Witness Name: Elizabeth O'Mahony
Statement No.: EOM/1
Exhibits: EOM/0001 - EOM/0028
Dated: 21/06/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF ELIZABETH O'MAHONY

I, Elizabeth O'Mahony, will say as follows: -

Introduction, professional background

1. I have been the NHS England Regional Director for the South West region since April 2018. Prior to that, I was the National Chief Financial Officer for NHS Improvement from 2016-2018. Prior to that, I was the National Chief Financial Officer for the NHS Trust Development Authority.

2. I joined the NHS in 1992 and until my appointment to my current role in April 2018, I have always worked in finance, including in roles at the South West Strategic Health Authority, Dorset and Somerset Strategic Health Authority, the South West Peninsula Strategic Health Authority and at NHS Trust level.

Overview and approach to statement

3. This witness statement was drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. The request I received on 29 April 2024 pursuant to Rule 9 of the Inquiry Rules ("the EOM/1 Rule 9 Request") asks me a series of questions focussed on my involvement in relation to various roles that Mr Tony Chambers ("TC") applied for (either successfully or not). This statement is the product of drafting after communications between those external solicitors in writing, by telephone and video conference.

4. I would also like to emphasise that prior to giving this statement, I had contributed to the process through which NHSE/2, (the NHS England Corporate Witness Statement that focussed on senior appointments) was drafted. This process is described in NHSE/2 and my involvement included meeting with NHS England's solicitors to

assist with responding to the questions contained within the NHSE/2 Rule 9 request and provided relevant documents and other materials to NHS England's solicitors, which were then disclosed as exhibits to NHSE/2.

5. Prior to this, in the summer of 2023, I had also been asked as part of NHS England's Project Columbus response, which is described as part of NHSE/1, to retain any potentially relevant documents and materials. I ensured that this request was actioned but I did not otherwise have any direct involvement in Project Columbus.

6. Throughout this statement I will refer to NHSE/2 as "the Appointments Statement", the contents of which I have read and agree with. This personal witness statement builds on that and responds to the specific questions contained in the Rule 9 Request from the Inquiry EOM/1. **[INQ0017193]**

7. Before turning to address the specific issues that the Inquiry has asked me to respond to, I also wanted to explain how I have approached the questions that the Inquiry has asked me around my reflections on the issues covered within my statement and on the broader issues the Inquiry is considering around culture and the potential regulation of managers. To help inform my response to these questions, NHS England's solicitors shared with me a copy of the Facere Melius Report dated August 2023. This contains Facere Melius's findings from their review "An independent review of the trust's responses, actions and decision-making following the increased mortality rate on the neonatal unit at the Countess of Chester hospital between June 2015-June 2016". I had not previously seen the Facere Melius Report or been made aware of its findings. My knowledge of the events that took place at the Countess of Chester Hospital NHS Foundation Trust is otherwise largely limited to what is generally in the public domain, supplemented by the limited information contained in the references and shortlisting pack provided by Hunters Healthcare for the Royal Cornwall Hospitals NHS Trust Chief Executive Office substantive appointment and connected conversations, including by text message. I have described this additional knowledge in my statement and exhibited relevant documents.

8. An overall chronology is included within the Appointments statements. I have set out below key dates relevant to the questions that the Inquiry have asked in EOM/1, **[INQ0017193]**

about my involvement with TC and his application for roles within the South West and other regions.

NHS organisation	Role sought by TC	Date	My involvement and outcome	Supporting documents
Royal Cornwall Hospitals NHS Trust	Interim Chief Executive	August 2021	I inputted into the shortlisting process and sat on the interview panel. TC was appointed to the role.	**Exhibit EOM/0001, INQ0017193**
Royal Cornwall Hospitals NHS Trust	Chief Executive	September 2021	I inputted into the shortlisting process, sat on the panel via MS Teams and supported the post interview reference checks process. TC was unsuccessful at interview.	**Exhibit EOM/0002, INQ0017195** **Exhibit EOM/0003, INQ0017196**
University Hospitals Dorset Foundation Trust	Chief Executive	November 2021	I inputted into the shortlisting process, which was carried out by a panel which I was also a part of. TC was not shortlisted for this role.	**Exhibit EOM/0004, INQ0102047** **Exhibit EOM/0005, INQ0102047**
Chesterfield Royal Hospital NHS Foundation Trust	Chief Executive	May 2022	TC was unsuccessful at interview. I have only become aware that TC named me as a referee in his application for this role as part of responding to my Rule 9 Request. I was not contacted at the time to provide my views.	**Exhibit EOM/0006, INQ0017210**
Medway NHS Foundation Trust	Chief Executive	July 2022	TC was unsuccessful at interview. I have only become aware that TC named me as a referee in his application for	**Exhibit EOM/0007, INQ0017237**

			this role as part of responding to my Rule 9 Request. I was not contacted at the time to provide my views.	
Dartford and Gravesham NHS Trust	Chief Executive	August 2022	TC was unsuccessful at interview. I have only become aware that TC named me as a referee in his application for this role as part of responding to my Rule 9 Request. I was not contacted at the time to provide my views.	**Exhibit EOM/0008, INQ0017213**

Role

9. The South West is one of seven NHS England regions and has a population of c. 6 million people across 7 counties. The health system is made up of 7 statutory Integrated Care Boards and 22 statutory NHS Providers (a combination of NHS Trusts and Foundation Trusts). Together, these Integrated Care Boards and NHS Providers work as part of Integrated Care Systems.

10. The South West regional team that I directly manage is made up of 550 people over 6 regional offices. As South West Regional Director, I am a full member of the national NHS Executive Group and I contribute to shaping and determining national prioritises.

11. As Regional Director I am accountable for delivery of national and regional priorities for health and care in the South West region, including driving continuous improvements in quality of care and health outcomes, improvements in performance against NHS Constitutional Standards and ensuring that local health systems operate within their combined budget. In addition, I am accountable for the oversight of performance improvement in the NHS across the entire region, including the oversight of any NHS licensed independent providers, which can include additional licence requirements for providers who are identified as a 'hard to replace' independent provider. The framework through which providers are regulated by NHS

England and the role of the NHS Provider Licence is set out in detail in NHSE/1 and I have not repeated that content here.

12. In my oversight role, I monitor and oversee the performance and quality of NHS services being delivered in the South West region, against a published set of oversight metrics. These metrics and local intelligence are used to guide oversight at system and or provider level, and guide decisions about the level and nature of delivery support or intervention that may be required. Monitoring arrangements depend on the type of information and may be monthly, quarterly or annually against agreed milestones and plans. In the South West we aim to use the oversight framework and local information to identify emerging issues and concerns early, so they can be addressed before there is a material impact or performance deteriorates. Depending on the nature of any issues my team may draw on national and other expertise where required.

13. My team and I also carry out £I&S billion of core commissioning for the South West region, including specialised commissioning (£I&S, the commissioning of the healthcare of secure and detained individuals (£I&S and the commissioning of vaccination and screening (£I&S). In addition, we are accountable for leading and co-ordinating NHS emergency preparedness resilience and response ("EPPR") across the region in line with national policies. Recent EPPR examples include:

    a. coordinating a health response to WW2 Bomb disposal;
    b. the Plymouth shootings;
    c. a range of Cyber Incidents;
    d. the 2021 G7 Summit that was hosted in Cornwall;
    e. Various festivals, including Glastonbury;
    f. Weather events, including mass flooding ; and
    g. the COVID-19 pandemic.

14. The regional role is pivotal in shaping the local NHS landscape, ways of working and supporting local systems to work in partnership to deliver sustainable care.

Responsibility for recruitment of senior staff

15. As a Regional Director, I have a formal role in the appointment of the Chairs of NHS Trusts and, more recently, the Chairs and Chief Executives of Integrated Care

Boards ("ICBs"). The role of NHS England in appointments to senior roles in NHS Trusts and NHS Foundation Trusts is set out in paragraph 10 of the Appointments Statement. As specifically outlined out in paragraph 10(e) of that statement, as a Regional Director, I am very often asked to sit on interview panels for Trust and Foundation Trust Chief Executive as an external member. This is not a mandatory part of the recruitment process but the vast majority of the time in the South West region I am invited to sit on these panels. As senior public servants, these appointees are expected to abide by the Nolan Principles of Public Life.

16. In our region, my experience has been that NHS Trust and Foundation Trusts almost always engage an external headhunting agency to carry out the executive search process for Chief Executives, whether the appointments are interim or substantive. The headhunting agencies have extensive databases and will usually sift through the candidates and organise the interview panel, although the input of the members of the panel will also be sought.

17. As far as I know, the South West has never appointed a Chief Executive to a Trust or Foundation Trust that is not already yet known in the NHS, or on a head hunter database. There is a relatively small pool of available suitable candidates, and the applicants are often known to myself or members of the interview panel. If I know of a candidate who is seeking a promotion or a new role that, I will often make them aware of opportunities or share their details, as described below.

18. This is in addition to the normal recruitment process, which will run as usual and once appointed by the Trust Remuneration Committee the headhunting agency will find candidates in whichever way they see fit. If there is an agency supporting, I will usually be asked at the longlisting and shortlisting phase if any of the candidates are known to me. At this stage I may also suggest any other names or provide information about those already identified. However, this would be high level information at this stage, for example around what I know if an individual's availability. I have described below in paragraph 57 as an example of this support role my involvement in relation to the application of the Fit and Proper Person Test on the appointment of a permanent Chief Executive Officer for the Royal Cornwall Hospitals Trust in September 2021.

19. It should be noted that for the appointment of Chief Executives or other senior staff in NHS Trusts and Foundation Trusts, the Fit and Proper Person Tests will be

undertaken by the employing organisation, and I would not input into that process other than on occasion where I have been asked to follow up on a query via my network. This reflects the statutory responsibility that NHS Providers have as the employing organisation to carry out the Fit and Proper Person Test.

20. For NHS Trust Chairs, I act as appointer on behalf of NHS England, but I am supported by a panel and a national appointments team. For Foundation Trust Chairs, the appointment is made by the Council of Governors.

21. Generally, if there were concerns raised with me (in the context of the South West Region, for which I am responsible) about an individual leader, they would be picked up in different ways depending on the issue. I have briefly described this below but broadly speaking, there are three main ways in which I could become aware of concerns of this nature:

    a. Through issues being raised with me or my office directly;
    b. By being made aware of concerns by another body, such as the Care Quality Commission;
    c. Through the ongoing NHS England oversight process that I manage for the South West Region.

22. The general approach I would follow if I became aware of concerns about an individual's leadership or behaviour and /or an issue had been raised with me, would be to first speak to the individual's employer. For example, a few years ago concerns were raised with me about the relationship breakdown and conduct of two Chief Executive Officers in the South West. My initial step was to speak to the Chair of each Trust and with each Chief Executive Officer. I then met with each Trust's Chair and Chief Executive together and at their request helped secure some independent HR advice to reach a resolution.

23. My understanding is that if any freedom to speak-up concerns are raised with a Trust about the leadership or behaviour of an individual they should formally notify the Care Quality Commission and this may trigger a review and the application of the Fit and Proper Person Test, which would be undertaken by the employer. NHS England is not always notified by the Care Quality Commission if this occurs.

24. If concerns were flagged through the NHS England Oversight Framework about an organisation or individual or through other routes (i.e. potential fraud) this may trigger

a leadership and governance review that would be commissioned by the Trust Board, and in my experience, speaking for the South West Region, NHS England would always be made aware of this type of issue and the proposed review. The scope of the review would be overseen by NHS England to ensure it adhered to relevant requirements (depending on the context of the issues under review), and that appropriate Trust governance was in place in relation to the review, including ensuring that the investigation was independent.

25. If a Trust does not undertake a review when we believe it is in the best interests of the NHS we can instigate enforcement action, initially through undertakings and ultimately through measures such as the removal of a board member, although to my knowledge the latter power has never been formally used by NHS England.

26. In general, in my role, I am asked for advice on the qualities of good senior leaders and whether certain individuals might be useful to interview. However, even when I sit on panels, I only act as an appointer in two specific scenarios (for NHS Trust and Integrated Care Board Chairs) and am otherwise a sounding board and external contributor to the appointing organisation's process. Ultimately, the Trust makes the final decision, taking into account stakeholder and interview panel members' views.

Prior knowledge of Tony Chambers in the period up until May 2021

27. To the best of my recollection, I first came across TC in early 2018 in my capacity as NHS Improvement Chief Financial Officer. At this time, the NHS Improvement Board commissioned some work looking at how the organisation could improve, and how it could better service the wider NHS. The Board asked the senior leadership team to each speak to a randomly allocated number of NHS Trust and Foundation Trust Chief Executives to seek their views, with this then informing the review.

28. TC was the Chief Executive I was asked to meet with, and we had a telephone call on 7 March 2018. It was the first time I had spoken to him. During this telephone call, I asked TC a set list of questions looking at what NHS Improvement was doing well and what the organisation could do better. I took a note of this call and sent it to Jonathan Brown, Office of the Chair and CEO, NHS Improvement who collated the responses and then shared this with the external organisation who had been commissioned to carry out the review (McKinsey & Company). My note of my meeting with TC is exhibited to this statement as **[Exhibit EOM/0009, INQ0102045],**

The resulting report was titled 'Optimising NHS Improvement's operating model and senior leadership structure'.

29. I did not hear from or have any further direct contact with TC again until 23 June 2021.

Royal Cornwall Hospitals NHS Trust

30. On 19 May 2021, I received an email from the Chief Operating Officer of NHS England and NHS Improvement. In this email, which was sent to all Regional Directors, the Chief Operating Officer shared TC's details and explained that he was looking for another Chief Executive role. **[Exhibit EOM/0010, INQ0017202]** It was not common for the Chief Operating Officer to do this but in this case, I suspect that it was prompted by a direct approach by TC to her. At the time, due to the ongoing impact of the Covid-19 pandemic, and as I have explained at paragraph 37 below, the Regional Directors and Chief Operating Officer were aware of the churn in the senior leadership community and a shortage of experienced interim leaders linked to the COVID pandemic as we had experienced an increase in leadership retiring or leaving the NHS. I do not recall reading this email and, having reviewed my emails and diary in the course of providing this statement, I cannot see that I did anything with the email or the information contained within it at that time.

31. I can see, for instance, that I confirmed on 21 June 2021 to Ms King, the HR advisor supporting the Interim Chief Executive Officer recruitment at Royal Cornwall Hospitals Trust, that I did not have any potential candidates to recommend at that time **[Exhibit EOM/0011, INQ0102055]**. I have described my involvement in relation to the Interim Chief Executive Officer recruitment at Royal Cornwall Hospitals Trust in more detail below.

<u>Interim appointment at Royal Cornwall Hospitals NHS Trust</u>

32. By way of background, on 18 June 2021, Ms King contacted me by email to say that she had been asked by the Chair of the Royal Cornwall Hospitals Trust to progress recruitment of an Interim Chief Executive Officer as soon as possible. She explained that the Trust had convened a meeting of its Remuneration Committee, at which the Committee had said they were keen to have between 2-4 CVs to consider. Ms King

confirmed that two candidates had shown an interest and she asked me to provide any views I had on them. She also asked me if I was able to suggest anyone else. Ms King also said that the Trust would very much appreciate my support on the interview panel. She proposed some potential interview dates and asked whether someone could deputise for me if these did not work **[Exhibit EOM/0011, INQ0102055]**.

33. On 21 June I replied to Ms King **[Exhibit EOM/0011, INQ0102055]**. This is the email I have briefly referred to at paragraph 31 above. In that email I confirmed that I would be content with either of the two individuals whose details she had shared (nether individuals were TC at this stage). I went on to say that I did not have any other potential candidates that would be available in the timeframe and given the 2 names shared were both experienced I did not think this an issue. I also said I was aware good interims were being snapped up and if the dates could not work for me personally then there were others in my team who could attend in my place.

34. Two days later, on 23 June 2021, I was contacted directly by TC regarding the interim Chief Executive role at Royal Cornwall Hospitals NHS Trust **[Exhibit EOM/0012, INQ0017194]**. Later in the evening on that same day, I received an email from Ms King. In her email, Ms King shared with me an email chain from Hunters Healthcare (a recruitment agency). The chain related to TC and included TC's CV **[Exhibit EOM/0013, INQ0017192]**.

35. There was an additional candidate's information. While I had not had any personal involvement with the individual while in their previous role, I was aware that since their departure there had been cultural issues at the Trust that were linked to the individual. In the email I expressed my view to Ms King that any fit and proper persons test would need to include considering these aspects. In contrast, at that point, I had limited but positive views on TC based on my interaction with him in 2018 and on what I understood the London Regional Director's views of his performance to be while at BHRUT. I did not reply to Ms King's email as we already had a telephone call booked for the next day, 24 June at 09.30-10.00. This was a standard part of the process and during this conversation Ms King would have updated me on the process and applicant list as an interested stakeholder. I do not have a record of the discussion.

36. My understanding was that the Trust had appointed Hunters Healthcare to support it in its recruitment to the interim Chief Executive role at Royal Cornwall Hospitals NHS Trust. However, another recruitment agency, Gatenby Sanderson still sent some CVs through to the Trust and these were considered by the Trust. As it happens, both agencies had sent through the same CVs. Initially this was for four potential candidates – Allison Williams, Paula Head **[Exhibit EOM/0014-16]**, Elizabeth Vaughen and TC. Subsequently, as the process progressed, this reduced down to TC and one other candidate.

37. As the NHS began to recover from the worst phase of the COVID-19 pandemic, the staffing landscape changed and there was high demand for interim Chief Executives, hence the lack of a wide candidate pool for this role. The pandemic period had been extremely intense and many leaders decided to retire early or move on, and there was a large volume of leadership changes as a result. In my experience, prior to the pandemic, there were far fewer interim Chief Executives. However, since then I have seen this more frequently.

38. Both TC and the other candidate put forward who proceeded into the later stages of the process had left their previous posts due to what was described to me as 'relationship issues' with the Chairs. Whilst it is unfortunate, it is not uncommon for this to happen. I had a conversation with the NHS England Regional Director for London about TC and was told that whilst there was a relationship breakdown at the Countess of Chester Hospital, TC had done a very good job at Barking, Havering and Redbridge University Hospitals NHS Trust. I do not have a record of this conversation. I had a similar conversation with the Regional Director for the South East in relation to the other candidate, who had also had a relationship breakdown with the Chair but who was also considered an appointable candidate. Again, I do not have a record of this conversation. While I do not hold notes of these discussions, the fact that I spoke to them is referenced in a text message I sent the Chair of Royal Cornwall Hospitals Trust **[Exhibit EOM/0017, INQ0102056]**.

39. On 25 June 2021, I received an email from the Ms King **[Exhibit EOM/0001, INQ0017193]** confirming that TC would be participating in an interview for the interim Chief Executive role on the 2 July 2021. The other candidate referred to above also interviewed for the role.

40. In advance of the interviews, I received another email from TC on 28 June 2021 **[Exhibit EOM/0012, INQ0017194]**. In this email, TC asked to meet with me as part of his interview preparation and, as a result, I had a telephone call with TC on 30 June 2021, 17.45 – 18.15 to discuss the role. This is normal practice in the South West region. When candidates are shortlisted for Chief Executive roles for Trusts in the South West, they will often have a conversation with me and the other people who will sit on the interview panel, and for other senior roles, it will often be with a senior member of our team. These meetings form part of the candidate's informal information gathering about the role, where they can ask questions about the organisation, the challenges and opportunities and how they work as part of the wider system and within the region. I think this is helpful for the candidate and can give me assurance that they understand the scale, complexity and challenges of the role, which in turn helps inform my part in the appointment process.

41. In this specific case, at the time, there was a lot less finance and performance data about Trusts and Foundation Trusts publicly available due to the effects of the COVID-19 pandemic. It made sense therefore that TC would have been particularly keen to meet with me and explore the performance of the Trust in advance of his interview as he would have found it difficult to find that information out himself.

42. TC interviewed (remotely, via Microsoft Teams) for the interim role on 2 July 2021 and performed well. I agreed with the other members of the panel that he performed much better than the other candidate who interviewed for the role. The interview panel consisted of: Mairi McLean, Chair of Royal Cornwall Hospitals; Paul Hobson, a non-executive director at Royal Cornwall Hospitals; Janet King, HR advisor to Royal Cornwall Hospitals; and myself. I do not recall that TC's experience at the Countess of Chester Hospital was discussed in the interview.

43. The process of seeking references then began. I was not directly involved in this process but was kept informed of the checks being carried out. I would like to emphasise that, to the best of my recollection, I did not see a copy of the references for TC at the time of the interim appointment. I did see them at a later point, in the context of TC's interview for the substantive Chief Executive Officer role at Royal Cornwall Hospitals. I have described this below.

44. As referenced in paragraph 18, it is the responsibility of the employing organisation to undergo the relevant Fit and Proper Tests for the candidate that they decide to appoint. As a consequence, I had no involvement in this process other than to know it was being done.

Interview for substantive appointment at Royal Cornwall Hospitals NHS Trust

45. As set out in detail in the Appointments statement, TC subsequently applied for the substantive role of Chief Executive at Royal Cornwall Hospitals NHS Trust but was not successful. I was on the interview panel for the substantive role in September 2021 but due to other diary commitments, and as the other candidate for the Chief Executive role was dialling into the interviews from Australia, I did not attend in person and also joined via MS Teams. I have been unable to find a record of the meeting but I recall joining it. The rest of the interview panel was made up of the Chair of the Trust, a non-executive director of the Trust (a different one to the NED present on the interim panel) the interim Chief Executive of Cornwall Partnership NHS Foundation Trust, the Trust HR advisor and myself.

46. On the 13 September, my personal assistant at the time confirmed that the office of the Chair of RCHT had been in touch and asked if I could ring the Chair later that day. I phoned the Chair as she requested. During this call, I recall that the Chair told me that the Medical Director of the Trust had been contacted by the Countess of Chester with some allegations that queried TC's ability to do the job. The Chair of the Trust had spoken to her HR advisor and given the stakeholder panels were set up for the next day (14 September); Tony was on site; and the allegations related to 2018 and were unsubstantiated at this point it was recommended that we continue with the recruitment process and do some further background checks. I agreed with this approach. I do not have a note of the conversation with the Chair.

47. On the morning of the interview, 15 September 2021, the information that the Chair had shared with me on 13 September was shared with the panel as a whole. We were told that the Medical Director of the Trust had been contacted by the Countess of Chester and that there was a query about TC's ability to do the job. We were not told at the time who from the Trust had made contact and the information shared with the panel by the HR advisor was very high level. I did not see any written record of these concerns. My understanding was that we were being provided with a summary of the concerns.

48. The view of the panel was that we already had prior knowledge that an alleged breakdown in the relationship between TC and the Trust existed. The HR advisor thought it would be sensible to leave the panel with the information they had, in order to avoid prejudicing the outcome of the interview. She advised that further checks could be carried out if TC was the preferred candidate following interview stage.

49. At the time, we were operating on the understanding that there had been a relationship breakdown between TC and the Chair of the Countess of Chester. In my experience, I have appointed people in my own team who have had relationship breakdowns elsewhere. They have excelled in my team, and my reflection is that relationships and the right role can affect people and their performance. Therefore, I wanted to ensure that all the key information could be captured as far as was possible.

50. We were also all clear that if it was decided that TC was the preferred candidate, then Fit and Proper Person tests would be carried out (even though he was already in post as an interim) and all concerns could be lodged throughout that process. It was also agreed that the HR advisor would finish the interview with a question, asking TC what had happened at Countess of Chester and if there was anything in their past that the Trust needed to take account of.

51. In the event, TC did speak about the events at the Countess of Chester Hospital in his interview. TC told the panel what he had included in his application and that there was an ongoing police investigation, that this would likely gather pace in January 2022, but that it would not affect him, or the Trust, and it would not take up a lot of his time.

52. I am unclear of the specific timescale but around the interviews (I think it was the day before the interviews) the Chair of the Trust attempted to follow up the concerns that had been shared with the Trust Medical Director with the Countess of Chester Hospital. However, my understanding is that there was no one who could talk to her who worked there at the same time as TC. The only information she was told was that a severance agreement had been put in place, and that as a result nothing else was shared. The Chair also followed up with Mike Bell, the Chair of Barking, Havering and Redbridge University Hospitals NHS Trust and my understanding is

that he gave a positive verbal reference and no new information was shared. I think but do not know for certain that the Royal Cornwall Hospitals Trust Medical Director also followed up with the Medical Director at Barking, Havering and Redbridge University Hospitals NHS Trust.

53. I can see that I also reached out to a colleague. I cannot recall now who this was, whether past or present, and I have no note or other record of the conversation. I have been unable to retrieve my telephone log for the date in question. However, I can see from a text message that I sent to the Chair of Royal Cornwall Hospitals NHS Trust that I refer to such a conversation taking place and that whoever I spoke to confirmed that "she could not remember anything sinister relating to Tony at the time (2018) but a set of very difficult circumstances and [Countess of Chester Hospital] chair did not put forward a strong case to back him [TC]" **[Exhibit EOM/0018, INQ0102052]**. The text contains my suggestion to the Chair of Royal Cornwall Hospitals NHS Trust in terms of how to proceed, including the suggestion that if TC proceeds through the process "further extensive due diligence" be carried out, perhaps alongside a review date in his employment contract.

54. The references and shortlist pack for the permanent role were shared with the interview panel on the day of the interviews. These had been obtained by Hunters Healthcare **[Exhibit EOM/0002, INQ0017195].** In the reference by the Chair of BHRUT, there is a reference to issues at the Countess of Chester Hospital, but nothing specific.

55. The Chair of Royal Cornwall Hospitals NHS Trust was pleased with the job TC was doing as interim Chief Executive Officer and was of the view that he had stabilised the board and had good relationships with clinicians. The other candidate had performed better at interview, but the Chair had not met him and that was a cause of concern to her, and therefore she was minded to appoint TC.

56. The rest of the panel, including myself, felt that the other candidate was the better fit for the substantive role, primarily as he wanted to permanently move to Cornwall and build his life there. TC was not based in the area and did not want to move there. However, it was and remains extremely important that the Chair has a strong relationship with the Chief Executive and is happy with the appointment, so a decision was not made on the day. The Chair spent more time meeting the other

candidate virtually, and eventually he was appointed. I felt both candidates were above the line in terms of having performed well and either could have been appointed at this stage.

57. I received an email from the Trust HR Director on 16 September 2021 **[Exhibit EOM/0019, INQ0017197]** regarding Fit and Proper Person Checks for TC but did not respond. This email was copied to the entire panel, but this did not mean any action on Fit and Proper Person tests would be for me or my team to action. This would have been an action for the Trust to take, and any concerns around a person should have been reported to the Care Quality Commission. The Chair of the Trust was still deliberating but by this stage TC was not the preferred candidate, and therefore no response was required.

58. In the intervening period, the Chair had spent some additional time speaking with the other candidate and had concluded that he was the preferred candidate. I was not present at this meeting but knew it was due to take place and I think it occurred on or around 16 September. My reason for thinking it took place on this date is that on the 17 September, the Chair of the Trust texted me to confirm she had made a decision but that she wanted to talk me through it. A copy of this text message is exhibited to this statement as **[Exhibit EOM/0020, INQ0102053]**. The Chair's decision was ultimately to appoint the other candidate, i.e. not TC. The Chair texted me later that same day to confirm she had spoken to TC. A copy of this text message is exhibited to this statement as **[Exhibit EOM/0021, INQ0102058] [EOM/0022, INQ0102059]**.

59. The Inquiry has asked me when I first found out about the full extent of the criminal investigation into events at the Countess of Chester Hospital. I cannot recall this exactly but I know that it was not during the recruitment processes described above. Although TC alluded to the police being involved, this can be the case in many different types of incident and I was not aware of any of the details of the criminal proceedings until August 2023. From a regulatory perspective, when criminal investigations are taking place in matters within the NHS, there is a lock down of information and only those who need to know will be provided with update.

60. If I was made aware that a potential candidate was under criminal investigation themselves, I would recommend to the employer that they secure legal and HR advice before proceeding. In addition, I would discuss with my line manager and

contact the NHS England legal and HR teams and ask for support and advice in the first instance. I would not want to jeopardise a case and therefore look for specialist advice. In all other cases I can think of where an individual is under criminal investigation the staff member has been suspended swiftly pending investigation and so this issue has not arisen. I would reiterate that at the time of the events I have described my understanding throughout was that TC himself was not subject to police investigation.

61. As set out in the above paragraph, there were no concerns about TC's ability to perform as a Chief Executive and none were shared by any other Regional Director. I have never seen the text message set out at **INQ0017259** before receiving this Rule 9 request and am unaware to what it relates.

Subsequent contact with Tony Chambers and my role in providing a reference

62. During TC's tenure as interim Chief Executive of Royal Cornwall Hospitals NHS Trust, I had four meetings with him – three 1:1s and one meeting with eight other CEOs to discuss how to create additional capacity over winter on 22 December 2021. **[Exhibit EOM/0023, INQ0102046]**

63. The 1:1s were on 30 June 2021, 9 September 2021, and 3 November 2021. Notes of these meetings, where held, are attached as **Exhibits EOM/0012, INQ0017194 and EOM/0024, INQ0017200**. I can confirm that I do not hold a record of the 1:1 that took place on 9 September 2021.

64. As interim Chief Executive of Royal Cornwall Hospitals NHS Trust, TC would also have been invited to fortnightly regional South West CEO meetings. These meetings are held via MS Teams and attendees include NHS Trust CEOs, Foundation Trust CEOs, Integrated Care Board CEOs, Community Interest Trust CEOs and my senior team.

65. As referenced in paragraph 63, TC emailed me on 27 October 2021 **[Exhibit EOM/0024, INQ0017200]**, requesting a conversation with me to speak about the next stage of his career. We had a conversation on 3 November and TC advised me that he was seeking a substantive role closer to where he lived. TC asked if I would

provide an IMAS reference for him, and I said I would. I also agreed to share his CV with the other Regional Directors, as I knew that they were recruiting for roles that he may have been interested in applying for. If I had known what I know now about the events involving LL and the concerns raised about TC's role, I would not have provided a reference or, if I had, I would have noted the concerns arising from his time at the Countess of Chester Hospital.

14 December 2021 email

66. On 14 December 2021 **[Exhibit EOM/0010, INQ0017202]** I shared TC's CV with the rest of the NHS England Regional Directors. While this is not common I was aware that Ann Radmore (the then Regional Director for the East of England) and some of the other RDs were looking for experienced interim CEOs. As I have already noted in relation to the NHS England Chief Executive Officer sharing TC's CV, there was a shortage of candidates for Chief Executive Officer roles (and particularly those who could step-in as experienced interims).

67. As I have already noted, after the main peak of the Covid-19 pandemic, many senior leaders in the NHS resigned from their roles, and there was a real shortage of interim leaders within the system. My reasoning for sharing TCs CV was due to this issue – I knew that other Regional Directors were, like myself, consistently on the look out for good quality, experienced candidates who might be able to fill roles that they had.

68. It is important to again emphasise that Regional Directors are not decision makers, but we are increasingly part of the process of recruiting senior individuals. Whilst I acknowledge that my colleague, the Regional Director for the North East and Yorkshire has used the word "recommendation" in relation to my email, I would not characterise my actions in that way. Rather, I felt it was an effective method of putting someone who was perceived as an experienced and reliable individual into a process and ensuring that colleagues knew he was available for consideration for any role. This was on the understanding his fitness for any roles he was considered for would be fully tested through the appointments process.

69. Again, had I known what I know now, I would not have shared TC's details in the way that I did.

References provided by myself for TC

70. The Inquiry has asked me to produce details and copies of all the references I have provided for TC. I can confirm that I have provided copies of relevant documents in which I understand I have been named as a referee as part of NHS England's response to NHSE/2. For completeness, I am exhibiting them here as **[Exhibit EOM/0006, INQ0017210] [Exhibit EOM/0008, INQ0017213] [Exhibit EOM/0025, INQ0017212]**. However, **EOM/0006, EOM/0008 and EOM/0025** are all applications made by TC, in which he named me as a referee without my knowledge and I was not in the event asked to provide a reference by any of the organisations in question. The only reference I knowingly provided was via IMAS, described below.

71. The Inquiry has also asked for detail around my reference to IMAS on 6 March 2022 **[Exhibit EOM/0026, INQ0017209]**, and the IMAS reference of the Chair of Royal Cornwall Hospitals NHS Trust **[Exhibit EOM/0027, INQ0017205]**. I had never seen this reference before and was surprised to see that the Chair had said that she had been made aware that "matters of grave clinical concern were discovered to have taken place. This led to a criminal investigation by the police".

72. If the Chair had known of any of these concerns or was herself concerned about TC's previous role at the Countess of Chester Hospital, she either had them after the recruitment or did not share this with me. TC finished his role as interim Chief Executive of Royal Cornwall Hospitals Trust in January 2022. The Chair's IMAS reference is dated 2 February 2022.

73. As far as I was aware, the Chair and the Board of Royal Cornwall Hospitals NHS Trust were very pleased with TC's performance as interim Chief Executive. During the 5 months TC worked at the Trust the Chair confirmed how pleased she was with TC on a number of occasions, along with the positive impact he was having at the Trust. Towards the end of his tenure at Royal Cornwall Hospitals Trust, the Chair confirmed she was hoping TC could be retained within the Cornwall and Isles of Scilly system in some capacity. A text message the Chair sent to me discussing possible options for TC in December 2021 is exhibited **[Exhibit EOM/0028, INQ0102060]**.

74. At the time of making my own IMAS reference, I was not aware that there was a concern around TC's ability to take on another senior role within the NHS.

75. I would like to be clear that if in the interview process for the substantive Chief Executive role at Royal Cornwall Hospitals NHS Trust, anything surrounding neonatal

mortality or grave clinical concerns was shared with me, I would have absolutely raised this, and provided information on this in any reference I gave for TC, if I did indeed feel able to give one in such circumstances. As I set out earlier in my statement, the information that was shared with me was that the reason for TC leaving the Countess of Chester was due to a relationship breakdown with the Chair and that this was not a significant enough concern for the interview to not go ahead, or for TC to be appointed should the panel have decided to do so.

76. If the Chair of the Trust had these concerns around someone working at her Trust, then as Regional Director I would have expected these to be shared with me.

Reflections

Involvement with TC seeking senior NHS roles

77. In terms of my reflections on helping TC look for other senior positions in the NHS, with the facts I now know, I would have been gravely concerned by TC's judgement and ability to perform as a Chief Executive. However, with the role at Royal Cornwall Hospitals NHS Trust, the required checks had been carried out and followed up, I did not know the scale of the concerns about his conduct and I did not see anything to raise alarm or cause any red flags at this stage and I spoke to someone to probe further. I did not know about the apparent serious governance failings at the Countess of Chester Hospital that are described in the Facere Melius Report.

78. I did not have a lot of interaction with TC during his role as interim Chief Executive at Royal Cornwall Hospitals NHS Trust, but from what I had seen in large regional meetings and other conversations, I had no reason to doubt his leadership ability.

79. I still consider that the role of the Regional Director in making senior appointments is appropriate. As outlined earlier in this statement, the Regional Director functions as an external assessor, and sits on many interview panels across the region. I believe that the experience doing multiple interviews allows me to identify what a high quality candidate should look like, and enables me to provide useful input to the decision maker.

80. I believe that ultimately, as the employing organisation, the Trust or Foundation Trust should remain responsible for formal appointment checks, including carrying out the Fit and Proper Person Test. I consider that it remains reasonable to rely on those background checks when interviewing candidates.

81. However, I consider that it would be helpful to have further safeguards in the process, if an individual is a part of an active investigation, so the panel are aware of some of the facts that can be shared, and so appropriate HR and legal advice can be sought.

82. Investigations are fairly common in the NHS. While these are not usually to the scale of the one that TC is involved with, they do occur. Whistleblowing in the NHS should always be taken seriously and when allegations are made against individuals, they are investigated in full, to ensure that the full facts can be established. Whilst it would not be my role as Regional Director to delve into the facts of the investigation, I believe had the appointment panel known more background about the nature of the investigation into TC, it would have been useful for the recruitment process. Whilst the panel must have reliance on the Trust HR Director and the corporate governance of the employing organisation to ascertain all the relevant background information, I think having some information gathered and shared with those involved in the appointments process about any potential or live investigations would be useful.

83. I would also further add that upon reflection, I consider that it would be helpful if the recruitment process and information provided by head-hunters is modernised. Aside from interview panels for the Chairs and Chief Executives of ICBs, I have never been provided with a media pack on any candidate who is interviewing for a senior role. I think that information of that nature will be useful generally for the panel and would be a further check to ensure we are fully aware of anything else that needed to be considered. However, I do not directly appoint head hunters and so can only speak from my experience about what is shared with me.

Effectiveness of current structures

84. I am aware of the current work NHS England is undertaking on culture, governance management structures and processes, regulation and other external scrutiny, which are set out in Part C of Section 3 of NHS England's First Corporate Witness Statement (NHSE/1). I endorse the positions set out in that statement in relation to changes that have been made since the events that took place at the Countess of

Chester Hospital. It is important to recognise that we could not have had the same level of guidance in place in the period 2015-2017 because we did not have the maternity and neonatal specific learnings that we now have arising from the reviews into East Kent, Shrewsbury and Telford, and the emerging findings in relation to Nottingham.

85. From the Facere Melius Report, it appears clear to me that we (NHS England) did not have the level of assurance then as we do now. That being said, I think that frameworks and policies did exist at the time, but it is unclear from just reading the report if these were being used to maximum effect.

86. For me, the question is not so much about more guidance and more recommendations, but how we can be assured that Trust boards are actually using these in a mature and safe way. This includes ensuring that Trusts are operating in line with good corporate governance and in an appropriately informed way.

87. My reflection is that NHS England now has the ability to collect a higher level of mortality data, which was not possible in 2015-16. The current guidance and framework must be used in a mature and responsible way, ensuring that information is triangulated through national quality groups, and when events of high magnitude occur, including any police involvement, NHS England as a regulator is being made aware in the correct way.

88. In my experience there is now a well structured governance system in place with reporting expectations at a Trust, Integrated Care Board (system), Regional and National level. At Trust level, there are routine Child Death Overview Panels, routine MBRRACE reporting and reporting to the Maternity and Newborn Safety Investigations programme and Healthcare Safety Investigation Branch by exception. Internal incident reports will also be made when necessary. Within the system, Local Maternity and Neonatal Systems are routinely updated, and System Quality Groups and Safeguarding Boards will be updated exceptionally. Within our region, the Perinatal Safety Surveillance Group, Regional Quality Group, Regional Mortality Group (looks at data trends in mortality) and Regional Maternity Group are all updated routinely. On a national level, the National Maternity Dashboard, National Patient Safety Surveillance Group and National Maternity Programme Board are all routinely updated, and the Executive Quality Group will be updated by exception.

89. In the South West, the Regional Mortality Group reports by exception to the monthly Regional Patient Safety Group, which includes other stakeholders such as the Care Quality Commission. The regional Patient Safety Group reports by exception to the monthly Executive Quality Group, which in turn reports to the NHS England Board.

90. Looking at what the Facere Melius report describes, governance processes such as the above did not appear to be happening at the Countess of Chester Hospital. It appears that there was a lack of agreed structure to handle the intelligence around the unexpected deaths. I think the NHS system has the correct checks and balances, the right systems in place, but these only will work if there is a culture of people feeling confident to use them.

91. In the South West region, Chairs, Chief Executives and other senior executives will come and speak to me often about a range of issues. I think if similar incidents were happening at a Trust in the South West region, senior leadership would approach me and my team and we would be able to offer support. Following from this, although the job is large, I still am of the view that the system of seven Regional Directors is correct.

Conduct of staff at the Countess of Chester

92. My reflections after having read the Facere Melius report is that there appears to have been serious issues with leadership, staff and culture at the Countess of Chester Hospital. It appears clear to me that the families were not being listened to, and that departments were siloed. I think the inexperience of the executive team at the Countess of Chester Hospital was significant in the mistakes they made, and there was not an open culture throughout the staff.

93. It also seems to me that the Board governance (in this sense meaning the Board and those committees reporting into it) was arguably not functioning, and there was not a culture where people felt empowered to report the unexpected deaths through the correct frameworks. On the basis of the Facere Melius report, the culture of the Countess of Chester Hospital appears insular and insufficiently challenging, which may have led to delays in seeking external involvement and in scrutinising events sufficiently. I was also struck by the fact that Board papers were circulated but taken back after the meeting, again suggesting a lack of trust and openness around how decisions were being made.

94. In terms of the issue of further regulation of NHS managers, I would like to see enhanced training and development for all senior leaders. Our roles are fast paced and constantly changing. The NHS culture of continuous learning and improvement that exists needs to be implemented by all involved from individuals to Boards and further regulation for the sake of it would not be helpful. Informal support and buddy systems also have merit in helping individuals develop. For instance, I have found that some Integrated Care Systems need quite a lot of support and that the structure for Integrated Care Board governance as a whole is not yet mature enough in all systems. There is learning to be drawn from well governed provider organisations that would help Integrated Care Boards develop. Regional Directors can help facilitate and enable this.

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 of its truth.

Signed: PD

Dated: 21 June 2024