Witness Name: Gillian Valerie Galt
Statement No.: 1
Exhibits: GG01 and GG02
Dated: 19 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF GILL GALT

I, Gill Galt, will say as follows: -

1. My full name is Gillian Valerie Galt.

Career background

2. After graduating from the University of Sheffield with a degree in English Literature, I trained and worked as a local newspaper reporter for three years.

3. My main interest as a journalist was covering matters of citizenship and local democracy which, in 2001, led me to move into a role as a Press and Public Relations Officer with a local authority where I worked for five years. Whilst undertaking this role, I studied for and obtained an advanced diploma in Communication Studies from the Communication Advertising and Marketing Education Foundation.

4. I started working for the NHS in 2006. During my time with the NHS, my professional development was supported by my line managers, with the opportunity to take part in a range of training. This included management development programmes as well as joining networks and meetings for the NHS communication leads and public relations professionals (including the Chartered Institute of Public Relations).

5. I worked as a Communications Officer and then as a Communications Manager with a NHS specialist hospital Trust before progressing to work as a Head of Stakeholder Relations and Engagement in a NHS commissioning and community services provider in a large city area. I stayed in this post until November 2013. Having gained over 15 years of communications experience, I joined The Countess of Chester Hospital (COCH) as their Head of Communications and Engagement in November 2013.

6. I handed in my notice in March 2017. I remained as Head of Communications and Engagement whilst working a three-month notice period. I left the COCH on 31 May 2017.

Your Role and Internal Governance

7. My role as Head of Communications and Engagement was to manage both the internal and external corporate communication channels for the COCH and support forums for staff engagement.

8. The communication function was responsible for content placement across communication channels that the team was responsible for producing or managing i.e. newsletters, screensavers, weekly bulletins, the website, and social media platforms. These channels would also be used for running routine NHS campaigns such as getting your annual flu jab, taking part in the NHS staff survey, and providing information on how to access NHS care during times of winter pressures.

9. The communications function would also issue proactive media stories and respond to media enquiries, predominantly from local or regional news reporters in line with the COCH's media policy.

10. I was also responsible for managing the medical photography and illustration service, which was a self-contained and established service that produced, designed and printed patient information leaflets and supported clinical photography requirements. I was the line manager for the Head of Medical Illustration and Photography. My role did not extend to undertaking any communications or public relations work for the hospital charity or the fundraising initiative known as The Babygrow Appeal. This was managed separately under the remit of the Director of Corporate and Legal Services.

11. At the time I joined the COCH, there was one Communications Officer reporting to me and supporting the service. During my time at the COCH, the team expanded to meet the communication requirements, and included a fixed term contract Communications Specialist, a seconded / part funded Corporate Design Lead, who supported design and digital content, and two fixed term contract Communication and Public Relations Officers.

12. For the majority of my time at the COCH, I reported directly to Alison Kelly, the Director of Nursing. We would meet every month to discuss communication issues. These meetings were often joined by the Director of Human Resources and Organisational Development, as a significant remit for the communications function was the development of internal communications and staff engagement. I had an agreed communications and engagement action plan to implement between 2015 - 2017, and these meetings would focus on reviewing progress with this action plan. Examples of the type of work included in this plan were the development and launch of a new staff intranet, embedding a new monthly team briefing system, increasing staff readership of the weekly staff newsletter, establishing new processes for the management of poster and screensaver campaigns, maintaining and developing staff open forum sessions, supporting staff recognition schemes and initiatives, increasing use of proactive patient stories, developing the COCH's social media approach, including responsiveness to social media, reviewing and establishing new corporate identity guidelines, reviewing and strengthening the hospital website, planning and publishing a patient facing newsletter called "Countess Matters" three times a year and producing bespoke plans / campaigns.

13. During my time at the COCH, the Board consisted of both Executive and Non-Executive Directors. I was not a member of the Board and did not attend private Board meetings. I was however available to meet with any member of the Board or senior manager within the COCH, if there was a requirement to support the communication of an initiative or matter that was part of their portfolio or area of responsibility. These meetings were informal and arranged as and when the need for communications support arose. As part of that arrangement, I recall meeting with Ian Harvey, Tony Chambers, Stephen Cross, Sue Hodkinson and other members of the Executive Team about different matters throughout my time with the COCH.

14. I attended the Corporate Directors' Group (CDG) and the People and Organisational Development Committee (PODC). Although I attended the meetings, I cannot determine whether my involvement was considered as that of a formal member. I say this because in my other NHS roles, my attendance at formal senior team meetings did not equate to the meeting as being quorate, and this might have been the case here with the COCH too.

15. The CDG was a forum for heads of service to discuss strategic and operational matters relating to hospital business. I would provide updates in relation to the development of internal and external communication channels and report on media interest that the COCH was receiving at that time. Members could ask for support from the communications team to promote a service.

16. The PODC was a staff Committee and forum in which we met with union representatives of the organisation. The Committee would, for example, consider proposed new policies and the impact that those policies would have on staff. Attendance at meetings would enable me to understand staff priorities within the COCH and address feedback through internal communications.

17. I do not recall membership of any other formal Committees during my time at the COCH. I did attend Patient Experience Groups and the Council of Governor membership communication meetings. The purpose of the Patient Experience Group was to report on patient surveys and discuss the feedback received. The Council of Governor communication meetings were held to look at planned news items to include in the "Countess Matters" and membership recruitment information.

18. The COCH's Executive team would generally meet on a weekly basis. The Executive team comprised of Board members, excluding the Chairman and Non-Executive Directors. I would not routinely attend Executive team meetings but would occasionally be asked to join the meeting for the agenda item relating to communications. Once discussions relating to the communications agenda item had concluded, I would leave the meeting.

19. As stated above, I did not attend private Board meetings. Roughly every two months, a public Board meeting would be held. The public meeting would be attended by the Directors, Non-Executive Directors and Chairman and were open to members of the public and the media. I would attend the public Board meetings in order to be available to liaise with the media, if they were present as well as public governors.

20. Prior to working at the COCH, I had spent five years working at a Primary Care Trust (PCT) and community service provider rather than within a hospital. Whilst my role was an administrative one, with no clinical or patient facing involvement, the working environments were very different. At the PCT, work was desk based, with formal meetings arranged and communications predominantly by email. The hospital by its

nature is a busy environment to work in, with the majority of staff engaged in delivering patient care rather than being desk based.

21. The COCH's leadership team were very visible within the organisation and sought to engage with staff through a variety of forums including walkabouts, blogs, staff updates and leadership briefings.

22. Whilst the wider management and governance structures at the COCH were less formal to that at the PCT, the working environments were very different too. I do not recall any changes to the governance structure whilst I was at the COCH. I do not know if the structure and processes for the management and governance of the hospital contributed to a failure to protect babies on the Neonatal Unit from the actions of Letby.

23. I was aware of safeguarding leads, information and training being available to all staff (relevant for both children and adult services). Safeguarding training was mandatory, and I believe that compliance with it was monitored in Board reports. I complied with all mandatory training requirements made of me, including safeguarding but I cannot recall who conducted the training. It was instigated as per the mandatory training schedule. From my training it was my understanding that suspicions or concerns about patient safety should be raised through the appropriate incident and safeguarding mechanisms, but if there was an immediate witnessed threat involving a member of staff's conduct towards a child, this should be reported to the police straight away by an individual with suspicions or concerns. I consider that this was my understanding during the time I was working with the COCH. I am not in a position to further comment on what the Board's role was in terms of training and safeguarding matters.

24. I recall the COCH supporting and promoting The Nursing Times "Speak out Safely" campaign when I first joined the organisation in 2013/2014. In addition, at a later point, the communications team ran screensavers on the role of Freedom to Speak Up Guardians as part of a commitment to raising awareness about points of contact and how the process was managed. The request to promote Freedom to Speak Up Guardians would have come to the communications team via the appropriate Trust Board lead or senior manager. I do not know whether the request for promotion of this was instigated by NHS England at the time.

25. I was aware of the COCH's Speak out Safely and Whistle Blowing Policy but do not recall any further guidance being provided by NHS England or other organisations. During my time with the COCH I developed a policy to the management of internal communications channels, including details of how staff could submit a request or promote an initiative on these channels. I have attached a draft copy of this policy at **Exhibit GG01.** INQ0102070

26. Having reflected on my time working with the COCH, I cannot say what information I should have been privy to in relation to whistle blowing. This is because the role of Head of Communications did not necessitate my involvement in issues such as whistle blowing or reporting concerns. I always assumed that those issues were dealt with appropriately by the relevant individuals.

Raising concerns and Freedom to Speak Up

27. During my time at the COCH, I developed a policy regarding processes for the management of internal communication channels including details of how staff could submit a request to promote a service or initiative on these channels.

28. I recall the Freedom to Speak Up policy and the role of Guardians was promoted via internal communication channels, specifically on the COCH's screensavers. I did not have any further responsibilities in respect of the Freedom to Speak Up Policy, but I was aware of the policies.

29. Whilst any policy could be accessed via the intranet, the intranet was a central repository for news and information, it was not a document library. Documents had to be accessed via the Trust's Sharepoint system, which was managed by the Risk and Patient Safety team.

30. The Care Quality Commission (CQC) inspected the COCH in 2016. Prior to the inspection, I was asked to run a staff awareness campaign, which included risk and patient safety and promoting the speak out safely campaign. I do not have a copy of or recall the detail of the final communications plan prepared in relation to the risk and patient safety campaign.

31. The CQC report prepared following their inspection and published in June 2016 confirmed *'a positive culture throughout the Trust'* and that '*staff felt well supported'*

and '*able to raise concerns*'. I believe the NHS annual staff survey results also monitored and reported on the awareness and effectiveness of Trust processes for raising concerns and speaking out safely.

32. In relation to the reporting of concerns regarding patient safety or suspicions and concerns regarding colleagues, my role was non-clinical and none of my team members were involved in the care and treatment of patients. I cannot comment from personal experience on the most effective way for members of clinical staff to raise concerns relating to patient safety. Had a member of my team raised a concern with me directly about a matter of patient safety, I would have responded to the concern and used the appropriate reporting systems. This would have been the incident reporting system as well as raising the issues directly with my own line manager.

Risk management throughout the hospital

33. A communications plan was developed to support the communication of the Risk Management Strategy and Operational Policy that appears at **[INQ0014962, page 11]** to staff. My assumption is that this is the staff awareness campaign that I was asked to develop to support staff in preparing for the CQC inspection, as mentioned above. I do not have a copy of or recall the detail of the communications plan. However, a communication plan would routinely include information about the internal communication channels to be used, relevant messaging on what the policy is and any other calls to action or key points of contact, as well as timescales and scheduling details for the communications to be issued.

34. My role did not require me to undertake any work in relation to governance. If a risk was identified that might generate public or media interest, then I would be made aware at that stage in order to establish public facing communications or reactive media lines. I do not recall what role the CDG played in relation to risk management or how it carried out this role. I was not responsible for entering information regarding a service issue to the Risk Register. This would be the responsibility of the Operational Service Manager.

35. I note that The Trust's Annual Governance Statement dated May 2015 **[INQ0004516]** describes the Corporate Directors Group as having *"delegated responsibility for overseeing and monitoring the risk management and assurance framework process"*. My role was non-clinical, and I cannot comment on how this worked operationally. My

involvement was limited to situations where any matters on the Risk Register required public facing or reactive media lines.

36. I note that the Risk Management Strategy and Operational Policy **[NQ0009506]** names the Corporate Directors Group as having "*delegated responsibility for reviewing the Organisational Risk Register and Board Assurance Framework*". The Policy also states that the Corporate Directors Group would meet quarterly to review the Executive Risk Register and, in particular, newly entered risks on that Register. As stated above, I do not know how this worked operationally as my role was limited to any matters on the Risk Register that required public facing or reactive media lines.

The management of concerns regarding the increase in neonatal mortality and Letby's actions

37. In late June 2016, I was asked to support the Executive team with making a public announcement regarding an invited Royal College of Paediatric and Child Health (RCPCH) review into the increase in the NNU mortality rate, and the communication about changes being made, including the downgrading of the NNU at the time. The announcement was published on the COCH's website on 7 July 2016 and made available to the local media. At this time I was not aware of any concerns / suspicions about the involvement of a member of nursing staff in the increased mortality rate.

38. The two NNU Action Planning Meetings on 30 June 2016 at 9am and 1pm will have been instigated by the Executive Team. I did not set up these meetings and I was not involved in drafting the agenda for the meetings either. I note my attendance is documented for both meetings but cannot recall if I was present for the duration or left after I received my actions and gave my update. However, I have set out below the nature of my contribution during those meetings.

39. At that point, the CQC's report into the COCH had just been published on 29 June 2016 following the CQC's inspection in February 2016. The reported highlighted staffing levels as an issue in the NNU and made references to compliance with staff resuscitation training as highlighted at **[INQ0005201, page 3]**.

40. The notes of the first and second NNU meeting on 30 June 2016 record that I was in attendance in relation to the CQC report. In terms of my involvement, I had engaged

with the CQC communications lead at the time in relation to the publication of their report and the COCH's planned announcement regarding the downgrading of the NNU. It was my understanding that the CQC were also having operational discussions with Alison Kelly and Tony Chambers, which I was not party to. My role in terms of my involvement with the CQC related just to the public-facing communications about the actual downgrading, as opposed to any detail about why the NNU was being downgraded.

41. I note the action log from the NNU action planning meeting at 9am references an individual member of staff and at 1pm updates specific details regarding their annual leave, other working and home circumstances. I do not have any recall of these discussions, and could not confirm if I was even present for them.

42. I do not recall when I became aware of paediatrician concerns or the strength of their feeling. My understanding at this time was that the Executive Team were working with the Consultants and that the NNU downgrade and Royal College Review were part of this work.

43. The published CQC report included references to their inspection findings for the NNU. Due to the close timing of their inspection report on 29 June 2016 and the planned COCH's press release on 7 July 2016, it was reasonable to assume journalists could either read the two reports in conjunction or infer that the action to downgrade the NNU was a direct consequence of the CQC report. The COCH's press release published on 7 July 2016 subsequently referenced the CQC report findings, as well as the draft Communication Handling Lines **[INQ0005201]**, including consideration of potential questions for the COCH about the CQC report findings for neonatal services.

44. In addition, the notes record that I was responsible for drafting further communications to the public and for patients, being a broad group of patients i.e. all those currently accessing maternity or neonatal services or expecting to access them in the near future. This would have been at the request of the Executive team and not communication specifically with the parents who had lost a baby on the NNU. The letter at **[INQ0002672]** is a draft of a letter that was prepared to go to parents expected to use the NNU about the downgrading of the NNU.

45. I do not recall there being any discussions at the two NNU Action Planning Meetings regarding when or how the parents of babies who had died or collapsed on the NNU

would be informed of the downgrading of the unit. I would not have expected to have been party to such discussions as I did not have direct contact with the families that had lost a baby on the NNU and was not asked to assist in relation to the drafting of any correspondence or communications with the families. Any contact with the families would be managed by the appropriate clinical and nursing leads. Colleagues responsible for communication with the families would be aware of and had access to planned public communications for context in their own communications.

46. The notes of the meeting on 30 June 2016 refer to the involvement of the Coroner. My understanding was that, where families subsequently requested representation via their solicitor, these relationships were managed by Stephen Cross in his role as Director of Corporate Affairs and Legal Services.

47. The notes of the first meeting on 30 June 2016 include a heading entitled, *'Actions to be Taken'*. One of the actions is a '*list of stakeholders to inform'*. This action point was allocated to Sian Williams (SW), the Deputy Director of Nursing. The notes of the second meeting record that Sian Williams had completed the list and that it was to be transferred into a table regarding the order of the cascade and who will do what. I do not recall being provided with or having sight of the list of stakeholders at that time.

48. The notes of the communications room action log at **[INQ0002834]**, at entries 86 and 87, indicate that a stakeholder list was being managed by Sue Hodkinson. The list of stakeholders that I provided details for logging in the communications room was for the communication leads and local media following discussions about the press release and public facing messages.

49. As stated above, the Executive Team initially asked me to assist them with the public announcement in relation to the downgrading of the NNU services (the press release). Due to the nature of the intended public announcement, there was a need for a range of communications to be prepared including:

    i. Information for briefing stakeholders (published) and appears at **[INQ0004319 pages 61 and 77]**
    ii. A press release and website news content (published) and appears at **[INQ0004319 pages 51 and 52 and INQ0002944]**
    iii. Internal communication for staff (published) including details of where to signpost general members of the public or patients with concerns and appears

at **[INQ0004319 pages 41,42, 57, 58, 65, 66].** I note that information was published at 11am and 2pm.

iv. A letter for patients currently using maternity services (drafted, but not published or finalised as far as I can recollect) and appears at **[INQ0002672]**

v. Key handling lines, supported by a media protocol, for out of hours media enquiries (drafted but not published) and appears at **[INQ0002820]**

50. For clarity, I was not involved in the development or production of the clinical document for cascade at **[INQ0004319 page 11, 12, 47, 55 and 56].**

51. To help with producing the above communications, a Communication Handling Lines document was also drafted but not published at **[INQ0005201]**. This document was used as a basis for establishing the approved content and messaging for the published communications, as well as preparing for further communications that may be required.

52. At the request of the Executive Team, draft communications were prepared in line with the COCH's media policy, a copy of which is included at **Exhibit GG02.** The copy I have provided is in draft form and so I am not aware about whether there are other versions or subsequent changes to the final version of the policy in place at the time. **INQ0102071**

53. Whilst preparing the draft Communication Handling Lines referred to above, I sourced information that was already in the public domain. This included the CQC report and patient friendly definitions in relation to neonatal care published by Bliss (an established neonatal charity). I also reviewed and included the COCH's media lines previously prepared in relation to the hospital being an outlier in standardised mortality ratios, as published in the Doctor Foster Hospital Guide from 2013/2014 (these described how mortality was reviewed generally in a hospital setting).

54. I further liaised with the Informatics team, the Patient Safety team and clinicians for input into how the downgrading of the NNU would be communicated.

55. Once the draft communications were prepared, they were circulated to the Executive team for review and amendment. Once in an approved draft form, communications would be circulated to a number of external organisations for review and comment including other local trusts, CQC, NHS Improvement and NHS England. The communications would then be further reviewed and amended prior to a final approval by the Executive team. Whilst feedback was received from multiple internal colleagues

as well as external organisation communications leads, I cannot recall how each individual contributed to the press release that was published on 7 July 2016.

56. I had contact with communication leads at the CQC, NHS Improvement, NHS England regional team, West Cheshire Clinical Commissioning Group (WCCCG) and Wirral University Teaching Hospitals (WUTH). This contact included telephone and conference calls to advise communication leads of the planned external announcement about the downgrading of the NNU, as well as emailed copies of the draft press release with the opportunity for them to contribute to it on behalf of their respective organisations.

57. The first action point on the neonatal services action log from 7 July 2016 refers to the opening of the communications room and a briefing to staff by Stephen Cross and Sue Hodkinson. Due to the impending publication of the press release regarding the downgrading of services at the NNU, the Executive team had decided to bring the various hospital managers together in one of the COCH's meeting rooms. This had been named the communications room. For clarity this was effectively an operational incident room, led by the Executive team, i.e. it was not set up by or run by the communications function.

58. The action log runs from 9.00am on 7 July 2016 and ends at 13.40 on 11 July 2016 (Action Log). My office was located next door to the meeting room they were using as their communications room. I continued working from my office, joining the communications room when available and required to attend. I do not recall which meetings I attended during the period 7 to 11 July 2016. I recall that while the communications room was operational, it was a very fast paced, command and control environment and I was focussed on the tasks within my remit.

59. The entry at number 10 on the action log refers to '*specific lines'* being provided to update parents with children in the NNU. As stated above, my responsibility was limited to communications with patients who either currently had children in the NNU or may be attending NNU in the future. I do not have a copy of the '*specific lines'* referred to and these have not been provided. I do not recall exactly what was said in the '*specific lines'* but these lines would have been based on the content of the press release.

60. As WUTH would be receiving additional babies as a result of the downgrading of NNU services at the COCH, WUTH needed to ensure the reference to the service that they

would be providing was accurate and that operationally they were ready to receive babies, with staff briefed in relation to the changes. As a result, I had an exchange of emails with Mike Baker, Head of Communications at WUTH, regarding the proposed press release and my email at 18.48 on 6 July 2016 attaches the current version of the press release for comment.

61. Entries at 25, 27, 42 and 77 on the Action Log refer to the various discussions taking place with the media and local and regional stakeholders on 6 July 2016 and 7 July 2016. The press release was to be published on the COCH's website and I was to proactively brief local media. The press release was also to be made available as a briefing to interested stakeholders.

62. The press release was also shared in advance of publication with communication leads from the CQC, NHS England, NHS Improvement and WUTH. My discussions with the communications leads included confirming the timing of the publication of the press release and that all relevant stakeholders from their perspective had been notified.

63. The staff received the same information as that published in the press release on the hospital website, together with some additional guidance from HR to support health and wellbeing.

The Press Release

64. As stated above, I prepared an initial draft of the press release. The draft was then circulated to the Executive team for review and amendment. Once in approved draft form, communications would be circulated to a number of external organisations for review and comment. The communications would then be reviewed and amended prior to a final approval by the Executive team.

65. While I cannot recollect the detail of the drafting process, as stated above, the opportunity for input or comment to on the press release was also given to organisations referenced in the statement (such as the CQC and WUTH) as well as NHS Improvement and NHS England (who were separate organisations at the time).

66. As stated above, I had been in communication with the communications lead at WUTH as WUTH would be receiving some of the babies that would have been treated at the COCH prior to the downgrading. My email at 18.48 on 6 July 2016 had attached to it

the current version of the press release for comment. On 7 July 2016, there was a further exchange of emails with WUTH at 13.12 with the subject *'external statement',* **[INQ0004915].** As far as I am aware, reference to the *'external statement'* was to the press release and the amendments that had been requested by WUTH to it. My email also refers to WUTH's concerns having been fed back to NHS England. I do not recall what specific concerns were raised by WUTH.

67. At 15.34 on 7 July 2016, I sent an email **[INQ0002943]** to all members of the Executive team confirming that following publication of the press release, the Chester Chronicle had been briefed.

68. Given that, the communications team had regular contact with the Chester Chronicle, it was normal practice for a reporter to be provided with an opportunity to ask further questions based on information that had been published or made available by the COCH. The COCH was not providing a media spokesperson for interview at this time so my reference to the discussion with The Chester Chronicle as *'not being easy'* was reflecting the fact that the reporter wanted more detail than I could provide as I was limited to advising the reporter about the information contained in the press release, and that as a result, the COCH's Executive team needed to prepare for being available for media interview, as well as providing further information, if required by the media.

69. My email to the Executive Team at 15.34 on 7 July 2016 also stated that '*we still need more lines around mortality, managing speculation around why and what the review involves'*. These additional lines were required to deal with further media or social media interest in relation to the downgrading of the NNU services. Social media monitoring was increasingly part of the communications team function, and when the local media published and shared any COCH news stories, we would monitor public commentary and feedback any relevant information internally. No further press release, response to a media enquiry or response to social media commentary was issued in relation to the downgrading of the NNU services.

70. Whilst the press release was published at 14.00 on Thursday 7 July 2016, the articles published by The Chester Chronicle and the Chester Standard went live on Friday 8 July 2016. This led to concern that media enquiries could be received over the weekend and that this would likely be received via the hospital switchboard and transferred to the manager or director on-call. I note the log at **[INQ0002834 action 54]** records that Sue Hodkinson is to speak with me to provide a handling line pack for

weekend on-call and clinical site coordinators. Handling lines, being a response to anticipated questions, were therefore prepared for on-call leads, should enquiries be received over the weekend (the Media Handling Lines) together with a media protocol. At 18.06 on 7 July 2016, I emailed the Executive Team with the Media Handling Lines and confirmed that I would get the Media Handling Lines into a more formal signed off document process the following day.

71. In the email I sent to members of the Executive team at 18:06 on 7 July 2016, I provided some media communications handling lines **[INQ0002820].** This included a potential questioning line phrased with language journalist might use *'If suggestions are made around foul play'* and a draft response which included *'Comments like this are not helpful'*. To explain this further, hospital communication professionals will likely at some point deal with media enquiries about unexpected death or deaths in a hospital setting. If you are publishing information about unexpected deaths, a member of the press could ask a question about whether anything untoward has happened. It would not have been helpful for journalists to have been speculating regarding *'foul play'*. Whilst there had been an increase in the mortality rate, the cause of that increase was not known and the RCPCH had been invited to the COCH to undertake an independent review of all aspects of the neonatal services.

72. On 5 July 2016 at 13.37 I received an email from Stephen Brearey, which refers to an information leaflet having been prepared by him with the intention that it be printed out and distributed on the NNU.

73. I sent an email at 16.41 on 5 July 2016 in response and I explained that it would be good to catch-up with him in order to discuss both the latest version of the communications following discussion with the Executive team and the patient information in keeping with the communication lines (that the Executive team had agreed). Stephen Brearey had proposed including in the information leaflet, a phone number for people to phone if they had any questions. I confirmed that I needed to get advice from the Director and Deputy Director of Nursing regarding where any concerned parents might call. It is not clear from the email whether any documents were attached to this email, but I note that Stephen Brearey's subsequent email to the Paediatric Consultants refers to attachments including a parent letter. I am not clear which draft is being discussed in the email chain.

74. A letter was being drafted to go to parents, who were anticipated would give birth at the COCH (I am referring to **[INQ0002672]**). The draft letter sets out the temporary changes to the NNU. As stated above, it appears that the email exchanges between the Consultants regarding the content of the draft letter to parents continued until the morning of 7 July 2016. The press release was published at 14.00 on 7 July 2016. I do not know if the consultants were commenting on a draft communication that did not include a reason for the downgrading of the NNU. The published press release explained that the COCH had seen an increase in neonatal mortality rates for 2015 and 2016 compared with previous years and that in light of this increase, the COCH had asked for an independent review.

75. The press release stated that any expectant mothers that wanted further information should speak with the midwife or obstetrician. Given the publication of the press release, as far as I am aware, the draft patient letter was not ultimately finalised or sent out to the expectant mothers.

76. It appears from the email exchange at **[INQ0002694]** that my email of 16:41 on 5 July 2016 was then forwarded to the Consultants on the NNU, together with the Ward Manager and Operational Manager. There followed an exchange of emails over a period of two days that continued until the morning of 7 July 2016. The emails indicate that I met with Stephen Brearey on the morning of 6 July 2016 while the email exchange was still ongoing. My recollection is that this meeting was for input into how the downgrading of the NNU should be described i.e. explaining the different levels of neonatal units, the types of babies that they care for and how they link to maternity services. I was not copied to these emails and do not recall having seen the email exchange. The email exchange indicates that it was forwarded by Eirian Lloyd Powell, who I understand was the NNU ward manager to Karen Townsend, who was the Divisional Director of Urgent Care at 12.01 on 7 July 2016. Karen Townsend then forwarded the exchange to Sue Hodkinson, the Executive Director of HR, who in turn forwarded the exchange to the Medical Director and Director of Nursing.

77. The email exchange includes a query from Dr Susie Holt regarding whether a letter should be prepared to go to the families who had experienced an infant death on the NNU. As stated above, my role and remit did not include having direct contact with the families that had lost a baby on the NNU and I was not asked to assist in relation to the drafting of any correspondence or communications with the families. Any contact

with the families would be managed by the appropriate clinical and nursing leads. I note that bereavement team involvement is also referenced in the press release.

78. As set out above, the draft document entitled, *"Communication Handling Lines"* was a working document used as a basis for developing the other final communications. It pulled together information already in the public domain, patient friendly definitions of neonatal care published by Bliss, previous media lines from other enquiries relating to how mortality was reviewed generally in a hospital setting, as well as being based on liaison with other colleagues relevant to their service areas. While I prepared the initial draft of this document, it was based on my understanding of the position of the Executive team and the general discussions that I had at the time. The draft document includes a line which stated, "*On this occasion, our work to date has failed to highlight any common theme for this rise in neonatal mortality rates*". I do not recall who informed me of this wording or the position of the Trust on the causes of the increase in the neonatal mortality rate. I confirm that I would not have had the relevant expertise, and it would not have been within my remit to make any comments about any themes on causes of the rise in the neonatal mortality rate. I consider that the individual or individuals who were responsible for addressing the Trust's position and matters of this nature would be in a better position to address whether the comment was accurate in view of what they knew about Letby and any other possible causes of the increased mortality rate at that time. The line referred to above was not included in the published press release on 7 July 2016, and I do not know who made the decision to not include it. I note that after issuing the press release, the communications room action log show work remained ongoing, which included looking at staffing rotas and deep dives into clinical case reviews through to 11 July. I was not asked to do any further communication about the outcome of this work at the time, and I understood this to be data gathering in preparation for the independent RCPCH review. While this line was not used in July 2016, I believe a similar line was used in the accompanying Trust website / press release announcement for the publication of the RCPCH review in February 2017, although I do not have a copy to confirm this.

79. I do not recall a meeting taking place with Sue Hodkinson **[INQ0005769]** to discuss the potential use of cameras on the NNU. As far as I am aware, cameras were not in fact installed. I do however recall that the RCPCH review also referenced that staff discussions had taken place about cameras being installed, and on reviewing this document for the Executive team, I advised that this was an area that may receive further media interest.

80. The log of the Executive team meeting on Wednesday 19 October 2016 **[INQ0003202]** indicates that I was in attendance for the Countess Briefing agenda item at the beginning of the meeting. The Countess Briefing was a standing item each month at which the Executive team could advise me of any specific items about hospital business for cascading to senior managers at the next staff briefing. I did not stay for the remainder of the meeting and was not present for when Ian Harvey presented a draft of the RCPCH review report. I note the update on this section sets out that a copy of the RCPCH review would only be shared with Executive colleagues at this stage, for clarity as I was not an Executive member this would not include me.

81. The log of the meetings of the Executive Directors Group on 7 December 2016 and 21 December 2016 record that Ian Harvey and I were to work on communications in relation to the *"Neonates Service Review"* and the communications stakeholder plan. I was not present at either meeting, and I do not know whether reference to the *"Neonates Service Review"* was to the RCPCH Review.

82. As far as I am aware, the work referred to in the meetings of 7 December 2016 and 21 December 2016 in relation to the RCPCH review did not begin until late January 2017 or early February 2017 due to the Christmas period and me having two weeks of annual leave in January 2017. I cannot recall the exact dates and times of the meetings with Ian Harvey. When I first reviewed the RCPCH review, I was provided with a hard copy, which was not removed from the Executive offices. I do not recall there being any redactions to the document that I reviewed and I would not have expected nor was I provided with the case notes or pathology reviews referred to in the RCPCH review. My recollection is that my review of the RCPCH report was close to the time of The Times media enquiry (3 February 2017). The RCPCH review was to be published on the COCH's website and the link shared with stakeholders following publication (being the same stakeholders that I worked with at the time of the press release in July 2016).

83. On receiving a copy of the RCPCH review to be published, the communications plan was to draft a statement for the website and a press release setting out the findings of the review (i.e. the recommendations). I also went through the RCPCH review to consider potential media enquiries or questions that might be raised by journalists following the publication of the RCPCH report.

84. I was responsible for publishing the RCPCH review on the COCH's website and I was to be provided with a final PDF version of the RCPCH review to upload by one of the corporate admin assistants for the Executive offices. When the final PDF version was provided, the document contained details of all the COCH staff members who had been spoken to as part of the review. I recall querying with Tony Chambers and Stephen Cross whether it was appropriate that the names of the staff members should be published. The list of staff members was subsequently redacted or changed, and I was provided with a revised PDF of the RCPCH review for publication on the COCH's website. I was not aware of any other redactions to the RCPCH review, and as stated above I cannot recall seeing any individual case reviews.

85. Whilst I was responsible for uploading the final PDF version of the RCPCH review to the COCH's website and confirming with communications leads the time of the proposed publication on the website, I was not involved in any decisions regarding to whom the RCPCH review was to be shared prior to its publication and was not aware that the Director of Corporate and Legal Services had been in contact with or shared a copy of the RCPCH Report with the Coroner.

86. The notes of an Executive Team meeting on 21 December 2016 state in relation to "*NNU Update", "IH to meet with GG re communication stakeholder plan."* I cannot recall the exact dates and times of meetings with Ian Harvey. However, I have set out above details of the meetings I recall having with the Executive team regarding the RCPCH Review publication.

87. On 4 January 2017, I attended the second part of a meeting of the Executive Directors Group. The notes record that I mentioned media interest in relation to Teletracking and the impact on staff being tracked. Teletracking was a bed management system that was being implemented in order to speed up patient flow. The media enquiry concerned the use of a new technology in the hospital. As with the introduction of any new technology, some staff had concerns around its implementation. The notes also refer to media enquiries having been received over the festive period based on a reporter reviewing the published Board papers. The enquiries related to the Strategic Estates Partnership (SEP), neonatal and teletracking. I do not recall what enquiries were raised or what response was provided to these enquiries.

88. The Neonatal Unit Action Log **[INQ0005326]** records that it was updated on 14 February 2017. This log records that I was to be the lead for the development of a

"Trust Communications Plan" and that by 1 February 2017, a draft document was to be shared with the Executive team to include a separate list of timings and stakeholder management. The document that was referred to will have been the wording prepared to accompany the publication of the RCPCH review on the COCH's website and to be used to notify the media and stakeholders. I do not have the wording that accompanied the publication of the RCPCH review on the COCH's website but recall that it summarised the findings of the review and the recommendations. Whilst I will have produced an initial draft of the proposed wording in line with the COCH's media policy, the wording will have been reviewed, amended and signed off by the Executive team.

89. I was not a member of the Executive team and would not routinely attend Executive team meetings. As confirmed by the notes of the Executive team meeting from 1 February 2017 **[INQ0007194, pages 67 to 68],** I was not in attendance at this meeting.

90. On 3 February 2017 an email was received from Sarah-Kate Templeton, the Health Editor at the Sunday Times giving notice of publication of an article about unexplained deaths of babies at the NNU **[INQ0003099]**. I prepared the initial draft response in line with the COCH's media policy, with input from Tony Chambers and Stephen Cross.

91. The response that was sent to the Sunday Times stated, "*we have done all we can to keep parents informed*". The information regarding keeping the parents informed would have been given to me by the Executive team, although I cannot recall exactly who. Any communications that I released always had to go through accuracy checks and therefore, this would have been approved by the Executive team. I was not responsible for communicating with families whose baby had collapsed or died on the NNU, but it was my understanding that the families had been informed that a RCPCH review was being undertaken, as per the July 2016 press release. Whilst I am aware that it was intended to contact parents and share the RCPCH review with the parents of babies who had collapsed or died on the NNU, I do not know whether or if so, when a copy of the RCPCH review was shared with the families. I do not recall enquiring about what the parents had been told, having any oversight of the process and or seeing any communication with them. As stated above colleagues responsible for communicating with the families would be aware of and have access to planned public communications for context.

92. The media policy at the time set out that final versions of any media release or statement would be signed off by the appropriate Executive lead for the service. In the

absence of this Executive lead, this responsibility would fall to the Chief Executive and Deputy Chief Executive or the designated deputy for the Executive lead. The policy also referenced that an individual could change content that featured as a quote and be given the opportunity for comment regarding factual accuracy.

93. The Executive Delivery Group notes of Wednesday 8 February 2017 **[INQ0004394]** reference that in relation to the NNU review launch I circulated an updated media brief and FAQs which was reviewed and agreed by all of the Executive Team, and it also mentions a staff communication is to be developed and agreed. As set out above, I believe the document referred to will have been the wording prepared to accompany the publication of the RCPCH Review on the COCH's website and to be used to notify the media and stakeholders. I do not have a copy of the media brief but recall that it summarised the findings of the review and the recommendations. The subsequent staff communication will have been based on similar content to the media brief.

94. In May 2017, I was asked to prepare for a further public announcement setting out that the COCH would be asking the police to investigate the deaths on the NNU that had been part of the RCPCH review. I note that email exchanges at the time indicate that I prepared the initial draft of the statement together with staff briefing lines, patient briefing lines, a media FAQ document and media protocol.

95. Whilst I prepared an initial draft of these documents, they would have been subject to review, amendment and sign off by the Executive team.

96. I liaised with the Cheshire police press office regarding this announcement as well as communication leads from NHS England, NHS Improvement and WCCCG. They will have been given advance notice of an intention to publish a statement, a draft copy of that statement and the opportunity to comment on the same.

97. The email exchange at **[INQ0012210]** indicates that Cheshire Constabulary and NHS England had commented on the statement and that those comments had been taken into account. I do not recall what comments or amendments were made by these organisations.

98. I do not have copies of the drafts referred to at **[INQ0010379, page 3],** which were staff briefing lines, patient briefing lines, FAQs, media statement and the media protocol. I note that at that point on 16 May 2017, the said documents were not shared by 3:44pm the following day. I cannot recall why this was the case.

99. I was not responsible for communicating with the families of patients whose babies had collapsed or died on the NNU. My communications with WCCCG and the Police related to the proposed public communications. I do not know what contact or communications happened with the parents of children who collapsed or died on the NNU at this time.

100. I did not attend private Board meetings. Therefore, I cannot comment on what was discussed regarding the neonatal mortality rate and Letby during January 2016 and May 2017 at private Board meetings. Roughly every two months, a public Board meeting would be held. The public meeting would be attended by the Directors, Non-Executive Directors and Chairperson and were open to members of the public and the media. I would attend the public Board meetings to be available to liaise with the media, if they were in attendance, as well as public governors.

101. Whilst the public meetings would likely have referenced any recent public announcement about the neonatal review (usually as part of a Chief Executive's update) any concerns raised about Letby would not have been discussed at a public Board meeting.

102. Most of the discussions that I was involved in regarding the neonatal mortality rate were in the run up to or in the immediate aftermath of the publication points being the press release in July 2016, the Times media enquiry on 3 February 2017, the subsequent publication of the RCPCH review and the announcement of the police investigation on 18 May 2017. The focus of these discussions was the planned communications.

103. From recollection, I don't remember having any other discussions with others at the hospital regarding the neonatal mortality rate and Letby during the period January 2016 – May 2017.

104. As the Head of Communications, my remit was to support the publication of Board approved information, and any supporting stakeholder and internal communications. I did not have any concerns about the public communications as these were only released after a thorough review process, signed off by the Executive team and input from relevant stakeholders.

105. While I am not clear what is meant by private communications, I can clarify that the internal communications for all staff would not be considered as private – as they would be distributed to a workforce of approximately 4,500. I did not have concerns about the messages for all staff as they also were only released after a sign off process.

Letby's grievance

106. I became aware that a nurse had been removed from clinical duties on the NNU and placed in an alternative non-clinical role. I cannot give an exact date for this awareness, but it was late summer 2016. I do not recall any specific conversation with me regarding the reason for this change. In terms of Letby's grievance, I was aware of a HR process involving a nurse from the NNU, but I was not aware of the details.

107. Letby's grievance which I now understand was submitted in September 2016 was not discussed at any public Board meetings that I attended. I did not attend any private Board meetings.

108. In hospital settings, sometimes doctors and nurses will have a difference of opinion about the care and treatment of their patients. My understanding was that there had been a breakdown in relationships between the medical and the nursing teams, which I had at the time accepted as a consequence of the unexplained increase in deaths and therefore, placing all staff on the unit under pressure. I understood that this would be addressed or worked through as part of the RCPCH review.

109. I became aware of a grievance process but cannot recall when and by whom. As my remit was regarding the drafting and publishing of public information, I would not expect to be made aware of the detail of individual HR or grievance matters. I never met Letby and was not present or involved in any meetings with Letby.

110. I am not aware of the grievance affecting hospital communications. It occurred in September 2016 which was after the communications announcing the NNU downgrade and RCPCH Review in July 2016. I cannot comment on how the grievance affected the Executive Team and their decisions, but I was not aware of it impacting on the publication of information in February 2017 regarding the RCPCH Report.

Culture and atmosphere

111. I rarely saw the Neonatal or Paediatric Consultants and I am unable to comment on their relationship with the Executive team or other members of the Board between January 2016 and May 2017 or comment about at what point it deteriorated. As mentioned above, I met with Stephen Brearey in July 2016 to support the drafting of information regarding the downgrading of the NNU services. The communications team would also occasionally work with Ravi Jayram, as he had an established media profile.

112. I did not routinely work with the consultants. Given the hierarchical nature within hospitals and my remit and position, I would not have considered approaching the consultants on a matter not relating to communications. The consultants did not approach me either.

Reflections

113. I do not feel I can comment on whether the hospital was sufficiently candid in its communications with the parents or families of babies who had died or collapsed on the NNU as I was not involved in those communications or any other related internal discussions.

114. In terms of communication and the information shared with regulators and other external bodies, this was published on behalf of the Board based on the information I was given and what I was told. Again, I cannot comment on whether what I was told by the Executive Board was accurate. I trusted that what I was told was accurate at that time and had no reason to doubt the accuracy of any information passed to me.

115. As the Communications Lead, I was not responsible for submitting the Risk Register entry regarding the increase in neonatal mortality rate. I cannot comment on how much impact reputational concerns or protecting the hospital had on the decisions made by senior management as I was not privy to the detail of all discussions taking place at Board level. In terms of the public facing communications, the messaging used was developed to take account of a very broad audience i.e. the general public, the media, prospective patients using maternity or neonatal services as well as staff at the COCH.

116. I cannot comment on whether the police should have been informed sooner regarding suspicions about Letby or what happened to those who raised concerns as I was not privy to the relevant Executive team or Board level discussions.

117. As the Communications Lead, you are not involved in clinical or HR discussions, and you do not have access to patient records, clinical notes, patient safety incident reports or details of any HR grievances or disciplinary actions. For purposes of patient and staff confidentiality and information governance issues, for someone in my level and position within the Trust, it would not have been appropriate for this detailed information to have been shared with me.

118. In light of Letby's convictions and with the benefit of hindsight my reflections are set out below.

119. My recollection of working at the COCH was that it was a good hospital to work at. There was a lot of pride in the hospital (from both staff and the community) and a lot of values that focussed on kindness and respect. There was extensive training that covered a wide range of patient safety matters, including safeguarding training, human factors training, training to help prevent the risk of people becoming terrorists or supporting terrorism, and training on how to spot fraud in the NHS. There were also campaigns to raise awareness of female genital mutilation, and domestic abuse. In a workforce where the majority of staff are compassionate, caring and considerate people, the thought of anyone deliberately harming a patient is incomprehensible. Strengthened safeguarding training with a clearer focus on how to escalate individual/team concerns including when it is appropriate to independently involve the police may help keep babies and other patients safe from the criminal actions of staff in the future. It would be helpful to base any such training on the real experiences of clinicians for better understanding and impact.

120. In announcing and publishing the RCPCH review, my understanding was that it was the COCH's intention to be transparent. As a communications professional, a clearer national policy on how invited reviews are developed and published would make the process more straightforward.

Any other matters

121. I am truly saddened for the parents and families who lost a baby on the neonatal unit and would like to offer them my sincere condolences. I hope this Inquiry helps to resolve unanswered questions for everyone involved so that this can never happen again.

Request for documents

122. I do not have any documents or other information which are potentially relevant to the Inquiry's Terms of Reference other than those exhibited in my statement.

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.

PD

Signed: _____

Dated: 19th June 2024 _____