IN THE WATFORD EMPLOYMENT TRIBUNAL

CASE NUMBER:

B E T W E E N:

Dr Hayley Dare **Claimant**

v

West London Mental Health NHS Trust **Respondent**

STATEMENT OF DR HAYLEY DARE

Background

1. In April 2000 I was employed by West London Mental Health NHS Trust (the Respondent) as a Clinical Psychologist and am still employed by the Respondent. In January 2007 I was appointed Joint Head of Women's Psychology, Women's Forensic Directorate. The Trust is one of the largest mental health trusts in the country, a leading national provider of forensic (secure) and specialist mental healthcare. It is divided into forensic – from high secure Broadmoor hospital through to low secure units – and local services – which involves general psychiatry and psychology.

2. In 2011, I was asked by the Respondent's Medical Director, Dr Nick Broughton, a consultant forensic psychiatrist to apply for the post of "Clinical

Lead" of the Women's Forensic Directorate which covers approximately 60 inpatient beds and includes a national service known as "Women's Enhanced Medium Secure Service". This highly specialist service, the largest in Europe aimed to take high secure women from a prison or high secure hospital environment and facilitate their care pathway back to the community. Most of the patients have suffered the most extreme child abuse – they have been forced to work as prostitutes, subjected to extreme violence and will generally have alcohol and drug dependency problems, together with violent tendencies and extreme self-harm (cutting deep into ligaments, removing 'chunks' of flesh' and at times putting themselves at risk of amputation due to the level of self-harm inflicted). The general public would consider this population to be "the extreme of the extreme".

3. The post of "Clinical Lead" required me to take responsibility for the clinical leadership, ensuring clinical services within the women's directorate provided a high quality of care, developing, implementing and monitoring clinical standards whilst having due regard to the limited financial resources allocated to the service (clinical governance). The role also involved contributing to the strategic planning process, not only for the women's directorate but also the wider clinical service unit. The clinical service unit is comprised of four directorates in total, men's forensic, women's forensic, adolescent forensic and specialist services (a gender identity clinic and a service for personality disorders). The post brought with it a modest increase of £10,000 per annum as an addition to my substantive NHS clinical psychologist contract. I was telephoned by Dr Broughton when he was on annual leave with regard to encouraging my application for the post which I took as a reflection of how keen he was for me to take up the position, in addition he met with me and spoke to me several times at work and encouraged my application.

4. I did have some reservations about applying for the job, as I was aware that the Trust had a long history of bullying staff. This information was

ascertained from talking to other clinicians, from the report of the Healthcare Commission (2009) and from the data in the NHS annual staff survey in which West London Mental Health Trust repeatedly fell within the lowest 20% for staff welfare **[pages 806-870]**. I voiced my concerns but was encouraged by the Medical Director to speak to a senior experienced consultant forensic psychiatrist, Dr Judith Edwards, for advice. Having spoken with Dr Judith Edwards, there was a brief exchange of e mails with Dr Edwards, in which I sought to highlight my reservations and that I had sought advice. I was told to ensure I had adequate support **[page 314].** I subsequently applied and on the 1st August 2011 I was successfully appointed as Clinical Lead for the Women's Forensic Directorate.

5. I was the first non-medically trained clinician in the Trust to be appointed as Clinical Lead, as this post has historically only been taken up by medically qualified doctors. I use the title "Dr Hayley Dare", as is common practice, as the term Dr refers to my doctorate of clinical psychology; a qualification that takes approximately 8-9 years of studying and training to obtain. My appointment as a Clinical Lead was therefore significant for all professional groups with respect to the future career pathway of all clinicians. It is important to emphasise that as "Clinical Lead" I was responsible for ensuring that appropriate arrangements were in place for leadership, appraisal, job planning and development of clinical staff (including psychiatrists, psychologists, nurses, occupational therapists etc.). I reported in turn to a "Clinical Director" who in turn reported to the Medical Director of the Trust.

6. I have a strong background of clinical experience, having worked within the area of mental health for 20 years, specialising in treating women in forensic settings since April 2000. The phrase "forensic settings" means women who are detained either under criminal sections or are detained under civil sections of the Mental Health Act. I am highly committed to the delivery of high quality care for patients and am highly regarded by those with whom I work, by patients, by the regional training courses (University College

London, Royal Holloway College and University of Surrey) and I am viewed as an expert within my field (chairing national and international conferences - Tavistock & Portman Clinic, London, British Association for Behavioural Cognitive Psychotherapy (BABCP)) and giving expert evidence to court. I had an unblemished career in the NHS.

7. Having taken up my position as Clinical Lead for the Women's Service, my clinical case load was immediately moved to a 'failing ward', Aurora. It is an acute admission ward of the medium secure service, in which patients typically should be quickly assessed both in terms of their mental health and risk to others, stabilised, and moved to a more definitive placement. Patients would be admitted for many reasons from prison, from other medium secure units, from general (non-forensic) psychiatric wards and from the community, if their health had deteriorated significantly (for example developing psychosis) and they were exhibiting extreme violence or challenging behaviour. Other psychiatric services would refer patients to our unit, due to their inability to manage the patient and because of our level of expertise in working with forensic women. On the first day of my post, having returned from annual leave, 5th September 2011, I was sent to Aurora ward because of a serious disclosure by a patient, who had alleged a sexual inappropriate relationship with a member of staff, and staff inciting patients to attack patients and other members of staff. The evidence was strong, and, following a detailed investigation I was subsequently praised by an Employment Tribunal Judge for the "thorough" investigation I jointly conducted **[page 454]**. Two members of staff were subsequently dismissed, one member of staff had to undergo significant training. During this Tribunal the Judge awarded the Claimant costs, as a direct result of Mr Weir actively attempting to mislead the Court, with respect to the evidence he gave.

8. During my investigation into the ward, I began to learn that the Trust Board had previously considered closing Aurora ward, due to a high number of violent incidents and poor patient care and lack of safety. I worked hard over

the next year, with Lilian Hove the Ward Manager, to transform the ward environment, creating a 'gold standard' for the service. We managed to reduce seclusion hours ("…..the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others..." The Code of Practice, Department of Health 2008), known to the public as a "padded cell", by 80% within one year's data returns, in addition to reducing levels of violence and increasing the number of patient discharges. Consequently I was asked to present details of the transformation to the Trust Board and also externally at national conferences.

9. However, I began to become increasingly concerned about patient care and staff welfare generally within the Women's Service and began discussing my concerns with the Executive Director, Mr Andy Weir, a career NHS manager who had spent a short time as a psychiatric nurse, and with the Clinical Director, Dr Paul Gilluley, a clinical psychiatrist who was my Clinical Lead line manager and medically qualified. I felt this was the appropriate course of action. On a day to day basis, I worked alongside another NHS manager, the directorate manager, Mr John Doherty, completing a range of outstanding investigations, action plans and documents for the service. There was a huge backlog of incidents that had not been completed and we worked efficiently and effectively to uphold patient care.

10. As part of my responsibilities as Clinical Lead, I had to represent other members of staff who fell within my clinical governance responsibilities - nurses, consultant psychiatrists, social workers, occupational therapists, psychologists. Many raised concerns with me about the lack of safety and high levels of violence on the wards, the level of self-harm that service users were engaging in, the failure of senior management to support clinicians, poor service delivery and on-going bullying by named senior managers and the Executive Director, Mr Andy Weir. **[pages 324; 326-327; 328; 330; 331-333; 335; 336; 337-338; 339-340; 341; 342; 388-390; 391-392; 408-409].**

11. I was viewed by other staff as different to previous managers because I would listen to and act upon their concerns and therefore was deemed approachable. I had worked hard to build up good working relationships particularly with psychiatrists, who I was informed by the Executive Director, would not be happy about my appointment since I was a consultant psychologist. Most of the e mails raising concerns about patient care and safety came from consultant psychiatrists.

12. At the beginning of March 2012, six months after being appointed Clinical Lead, I was informed that the Care Quality Commission (CQC) had received an anonymous letter, expressing concerns about poor patient care on Russet ward. This was an enhanced medium-secure ward, of female patients with extreme complex needs, extreme levels of self-harm and violence to others, and co-morbid diagnoses (complicated psychiatric cases). I discussed this with my line manager, the Clinical Director, Dr. Paul Gilluley, a consultant forensic psychiatrist. It is important to note that Dr Gilluley was also clinically responsible for all the patients on Russet Ward, since all patients had been admitted under his care and all of his clinical practice was on this ward, as well as being responsible managerially. I was later informed that there was, "no need for a formal investigation", by Dr Gilluley in a one-to-one line management session **[page 325].** Later in the statement, I will describe the closure of this ward, which meant there was no accountability for poor care by Dr Gilluley.

13. On 5th March 2012, there was a 'divisional call' made to Russet ward. A 'divisional call' is the most serious request for immediate assistance to a clinical area. Every ward has a 'response' nurse on duty for every shift to respond to incidents. There are about twenty one wards across the forensic service, including men's, women's and adolescent Wards and therefore about twenty one 'response' nurses available at any one time. When a "divisional call" is put out, all response nurses must attend en masse. I

attended Russet ward after the divisional call had been made and was concerned to be given explicit details about a serious breach in security – plastic bags and tin cans had been found in a patient's bedroom, these can and have been used as tools for suicide and as weapons against others and therefore are classified as contraband. The patient also had access to internet enabled devices, again classified as contraband. I wrote an e mail to the Ward Manager **[page 324]**, copying in Dr Gilluley, who was responsible for patients on this Ward and also the Trust's Clinical Director. There was no response to my e mail. I therefore raised the issue again in a 4-way meeting with the Executive Director, Mr Andy Weir, the Clinical Director, Dr Paul Gilluley and the Acting Director Manager, Mrs Karen Jones. I was informed by Karen Jones, that the matter had been dealt with

14. Two months later the same issues occurred, and the same issues were raised, this time by the Head of Safety and Security (Mr Doherty). At the time, I was copied into an email from the Head of Safety and Security to the Executive Director, Mr Andy Weir, in which it was stated "security policies and procedures are clearly not being followed and this is leaving both patients and all staff at extreme risk" **[page 326-327]**.

15. On 8th May 2012, the independent patient advocate, Marion Dunn (contracted via the charity "Women in Secure Hospitals, WISH"), wrote directly to me about her concerns regarding nursing care on Russet Ward. I raised this directly with the Executive Director, Andy Weir, as these issues were now becoming cumulative **[page 328]**

16. Despite raising concerns about patient care and safety on Russet ward, I was excluded from a discussion about how to address the issues. The discussion involved only nursing staff, none of whom had direct clinical caseloads (Executive Director, Deputy Director of Nursing, and Senior Nurse Manager). A decision was subsequently made to hastily move a Ward Manager and several members of the nursing team from Parkland ward to Russet ward,

resulting in the significant de-stabilisation of Parkland ward **[page 330]**. At the time **[page 329]** the Deputy Director of Nursing, Dr. Anne Aiyegbusi, stated *"..there have been an escalating number of concerning safety (sic) and patient care issues arising from Russet ward. These issues are of sufficient gravity that Andy Weir, Doreen Whande and I took the unusual decision yesterday to ask Enoch Aboagye to take over ward management..... We keenly appreciate that rapid transfers such as this are contrary to the model of care."*

17. This immediate response to concerns was welcomed by me and others. I remained concerned that as Clinical Lead, I had detailed knowledge of patient's histories and difficulties and should have been consulted about any proposals regarding moving staff and would have helped in managing the finer points of informing patients and reducing the risk of harm to patients. The Trust had constant movement of nursing staff within the women's service, generally with little notice and no consultation, and patients suffered as a result. Each time this would impact on the patient group, leading to anxieties and the worsening of patients' conditions, given the diagnoses and histories of all admitted patients ("a fear of abandonment"). In the case of the staff changes outlined in the point above, the de-stabilisation of patients was considerable and led to an escalation in violence, including a Ward Manager being threatened with assault and a patient fracturing their hand having punched a wall repeatedly because of her distress at the staff changes. I raised my concerns again in an e mail about the results of this sudden change and the negative effects on patients **[page 330]**

18. In my role as Clinical Lead, it was imperative that I addressed these issues. I am a very 'hands on' clinician and would be regularly on the wards, trying to model good practice, support and motivate staff. I work from a constructive critical approach and would be very explicit about the need for good communication. I would expect any member of staff from a healthcare assistant (unqualified staff) upwards to speak up, if ever they felt I had not

done something appropriate and I would do the same likewise. However, my managers did not support this approach and managerially I would generally feel that I was working without senior support.

19. I repeatedly raised concerns about poor patient care, lack of safety, low staff morale and incidents of bullying. These concerns followed from e mails sent to me (for example, **[pages 330-333]**) and discussions that I would have with staff. I initially raised my concerns verbally and by e mail in 1:1 line management sessions, in 4-way meetings with Mr Andy Weir, Dr Paul Gilluley and the Acting Directorate Manager, Mrs Karen Jones and in a wide variety of meetings - Clinical Governance Meetings, Directorate Management Meetings. However, this led to pervasive, systematic bullying of myself (including comments about my sexuality and gender specific roles, exclusion, isolation etc.) as I had refused to 'sign up' to the 'management approach', which appeared to be to bully staff that raised their concerns and to stop the flow of concerns to the higher management.

20. In June 2012, the Ward Manager of Russet ward, Enoch Aboagye, approached me for support, stating that he had not been given the nursing management support he required and that he was concerned by the high levels of violence and aggression towards staff and fellow patients, poor clinical input to the ward, an 'absent' consultant (Dr Paul Gilluley, the Clinical Director), disengaged staff and staff with performance management issues. I began to meet with him on a monthly basis, along with other ward managers, on a supportive 1:1 basis to find solutions. The level of disturbance on Russet ward was discussed at a higher level, at the monthly Senior Management Team meeting attended by twenty-seven senior managers and for the first time, it was agreed that a ward, namely Russet ward, was to be placed on the Clinical Service Unit Risk Register. The Risk Register is a method of monitoring specific areas of risk and is reviewed on a monthly basis, with a risk rating assigned to it accordingly, it indicated that the Trust saw the ward as a risk liability.

21. On 2nd August 2012, I commenced a period of planned sick leave for essential elective surgery. My sick note from the consultant surgeon covered me for a period of 8 weeks, but I returned to work after only 4 weeks. During my period of sick leave, staff began trying to contact me (leaving messages on my mobile phone, emailing and texting me) due to their significant concerns about the Women's Service.

22. Approximately 2-3 days after I commenced planned sick leave, Mr Andy Weir (Executive Director) and Dr Paul Gilluley (Clinical Director) made a decision to close Russet ward. I was surprised that I had not heard about this decision prior to going on leave especially as it was unlikely that such a high risk, high level and labour-intensive decision had suddenly occurred two days after I had gone on sick leave. Whilst all of the patients were Dr Gilluley's patients, normal management practice would have been for myself as the Clinical Lead to be consulted, as even though Dr Gillluley was above me in the management structure, I was clinically responsible for the delivery of care across the service. Clinical staff on the three Women's Enhanced Medium Secure Service (WEMSS) were formally informed on 13th August 2012 of the closure, with the first patients moving two days later on 15th August 2012 **[page 335]**. I believe the details were hidden from me because I would have not allowed the closure to occur before the detailed placements of all the patients had been identified and finalised.

23. As a consequence of the hastily planned closure, the patients were moved throughout the service to different wards, but the placement of the service's eldest patient (72 years) had been 'overlooked' (Patient '1') on Parkland Ward. Just prior to the time of the closure of Russet ward, Patient '1' had been admitted to Ealing General Hospital, due to a declining physical state and was subsequently not counted in the numbers for beds in the service. Patient '1' was then discharged from Ealing General Hospital, but no longer had a bedroom on Parkland ward, as Mr Weir and Dr Gilluley had filled her

bed with a displaced patient from Russet ward. Consequently, despite continuing to undergo Electro-Convulsive Therapy (ECT), after returning from Ealing General Hospital, and having a catheter inserted into her bladder due to incontinence, Patient '1' was put in a windowless, isolated seclusion room (referred to by the general public as a "padded cell') to sleep on a temporary bed for 4 weeks. This was a grossly inappropriate, humiliating and dangerous action for an individual with significant physical illness and memory loss following ECT. The isolation of the exclusion room from the main ward meant that she had to spend her days in the sitting room and could not rest on a bed in the day and subsequently was found daily slumped in a chair. A side effect of the anesthetic administered for Electro-Convulsive Therapy (ECT) is significant drowsiness and the need to sleep. Patient '1's belongings were also locked securely away, as she had no bedroom in which to house her personal items.

24. In addition to this issue, the hastily planned closure of Russet ward resulted in a breach of safeguarding procedures. Safeguarding is a process whereby multi-disciplinary work is conducted to minimise and manage risk to adults who may be vulnerable and unable to protect themselves against significant harm or exploitation. Individuals who are the subject of safeguarding must be protected from harm or damage with an appropriate measure. On Russet ward Patient '2' had threatened to kill and had attacked Patient '3' on four previous occasions. Safeguards had previously been put in place to ensure the safety of Patient '3', which included keeping the two patients physically separated by having their bedrooms on two separate corridors, a significant distance apart, visually and physically, with the nursing station between the two corridors. During the rapid closure of Russet ward, safeguarding procedures had been ignored, despite all of the patients being under Dr Gilluley's care and their histories being well known to him. These two patients were then put in bedrooms directly opposite each other, on Parkland ward, approximately five feet apart. Subsequently, Patient '3' was viciously assaulted – put in a headlock and repeatedly punched in the head

and face – by Patient '2' on two separate occasions on Parkland ward, which resulted in a significant deterioration in Patient '3's mental health and manageability. Patient '3' was angry with ward staff, who she believed had not protected her from being assaulted. Consequently, Patient '3' began assaulting nursing staff and was secluded (placed in a locked, isolated room) and then sent to a High Secure Hospital, a backward step in terms of her own progress. The entire incident, including feelings of being left vulnerable by the staff that she trusted most, re-activated significant early trauma for Patient '3' and caused significant deterioration and she was then violent to ward staff as her protective coping mechanism.

25. Prior to Patient '3's transfer to Parkland ward, she had in fact been recommended for transfer to a low secure unit, with a realistic view of discharging her to the community. As a consequence of being assaulted and her deterioration in mental state, she was transferred, via mechanical restraint (the application of devices including belts, harnesses, manacles and straps on the person's body to restrict his or her movement) to a High Secure Hospital, without notice. The reasons for this transfer to high security rather than low security were hidden from the patient's family and the patient suffered needlessly because of the poor planning around the closure of Russet ward.

26. At this point, I did not know what to do, and had repeatedly explained and outlined the problems, and attempted to find my own solutions, but was feeling increasingly worried about poor patient care and safety concerns. I contacted the Trust's Medical Director, Dr Nick Broughton, to seek his advice regarding the patient care and safety concerns that I had about the Women's Service. Dr Broughton appeared unwilling to discuss these failings, particularly as he was very close to Mr Weir and asked me to raise my concerns directly with Mr Andy Weir. This simply kicked the issues back down the chain where they had already been raised. I later learned that at the time, Dr Broughton was having his own difficulties and had been found

out to be acting illegally and in bad faith in his treatment of another consultant, Dr Chhabra, as outlined in the Supreme Court ruling **[721-722]** including authorising the rewriting of an expert's independent report to support and strengthen the Trust's case against Dr Chhabra.

27. On 31st August 2012, I attended a formal meeting with Andy Weir, to discuss my concerns about the poor care the patients were receiving.

28. On 11th September 2012, Mr Steve Trenchard, the Executive Director of Nursing, was asked by nursing staff to attend the Women's Service due to significant concerns that nursing staff had in relation to the closure of Russet Ward and the increase in violence on the subsequent Wards affected. In his email to the Consultant Nurse, Mrs Gillian Kelly, Mr Trenchard writes about the themes and issues arising from his visit, on which I was copied:

> *"There was a high level of emotionality in all staff I spoke with concerning the recent decision to close the Ward and relocate the women – specifically in the lack of involvement and consultation.... The decision in itself was understood to be financially and not clinically (i.e. to the benefit of the women) motivated..... There were concerns about patient safety, power changes and mixing people experiencing psychosis and having personality disorders on the same Ward...Examples where (sic) of staff working three per shift (no frequency) this again added to a sense of being uncontained and unsupported. Examples where (sic) given of managers shouting in meetings and of this style being known about and not effectively challenged"* **[pages 337-338]**

29. On 2nd October 2012, the Care Quality Commission (CQC) made a compliance review visit to the Trust and attended Parkland Ward as part of their visit. I was interviewed as part of my Clinical Lead role and was questioned by the Care Quality Commission about poor clinical practice, staff welfare and the

impact that this was having on the delivery of patient care. The CQC later published their report **[pages 352-375]** and found the Trust was not meeting the standard for 'Outcome 14: Supporting Workers'. The report comments on the Trust being *"in the worst 20% of all Trusts"* in the NHS Survey 2011/2012 *"that included staff job satisfaction, percentage of staff experiencing discrimination at work in the last 12 months, percentage of staff agreeing that their role makes a difference to people and effective team working"*. The report commented on a staff member stating

"when we give our feedback to management nothing happens" and that staff spoke of a "culture of fear and feeling bullied" **[pages 352-375].**

The report was not circulated within the Trust as had happened previously, and Mr Weir the Executive Director denied having seen or read the report.

30. On 20th December 2012 as a result of on-going reports of incidents on Parkland ward, in my capacity as Clinical Lead, I attended the Parkland Clinical Team Meeting (previously known as a Ward Round). I was shocked by angry and hostile comments made by the entire multi-disciplinary team, including Consultant Psychiatrist, Consultant Clinical Psychologist, Social Worker, Nursing Staff, Associate Specialist doctor and junior doctor, about incidents and issues that had occurred on the ward that had been raised with the Acting Directorate Manager Karen Jones, but to no affect. The clinical team stated that they were unable to discharge their duty to deliver the higher standard of care that they were used to delivering, that they had lost control of the ward and were shocked that their grave concerns were not being appreciated. I was so concerned by the information disclosed - multiple medication errors, a patient collapsing and transferred by blue light to Ealing General Hospital because staff 'forgot' to give her antibiotics, a clinical room being left open, medication being found by patients' on sofa, staff shouting at patients. Given the information provided, my real and genuine concern was that the ward would suffer a death, and so I immediately telephoned the Executive Director, Mr Weir from the ward. He failed to attend, but instead the Service Manager, Maureen Cushley attended

the ward. She appeared to understand the situation and suggested that control could be returned by addition of a covering Ward Manager, which would be placed on the ward. She assured me that the appropriate interventions would be in place over the Christmas period, whilst I was on annual leave.

31. On 4th January 2013 despite assurances from the Head of Service, Dawn Harwood and the Service Manager, Maureen Cushley, that appropriate interventions and procedures would be in place to ensure the safety of the patients and staff, a 'Response team' (consisting of 7 nurses/HCAs specifically trained in Preventing and Managing Violence and Aggression (PMVA) techniques) failed to prevent Patient '4' and Patient '5' punching and attempting to strangle Patient '2' in front of them. As a result of the vicious attack Patient '4' got blood on her hands and gained entrance to the locked Clinical Room, a secure room containing medication, sharps and other clinical implements, despite there being a member of nursing staff present in the clinical room. Whilst in the room, Patient '4' stole a preloaded syringe and later used the syringe to repeatedly stab herself. The staff on the ward were unaware at the time that she had stolen the syringe. Despite reassurances from senior management, staff still felt that there was a loss of control on the ward and the level of threat to patients and staff was ongoing and unacceptably high. My own view was that the situation had deteriorated to such an extent that control had been totally lost.

32. In a 4-way meeting on 16th January 2013, with Executive Director Mr Weir, Clinical Director, Service Manager and myself, I raised concerns about nursing staff not complying with medical issues: Patient '6' had not been given antibiotics, her saturation levels of oxygen dropped to 85 percent which indicates a life threatening situation but no action was taken and she was left naked in a corridor, Patient '7' was discovered to have a fractured hand as a result of self-harm and was not taken to A&E as directed, Patient '8' on Pearl ward was not taken to a critical medical appointment but allowed to go on

town leave despite a real risk of collapsing whilst out **[page 384]**. A catalogue of systems failings resulting in serious harm to patients was emerging. Mr Weir said that he would do something about it.

33. On 17th January 2013 I was asked to meet with Mr Weir in his office and was told to stop putting my concerns in writing and that "no-one" was to know that we had "had this conversation". I was deeply worried about this and in my clinical supervision session a few days later, 23rd January 2013, I discussed this with my clinical supervisor, Dr Kingsley Norton (Consultant Psychiatrist and Consultant Psychotherapist), along with details of issues within the women's service. These accounts are corroborated by Dr Emma Foster, a Consultant Clinical Psychologist, who attended fortnightly joint supervision with me.

34. On 25th January, I received an email **[page 391-392]** from Dr Norton, Consultant Psychiatrist, in which he stated that following the supervision session, he had been so concerned about what he had been told, he felt duty bound to seek advice and discussed:

> *".....the very worrying developments and perceived deterioration of the standard of clinical care in The Orchard. Of equal concern and alarm was the advice you, Hayley, reported having been told by a very senior managerial colleague, to stop voicing your concerns and that the conversation containing this advice was off the record".*

The e mail continued that Dr Norton had spoken with the Deputy Clinical Lead of Hammersmith and Fulham, Dr Oliver Dale, and also had planned to speak with the Trust's Deputy Medical Director, Dr Michael Phelan, about the issues. In the e mail the Trust's Whistleblowing policy was attached and I was reminded of my responsibility **[pages 73-81]**. Dr Dale, in his correspondence to Dr Kingsley, stated

> *"someone has raised an extremely serious allegation and rightly or wrongly feels very threatened, she is under enormous pressure and her position is in effect threatened as well. The implications are that*

clinical practice in a highly sensitive area is compromised..." **[pages 391-392]**.

I recognised that I had a duty to whistleblow but was shown a Private Eye article **[pages 315-322]** about what had happened to whistleblowers and was warned that the Trust would try to destroy me if I disclosed what had been happening.

35. On the 25th February 2013, I attended a Trust-wide Leadership Forum, with all the other mangers in the Trust. Whilst on a coffee break, I was approached by David Shelton, my clinical psychology line manager who told me that Andy Weir had decided to, *"cut your 6 psychology sessions"*, which would have effectively resulted in the overall loss of my job. I was so very distressed by this, that I was unable to contain my emotions and was observed by others to be very tearful. I attempted to compose myself and conceal my distress, by excusing myself to attend the ladies toilet. However, I was followed to the toilet by the Human Resources Manager, Mrs Maninder Wallia, who observed my distress and asked why I was so upset. Having informed Mrs Wallia about the reason why, Mrs Wallia, who was present in the meeting where Mr Weir proposed to cut my psychology sessions, stated *"That's not how we agreed it would happen; he shouldn't have told you like that but please don't tell them I told you"*. The following day I was summoned to a meeting with Mr Weir and told there had been a 'misinterpretation' before asking if I wished to take out a grievance against Mr David Shelton for his comments. I subsequently received numerous emails from Mr Shelton apologising for his actions **[page 402]**

36. During March 2013, Mr Weir published a consultation paper **[393-399]** which proposed the significant reduction of staff in the service. This was met with significant concerns by experienced clinical staff, including three experienced Consultant Psychiatrists who told me of their concerns. The cohort of trainee junior doctors also raised significant concerns. All of these concerns were subsequently put in writing both in e mails to me and in official responses to

the consultation **[400-401; 404-406; 412-413; 415-419; 874-875]**. All independently highlighted significant patient safety issues, should the proposals go ahead, leading to "unsafe care" and putting "patient care in jeopardy" **[400-401; 404-406; 412-413; 415-419; 874-875]**. The responses were effectively ignored by the Respondent and in August 2013 the proposals were implemented. Consequently, all three experienced Consultant Psychiatrists - Dr. Sian McIver, Dr. John Jacques and Dr. Aideen O'Halloran - left the service within the same month, leaving one 'newly qualified Consultant Psychiatrist with no experience of working with women and two doctors employed as locums and who had not obtained their Certificate of Specialist Training (the locums could not sign section documents). This therefore resulted in a phenomenal loss of corporate memory to the service, with three inexperienced 'consultants' caring for a highly complex and challenging patient group. Two months after the proposals were implemented the service experienced its first 'unexpected death by ligature' – a patient had tightly wrapped pyjama bottoms around her neck causing death. This was the first suicide in three years. I am unsure if the coroner has yet classified the death as suicide formally.

37. On the 7th March 2013, in my line management session with David Shelton, a clinical psychologist, I was told that I was "*afraid of my own shadow, why don't you just leave?*", and, "*why don't you ask your parents to financially support you?*" Mr Shelton also made references regarding my capacity as a mother to my children and "*how do your parents feel having such a miserable daughter like you.*" This meeting was so distressing to me that I took handwritten notes in my diary **[page 407].** I was so very distressed by the content of the session that I had to leave work early as a consequence. I subsequently wrote my concerns in an e mail to Dr. Emma Foster, Consultant Clinical Psychologist, for advice **[page 410]**

38. There were concerns that reviewing patients in seclusion was unsafe. These patients are violent to others, and on 8th March 2013, e mails were

exchanged with the Medical Director which I was copied into regarding the concerns in relation to seclusion reviews – which is when a doctor and nursing staff enter the room to engage a the patient, who has been secluded as a consequence of their imminent risk of violence to others. These were being conducted at the Orchard in a disorganised and haphazard manner. This was brought to light following a near-attack of one of the Core Trainees. The email stated, *"The issues have caused trainees to feel significant trepidation over their safety when conducting reviews at the Orchard."* **[page 408-409]**. I was concerned that the service was becoming increasingly unsafe to both patients and staff, that a serious, potentially life-threatening incident would occur. It was at this point that I felt I had no choice but to "whistleblow", before one of the junior doctors or other members of staff were killed or seriously harmed.

39. I spent some time re-reading the Francis report on the weekend of the 8th to the 10th March and could see that the same pattern of poor care that occurred in the Mid-Staffordshire Hospital was happening in the service that I worked in. On 11th March 2013 I discussed my concerns confidentially with a colleague, who said that if I was going to whistleblow, I should approach the Chief Executive, Mr Steve Shrubb (above Mr Andy Weir) but not before I had all the evidence in documentary form and that all the evidence was verifiable. She noted that Mr Weir had had many complaints about his attitude to patient care and about his behaviour to staff and had always survived. I then spent the week from the 11th March to the 18th March documenting all the evidence that I was going to present to the Chief Executive.

40. I had spent the weekend of the 15th to 17th March reconsidering whether to whistleblow. I recognised that the standard of care being delivered was poor in many areas and that the unit was becoming increasingly unsafe. Despite being very fearful about the consequences and what would happen to me, I

decided that I had no choice but to whistleblow, first thing on Monday 18th March 2013, to the Chief Executive, Mr Steve Shrubb.

41. I arrived at work on the 18th March 2013 and immediately telephoned the Chief Executive's office, requesting a meeting with the Chief Executive to raise my concerns about patient care and staff welfare. I became tearful on the phone, when I was asked for my name, through sheer fear about whistleblowing. I was given an appointment to meet with the Respondent's Chief Executive, Mr Steve Shrubb, for the following day.

42. On 19th March 2013, I met with Mr Shrubb and made a protected disclosure, stating at the beginning of the meeting, "*In light of the Francis Report and the Mid-Staffordshire inquiry, I have a duty to formally raise my concerns about patient care, staff welfare and a culture of systematic bullying within the Forensic and Specialist CSU*" **[Annexe, Tab 27, HD handwritten notes]**. I spent approximately two hours with the Chief Executive, providing details and dates of incidents that I had documented prior to the meeting. At the end of the meeting Mr Shrubb stated "*Before I ask what you want of me, I would like to ask something of you. Would you be willing to participate in an independent investigation?*" I agreed to participate on the basis that my concerns would be independently investigated. I stated at the time, that I would not participate in an internal investigation for fear of a 'whitewash'. Mr Shrubb confirmed that the investigation would not be internal and that arrangements would be made, so that I did not give evidence on site. (This subsequently turned out not to be true and the report was authored by an employee of Capsticks, solicitors for the Respondent, therefore not independent at all.)

43. On 22nd March 2013, three days later, Mr Andy Weir was suspended from work. On 25th March 2013, details of Mr Weir's suspension were circulated by e mail to the Trust employees stating that senior staff had raised concerns in addition to information about an investigation commencing. However, at

this stage nobody was aware of my actions and the fact that I had made a protected disclosure.

44. On the 5th April 2013, following complaints from the three consultant psychiatrists, nursing staff, psychologists and occupational therapists, about the proposal regarding the reconfiguration of the women's service, and about several cuts and reductions in staff to be made to the service, I wrote to the respondent making suggestions about how similar cost-savings could be made without reducing the level of care to patients **[pages 415-419]**. In addition to my letter, the three senior experienced Consultant Psychiatrists also wrote letters raising their concerns, as I have already mentioned (refer to point 36). The suicide mentioned previously occurred after this.

45. In this letter, I expressed my concerns about the impact that the reduction of Consultants would have with service users and that it would further compromise the safety and quality of care provided. I could see that despite the closure of Russet Ward and the reduction of a dedicated consultant post, further cuts were required, but I was concerned that cutting medical staffing, particularly consultants, was a poor choice. I expressed my concerns that as Clinical Lead of the women's service, I had not been involved in any discussions surrounding the consultation, and my views and input were not sought prior to the publication of the paper. I was told that there was a need to reduce staffing levels with no consideration to the impact on patient care and staff morale. There was never any consideration to any NHS managers losing their post, and two Band 9 NHS managers had just been appointed to swell the ranks at an approximate cost of £250,000. I contended that this undermined my role as Clinical Lead for the Women's Service **[pages 415-419]**.

46. Following my meeting with the Chief Executive, I attended an investigatory meeting on the 8th April 2013 as part of the "external investigation". The meeting was chaired by Bridget Prosser. At the time of the investigation, Ms.

Prosser repeatedly stated that she was "independent". Last week, Monday 19th May 2014, I received a redacted copy of this "independent" report to find that it was published by Capsticks who are solicitors for the Trust. I have since sought expert advice on whistleblowing, and counsel found an announcement in the *Birmingham Post* of Ms Bridget Prosser being appointed to Capsticks solicitors **[page 311-312]**. At no point did Ms Prosser state that she worked for Capsticks solicitors.

47. Despite raising my concerns to the Chief Executive about patient care and staff welfare, in my second interview with Ms. Prosser, Ms Prosser confined the interview to questions solely about the Executive Director, Mr Andy Weir's, alleged bullying behaviour. Ms. Prosser did not question me further about patient care, but confined the meeting to wanting examples and/or confirmation of bullying, harassment and intimidation. I now realise that Ms. Prosser may have been instructed not to allow evidence that would expose the Respondent to criticism about poor patient care and that the investigation was being changed from one into whistleblowing to one investigating bullying and harassment.

48. During the investigation I informed Ms Prosser of the following:

a) Examples of how the quality of patient care was being compromised through exclusion of information, consultations and meetings, such as a Quality Network Peer Review (June 2012) and the closure of Russet Ward within the Women's Directorate (August 2012).

b) I stated that by June 2012, I was so concerned about the number of assaults on staff and patients and the lack of nursing leadership by the Acting Directorate Manager, Karen Jones, that I again expressed my views to the Executive Director and the Clinical Director. Having raised concerns about patient welfare and delivery of care with my then line manager, Dr Paul Gilluley and Mr Weir, I was addressed about the shoes I was wearing **[page 325]** and informed that unless

my footwear was changed I would be subjected to formal management procedures, despite other female colleagues (Julia O'Connor, Dawn Harwood, Natasha Hurangee) wearing similar shoes. The issues that I had raised about patient care were not addressed.

c) I discussed how a frail elderly woman (72years old), who was undergoing ECT and had been cathatarised, had been made to sleep on a temporary bed in a windowless, isolated seclusion room for 4 weeks because the Executive Director and Clinical Director had 'forgotten' she required a bed. When I refused to agree to the admission of a new patient to the unit, until Patient '1' was given a bed, Dr Gilluley shouted at me, stating that Patient '1' had nothing to do with the new admission. I explained that I could not possibly justify a new admission, when we had an elderly women sleeping on a camp bed in a seclusion room.

d) I informed Ms. Prosser that on 17th January 2013, 30 minutes prior to a large meeting in which I would be presenting the outcome of a six-month project, Mr Weir spoke of the anger and hostility towards the project, in addition to informing me that I was to stop putting my (clinical) "concerns in writing" and that it was "best that no-one knows about this conversation". I subsequently informed my Clinical Supervisor, Dr Kingsley Norton about this comment **[page 391-392]**

e) I reported the incident that had occurred in January 2013, when a response team failed to prevent two patients (Patients 4 and 5) seriously assaulting a third patient (Patient 2) by punching her and attempting to strangle her.

f) I spoke about specific issues of bullying including being accused by Mr Weir of having an affair with the Women's Directorate manager, despite this being adamantly denied. Inappropriate references were

made to me at the time about my status as a recently divorced/separated woman.

g) I spoke about observing others bullying staff including Mr Weir and Mrs Karen Jones (Service Manager), giving specific examples of when this had been observed.

h) I also attempted to raise with Ms Prosser incidents whereby reports had been secretly and illegally changed by senior members of staff to strengthen the case against those staff and that this behaviour appeared to be only directed against black and minority ethnic (BME) staff but Ms. Prosser did not seem interested in this.

49. I am aware that sometime in April Mr Weir was interviewed. Having conducted, observed and participated in numerous investigations I am fully aware of the process involved. Therefore, Mr Weir would have been informed of the allegations against him and should have been given a copy of the terms of reference. It would have been at this stage that Mr Weir and his close network of supporters would have been made aware that I had not only participated in the interview, but that I had instigated the investigation, as a consequence of whistleblowing.

50. On Monday 29th April 2013, having arrived at work, I entered my office and noticed a plain brown envelope on the floor, seeming as if it had been put under my office door. I was running slightly late and needed to get onto the ward, so hastily picked the letter up and placed it on my desk. Later in the day, I returned to my office and opened the letter which was dated 26 April 2013. The letter was remarkable and threatening and is available at **[pages 456-457].** It was addressed to "Dear Colleagues" and stated "how difficult it is to beat a Board member". There was a request for me to withdraw my evidence from the Prosser investigation and a statement of how "hard it will be on your children if you are unemployed". At the end of many of the

paragraphs it was written "You cannot win" or "You cannot beat us". Please note that Andy Weir was a Board member. The letter contained further information about an investigation the Trust had conducted into a "Dr Chabra" (sic) at Broadmoor which had ended up in the Supreme Court many years later. The threat was clearly that a) the investigation would continue for many years, and, b) the Trust would conduct itself in an underhanded manner. The letter also stated that, "we can do as we like. You cannot beat us."

51. The information supplied in the letter appeared to be from someone on the Trust board and/or from someone in the Human Resources Department and also appeared to be threatening the Respondent Trust to not proceed with the investigation, otherwise secrets would be revealed about the Chhabra case.

52. I attended the Director of HR and saw the Chief Executive. This letter was reported to the police by the Trust and a criminal investigation commenced. I was very distressed by the letter, in part because of the reference to my children. I was already under the care of Occupational Health at this stage and was being supported by Dr. Janet Ballard, Occupational Heath Lead Physician and Professor Tom Sensky and would speak regularly with them about the insidious pervasive bullying I was being subjected to. Whilst initially no-one was aware that I had whistleblown, from late April it was apparent that certain members of senior staff had been made aware of my actions.

53. In May 2013, I became so concerned about a meeting to which I had been summoned, without being given an agenda, that thirty minutes prior to the meeting I asked Mr Paul Meechan, Service Director, what the function of the meeting was. The meeting was to discuss an urgent referral to assess a pregnant woman in prison, over which there had been some issues raised about a Consultant Psychiatrist urgently completing an assessment without a

member of nursing staff. As far as I was concerned the matter had been dealt with and in order to diffuse a seemingly increasingly aggressive attitude towards the case, I emailed all those involved and apologised on behalf of the service. Therefore if there were still outstanding issues, the issues should have been addressed either directly with myself and/or the consultant psychiatrist concerned. However, when asked, Mr Meechan responded in a pointed manner, that the meeting was to discuss "process", staring directly at me. This interaction was witnessed by Mrs Lilian Hove, Ward Manager, who commented upon the manner in which Mr Meechan had spoken to me. I felt as if I was being targeted for whistleblowing by a close and personal friend of Mr Weir's, for a matter which I had already apologised for and which happened in other parts of the service without the staff being reprimanded.

54. I returned to my office and telephoned Mr Meechan to discuss my concerns about the meeting, as I very much felt there was an ulterior motive to the meeting. I voiced my concerns and stated that I did not know why so many staff were being involved in a clinical issue that should have been discussed in the referral meeting, with all the other clinical cases. I stated that if there were outstanding concerns, these should be dealt with on an individual basis and not publicly, whereby individuals may feel humiliated. I then stated that I was concerned about attending the meeting because of this issue and that I felt this was as a result of anger in certain individuals, knowing that I had actively participated in the Respondent's investigation. Mr Meechan stated that he did not know that I had any involvement in the Trusts' investigation, denying that he knew that I had even given evidence. Mr Meechan also stated that I had now informed him of information that he did not wish to know, as he wished to remain "uncontaminated" by the investigation. However, Mr Meechan appears not to be telling the truth on these points, because by this date Mr Meechan had already attended two interviews conducted by Ms Bridget Prosser and therefore had "contaminated himself" by aligning himself with and hearing evidence of two supporters of Mr Weir.

Mr Meechan would therefore have known of my involvement in the process and may have been actively trying to cause me detriment because of his previously close friendship with Mr Weir.

55. At this time I was finding it untenable to do my job, as a consequence of on-going insidious bullying and attempts to de-construct my position, in addition to the profound effects of the anonymous letter. With support and advice from Occupational Health, I emailed Ms Rachael Moench, Director of Organisational Development and Workforce Planning, seeking advice about taking whistleblowers leave **[page 458]**. Ms. Moench stated that I could initially have 5 days compassionate leave, followed by 5 days' annual leave, the latter being at my request. However, on 24th May 2013, Dr. Ballard and Professor Sensky met with Ms. Moench to discuss my situation, having sought my permission. Dr. Ballard and Professor Sensky wrote:

> *"Dr D sent you an email previously about her circumstances. We were copied into this. As we mentioned, in our view, the email understated Dr D's situation in two important respects. First, the pressure she has been under by her account has been insidious but also relentless and pervasive. She has clearly had to face stressors which are extraordinary, and her current stress reflects this, rather than reflecting her capacity to manage her usual job role. Secondly, it is evident from having explored her responses to the stressors she has faced, that she has tried hard to explore different approaches to manage her situation.... We do not consider that being signed off sick by her GP is an appropriate response to the situation, because although she clearly has work-related stress, this is attributable to her exceptional circumstances rather than to any particular vulnerability on her part. If she had not become a whistleblower, she would not now need to take time away from work".* **[page 459]**

56. My leave after the 1st June 2013 was then classified as "special leave" and was given initially a week at a time because I was suffering detriment following whistleblowing. The period of "special leave" ended upon my return to work in September 2013.

57. In June 2013, Mr Weir was arrested at his home address and computers and mobile phones were seized, following a police investigation, initiated by the Respondent. The Respondent provided information technology analysis to the police at this time. I was informed only orally that the analysis demonstrated that there was a 93% likelihood that Mr Weir wrote the anonymous letter. It was because this likelihood was so high that the police were able to convince the Criminal Prosecution Service of a high likelihood of conviction and arrest Mr Weir. Mr Weir was initially charged with blackmail but this was reduced to "malicious communication" in the hope of securing a successful prosecution. After a lack of forensic evidence the charge was dropped. I have not been given a copy of the investigation report. In meetings with the Metropolitan Police, I was offered victim support and advised that, given the bullying I had been subjected to, I should record all management meetings, in case I was subjected to further incidents.

58. On 20 June 2013 I emailed the HR director, Mrs Rachel Moench, to arrange a meeting with her and Mr Steve Shrubb, the Chief Executive, to discuss the way forward. A meeting subsequently took place on 1 July 2013 to discuss my return to work. From the meeting I understood that there would be an option for me to either return to working within forensic or to work elsewhere in the Trust and at this stage felt positive about the meeting. I requested a meeting with the next level of management down in order to ascertain clarity in the detail of the options presented.

59. On 3 July 2013 Ms Moench wrote to me **[page 524-525]** confirming the main points discussed at the meeting which were as follows:

i. To have a carefully planned return to work and that the priority was to continue to support me and find a way forward that suited both myself and the organisation.

ii. There were two main options for my return to work:

i) Return to work in a clinical psychologist role in another Clinical Service Unit (CSU), most likely the local services.

ii) Return to my role in specialist and forensic services. The particular difficulties and sensitivities of returning to this role were acknowledged and support arrangements within the senior team set up were outlined in light of Mr Weir's suspension and on-going criminal investigation.

60. I was given two weeks to make my decision in respect of my return to work. On the 17th July 2013 I attended a meeting with Ms Sarah Rushton, who was Acting Executive Director, and appointed by Andy Weir. Mrs Rachel Moench was also present. During this meeting I felt obstacles were being put in my way of returning to my role within forensics. During the meeting I was told "it would be personal" and be personal for a "long time" in regards to working with the remaining individuals within the forensic service. It was also put to me that a return to my previous role/job could be deemed "a step too far." **[pages 529-530]**. The clear implication of the meeting was an attempt to make it clear it would be too difficult for me to return because of my role instigating the investigation. The topic of conversation then focused on my option of working within the men's forensic directorate but returning in the capacity of a psychologist, which would result in my managerial responsibilities being removed. It would also involve my line management accountability being to the same staff identified as part of the bullying culture. I was informed that my salary and working hours would be protected. However, I was told that "others would find it too difficult" if I

were to assume any other managerial role in the service. I questioned whether there was a role of parity available to me elsewhere in the Trust, which both Mrs Moench and Ms Rushton seemed surprised by. They stated that they would need further discussion about this and would write to me after the meeting.

61. On 18th July 2013, I received an email **[pages 527, 528-528A]** from Mrs Moench summarising the meeting. The email stated that I was appointed on the 1st August 2011 for 2 years with an option to extend for one year by mutual agreement. It was concluded my role as Clinical Lead could only be reasonably obtained should I decide to return to my original role in the women's service. However, whatever role/area I decided to return to work in, some members of the senior management team would be the same whether it be the men's or the women's service.

62. Following the meeting and subsequent email of 18th July 2013, I contacted the Chief Executive, Mr Shrubb, on the same day outlining my concerns copied to Ms Moench. I was concerned that it was unlikely I would be able to return to the Women's Directorate in the immediate future and even more unlikely I would be able to retain my role as Clinical Lead within the Forensic Service. This left me particularly concerned about my position with the Trust. Further to this I wanted clarity on how coaching would address the concerns about my future role within the Trust and potential adverse effect on my career. I wished to discuss these matters with Mr Shrubb further. However, to date Mr Shrubb, the Chief Executive, has never responded to this email.

63. I emailed Ms Moench further on the 22nd July 2013 **[pages 529-530]**. I raised the issue again that I was faced with having to return to work in my former role as a psychologist rather than as a Clinical Lead and that this would adversely affect my career.

64. I was contacted on the 23rd and 30th July 2013 by Mrs Moench acknowledging my concerns but providing no substantive answer and arranging coaching support. I was asked to remind Mrs Moench of my leave dates so that a timescale for my return could be organised.

65. In August 2013 I attended a meeting with my union representative from Unison – Ms Lianne Brook, Managers in Partnership, a subsidiary of Unison that deals with senior managers only - Sarah Rushton and Rachel Moench. At the meeting issues of the bullying were raised by my union representative. Ms Rushton's and Mrs Moench's response was that "things were changing" and that the Trust was utilising the services from Tavistock Consulting, a management consultant company, to deal with the issues. During the meeting my Union rep raised her concerns about comments made by one of my line managers, Mr David Shelton. Mr Shelton had stated in a telephone call on 3rd July 2013 there would be a "target on my back" upon my return to work. Mrs Moench therefore asked me, if I would like to put in a grievance about this and other comments Mr Shelton had previously made. I stated that I did not wish to pursue a grievance, even stating that this would not really be a good start to my return to work. My union rep agreed with this. I did however, as I have always done, acknowledge that there were difficulties in my supervisory relationship with Mr Shelton and whilst I had previously always addressed them directly with him, felt that the suggestion of mediation would be helpful for us both. During this meeting, it was agreed that I would return to work in my original role on 30th September 2013.

66. As instructed, I attended a return to work meeting on the 30th September 2013. In the meantime, Dr Paul Gilluley had been replaced as Clinical Director in my area of the service by Dr Claire Dimond. The Service Director was now Mr Paul Meechan, a new post appointed by Mr Andy Weir (who remained suspended). Mr Meechan was a long standing friend and colleague of Andy Weir. The meeting was with Dr Clare Dimond and Mr Paul Meechan. Unbeknownst to me, at this stage, Ms. Rushton, Mr Meechan and Dr.

Dimond were already collaborating in raising concerns about me **[pages 541-543].** An e mail had been sent jointly two weeks prior, on 16th September, stating that they had *"deep concerns with regard to Hayley's capacity to be managed in a regular way".*

67. During this return to work meeting, I was informed that I was to attend external mediation sessions with Mr David Shelton, and that for the next six months my Clinical Lead line management sessions would be held jointly by Dr Claire Dimond and Mr Meechan. I questioned Mr Meechan's role in the sessions and was told that he would be there to ensure there were no "misunderstandings or things taken out of context." I was concerned about these arrangements as I felt I had gone from having one bully to two bullies in my line management sessions. I therefore requested if I could have input into who would accompany Dr Dimond and me in line management sessions, but was informed that this had already been decided and Mr Meechan would be in attendance. I later emailed Ms Rushton to again express my concerns about the line management arrangements and to seek clarification for the rationale. Ms Rushton wrote "*I explained that we were putting in place an exceptional arrangement of joint management to reduce any ambiguity regarding perceptions*" **[pages 549-552]**. No other Clinical Lead or manager was being subjected to this arrangement.

68. On the same date I later met with Maureen Cushley (Service Manager) and Dawn Harwood (Head of Service). The purpose of the meeting was to receive a handover of events within the last four and half months. Ms Harwood spent no longer than a cursory ten minutes giving me information, before concluding the meeting. I was not given any information regarding significant events that had only taken place in the previous two weeks (including a Care Quality Commission visit, and a Quality Network Review of the Service).

69. At 12.00pm on the same day I attended a referral meeting held by Paul Meechan. Having made my first comment in a meeting, summarising the

views expressed by staff in the meeting, Mr Meechan replied, "I am so very tired of all this rhetoric that keeps on being trotted out." Mr Meechan continued in an aggressive tone to denigrate me in front of staff about the summary I had made. Two Ward Managers approached me after the meeting to express their concerns about how rudely and aggressively Mr Meechan had spoken to me.

70. In the week of my return to work I was excluded from a Trust Board visit to one of the Wards in the Women's Directorate on the 2nd October 2013. I was neither invited nor informed that the visit was going ahead. I had previously always been invited to and attended these visits within my role as Lead Clinician of the Women's Directorate.

71. On the 3rd October 2013 my clinical psychology manager Mr David Shelton (a qualified psychologist, but without a doctorate and therefore referred to as "Mr") refused to meet with me stating aggressively that he would not meet with me because we were "being sent to mediation". During mediation, I subsequently learned that he had been incorrectly informed that I was taking a grievance against him. This incorrect information led to a breakdown in our relationship and caused me detriment because there was a serious relationship breakdown between one of my line managers and myself.

72. Immediately after being spoken to by Mr Shelton in an aggressive manner, I received a call from Dr James Barrett, Consultant Psychiatrist and Clinical Lead for the Gender Identity Clinic, on my personal mobile. I discussed with Dr Barrett my first week back and how I had been on the receiving end of hostility and aggression, in addition to being excluded from information/meetings. Following my discussion with Dr Barrett, in which I had become tearful, Dr Barrett contacted Mrs Moench as a supportive measure, informing her that I had been distressed during his telephone conversation with me and that I was finding it difficult being at work, due to the hostility I was being subjected to.

73. The following day, 4th October 2013, the Acting Executive Director, Ms Sarah Rushton, emailed me **[553-554]**, asking me to attend a meeting on Monday 7 October 2013. The purpose was to discuss my concerns with management, namely the HR Director Mrs Moench, the new Service Director Mr Meechan (a friend of Andy Weir) and Dr Dimond, the Clinical Director. In a series of e mails to Mrs Moench, I repeatedly requested that I did not wish to meet with Dr. Dimond or Mr Meechan, but that I would be happy to meet with Mrs Moench to discuss the human resources issues. I stated that I had felt intimidated and bullied Mr Meechan and Dr Dimond.

74. Despite my repeated objections to the meeting Mrs Moench denied my concerns and insisted the meeting went ahead. It was agreed that Dr Dimond would not attend. I became quite upset at the meeting as I was being made to talk about feeling intimidated and bullied by an individual who had engaged in this behaviour (Mr Meechan, a career NHS manager and long standing friend of Andy Weir). I did however, confront Mr Meechan in regards to his behaviour to which he apologised but followed it up with "there are going to be times when we have a difference of opinion, you know Hayley." During the meeting with Mrs Moench and Mr Meechan I was asked whether I was okay to return to clinical duties. I replied that I was fine.

75. Following the meeting I chaired and attended an admission panel. I was able to give significant clinical input to the meeting, without difficulty. After the meeting I was approached by a Consultant Psychiatrist to discuss a challenging, high profile case. I was able to offer her support, advice and clinical information about the case and the Consultant Psychiatrist thanked me for my 'invaluable' advice and support. At no point were there concerns raised about my emotional state, clinical ability or managerial ability.

76. I spent the entire day on the 8th October 2013 on Aurora Ward seeing patients and also seeing the Ward Mangers to catch up on how things were.

On the 9th October 2013 I received an electronic note via my blackberry that a meeting had been scheduled with Mr Meechan and Dr Dimond that day. I emailed to ask if it was possible to re-arrange the meeting as I had a full day of clinical work on Aurora Ward. Mr Meechan refused this request stating I had to attend. I was not informed about the agenda for the meeting. The meeting was in Mr Meechan's office and was with Dr Dimond and Mr Meechan.

77. At the meeting I was informed by Mr Meechan, a long-standing friend of Mr Andy Weir still suspended, that I was going to be referred to Occupational Health. Mr Meechan then asked whether there "is anyone at home you would like us to contact?" I was perplexed by this question and replied, "what are you sending me home now?" I was then informed by Mr Meechan that they were going to inform the staff I was "sick" although they had not yet received an opinion from the Occupational Health Physician and I had not been described as being unwell. When I asked about my patients, Dr Dimond responded by saying, "the patients are no concern of yours" and "that is for us to deal with."

78. It became clear that Mr Shelton, psychologist and my line manager, had been directed to make the occupational health referral, labouring under the misapprehension that I had taken a grievance out against him. Before I had even left the site, Mr Shelton had already approached staff and informed them I was sick with "work-related stress" when no such diagnosis had been made.

79. In the referral to Occupation Health, **[page 565]**, Mr Shelton wrote that I was unable to attend a meeting (07/10/13) due to me becoming distressed. This was categorically untrue as I had attended all scheduled meetings. The purpose of the Occupational Health referral was stated as the Trust's concerns about my ability to perform my managerial and clinical duties/roles both as Clinical Lead and as Consultant Clinical Psychologist. Prior to sending

the referral Mr Shelton, my line manager, had neither seen, spoken or met with me. This is poor managerial and clinical practice.

80. On the 14th October 2013, I made an appointment to see my GP, as directed. A thorough assessment was carried out by my GP, Dr Victoria Whitbread. During the appointment, Dr Whitbread informed me that she felt that she was unable to issue me with a sick note because in her opinion I was not sick, but had experienced a normal reaction to a difficult situation.

81. On the same day I emailed Mr Shelton to inform him that my GP was not prepared to issue me with a sick note and I wanted advice on the next steps **[page 567]**. Mr Shelton e mailed back stating that it was "mutually agreed" that I was not fit for work and that an Occupational Health assessment would be carried out before I could return to work. In his e mail Mr Shelton informed me that there was the option to "*suspend*" me from work on "*medical grounds*" but advised "*the best course of action would be to ask your GP to reconsider their position*" **[page 567]**.

82. On the 15th October 2013 the Trust wrote to me with regards to my Clinical Lead role within Specialist and Forensic Services. I was informed that any changes to the CSU leadership structure would supersede my existing agreement that would extend the Clinical Lead role for up to another year (1st August 2014).

83. On the 15th October 2013 I emailed the Trust's occupational health doctor, Dr Ballard, following Mr Shelton's e mail. Dr Ballard responded saying that it would not be appropriate for Mr Shelton to contact my GP, as had been suggested. Further to this "*it is the individual's decision whether they feel fit enough to be at work which can be influenced by opinions of others such as managers and GP's*" **[page 573]**. Dr Ballard told me to inform Mr Shelton that I would discuss the matter fully with Dr Ballard at my Occupational Health appointment.

84. Whilst I was on leave Mr Shelton and Mr Meechan were informing staff and the Trust that I was "sick". I believe this was an attempt to medicalise and brand a whistleblower as "mad or bad", and was a smokescreen created to distract from the ongoing Prosser investigation into clinical concerns. I did not want to go off sick as I felt the Trust were attempting to create a sideshow to the important issues of patient safety.

85. I received an e mail on the 17th October 2013 from Mr Meechan informing me that the 'Tavistock' would "*not normally provide coaching or mediation to people during periods of sickness absence because it could create confusion between mediation/coaching and a therapy type intervention*" **[page 574]**.

86. On the 22nd October 2013, I attended an Occupational Health appointment with Dr Ballard. The appointment lasted an hour and a half. The following day, on the 23rd October 2013, Dr Ballard emailed Mr Shelton informing him that I was fit to work, in her medical opinion. I felt this was important as I wanted to deal with the whistleblowing issues regarding patient safety.

87. On the same day, 23rd October 2013, one of the patients within the women's service committed suicide. I was not contacted about the suicide except unofficially by a colleague seeking advice and experience about what needed to be done. Since the Trust knew that I was not officially "sick", I should have been informed about the suicide as part of my role as Clinical Lead. However, a Ward Manager who was away from work on sick leave was contacted and was informed about the suicide. I felt this was another attempt to ostracise and exclude me from the service and directly impacted on my role as Clinical Lead as a consequence of having made a protected disclosure.

88. It was not until the 25th October 2013 that Mr Shelton contacted me regarding the outcome of the Occupational Health report. I was informed that I would be expected to return to work and another return to work

meeting was arranged for me – this time with Dr Dimond, Mr Meechan and Mr Shelton.

89. On 7th November 2013, I attended this second return to work meeting. In the meeting I raised my concerns about how I had been managed and requested clarification about how my leave would be categorised as both my GP and the Occupational Health Physician had refused to provide me with a sickness certificate on three separate occasions because neither believed that I was unwell or needed to be away from work. During the meeting, I stated that I wished to clarify that at no point had I ever stated that I wished to pursue a grievance against Mr Shelton, despite Mr Shelton and Tavistock Consulting having been informed of this untruth. I explained that I had raised concerns about Mr Shelton's behaviour and management approach on several occasions and in my meeting on the 13th September 2013, my union representative, Lianne Brooks, had raised her concern about a comment made by Mr Shelton. I have always been clear that whilst there were difficulties in my relationship with Mr Shelton, despite being asked, I have never stated that I wished to pursue a grievance.

90. On the 22nd November 2013, I received a letter from Paul Meechan, Service Director and career NHS manager, purporting to summarise the discussion points of the second return to work meeting. I was extremely shocked and distressed by the letter due to the inaccuracies and fabrications within the letter. I started to become unwell. I have a full transcript of the meeting that was held on 7th November 2013, in which it is very clear what I said. I had attended a mediation session on 6th November 2013, in which it emerged that both Mr Shelton and Tavistock Consulting, had been informed that I had stated that I had wished to pursue a grievance against Mr Shelton. I was shocked by this and it may have partially or fully explained Mr Shelton's attitude towards me upon my return to work. This appears to be an approach and tactic used by the Trust to create adversarial positions quicker, in order to depict the issuer of the grievance as a problematic person and vexatious

complainant, thus allowing proceedings to commence to dismiss the complainant as unmanageable. Whilst there have been difficulties in my relationship with Mr Shelton, at no point have I ever stated that I wished to put in a grievance against him. To date, I have always resolved my difficulties with Mr Shelton by discussing the issue after the event. It was very important to me, that I stated my reluctance to issue a grievance in front of Mr Shelton, Mr Meechan and Dr Dimond, highlighting the fact that both Mr Shelton and Tavistock Consulting had not been told the truth. I have now been asked to put in grievances against Mr. Shelton on three separate occasions.

91. For the avoidance of doubt, I have sound recordings of all management meetings, following advice from the Metropolitan Police. Transcripts will be made available.

92. As I have a complete transcript of the meeting held on 7 November 2013 with Mr Meechan, Dr. Dimond and Mr Shelton, I have clear evidence of the content of the meeting and how information has been manipulated. It would seem that the aim of the letter by individuals and the introduction of false statements was to create an image of me being untrustworthy, unreliable and lacking credibility as a witness **[page 745]**. Impugning my character in this manner, following raising concerns about poor treatment of patients and staff, has been devastating and has led to a significant deterioration in my health.

93. I was deeply concerned that rather than investigating my concerns about poor patient care and safety, the Trust was instead attempting to focus on undermining my credibility and professional standing, in addition to utilising the information I supplied for their own purposes, namely to seek for Mr Weir to leave the Trust but without proper investigation and without looking at the underlying and serious damage to patients.

94. Taking for example the meeting held on 7th October 2013, had the Trust been so concerned about clinical care and my health at the time, presumably they would not have allowed me to carry out clinical work. Instead it took them two days to rely on the statement made by Mr Meechan and endorsed by Mrs. Moench and Ms. Rushton, *"...that the Trust takes seriously its duty of care to patients and staff"* to justify the rationale for sending me home. If they truly had this concern during the meeting of the 7 October, and particularly given Mrs. Moench's role in the Trust, I would have been sent home immediately. If there was any validity to their subsequent action to send me home because of illness, this would have been verified by the Occupational Health Physician, Dr. Janet Ballard, and by my General Practitioner, Dr. Victoria Whitbread.

95. Given my concerns about how I was being excluded from meetings and information, which was making my role as Clinical Lead untenable, I requested a meeting with Ms. Sarah Rushton, Acting Executive Director.

96. I took annual leave on the 13th December 2013. On 19 December 2013, Ms. Rushton wrote to me summarising the meeting I had had with her on 13th December 2013. In the e-mail Ms. Rushton stated that I had not given examples or incidents of bullying and harassment, despite the fact that I had **[pages 710-713]**. During the meeting, Ms. Rushton explicitly asked me if I felt bullied by Mr Meechan and Dr. Dimond, to which I said yes. This was on the basis of some of the examples I had given. I did also say that some of the bullying was subtly threatening. In the email Ms. Rushton stated that *"I would like to ask you to consider putting these allegations in writing so they can be properly investigated..... If you do believe that you are being bullied by Paul* (Mr Meechan) *and Claire*(Dr Dimond), *it is clearly not tenable that we move to normal management relations at this point, indeed I will need to consider what management arrangements are in the best interests of service delivery whilst an investigation takes place."* This statement in itself I found harassing, because it would lead to further detriment if I complained about

bullying. I felt that I was being put in an untenable position; if I complained I would effectively be moved and if I did not challenge it, they would assume that I was being vexatious.

97. Over the Christmas period, December 2013, my health began to deteriorate significantly. I had a combination of stomach problems, upper back pain and numerous migraines, something which I have not experienced before and which I believe were all stress-related. My sleep became very disturbed, with recurrent nightmares, invasive thoughts and reliving particular meetings, leaving me with strong feelings of fear and distress. For the first time in my life, I began having panic attacks. I realised that all of these symptoms were related to my stress about work, particularly as my mood was lowering. The closer the time came to return to work, the more intense my symptoms became, until I sought advice from my GP, Dr. Victoria Whitbread. Dr. Whitbread signed me as unfit for work and commenced me on a medication regime.

98. I was acutely aware at this stage that not only had the Trust failed to investigate the concerns I had raised about poor patient care and safety, I was being increasingly targeted as a consequence of whistleblowing. My health had deteriorated significantly as described and I was struggling to cope.

99. On the 8th January 2014, despite having been informed that I had been signed off sick for work, Ms. Sarah Rushton sent an e-mail to my home e mail address **[page 733]**. The e-mail reiterated the request for me to clarify if I was "*planning to take action in regards to the allegations made*". I was upset to receive an email from Ms Rushton, to my 'home' e-mail account, when the Trust was aware that I had been signed off sick with work-related stress, as stated on my sickness note. The e-mail requesting such a significant decision when I was unwell, was outside the remit of the sickness policy and suggests how keen the Trust were to cause me further detriment that they were

willing to breach the sickness policy by exacerbating my anxiety. I was so unable to deal with work-related issues, in addition to daily activities that I had to seek support from a friend to respond to Ms. Rushton on 20th January 2014, to write that the work environment was the sole cause of my illness and detriment and that I was finding things very difficult.

100. I was aware of a need to return to work, but was very concerned at this stage about my health and well-being, in addition to my professional reputation. I therefore contacted my union to seek advice. A letter was constructed, which I agreed with, outlining my concerns and requesting a meeting to positively look at a way forward, with the Chief Executive, Steve Shrubb. Mr Shrubb agreed to meet with me and my union rep on the 5th March 2014.

101. I attended the meeting as agreed. The Chief Executive, Mr Shrubb, was accompanied by the HR Director, Mrs. Moench. I recorded the meeting as advised by the Metropolitan police. The meeting began by Mr Shrubb updating us of a pending announcement about changes in the management structure, before starting to discuss options for my return to work "*there are three options, the two first options if you like with the ones that I really want to put our energies behind and that's finding the conditions that allow you to stay employed in the Trust. If it can't be in your existing job then, you know, we're a large Trust and last time I looked we didn't have, we weren't overflowing, our cup wasn't overflowing with highly qualified, effective and efficient clinical psychologists*" **[pages 762-792]**.

102. The meeting discussed options to return to Forensic services, to move to working in Local Services or to look at options for leaving the organization. During the discussion, Mr Shrubb made several highly complementary comments about me including "*I can use passionate committed people, if I could clone you, I'd use 20 of you*" and stating that he wanted me to remain in the Trust. I had entered the meeting with a high degree of anxiety and

trepidation but felt very much reassured by Mr Shrubb's positive comments. As the meeting was seemingly progressing in an unanticipated positive way, my union representative unexpectedly requested that we have a five minute break, which was agreed. My union rep and I therefore got up and left the room, leaving all our belongings in the room.

103. As advised by the police, I had recorded the meeting. However, as the meeting appeared to be progressing so well, I forgot about the recording, until over an hour later when I was almost home. I then listened to the recording and was absolutely devastated to hear the conversation that took place, as soon as my union representative and I left the room. There was an immediate discussion between Mrs Moench (RM) and Mr Shrubb (SS) that I would not be returning to the Forensic service

> *"We have to be really careful here because there's no way she can come back to Forensic"* (RM)
>
> *"She's not going back into forensics. Our job is to sit down and go through the three options; option one ain't going to happen, is it?..... . I'm buggered if she thinks she going to screw me for a load of money and I'm buggered if I'm going to spend money sticking her in another Trust. "* (SS) **[pages 762-792]**.

When discussing how they were going to *"just push her into local services"*, Mr Shrubb then stated *"I'll put money on it if she goes to local services I give it three months before she fingers someone else..... The great thing about her going to local services, is that Sarah (*Rushton*) knows her."*

104. Furthermore, during the discussion, Mrs Moench made derogatory comments about me

> *"she's so manipulative, she's so manipulative..... She's a victim through and through. She's got that kind of look"* **[pages 762-792]**.

and also accused me of being under the influence of alcohol. Both Mrs. Moench and Mr Shrubb discussed whether both myself and/or my union representative were under the influence of alcohol, later stating "*Great, a pair of alcoholics*". I was also described by Mr Shrubb as

> "*she's totally exploitable*" "*she's a very, very disturbed woman. God she reminds me of my first wife*" **[pages 762-792]**.

105. The discussion also made derogatory comments about Dr Sian McIver and Mr John Doherty, in addition to prejudging that Dr. Anne Aiyegbusi was not capable of becoming Director of Nursing, nor would she be appointed and that they would have to find something else for her to do, even before the interviews had taken place. This was a job that she had applied for and for which interviews had not yet taken place **[pages 762-792]**. Dr. Anne Aiyegbusi was acting as Interim Director of Nursing and had been encouraged by Mr Shrubb to apply for the substantive position. The interviews subsequently took place and Dr. Aiyegbusi was not appointed.

DAMAGE TO MY HEALTH AS A RESULT OF MAKING PROTECTED DISCLOSURES

106. I was absolutely devastated by the conversation that took place, which demonstrated that Mr Shrubb and Mrs Moench had been so disingenuous and maligning and had behaved in such a detrimental manner to other staff, Mr Shrubb's family members and to myself and my union representative. I was so distressed that I had to be given "Diazepam" later that evening. My health deteriorated rapidly at this point, to such an extent that I was unable to engage in daily functioning, for example taking my children to school, responding to letters and emails, avoiding telephone calls wherever possible, avoiding social occasions, reducing communication with family members and requiring higher and higher doses of medication.

107. Since whistleblowing and the detriment I have suffered as a consequence of my actions, I am being treated for depression and anxiety. I have been under the close care of my General Practitioner Dr Whitbread and have at times seen Dr Whitbread on a weekly review basis because of the deterioration in my health. I have experienced suicidal ideation, extreme low mood, disturbed sleep, nightmares, nausea, vomiting, severe back pain (due to muscular tension), migraines and panic attacks. As previously stated I have been unable to engage in basic day to day activities at times; for example being unable to take my children to school, avoiding social contact, being unable to instruct my legal representatives, unable to engage in personal care etc.

108. I was initially prescribed an anti-depressant medication, which had to be increased in dosage due to my non-response. However, I developed significant, intolerable side effects and therefore my medication had to be changed and slowly titrated. My anti-depressant medication has continued to be increased to date, in an attempt to treat the depression and anxiety. I have also been prescribed sleeping tablets (Zopiclone) and since my meeting with the Chief Executive and Mrs Rachael Moench, have been prescribed Diazepam, due to the extreme anxiety I have experienced. I have also had to have anti-sickness medication, to help address the side effects of all the medication. In addition to this I have to take Propananol and Sumitryptin to help manage my migraines.

109. Following my meeting on 5th March 2013, I was assisted by a friend to write to the Trust to make a Subject Access Request. Whilst the Trust has failed to fully comply with this request, I have now seen the extent of behaviours against me. Documents reveal that my line manager Dr. Dimond has labeled me vexatious. This is despite the fact that prior to me whistleblowing, I had not made any formal complaint about any member of staff in my twenty years of working for the NHS. Dr. Dimond also wrote to the Medical Director and met with the Chairman of the Trust, stating that I

was "not a credible witness" **[page 745]**. Dr. Dimond makes a point that as my line manager she should have been contacted to seek her views about me, prior to the investigation commencing; however, Dr. Dimond failed to point out that prior to me whistleblowing and since becoming my line manager, she had only ever seen me once in fourteen months (13th February 2013) for a line management session. She did not see me again for any line management meetings until December 2013.

110. Dr. Dimond participated in a letter written to the Chief Executive to complain about the investigation into Mr Weir **[pages 734a-b]**. Her loyalty to Mr Weir is unwavering and her anger towards me for whistleblowing is apparent. Dr. Dimond has systematically sought out to denigrate and destroy my integrity and professional reputation, as a consequence of me whistleblowing. In the documents that I have received as a consequence of my Subject Access Request, it is evident the lengths that Dr. Dimond has gone to undermine my credibility, my integrity and my professional standing. As a result of this, I am now aware that when I return to the Trust, I will be subject to an investigation **[page 741]**

111. Furthermore, it is evident that Ms. Rushton and Mrs Moench have also actively been involved in some of the distressing correspondence that I have received including the threat of medical suspension (despite this being contrary to Trust policy **[pages 167-233]** and also the letter written to me from Paul Meechan on 22 November 2013.

112. I no longer have any confidence in my Trust, given that the duplicitous behaviour is from the Chief Executive down. I fear that my career has been destroyed as a consequence of me whistleblowing and my health has suffered significantly. The Trust did not complete a full investigation into the concerns I raised and it did not conduct an independent investigation, as it has been alleging. Ms Bridget Prosser was employed by Capsticks solicitors. Had I have known this at the start; I would not have agreed to participate in

the investigation. To date, I have never seen a full copy of the investigation reports by Ms Prosser. The Trust failed to investigate many of the issues I raised when I whistleblew about poor patient care and safety. To date, this has not been investigated.

The contents of this statement are true to the best of my knowledge and belief

Signed.....

Dr. Hayley Dare

14 September 2014

Tab 27

In light of the Francis Report ~~duty to raise~~ & Mid Staffs I have a duty to raise concerns about patient care and safety and staff welfare. Due to the systematic bullying within the Women's Service I have been told that I will be robustly managed if I raise my concerns. I am not here to give you a list of details as I do not think that is a productive use of time. However, I do have a detailed log of evidence to support the concerns I am raising.

I am very concerned about the systematic de-construction of the Women's Service which I know is a view shared by the Consultants and other members of the MDT. Staff who have worked across Directorates have stated their shock about how much patients are used as pawns simply being moved about to suit operational needs. Since being clinical lead I have raised concerns repeatedly about poor delivery of care and safety of patients and staff alike. My concerns are predominantly ignored until there is a crisis. Recently I was asked to see Exec. Dir (17th Jan 2013) prior to the 4 Strat meeting & told not to keep raising issues by email & that concerns I have should be written. I was told that it was probably best that I didn't say we had had this conversation.

I am concerned about the impact of both the quality and safety of the care delivered particularly in light of the ~~alleged~~ consultation paper. We have been told it is not up for consultation as to whether we are reduced from 4 to 3 clin. teams. Currently staff morale is so low but when I have raised this to try to address it, I am told "it's piffle" but as you know this is what is correlated to poor patient care. When staff try to raise their voices they are stifled and intimidated by the Exec Direc., Clin. Direct and other senior staff. Recently Consultants felt so bullied in a mtg by the Clin. Service Manager, they requested a meeting to address it. The newly appointed Consultant informed CD and suddenly at the meeting the Clin Dir & Exec Dir appeared to ensure concerns weren't raised. Consultants were too intimidated to say anything.

Mismanagement is leading to a massive ↑ risk to the organization

- Trainees concerned about safety, nearly attacked
- 3 out of 4 Consultants want to leave & are looking to get out of Wayen's service
- Already lost 20% Consultant despite Nuffield Trust March 2013 publishing report more consultants = ↑ productivity
- Why don't you resign, apply for band 7 job, Ask parents for money Go back to Wales (CD said to SMc)
- Safeguarding issues ignored
- Vulnerable, most elderly patient put in seclusion room to sleep for 4 wks Medication errors +++ life threatening Respoye team 'permitting' 2 patients to assault patient in front of them
  → lead to criminal proceedings
- Intimidation & bullying by AW cohort. Seen it / Experienced it.
- fear death or serious injury / Never event.

- 72yr old frail woman who nearly died in ED 4 1 month ago is now sleeping in de-escalation whilst we have 14 empty beds in the service. Belongings are locked in the activity room. She is a disorientated frail elderly woman.

- Safeguarding issues were ignored when raised by a Consultant, a psychologist and W.M. [redacted] has attacked [redacted] on 4 occasions and were placed in bedrooms next door to each other when an opportunity arose to separate them.

- Concerns on Rupert Ward can now not be addressed or have been filtered throughout the service. There is now no accountability or responsibility for the issues on Rupert. The clinical concerns cannot be addressed and is abdicates responsibility particularly of senior clinicians on the team.

- [redacted] is now socially isolated on Rupert. According to those who carry out the obs, there is no change. How will she be re-integrated? 'Specialness'

- No RC cover in The Orchard / Pearl on at least 3 occasions, most recent was last Friday. PG failed to arrange cover for his AL (cruise)

- No handover documented for transfer of patients ? Was there a handover. Disputed

- Specific issues regarding closure
  - Temporary closure, but how on earth will ever be re-opened. At what point in terms of Numbers? Will we use de-escalation rooms?!
  Advice was to maximise Numbers between now and end of year. How can we admit when over-Numbers already? Why was part of Rupert not closed? Have 4/6 split. Could have simply ½ Ward. Elstar → Clearly other agenda's

- Speed of closure: Why so necessary?
  Why done 1 week after I went on leave when no inkling before
  Why was I still being told NP needed another 3 months for assessment, despite knowing she was being returned to prison

- Staff unheard. Done deal prior to meeting
  - Staff morale @ all time low
    anxiety @ all time high

→ Can close a ward at any point
→ Reasons not accepted for closure
→ Vote of No confidence
CQC

- Impact on service users ?? considered
  ↑ S.H increased.
  De-stabilization of ward
  → Approached by HCA's & Nursing staff please you have to do something.

↳ I'm being told it all settled down.

No discussions at DMT. Issues not disagreed, glossed over.

- 72yr old frail disorientated woman receiving ECT has a 'bedroom' in de-escalation suite. Isolated from ward, so on 1:1 @ night. No bed to sleep in the day so forced to sleep in chair due to side effects of ECT. Despite us having 14 empty en-suite bedrooms in the unit, we are placing this vulnerable woman in a de-escalation suite, whilst her belongings are inaccessible being locked in the activity room

  - No planning / needs of service user
  - No senior staff from MDT or Damson involved in discussions
  - Decision made in absence of RC & NM
  - RC not asked & informed in passing. 'By the way....'
  - 2 patients were being assessed for Damson: BS had never been considered for Damson. Delayed discharge needs 1 bed due to disability 3-6 longer months.

Bed on Acute ??

Anne / Doreen

- Safeguarding issues ignored by Clinical Director when raised by Consultant, Psychologist & a ward manager. [redacted] has attacked [redacted] on at least 4 occasions
  - Why were they not separated when an opportunity arose to do so (→ ulterior motives / service users needs not considered)
  - → if were going to shut (R), should have separated [redacted] & [redacted].
  - [redacted] is mentally ill. When raised this with PG 'pure PD' despite clear documented long-standing history
    Extremely paranoid, delusional perceptual hallucinations, sex disin
    responded to anti-psychotics + mood stabilisers
    Used NE high profile status for ensuring no locum or Melrose

(5)

Subject to regular reviews by PG

Raise Boundaries

- Concerns on Rupert ward have not been addressed as problems hidden and dispersed throughout Orchard. No accountability / responsibility despite issu being raised from reviews. Clinical concerns ward have not been addressed as all responsibility abdicated

- KT is now socially isolated on a ward. According to those actually carrying out 1:1 OBS there is no real change. She requires 24 hour external containment
  - Reports being 'lonely, inhumane'? It is not clear why (R) won't take her. How will she be re-integrated 'successfully'

12th Sept

→ Last friday Chaje - Who on call.

- No RC cover arranged on at least three occasions. Understand that last friday no RC cover at all for Orchard - Sian, Carlo (A/L), Jake (S/L) Aideen (jury) Paul (St Andrews). Paul previously went on A/L not arranging cover. (Sian) unclear / not communicated

Formal CPA handover →

- Unable to find documented handover of patients to Parkland
- Specific issues regarding closure.
  - How do you re-open a ward? At what capacity do we re-open?
  - Why was Russet not moved to 4/6 split, resulting off ward.
  - Why was Eistar not used → Other agenda Harper's PICU?
  - Staff have been dispersed throughout into other jobs
    - → ?? Re-formation of a team.
  - Why was ward closed at such speed?
    - Created high levels of anxiety in staff and patients
    - Presented as 'fete à complete' — MSK wards not included despite it impacting on them

What exactly is proposal regarding psychology input at Maluggie.
- EG 'fit to work'
- DS not there till I scream that up and then they'll re-configure again
- Unable to fulfil needs of 5 bedded ward, let alone 10 bedded P.D
- Questioned why & whether they need X input
- After 2 years still doesn't know wards!

Advice was to maximise numbers but yet working in opposition to this. I had been liaising with services on this basis.

Why closed 1 week after I had gone on leave, when no INKling of this proposal NP issue.

- Service users needs not prioritised [redacted]
  - → Anxiety
  - → S.4 increased
  - → Use of EE & 0's increased
  - → ½ service now on zonal ots ; ½ not.

Reduction of costs will not be realised due to problems being transferred.

financial issues of Service

Massive. Budget not being managed. Over-performing, being overpaid for WEMSS but yet we are still £228 K overspent. Unsustainable

When I have tried to raise, told not my issue is a nursing issue.

- Staff Morale at all time low

Staff unheard, un-consulted, high anxiety. Medics, nurses, MDT

Vote of no confidence, CQC involvement

No reflective practice / staff support at this time

Parkland ju Many changes - PA leaving. Nursing staff

WM S/W - absent (4 different)

Risen leaving.

Consistency of staffing Parkland / Pearl

Steve Trenchard mtg è staff

DMT

- Significant Clinical Decisions made without consultation or even information
  eg. Closure of Russet, 8C posts, approaching medics for community job
  Quality Network Peer Review - Not informed about til few days before
  → Documentation

- Blocked from MAC

- Micro-Management of SA post. Ed "I should have been involved. Should have challenged Capsticks view"

- Mixed messages regarding me as 1st non-medical clinical lead. Excluded or blocked.

- Ward managers shouted at in meetings. Sent aggressive e-mails

- Told I'm crazy in a mtg; Repeated.

- Line manager acknowledges I'm bullied & states our relationship will always be difficult whilst AW & CJ continue to have spotlight on you. Informs me I am only one of the 11 line managers that he is asked about.

- Told AW suggested cutting my 6 X sessions in coffee break at The Stoop. HR panics & states no there has to be a discussion, when sees my distress. Quick cover up Next morning. E-mails apologising now handled but ago what said.

- Sessions being scrutinised. Appointed 0.9 WTE (0.6 + 0.3) - Veiled threat in emails

- Secretarial support removed

- Job titled stripped w/o consultation via an e-mail. Not given new J.D.

- C.D. - fabrication of gossip by locum, on first day. Outraged when I addressed it. "I want nothing to do with this service", when I raised concerns in mtg.
  Gossip: Alleged sexual relationship with MAN

- 5 month consultation/strategy shelved. CJ walks out of mtg, having said it not a good use of her time. Rude and disrespectful to all. Strategy never sorted up. Looked at new way of working to reduce costs.

- Suggestion of income generation (£500K) Ex. Dir "I'm not interested"
  - Want to market women's service
  - PAN London Market

IN THE WATFORD EMPLOYMENT TRIBUNAL

CASE NUMBER:

B E T W E E N:

Dr Hayley Dare **Claimant**

v

West London Mental Health NHS Trust **Respondent**

ADDENDUM TO STATEMENT OF DR HAYLEY DARE

1. In order to assist the Court and for good case management, a copy of my witness statement in draft form was sent to the Respondent in May 2014.

2. My draft statement was dated 27 May 2014 and included a detailed annex of documents. The Respondent was given full access to all of these documents, including all audio recordings at the time.

3. The Respondent has therefore been fully aware of the information that I would be presenting to Court and therefore in a position to advise their witnesses appropriately. My draft statement remains unchanged from the 27 May 2014, albeit two typing errors (effect was changed to affect; there was a typing error in the spelling of Executive). Page numbers have now replaced the references to the annex.

4. Having made a protected disclosure to the Respondent's Chief Executive on 19 March 2013, I was concerned that individuals would be aware of my actions. Whilst initially staff were not aware of my actions, it became apparent that sometime during April 2013, certain members of staff were informed that I had spoken to the Chief Executive and I began to suffer detriment as a result, including the receipt of an anonymous letter, which made reference to aspects of my statement, given to Ms. Bridget Prosser and also to my children. It was shortly after this time that I was placed on 'Special Leave' by the Trust for six months.

5. Having conducted a number of investigations in my capacity as Clinical Lead, I am aware that as part of the process, terms of reference are produced detailing allegations. I therefore presume that at some point in April 2013, Mr. Andy Weir was given either terms of reference for the investigation, detailing incidents that I had reported or was given access to my statement. The detriment that I began to experience at this time, was confined to a particular group of staff, some of whom gave evidence to Ms Prosser for the investigation in support of Mr Weir. These individuals also later wrote a letter to the Respondent's Chief Executive almost a year after Mr. Weir had been suspended, in strong support of Mr. Weir. A copy of this letter has been submitted to the Court.

The contents of this statement are true to the best of my knowledge and belief

Signed.....

Dr. Hayley Dare

14 September 2014