THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Dr Geraldine Walters – Expert Adviser on Nursing
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Ms Jacqui Featherstone – Expert Adviser on Midwifery
Professor James Walker – Expert Adviser on Obstetrics

OWEN GALT

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DR KIRKUP: Thanks you for coming. I'll Bill Kirkup, I'm chairing the panel, and I'll ask my colleagues to introduce themselves to you.

PROF FORSYTH: Yes, we met before on a previous visit here. Stewart Forsyth, paediatrician and medical director in Dundee.

MS FEATHERSTONE: I'm Jacqui Featherstone, I'm the Head of Midwifery and Head of Nursing at the District General Hospital of Essex.

PROF WALKER: I'm Jimmy Walker, I'm an obstetrician and professor of obstetrics in Leeds and I was previously involved with the National Patient Safety Agency, and chairman of CMACE.

DR GALT: Very nice to see you.

DR KIRKUP: You'll have noticed that we're recording proceedings, and we will make an agreed record of them subsequently. You also may have noticed that we have family members in attendance as observers of the session, and others may listen to the recording at a subsequent time. And as you know, we have removed mobile phones, laptops, recording devices; the point being that nothing that happens in the room goes out of the room until we're ready to produce a report that's got everything considered in context. Do you have any questions for me about the process?

DR GALT: No, and I have no electronic equipment.

DR KIRKUP: Okay – no, no, just if there were any other questions about what we were going to do. That's fine. Can you tell me when you started at the Trust and what you've done subsequently?

DR GALT: Yes. So just by introduction, my name's Owen Galt, I'm the current Clinical Director for Women's and Children's Services at UHMB. I joined the Trust in January 2007 as what they would term a generic paediatrician, so a paediatrician who works in both acute and community paediatrics. I'm based in Lancaster, and when I was first appointed I had one clinic per week in Kendal, at Westmorland General Hospital.

DR KIRKUP: Okay and when did you become Clinical Director?

DR GALT: Clinical Director was – right, so let's go through the stages. I was appointed a Clinical Lead in paediatrics in – I think it was May 2010, and became Clinical Director in – I think it was April 2012, when the Trust restructured. So I've been clinical director for women's and children's services since the reorganisation.

DR KIRKUP: Okay, thank you. I'll ask Stewart to continue.

PROF FORSYTH: Thanks. Can you just begin by giving us a rough outline of how paediatrics is distributed across the Trust?

DR GALT: Okay. I'll give you a bit of history, if that's okay, just to be able to describe things, and that puts things in context, which I'm not sure whether you will have got from other people yet. So when I first joined the Trust we had, I think, seven consultants in Lancaster working on a traditional three-tier rota system, so we had a number of middle grade trainees from the North West Deanery, and some staff grades on the middle grade rota, and approximately seven GP trainees or junior trainees in paediatrics on the first tier of the rota; perhaps four or five consultants working in the generic role, and two or three working completely for acute paediatrics, so no full time consultant community paediatrician in Lancaster.

Outpatient services are provided in Lancaster, and the acute services. Westmorland General, since I've been in post, has only ever had outpatient services provided from there. Furness General Hospital, when I arrived, I think, had – well certainly four consultants, and a diminishing number of middle grade staff grade paediatricians. The North West Deanery hadn't – I don't think has ever provided middle grade trainees to Furness because of the size of the population, the activity levels. I don't think it's deemed a large enough unit to be able to provide the best educational training experience, and approximately five junior doctors who are GP trainees.

So I suppose if you look at the proportion of the staffing, Lancaster's a larger unit; Furness is a smaller unit. In terms of activity, probably best broken down in terms of number of births. Lancaster has a level 2 neonatal unit with approximately 2,000 births per year. Furness has a level 1 special care baby unit, which has approximately 1,000 - 1,200 births per year, so not quite double the size in Lancaster, but not too far off. Both sites have acute paediatric wards with short stay paediatric assessment units embedded within them, and again, comparative numbers, I think the number of admissions in Lancaster is comparatively higher. Furness has, I think, got 14 beds on the ward, and Lancaster's got 21, and obviously the activity fluctuates throughout the year.

PROF FORSYTH: What about special baby units [inaudible], how many admissions do you have to the neonatal unit in Lancaster per year?

DR GALT: Lancaster approximates about 180 admissions per year, and those are babies who are born at 28 weeks gestation and upwards. We do aim to transfer out intrautero babies that are born – that are likely to be born at less than 28 weeks gestation, commissioned for an average of one intensive, two HDU and seven special care cots. The unit has got 10 cots in total, so by most DGH standards even, it's still relatively small.

The unit occupancy is about 80%, and the way that we've set up the ward rounds, we have a separate consultant of the week doing ward rounds during the morning in Lancaster on Mondays, Wednesdays and Fridays, to make sure that there's some specific consultant input dedicated to the unit throughout the week.

The unit in Furness has approximately 100 admissions per year. They look after babies from 30...

PROF FORSYTH: Sorry, how many did you say went into Lancaster?

DR GALT: About 180.

PROF FORSYTH: 180.

DR GALT: Yes.

PROF FORSYTH: Okay, so 100 into Furness.

DR GALT: Yes.

PROF FORSYTH: And it's a level one unit.

DR GALT: It's a level one unit looking after babies from 32 weeks upwards. Now that doesn't mean that they don't get occasional emergencies, so I think each year we do have about two babies per – so about two babies per year born at less than 26 weeks gestation, where because of the geographical distance or the immanency of delivery, it's not possible to move that lady from Furness to a level three unit, so the level three units are in Preston and Burnley. So from Furness, a good hour and a half's drive, I suppose, going at speed.

PROF FORSYTH: Okay, so you came in 2000 and...

DR GALT: 2007.

PROF FORSYTH: 2007, yes. So what did you think in terms of the issues about paediatrics, particularly around the period of 2007/08?

DR GALT: What do I think of them?

PROF FORSYTH: Well what did you see were the sort of key issues for paediatricians at that time?

DR GALT: Oh, right, yes. I mean, I've been trying to think about this in terms of when I first came into the Trust, did it feel different to where I'd worked previously? Was there something which was strikingly obvious that was going wrong? And I don't think I felt that, so I think – certainly my first consultant post, I trained in the Eastern Deanery in some of the – one of the largest teaching centres down there, but also in the smaller units there. And I don't think there was a big step in governance or reporting or anything else between the hospitals that I've worked in there and in Lancaster. Now I suppose that's coming from the point of view of a middle grade trainee where perhaps things have changed in the past seven years, but I don't really think that the Eastern Deanery focused on making sure that middle grades knew exactly what risk and incident reporting and root cause analysis. We didn't get trained in any of those types of things.

And as a junior consultant, if nobody else seems to be flagging up there was any concerns, and as I say, I don't think in Lancaster there were any major things that I thought 'That's definitely wrong'. But I picked up immediately when I came into the organisation...

PROF FORSYTH: Can I ask – sorry.

DR GALT: I'll go on. Moving on from there, I think one of the things I did pick up quite quickly was in terms of management of guidelines, everything was placed onto the Trust intranet, and that was not a very good way of searching or making sure that documents were – if you searched for something it wouldn't pop up with the most recent thing right at the top of the list. So expanding on an idea that I'd had when I was a trainee, I designed a paediatric intranet site that meant that we had all of our guideline documents in one place, and it was much easier then for the department to be able to search for things and know that they were the up-to-date documents.

PROF FORSYTH: As a new consultant coming in to work in Lancaster, what was the impression you got about your colleagues in Furness, and how would you feel the relationships between Lancaster and Furness were at that time?

DR GALT: There was a – well, I think geographically, obviously, there's a gap between the two, and I think organisationally there was as well in that I know

the Trust had merged in fact seven years previously or something, but the – Lancaster very much, I think, saw itself as the bigger unit, and Furness, perhaps if something were – you know, if you were generating a cross-bay guideline, because the bulk of the paediatric expertise and the number of nursing staff and everything else was in Lancaster, moving it across to Furness was perhaps regarded as the big hospital down the road telling us what to do.

By the same measure, I suppose, things coming from Furness, perhaps, were less easy to integrate into Lancaster in terms of volume of generation. But having said that, before, I think, I came into the Trust, the guideline lead for paediatrics was based over in Furness, and he it was very organised at making sure that paper versions of guidelines were available in folders. However, that's not the way that things were moving, I suppose, I think things had to become electronic.

PROF FORSYTH: And do you think that at all had any impact on quality of care?

DR GALT: I think certainly that bringing things forward, even sort of closer than seven years ago, I think it isn't easy, and it certainly in the past hasn't been easy to expect that staff move between the hospitals to be able to cover shifts. So if, perhaps thinking about the special care baby unit in particular, because it's a small unit you don't need lots of staff to be able to look after the babies which are there. So although we're admitting 100 babies per year, there are times throughout the year when there are no babies on the unit at all. Or you may have one baby that requires some feeding, so the average occupancy, I think, and this is going to be a bit of a guess, I think there's about 45% when I had a look at it, but the nature of the intensity of the work there means that you don't need many staff to look after those babies under normal circumstances, which means you don't need many staff on the rota, and I think the historic establishment was about 11.9 whole time equivalents.

It doesn't take too much of long-term sickness or other reasons for absence to be able to destabilise the number of staff that you have to be able to make that rota run effectively. And if hospitals – I suppose if hospitals were very close together, a unit of that size would have been merged into a larger unit some time previously. Because of the geographical distance, that hasn't happened, but the ease of rotating the staff around historically to be able to

say there's a need to be able to cover a unit in Furness has been difficult. I think it's becoming easier, but certainly up until about two years ago there was a lot of resistance from staff to covering shifts over in Furness.

PROF FORSYTH: So how did the paediatric community react to the various incidents that had happened around 2008/2009?

DR GALT: Well, this was a time when I was a – a junior paediatrician, so I suppose I've not had full access; I certainly didn't have full access at the time to any of the significant meetings that were happening. Certainly I was aware, I think, of the significance of the death of Joshua Titcombe, because the – I'm just trying to think what the title was that Paul Gibson had at that stage. I think he was clinical director of paediatrics, I think the lead commission for paediatrics at the time, was working from an action plan, which certainly was to revamp the sepsis guideline for neonates.

I suppose in terms of [neonatal Sepsis ~~neonatal tardia~~?], the majority of babies may present with some subtle symptoms of sepsis; they may not have any culture positive results from that, but we need to make sure that babies are given antibiotics at the earliest opportunity if we can. For group B streptococcus there are certain risk factors which are known to increase the chance of morbidity, so most of the guidelines are based on that. And as far as I can remember, the guideline that when I came into the Trust had those risk factors in place.

What we moved onto having was a single guideline for incorporated prolonged rupture of membranes and prematurity and group B streptococcus, and the baby who appears to be septic, because otherwise you're working from different documents and they may have all said slightly different things, but bringing them all into one pathway meant it was quite easy to come up with a plan based on looking at the risk factors. We also embedded some extra risk factors in there, certainly with maternal pyrexia; was a risk factor which was strengthened based on the background of that.

And Fiona Rainsford, our practice educator, developed and did a lot of work on – it's the assessment tool, but I think it's based on NICE guidance.

PROF FORSYTH: So this would be around what time?

DR GALT: So around – well, I think the – 2009, I think that would be. And I think that guideline served as well. The – I think...

PROF FORSYTH: So in practice that's gone into practice and people are complying with it, are they?

DR GALT: They were compliant with it, yes. I think we're slowly moving over to the new NICE guidance, but I think that's more about how long to give the baby antibiotics for and looking at CRP, so our laboratory has traditionally reported microbiology results at 48 hours and the NICE guidance would prefer it to 36 hours, so it's making sure that that's a reliable process really.

PROF FORSYTH: Can I ask a bit more about the paediatric involvement down in Furness, and particularly availability of paediatricians and urgent situations and presumably we're talking about maternity services and neonatal services. And secondly, ensuring that staff maintain their skills, particularly around resuscitation and stabilisation of babies. How can you assure us that that is now in place, and was there an issue previously?

DR GALT: Okay. When I took over from Paul as the clinical lead in 2010, I took on the responsibility for doing appraisals for each of the consultants as part of that role. I think it's reasonable to say that the monitoring of training up until that point had probably taken place, even a paper record or as an Excel spreadsheet, and that didn't give full assurance that people were up-to-date with basic – well, I suppose not basic, but the advanced resuscitation skills, the neonatal life support and advanced paediatric life support courses. So whilst I was going through the rounds of appraisals at the start of that period, I was gathering data in terms of what training had been put in place.

Now again, that was still based on an Excel spreadsheet that I put in place, albeit probably more robust than the previous system, because the Trust didn't have a central computer store of that type of information, so you'd have to – I think if you wanted to find that individually from each department you'd have to go to each department and find their paper record or their Excel file and ask what the training was that was up-to-date.

Bringing that forward, we've now got the training management system, computer system, which has areas within it for mandatory training, but includes resuscitation and training and other training logs that are kept up-to-date. I think throughout each of the years that I've done appraisals, the consultants have been quite robust in making sure that I've reviewed the TMS record, and where people have lapsed or – not by a long way, but where

they've either gone out of date by a couple of months or are coming up to being out of date for resuscitation training, that's been an item in their personal development record to make sure that that gets done.

PROF FORSYTH: When you started that bit of work were you aware of difficulties; incidents of failed resuscitation, failed intubation, failed insertion of longlines, unworkable transfers?

DR GALT: Because I was a clinician in Lancaster, I think I'd probably be able to – I would have been aware at the time of the relative competencies of the doctors there, and I don't think I had any concerns about the colleagues that I was working with.

PROF FORSYTH: So you're not aware of any audits that had been done in terms of...

DR GALT: Well, again, referring back to Fiona Rainsford, Fiona Rainsford did put in place a resuscitation audit, which expected that people would complete a form after resuscitation had taken place. I don't think that was filled in comprehensively for each resuscitation, so I think the data would have been missing to be able to get a complete record.

PROF FORSYTH: So when there's a call for a paediatrician of a baby they think's requiring resuscitation, who goes for both Furness and also Lancaster.

DR GALT: Yes, I mean the – so Lancaster on site at all times will have a junior doctor and a middle grade paediatrician, so they have standard bleep systems that...

PROF FORSYTH: So who goes – the middle grade or the junior doctor?

DR GALT: Well the...

PROF FORSYTH: If these are GP trainees, I mean they're not going to be skilled in doing full resuscitation, are they?

DR GALT: No, but – well, it depends what has been – what the situation is. So if it's an elective section, the GP trainee would probably be attending at that one. If it is for a resuscitation call then the resuscitation that we would expect switchboard, the junior doctor if they're not there already, the bleep will still go off, the middle grade paediatrician, the neonatal nursing staff on the unit, the bleep holder, and in general switchboard will call the consultant on their mobile phone to be able to alert them to the fact that there's a resuscitation

happening, and that happens particularly at night time, we're not on site at three o'clock in the morning. We'll get a phone call from home to attend.

PROF FORSYTH: Furness?

DR GALT: Furness, we've got at the moment a consultant delivered service whereby there's a consultant...

PROF FORSYTH: Was that in the past before you...

DR GALT: Well in the past, yes, it's going back.

PROF FORSYTH: Yes, because we're talking about 2007/08 when you were –

DR GALT: I'm not going to be able to be very clear on the dates on this bit, but historically, where you had a small number of middle grade doctors and a small number of junior doctors, if the middle grade was on site they would get called to the resuscitation, but the consultant would be on call from home, so they would get called in from home. If the – the Deanery was not prepared to have, after a certain point in time, but I don't know when that date was, they weren't prepared to have the junior doctor on site with no senior support back up, so the consultant started working – consultant resident on call within the hospital so that they would be there in an emergency situation on the site, so they would get called direct.

PROF FORSYTH: So when did that happen? When was that changed?

DR GALT: I think that preceded my appointment into the Trust, but probably not by much.

PROF FORSYTH: So the consultant was actually resident on call?

DR GALT: Yes.

PROF FORSYTH: And so what happens now? Is the consultant resident on call?

DR GALT: The consultant is resident on call at the moment. The number of middle grades...

PROF FORSYTH: Are they actually resident on call or first on call?

DR GALT: Yes, they're in the hospital. Because we've increased the number of consultant staff there should be – they're working more of a shift system rather than being resident on call now, so they'd be expected to be awake ~~away~~. We've got a back-up consultant on call at home as well if there's an emergency, to be called in. So from that point of view it's much more robust.

The number of junior doctors that we have doesn't allow for that 24/7 cover of a rota, so at night time when the activity is low, a consultant is on site

as the paediatric doctor, and that's really because in terms of – there's very few middle grades free in the NHS for paediatrics, so as the staff grades have left, we've been moving over to a full consultant delivered system, which would be purely shift based.

PROF FORSYTH: So is that going to be sustainable?

DR GALT: A very interesting question. The – the applicants that we've had for posts in recent years have been of a good quality that we've been able to recruit into post, and they tend to be consultants who have just qualified so that we know their training and their skills are up-to-date, and they're enthusiastic and – and keen.

If I were to think about is it sustainable, there's a number of factors that I'd have to bear in mind, I suppose. So first of all, is the geographical isolation of the unit, and although it's a very nice part of the country to be able to live in, if you are interested in outdoor activities, if you want to be living in an area which is connected to the M6 or the M25 with lots of amenities around you, then it wouldn't suit that sort of lifestyle. In my box here, can I just have a little grab in this? I was having a little think about this prior to coming along. Let's see if I can find the right little section.

So in terms of the pool of – the geography that you have to pool from, if you have a think about a geographical area surrounding the Trust – I'll bring these up to, I suppose – but – so what I've done on these is basically draw a circle with a radius of 44 miles around it. So if I drop that onto Barrow-in-Furness, most of the circle is out at sea, and the only other units which are fairly close by Whitehaven and Lancaster, because of the geography. Although it captures Blackpool, that's actually a drive down through and back down again.

If you drop it onto London, I think that was UCL that I based that on by there, it encircles more than the M25, most of Kent, most of Essex, probably a bit of Suffolk and – is that Hertfordshire? I'm not sure. That's probably a population of about 15 million people, and this is about half a million people, so not only has that got a bigger population, you can actually get it from all different sites, and by here you can't. You're only really going to be able to get to it from Furness. There's other places which are equally geographically

remote where I would also worry about whether or not it's sustainable – apart from Manchester, as again Manchester covers quite a large area.

So I suppose in terms of is it sustainable, whilst there are sufficient trainees and paediatrics to come off the training system, or if you went to international recruitment, good quality candidates coming from international recruitment that want to work in the UK, then yes, I think it is a rota which is deliverable in the short-term, perhaps going for about a decade. What happens after that is a little bit more difficult to know. If, as predicted, the Royal College reduced the number of trainees and paediatrics to the point where it balances out the number of posts coming up and the number of trainees being trained, or perhaps even flipped slightly the other way, then my expectation probably is that most people would want to go and work in a big hospital with nice shiny doors and everything in the city somewhere rather than in those places around the edges. So anything which is around the edge, not just Furness, but you've got Whitehaven, Carlisle, Scarborough, those sorts – Great Yarmouth, all those small populations around the edge of the country, I would imagine, are going to be vulnerable in years to come if there's not sufficient consultants in the training pool.

PROF FORSYTH: Okay, my final point, during this period of time we're looking at, have there been performance issues with paediatricians?

DR GALT: Yes. And I think one of the – one of the things, and I won't name any names for the purpose of the record, but we have – one consultant has been suspended from duty for – basically it takes a very long time to investigate these things, but suspended from duty for a period of approximately two years and then dismissed. One consultant has been investigated by the GMC and deemed competent to continue working, and the...

PROF FORSYTH: And is now back at work or...

DR GALT: [redacted]

DR KIRKUP: So were they based at Barrow?

DR GALT: They're based in Furness, yes.

PROF FORSYTH: So is there just the two of them?

DR GALT: Well at the time it represented 50% of the staff.

PROF FORSYTH: I shall rephrase that. There were no others? There was just...

DR GALT: The – no, the last associate specialist that we had at Furness also had an investigation by the GMC. The – and in terms of incidents, there are incidents of less severity whereby we have – I think the risk system, the reporting system we have in place now I think allows us to be able to do the root cause analysis and address those – but not performance issues, I think, but more that – I think the majority of stuff tends to be documentation issues, and, 'Please write things down better next time' type of thing.

PROF FORSYTH: So these were clinically related issues, they were not...

DR GALT: Yes.

PROF FORSYTH: ... non-clinical issues. I don't need to necessarily know, but...

DR GALT: Right, okay. The one that was dismissed, clinical related issue; the one that was investigated, clinical related issues; [redacted], so I don't think I ought to say anything further than that because that's – particularly if it's being recorded. In terms of professional conduct, I think they've generally been dealt with on a one-to-one basis. There is another consultant that was on his final warning before he decided to leave the Trust, that had been a very good clinician, but at times had been known to upset the nursing staff with his attitude.

PROF FORSYTH: Quite a turnover.

DR GALT: There's a bit of a mixture at Furness, and I think that was the – and I think historically it's quite difficult to determine how fast to work on those individuals, I suppose, because if you go in with a very heavy hand and say, 'You're not working, you're not working, you're not working,' so four out of five perhaps, there's nothing left to be able to run the service. And I think we found out in January last year, even if you think the service is unsafe, it's very difficult to be able to do anything about it, but that doesn't seem to be – I don't know if that's the scope of the investigation or not. That relates to the neonatal unit.

PROF FORSYTH: That relates to – sorry?

DR GALT: It relates to the special care baby unit over in Furness.

PROF FORSYTH: January of last year.

DR GALT: January last year the – the small pool of neonatal nurses got to a stage whereby running a complete rota was difficult. The medical staff were there,

~~but~~ there were more robust numbers at that stage, but the nursing staff were – the numbers were weak, let's put it that way. At the same time, the midwifery staff were also suffering from either work related stress or other illnesses to the point that Sascha Wells, the head of midwifery, had concerns that she was unable to maintain an appropriate number of nursing staff – of midwives to run the obstetric service.

So I think part of this was because of fresh eyes. We had a new assistant chief nurse for children, who was an interim person called Sheila Lloyd, who came to the organisation and said – as well as Sascha flagging up the concerns about the midwifery numbers, said that it's impossible to sustain the neonatal nursing staff numbers whilst we have this period of sickness in place. And as I've described, it's quite difficult to get the nursing staff to move between the sites.

Although it's – in hindsight we would have probably wanted to do things differently, at the time there was relatively little notice before there would have been no nursing staff available to be able to run the special care baby unit. Now, because neonatal nursing staff nationally are in short supply, most of them will base themselves in a big teaching centre where you get to look after 24-week gestation babies and you've got all the machinery and the back-up and the support and things. It was very difficult to find staff to be able to cover the shift that was going to be coming up. I suppose my concern that I'd like to point out was that regardless of the processes that we had in place, which we were saying, 'Look, we've got no staff for this Thursday,' I think it was, 'there's going to be no nursing staff here to be able to cover this.'

The decision to step the unit down and transfer women who were requiring transfer to Lancaster, which I don't think would have been large numbers, that decision was overturned. To my recollection, it wasn't just overturned. We had no staff <u>for the rota in the days coming up</u> ~~on site~~, and the statement that came out from Sir David Henshaw and Jackie Daniel was released before we had staff in place. And I don't think they'd have put that out knowing that, and I don't think my staff told the executive team that we had staff, so I think possibly, I don't know, I've got no proof, was pressure exerted from strategic health authority, NHS England or something to be able to keep

the service running, to keep the NHS name or the – or something safe at the detriment, potentially, of patient safety.

DR KIRKUP: Was that investigated subsequently?

DR GALT: Yes.

DR KIRKUP: And what was the conclusion?

DR GALT: The conclusion was that regardless of the – that's the [Julie Bloor?] report, which I don't know whether you – it's not in the terms of reference, but I'm assuming you have access to. I think it was deemed that the decision to continue providing the service had been the correct one. And that the reorganisation as in myself and the team around me hadn't really considered well enough in advance mitigating actions that could have been considered to prevent that situation arising, despite the fact there's very few nursing staff around and it wasn't something that we could have predicted months in advance. I suppose I think we could have probably had more robust crisis policies or something in place, but the – they weren't. So that was the situation that we found ourselves in at the time.

Now, I can either agree to agree with the report that has been provided, which I suppose I should do if I was being entirely professional and considering the NHS in its entirety, but because I know that we didn't have staff on shift at the time that the decision to reverse our concerns was made, I think it's worthwhile that you know about it.

DR KIRKUP: Where did the nurses materialise from to cover the shift on the Thursday?

DR GALT: I think, if I remember rightly, we had a practice educator who worked either a very long day – I think she he actually probably worked two long days, and I think an agency nurse from Nottingham. So it wasn't the standard nursing staff that were in place at that stage, it was an agency nurse and somebody who was neonatal trained, but wouldn't normally be expecting to continue to sustain a unit.

DR KIRKUP: And did one of your nursing colleagues sign that off as acceptable?

DR GALT: What do you mean by acceptable? At the time, that was the – that was the best staffing that could be arranged.

DR KIRKUP: Yes, I appreciate that.

DR GALT: Yes, so in terms of acceptable...

DR KIRKUP: Was there a process where somebody said, 'Yes, okay, that's how you're proposing you'll keep the unit open. I agree that's acceptable,' or was there not?

DR GALT: The person – I don't know if you've called her to interview, the person to ask for that would be Sheila Lloyd, because she would have been the assistant chief nurse at the time. I think probably there was a huge sigh of relief that we managed to get one agency nurse, and that there was a solution that meant that that could be a sustained service, but I think there's – you know, I think how far do you have to go to be able to say, 'Excuse me, this doesn't seem to be a sustainable situation here.' No matter for how long for, we need to be able to make the situation better, and if it's going to compromise care – so I suppose it's a delicate balance now. So is having the potential to have a unit with no nurses worse or better than the potential to have – to transfer women down the road to Lancaster whilst they're in labour?

Now that's, I suppose, that wasn't my decision to make, that's the decision that whoever made it within the strategic health authority made, and they made the decision to keep the unit open. And we got by fortunately.

DR KIRKUP: As you were suggesting, I think, there was a distinction between safety and sustainability.

DR GALT: Yes.

DR KIRKUP: A short-term issue and the long-term issue.

DR GALT: Mmm.

DR KIRKUP: Okay, thanks. Jimmy?

PROF WALKER: Yes, I've just got one thing. You talked about development of a guideline for sepsis or potential sepsis in a neonate. Was this something which was developed in collaboration with obstetricians?

DR GALT: Yes, it was actually a very comprehensive guideline, and I think – I wouldn't necessarily just say obstetricians, it was developed in collaboration with maternity services – and again, dipping into my little box. So the maternity services had one half of the guideline, and what we needed to do was make absolutely certain that ours was aligned with the maternity services guideline, so this is the paediatric version. And the – the maternity services guideline and all of the monitoring of babies formed part of one part of it, and that forms part of the other part of it, the paediatrics, so it was completely

aligned. Everything ran through, so there was no gap between any of the guidelines. It took months to make sure it was all correct.

PROF WALKER: Okay, so the problem is a neonatal guideline when you're dependent on the baby being referred into your arena to therefore be then looked after correctly. So are you saying that guidelines for say management of a potential septic baby now is in place from delivery, so therefore it's a practice which is expected to occur by the obstetricians and the midwives, and with or without referral to you, depending on factors.

DR GALT: Yes. This guideline allowed the women to be assessed pre-delivery in terms of risk factors and from ruptured ~~ductal[?]~~ membranes and swabs which were positive or negative, and various combinations about that. When the baby is born, if risk factors are present, so you've got two groups of risk factors; one on here is where you'd actually need more than one risk factor to trigger a septic screen, and these on this side are ones where you'd automatically expect a septic screen to be performed. So the pathway is relatively easy to follow.

I suppose the innovation that came along with this guideline was the expectation that babies would with one risk factor would be observed one hour/two hours of age, and then two-hourly for the first 12 hours of life, so the midwives would be looking for evidence of sepsis developing. The triggers are all written down here. I haven't got the observation chart here, but there's a separate observation chart that goes with it to make sure that they are being plotted on a regular basis. And there's an expectation, just working through there, one of the big risk factors or more than one of the risk factors on here, or any of the triggers for indicating possible sepsis triggers a paediatric review and an expectation that partial septic screen will be performed, or if the baby is very unwell, a full septic screen.

PROF WALKER: Okay, the other thing I wanted to ask was that you are now clinical director for women's and children's, so therefore we've been talking very much about the neonatal side of it, but what about the maternity side and the obstetrician side of it? Is there a lead obstetrician, clinical lead in obstetrics?

DR GALT: Yes.

PROF WALKER: Are they based in Lancaster?

DR GALT: Yes, now I suppose this is where there's a slight difference between the two sides of the division. So in paediatrics we have a clinical lead based on each side, and for obstetrics we have a clinical lead called David Burch, who's based in Lancaster, but is quite happy to work across the bay in terms of meeting with his colleagues over in Furness. So clinically he's working in Lancaster.

PROF WALKER: But you as the clinical director, do you feel quite comfortable that the level of governance we've got in paediatrics is matched by the level of governance we've got in the maternal side?

DR GALT: I think it's probably the other way round. I think I've probably got – I think because of the investigation that happened and the Monitor action plan, and making sure that everything's been in place, the level of governance was – and because CNST is in place, the level of governance on the maternity side is, or has historically been the first to develop and is much more robust.

When we got to a stage of the review paper from Monitor, so November 2012, I think, there were still some outstanding issues from there, which made the executive team – so Jackie Daniel felt that we should be in special measures. So we had – as a division – so we had an intensive support programme put in place. At the time, and I think looking back at the original Monitor report, I think the Trust, possibly correctly, assumed that maternity had the greater level of risk or greater proportion of the 118 points to resolve, not that paediatrics was – or neonates was exempt from that, but I think the focus was on making sure the right number of midwives were in place, making sure the governance structure was more robust.

When we went into the intensive support programme, I specifically asked that we went through a similar project with paediatrics as we had been through with maternity, because I think – hopefully I'm not sounding too critical of the Trust, it's not just a problem in maternity. If we – if you think about some of the things that I've mentioned, the incident and risk reporting across the Trust probably wasn't as robust as it should be. Governance systems weren't as robust as they should be, and they had evolved and developed and been put in place for maternity. And we potentially would have had a very robust maternity service, and particularly within my division, a weaker paediatric part. So I wanted that to make sure that we're up-to-date with

guidelines for paediatrics in the emergency department, get the right number of staffing in place and things like that. So it's – I think governance and maternity is stronger, or had been stronger – I think it's probably about equal now, but has in the past been stronger in maternity than paediatrics following on from – certainly about 2011/2012.

PROF WALKER: One of the things highlighted in the Central Manchester Report, and other reports, is that the access to theatres during the day, and particularly out of hours. Is that something which is still highlighted as something you need to tackle?

DR GALT: Right, on the Furness site the maternity unit delivery suite is geographically separate from theatres, and I think, again, presumably this is historic practice that people just become blind to. It seems to be about if you put a frog into boiling water it will jump out immediately, but if you just warm it up gently and keep it there, it won't. And I think it's the same in terms of within an organisation, if everybody thinks that things are acceptable and it seems that nothing else is going on around you to be able to say otherwise, what looks like ~~an~~ unacceptable practice to people coming in from outside becomes the norm.

So women being pushed from delivery suite up the main corridor to the theatre suite for an emergency section seemed to be normal practice. As it is at the moment, we still have the geographical separation of the theatres. There is a private, or more private cut through, so that women can be pushed through the medical assessment unit. There's some curtains which go across the main corridor in the hospital, and the lady can get wheeled down to theatre that way, so it's still geographically separate.

The CQC, I think, initially suggested making some changes to that, which there were architect plans drawn up for two theatres to be built within the spaces between the delivery suite. That is one solution. That wasn't put in place because of the Better Care Together service reorganisation, so going to be one hospital/two hospitals question. And I think it was felt it wouldn't be good use of public money, but it wasn't up to me to decide this, I suppose. But I don't think it was felt to be good use of public money to build £6 million's worth of theatres and then two or three years down the line say, 'Actually, we don't need those anymore.'

Our estates manager at the moment is again a new person who's come into the organisation and has identified that if we move around the wards so that the gynaecology ward is moved out of its current location on Ward 1, paediatrics moves across onto Ward 1, and delivery suite goes where paediatrics is at the moment, there's a route through the end of the paediatric ward directly into theatres. That's a – certainly less disruptive in terms of the building structure, but probably not any more – I think the whole estate redesign that's possibly being thought of at the moment is about £15 million's worth, but it also includes a revamped acute floor as well.

So I think once Better Care Together has determined what the commissioners would like for their services, if there is capital funding available then there will be that jiggling around of the wards so that you don't have that – the same route as previously.

PROF WALKER: So I can understand this problem, or configuration everyone calls it nowadays around the configuration. But you do have a situation where you have something flagged up as being a problem or a concern over four years ago, and it's still not being resolved. Is that something that concerns you?

DR GALT: Well, my gut instinct is yes, but I think it's based on is the solution that we have in place now an appropriate mitigation compared to what was in place previously? And I suppose we need that – I suppose the executive team on the Board should have made that decision as to whether to put those theatres in place and say, 'Let's build that £6 million regardless of what the future is for the services in Furness,' or I think people have felt that the solution which is in place is acceptable until such point that that – the configuration is determined, and that's the stakes in the ground that the commissioners have put in mean that they would like to maintain obstetric services at Furness General Hospital, and that should enable us to be able to say, 'Right, let's get this sorted now.'

PROF WALKER: Okay, thank you.

DR KIRKUP: Jacqui?

MS FEATHERSTONE: Just a couple of things I wanted just to – what was the relationship with the midwives and the paediatricians? Is there a good relationship?

DR GALT: I don't think – it's not a bad relationship, but I suppose historically there's not been – I suppose it probably relates to people historically working in little

silos, so the paediatricians, as far as I'm aware, haven't had a nasty relationship with the midwives. The opportunities to meet would generally be at mortality or morbidity reviews, or during day-to-day working, going onto the postnatal ward, doing baby checks and going into the theatre as an emergency.

I think we're working much more cohesively now compared to previously, but if I were to think about how easy it is for midwives or nursing staff in general to have free time to attend training events, for example, if you're short staffed and needing to run the units, you will tend to put your nursing staff onto the unit, and if that means that there's not a lot of opportunity to get to training days, first of all, that diminishes their training, but it also prevents that interaction with medical colleagues.

The expectation, or certainly at the moment we have – the acute midwife numbers are such that we're meeting midwife to birth ratios at 28:1. We need to have more community midwives in place, and that's recruitment that's going on at the moment, there's a recruitment drive going on at the moment. And once you have the right number of nurses you should be able to expect that there'll be sufficient around to be able to enhance that relationship.

MS FEATHERSTONE: Does the rota for the paediatrics allow them for a paediatrician to be on the postnatal ward every single day to do postnatal, or are they doing something as well?

DR GALT: Which site?

MS FEATHERSTONE: Barrow.

DR GALT: Barrow, okay. So the – we don't have an expectation at the moment that midwives will do the postnatal checks, so a paediatrician does those every day. I suppose the responsibility generally will come down to the GP trainee, the junior doctor tier once they've been adequately trained at the start of their rotation, but the consultant staff would be available to assess babies where there were concerns. So that probably doesn't mean that they'd go on to the postnatal ward every single day unless they've made that part of their routine habit.

MS FEATHERSTONE: Okay, thank you.

DR KIRKUP: Okay, I've just got one, but it potentially involves information which could be clinically confidential, so we'll just have a brief pause while we ask the observers to leave the room, please.

DR GALT: Okay.

[*Observers leave*]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 12th November 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth - Expert Adviser on Paediatrics
Mr Julian Brooks - Expert Adviser on Governance
Dr Catherine Calderwood - Expert Adviser on Obstetrics

SAEED GHANIM

Transcript produced by Ubiqus
7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

(At 11.44 a.m.)

DR KIRKUP: Thank you for coming. My name is Bill Kirkup. I will ask my colleagues to introduce themselves to you.

DR CALDERWOOD: Catherine Calderwood. I am an obstetrician and gynaecologist in Edinburgh, and I am Medical Advisor to Scottish Government and National Clinical Director for Maternity and Women's Health for NHS England.

PROF FORSYTH: Stewart Forsyth, paediatrician and medical director from Dundee.

MR BROOKES: And I am Julian Brookes. I am currently Deputy Chief Operating Officer for Public Health England, but was previously Head of Clinical Quality at the Department of Health.

DR KIRKUP: You will see that we are recording proceedings and we will produce an agreed record at the end. You may also know that families are able to attend as observers, but as it happens we don't have any here today. But they may listen to the recording subsequently. However, there will be a second part of the interview where we can discuss any clinically confidential matters, which people won't be able to listen to or subsequently access. You'll also know we have asked you to hand in any mobile telephones or recording devices. We don't want anything to go outside the room until we are ready to produce the report with all the findings in context. Do you have any questions for me about the process?

DR GHANIM: No, thank you.

DR KIRKUP: Okay. I am going to start with a very general question then and then handover to colleagues. My question is can you explain when you started working at the Trust and what you have done there?

DR GHANIM: I started in December 2005. Previously, I was consultant in Scotland since 2000. And I moved on 12 December 2005 to Barrow. And I've been working there as Consultant Paediatrician until my retirement in April 2014.

DR KIRKUP: Okay. And you retired then, so you are not practising now?

DR GHANIM: No.

DR KIRKUP: Okay. That's great. Thank you. I will hand you over to Stewart.

PROF FORSYTH: Thank you. Can you give us more details of your previous employment? When did you first come to the United Kingdom?

DR GHANIM: I came in 1982.

PROF FORSYTH: 19 –?

DR GHANIM: 82. And I passed ~~practice~~ PLAB test in that year and I got paediatric job in Joyce Green Hospital in Dartford in Kent.

PROF FORSYTH: And your main training was where as a registrar?

DR GHANIM: I had in Iraq. I was a graduate from Iraq and I graduated '73, so worked before coming to the UK. I worked for –

PROF FORSYTH: So did you train in a specialist area?

DR GHANIM: I was already a paediatric registrar.

PROF FORSYTH: But within paediatrics did you have a special interest?

DR GHANIM: Before coming to the UK in '82 you mean?

PROF FORSYTH: No, sorry. In your paediatric training did you specialise in an aspect of paediatrics, whether it was gastroenterology or diabetes?

DR GHANIM: No. General paediatrician.

PROF FORSYTH: You're in general paediatrics. So when you took up the post in Barrow you were based in Barrow. You have always been based in Barrow have you?

DR GHANIM: Yes.

PROF FORSYTH: So your job then, although you are now retired, was general paediatrics?

DR GHANIM: Yes.

PROF FORSYTH: How much training had you had in neonatology?

DR GHANIM: When I came and I got my membership and went back to Iraq and then came back again in '95. So I came as a staff grade paediatrician in Oldham and I was almost running the day-to-day neonatal unit in Oldham.

PROF FORSYTH: Okay. So can you give me just a rough outline of what your weeks – your job description for during a week would be what you did in terms of clinics, ward work, and on call?

DR GHANIM: In Barrow?

PROF FORSYTH: In Barrow.

DR GHANIM: We were four consultants so we are on call one in four. Or according to BMA because we have prospective cover we are 1 in 3.2 if you like. And I have Monday afternoon clinic. I have Wednesday morning –

PROF FORSYTH: What kind of clinic was that? A general paediatric clinic?

DR GHANIM: I have general clinic usually three weeks and then an asthma clinic, which is my interest.

PROF FORSYTH: Sorry. Which clinic?

DR GHANIM: Asthma. So that is once a month. And I got a clinic on Wednesday morning, which is general clinic as well. And Wednesday afternoon which is a enuretic clinic, which is part of the community work.

PROF FORSYTH: An enuretic clinic?

DR GHANIM: Yes. And since 2010 I started doing also a Thursday morning clinic, which is community clinic but in Barrow.

PROF FORSYTH: What happened in terms of specialist clinics in Barrow? Were there specialist clinics? I mean you say you did an asthma clinic but was there an asthma specialist that came to Barrow and did clinics as well?

DR GHANIM: When I was in Scotland I used to go to Aberdeen to [inaudible].

PROF FORSYTH: Were you in Aberdeen?

DR GHANIM: No. I was in Elgin but I – I was in Elgin.

DR CALDERWOOD: Elgin.

PROF FORSYTH: Elgin. Right. And so I am just trying to get a feel for how you maintained your skills and knowledge. For example, even in asthma, if you were doing an asthma clinic.

DR GHANIM: That is my interest so I built up my interest by also interacting with the consultants in Aberdeen as well. It is five years I was doing the asthma clinic for Professor ~~[inaudible]~~Helms, who is one of the –

PROF FORSYTH: But about your skills and knowledge in neonatology? Because clearly when you are on call, one in four or one in three, you were covering the special care baby unit.

DR GHANIM: Oldham is my main area where I did a lot of work in neonatology because basically I was running the unit– I was more doing the day-to-day ward rounds and all the care, mainly in the special care baby unit. So during the daytime I am almost in charge of the unit. I was staff grade but I was running the unit. And it is a level 2 unit at the time.

PROF FORSYTH: But in Barrow – You have been in Barrow for how many years?

DR GHANIM: 2005. Nine years.

PROF FORSYTH: Nine years. So during that time I am just wondering how you felt you maintained good skills in neonatology if you were coving – even as a level one unit that is still – You were obviously having to look after some sick babies at birth. I just wondered how you maintained these skills.

DR GHANIM: That is the system we had at the time. I mean we are not, although we are part of a bigger organisation there is not much interaction with, for example, Lancaster or a tertiary unit.

PROF FORSYTH: There is not much –

DR GHANIM: Not much.

PROF FORSYTH: Why is that?

DR GHANIM: Well, I mean historical. I think there are – And practical as well, because of the distance. So we are only four in Barrow, so –

PROF FORSYTH: So did you feel comfortable with the on call for neonatology when you were on call?

DR GHANIM: Yes. I am confident. When you develop skills you don't lose them. But obviously you need to maintain and update your skills. And I'm very good with – updating my knowledge

PROF FORSYTH: Did you do that?

DR GHANIM: – attending my CPD and that. But hands-on that basically is the work we were doing in Barrow.

PROF FORSYTH: Was ~~their~~ there one of the paediatricians in Barrow who took special interest in looking after the special care baby unit?

DR GHANIM: Yes.

PROF FORSYTH: Who was that?

DR GHANIM: Dr Ward.

PROF FORSYTH: Who?

DR GHANIM: Dr Ward.

PROF FORSYTH: Who looks after the special care baby unit now? You left in 20 –?

DR GHANIM: 2014, yes.

PROF FORSYTH: So Dr Ward is still going that is he?

DR GHANIM: I don't know. As far as I know – Sorry. I think he left the Trust.

PROF FORSYTH: So you don't know who is looking after the special care baby unit?

DR GHANIM: I have no idea. No.

PROF FORSYTH: What about your relationship with the obstetricians? Did you work well as a team, the paediatricians the obstetricians?

DR GHANIM: I can't help but compare with when I used to be in Scotland because it is very similar setup we are four or three with a locum there, so it is almost

the same set up. But when I was in Scotland there was a lot of interaction with the obstetricians and they would readily discuss issues with you. But in Barrow I haven't had anybody talk to me for the whole nine years, obstetricians, about a serious case or whatever.

PROF FORSYTH: You haven't talked to them?

DR GHANIM: Well, I mean if they have a pregnant woman they should tell me if I anticipate any problems. So there is very little contact with them. There is a perinatal meeting.

PROF FORSYTH: How often do you have perinatal meetings?

DR GHANIM: It is once every two months.

PROF FORSYTH: And do people attend? Do the consultants attend?

DR GHANIM: I don't know. I mean I can't name names. I mean there are only a few obstetricians who attend to be honest, regularly. And there are some people you can tell they are not interested to attend. They just come for just five minutes sign there name is there and that is it. I am not [redacted] actually, I took over the perinatal meetings and I tried to develop it into a little bit more. It is one hour every two months. There is never enough to interact with people, to see midwives and build up teamwork and the relationship. So many obstetricians say, "We are busy." And I am sure they are busy but –

PROF FORSYTH: So do you think patients were put at risk because of that?

DR GHANIM: I think this is not something that – Perinatal meeting, we should discuss all – They should know what we are doing and we should know what they are doing. We all work for a common purpose, to produce a healthy baby. So I find it very unsatisfactory, the set up.

PROF FORSYTH: So why was that not resolved? I mean you are all consultants. You are all paid large salaries to deliver good quality care. Why was this situation allowed to continue?

DR GHANIM: Well, I mean basically I would say there is poor leadership.

PROF FORSYTH: Do the consultants themselves not feel they have a leadership role?

DR GHANIM: They do. We do. We raise our voice. In the seniors meeting we talk about these issues and many other governance issues, but nobody listened.

PROF FORSYTH: Who is nobody? Who did you take the issues to?

DR GHANIM: Well, I mean I have written to the Chief Executive, Ian Cumming, in 2006, six months after I started the job. I have also written –

PROF FORSYTH: So what did you say in that correspondence?

DR GHANIM: I identified four or five issues regarding the learning culture, the leadership, and the clinical governance issues that I was worried about, and the team work.

PROF FORSYTH: Did you get a reply?

DR GHANIM: No. I got the letter in reply from Ian Cumming to say, "Thank you for your letter. I now pass it to Peter Dyer, the Clinical and Medical Director, and I am sure he will get in touch with you soon." Never heard from him.

PROF FORSYTH: Do we have a copy of that letter?

INVESTIGATION SECRETARY: No, but maybe I can take a photocopy after.

PROF FORSYTH: At the end, maybe if you could leave us a copy of that letter that would be helpful. Would that be okay? What about – Were you speaking on behalf of all your paediatric colleagues or was this just your opinion?

DR GHANIM: What do you mean, sorry?

PROF FORSYTH: When you were writing to – was it the Chief Executive at that time?

DR GHANIM: Yes.

DR KIRKUP: Ian Cumming.

PROF FORSYTH: Ian Cumming, yes. Were you sending the views of all your colleagues or was this just your personal view? I am just trying to work out whether the paediatricians were united in this.

DR GHANIM: No. We are not united. We are a dysfunctional team as well. I know what you are getting at. We are a very dysfunctional team but it is poor local leadership as well, you see. And that is the trouble. There are personal agendas and we are not quite united.

PROF FORSYTH: So why dysfunctional? What are the big issues within paediatrics that the consultants are obviously not working together? What divides you? Is it purely personality or do you have differences of professional opinions?

DR GHANIM: I mean part is personality, but that is a small part of it, I think, in my judgement.

PROF FORSYTH: What is the main reason?

DR GHANIM: I think the main reason is that the three consultants they are dissatisfied with the service, the service is not safe. We raise our voices that things are dictated to us from Lancaster without a proper consultation with us. And the local leader or clinical lead just uses these issues for his own agenda. So he is not reflecting our opinion. We have written a letter in July 2009, supposed to be collective letter, to Tony Halsall to raise the issues about governance, about the leadership of Paul Gibson, and to raise all these sort of issues. And I was tasked to do the letter. So I did the letter in a draft form. I got it in a draft form. I don't know whether it was sent or not because we agreed that Paul Gibson is trying to make the issue as people or consultants in Barrow are part of the problem and we are saying you should look into the picture carefully. There are governance issues. There are a lot of problems in Barrow. But, unfortunately, the local lead is using it for his own agenda. I don't know if this passed to him or not.

PROF FORSYTH: So what do you think his agenda is?

DR GHANIM: I don't know. I mean I obviously have to tell you what I feel. I mean the local leader is using it to his own agenda. His agenda is to – He is bragging about that he is being the highest paid paediatrician in the UK. And his intention – not intention, but his – Sorry, I am stuck with the word. You get what I mean. He is trying to keep the status quo just for financial gains, really, basically, for his own gain. And therefore he is not looking at the bigger picture of the governance issues and the other issues. And we are dissatisfied with this and there was an investigation into that, not me complaining. I was the loudest voice in objecting to that but I did not put a formal complaint, but another colleague put a formal complaint about it.

PROF FORSYTH: During your time, has there ever been a strategic plan for paediatrics across the Trust?

DR GHANIM: In 2008, I think – I think 2009. 2009, I think. The Trust commissioned Andy Mitchell, he is a paediatrician from the South with wide experience, to look into the paediatric service. He produced a very good report, but one that did not suit the agenda of – You know they just put it on the shelf. It has very good recommendations if you have read it.

PROF FORSYTH: Can I just go back to the point about having specialisation of paediatrics across the southern part of Cumbria? I mean do you have – if a

child has gastrointestinal problems, do you have a paediatric gastroenterologist doing a clinic at any time in the area?

DR GHANIM: We don't have a paediatric gastroenterologist. We have paediatric neurologist.

PROF FORSYTH: Neurologist?

DR GHANIM: Neurologist. Dr Newton. A ~~neurologist~~ nephrologist as well.

PROF FORSYTH: Is part of your four consultants?

DR GHANIM: Sorry?

PROF FORSYTH: Are they part of the four consultants at Barrow? Are they visiting?

DR GHANIM: No. They are visiting consultants. We have visiting clinics. Richard Newton is the neurologist form Manchester. We have Nick, sorry I forgot his name, for nephrology.

PROF FORSYTH: A visiting consultant in nephrology, right.

DR GHANIM: We have cardiology and we have endocrinology, which I used to liaise with. So that is part of my job, is to liaise with them.

PROF FORSYTH: Cystic fibrosis?

DR GHANIM: Cystic fibrosis, yes there is. But ~~you can [inaudible]. It is not part of the [inaudible]~~ it is shared care. Dr Ward is the local lead. As it happened he has already done it before.

PROF FORSYTH: Who does the neurodisability?

DR GHANIM: Dr ~~[Labe?].~~Olabi.

PROF FORSYTH: Dr ~~Labe~~ Olabi. Alright. So you don't have a visiting neurologist?

DR GHANIM: Sorry?

PROF FORSYTH: You don't have a visiting neurologist?

DR GHANIM: Dr Richard Newton is the visiting neurologist.

PROF FORSYTH: And in terms of neonatology how do – is there a fully trained neonatologist that visits to check that standards have been maintained in Barrow?

DR GHANIM: No

PROF FORSYTH: Why not? Okay. Thanks. I will stop there just now.

DR CALDERWOOD: Thank you. That has been very helpful. As an obstetrician I am interested to hear your comment about no talking to each other. You said that no obstetrician talking to me for nine years.

DR GHANIM: This may be an exaggeration. It is a reflection of the relationship. I mean I can still name the obstetricians in Elgin. I can still name the obstetricians, obviously, in Barrow, but that is not the point. What I am trying to make is that we were in constant contact. I can name names that, for example, Vincent Bamigboye, whom you interviewed earlier, I can say he is the only obstetrician whom you see in the perinatal meeting, for example. He comes from start to finish and he also talks to you in the corridor and if there is any patient problem. He is the only one I would say and also Dr Veena Sharan who retired in 2010..

DR CALDERWOOD: So you wouldn't have had warning about women that they were worried about? There wasn't any kind of communication you might expect a baby incoming or that there was a woman they were delivering?

DR GHANIM: Exactly. That is what I am trying to say. There was no such a thing, as if it is not their job.

DR CALDERWOOD: And when there was a problem then on the labour ward was there good communication to get hold of the paediatrician by the person on call or the person with the correct expertise? Did that communication happen?

DR GHANIM: Can you ask the question once more?

DR CALDERWOOD: When there was a problem on labour ward and they needed a paediatrician did they communicate then in a timely way? Did they call you in advance?

DR GHANIM: Who did?

DR CALDERWOOD: The obstetricians or the midwives.

DR GHANIM: No. The obstetricians, except with Vincent Bamigboye, no body ever rang me in the home in nine years.

DR CALDERWOOD: And if it was an emergency situation did they?

DR GHANIM: They don't. I mean we are talking about an emergency of course, yes.

DR CALDERWOOD: Emergencies they wouldn't phone you? Who did they phone? The junior? So there wasn't – There would have been people being bleeped but there wouldn't have been a call to the consultant directly?

DR GHANIM: Sorry, say that –again?

DR CALDERWOOD: You would have been being bleeped, I suppose, using the bleeps, the on call team? You are saying that nobody would have phone the consultant directly if there was problem.

DR GHANIM: I don't get the question.

DR CALDERWOOD: So there would have been an emergency bleep in an emergency?

DR GHANIM: For the paediatricians, yes.

DR CALDERWOOD: But no one would have called the consultant to get you to come?

DR GHANIM: No. Sorry. I may misunderstand the question. I mean mostly we are alerted to an obstetric problem on labour ward by either the neonatal nurse on the special care baby unit or by the junior doctor or middle grade doctor, paediatrics. But we were not informed by any of the team in obstetrics.

DR CALDERWOOD: And was that different to what you were used to in Elgin?

DR GHANIM: Yes.

DR CALDERWOOD: You said in part of your statement to Professor Forsyth that you felt service wasn't safe. Can you give me some specific examples of where you felt it wasn't safe?

DR GHANIM: Well, there are many aspects to this: first of all, the lack of interaction with bigger units, the number of consultants on the rota, the interaction with the obstetricians, the lack of team work. All these issues and maybe others that don't come to my mind now.

DR CALDERWOOD: Did you feel – It is a small unit and emergencies would have happened relatively rarely, did you feel that –

DR GHANIM: That is part of the problem, yes.

DR CALDERWOOD: – did you feel you were equipped to deal with a very sick baby, perhaps pre-term or very unwell baby in the neonatal unit?

DR GHANIM: I mean, you see, I know where you are coming from, but we are a very small place, whatever experience we gain before we can, no matter how small the number is, it is maybe enough to keep us going in terms of hands-on experience and doing the job. And that is why I personally – and part of my arguments within the department and that's the same thing that I had when I was in Elgin, because we had the same challenges there, is that we need a number of consultant paediatricians, more number, and more maybe

junior doctors or trained neonatal nurses. We have to invest in nurses as well. The middle grade – because this would dilute your experience. I was middle grade myself. I was doing most of the work. We are a small unit. It is not fair on us or on the children or on the families because we are going to be deskilled and lose experience. So I was a little bit reluctant about middle grade. I was always in favour of having enough numbers of consultants, enough numbers of junior doctors, and train the neonatal nurses to be specialist nurse practitioners. I was in favour of upgrading the middle grades to associate specialist to share the on-call rota with consultants.

DR CALDERWOOD: And were you supported in that idea?

DR GHANIM: Well, that idea was taken up by Owen Galt when he came and presented and this. He said we needed ten consultants, maybe. And we trained nurses for neonatal nurse practitioners. But I said this needs time so you have to start now. And they kept on dragging it. So on paper it was a good idea. In practice nobody had done anything about. Sorry, that is not fair, maybe. The number of consultants has increased substantially recently.

DR CALDERWOOD: And do you think that then has improved the safety?

DR GHANIM: I haven't been practicing for a while so I don't know.

DR CALDERWOOD: In the February of this year? You were still there in the February of this year. January, February. Just before you retired?

DR GHANIM: I cannot comment. I don't know.

DR CALDERWOOD: I think I am hearing from you that you would worry more consultants make the skills diluted perhaps less, you are going to have less cases.

DR GHANIM: That's the problem in a small unit. There is a balance. Are you going to be too stretched, too tired? If you ~~[inaudible]~~have less people obviously you have more work. But at the same time you ~~have~~ work long hours It is risky because you are tired as well. You are doing two [inaudible] on call. If there is more consultants – What I am trying to say is that to have more consultants and more middle grade is not in a very small place is not going to sustain the service.

DR CALDERWOOD: And you were involved in at least one case that was high profile, had a lot of media attention, what I was wanting to you. What I was

wanting from you – or should we maybe leave to the end question about specific –?

DR KIRKUP: I think it is probably to do in one go in the confidential bit.

DR CALDERWOOD: We will leave that until the end. When you wrote the letter of concern and you were saying there was some six months after you started and then, again, in 2009, and then Andy Mitchell's report you said was very good with good recommendations. Do you feel that those were taken seriously?

DR GHANIM: No.

DR CALDERWOOD: Did something happen after these recommendations?

DR GHANIM: No. Sorry. For record I am shaking my head but I say no.

DR CALDERWOOD: And what did you and your colleagues then feel? You had the report from Andy Mitchell, what did you do when nothing happened?

DR GHANIM: I have to tell you I am very dissatisfied with ~~the~~ that – I have to tell you a little bit about how we were meeting. We had weekly seniors' meeting attended by Paul Gibson, so Paul Gibson comes from Lancaster to Barrow almost every week, which is on Thursday. And Owen took over he said we need to discuss the set up of these meetings. And I told ~~him~~ Paul Gibson in these words, "Look, you are not doing anything. You are just getting travel expenses. This is not the right thing. You are not addressing the governance issue." Dr Ward also has written an email to that effect, a very strong one to say, "Look, we are talking about action plans and theoretical things. We need something done here. It is serious." So I told ~~him~~Paul, "We don't need you in this case. If you don't do the thing, if you don't address the issues there is no point in coming here. We can have our own meetings because we have lots of problems here. And then you can come every now and then to pick up to see how you solve it." But it was minuted in the seniors' meeting but that was rejected so he thinks that he is useful in coming to Barrow. But I didn't see any use of him coming. But Owen was just the opposite he very rarely come to our meetings despite we having lots of problems and myself and Dr Ward would like him to come.

DR CALDERWOOD: And what actually happened though in the end? You are saying he came and had meetings, but what action then came out of those meetings?

DR GHANIM: No action. Just waffle. There is nothing.

DR CALDERWOOD: So the recommendations in Andy Mitchell's report were not followed?

DR GHANIM: No.

DR CALDERWOOD: And were there any changes?

DR GHANIM: People in these sorts of positions they can put on paper things that they did this and they done that. I have not a good memory. They said we have to take a serious ~~—You have to do~~ look – But in practice nothing happens.

DR CALDERWOOD: You didn't feel the unit changed, there were changes within the unit?

DR GHANIM: No. They changed for the worse, because I and Dr Ward were always insisting that we are a very small unit. We need more admissions. First, for the midwives to understand the these issues, the things that they tried to keep on the post-natal ward, these issues although small but in order for the midwives to appreciate that these can be serious – You know, you have low blood sugar, you have low temperature, this can be not very serious but it can be very, very serious. So they want just to keep the number less on special care. That is the objective, basically. It's to downgrade the unit rather than think about the patient safety. So suddenly we find that these are not admitted, and it is all dictated by the management, by Lancaster, basically.

DR CALDERWOOD: And what was the relationship between the nurses and the midwives on the neonatal unit?

DR GHANIM: We don't get involved. It is not good. But I have no really direct knowledge of conflict. We do when we go to the perinatal meeting. Unfortunately, because there is only one neonatal nurse so they don't attend the perinatal meeting so we don't see if there is any problem – some midwives do attend to perinatal meeting.

DR CALDERWOOD: And when you were called to the postnatal ward or to the neonatal unit did you and your colleagues attend? Did you feel that – Would the nursing staff, the midwifery staff feel they were well supported by the paediatricians?

DR GHANIM: I personally once they ask me to attend I do. I take my time to actually have a thank you email from parents about the care that we provide.

DR CALDERWOOD: And your colleagues?

DR GHANIM: I think they do. Of course they do.

DR CALDERWOOD: They do?

DR GHANIM: I think.

DR CALDERWOOD: Okay. Thank you.

DR KIRKUP: Thanks. Julian?

MR BROOKES: Thank you. I'd just like to ask some questions about governance. First of all, you've raised on a couple of occasions in what you've been saying that there were concerns about the governance. I am still not clear what those concerns were precisely. If you had written to two separate chief executives with concerns about clinical governance within the unit what were those specific clinical governance concerns?

DR GHANIM: These were first, basically, the culture in the department. There is no culture of learning. There is poor leadership. The number of staff is very stretched, especially senior staff and nursing staff as well. So these are the main issues I raised. And there is also friction and no cohesion in the team.

MR BROOKES: Okay. So on the leadership side, what was the structure in terms of leadership for you? Who did you report to? Who were you accountable to?

DR GHANIM: Well, locally, we have a local lead.

MR BROOKES: Who was?

DR GHANIM: Name?

MR BROOKES: Yes.

DR GHANIM: Dr ~~Labe~~ Olabi.

MR BROOKES: And who did they report to?

DR GHANIM: I think Dr Paul Gibson first and then Owen Galt.

MR BROOKES: So we reported to the Clinical Director?

DR GHANIM: Yes.

MR BROOKES: And then through the Clinical Director to the board?

DR GHANIM: That is the structure I would assume.

MR BROOKES: But you are not certain?

DR GHANIM: I am not certain because there are so many changes. Every five months there is a new structure. We had the family division, then we were

put in a division with the surgical department as well. So there are so many changes and you get lost with these sorts of changes.

MR BROOKES: So if there was a serious incident or a serious concern about treatment of a patient how would you report that? How would you act that?

DR GHANIM: I think probably I would say I was – I am not sure about, it maybe unfair that. But I think I personally am the most ~~personal~~ paediatrician to raise concerns in terms of writing. It used to be called, I think, incident report.

MR BROOKES: Serious untoward incident.

DR GHANIM: Not serious but patient incident report.

MR BROOKES: If you had one who would that go to? How did the system work that you were working with?

DR GHANIM: Well, if you have feedback you know who goes to, but you write it and you don't have a feedback so you don't know who is dealing with it and what is done about.

MR BROOKES: Who did you send it to? Who would you send it to?

DR GHANIM: It changed. The incident reporting has changed. So I had paper incident reporting, which I have couple that actually I have here, but I tried to remember – So later it was electronic so you can do it electronic.

MR BROOKES: Were you clear on who you should be working with to resolve these kinds of issue? Was there systems in place? Were there protocols about how you should work?

DR GHANIM: Well, one of the incidents I reported and I reported and then I had a letter from Peter Dyer to say, "Can you ~~so~~ do the investigation for it?" And I did. And I put my own recommendations about what the solution, ~~I think,~~ should be. And it was an incident that I have here in my folder about – because you are in a small hospital and cannot have a radiologist on call out of hours – we don't have any radiologist with paediatric interest. So we need access to a specialist opinion and I recommended that we should have a link, either via email or by the PACS system, which we had, for the radiology for transmitting – I am sorry, I am not technical, but it is transmitting images.

MR BROOKES: I understand.

DR GHANIM: So I put this, actually, that my recommendation, my suggestion, in 2006. The Trust only implemented this in February 2014. They commissioned a service with Alder Hey to view images.

MR BROOKES: Okay. So I can understand your frustration. But you are part of a clinical division and you are part of a single trust, which includes Lancaster but is not just Lancaster, it is yourselves as well. I'm surprised that you felt it was unacceptable that the Clinical Director should come down and spend time at one of the hospitals within that trust.

DR GHANIM: I'm not surprised at all.

MR BROOKES: I'm surprised you think that is not acceptable

DR GHANIM: I'm sorry. I maybe misunderstood. I am saying that he is coming for ~~paperwork~~ paper exercise. He is not addressing the concerns that we are raising. That is what I am trying to say.

MR BROOKES: But isn't it important that he spends time there to understand your services, understand how you operate?

DR GHANIM: But he doesn't understand, you see. That is the problem. He was coming and attending meetings. He doesn't know about the staff. He doesn't know much about the staff.

DR KIRKUP: I was going to ask this at some point but now seems like the right time. But didn't he want to attend ward rounds? Didn't he want to come on clinical sessions?

DR GHANIM: No. Alright, well, I know he must have said that. I recall this. When we started he asked me if he can ~~schedule~~ shaddow me in a ward round. I said no because – You see, because you have to think about the culture. Barrow is always there are locums. The nursing staff basically they look down at any newcomer and don't want to start this way, as if I am second-class consultant coming there. So I didn't feel that's appropriate. That's true.

MR BROOKES: You are commenting that he didn't ~~now~~ know the staff yet you are not letting him find out about people. You are not letting him understand how you work. You are refusing to cooperate.

DR GHANIM: No. That is not correct.

MR BROOKES: That is what you are saying.

DR GHANIM: No. That's not correct. We can sit in a clinic, as I was doing when I was in Elgin. That's fine. It's different from – As I said, the set up is there. Let me tell you to start with, when I started or before I started in Barrow I applied for an acute paediatrics course because I hadn't been on such a course and it is acute paediatric emergencies and things like that and I felt

that it is important in a district hospital to update your knowledge and he rejected it. So it is not a good start. To be honest I wasn't going to come to Barrow because of that. Because I thought that is not a good start. But for family reasons and things like that I came. So it depends. It depends on how your feel personally. He could have attended our daily handover meetings in the morning which is a better way of learning about the quality of service we provide.

I used to work with Professor ~~[inaudible]~~Helms. Treats me as a equal. I sit with him. I do the clinic. No problem. You have to think about the person in front of you and I didn't think it is appropriate of him. I tell you what, he doesn't know, for example, when I was asking for appraisal and job plan for over three years, and eventually – I started in 2005 – I had my first appraisal session with him in 2009. And I told him that in the appraisal, as you know we have to show the thank you cards and things like that, and I told him that I have thank you from Liverpool University for being nominated by the students for teaching. And he didn't know that. So how – This letter was sent by Liverpool University to Peter Dyer and he sent me the letter to say that it is sent to the relevant department.

MR BROOKES: So in your view was the clinical management of your division appropriate? Did it work well?

DR GHANIM: Say that again.

MR BROOKES: The clinical management of your division, did it work well?

DR GHANIM: No.

MR BROOKES: So what was wrong with it?

DR GHANIM: They are detached. I mean there are historical problems. ~~Barrow~~ Lancaster thinks of themselves as a parent unit so there are historical clashes. But also there is a problem with leadership. There is problem with vision, strategy. There is a problem on every front. We raised concerns and that is not addressed and you get frustrated. But on the other hand he doesn't – Okay. We have problem, for example, with the rota. We tried to solve it within our department. We didn't solve it. So [inaudible]. We copied the email trail to him. He came to me one day and said, "On your CV in Scotland and before you were the rota master and things like that. Can you do the rota?" So I said, "Of course I will do it. But you have to speak to Dr

~~Labe~~ Olabi first, I don't want more conflicts. So speak to him. I am more than happy to do it." So if you are a leader you should – and if you know that is the right thing to do then you have to do it. It is not – So I don't know what excuses Dr Labe gave him. And then I never heard about it from –him again.

MR BROOKES: Okay. If I can change this slightly, I would like to understand a little bit about the structure in which you worked, the governance which you worked within. Was there clear protocols about the way in which you operated? Were they agreed across trust or did you agree them within Barrow for the particular purposes of your unit?

DR GHANIM: There were – First of all, the culture of audit and things like that is almost non-existent. I mean I tried to do – There is no – There is very little, and it is only when it is forced on them by CQC and they started to do the things. ~~And~~ then we have a list of the –audits to be performed as a priority in 2013?

MR BROOKES: I was going to come onto audit.

DR GHANIM: So what was the other subject? Sorry.

MR BROOKES: For example, was there a clear understanding about clinical guidelines, transfers of children to other units, the way in which you operated as a unit? How did you operate? Was there an agreed understanding about how you operated as an organisation?

DR GHANIM: We used to be a part of the consortium for guidelines and there is a booklet. And then we had then Dr Asghar was tasked with doing the guidelines. But they are not comprehensive.

MR BROOKES: Were the guidelines used?

DR GHANIM: What do you mean, exactly?

MR BROOKES: Did you follow the guidelines? Were those guidelines used?

DR GHANIM: Yes. Guidelines are there to guide you.

MR BROOKES: Did audit compliance to those guidelines?

DR GHANIM: Sorry?

MR BROOKES: Did you audit compliance to those guidelines?

DR GHANIM: No.

MR BROOKES: So how do you know they were being followed?

DR GHANIM: Well, that's for the department.

MR BROOKES: But were you following them?

DR GHANIM: Yes.
MR BROOKES: Were your colleagues following them?
DR GHANIM: I think so.
MR BROOKES: But you don't know?
DR GHANIM: Sorry?
MR BROOKES: But you can't be sure?
DR GHANIM: I ~~have~~ know an instance where these guidelines were not followed for example. The guidelines changed, for example, 2010 with regard to keeping oncology patients. And I have an instance where this is not followed.
MR BROOKES: Thank you.
DR KIRKUP: I just want to pick up a couple of points from you've said and then we will move onto the second part of the interview. But just before we do that I just want to be clear about your career previous to coming to Barrow. What was the post you were working in at Elgin?
DR GHANIM: Sorry? What was the post?
DR KIRKUP: What was the post?
DR GHANIM: In Elgin?
DR KIRKUP: Yes.
DR GHANIM: Consultant paediatrician.
DR KIRKUP: So you moved from a consultant job in Elgin to a consultant job in Barrow?
DR GHANIM: Correct.
DR KIRKUP: Can you explain the reasoning behind that?
DR GHANIM: It is basically for the family reasons I just alluded to initially. I have friends and relatives around the Manchester area and the Northwest.
DR KIRKUP: So if we were to follow up with Elgin we wouldn't find that were any clinical problems in Elgin that prompted you to leave?
DR GHANIM: No.
DR KIRKUP: Okay. You said that there needed to be more admissions in Barrow so that midwives would understand the implications of some of the things they were doing within the post-natal ward, but that management were trying to reduce the number of admissions. Can you explain to me what sort of admissions they were trying to reduce?

DR GHANIM: These are like the ones – I just said like a child with hypoglycemia or they check – So they keep –

DR KIRKUP: I understand. But you said they were trying to reduce the number of admissions in Barrow. You suggested that they were trying to run the unit down.

DR GHANIM: Yes.

DR KIRKUP: What kind of admissions are they trying to stop?

DR GHANIM: These kind of admissions.

DR KIRKUP: But hypoglycaemia would be something you picked up after delivery in the ward, wouldn't it? How could you stop that as an admission?

DR GHANIM: No. Not on the ward. They usually go – I mean these are usually picked up in the post-natal ward, not on the special care baby unit. But if it is picked up on the post-natal ward I was of the view that these cases should move on to the special care baby unit.

DR KIRKUP: Right. And management were trying to stop you moving them to the special care baby unit?

DR GHANIM: Yes.

DR KIRKUP: Right. I see. Management, who? Management is a very amorphous term. Who, specifically, was trying to?

DR GHANIM: I can't say. I mean, basically, the loudest voice would be [Lynn Shannon?], but I think as a neo-natal matron Angie Whitaker was of this kind of view.

DR KIRKUP: Right. Okay. How would that interfere with the midwives ability to recognise the significance of these things? You have lost me a bit there.

DR GHANIM: If the midwives – If keeping it on post-natal ward, first, the midwives are very stretched. We know that very well. And if you keep it you ~~aren't realising~~are trivializing the problem, if you see what I mean, because you are saying that this is not an issue that needs special care.

DR KIRKUP: Okay. I understand.

DR GHANIM: Sorry. Am I clear now?

DR KIRKUP: Yes. I understand that. Thank you. The last one in this section from me. I am going to go back to this disagreement that you had with Dr Gibson about coming on ward rounds. Can I ask who you took that up with? You weren't happy with this idea of his. Who did you take that up with?

DR GHANIM: I don't understand the question.
DR KIRKUP: He said he would like to go on ward rounds.
DR GHANIM: He asked me, "Would you like?" I said no.
DR KIRKUP: You said no to him. Did you say it to anybody else?
DR GHANIM: No, I didn't.
DR KIRKUP: Okay. Were you aware that there were any complaints about the way that he was behaving?
DR GHANIM: I understand there was problems between Dr Gibson and ~~[Anda Salavi?]~~ Dr Olabi as well. But this is second-hand information.
DR KIRKUP: You weren't aware that personally?
DR GHANIM: Sorry?
DR KIRKUP: You weren't aware of any actions as a result of that personally?
DR GHANIM: There were actions by Paul Gibson against that person, yes.
DR KIRKUP: No. Against Paul Gibson. Any complaints about him?
DR GHANIM: From that person you mean?
DR KIRKUP: I don't know who from. That's what I am asking. Let me be more clear then. Were they from you? Did you complain about his behaviour?
DR GHANIM: I did. As I said, initially, I wrote to Ian Cumming about it. Is that what you mean? I wrote to Ian Cumming.
DR KIRKUP: About Dr Gibson?
DR GHANIM: About Dr Gibson, yes.
DR KIRKUP: I see. Right. I thought that when you initially described writing to Ian Cumming you were talking about concerns about safety and dysfunctional teams and so on. That was how you described it first.
DR GHANIM: No. With Ian Cumming we had a meeting about the safety, but I don't remember when. So we had a big meeting and Paul Gibson, I think, was there.
DR KIRKUP: You said that you had written into Ian Cumming six months into the job in 2006 about four or five issue, including the lack of learning culture, lack of leadership and clinical governance. Is that the same letter that we are talking about or were there two?
DR GHANIM: Yes. That was on 7 August 2006.

DR KIRKUP: Okay. We need to have sight of the letter, I think. But in that letter, perhaps you can tell me now to help me out at the moment, did you raise complaints about Dr Gibson's behaviour?

DR GHANIM: Yes. I did. But I have written again in June 2009 to Tony Halsall.

DR KIRKUP: Okay. That is clear. Thank you. Does anybody else want to ask anything at this stage? Shall we move into the second part of the interview then? We'll have a brief pause while we ask people to – This is where we can talk about clinically confidential information.

DR GHANIM: Can I go to the toilet?

DR KIRKUP: Sorry? Yes, of course. Sorry. I didn't hear what you said. Yes, no problem.

(In private session)

THE MORECAMBE BAY INVESTIGATION

Wednesday, 22 October 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics

PAUL GIBSON

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(At 10.21 a.m.)

DR KIRKUP: Hello, my name's Bill Kirkup, I'm chairing the Panel. I'll ask my colleagues to introduce themselves to you.

PROFESSOR FORSYTH: Good morning, my name's Stewart Forsyth, I'm a paediatrician from Dundee.

MR BROOKES: I'm Julian Brookes, I'm currently deputy chief operating officer for Public Health England, but was previously head of clinical quality at the Department of Health.

DR KIRKUP: You'll see that we're recording proceedings; we'll produce an agreed record at the end of that. You may also know that we have open proceedings to family members as observers. As it happens, we don't have any here today. I think we do have some questions about specific cases, and we will put those into a closed confidential session at the end of interview. Until then, the previous part of the recording may be listened to by family members. And you'll know also that we've asked you to hand in any mobile phone, recording device; that's just to emphasise that we don't want anything to go outside the room until we produce the report with the findings in context. Do you have any questions for me about the process?.

MR GIBSON: No, that's very clear, thank you.

DR KIRKUP: Okay, I will start, if I may, with a very general question, which is could you just outline for us when you started at the Trust, what you've done and what's happened since?

MR GIBSON: Right, I might have to check with my CV, but I started in September 1993 as a consultant paediatrician. So I think from the point of view of this – the investigation, so then I was made the first – I think we used the terminology 'clinical director' at that time for a children's directorate, which was the first time we'd had a children's directorate. And...

DR KIRKUP: When would that have been?

MR GIBSON: Can I just check? I'm pretty sure it's 2003.

DR KIRKUP: Yes.

MR GIBSON: And I held that position until approximately 2007. Let's just see. Yes, so 2002 to 2007, and then in 2007, and I think it's relevant actually, then the children's directorate and the women's and gynae directorate were taken into

the surgical directorate. And then from 2007 until 2009 I remained as the head of the children's department inside the enlarged surgical directorate.

In 2010 there was great hopes that we were going to do fantastic things for child health in Cumbria, and I was appointed as the associate medical director for child health for Cumbria, which after a period of time acquired the name health builders, so I was the associate medical director for health builders in Cumbria, which was supposed to be a provider role. That didn't work out, and I occupied a very interesting middle zone until February 2013, and from March 2013 until May 2014 I was a Royal College of Paediatrics volunteer in Sierra Leone. And then I returned and started back as a traditional old school paediatrician based at the Royal Lancaster Infirmary.

DR KIRKUP: Okay, that's very helpful, thank you. I'll hand you over to Stewart.

PROFESSOR FORSYTH: Yes, I think I pick up one or two areas we want to explore a bit further from your introductory comments. When you first started back in 1993, so what was – were you appointed originally to Lancaster?

MR GIBSON: Yes. So at that time we were five trusts, so...

PROFESSOR FORSYTH: There were five trusts then?

MR GIBSON: Yes, so there was a South Cumbria PCT, I think – no, it was a South Cumbria Community Trust. There was a Lancaster Community Trust. The Royal Lancaster Infirmary was one trust, Westmorland General Hospital was one trust and Furness General was a different trust.

PROFESSOR FORSYTH: Right. So were you very much – you were very much working within Lancaster, around Lancaster.

MR GIBSON: It was – yes, it was very...

PROFESSOR FORSYTH: Nothing really to do with your colleagues in Furness?

MR GIBSON: Nothing whatsoever. I met them once or twice socially but – yes, nothing professionally, and very, very little contact.

PROFESSOR FORSYTH: So you were very much independent at that time.

MR GIBSON: Very much so.

PROFESSOR FORSYTH: And did that format stay until when? When was the next sort of change?

MR GIBSON: Oh, gosh. I'm trying to remember when the – I think – gosh, I think it coincides with the appointment of Ian Cumming as the clinical director, but I'm – as the CEO, yes. Yes, as the CEO. When the three acute trusts were made

into one and the two community trusts were made into one, and I think that's around 2000 – I could go and look it up, but anyway it was...

PROFESSOR FORSYTH: About 2003 then, when you were...

MR GIBSON: Yes, I think it was more like 2000 that that happened for – oh...

PROFESSOR FORSYTH: Because you became the clinical director in 2003.

MR GIBSON: Oh, that's true. No, no, no, no. For quite a long – well, it might even have been earlier actually, it might have been 1998, so for a long time the – it was a women's and children's directorate, and – yes, so the paediatricians have been saying for decades our voice is never heard, so we'd never had a paediatric lead in the division or directorate, whatever name it had. And the head of the nursing side was always a midwife because there's some legislation connected to that. So, you know, we were in that set up for quite a long time, so it might even have been – I just can't remember which particular reorganisation it was.

PROFESSOR FORSYTH: Okay.

MR GIBSON: And then in the 2003, what happened there was we followed the emergency department, so the emergency department had been nestled inside surgery, and – well, paediatricians had said their voice was never heard and their special needs and things were never quite understood and things. And they(Emergency Dept.) kind of slipped out as a standalone division, and then quite close behind them when paediatrics slipped out separately from the women's and children's, and that was in 2003, and that's when I was appointed as the divisional lead or the directorate lead, or whatever...

PROFESSOR FORSYTH: So you had responsibility for the whole of South Cumbria for...

MR GIBSON: Yes, across – yes, so then for what was then University Hospitals of Morecambe Bay, or Morecambe Bay MBHT, whatever that stood for. So that was the three hospitals, yes, and that was my responsibility.

PROFESSOR FORSYTH: So that was 2003. So how did that progress from a sort of – from a clinical point of view? Just give me a picture of what the distribution – well, we'll take it from a paediatric perspective was across the trust. How many consultants were there in total? How many were based in Lancaster? How many were based in...

MR GIBSON: Right, there were three hospital consultants – yes, when it was stable there were three consultants, acute consultants at Furness, and when there was someone in post it was a single community paediatrician in Furness. In Lancaster there was – so in 2003 there was – I suspect at that time there were four of us in the hospital and one community paediatrician. And there was – there were a few senior clinical medical officers in the community in Furness and Kendal and Lancaster.

I would describe it as exceedingly dysfunctional. I mean I think it still is dysfunctional, but it was – I would describe – it was exceedingly dysfunctional then. There was a very good senior nurse at Furness who had spent a lot – you know, had – I think she'd done her nurse training and had done practice as a senior in the South of England. She came as matron for paediatrics to Furness, and she left the Isle of Wight, which she'd spent all this time, and [redacted] And her insight, which I've always found very useful, was that Barrow is very insular. She found it as insular as the Isle of Wight. And I suspect it's pan-NHS, but it was certainly a very prominent feature with us that our coming together, our amalgamation was fraught, and you can still see the difficulties today. So culturally, actually the three sites, Furness, Lancaster and Kendal ~~Barrow~~ are different, but Lancaster and Furness – sorry, Lancaster and Westmorland, Kendal have worked very closely for a long time, so there isn't really a big cultural thing there. But there's a huge Cultural difference between Furness and Lancaster, just cultural different way of things, and there are attractive things and unattractive things on both parties, if you know what I mean. So I don't think the trust realised it was struggling with that, and I found that personally very hard work.

PROFESSOR FORSYTH: Did you have a solution to it as clinical director at that time? What were you sort of saying to the trust?

MR GIBSON: The sort of things that I was – that I thought we should do, and I mean it wasn't just me, I mean it was mutual, (~~both~~ myself and the CEO and medical Director), so by the time I was appointed as the clinical director, ~~but~~ I wanted to spend a day a week in Furness because I'd seen most of the clinical directors were coming from Lancaster, and you could just tell that wasn't working. And lots of them would do a flying visit for half a day a week and be

really quite, I don't know, I suspect dictatorial or, you know, I kind of – I suspect a military type of leadership model, but I'm only guessing, I wasn't there with ~~when~~ the radiologists and the surgeons and physicians.~~,~~ ~~s~~So I was really keen to go and spend time, and that fitted, in a sense, what I'd learned from working overseas previously, that if you wanted to understand things and move things in a new direction, you had to be seen and understood and respected and whatever.

So – but by that time the Trust was also very keen, so that was mutually very – that was bilateral, that when I was appointed they wanted me to spend a day a week there, and I wanted to spend a day a week there. And I felt that the person who'd made the biggest impact on child health at that time was our senior nurse, called Lyn Shannon, so she was a cross-bay appointment, and she was doing, I thought, great things for paediatrics, trying to rotate ~~move~~ some of her nursing staff across the sites, although there was and remains a lot of resistance to that. And she was spotting other things that I would just never have thought of. So, for example, some of the nurses in Furness were on permanent night duty, and so they were missing out on lots of learning opportunities and just working alongside other people.

So I thought that the model that we should be moving towards was more backwards and forwards across sites and actually more physically sharing things and doing things together. And my day a week was in a sense my contribution to that.

PROFESSOR FORSYTH: And did you make much progress with that approach?

MR GIBSON: Well it's funny, when I got the invitation to come to you, actually it brought up – I actually feel I had a bad experience, so I did find – I found the guys at Furness really, really, really difficult to manage. And...

PROFESSOR FORSYTH: Were these individuals who'd been there for some period of time then, or did the newcomers sort of adopt a similar position?

MR GIBSON: Yes, so two – yes, they'd been there for – let's see, somebody had probably been there about eight years, somebody else had been there about two or three. There'd been a really – a really positive guy that would have been a benefit to anybody's team called Dr Rifkin ~~Rifkind[?]~~. Now, he'd recently moved to Bury or Burnley, and that's why I say it was – there was supposed to be an establishment of three. There was a period when it was

often down to two, and it was very, very difficult. But actually, as people came in it was really interesting from my point of view. As people came in, they very quickly in a sense picked up the culture that they'd moved in to. And frequently when I'm talking to people, I think there are many of my colleagues in Lancaster who I think are quite functional and work very, very well, but I'm very suspicious that if they'd been appointed to Furness that they would have become difficult to work with.

There are other individuals who you could have dropped them in anywhere and they'd have been absolutely fine. So then – so the thing that you reminded me of is I do recall that in approximately – probably about 2004/2005, one of the problems had been that the rotas were very difficult to run, and I didn't want...

PROFESSOR FORSYTH: Sorry?

MR GIBSON: The consultant rotas were very difficult to run, and I didn't actually want anything – I didn't want to take that responsibility. You know, I wanted people to be responsible for themselves and to find solutions with help for their problems. And I just didn't think it would work if the consultant radiologist, for example in Lancaster, told the guys in Barrow what rotas to work. But the rota never worked, and there was one – it seemed to happen every summer that we'd be down, ~~the~~ two consultants would be away and one consultant would be running it on his own. And this happened one – this happened on my first summer, so I felt this has happened on my watch and it won't happen again. And we talked about it and we agreed it wouldn't happen again, and then it happened the next summer despite having had these discussions. So then I took a more hands on, so I approved rotas., ~~s~~So I left them to run the rota and suggest it but it required my approval.

And the summer after that, one of the consultants took his leave and came back late and left the situation with one consultant, so I sort of initiated something that was taken further, and he – I mean it was distressing for me and it was distressing for him [redacted] Shortly after that, my – two of my colleagues then – they then reported me to their – to Ian Cumming, the chief executive, saying they didn't like my style of management.

PROFESSOR FORSYTH: These are two from Barrow?

MR GIBSON: Two from Furness. So they reported that – they fed back that they didn't like my bullying, intrusive management style, and that then went to a very formal inquiry. And so with the passage of time, and I felt that I met people halfway, so I did what I had done overseas, so I joined people on their ward rounds, and I didn't realise they were finding that intimidating for the first six months, and then when I found they didn't like that, then I stopped going on the ward rounds, with the intention to restart it, but never did. And if I sat on a handover, I came up especially on a Monday because they had a special sort of grand handover on a Monday morning, if I came onto that that was kind of seen as spying in the camp and things.

PROFESSOR FORSYTH: Just to get this in the chronological order, so what time – what year roughly was this sort of...?

MR GIBSON: So this was happening around about 2005/2006. So – and it was seen – so anyway, so when it was investigated I was quite happy to say I had done these things with good intention and I hadn't appreciated, and maybe I should have asked more what would have worked better for you, but to explain to people what I was going to do.

The reason for telling the story really is that actually in a sense I then felt muted as a clinical lead for the subsequent 18 months, so there was no kind of big decision at the end of the investigation.

PROFESSOR FORSYTH: So what sort of support were you getting at that point? Who were you accountable as the clinical director, or was that associate medical director or...

MR GIBSON: Yes. At the time actually I thought I had good support, so I didn't abuse it, but I could go and talk to Ian Cumming any time that I wanted. We usually met for a beer. I would ring him up and we'd meet for a beer every two or three months. The medical director for a lot of that time was David Telford; very supportive.

With hindsight, and I was getting plenty of – you know, I was – I felt I was given lots of support. Some of it was a Catch 22, so I went to Ian Cumming and said, 'I think coaching would help me,' and I eventually ended up – I got a coach and they were happy to fund that. And I remember asking him, and I said, 'Well nobody else has got a coach,' and he said, 'Well, yes, but you've got to know you need a coach and ask for a coach to get a coach.'

So I did actually feel very supported, but when I stand back on it now and I think actually I wasn't supported, so there wasn't a corporate – there wasn't – no other directorate was actually attempting to do with what now I can – you know, I've read more and looked at other stuff, so I think we were trying to do something that nobody else was doing. And it wasn't part of a framework. I mean it was – you know, with hindsight I mean it was – I learned a huge amount from doing it, but we didn't – you know, if I look back very critically at my time I think actually it's very like – I mean working in Sierra Leone is no harder than working in the NHS, and is perhaps easier. And you've kind of got to – well my way of – you know, it's very rare that you can come in and kind of change everything, and you often – you take it an increment and then the next guys come and stand on your shoulders and they can take it another increment.

Anyway, so that's...

PROFESSOR FORSYTH: Can I ask you, therefore, at that time did you have any concerns about the quality of clinical care that was being provided in paediatrics across the trust, but also particularly Furness?

MR GIBSON: I suppose – yes, we're all kind of centric, so I have to factor in that I'm Lancaster-centric. I always felt that things – and I still feel that things are dangerous in Cumbria full stop. At that time...

PROFESSOR FORSYTH: Sorry?

MR GIBSON: I think things are dangerous in child health in Cumbria. Initially I didn't know about more of Cumbria, but at that time I thought things were dangerous in Furness, and the ultimate test was would I be happy if a niece, nephew or grandchild was looked after there, and the answer would be – was no. And because I'd been away for two years I'm not sure, but two years ago it would have still been no.

PROFESSOR FORSYTH: And so did you feel that the sort of modern way of paediatric services was not happening in this area?

MR GIBSON: I have – I suspect I have a different take on it to most others, so I think the problem in Furness is everybody's, and we can either start with the most frontline person and work our way up to the Secretary of State for Health or ~~and~~ we'll start with the Secretary of State for Health and work all our way down. I've got examples of how the service was undermined unintentionally by really

well-intentioned people at the Deanery, at the regional level, within the trust, and it is very, very like working in Sierra Leone. So if a child dies of malaria because 20 things went wrong, nobody actually feels responsible, because if I didn't – if I'm in the lab and I didn't really read the malaria slide promptly, within 60 minutes, nobody'll ever know that because 19 other things are wrong and broken, and so nobody'll be able to kind of finger me. And that's my feeling about child health in Cumbria, that actually the whole system is full of highly motivated, really well-intentioned people who don't realise that their actions are having a negative effect in other places.

So if I go back to being the clinical lead; now talking to other clinical leads, they felt – they said, 'Well, if you take the headmaster as a model, the headmaster representing the staff, the teachers, so the consultants, or are you representing the organisation – you know, you're kind of representing the local authority with others, the Department of Education, whatever, or are you representing the pupils?' And they said, 'Well the reason we ask you that, because you don't really seem to be the junior rep or the representative for the consultants, and you don't seem to be particularly taking the trust line or the commissioner's line.' And the reason for doing that is I don't – I think everybody was making errors, and I'm probably still making errors today.

PROFESSOR FORSYTH: In terms of neonates, at that time particularly, 2003 onwards, did you feel that this was a particularly vulnerable area?

MR GIBSON: No, I didn't think it was more vulnerable than the general side. I think neonates, in a way, is just psychologically – I personally find a children's ward a more dangerous place. So a neonatal unit's got a door and everybody that's in there is kind of sick, and actually if the ~~[inaudible]~~ blood test hasn't been done, or the blood gas hasn't been done or the x-ray hasn't been done, it's actually very easy to spot it. Whereas a children's ward where you've got patients coming in from home, from emergency departments, surgical patients, all sorts of things, it's a more dangerous – it's a more dangerous environment.

It is quite difficult to remember back then, you know, there were no established neonatal transfer units. It was very – Newcastle, Manchester, Liverpool, like it was a long journey for them to come out and pick up a baby, and there was – again, well intentioned, like people wanted to be able to

deliver care to babies to show that – to demonstrate to their community that their hospital could look after cases and look after them well.

PROFESSOR FORSYTH: So do you think that, particularly in Furness, there was a tendency to hold onto high risk women or high risk babies?

MR GIBSON: I think – yes, I think so. And the same has happened in Lancaster. I mean I think we – we came in – I think Lancaster came into line quite quickly when we saw the validity of the new networks as they were established. But there is a bit of a wrench to think well, we think we've been looking after – we feel we've been looking after 27-weekers and 28-weekers fine for the last 10 years, and now to be told they need to go down to Preston, and they'll probably only be there for two or three days, it – you have to take your head round. And the way I explained it to people is actually people aren't saying that you can't look after them properly or that you've not looked after them properly for the last 10 years, but – and it was easy because it was around the new Millennium – you could say, 'But we're now talking about 21st Century care, so there's no...' because sometimes the sort of – people interpret these things that we have to ship babies out, then I think people often interpret it as an implied criticism of their career or their last five years or their last 10 years in their unit. So I think it's important to say, 'There's no worries about 1990 to 2000, but this is the way forward.'

So yes, there was a tendency to hold on, there was a tendency in obstetrics to hold on to cases; some tendency in paediatrics to hold onto cases, which I think was a normal reaction – is normal behaviour. But it was then – yes, it was slightly more challenging in Furness than say Lancaster to say, 'Yes, but we have to change because it's actually the right thing to do for a 29-weeker or a 1 kg baby, this is the future.'

PROFESSOR FORSYTH: So when the first of the major incident occurred, you were clinical director at that time, weren't you, around 2008/2009.

MR GIBSON: ~~Yes.~~ I was the cross bay lead for paediatrics. In 2008 the clinical director was a surgeon.

PROFESSOR FORSYTH: So what was your involvement? How did you feel sort of from a management perspective these were handled? Did you feel as the clinical director you had your place and your voice was being heard?

MR GIBSON: Let's see, in – right, so it's October/November 2008, so at that time it was now directorate of surgery, so we were part of surgery. And I was the lead – I was the cross-bay lead clinician for – for paediatrics. And I was involved remarkably little in the process for about the first 12 months. There'd been a short – I'd been asked for an opinion about the particular organism and the prognosis, so Tony Halsall, the chief executive, had asked me at some – I suspect around February or March, what did I think about this particular streptococcus that had been grown, because some other people had given the opinion that there wasn't lessons to be learned from this because it wasn't – a Group B Streptococcus, ~~could be pneumococcus~~. And so I'd given some opinion at that stage.

I felt then, and I still feel that the midwives – that too much blame – I can understand – you know that too much...

DR KIRKUP: Can I just stop you for a second?

MR GIBSON: Yes, sure.

DR KIRKUP: Because I think we're going to get into clinical details here.

MR GIBSON: Okay.

DR KIRKUP: Not appropriate for this part of the interview.

MR GIBSON: Oh, no, no, I wasn't – no, no, I won't go into any more clinical detail. It was just that one with the organism.

PROFESSOR FORSYTH: Oh, yes, but we don't want to go into specific cases at this stage.

DR KIRKUP: We will have a chance to do that, but I need to formally draw the first part of the interview to a close before we get onto that.

MR GIBSON: But my feeling is that the midwives were disproportionately the focus of attention, and the paediatric team, me included, were incredibly overlooked and bypassed. And I think a lot of that...

PROFESSOR FORSYTH: How about the obstetricians?

MR GIBSON: I have a suspicion that the obstetricians were less in the focus than they should have been. But my reading of the – I mean I think there's a national – I think we've got a very long history that midwives and obstetricians and paediatricians are very separate entities, and without – yes, so I think it – so I think we're quite tribal, and my suspicion about obstetrics and midwifery in Furness is that it was like a dysfunctional marriage where superficially it

looked okay, but it was more like a marriage where people met in the same house but kind of had their own lives, and would go to important dinners together but actually there wasn't really – they didn't really feel that these cases were each other's. And it felt a very black and white, 'This is a normal woman, this is a normal pregnancy, this is midwifery,' and then when a decision was made that it was no longer standard and normal, then it became obstetric. And then paediatrics, I'm sure, was perceived by the others as the baby's been born and they're sick. Where's the paed? Get the paed here. And I think people – I mean it's more comfortable; it's easier to live and work in groups like that, and it's harder to be the person at the interfaces and the borders. And I can see that happening – I think that happens nationally, I think it happens – I think my suspicion is in good units it's recognised and it's addressed and there are tricks and things that people do to address it.

I can see when I started in 93 it was like that in Lancaster, and it's much less so now than it was. But it was quite apparent in Furness, but even within that then, but obstetrics in Furness weren't really that close with obstetrics in Lancaster and midwives – you know, and paediatricians in Lancaster weren't – weren't really – we didn't have a knowledge and understanding and empathy with what our paediatric colleagues were grappling with at the other end of the district. So it wasn't – it isn't a uniquely Furness phenomenon, it was all throughout our...

PROFESSOR FORSYTH: And Furness was an issue because of course the neonatal unit or special care baby unit was really a level one unit there. Did that present difficulties because the paediatricians felt that it would be inappropriate to accept a baby for this particular unit? Did that fuel some of the discomfort?

MR GIBSON: Yes, and – well even – at that stage it hadn't even got to level one terminology. I think we probably – I'm just trying to think when the networks – I think the networks were just coming in then, so we probably were moving our way towards it. But it was institutionalised more than that, so there are no paediatric registrar trainees in Cumbria, full stop. And there were two or three – well at that time there were two or three obstetrics and gynaecology registrars at Furness, so I mean I think understandably, the obstetricians, the midwives, the hospital had a perception, 'We're an obstetric unit,' and didn't

have a perception that 'When these babies are born actually we haven't got a really big, robust team to look after that.'

PROFESSOR FORSYTH: It's only when you mentioned earlier on about the Deanery being part of the problem, so to speak.

MR GIBSON: Yes.

PROFESSOR FORSYTH: Is this where you're coming from there, that no trainees in paediatrics but there's trainees in obstetrics?

MR GIBSON: Well the Deanery's been part of the solution and part of the problem, which I think is – so the Deanery, I think, was a force for good in terms of – you know, they were really stroppy with saying, 'If you can't get your guys' hours down to this we're going to take all junior, all SHO trainees out.' And I remember at the time thinking, 'Well this is really, really hard.'

But interestingly, the Newcastle Deanery hasn't done the same in the north of Cumbria, and actually north of Cumbria, I think, is in a worse situation. So actually the Deanery then saying, 'Look, if you're not giving good training, we think there's a good correlation with if you're not giving good training you're not giving good care, and you're going to have to address these situations.' So improvement was – came as a consequence of that.

I think where the Deanery let us down was, and I can't exactly remember, but approximately 2008 or 2009, the Department of Health gave a special £250 million pot to expand middle grade trainees in obstetrics and paediatrics, realising there was a national difficulty with achieving the European Working Time Directives. And I think – I mean I went back to the original documents and there was nothing said in the documents that it was to support ST type trainees, it said it was to support European Working Time Directives. And nowhere in the documentation did it say it was to support anaesthesia. In our Deanery – well, as the money came into our region it was given to the Deanery to deal with, and the Deanery added anaesthesia to the list of specialties that would benefit from it, and stated that if you didn't have trainee registrars then this money wasn't meant for them. So that meant that Cumbria got none of this investment, so – no, we spotted – well, we didn't realise that, so we put in – we'd worked out a case for some of this money to come for a consultant – sorry, it was money for consultants to support the European Working Time Directive. So we worked up cases for Lancaster and

we worked up cases for Furness, and when we met with the Deanery representatives they actually came up to help. They said, 'Well forget the Furness stuff, there's no money going to Cumbria because there are no trainees in Cumbria.'

And I remember Tony Halsall twigged, and you could see him twigging. He said, 'Oh, okay. Can we put in an integrated joined-up package as a unified trust?' which they said yes. So then we tried to cobble together the two proposals and add it all inside there. And again the answer came back, 'No, no, these ones are going to Furness, you can't have those consultants.' So that's – I think that was all well-intentioned, but I think that just made the matters worse, that the number of consultants was going up everywhere around the country with this particular pocket of money, and Cumbria stayed the same and made child health worse than Furness.

PROFESSOR FORSYTH: Do you think – I mean it seems to me that there's a scope for training trainees in paediatrics across Cumbria? I mean do you think that or...

MR GIBSON: I think there is, but we've never successfully persuaded the college and the Deanery, because they – I'm sympathetic to their point of view, they were reducing numbers and the last thing they wanted was folk like us pitching up and saying, 'Well, actually we think we can give a special kind of training in Cumbria with the population spread out,' I mean, more like a – different to, but more similar to a Scottish type scenario with good community practice and someone [inaudible].

PROFESSOR FORSYTH: Yes. Before I hand over to my colleagues, and again, to give me a general view, were you involved in discussions from the outset, did you actually have a chance to speak with the parents involved?

MR GIBSON: No.

PROFESSOR FORSYTH: Even though there have been issues with say the baby that had been born here and not – you didn't actually meet the parents at all?

MR GIBSON: No.

PROFESSOR FORSYTH: So who was speaking to the parents, generally again?

MR GIBSON: Quite early on Tony Halsall took the responsibility upon himself to be the person that met with the family and dealt with the family.

PROFESSOR FORSYTH: Okay. And there have been a number of reviews of children's services, which I'll come back to if my colleagues don't pick that up.

MR BROOKES: Can I just pursue the last point that Stewart was making? Was the practice of Tony – was that normal practice? Would you normally expect within the systems to have been engaged in issues of clinical concern, serious untoward incidents as clinical director or associate clinical director? And was therefore this separate and different, or was this just the way it worked?

MR GIBSON: I'm not quite sure why – I'm not sure how it the case/the complaint came into the system. So I think if it had come in as a – I just don't know exactly when concerns were raised or if they found a medical complaint. I'm not sure how it came in, but trying to look back at it, I think it came in – I don't know whether it came in as a very obstetric thing about 'the way my family's been looked after', and I've never understood why it was such a midwifery issue and why it wasn't a paediatric issue, because to me, there was lots of paediatric things, [redacted] and that – I suppose the feedback loops that we've got now, and the inquiries that we have for child death, none of that existed then, but it was odd that it came that way. I must admit, I was very impressed with Tony Halsall, that he – you know, I kind of thought, oh, this is the nurse in him coming out and being at the front of the organisation.

MR BROOKES: But was it normal? Would you have normally...?

MR GIBSON: No, I'd never heard of that before. No, I don't think – no, I wouldn't describe that as normal.

MR BROOKES: So you were routinely involved in issues around clinical quality?

MR GIBSON: Oh, yes. So if there'd been – yes, I mean if we had – I mean with hindsight, I mean I think it's – I mean it's very noticeable, really in a sense I feel I've been away 20 months, in the 20 months how we're much more focused on untoward incidents of all sorts. But extraordinary – you know, when I look back, but we've been doing that for 15 years in paediatrics, and we started – it just evolved, but if we had a resuscitation, so it started off with resuscitations if a child had died or it hadn't gone well we'd have a debrief and then we kind of expanded a bit. We'd try and have as many resuscitation

debriefs as possible, and we did that on both sides of the Bay (Lancaster and Furness).

So in a way, to me it's a bit of – you know, well it's annoying in a way that we were building up a tradition of looking at – they were usually around resuscitations, but we were building – beginning to build up a culture of looking at those things. And yet some – I don't know, it just didn't – maybe it was because of the hop to St Mary's and then to Newcastle, and the deaths didn't happen in our trust and we lost – I mean I didn't even know this particular [redacted] child had been born and had died. I didn't know about it for about four months.

MR BROOKES: So if we don't look at specific cases, and if you could just describe how, from your perspective, the clinical governance arrangements worked within the trust, particularly at the beginning, 2007, and through your time there. So how did you link, in terms of governance, to the directorate, to the medical director, to the board? How were clinical issues pursued through the board?

MR GIBSON: Okay. So there was a check in the system, so – well one of the – yes, there was an extra layer – it felt as if there was an extra layer of bureaucracy came when the division or the directorate ~~director~~ of paediatrics was pulled into surgery. So – and I can see the reasons, because I think at that – I can't remember, we either had seven or eight divisions, and everything was streamlined back into five directorates. So previously it would have been very easy to get all hauled up at our regular cycle with the chief executive and the senior officers to look at a whole variety of things on a – we didn't call it a dashboard then, but anyway, a whole variety of things, including clinical governance things.

When we went into surgery there was just another whole layer that you went through, so anything that was happening in paediatrics and obstetrics and gynaecology stepped into the – went into the surgical, which included anaesthesia, went into their process, and instead of me doing it because I was now – I was then the clinical lead, it kind of got past ~~passed to~~ me into the surgical system.

I think the other thing that's worth pointing out, I mean at the time I think the most sophisticated – yes, it's kind of – yes, it's surprising in a sense, but I

think the most – the most sophisticated governance was actually happening in obstetrics, driven by the CNST process, and people wanting to move up in the hierarchy of banding. And to me, they were the envy of how to go at things, you know, so there was funding for a governance midwife, there was funding for – you know, to help with writing protocols and to make systems work. But...

MR BROOKES: So were the processes clear? So if you were a jobbing clinician working in paediatrics, for example, or any other area, if you had a concern would you know who to go to? Would you know how they would handle that, how things would be resolved, or was it less clear?

MR GIBSON: No, it was less clear. And the systems – yes, and the system that we have today is completely unrecognisable to the system then ~~them~~. So there was no – I'm not absolutely sure today whether we've truly got a culture of no blame and a culture of learning, but most certainly then we didn't have that culture. So it would be fine for people like me to swan into say one of our resuscitation debrief meetings and say, 'This is all about learning, and we've only brought together the people who were involved that are here today,' but you could tell from staff that they didn't trust this no blame – this statement that the culture was a learning culture and a no blame culture.

MR BROOKES: Okay. Just going back to something you were discussing and you were describing with Stewart about when you're going on your visits as clinical director, and these were felt as intrusive by the clinicians. Did you spot things which you felt were not being appropriately done when you were doing those visits? I'm just trying to understand whether – you know, anyone feels if someone's looking them then it's slightly different and concerned, but did you do that because you wanted to get to know them? Did you do that because you had concerns about their clinical practice? What was the motivation behind doing that?

MR GIBSON: So my motivation for doing it that way was I wanted to be part of their team and I wanted them to be part of my team, and I singularly failed in that.

MR BROOKES: Okay, so that answers that. So then what did you find? Did you find anything that concerned you in terms of the way in which they were operating?

MR GIBSON: Yes, I would just describe it as a mess. There weren't enough consultant paediatricians, there just wasn't enough staff. There was a management camp and a clinical camp. There was a paediatrician's camp and there was children's nurses' camp. The doctor/nurse relationship I would describe as a 1960s relationship, which was just in huge marked contrast to Lancaster.

Part of it is my personal style, so I know from starting in 1993, like I was really – the best places that I've worked randomly over the years have always been places that with hindsight that I could see actually the consultants met every week and had a coffee and an hour together or something like that. So in Lancaster, from about – probably about 1997/98, something like that, we eventually, with false starts and whatever, eventually got ourselves up to a system with the three of us, and sometimes our community colleagues, we would meet regularly. And that's still running today, and I still think that's a really good model to – I would encourage people to try to do that.

The guys in Furness didn't want to meet regularly, and they certainly didn't – they weren't happy with the senior nurse and our senior manager and perhaps the ward sister joining us for an hour on Thursday afternoon, but that's what I – I kind of pushed and hung in there and pushed for that, but it was – people didn't want it. And then there were lots of things that needed change, so in a sense that's a very processy thing, but there were lots of things, I felt there were lots of things that would have been positive – I knew they were positives and negatives, so I really liked the sound of the way they had this – what they called a ground round on a Monday, where the person that was finishing the weekend kind of gave a big handover to the whole team on the Monday. I thought there were going to be lots of nuggets in there that we could think about importing down to Lancaster, but I thought there were lots of things that we could be bringing up from Lancaster, but there just was a lot – there was a lot of resistance to doing it.

So a very easy one is the rotas; like the Lancaster rota is platinum. You know, my colleague is beating us up at the moment because the rota for next year is about to be printed, so I'll know every weekend I'm on call, my holiday and whatever. And the Furness thing is like people give two weeks' notice that they were going to take two weeks' holiday and leave one consultant

there. So that's it on sort of a very processy thing, but then when it comes to things like resuscitation or management of sick children and whatever, there were an awful lot of things that needed addressing and sorting out.

MR BROOKES: Okay. I'm just conscious that you said when you were talking about, that you still had concerns about the safety of children's services now. I just wondered if you could expand on that slightly.

MR GIBSON: I don't think anybody – I don't think anybody grasps the whole of child health, and I think everybody comes from their tribal camp with their views. And I know and – you know, so I know, and I'm very close to colleagues with some of the commissioners and some of the acute guys and some of the community guys and some of the GPs. I think the GPs don't understand the complexity of trying to run a 24-hour service in a DGH. And it's only because of pressures from multiple inquiries and things like that that people understand we're going to need more than four consultants to run this service if we want it to be 24 hours of service. And quite often I talk to GPs and the GPs say, 'Well, it would be great, we can have these...' let's say you're expanding to nine consultants, and they ~~you~~ say, 'well we can have them working out on practices and networks of GPs and then they can do the on call.' And there's just the naïve innocence of how complicated it is to run a 24-hour rota, and it doesn't matter whether you're looking after 750,000 patients or whether you're looking after a population of 70 children. If you want to run a 24-hour round the clock service, there's just a minimum number.

So I think not out of – not for any malignant reasons, I don't think the GPs have a grasp of the total service, and I don't think they have a grasp of what community paediatricians are up to, but also I don't think the commissioners actually fully understand it. They're trying hard to understand but don't understand it.

MR BROOKES: So if I was to repeat back what I think I've heard...

MR GIBSON: Sure.

MR BROOKES: ... lack of understanding as commissioners.

MR GIBSON: Yes.

MR BROOKES: And primary care, about the complexity of what's doing, staffing issues and culture.

MR GIBSON: Yes.

MR BROOKES: Are those the key issues?

MR GIBSON: Yes.

MR BROOKES: Okay. Thank you.

DR KIRKUP: Yes, I'll just pick up, I think, one issue in this part of the interview, which I need to go back to this situation round about 05/06, I think, when you described a dysfunctional unit, extremely dysfunctional I think you said, and a mess.

MR GIBSON: Yes.

DR KIRKUP: What was it brought that to your attention?

MR GIBSON: I would say everything really. So if you talked to any of the clinical directors, they would just say, 'This is really, really difficult.' So if it was a Furness director coming and looking after Lancaster they'd just say, 'This is really, really difficult.' And it was particularly true then if I was listening to the Lancaster clinical directors who were then coming ~~covering~~ across to Furness, and the sort of language would be – it's a bit like the Dementors from *Harry Potter* or something, it's really, really draining; to change anything is really, really difficult.

DR KIRKUP: Yes, I understand there were organisational complexities and the difficulties of the merger and all of that. But what was it made you think that the paediatric unit in Furness was so particularly in need of attention, because you clearly did from everything that you've told us.

MR GIBSON: I think my diagnosis is made by looking at the staff as opposed to looking at the patients. So there wasn't data that I could put my hand on and say – you know, at that time I didn't have access to data that says the length of stay for asthma cases or the length of stay for fever or whatever. But it was just that the staff relationships were just – as I say, they were very 1960s, and...

DR KIRKUP: How did you know? You're a clinician, you've got responsibility across the bay, but how would you know what went on in the FGH unit?

MR GIBSON: Well I didn't – I reckon I probably scratched the surface. I was spending – I spent a day a week minimum, so I went across every Thursday and arrived at half eight, and came back at six.

DR KIRKUP: Okay, what did you do on a Thursday and what did you see that made you concerned?

MR GIBSON: Okay, so I – at first I used to do a clinic about every three weeks, and that was dysfunctional, so – it was almost as if the consultants' ward rota was written by the lowest level of clerk that the NHS employs, because she had to work out when people were doing clinic, and you just thought this is – doesn't anybody see that it's not appropriate for this woman to be pulling her hair out because consultants aren't coming to clinic, but she shouldn't have been trying to work out who was doing the ward this week. So if somebody was doing a ward – or she worked out if the person was doing the ward this week then only put them in for one clinic or something like that. But it was actually because of what she was writing down, it kind of implied who was doing the ward that week.

And then if you – when I sat in on a handover it just felt – it just felt 'this isn't smart, this isn't slick', and different consultants are giving out very different messages to other guys. And occasionally patients would get moved from one consultant to another consultant and you think, 'Why is that happening? Do the guys think this guy's better or are they – is it a bit of a turf war who was actually on call the night before?'

DR KIRKUP: Okay, you're getting signals that maybe all isn't well.

MR GIBSON: Yes.

DR KIRKUP: But they're fairly superficial signals. What did you do to look in a bit more depth?

MR GIBSON: I – maybe I – I'll keep thinking about what was the evidence that I felt that it was ~~wasn't~~ dysfunctional, but the things that I was trying to do was to be there every week, to have a meeting every week, to make it multi-professional with nurses, manager and consultants. To encourage people to write, that we would have cross-bay guidelines, that we would have the same on all sites, that we would aim for the same standard on all sites.

I suppose the consultants in Furness were quite correctly, I think, jumping up and down that there wasn't enough of them, and they needed more consultants. And there was two – you know, the noise grew loud enough on two occasions, like this built up over a year, so there was one occasion when Ian Cumming actually came with the medical director and listened, you know, sat down and have a very long listen about the need for more staff.

DR KIRKUP: From what you've said to us earlier though, there were other problems. Leaving the staffing aside for a minute, the staffing by itself doesn't create an extremely dysfunctional unit. It might create an extremely pressurised unit, but it doesn't create an extremely dysfunctional unit, so what was going on that created an extremely dysfunctional unit?

MR GIBSON: I think it was the behaviour of individuals and the behaviour of groups. So just to slightly rehash what we said before, I mean I think the midwives are working here in one group, O and G (Obstetrics and Gynaecology) ~~ONG~~ doctors in one group, paediatric doctors in one group and children's nurses in another. And then within that they were working as individuals, so I could see that each consultant paediatrician did his own thing. And actually when you look across at ONG, that's what it looked like was happening over in O and G (Obstetrics and Gynaecology) ~~ONG~~ as well, that they did their own things their own way. So if one obstetrician thought it was all right to look after triplets at Furness, he would look after triplets at Furness even if somebody else, one of his other colleagues mightn't agree with him. So there wasn't that sort of – there was an absence of the sort of governance which happens around the water cooler and the coffee kettle.

DR KIRKUP: And based on particular instances of clinical care?

MR GIBSON: Yes, I could – it's interesting, the individual – yes, it's interesting. The individual cases – it's funny – yes. Yes, I could pull out individual cases and I'd say well I was unhappy about that, I know that particular case or...

DR KIRKUP: I'm not necessarily looking for any individual case.

MR GIBSON: No, no – yes.

DR KIRKUP: Nor am I suggesting that they all have to be significant incidents, but you are basing what you're saying on instances of clinical care where what you saw didn't match up to what you expected to see.

MR GIBSON: Yes. But I think the main piece of evidence, the main driver was actually the dysfunction of the professionals, and then by implication that wouldn't be good for the children. So I think more of – I think the way I felt, and I think it probably was feeling my way into it, was more by looking at how the professionals are behaving to each other, and then by implication, the effect that that has on what must be coming out at the end.

DR KIRKUP: Just by implication, or did you see things that concerned you?

MR GIBSON: Oh, no, there'd be stuff that I personally would have cried if I'd done that, and have been really upset if my Lancaster colleagues had done that.

DR KIRKUP: Right, that's what I was trying to get at, thank you. You were sufficiently concerned by that to take some remedial action, which then prompted – how can I describe it? I don't want to put too many words into your mouth, but a backlash from the paediatricians in FGH. And that took the form of allegations against you?

MR GIBSON: Yes, I was – yes, the allegation was that – that my – well, yes, the allegation was that I was just the same as all the other clinical directors from Lancaster who had been sent up to Furness, which was that I was overbearing and bullying.

DR KIRKUP: Okay. And the reaction to that was?

MR GIBSON: So the reaction to that was there was a formal inquiry, so the chief executive passed it over to HR to make a formal investigation.

DR KIRKUP: Okay, hang on just a second. I think you mentioned the incoming chief executive.

MR GIBSON: Yes.

DR KIRKUP: The first time that you mentioned this.

MR GIBSON: Yes.

DR KIRKUP: Can you just identify...

MR GIBSON: Yes, It was, it was still Ian. Yes, this all happened at the time of Ian Cumming.

DR KIRKUP: So it wasn't the incoming chief executive; it was Ian Cumming.

MR GIBSON: Oh, sorry, my apologies.

DR KIRKUP: I think you said the incoming chief executive.

MR GIBSON: No, sorry, I meant – it was the chief executive, Ian Cumming.

DR KIRKUP: Right.

MR GIBSON: Sorry.

DR KIRKUP: My ears aren't as good as...

MR GIBSON: No, no – well no, sorry, I hadn't spotted there was – such a close...

DR KIRKUP: Okay. Were there any other formal investigations of clinical directors going on at that time or subsequently? Let me just explain that.

MR GIBSON: Yes.

DR KIRKUP: You said that the allegation was that like all the other clinical directors from RLI, you were overbearing and bullying, but yours resulted in a formal investigation. Did any of the others?

MR GIBSON: Not that I know of.

DR KIRKUP: Why would yours then?

MR GIBSON: Well my – yes, my analysis has always been that it was a tit for tat that because I'd drawn a line and put a boundary and it had been crossed and I'd then taken it forward, that this was a push back, a hit back to it.

DR KIRKUP: Okay. And what form did the investigation take? It was done by the director of HR?

MR GIBSON: Yes, it was – or, yes, a senior member of HR called ~~[~~John Barstow~~?]~~ led the investigation.

DR KIRKUP: And the outcome was?

MR GIBSON: I'm trying to think. It was – things just carried on as normal. It was written down on paper, and ~~that~~ things just carried on as normal. I mean with hindsight, I would – with hindsight I would have preferred that the Trust had handled it differently, and also I would have handled it differently. So I think it would have been better for Ian Cumming, the chief executive, to have a discussion with me and say, 'What's this about?' And with the benefit of hindsight, if he'd just thrown it out and said, 'You're our ~~are~~ clinical director; I want you to be clinical director and we'll support you.'

DR KIRKUP: Why didn't he do that?

MR GIBSON: I don't know. I don't know.

DR KIRKUP: Did you have a conversation with him at any stage?

MR GIBSON: No, no.

DR KIRKUP: How long after that was it that he left?

MR GIBSON: It's – yes, probably a year, I can't quite – I mean I could chase the dates down, but we're probably talking about a year to 18 months.

DR KIRKUP: Okay. Right, a couple of follow up questions on this then. What was communicated to the organisation in general?

MR GIBSON: About the investigation?

DR KIRKUP: Yes. I mean everybody must have known about it.

MR GIBSON: Yes, I'm not sure how widespread it was actually.

DR KIRKUP: Okay then, what was communicated to you? Did you get a formal letter?

MR GIBSON: I got a full copy of the – I got a full copy of the report which was given to Ian Cumming, and that made me think I've slightly been a bit naïve here. So I was encouraged to look at the totality bit and see was there learning in it for me, and could I have done things differently? And there definitely was. And so with hindsight, I felt that I met – I took big steps forward and said, 'Actually, now that people have explained this to me I can see how joining ward rounds without a proper explanation and without some in depth pre-discussion could be seen as intimidating and intrusive, or joining in – just...'

DR KIRKUP: Did you feel it was a kind of rap on the knuckles for you?

MR GIBSON: Well I felt that my colleagues didn't make any attempt to meet me halfway. They just bunged in a complaint and I'd taken this step, and that nothing came from that. And as a consequence of that, really my last – you know, between that happening and then us going into surgery, I became much less effective.

DR KIRKUP: You said you felt muted when you described it the last time.

MR GIBSON: Yes.

DR KIRKUP: Yes. So you must have taken that as some kind of, perhaps not formal, but there was some kind of implied reprimand in there.

MR GIBSON: No. I think the organisation was wrong.

DR KIRKUP: Yes, yes, but...

MR GIBSON: But I was muted, yes. So I didn't...

MR BROOKES: Look – sorry, it's exactly the same point, I'm just trying to clarify in my mind; were you formally reprimanded – what was the formal outcome?

MR GIBSON: No, I didn't have a formal reprimand. There was an investi – I'd actually have to go and read it again. No, there was no reprimand or...

MR BROOKES: So why did you feel muted if – you weren't, you obviously didn't feel vindicated by the report into what you'd done.

MR GIBSON: Yes, I just felt that it was harder for me to – I mean I tried not to flex authority and use authority, so I tried to be more participative, but I found it harder to do that. So I wasn't formally – so I'm obviously not twigging the question properly.

DR KIRKUP: No, no, I think the question that I had next on my list was what was communicated to those paediatricians who had raised the complaint.

MR GIBSON: I don't know. I don't know.

DR KIRKUP: Because it seems to me that's the vital part in all of this. So unless you knew that they had been told that their complaint was...

MR BROOKES: Upheld or not.

DR KIRKUP: ...upheld or not, then you are going to feel muted. You're bound to, aren't you?

MR GIBSON: Yes, yes. I mean things did – I remember things did get very difficult then, so we used to – as I say, we used to have a meeting from four till five on Thursdays, but it got to the point where the consultants would lock themselves in one of their rooms from three till four to have a meeting before they would then come out and join me and the senior nurse and the manager and whatever. And – yes, I was muted in the sense that I couldn't invite myself into their meeting.

And then that – I mean it would – yes, it would be quite fun – I mean I've put – I mean I can get the report quite easily because it's sitting in one of my appraisal folders, because I learned a lot, you know, I personally learned. I suppose I walked away thinking I learned a huge amount from this, and I don't think anybody else did. I don't think the organisation did, or my colleagues, but you know, selfishly I thought well I've learned lots here. And then quite soon after that then we went into the division of surgery, and the responsibilities changed again.

DR KIRKUP: Okay. And again, I just want to – I think this is my last one on this, but I just want to test this out really.

MR GIBSON: Sure.

DR KIRKUP: You've got here a clinical director who's faced with what he sees as a difficult bunch of colleagues in one location. They're extremely dysfunctional, the service is a mess, I think you've said. He tries to take some steps; they react against that, the outcome is unclear to everybody, but it certainly is not that: here's a clinical director trying to set about improving the service. Am I right about that?

MR GIBSON: Correct, yes. And I can see – I can see that's repeated itself. So I see lots of really committed, really good clinical staff who've stepped up to the

plate and have been destroyed, have gone off sick early, and I think that we in a sense haven't been given – and I don't know how generally that is across the NHS, but – so if we go back to that thing. I felt that I was given lots of support, and I was. I don't have to re-describe it; I felt that I was given lots of support, but actually I realise now there was another sort of support that I didn't realise I wasn't getting, which was to say...

DR KIRKUP: Backing your judgment.

MR GIBSON: ...backing judgment.

DR KIRKUP: As a clinical director.

MR GIBSON: And I've seen that with lots of the – the nurses have ended up taking early retirement or going off sick permanently and stuff, where they've stepped up. And there seems to be two parts to that. One is they're also – they're not given a wing of protection and saying, 'You spent 15 year or 20 years becoming this good as a clinician, but actually you need a whole bunch of different support.' And it's not just about going for nine days to the King's Fund or something like that. And I think there's another component that when things go wrong I think people who have got a long career in management are more robust at protecting themselves as individuals, whereas the clinicians are sort of saying, 'Well actually that is my fault, I didn't...' you know, they're used to saying, 'actually I connected the wrong drug.' You know, from the environment where they've come from, they're often the fall guy, I think. So I think that's...

DR KIRKUP: Okay. Any follow ups on that?

PROFESSOR FORSYTH: If I can have a couple of...

DR KIRKUP: Yes, go on.

PROFESSOR FORSYTH: One is your relationship with the clinical director for obstetrics and gynaecology, how did that work? Because clearly your services are related, particularly around – did you feel that you worked well together, that you felt you were being involved in some of the issues, particularly around obstetrics? My understanding, there was a clinical director based down in Barrow.

MR GIBSON: Yes, so the clinical director at the time – yes.

PROFESSOR FORSYTH: So how did that work?

MR GIBSON: Can I use names? It was just – yes, it was a Furness based clinical director. Yes – no, we didn't – we didn't succeed at linking up. There just wasn't joined up working.

PROFESSOR FORSYTH: Why, were there – again, was this a cultural thing or is it professional?

MR GIBSON: It is a cultural thing. So I mean a common scenario would be a neonatal nurse would ring Mrs Shannon, who was the head of children's nursing, and say, 'Look, there's a pair of – I don't know – 33-week gestation twins, and they're going to deliver them here. And the obstetrician wants to deliver them here, and the consultants paediatricians won't say anything – the paediatric consultants won't say anything to the obstetric consultant.' So it would come through to Mrs Shannon, it would come through to me, and then I would ring the ONG clinical director, and with something as kind of that clear cut that actually the right thing to do here, if it's safe, is to transfer the babies, he would intercede and make that happen.

But that would happen at that level, but on a more general level in terms of writing guidelines and protocols and things together, that didn't happen. It would have been great because I was – you know, I'd have loved to have joined up because they had a lot of resource that because of the CNST funding that came in to allow them to create extra staff to do things. But we just didn't – I mean I think we've got to that maturity now, but just right at that point in the middle of the 2005 to 2009 or something.

PROFESSOR FORSYTH: And so did you have sight of, for example, some of the reviews that took place subsequent to one or two of the incidents, including the Fielding Report, did you see that?

MR GIBSON: Yes, I had to go and – yes, yes, it's interesting, isn't it, what – the reports were just coming through, I suppose, as I – just as paediatrics and gynaecology were leaving surgery and setting up as their own – as a different directorate again, and I was just – so I had to go and look for those, so I have seen the Fielding Report. Yes, and I was just gradually going out of the loop because my role, that was kind of moving sideways into other things.

PROFESSOR FORSYTH: And the Paediatric Reviews that have been subsequently undertaken, you were involved in these, were you?

MR GIBSON: Yes. I'm trying to think of how many there have been, but...

PROFESSOR FORSYTH: There was the Craft Report and the Mitchell Report.

MR GIBSON: Yes, so the Mitchell – so Mitchell, I was instrumental in him coming, so Peter Dyer, who was the clinical director at that time, said that the board wanted to know – to understand paediatrics and child health better. Well, in fact what he said was he wanted to understand ophthalmology because they thought ophthalmology were pulling the wool over their eyes, and they wanted to understand child health better.

PROFESSOR FORSYTH: Metaphorically speaking.

MR GIBSON: And they wanted to understand paediatrics better because they felt it was complex and they needed somebody from outside, and someone gave me a recommendation for Andy Mitchell, so he came and did a report for University Hospitals of Morecambe Bay. And what was very interesting about that was on his first verbal presentation back, the chief exec – Tony Halsall had invited the chief executives of North Lancashire and the chief executive of Cumbria, and they both sent senior representatives. The Cumbria people took it really, really seriously. You know, their nose was out of joint – both parties' noses were out of joint, demanding to know what the hell a provider was doing commissioning a report of this nature. The Cumbria guys, within about five minutes, were quite happy about it, and subsequently approached Andy Mitchell to do a second report with a slightly different question on their total footprint. And the North Lancs people were never interested and just didn't want to play ball with it at all. So that was that one.

And, yes, Alan Craft's one, and – yes.

PROFESSOR FORSYTH: Okay, just as a final point, do you feel that the children's services are getting somewhere?

MR GIBSON: Yes. It feels – yes, it's been really noticeable...

PROFESSOR FORSYTH: Since you've come back you feel it's...

MR GIBSON: Yes, I've come back and it's almost unrecognisable. I mean there's lots of things the same, but the culture of the whole organisation feels different. I've got a very Lancaster-centric view now, because I'm not doing any clinical work or travelling up. Oh, it's – yes, and it will polish. I mean it's a bit clonky at times and a bit ham-fisted at times, but you think, yes, the journey has kind of raced on.

PROFESSOR FORSYTH: Okay, thank you.

[*The remainder of the interview was held in private*]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 July 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Dr Geraldine Walters – Expert Adviser on Nursing

KAY GILBEY

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DR KIRKUP: I'm Dr Kirkup; I'm chairing the Panel. I'll ask my colleagues to introduce themselves.

DR WALTERS: I'm Geraldine Walters and I'm director of nursing at King's College Hospital.

MRS GILBEY: King's College?

PROF FORSYTH: Stewart Forsyth. I'm a paediatrician and medical director from Tayside, Scotland.

MRS GILBEY: Hello.

DR KIRKUP: As you can see, we're recording proceedings. We will make an agreed record after that. We sometimes have family members present as observers during interviews. As it happens, there aren't any at the moment, but they will have the ability to listen to the recording –

MRS GILBEY: Of course.

DR KIRKUP: – after this, they'll be able to do that. You'll also be aware that we've removed telephones, recording devices and so on from the Panel and from anybody else who's present, as well as yourself. That's just to underline the importance that nothing that we talk about today goes outside the room until we've produced a final report with everything considered in context. Do you have questions or not? Okay. I'd just like to ask a general question to start with and then hand over to Geraldine. Can you tell me when you started at the Trust and what you've done since then?

MRS GILBEY: I've been at – I've been in Morecambe Bay for a long time.

DR KIRKUP: Pre-Trust?

MRS GILBEY: Pre-Trust, alright?

DR KIRKUP: Right, okay. Yes.

MRS GILBEY: So, I'll just go back to Trust, shall I? Yes. My husband's job, we moved up. We lived in Wales; we moved up here I think [inaudible] time. I was ward manager for about 18 years. Well, in my career, not just there, and then I went into management. I became – I think they were called nursing officers in those days. And then when the Trust merged – oh, no. I was a deputy director of nursing, sorry, in Kendal in the '90s – just in Kendal. Then the Trust merged and I became senior nurse at Westmoreland General, and I worked half time there and half time for the medical division. Then after two years, I became senior nurse and eventually became senior nurse across the bay, because the other two people on the other two sitessides left, if that makes sense, and then I worked for the director of nursing, and then she decided to leave, and I was asked to do an acting job for six months – three to six months. I actually did it for 18 months. I think you must think that is strange, and I'll explain why that happened.

PROF FORSYTH: Sorry, what date was that? What year are we on to now?

MRS GILBEY: Oh, about 2006.

PROF FORSYTH: Right.

MRS GILBEY: And so why – the chief exec that asked me to do it left within a couple of weeks of asking me. We then had an acting chief exec for four or five months, and then the permanent chief exec came into post. So, I stayed as acting director over that six-month period. The director of – the chief exec said that he would be going out to advert, and I said, 'Fine.' It was not a [inaudible] job. And I was in my 60s then. It was never a job I was going to apply for. So, he said, 'I'm going out to advert,' and I said, 'Yes, that's great.' He said, 'Will you, you know, talk to the candidates?' and I said, 'Yes, of course I will.' And

he appointed somebody. They were due to start – now, are you going to ask me exactly when? – but I think it was September/October. That period, at the end of 2007, because we have to give four months – three or four months' notice, ~~[and they have on short notice?]~~. Two days before they were due to come, due to personal reasons they didn't come. So, that was why my acting stayed an acting for a long time. Does that make sense?

DR KIRKUP: Yes. And when your acting period came to an end, that was because they did appoint a substantive director of nursing in 2008.

MRS GILBEY: They got a substantive – when I finished in July 2008, they actually had somebody substantive then who I'd actually been in contact with for a few months, because she again had to give, I think I'm right in saying, four months' notice, because I think the Trust where she worked, there would have been a foundation; they wanted her to do some work. But she used to come on; we used to discuss things so that the handover wouldn't be –

DR KIRKUP: Okay. And what did you do after that?

MRS GILBEY: I became her deputy.

DR KIRKUP: Right.

MRS GILBEY: Until I retired in – I was 65, so that would be – sorry – that would be 2010.

DR KIRKUP: And when you were deputy, did that have responsibilities across the three sites, or was it just for one site? It was all three sites?

MRS GILBEY: All three sites.

DR KIRKUP: Okay.

MRS GILBEY: Alright?

DR KIRKUP: Thank you. I'll pass you over to Geraldine.

DR WALTERS: So, when you were a senior nurse across the bay, what specialty were you [inaudible]? Was it [inaudible]?

MRS GILBEY: Well, there were three of us and we all had to find roles. This was in 2004 time, yes? And mine were return to practice, education and training, and safeguarding of vulnerable adults – plus other bits, but they were a lot of my main remit.

DR WALTERS: And your clinical role was in what?

MRS GILBEY: When I worked half time, I worked half time for the medicine division. My history of being a manager was always in medicine – [coronary care?].

DR WALTERS: Right. So did – the board experience then, from 2006, what were the big issues going on while you did your [inaudible]?

MRS GILBEY: One of the biggest issues that affected me was the increase in MRSA bacteremia. We had a real issue with MRSA bacteremia as the numbers were going up. They actually employed, sometime at the end of 2007 a consultant nurse, because it was a real concern. We had some safeguarding issues as well, safeguarding adult issues, if I'm – I can't remember exactly, I'm sorry, but we did have them.

DR WALTERS: Anywhere in particular or –

MRS GILBEY: Yes. We had a unit that was separated from the main site. I went and did quite a bit of work in there, and realised that looking at historical cases that unit needed to be brought into the main building.

DR WALTERS: So MRSA bacteremia and safeguarding.

MRS GILBEY: Yes.

DR WALTERS: What sort of things did the board sort of want you to tell them about generically about [inaudible]?

MRS GILBEY: We had – there's a word – not [inaudible] – appointed appointments; there's a special word for it. Somehow I just can't remember. And we used to look at that on a regular basis. I think we had those every month apart from August, and they were very – I mean, they were around the 98% A&E ~~attendants given to me[?]~~ target to be seen within four hours. There were other aspects of quality, definitely, in those reports. I totally just can't remember off the top of my head. At one time, though, a report did go to the board regarding maternity.

DR WALTERS: Oh, right.

MRS GILBEY: That was following the Healthcare Commission survey that was done in 2007. Two papers went to board during that time: one to say that it had been done, and a further one that said it would be reported on at a further board meeting.

DR WALTERS: And was it positive or...?

MRS GILBEY: Yes, it was.

DR WALTERS: Were there any concerns about maternity while under that board?

MRS GILBEY: You know, I have to be totally honest and say I don't remember anybody, or the head of midwifery, coming to me and saying, 'Hey, please come. We've got a concern.'

DR WALTERS: Right.

MRS GILBEY: And I'm sure I would remember that, but I don't. If there was any, I honestly don't remember. But I don't think there were.

DR WALTERS: Did you have any involvement – direct involvement in things like serious incident reports – anything like that?

MRS GILBEY: The governance department was directly managed by the medical director at the time, but we had an excellent working relationship. I don't remember him speaking to me about anything – anything which would have caused me concern. I can't say no-one ever did, but nothing – I feel, because I remember certain things, I would have remembered that, but I'm sorry, I have to just be honest: I don't remember.

DR WALTERS: So, it wasn't part of your role to sort of attend sort of risk – or meetings about serious incidents or anything like that?

MRS GILBEY: No.

DR WALTERS: And did the board get a view of serious incidents or any information?

MRS GILBEY: Yes, it would. The information was discussed. It definitely was discussed. Every week the board met. I'm just trying to think. They were discussing – you know, big issues were discussed at the actual ~~intel[?]~~ board meeting that, you know, you have every week.

DR WALTERS: With the non-execs and DR KIRKUP and –

MRS GILBEY: No, just the –

DR WALTERS: Just the execs.

MRS GILBEY: Just the execs, and then we met – I mean, we had one non-exec who took an interest in risk complaints, very much so. She was very active in that area, if I may say.

DR WALTERS: So, it must've been sort of towards the end of the time that you were acting into the role that the five incidents happened that prompted the Fielding Review.

MRS GILBEY: Yes. It was – well, as far as I know, it was after I finished. I finished – I think it's officially I finished at the end of July, but I went on holiday, so I finished just before that, so yes.

DR WALTERS: And what did you think about those five incidents? Did you talk to anybody in midwifery about them or –

MRS GILBEY: No. My director of nursing then, she dealt with those.

DR WALTERS: Okay. So, when – before Jackie came –

MRS GILBEY: Yes.

DR WALTERS: – did you have much to do with the head of midwifery or –

MRS GILBEY: Yes, I met up regularly – you know, every – at least every two weeks, and I don't remember her raising any concerns in that period of time.

DR WALTERS: And did you ever have the opportunity to go to the Barrow unit?

MRS GILBEY: I would have done, because the chief exec at the time was very keen that we were out and about, and I was often in A&E units because of certain issues, and when I was on the site, I would very much have gone to different places. I wouldn't say I would go every fortnight, every three weeks, but I would definitely go at times.

DR WALTERS: Yes. So, was there a sense of worry about these five incidents, or did people think, 'Just a tiny few that haven't [inaudible]'?

MRS GILBEY: I think I'm right in saying that they came to light after I'd finished. Jackie, the director of nursing at the time, became very, very involved with midwifery. You know, that was what she spent – and I did more, if you like, the general nursing side. I looked at various aspects of ~~soundness[?]~~quality, introducing productive ward – those type of things.

DR KIRKUP: Can I just ask why the director of nursing – we're talking about Jackie ~~Hunt~~ Holt here, right? But why did she become very preoccupied with midwifery?

MRS GILBEY: Because she was worried because of these incidents.

DR KIRKUP: And what time periods specifically are we talking about here?

MRS GILBEY: I would say from September onwards.

DR KIRKUP: September of which year?

MRS GILBEY: 2008. If I remember correctly –

DR WALTERS: As soon as she got there.

MRS GILBEY: If I remember correctly.

DR KIRKUP: And what was it that precipitated the concern in particular? Was it one incident? Was it a report?

MRS GILBEY: Well, there was one incident, I believe, and then there was another. I can't remember it all, but, yes – and I haven't gone back and looked it up or anything or –

DR KIRKUP: But, I mean, let me just be clear about this: it was the occurrence of the incident in 2008.

MRS GILBEY: Yes.

DR KIRKUP: You're not saying that it was the inquest that was held in 2010 or 2011. It was the actual incident that...

MRS GILBEY: I'm just – just let my brain think of years.

DR KIRKUP: Sure. Sure – no problem.

MRS GILBEY: I imagine 2010... when I retired in 2010, after about six months, seven months, I had a phone call from the director of nursing asking would I come back for three months purely to do nursing, because she was spending

a lot of time – so I might have got my timeframe a little bit wrong. But she was concerned, definitely, at the end of 2008, at some of the issues that had happened. I can't remember that – how much time she spent where. I do know that it was when I came back for a few months that she definitely spent time in midwifery and was appointing new deputies.

DR KIRKUP: Okay, but that wasn't the first time; the first time was in 2008[?].

MRS GILBEY: Yes. No, she was – sorry.

DR KIRKUP: That's – no, that's fine.

MRS GILBEY: I'm sorry. Time framing[?].

DR KIRKUP: That's fine. I'm sorry to [crosstalk] about the specific times, but I need you to do it.

MRS GILBEY: No, you're right, because I would be the first to say time just goes by now.

DR KIRKUP: Sure thing. Sorry, Geraldine.

DR WALTERS: No, that's helpful, actually. So, the five incidents in 2008 were things that sort of, [of course, you've said?] to the Fielding report.

MRS GILBEY: Yes.

DR WALTERS: Can you remember the sort of Trust response to that at all?

MRS GILBEY: No. I mean, I didn't know – I mean, the director of nursing was saying to me that she was going to commission a report and she told me who it was, and it was somebody I had met on many occasions. So she did mention it then, but, no, I don't know. She –

DR WALTERS: So, Jackie instructed, did she?

MRS GILBEY: Yes, yes.

DR WALTERS: So you left in 2010.

MRS GILBEY: '10/'11.

DR WALTERS: '10/'11. What was going on then?

MRS GILBEY: Are you asking me to relate this to maternity?

DR WALTERS: Well, in just –

MRS GILBEY: You know, I'm just –

DR WALTERS: What was – what were the things that were taking everybody's time? You know –

MRS GILBEY: I mean, we hadn't[?] improved MRSA; that – I mean, it wasn't good, but it was definitely on the mend. We were introducing productive ward; we were looking at standards; we were looking at introducing patient safety bundles, so I spent quite a bit of time doing that. They were introducing it. Oh Lord, it's hard to remember them all.

DR WALTERS: Let's just go back to the Trust in general then. Obviously you've worked at the Trust a long, long time.

MRS GILBEY: Yes.

DR WALTERS: What did you think the sort of morale and culture was like in those years?

MRS GILBEY: I suppose I'd say to you, if you asked me about culture, there were three cultures. And every – because they served different types of communities, because there was quite a distance between each one, and so many people thought we were going to make it one culture, and I think one of the hardest things you can try and do is to change culture. It's a lifelong task really. And the people didn't really – each director of nursing, and they had a few ~~odd~~ manager days and different things to bring people together to try and get cross-pollination of, you know, to change the culture, but I think people

went back to their own – they saw it as their own organisations. I think that would be the truth. They never saw it as a real cohesive merger. It might be wrong, but that would be my understanding.

DR WALTERS: Yes. Do you think there was sort of – within each organisation, were people quite positive? Was morale high or –

MRS GILBEY: I think there's a problem sometimes. When people have only worked in one place, they have nothing else to compare it to. And one of the areas I think they never moved – so, if you you've nothing to compare it to, you've nothing actually to say whether it's better or worse than, and sometimes that can make you think you're being badly done to when actually it's not – you know, if you're sent somewhere else, you haven't quite got experience where you were actually working.

DR WALTERS: And did you have any sort of concerns around quality of care or safety from your position in the Trust?

MRS GILBEY: No. I mean, I've always believed you're only as good as your worst nurse at three o'clock in the morning, and you have to be aware of that. That was why ~~before [inaudible] the~~ in 2004 the director of nursing sent me in to do quite a lot of work on one of the sites. There were issues of bullying on one of the sites. So, I went in for – I don't know - 20 nights - to speak to the night staff: different people on the unit were a bit ~~of [an art?]~~apprehensive so they wanted people with them, and I said, 'Well, if you want to come, that's fine.' But actually that experience showed me that I didn't find any bullying, and I felt I was reasonably approachable. And I did speak to something like 60% of permanent night staff. ~~I'm not looking for permanent night staff,~~ but they have permanent night staff, and I did speak to quite a lot of people. And I didn't – I

used to, at the end of the conversation, I did say to them, 'Is there anything else you'd like to raise with me, because I'm here now; you've got my attention?' and there was very little at that time, and that was – I'm just trying to think. That would be 2005/6 – just before the director of nursing left.

DR WALTERS: Is there anything you'd like to draw to our attention that you think we need to know or should ask?

MRS GILBEY: I don't think so. I mean... I really don't think so. I think morale does fluctuate. That's the thing about morale; I think it does fluctuate on various times and various reasons. But generally speaking, I'm not saying it was wonderful, because I think the staff surveys, and you must have seen those, all showed those, but I do think it's sometimes a lack of people never working in other places, yet I was in Kendal and all of that, and I did work in a lot of places before I went there.

DR WALTERS: Okay.

DR KIRKUP: Thank you. Stuart?

PROF FORSYTH: Thank you. Actually there are a couple of points. One is you must – the head of midwifery changed around 2007.

MRS GILBEY: Yes. I don't – have tried to remember. I'm not sure but she left [redacted] because I think, if I remember correctly, there was a head of midwifery that was acting, and I think two or three people did it in rotation, if I remember it correctly, and then a head of midwifery was appointed.

PROF FORSYTH: And [inaudible], did you notice a difference when the new head of midwifery came and you had your contact with her? Did she raise issues –

MRS GILBEY: Mmm – I knew her.

PROF FORSYTH: Yes.

MRS GILBEY: She used to work at the Kendal when I – you know. [crosstalk]

PROF FORSYTH: So did she come to you and raise – you know, she's come in and did she raise issues with you about the midwifery unit?

MRS GILBEY: No. I would definitely have remembered that. I would...

PROF FORSYTH: Okay. So, did she introduce any, you know, new changes or – again, can you remember anything along those lines?

MRS GILBEY: She was a person that had worked on a community mainly, but I'm doing hospital, and that's how I first got to meet – because she was based in the Kendal area where I've been doing that job. And I knew at the time she was a great believer in rotation – that, you know, she thought it was good that other people and – you know, rotated. And we had similar views on that, because I always used to laugh that she had what I wanted: she had her midwives rotating days, nights – everything – doing on call, and I struggling at times to try and get – in Kendal they had rotated, but the other sitessides had struggled a bit to get the rotation up and running for night and day staff. So, I – I can't remember if she said she was introducing the rotation, but I know she was keen on that.

PROF FORSYTH: In terms of your reflections on what happened, I mean, are there things that come to mind, possibly with the benefit of hindsight, that you felt should have been done – something should be done quicker rather than later? What are your thoughts there?

MRS GILBEY: With the benefit of hindsight, I could beat myself up and say, 'Why didn't I go to the maternity units? Why didn't I spend time there, more?' Do you know what I mean? But you think you're spending time – you know, if you

think you have so many complaints about a certain ward, I would then look at those complaints and go into that ward, try and talk to staff, try and talk to lots of people, find out what the reason was: was there a problem? You know, and unless something's brought to your attention, you put your energies where you think they should be, I think.

PROF FORSYTH: So, did you see any complaint letters? Did they come on to your desk, regarding the maternity unit in Furness?

MRS GILBEY: I would occasionally – as I said, we had a non-exec who used to look at a lot of the complaint letters, and once she brought something to my attention and said, 'Hey, do you realise there have been three complaints in six months about ward X?' and I said, 'No.' So, I went straight away. I mean, I haven't picked that up, and we did introduce a better system actually that highlighted areas that were below standard[?].

PROF FORSYTH: So, who sighted –

MRS GILBEY: But I don't remember seeing lots of complaint letters. I'm so sorry; I just don't remember.

PROF FORSYTH: In the organisation, who signed off the responses back to the family?

MRS GILBEY: The chief exec.

PROF FORSYTH: So, the chief exec did. So, the director of nursing, the medical director, didn't?

MRS GILBEY: No. They would often have a lot of input into it, but they were signed off – I'm sure I'm right in saying – at that time by the chief exec. Of that I'm sure, unless he was on holiday.

PROF FORSYTH: So, it would have been quite difficult as a director of nursing to really get a feel for the range of complaint letters that were going out.

MRS GILBEY: No. No, I could go down – and I did go down – to complaints whenever I wanted. You know, that was never hidden away.

PROF FORSYTH: No.

MRS GILBEY: Never hidden away at all.

PROF FORSYTH: That's fine.

DR KIRKUP: Thanks. You've mentioned that you were asked to come back into the Trust after you'd retired. Was that in 2012? I'm sorry to weave all over the place.

MRS GILBEY: Can I just think back? No, it was December 2011.

DR KIRKUP: Okay. But this –

MRS GILBEY: I think. I'm sure I'm right.

DR KIRKUP: But this email correspondence relating to you, and it dates from 2012, I'm trying to clarify whether you were still even at the Trust or not.

MRS GILBEY: Ah. I say – I say – I've never explained exactly what happened. I came back at the end of 2011, and by May/June – that type of time –

DR KIRKUP: 2012.

MRS GILBEY: – Jackie – 2012.

DR KIRKUP: Yes.

MRS GILBEY: I'm just getting this right. Had Jackie appointed her deputies then? Yes. She must've done. I stayed on because we found issues in 2011 – that would be right – issue in the complaints department, and we unearthed some complaints that hadn't been dealt with on time and things like that. And I took

over some of the role of ensuring some of this was filed, brought up to date and that sort of thing.

DR KIRKUP: That would be complaints across the Trust as a whole –

MRS GILBEY: Yes.

DR KIRKUP: – not specific to maternity?

MRS GILBEY: No. Complaints across the Trust.

DR KIRKUP: Did you have a specific role in relation to maternity?

MRS GILBEY: No, not –

DR KIRKUP: Not in 2012?

MRS GILBEY: I didn't have anything – I didn't do anything. Jackie was doing maternity then. I literally was doing general nursing when I came back.

DR KIRKUP: Right, right. Okay.

MRS GILBEY: Is there something you've got there that says differently, because...

DR KIRKUP: No, not at all, but you were involved in a couple of investigations of [inaudible] crimes.

MRS GILBEY: I did investigations – for my sins, I did a lot of investigations into medical staff and nursing staff.

DR KIRKUP: Right. And that – that – was that specifically when you came back again, or was that before you left?

MRS GILBEY: No, no. Was this regarding an email?

DR KIRKUP: Yes.

MRS GILBEY: I mean, but you wouldn't – I wouldn't say to you the title of it, yes?

DR KIRKUP: There are two emails, in fact, that would be regarded as inappropriate by most people.

MRS GILBEY: Right. No, this was – I'm trying to phrase it correctly.

DR KIRKUP: There was one that referred to the NMC –

MRS GILBEY: No.

DR KIRKUP: – treaters[?].

MRS GILBEY: Well, yes – this is NMC and a word.

DR KIRKUP: Yes.

MRS GILBEY: I was the investigating officer then, but that was in – just let me think – I'm so sorry. I thought I was – I thought I was employed as deputy properly then when I did that.

DR KIRKUP: Okay.

MRS GILBEY: Hang on. I thought – I'm sure I was. I did an investigation because I actually took the investigation further, because I was actually asked to investigate one person giving a password to somebody else [inaudible]. When I saw the title, I'm a great believer in professionalism, and I couldn't let that go, and so that formed part of my investigation into that.

DR KIRKUP: Yes, okay. No matter about whether it was when you'd – before you'd retired or after you'd come back after you retired. That doesn't matter.

MRS GILBEY: I did it –

DR KIRKUP: But I would like to pick up that issue with you.

MRS GILBEY: Yes, of course.

DR KIRKUP: One issue was that – and I appreciate what you've said about that – one issue was the password, which was to do with IT rules[?] and all of that, but there's a third issue, which is about the content of emails. Did you form a view on that?

MRS GILBEY: I made an opinion on the title. I made – I mean, I met the midwives there, and I think it was one of the most upsetting days. They couldn't talk to

me for crying their eyes out. They said to me that the girl who had—~~the ward~~ – she's rung the ward manager, asked the ward manager to go into her email account and forward the email to her home address, because she wanted to work on it at the weekend. I never – I mean, I never saw this as collusion, if that's what maybe you're indicating. I think she just – the person who entitled the email the entitlement had sentried[?]? her as a union – she was the union rep. That horrified me. She was the union rep, and she'd actually sent that as a guidance [inaudible], and I believe that's what it was, if that's what you're trying to say to me.

DR KIRKUP: It's the third issue that I'm asking about, yes.

MRS GILBEY: Yes.

DR KIRKUP: Did you specifically form the view that it didn't represent collusion?

MRS GILBEY: No, I didn't think it did represent. I felt she was guiding her as a rep.

DR KIRKUP: Yes. That's – sorry to want to be precise about this, but I do want to be precise about it. One of your conclusions was specifically that this is not collusion.

MRS GILBEY: Right.

DR KIRKUP: So, is that correct?

MRS GILBEY: I can't – I didn't – without reading it, I can't remember, but I didn't feel it was. I mean, I remember that much.

DR KIRKUP: Yes, okay. Did you have any other involvement with an email exchange that refers to somebody going to Thailand over the period?

MRS GILBEY: Yes. Now, that was –

DR KIRKUP: Yes. [Similar language?].

MRS GILBEY: – that was after I'd virtually – it was the day before I went into hospital, I think. It was December 12, was it?

DR KIRKUP: Yes, I think so.

MRS GILBEY: Yes. I was asked to interview, with the assistant chief exec, the head of complaints and why she'd sent the email.

DR KIRKUP: Does the occurrence of two email trails that contain inappropriate references and content, does that trigger any alarm bells in you? Does that make you concerned about staff attitude at all?

MRS GILBEY: Yes. Yes, it does.

DR KIRKUP: Are you saying that now in hindsight, or did it at the time?

MRS GILBEY: Well, it's – yes, yes. I mean, it was two very different occasions. But when you put the two together, yes.

DR KIRKUP: But you didn't raise a concern at the time about that?

MRS GILBEY: I mean, the first one, yes, I did raise a concern, because I wasn't actually asked to investigate the title of the email. That was what I went on and did. The second one, I don't think I knew for a few weeks before, and I was asked to investigate that bit of the email, but – and then I went into hospital the next day.

DR KIRKUP: Okay. Let me go back to 2006-2008, when you were acting director of nursing. Did you have concerns at that time about any issues in the maternity unit specifically in Furness?

MRS GILBEY: No, I didn't.

DR KIRKUP: Did anybody raise any concerns with you –

MRS GILBEY: No.

DR KIRKUP: – about staffing or capacity constraints?

MRS GILBEY: No. I would – because if somebody had raised that with me, I know that I would have taken that to the chief exec. I know I would, if it was a capacity thing or if they needed more staff. I mean, our chief exec at the time would always listen.

DR KIRKUP: Listen and act, or just listen?

MRS GILBEY: Yes. Well, I found him approachable. You can only speak as you find.

DR KIRKUP: Sure. Were you involved in any preparations for inquests?

MRS GILBEY: No.

DR KIRKUP: Were you aware of any issues around the preparation of staff for inquests?

MRS GILBEY: No.

DR KIRKUP: Anything that the Trust [inaudible].

MRS GILBEY: No. Is there something else I've forgotten?

DR KIRKUP: No, no – no, no, no. I'm just –

MRS GILBEY: No, it – honestly no.

DR KIRKUP: Okay. Another questions you want to follow on? Is there anything that you would like to tell us that you think that we haven't covered but you would like to add?

MRS GILBEY: No. I'm sorry.

DR KIRKUP: Okay. Thank you.

MRS GILBEY: Thank you.

[Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Monday, 22 September 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Mr Julian Brookes – Expert Adviser on Governance (in the Chair)
Dr Catherine Calderwood – Expert Adviser on Obstetrics
Dr Geraldine Walters – Expert Adviser on Nursing

JUNE GREENWELL

Transcript produced by Ubiqus
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MR BROOKES: Good morning. My name is Julian Brookes. Can I first start with an apology? Bill Kirkup, who is chairing this Investigation, as I'm sure you know, unfortunately can't be here today, so he's asked me to chair this session on his behalf. What I'm going to do is we're going to introduce ourselves and ask you to introduce yourself for the record, then we're going to go through some housekeeping stuff and then we'll start the questions, if that's okay.

DR CALDERWOOD: Morning. I'm Catherine Calderwood. I'm an Obstetrician in Edinburgh and I advise the Scottish Government.

DR WALTERS: I'm Geraldine Walters. I'm Director of Nursing at King's College Hospital NHS Trust.

DR GREENWELL: In which?

DR WALTERS: King's College Hospital London.

MR BROOKES: I'm Julian Brookes. I'm currently Deputy Chief Operating Officer with Public Health England, but was previously Head of Public Procurement at the Department of Health. Welcome.

DR GREENWELL: As you know, I am June Greenwell. I don't know how far back you want to know of my background.

MR BROOKES: We'll do that in a second. Firstly, as you're aware, there are microphones today. We are recording all these sessions. These sessions are open to relatives. As you can see today, no one is attending this particular session. The recording is for two main reasons: one is to ensure that we have an accurate recording of the discussions. Secondly, if a family at a later stage wishes to hear what was said, under controlled conditions, we'll allow that to happen, so that they don't have to sit on all the evidence that we hear, because we hear an awful lot, as you can imagine.

The second thing is you'll have been asked to hand in your phone. That's because we are conscious that it's very easy for people to misinterpret out of context what is said. Therefore, we ask anyone who enters this room to not have anything that has the potential for recording in it, so that we ensure that the evidence that is given stays within the context of the investigation and will be taken into consideration with everything else we hear and not taken in isolation. That's really important.

The final point just to make is, if we get into a situation where we feel it relates to individuals or patients, etc., we will do that at the end in a closed

session and we will formally finish the open session and move to a close session to do that. We will consider that as we go along.

The only other thing to say is no fire alarms today. If there is a fire alarm, it's genuine and we will leave appropriately. That's all I really need to say as an introduction, and we'll now start the questions, Geraldine.

DR WALTERS: Morning, June. Could you just tell us about your role at the Trust, when you started, what it was like?

DR GREENWELL: I started in 2004. I moved over from the PCT. I had been a non-exec for the PCT. Before that, the PCT had been preceded by a Health Authority; I had been a non-exec with the Health Authority. Before that, with a gap of a couple of years, I was Chair of ~~both~~ the Community Health Council for Lancaster and Morecambe. Before then, I was working for South Cumbria Health Authority as a community nursing research officer in Barrow.

DR WALTERS: When you first arrived at the Trust, what were your impressions?

DR GREENWELL: I'll be discreet. I had expressed an interest in elderly care and maternity services, the maternity services because I'd been Chair of the Maternity Services Liaison Committee while I was on the Primary Care Trust. I can't remember, to be honest, whether it was the Health Authority or the PCT, but while I was in that area – and elderly care because the community nursing research project I'd been involved was linked to Nottingham University. It was looking at the care of elder people after discharge from hospital. The then director of nursing didn't want me involved in either of those.

The third thing I expressed an interest in was risk management. Nobody else was interested. None of the other execs had expressed any interest in risk management, so I joined the risk advisory group, as it was known, and that gave me an insight into the governance arrangements of the Trust that left me concerned. I did write to the Chief Executive saying that I thought this structure was inadequate.

MR BROOKES: When was that?

DR GREENWELL: That would be some time in 2004-05, but exactly when I can't recall. What bothered me was that the risk advisory group was an advisory group; it couldn't make any decisions or take any actions. It reported to the clinical governance so-called committee, which met on a Friday afternoon. About 30 people attended. It rambled. It was anecdotal and it didn't make

decisions. Their recommendations then went to the board, and sometimes the decision weren't made that needed to be made. You had three structures that risk issues went through. It wasn't operating as I felt it should be. It certainly wasn't operating in a way that the risk group on the PCT had operated.

The clinical side of it, if anything, was anecdotal. I know that clinical governance in the early 2000s was a relatively new concept, that managers should be involved in clinical governance. The other element was the audit committee. The culture seemed to be that the audit committee's job was to defend the Trust against the audit committee. I got to have a look at what the audit committee as saying and, unusually, the Chief Executive and the senior directors were on the audit committee, so there was no independence. I was concerned, without being any great expert. Just from looking at it, it seemed to me that it wasn't working properly.

There was almost three phases to the governance arrangements. I've been trying to think this out for today. When the Chief Executive left, ~~the then Chief Executive left and~~ there was an interregnum, some things started to improve.

DR WALTERS: So that was when Ian Cumming left and Tony Halsall started.

DR GREENWELL: No, there was a gap between the two before Tony was appointed. That was when the audit committee changed. I was asked to chair the audit committee, which was a shock because I'm not an accountant, but I discovered very rapidly that ~~the~~ audit committees had been briefed nationally to review ~~wards him within~~ the whole of governance, including clinical governance. I realised this was an opportunity to cover a wider agenda, ~~and started looking at some things and~~ working closely with both the audit commission and internal audit. With the support of the lead directors, we altered the structure and membership of the audit committee, so it became a non-exec-led group with the finance director and anyone else we wanted in, for any particular issue.

That was a sort of middle phase, and then Tony Halsall arrived. A bit later, Jackie Holt arrived, and earlier Peter Dyer had been appointed. Those three really made a difference. I can remember very vividly the first audit committee that Tony attended. I'd got on the agenda the – what do you call it? – the maternity litigation.

MR BROOKES: CNST?

DR GREENWELL: Yes, that's right. Why were we stuck at CNST level one and how much investment would be needed to move forward? I wasn't getting anywhere, but I realised from being on the risk committee that ~~actually the management of some elements of maternity risk – not big things – but~~ you couldn't always get the board actively promoting what needed to be done. The head of midwifery, a midwifery risk manager, myself, and one or two others would be ~~were~~ trying to get the board to make a decision, and then it would be put off and the deadlines were getting nearer for the point in the year when we had to submit things to CNST. It was just slow-moving.

MR BROOKES: Where was the delay at the board?

DR GREENWELL: First of all, things had gone through the system that I described, but then the board seemed to be focused on things that were targets for the board. It wasn't all financial. I forget now the detail. I think there was a star system at that point, or a points system, so for my first few years, the Board was focussed on how we were managing on all the things that you were getting assessed on from the centre, which weren't all financial... The kinds of decisions that needed to be made, operationally, in terms of the board agreeing to some CNST related action, it wasn't a top priority, so you had to keep on sticking your neck out and pushing. There were people on the board who... I wasn't the only voice, but it was so slow. The end of the year was coming and you just couldn't get things moving, and the Risk Advisory Committee had no operational authority.

~~I decided that one of the things...~~ We looked at two things at that time in the audit committee. One of them was the special increment for teaching to see where that money was coming in and how it was being spent. The other was what would have to happen in order to push maternity services up, from CNST Level 1 ~~level one~~ to move it forward. Soon after he was appointed Tony arrived to watch the audit committee's ~~first visit~~ and we were getting the feedback on this issue about maternity. He said, '~~Yes,~~ I can't see why this trust is satisfied with being at CNST level one.' Inside my head, I was almost shouting 'hallelujah'. I don't have to worry now. He's taking it on'. I think there's a sober comment in one of the minutes saying, 'It was recognised ~~ing~~ that the board was accepting this as an issue of considerable priority, and the

audit committee would not continue exploring this area because it was now passing to the board.' This was the beginning of the feeling that things were definitely beginning to improve.

The risk structure changed, so it became a risk management committee rather than an advisory group. I can't remember exactly when, but I know there was a point where the only clinical area that had a risk management policy was the maternity services. I remember the paediatrics head of nursing who was on risk management saying, 'Can I have a copy, because we need to do that?' There was a ~~It was the~~ push to drive through that kind of attitude to risk management, and then Tony got going with Peter and later with Jackie, looking at how we score risk and how the Trust as a whole, ~~in~~ the clinicians and directors, should score risk collectively and then have a risk mitigation strategy and all of that was happening. There was a definite change. There's culture one, then an interregnum with some improvements then this improvement phase. That was the point when the new medical director, I think it was the Darzi or some name like that recommendations.

MR BROOKES: Lord Darzi.

DR GREENWELL: Yes, for three streams that we should look at: patient safety, clinical effectiveness and something else that I can't remember. Those three were set up as clinical committees reporting to the board, so that was happening, then Jackie Holt joined us and that made a tremendous difference. She was saying to Tony, 'We really need a clinical quality and safety committee,' and I was asked to leave the audit committee, which I thought was entirely appropriate because it did need an accountant, and chair the clinical quality and safety committee. (CQSC)

But b~~B~~ecause CQSC~~it~~ had emerged out of the audit committee, we came to realise the structure ~~had~~ was flawed. It should have been clinically led, not non-executive-led but, because it had emerged out of the audit committee, it was non-exec-led, with directors and Board level clinicians. There was the medical director, and the nursing director; Angela Oxley, who was then the head of midwifery, was involved if maternity items were on the agenda ~~or not,~~ .B~~b~~ut it needed to change. Just before I left, we were having discussions about what new structure should be introduced. I don't know what

has happened subsequently, but it certainly needed to be a more dynamically clinically led group.

~~It still meant that you had to overcome a problem.~~ Sorry, I'm going on; it's such a relief to talk about it. Another thing that had bothered me was there was no central point at which all external clinical reports came into the Trust. Things like Royal College recommendations or the confidential enquiry reports, which to me are some of the most important documents and reports from~~, the~~ internal audit, external audit, Royal Colleges, patient safety, all those reports started to come to a central point at the Trust. Before that, I'd gone to our Chairman and said, 'You can't actually find anybody who's bringing all that together.' She said, 'Yes, I know. I get some sent to me and some sent to other people.' It didn't feel for quite a while that it was changing, but then it did, with new risk management structures and CQSC...

I'm making myself sound as thought I'm the source of all wisdom and I'm not, but it was frustrating. Definitely, the combination of Tony, the new medical director, the new director of nursing and a very articulate strong finance director made a big difference... One of the interesting things for me was the way the HR director and the finance director found that attendance at the clinical quality and safety committee was valuable they ~~and~~ said to me, 'We've never got into these things before.' Things like the dreadful mortality figures, which we couldn't understand, there was one month when we went through every single one of them and we couldn't understand them. It was reported in the press.

MR BROOKES: What couldn't you understand?

DR GREENWELL: For instance, the glaring example was the fact there were considerable numbers of excess deaths in haematology. There weren't. We very rapidly discovered that whoever was the on-take consultant in A&E, their name and their speciality were associated with the people who they ~~were~~ admitted. So a patient admitted to A and E when the haematology consultant was in charge would be coded as a haematology case. The nature of the collection of statistics meant that you couldn't change ~~that~~, so what happened was that the Trust~~is the~~ moved from Dr Foster to – and I can't remember the name of the other organisation we ~~you~~ used – that provided – what would you

call it? – that looked at the figures and there was clinical discussion led by the consultants looking at those figures, so they were more accurate.

We got a report that actually, I forget the word, tidied up and dealt with anomalies. Even though we'd got a new interim director of nursing and she was going round every ward trying to see that the consultant name was altered so that we got accurate statistics, but she couldn't do it. There was something about the way nationally statistics are collected from ~~the~~ A and E ~~MD~~ records that meant it still went in as a haematology death.

The glaring example ~~one~~ I remember us looking at that was listed as an excess death was a 96-year-old who'd been in hospital for six weeks. He'd come in with a fracture. [redacted] It was an excess death, because you shouldn't die of a fracture.

DR WALTERS: Were you looking at coding at all?

DR GREENWELL: Yes, we were, that whole area. We got the people in who did the coding for us and certainly things were improved but, the trouble is, nationally it was reported based on statistics that were not accurate. There was a determination to improve mortality figures, but there was also an awareness that the published figures were not filtering –

DR WATERS: Did the Trust accept that, actually, that was the data that they had submitted? It's really about Trust housekeeping, isn't it?

DR GREENWELL: Yes, partly it was. I know there was ~~a~~ huge effort to correct it and I know it failed and I don't know why, but there was a genuine effort.

DR WATERS: Did the board take an interest in the sort of resourcing and coding?

DR GREENWELL: Yes, they did. I remember us spending time with the clinical audit people, and there was a real attempt to do it, but I couldn't tell you now whether it's actually working well. All I know is we did one month go through absolutely every excess death. We were reassured that there were clinical committees of clinicians who went through those excess deaths in the same way, because you want to be certain that the excess deaths are being dealt with.

DR WALTERS: Just going back then, you started in 2004. You said that the director of nursing didn't want you involved in elderly care or maternity services. Why was that?

DR GREENWELL: The Chair of the Trust was a professor of general practice who'd taken a keen interest in elderly care. He was linked with that and the Director of Nursing ~~she~~ didn't want anyone else. There was another Non-Exec ~~someone else~~ from within the Trust also interested in the maternity service ~~team~~. While I'd been Chair of the maternity services liaison committee, I'd proposed from the PCT –(it's an uncomfortable situation, because an outside body is looking at the work of the Trust ––)I'd suggested that this other Non-Exec and I ~~they did a joint report, that a non-executive from the hospital Trust and myself~~ prepared a joint report – and presented it to both organisations.; ~~and~~ I got nowhere with that. I had a feeling. I know it was reported to the Chair that I was looking to micromanage the nursing service. My perception was of resistance to Non-Exec scrutiny I didn't feel I was trying to micromanage at all, but ~~I think~~ there was an apprehension about that.

There were concerns I shared with other Non-Execs ~~we had~~ about the way nursing was managed and, in particular, there was a very real concern, which was nothing to do with maternity, it was about child protection.~~on child protection~~. Again, we just couldn't get action on that until there was a change and the director of nursing left. The person who acted up in an interregnum before a new permanent appointment was made,immediately took that issue on board, and also took on board complaints about patient care in an elderly care ward. Again, you saw things improving.

DR WALTERS: When you were chair of the MSLC, were there any concerns coming from that route about the maternity service?

DR GREENWELL: No, there weren't. It was interesting; when I took over, I got the checklist of all that we were supposed to doing as the maternity services liaison committee. The consultant was quite closely linked. The head of midwifery and her deputy were there. We had quite a strong patient group, (and it's not easy keeping a patient group for maternity) going at Furness General, a less strong group at Lancaster and some interested people at Kendal. There were a lot of small things that they were reporting on, but maternity it was not the area that worried me. I was far more worried by elderly care than I ever was by midwifery.

I pored over that CQC report that came out after the Coroner had made his comment. I think it was 2011, but it might have been done early 2012.

They had done one report in the summer and then they came back again. The section on talking to patients had exactly the same feeling of patient satisfaction that I had picked up earlier with the maternity services liaison committee.

The other thing that heartened me was a group of women in Barrow got together to create a blog or a website, whatever it was called, in support of the midwives and maternity services, which I thought was wonderful, and then it disappeared. I asked why and was told the woman who had started it was put under enormous pressure locally to remove it.

DR WALTERS: What time was that?

DR GREENWELL: That would have been around 2011. It was when the skies fell in after the Coroner's comment, when Sky TV and the police announced they were initiating an inquiry. That awful afternoon when Sky TV started to come up and *The Sun* newspaper, then it turned out all the police had gone home but they'd arrived anyway, or they'd contacted the Trust. I was saying to Tony Halsall, 'We're bound to get over it.' He said, 'June, you don't understand it. You can manage press reaction and media reaction if it's local. Once it's become national, we'll be very lucky if we can get out of this. Every organisation that scrutinises us will scrutinise with far greater intensity and, inevitably, they will find things that we are not doing well.' He wasn't being apologetic or evading anything.

Several of us were saying, 'Why don't we rebut some of these claims? Furness General is not a ~~It's not the~~ baby deaths' hospital.' As far as we could see from maternity and mortality statistics, we were about average, which doesn't mean that you don't explore every death, but there are some clinical deaths that aren't avoidable. As far as I could see (– although I have to say that I couldn't get the detailed figures that I wanted. I asked for them and our clinical information unit, at that time, was not adequate.) It looked to me as though this moniker that the national media was using of a 'baby deaths' hospital' was producing intense anxiety and naturally so.. If I was living in that area and my daughter was pregnant, I would have been horrified at the idea of her going to a hospital to have a baby when the press, even reputable papers, was labelling it the 'baby deaths' hospital'. It didn't seem to me to be justified.

DR WALTERS: As you say, that was after the skies fell in. Going back in time, what did the board spend most of their time on, up until about 2008 or 2009? What were the proportions?

DR GREENWELL: It differed. Certainly in that first phase, I would say all of the board time went on things that were nationally reported, whatever were the indicators, ~~the list of~~ things like waiting times, cancer treatment, equality and diversity reporting. Stuff like that that had to be reported nationally was what the board focused ~~reported~~ on in order to maximise their chances of getting a good star rating, because there was a commitment to become a Foundation Trust. The first move to that had failed and the Trust ~~they~~ wanted to reapply, and the board needed to deal with that. It wasn't just money, but it was definitely a focus on all the things that were nationally reported. It was looking up, rather than looking down and across, I would have said.

DR WALTERS: When did maternity first hit the board as an issue, for any reason?

DR GREENWELL: Definitely with Baby Titcombe's death. There's no doubt about that.

MR BROOKES: We won't talk about specifics.

DR GREENWELL: Sorry, but that was the question ~~point~~.

DR WALTERS: Around about that time, Dame Pauline Fielding's review was commissioned. Can you tell us what you remember about how that came about?

DR GREENWELL: Yes. Particularly the Dame Fielding report, because it wasn't properly reported, ~~on~~ and I'm partly to blame for that. I've a measure of responsibility. I know it was for two very different reasons. At that time, I was being interviewed, as were others, [redacted] of PriceWaterhouse, Ernst & Young, Grant Thornton –

DR WALTERS: Even before then, who made the decision that there needed to be an external review?

DR GREENWELL: My impression was it was partly out of our hands. It was the region and the Trust and that whole issue of gold communication or something like that. From the Coroner's comment and onwards, and you're asking me about before then, and I can't hold in my head clearly enough what happened before the Coroner's comments and after the baby death that concerned us.

To my mind, the report I remember most and was most pivotal was the internal one that the head of midwifery did.

DR WALTERS: Just going back, the Strategic Health Authority suggested that there needed to be some sort of external review.

DR GREENWELL: There was a whole series of external reviews. There wasn't just one.

DR WALTERS: Have you a view particularly of Dame Pauline Fielding's, because that was really the first one?

DR GREENWELL: No, it wasn't the first one. The internal report I'm talking about, the head of midwifery had been very concerned that what had caused the death of a baby in Barrow, the same factors might be present in Lancaster. They wouldn't be the same in Kendal, because the nature of midwifery was different. When she looked at it, she realised she was right: the same risk was there. It hadn't happened but the risk was there.

It was connected to the fact that when – and you will know more of this than I do, but it is something along these lines – when they stopped having babies in separate wards, newborn babies were brought into the ward and kept alongside their mothers much more than they had been. When the newborn babies had been kept in a nursery, there'd been a process for checking temperatures, I think it was – I can't remember all the details – that had been very well established. When there was the move for babies to be beside their mothers that same strong process had not been adequately re-established. When she realised that, she altered that, and ~~but~~ also sent her report to – I think it was ~~the Midwifery or~~ some national midwifery organisation, which sent it out as a recommendation to all Trusts.

To me, that internal report that we had presented to us when we looked at it in detail by the clinical quality and safety committee, was by far the most important report ~~of all the major ones,~~ because it actually focussed on ~~got~~ what was a major risk area in the Trust that none of us had realised. Of all the list of reports that's commented on, Angela Oxley's report was the most valuable ~~and~~ then Angela disappeared to do a VSO ~~in~~ midwifery, I think in Cambodia, and I didn't blame her, because she just was caught up in this whirlwind, this perfect storm that hit us.

DR WALTERS: Was the board at all involved in setting the terms of reference for Dame Pauline's report?

DR GREENWELL: I can't remember that. You'd have to ask either the director of nursing or –

MR BROOKES: You don't recall the discussion in one of your board meetings on the terms of reference or do you?

DR GREENWELL: I can't recall it on the terms of reference. I can recall ~~it~~ very, very clearly ~~carefully~~ at my own interview with Dame Paula and what happened subsequently in terms of not presenting that report to the board in a timely way. I was getting used to the fact that I had to prepare myself for a lot of interviews that were going on, and I thought Dame Paula would really ask a great many very penetrating questions.

In fact, when she asked me about my background; it turned out that we both had a similar mixture of nursing and academic backgrounds. Also, she was then Chair – and this should be irrelevant, but it wasn't – of the Lancaster and Morecambe U3A, University of the Third Age. I was chairing the Lancaster and Morecambe Older People's Partnership Board. I was supposed to be having a half-hour interview and I know, by half-past, she looked at me and said, 'We'd best start talking about midwifery.' We both chuckled and spent quarter of an hour talking about midwifery.

MR BROOKES: Did you get the penetrating questions you were expecting?

DR GREENWELL: No, not at all, and then there was a real cock-up. You know the notion that you have conspiracies and you have cock-ups? There's actually the third element. You have the cumbersome structure that makes cock-ups very likely, and that's what we had. Dame Fielding's report came out and one of the things she was recommending was that – I think I am remembering this correctly – we should make less use of healthcare assistants in midwifery. As our Director of Nursing said, that's not actually the direction of travel now. There was something else she was recommending that was also not how midwifery was moving.

A report comes out. It goes to the director of nursing; it goes to NHS internal audit. The Trust comments on it; it goes back to internal audit. It then comes back from internal audit to the execs, and then the theory was it went to the clinical safety committee and then the Trust, but the timing of the meetings

meant that you could miss a meeting just by a few days because the report hadn't come back from internal audit, and we missed it. It got lost in the welter of things going on.

When I read all this about, 'I can't believe that the Trust refused to report on...' ~~you~~ I groaned. There wasn't a refusal to report; it should have been reported to the board in a timely fashion. It wasn't, but it wasn't a conspiracy to conceal anything. It was the fact that the whole process just lumbered backwards and forwards and there were these weaknesses in what was recommended. My impression, when I subsequently looked at it, is there were some very useful and important comments about communication between consultants and midwives. We should have picked up on that more than we did. By then, it had almost got lost in the welter, because there was also a Manchester clinical inquiry, which I thought was more informative, but that's a personal view. As I say, there are all these endless CQC, M~~m~~onitor, and external consultancy inquiries going on at the same time.

DR WALTERS: So it went to the private board meeting, didn't it? The Fielding report went to a private meeting.

DR GREENWELL: I think, if it was a private board meeting, it may well have been referred to... I can't recall what a private board meeting would be.

DR WALTERS: It was probably one that wasn't in public.

DR GREENWELL: I know what it should be, but I can't remember us having one.

MR BROOKES: We have the minutes from the 27 April, when there was a discussion.

DR GREENWELL: And what was that?

MR BROOKES: That's a private meeting. It says that's a Trust board meeting, 27 April, private meeting.

DR GREENWELL: Ah, so it was part 2.

MR BROOKES: It says part 2, private meeting.

DR GREENWELL: That may have been one of the points where there were comments going backwards and forwards – I can't honestly remember it – partly because I know, my own interview being so friendly and casual, that this wasn't one of the reports that I had a red star alert in my head to look out for. I should have done and I accept that.

DR WALTERS: It sounds like the SHA suggested there ought to be a review.

DR GREENWELL: That's my understanding, but I can't be certain of that.

DR WALTERS: It was done. The way it reads, and you must say if it wasn't like this, that this is something we need to do to demonstrate that we're doing it, but maybe we don't see it as important in that report.

DR GREENWELL: No, it didn't feel like that at all. It felt to me like this was a report that we thought would be very useful, and then it came back including some recommendations that were definitely not useful, and then it had to shuffle several times backwards and forwards between internal audit and the trust. The final version got lost in that process. That would be my reading of it.

DR WALTERS: As you say, there were things about culture in it. There was something in there about access to obstetric theatre at night, delays and all sort of things.

DR GREENWELL: Yes, that would be caught up, you're reminding me, in a lot of discussions about Furness General medical staffing, consultant staffing, and how you got... First of all, there were enormous difficulties for quite a while, between about 2004 and 2009-10, I think, in recruiting consultant staff at Barrow. There were real concerns about the interrelation of paediatrics and maternity, and how you dealt with it, and then an awful lot about the European Working Time Directive, covering the hospital at night, who was on call and who wasn't. I have to say I can't recall all those details, but I know those sorts of conversations had been going on for a long time.

I remember a point when the non-execs in particular quite erupted about the length of time taken to recruit consultants. It was unacceptable that an advert would go out months after a vacancy had become obvious. That started to improve quite dramatically. The number of consultant vacancies went down and the reliance on locums went down. For a while before I left the Trust board that was one of the positive features, but I couldn't give you any dates as to exactly when that was.

DR WALTERS: The board was aware that there was this potential problem with maternity and there being –

DR GREENWELL: With obstetrics?

DR WALTERS: Yes. There had been these five incidents, which were believed not to be related.

DR GREENWELL: Sorry, there'd been...?

DR WALTERS: There were five incidents that were supposed to be not related, which was the issue that initiated the Pauline Fielding report.

DR GREENWELL: Then there were the maternal deaths.

DR WALTERS: I can't understand why the board wasn't more anxious to see the report and the action plan.

DR GREENWELL: It was I think because there was so much being reported on, including the Manchester report and the internal reporting, and so many other things happening. It didn't feel like the most important report is all I can say.

DR WALTERS: Given that I suppose the board felt that there was an issue here, what were they seeing in terms of a systematic approach towards the action plans from board to ward?

DR GREENWELL: It was definitely how can we... My strong memory and one of the biggest issues was how we could strengthen consultant cover for obstetrics and paediatrics at Barrow, given the difficulty of recruiting consultants and the fact that, if you looked at all the stuff that was coming to us on how many numbers of patients consultants should have in order to be competent, and then you looked at the numbers in Barrow, then really there was a big divide. It's not just Barrow; it's the common problem of how you provide clinical high-quality specialist care with relatively small numbers of patients, particularly when hospitals are geographically ~~they're too~~ remote.

I did some research work in London, where hospitals were maybe a mile and a half apart, teaching hospitals. Furness General, as you'll know, is not the kind of location ~~place~~ where you can have somebody at night popping over from Lancaster. The attention of the board was going on that big issue and how we dealt with that, and that was taken very seriously.

DR WALTERS: Were the economics brought into the debate as well?

DR GREENWELL: They were, but it wasn't a big issue. If you could find a satisfactory answer, you could stop paying these huge locum medical fees. The Trust seemed to be paying out a vast amount on locum expenditure. Getting people in permanent posts would save money and also reduce clinical risk.~~post was about saving money~~.

DR WALTERS: When you chaired the quality and safety committee, and there were details of incident reports coming from maternity and also other places, how did you assure yourself about the quality of those reports?

DR GREENWELL: Looking at ~~If it was a serious~~ untoward incident reports, an awful lot came to us. I have to say, the form in which it came from ~~it came from~~, the clinical intelligence unit, was not always helpful. There was a whole array of things from relatively minor low-risk reporting –slips and trips as well as ~~the~~ falls, and whether falls were serious or not – right up to the serious untoward incidents. If it was a serious untoward incident, my memory is, the way of finally coming to a conclusion on those changed over time. In the early phases, if there was a baby death, a maternal death or any other death, then that would then be reported; the details would be reported. There would then be a full investigation along the lines of, I think, national patient safety. There was a definite root cause analysis process for looking at the whole array of the risks associated with that, and then that report came back to clinical quality and safety, having been looked at by clinicians.

Then it needed to be signed off by the public health directors, if my memory... Cumbria public health had a very different attitude to signing off SUIs to the Lancashire ones. We would look at the list of SUIs that were still alive and there'd be SUIs going back a long time from Cumbria still on the alive list, requiring us to look at it again, whereas the Lancashire list would be much, much shorter; it would be the more recent ones.

I didn't have any misgivings at the thoroughness of the way SUIs were looked at. The area of concern, which arose through looking at maternal deaths, was the public health aspect of this, ~~because~~ Tthe medical director who was appointed sometime, halfway through my stint, I think, had set up a public health liaison committee, and I was on that, along with the director of nursing, the director of midwifery and the public health people from Cumbria and Lancashire, and then we could invite others to join discussions as needed.~~anyone in~~.

We were very bothered that there'd been, over time, three maternal deaths that all related to the ongoing problem of obesity and poor cardiac health. They were maternal deaths, but they hadn't occurred – I think one had occurred during childbirth, but it was – what do they call it? – placenta embolism or something like that, which was purely clinical. Others were heart- and obesity-type-related issues. That was one of the issues: we felt

that there needed to be a much stronger PCT public health liaison with GPs about how that kind of area was looked at and managed.

DR WALTERS: Was there any reflection that, possibly, the unit wasn't risk assessing properly?

DR GREENWELL: I'd say that the attitude was we're not getting everything right, but this particular issue of obesity and cardiac health, if women are being managed as GPs, as a lot of them were... I never understood who was sent from the consultants and who wasn't, but certainly a lot of pregnant women's ~~pregnancy~~, after one initial visit, ~~my understanding was,~~ were managed by GPs. We felt therefore that this issue of obesity and cardiac health needed more attention at that level, and so did the public health people who were on that public health committee.

The other issue, which was difficult, was that there did seem to be – what's the right term? – I think two of the women were from minority ethnics groups, but it wasn't a big Asian community. It was lone women who had married, come to Barrow and they didn't have a significant local ethnic community network. We did ~~wonder~~, feel, that we couldn't do anything locally, because the numbers were tiny. I know our medical director did try to see whether, working with public health people, it wasn't possible for nationally somebody to look at ethnic minority women who were not part of an ethnic minority group in their locality and whether that induced more stress during pregnancy or whatever. Maybe it didn't, but certainly nothing could be followed up on that.

DR CALDERWOOD: Thanks very much. I think we've covered a lot of what I was going to ask. We've talked extensively. I think I was particularly interested in what you've just been talking about, because I have some minutes from your minute where it states very clearly that Dr Greenwell was observing the maternal deaths, and clearly you have talked at length – the minutes presumably don't cover everything – about your concerns, talking about the statistics you were concerned about and also whether perhaps there was some theme. I get a hint that, although the root cause analyses had said that they were natural causes and that there was no untoward care, there was clearly a lot more discussion.

DR GREENWELL: There was, yes.

DR CALDERWOOD: You've also hinted, maybe just a little ~~list~~, about not quite knowing whether women, when they saw a consultant, how their care was. They were often sent back to primary care.

DR GREENWELL: It appeared, from what I could follow, that women in the area, a lot of women, area had their obstetric care managed by GPs. As far as I know that is not uncommon. I may be wrong.

DR CALDERWOOD: I suppose I would expect the GPs to be managing women who didn't have particular obstetric or medical risk factors.

DR GREENWELL: Yes, so there's an initial process of them coming in to see a consultant who decides whether they can be managed by GPs. That was the kind of area where the weakness of the clinical quality and safety committee, as I said before, is it didn't have a big enough, strong enough clinical input. It had a medical director and a nursing director, and they were both committed and active, and we could call on other people, but that's the sort of thing where you needed a couple of consultants on that committee saying, 'Hold on, we've got to hammer away at this.' As a non-exec, you could do a certain amount, but you couldn't stir things up in a way that a consultant can. ~~and we knew that.~~ The public health people were really keen to move on this, the ones we were working with, but it just seemed to peter into the sand.

DR CALDERWOOD: You've alluded that there was a lot more discussion than was recorded in the minutes. Did you feel that the committee presumably would not have gone into the detail of the root cause analysis? Did you feel assured?

DR GREENWELL: I felt quite certain that there was a thorough root cause analysis done. I felt that, as a non-exec-led committee, it wouldn't have been appropriate for me to be involved in the clinical root cause analysis, but I was satisfied that it was happening. That seemed to me to be an appropriate level of responsibility. I never had a sense that things were being covered up.

As I say, the energy with which Angela Oxley investigated where there was a definite risk area and reported on it and dealt with it, gave ~~was~~ another feeling of reassurance that, if people do sense something's going wrong, they don't hide it. All the effort that was going on looking at the medical staffing at Barrow went on continuously, because of the difficult problems of inter-relating paediatrics and obstetrics. You could see an answer for paediatrics if it was just paediatrics but, by the same route, you needed a paediatrician there in

order to have proper obstetric service. I don't know what they've done now, but it certainly wasn't easy.

DR CALDERWOOD: That often is something that isn't understood by people outside the speciality, and both for the adults as well.

DR GREENWELL: Yes, especially at nights – the emergency backup and how you provide that for two specialities.

DR CALDERWOOD: We've seen in some of the minutes, once the Fielding report did appear, there was an action plan and then there was an audit to find out whether the action plan had been carried out. What's your sense of how that piece of work –?

DR GREENWELL: As I say, I am aware that that's one piece of work that I didn't follow up with the energy I should have done. I was taken aback by the fact of recommendations in relation to the midwifery side, which were not appropriate recommendations. It left me feeling that I could leave ~~have left~~ that to Jackie and Peter to deal with. They were not the big worrying areas. Investigating why a child death had happened when it shouldn't have happened, investigating SUIs, being satisfied that there was NOT a problem with root cause analysis; those were the big things. I should have taken the Fielding report more seriously, and I know it was partly because I'd had such a jolly nice conversation and it hadn't struck me as being one that I needed to monitor, and I should have done. At no point did I feel there was any conspiracy, but there certainly was a cock-up.

MR BROOKES: Can I just ask you something slightly different? This is about your role with the board. What was your assessment of the governance systems of the organisation, not just about maternity, in totality and the role that you were able to play in the assurance of the organisation's governance?

DR GREENWELL: As I said, I see it as having three phases. There was a phase up to when there was a change in the Chief Executive, where I was really concerned and it seemed to me that the governance arrangements were inadequate. The Trust was too defensive, the structure of the audit committee, the nature of the risk management, etc.

MR BROOKES: You've been through some of that, yes.

DR GREENWELL: Then during the gap between Chief Execs, there was an improvement but not as radical ~~an~~ improvement. Then along came Tony, and

Jackie and Peter got involved more. That's Chief Executive, Director of Nursing and Director of Medicine. At that point – and also some new non-execs, one of whom had a background at risk management at a university, and he pushed as well and worked with the Chief Executive.

MR BROOKES: At the point of your leaving the organisation, were you confident that there was good governance in the organisation?

DR GREENWELL: Not entirely, ~~but~~ I certainly was aware of the weaknesses of the clinical quality and safety committee and the lack of adequate consultant involvement... The areas that concerned me were the nature of the clinical quality and safety committee and the fact that it wasn't as strongly clinically involved as it should have been. The quality of the clinical information feedback to clinicians was also not strong enough. When we asked for things like breakdowns of complaints, it came as a long document of raw data. When you're under work pressure, as all clinicians are and all board members are, you're paying somebody to analyse that, not to present it as raw data and we were getting raw data. I could see why some clinicians were saying in public meetings, 'This is hopeless. We're not getting the kind of feedback of clinical information that we need in order to improve all aspects of our service.'

I know there were attempts being made to improve that and it was improving. There was a change ~~chance~~ of personnel that was about to happen just as I left, but there was certainly that area of weakness. In terms of the risk management and the effort that went into compiling the risk scores and a risk mitigation process, that was far, far stronger at the end. I'm sure it's never perfect – you have to keep on improving it – but the difference between the position when I left the Trust and the position when I arrived was absolutely massive.

MR BROOKES: That's very helpful. One last thing to add, if I could. You mentioned that you had a different experience between two PCTs, in terms of signing off SUIs. Did you ever discuss with Cumbria why they weren't signing off?

DR GREENWELL: I left that discussion to our medical director, because the personalities involved were strong and forceful.

MR BROOKES: Were you aware of the outcome~~ether conduct~~?

DR GREENWELL: It didn't seem to get anywhere is all I can say.

MR BROOKES: If I were to say it might have been because they felt the analysis was inadequate...?

DR GREENWELL: It's very difficult to say, because we did ask that: is our analysis inadequate? It was much more, 'No, you need to keep these things alive in case something else turns up,' kind of thing. That's my memory. You'd get this list of SUIs that were still alive, as it were, and some of them were going back a long time and nothing new was happening. They just weren't being signed off. That was one thing I didn't get anywhere with. I think our then medical director would be able to answer questions on that.

DR WALTERS: Did the board go and visit the maternity units at all, the different members of the board?

DR GREENWELL: Yes.

DR WALTERS: What impression did they get?

DR GREENWELL: The issue that the CQC had rightly picked up~~, the CQC~~, on the layout and the design of the ward, the unit at Barrow,~~ was~~ that was recognised as a major failing and it needed to be addressed. There were certain plans that we approved for changing the layout of the ward. It was a hospital that had been created in the 80s and it certainly hadn't been well-designed. There was no question about that. There was that element to it.

I can't now recall anything else that we picked up that needed... It was the medical staffing and the design of the ward. They were certainly the two. You know the CQC report after the Coroner's comment highlighted two areas as reasons why we were declared non-compliant and one was related to the layout in the ward. It was the way women were transported to the operating theatre and it was loss of dignity, and it was a valid comment. The other was the cleaning of a small alcove that housed the IT system, I think. Certainly that was dealt with and the cleaning regime was reviewed. Dealing with the other issue, the transfer of patients, that couldn't be dealt with adequately without a redesign of the ward and that was going ahead.

MR BROOKES: I have no more questions. Thank you very much for your time.

DR GREENWELL: Do you mind if I add one comment, at the end?

MR BROOKES: Indeed, briefly.

DR GREENWELL: Of all the things that have happened, the thing that has bothered me the most is the way the media labelled Furness General maternity as the

'baby deaths' hospital. That title hung over the district and it's certainly affected families as well as staff... Anecdotally, I was getting feedback that it was causing, ~~and~~ not surprisingly, a great anxiety to women waiting to have their babies at Furness General. The distance is such that, for most women, there wasn't another choice.

The work I looked at left me feeling that the number of baby deaths were not out of line with what was reported in the national confidential inquiry figures. The Trust was told – we did ask, 'Can we not rebut this? Can we not put out our press releases saying, "This moniker of the baby deaths' hospital is damaging and it's inaccurate"?' As non-execs, we were told, 'No, that isn't how the NHS works. If the media's saying this, you leave it to somebody else to deal with.' It just seemed to me completely damaging and wrong.

~~Assuming that my understanding is correct that we were about average, and~~ Just a matter of months ago there was a list, again in the *Westmorland ~~Western~~ Gazette*, of all the baby deaths that had ~~have~~ happened in the Trust over a decade.. If you don't know your way around this system, and you total every stillbirth and every neonatal death over several years, and get the figure together, it looks really alarming. If there's one thing I do hope this inquiry can deal with, it's somehow providing a statement that counteracts this kind of press reporting.. Not overlooking anything, not brushing anything aside, but if you come to the conclusion that labelling Furness General as ~~the title~~ ' the baby deaths hospital' is ~~was~~ unjustified, then I'd be so relieved if somebody with authority said so, because ~~I do think~~ it continues to hang over the district in a way that's most unfortunate.

MR BROOKES: Thank you very much.

DR GREENWELL: Thank you for having me.

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 October 2014

Held at:
Park Hotel
East Cliff,
Preston,
PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Dr Geraldine Walters – Expert Adviser on Nursing

JULIAN GRIEVES

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(At 11.34 a.m.)

DR KIRKUP: Hello. Make yourself as comfortable as you can under the circumstances. My name's Bill Kirkup, and I'm the Chair of the investigation Panel. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: I'm Geraldine Walters, and I'm Director of Nursing at King's College Hospital.

MR BROOKES: And I'm Julian Brookes, currently Deputy Chief Operating Officer, Public Health England, but previously Head of Clinical Quality at the Department of Health.

MR GRIEVES: Hi.

DR KIRKUP: You'll see that we're recording this meeting and we'll produce an agreed record of the interview. You may also know that we've invited families to be present as observers. As it happens, we don't have anybody for this session, but they may listen to the recordings subsequently.

When we get to some matters that might bear on confidential issues, we'll have a break, and make sure that the room is clear and that people are not then able to listen to that part of the recording.

You also know that we've asked you to hand in any mobile telephones, laptop, other recording devices. Just to emphasise the fact we don't want anything to go outside until they're ready to produce a recording [inaudible]. Do you have any questions for me about the process?

MR GRIEVES: No. I read the protocol. I think I know what's going to happen.

DR KIRKUP: Okay. Well I'll start off with a very general kind of question, which is can you explain when you started at the Trust and what you did there, and what you've done subsequently?

MR GRIEVES: Okay. In order to get my thoughts together, I've made kind of timelines and some notes, so I hope that's okay if I refer to them?

DR KIRKUP: Absolutely.

MR GRIEVES: So, I joined the Trust shortly after it was formed. So I've been there for over 13, 14 years now. I came into a service manager post in the surgical division, and worked in a number of surgery directorate operational posts, in that period. Doing most specialties. So maxillofacial, anaesthetic. So I'd be the kind of first line manager of those services, and that happened until – that

was just a post that I was in for a long period of time.

In 2010 the surgical division was restructured, and through the interview process I didn't get one of those posts. So there was then kind of a situation of hiatus of I didn't have anywhere to go, I was kind of not slotted into one of the posts.

I continued to work in surgery at that point. So this is May 2010. In June 2010 I was approached – and that was my first communication with the Women's and Children's division, really. They, at that point, had a temporary divisional general manager in post. Fraser Cant. He was covering from – for someone called Steve Evans who had been off on long term sick leave.

So I was approached by my then manager, and had a chat with her and Fraser, because the structure that they had in women's and children's was somewhat lacking. The work that I'd done in surgery seemed to fit with what they needed, so I began to work for them, initially at one day a week at that point. So this was June 2010.

It was quite a flexible arrangement at that point. The – my job description at that point, and I do recall it, was, 'Keep the numbers right.' What was meant by that, from an operational point of view, was in relation to things like 18 week journeys and making sure that patients got their follow-up appointments on time, etc. The kind of performance – key performance indicators that the business side of the division is judged on. Keep them right. That's your role when you come in and work for us.

So I entered the division at that point, and it was one day a week. They had – just to kind of give you an idea what they were doing at that point. They had a really limited infrastructure, they had a lot of secretaries off sick with stress at Furness General. Their admin processes were somewhat lacking. They hadn't done any kind of capacity and demand work, which is what I kind of – what I am good at and focus on. Their 18 week knowledge wasn't great, and the kind of day to day operational seemed to be done by Angela Oxley, who was the Head of Midwifery at that point.

So that's the kind of environment that I went into. What I did at that point was really kind of did an assessment of what they needed to do to bring it up to speed, produced an action plan for Fraser, drafted some people in to help the secretarial situation, sorted that out.

So Ibrahim Hussein who was the Clinical Director at that point as well, I had – I didn't find him wholly supportive in what I was trying to do then. So I think he felt somebody was coming in from another division and felt a bit challenged by that. Because I would say, 'Why do we do this?', and I was purely looking at the admin functions. So I don't think I had a great relationship with him. Found him a bit dismissive of the things that I was trying to do, and what I was trying to do was get them on track and get a really – some clear processes and protocols in place from an admin point of view.

DR KIRKUP: How long did you carry on working there one day a week?

MR GRIEVES: I was looking back yesterday to try and do that. I think the next point from June 2010 to January 2011 where I was formally put into a service manager post in what was then family and clinical services. I think it was a very flexible arrangement. I think it built up over time. Relatively quickly because surgery could – were prepared to release me. Family and clinical services needed me to do more and more. So it was kind of a tapered release.

DR KIRKUP: But it became for a while one division anyway?

MR GRIEVES: Excuse me?

DR KIRKUP: It became for a while one division anyway? When was that?

MR GRIEVES: It did. Well, at that point it was family and clinical services.

DR KIRKUP: Right.

MR GRIEVES: So that was women's and children's and core clinical services, which are now two separate divisions in the Trust, joined together at that point.

DR KIRKUP: Okay. It's a bit hard to keep track of.

MR GRIEVES: I know. Well I've got the various – at these different time points, I've got the various different organisation charts if they're any use to you. Or I can refer to them if you want.

DR KIRKUP: Actually, I think they are, yes. You keep them.

MR GRIEVES: Yes. So we had, at that point, a divisional administrator in place in the family and clinical services division. She was trying to do a number of tasks of trying to keep the medical staffing going, trying to keep the medical secretaries going, and trying to keep the 18 week journeys going. It was way too much for her.

DR WALTERS: Who was that?

MR GRIEVES: That was somebody called Vanessa Chew. C-H-E-W. But I was still a service manager for surgery at that point. I was kind of juggling both things. But I'd started going to some senior management team meetings. Kind of people that were there was Fraser – obviously he would chair those. Angela Oxley. They had a guy in called Alan Currie[?]. I don't know whether he – whether you've come across Alan. Alan was doing some work within family and clinical services at that point; and the finance manager, somebody called Michael Ash-McMahon.

So example of things that we'd talk about during those, I went back and had a look at what were we talking about, the divisional management team at that point, was, you know, kind of operational stuff about where our patients might be breaching their targets.

DR KIRKUP: Okay. I'm trying to get a track through your career in the Trust first of all. Then we'll come to some more specific issues.

MR GRIEVES: Okay. Sorry. I'm trying to be as exhaustive as I can be. Okay. So that transpired until January 2011. I was put into a service manager post in family and clinical services. That was – yes – I worked directly to the DGM. I've always worked directly to the DGM in all of these posts. So in the last three years, since I transferred over properly, I've worked with three DGMs.

DR KIRKUP: Right. I just want to be clear about this. Divisional General Manager?

MR GRIEVES: Yes. Sorry.

DR KIRKUP: See, I'm old enough that it means district general manager.

MR GRIEVES: I remember them.

DR KIRKUP: Very different post. Okay. Carry on.

MR GRIEVES: So yes, I worked directly to the DGM, and I can show you the structures there. Because what there was, there was head of services in place. So we would have had a head of service for obstetrics, gynaecology and midwifery, Sascha Wells; and we would have had a head of service for the paediatric side of things. So they were kind of the nominal head of service, and I would be a direct line accountability to the DGM for the business admin side of things.

DR KIRKUP: Okay.

MR GRIEVES: So I won't go in to what I was doing there. If you want to talk, I can go...

DR KIRKUP: We'll come back to it.
MR GRIEVES: Sure.
DR KIRKUP: You can tell us what you did next.
MR GRIEVES: So that was January 2011. March 2011, Angela Oxley then went at that point. So I've got a structure that happened in July '11. To bring it up to date, June 2012 there was an official split of the family and clinical services division. That split into these two divisions that are there right now, called clinical services, women's and children's services.
DR KIRKUP: Okay.
MR GRIEVES: It wasn't until October 2012 that I was appointed to the Business Manager for Women's and Children's Services. So my official title is Business and Support Services Manager.
DR KIRKUP: And still is?
MR GRIEVES: And still is.
DR KIRKUP: Right.
MR GRIEVES: To this day.
DR KIRKUP: Okay. That's helpful.
MR GRIEVES: Sorry, that was a bit more than you wanted.
DR KIRKUP: It gives us a perspective on where you were and on some of the organisational structures were [inaudible].
MR GRIEVES: It took me quite a long time to get to that point because, you know, a lot's happened in three years.
DR KIRKUP: I'm sure it has.
DR WALTERS: So you've got some divisional changes then, and you were working one day a week on getting the numbers right.
MR GRIEVES: Yes.
DR WALTERS: So presumably they weren't right?
MR GRIEVES: They were. We were – they were better than some of the other divisions, but it was a case of, 'Keep us out of the red.'
DR WALTERS: Okay. So that was – they were the biggest tasks?
MR GRIEVES: They were absolutely the biggest tasks. It was primarily focussed on gynaecology. I've had nothing really to do with the obstetrics side of things. Because there was the head of service there, because there's no 18 week journey there, I haven't had anything to do with the obstetrics side of things,

and still have next to nothing.

DR WALTERS: So there was a weak infrastructure. People off sick with stress. No capacity and demand work. It sounds like total chaos. Is that how it felt?

MR GRIEVES: It wasn't a good set up. It wasn't what I'd created in the surgical divisions that I'd worked in. I think, at that point, it wasn't really a cross-bay service either. Still operating as three very different sites. Not a lot of cohesion there, although we had a cross-bay clinical lead, that didn't really work I don't think. So yes. It wasn't in a good situation really.

DR WALTERS: Right. So you reported directly to Fraser?

MR GRIEVES: I did.

DR WALTERS: And did you pick up sort of how the clinical risks were being handled in the division at all? Were you aware of the structure and what Dr Hussein was doing around that?

MR GRIEVES: No. No.

DR WALTERS: Was it ever discussed at any of the operational meetings?

MR GRIEVES: No. So in terms of risks, or mortality figures, not in my – not that I can recall in the meetings that I went to. No.

DR WALTERS: So from about 2010 onwards, obviously the momentum started to gather a little bit around concerns about obstetrics. Barrow Neonatal. How did that feel – what did that feel like in the division?

MR GRIEVES: I've got to say I wasn't really part of it. I was so focussed on trying to – and I'm not saying that to be – I was so focussed on trying to get the admin functions and all of that sorted out, that that was somebody else's issue from my point of view.

DR WALTERS: So it wasn't something that, you know, 'We've got quite a lot of operational issues to deal with, and actually you've got – we've got some risks and safety issues bubbling up here, which are gaining more and more momentum'?

MR GRIEVES: I don't recall them being discussed in any depth, and I had a look back at our divisional management team meetings and no, it was more about the business function side of things. The cost improvement programs, the – where we are with numbers. Whether that was being discussed in a different place at that point, I don't know.

DR WALTERS: So was safety and risk ever discussed in the same breath as cost

improvement?

MR GRIEVES: At that point? Or since then?

DR WALTERS: Perhaps tell a story.

MR GRIEVES: Well, you know, we have cost improvements to make, and that's not going to – that's not going away. What was clear, particularly in the latter stages of when Fraser was there, was kind of a view of holding the line and not compromising the service in any way to deliver a cost improvement so – and that was something that was really kind of sacrosanct in what we were looking at for cost improvements. We should not be looking to put ourselves in a position where there's – it compromises safety in any way.

DR WALTERS: And what – at what point did that become more explicit?

MR GRIEVES: Probably from about 18 months ago. So I'm looking from 2012 onwards. I think particularly after the CQC report.

DR WALTERS: Yes. Were you aware of the Fielding Report coming out?

MR GRIEVES: No.

DR WALTERS: Was – were there any action plans within the division, in response to the Fielding Report at all?

MR GRIEVES: I've never seen the Fielding Report.

DR WALTERS: Right. Obviously after about 2011 – when did Gold Command come in? Sort of towards the end of about 2011, 2012?

MR GRIEVES: Yes, I think so.

DR WALTERS: What was the impact of that?

MR GRIEVES: On me? And my role?

DR WALTERS: Well you and your role. But what could you see happening in the division?

MR GRIEVES: I suppose just a more rigorous approach to assurance, and kind of building up evidence. To me, in particular, or – of providing some of that evidence I could see that going on in the midwifery side – on the midwifery side of things. But it was amidst a more robust and serious approach to it, I think.

DR WALTERS: So obviously at one point, suddenly, everything sort of tips over. There's a lot of media interest. CQC are coming in. The SHA are coming in. What was the reception of that within the division? How did they sort of explain it or rationalise it?

MR GRIEVES: What, post visit?

DR WALTERS: Well, obviously there was a lot happening, all at the same time. And people internalise that, and interpret it on the ground in very different ways, don't they. I'm just wondering, what was the feel of it?

MR GRIEVES: I think, I mean the general sense that I saw was we need to get our house in order. I think that was – that's the best way I could describe that. I saw them developing an action plan for I think I was something like 100 plus action points on things that had been raised, at that point, through the CQC, and there was workbooks being developed there of, you know, 'Here's the action. This is what we've done to mitigate it. Are we red, amber or green? Have we solved that issue, really?' So I could see those being worked up by Sascha and Val Wilson, who was in at that point, who was doing a lot of the governance work.

DR WALTERS: And what were those actions designed to do? How – what impact were they having on the day to day operation of the division?

MR GRIEVES: I'd struggle to answer that question really, from an obstetric point of view. Because as I was saying I was really kind of focussed on the non-obstetric side of things, and there was quite a clear division there.

DR WALTERS: Were you ever, as the role that you were in, if clinical risks were reported to the central Trust committee, and then were sort of asked the division, you know, 'This needs to be sorted out.' Were you ever aware of how those actions were taken forward?

MR GRIEVES: No.

DR WALTERS: So if there was something like a medical staffing concern. Or making sure [inaudible] covered. Is that something you were involved with?

MR GRIEVES: No.

DR WALTERS: Right. Who was?

MR GRIEVES: I'm assuming that Fraser would have done that directly with Chief Operating Officers.

DR WALTERS: Right. So in terms of getting the numbers right then, were you involved in how clinics were staffed, or how – which doctors were available to do things?

MR GRIEVES: Yes. From an outpatient point of view. So what I was trying to do, at that point in – but it was really the gynaecologist side of things – was get that

balance, or, 'What's our referral levels that were coming in?' 'Where are all our clinics at?' 'How can I balance that capacity and demand and how do I link all of our outpatient clinic capacity to their job plans?'

So I was trying to work on getting some structure into the thing, because it didn't – when I first went into the division, I'm saying, 'Okay, well what capacity have we got?' and, well, 'He does a clinic every Thursday morning...' 'Well, where's it all written down so I can see how many patients we can deal with?' So it's trying to get some structure into it, of how we actually – have we got a balanced system?

DR WALTERS: And were you in a position where there were any doctors to [inaudible] what they wanted cover their clinical commitments in the hospital, and their on call? That sort of thing?

MR GRIEVES: Yes.

DR WALTERS: Was that mainly gynaecology that you were dealing with?

MR GRIEVES: Yes.

DR WALTERS: So in terms of the sort of tripartite financial management, operational management quality, how did those two come together in your division?

MR GRIEVES: I think from a meeting point of view they were very much disparate. I think there wasn't really a pulling together and a linkage of that. I didn't really see that there.

DR WALTERS: So you – would you agree then that the three elements were sort of slightly stylised?

MR GRIEVES: Yes, I think that's fair to say.

DR WALTERS: Okay, that's it from me.

DR KIRKUP: Thank you. Julian?

MR BROOKES: I'm just interested on your take on – could you describe to me the governance arrangements for the Trust when you started in the division?

MR GRIEVES: In the – 2011 I would struggle to do that, you know. I wasn't brought in to look at governance in any way, and I'm not being evasive when I say that. I say I don't genuinely know how they were discussed, or where that discussion was going on. That there may have been some indicators that were...

MR BROOKES: Sorry, I'm not asking you to – what didn't happen. It's you're working in an organisation. It has a governance structure...

MR GRIEVES: Yes.

MR BROOKES: Were you aware of it, as somebody who worked within that organisation? Would you know where serious untoward incidents went? Would you understand the routes for dealing with clinical quality issues? For financial propriety? Those kinds of things.

MR GRIEVES: No. I wasn't really operating at that level.

MR BROOKES: But that happens at all levels. So you weren't...

MR GRIEVES: Okay. I couldn't sit here and say, 'This is how it functioned at that point.'

MR BROOKES: So did you have any involvement in serious untoward incidents at all? Or any investigations?

MR GRIEVES: The only – the only involvement that I've had in terms of incidents is where the Trust had a lot of issues with follow up patients not getting their follow up appointments, and somebody was brought in externally to do reports, and I had some involvement in that.

MR BROOKES: So –

MR GRIEVES: So this was some –

MR BROOKES: We'll save that for later.

MR GRIEVES: Okay.

MR BROOKES: Okay. So what were your assumptions about where, if there was a concern about quality of service, where would you assume that was being dealt with?

MR GRIEVES: I assume that they were being dealt with with the heads of service, who were running the kind of qualitative side of things, with the DGM, with the board members.

MR BROOKES: Okay. You attended divisional meetings, general management meetings, operational...

MR GRIEVES: Yes. Operational meetings. Weekly operational meetings.

MR BROOKES: Who attended those? Was there any clinicians at those meetings?

MR GRIEVES: There would have been – yes. Initially there was – Ibrahim Hussein would have been to those meetings, at that point. We still hold weekly operational meetings now, and there's a clinical director and a clinical lead there as well.

MR BROOKES: Okay, and the idea is just to encapsulate the business of the

division?

MR GRIEVES: Yes.

MR BROOKES: And yet, from what you were – I think I heard you say already – there was no discussion about the clinical services you were providing, other than in terms of performance targets?

MR GRIEVES: I can't recall any qualitative discussions happening. Or governance. Or a lot of governance discussion happening. In that they may have been happening in separate meetings. But it was – it was focussed towards the business side of things.

MR BROOKES: But your business is provision of good medical care?

MR GRIEVES: Absolutely. Yes.

MR BROOKES: Okay, nothing more, sir.

DR KIRKUP: Okay, do you have anything you'd like to come back?

DR WALTERS: No.

DR KIRKUP: Okay. I don't have any general questions, but we do want to ask some specific questions that might have issues around confidentiality. So we'll take a notional break in proceedings at that point.

[The interview continued in private]

(The interview concluded at 12.09 p.m.)