Witness Name:
Tracy Bullock
Statement No.: 1
Exhibits:
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THIRLWALL INQUIRY

WITNESS STATEMENT OF TRACY ANN BULLOCK

Personal details

I, **Tracy Ann Bullock**, of the University Hospitals of North Midlands, Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG will say as follows:

1. I have been asked by Tim Suter, Solicitor to the Thirlwall Inquiry, to provide a witness statement and I should like to thank you for giving me the opportunity to support the Thirlwall Inquiry in respect of the terrible events that occurred on the Neonatal Unit at the Countess of Chester Hospital.

Nursing and Management Career

2. I am employed by the University Hospitals of North Midlands NHS Trust (UHNM) as the Chief Executive Officer (CEO) although I&S I have held this role since 1 April 2019. Before this I was the Chief Executive at the Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) from October 2010. At the time of leaving MCHFT it was considered one of the best performing NHS Trusts in the country. The Care Quality Commission (CQC) rating was "Good", the Trust was meeting financial obligations, exceeding operational targets and standards and had one of the best staff survey results in the Country and a positive year on year improving patient experience survey. I took the post at UHNM as this was a significantly larger and more complex organisation with significant financial and operational challenges and I felt my experience of organisational turnaround would be beneficial.

3. I joined MCHFT initially as the Director of Nursing and Patient Experience in 2006. I subsequently undertook the roles of Director of Nursing and Operations, Chief Operating Officer and Director of Nursing, followed by Deputy Chief Executive and Director of Nursing until I was appointed as the Chief Executive Officer in October 2010. At this stage I had to relinquish the Director of Nursing role although I did maintain my nursing registration.

4. At the time I joined MCHFT, the trust had significant quality and safety concerns and was under scrutiny from the Police, regulators and national inspectorates. I was appointed as part of a newly formed executive team to support the turnaround of MCHFT which I am delighted to say was successful.

5. Prior to joining MCHFT my career path was as follows:

- I started training as a nurse in 1984 at the Royal Bolton Hospital and qualified in 1987. I maintained my professional registration with the Nursing and Midwifery Council (NMC) until September 2023 at which point I relinquished my registration I&S I&S
- After qualifying as a nurse in 1987 I undertook the roles of Staff Nurse, Senior Staff Nurse, Junior Sister and Ward Manager until December 1999.
- In December 1999 I became the Clinical Risk Manager until I left Bolton Hospital in 2002.
- In 2002 I joined a newly formed national team as an Associate Director within the Modernisation Agency and subsequently the Department of Health. This was a team of varied healthcare professionals brought together who were instrumental in providing leadership development and operational support to some of the most challenged NHS Trusts in the country to achieve turnaround and latterly Foundation Trust status. This role gave me the opportunity to gain breadth as well as depth to my NHS experience as I was able to gain experience working in Acute, Primary Care, Ambulance and Mental Health Trusts. I became aware of MCHFT through this role as I was asked to conduct a diagnostic assessment in respect of the challenges it had. I undertook this national role until 2006 when I joined MCHFT as the Director of Nursing.
- From 2000 until 2019 I also held a seconded role undertaking investigations and reviews of NHS organisations for the Commission for Health Improvement, then the Health Care Commission and more latterly the Care Quality Commission (CQC).

6. I have worked in the NHS for 40 years on the 18th June 2024 I&S I&S

The role and training of a Chief Executive

7. MCHFT was my first CEO post and as I have always done when taking on a new role, I sought a coach to support me during the transition. There was no formal training for new CEOs at that time, although there was an Aspirant CEO programme but I did not undertake this as I did not initially aspire to be a CEO. However, the coaching, along with joining the CEO network for the Northwest was hugely beneficial. The regional CEO for the Northwest Strategic Health Authority (SHA) at that time met regularly with the CEOs both individually and collectively and was very supportive to me in advising on my development. This led to me undertaking some of the courses and conferences I attended, these varied from leadership development, quality and patient safety conferences, learning from inquiries such as Mid Staffs etc. I also sought a more experienced CEOs as Mentors, people I could call upon to discuss any unfamiliar concerns or issues. Please note that from around 2014 the Northwest SHA ceased to exist and was replaced by NHS England national and regional teams.

8. I also took part in the collective learning and development through the above Northwest CEO group. The CEOs were brought together every other month, sometimes more frequently and through these events I learned about new leadership thought pieces,

new developments within the NHS and new Policy developments. This was also a forum where CEOs would share learning and seek support from each other.

9. During my 40 years in the NHS, I have consistently undertaken training and development to support my career role at the time and these have been varied and numerous. I have always undertaken all of my statutory and mandatory training such as moving and handling, safeguarding (adults and children), cyber security, Cardio-pulmonary Resuscitation, Mental Health Act training, infection prevention and control, Oliver McGowen Training, Fire training etc. The mandatory training I have undertaken during my tenure as a CEO is over and above that required for a CEO due to the fact I was also registered as a nurse until September 2023 and therefore undertook the mandatory training required for a nurse as well.

10. As a qualified nurse I took the opportunity to undertake a Bachelor of Science degree in Psychology and Biology. I also undertook other training courses, conferences and learning both internal and external. Much of this training was driven by me as I wished to develop and learn especially as I progressed into new roles. The training included learning such as the 998 Teaching and Assessing in Clinical Practice course and the Leading Empowered Organisations (LEO) training course for middle managers. The Care Quality Commission also provided training for me to undertake my seconded role with them to conduct investigations and reviews of other NHS organisations.

11. When I was appointed to the national role in 2002, this was a new team undertaking new work, so I was extensively trained in leadership and organisational development and I completed courses such as Appreciative Inquiry. I trained as a practitioner in Myers Briggs psychometric testing (MBTI) at levels one and two and am an administrator of the Fundamental Interpersonal and Relationship Orientation Behaviour (FIRO-B). I am trained in project management to PRINCE 2 level, I completed the Top Managers Programme in 2006 with the Kings Fund, and I completed a bespoke leadership and management course at Berkhamsted University which was designed to specifically skill up this new team to undertake its role. I also self-sourced and funded a Healthcare Financial Management Association online course.

12. Sometime after becoming a Director, I also attended an NHS Providers course that was designed as an induction for first time Board Directors. I did not do this course initially as it was not available when I first became a director but once it was launched, I was very keen to attend and was supported by my CEO at the time to do so.

13. Throughout my career I have continued to learn and develop and more latterly as the CEO at UHNM, I introduced a quality improvement programme called Improving Together. The quality improvement principles of this programme are to empower and enable staff to engage more deeply in the trust and to have the tools, skills and competence to take responsibility for their own areas, to identify their own problems and to seek the resources required to put solutions in place. This is a 5 to 7 year cultural change programme requiring all staff to be trained in quality improvement tools and techniques including all Board members. This programme is 3 years in, and we are already reaping benefits for patients, such as reduced falls, reduced pressure ulcers, reduced medication errors and benefits for staff such as improvements in our staff survey, in particular staff feeling valued, motivated to come to work and engaged in the organisation. Our staff retention rates are now the best

they have ever been and as such we are able to recruit staff and have some of the lowest nurse, midwifery and nursing assistant vacancies for an acute trust in the country.

14. The above is a flavour of some of the main development opportunities I have undertaken but is by no means all as throughout my 40 years, I have attended many hundreds of study days, courses and conferences to keep my perspective fresh and up to date.

15. As well as receiving regular training and development, I extensively mentor, coach and teach healthcare professions in respect of leadership and the NHS in general. I teach regularly for Keele University on their Clinical Leaders Course and have presented both locally and nationally at conferences and have been invited to other organisations to present on their leadership development courses. All of these are a source of learning for me both from the delegates and through the course preparation that I have to do.

16. Specifically in relation to children, I have always undertaken the mandatory safeguarding children's course. These were provided internally through the organisation I was working with at that time. As a Director of Nursing, my safeguarding training was enhanced, and I was a member of the Local Safeguarding Childrens Board (LSCB). These meetings were a rich source of learning, also as part of the LSCB we undertook development as a collective board to ensure we had the necessary skills and learned from the cases that were presented to us.

17. Also, from December 1999 to 2004, I was the Clinical Risk Manager at the Royal Bolton Hospital. This was the first such role for Bolton Hospitals and they were relatively new to the NHS which meant there was no predecessor to learn from or an established portfolio of work. The role required a deeper understanding of all clinical risks to an organisation that had the potential to cause harm to patients or staff. As this was a new role, I pursued external training and this sometimes included safeguarding. I cannot recall who provided all the training I attended although some was through the NHS Litigation Authority, now NHS Resolution. I also sought a mentor from a more experienced Clinical Risk Manager at another trust.

18. As part of this role, I would also read any national reports and investigations in respect of clinical concerns that had arisen at other trusts to ensure my own organisation could take the learning from these. My approach would be to undertake a gap analysis against the recommendations in the report and assess where my organisation was against those recommendations. I would then develop an action plan to address any identified gaps. I have carried this approach with me throughout my career.

19. Such reports included the Clothier Report, Kennedy Report and the report into Harold Shipman. I am specifically asked if I read the Clothier Report in relation to Nurse Beverley Allitt, and as above can confirm I did read the report but not until I became the Clinical Risk Manager at Bolton Hospital in 1999. I read the report in 2000 when I became aware of it through my network with other Clinical Risk Managers and I subsequently downloaded the report and incorporated the learning into the governance processes of the trust and into the induction and regular training that I provided for staff at Bolton Hospital.

20. The Clinical Risk Manager role requires learning from all such inquiries, and I could not see that this had taken place at the time of the publication of the Clothier report in 1994. I have carried this method of learning with me into subsequent roles. I also made it my business to read reports published after I left the Clinical Risk Manager role, such as the Mid Staffs Inquiry, events at Liverpool Community Trust, Manchester Mental Health Trust and the various Ockenden reports and would similarly ensure a gap analysis was undertaken.

21. In respect of Letby, the Inquiry is still underway however, I am keen that learning in UHNM takes place as soon as possible. As such I have used the chronology produced by a journalist into the events that unfolded and a review of that is underway. After the trial I also spoke to the current CEO at the Countess of Chester to ascertain any learning, as described in paragraph 68.

22. In response to the question asked in the Rule 9 request of *'when a member of staff's conduct towards a child should be reported to the Police'*, that would depend on the circumstances and would not likely be a decision taken in isolation. If it was gross misconduct and a child had come to harm, it would be reported at the earliest opportunity, however, it is rare that an issue presents itself so obviously and does not first require a form of investigation. However, anything including and involving children would have a low threshold and I would invest significant time, effort and resource into conducting a thorough investigation and in making the area safe for that child and other children. I would also, as routine, make sure that the following were informed as soon as possible:

- CQC
- Integrated Care Board (ICB) Chief Nurse and Chief Executive
- Depending on the circumstances, the Chief Executive of NHS England Midlands Region and Regional Chief Nurse
- The Police, if appropriate

As well as informing the above, I would seek advice to understand if they felt there was more that should be done. Again, depending on the circumstances of the matter at hand other bodies or individuals may also be informed such as the Royal Colleges, Professional Registration organisations.

23. If the circumstances allowed, I would always seek the counsel of my Chief Nurse who has safeguarding within their portfolio and my Chief People Officer.

<u>What factors do you think inhibit or encourage members of staff to raise concerns about patient safety? How can the factors which inhibit staff from raising concerns best be mitigated? What processes did you find effective to enable staff to raise concerns when you were a Chief Executive?</u>

24. I am aware that as a CEO I hold a very privileged role and that my leadership style and approach is instrumental in setting the culture of an organisation and in developing and maintaining positive working relationships. These are very necessary attributes to support and encourage staff to raise concerns. I am very proud that I was able to leave a very positive culture at MCHFT and that I am respected for my reputation in relation to the development of positive cultures, engaging and inspiring staff and motivating other leaders to always give

their best and support others to do so. I am also pleased that I will leave a much improved culture at UHNM.

25. As a leader, I pride myself on how I conduct myself and the feedback I routinely and regularly receive is that of someone who manages and leads with openness, transparency, concern, compassion, and an interest in people; with significant professionalism and integrity and always being authentic and true to my own values and that of my organisation. I will always portray a consistently positive manner as I am aware that other staff will mirror the behaviour of leaders, so if I want people to behave well, then I need to consistently demonstrate that behaviour. These things are important to me, and I believe are necessary attributes to be an effective leader as I am aware that leaders cast a shadow across their organisation and that can be positive or negative.

26. Effective, visible, positive leadership, focussed on compassion and learning will encourage staff to raise concerns. Also having appropriate Policies and processes such as Freedom to Speak Up, Resolution Polices will help staff to understand the trusts aims and ambitions, also what is and is not acceptable. More important though is staff seeing that raising such concerns will make a difference and will lead to change. I personally thank any member of staff who has taken the time to raise a concern with me and encourage other managers to do likewise and to view this as a rich source of information and learning.

27. Staff will raise concerns if they believe something will change as a result, that they will be treated positively and they see the culture of their organisation and particularly leaders as being open, transparent, and compassionate. Staff will be fearful of raising concerns if they see people being treated badly for raising concerns, if they do not see the change required, and if they see poor or inconsistent leadership behaviours.

28. In my view, there are two very important leadership behaviours that I believe I portray and which make a significant difference in respect of organisational culture and that is relationships and conversations and ensuring these are positive. Without these, I do not believe it possible to be a good or positive leader or to develop a positive culture.

29. Not having or demonstrating the above will impact on staff wellbeing, staff behaviours and organisational culture and will create a reluctance of staff to report issues as they arise. Also, if leaders do not know their staff, they will not know what is concerning them, therefore, as a CEO I spend at least 30% of my time talking to staff and patients to understand what it feels like to work or be a patient in my organisations. I believe that we cannot neglect this, otherwise how will staff know us, respect us, understand what we want to achieve and more so, come to us if things are going wrong. If behaviours are inconsistent, rude, aggressive, disinterested, don't value, involve and engage staff, then we will not get the best out of our people, and they will be less likely to raise concerns when things are going wrong. Staff welfare has always and will continue to be my number on priority.

30. There are many policies and processes that organisations can and do have in place to support staff to raise concerns and these may include:

- Freedom to Speak Up Processes

- Employee Support Advisors,
- Whistleblowing procedures
- Resolution Policies and Procedures
- Incident Reporting Processes
- Professional Nurse and Midwifery Advocates
- Unions
- Effective induction and training
- Effective leadership development. At UHNM we created a leadership development programme called *ENABLE* which is focussed around consistent leadership behaviours, Being Kind and making UHNM a great place to work for everyone.

All of the above are effective to a degree but if the culture and leadership behaviours are not appropriate then they will have limited impact.

<u>The responses to concerns raised about Letby from those with management responsibilities within the Countess of Chester Hospital</u>

31. The issues in respect of Lucy Letby only really surfaced publicly at the latter part of my tenure at MCHFT when she was arrested and even at that time the scale of what she had done only just started to emerge. Whilst I was working within the Cheshire and Mersey region, I cannot recall any collective formal or informal meetings between CEOs in the Cheshire and Mersey region to specifically discuss this case. There were no meetings that I attended or recall where the specific issues regarding the neonatal unit at the Countess of Chester were discussed by the time I left MCHFT.

32. When I was appointed as the Director of Nursing and Patient Experience at MCHFT in 2006 I was aware of the Countess of Chester Hospital as it was also in the Cheshire and Mersey region. However, MCHFT did not have a working relationship with them as they were too far away for our population, and there were nearer hospitals to them.

33. During my tenure at MCHFT there were a number of CEOs at the Countess of Chester that I got to know through the regional CEO meetings at that time and I would speak to all of them informally at various Cheshire and Mersey regional meetings or through ad hoc calls to discuss various matters.

34. I knew Tony Chambers between the years of 2012 and 2018 and I believe this to be his tenure as the CEO at the Countess of Chester. I knew Tony Chambers prior to 2012 as he was also a nurse and trained at the same hospital (Bolton) as me. We did not train together as he started his training sometime after me but as students, we would periodically come across each other on various wards. Tony Chambers then left Bolton to do other things and I did not see him again for a number of years until he rejoined Bolton Hospital as a bed manager, but I cannot remember when this was.

35. I commenced my role as Clinical Risk Manager in 1999 and would occasionally see Tony Chambers around the hospital site and I would have conversations with him. In 2002 I left Bolton Hospital to join the national team and I did not see Tony Chambers until a few

years later when he joined the same national team, and we were both pleasantly surprised to see each other again. I don't know the exact timings, but Tony Chambers was not with the team for very long as he left to take up the role of Chief Operating Officer at Mid Yorkshire Hospital. I remember this well as I was doing some work to support Mid Yorkshire Hospital at that time. I do not recall seeing Tony Chambers again until he joined the Countess of Chester as their CEO although he did contact me prior to the interview to let me know he was applying and to enquire about the Cheshire and Mersey region and MCHFTs relationship with the Countess of Chester. There was further contact with Tony Chambers up to him becoming the CEO at the Countess of Chester, but I cannot recall the number of contacts.

36. Once Tony Chambers became the CEO at the Countess of Chester, I did see and speak to him more and this was usually at the regular Cheshire and Mersey regional CEO meetings where I would see and speak to all CEOs in the region. As with other CEOs I also had occasional phone calls with Tony Chambers.

37. Whilst I was the CEO at MCHFT, Tony Chambers did ring me specifically in respect of the high Neonatal Unit mortality rates at the Countess of Chester. Tony Chambers wanted to talk things through and to seek my views and I recall that this particular conversation led to my discussion with Michael McGuighan. This was an informal discussion, and I did not make any notes of the call. I did not know Lucy Letby's name at that time and I do not recall Tony Chambers disclosing the names of any individuals during our discussion. I cannot recall all of the detail of what we discussed but in essence he advised of an increase in neonatal mortality rates and he advised of the steps he/the trust had taken and he wanted to know if there was anything further I would suggest.

38. I cannot recall all of the things he said had been done but I do recall him saying the Coroner had been asked to review the cases and that there either had been, or would be, a Royal College investigation. I believe there were about 4 or 5 other things that he mentioned had been done, but I cannot recall what these were. Tony Chambers advised that no conclusions had been drawn at that time based on the actions taken to date and he advised me that the Paediatricians were not happy with this, and he felt they would only be content with a Police investigation. I recall Tony Chambers was not averse to that but wanted to concluded avenues already in progress.

39. Tony Chambers did say that a nurse was being implicated by the consultants, but at this stage I did not think the implication was of intentional harm and there was nothing in the discussion that indicated the scale of the eventual outcome of this case, and I don't think anyone fully understood this at that time.

40. There were two suggestions I made to Tony Chambers. The first was in respect of whether their Board of Directors were aware of the mortality rates and the issues the Paediatricians were raising and the second was whether he had sought their views in respect of governance, process and any additional actions. Tony Chambers confirmed they were aware, and they had had discussions in their private Board.

41. Tony Chambers also described to me the poor and worsening relationship between him, and the Paediatricians and he was very concerned about this. We did discuss strategies and tactics about how he might go about trying to resolve these issues, such as facilitated

discussions. My impression was that Tony Chambers was saddened and concerned by the loss of relationship between him and the Paediatricians and wanted to work on restoring this and gaining their confidence again.

42. It was during this part of the discussion that I recalled that Michael McGuighan, a relatively new Consultant Paediatrician, had left MCHFT to join the Countess of Chester. I remember Michael McGuighan very well as it was his first consultant post with MCHFT and he was very polite, professional and quiet. As Tony Chambers had described the very tense atmosphere, I felt concern for Michael McGuighan's wellbeing and after the discussion with Tony Chambers concluded, I asked if he would mind me reaching out to him to check on his welfare. Tony Chambers said he was fine with this.

43. It appeared to me that Tony Chambers was concerned about the higher mortality rates and as far as I could see, based on what I knew at that time, he seemed to be taking it seriously and wished to explore every possible avenue to get to the root cause. To my recollection, this was the only specific discussion I had in respect of the neonatal unit mortality rates at the Countess of Chester with Tony Chambers, or anyone else. Although I did subsequently have phone calls and see Tony Chambers at Cheshire and Mersey regional CEO meetings and other work related meetings where we would discuss many items and some of these did include updates from the above initial discussion and how things were going. I also recall having similar discussions with other CEOs but these were very limited as at this time, very little was known. I cannot recall specific dates, times or things that were said in what would have been brief snatches of discussions.

44. Following the call with Tony Chambers, my initial intention was to approach one of the Paediatricians at MCHFT to see if they would reach out to Michael McGuighan to see how he was as they clearly knew him better than me. However, after further consideration, I did not feel this was appropriate due to the sensitivities and confidentiality of the case. At this time, it appeared to me that the neonatal issues at the Countess of Chester were not widely known about, and I did not want to break any confidences by discussing further with my consultants.

45. I do recall having a discussion with Michael McGuighan, but I cannot remember all of the details of what was said although his police statement at Exhibit INQ0001985, pg.14-15 has been a useful prompt. I cannot remember the date of the call but note Michael McGuighan suggests that it took place on the 30 March 2017 and I have no reason to dispute that. I have read Dr Michael McGuighan statement [Exhibit INQ0001985, pg.14-15] and agree with the way he describes the meeting was likely to have been set up.

46. I do not recall whether or not I described Tony Chambers as a personal friend as we do not and have not socialised outside of work-related events. I would have at least described Tony Chambers as a very good colleague. The point I was trying to relay to Michael McGuighan at this time was that I had known Tony Chambers for a long time, and I did so as a way of justifying why Tony Chambers would ring me to discuss such a sensitive and confidential matter.

47. Whilst I do not recall all of the detail, there are aspects of Michael McGuighan's statement [Exhibit INQ0001985, pg.14-15] that do not resonate with me, they are not a

recognised approach or language that I would use although this may be Michael McGuighan's paraphrasing. The intention of calling Michael McGuighan, as stated to Tony Chambers, and as confirmed by Michael McGuighan in the final paragraph of his statement, was to see if he was OK and if he needed any support or someone to talk to. To my recollection the call was friendly and relatively brief. When we spoke, we obviously got on to discussing the issues occurring which I only knew of at a very high level, I did not know the detail or people concerned and Michael McGuighan was very professional and said very little about the circumstances that were taking place at the Countess of Chester.

48. I do not recall saying that the Paediatricians were *'refusing to accept these clinical issues'*. At that stage I did not know what the clinical issues were, and as far as I could tell these were not known outside of the Countess of Chester.

49. I do not believe I would have said *'things will end badly for some people',* that is not a language or approach that I would use or something that I can see myself saying. Based on what I understood was happening and the fractious relationships as described to me by Tony Chambers and Michael McGuighan, I would have likely advised that such things always end badly.

50. This is based on my experience of leadership and the impact of poor relationships between clinicians and managers. I am aware that in such circumstances things often end badly as it usually translates into poor patient outcomes, poor patient (family) experience, poor staff morale and wellbeing. There is significant literature and research available which demonstrates this, and I witnessed this first hand when working nationally in some of the challenged organisations I supported, and I use this material in the training that I deliver to date. During our discussion and not knowing any great detail about the issues, I most likely wondered if this could be part of what was playing out in the neonatal unit at the Countess of Chester, and I may have expressed that to Michael McGuighan.

51. I was very concerned that Michael McGuighan was in the middle of something that was very unpleasant, and I was concerned for his wellbeing as he struck me as a mild character. I believe I would have advised him to be his own person and come to his own conclusions.

52. Tony Chambers did describe to me two particular Consultant's who he felt were driving the consultants thinking in the neonatal unit. He did not name them, but I did not say it would end badly for them and I do not recall Tony Chambers saying anything like this. At this stage, it appeared to me that no one knew what the cause was, and I could not have known then who had done what to draw a conclusion on what might happen and to whom.

53. Even with Michael McGuighan's statement as a prompt [Exhibit INQ0001985, pg.14-15], I cannot recollect any discussion with Tony Chambers or Michael McGuighan about an email being talked about. I did not see a copy of any such email as these were both telephone conversations.

54. I do recall Michael McGuighan being supportive of his colleagues and my impression was that he shared their views on where things were at, and I got the impression that Michael McGuighan felt safe.

55. I note Michael McGuighan makes a statement on what he believes I was implying and clearly these are his views. I most likely would have asked Michael McGuighan to be sure all avenues had been explored.

56. I most certainly would not have used words such as *'egotistical'*, *'selfish'* or '*in denial'* or *'bad people who are heading for a downfall'* although recognise he is not saying that I used those words. This is not a language or style I would use or have ever used. Again, I would not presume to make such judgements about people I do not know or situations where I only have the scantiest of detail.

57. The final paragraph of Michael McGuighan's statement [Exhibit INQ0001985, pg.14-15] sums up the essence of the discussion that I recall: *"I did not feel any pressure from the call or that she was telling me to shut up. It was purely that she was concerned that I was in a tricky position, wondering if I was making the right judgement call, and warning me about how it might be seen by other people. It was purely a friendly call to tell me to be careful about the situation"*. However, I find Michael McGuighan's final paragraph does not correlate with some of what he suggests I have said as set out in his statement.

58. I made no notes of this call as it was, to me, a call to check on Michael McGuighan's welfare and to see if he needed anything. I think I concluded the call expressing my concern for him, offering that he could call me at any time, and I think I would have most likely suggested he used his colleagues at MCHFT who he knew better.

59. Since Tony Chambers left the Countess of Chester I have had a small number of calls with him, but these were not necessarily about the issues at the Countess of Chester, and I recall some of them being specifically about what Tony was up to career wise and sharing of learning in respect of Covid19. Tony Chambers was working in London at that time and Covid19 had hit London first, so I was keen to understand any learning from what they were seeing in London and Tony Chambers agreed to provide this and gave me some very useful insights which I took forward in my own organisation.

60. I do not recall any other calls with Tony Chambers solely about the issues in respect of the neonatal until it became much more public as it was viewed very much as confidential, especially when it became known a Police investigation was underway.

61. I have seen Tony Chambers a couple of times since I left MCHFT at work related conferences and events. Also, between 29th December 2018 and currently to 2024 there have been thirty four WhatsApp contacts between us. Of these, the only ones relevant to the neonatal issues at the Countess of Chester were two WhatsApp messages from me to Tony Chambers asking about his wellbeing and these were the 18th August 2023 and 5th October 2023. The remaining WhatsApp messages were not relevant to this case.

62. I am not aware of any discussions happening within the Cheshire and Mersey region between the CEOs. At the time I left MCHFT there was still no concept of just how significant this case would be. Whilst as a group of CEOs we did discuss best practice and issues of concern, I do not recall any such discussions in respect of the neonatal unit at the Countess of Chester, nor do I recall any discussions taking place in relation to whether any such

conversations should take place. As stated, the scale of this was not known until the trial and what was shared in the public domain. However, I am aware that I did not attend every meeting due to I&S, so discussions may have happened that I was not party to.

63. The only people who discussed concerns about this case directly with me was Tony Chambers and Michael McGuigan as described above. To my recollection I only became aware of Lucy Letby's name through the media. Whilst there were discussions with other CEOs these were very brief as we knew very little, and the conversations were usually about us trying to find out more.

64. There is learning at national and regional levels in respect of significant events such as these however, I was not involved in any such learning whilst at MCHFT. However, I can site examples of other significant events such as Ockenden, where I know learning has taken place at regional and national levels so it may be that this occurred after I left.

65. I do not recall any discussions with me about the mortality rates on the neonatal unit at the Countess of Chester between 2015-2017 for the period 2015-2016. Neonatal mortality rates are published by MBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) nationally and there is benchmarked data available so you can see how your own trust performs against peers. I use this data to assess where my own trust is in relation to other NHS trusts however, other trusts are not named so I would not know which trusts had high/low mortality rates.

66. I was involved in a piece of work being undertaken in the Cheshire and Mersey region in respect of Maternity services which may have included neonates, but I cannot recall the dates of this. The work was looking at whether we had the right number and configuration of maternity units for the region, but I cannot recall who led it, or if it included discussions about neonatal mortality rates.

67. I do not believe I would have specifically been made aware of the mortality rates at the Countess of Chester because I was at a neighbouring hospital unless it was something that would directly impact on MCHFT. If the Countess of Chester required the mutual support of another hospital, it would not have come from MCHFT, it would most likely come from larger and nearer neighbouring hospitals or a specialised hospital such as Liverpool Women's, but I do not know if any such discussions were had with them, but there were no discussions with me in that regard.

68. After Lucy Letby's trial was concluded, I contacted the CEO at the Countess of Chester, Jane Tomkinson, to see if she would meet with me to understand any learning from the case that we at UHNM could use prior to the release of the national independent inquiry. It took some time to arrange this, but I had a very useful Teams discussion with Jane Tomkinson and I got useful insights in respect of early learning which I have subsequently shared within UHNM and we are weaving this into our own internal review of the material published to date in respect of the Letby case and how we can learn from it.

69. Over the years, as an experienced CEO, I have been informally contacted by other CEOs seeking advice or simply to chat through issues that many of us encounter. This has

included issues such as sharing learning from managing Covid, sharing learning from working in a challenged organisation, dealing with contract disputes with commissioners, addressing CQC concerns etc.

Reflections

70. I have been asked to comment on whether I think the crimes of Letby could have been prevented if the babies had been monitored by CCTV and I can respond as follows:

- Whilst CCTV would be a very good deterrent, I cannot say that this would have prevented the crimes of Lucy Letby although it may have made it easier and/or quicker to identify the culprit. I suspect that if someone is minded to do such terrible things, they are likely to find a way of doing so. I also understand from what has been published about the case that many of the crimes committed would have looked like actions being taken during routine care, such as the administration of drugs.
- I do not believe staff would have an issue with the introduction of CCTV directly in patient care areas however, this would need to be tested with families, in view of the privacy and dignity issues.

71. Keeping babies safe in neonatal units from criminal action must be a priority for all organisations. There is no one silver bullet in this regard, but in my mind, there are clearly mitigating actions that can be taken which I have outlined below:

- Visibility of both local and senior divisional / Board leaders. Walk abouts, informal discussions with staff. Developing relationships will ensure staff feel more able and willing to talk to you.
- Ensuring wards / departments are resourced to the right levels.
- Ensure staff receive appropriate mandated / statutory training and training identified as part of a PDR.
- Appropriate scrutiny of performance and quality metrics by divisional board / Trust Boards and quality committees.
- Robust Freedom to Speak Up processes with monitoring of trends and actions.
- Recruitment processes – ensure employment checks are robust and interview processes are values driven.
- Individuals need to be clear on their roles and responsibilities so if issues are identified, it is clear who is responsible for addressing, escalating etc.
- Ensure escalation processes are robust and issues are appropriately captured, recorded and addressed.
- Regulation of managers. I am unaware of any reluctance from managers in respect of being regulated whilst also noting this is by no means straightforward in terms of impact as many senior managers are already regulated through their role e.g., Chief Finance Officers, Doctors, Nurses and other healthcare professionals. It should also be noted that many of the high-profile safety events that have occurred in the NHS have been as a result of action or inaction by regulated professionals. Therefore, this cannot be seen as a single solution. The approach of professional regulation should focus on developing the most effective leadership characteristics and it

should be developmental in nature and meaningful for novice managers and those with greater experience.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: PD

Dated: 29/05/2024