q.** You resigned, you tell us at paragraph 16, midway
7 through the Letby trial and you say it's an action you
8 felt was forced upon you.

9 If we can have, please, INQ0108901, page 2 and 3,
10 this month, 12 February, the Employment Tribunal handed
11 down its decision in relation to the proceedings you
12 commenced, we don't need to go into the details of that
13 here, but the judgment is a public judgment, but we do
14 see at page 3, that:

15 "The Regional Employment Judge found as a fact that
16 there had been deletions of emails from the claimant's
17 work email account without her knowledge."

18 And it carries on at paragraph 6:

19 "... common ground that a good deal of material one
20 would expect to find in the claimant's HR file is
21 missing, including appraisals from 2019 to 2022."

22 I think it's right to say that they couldn't say
23 which witnesses or who had deleted documents and emails,
24 but that was found to be the case?

25 **A.** Yes.

18

1 them in the files.

2 In terms of the findings of Judge Franey, these
3 documents and messages relate to matters to do with my
4 own employment and the measures that the people involved
5 in what they call Project Countess were undertaking from
6 the moment that I raised concerns until I was excluded
7 in 2022 to exit me from the Trust.

8 **Q.** You were subjected to detriment because you'd made
9 a protected disclosure. Can you again, very briefly,
10 what's the significance of a protected disclosure?
11 What's your experience in that context, making one in
12 the organisation at that time?

13 **A.** My experience of making the protected disclosure was --
14 well, it was horrific, quite frankly. I was very
15 careful to go through the proper channels and initially
16 that seemed to me, having taken advice about how to deal
17 with what I was experiencing, it seemed to me doing that
18 through the appraisal process for Mr Haythornthwaite
19 seemed to be the most appropriate and most positive way
20 of addressing it.

21 So when giving opportunity to give feedback for the
22 appraisal, I shared confidentially with the senior
23 independent director Roz Fallon, examples of what had
24 been happening since Mr Haythornthwaite's arrival in the
25 organisation, not only to me but to others, and I fully

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1 expected that that would form part of a discussion at
 2 his appraisal and hopefully would inform future
 3 development, reflection, and probably working together
 4 to resolve these issues, even though they didn't apply
 5 solely to myself.

6 What actually happened was that when Ms Fallon made
 7 Mr Haythornthwaite aware that I had raised these -- and
 8 I am sure that she put it in at its lowest -- the
 9 behaviours increased in their intensity and ferocity,
 10 and others seemed to start to behave in a similar way,
 11 until we came to a meeting on 18 July 2022, where having
 12 taken advice from my mentor, Dame Angela Pedder, in how
 13 to deal with this issue, and the experience I'd had
 14 since raising it appropriately, there was -- I -- in
 15 a one-to-one meeting discussed with Mr Haythornthwaite,
 16 the fact that there was an internal and external
 17 perception that we were not getting on and not working
 18 well together, and I wanted to discuss it.

19 Now, I knew that doing this was not without risk,
 20 but I didn't anticipate the aggression with which that
 21 invitation to discuss the issue was met and I was
 22 subjected to a very long, aggressive monologue about my
 23 personality, my approach to leadership, veiled threats
 24 and comments about what other people may or may not have
 25 said but not telling me exactly what they said or who

21

1 if you like, some advice about what you've done well,
 2 what you could do better. So there was a great deal of
 3 evidence gathered prior to the appraisal.

4 Also as the Chief Executive, you have objectives to
 5 deliver in any given year, and they fall into different
 6 categories. They might be financial, they might be
 7 operational. Some of them would be cultural, and in
 8 this organisation, particularly in the first year, a lot
 9 of it was around developing strategies because the
 10 organisation didn't have any strategies when I arrived.
 11 So it, as well as going through how well or badly you'd
 12 achieved your objectives, it was also reflecting how
 13 colleagues at different -- in different roles in
 14 different departments and at different levels of
 15 seniority across the organisation and also partners and
 16 stakeholders in the local health and care system were
 17 invited to give feedback, and I think it's fair to say
 18 that there were some comments that were helpful in terms
 19 of my development, particularly around perhaps being --
 20 delegating more was one of them, but overall the
 21 feedback that I had from stakeholders, colleagues, and
 22 some Non-Executive directors, was overwhelmingly
 23 positive and the appraisals were glowing.

24 **Q.** And this is with Sir Duncan, and they --

25 **A.** And with Chris Hannah and also with Ian Haythornthwaite

23

1 had said it, which I now understand to be gaslighting,
 2 although I didn't really know the meaning of that term.

3 There was banging of the fist on the table and
 4 shaking of their -- his hand in my face -- his finger in
 5 my face. It was frightening, and distressing. And
 6 I really did everything I could to try to bring it to
 7 a close and get out of the room.

8 **Q.** Just pausing there on the question of appraisals which
 9 you've raised, please. When your Chief Executive, was
 10 it Sir Duncan Nichol and then the subsequent chair who
 11 did the appraisals for you?

12 **A.** Yes.

13 **Q.** What else happens with an Executive apart from appraisal
 14 by the chair? Is it feedback from people that are
 15 working -- that you're leading, if you like, as well,
 16 what was it like for you when you were being appraised
 17 by Sir Duncan?

18 **A.** Yes, the appraiser, which in my case was the chair,
 19 coordinates the appraisal but it's not simply an
 20 assessment done by that individual of your performance.
 21 It's very important to receive what's known as
 22 360-degree feedback. So multiple people are asked to,
 23 in a structured way, and it was administered by the then
 24 HR director, Alyson Hall, to give feedback on aspects of
 25 your performance as well as to give, in a freehand way,

22

1 weeks before it was decided that I needed to leave the
 2 organisation.

3 **Q.** So the Inquiry shouldn't get the impression that being
 4 appraised by Sir Duncan is just something between the
 5 Chief Executive and him, there was more information --

6 **A.** Oh definitely not, no.

7 **Q.** -- that's gathered?

8 **A.** Yes, in a way -- I've done many appraisals myself and
 9 it's helping the appraisee to reflect on what others
 10 have fed back is their observations about their
 11 performance and also the more -- the things that you can
 12 quantify more easily. There are measures of success,
 13 obviously, as well as measures of how well or badly you
 14 are doing in terms of leadership and that might be
 15 financial, it might be operational, it might be -- most
 16 importantly should be -- patient outcomes.

17 **Q.** You tell us in your statement that you had conversations
 18 with Mr Harvey and Mr Chambers prior to starting your
 19 role at the Trust, one with Mr Harvey as part of your
 20 induction into the Wirral University role.

21 **A.** Yes.

22 **Q.** You met him in 2017. Can you tell us about those early
 23 conversations before you were working at the Trust with
 24 Mr Harvey and Mr Chambers, about the Trusts and
 25 encouraging you or not to apply to the Trust?

24

1 **A.** Yes. I had taken up the role at Wirral Hospitals in
 2 January 17, and the Countess of Chester was our nearest
 3 District General Hospital. There were a lot of services
 4 in which the two organisations collaborated. And there
 5 was at the time a-- an informal, if you like, intention
 6 to bring the organisations closer together. So
 7 Mr Harvey was the first person that I reached out to in
 8 terms of Medical Directors in the Cheshire and Mersey
 9 system to go and see, and to get to know because we were
 10 hopefully going to be working closely together and
 11 I particularly wanted to talk to him about the services
 12 where we collaborated, and that included the vascular
 13 service and a few other services, but it didn't include
 14 neonates.

15 Mr Harvey was very welcoming and open in his
 16 discussions, and we had a number of things in common
 17 that we were able to discuss and I felt that he was
 18 going to be a good colleague.

19 I did, however, find it surprisingly -- surprising
 20 and a bit -- I was slightly taken aback that he started
 21 talking about the problem with neonates because
 22 I actually had no knowledge of it whatsoever at the time
 23 because I --

24 **Q.** So this is February 2017, you say?

25 **A.** Yes.

25

1 organisation at some time.

2 Can you tell us about that?

3 **A.** Yes, this was after I'd been appointed, so the
 4 interviews were in March, and I'd started on 1 April and
 5 we had several conversations in the intervening period.
 6 I do remember that this was an offsite meeting and he'd
 7 suggested that we met in a coffee shop in between the
 8 two hospitals where we were both working, and he told me
 9 that he was applying for a role in a hospital on the
 10 south coast in a big teaching hospital. I was quite
 11 taken aback. I hadn't even started in the role yet, and
 12 my new boss was telling me he might be leaving. He was
 13 quite confident that he would be leaving, and when you
 14 choose to apply to an organisation for a role such as
 15 Medical Director and Deputy CEO, it's important that you
 16 know who you're going to be working for, and at the time
 17 when I applied, I had felt that I would learn a great
 18 deal from the team that I would be joining, and in
 19 particular from Mr Chambers, because he had been CEO for
 20 six years at that point.

21 So this was a concern, but I understood why at this
 22 point in his career he might want to move on, and I was
 23 grateful that he was choosing to be so open with me.

24 **Q.** You say at paragraph 45:

25 "At the time that [you] joined, the Trust had

27

1 **Q.** Carry on.

2 **A.** I'd been working in the West Midlands and therefore
 3 I hadn't heard on the grapevine, or in any way, shape or
 4 form, that there was a police investigation in -- at the
 5 Countess. Actually, sorry, there wasn't a police
 6 investigation, that there had been unexpected and
 7 unexplained deaths in the neonatal unit, and that there
 8 had been greater numbers than would be expected.

9 So I didn't know to what he was referring but he
 10 said, "This issue we've got with the paediatricians is
 11 how it started" and he went on to discuss how they had
 12 asked for more numbers in the consultant body in the
 13 department, that it had been not approved, it was
 14 unaffordable. But they had kept on making the point and
 15 stamping their feet, is how he put it, until they got
 16 what they wanted and, you know, they were the problem.

17 So I left feeling that in the back of my mind,
 18 thinking: I wonder what that was about? But it wasn't
 19 until later that I discovered that he was referring to
 20 the concerns they had about the deaths and unexpected
 21 collapses on the neonatal unit, and his irritation at
 22 their persistence in that.

23 **Q.** What about Mr Chambers? You tell us at paragraph 31 in
 24 meetings with him prior to starting your new role, he
 25 shared he was planning to move on to a bigger

26

1 a solid reputation externally as an organisation which
 2 provided good medical care and attracted high calibre
 3 clinicians. It was a first wave Foundation Trust ..."

4 So when did you expect and what were you relying on
 5 when you tell us that, that it had that reputation?

6 **A.** Well, I had trained in the region. I, as you know, went
 7 to medical school in Manchester and I had worked
 8 clinically across the north west for many years and the
 9 Countess of Chester was known as a -- an organisation,
 10 you know, the best went to, in terms of consultants.

11 A bit like Wye Valley in the sense that people would
 12 choose to go there rather than to a big teaching
 13 hospital, because they wanted the -- there's quite
 14 a different experience of working in a District General
 15 Hospital as opposed to a teaching hospital. Most of my
 16 experience prior to Mid Cheshire had been in teaching
 17 hospitals.

18 So people were -- there was a lot of competition for
 19 consultant roles at the Trust, I have to say, I didn't
 20 know much about the other professions in the
 21 organisation, but certainly in the medical world people
 22 in the Trust would take leadership roles nationally in
 23 their respective Royal Colleges, at -- in education
 24 establishments, and they were often, I would say,
 25 punching above their weight in terms of the size of the

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1 organisation and the representation that it had across
2 the health economy and even nationally. The president
3 of my own college was at one point the consultant at the
4 Heart and Chest -- sorry, not Heart and Chest -- the
5 Countess of Chester.

6 So I really, knowing it had been a first wave
7 Foundation Trust and that the chair was a very eminent
8 NHS leader who -- highly respected and had been the
9 Chief Executive of the NHS as a whole, I was optimistic
10 that having spent quite some time now in turnaround
11 roles, that I was actually going to an organisation that
12 was solid.

13 This just the looking at the CQC report, it also, at
14 first glance, would imply that it was a good
15 organisation who were delivering good care. And whilst
16 that was true within individual specialties, there were
17 real issues that I didn't expect that I found when I got
18 there. So I was expecting to go into a high performing
19 organisation with a high performing team, and I was
20 looking forward to not doing that turnaround role, which
21 I'd been doing for quite a number of years by that
22 point.

23 **Q.** You mentioned the CQC reports. Can we go perhaps now to
24 have look at the relevant ones in the period.
25 INQ0014183, page 1 is the report arising from the
29

1 time of the inspection. Shortage of paediatric
2 consultants was recorded on the Divisional Risk Register
3 on 21st October 15 however approval had been obtained to
4 increase medical staffing and the number of palliative
5 care consultants was below the recommended staffing
6 levels."

7 Looking at the CQC report there, the reflections or
8 the summary of the leadership, before I take you to the
9 next one, is fairly positive, isn't it?

10 **A.** Yes, it is, and I would agree with quite a bit of what
11 is written there, although it is obviously high level.
12 The leaders at Executive level certainly were visible in
13 the organisation, and people did know who they were,
14 which is -- you know, that's absolutely essential. But
15 what -- so this was obviously two years before I applied
16 for the role.

17 **Q.** Yes. We'll go to the one -- shall we have a look at the
18 INQ0014183, page 1. This was an inspection visit 13 to
19 15 November 2018. So very shortly after you've arrived
20 in the August. And the report 17 May 2019. And we see
21 there that "Requires Improvement" in a number of
22 categories, including on services safe. And we see at
23 page 3:

24 "Our rating of the Trust went down."

25 Setting out why it was rated as "Requiring

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1 inspection in 2018, and the report in May 2019 and we
2 see a services care in "Good"?

3 Sorry, if we can go to an earlier one, not that one.

4 Can we go to INQ0002649, page 1. This is one from the
5 visit in 2016, and we see there overall rating for the
6 hospital "Requires Improvement". "Good" for various
7 services apart from end-of-life care.

8 If we go to page 2, for leadership and management,
9 recording there:

10 "The hospital was led and managed by an accessible
11 and visible Executive team. The team were well known to
12 staff, visited most wards and departments regularly,
13 responded to issues that staff raised. However some
14 staff on surgical wards did not feel they were as
15 engaged with board members."

16 It continues:

17 "There was clear leadership and communication in
18 services at a local level, senior managers were visible,
19 approachable, and staff were supported in the workplace.
20 Staff achievements were recognised both informally and
21 through staff recognition awards."

22 Over the page, page 4, medical staffing:

23 "Medical treatment delivered by a skilled and
24 committed medical staff, information received showed
25 that medical staffing was generally sufficient at the

30

1 Improvement".

2 If we go to page 5, in terms of are the services
3 well led, penultimate two paragraphs:

4 "There was no clear strategic objective in place to
5 lead the organisation. This meant that there was no
6 robust and realistic strategy for achieving Trust
7 priorities and developing good quality, sustainable
8 care.

9 "Staff did not always feel actively engaged or
10 empowered. We received mixed comments from some staff
11 groups in relation to the level of engagement and
12 support they received ..."

13 And over the page it reflects at page 6:

14 "The Trust board had undergone changes in its
15 representation including the Chief Executive and Medical
16 Director. Changes in senior leadership such as the
17 appointment of the interim Chief Executive and interim
18 Medical Director had led to recognition that
19 improvements were required.

20 "Staff were positive about the support they received
21 from their local departmental team leaders."

22 So this is very early on, of course, in terms of
23 your arrival. Does that sound about right, how it's
24 been recognised there?

25 **A.** Yes. I would say that perhaps they hadn't quite

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1 appreciated the breadth and depth of the issues. The
2 inspectors, I had literally been in the acting Chief
3 Executive role for five weeks because when I was asked
4 to act up, I -- in the first few weeks I was actually
5 out of the country on a pre-planned trip which
6 I couldn't do anything about.

7 So when the CQC arrived, I'd been, if you like, on
8 the ground as the acting Chief Executive for five weeks.
9 So their interview with me as the Chief Executive was
10 very much a collaborative discussion, rather than
11 challenging me about what I had or hadn't done in the
12 organisation.

13 We were sharing observations almost as much as them
14 asking me questions and it was a very long discussion.
15 I remember a particular area of discussion was
16 governance. I don't think it comes out quite as clearly
17 here as it could have done, that there was just a vacuum
18 of governors in the organisation, from board -- from
19 ward to board. And the same was true of performance and
20 oversight. And it's hard for me to, having read the
21 previous report, and thinking that's what I was coming
22 into, what I found was more akin to what you see here,
23 except that having come from an organisation which had
24 been rated as inadequate by the CQC for safety in
25 particular and other areas, what I found at the Countess

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1 there was also quite a bit of discussion about some very
2 practical issues around patient safety and also about
3 reporting.

4 **Q.** We'll come to those.

5 **A.** Okay.

6 **Q.** You set those out in your statement. Just completing
7 the series of CQC statements, if I may -- reports,
8 rather, INQ0014184, page 1, is the 2022 report, where
9 services -- "Are services well led?" They're recorded
10 as "Inadequate" if we look at page 1, the Trust
11 "Requires Improvement". The only are it grants as
12 "Good" was "Are services caring?"

13 And if we go out to page 3 it sets out: the well-led
14 provider rating was "Inadequate":

15 "The Trust did not have suitable governance systems
16 and processes to effectively manage patient referral to
17 treating waiting times."

18 If we go over the page, page 4.

19 "Warning notices were served."

20 "Needed to make significant improvements in the
21 quality and safety of healthcare provided in maternity
22 services."

23 And then if we go to page 8, "Leadership".

24 "Several new appointments to the board, and the
25 plans the board had developed had not yet had time to

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1 was actually more seriously concerning than what I found
2 at Wye Valley, and it was hard to see how that had
3 completely gone under the radar, and that if the report
4 from 2016 was accurate, and I have reason to believe
5 that it might not have been, that a great deal of
6 deterioration had happened, both in terms of what you're
7 reading here but also what I was seeing and hearing, and
8 it was hard to understand how and why that had happened.

9 I did feel both at this inspection and subsequently
10 that perhaps there was a bit of an agenda in the terms
11 of that the CQC were more open to finding negative
12 things than perhaps they had been in 2016.

13 **Q.** Why was that, do you think?

14 **A.** Well, it was after the Trust had -- it was after the
15 police had arrested Letby, and I know that that came as
16 a big shock to the NHS and presumably the regulators.
17 And I would have expected them to look back at their own
18 reviews of the organisation and their interactions from
19 NHS -- well, it was NHS Improvement at the time -- their
20 point of view, to see whether they had any inkling of
21 the issues that were now being raised about the
22 organisation and whether they had actually assessed
23 their -- the levels of risk in the organisation
24 correctly.

25 So a lot of the discussion was about governance but

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1 evidence their impact or sustainability. Not all senior
2 leaders were visible or approachable in the
3 organisation. Leaders not always fully sighted on risk
4 within the Trust or acted upon it in a timely way."

5 Then if we go to page 10 and "Culture". Take your
6 time, please, and others might wish to, to read what's
7 said about culture, and the NHS staff survey.

8 So the results showed the Trust scored the lowest
9 nationally for staff morale. That is 2022, so you've
10 been there some time by then?

11 **A.** Yes.

12 **Q.** So what's your view about that? I mean there's clearly
13 no improvement, and on the face of it, it gets worse
14 during your tenure on the face of that report. So what
15 would you say about that?

16 **A.** Well, a number of things. So first of all the CQC came
17 to do this unannounced inspection when we were still in
18 the thick of Covid. We had at the time 100 patients
19 being treated for Covid in the hospital. That's many
20 wards-worth of patients. They kept saying to us "We
21 don't want to hear about the pandemic." Literally those
22 words. They said it to a number of my Executive
23 colleagues and to me during their interviews.

24 Within two days of them arriving, one of the lead
25 inspectors who should have been part of my interview,

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1 contracted Covid, and she'd been interviewing people in
2 close proximity, and it was a very odd experience. So
3 I think the most important line there is that the bold
4 at the top, it says:

5 "The Trust was working towards an open culture where
6 patients, their families and staff could raise concerns
7 without fear. However, this was not yet embedded."

8 The issue was that previously, staff -- there wasn't
9 an open culture, and staff couldn't raise concerns
10 without fear. And during the pandemic, where we were --
11 in terms of inpatient care, and numbers of beds
12 occupied, and the proportion of those beds, we were
13 amongst the hardest hit in the country. We were the
14 hardest hit outside of London and the fifth hardest hit
15 in England overall. There are many ways of measuring
16 the impact of Covid but I'm talking about how -- the
17 proportion of your beds that have patients being treated
18 for Covid as opposed to something else, and at times we
19 had -- it was 70% plus. So eight, nine wards of
20 patients.

21 I was personally very visible as a leader, and that
22 was -- all of this was examined in my recent Employment
23 Tribunal.

24 **Q.** Oh don't worry, I'm not asking you specifics about you
25 but --

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1 at paragraph 48 you comment on the fact that:

2 "The focus at the Trust for at least the previous
3 nine or ten years appear to have been largely on finance
4 but in a very short-term way."

5 So can you elaborate on that, please? Are you
6 saying finance rather than patient safety? Or should it
7 be the same or what?

8 **A.** I think patients were -- had become lost in the
9 organisation. They were -- there were lots of words
10 said about the importance of the people that we serve,
11 the importance of our staff, the importance of patients,
12 but if you looked at the actions that were taken and the
13 priorities of the board, and the priorities that were
14 given to the divisional divisions and their services,
15 they were all about efficiency, which is a euphemism
16 for, in their experience, rather than what I believe it
17 to be, in cost cutting.

18 So every year, there would be a financial target for
19 each service and division and for the Trust overall, and
20 the way that that was being delivered was in
21 salami-slicing the organisation to the point where you
22 had very overworked staff, even at a quite junior
23 administrative level, who were doing the jobs of
24 multiple people. And you had senior managers who
25 weren't able to be true leaders because they were acting

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1 **A.** No, no.

2 **Q.** -- the business of changing a culture or improving it
3 more widely --

4 **A.** It was a really difficult place to -- I talked earlier
5 about what do you do? You go and you listen to people.
6 You don't try and improve the culture. There's
7 a reference here to the reward and recognition scheme,
8 and on the face of it, that looks really positive. But
9 when you actually talked to people, they would say, "Oh
10 this is all a stitch-up by HR. It's all the favourites,
11 the usual people. Often the HR people will nominate
12 each other or their friends".

13 So there was even distrust about whether or not you
14 took that at face value and I think you have to, about
15 whether the review and recognition system was an open
16 and transparent process.

17 So when you're celebrating people -- trying to
18 celebrate people for raising concerns, and they're not
19 even trusting that you're celebrating the right people
20 for doing well and achieved going above and beyond, the
21 depth of the distrust is something that takes years and
22 years to address.

23 **Q.** Looking at your statement, if you look at your statement
24 dealing with what you found in terms of governance when
25 you joined, you comment on a number of things. Firstly

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1 down doing roles that had -- the people who should be
2 doing those had been stripped out of the organisation to
3 reduce costs.

4 And whilst the focus was on all of that, there was
5 also investment in very expensive technologies which
6 were aimed at improving productivity rather than patient
7 outcomes, or certainly the way in which they were being
8 used, it seemed that that was the priority.

9 **Q.** You say it was a new electronic patient record platform
10 that was being introduced?

11 **A.** Yes, it was -- the thing I'm referring to is really the
12 operational flow management tool, which is a way of
13 tracking the movements of staff and patients through
14 the -- flowing through the organisation. And there was
15 a very significant investment made into that system, but
16 there was a £500,000 annual fee being paid which the
17 board didn't seem to be sighted on.

18 So there was a disconnect between what was happening
19 at service level in terms of the cost cutting and the
20 failure to invest in, for example, the right levels of
21 staff in theatres or on the wards, or in the maternity
22 unit, and actually, there are things that very
23 significant things that should have happened in the
24 maternity unit that didn't happen, in terms of
25 investment.

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1 And yet, big investments being made in large
 2 electronic platforms, without getting the basics right
 3 that the board did not seem to be fully sighted on, in
 4 terms of what the implications were for the
 5 organisation.

6 **Q.** And you say there was little performance oversight,
 7 divisional leaders seemed to be working almost
 8 autonomously?

9 **A.** Yes, something I would be used to, and I've seen in
 10 every other organisation, would be a performance and
 11 oversight framework, which is about how you support your
 12 leaders of services and divisions, and I'm not just
 13 talking about clinical services. I mean people who were
 14 working across the organisation, how you would review
 15 their objectives, how they were delivering them and what
 16 the outcomes were, particularly for at the end of the
 17 day outcomes, and if they were failing in that regard,
 18 you would put in additional support.

19 And those would be regular -- it would be an organic
 20 way of running the organisation, they would be regular
 21 meetings at different levels. But at the very least
 22 I would have expected there to be quarterly performance
 23 and oversight meetings with the large divisions.

24 Once I'd been there for a couple of months and
 25 I didn't see any of these in the diary, I actually asked

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1 are living in its constituency. It would describe over
 2 a period of time, within the NHS it tends to be
 3 a five-year strategy of what services would grow and
 4 where you would collaborate, where you would invest, how
 5 you would innovate, how you would develop people, how
 6 you would improve standards. There would be supporting
 7 strategies such as people and organisational
 8 development, digital, infrastructure. There wasn't even
 9 a clinical services strategy which described: what
 10 specialties are we doing? How are we doing them? How
 11 are we going to grow and innovate them and what actually
 12 should we do less of that somebody else does better?

13 And the first thing I looked for as the Medical
 14 Director -- and I had asked for it before I started --
 15 was the clinical services strategy. And I was told
 16 there wasn't one and therefore was, you know, given that
 17 as one of my first objectives by Mr Chambers when
 18 I arrived.

19 And as the Medical Director, really, that was the
 20 only strategy that I could drive forward, and it was
 21 only when I became acting Chief Executive that we
 22 started work on the other strategies.

23 When I asked about, in terms of the board, about,
 24 you know, where is our strategy, what are our strategic
 25 objectives, how do you know that we are meeting them and

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1 at an Executive Directors' meeting: when and where do we
 2 have the divisional performance meetings? And there was
 3 an uncomfortable sort of shuffling in the room and one
 4 of the colleagues in the room said, "We don't talk about
 5 performance" and I said, "What do you mean, you don't
 6 talk about performance?" And they said, "It's not
 7 a word that we use in here. We talk about autonomy and
 8 creativity".

9 And I think creativity is really important, and
 10 autonomy, if it has been earned and can be shown to be
 11 safe, is a very positive thing for a leader of a service
 12 or a division, or indeed of an organisation, but when
 13 your organisation is being shown to fail in the worst
 14 possible way, the fact that it's seen as a positive that
 15 you don't have close monitoring and support for those
 16 leaders is really alarming, and I think that was one of
 17 the -- I remember it so clearly because that was one of
 18 the more shocking moments, and there were many of them,
 19 in my first months at the Trust.

20 **Q.** You also say that:

21 "The Trust did not have a corporate strategy."
 22 What did you mean by that?

23 **A.** Well, an organisational strategy would describe what the
 24 purpose of the organisation was, what it was there to
 25 do, in order to serve the people, the population that

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1 how do you know you're addressing the risks associated
 2 with them, if we don't have a strategy? I was told that
 3 the model hospital was the document that was used for
 4 strategy but the model hospital is not a strategic
 5 document.

6 So in discussion with the board, and in particular
 7 with Sir Duncan, it was agreed that one of my objectives
 8 in year one was to develop and deliver an organisational
 9 strategy for the next five years, and we did do that.
 10 We did it in a very collaborative way, and the final
 11 event actually we had 130 stakeholders at a meeting.
 12 I remember it so clearly because it was the last time
 13 that we were all together before the pandemic was
 14 declared and lockdowns started, where we presented to
 15 multiple stakeholders from across the system, and
 16 including in North Wales, our proposals and asked for
 17 their input and feedback, having done that in a more
 18 informal way prior to that, and then that strategy
 19 document was delivered to and accepted at board in there
 20 shortly after that, in 2020.

21 **Q.** At paragraph 52 you also refer to recording your
 22 surprise that there was no Board Assurance Framework,
 23 and "Where do we look at it?", you say. So tell us what
 24 was the Board Assurance Framework? What did you not see
 25 that you expected to see?

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1 **A.** I think there was a Board Assurance Framework, it just
 2 didn't appear in the places that I would expect and
 3 wasn't used as a living document in the way that I would
 4 expect to manage risk. So the Board Assurance Framework
 5 would have been the highest level risks in the
 6 organisation in terms of addressing their strategic
 7 objectives, and this probably wouldn't mean much to
 8 patients, but if you put it to patients and families
 9 that this is really about how we are keeping you safe,
 10 giving you the best possible access and outcomes, and
 11 spending the Cheshire West and North Wales health pound
 12 to the best possible benefit of you as a community and
 13 protecting our staff, the importance of it becomes
 14 clear.

15 So it's not a dry document. It's something that you
 16 need to examine on a regular basis. You have to have
 17 very clearly defined strategic objectives in terms of
 18 the things that I've just listed and others, and you
 19 need to understand what is the risk to delivering those
 20 and what you're doing to mitigate them, and how is that
 21 risk reducing or increasing over time.

22 So in the notes that I made or in reference to
 23 the -- they called it QSPEC, it was the Quality Safety
 24 and Experience Committee, yes?

25 **Q.** Patient Experience?

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1 "The Non-Executive Directors were, however,
 2 predominantly (and increasingly) from finance and
 3 business backgrounds ..."

4 Was that your experience upon arrival? That's your
 5 understanding of the NEDs that you were working with?

6 **A.** That's right. Yes, there was one who had a nursing and
 7 midwifery background for many years previously, that was
 8 Roz Fallon, but the rest were finance and business.

9 **Q.** Can we have on screen, please, INQ0099064-page 5. And
 10 it's an email from Mr Cross to yourself, Dr Gilby.

11 "Hi Susan, please find attached governance framework
 12 overview for consideration. This a working document and
 13 I am happy to amend as you wish."

14 This was sent to you 13 November, and then if we can
 15 see page 6 and page 7, if we can scroll slowly, please,
 16 so people have a chance to see the Governance Framework
 17 Overview sent to you.

18 Then if we can go to the same INQ number, page 4, we
 19 see an email from you, 13 November:

20 "Sending this via personal e-mail. I asked Stephen
 21 and Claire for a document which gave account of our
 22 governance framework including risk management framework
 23 and strategy. Over three weeks later this is what's
 24 been produced. I feel that it falls significantly below
 25 what I would expect to see and it concerns me that it

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1 **A.** Patient, yes. So that was -- in most organisations
 2 would have been called a quality and safety committee,
 3 it's the subcommittee to the board, where I believe to
 4 be the most important subcommittee, where they talk
 5 about -- they look at data, and they receive reports
 6 surrounding patients and staff, safety and experience.
 7 And there are elements of the Board Assurance Framework
 8 which refer to patient safety, quality of services, and
 9 patient and staff experience.

10 And so those elements of the BAF should have been on
 11 a regular basis been discussed at that committee, and
 12 the operational teams challenged by the Non-Executive
 13 Directors as to any improvements that needed to be made,
 14 how those were being made and how they were being
 15 monitored.

16 **Q.** In terms of the background of those Non-Executive
 17 Directors on QSPEC and generally looking at issues of
 18 quality, do you think it's helpful if they have medical
 19 or clinical backgrounds?

20 **A.** I think it's essential that the -- some of the
 21 Non-Executive Directors on the Quality Committee have
 22 medical -- there should be at least one person with
 23 a medical background, and another with other clinical
 24 experience.

25 **Q.** You comment in your statement at paragraph 55 that:

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1 took so long to produce such an inadequate document.
 2 I intend to use this as a trigger to commence the review
 3 of board support which was previously discussed."

4 Was that your understanding, that that had just been
 5 produced at your request? You deal with it later in
 6 your statement as well, that Claire Raggett had put this
 7 together at your request?

8 **A.** Yes, one of the many things that I'd asked to see,
 9 having found myself suddenly in the acting Chief
 10 Executive role, was the Board Assurance Framework and
 11 the governance handbook and also the governance
 12 framework, and Claire Raggett was Stephen Cross's
 13 assistant so I asked Stephen directly and he said, "Oh
 14 can you liaise with Claire" so I repeatedly asked
 15 Claire. I was feeling a bit like a -- well, I didn't
 16 have the tools that I needed to lead the organisation in
 17 many ways, and this was one of the issues, and
 18 I repeatedly asked her, and then she produced what
 19 you've just shown, which is not a governance framework,
 20 and indeed, it even refers to the governance
 21 framework -- it actually refers to the governance
 22 framework as being one of the things that will support
 23 a governance framework. It's a nonsensical list of --
 24 clearly hurriedly put together in a bit of a panic, and
 25 it was simply that the person who was responsible for

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1 governance in the organisation, who was the company
2 secretary and was the Director for Corporate and Legal
3 Affairs.

4 **Q.** Mr Cross?

5 **A.** Yes, genuinely didn't understand what a governance
6 framework was, or what a governance handbook should look
7 like, or what the requirements of governance in a NHS
8 Foundation Trust were. And I actually, until I saw
9 this, didn't remember that I'd sent this to Sir Duncan's
10 personal email and I don't know why I did that, except
11 that I had found that questioning Mr Cross was not
12 something that you do in the organisation. And I was
13 actually warned that, "Be really careful about this,
14 he's got very powerful friends".

15 And I am not one, as perhaps you've seen from my
16 Employment Tribunal judgment, who is going to take
17 threats like that and therefore take a back step and not
18 do the right thing. So I needed Duncan to be aware that
19 this is a very serious concern and I know that this
20 email was followed up with a discussion. But the worst
21 thing for me was the fact that when I said to
22 Claire Raggett "Look, this isn't a governance framework,
23 you know, this is what" -- I described what a governance
24 framework looked like and I said, "You must have it, you
25 know, where is it?" And she burst into tears and she --

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1 awareness in the organisation, wasn't around the Board
2 Assurance Framework, it was -- because that is a risk
3 register. It was more at service provision level. So
4 the risk register there for the divisions would be, in
5 terms of their objectives and their -- the services that
6 they had to deliver, what was a risk to delivering that
7 or to delivering it safely, for example? So you would
8 describe the risk, so I'm trying to think of an example.
9 So if you had not enough nursing staff in the emergency
10 department, the risk would be that patients would not be
11 seen and assessed in a timely way, for example, and
12 there would be a whole other list of risks associated
13 with that problem.

14 And then there's a national scoring system for what
15 is the likelihood of that happening, and what is the
16 impact of it? So the impact could clearly be very
17 serious indeed. So if it was catastrophic, that is,
18 say, the death of a patient, that would be the most
19 serious impact and it would receive a high scoring. And
20 then you would factor those and you would quantify the
21 risk.

22 You would then describe what was currently happening
23 in order to mitigate that risk. So for example, our
24 establishment of nurses in the emergency department is
25 not great enough to keep patients safe, and therefore we

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1 Claire is a very honest person and Claire said to me,
2 "I've been told not to tell you that we don't have one".

3 And another moment where the depth of the issues
4 that you're going to have to deal with suddenly becomes
5 deeper, and not any that, you then worry about the
6 people around you who are reporting to individuals who
7 are requiring them not to be honest and open with their
8 new, albeit acting, Chief Executive. So what else are
9 they being asked to do? Why was she so fearful?

10 And the discussion that we had at board was very
11 much along the lines of I would find it, and I think the
12 board and the organisation would find it, helpful to
13 have an independent review of our governance structures,
14 systems and processes from ward to board.

15 **Q.** And you instructed Facere Melius to do that first
16 governance review?

17 **A.** That's right, yes.

18 **Q.** And you have been requesting something that also
19 includes risk management. The Inquiry has seen evidence
20 around the risk register and heard from the Head of
21 Patient Safety and Risk Management. What's the purpose,
22 first of all, of a risk register, and what is risk
23 management in a hospital?

24 **A.** The purpose of a risk register and what I was referring
25 to in terms of the risk management sort of knowledge and

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1 are mitigating that by employing agency staff, and we
2 are mitigating the risk to agency staff by doing X, Y
3 and Z. It might be induction, it might be supervision,
4 working alongside experienced staff, et cetera. You
5 would then rescore the risk and say what is the
6 mitigated risk, but you would be always working towards
7 a fundamental solution of the problem that had led to
8 the risk.

9 So what I had done at Wye Valley where there was
10 also a problem with identifying and managing and
11 mitigating and even describing risk, was we had put
12 together an Executive risk group. So every member of
13 the Executive team, I think with the exception of the
14 Chief Executive in that case, would sit with the
15 divisions, and we would go through their risk registers
16 and support them to identify the biggest risk. Have we
17 really captured the issue here? Are we talking about
18 the wrong thing? For example, you might talk about
19 reputation instead of the real risk, which is harm. And
20 it was a learning process.

21 So we'd certainly had that at Mid Cheshire as well,
22 and at Wirral. So at the Countess again having expected
23 there to be quite a mature process for this, I wasn't
24 seeing these risk meetings happening, and that's because
25 they weren't. They were happening within the divisions

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1 but there was no -- again, no oversight. So we
 2 decided -- I'd recommended that we do an exercise where
 3 we sit down with every division and the lead Executive
 4 for risk was the Director of Nursing, that sat in that
 5 portfolio. So that would be at the time Alison Kelly
 6 and she would lead an exercise with the Executive team
 7 and the senior members of the division to go through
 8 their risk register line by line, over -- I mean at
 9 least half a day, sometimes more than that for the
 10 bigger divisions, to actually make sure that these risks
 11 were the problem was properly identified, the risk was
 12 properly characterised, it was properly scored, the
 13 mitigations were identified, and the progress of
 14 addressing that issue was being monitored.

15 So in the very first of those meetings it became
 16 very obvious, quickly, that the Executive team didn't
 17 understand risk any more than the divisional leads did,
 18 and the sorts of things that I'd seen at Wye Valley, in
 19 terms of the inability to describe risk and to address
 20 it appropriately was in fact it was worse, what I was
 21 seeing was worse. And particularly because at
 22 Wye Valley the other Executives were -- I was the
 23 Medical Director, the other Executives were at least as
 24 able as I was, if not more so, to be able to support the
 25 divisions to learn and develop in this area. What I was

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1 **MS LANGDALE:** Dr Gilby, you mention at paragraph 79 of your
 2 statement that you were also made aware of issues in the
 3 human resources team and that was a matter of concern to
 4 you in your early time at the Trust. What was your
 5 concern about that?

6 **A.** When I first started and had a short period of time as
 7 the Medical Director, I didn't see the human resources
 8 function around the responsibilities of the Medical
 9 Director and the medical workforce and medical training
 10 set up in a way that I had seen in other organisations.

11 And then, when I became the Chief Executive acting
 12 into the role, going around the organisation and talking
 13 to colleagues in different departments and specialties
 14 and at different levels, HR support or lack of it, or HR
 15 support to that approach to their work was something
 16 that was frequently raised in almost every conversation.

17 And the substantive director of HR, Sue Hodgkinson,
 18 became quite unwell and she had to have a period of time
 19 off work. We had an interim director of HR, which was
 20 going to be initially for a period of about three
 21 months, and having looked at the structure of the
 22 portfolio, she felt that, you know, there were some
 23 probably improvements that could be made but they were
 24 for Sue Hodgkinson to make when she returned to work,
 25 which we were fully expecting her to do.

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1 seeing around me from the Executive team was that they
 2 were as much in need of that learning and development as
 3 the divisions that they were leading and so initially
 4 perhaps inappropriately putting my sort of interjecting
 5 and having to sort of tactfully say, "I don't think
 6 we're on the right page here and can we take it back to
 7 the beginning", I eventually said, "I'm going to lead
 8 these exercises".

9 And they were still ongoing when we got to the point
 10 of the pandemic, and unfortunately a lot of the work
 11 that we were doing in terms of improving governance was
 12 slowed down, if not completely halted for periods of
 13 time.

14 But that was something I think that was really
 15 a fundamental issue in the organisation, that meant that
 16 the -- which means that the strategies that were being
 17 in the neonatal unit were not being seen at board level.

18 **MS LANGDALE:** That's the moment, my Lady, I think to pause
 19 for the morning break.

20 **LADY JUSTICE THIRLWALL:** Thank you very much. We'll take
 21 a break now until quarter to 12. So if we'd all be back
 22 by then, please.

23 (11.27 am)

(A short break)

24 (11.45 am)

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1 So I invited Alyson Hall, who was the interim
 2 director, to do a sort of root and branch review of the
 3 HR structures and functions and processes, literally as
 4 a -- to see whether there were any recommendations or
 5 tools for improvement that Sue could use on her return,
 6 and also, for us to be able to report to the board if
 7 there was a need for improvement in funding or resources
 8 in other ways.

9 So that process started, and then she came to me to
 10 say that both her and the person who was helping her
 11 with this process were having conversations with HR
 12 professionals who were raising very serious concerns
 13 about bullying and harassment within the HR division,
 14 and this was from -- not from Sue Hodgkinson herself,
 15 there was no suggestion of that at all, it was from
 16 senior members of the HR team who reported directly to
 17 Sue.

18 This was obviously really concerning, but people
 19 were speaking up, which was heartening, in a sense. And
 20 so we had to change the focus of the review to listening
 21 to these individuals and actually doing a full
 22 investigation into the concerns that they had raised,
 23 which resulted in a report which, my recollection is
 24 that it was a shocking indictment of the way in which
 25 these individuals, but also people within their

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1 portfolios, were behaving towards not only each other
2 but towards partners in the business. So they would be
3 supporting a particular specialty or division but the
4 way in which they enacted their responsibilities was
5 inappropriate in the extreme. And that had resulted in
6 this way of working to be learned by non-HR
7 professionals, which was why relatively junior, or
8 relatively inexperienced -- I've used the word "junior"
9 a few times and I don't mean that in a derogatory sense,
10 people that were still in their roles and developing
11 would learn behaviours that were unhealthy for them and
12 their colleagues in the organisation.

13 **Q.** You say in your statement:

14 "Human resources staff were feared in some cases
15 rather than seen as a partner in delivering safe patient
16 care. They were also seen as barriers to the official
17 recruitment and on-boarding of staff. I also observed
18 several times that when a member of staff had
19 performance or behavioural issues in their role they'd
20 be moved sideways around the organisation. This was
21 especially the case in the nursing division."

22 **A.** Yes.

23 **Q.** So in terms of performance management, which of course
24 is a function of HR, and sometimes investigating and
25 sometimes making findings --

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1 they weren't trained to do and weren't happy doing, and
2 there was therefore a lot of harm and, you know,
3 discomfort to the individuals concerned.

4 **Q.** We know of course in the context of the Inquiry that
5 Letby was placed in the risk and governance team in
6 2016, and remained there until her arrest in 2018. In
7 your experience of other cases, were these short-term,
8 sideways moves, or was there anything that was lengthy?
9 That was clearly a lengthy period but did you see if
10 that arose --

11 **A.** They were always long term moves. I don't think I ever
12 saw anybody moved into a role like into risk and
13 governance or patient safety or education, and then
14 moved back to their initial role.

15 **Q.** Was the transparency around it -- I don't want to know
16 about any individual cases -- but would there be
17 transparency around why this nurse might have been
18 having a clinical facing role and then moved into
19 something administrative if that happened or if --

20 **A.** Absolutely none, no. It was -- and of course, that then
21 results in, you know, rumours running rife around the
22 organisation, often what has been said about the
23 individual isn't accurate, which is why it's not fair,
24 not just on patients and the service and colleagues, but
25 also on the individuals, to treat them in that way. And

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1 **A.** Yes.

2 **Q.** -- making decisions, are you suggesting there that those
3 difficult decisions might have been avoided and were
4 sideways moves, or what?

5 **A.** Yes, on occasions they were avoided and sideways
6 moves -- I've never seen sideways moves happen in the
7 way they happened in the Countess and even when I was
8 substantive Chief Executive, they would be happening
9 without my knowledge. I would discover that -- and it
10 was exclusively in the nursing portfolio at this point
11 -- that a senior nurse in a particular department had
12 been moved into a different department or into
13 a non-patient-facing role because of concerns about
14 their -- usually about their behaviour rather than their
15 competence.

16 It seemed that if there was a clinical practice or
17 competence issue, that that would be dealt with
18 appropriately, but if the issue was about behaviours or
19 competence within a managerial or leadership role, that
20 wasn't addressed, and so there were quite a number of
21 these moves had been made historically, and as a result
22 of that, there were individuals across the organisation
23 increasing in numbers who everybody was concerned about
24 because of their not necessarily exhibiting the right
25 values, but also, because they were put into a role that

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1 we have policies for performance management or conduct
2 issues that are there for a reason, and they're to keep
3 the individual safe as well as colleagues and patients
4 in the organisation, and those policies were just not
5 being followed.

6 When I became aware of it, I would take steps to
7 question and challenge that, and it was stopped. But it
8 certainly -- it was not -- the reason it wasn't raised
9 with me is because it was so endemic it didn't occur to
10 anybody that this wasn't the right thing to do. And it
11 seemed to stem partly from the values of the
12 organisation at the time were safe, kind, effective,
13 which on the face of it seem perfectly sensible values
14 to have in a hospital. But it's how you interpret and
15 live those values that's important. And the word "kind"
16 was used a great deal by the Executive team that I first
17 joined, in terms of iterating those values.

18 So if somebody was found to be poorly performing or
19 there were multiple concerns being raised about their
20 behaviour, the kindness would be just to move them
21 sideways and not to deal with it, whereas to me, that
22 was a misinterpretation of that value on a number of
23 levels. And "safe", "kind", "effective", was something
24 that was repeated almost like a mantra everywhere, and
25 I actively discouraged this, because it was becoming --

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1 it was having a negative effect. It was almost becoming
2 a toxic value in the organisation, and people were very
3 cynical about it.

4 **Q.** Paragraph 93 of your statement. We touched upon risk
5 earlier and assessment of risk. And you say:

6 "At the time of [your] joining the Trust there was
7 a reluctance to report incidents, for fear of the
8 consequences ... [and] the reporting of 'low harm' and
9 'no harm' incidents was very low in comparison to peer
10 hospitals ..."

11 **A.** Yes.

12 **Q.** What's the importance of being able to discuss and
13 report low harm and no harm? Is it to get the
14 reflective culture you've been referring to earlier and
15 the sharing of knowledge from there was events or why do
16 you say it is so significant they didn't seem to be
17 reporting those events?

18 **A.** It is partly to have that reflection, and to -- for
19 people to learn, you know, how to report incidents, and
20 the benefits of doing so. But it's also -- almost like
21 a canary in a mine. If you have multiple low and no
22 harm incidents in a particular area or of a particular
23 issue, then it gives you an indication of where you
24 might need to review the service or the procedure, and
25 have an intervention.

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1 organisations where they report a lot of low harm and no
2 harm.

3 **Q.** Paragraph 104 in your statement. You tell us that:

4 "On 24 May 2018 Sir Duncan called me to discuss the
5 neonatal situation, and asked for my help. He then sent
6 me a list of questions that the consultant
7 paediatricians had submitted to the Chief Executive
8 Officer [Mr Chambers] followed by a draft response."

9 The Inquiry has examined the paediatrician's
10 questions and the response that went back ultimately, so
11 we don't need to go back to that document. But can you
12 just tell us what Sir Duncan Nichol said to you and the
13 conversations you had with him about the breakdown in
14 relationships between the paediatricians and the
15 Executives.

16 **A.** Before he sent me this list, and actually, I'd been
17 appointed in the March, and it was in the -- in that
18 interim period where people were starting to be open
19 with me as they wouldn't have done as a candidate, about
20 the relationship issues between the Executive team and
21 the paediatricians.

22 **Q.** So you didn't have any clue about it when you were
23 a candidate?

24 **A.** No, the only thing I knew was what Ian Harvey had told
25 me in January 2017.

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1 But more importantly, it's an indication of a really
2 healthy safety culture. So what happened at the
3 Countess was the first question would be: well, did
4 anybody really come to harm here? Well, no. So I'm not
5 going to mention it, because if I do -- and I wouldn't
6 say this was universal, but it was more common than not,
7 the staff would feel that if they did, not the
8 Executive, but their immediate line management or
9 perhaps the level above that, would be -- would not
10 appreciate that in the spirit in which it was meant. It
11 was: why are you reporting these incidents? It's making
12 my service look bad, it makes me as a leader look bad.

13 And it goes back to the behaviours of attitudes of
14 HR and perhaps, you know, some of the Execs that they'd
15 learned, which is managing people in an aggressive way
16 as opposed to celebrating the person who has reported
17 the most no-harm incidents.

18 So it's been -- there is plenty of research and data
19 that shows that the Trusts who have the highest 10, 20%
20 reporting rates for low and no-harm incidents, tend to
21 be those who are categorised as "Outstanding"
22 organisations or "Good" organisations, particularly in
23 the safety element of the CQC standards. But putting
24 the CQC to one side, the outcomes for patients and the
25 experience of staff tend to be the best in those

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1 **Q.** February 2017?

2 **A.** Sorry, February 2017. So more than a year before
3 I applied for the role, and it didn't really come up
4 again, in terms of the relationship, I obviously knew
5 about the issue by then.

6 So one of my meetings with Tony Chambers, he
7 discussed with me the problems that they were having
8 with the paediatricians and Duncan was meeting with the
9 paediatricians at the time to try to broker some sort of
10 improvement in relations. I think everybody
11 acknowledged that it's a potential patient safety issue
12 for there to be conflict between or a totally broken
13 relationship between the leadership of the organisation
14 and specialty experts in one of the important
15 specialties in the organisation.

16 So by the time this list of questions was sent,
17 I was aware, and they had discussed it with me. And
18 Duncan was very, very concerned. He was visibly trying
19 to broker peace, if you like, between the two groups,
20 and I do find --

21 **Q.** What did you say about the draft? You were sent the
22 draft from Mr Chambers?

23 **A.** Yeah.

24 **Q.** And he asked you and Sir Duncan to read it or review
25 it --

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1 A. Yes.
 2 Q. -- and you say "I found the draft to be tone deaf".
 3 A. Yes, I think he was concerned that the questions weren't
 4 necessarily being answered and he was starting to
 5 question the approach that was being taken to the
 6 paediatricians, and now that I'd been appointed, I think
 7 that he felt, before this was sent, that he should run
 8 it by me.

9 I don't know whether he discussed that with Tony in
 10 advance but I don't think that he did.

11 When I read -- I read first of all the
 12 paediatricians' list of questions, and, you know, you
 13 could -- I'd never met them before that point, I didn't
 14 know their names. But you could see the anguish coming
 15 off the page, and yet the response that had been
 16 formulated read as though, with all due respect, it had
 17 been written by lawyers. That it was very defensive, it
 18 was dry, it didn't acknowledge their experience, and
 19 I felt that you could -- if you were trying to broker
 20 the peace that Duncan was describing his desire was,
 21 that this probably was going to be detrimental, and so
 22 I had a very -- I remember it was quite late at night,
 23 I had a very long conversation with Sir Duncan on the
 24 phone about what -- how it might be reframed.

25 So the substance of the answers were not different;

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1 A. Yes, I felt they did believe they were being genuine,
 2 but they were wrong. They were very dismissive of the
 3 paediatricians and on a number of occasions it was said
 4 to me that they were just looking for somebody to blame
 5 and they had -- I remember Tony on one meeting said --
 6 well, he looked around the room and, you know, he
 7 physically pointed and he said, "And they said, well,
 8 we'll say it was her". And in fact ... so at this point
 9 I hadn't seen the Royal College review, I was told the
 10 Royal College review had not found any evidence of
 11 deliberate harm. I was told that there had been
 12 a detailed specialist review of the cases and that had
 13 not come up with any evidence of deliberate harm. I had
 14 no reason not to take any of this at face value at this
 15 point. And so did we have a group of paediatricians who
 16 were making something up? They didn't ever give me that
 17 impression; they just felt that the paediatricians were
 18 unable to accept that they weren't the best, and so when
 19 outcomes were poor, they were looking for somebody to
 20 blame.

21 There was nothing at my disposal that enabled me to
 22 challenge that view at the time.

23 Q. Paragraph 145, you say you were surprised that
 24 Mr Harvey:

25 "... told me that he had had no Maintaining High

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1 it was the way in which it was being expressed in
 2 particular.

3 Q. And at that time you hadn't spoken in detail to
 4 Mr Chambers, Mr Harvey, or any of the paediatricians?
 5 It was just Sir Duncan --

6 A. I'd never met the paediatricians. And I had spoken to
 7 Mr Harvey and Mr Chambers but only in very sort of high
 8 level terms. And it was mainly them expressing their
 9 frustration about the ongoing behaviours and about the
 10 reputation issues of the police investigation because
 11 this was prior to Letby's arrest, and they were fairly
 12 confident, I would say very confident in some cases
 13 that, you know, they've been investigating for X number
 14 of months, I'm sure they're going to tell us soon that
 15 it's all over and, you know, the problem is the
 16 paediatricians and their department.

17 And that was the mantra I was given right up until
 18 the day I started.

19 Q. Did you, from Mr Chambers or Mr Harvey in those early
 20 stages before she was arrested or -- get the sense
 21 whether they thought the concerns of the paediatricians
 22 were genuine at that time, albeit wrong in their view,
 23 in terms of what the evidence led to, as far as they
 24 were concerned, but that they were being genuine in
 25 using them?

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1 Professional Standards ... cases in his six years as
 2 Medical Director."

3 A. Yeah.

4 Q. Do you remember? What do you mean by that? Why was
 5 that surprising?

6 A. Well, he was responsible for the registration and
 7 revalidation and training of hundreds of medical staff,
 8 and the notion that in six years, not one single doctor
 9 had any concerns raised around their practice or
 10 behaviours that required examination by the GMC or to go
 11 through an MHPS process, it seemed highly unusual. And
 12 I remember -- again I can visualise that conversation --
 13 he was proud of that.

14 I, on the other hand, had been a Medical Director,
 15 albeit in two different organisations, for a number of
 16 years and prior to that an associate Medical Director
 17 for several years and even as a clinical director for
 18 that, had had cases where it was necessary to use the
 19 policies around Maintaining High Professional Standards
 20 to address a doctor's practice, whether it was
 21 competence behaviour or professionalism. And I just
 22 found it very hard to believe that there were no
 23 concerns of that nature in the organisation for an
 24 entire six years.

25 Q. You set out in that paragraph what you say his parting

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1 words were after that conversation. What was that
2 about?

3 **A.** Well, it was our handover meeting. And it to be fair to
4 Mr Harvey, it probably was quite an emotional couple of
5 days for him. He'd been a consultant and then a Medical
6 Director in the Trust for decades, and he was in his
7 last hours in that organisation. So the handover
8 process to me probably was, I would imagine, a very
9 minor part of what was happening in his head that day.
10 We sat in Meeting Room 1 in the Long House. He had an
11 A4, a ringbinder with notes to hand over to me. I made
12 handwritten contemporaneous notes which I believe you've
13 seen --

14 **Q.** The Inquiry has seen all of your handwritten notes, yes.

15 **A.** And he went through various specialties, the challenges
16 in those specialties. There was very little, if
17 anything, said about the neonatal department that --
18 we'd had that conversation previously. And then we
19 stood up to go, and as we walked out the door, he's
20 packing his things away and he said to me "You need to
21 refer those paediatricians to the GMC". And I said,
22 "Well, why haven't you?" And he jokingly said, "I don't
23 want to" -- I can't remember the exact words now, but
24 "I don't want to break my clean record" was effectively
25 what he was saying.

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1 that discussion over a couple of months with Mr Chambers
2 and also at this point with Mr Harvey.

3 **Q.** You met with Mr Chambers you say on the first day of the
4 Trust and then you went on to meet Dr Brearey and
5 Dr Jayaram. And again, we've got all your notes, all of
6 the core participants have all of your notes, but
7 summarising, if you can, your discussions with
8 Mr Chambers around the issue of Letby's arrest and what
9 was going to happen or what might not happen, what kind
10 of discussions did you have him about that topic?

11 **A.** They changed as time went on, as my first few weeks went
12 on, because my view of things changed once I'd had
13 a chance to speak to the paediatricians and look at
14 documents. So initially, and this is particularly on
15 day one, the same day, I think as the handover with Ian,
16 first of all, Tony Chambers was very concerned about the
17 breakdown in the relationship, and he emphasised the
18 need to address that, to fix it, and he had already made
19 some effort to identify a team of people who were
20 professional mediators who might be able to help but he
21 felt that it needed, the commissioning needed to be done
22 by somebody who wasn't conflicted. And as just about
23 every member of the board was conflicted, that meant
24 that it needed to be me.

25 He gave me the contact details of the person who

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1 And I can understand why, because I know, I've read
2 the transcripts, that Mr Harvey denies that he said
3 that. I can understand why he says he doesn't recall
4 saying it, given the nature of that day and all of the
5 other things he'd had to deal with around the tragedies
6 on the neonatal unit and the paediatricians raising
7 concerns, but to me, it was a very significant meeting,
8 and it was a very shocking statement.

9 **Q.** Although you say you'd put your notes away at that point
10 and --

11 **A.** I had and was already at the door, yes.

12 **Q.** If it was said to you, would it be flippant? Could it
13 have been a flippant remark?

14 **A.** No, it wasn't a flippant remark.

15 **Q.** Not a serious one?

16 **A.** No, he was serious. I mean, he said it in a --
17 I wouldn't say a jokey manner, it was sort of "Huh, and
18 by the way", it was like that. So obviously I came away
19 from not just that but also the briefings I had before
20 I started thinking: it looks like one of my initial
21 serious tasks as a Medical Director is to have a look at
22 this for myself and I obviously have to meet with these
23 paediatricians and I will make it a priority, because
24 I was being given the impression that I had some problem
25 doctors that needed dealing with, and I think we'd had

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1 he'd been in touch with, and he told me that they would
2 be expecting my call, and I did call them the same day,
3 because I agreed with him that if there has been
4 a complete breakdown of relations, then that is
5 a patient safety issue as well as a staff experience and
6 safety issue. So that was on the one hand wanting to
7 fix the relationship with the paediatricians for all the
8 right reasons, and --

9 **Q.** And we know for various reasons the mediation didn't
10 go --

11 **A.** No.

12 **Q.** Didn't take place in due course, did it?

13 **A.** And on the other hand, the discussions about the very
14 recent arrest, I found to be quite bizarre. So I would
15 have expected and I did expect to come in, as I said
16 earlier, to particularly an Executive team who were
17 absolutely reeling from the fact that a person had been
18 arrested for multiple -- in the investigation for
19 multiple murders and attempted murders in their
20 organisation under their watch. And what I found and
21 what Tony wanted to discuss with me, was his concern
22 that actually, he still believed, in spite of the
23 arrest, that no deliberate harm had been caused. He
24 kept repeating that there was no single cause found, and
25 I said to him, "Well, it's not for you to find the

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1 cause. You have unexpected and unexplained collapses
2 and deaths of patients, and that even one of those, is
3 a cause of concern".

4 And he just was very focused on the worry that the
5 paediatricians may have caused this nurse harm, and that
6 that his worry was a wrongful conviction. But he was
7 still confident that even though she'd been arrested,
8 that there would be no progress, that there wouldn't
9 ultimately be a charge.

10 And at first, I was -- I'd mostly listened. But
11 that changed after I had spent time with Dr Brearey and
12 Dr Jayaram, and also had gone through a large number of
13 documents I found in Ian Harvey's old office.

14 **Q.** Shall we put appendix 1 up which sets out the documents
15 in a box file that you found, and that's INQ0101076,
16 page 53. It's your appendix 1.

17 Here we are, here's the list. If we scroll down the
18 list, you -- did you find this index? Who produced the
19 index to the documents?

20 **A.** I did.

21 **Q.** You did. So if we go down -- well, tell us, how did you
22 find the documents? We know Mr Harvey texted you about
23 them later, we can go to that, but how did you find them
24 and what did you do when you found them?

25 **A.** Well, having spoken to Dr Brearey, I then arranged to
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1 in here. Opened it up only to find the list of printed
2 out emails, the reports --

3 **Q.** Is this the order?

4 **A.** No, that's not the order. The order is changed from the
5 original because I gave it to the police, actually we
6 went through it together. DCI Hughes and I went through
7 it together. And he took it away and then gave back to
8 the Trust the documents that they already had copies of.

9 **Q.** So you gave this index as we see here with all of the
10 documents in it to the police?

11 **A.** Yes.

12 **Q.** Because there's a number, for example, the letter from
13 Tony Chambers to Lucy Letby, some of the handwritten
14 notes of Mr Harvey that we haven't yet seen?

15 **A.** Yes.

16 **Q.** But the police had all of these, as far as you're
17 concerned?

18 **A.** Yes, they did.

19 **Q.** And the summary to the board prepared by Sue Hodgkinson.
20 So that was all handed over. And if we can go please to
21 INQ0101076, page 53. Sorry, that is the one we've on.
22 If we go to INQ0099064, page 18. So this should be
23 a text from Mr Harvey to you, Dr Gilby. 0099064,
24 page 18.

25 We see there you have his phone number, you're
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1 meet with Dr Jayaram, who was on annual leave, actually,
2 and came in to see me. And he asked that we didn't meet
3 in the Executive suite. He wanted to meet in
4 a different location, so that he didn't have to bump
5 into Mr Chambers or any of the other Executives.

6 So I agreed to meet him in what had been Mr Harvey's
7 old office, so he hadn't moved when the others moved
8 into a shared space. He had kept his -- the traditional
9 Medical Director's office in the main hospital building.
10 It was a really large room, and I got there early, and
11 I was sitting at what had been his desk, and the room
12 was otherwise completely empty of documents. And Ravi
13 was a little bit late, and the desk was about this size,
14 it had drawers, and I started opening them because
15 officially this was my office but I wasn't intending to
16 use it for my personal use. And then the very bottom
17 drawer I opened, and unlike every other shelf and drawer
18 in the room, it had a large box file. And on the side
19 of the box file was written the letters "NNU" which
20 I took to mean neonatal unit. And I thought: what?
21 I mean, I just could not believe that there was
22 a significant pile of documents relating to the neonatal
23 left in an empty office in the main hospital. And this
24 was something that might have been handed to me at the
25 handover so I thought perhaps there's nothing important
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1 messaging each other at various times, aren't you,
2 Dr Gilby?

3 "Hi Susan -- hope all okay. Just had a long chat
4 with Tony. Rumour has it that I can expect to hear from
5 the GMC -- alleged paedics have referred. I left a file
6 of neonates documents for you locked in desk drawer in T
7 block office. Please could you get Claire Raggett to
8 copy them for future reference."

9 So he's left them in a place, knows you're going to
10 see them or should see them. Did you get the text
11 before you'd seen the box or after --

12 **A.** No, well after it.

13 **Q.** Okay. So you read the documents, do you --

14 **A.** Yes.

15 **Q.** -- before you speak to Dr Brearey or Dr Jayaram or
16 around the same time?

17 **A.** No, I'd already spoken to Dr Brearey, so I'd already
18 spent three hours with Dr Brearey -- I don't know if you
19 want me to talk about that meeting but I spent three
20 with Dr Brearey and then as a result of that, had
21 arranged to meet with Dr Jayaram.

22 **Q.** What did you learn from talking to Dr Brearey that you
23 didn't know about before? You've set out in detail what
24 you've said about different babies, I don't need to ask
25 you about that, but what did you ascertain in that
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1 meeting that you hadn't been aware of until you spoke
2 with him?
3 **A.** To be honest there was very little that he said that I'd
4 been aware of previously. He very calmly took me
5 through the timeline of events, but before starting
6 that, he said that they had been raising concerns
7 about -- and initially, it was about unexplained,
8 unexpected clinical collapses and deaths in the unit,
9 and they hadn't been listened to, and it hadn't been
10 addressed appropriately.

11 Now, that bit of it I had heard from the Executive
12 team and Sir Duncan. So I was listening with an open
13 mind to what I thought was going to be the other side of
14 the story of -- of what I'd so far heard, which was it's
15 a -- there's problems on the unit, problems with the
16 individuals. But he started to tell me the pattern of
17 events, and not just the clinical pattern, but what
18 happened as a result of them raising concerns. And we
19 didn't get very far into the conversation before it
20 became obvious to me as a clinician, never mind as an
21 Executive, that these just -- it was most unlikely that
22 these were clinical explainable collapses. It didn't
23 seem possible. And I think at one point I made an
24 exclamation when he told me about a particular issue,
25 and he said to me "You've been here for five minutes.

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1 What Dr Brearey was describing to me was something
2 that I have never ever seen or heard of in my clinical
3 practice, and just one of those for me would have been
4 enough as a Medical Director or a director of nursing to
5 absolutely want to get to the bottom of what has
6 happened here.

7 And to involve the parents right from the beginning,
8 in terms of being open about their concern that we
9 haven't really got a full -- we haven't got an
10 explanation, we are going to get external help. Being
11 open about the fact that we will learn everything we can
12 about the death or collapse of your baby --

13 **Q.** Would you have asked any of the parents about their
14 experience of the treatment of the baby or their
15 interactions with the staff?

16 **A.** Definitely, yes. When you're investigating an adverse
17 event, whether or not you believe that there's been
18 deliberate harm, it's the most important people. They
19 are the most important people. And if it's possible,
20 you should talk to the patient. Clearly in these cases
21 that's not relevant, but you -- not only would you talk
22 to the parents because they were there, but even had
23 they not been there, you would want to sit down with
24 them and explain the entirety of the baby's admission to
25 the opportunity, what had gone well, what had not gone

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1 You get it. We've been trying to tell them for years".

2 And so I went out and asked Claire Raggett to clear
3 the afternoon. And so we spent three hours going
4 through the timeline, both clinically and
5 non-clinically, of everything that had happened. So
6 I discovered clinical histories of patients who were
7 doing well, who were expected to go home, who perhaps
8 even the day they were due to go home, suddenly having
9 a cardiorespiratory collapse and being refactored to
10 resuscitation in a way that you would never expect with
11 a child or especially with a baby. Perhaps it was
12 helpful that my background is critical care and I have
13 spent quite a bit of time in paediatric critical care
14 and in surgical neonatal and critical care.

15 But even had that not been the case, even with
16 adults, on an intensive care unit you have a watchlist
17 of patients who are at risk of deterioration or who are,
18 you know, whose clinical condition is fragile, and if
19 they deteriorate it's not like flicking a switch, it's
20 a gradual worsening of their vital signs, if you like,
21 if their oxygen saturations, their blood pressure, their
22 heart rate change, either became too fast or too low,
23 wrong rhythms, you see patterns in breathing changing,
24 interventions take place to stop that from
25 deteriorating.

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1 well, what you were concerned about, what were their
2 concerns? Do they have any concerns? And I'm sure in
3 some cases it would be an entirely -- I'm not talking
4 about these particular cases but generally, in medical
5 practice, and I can actually think of a recent incident
6 of this, that you would perhaps -- perhaps it would be
7 a surprise to the parents that you were concerned or to
8 the patient that you were concerned about a particular
9 outcome, but it's very important to -- it's their
10 health; it's their child's health and it's very
11 important to have their input right from the beginning.

12 And often, they've got valuable insights, but it's
13 just -- it's their right to know what is happening with
14 their care and what is happening, and to review the care
15 afterwards.

16 So one of the things I did learn from Dr Brearey is
17 that the parents -- and he was quite distressed about
18 this -- that the parents had not been offered candour in
19 the way that he would normally want to use, you know, in
20 a poor outcome. And he was very distressed about that.
21 But we went through each collapse and each fatality one
22 by one and also each incident of them going to or
23 communicating with the Executive team about their
24 concerns, and the final events that finally led to the
25 police being called.

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1 And I confess that I did have in my mind questions
2 about why were they not able just to go to the police
3 themselves? Our A&E Consultants, for example, would
4 call the police all the time, and they don't ask the
5 Executive team if that's okay. But later, I went --
6 I learned that the interactions had been so threatening
7 that they were fearful.

8 So we had discussions about the clinical scenarios,
9 and it was the first time I was hearing that so you
10 asked me what did I learn? Well, I learnt clinical
11 information that gave me great concern. Not just about
12 the findings, but the nature of the collapses and as
13 I said the unexpected nature of them, and I also learnt
14 of the efforts they'd made to go through the right
15 processes and use investigations to get to the bottom of
16 it.

17 **Q.** You comment in your statement on the Freedom To Speak Up
18 process, it's going back in your statement at
19 paragraph 119. You say before you joined the Trust, the
20 Trust had adopted a Freedom to Speak Up process such as
21 had been recommended in 2016 by Sir Robert Francis.

22 Then you continue at paragraph 120:

23 "Somewhat unusually, the Freedom to Speak Up
24 Guardians at the Trust were mainly Executive officers --
25 I recall that Sue Hodgkinson (the Human Resources

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1 on a part-time basis. And it was made very clear to me
2 that the intention was that that would be one of the HR
3 team who reported to Sue Hodgkinson and her deputy,
4 although we were interviewing several people but
5 a decision had been made in advance of the interviews.

6 Now --

7 **Q.** Sorry, can you say that again, the decision --

8 **A.** The decision had been made in advance of the interviews
9 who was going to be appointed. However, that didn't
10 happen, because the interviews, I think, took place
11 after I became acting Chief Executive and I chaired the
12 interview panel, and we appointed an external person.

13 **Q.** Do you think this is peculiar to the NHS? You describe,
14 for example, how Sir Duncan approached you and was
15 encouraging you because of your reputation and here you
16 are describing in another division not only interviews
17 lined up but a decision --

18 **A.** Yeah.

19 **Q.** -- or people already talking about who is the right
20 person for the job. It doesn't reflect how it works or
21 doesn't reflect how it should work generally, does it,
22 in any case?

23 **A.** No, I mean when it came to appointing both the Medical
24 Director and the Chief Executive of the Trust, they were
25 using independent recruitment consultancies, so

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1 Director) and Alison Kelly ... were amongst them."

2 What was your experience or expectation, then, as to
3 where the Freedom to Speak Up Guardians would come from
4 in the Trust or any Trust?

5 **A.** Well, my previous experience of the Freedom to Speak Up
6 process had been at Wirral University Hospitals, where
7 the Freedom to Speak Up officers were independent from
8 the Executive and the board. There were Freedom to
9 Speak Up champions on the board, both Non-Executive and
10 Executive, but the people would -- staff were being able
11 to go to someone who was completely independent from the
12 leadership of the organisation to raise a Freedom to
13 Speak Up concern, which makes sense because if you
14 don't -- if you're not worried about raising the
15 concern, you would do it through normal line management
16 channels. So by definition, you're going through
17 Freedom to Speak Up process, where you don't feel able
18 to use the line management route. And ultimately, the
19 line management route leads to the Executive and the
20 board. So it was counter-intuitive that the people who
21 were hearing Freedom to Speak Up concerns were the top
22 of the line management tree.

23 And there was a process already started, when
24 I arrived, to recruit a Freedom to Speak Up Guardian
25 who -- it would be their sole role in the organisation

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1 headhunters, and there were a number of other applicants
2 and there were external people on the panels, very
3 senior, including NHS England, etc. So there was the
4 safeguards were there, but internal processes didn't
5 seem to work that way.

6 **Q.** Is it the fear of dismissing people, do you think, or
7 performance managing people, that people are moved to
8 different jobs and sidelined to different jobs -- I'm
9 not obviously talking about your job as a Medical
10 Director but generally within an organisation if someone
11 doesn't fit in one part of it, move them to another
12 part, rather than take difficult decisions --

13 **A.** Yeah.

14 **Q.** -- about --

15 **A.** I mean, I think that's separate from the Freedom to
16 Speak Up Guardian process which I think was more about
17 control, which -- but if you're referring to moving
18 people around the NHS or around an organisation, yes, it
19 does seem to me -- and it is something that was
20 attempted with me actually, at the end of my time at the
21 Countess, that if someone seemed to be a problem for
22 whatever reason within that particular organisation,
23 then rather than have something that's going to look bad
24 in the public domain, we will simply move them somewhere
25 elsewhere they will hopefully have some time to apply

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1 for another job where there is a competitive process
2 somewhere else but we'll give them that breathing space.

3 Occasionally there is genuinely a role that that
4 individual's skills and experience would be helpful for
5 and it is a temporary role, and there's no employment
6 rights associated with it. But I've seen -- and this
7 isn't just in Chester or even just in the north west,
8 I have seen time and again Executives moved from
9 a provider organisation, a provider Trust, into
10 a regulator or a think-tank or a system role, so
11 NHS England or an ICB still being paid for by the
12 provider Trust, and nobody is questioning it.

13 And often it's not the fault of the individual.
14 They've done nothing wrong, but they've just become
15 a thorn in the side of either the organisation or the
16 system, and this is something they are offered as a *fait*
17 *accompli*: you know, move or we'll make life difficult
18 for you. You may lose your job.

19 And most people in that position are -- they're
20 providing for families and they can't afford to
21 challenge that behaviour. Or, they can't, in terms of
22 their own personal resilience, go through what they know
23 will be an incredibly difficult and protracted process
24 to stand up for what's right.

25 And when I've seen it happen to others, it's been
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1 been properly implemented from the outset ..."

2 In relation to the events we're dealing with?

3 **A.** Yes.

4 **Q.** "... rather than being an adjunct to a human resources
5 function that was a bullying hotspot, the
6 paediatricians' concerns might have been objectively
7 listened to sooner -- and they may have been more
8 forceful about raising the issues because they might not
9 have had the same fear about retribution."

10 **A.** Yes.

11 **Q.** So do you think Freedom to Speak Up and those systems
12 can be effective --

13 **A.** Yes.

14 **Q.** -- if they're used properly?

15 **A.** They can. The Freedom to Speak Up Guardian, if you
16 like, it's a different term in different places, would
17 effectively act as their advocate. The Freedom to Speak
18 Up Guardian should have direct access to the Chief
19 Executive and if there is an issue with the Chief
20 Executive, to the chair and, you know, further to the
21 board, if there are issues with the chair.

22 But the paediatricians didn't have that independent
23 voice, making sure that the proper listening was being
24 done and the proper examination of their concerns, and
25 more importantly, perhaps, that they weren't suffering

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1 with that in mind that they had no choice. And there's
2 been a reluctance, particularly from NHS England as it
3 is now, to really listen to some individuals who are
4 saying, "I'm raising a concern, I need your help to deal
5 with it". So as I told you earlier that I had wanted to
6 go through the proper channels to raise my concerns and
7 I did that through the appraisal process and I did that
8 through the formal grievance and bullying and harassment
9 policies, and when that didn't work and when I was
10 attacked further I went to NHS England -- sorry, I went
11 to the lead governor, and when no action was taken then,
12 I then went to NHS England at regional level. And I was
13 given some assurance that I had their full support, they
14 didn't want a change of regime, as they put it, a change
15 of Chief Executive, that they would speak to the senior
16 independent director and address the matters.

17 When I returned from some leave, I was dismayed to
18 find that actually they just took a step back and then
19 some time later I was offered a role as yet undefined in
20 NHS England, but the Trust required me to drop my
21 concerns about bullying and harassment in the
22 organisation and particularly by the chair but not
23 exclusively so.

24 **Q.** You say in your statement at paragraph 128:

25 "I believe that had the Freedom to Speak Up process
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1 detriment as a result of having raised those concerns.

2 They may have been wrong, but they had the right to be
3 listened to and for their concerns to be properly
4 investigated, and they were raising the most serious
5 concerns you could ever have, which is unexpected and
6 unexplained deaths and collapses of babies in an
7 environment where they should be at their safest. It's
8 hard to understand why that wasn't taken as seriously as
9 it might have been.

10 **Q.** You set out at paragraphs 189 onwards you had a meeting
11 with Dr Jayaram, and you say he told you of his
12 frustration regarding the fact that the paediatricians
13 hadn't been allowed to contribute to the terms of
14 reference of the Royal College review. Can you remember
15 that meeting and what he said about that?

16 **A.** Yes. Again, this was a very long meeting with
17 Dr Jayaram on the same day that I'd found the documents
18 and shortly after I'd met with Dr Brearey. And he spoke
19 less about the clinical scenarios, because he was aware
20 that I already had been briefed on that by Dr Brearey,
21 and more about the various investigations and processes
22 that went on around their -- the concerns that they had
23 raised.

24 So I had been told that the Royal College of
25 Paediatricians review -- of Paediatrics and Child Health

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1 review had excluded any possibility of deliberate harm,
2 but I had a glance through that paper before meeting
3 with Dr Jayaram, and it was clear that it was at the
4 Invited Service Review, which is not a review of the
5 clinical cases.

6 So I raised that with Dr Jayaram, and he -- and
7 I said, you know, why didn't they look at it? And he
8 said, "We were not allowed to contribute to the Terms of
9 Reference, even at an early stage. It was drawn up
10 solely by the Medical Director without any reference to
11 our specialty, knowledge, or expertise, or the concerns
12 that we had".

13 And not only were they not sighted on the Terms of
14 Reference, but when the report was delivered, they
15 weren't allowed to review and give feedback on it in
16 a meaningful way.

17 **Q.** The Inquiry has heard evidence, of course, from the
18 RCPCH, Dr Hawdon, and seen all the documents you read in
19 the box of documents read by Mr Harvey. When you had
20 read them and you'd spoken with both of the
21 paediatricians, you told us you had discussions then
22 with Tony Chambers and Sir Duncan Nichol about your
23 report, your views?

24 **A.** Yes.

25 **Q.** And what you had learned through that process. But what
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1 but what I had seen was her brief synopsis of each
2 occasion and that in no way, shape or form was a full
3 case review and the methodology and the conclusions, to
4 me, did not give any assurance whatsoever.

5 And Sir Duncan's reaction was, first of all he fully
6 accepted what I was saying, which was in stark contrast
7 to the same conversation that I had with Mr Chambers and
8 actually I'd had the conversation with Mr Chambers out
9 of respect first. And he -- I think almost the first
10 thing he said to me is "I'm just horrified at the
11 prospect that maybe some of these deaths or collapses
12 could have been prevented if we'd taken action sooner".

13 And I said to him that I didn't know, at that stage,
14 whether that was the case or not, but it was absolutely
15 imperative that we found out -- that we looked at
16 ourselves and really independently assessed whether
17 there was something that could have been -- could have
18 done differently. I can talk about that -- what
19 happened to that letter of claim.

20 But he was very upset, actually, very visibly upset.
21 And he asked me if I would tell what I just told to him
22 to the rest of the Non-Executive Directors and he
23 arranged for an urgent meeting in private with all of
24 the Non-Executive Directors, and I was accompanied at
25 that meeting by Dr Jameson, who was the chair of the
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1 was Sir Duncan Nichol's reaction? First of all, what
2 did you say to him you had learned from that process and
3 what you thought about that situation and what was his
4 response?

5 **A.** I'd told Sir Duncan about my meeting with Dr Brearey and
6 also with Dr Jayaram. I'd also told him that I'd had
7 the opportunity to review their reports upon which the
8 board was relying in terms of being assured that there
9 was no evidence of deliberate harm, and I also told him
10 that I had been taken through the timeline of events of
11 the concerns raised by the paediatricians and who they'd
12 been raised with, and what the response had been. And
13 I had come to my conclusion that the board, and in
14 particular the Executive team, had got this wrong, and
15 I explained to him why. So I went through the clinical
16 rationale, and also some of the evidence that I'd seen.

17 I explained to him, and he seemed to be hearing it
18 for the first time, the difference between a Royal
19 College review of cases that might lead you to suspect
20 or be satisfied that it hadn't -- there hadn't been
21 deliberate harm, and therefore commission or not
22 commission further forensic reviews, and a service
23 review, which is what this was. And I also explained to
24 him that at the time I didn't know that Dr Hawdon had
25 written to Mr Harvey to say, "I can't do this review",
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1 Medical Staff Committee.

2 And the response that I had from the Non-Executive
3 Directors without exception was the exact same response
4 that I'd had from Sir Duncan: they were visibly upset,
5 horrified, the very first words that were expressed were
6 "We need to look at ourselves".

7 It was a very, very difficult discussion. But there
8 was no defensiveness at all, and it was just horror.
9 But I also think there was -- there had been a lot of
10 confusion and puzzlement.

11 I think -- I don't think they had really understood
12 everything that was being said and hadn't been sighted
13 on the various reports in detail, hadn't had time to
14 consider them. Had very much deferred to the medical
15 expertise of the Medical Director, and I think they had
16 a lot of pieces of the jigsaw that just weren't there
17 and so my discussion with them kind of was starting to
18 fill those gaps, and it was an awful dawning
19 realisation.

20 **Q.** In terms of the medical expertise of the Medical
21 Director, you say at paragraph 135 of your statement:
22 "Ian described the Royal College of Paediatrics and
23 Child Health review to me, saying that the Terms of
24 Reference could have been better and didn't include
25 a review of the cases. He told me that pathologists at
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1 Alder Hey Children's Hospital had discussed the cases
2 and that an expert review by Dr Jane Hawdon had found
3 all but two of the deaths explained. He said that the
4 pathologists at Alder Hey had felt that they were all
5 explained. He also told me that the Coroner Alan Moore
6 had no concerns."

7 And we see in your note that you do record all but
8 two of the deaths explained.

9 Again, did he tell you that in one meeting at one
10 time? Was that your understanding about the level of
11 assurance that he had on the topic?

12 **A.** Yes, he told me that in one meeting, yes.

13 **Q.** In one meeting?

14 **A.** Yes. It was before I started, but just before, so he
15 hadn't given me the opportunity to read any of those
16 reports. I didn't see them until after Ian had left.

17 **Q.** So you weren't able to say what you've said about
18 Dr Jane Hawdon's report?

19 **A.** No.

20 **Q.** Or even about the two deaths, if you like?

21 **A.** No.

22 **Q.** So it was a one-way conversation, if you like, on the
23 detail at that point?

24 **A.** Yes, he was giving me the information rather than
25 asking -- he certainly wasn't asking my opinion.

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1 response?

2 **A.** Well, I had been told by the paediatricians that they
3 had asked for an Extraordinary Medical Staff Committee
4 Meeting with a view to describing what had happened to
5 them when they'd raised concerns, and asking for a vote
6 of no confidence. And I became aware that Tony knew
7 about this, but they had planned it back in July, before
8 I started, and the reason it was delayed until September
9 was because they wanted as wide a -- as many of the
10 medical staff to be present as possible so that they
11 could all hear the story, because they were only going
12 to tell it once, and they had to have Cheshire Police
13 Authority's approval to do so.

14 I remember sitting in Tony's office with him, and
15 saying -- him saying to me: "I can't have a vote of no
16 confidence. I can't have it. I've done nothing wrong,"
17 and we had the usual conversation about the -- his view
18 of the situation in terms of the paediatricians and the
19 way they behaved.

20 And I actually said to him that I -- if he really
21 believed he'd done nothing wrong, and I had no reason at
22 that point to believe he had, I certainly didn't, and
23 I don't to this day, believe that he was deliberately
24 lying to hide the murder and attempted murder of babies
25 on the unit. I don't think that for one moment. But

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1 **Q.** In the meeting you mentioned a moment ago with the NEDs,
2 Sir Duncan Nichol and Dr Jameson was there. You say:
3 "Dr Jameson told those at the meeting that the
4 Consultant paediatricians intended to present their
5 experience to an Extraordinary Committee Meeting and
6 they were asking for a vote of no confidence in the
7 Chief Executive Officer."

8 As far as you were aware, was that the first time
9 the NEDs knew of that or was it the first time
10 Sir Duncan as well?

11 **A.** No, Sir Duncan knew about it much earlier. I don't know
12 whether the other NEDs did. Sir Duncan may have briefed
13 them privately, but it certainly -- I don't think that
14 Dr Jameson knew whether they knew or not. So he was
15 making it clear to them that that was potentially about
16 to happen.

17 **Q.** You say at paragraph 254:

18 "I recall Tony Chambers was made aware (presumably
19 by Sir Duncan Nichol) of the impending request for
20 a vote of no confidence. Tony asked me to do what
21 I could to persuade the paediatricians against this."

22 **A.** Yes, that's right.

23 **Q.** What was your response to that?

24 **A.** Um ...

25 **Q.** You say "I did make efforts to do so", but what was your

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1 I said to him, "If you really feel that everything has
2 been done that should have been done then you have
3 a right to a voice as well. So why don't you go to the
4 meeting and provide some balance and stand up for
5 yourself?"

6 And he said repeatedly "I can't have a vote of no
7 confidence".

8 And he meant even if -- or I took him to mean even
9 if the vote of confidence is not passed. It was having
10 that on his record seemed to be an absolute red line for
11 him.

12 I knew that he was having discussions with
13 Sir Duncan but I wasn't party to them and it wouldn't
14 have been appropriate for me to do so, but by this time
15 I had the trust and confidence of the paediatricians and
16 I was discussing with them the upcoming meeting more in
17 terms of the content of the presentation and the
18 liaising with the police. And they made it very clear
19 to me that they were going to go ahead with that action,
20 and nothing that I said to them, in terms of a dialogue,
21 you know, perhaps with me in the room, would that help,
22 that nothing was going to deter them from going through
23 with that.

24 So what then happened was I was told that
25 Tony Chambers had decided to step down. We did speak

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1 briefly but mostly the conversation was with Sir Duncan,
2 but Tony said, "Look, I need you to speak to them and
3 tell them that I'm going to step down and I give you my
4 permission to do that", and Duncan also gave me his
5 blessing to do that. So I had another discussion
6 shortly after that with the -- it wasn't just with
7 Drs Brearey and Jayaram, most of the conversations were
8 with the entire group of paediatricians who were
9 involved. I think seven at the time.

10 And I explained to them that it was going to be
11 announced that Tony Chambers would be leaving the
12 organisation. He would be doing so before the meeting,
13 and therefore, you know, they -- the vote of no
14 confidence would be null and void. And as a result
15 of -- and Dr Jameson had the same conversation. And as
16 a result of that, they decided not to ask for the vote
17 of no confidence. I think they were mostly concerned to
18 find out whether other teams or other individuals that
19 had similar experience in raising concerns and being
20 -- and suffering detriment as a result.

21 **Q.** And you tell us it's Dr Gibbs who gave the clear and
22 calm presentation?

23 **A.** Yes.

24 **Q.** And other paediatricians commented about their
25 individual experiences?

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1 of more the issues in her portfolio around quality
2 governance, leadership, HR, that sort of thing, and in
3 strategy. But she was a very visible and caring leader
4 to the nursing team.

5 **Q.** You say at paragraph 265 -- well, how much did you
6 discuss the events that this Inquiry is interested in
7 with Ms Kelly and what was her response to your views
8 about them?

9 **A.** We discussed it at length on numerous occasions, and at
10 particular -- you know, there were particular events.
11 So further arrests of Letby, when Letby was charged, and
12 when some of the findings from the report that
13 I commissioned were being made available to me, but very
14 early on, I discussed with her the findings of -- that
15 my discussions with Drs Brearey and Jayaram and the
16 other paediatricians and also with the documents that
17 I'd had the opportunity to review, and even we discussed
18 some of the clinical scenarios, because Alison also had
19 an experience of critical care nursing and she agreed
20 with me that patients don't just suddenly go from doing
21 well to suddenly dying. And they certainly don't do
22 that in the numbers that we were looking at.

23 So there was never any -- the approach that I found
24 from -- certainly from Tony at the time that we were
25 working together, which was this will be nothing, it

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1 **A.** Yes, Dr Gibbs delivered a presentation supported by
2 PowerPoint, and then one by one, each paediatrician
3 stood up and talked about their personal experience of
4 different aspects of the events of the previous two or
5 three years, and I remember, and this was the case with
6 my discussions with him as well, that Dr Jayaram focused
7 quite a lot, if not entirely, on the grievance process,
8 and the trauma of having to deliver an apology to Letby
9 and having to sit in a room with a mediator and Letby.
10 And others had had similar and difficult experiences
11 which were personal to them, which they described.

12 **Q.** During the course of your first year as Chief Executive
13 Officer you tell us at paragraph 263 that three
14 Executives, Lorraine Burnett, Sue Hodgkinson and
15 Stephen Cross, left the organisation, as of course did
16 Mr Harvey and Mr Chambers.

17 Ms Kelly remained, of course, and you said she'd
18 proved a really important asset during the Covid
19 pandemic; is that right?

20 **A.** Yes, in terms of her visible leadership and support for
21 the nursing staff who were going through a terrible
22 experience, and as everybody will appreciate, very
23 hands-on, and in that respect, she was, you know,
24 consistently strong throughout my time working with her.

25 Where she wasn't as strong was perhaps in the sort
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1 will be the paediatrician's fault, was once the arrest
2 had taken place, I don't believe that Alison had that
3 view. But what she was insistent about was that she had
4 no knowledge of any of these concerns throughout 2015
5 and well into 2016, and the meetings that I was being
6 told that she'd been chairing, even, she had no
7 recollection of it, and she hadn't been there.

8 And Duncan also was of the view that that was
9 probably the case: that most of the events centred
10 around Ian Harvey, Stephen Cross and Mr Chambers, and
11 that he had a lot of confidence in Alison Kelly. So it
12 wasn't until -- I felt it was really important that we
13 had an independent sort of verification of this, rather
14 than me saying to her, "Well, you know, I've been told
15 that you were chairing the incident panel in July '15,
16 and many other instances, where you were made aware".

17 I needed to know, and see the evidence, that that
18 was the case before really challenging her with it in
19 the sense that her position was completely untenable.
20 And that didn't come until 2021, early 2021, because the
21 Facere Melius investigation was delayed by the pandemic
22 so it was brought to my attention that there was plenty
23 of evidence to that effect, and for that reason, and
24 others, Alison stepped down from her role in about
25 March 2021.

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1 Q. Paragraph 279, you tell us:
 2 "In addition to informing the board of my concerns
 3 regarding how the Trust had responded to increased
 4 mortality rates on the neonatal unit, I shared those
 5 concerns verbally in late 2018 and early 2019 with
 6 regional directors at NHS Improvement, NHS England,
 7 namely Bill McCarthy and David Levy and with Andrew
 8 Bibby at the Specialised Commissioning Unit. I also met
 9 with and fully briefed the local MPs ..."
 10 In terms of as a Chief Executive and mortality rates
 11 increasing, at any time in your career in any
 12 institution, who should you be communicating those
 13 increases to? Who would you expect to be talking to
 14 about them?
 15 A. You would expect to be talking to your commissioners,
 16 who at that time would have been the local CCG, the
 17 Clinical Commissioning Group. You would expect to be
 18 talking to the regulator. So at that time it would have
 19 been NHS England -- sorry, NHS Improvement, which then
 20 became NHS England. You would also expect to be talking
 21 to the CQC. So every organisation has a CQC
 22 relationship manager and --
 23 Q. And why would you be talking to them? What are you
 24 supposed to do if you have the increase and you don't
 25 know what they mean anyway, so what are you supposed to
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1 Q. And in terms of learning from deaths generally, perhaps
 2 we can have on screen, please, INQ0086797, page 13. So
 3 if we can go back to page 13, so INQ0086797, page 13.
 4 This is a Countess of Chester document, Mortality Review
 5 responding to and learning from the death of patients.
 6 It appears from September 2017 a Learning From
 7 Deaths Group is established. If we look at page 14, INQ
 8 page 14, if we scroll down. "Duties and
 9 responsibilities":
 10 "On delegation of the Chief Executive, Medical
 11 Director is accountable to the board for ensuring
 12 compliance with this policy across the Trust and, as
 13 such, has responsibility for the Learning From Deaths
 14 agenda."
 15 It looks as though this document came into being in
 16 about 2019; is that right?
 17 A. Yes.
 18 Q. When these meetings began?
 19 A. Yes.
 20 Q. If we look at appendix 1, INQ0086797, page 21, you see
 21 the terms of reference for the Mortality Surveillance
 22 Group. Scroll down slowly, and then, when we see what
 23 the duties are, we see the membership. That's the group
 24 composition. We see meetings into 2018, meetings of the
 25 Learning From Deaths Group, and we see data being
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1 do with --
 2 A. Well, they would be having -- they would have oversight
 3 about what you were doing about it. Whether you were
 4 taking the right actions, whether you needed additional
 5 support, either from their own organisations or from
 6 other organisations, who they could broker that from,
 7 where they could broker that support.
 8 Q. So for example, when you commissioned reports or
 9 reviews, in relation to governance or anything else,
 10 would you share that more widely than within the Trust?
 11 A. It depends what the review is. If it's a small review
 12 and not organisation-wide, it probably would be shared
 13 with the board, but a review of organisational
 14 governance, for example, which we commissioned in early
 15 2019, would be shared with the CQC and with your
 16 relationship partners within the CCG and NHS England.
 17 So yes, it's also something that should be discussed
 18 at board, which is a meeting in public. So your
 19 responsibility, ultimately, is to the public that you
 20 serve and it's very important that they see that where
 21 there are concerns they're investigated, that the
 22 learning is identified, and that the implementation for
 23 improvements is being monitored. So board is really the
 24 place where you are accountable through the Non-Execs
 25 and the governors through the public.
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1 analysed and looked at.
 2 Can you tell us about that development? Is that
 3 a development in your time?
 4 A. No, this was -- it was a national requirement, and the
 5 process and the governance around mortality has changed
 6 considerably since that time, but at the time, every
 7 Trust was expected to have a mortality governance
 8 framework of which a -- it was called different things
 9 in different places but which the Learning From Deaths
 10 Group would form a part.
 11 What I saw, and I'd sat in on these meetings, what
 12 I saw at the Countess was just not fit for purpose in
 13 any shape or form. I actually had a special interest in
 14 mortality governance and learning from deaths, which
 15 stemmed from my time at Mid Cheshire Trust. So when
 16 I became the Associate Medical Director there, the Trust
 17 was an outlier in terms of statistics associated with
 18 unexpected as opposed to expected, numbers of deaths,
 19 and the Medical Director there at the time had led
 20 a complete root and branch review, and improvement in
 21 how we approached learning from deaths, but also how we
 22 reviewed deaths, and we would go through every single
 23 set of notes of every single patient who died in that
 24 organisation, every week. And there were a group of
 25 very senior clinicians, including myself, who would do
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1 this every -- I think it was every Friday lunchtime,
2 actually. We would sit for two hours and go through
3 every set of notes, and you wouldn't just identify
4 whether or not the patient's death was expected or
5 unexpected. It may be that the death was inevitable and
6 in many cases very elderly, very sick people, that was
7 the case. In most cases.

8 But you looked at the whole pathway of the patient,
9 and identified areas for improvement in the care of the
10 patient irrespective of whether that would contribute to
11 the death of that patient or not, because the purpose of
12 the learning is to improve care overall. So that whilst
13 it might not have been a contributory factor in this
14 patient's death, which was unavoidable, it might be
15 something, in the future, that could be adversely --
16 that could adversely impact on another patient.

17 And a report from that learning would go to the
18 Quality Committee, would go to the clinical governance
19 group, and ultimately to board in a really meaningful
20 way, along with the reported data which was available to
21 every Trust. But there is a lot behind the data and you
22 have to understand how to interpret it. And you have to
23 be looking in the right places.

24 And what I found when I went to the Countess is that
25 first of all, they weren't looking through the patients'

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1 But it was probably the least adequate approach to
2 learning from deaths I've seen anywhere in my career,
3 and given the history in this organisation at this point
4 that was very disturbing, to say the least.

5 **MS LANGDALE:** My Lady, I see the time. It may be time to
6 take a break now.

7 **LADY JUSTICE THIRLWALL:** Very well, thank you. I will take
8 a break now and we'll start again at 2.00.

9 (1.06 pm)

(The Short Adjournment)

11 (2.00 pm)

12 **MS LANGDALE:** Dr Gilby, before lunch you were giving
13 evidence about the national guidance on Learning From
14 Deaths, and the National Quality Board requirements for
15 Foundation Trust boards, and how the hospital, when you
16 arrived, were looking at mortality reviews and you give
17 your comments about how you found that system.

18 You also tell us at paragraph 232 of your statement,
19 that you effectively reviewed Serious Incident and
20 Mortality Panel records in respect of the neonatal
21 deaths; is that right?

22 **A.** Yes. From the meetings in July 2015.

23 **Q.** And 2015 and 2016? Or what were you looking at?

24 **A.** No, I was looking at the -- well, in fact I attended the
25 Serious Incident Panels for the time that Kelly was

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1 notes; they were just looking at the statistics,
2 numbers, and only if a death had been reported as
3 an incident was it examined properly at this time in
4 2018.

5 The group, you can see the membership is basically
6 with one exception, members of the board. Three members
7 of the board, and an Associate Medical Director who
8 actually was a Consultant obstetrician. So there was
9 a -- there was limited knowledge about best practice in
10 terms of mortality governance, and the reporting into
11 QSPEC, as they called it, to my horror, actually, at the
12 time, was verbal. So the Associate Medical Director
13 would give a verbal report to the Quality Committee, who
14 would then reassure the board that there were no issues
15 around mortality but there was no data to be examined.
16 There was no real identified learning, and it was really
17 clear that they were focusing on the wrong things and
18 didn't understand the data that was being presented to
19 them in these learning from deaths meetings.

20 So it was quite a challenge to -- again, it was
21 a cultural challenge, to engage the clinical staff, to
22 come together, to actually see the benefits of looking
23 at every death in the organisation. This is before the
24 current national requirement, which does enforce that,
25 if you like.

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1 still the Director of Nursing but I was looking at the
2 meetings where the paediatricians had brought cases that
3 they were concerned about.

4 **Q.** At so-called Neonatal Mortality Meetings, those
5 meetings. The Inquiry has seen lots of evidence about
6 meetings so I'm not asking you for the particulars but
7 I just want to understand what you had a look at?

8 **A.** No, the general conduct of the Serious Incident Panel,
9 and whether that was going through the right processes,
10 but also a bit like the issues with risk, the right
11 questions weren't necessarily being asked to get to the
12 root of a problem. So I was looking at how those were
13 conducted and the methodology they were using but also
14 the -- whether the attendance was appropriate and
15 whether the clinicians who were actually involved in the
16 cases had the opportunity to contribute.

17 **Q.** What's your understanding, and you may want to say or
18 not say, in 2015/2016, about when deaths should be
19 reported through the STEIS system, the neonatal deaths?
20 In what circumstances?

21 **A.** In 2015/16 -- I mean, it's changed a number of times but
22 I expect that at that time you would expect an
23 unexpected collapse and death would be reported in the
24 STEIS system.

25 **Q.** Why do you say that?

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1 A. That was my understanding of the regulatory requirements
2 at the time.

3 Q. You say in paragraph 236:

4 "I had not seen any evidence of neonatal mortality
5 and morbidity data being discussed at Trust governance
6 meetings."

7 When you say governance meetings, do you mean the
8 patient safety meetings, QSPEC meetings?

9 A. Yes.

10 Q. And the Trust's board itself?

11 A. Yes, that's right.

12 Q. And would you have expected data to have gone to those
13 meetings?

14 A. Definitely, yes.

15 Q. And when you say "data", are you talking about realtime
16 numbers that people on the wards are aware of or that
17 they've accessed through a data viewer, or something?

18 What way do you expect -- would you have expected
19 numbers to have been discussed on a board meeting?

20 A. It wouldn't just be numbers; it would also be even with
21 low numbers, if they are unexpected, then that should be
22 reported as an incident. So all Serious Incidents
23 would -- there should be a report at every Quality
24 Committee as to the progress being made to identify the
25 learning and to monitor the implementation of it.

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1 actual problem that needs to be investigated or whether
2 it's an in-month anomaly.

3 Q. And indeed, you say, in suggested lessons learned or
4 recommendations, that boards should be mandated to use
5 evidence-based reporting tools which enable them to spot
6 variations in outcomes in realtime?

7 A. Yes. So it's not uncommon for -- it doesn't necessarily
8 need to relate to mortality, but for data to be
9 presented as bar charts, RAG ratings, and to be compared
10 with, say -- and this was the case at the Countess -- to
11 be compared with the previous month when you actually
12 don't know whether the previous month was part of
13 a trend, whether it was an outlier or not.

14 Q. Did you have a lead reporter at the Countess of Chester
15 when you were there, to report the data to MBRRACE?

16 A. Yes.

17 Q. We know the data was reported because we saw the results
18 of course two years later, but in terms of entering data
19 around deaths, who would you expect to be doing that in
20 the hospital when you were there?

21 A. In terms of MBRRACE I would expect it to be the lead for
22 the specialty, but for the hospital as a whole, there
23 was an employed data analyst and business analyst,
24 and -- but the ultimate responsibility lay with the
25 Directors of Nursing and Medical Directors.

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1 And in terms of data, there would be monthly
2 escalated data on mortality in terms of both specialty
3 and conditions, so for example, if it was in respiratory
4 medicine as well as the overall mortality trend, as well
5 as the actual in-month numbers, you would be able to
6 analyse that further into conditions. So it might be
7 pneumonia or Chronic Obstructive Airways Disease,
8 et cetera.

9 That's what I wasn't seeing. And when they were
10 looking at the statistics, they were focusing on things
11 that clearly weren't really issues. It's actually --
12 dealing with mortality, standardised mortality data is
13 actually quite a complex thing for boards and Quality
14 Committees to understand, and in my previous experience
15 I'd found it was beneficial to do learning sessions for
16 the board and other members of the subcommittees on how
17 to interpret that data and in what ways it can be most
18 meaningfully interrogated and presented. I'd done that
19 in both of my previous two Trusts and it had been really
20 effective and we'd also changed the way in which the
21 data was reported from RAG ratings to data control
22 process charting, which gives you an opportunity to see
23 how trends change in time but also if you've got a step
24 change, either positively or negatively, you can use
25 process control data to see whether you have got an

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1 Q. At paragraph 277 of your statement, you refer to the
2 circumstances of the police investigation, and you being
3 the Chief Executive Officer when that was taking place.
4 The Inquiry has heard evidence about Mr Cross allegedly
5 saying that there would be blue and white tape
6 everywhere if the police were called in, and it would be
7 very difficult for the hospital. What was it like in
8 fact, when the police came and did their investigation?

9 A. When I arrived, the police investigation had been going
10 on for well over a year. I think it was 15 months, and
11 Letby had already been arrested. But my understanding
12 of the experience in the Trust in the first year was
13 that the police were very respectful and discreet in
14 terms of the ongoing work of the Trust and not causing
15 unnecessary distress to patients and families and other
16 members of staff. Even to the extent that if you talked
17 to people across other departments of the Trust there
18 was very little knowledge of the investigation and its
19 impact. It wasn't immediately obvious that the Trust
20 was at the centre of a huge police investigation.

21 My own experience was that all of the police
22 officers that I dealt with and principally, that was
23 Detective Chief Inspector Paul Hughes, but also with
24 other senior officers, were extremely considerate about
25 the services we were continuing to provide, and about

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1 our staff and their concerns for their support.
 2 They worked very much with me to try to make giving
 3 witness evidence easier for members of staff, and there
 4 was no disruption to services whatsoever, and there was
 5 certainly no visibility of the investigation as you
 6 walked around or approached the organisation.
 7 **Q.** You provided a second statement, Dr Gilby, and you
 8 raised a number to matters there. Firstly at
 9 paragraph 4, you raise, as far as you're aware, how many
 10 people understood that there was going to be or could be
 11 a vote of no confidence against Mr Chambers. Would you
 12 like to tell us what your understanding is about how
 13 widely that was understood that that was an issue?
 14 **A.** It was very widely understood. And so I have read the
 15 transcript of Mr Chambers' evidence and I was very
 16 surprised to see that both he and Lyn Simpson said that
 17 they knew nothing of that. I had a number of
 18 discussions with Tony Chambers, as I said earlier, where
 19 he was at great pains to tell me how distressing the
 20 prospect of a vote of no confidence was to him, and how
 21 he couldn't have that on his record, irrespective of the
 22 outcome.
 23 I appreciate a great deal of time has lapsed since
 24 then but I remember those discussions very clearly and
 25 also there were -- members of the senior medical staff

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1 **Q.** "... in August 2017 to help me find emails to and from
 2 Mr Harvey which would have supported statements I have
 3 made to the police and to the GMC ... confident the
 4 emails in question were stored at the time in folders on
 5 my Outlook account. IM&T could not find any emails sent
 6 to or from Ian Harvey before June 2016. Of particular
 7 note are emails sent in the weeks commencing the 8th and
 8 15th February 2016."
 9 And he therefore asks if you could request
 10 a thorough investigation of the hospital server, and if
 11 necessary, interview relevant staff with a view to
 12 answering the following questions. And he lists the
 13 questions.
 14 So what was your response to that and what were the
 15 discussions on that topic that you'd had with Dr Brearey
 16 about his emails?
 17 **A.** Dr Brearey told me, prior to this, that he had concerns
 18 about a number of missing emails which he had been at
 19 pains to make sure were in files and were maintained,
 20 and I can understand why he would have done that.
 21 I discussed at the time with the then head of IT whether
 22 it was possible that these could have been deleted. But
 23 to be honest, I wasn't getting anywhere with that
 24 discussion. So I asked Claire Raggett to organise for
 25 all the accounts that Dr Brearey had had access to, and

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1 were aware and had been aware since July 2018.
 2 Sir Duncan and other members of the board were aware.
 3 It was widely expected that that vote would go ahead
 4 right up until the point where Mr Chambers announced his
 5 resignation.
 6 **Q.** You also at paragraph 6 tell us you'd:
 7 "... read the transcript of the evidence given to
 8 the Inquiry by Dr Brearey and noted he was challenged
 9 about the lack of apparent evidence to support some of
 10 what he was saying ..."
 11 And you wanted to bring to the Inquiry's attention
 12 a communication that you'd had. If we can have on
 13 screen, please, INQ0014610-page 1. An email from
 14 Dr Brearey to yourself, May 2019. I'll give people time
 15 to read that, if we can scroll up so it can be read.
 16 Dr Brearey is asking you:
 17 "Further to discussions we have had since
 18 August 2018, I am writing to confirm my request that you
 19 investigate emails to and from Mr Harvey that I have not
 20 been able to locate on my computer and Outlook account."
 21 "I asked for help from IM&T... "
 22 What does that mean?
 23 **A.** Information management and technology.
 24 **Q.** And that's a department in the Trust, is it?
 25 **A.** Yes, it's basically the digital services.

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1 to look into Mr Harvey's emails to see whether she could
 2 find these and to get the assistance of the IT team to
 3 do so, and in spite of those searches we were unable to
 4 locate any of the documents that he was concerned about.
 5 At the time, I felt there was really no more we
 6 could do. And I searched through the documents that
 7 I had myself of Ian Harvey but there were no relevant
 8 emails between him and Dr Brearey.
 9 However, much later, during the course of my own
 10 employment case against the Trust, as I've mentioned
 11 earlier, we discovered that files and emails had been
 12 selectively and comprehensively deleted, and were
 13 unretrievable. And evidence was given, and finding of
 14 fact was that that had been done deliberately and it
 15 wasn't possible to retrieve any of those documents.
 16 That there -- it reminded myself and my legal team
 17 of the email from Dr Brearey and the discussions that
 18 I'd had with him about this and I therefore wanted to
 19 make both Dr Brearey, which I did at the time, and also
 20 the Inquiry, aware of the fact that this had happened to
 21 me and therefore it was entirely plausible that it may
 22 have also happened to him.
 23 **Q.** That can go down now, please. Thank you.
 24 Going back to your first statement, Dr Gilby, your
 25 lessons learned and suggested recommendations, you say

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1 at paragraph 298:

2 "It is a false economy for a Trust to cut back on
3 numbers employed, and systems deployed, to analyse
4 healthcare outcomes and patient safety."

5 Would you like to expand upon that?

6 **A.** Yes. In the -- so the financial outturns are imposed
7 upon an organisation by the regulator, which is now
8 NHS England. And the focus of the organisation, because
9 of the way of the top-down command and control nature of
10 provision of healthcare currently is that the focus
11 becomes delivering that financial outturn, and if the
12 organisation is not patient focused, that can be done at
13 the risk of harm to patients via dismantling systems and
14 processes, and removing what are seen as dispensable
15 staff in numbers, which -- who would have previously
16 been investigating incidents, reporting incidents,
17 supporting staff to do so, and making sure that the
18 proper governance processes were being followed.

19 So even if you have an appropriate policy and an
20 appropriate structure of reporting, you need people to
21 actually follow those policies, and to be enabled to do
22 the work to be freed up to do the work. And what was
23 happening at the Countess is that people who were in
24 administrative roles were seen as dispensable, and so
25 the object was to cut the payroll as much as possible to

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1 clinicians would be having to deal with incident
2 reporting with quality governance issues in general,
3 almost in their own time. They would be given maybe
4 four hours a week in which to do that, but the amount of
5 work that was required for a department of that size was
6 much greater than could be delivered in that time. And
7 the technical staff, if you like, who would have
8 supported them had they been there, had been stripped
9 out and often replaced --

10 **Q.** When you say "technical stuff", does that mean, for
11 example, risk management, risk team, people who
12 should --

13 **A.** Yes, people in that field whose full-time role was to
14 support the quality governance work including risk
15 management and incident reporting, mortality data and
16 feeding into national databases such as MBRRACE or the
17 joint registry in orthopaedics, that it was very common
18 to go to a department, and this was particularly the
19 case in Women's and Children's, and find that the
20 support for the clinicians in those areas was minimal,
21 and often the people who were in the roles were in
22 a lower band. And this is something that in the
23 organisation I saw across the board, really, that people
24 would be paid at a lower pay scale than you would see in
25 the neighbouring Trust.

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1 achieve the desired financial outturn without really
2 looking at the quality impact of those cuts, if you
3 like. Every division was given their financial
4 objective of the percentage of their outturn that they
5 had to cut each year and they would definitely do so by
6 cutting the payroll.

7 But there comes a point where that becomes a danger
8 to staff and also, most importantly, to patients.

9 **Q.** And in terms of, you say they're seen as admin roles, in
10 terms of the support you'd had as a Medical Director or
11 leading an organisation or Chief Executives, there is
12 a fair deal of support needed, presumably?

13 **A.** Yes.

14 **Q.** What about doctors? They see patients in the clinic.
15 Are they expected to type their own letters, their own
16 communications? Or did they have proper support? How
17 did that work?

18 **A.** It's really variable across Trusts but I would say that
19 they had very little admin support, doctors in
20 particular, and this was a real issue within the -- in
21 the Women's and Children's Directorate, because they
22 were under the umbrella of a much bigger directorate who
23 had what they saw as bigger, more important concerns,
24 such as the emergency department or at one point it was
25 elective care. And therefore we found that very busy

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1 So actually, the Countess of Chester was midway
2 between Mid Cheshire Trust and the Wirral Trust so I'd
3 worked in all three of them, and over a relatively short
4 period of time, and I saw people being -- not being
5 valued for the work that they were doing and the roles
6 that they were delivering, because there seemed to be a
7 lack of understanding in that every single person in
8 that hospital contributed to patient outcomes and
9 patient safety. Before the pandemic, I used to hold
10 team meetings with non-clinical teams who would come
11 along and we'd talk about their role and what they were
12 doing in patient safety, and it was, if I remember the
13 finance team saying, "Nobody has ever said to us before
14 that we have anything to do with patient safety".

15 And the same was true of everything, really, from
16 catering to medical engineering. So people weren't
17 being valued in the way that I've seen in other
18 organisations. And yes, every organisation had to make
19 financial efficiencies, but what I'd seen previously was
20 a much greater degree of quality impact assessment
21 before those were approved, whereas at the Countess the
22 divisions seemed to be working autonomously without much
23 oversight and the impact of those reductions in support
24 staff was -- wasn't appreciated at board level.

25 **Q.** Paragraph 301. You say:

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1 "One manifestation of unacceptable bullying
2 behaviour -- the making of ill-founded threats to report
3 staff to their professional bodies (for example the
4 General Medical Council or Nursing Midwifery Council)
5 should be particularly discouraged."
6 First of all, have you come across that being used
7 in other work in other jobs -- you don't need to tell me
8 where or how -- but have you come across it being used
9 as a threat in circumstances where somebody experiences
10 bullying and says they're being bullied, and they're
11 told that they will be reported? Is that something
12 you've encountered.
13 **A.** Do you mean prior to the Countess?
14 **Q.** Yes.
15 **A.** No. But I have come across people being afraid of that
16 as a possibility, with no good reason for it. And
17 I think that begs questions around the culture and the
18 conduct of those regulatory bodies. Why do professional
19 clinicians, whether it be nurses, midwives or doctors,
20 see their professional regulator who are there to yes,
21 protect patients, but also to support clinicians, as
22 a threat? If you were inappropriately referred to your
23 regulatory body, you would expect there to be an open
24 and fair examination of the issues presented to them,
25 and it's not --

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1 Unfortunately -- well, tragically, this very
2 talented and dedicated doctor took his own life as
3 a result of the mental illness that was exacerbated by
4 this process, and those -- this was -- there was an
5 account of this incident in the British Medical Journal
6 and it wasn't the first time that there had been
7 articles about the experience of being under
8 investigation by the GMC.
9 So I think it -- rather than it being always
10 employers who are causing clinicians to have a lack of
11 confidence in the support they might get from their
12 regulator, it's these tales from their colleagues that
13 are sometimes well known, that make them fearful of the
14 process that actually it should be fair and open, and
15 they shouldn't be at all afraid of it.
16 As you will be aware, I was threatened with referral
17 to the GMC myself in my latter months, and also after
18 I had -- even after my employment had ended at the
19 Countess of Chester, and I was not concerned, because
20 I knew that I had nothing to fear in the sense of GMC
21 findings, but the reason it was happening, and I was
22 well aware of the reason, was because they knew that
23 I potentially would see that as a threat and that it
24 would make me step away from the actions that I was
25 taking and the truth that I was seeking.

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1 **Q.** So you think doctors should have more confidence --
2 **A.** Yes.
3 **Q.** -- or nurses, that if it's malicious or just arising out
4 of a set of circumstances --
5 **A.** Yes.
6 **Q.** -- and it's being cynically deployed they should feel
7 reassured by that: the regulator will understand that or
8 work that out?
9 **A.** They should, but I don't feel that doctors and nurses do
10 have that confidence. And part of that is from very
11 well publicised accounts of long, drawn out
12 investigations into concerns that perhaps were
13 unfounded. And unfortunately, in my own experience,
14 I have worked with a doctor who was -- he worked across
15 two Trusts, one was a big teaching hospital and the
16 other was a DGH, and prior to me becoming Medical
17 Director there -- this is not the Countess -- he had
18 been referred by a patient to the GMC, and without
19 justification, as it turned out. But the GMC, 18 months
20 down the line, hadn't taken any action to resolve the
21 situation. And this doctor became very distressed and
22 depressed as a result, and so myself and the Medical
23 Director and the teaching hospital took some action to
24 write to the GMC to agitate for a resolution to this
25 issue.

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1 **Q.** You say in your statement:
2 "Maliciously threatening or submitting ill-founded
3 reports to professional boards should itself be
4 a disciplinary offence."
5 **A.** Yes. I think that's part of a code of conduct that
6 should be absolutely embedded in public service, that
7 maliciously reporting somebody or using the regulator as
8 a threat should be a never event.
9 **Q.** You say at paragraph 304:
10 "The backgrounds of Non-Executive Directors on NHS
11 boards should be balanced in relation to healthcare
12 experience and finance backgrounds. There should be at
13 least one medically qualified Non-Executive member with
14 a proven track record in the core business of the
15 organisation, whether that be mental health, acute care
16 or specialist services. Mandated training courses
17 should be provided for all new Non-Executive Directors
18 with education in safety standards and quality assurance
19 related to healthcare and how to constructively
20 challenge Executives and when to bring additional
21 expertise to the board."
22 My question specifically, how to constructively
23 challenge Executives. In your experience, can it get
24 a little cosy or a bit comfortable and get difficult for
25 Non-executive Directors to do this?

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1 A. Yes, I think there is a possibility of it getting cosy
2 although to being a sort of groupthink, and I think that
3 at various stages, the Countess were very comfortable
4 about their -- the board was very comfortable about the
5 performance of the organisation as a whole. Coming into
6 it from the outside, I was very shocked by the state of
7 the organisation and it clearly was -- nobody was
8 challenging the Execs to say, "Why are we where we
9 are?", because they didn't recognise that where they
10 were was so far from the norm as to be inadequate, in my
11 view. But I've seen boards where there hasn't been
12 enough knowledge in the Non-Executive Directors to
13 challenge the clinical Executives, or to -- I don't mean
14 challenge in an aggressive way, I mean to have informed
15 discussions where they are asking questions, seeking
16 clarification.

17 They're often unable to do that because they just
18 don't have the background, whereas you observe
19 a different type of questioning of the, say, Director of
20 Operations or to the Director of Finance, and I've seen
21 on many occasions board meetings being very focused on
22 finance and operations because that is the comfort zone
23 of the Non-Executive Directors when it comes to
24 challenging papers that are brought, or business cases.

25 Q. In your experience, do Non-Executive Directors and the
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1 value to the organisation and more particularly to
2 patients and the community that we serve.

3 I, when appointed as Chief Executive, was one of
4 only question medically qualified Chief Execs in the
5 whole of England in acute and specialist Trusts, and
6 I think at the time there were 162 of those.

7 It seems to me that we have got things the wrong way
8 round, and the clinical leadership should be enabled by
9 really strong financial Executive leadership alongside
10 it, and digital, and HR professionals, but unfortunately
11 there is no mechanism for medical staff as through their
12 training, whether undergraduate or post-graduate, to
13 understand the benefits to patients of actually leaving
14 a service, let alone a whole organisation.

15 It was a very difficult thing for me to agree to
16 step aside completely from clinical practice and be
17 a full-time Executive Medical Director. But I could see
18 that there was so much to do at Wye Valley that it was
19 about making the biggest difference to the most numbers
20 of -- the highest numbers of patients for the longest
21 time, and I could do much more good in doing that with
22 the knowledge I'd brought from my clinical practice and
23 my interest in risk and governance and patient safety,
24 than just the patient in front of me and their families,
25 because there were many people around me who were

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1 Chair meet without Executive Directors very often or at
2 all, where they might say things in a more open fashion
3 if they've got worries or concerns?

4 A. Yes, they do, yes. I'm sure that in most organisations
5 the Non-Executive Directors will have meetings without
6 the Executive, and you would hope that the clinically
7 qualified Non-Executive Directors would be able to
8 perhaps explain some of the background and some of the
9 questions that they should be considering in those more
10 clinically orientated papers. And vice versa, in terms
11 of finance.

12 Q. You say:

13 "Healthcare provider organisations should be
14 clinically led with leadership and management training
15 becoming an integral part of undergraduate and
16 post-graduate training programmes in all clinical
17 professions, particularly in medicine."

18 Why do you think that would assist?

19 A. I think the UK is quite unusual in that it's rare for
20 a medically qualified person to be the Chief Executive
21 of a provider Trust, whether it's a hospital or --
22 particularly in hospitals, sometimes in mental health
23 Trusts and community Trusts, it is more common.

24 I think that understanding of the core business and
25 being entirely patient focused brings a great deal of
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1 skilled and could do exactly the same job that I was
2 doing.

3 I also find that when you -- I used to give lectures
4 to medical students and junior doctors and sometimes
5 even consultants about how the NHS is structured. Where
6 do we get our money from? You know, how is it
7 regulated? And I'd be really surprised to find that not
8 only do the undergraduates not know any of this, but
9 even consultants of many years' standing are hearing it
10 for the first time.

11 And the distrust this engenders between very
12 talented bright, professional clinicians and Executives
13 who they don't understand why they're there or what they
14 do is to great detriment to the people that we serve.

15 So I do feel that it should be a core part of the
16 business of becoming a doctor or indeed a nurse.

17 Q. You say:

18 "Mentoring and coaching should be mandated for all
19 Executives in their first board role."

20 In what form? Who should be the mentors and
21 coaches? What are you thinking that would assist with?

22 A. Well, first of all I would say that it needs to be
23 somebody completely independent from the organisation in
24 which you're working. I had the benefit of really
25 strong support when I went into my first Medical
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1 Director role in terms of professional coaching and
2 mentoring from a very experienced Medical Director in
3 a different part of the country, and the Trust
4 Development Authority, which preceded NHS Improvement,
5 the Medical Director there made sure that that support
6 was made available to me, knowing what I was going into.

7 But that is actually quite unusual so I believe that
8 a mentor should be somebody who is experienced in the
9 role and it should be chosen on an individual basis
10 because it -- the Trusts were all very different, and
11 the challenges going into a smaller specialist Trust are
12 very different as to going into a big district general
13 hospital with all the different services that it has.

14 In terms of coaching, that should be with somebody
15 who is a professionally trained coach, as opposed to
16 somebody who is within the organisation and is doing
17 this as an adjunct to their day job.

18 **Q.** You say:

19 "All unexpected cardiorespiratory collapses should
20 be reported as serious patient safety incidents and
21 there should be a framework for the investigation of all
22 clusters of patient safety incidents."

23 Cardiorespiratory collapses, why do you identify
24 that as a single collapse or cause that requires serious
25 patient safety incidents?

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1 **Q.** Don't comment on that. Just whether, in 2018 or not --

2 **A.** In 2018 I found it odd that given the circumstances of
3 the organisation, the CQC chose not to inspect Women's
4 and Children's Services, particularly as it was one of
5 the areas where I had the most concern. And some of the
6 things that they found in 2022 were even after
7 improvements that we had made, especially in maternity.

8 So when I queried the decision not to inspect
9 Women's and Children's services, they said that they
10 weren't going to do that because of the ongoing police
11 investigation, and --

12 **Q.** When did you query that?

13 **A.** At the time. And that, to me, it seemed
14 counterintuitive. The police obviously would be
15 consulted as to whether there was any risk of it
16 interfering with their investigation and I'm quite sure
17 they would have said no, there wasn't, because they were
18 investigating events from 2017/16, and we had a duty of
19 care, as did the CQC to the patients in the here and now
20 in 2018/19 and I actually found the CQC reports over the
21 years as a useful tool to help colleagues to recognise
22 the need for improvement, and to get the board to see
23 the need for investment in some cases. And there was
24 a great deal of need for investment particularly in
25 maternity at the time.

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1 **A.** Well, cardiorespiratory collapse is what happens as the
2 ultimate outcome of an undetected and untreated
3 deterioration in the patient generally. So the original
4 problem may be sepsis, for example, or it could be
5 trauma or it could be following a procedure.

6 When we say cardiorespiratory collapse, I mean
7 a cardiac arrest or a stopping breathing.

8 So if that happens it's at the end of
9 a deterioration, more often than not, and it should be
10 something where there is an intervention, the
11 deterioration is recognised and then there is
12 an intervention to try to prevent the cardiac arrest if
13 it is preventable.

14 So for this to happen out of the blue is very rare
15 even in adults, and each instance of a cardiorespiratory
16 arrest should be treated as a serious incident if it is
17 not anticipated.

18 **Q.** Paragraph 312, the Care Quality Commission. You point
19 out they were made aware of concerns about unexpected
20 and unexplained deaths in a February 2016 inspection,
21 but their 2018 inspection didn't examine Women and
22 Children's Services.

23 What do you say about that?

24 **A.** From reading of the transcripts, I know that there is
25 some controversy about what was said in CQC --

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1 So that, to me, didn't make any sense.

2 **Q.** Next paragraph, you say:

3 "Healthcare provider organisations should be run on
4 a basis of openness. The public should be helped to
5 understand that healthcare is not risk free. Admission
6 of mistakes and the learning from them should be widely
7 communicated."

8 How do you think those communication strategies
9 enabling transparency should be put together? How do we
10 achieve what you've set out there?

11 **A.** Well, I'm sure it's multifactorial, and I probably would
12 give a better and more considered answer if I'd thought
13 about the mechanisms of it. But there are reporting
14 mechanisms which most members of the community are not
15 going to go and read the board papers but there are
16 opportunities through, especially now, with digital
17 facilitation, to have on your website information about
18 how do we investigate incidents, what sort of
19 investigations -- what sort of the incidents do we have?
20 How common are they?

21 There's loads of opportunities to do that. And
22 I think also there needs to be overt accountability so
23 owning issues when they happen as opposed to deflecting
24 and defending. One of the things that I was very -- it
25 meant a lot to me that when we got to the end of the

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1 trial, we needed to be able to own and be accountable
2 for what had happened in the organisation, and
3 I therefore commissioned a report, a review into how the
4 Trust had responded to the concerns raised by the
5 paediatricians.

6 It was my intention that once that report was
7 finished and before the verdict, we would prepare
8 something for the public, but obviously initially
9 privately for the parents, so that we could stand up.
10 I personally would have stood there and said: we made
11 mistakes, there is learning, and we are accountable for
12 this and we want to be held to account for how we
13 implement that learning. But unfortunately, that is not
14 how the NHS operates. And there was a great deal of
15 resistance to my intention to openly say that after the
16 verdicts. That was my intention, and it was known to be
17 my intention and it was made very clear to me that that
18 was not how we deal with things.

19 I think if we started to be more open in, either in
20 person with patients and the population or on our
21 information sites that people can access very readily,
22 about where things have gone wrong and what we're doing
23 about it, the ownership of that, then the patients and
24 the public would have greater trust in the fact that we
25 are doing our best for them even though those delivering

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1 away from that, but to openly seek to understand, and to
2 recognise that it isn't unthinkable. It's happened time
3 and time again. And that we need to make sure it's not
4 happening here.

5 And I'm reassured to a certain extent in that I have
6 been contacted by Medical Directors in other
7 organisations to ask how they can learn from the
8 experience, and I'm hoping that that in the future will
9 be possible for them. But the Clothier Report, for
10 example, which was published after the crimes of Beverly
11 Allitt, was not something that was ever considered or
12 mentioned in any of the training that I've done, either
13 nationally or internationally, in terms of leadership,
14 patient safety or culture within organisations. And
15 I think that's something that needs to change.

16 **MS LANGDALE:** Thank you. Those are my questions, Dr Gilby.

17 **THE WITNESS:** Thank you.

18 **MS LANGDALE:** My Lady, there are no questions from Families
19 1 and 2, no questions from the former Exec's legal team
20 either. So that concludes our questioning.

21 **LADY JUSTICE THIRLWALL:** Very good.

22 So as you know the way it works is that people
23 indicate which areas they would like questions asked
24 about and sometimes that they would like to ask them
25 themselves, but obviously decisions have been taken by

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1 care are humans and sometimes things do go wrong.

2 **Q.** Finally you say:

3 "I believe that the historical cases both in the UK
4 and internationally, together with known pathological
5 variations in human behaviour, make the emergence of
6 a future clinically qualified serial killer a certainty.
7 All available academic research should be deployed and
8 further research undertaken to enable identification of
9 'red flags' at the earliest opportunities. Boards
10 should be required to address this theoretical
11 possibility as part of their programme of development of
12 workshops."

13 Would you like to elaborate on that?

14 **A.** Yes, well, obviously I'm not a psychologist, but it --
15 there are so many cases over the years reported
16 internationally that it would be foolish for us to
17 believe that this will never happen again in the sense
18 that there will never be another Letby, Shipman, Allitt.
19 But there are reports already, and there is academic
20 research, which if it was properly shared with leaders
21 in healthcare, and that we were required to consider it
22 and how we would respond to the sorts of concerns that
23 paediatricians were raising in 2015 and 16, and to look
24 back at those cases, that when somebody is asked to
25 think the unthinkable, they are not triggered to back

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1 all parties that they don't want to ask you any more
2 questions. So thank you very much indeed for making
3 yourself available today. I know it has been a long
4 session and we're very grateful to you.

5 **THE WITNESS:** Thank you.

6 **LADY JUSTICE THIRLWALL:** Thank you.

7 Do feel free to exit.

8 **(The witness withdrew)**

9 **LADY JUSTICE THIRLWALL:** Ms Langdale, I think that's the
10 last witness from whom we're going to hear.

11 **MS LANGDALE:** It is, my Lady. And it's oral submissions in
12 Liverpool, 17 March.

13 **LADY JUSTICE THIRLWALL:** 17 March. Thank you very much
14 indeed. And the deadline for written submissions is now
15 4 March now, rather than 20 February. Thank you very
16 much. We'll reconvene in Liverpool in about a month's
17 time.

18 **(2.45 pm)**

19 **(The hearing concluded)**

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