

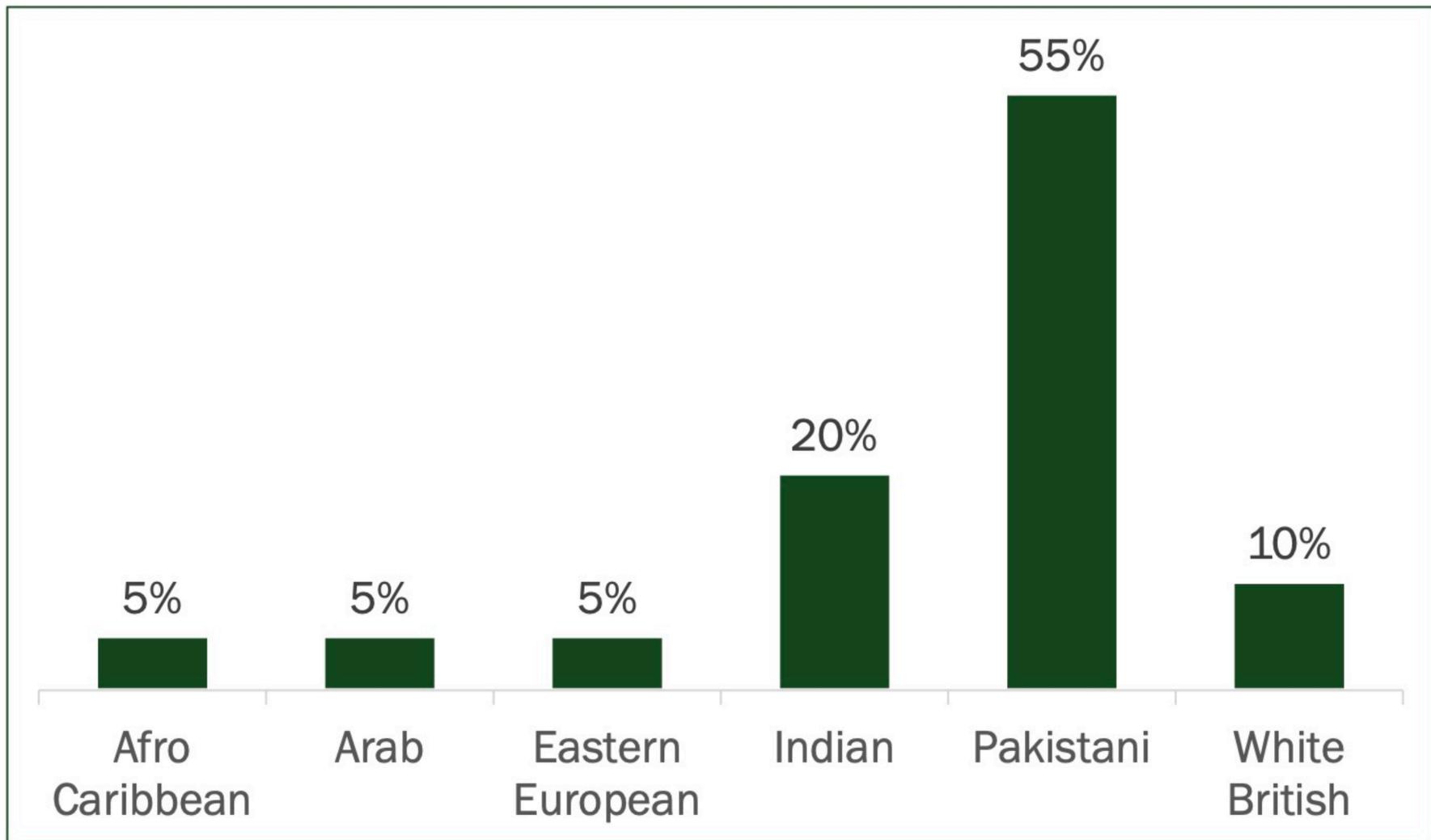


EVENT REPORT: HOLDING THE NHS LEADERSHIP TO ACCOUNT

MAY 2025



Ethnicity of Participants



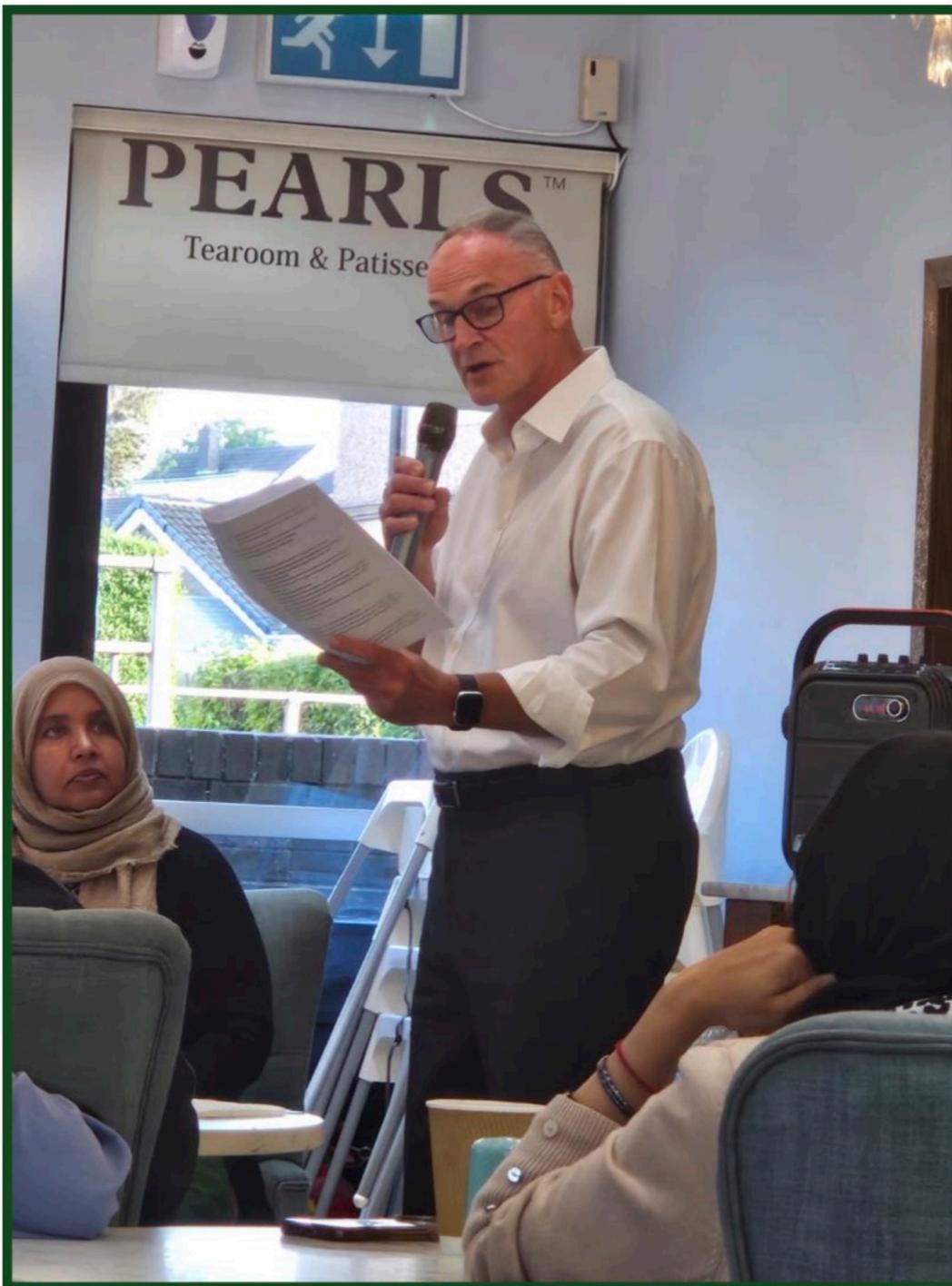
Introduction

This impactful community session brought together over 80 women from diverse backgrounds to hear from Dr Maxwell McLean, a former NHS Trust Chair and senior police officer, on serious failings within hospital leadership and patient safety. Titled "Holding the NHS Leadership to Account: Dishonesty and Inequality in Hospital Services," the discussion was hosted at Pearls Tearoom and facilitated in a relaxed "Tea & Chat" format, encouraging participants to share their personal experiences and questions openly.

Dr McLean's story was not only compelling because of his seniority and experience, but also because of the courage he demonstrated in raising concerns that ultimately cost him his role. His presence prompted an outpouring of similar stories from attendees, shedding light on the deeply

personal and tragic consequences of systemic healthcare failings, specially for South Asian and minority communities.

About the Speaker: Dr Maxwell McLean



Dr Maxwell McLean retired from West Yorkshire Police in 2010 after 30 years of service, during which he served as one of the region's most senior detectives. He was commended 12 times for integrity and specialised in cases involving domestic abuse and child protection. Following retirement, he earned a PhD and went on to serve as Chair of an NHS Foundation Trust from May 2019 until October 2023.

Dr McLean was removed from his post partway through his second term,

following his decision to raise serious concerns about patient safety, preventable infant deaths, and leadership misconduct. He had taken these concerns directly to the Trust's CEO, NHS England's Regional Director, and the Care Quality Commission. Despite the independent investigation confirming all nine concerns he had raised, he was dismissed in what he described as an unjust and politically motivated decision made by an unlawfully constituted board.

Key Issues Raised by Dr McLean

In his address, Dr McLean gave a detailed account of the events leading to his dismissal. He emphasised that as Chair of the Trust, his statutory and contractual role included holding the CEO to account, as outlined in the Health Act 2009 and the NHS Constitution. However, he explained that when he began to question poor leadership practices and failures affecting patient safety and staff wellbeing, he faced resistance, silence, and ultimately removal.

Among the most severe issues he raised were preventable infant deaths, specifically three cases in just 12 days in the maternity unit, involving South Asian babies. He explained that internal policy mandates such investigations be completed within 60 days, but one case dragged on for 13 months, delaying corrective action and leading to further tragedies.

Other issues included:

- A suspended female employee from an ethnic minority background who was a known suicide risk. Despite urgent communication from the union and others, the CEO failed to respond for over a week.
- Long-serving, ill-health nurses being “bounced out” of the Trust with little compassion or due process.
- Systematic obstruction of information flow to the Board, preventing full transparency on urgent matters.
- A pattern of absenteeism by the CEO at key meetings, including new staff induction sessions and critical board discussions.

Perhaps most concerning was the CEO’s refusal to implement a legally required health inequality strategy, despite repeated prompting, and the failure to analyse waiting list data by ethnicity and poverty levels. These are essential tools for addressing systemic inequality in healthcare access and outcomes, and their omission had direct implications for the most vulnerable patients.

He also discovered that reports of rising violence toward A&E staff were not being communicated to him in his capacity as Chair, leaving leadership unaware and unprepared to address escalating safety concerns.



In September 2023, an independent review found that all nine issues he raised were valid and substantiated. However, just weeks later in October, the board met without his knowledge and voted to terminate his contract, a decision which he later learned had not, in fact, been unanimous as claimed in public statements. Dr McLean accused the Trust of issuing a dishonest media strategy to protect the CEO and dismiss his claims, despite the findings of the investigation.

Public Testimonies and Community Impact

Following Dr McLean's address, audience members shared powerful and often traumatic personal experiences. Several women described poor maternity care that had long-lasting emotional and physical consequences for both mothers and babies.

One mother recounted how she developed sepsis after a prolonged labour lasting over 28 hours. She expressed fear about having more children and described being made to feel like a second-class citizen during her aftercare. Another attendee described the death of a family friend's newborn, who was diagnosed with a heart defect at birth. The hospital initially assured the family the baby would receive surgery "as soon as possible," yet six days passed without any operation. Tragically, the baby died on the scheduled day of surgery. The family was left devastated and confused as to why such a critical procedure had been delayed.

Another woman recounted how her daughter-in-law experienced complications during labour involving an improperly administered epidural that numbed her body up to the shoulders. The baby was delivered by forceps, leaving him with severe bruising and a deep cut to his eyebrow. Staff reportedly laughed off the injury. The child now has a permanent scar and narrowly avoided permanent eye damage.

These testimonies pointed to a broader failure in how some hospital trusts treat patients, particularly those from ethnic minority backgrounds. Many women expressed feeling unheard, dismissed, or patronised when trying to advocate for their health or that of their children. Several NHS workers in the audience, also from South Asian backgrounds, described similar treatment from within the system, highlighting a culture of silence and unequal treatment across the board.

One particularly resonant comment was, “*If someone like you [Dr McLean], in your senior position, couldn’t be protected, what chance do we have?*”



Themes of Discussion

A central theme throughout the evening was the concept of **accountability**, or the lack thereof, within NHS leadership. Dr McLean emphasised that he never saw himself as a “whistleblower,” but rather as someone fulfilling his duties as Chair, as required by law. He explained how the Chair’s primary role is to hold leadership to account for delivering safe and effective patient services, not to serve as a symbolic figurehead.

Another theme was the influence of **religious and cultural beliefs** on patient advocacy. Some attendees reflected on how, within their communities, outcomes like infant death are sometimes accepted as “God’s will,” discouraging families from pursuing complaints. However, the consensus in the room was that *spiritual beliefs should not deter*

anyone from challenging injustice or demanding accountability, especially where lives are at risk.



Dr McLean's Closing Reflection

When asked if he would have done anything differently, Dr McLean answered, *"Not much to be honest."* He expressed regret that his lack of employment rights (as a non-worker Chair) left him unable to access a tribunal. He also revealed that he did not belong to a union, because one does not exist for NHS Chairs. Despite legal and financial barriers, he vowed to continue fighting through a crowdfunding campaign to cover legal expenses.

He concluded by affirming that his motivation was not personal gain but rather public principle. "It's not about the money, it's about standing up to a cover-up and lies. This is for the community, for safe patient services."

Conclusion

This session was a profound and emotional reminder of the consequences of leadership failure in public services. Dr McLean's testimony, supported by the lived experiences of attendees, revealed a troubling pattern of dishonesty, discrimination, and negligence within parts of the NHS.

Importantly, the event did not just focus on highlighting problems, it sparked conversation, healing, and a renewed commitment to **demanding accountability and systemic reform**. For many in attendance, it was the first time they had felt heard or understood. It was also a rare opportunity to hear firsthand from someone who had once operated at the very top of NHS leadership, and who paid the price for standing up for what was right.

If the NHS is to truly serve all communities equally, it must ensure its leadership operates with integrity, transparency, and genuine accountability. Sessions like these are not only necessary, they are essential.

**Report created by the Tea & Chat participants
supported by the MWC Team**

