Monday, 24 February 2025

(9.59 am)

LADY JUSTICE THIRLWALL: Good morning. Ms Langdale.

MS LANGDALE: May I call Dr Gilby, please.

LADY JUSTICE THIRLWALL: Dr Gilby, would you like to come forward, please, and take the oath?

DR SUSAN GILBY (sworn)

Questions by MS LANDGDALE

MS LANGDALE: Dr Gilby, you have prepared two statements for the Inquiry, the first dated 29 May 2024 and the second 14 January 2025. Can you confirm the contents are true and accurate as far as you're concerned?

A. Yes, I can.

Q. And do you have them in front of you?

A. I do. Thank you.

Q. You tell us in your statement that you were working at the Countess of Chester from 1 August 2018, can you briefly tell us your various roles and the date that you submitted your resignation?

A. Do you mean my roles at the Countess of Chester?

Q. Yes, at the Countess of Chester.

A. When I commenced working at the Countess of Chester on 1 August 2018 it was as the Executive Medical Director, the Deputy Chief Executive, and the Strategic Medical Director for the Cheshire West Integrated Care

Partnership. I fulfilled that role for a mere seven weeks until Mr Tony Chambers, who was the Chief Executive Officer, left the Trust, and I was asked to act up into the post of Chief Executive Officer, pending the appointment of a substantive replacement for Mr Chambers.

I did that from September, I think September 18, thereabouts, 2018, until 1 April 2019, when I became the substantive -- I took up the post of substantive Chief Executive Officer and relinquished the post of Medical Director.

Q. And subsequent to that?

A. Subsequent to that, I continued in that role until, well, I was employed in that role until 5 June 2023, but in practice, I relinquished, had to step down from the role on 2 December 2022 when I was unlawfully excluded from the organisation.

Q. We'll come to that briefly soon enough.

A. Thank you.

Q. You also provided the Inquiry with your CV. Can I ask you about some of your earlier appointments and your qualifications?

A. Yes.

Q. So, firstly, your qualifications.

A. Well, my medical qualifications are: I studied medicine

at the University of Manchester and achieved Bachelor of Medicine and Bachelor of Surgery in 1992. I then went on to -- I'd studied and practised in a number of specialties. In those days it was possible to try out specialties in -- at a junior level before deciding on a final commitment, and I chose to train as a consultant in critical care.

In those days, you also had to train in anaesthesia so I became a Fellow of the Royal College of Anaesthesia, and later, a Fellow of the Faculty of Intensive Care Medicine and that led to, after a long period of time training, to becoming a consultant with specialist accreditation in critical care and anaesthesia in 2005, and I specialised at that time in cardiothoracic anaesthesia and intensive care.

Q. And you moved into leadership roles, didn't you; by about 2012 you were clinical lead for theatre and critical care new build projects?

A. Yes, that's right. My initial roles in leadership were very much in education and leading junior medical staff. So when I was a consultant at the Liverpool Heart and Chest Hospital, I think only three months after taking up my post, I became the college tutor for training in anaesthesia there. After the birth of my third child, when he was around two years old, I decided to move to

a hospital more locally to me, and I went to Mid Cheshire Trust. When I got to Mid Cheshire Trust I found that there were lots of issues with professional leadership and professional standards, and also with best practice in terms of patient safety and outcomes, and therefore took it upon myself to help to improve those things, and that led to being asked to take on the clinical director role for anaesthesia and critical care.

And then, when the Trust was successful in getting funding for a new critical care unit and surgical theatres and assessment unit, they asked me to be the clinical lead for that programme.

Q. And you, between November 2013 and March 2015, were the Associate Medical Director, division of medicine and emergency care at Mid Cheshire?

A. Yes.

Q. What was the culture like? The Inquiry is investigating culture in the NHS widely and specifically within the Countess, so how would you have described the culture there?

A. I would say that the culture at Mid Cheshire Trust at that time was the most open and positive that I've seen in my career. It was in stark contrast to other experiences I've had. When I first raised concerns,

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

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

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

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

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

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

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

I think it's not the targets in itself; it's more

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

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

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

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

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

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

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

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

because they didn't have interactions with other organisations who were doing well.

So I found a very open and willing workforce who absolutely embraced the changes that we needed to make. We did need to bring in quite a lot of external support to bring new ways of working and new governance and I think most of all to develop the sort of safety culture that I had seen at Mid Cheshire Trust and the examples I'd seen at Mid Cheshire had been incredibly useful in taking those to Wye Valley and turning around the safety culture and governance and professional standards in that organisation.

Q. Do you think that the safety culture and governance did strengthen in the periods you were there between 2015 to 2017?

A. Oh, absolutely, yes. And I wouldn't have moved back to the north west had we not managed to achieve that. There was a further inspection by the CQC, which rated the Trust as "requires improvement"; they were moved out of special measures relatively quickly and there was a new structure put around the organisation which has helped them. I've followed the progress of the Trust quite closely since. It became part of a group which meant that they had connections with other organisations, which geographically were relatively

distant, but one of them, South Warwickshire Trust, led by Glen Burley, who is an extremely experienced Chief Executive Officer and his team, meant that they were able to continue to develop and improve practice in governance and leadership and leaders had others to whom they could turn whom were more experienced who would help them in their development and that was a very positive outcome for that Trust, and I believe it continues to this day.

Q. And it presumably takes more than one or two leaders, doesn't it, to influence and make that change? How do you think a culture can change in a hospital? What are the key planks to achieve that?

A. I think it's a mistake to feel that you can go in to an organisation and make an intervention to change the culture or improve the culture. First of all, you have to understand the -- where the current cultural views and behaviours have stemmed from and they were different in different organisations.

As I said I think at Wye Valley it stemmed most only from the fact that they were geographically and culturally isolated, and so opening the whole workforce's eyes to the possibilities of how to improve outcomes for patients, and also the experience of working in the organisation was key. So lots of

listening events, lots of presentations, both from internal and external individuals and bodies.

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

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

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

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

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

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

A. Yes.
Q. Executive Medical Director, January 2017 to July 2018. And again, as a snapshot, what did you find there with the culture?
A. I found that quite a challenging organisation. I didn't perhaps do the levels of due diligence that I would normally do but I had my youngest child at this point, well, he was eight when I went to Wye Valley and I was working away from home, and it wasn't ideal so when we came out of special measures at Wye Valley, this was the first Medical Director role that came up that would allow me to live at home during the week and I was successfully appointed. But even during the interview process, there was a stakeholder panel which consisted of consultants across different specialties in the organisation and I found their approach to discussion in the stakeholder panel to be very aggressive and it did make me question, when I was successful and offered the role, whether I actually wanted to go to that organisation but I felt that it was perhaps just a one-off. Unfortunately I did find that relationships were very tense there between Executives and the consultant body, in particular, but the standards of care were very high and I don't think people were as open as they had been in Wye Valley to learning. I felt

that they were very confident that what they were doing was excellent and that sharing mistakes was perhaps a risky thing to do, and it took some time, but even in that organisation they did eventually start to reap the benefits of sharing learning from incidents and issues.

But it didn't feel like a collaborative organisation in the way that Mid Cheshire and Wye Valley had done.

Q. Moving to your first statement then now, please, at paragraph 10, you tell us, as you just have, in oral evidence that you were appointed as Chief Executive Officer in 2019. What were your duties and responsibilities in that role?
A. Well, they are quite considerable. So first of all, to develop and to develop the strategy for the organisation in collaboration with partners across the system, stakeholders, patient groups, and the local authority, and then to deliver that strategy and to deliver the Trust's strategic objectives, obviously to appoint and lead the Executive team in the delivery of the Trust's objectives, to advise the board around working in the -- the integrated care systems that we were developing at the time so in working in those systems. As the accountable officer, to be responsible for the legal obligations of the Trust, including those of finance, those -- but the most important thing was to be

a visible, values-driven leader of the organisation in terms of the workforce. There were 5,500 employees at the time, many of whom were part-time, but a large workforce spread over two main sites.
Q. And who encouraged you to apply for that role, if you were encouraged to apply for it?
A. I was. Sir Duncan Nichol and the other Non-Executive Directors of the board encouraged me to apply for the CEO role, but actually going back to my application for the Medical Director role, it was Sir Duncan who had approached me in March 2018 when Ian Harvey announced his intention to retire that summer.

As you said I was working at Wirral Hospitals, Sir Duncan lived in the area that we served, had seen some of the work that I had done there, and was interested in my thoughts on the vacancy that was coming up. I was in the process for a bigger organisation at the time and wasn't terribly interested, I have to say, but he was quite persuasive and when it became apparent that there was a system role within this potential appointment, and the fact that it was -- it fitted very well with my geographical location and family commitments, I decided to look at it, and it was a very exciting opportunity. I applied and was appointed.

The Deputy Chief Executive element of that was

something that I didn't think too closely about. It was quite common for the Medical Director to be a Deputy Chief Executive because it shows that there is a commitment to clinical leadership in the organisation. It was something of a shock to find myself having to therefore act up after only seven weeks in the role, and when Sir Duncan asked me to do so, I did say to him that I felt that my time in the organisation hadn't been long enough to act into the role, and I didn't feel confident that in such a challenged organisation, I would be able to deliver what they needed.

However, it was pointed out to me that when you're the Deputy Chief Executive it is expected that you act up if that's what is required.

But also, more importantly, Sir Duncan and the other Non-Executives gave me their full support and assurance that they would support me during this time. I expected it to be for potentially a matter of weeks until they found somebody perhaps more experienced. As it turned out, it was five months before the process for the substantive role was fully commenced, by which time I'd obviously had to do quite a lot in the role to move things forward. And I was encouraged at that point to apply almost having undergone a five-month assessment and interview process. So it was a difficult

decision --
Q. Your employment was three weeks, wasn't it, that you started after Lucy Letby had been arrested?
A. Yes.
Q. How did that impact? We'll go into some of the details later, but how did that impact the organisation and the role that you were taking on?
A. The arrest took place when I was -- I think I was out of the country at the time. So in the -- the weeks in between the arrest and the -- my taking up the role, I didn't -- wasn't sighted on how this was being received, how this news was received in the organisation. But I did prepare myself to arrive and find colleagues reeling from this news. I know you'll go into the detail later, so there had been discussions leading up to this of what I might expect from Operation Hummingbird.

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

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

So that was a surprise.
Q. You resigned, you tell us at paragraph 16, midway through the Letby trial and you say it's an action you felt was forced upon you.

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

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

And it carries on at paragraph 6:

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

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

Q. Very briefly, what period of time, what documents were you unable to find or retrieve?
A. Well, for a very long time, until this Inquiry enabled me to access -- well, order the Trust to enable me to access my emails and the copious numbers of files that were saved on my personal drive, I wasn't allowed to look at anything at all. So when I was looking for documents relevant to this Inquiry, I found that there were emails over periods of time which were entirely missing. So there were chunks of emails -- no emails at all, sorry. And as you can imagine how many emails a Chief Executive might get in a day, there were weeks and weeks of emails just not there. They also weren't in the deleted folders and there was nothing in the sent folders.

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

them in the files.

In terms of the findings of Judge Franey, these documents and messages relate to matters to do with my own employment and the measures that the people involved in what they call Project Countess were undertaking from the moment that I raised concerns until I was excluded in 2022 to exit me from the Trust.
Q. You were subjected to detriment because you'd made a protected disclosure. Can you again, very briefly, what's the significance of a protected disclosure? What's your experience in that context, making one in the organisation at that time?
A. My experience of making the protected disclosure was -- well, it was horrific, quite frankly. I was very careful to go through the proper channels and initially that seemed to me, having taken advice about how to deal with what I was experiencing, it seemed to me doing that through the appraisal process for Mr Haythornthwaite seemed to be the most appropriate and most positive way of addressing it.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. And with Chris Hannah and also with Ian Haythornthwaite

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

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

A. Oh definitely not, no.

Q. -- that's gathered?

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

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

A. Yes.

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

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

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

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

Q. So this is February 2017, you say?

A. Yes.

organisation at some time.

Can you tell us about that?

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

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

Q. You say at paragraph 45:

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

Q. Carry on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sorry, if we can go to an earlier one, not that one. Can we go to INQ0002649, page 1. This is one from the visit in 2016, and we see there overall rating for the hospital "Requires Improvement". "Good" for various services apart from end-of-life care.

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

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

It continues:

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

Over the page, page 4, medical staffing:

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

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

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

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

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

"Our rating of the Trust went down."

Setting out why it was rated as "Requiring

Improvement".

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

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

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

And over the page it reflects at page 6:

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

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

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

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

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

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

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

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

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

Q. Why was that, do you think?

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

So a lot of the discussion was about governance but

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

Q. We'll come to those.

A. Okay.

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

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

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

If we go over the page, page 4.

"Warning notices were served."

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

A. No, no.

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

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

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

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

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

at paragraph 48 you comment on the fact that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. You also say that:

"The Trust did not have a corporate strategy."

What did you mean by that?

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

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

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

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

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

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

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

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

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

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

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

Q. Patient Experience?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Mr Cross?

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

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

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

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

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

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

A. That's right, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11.27 am)

(A short break)

(11.45 am)

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

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

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

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

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

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

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

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

Q. You say in your statement:

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

Q. February 2017?

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

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

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

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

A. Yeah.

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

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

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

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

So the substance of the answers were not different;

it was the way in which it was being expressed in particular.
Q. And at that time you hadn't spoken in detail to Mr Chambers, Mr Harvey, or any of the paediatricians? It was just Sir Duncan --
A. I'd never met the paediatricians. And I had spoken to Mr Harvey and Mr Chambers but only in very sort of high level terms. And it was mainly them expressing their frustration about the ongoing behaviours and about the reputation issues of the police investigation because this was prior to Letby's arrest, and they were fairly confident, I would say very confident in some cases that, you know, they've been investigating for X number of months, I'm sure they're going to tell us soon that it's all over and, you know, the problem is the paediatricians and their department.

And that was the mantra I was given right up until the day I started.
Q. Did you, from Mr Chambers or Mr Harvey in those early stages before she was arrested or -- get the sense whether they thought the concerns of the paediatricians were genuine at that time, albeit wrong in their view, in terms of what the evidence led to, as far as they were concerned, but that they were being genuine in using them?

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

There was nothing at my disposal that enabled me to challenge that view at the time.
Q. Paragraph 145, you say you were surprised that Mr Harvey:

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

Professional Standards ... cases in his six years as Medical Director."
A. Yeah.
Q. Do you remember? What do you mean by that? Why was that surprising?
A. Well, he was responsible for the registration and revalidation and training of hundreds of medical staff, and the notion that in six years, not one single doctor had any concerns raised around their practice or behaviours that required examination by the GMC or to go through an MHPS process, it seemed highly unusual. And I remember -- again I can visualise that conversation -- he was proud of that.

I, on the other hand, had been a Medical Director, albeit in two different organisations, for a number of years and prior to that an associate Medical Director for several years and even as a clinical director for that, had had cases where it was necessary to use the policies around Maintaining High Professional Standards to address a doctor's practice, whether it was competence behaviour or professionalism. And I just found it very hard to believe that there were no concerns of that nature in the organisation for an entire six years.
Q. You set out in that paragraph what you say his parting

words were after that conversation. What was that about?
A. Well, it was our handover meeting. And it to be fair to Mr Harvey, it probably was quite an emotional couple of days for him. He'd been a consultant and then a Medical Director in the Trust for decades, and he was in his last hours in that organisation. So the handover process to me probably was, I would imagine, a very minor part of what was happening in his head that day. We sat in Meeting Room 1 in the Long House. He had an A4, a ringbinder with notes to hand over to me. I made handwritten contemporaneous notes which I believe you've seen --
Q. The Inquiry has seen all of your handwritten notes, yes.
A. And he went through various specialties, the challenges in those specialties. There was very little, if anything, said about the neonatal department that -- we'd had that conversation previously. And then we stood up to go, and as we walked out the door, he's packing his things away and he said to me "You need to refer those paediatricians to the GMC". And I said, "Well, why haven't you?" And he jokingly said, "I don't want to" -- I can't remember the exact words now, but "I don't want to break my clean record" was effectively what he was saying.

And I can understand why, because I know, I've read the transcripts, that Mr Harvey denies that he said that. I can understand why he says he doesn't recall saying it, given the nature of that day and all of the other things he'd had to deal with around the tragedies on the neonatal unit and the paediatricians raising concerns, but to me, it was a very significant meeting, and it was a very shocking statement.
Q. Although you say you'd put your notes away at that point and --
A. I had and was already at the door, yes.
Q. If it was said to you, would it be flippant? Could it have been a flippant remark?
A. No, it wasn't a flippant remark.
Q. Not a serious one?
A. No, he was serious. I mean, he said it in a -- I wouldn't say a jokey manner, it was sort of "Huh, and by the way", it was like that. So obviously I came away from not just that but also the briefings I had before I started thinking: it looks like one of my initial serious tasks as a Medical Director is to have a look at this for myself and I obviously have to meet with these paediatricians and I will make it a priority, because I was being given the impression that I had some problem doctors that needed dealing with, and I think we'd had

that discussion over a couple of months with Mr Chambers and also at this point with Mr Harvey.
Q. You met with Mr Chambers you say on the first day of the Trust and then you went on to meet Dr Brearey and Dr Jayaram. And again, we've got all your notes, all of the core participants have all of your notes, but summarising, if you can, your discussions with Mr Chambers around the issue of Letby's arrest and what was going to happen or what might not happen, what kind of discussions did you have him about that topic?
A. They changed as time went on, as my first few weeks went on, because my view of things changed once I'd had a chance to speak to the paediatricians and look at documents. So initially, and this is particularly on day one, the same day, I think as the handover with Ian, first of all, Tony Chambers was very concerned about the breakdown in the relationship, and he emphasised the need to address that, to fix it, and he had already made some effort to identify a team of people who were professional mediators who might be able to help but he felt that it needed, the commissioning needed to be done by somebody who wasn't conflicted. And as just about every member of the board was conflicted, that meant that it needed to be me.
He gave me the contact details of the person who

he'd been in touch with, and he told me that they would be expecting my call, and I did call them the same day, because I agreed with him that if there has been a complete breakdown of relations, then that is a patient safety issue as well as a staff experience and safety issue. So that was on the one hand wanting to fix the relationship with the paediatricians for all the right reasons, and --
Q. And we know for various reasons the mediation didn't go --
A. No.
Q. Didn't take place in due course, did it?
A. And on the other hand, the discussions about the very recent arrest, I found to be quite bizarre. So I would have expected and I did expect to come in, as I said earlier, to particularly an Executive team who were absolutely reeling from the fact that a person had been arrested for multiple -- in the investigation for multiple murders and attempted murders in their organisation under their watch. And what I found and what Tony wanted to discuss with me, was his concern that actually, he still believed, in spite of the arrest, that no deliberate harm had been caused. He kept repeating that there was no single cause found, and I said to him, "Well, it's not for you to find the

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

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

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

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

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

A. I did.

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

A. Well, having spoken to Dr Brearey, I then arranged to

meet with Dr Jayaram, who was on annual leave, actually, and came in to see me. And he asked that we didn't meet in the Executive suite. He wanted to meet in a different location, so that he didn't have to bump into Mr Chambers or any of the other Executives.

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

in here. Opened it up only to find the list of printed out emails, the reports --

Q. Is this the order?

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

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

A. Yes.

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

A. Yes.

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

A. Yes, they did.

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

We see there you have his phone number, you're

messaging each other at various times, aren't you, Dr Gilby?

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

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

A. No, well after it.

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

A. Yes.

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

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

Q. What did you learn from talking to Dr Brearey that you didn't know about before? You've set out in detail what you've said about different babies, I don't need to ask you about that, but what did you ascertain in that

meeting that you hadn't been aware of until you spoke with him?

A. To be honest there was very little that he said that I'd been aware of previously. He very calmly took me through the timeline of events, but before starting that, he said that they had been raising concerns about -- and initially, it was about unexplained, unexpected clinical collapses and deaths in the unit, and they hadn't been listened to, and it hadn't been addressed appropriately.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Then you continue at paragraph 120:

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

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

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

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

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

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

Now --

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

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

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

A. Yeah.

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

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

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

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

A. Yeah.

Q. -- about --

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

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

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

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

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

And when I've seen it happen to others, it's been

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

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

Q. You say in your statement at paragraph 128:

"I believe that had the Freedom to Speak Up process

been properly implemented from the outset ..."

In relation to the events we're dealing with?

A. Yes.

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

A. Yes.

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

A. Yes.

Q. -- if they're used properly?

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. And what you had learned through that process. But what

was Sir Duncan Nichol's reaction? First of all, what did you say to him you had learned from that process and what you thought about that situation and what was his response?

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

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

but what I had seen was her brief synopsis of each occasion and that in no way, shape or form was a full case review and the methodology and the conclusions, to me, did not give any assurance whatsoever.

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

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

But he was very upset, actually, very visibly upset. And he asked me if I would tell what I just told to him to the rest of the Non-Executive Directors and he arranged for an urgent meeting in private with all of the Non-Executive Directors, and I was accompanied at that meeting by Dr Jameson, who was the chair of the

Medical Staff Committee.

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

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

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

Q. In terms of the medical expertise of the Medical Director, you say at paragraph 135 of your statement:

"Ian described the Royal College of Paediatrics and Child Health review to me, saying that the Terms of Reference could have been better and didn't include a review of the cases. He told me that pathologists at

Alder Hey Children's Hospital had discussed the cases and that an expert review by Dr Jane Hawdon had found all but two of the deaths explained. He said that the pathologists at Alder Hey had felt that they were all explained. He also told me that the Coroner Alan Moore had no concerns."

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

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

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

Q. In one meeting?

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

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

A. No.

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

A. No.

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

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

response?

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

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

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

Q. In the meeting you mentioned a moment ago with the NEDs, Sir Duncan Nichol and Dr Jameson was there. You say:

"Dr Jameson told those at the meeting that the Consultant paediatricians intended to present their experience to an Extraordinary Committee Meeting and they were asking for a vote of no confidence in the Chief Executive Officer."

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

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

Q. You say at paragraph 254:

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

A. Yes, that's right.

Q. What was your response to that?

A. Um ...

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

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

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

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

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

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

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

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

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

A. Yes.

Q. And other paediatricians commented about their individual experiences?

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

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

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

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

Where she wasn't as strong was perhaps in the sort

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

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

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

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

will be the paediatrician's fault, was once the arrest had taken place, I don't believe that Alison had that view. But what she was insistent about was that she had no knowledge of any of these concerns throughout 2015 and well into 2016, and the meetings that I was being told that she'd been chairing, even, she had no recollection of it, and she hadn't been there.

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

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

Q. Paragraph 279, you tell us:

"In addition to informing the board of my concerns regarding how the Trust had responded to increased mortality rates on the neonatal unit, I shared those concerns verbally in late 2018 and early 2019 with regional directors at NHS Improvement, NHS England, namely Bill McCarthy and David Levy and with Andrew Bibby at the Specialised Commissioning Unit. I also met with and fully briefed the local MPs ..."

In terms of as a Chief Executive and mortality rates increasing, at any time in your career in any institution, who should you be communicating those increases to? Who would you expect to be talking to about them?

A. You would expect to be talking to your commissioners, who at that time would have been the local CCG, the Clinical Commissioning Group. You would expect to be talking to the regulator. So at that time it would have been NHS England -- sorry, NHS Improvement, which then became NHS England. You would also expect to be talking to the CQC. So every organisation has a CQC relationship manager and --

Q. And why would you be talking to them? What are you supposed to do if you have the increase and you don't know what they mean anyway, so what are you supposed to

do with --

A. Well, they would be having -- they would have oversight about what you were doing about it. Whether you were taking the right actions, whether you needed additional support, either from their own organisations or from other organisations, who they could broker that from, where they could broker that support.

Q. So for example, when you commissioned reports or reviews, in relation to governance or anything else, would you share that more widely than within the Trust?

A. It depends what the review is. If it's a small review and not organisation-wide, it probably would be shared with the board, but a review of organisational governance, for example, which we commissioned in early 2019, would be shared with the CQC and with your relationship partners within the CCG and NHS England.

So yes, it's also something that should be discussed at board, which is a meeting in public. So your responsibility, ultimately, is to the public that you serve and it's very important that they see that where there are concerns they're investigated, that the learning is identified, and that the implementation for improvements is being monitored. So board is really the place where you are accountable through the Non-Execs and the governors through the public.

Q. And in terms of learning from deaths generally, perhaps we can have on screen, please, INQ0086797, page 13. So if we can go back to page 13, so INQ0086797, page 13. This is a Countess of Chester document, Mortality Review responding to and learning from the death of patients.

It appears from September 2017 a Learning From Deaths Group is established. If we look at page 14, INQ page 14, if we scroll down. "Duties and responsibilities":

"On delegation of the Chief Executive, Medical Director is accountable to the board for ensuring compliance with this policy across the Trust and, as such, has responsibility for the Learning From Deaths agenda."

It looks as though this document came into being in about 2019; is that right?

A. Yes.

Q. When these meetings began?

A. Yes.

Q. If we look at appendix 1, INQ0086797, page 21, you see the terms of reference for the Mortality Surveillance Group. Scroll down slowly, and then, when we see what the duties are, we see the membership. That's the group composition. We see meetings into 2018, meetings of the Learning From Deaths Group, and we see data being

analysed and looked at.

Can you tell us about that development? Is that a development in your time?

A. No, this was -- it was a national requirement, and the process and the governance around mortality has changed considerably since that time, but at the time, every Trust was expected to have a mortality governance framework of which a -- it was called different things in different places but which the Learning From Deaths Group would form a part.

What I saw, and I'd sat in on these meetings, what I saw at the Countess was just not fit for purpose in any shape or form. I actually had a special interest in mortality governance and learning from deaths, which stemmed from my time at Mid Cheshire Trust. So when I became the Associate Medical Director there, the Trust was an outlier in terms of statistics associated with unexpected as opposed to expected, numbers of deaths, and the Medical Director there at the time had led a complete root and branch review, and improvement in how we approached learning from deaths, but also how we reviewed deaths, and we would go through every single set of notes of every single patient who died in that organisation, every week. And there were a group of very senior clinicians, including myself, who would do

this every -- I think it was every Friday lunchtime, actually. We would sit for two hours and go through every set of notes, and you wouldn't just identify whether or not the patient's death was expected or unexpected. It may be that the death was inevitable and in many cases very elderly, very sick people, that was the case. In most cases.

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

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

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

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

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

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

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

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

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

(1.06 pm)

(The Short Adjournment)

(2.00 pm)

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

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

A. Yes. From the meetings in July 2015.

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

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

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

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

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

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

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

Q. Why do you say that?

A. That was my understanding of the regulatory requirements at the time.
Q. You say in paragraph 236:
"I had not seen any evidence of neonatal mortality and morbidity data being discussed at Trust governance meetings."
When you say governance meetings, do you mean the patient safety meetings, QSPEC meetings?
A. Yes.
Q. And the Trust's board itself?
A. Yes, that's right.
Q. And would you have expected data to have gone to those meetings?
A. Definitely, yes.
Q. And when you say "data", are you talking about realtime numbers that people on the wards are aware of or that they've accessed through a data viewer, or something? What way do you expect -- would you have expected numbers to have been discussed on a board meeting?
A. It wouldn't just be numbers; it would also be even with low numbers, if they are unexpected, then that should be reported as an incident. So all Serious Incidents would -- there should be a report at every Quality Committee as to the progress being made to identify the learning and to monitor the implementation of it.

And in terms of data, there would be monthly escalated data on mortality in terms of both specialty and conditions, so for example, if it was in respiratory medicine as well as the overall mortality trend, as well as the actual in-month numbers, you would be able to analyse that further into conditions. So it might be pneumonia or Chronic Obstructive Airways Disease, et cetera.
That's what I wasn't seeing. And when they were looking at the statistics, they were focusing on things that clearly weren't really issues. It's actually -- dealing with mortality, standardised mortality data is actually quite a complex thing for boards and Quality Committees to understand, and in my previous experience I'd found it was beneficial to do learning sessions for the board and other members of the subcommittees on how to interpret that data and in what ways it can be most meaningfully interrogated and presented. I'd done that in both of my previous two Trusts and it had been really effective and we'd also changed the way in which the data was reported from RAG ratings to data control process charting, which gives you an opportunity to see how trends change in time but also if you've got a step change, either positively or negatively, you can use process control data to see whether you have got an

actual problem that needs to be investigated or whether it's an in-month anomaly.
Q. And indeed, you say, in suggested lessons learned or recommendations, that boards should be mandated to use evidence-based reporting tools which enable them to spot variations in outcomes in realtime?
A. Yes. So it's not uncommon for -- it doesn't necessarily need to relate to mortality, but for data to be presented as bar charts, RAG ratings, and to be compared with, say -- and this was the case at the Countess -- to be compared with the previous month when you actually don't know whether the previous month was part of a trend, whether it was an outlier or not.
Q. Did you have a lead reporter at the Countess of Chester when you were there, to report the data to MBRRACE?
A. Yes.
Q. We know the data was reported because we saw the results of course two years later, but in terms of entering data around deaths, who would you expect to be doing that in the hospital when you were there?
A. In terms of MBRRACE I would expect it to be the lead for the specialty, but for the hospital as a whole, there was an employed data analyst and business analyst, and -- but the ultimate responsibility lay with the Directors of Nursing and Medical Directors.

Q. At paragraph 277 of your statement, you refer to the circumstances of the police investigation, and you being the Chief Executive Officer when that was taking place. The Inquiry has heard evidence about Mr Cross allegedly saying that there would be blue and white tape everywhere if the police were called in, and it would be very difficult for the hospital. What was it like in fact, when the police came and did their investigation?
A. When I arrived, the police investigation had been going on for well over a year. I think it was 15 months, and Letby had already been arrested. But my understanding of the experience in the Trust in the first year was that the police were very respectful and discreet in terms of the ongoing work of the Trust and not causing unnecessary distress to patients and families and other members of staff. Even to the extent that if you talked to people across other departments of the Trust there was very little knowledge of the investigation and its impact. It wasn't immediately obvious that the Trust was at the centre of a huge police investigation.
My own experience was that all of the police officers that I dealt with and principally, that was Detective Chief Inspector Paul Hughes, but also with other senior officers, were extremely considerate about the services we were continuing to provide, and about

our staff and their concerns for their support.

They worked very much with me to try to make giving witness evidence easier for members of staff, and there was no disruption to services whatsoever, and there was certainly no visibility of the investigation as you walked around or approached the organisation.

Q. You provided a second statement, Dr Gilby, and you raised a number to matters there. Firstly at paragraph 4, you raise, as far as you're aware, how many people understood that there was going to be or could be a vote of no confidence against Mr Chambers. Would you like to tell us what your understanding is about how widely that was understood that that was an issue?

A. It was very widely understood. And so I have read the transcript of Mr Chambers' evidence and I was very surprised to see that both he and Lyn Simpson said that they knew nothing of that. I had a number of discussions with Tony Chambers, as I said earlier, where he was at great pains to tell me how distressing the prospect of a vote of no confidence was to him, and how he couldn't have that on his record, irrespective of the outcome.

I appreciate a great deal of time has lapsed since then but I remember those discussions very clearly and also there were -- members of the senior medical staff

were aware and had been aware since July 2018. Sir Duncan and other members of the board were aware. It was widely expected that that vote would go ahead right up until the point where Mr Chambers announced his resignation.

Q. You also at paragraph 6 tell us you'd:

"... read the transcript of the evidence given to the Inquiry by Dr Brearey and noted he was challenged about the lack of apparent evidence to support some of what he was saying ..."

And you wanted to bring to the Inquiry's attention a communication that you'd had. If we can have on screen, please, INQ0014610-page 1. An email from Dr Brearey to yourself, May 2019. I'll give people time to read that, if we can scroll up so it can be read.

Dr Brearey is asking you:

"Further to discussions we have had since August 2018, I am writing to confirm my request that you investigate emails to and from Mr Harvey that I have not been able to locate on my computer and Outlook account."

"I asked for help from IM&T... "

What does that mean?

A. Information management and technology.

Q. And that's a department in the Trust, is it?

A. Yes, it's basically the digital services.

Q. "... in August 2017 to help me find emails to and from Mr Harvey which would have supported statements I have made to the police and to the GMC ... confident the emails in question were stored at the time in folders on my Outlook account. IM&T could not find any emails sent to or from Ian Harvey before June 2016. Of particular note are emails sent in the weeks commencing the 8th and 15th February 2016."

And he therefore asks if you could request a thorough investigation of the hospital server, and if necessary, interview relevant staff with a view to answering the following questions. And he lists the questions.

So what was your response to that and what were the discussions on that topic that you'd had with Dr Brearey about his emails?

A. Dr Brearey told me, prior to this, that he had concerns about a number of missing emails which he had been at pains to make sure were in files and were maintained, and I can understand why he would have done that. I discussed at the time with the then head of IT whether it was possible that these could have been deleted. But to be honest, I wasn't getting anywhere with that discussion. So I asked Claire Raggett to organise for all the accounts that Dr Brearey had had access to, and

to look into Mr Harvey's emails to see whether she could find these and to get the assistance of the IT team to do so, and in spite of those searches we were unable to locate any of the documents that he was concerned about.

At the time, I felt there was really no more we could do. And I searched through the documents that I had myself of Ian Harvey but there were no relevant emails between him and Dr Brearey.

However, much later, during the course of my own employment case against the Trust, as I've mentioned earlier, we discovered that files and emails had been selectively and comprehensively deleted, and were unretrievable. And evidence was given, and finding of fact was that that had been done deliberately and it wasn't possible to retrieve any of those documents.

That there -- it reminded myself and my legal team of the email from Dr Brearey and the discussions that I'd had with him about this and I therefore wanted to make both Dr Brearey, which I did at the time, and also the Inquiry, aware of the fact that this had happened to me and therefore it was entirely plausible that it may have also happened to him.

Q. That can go down now, please. Thank you.

Going back to your first statement, Dr Gilby, your lessons learned and suggested recommendations, you say

at paragraph 298:

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

Would you like to expand upon that?

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

Q. Paragraph 301. You say:

"One manifestation of unacceptable bullying behaviour -- the making of ill-founded threats to report staff to their professional bodies (for example the General Medical Council or Nursing Midwifery Council) should be particularly discouraged."

First of all, have you come across that being used in other work in other jobs -- you don't need to tell me where or how -- but have you come across it being used as a threat in circumstances where somebody experiences bullying and says they're being bullied, and they're told that they will be reported? Is that something you've encountered.

A. Do you mean prior to the Countess?

Q. Yes.

A. No. But I have come across people being afraid of that as a possibility, with no good reason for it. And I think that begs questions around the culture and the conduct of those regulatory bodies. Why do professional clinicians, whether it be nurses, midwives or doctors, see their professional regulator who are there to yes, protect patients, but also to support clinicians, as a threat? If you were inappropriately referred to your regulatory body, you would expect there to be an open and fair examination of the issues presented to them, and it's not --

Q. So you think doctors should have more confidence --

A. Yes.

Q. -- or nurses, that if it's malicious or just arising out of a set of circumstances --

A. Yes.

Q. -- and it's being cynically deployed they should feel reassured by that: the regulator will understand that or work that out?

A. They should, but I don't feel that doctors and nurses do have that confidence. And part of that is from very well publicised accounts of long, drawn out investigations into concerns that perhaps were unfounded. And unfortunately, in my own experience, I have worked with a doctor who was -- he worked across two Trusts, one was a big teaching hospital and the other was a DGH, and prior to me becoming Medical Director there -- this is not the Countess -- he had been referred by a patient to the GMC, and without justification, as it turned out. But the GMC, 18 months down the line, hadn't taken any action to resolve the situation. And this doctor became very distressed and depressed as a result, and so myself and the Medical Director and the teaching hospital took some action to write to the GMC to agitate for a resolution to this issue.

Unfortunately -- well, tragically, this very talented and dedicated doctor took his own life as a result of the mental illness that was exacerbated by this process, and those -- this was -- there was an account of this incident in the British Medical Journal and it wasn't the first time that there had been articles about the experience of being under investigation by the GMC.

So I think it -- rather than it being always employers who are causing clinicians to have a lack of confidence in the support they might get from their regulator, it's these tales from their colleagues that are sometimes well known, that make them fearful of the process that actually it should be fair and open, and they shouldn't be at all afraid of it.

As you will be aware, I was threatened with referral to the GMC myself in my latter months, and also after I had -- even after my employment had ended at the Countess of Chester, and I was not concerned, because I knew that I had nothing to fear in the sense of GMC findings, but the reason it was happening, and I was well aware of the reason, was because they knew that I potentially would see that as a threat and that it would make me step away from the actions that I was taking and the truth that I was seeking.

Q. You say in your statement:

"Maliciously threatening or submitting ill-founded reports to professional boards should itself be a disciplinary offence."

A. Yes. I think that's part of a code of conduct that should be absolutely embedded in public service, that maliciously reporting somebody or using the regulator as a threat should be a never event.

Q. You say at paragraph 304:

"The backgrounds of Non-Executive Directors on NHS boards should be balanced in relation to healthcare experience and finance backgrounds. There should be at least one medically qualified Non-Executive member with a proven track record in the core business of the organisation, whether that be mental health, acute care or specialist services. Mandated training courses should be provided for all new Non-Executive Directors with education in safety standards and quality assurance related to healthcare and how to constructively challenge Executives and when to bring additional expertise to the board."

My question specifically, how to constructively challenge Executives. In your experience, can it get a little cosy or a bit comfortable and get difficult for Non-executive Directors to do this?

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

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

Q. In your experience, do Non-Executive Directors and the

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

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

Q. You say:

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

Why do you think that would assist?

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

I think that understanding of the core business and being entirely patient focused brings a great deal of

value to the organisation and more particularly to patients and the community that we serve.

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

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

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

skilled and could do exactly the same job that I was doing.

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

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

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

Q. You say:

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

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

A. Well, first of all I would say that it needs to be somebody completely independent from the organisation in which you're working. I had the benefit of really strong support when I went into my first Medical

Director role in terms of professional coaching and mentoring from a very experienced Medical Director in a different part of the country, and the Trust Development Authority, which preceded NHS Improvement, the Medical Director there made sure that that support was made available to me, knowing what I was going into.

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

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

Q. You say:

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

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

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

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

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

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

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

What do you say about that?

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

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

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

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

Q. When did you query that?

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

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

Q. Next paragraph, you say:

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

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

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

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

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

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

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

care are humans and sometimes things do go wrong.

Q. Finally you say:

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

Would you like to elaborate on that?

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

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

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

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

THE WITNESS: Thank you.

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

LADY JUSTICE THIRLWALL: Very good.

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

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

THE WITNESS: Thank you.

LADY JUSTICE THIRLWALL: Thank you.

Do feel free to exit.

(The witness withdrew)

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

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

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

(2.45 pm)

(The hearing concluded)

I N D E X