Witness name: Jeremy Butcher
Dated 3rd July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JEREMY M BUTCHER MB BS FRCOphth

I, Jeremy Butcher, will say as follows -

Career/background

1. I am a consultant ophthalmic surgeon. I qualified with MB BS at London Hospital Medical College, part of London University, in 1985. After house posts and an accident and emergency senior house officer post in London I came to Chester to do the Vocational Training Scheme in General Practice (two years at the Countess and one year in general practice 1987-1990), after which I trained to become an ophthalmologist in Liverpool and Manchester before doing a year's Fellowship in paediatric ophthalmology at Great Ormond Street Hospital until 1998. I obtained Fellowship of the College (later to become 'Royal') of Ophthalmologists in 1992. I was appointed as consultant in ophthalmology at the Countess of Chester in 1998 and remained there until I left after being exposed as a whistleblower by the Medical Director in June 2021. I took early retirement and was then appointed as a consultant in ophthalmology at Arrowe Park Hospital later in 2021, where I remain.

   While at the Countess as a consultant I also worked as a paediatric consultant ophthalmologist for one session a week at Manchester Royal Eye Hospital from 2002 until 2018, although for the last nine months I was half time in each of the two hospitals, after which I reverted to full time at the Countess.

2. From 1998 and including the period 2015-7 I was responsible for seeing all the children with eye problems at the Countess, and I had been solely responsible for screening premature babies for retinopathy of prematurity (ROP) since my appointment in 1998. I was therefore a regular visitor to the neonatal unit (NNU). I was also the secretary to the Medical Staff Committee (MSC) of all the consultants and permanent medical staff at the Countess from about 2010 until 2020 and I was lead clinician for ophthalmology from 2010 until 2017.

My Role in the Neonatal Unit

3 Because of the specialised nature of my paediatric practice and my close links with Manchester paediatric ophthalmology colleagues I was close to paediatric colleagues

at the Countess, particularly Stephen Brearey. As well as examining premature babies on the NNU I would occasionally be asked to examine neonates for other abnormalities or for suspected non-accidental injury.

4 From about 2016 Stephen Brearey told me that there were serious concerns about excess deaths on the NNU, that Ian Harvey and Tony Chambers were trying to silence the paediatricians, and that a member of staff was involved. However, he emphasised that these concerns were to be kept confidential.

Medical Staff Committee

5 The MSC is the standing Committee representing the consultants and other permanent medical staff in the hospital. It exists in every NHS hospital as far as I'm aware and I assume that its origins go back to the beginning of the NHS itself.

6 As I could not find a previous written constitution I drafted the constitution for the MSC in 2017, based on a model British Medical Association (BMA) document, and disseminated it to all the members for discussion at the next MSC meeting. There were no comments and therefore I considered it adopted from then on.

7 The MSC exists to represent the interests of the permanent medical staff within the hospital, to provide a way of communicating medical opinion to both the hospital management and more widely, to provide representatives to BMA meetings and ultimately to express confidence or otherwise in the governance of the hospital.

8 All permanent medical staff (consultants, associate specialists and staff grades) are automatically members of the MSC. There are two officers of the Committee in Chester, the Chair and the Secretary. These posts are not renumerated. In practice candidates nominate themselves for these positions and a vote among members would be conducted by the existing secretary. This is normally unnecessary because there is no competition for posts. The normal term is five years renewable but officers continue in practice for want of volunteers to replace them.

9 I was secretary of the MSC from about 2010 until 2020, when I took on the Chair of the joint Local Negotiating Committee instead.

10 My role as Secretary of the MSC involved administering the bank account, organising the meetings, drafting and disseminating the agenda, taking notes of the meetings, drafting and disseminating the minutes, conducting any votes agreed and organising leaving dinners for those retiring doctors who wished it.

Change in Management Structure

11 Paul Jameson, the Chair of the MSC, told me that he no longer sat on the Board of the Trust. He also told me that Tony Chambers had said that he considered the consultants as no more important than any other staff group such as porters. I do

not know when this change took place and the senior managers would not have wanted to discuss this or anything else with a consultant like me.

Approaches from the paediatricians regarding concerns

12 I think that Dr Brearey told me about enduring concerns and difficulties because of our shared paediatric interests rather than in my capacity as secretary of the MSC. I relayed his concerns to my MSC colleague, Paul Jameson, and he told me that Ian Harvey, the Medical Director, had said that Drs Brearey and Jayaram were troublemakers. I cannot remember when these discussions took place. I continued to express my concerns to Dr Jameson and push for some sort of MSC response to defend our paediatric colleagues against what I considered to be bullying and to persuade senior management to call in the police.

The breakdown in relationship between consultant paediatricians and Trust management

13 As above, I first became aware of a breakdown in relationships because of confidential talks with Dr Brearey in about 2016-7.

Discussions with senior management about the breakdown in relationships and concerns

14 I had no discussions with senior management about such matters.

Minutes of the MSC 1st November 2017 (INQ0004451)

15 When I agreed the agenda I wanted put on record that the paediatricians needed our support and I remained keen that the wider consultant membership should know what our paediatric colleagues had been going through. I wrote the minutes to reflect what was discussed and who said it as accurately as possible. My memory is that there was no discussion. The members had been told nothing about the facts of the case and were therefore in no position to discuss it. The matter was always surrounded by secrecy until I persuaded the Chair to allow the paediatricians to give the membership a timeline at a subsequent meeting. I felt that the paediatricians needed our support because they were still going through a traumatic experience; to suspect a colleague of harming patients is bad enough, but to be victimised by the senior management is worse. The minutes, in effect, told them that we were with them but this was the limit of the support that we offered.

Minutes of the MSC 6th June 2018 (INQ0004485)

16 I transcribed my own comments into the minutes of the above meeting when I alleged that the executives seemed to have little respect for the MSC. This was based on long experience. The senior managers had asked for our cooperation with what was plainly an expensive technological white elephant (Teletracking), had awarded themselves an I&S pay rise when consultants and other staff had been awarded I&S year on year, had asked us to accept a reduction in annual leave to help the hospital after their pay rise, and had treated the paediatricians badly. The

Chief Executive had taken every opportunity to emphasise that consultants were not above any other group in the hospital.

17 At the same meeting Dr Jameson told the meeting that the paediatricians were feeling marginalised, stressed and isolated and said that there may have to be an extraordinary MSC meeting to demonstrate support for our colleagues. The paediatricians were feeling that way in my view because of the way that they had been treated by the senior management and because of the way that the accusations had split opinion among the nursing staff on the NNU with some supportive of Lucy Letby and opposed to the consultants.

Ian Harvey's resignation

18 Discussion among the consultants was that Ian Harvey was leaving because he could see that things were going to be difficult for him and Irrelevant & Sensitive I&S I don't know the real reasons why he stepped down and as far as I know the MSC were not involved in any way.

MSC meetings September 2018 (INQ0098147)

19 Two meetings of the MSC were held in September. The pre-meeting held on the 11th was not really an MSC meeting but I wanted to make it public that Dr Jameson and I had attended a meeting with Sir Duncan Nichol and Susan Gilby. I wanted to try to counter the secrecy that had attended the whole matter. Dr Gilby and Sir Duncan wanted to tell us how to conduct the extraordinary meeting of the MSC on the 19th, ostensibly to avoid the meeting interfering with the police investigation. A police statement was to be read out at the beginning of the meeting. I was not to disseminate the draft minutes to the membership after the extraordinary meeting, even though they would have heard evidence from the paediatricians in person and that there would be no new information in the draft minutes. I was to circulate the minutes only to Drs Jameson for circulation to Dr Gilby, even though she was not a member of the MSC. I was to keep the minutes to show any members who wanted to see it. I was unhappy about this but could not do anything about this as it was agreed by my Chair, Dr Jameson. The minutes that Paul Jameson has submitted to the Inquiry are those from my own records. I was asked to make two changes by Dr Jameson, to add the name of a member to apologies and to change an initial in the minutes, and I would have opposed making any changes suggested by Dr Gilby, an invited attendee. No members ever asked to see the minutes that I held on my NHS email account and on my NHS laptop.

20 The extraordinary meeting of the MSC was called by me on the 19th September with Dr Jameson's agreement. I wanted the paediatricians to provide a timeline of their experience to the membership so that the members could hear first hand instead of relying on rumour. At the meeting we had a record attendance.

21 Dr Gilby and Sir Duncan were invited to the meeting against my wishes. I assumed that Dr Jameson, the Chair had invited them. I felt that their presence would inhibit discussion.

22 Tony Chambers resigned as Chief Executive an hour before the meeting. It was said that Sir Duncan had persuaded him to resign (rather than risk a vote of no confidence by the MSC) with the promise of a good employment reference. However, although I had discussed a vote with Dr Jameson we had made no concrete plans. I had prepared no voting papers and I very much doubt that we could have pushed on with a vote in the presence of the Medical Director (Dr Gilby) and the Chair of the Trust in attendance. It was also said much later that Dr Gilby (as Chief Executive) was still trying to prevent a good reference for Tony Chambers in 2021. Tony Chamber's original appointment as Chief Executive was said by the late George Foster to have been pushed through by Sir Duncan, in opposition to the consultants' favoured candidate, and I can only speculate on his motives if this was true.

23 As will be seen from the minutes of the meeting there was very little discussion from the floor after the paediatricians had given an account of their experiences. It was clear that the members were astonished by the account. I think that discussion was significantly inhibited by the presence of Dr Gilby and Sir Duncan. I wanted very much to ask who had been Chairman of the Trust while all the deaths and the failure to call the police had occurred, and why the news of the investigation had reportedly come as such a shock to the non-executive directors. I was not brave enough in the presence of Sir Duncan, the former Chief Executive of the NHS who was said to be an important Freemason. I can only speculate that others were similarly inhibited.

24 The paediatrician Dr Holt was recorded as saying in the meeting that the paediatricians had no confidence in the Board. I shared this feeling and I'm sure that the rest of the MSC would have agreed and would have valued the chance to express it.

25 The MSC agreed no action following the presentation by the paediatricians.

Culture and Atmosphere

26 In my capacity as Lead Clinician for ophthalmology I had interactions with Ian Harvey and once with Sir Duncan. I met Stephen Cross I&S I&S To my memory I never met Sue Hodkinson, Alison Kelly or the non-executive directors. I met Tony Chambers when we were both invited to a dinner by the Chester University Chancellor. I was also in contact with Ian Harvey as MSC secretary, particularly in that he preceded me as MSC secretary before he became Medical Director.

27 I had a difficult relationship with Ian Harvey. Even as Divisional Medical Director he threatened me with suspension when I and Stewart Armstrong (a senior ophthalmologist) were opposed to nursing management changes in our outpatient

department. He said that I could be accused of bullying but I have since heard that this was a tactic that he used against other consultants. He commissioned a secret inspection of our department as Medical Director by an orthoptist, much to the dismay of my colleagues. I approached him with the Lead Clinician for ear nose and throat, Mr Robert Temple, to tell him that the electronic patient record system was unsafe in our specialities. He took no action. I&S I&S Ian Harvey was very unhelpful. Whenever I saw him he seemed to me to be thinking of how he could use the information I was giving him against me or to divide and rule colleagues. I met Sir Duncan once before I saw him in September 2018. When he started as Trust Chair he came to meet Lead Clinicians individually. I told him of our aspirations and didn't hear from him again.

28 Relationships at the Hospital varied between departments. Clinicians' and junior managers' relations depended on personalities and it's difficult to generalise. I think that relations between clinicians and senior managers generally soured over the period from Tony Chamber's appointment and continued to worsen after his departure. I don't think that I can comment on relationships between nurses, midwives and managers. I don't think that relationships between professional groups were particularly problematic at the Countess generally, although Tony Chamber's antipathy towards consultants may have had something to do with his nursing background.

29 I was a regular visitor to the NNU between June 2015 and May 2017 in my role as screener for retinopathy of prematurity, as well as before and after that period. I have always found the staff to be excellent, caring and efficient. I did recognise some signs of sensitivity during that period and subsequently, which is unsurprising considering that some nurses would have felt loyalty toward Miss Letby. At the time of writing I am still attending regularly for ROP screening, even though employed at another Trust. I remember Miss Letby helping me on one occasion with an examination for ROP but nothing out of the ordinary happened.

30 I have no knowledge of Stephen Cross's involvement in decision making during the period. He was said to be an ex-police officer but I don't know whether this is true.

31 Professional relationships affected the governance of the hospital during the whole period from the appointment of Ian Harvey as Medical Director and then Tony Chambers as Chief Executive in that there seemed to be deep suspicion amongst senior management that consultants were poorly motivated, lazy and interested in personal gain. My impression was that relationships between doctors and nurses were not more difficult than in other hospitals. During this period I worked every week at the Manchester Royal Eye Hospital and have experience of other hospitals dating back to 1985.

32 The quality of relationships in the Hospital and the culture I experienced on the NNU did not significantly change after June 2016 as far as I can tell.

Increased Mortality and Investigations

33 I am not aware of any groups or other measures concerning adverse incidents or deaths that were set up following Lucy Letby's suspension, trial and conviction. There may have been changes in paediatrics that I am not aware of. As previously referred to there was an obsessive degree of secrecy surrounding the whole affair with senior management using the active police investigation and then the trial to shut down any discussion of changes that could be made to any processes.

34 I am not aware of the Trust's risk management strategy leading to any serious investigation of excess deaths and unexplained collapses. It seems clear to me that the executives were concerned to silence the paediatricians rather than to find a cause for the deaths and injuries.

35 I thought at the time and still think that the proper external bodies to investigate possible murder and assault are the police service and the coroner service. I said at the time that I would have approached the police despite the senior management's view if I had been a paediatrician but I think that this could have been a career-ending move. I don't think that the BMA as a union or the Royal Colleges as academic bodies are bodies that can investigate when there are suspicions of intentional harm. I understand that there was a threat to report the paediatricians to the GMC and this was a very potent threat, coming from the 'responsible officer', Ian Harvey.

Grievance process

36 I was told in confidence by Dr Brearey that Miss Letby's grievance procedure was upheld, probably in 2017.

37 The paediatricians did not approach the MSC with concerns about the grievance process and, as can be seen from the minutes of the meetings, the grievance procedure was only explained to the membership in September 2018. The failure of management was so total and astonishing that consultants had not yet been able to understand it up until the time I left in my opinion. As I will explain further on in my evidence, the culture of the Countess continued to worsen even after the departure of the executives involved in the reaction to Miss Letby's crimes.

Raising Concerns and Freedom to Speak Up

38 I was aware of the lip service paid to whistleblowing but not to the Freedom to Speak Up Guardian at the time. The established way of raising concerns was to approach the medical managers who would then escalate concerns as necessary to the medical director or chief executive.

39 In my experience there was no effective way of raising concerns about colleagues or any other areas of concern. I have many concrete examples but I will give just some. In 2013 I conducted the appraisal for I&S

I&S

I&S I asked for Ian Harvey's help to try to come to some resolution but none was forthcoming. I always had the impression that he was enjoying my difficulties and found it convenient to see a divided department.

Safeguarding of babies in Hospitals

40 Those consultants seeing children regularly were required to have Level 3 Safeguarding Training. This three yearly training concerned spotting evidence of non-accidental injury inflicted by those around young children and correct routes of referral rather than intentional harm by staff.

41 I am not aware of any advice from my professional academic body, the Royal College of Ophthalmologists, concerning members of staff suspected of harming any patients. I think such incidents are thought to be so exceptional that no policy statements are necessary.

Reflections

42 In retrospect it is clear that the number of babies dying in a very short time was unprecedented but the difficulty in identifying a cause was the implausibility of a member of staff deliberately harming them. It would have been very difficult and disturbing to consider it.

43 There is no question that the actions of the senior management made it very difficult and risky for the paediatricians to discuss their concerns with other colleagues. It is quite clear to me that secrecy is often used by managers to conceal misbehaviour and to avoid embarrassing publicity. None of the doctors working in the Hospital were kept informed.

44 The way that the paediatricians were treated is outrageous. To be made to apologise to a mass murderer is the stuff of improbable fiction.

45 Senior managers in the NHS should be held responsible for patient care in the broadest sense. It is clear to me that until managers are prosecuted and jailed the culture will not change.

46 Managers throughout the NHS pay lip service to whistleblowing, and in that they follow their political masters. However, in my own painful experience, and regularly in the media, there are many examples of whistleblowers who are persecuted and leave their posts while those being reported stay. I think that raising concerns

almost always threatens the positions and power of those in senior management and this explains why they react the way they do. In reality there is no higher authority for concerned clinicians to go to. In the current NHS culture I don't think that whistleblowing can work.

47 I am concerned with the way that Royal College inspections can be used as a weapon by unscrupulous managers and by the way that the inspecting colleagues are so flattered and self-important as not to see the way they are being used. The Royal College of Paediatrics and Child Health inspectors must have been told by the paediatricians about their suspicions and plainly should have advised an approach to the proper authority, the police service.

48 It is clear to me that Medical Directors' powers should be split. To have power over employment as Executive Director and power over medical registration with the General Medical Council as Responsible Officer represents a threatening excess of authority. In the hands of an I&S individual like Ian Harvey this can stifle concerns and opposition.

49 I think that there should be statutory medical representation from the employed consultants on all Trust Boards. It is clear that Medical Directors as medical managers and Executive Directors cannot serve this function and I suggest that Chairs of MSCs or their deputies should sit on all Boards.

50 I think that CCTV could make it difficult for another Lucy Letby to commit similar crimes but at a cost of sending the message that staff are not trusted to care for patients and we may lose more than we gain. One of the most disturbing aspects of the modern NHS is the loss of trust in the professionals caring for patients.

51 Although an Inquiry like the present one is required to make recommendations for keeping babies safe from criminal actions I am very wary about changing the way we care for babies on the basis of one unprecedented crime.

52 A range of security systems relating to monitoring of access to drugs and babies would run the risk of creating clinical difficulties and delays that would impair the ability to assess and treat babies promptly.

53 It has been clear to me for about 20 years that managers at the Countess are concerned with control and power rather than quality or finance. I often joke that in a perfect hospital they would have complete control and there would be no patients. I have plenty of examples to back up my claim.

54 The Letby case demonstrated how demoralised and disempowered consultants are at the Countess, although not because of any disagreement between me and the Chair of the MSC. It is a national phenomenon and in my opinion results from long-standing and deliberate political policy. With the benefit of hindsight I would have approached the police myself but probably would have been sacked or reported to the GMC.

Any other matters

55 As I alluded to at the beginning of my evidence I feel that my own experience as a whistleblower shows that the culture at the Countess had not changed with the change in executives. I and two other ophthalmic consultants were asked in 2018 by Dr Darren Kilroy, Susan Gilby's successor as Medical Director, I&S

I&S

I&S

I&S

I&S I apologised to all because I could see that I could not take my concerns any further and took early retirement so that I could leave as soon as possible.

56 I think that the MSC at the Countess was toothless and that in that respect it was representative of a demoralised and demotivated consultant work force. I know from the BMA online forum for Chairs of Local Negotiating Committees that this is a national phenomenon. I think that in practice doctors who become medical managers seem to be assimilated into the senior management culture and behave in the same way towards staff expressing concerns. Despite the level of work connected with being an MSC officer there is no time or money that goes with the post. This is hardly surprising as the interests of the MSC are seen by senior management as inimical to their interests. Perhaps if these posts were remunerated the MSC would become more professional and more difficult to ignore. It is also remarkable that Trust Boards will often include only one medically qualified member, sometimes no longer in active practice, although from my own experience having medically qualified managers is no guarantee of a good service to patients or an adequate response to concerns.

Statement of Truth

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

Signed Personal Data 3/7/24.