Report on an investigation into allegations made by Dr Kim Holt, Consultant Community Paediatrician

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Contents

1 Introduction and Terms of Reference

1.1 This is the report of the investigation undertaken by David Widdowson and Nadia Persaud of Bevan Brittan LLP into allegations made by Dr Kim Holt (Dr KH), Consultant Community Paediatrician, employed by Great Ormond Street Hospital NHS Trust (GOSH).

1.2 David Widdowson has been a qualified solicitor for 25 years and is a partner specialising in employment law. He is also a mediator accredited by the Centre for Dispute Resolution. Nadia Persaud qualified 14 years ago and is a Senior Associate in medical law. Both have more than 10 years experience of advising in relation to NHS investigations and inquiries.

1.3 The terms of reference we were given by Professor Trish Morris-Thompson, Chief Nurse at NHS London were as follows:

1.3.1 To investigate allegations made by Dr KH concerning:

1.3.1.1 the management of Children's Services in Haringey Teaching Primary Care Trust (HTPCT) during 2006 and 2007, in particular

1.3.1.2 excessive workload for consultant community paediatricians

1.3.1.3 the behaviour of managers towards clinical staff

1.3.1.4 administration and clinical governance issues within the Child Development Centre (CDC)

and as otherwise set out in two undated letters sent in or around June 2006 addressed to Haringey Teaching PCT ("the Disclosure Letters");

1.3.2 the treatment afforded to Dr KH by her employer Great Ormond Street Hospital NHS Trust (and relevant managers employed by HTPCT) following the Disclosure Letters, her subsequent absence from work and the matters covered by her grievance of January 2007;

1.3.2.1 and all issues arising in the course of the investigation reasonably ancillary thereto.

2 Our investigation

2.1 We met with Dr KH on a number of occasions, initially together with her British Medical Association representative, (PJ). Dr KH provided us with extensive detail of her history with GOSH and her employment in the Health Service prior to that, and also of the issues that she had raised. She also provided us with very extensive documentation.

2.2 We then interviewed those persons who appeared to be relevant to the matters we were asked to investigate. Some of the witnesses that we considered as relevant to our investigation declined to participate. These witnesses included two of the Consultant Community Paediatricians who had worked at the CDC during the period relevant to this investigation.

2.3 A full list of those interviewed is at Appendix 1.

2.4 A list of the documents that we have reviewed is at Appendix 2.

2.5 Copies of the documents referred to in this report are at Appendix 3.

2.6 A chronology is at Appendix 4.

3 Related Investigations

3.1 The concerns raised by the Consultant Paediatricians in 2006 are likely to give rise to speculation as to whether and, if so, to what extent these might have had a causal bearing upon failures in the care provided to Baby Peter in 2007. It was not however within the Terms of Reference of this investigation to enquire into the facts surrounding the care and treatment of Baby Peter as these have been separately and thoroughly investigated by others (see below).

3.2 The investigations which have enquired into Baby Peter are as follows:-

3.2.1 A Serious Case Review by Haringey's Safeguarding Children Board. The Report was published on 11 November 2008. This initial report was considered inadequate by the Secretary of State for Children, Schools and Families and a second review was called for.

3.2.2 The second Serious Case Review was carried out by the Haringey Safeguarding Children Board (albeit by a different Panel), and has been submitted to OFSTED. The Executive Summary was available for our review.

3.2.3 A Joint Area Review ("JAR") report was commissioned on 12 November 2008 by the Secretary of State for Children, Schools and Families. The investigation was carried out by OFSTED, the Healthcare Commission and HM Inspectorate of Constabulary. The remit of the investigation was to undertake an urgent and thorough inspection of the quality of practice and management of key services which contribute to the effective safeguarding of children in the local area. A review of the action taken in response to this JAR was published in July 2009.

3.2.4 An independent review of Child Protection Practice of Dr AZ was commissioned by GOSH and prepared by Prof JS and Dr DH. The remit of this report included a review of the standard of clinical care provided by Dr AZ and a review of the systems where child protection cases are seen at St Ann's Hospital.

3.2.5 A Post-death Incident Review was prepared by Verita on behalf of NHS London and was published in April 2009. The remit of the investigation included a review of the steps taken by the relevant NHS organisations, following the death of Baby Peter.

3.2.6 A review into the involvement and action taken by health bodies in relation to the case of Baby Peter was undertaken by the Care Quality Commission ("CQC"). This report was published in May 2009. The report focused on the involvement of health professionals in relation to the care provided to Baby Peter and included a review of safeguarding practices and the specific actions taken by trusts in response to the serious case reviews. The CQC considered whether further action was required to safeguard children as a result of the Baby Peter case.

3.3 In addition to the above, an investigation was commissioned by GOSH and was completed on 31 March 2009. The remit of the investigation was to investigate concerns which were raised by Dr KH largely relating to safety of the workload and working environment, and concerns over staffing levels for child protection at the CDC. There is some degree of overlap between this investigation and our own.

4 The background to our investigation

4.1 The CDC, based at St Ann's Hospital in Haringey, provides child health services including services to address neuro-disability, behavioural problems, autism, care of Looked After Children and child protection medical examinations. Dr L had been the sole Consultant in the CDC, working together with a team of therapists, when HTPCT took over the responsibility for the service in 2001. His employment transferred to GOSH under the TUPE Regulations in April 2003 and he left his employment the following year. He did not carry out any clinical duties following the transfer. After his departure, discussions were commenced between HTPCT and GOSH directed at GOSH taking over the employment and professional management of the medical staff, with a view in the longer term to GOSH assuming overall responsibility for Children's Services on behalf of HTPCT at the CDC. GOSH took over the responsibility for the medical staff in May 2003.

4.2 Four Consultant Community Paediatricians were recruited to the Service by GOSH, including Dr KH, who joined in 2004. At all material times, Children's Services were managed by JE, (then employed by HTPCT) and on the clinical side led by Dr DE (DE), an employee of GOSH. Although there were changes in the body of Consultants, this arrangement continued until April 2008, at which point GOSH assumed full responsibility for Children's Services and the HTPCT staff involved (including JE) transferred to GOSH's employment.

4.3 In early 2006 financial cuts were required to the services and this sparked some difficult and vigorous debate between the management team and the clinical teams. At around the same time, the Consultant team at the CDC had raised a number of concerns in relation to the administration systems in place at the CDC. It is alleged by Dr KH that as a result of raising these concerns she was subsequently targeted and bullied by the management team, resulting in her raising a grievance in October 2006 and ultimately in her being signed off work with work related stress in February 2007. In addition, it is alleged that concerns that Dr KH had raised in relation to her

workload in early 2006 were not addressed and indeed increased demands were placed upon her. When Dr KH was signed off with work related stress in February 2007 there then followed extensive discussions concerning the basis of a return to work which essentially remain unresolved. In Dr KH's view, the way in which GOSH have conducted these discussions is further evidence of penalising her for having raised the concerns that she did.

5 Summary findings

5.1 The concerns raised by the Consultants at St Ann's in March-June 2006 fairly reflected their views, which were genuinely and reasonably held and which, if left unaddressed, could have impacted on patient safety.

5.2 It is our view that the HTPCT management team and GOSH took these concerns seriously and in response made genuine attempts to alleviate them, so far as it was operationally possible to do so. The issue of excessive workload for Dr KH had not, however, been dealt with prior to the commencement of her absence through sickness in February 2007 and it does not appear that the issue of communication between management and clinical staff was specifically addressed in the action plan drawn up in response to the concerns.

5.3 The Consultants' concerns were over potential risks to patients and so related to patient safety. Insofar as Dr DE considers that issues of increased waiting times through excessive workload, lack of follow-up appointments and the unavailability of notes did not affect patient safety, that is a conclusion with which we would not agree.

5.4 HTPCT were concerned to mitigate, so far as they could, the effects of the financial cuts required in 2006, so far as they related to Children's Services. Following consultation with the Consultants and at JE's submissions to the Board, these were reduced by £100,000. It is our view, however, that inadequate consideration was given by those responsible for implementing these cuts, to the named doctor role, both in terms of who should assume the responsibility of this, the way in which that responsibility was assigned to Dr B and the impact upon the service generally.

5.5 The problems with individual consultant workload in 2006/7 were significant and exacerbated by sickness and also by the recruitment difficulties which continue.

5.6 It is evident that relationships between management and clinical staff were poor but we cannot fairly conclude that that was the sole fault of the management team. We consider that factors such as the isolation of the consultant team at the time from GOSH, the high demands of the Haringey population and the acute financial pressures on the service (and consequent excessive workloads) all combined to exacerbate the difficulty in relationships.

5.7 Dr KH appears to be regarded as a good doctor as to whose competence and clinical abilities no concerns have ever been raised. She has always expressed a desire to return to her substantive role at St Ann's Hospital where there is an urgent need for Consultants in her discipline.

5.8 On the evidence before us we cannot conclude that the treatment of Dr KH by GOSH following the matters contained in the Disclosure Letters up to the present day disclose any targeting of Dr KH, in the sense that Trust management have deliberately sought to penalise Dr KH, in particular to be obstructive to a return to work at St Ann's, as a punishment for her having raised the concerns that she did. However we believe that the issue of her return to work has not been managed effectively, given the circumstances in which her absence arose and the provisions of the GOSH Whistleblowing policy.

5.9 The suggestion by RC that his wording be included in the letter setting out the findings of Dr HC and MP on Dr KH's grievance was not in accordance with best practice in circumstances where those added significantly to those findings but where he had not himself been present at the hearing.

5.10 The response of GOSH to the recommendation of the grievance panel that efforts should be made to facilitate and improve relationships between Dr KH, Dr B and the rest of the team at St Ann's was inadequate.

5.11 The unquestioning reliance by RC and Dr DE on the written comments of Occupational Health concerning Dr KH's possible return to work at St Ann's has resulted in an inadequate depth of consideration of the problem as a whole. There should have been greater efforts made to discuss with Occupational Health possible ways by which a return might be effected.

5.12 Although Dr KH has not sought to raise her concerns specifically under GOSH's Whistleblowing Policy, those were matters which are properly the subject of the policy and GOSH should have been alert to treat them as such. As noted in 5.8 above we do not conclude Dr KH has been directly targeted, but we do consider that she is entitled to feel aggrieved when, having raised patient safety and other concerns, she later finds herself in the position where she is told she cannot return to her job. It is recognised that issues surrounding her health and relationships have intervened but, for the reasons set out at 5.9 and 5.10 above, we consider that not enough has been done to attempt to restore Dr KH to her position at the CDC.

6 Recommendations

6.1 We have three recommendations arising from our investigation.

6.1.1 Given our finding as to the approach so far taken to improving relationships between Dr KH and the rest of the team at St Ann's, we recommend that the Trust engage the services of a person who is expert and skilled in the field of conflict resolution and mediation in the workplace, with a view to establishing, if possible, a solution reasonably acceptable to all by which Dr KH can return to work at St Ann's Hospital as a Consultant Community Paediatrician.

6.1.2 We recommend that there be a meeting with Occupational Health to explore fully the requirements they would consider appropriate and necessary to a return to work and to seek potential solutions to the problems identified.

6.1.3 We recommend that in future, drafting and recording of documentation relating to formal Trust procedures, in particular the grievance procedure, be undertaken by those present at the relevant hearings, and that any review by other persons be confined to drafting amendments to clarify matters rather than substantive changes.

7 Dr Holt

7.1 Dr KH qualified as a Doctor in 1985 and became a Consultant in Community Paediatrics in 1994. Prior to her employment with GOSH, she worked in Sheffield Children's Hospital NHS Trust. Dr KH's previous experience had included twenty years of working with deprived and disadvantaged communities and working within community paediatric teams. She holds an MSc in Community Child Health. A very positive reference was provided to GOSH by Professor Leon Polnay (Emeritus Professor in Community Child Health).

7.2 In August 2004, Dr KH's family relocated to London, and Dr KH applied for, and was offered, a post as Consultant Community Paediatrician at the CDC at St Ann's Hospital, employed by GOSH. Dr KH is married with four children.

7.3 Dr KH commenced employment with GOSH on 23 August 2004. In July 2006, she took an extended period of leave (5 weeks), returning at the beginning of September 2006. In February 2007, she commenced a period of absence arising from work-related stress. The diagnosis was of a major depressive episode (DSM IV criteria). Dr KH told us this was the first occasion she had suffered from this condition. On 5 May 2009 Dr KH returned to a working environment, although not at St Ann's Hospital. She presently works on a part-time basis in Neurodisability at GOSH, this being on a time-limited supernumerary basis. This return to work is not part of an integrated return to work plan.

7.4 In August 2009 Dr KH brought an internal grievance complaining about her treatment and a return to work. GOSH have responded indicating that this will be progressed following the conclusion of this report.

8 The Child Development Centre

8.1 The CDC operated by HTPCT is located at St Ann's Hospital in Haringey. When the PCT came into existence in 2001, the lead clinician and sole Consultant Paediatrician in place was Dr L. The way in which Dr L operated the services was considered unsatisfactory by HTPCT and his employment was terminated in 2004 on his retirement. The then Chief Executive of HTPCT, DS, reviewed the medical staffing and had reached the conclusion that four Consultants were needed, each with different specialities. DS had previously been the Associate Director for

Children's Services and was aware of the benchmark for staffing. At around the same time, the Victoria Climbié case had occurred, and HTPCT had experienced serious difficulties in attracting permanent staff to work at the CDC. Discussions had already taken place with GOSH. As lead commissioners for GOSH, the PCT had a strong relationship with it, and it was DS's opinion, and also that of the Chairman of HTPCT, RS, that it would be better to have Children's Services at HTPCT managed by GOSH, in part at least because it would be much easier for them to recruit medical staff, given the strength of its brand.

8.2 The outcome of those discussions was an agreement that GOSH would provide and manage the medical staff, whilst the service would continue to be managed by HTPCT staff. The HTPCT employee with primary responsibility for the CDC was JE, who at that time was Assistant Director of Operations. She was assisted by SP as Service Manager for Specialist Child Health Services.

8.3 The new arrangement, with GOSH managing the medical services, was successful in that four Consultants were appointed. These were Dr B, Dr EB, Dr W and Dr KH.

8.4 The designated doctor, for child protection issues was Dr B, and the named doctor was Dr EB. Dr KH was the designated doctor for Looked After Children.

8.5 In 2005 there was a mounting financial crisis at HTPCT. Each department had to take out costs of £450,000 including the directly provided Children's Services. As a result of this, the intention that GOSH would take over the running of the whole of Children's Services at HTPCT was put on hold. A discussion paper on cost savings for Children's Services was prepared by JE in April 2006 – see pages 1 to 11 Appendix 3. This paper was widely consulted upon and a meeting was held with the team (medical, therapy and administrative staff) at the CDC in which strong representations were made against the proposals.

8.6 A letter from the Multi-Disciplinary team at the CDC (which included the four Consultants, together with therapy staff) was drawn up – see pages 12 to 13 of Appendix 3. Timings are not clear here. The letter was largely concerned about the proposal to split up the medical team from the allied health professionals. Shortly after this letter was sent, a further and more detailed letter was sent from the Consultant team re-iterating the strong opposition to the proposed split, and

providing the specific risk factors which would attach to such action - see pages 14 to 18 of Appendix 3.

8.7 The outcome of the consultative process was that the original proposals were altered, and the total amount of the financial cut was reduced to around £350,000. In so far as the Specialist Child Health Service was concerned, this resulted in a reduction of 0.8 of a Consultant Paediatrician, together with 2.5 whole-time equivalent (WTE) support and administrative staff. The reduction of 0.8 Consultant Paediatric time was achieved by the decision not to replace Dr EB who had, by that time, obtained an alternative position at Islington PCT. The loss was agreed at 0.8 WTE as the tuberculosis service was returned to an appropriate specialist Consultant at the North Middlesex Hospital. The controversial proposed split of the clinical team from the allied health professionals did not take place.

8.8 Dr EB had also undertaken the role of the named doctor for child protection. This role was thereafter undertaken by Dr B, together with her role as the designated doctor for child protection. As it was explained to us, the designated doctor is responsible for providing a strategic, professional lead on safeguarding children and the named doctor is responsible for ensuring the operational safeguarding of children within the organisation and for supporting the clinical governance role. The designated doctor, as pointed out in the CQC Report, should provide advice and support to the named doctor. There is a conflict of evidence as to whether this role was formally transferred to her, or whether she simply accepted this additional responsibility as something which had to be done.

8.9 The discussions between HTPCT and GOSH continued and resulted in an agreement that GOSH would take over the entirety of Children's Services for HTPCT with effect from April 2008. At that point, all the HTPCT employees engaged on Children's Services transferred to the employment of GOSH, including JE and SP.

8.10 A business case was put forward by GOSH for April 2008 to increase the medical staffing in the CDC. This sought an increase to 9 WTE doctors (a mix of middle-grade and Consultants). The current medical staffing in the CDC compromises 6 Consultant Paediatricians (4 WTE), an Associate Specialist, a Specialty Doctor (0.6 WTE), with current vacancies for 1.8 further Speciality Doctors. There are also locums who do approximately 5 PA sessions per week. We were informed that,

from May 2009, the designated doctor and named doctor roles have been separated out again, Dr B retaining the designated doctor role, and Dr Hayman the named doctor position.

9 Dr Holt's allegations – Part 1

9.1 The first part of the allegations made by Dr KH that form the subject of this investigation relates to the management of the CDC. The timeframe is essentially early 2006 up to 14 February 2007, which was the last date when Dr KH worked in the CDC, although Dr KH's belief is that some of these concerns remain.

9.2 Dr KH pointed to three documents in which she says these concerns were raised;

9.2.1 A letter from the Multi-Disciplinary Team, and a related letter from the four Consultants (undated) see pages 19 to 20 of Appendix 3 ;

9.2.2 A letter from all four Consultants to JE and Dr DE (undated) see pages 12 to 18 of Appendix 3;

9.2.3 Dr KH's appraisal in June 2006 (which raised no new relevant matters but repeated some of the comments relating to managerial behaviour).

9.3 In interview Dr KH identified the following areas as being her principal concerns:

9.3.1 The availability of proper notes in respect of the children;

9.3.2 The blame culture in the CDC;

9.3.3 Administrative problems in relation to CDC organisation;

9.3.4 The workload of Consultants.

9.4 To this may be added from the documentation we have seen:

9.4.1 The division and poor communication between the clinical team and the management team.

9.4.2 A lack of respect for clinical opinion resulting in the management team interfering in clinical decisions.

9.5 For the purposes of this Report, we have split these concerns into three main headings; workload, management style and relationships, and administrative concerns.

10 Workload

10.1 From information provided by Dr KH, and from the surrounding documentation including opinions from Occupational Health and her own psychologist, the primary area of concern for Dr KH and the primary cause of her ill-health from February 2007, was the workload that she had at the CDC. The excessive workload also represented part of the reason for Dr KH's request for extended leave in June 2006.

10.2 Whilst it is acknowledged that feelings of over-work will not be uncommon amongst NHS Consultants, both Dr KH and Dr B clearly felt that their workload in the CDC at St Ann's Hospital was too high in 2006/7 and there is no evidence that we have seen or heard which suggests their views were misplaced.

10.3 In interview with us, Dr DE indicated that the cuts to the services would not necessarily have increased the day to day workload of the Consultants. He suggested that the impact of the cuts would have been to increase the waiting times for appointments. In addition, he considered that Dr KH increased her own workload by becoming more intensively involved with patients than other Consultants would. He evidenced this by confirming that when other Consultants took over her workload they were able to discharge some of the patients, as it was considered that they did not need medical input.

10.4 On the issue of Dr KH's working style, we heard evidence from BD (Social Worker). He confirmed that Dr KH was highly committed to her patients and would often go over and above the level of input of other Consultant Community Paediatricians. She was readily accessible and provided a lot of support to the wider team. He gave an example of a Looked After Children case where the Judge had specifically commended Dr KH, BD and a dietician for the good level of co-operation between them, which had worked to safeguard the child's needs. We also note the supportive letters provided by the Vale School and from the parents of Patient GJ. The latter referred to Dr KH as being the first paediatrician, in their experience, over the previous 5 years, to have carried out her job efficiently, effectively and with

complete understanding of the patient's condition. They commented upon the time taken by Dr KH to read the case notes thoroughly before assessing the patient and the time taken to observe the child in the school setting. An example of Dr KH's positive team working is also seen in the letters provided by Sue Davies dated 2 January 2007; AD dated 7 April 2007 and Michael Artemis dated January 2008 - see pages 21 to 26 of Appendix 3.

10.5 In our view Dr KH may have provided a more intensive level of care to the children that she cared for than other Consultant Community Paediatricians but there is no suggestion that this was at an inappropriate or excessive level. It might be said that she could have alleviated her workload by reducing that level but it was her style of working and it is to be noted that her additional efforts were found to have contributed to the safeguarding of children for whom she had responsibility and for which she was commended for her conscientious approach. One area where she took on additional work which she need not have done was in agreeing to do an ADHD Clinic for the Local Authority. Dr KH acknowledges this but maintains that her workload would still have been excessive without that.

10.6 Dr B similarly found the workloads heavy, although at least up to the point where Dr EB left, not unmanageable. For Dr B, Dr EB's departure left her with the additional responsibility of the named doctor role, a transfer of responsibility she described as "insidious". The work needed to be done, and within tight timeframes. Her workload increased significantly when Dr EB left, and then again when Dr KH went off sick in February 2007. After that time, Dr B ended up working 4 PA's extra, on a regular basis. Dr B herself became unwell in 2007 although it is not clear whether, and, if so, to what extent this was related to excessive workload.

10.7 The merging of the named and designated doctor roles was not in our view given the careful consideration it required. Dr DE told us that there was nothing to prevent this happening and that that was the situation in Camden. Dr DH however told us this was, in her view, a mistake in Haringey given its particular needs and the isolation of the clinical team. Of equal concern, however, is the way in which the transfer of responsibility was carried out. We would have expected to have seen more planning of the way in which Dr B's job would change and a greater level of discussion with her over how it would be managed.

10.8 The proposals in 2006 by HTPCT conveyed by JE to make cuts, clearly provoked strong reactions from the Consultant team. The loss of Dr EB's position was a source of major concern.

10.9 By the time that Dr KH returned from her period of leave in September 2006, Dr W was also shortly to leave, and did so in October 2006. From that point, the Consultant team was down to two – Dr KH and Dr B, and both expressed in strong terms the extreme pressure that they felt on workload at that time. A letter written to Dr DE by Dr KH on 28th November 2006 confirmed that notwithstanding previous requests to reduce her excessive workload, her workload had in fact increased. Dr KH made it known at this time that this position was not sustainable in the long term and would impact upon her own wellbeing, and that of her family.

10.10 In relation to the decision not to replace Dr EB in 2006 as part of the required programme of cuts, we accept that this was done, as Dr DE and JE both say (endorsed by the Trust's Chief Executive, TB, and its then Chairman, RS), out of financial necessity rather than any routine operational assessment. Whilst the Consultants dismay at this step is understandable, it was, as we see it, the result of the financial pressures being felt at that time throughout the NHS. We comment elsewhere on the Named Doctor aspect of this which we do not consider was properly dealt with.

10.11 In May 2008, comments made by Dr DH and Prof JS in the report commissioned by GOSH into the child protection practice of Dr AZ, indicate that the position in relation to workload was still far from satisfactory. They record Dr B's views as expressed to them that it was a "clinically risky situation", with amongst other things, too few staff. Their conclusion was that this, in part, resulted in the present arrangements for child protection cases at St Ann's as being a cause for "grave concern". It is understood that another of their concerns – the combination of the named doctor and designated doctor roles – has since been remedied, and recruitment has been made to vacant positions so that the Consultant Paediatrician complement is now back broadly to the level prior to Dr EB's departure, that is to say four whole-time equivalent Consultants.

10.12 We note that a suggestion was made by the Occupational Health team in February 2007 that a review should be undertaken of all job plans for the Consultant paediatric staff working in the CDC to ensure that there was not an overload on this

highly specialised team. The Occupational Health team did not receive a response to this suggestion.

10.13 The situation at present has however improved, to the extent that there are now nine doctors working at the CDC. More money has been made available for the Service, which has made this possible, and this in part must be regarded as a response to the Baby Peter case.

10.14 One further matter raised by Dr KH related to her secretarial support and reduction in that, which she alleged had taken place in October 2006, when her then secretary left and was replaced by only a part time secretary. We were unable to obtain documentary evidence confirming the secretarial cover provided in 2006/7 although the evidence in a letter from EH dated 2 February 2008 suggests that full-time secretarial cover was restored to Dr KH by the end of January 2007, replacing part-time support between then and the departure of Dr KH's previous full-time secretarial support, AD, in October 2006. Both Dr SB and Dr KH gave evidence to confirm that their secretarial cover had been reduced. This, as both EH and AD make clear, would have added to the work load of the Consultants, putting more pressure upon them.

10.15 In relation to workload, we conclude as follows:-

10.15.1 In our view from the evidence we have seen, the workload of the Consultant team was excessive between 2006 to May 2008.

10.15.2 Despite the issue of workload being raised directly by Dr KH and Occupational Health, there is no evidence that this was adequately addressed before Dr KH became unwell in February 2007.

10.15.3 Dr KH did not unreasonably increase her own workload through her conscientious manner of working.

10.15.4 It is accepted that the decision in May 2006 to cut the Consultant post (0.8 sessions) was a decision made out of financial necessity and not operational assessment.

10.15.5 It is our view that the consequences of the decision to cut the named doctor post were not adequately considered by the management

team and clinical lead. It appears that no risk assessment was carried out in relation to merging the two roles, no formal transfer of the role took place and there was no review of Dr B's job plan or capacity to undertake this task.

11 Management style and relationships

Communication

11.1 The four Consultants raised a number of concerns in the letter addressed to "Dear Jane and David" - see pages 19 to 20 of Appendix 3. There is an issue as to when this document was produced. It appears that SP held meetings with each of the Consultants at the end of March 2006, and that these meetings were based upon the issues that are referred to in the letter - see pages 27-35 Appendix 3 for notes of the meetings. The output of those meetings was an action plan which uses the same 15 categories referred to in the letter. That action plan document was created in May 2006. In the note that we have seen of SP's meeting with Dr KH, there is reference to Dr W agreeing to write up notes of a meeting between SP and the Consultant team on 27 March 2006, which SP records as being received by her in the form of a letter to JE and DE on 5 April 2006.

11.2 The precise dating of this letter is less important than the matters raised, and the actions taken as a result.

11.3 Dr KH observes that SP's notes do not deal with the concerns raised in the Consultants' letter in the paragraph commencing "Communication with Senior Management is our most serious concern". The notes of SP's meeting with Dr KH do not follow the same format as that letter, and since that letter appears to have been received after the date of this meeting, that is perhaps not surprising. Given, however, that the communication issue is described as the Consultants' "most serious concern", it would also be surprising if that was not a matter that had been raised by the Consultants at the meeting on 27 March 2006.

11.4 In any event, it was certainly an issue that had been raised by 5 April, but was not overtly addressed in the action plan of May 2006, or the update of May 2009.

11.5 A further letter had been written by Dr B on 22 March 2006, also raising concerns about the communication with the management team - see pages 36-37 Appendix 3. This letter refers to her concerns relating to the manner in which she was spoken to by Dr DE and JE. Dr B's evidence however is that a meeting was held with her to discuss her concerns following this letter, and that the communication between Dr B and the management team improved after this time.

11.6 Dr KH believes that there was an aggressive management style, which amounted to bullying. That was a view expressed to us in such forcible terms by Dr KH only. NB also spoke of a "bullying culture" although the only example she gave was an incident rather than any consistent course of behaviour. Dr W felt that relationships were poor, and that JE could be quite confrontational, divisive and hierarchical. Such criticisms as there were, appear to be directed largely at JE rather than SP, who seems generally to have been regarded as well-meaning and more willing to engage**.** Dr LW, an Associate Specialist who has been in the CDC for the longest time, reports no problems of this nature with any of the management team.

11.7 Dr Z, who was a trainee during 2006/2007, was critical of the very poor level of communication within the CDC. She experienced an absence of direct oral communication with the management team, and referred to "shouty emails" and post-it note messages as being a usual mode of communication. Dr Z felt that this style of communication created a very hostile environment within the CDC and described the environment as pervasive, insidious and quite unbearable in the context of the workloads. Dr Z did not feel that she could continue her work at the CDC, and therefore asked for an early return to the North Middlesex Hospital.

11.8 NB (physiotherapist and Manager of the therapist team) referred to a very difficult meeting where the service cuts were discussed. NB confirmed that she was vocal during that meeting, understanding that it was a consultation. She was later however spoken to by the management team who confirmed that she should not have spoken out at the meeting and that she should have adopted the management line. Following this meeting NB has not felt comfortable in speaking up at meetings, and has felt that her confidence took a large knock as a result of this.

11.9 We are tempted to regard the overall situation as one of an issue of leadership which was a matter Dr KH had taken up in a letter to CC in November 2006. Insofar as the Consultants felt that there were difficulties with management or that

management were behaving in an inappropriate manner, it would be to Dr DE that they should no doubt have looked for a resolution. It is clear from our meeting with Dr DE that he had many calls on his time, and was not able to devote the level of time to the Consultants at the CDC as might be possible in a group of clinicians not remotely located. His relationship with JE, SP and, more recently, Dr B appears to be good, but much less so with Dr KH and Dr W. Dr W described him as something of an "absentee father". Dr W's recollection was that when the Consultant team required Dr DE, he was not available and he rarely engaged with the Consultant team in a positive way.

11.10 Whilst we heard evidence in relation to JE's aggressive management style, we also heard considerable support for JE, who is recognised as being a strong manager by those to whom she reports, and who is a highly experienced therapist as well a manager. We heard from several sources that she was very torn over the financial cuts which she knew she had to implement, and indeed successfully argued the cuts required from Children's Services down from £450,000 to £350,000. Her reaction to the meeting, acknowledged by all to have been difficult, at which these proposals were first tabled, was one of great upset and overall, we consider that her intentions were not inappropriate and were directed towards a well-run Children's Service. She has a direct style, and it is perhaps not surprising that, given the matters with which she had to deal, and the news that she had to deliver, this might provoke strong reactions in those to whom she was speaking.

Interference in clinical decision making

11.11 Dr KH complained also of interference in clinical decisions. There were two particular cases in each case where JE had, as Dr KH saw it, interfered with her management of a case. In respect of each of those, JE gave us a rational explanation for her actions. In one case, there was a balance that had to be struck in relation to prioritising various treatments, in the context of a child who had complex family dynamics. In the other there had been some discussion between Dr KH and JE over an MMR vaccination for a patient and his challenging family where the two had disagreed over the issue. Dr KH had then been angry to see JE present in the CDC at the same time as the patient was visiting, assuming (wrongly so JE says) that she was deliberately there to become involved in the patient's care.

11.12 Evidence was received from MZ and SR in relation to the changing of a clinic letter by a member of the Management team (SP). The doctor who wrote the letter was on annual leave when the mother of the child called in to query the dosage of medication. SP allegedly changed the letter to reflect the mother's request and did not check this with a member of the clinical team before doing so. SP was unable to recall this episode (and no documentary evidence was available to confirm this) but she accepted that if this had been done, the correct process would have been to have checked this first with a doctor. SP confirmed that she did not feel that it was her place to override clinical decisions and would not knowingly have changed a clinical decision.

11.13 We do not, however, consider from the examples given that it can fairly be said that decisions taken by clinicians were deliberately and/or unreasonably interfered with by the management team. The difficulties that there have been stem in our view from the communications difficulties which were evident.

Supervision and training of Junior Doctors

11.14 We heard evidence from 2 junior doctors who were present at the CDC between September 2006 to May 2007. Both doctors gave evidence that they were concerned about a lack of supervision by Consultant staff, lack of training and poor communication and support whilst at the CDC. The situation became acute from February 2007, when Dr KH left the CDC on sick leave. At this time Consultant cover was only available from Dr AZ and Dr B. Dr B was also on sick leave between 16 April 2007 to 14 May 2007. As a result of their concerns, they sought an early return to the North Middlesex Hospital. One doctor was unaware of Dr DE's lead clinical role and was unaware that she could go to him for support. Apart from one session on immunisation, he did not provide any clinical supervision or training to the junior doctors, or enquire as to their needs, which, in light of the much reduced Consultant support at that time, they felt he might have done. Dr DE, on questioning, was unable to recall the role he had taken in relation to the junior doctors. He confirmed that they would have had Consultant supervision.

11.15 The Junior Doctors gave evidence in relation to being assigned tasks which they believed were outside of their level of expertise. This included seeing Looked After Children, who often had challenging emotional and behavioural problems, and preparing Court Reports. SP confirmed that the management team would not generally be responsible for assigning tasks to the junior doctors. This was the

responsibility of Dr B. SP could not recall any proactive decision to make the junior doctors do things that they should not be doing. She confirmed that if this happened inadvertently, this would have been as a result of the vacancies, sick leave and service referral demands.

11.16 In relation to management style and communication, we conclude as follows:-

11.16.1 In respect of Dr KH's allegation in relation to aggressive management style it is clear that relationships were not good and the communication process difficult.

11.16.2 We suspect that the fact the clinical team were employed by GOSH effectively as an out-post was a contributing factor in that their employer was different to those responsible for their management on a daily basis and they did not have easy access to colleague support. This was of some concern to CC who ensured that he visited on a periodic basis in an effort to reduce what he perceived might be their feeling of isolation.

11.16.3 It is our view that the combination of an assertive manager, in the form of JE, an often unavailable clinical leader, the isolated nature of the Consultant team from GOSH and the North Middlesex, the high demands of the Haringey population and budgetary cuts all conspired to produce a situation where relationships between clinicians and management were poor. We do not consider, however, that this descended into a bullying regime.

11.16.4 Now that the entirety of Children's Services is within the responsibility of GOSH and recommendations have been made to improve the communication with the North Middlesex team, we would expect this situation to have improved. The evidence received from those still working at the CDC indicates that the working environment is now much improved.

11.16.5 The evidence suggests that the training, supervision and support provided to the trainee doctors between September 2006 to May 2007 was inadequate.

11.16.6 We have not received any clear evidence upon which to conclude that there was any deliberate, inappropriate or sustained interference by the management team in relation to clinical decision making.

12 Administrative issues

12.1 From the documentation received, it would appear that concerns of a systemic nature were comprehensively raised by the Consultants at a meeting on 21 March 2006. Following this meeting SP met each of the Consultants to discuss their individual concerns. These meetings took place between the 30 March and 5 April 2006 – see pages 27-35 Appendix 3 for the notes. In addition to these meetings, JE met with Dr B as Clinical Lead. A further Consultants meeting was held on the 27th March 2006 to discuss the "whole system difficulties" impacting upon the Consultants. The notes of the meetings on 21 March and 27 March 2006 were not available to us for review. Following the meeting on the 27 March 2006 the Consultants were asked to put into writing their concerns about the systems. This was done in the form of the "Dear Jane and David" letter – pages 19-20 of Appendix 3 . This letter appears to have been received by SP on the 5 April 2006.

12.2 The extent to which the matters complained of in the Consultants' letter were dealt with, is variable. Our Terms of Reference are to consider the concerns raised by the Consultants – whether these were well founded and how strategically the Management team responded to these. The report commissioned by GOSH into Dr KHs patient safety concerns covered the action taken by GOSH and HTPCT in response to these concerns, up to publication of the report. Broadly, the conclusions were that the concerns raised by Dr KH and her Consultant colleagues had been rectified by the date of the report.

12.3 All of the management team that we met with (Dr DE, JE, SP) accepted that the concerns raised by the Consultants were real. JE confirmed that the management team were aware of the concerns and their view of the letter was that it was helpful to have all of the concerns set out clearly in one document. Both JE and SP gave evidence to the effect that SP was given the task of compiling an Action Plan to address the concerns raised. Evidence to corroborate this can be found in the Minutes of a Consultants meeting dated 18 April 2006 and the Action Plan itself (created in May 2006). Both Dr KH and Dr B were very forthcoming in their meetings with SP.

12.4 We were informed that changes were made as a result of the letter, but that these were made "on a journey" and could not be carried out overnight. It is accepted that some of the issues still exist – such as electronic medical record systems. In relation to the latter, the Trust is in the process of implementing an electronic medical record system, (RiO). Another area which still requires further action is in relation to the availability of notes. Immediate responses to the concerns included the introduction of the D:Scribe system which reduced the time in which reports were produced (reports were returned within 48 hours of typing). Dr KH appears to have accepted that improvements were made in 2006 and this can be seen from her letter to CC dated 3 November 2006 in which she states that "There have been significant strides made in the administration of the Service particularly in the past 6 months." It is noted that she goes on the state that there were however still significant concerns and that the blame culture persisted.

12.5 One area of concern which was marked as high risk was for child protection follow up. We understand that from October 2007, a weekly clinic has been commenced to address this.

12.6 Dr DE indicated to us that, in his view, the concerns raised by the Consultant team affected the quality of services, but not patient safety. We are unclear as to how he reaches this view. Whilst we are not practitioners in child health, the lack of notes on consultation and delays in seeing children must as a matter of common sense in our view have the potential to affect patient safety. This is reflected in the categorisation of the concerns by the Consultants, in terms of the level of the risk posed. Dr KH also made the point clearly to us that if a patient has to wait longer for an appointment, inevitably the risk to them is likely to increase. Additionally, the Community Paediatric Medical Team Bid document in April 2008 highlights a number of patient related risks arising from low staffing.

12.7 It was brought to our attention that the clinical staff had begun completing Clinical Incident Report forms to highlight the administrative problems within the CDC. We have had sight of the Reports completed between January 2006 to December 2006. 50 Clinical Incident Report forms were completed between January to June 2006 and 16 between June to December 2006. Dr W and Dr KH told us that they were advised by the management team to cease completing these forms. This matter was discussed with SP who indicated that she had initially encouraged the Consultants to complete these forms but was then deluged with forms, sometimes a

number relating to the same issue. She therefore requested that they be sensible about deciding when to complete these forms. It was not accepted by her that the Consultants were instructed to cease completing them altogether. NB has given evidence to support the direction from SP that careful thought should be given before completing the forms. From our review of the forms it is clear that the majority of these were completed by MW and Dr B. Dr KH completed only 5 of the 66 forms that were provided to us.

12.8 In relation to administrative issues, we conclude that:-

12.8.1 The concerns raised by the Consultant team were genuine and well-founded.

12.8.2 Left unaddressed, the concerns raised had the potential to impact upon patient safety.

12.8.3 The Management team did respond to the concerns raised, and an Action Plan was put together following consultation with the Consultants. Although that plan did not deal with the issue of communication which the Consultants had described as very important in 2006, that is not identified by Dr B or any of the other clinical staff still working in CDC as an ongoing problem.

12.8.4 A number of the concerns raised have been addressed, but there are further areas for improvements to be made. Dr B specifically identified late follow-ups, IT systems and child protection follow-up although she indicated that progress was being made by the appointment of extra specialist and consultant posts and setting up the RIO IT system.

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12.8.5 On the evidence that we have seen, we do not consider that there was an instruction to the Consultants to cease completing clinical incident report forms. The direction was to give careful consideration before completing them.

13 Dr Holt's allegations – Part 2

13.1 The second part of our terms of reference deals with events since the Disclosure Letters which Dr KH contends amount to targeting of her by her employer because of the matters that she raised.

13.2 There are three primary aspects to this:

13.2.1 Dr KH's grievance of November 2006, heard in January 2007;
13.2.2 The discussions relating to her job plan;
13.2.3 Her desire to return to work at the CDC.

13.3 When she originally applied to join the team at the CDC, Dr KH indicated that she would prefer to work part-time, but agreed to work full-time initially. At various points between her starting and September 2006, this matter arose again (for example, in March 2005 when Dr KH raised the possibility of a 9-day fortnight).

13.4 Matters came to a head in mid-2006. As Dr KH told us, this was caused by the workload which she was beginning to find unsustainable and also family issues, in particular relating to her daughter. Dr KH met with SP in June 2006 to discuss reducing her workload. In addition, Dr KH indicated she would like to take an extended period of leave due in the summer, essentially for the entire month of August. The issue of flexible working was then discussed at meetings between Dr KH and Dr DE, on 19 and 25 July 2006.

13.5 The result of those meetings is contained in an undated letter from Dr DE to Dr KH, and also in a note that Dr KH herself prepared. Although there are some discrepancies between the two documents, it was agreed that Dr KH would return to work on 10.5 PAs, but with a view to reducing that over a period of time. A subsequent discussion between Dr KH and Dr B identified 1 November as a realistic timeframe for that. The target appeared to be 8.0 PAs, the areas of disagreement between Dr KH and Dr DE being in the precise makeup of those.

13.6 It can fairly be concluded in our view, therefore, that there was agreement at that point that she would return on a full-time basis as before, with a view to reducing to 8.0 PAs in the reasonably short term.

14 The grievance

14.1 On her return from extended leave, Dr KH received a letter from JE. There were two aspects to this. First, she was told that the discussed reduction to 8.0 PAs was "not possible or practical at the current time", and second, she was informed that she had been referred to the Trust's Occupational Health service to ensure that she was fit to return to work, her extended leave being described as a "period of ill-health". A separate letter had been sent to Occupational Health. These letters are at page 38 and 39 of Appendix 3, and it can be seen that, in the letter written to Occupational Health, there is a reference to Dr KH having been unwell, having felt "stressed and tearful" and "prone to emotional outbursts". Occupational Health were asked to address the concerns over her health and emotional difficulties, and assess her readiness to return to work. The letter also refers to a proposed reduction in sessions which JE says that she is "happy to accommodate".

14.2 Dr KH told us that she was devastated to see this letter and, subsequently the referral to Occupational Health as, although she had indeed been feeling the effects of her excessive workload, and had also been distressed over the issues with her daughter, there was no question of any ill-health, and she was wholly unaware of what was meant by the "emotional outbursts" referred to. She told us that nothing of this nature had been raised with her in her appraisal or indeed in any other way. Having reviewed the appraisal documentation from June 2006, there is indeed no record of this being discussed. SP told us that she had on one occasion taken Dr KH aside after an incident where a member of the Trust reception staff had been upset at the way Dr KH had spoken to her and there is a note prepared by SP on 29 June 2006 detailing an incident and referring to this as being "the 3rd incident …of… Dr Holt being unhelpful or rude to admin staff". There is no evidence that this was ever shared with Dr KH.

14.3 Dr KH wrote to JE and also Dr B, who had apparently also been a signatory to the 1 September letter (although Dr B told us she had not seen it and would not have agreed the last paragraph), refuting the allegation of ill-health. She asked them both to retract their comments about that and also about her emotional difficulties, saying "that will then put an end to the matter". That letter was circulated at a very senior level within GOSH, including to the Chief Executive, Dr JC.

14.4 Dr KH did attend the Occupational Health appointment. The conclusion was that Dr KH was fit to return, had no health problem, and was not suffering from stress. Reference was made to an excessive workload which, BT concluded, "is likely to become detrimental to her health if she is unsupported in the long-term". The comment made by JE in her letter as to reducing time commitment was taken up as a helpful development. A copy of the letter from BT is at pages 40 to 41 of Appendix 3.

14.5 Dr KH received a reply to her letter from JE and Dr B on 15 September 2006 which stated that they agreed that the period of leave taken was extended annual leave, and said that they would respond more fully "following discussion with colleagues at GOSH". Dr KH did not have any further reply to her letter and, on 10 October 2006, referred the matter to the Director of Operations at HTPCT by way of a formal grievance – see pages **(**42**)** to **(**44**)** of Appendix 3.

14.6 In her grievance, Dr KH refers to two occasions on which she had attempted to raise the issue with Dr B prior to lodging her grievance. Dr B recalled speaking to Dr KH for "several hours" and, as she put it, thought that Dr KH had understood the position she had been in. Dr KH has no recollection of this discussion.

14.7 The grievance was referred to RC. He considered that the grievance should be dealt with under the GOSH procedure, as Dr KH was a GOSH employee, and appointed Dr DE to hear it. Dr KH took objection to this in that she felt that he himself appeared to have been involved in the matters of which she was complaining, and so Dr DE was replaced by a Deputy Chief Executive of the Trust, Trevor Clarke.

14.8 The grievance was scheduled for hearing on Tuesday 5 December 2006. An adjournment was required, and ultimately the grievance was heard on 11 January 2007. RC told us that the reason for the adjournment, to his recollection, was because of the unavailability of one of the participants.

14.9 The management case for the hearing was received by Dr KH only two days before. This is puzzling, as there is a letter from RC to Dr HC, Dr DE, Dr B and JE dated 15 November 2006 apparently enclosing both the management case and the staff side case. Dr KH took objection to this late receipt of the papers but the evidence from both Dr HC, (who ultimately presided over the hearing) and MP was that Dr KH

appeared well-prepared, and they did not consider that she was prejudiced by late disclosure.

14.10 In the management statement of case, reference was made to a number of incidents prior to Dr KH's extended leave, on which reliance was placed to justify the referral to Occupational Health, and which were described as "emotional outbursts". Dr KH vehemently denies these and it is to be noted that none had been formally raised with her in advance of the grievance.

14.11 Dr HC told us that both she and MP were very persuaded by the case that Dr KH presented. MP said that the outcome had been a joint decision between himself and Dr HC, and they were in agreement. In interview, however, MP expressed himself in more qualified terms than Dr HC, saying that he did not consider that Dr KH's grievance had been upheld, although he considered that management had not followed "best practice", with regard to all of their actions in relation to Dr KH. Dr HC's view was that, in that Dr KH's complaint was essentially about the handling of the referral to Occupational Health on her return from her extended period of annual leave, that was upheld, and the referral had been inappropriately managed. As to the matters which arose during the hearing relating to the behavioural incidents specified by JE and Dr B, Dr HC considered that they did not have any documentary evidence to indicate that any of these had been raised with Dr KH before, and therefore they could not reach a conclusion on that. MP agreed with that.

14.12 These issues are of some significance, in that the outcome of their deliberations was set out in a letter, initially drafted by MP, and then amended by Dr HC. Dr HC assumed that MP would then send the letter to Dr KH, but instead, he referred the draft to RC. MP explained that his reason for doing so was that this was the first grievance brought by a clinician that he had heard, and he was keen to get RC's approval to the draft, to ensure that he had covered policy, protocol and legal issues.

14.13 Dr HC told us that RC had then responded with an email containing substantial and significant changes, which he wished to be included in the report. His proposed inclusions are in his email to MP of 18 January 2007 (see page 45 of Appendix 3). The position with the various versions of this document is confusing and neither Dr HC, MP nor RC were able to provide us with the original version of the letter. There is a version, however, which is significantly shorter than the others (see pages 46 to

48 of Appendix 3) and we think in all probability this is the one that MP sent to RC. At all events, from the email of 18 January what RC proposes by way of addition is extensive. It also, as we see it, considerably changes the thrust of the response of the panel and, it must be said, more adversely to Dr KH. For example, he includes a phrase "Whilst as mentioned, the Panel could not support KH's grievance" which was not in the original letter (and which was not ultimately included by Dr Cass in the final version) and also proposed a number of findings critical of Dr KH's behaviour and supportive of the management team. Dr HC included some but not all of these in the final version which we believe is that at pages 49 to 52 of Appendix 3.

14.14 Dr HC told us that she felt pressurised by this, but was told by RC that it was necessary to include these matters because, as drafted, it could be perceived as critical of HTPCT management;. That in turn could adversely affect discussions which were taking place between GOSH and HTPCT about GOSH assuming full responsibility for Children's Services. RC said that he had certainly not intended to pressurise Dr HC into anything but was simply trying to clarify the views of the panel and ensure that the letter covered fully all the points that had arisen. He pointed out that the letter was ultimately signed by Dr HC without incorporation of much of what he had proposed, and further pointed out that the surrounding email exchanges between himself and Dr HC are polite and amicable, and not consistent with feelings of being pressurised, and we agree that RC's point is supported by the documentation we have seen. He further pointed out that it would, in any event, have been unlikely that he could feasibly pressurise Dr HC, since she was senior to him within the organisation. Dr JC told us she had no detailed knowledge of KH's grievance and certainly did not tell RC to make any amendments to any letters. She also said that she would be surprised if RC had made the comment alleged by Dr HC as there would have been no purpose in him doing so as there was no issue about whether GOSH would take over full management of HTPCT's Chidren's Services, only when. Those discussions at that time were on hold because of the financial issues being addressed by HTPCT.

14.15 Whilst we acknowledge the points made by RC, we find it unusual that an individual who had not been present at a grievance hearing should find it appropriate to propose changes which we find it difficult to agree were simply by way of clarification. They seem to us to be much more substantive in nature, and it is not our experience that this would be regarded as common or best practice.

14.16 Although initially Dr KH was unhappy with the decision of the panel, there was an exchange of correspondence between her and Dr HC which clarified some issues to her satisfaction. In her letter to Dr HC of 20 April, Dr KH stated "as my grievance has been upheld", and went on to refer to "further harassment or discrimination". These letters are at pages 53 to 56 of Appendix 3. JE saw that letter, and took exception to those remarks. She raised this with RC, who in turn contacted Dr HC (by email dated 21 June 2007), suggesting a further letter be sent to Dr KH, making it clear that the panel had not accepted that Dr KH had been subjected to bullying and harassment. Dr HC responded by saying that she would not do so, and there expressed some regret at having altered the original wording of their letter in response to RC's proposal. JE was unhappy with that response, and sent an email to RC saying so but the matter went no further. These emails are at pages 57 to 58 of Appendix 3. We understand from JE that her concern was that Dr KH had not been slow in broadcasting that she had won her grievance, and had done so in an unhelpful manner. Dr B too told us that Dr KH had come into the CDC and "shouted that she had won her grievance". Dr KH does not accept that she had broadcasted or shouted the outcome of the grievance.

14.17 Our overall conclusions in relation to the grievance issue are:

14.17.1 In process terms, the grievance was held properly, and we do not think there was any unreasonable delay. The situation regarding the management case and the date of its disclosure is unclear. Although Dr KH feels she was prejudiced by this, a postponement was not requested and the panel felt her case was presented very well. We do not consider that Dr KH was prejudiced materially by that nor could we fairly conclude on the evidence that the document was deliberately withheld until a very late stage.

14.17.2 The intervention from RC did propose some changes to the sense of the original findings. Dr HC, although ostensibly originally content to accommodate some of RC's suggestions, later expressed some discomfort at that.

14.17.3 Given that Dr KH's initial grievance was about the referral to Occupational Health, we do not think it is unreasonable for her to

regard it, from the letter that she ultimately received, together with the clarificatory letter from Dr HC of 5 April 2007, as having been upheld.

14.17.4 Although we in no way suggest that RC was improperly motivated, substantive intervention by persons uninvolved in procedures of this nature seems to us to be unwise and contrary to best practice.

15 Facilitation and "mediation"

15.1 One of the developments following Dr KH's return to work starting with the letter of 1 September 2006 referring Dr KH to Occupational Health was a deteriorating relationship between Dr KH and Dr B. Dr B told us she felt that the difficulties in their relationship had started rather earlier but it is clear that matters became significantly worse after this point. This was clearly apparent to Dr HC and MP at the grievance hearing, in that they specifically raised the issue (albeit prompted by RC), and they proposed that "formal Trust-led facilitation be conducted between Dr B and Dr KH to allow them to work together in a constructive and mutually supportive environment". RC told us that this had been discussed, and JM's name had come up as someone who had done some work of a similar nature with another group of doctors in GOSH. It was agreed that MC would approach him. There was some delay in doing so, to which Dr KH took objection, raising the issue on several occasions in emails in which she evidenced a strong desire to make the mediation work.

15.2 By this time Dr KH was absent from work through sickness, described by her GP as work-related stress, that absence commencing on 13 February 2007.

15.3 JM, when we met with him, was at pains to point out that he is an organisational development specialist, rather than an expert in conflict resolution or mediation although we note from the report commissioned by GOSH (paragraph 5.45) that he describes the task given to him as being one of "conflict resolution" rather than "mediation". He told us that he felt that, by the time of his involvement, all three of the main protagonists were in entrenched positions, and he did not detect very much desire, on the part of any of them, to re-establish a functioning working relationship, rather to try and persuade him that their point of view was the right one.

15.4 JM held meetings with all members of the team individually and these were then followed by a meeting on 14 September 2007 which was attended by himself, Dr B, Dr KH, Dr DE, Dr B and SP. Dr B recalls the meeting as being a "total and utter disaster". Dr KH, she said, spoke at length, and on one occasion, when Dr B tried to talk about her own problems, she simply received a raised hand from Dr KH and was cut off from speaking. Dr DE has a similar recollection. Dr KH told us that she felt isolated in the meeting, as she was not accompanied or represented. She said she found the meeting intimidating, describing it as a "group bullying session". She recalls overt hostility on the part of Dr DE and Dr B. She took great exception to a comment by Dr DE (which had been made before) that she had been manipulating Occupational Health. BT confirmed to us that she certainly did not feel that was the case from the meetings she had had with Dr KH. Dr DE could not specifically recall making this comment but said that he might have made a comment about Occupational Health having heard only one side of the story, a comment which, in the circumstances, he did not think was unreasonable. Dr KH also recalled DE threatening to refer her to the Medical Director and being taken off the payroll. She was also in addition annoyed that JE was not present, as Dr KH considered that JE was an important part of the picture. JE told us that she did not regard it as appropriate for her to attend, as it was largely about team-building and working on the relationship between Dr KH and Dr B as had been identified in Dr HC's letter dealing with Dr KH's grievance. JE did not feel she was part of the direct team, and her involvement was therefore unnecessary. SP's memory of the meeting was of Dr KH confirming she felt there was very poor communication in the team, and that if this could be resolved, she would be able to return to work. She felt however that Dr KH offered no evidence that she herself might have to change to make this work.

15.5 There was a common view, following the September meeting, that it had not been successful. Although Dr KH contacted RC and indicated her willingness to engage in another process, this did not happen, and the process came to a conclusion when JM wrote to MC on 2 November 2007 (see pages 59 to 60 of Appendix 3), confirming advice that he had previously given to Dr DE in an email on 9 October and in effect saying that the prospects of any resolution of differences were "not strong" and would certainly take some time. He recommended that GOSH should consider alternative options for the future staffing of Haringey Children's Services. He further suggested that the Trust may want to consider supporting Dr KH in leaving the service. JM told us at interview that he regarded the parties as all being

in entrenched positions, and did not feel that this was the responsibility or fault of anyone in particular.

15.6 In relation to this issue we have concluded as follows:

15.6.1 Although the initial decision to appoint JM to carry out the task envisaged by Dr HC and MP in their letter dealing with Dr KH's grievance was understandable by reference to his previous work with the Trust, he has made it clear that he is not a specialist in conflict resolution and does not hold himself out as such.

15.6.2 The response to Dr KH's grievance had talked in terms of "facilitation", and referred only to Dr B and Dr KH. At Dr B's suggestion, the process had widened to include the whole team, and the term "mediation" had begun to be used.

15.6.3 The process adopted by JM, although not inconsistent with what we understand to be a mediation process, did perhaps stop rather sooner than one might expect in a mediation. Regardless of how the initial meetings had gone, if at the first round-table meeting, positions become entrenched, or the dialogue were dominated by one person, one would expect further individual meetings to take place, with perhaps stronger control on the part of the person presiding. We hasten to say we attach no criticism to JM as, as we have noted above, he has made it clear that mediation is not his specialist area.

15.6.4 It is our view that, whilst the choice of JM was understandable, in the event the skills required in this situation were not within his area of expertise and could be found elsewhere. GOSH appear to have subcontracted the problem to him and thereby lost ownership of it. There would be much to be said for addressing the issue of mediation again, using a specialist in the field, and we return to this below.

16 Job plan

16.1 Running alongside both the grievance and the mediation issue were discussions which Dr KH was having with DE and RC over a change to her job plan to reduce her time commitment. SP was also present at these meetings. It will be recalled that this was something that Dr KH had initially raised in June 2006, and continued as a subject of discussion at a large number of meetings throughout 2007.

16.2 Although Dr KH returned to work on 5 September 2006, she fell ill in February 2007, due to stress brought on by her workload. Thereafter a feature of the job plan discussions was the factor that any plan agreed would have to be such as would ensure that her workload was not at a level which might result in a recurrence of her illness.

16.3 From a team management point of view, there were some limitations on what might be agreed. Given the historic workload issue, and the fact that during this period Dr B herself was also seriously ill, and both Dr EB and Dr W had left, any arrangement reached with Dr KH would have to be such that it was possible in practical terms to find others to do the remainder of her original role. The progress of discussions between June 2006 and October 2007 is helpfully set out in a timeline summary prepared by SP which is at page 61 of Appendix 3.

16.4 There is a great deal of correspondence passing between Dr KH, RC and Dr DE, dealing with a wide variety of arrangements. Dr DE and RC's approach was largely directed to what could be feasibly agreed as workable in practice but at the same time taking into account Dr KH obtaining the right volume of work and the right mix for her.

16.5 This was clearly a difficult process for all concerned although by September 2007 a measure of agreement on Dr KH's job plan going forward was reached. This is dealt with in more detail below. RC's view based on comments from Occupational Health was that a return to work was not possible while their opinion remained as to the risk of Dr KH returning to an environment where the workplace and interpersonal issues were unresolved. There then followed discussions over Dr KH possibly leaving the Trust. In our view, there is no evidence that Dr DE and RC approached this issue otherwise than on a bona fide basis, trying to agree a system which worked for Dr KH but at the same time also worked for the department. By the

same token, we do not think it can be said that Dr KH behaved improperly or had ulterior motives – it is apparent from the correspondence that she was very concerned with ensuring that she did not return to a working pattern which would again threaten her health, and she was supported in that by the contributions of BT from Occupational Health as well as her own psychologist. All parties spoke to us of their frustration in this process but it is our view that the lack of agreement arose from the inherent nature of the discussions and competing demands, on the part of the department, of the need for any changed working arrangement to be capable of working in practice on the one hand and, on Dr KH's part, an arrangement which would give her the right balance of work and which did not risk a repetition of the circumstances which had caused her illness. It was this that prolonged the process, rather than any culpable behaviour on the part of any of the parties involved.

17 Return to work

17.1 On 13 February 2007, Dr KH was signed off from work by her GP for a period of 4 weeks, attributable to work-related stress. As noted earlier, this was an episode of clinical depression. She was referred to the GOSH Occupational Health department, and was seen by Dr JW on 22 February 2007. Dr JW's recommendation was that, once the grievance process had been completed, there should be a "short graduated return to work". She also offered the suggestion that a reasonable accommodation beyond that might be a flexible working approach, where Dr KH's total number of hours remained the same, but where there was some flexibility in time of arrival and departure.

17.2 Dr KH remained signed off work by her GP for successive periods up to August 2007. During that time, discussions about her job plan continued, and a measure of agreement appeared to have been reached, whereby she would return to work on a 10 PA job plan, but on a graduated basis, from the beginning of September 2007. That was said to be subject to Occupational Health clearance, which in the event was not forthcoming, as it was felt that the facilitation process (see above) ought to be completed first. After the 14 September (the date of the round table meeting with JM) RC reports an Occupational Health recommendation that Dr KH was then ready to return to work provided that the mediation continued and that annual and study leave procedures were clarified to her. These views are set out in the letter of 11 October 2007 from Dr KH's psychologist to BT.

17.3 At this time an issue over pay arose, Dr KH contending that, with effect from 20 July 2007, she had been ready to return to work, and that all that had prevented that was the holding of the facilitation meeting. This, she felt, had been unreasonably delayed and she should not therefore be penalised by being reduced to half pay which would have been her entitlement if the reason for her continued absence truly had been through sickness. At this point, she chose to involve her BMA representative, and there were then a number of meetings between RC and MB to deal with this and matters more widely. Dr KH's pay was restored retrospectively in March 2008. By that time also JM had reported on his pessimistic view of the likely success of facilitation.

17.4 In her letter to RC of 24 September 2007, BT expressed the view that

> "there are certain workplace issues that should be addressed to ensure that [Dr KH] does not suffer recurrence of her depressive symptoms…certain team behavioural issues that have caused problems for [Dr KH] in the past should be discussed and boundaries agreed".

17.5 On 28 November 2007 a round-table meeting occurred between RC, MC, Dr DE, Dr KH, MB and Dr KH's husband. In his letter summarising the content of that meeting, RC referred to the advice from Occupational Health and went on to say that the Trust were "adamant" that Dr KH could not return to work unless and until those requirements were met. He then said that he did not think it would be possible for the Occupational Health requirements to be met given the previous efforts that had been made to address the requirements. On that basis, there were two possible options – redeployment within GOSH or elsewhere, or alternatively, leaving the Trust on the basis of a financial settlement. It was agreed there would be a further meeting in January 2008, and, in the meantime, a number of things would happen, including RC contacting the PCT's in the North Thames area wiuth a view to identifying possible opportunities for Dr KH.

17.6 Dr KH responded to RC's letter on 10 December 2007. She expressed her shock at the meeting, instead of being a return to work discussion, revolving around her being redeployed elsewhere. As she put it,

"I am having some difficulty in understanding why you believe that mediation has now run its course, and why I personally should be the team member that is excluded from the work place."

17.7 Despite this, she engaged positively with RC on the possibility of redeployment elsewhere. She told us that she felt that a return to the CDC was now closed off to her, and that, if she did not actively engage with RC in redeployment, she would lose her job.

17.8 A further meeting was arranged for 22 February 2008, prior to which there was an exchange between RC and MB, in which RC said that he had been unable to find any redeployment opportunities within GOSH, and that a return to the CDC could not be considered. He raised again the possibility of "financial assistance", and then identified the only remaining option as being a reference of "the matter upwards for a decision on [Dr KH's] future employment status with GOSH". Prior to the meeting, Dr KH herself wrote to RC, and reasserted her wish to return to Haringey. She also made the point that if JM's view on the likely success of a mediated solution was the main reason that he had come to the view that she could not return to Haringey, then it would be reasonable for there to be a discussion with JM before a final decision was made. RC replied to that, re-asserting that she could not return to Haringey on the basis of the Occupational Health advice and the inability to meet their stipulated requirements for a return to occur. In relation to JM, RC simply stated that he would not be able to direct his attendance at the meeting, but confirmed that his feedback from the mediation had been shared with all parties.

17.9 There was then a gap where the issues relating to Dr KH's pay were resolved (in her favour). Then in April 2008, RC contacted Dr KH concerning the possibility of her moving to the Trust's Neurodisability team on a supernumerary basis for a 6-month period. Dr KH expressed some interest in that, and an email from RC to Dr DE on 22 April 2008 records a meeting at which Dr KH was said to be very keen on the position; that it would be for 6 months; that either party could bring the placement to an end immediately if things did not work out; that there would be a review at the end of 6 months, though no commitment to go beyond this, and that this would be part of a package which resulted in her leaving the Trust at its end.

17.10 There then followed a lengthy period where RC and Dr KH's new BMA representative, PJ, negotiated about detailed terms surrounding the matters that

had been discussed relating to the Neuro-disability placement. During this period, Dr KH sought the advice of solicitors, who took over the negotiations on her behalf. These came to an abrupt end in November 2008 when, in a "without prejudice" letter to the Trust's solicitors, Dr KH's solicitor referred to problems that Dr KH had experienced in applying for jobs elsewhere, where the feedback she had had related to the length of time that she had been out of the clinical environment and a possible association with the current child protection issue in Haringey PCT, clearly a reference to the Baby Peter matter. That letter went on to refer to the fact that Dr KH had "raised concerns around the safety of both her own and other Consultants' workloads and the working environment as early as 2006", and, further, "appraisal from June 2006 clearly indicates her concerns over staffing levels relating to child protection".

17.11 The Trust's solicitors in reply stated that GOSH were "not aware that your client has ever raised concerns over the management of child protection issues at Great Ormond Street Hospital for Children NHS Trust or Haringey PCT in the past". They went on to say that if it was Dr KH's position that such concerns had been raised, then the negotiations which were taking place would have to stop and the Trust would formally investigate such concerns. A discussion between both firms of solicitors took place on 28 November 2008, and the Trust's solicitors wrote following that to say that:

1. The Trust accepted that Dr KH had raised concerns about staffing levels and the impact of cost savings on the Service provided in 2006;

2. Dr KH had raised concerns about her own workload, and relationships with other members of the team;

3. There were organisational issues with the Service, relating to staffing, secretarial and administrative support, which GOSH, now that it was in full management control of the Service, had rectified.

17.12 They went on to say that, provided Dr KH accepted that her concerns had been addressed, the negotiations could continue. We have not been provided with any further correspondence relating to this matter, but it is evident from the letter from JudE dated 22 December 2008, that Dr KH's solicitors had replied in the negative, and accordingly, GOSH had commissioned an investigation into her concerns.

17.13 Independently of this, there was an exchange of correspondence between Dr KH and RC concerning her return to work, Dr KH re-asserting that she wished to return to the post in Haringey. RC wished to obtain further medical advice from Occupational Health, and stressed that he was not necessarily suggesting a return to her post in Haringey.

17.14 BT from Occupational Health reported to RC on 16 January 2009, and confirmed that Dr KH was fit to return to her post in Haringey, provided that she was not returning to the work-related issues which caused her ill-health in 2006/7. She went on to say that mediation had not been successful nor had there been resolution reached on the issue of working hours. Accordingly, because of these unresolved issues, unless there had been a significant change in management personnel at the CDC, it was possible that Dr KH might suffer a recurrence of her stress-related depressive illness, were she to return. She also said that, subject to issues as to workload, she would be fit for a post elsewhere in GOSH.

17.15 A meeting to consider this report took place on 4 February 2009, the outcome of which is recorded in RC's letter of 10 February 2009. Dr KH had proposed further mediation, but RC felt that the Trust had conducted a "thorough mediation process…but this proved unsuccessful." It was not considered by him that any further mediation attempts would be successful and indeed the process has not been recommenced. There was then some further discussion about the Neurodisability placement.

17.16 During our meeting with BT we questioned her as to what steps, if any, could be taken to progress this matter from an Occupational Health perspective. She told us that RC's communication of 9 January 2009 was the first time she had had any detail of the approach and view of management on the issue. We were informed that progress could be achieved if Dr KH were seen by the Occupational Health Physician who would need to be provided with a statement confirming Dr KH's proposed line management and an up to date proposal in relation to her workload. Following receipt of this information, there could then be a multi-disciplinary meeting with Occupational Health, JE, Dr B, Dr DE, RC and Dr KH.

17.17 Dr KH commenced her placement in Neuro-disability on 5 May 2009, on a two days per week basis. This was expressed to be for a period of three months, with a

review in July 2009. By agreement with Dr AS, she increased her sessions in June. On 18 June RC wrote to her about a second placement at the Royal Free Hospital for one morning per week, for a period of 3 months. In that email, he referred to the placements as being designed to "facilitate your eventual return to work in a community paediatric role". That placement has not, however, yet commenced at the time of this report.

17.18 Our conclusions in relation to the return to work issue are as follows:

17.18.1 Dr KH clearly has a strong desire to return to what she regards as her post at the CDC.

17.18.2 It is clear from our interviews, in particular with Dr B and SP, that that would be perceived as potentially seriously problematic, in particular by Dr B, who believes that the balance of the team of the team could be badly disrupted. Dr KH feels she has amicable professional relationships with some members of the team.

17.18.3 There is no doubt that a considerable amount of work would need to be done if the relationships concerned are to be repaired. Dr KH has on many occasions indicated her willingness to engage in further mediation, and we believe she is genuine in that wish. If that is to happen, then certainly her behaviour as perceived by Dr B and others at the meeting of 14 September 2008 with JM should not be repeated and nor should she be left with the feeling of being intimidated. If an experienced mediator were to be appointed to deal with this, we would anticipate that sufficient control would be imposed on the process to ensure that that did not happen.

17.18.4 At present, RC's position is that Dr KH cannot return to her substantive role at the CDC unless the conditions set out in BT's letter of 16 January 2009 are met. BT told us that the email that she had received from RC dated 9 January 2009, was the first time that they had had any detail of the position and what management were doing. There appear to have been no meetings with BT, and one that was proposed by Dr KH in early 2008 was not agreed by RC.

The information received from BT indicated that further information and a multi-disciplinary conference could assist.

17.18.5 It is of course entirely correct for an employer not to take any steps to expose an employee to a workplace situation which could be damaging to her health. The Occupational Health reports clearly anticipated a risk to Dr KH in specified circumstances.

17.18.6 Dr KH feels strongly that she should be entitled to return to the CDC and that she has done nothing wrong which should prevent her from doing so. She clearly feels that the Trust's refusal to allow her to do so is connected with the fact that she spoke out in 2006 about the state of affairs in the CDC, and the problems with her own workload and Children's Services.

17.18.7 The Trust has a policy entitled "Guidance to Staff on Raising Concerns in the Workplace – 'Whistle-blowing'". It is fair to say that Dr KH has never formally raised her concerns within the context of this policy. Nonetheless, she tells us that she considers herself as a "whistle-blower" and we think that that is a fair description. She considers that she has done all she can to bring the concerns that she had to the attention of those she felt should be informed. That included:

a. JE, the person primarily responsible for Children's Services in HTPCT;
b. Dr DE, the Lead Clinician at GOSH for her Consultant Team at the CDC;
c. The Director of Operations at HTPCT;
d. The Chief Executive of GOSH, JC;
e. The Chair of GOSH, CC

17.18.8 It is her perception that, having raised these concerns, the Trust has targeted her. By that, we understand her to believe that they have sought to penalise her for doing so in a number of ways – by the Occupational Health reference by JE and Dr B, the protracted

negotiations over her job plan, the difficulties that she had with her pay and most importantly, the refusal to allow her to return to her job.

17.18.9 We do not think that we can safely conclude that the matters of which Dr KH complains are part of an orchestrated campaign motivated by the disclosures which she made. It is clear to us that those disclosures were dealt with seriously, and with the intention of remedying such matters as, on investigation, proved to require remedy. Although Dr KH's grievance was largely upheld (and it is our view that is the correct way of interpreting the decision of Dr HC and MP), it was equally clear to us that there was no impropriety on the part of JE and Dr B, and no ulterior motive in what they did. We have indicated above that the negotiations over the job plan were protracted and difficult, but we can find no evidence to suggest that DE and RC were deliberately causing difficulties – to the contrary, the tone of correspondence and emails, whilst evidencing some frustration, is generally positive and constructive, and attempting to accommodate Dr KH's requirements if possible. Similarly Dr KH's approach was reasonable and rational given her understandable concern not to have to return to a working environment which had caused her illness.

17.18.10 Furthermore, if it were the case that the Trust behaved in the manner alleged to people who raise concerns, one would have expected Dr B to make the same complaints, but she does not. As observed above, Dr B did in March 2006 complain in writing about the way in which she was spoken to, but this matter was resolved shortly after her concerns were raised.

17.18.11 By the same token, however, Dr KH feels that the commitments made in the Whistle-blowing Policy have not been kept so far as she is concerned, and we express some sympathy for that view. In our view, there is a real question as to whether it can fairly be said that, having raised the concerns that she did (which in our view would fall squarely within the Policy, given their nature), she has been supported and protected as the Policy suggests, and, from her point of view we can understand how she feels that she has been

"penalised" for doing so). As we say above, we do not conclude that there has been any targeting. By the same token, the outcome that has been reached is that an experienced Consultant Community Paediatrician, for whose skills there is an urgent need at the CDC (see Dr JC's letter to the Guardian which is at page 62 of Appendix 3), and as to whose competence and commitment there is no challenge on any evidence we have seen, has not been able to return to the post that she left, initially through illness. We do not say that that has arisen because of the disclosures that she made, but subjectively, we consider that she is entitled to feel that she has not had the promised protection. We say that because of the conclusions that we have reached in relation to the mediation/facilitation process, and also the issues addressed above with Occupational Health. The approach by GOSH to each of these could have been more proactive and constructive.

17.18.12 We do not, of course, suggest that Dr KH simply return to work at the CDC. Clearly the issue of her relationships with the management team and Consultant colleagues there (in particular, Dr B) need to be resolved to the extent that, at the very least, they form the basis of an effective working relationship. Clearly, unaddressed issues could have an adverse impact on service delivery. We do believe, however, that if GOSH is to remain true to the principles in the Whistleblowing Policy, greater leadership in this respect ought to be offered, and the services of an appropriate individual engaged to promote an improvement in these relationships, if that is possible.

17.18.13 At the same time, further work should be done in conjunction with Occupational Health, with a view to exploring ways in which the issues relating to Dr KH's health can, if at all possible, be resolved. Again, we do not believe that sufficient effort has been made here, to date. Section 17.16 above, sets out the further action which could reasonably be taken.

17.18.14 It may be that, even if our recommendations are adopted, there will not be a successful outcome. Equally, if there is, the CDC will have restored to it a Consultant who is an experienced specialist in the

services it needs, and Dr KH will have restored to her the work that she evidently enjoys and wishes to continue with. We do not say that this will be a simple matter – clearly there have been things said and done which will take some time and effort to resolve. It is our view, however, that in all the circumstances, that effort would be worth it.

17.18.15 It is also important in our view that Whistleblowing Policies in the NHS are effective and are seen to be so. It is crucial that staff should feel able to raise concerns when matters arise which concern them. They should feel confident, when doing so, that those concerns will be treated appropriately and, as importantly, that they will not suffer adversely as a result. It may sometimes be a feature of doing so that relationships with colleagues may come under pressure but in our view an employer has an obligation to be alive to that possibility and take proper steps to remedy those if the confidence of employees in these policies is to be maintained.

18 Concluding Observations

18.1 Our findings and recommendations are summarised at paragraphs 5 and 6 above. Overall we consider that this is a case where a number of features which are not uncommon within the NHS have combined with some factors specific to Haringey, the CDC and the individuals working in it to produce a situation where a competent, experienced and willing consultant whose skills are needed has not been able to return to her job.

18.2 The CDC will not be unique in having its resources constrained through the need to make financial cuts. Equally the Consultants involved will not be unique in opposing those cuts and expressing their views forcibly as to the consequences. The strain on interpersonal relationships that that can cause has been a feature here.

18.3 The local issues are dealt with in the body of this report and we have set out our conclusions as to those. We think that much of these could have been addressed by better communication between all concerned and, although we do not say that anyone is to blame for the problems that arose in this respect at the CDC, we do think that the responsibility for devising and implementing systems to promote improved communication primarily rests with the leadership of the employer

organisation. The Consultants identified this as their main concern in their letter of April 2006 and Dr KH raised it also in her letter to CC in November 2006 as an ongoing concern. We have seen no evidence that this was responded to and it had not been addressed in the action plan drawn up by the HTPCT management team in May 2006. A good example of how communication deteriorated was in the facilitation/mediation meeting of September 2007. All involved found this an unsuccessful process and Dr KH must bear her part of the responsibility for this along with the others involved. An experienced mediator would however normally be able to prevent that happening and we express the hope that, if our recommendations are acted upon, the damage that has been done may yet be capable of remedy.

18.4 The problems that the Consultants identified were, as we have found, real and their concerns genuinely and reasonably held. We have found also that HTPCT/GOSH tried to do something about them. Although it is not part of our terms of reference to assess the current state of affairs in the CDC there is nothing that we have seen or heard which would lead us to the view that the conclusions in that respect in the report commissioned by GOSH in 2009 should be reviewed. Dr KH has provided us with her comments on that report which acknowledge that steps have been taken. Her main concerns are over her own position and those we have addressed in this report.

18.5 The issue of interpersonal relationships and whether the poor quality of those in the CDC in 2006/07 was attributable to any one individual or group is not easy to address and our findings on this are set out in paragraph 11 above. In short we think that most, if not all, people here were well intentioned and we cannot say that there was seriously culpable behaviour on the part of any. What does seem to have been lacking is an ability to “stand in the other person’s shoes” and this is an aspect where mediative skills could be very constructively productive.

18.6 As for Dr KH we found her a highly intelligent, articulate doctor who is committed to her work. She clearly believes she has been treated badly in that she has been made as she sees it to believe that she has done something wrong. She has pursued this matter with considerable energy which at times may have meant she has appeared intransigent or obsessive. We however do not think that would be the right way to view her actions although, in the same way as we consider that GOSH should change its approach to the issue of her return to work, equally we believe Dr

KH should be willing to accept our findings that she has not been targeted for speaking out and so mitigate some of her evident mistrust of GOSH's motivation. Whether she is able to do so may depend on her perception of how her employer responds to the findings and recommendations in this report.

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