

Tuesday, 5 November 2024

(10.00 am)

**LADY JUSTICE THIRLWALL:** Ms Langdale.

**MS LANGDALE:** Good morning, my Lady, may I call Mrs Williams.

MRS SIAN WILLIAMS (sworn)

Questions by MS LANGDALE

**LADY JUSTICE THIRLWALL:** Thank you very much Mrs Williams, do sit down.

**A.** Thank you.

**MS LANGDALE:** Mrs Williams, you have in front of you a bundle of documents that we have given you this morning and there should be your statement and a number of other documents we gave you, there is also a screen in front of you and the documents will be called up on that screen.

**A.** Okay.

**Q.** So whatever is easier for you, I will give you a reference in the hard copy, there will be a reference for the screen and let's see how we go in terms of how easy they are for you to navigate.

**A.** Thank you.

**Q.** If there is any difficulty. Just say so. I will probably pick it up anyway but just say so?

**A.** Thank you.

1

employed as the Chief Nurse and then employed me as the deputy so it sat in such a way that the hospital was broken up into divisions. So each division had their own Head of Nursing and who reported directly to Mrs Kelly, the Chief Nurse, and I was the deputy so I was aside her.

I did have some reports, people report to me, I had things -- people like the transfusion hospital, the wide transfusion who covered the whole hospital so didn't sit in a specific division. So some nurse specialists like the Macmillan team. I also line-managed the Patient Experience Risk Team as well. So they were my reportees. I then reported to Alison Kelly.

The other heads, the Heads of Nursing didn't report to me as deputy, they reported direct to Alison Kelly.

**Q.** Would Alison Kelly sometimes share with you what they had reported to her and have discussions with you about anything?

**A.** I -- yes. I recollect she -- they may have shared the odd thing with her, but not in any great level of detail.

**Q.** In terms of the neonatal unit, would Eirian Powell have had direct conversations with you about the unit or reported to you in any formal sense?

**A.** Not formally, no, Eirian Powell reported

3

**Q.** So you have helpfully provided the Inquiry with a statement dated 11 June 2024. Have you had an opportunity to read that again before coming here today?

**A.** Yes, I have.

**Q.** Can you confirm the contents are true and accurate as far as you are concerned?

**A.** As far as I am concerned I recollect they are true.

**Q.** If we go to paragraph 2, you set out that you qualified as an Enrolled Nurse in 1980, then a Registered Nurse in 1986 and you worked as a Ward Manager from 1994 to 1998, Diabetic Specialist Nurse from 1998 to 2003, Head of Nursing Medical Division, a Band 8, from 2003 to 2013.

Then you were Deputy Director of Nursing Band 8D from 2013 to 2017 when you retired and I think you went into some commissioning work then?

**A.** Yes, yes.

**Q.** In terms of your time at 2015 and 2016 you set out at paragraph 4 that your position was the Deputy Director of Nursing. Can you just tell us where that role sat in terms of the hierarchy and the structure and the responsibilities at that time?

**A.** Okay. So when I came into post, Mrs Kelly was

2

directly to Karen Rees is my recollection, she was the Head of Nursing for Urgent Care.

**Q.** Would you ever go down to the neonatal unit for any reason?

**A.** Not specifically. I did visit it when I first came into post because prior to that it had belonged to another division, if you like. I did visit it I think as Head of Nursing I went down there, you know, just to be nosy, I am that kind -- I am out and about, I am that kind of person, really, you know.

**Q.** So when you were being curious, nosy, however you want to describe it, going down to look at the unit, what was your impression of the unit: small, large, medium?

**A.** Very tight for space, very small. I was a little surprised given the -- the paediatric unit had been updated and that hadn't, so -- but -- it was cramped, I would say.

**Q.** We know from the parents they couldn't be with their babies when their babies were born, if they had C sections they were in another part of the hospital; were you aware of that?

**A.** Not to that level of detail, no.

**Q.** Did you see any beds there or patient beds where parents could be with babies?

4

1 A. Sorry?

2 Q. Did you notice there was no facility for

3 parents to sleep alongside their neonates?

4 A. I think I was informed of that, yes.

5 Q. Was that typical around that time in hospitals

6 as far as you were aware, or you don't know?

7 A. I couldn't say what other hospitals were --

8 were like because, you know, I probably spent most of my

9 adult working life there, really.

10 Q. By this time about 27 years in nursing,

11 weren't you, by 2015/2016?

12 A. Yes, so I had never worked on the neonatal

13 unit. I had no paediatric experience. When in an adult

14 ward and if a patient relative wanted to stay then we

15 would try and accommodate them with a fold-up bed or

16 a recliner chair or something at the bedside. But I ...

17 Q. You say at paragraph 4 in the Patient Quality

18 and Safety Team you worked alongside the patient

19 Experience and Complaints Team?

20 A. Yes.

21 Q. Did you ever get any complaints at the time

22 around inability to be with babies on the neonatal unit?

23 A. I don't recollect any specifically. There may

24 have been some but I don't recollect any.

25 Q. We asked you at paragraph 6 about the culture

5

1 a group in the neonatal unit, doctors?

2 A. Pleasant. No issues. Constructive often.

3 No, no, nothing that would concern me.

4 Q. What about the nursing group, did you have

5 much to do with Eirian Powell as the ward manager?

6 A. Nothing to do with her on a one-to-one basis.

7 I might have seen her in passing if I passed through.

8 She used to come to the ward manager's meetings where

9 Alison Kelly chaired and that's probably it, really.

10 Q. Your impression of her and unit and the nurses

11 and how they worked together?

12 A. I -- I couldn't give the impression because

13 I wasn't there.

14 Q. We asked you about when you first became aware

15 of the increased mortality rate in the NNU. You say you

16 can't specifically remember. Can I take to you a couple

17 of meetings, QSPEC meetings, and let's see where we get

18 to with that.

19 If we go -- it is in your enclosure 1, for the

20 electronic reference it is INQ0003200, page 3. It is

21 the standing agenda item, Mrs Williams, number 12 --

22 A. Yes.

23 Q. -- on page 3 of that hard copy --

24 A. I have it.

25 Q. -- document.

7

1 and atmosphere on the NNU at the hospital and you say

2 you weren't involved in the day-to-day running of the

3 unit. Did you detect over that year any sense of the

4 nature of the relationships, for example between the

5 nurses and doctors on that unit or generally?

6 A. No, I detected nothing.

7 Q. What about between doctors and managers,

8 because you were at meetings, we will come to them

9 later, weren't you, with some of the Executives,

10 Tony Chambers and Alison Kelly, and some of the doctors?

11 We will move on to the details of them in July time in

12 2016. Did you think the relationships were still not

13 worthy of comment in any way or what did you think?

14 A. I wasn't aware of any specific issues with the

15 Exec Team at the point of when I was appointed and you

16 know up to 2015, you know mid-2015 or onwards. I wasn't

17 aware of anything.

18 I wasn't operational so I -- you know, I didn't see

19 them and Alison Kelly tended to, you know, manage that

20 side of it.

21 Q. Did you get on with all the doctors and

22 nurses, you never had any difficulty with anyone?

23 A. I never had any difficulties with any of the

24 doctors.

25 Q. What were they like, if you can comment on

6

1 **LADY JUSTICE THIRLWALL:** It is not on the screen

2 yet.

3 **MS LANGDALE:** Thank you. We may find ourselves

4 going faster than the screen, Mrs Williams.

5 A. Sorry.

6 Q. Not at all. If we look there, this is an

7 Executive Directors Group meeting, Wednesday,

8 9 September --

9 A. Yes.

10 Q. -- in 2015.

11 A. Yes.

12 Q. We see there standing agenda item and you have

13 reported that a baby death had been reported to STEIS

14 and an investigation was taking place. We know that

15 that was Baby D, one of the indictment babies, with an

16 unexplained and sudden death.

17 At the time, do you remember now what you knew

18 about that baby death and why it had been reported to

19 STEIS?

20 A. I'm afraid I don't remember why it was

21 reported to STEIS. I think at that point I was sitting

22 in for Alison Kelly, who was on leave, and it will be

23 just information that she gave me to tell the team.

24 So I -- I don't recollect as to why it was reported

25 to STEIS.

8

1 Q. That in fact was a third death in less than  
2 three weeks on the unit. We are going to come to  
3 a Serious Incident Review that you were present at.  
4 When you made this report, you may have been aware that  
5 that was the third death. Can you remember now?

6 A. No, I can't remember, I'm sorry.

7 Q. If, when we go to later documents, it looks  
8 like you are aware there is three Datixes for deaths in  
9 that period, would there be any reason as far as you are  
10 concerned why the cluster of deaths wouldn't be reported  
11 to STEIS rather than just the death or one death of  
12 Baby D?

13 A. No, I -- I wouldn't know the reason why.

14 Q. Who would be responsible for making the  
15 reports on STEIS system?

16 A. It would be -- I mean, anybody could make  
17 a report on Datix that then generates the -- into STEIS.  
18 So if my recollection serves me right, it would be  
19 somebody like Ruth Millward or her team that would STEIS  
20 report it.

21 Q. You have said the Executive Directors Group,  
22 that it's being investigated?

23 A. Yes.

24 Q. You would expect that that would be followed  
25 up in further meetings, wouldn't you, and discussion

9

1 period and therefore a panel was set up to independently  
2 review all of the cases again on an individual basis to  
3 identify any common themes or trends and lessons to be  
4 learned.

5 You are at that meeting, as are a number of other  
6 people. What do you remember about that? Did you read  
7 that report?

8 A. I don't specifically remember reading it,  
9 I couldn't tell you specifically yes or no. However,  
10 what I can say, generally speaking, it would be my --  
11 how I work that I tended to try and read the reports  
12 beforehand, so if I had any questions I would have them  
13 prepared if -- so I would try and read the information  
14 beforehand.

15 Q. Are you the sort of person that would ask  
16 questions -- you referred to yourself earlier as nosy,  
17 but would you ask questions if you had any?

18 A. Yes, yes.

19 Q. We know having seen that report, and having  
20 heard from Mr McCormack and also Julie Fogarty that, in  
21 fact, it dealt with obstetric issues, not the neonatal  
22 deaths and there was no input from a neonatologist, and  
23 certainly not Dr Brearey, into that.

24 Would you have remarked or noticed at the time that  
25 despite its description, it didn't in fact address the

11

1 about what had happened?

2 A. I would have expected a report to go through  
3 the governance process through the -- the governance  
4 team, through the director, that type of thing and to  
5 the -- there is a panel that would often go through the  
6 reports. I would expect something like that to have  
7 happened.

8 Q. Do you remember anything of that now?

9 A. I don't remember. That's not to say it didn't  
10 happen, I just don't remember.

11 Q. While you were in that enclosure, if we can go  
12 please to INQ0003204, page 5?

13 A. Yes.

14 Q. These, when they come up, are Quality, Safety  
15 and Patient Experience Committee minutes of meeting  
16 14 December 2015. So for you it's the second set of  
17 minutes in enclosure 1 at paragraph 11 which should be  
18 highlighted for you, Mrs Williams?

19 A. Yes, I have got it.

20 Q. Just a bit further down, paragraph 11. Thank  
21 you, Mrs Killingback, that is where we are looking.

22 We see there at this meeting that Julie Fogarty  
23 presented a review of neonatal deaths and stillbirths at  
24 the Trust during January to November 2015. It had been  
25 recognised that there had been an increase during the

10

1 neonatal deaths and certainly unexplained deaths and  
2 their reasons?

3 A. I might have done, I might have remarked about  
4 it at the time. But clearly it was either incorrectly  
5 labelled or, you know, there was a belief that that's  
6 how it was handled, if you like.

7 Q. Because it looks as though it's being flagged  
8 up that there is a need to independently review all of  
9 the cases and that included neonatal, unexpected and  
10 sudden deaths. They were in need of examination,  
11 investigation; that is what's being identified here,  
12 isn't it?

13 A. Yes, it does look like that.

14 Q. It doesn't look as we know that that was done  
15 for a long time. Can you think of any reason for that  
16 given that that's been set out there?

17 A. No, I can't comment unfortunately.

18 Q. If we go further down electronically and for  
19 you and me, Mrs Williams, over the page to paragraph 12,  
20 we see that at the meetings, there is Serious Untoward  
21 Incident updates and other incidents. Those can come  
22 down because we are not interested in those ones now, if  
23 it can be taken off.

24 But the fact is at QSPEC SUIs are discussed, aren't  
25 they?

12

1 A. Maybe.  
 2 Q. Should be?  
 3 A. Yes, maybe not specific ones. Sometimes  
 4 trends and themes, not always specific cases.  
 5 Q. Going back to your statement, if I may. At  
 6 paragraph 13, you refer to having been on QSPEC and you  
 7 also refer to the Whole Hospital Monthly Ward Managers'  
 8 meetings chaired by the Director of Nursing; is that  
 9 Ms Kelly?  
 10 A. Yes.  
 11 Q. So what's the purpose of those Hospital  
 12 Monthly Ward Manager meetings?  
 13 A. So the purpose was to bring staff together so  
 14 they work as a team, to share any good practice, to give  
 15 off information, you know, if there's issues that need  
 16 to be raised, so it's done in that way and give them the  
 17 opportunity to ask questions and to raise anything they  
 18 want to raise, you know, with the rest of the ward  
 19 manager group.  
 20 Q. What was the number that usually attended  
 21 roughly?  
 22 A. It was a fairly big number so, you know, 20  
 23 plus, 30, sometimes it depended.  
 24 Q. I think Ms Powell said it could be around 40,  
 25 I may have remembered that incorrectly, but a number of

13

1 Q. Would that be right?  
 2 A. Yes, as in every hospital that I have been to,  
 3 yes, that would be right, yes.  
 4 Q. So were you present at those meetings in  
 5 preparation for the CQC?  
 6 A. Possibly, unless I was away.  
 7 Q. What sort of discussions would happen around  
 8 an inspection, what were you discussing?  
 9 A. Going through making sure everybody knew good  
 10 practice, you know, how to raise concerns, that -- that  
 11 everybody had the basic knowledge.  
 12 Q. There is a document it's in enclosure 5, if we  
 13 go to it at INQ0017298, page 1.  
 14 A. What did you say the number was?  
 15 Q. For you it is enclosure 5 at the very end, it  
 16 is the engagement meeting agenda, Countess of Chester  
 17 Hospital, this one happens to be 22 December 2016 and  
 18 you are present?  
 19 A. Yes.  
 20 Q. It is just a couple of pages. Is this an  
 21 internal meeting? I just wanted to understand, is  
 22 this -- you are having a discussion with someone from  
 23 the CQC here, inspection manager; yes?  
 24 A. Yes.  
 25 Q. So what would be this kind of meeting?

15

1 people?  
 2 A. A number of people.  
 3 Q. Was the NNU ever discussed, the neonatal unit,  
 4 and rising mortality rates and any issues across the  
 5 wards?  
 6 A. I don't recollect any discussion.  
 7 Q. Because if people were worried about infection  
 8 or something like that, they would be discussing that in  
 9 those meetings, wouldn't they, because obviously  
 10 infections can go from one ward to another, can't they?  
 11 A. If it was, if it was an infection issue,  
 12 generally speaking, the infection control nurse would  
 13 attend, that would be my recollection and have  
 14 a conversation if necessary.  
 15 Q. With everybody, with all the managers?  
 16 A. Yes.  
 17 Q. So generic issues that may impact on you all  
 18 were discussed; is that the point?  
 19 A. Yes, generic issues that may impact just staff  
 20 developments, ideas, sharing opportunities.  
 21 Q. Ms Powell also referred to when the CQC  
 22 inspection was going to happen in February 2016, that  
 23 there were meetings that discussed preparation for that  
 24 inspection?  
 25 A. Yes.

14

1 A. They would go through areas of -- that they  
 2 had picked up externally from organisation -- from other  
 3 organisations because you get those sort of things.  
 4 As you can see the neonatal review and other  
 5 events, Serious Incidents, that type of thing.  
 6 Q. It says "Strategic update key risk areas".  
 7 Can you remember what was updated or what was discussed  
 8 around maternity or neonatal services?  
 9 A. I can't remember. I can't remember, I'm  
 10 sorry.  
 11 Q. That is the one in December.  
 12 A. Yes.  
 13 Q. If we go to INQ0017296, page 1, we see one for  
 14 24 August 2016, for you it's just a couple of pages  
 15 along, Mrs Williams: Last inspection, 15 February,  
 16 action plan discussed for each core area, assurance  
 17 sought that plan is smart.  
 18 What's that?  
 19 A. I think it's an acronym for --  
 20 Q. Another one.  
 21 A. I can't remember but yes, smart, you know,  
 22 keep it brief, you know, make it focused, I can't  
 23 remember what it meant.  
 24 Q. What did it mean in practice?  
 25 A. It meant that it, it -- that it was focused,

16

1 you know, rather than being a long action plan, it was  
 2 focused on the key areas is my recollection.  
 3 **Q.** Did you see the CQC inspection report that was  
 4 done following the visit in February 2016?  
 5 **A.** I -- I -- I can't remember seeing it. I could  
 6 have done in my role but I specifically can't remember.  
 7 **Q.** How were they received as a hospital,  
 8 important documents, presumably?  
 9 **A.** Yes.  
 10 **Q.** They get attention from Executives and senior  
 11 managers, do they?  
 12 **A.** Well, they come via the Executives,  
 13 definitely, yes.  
 14 **Q.** Is it important to any hospital, but from your  
 15 experience the Countess of Chester, to get a good rating  
 16 from the CQC, is that important?  
 17 **A.** I think it's important, it -- for, for a, you  
 18 know, a good rating. I think it then sends out the  
 19 right message but, you know, sometimes it can be over  
 20 focused, if you like, but I think it is important to get  
 21 a rating that's acceptable.  
 22 **Q.** What do you mean "over focused"?  
 23 **A.** In that people become target driven.  
 24 **Q.** Expand upon that, if you will?  
 25 **A.** Well, just things like A&E targets, that type

17

1 this discussion?  
 2 **A.** I don't recollect. The only thing I can  
 3 remember, I would not even remember, I would say  
 4 possibly the external review.  
 5 **Q.** The RCPCH review?  
 6 **A.** Yes.  
 7 **Q.** So you think they likely just saw that?  
 8 **A.** Sorry?  
 9 **Q.** They likely had access to that but nothing  
 10 else?  
 11 **A.** Well, I am not sure if it was completed by  
 12 them, but maybe they were being updated.  
 13 **Q.** Right, when it was completed.  
 14 So they would get the external review. Did they  
 15 ever get your internal review, your staffing analysis  
 16 from Julie Fogarty?  
 17 **A.** I don't know.  
 18 **Q.** You never gave it them?  
 19 **A.** No.  
 20 **Q.** Were you asked to share that with them?  
 21 **A.** No.  
 22 **Q.** We know, and Julie Fogarty is giving evidence,  
 23 when you had done that you had concerns that the police  
 24 should be called?  
 25 **A.** I did.

19

1 of thing.  
 2 **Q.** A&E targets?  
 3 **A.** Yes, that was just an example.  
 4 **Q.** So they wanted to tick a box, just achieve  
 5 something without thinking about it further, what do you  
 6 mean?  
 7 **A.** I think sometimes it is just you have to, you  
 8 know, look at the bigger picture.  
 9 **Q.** Sorry I missed that?  
 10 **A.** You -- sometimes I think it's make sure  
 11 everybody looks at the bigger picture, not just one  
 12 single area.  
 13 **Q.** Was that something you found yourself ever  
 14 saying in discussions with Executives or generally?  
 15 **A.** No, not -- I cannot recollect it. It's  
 16 just --  
 17 **Q.** More your observation looking back?  
 18 **A.** More from other hospitals' observations as  
 19 well.  
 20 **Q.** We can see there that there is references  
 21 again to the maternity neonatal services. As far as you  
 22 were concerned at this point, what was being discussed  
 23 in August 2016 about neonatal services, we know you have  
 24 done your staffing analysis and stuff by then, we will  
 25 come to that later. But what were they being told in

18

1 **Q.** Yes?  
 2 **A.** Yes.  
 3 **Q.** Is that something you would have thought to  
 4 share with the CQC in one of these meetings?  
 5 **A.** I think we were guided by the Executive Team  
 6 as to what to share.  
 7 **Q.** Right. What was that guidance -- that can  
 8 come off the screen thank you, Ms Killingback -- what  
 9 was the guidance on this topic?  
 10 **A.** Just that they were undergoing a review.  
 11 I don't recollect specifically.  
 12 **Q.** Were you told that you could share your  
 13 concerns about the staffing analysis with anyone or not?  
 14 **A.** I wasn't told one way or the other, if  
 15 I recollect.  
 16 **Q.** But either way you don't -- you didn't tell  
 17 the CQC?  
 18 **A.** No.  
 19 **Q.** You tell us at paragraph 18 of your statement  
 20 that you remember being involved in a mortality review.  
 21 Can we go, please, to enclosure 2, and it's INQ0003530,  
 22 page 1.  
 23 **A.** Yes.  
 24 **Q.** We only need the top bit, please,  
 25 Ms Killingback, which refers to C and D. Just that bit.

20

1 Thank you.  
 2 So this is described as a Serious Untoward Incident  
 3 Review and we can see there, Mrs Williams, we have you,  
 4 Dr Brearey, Alison Kelly and Ruth Millward, Head of  
 5 Patient Safety, so that is a senior team there, isn't  
 6 it, meeting?

7 A. Yes.

8 Q. Apart from in the context of the neonatal unit  
 9 did you have many meetings of that level of combination  
 10 of staff?

11 A. Not huge numbers. If there was a couple of  
 12 Never Events in theatre or something like that, then  
 13 yes, we would get together.

14 Q. So less than fingers on one hand?

15 A. I can't -- I can't remember.

16 Q. But not many?

17 A. I -- I can't remember this being called  
 18 a Serious Incident -- to be honest, I can't remember the  
 19 meeting but I can't remember it being called a Serious  
 20 Incident Review meeting. I -- you know ...

21 Q. We don't see this, before we go to the detail,  
 22 appear again in QSPEC, you know, we saw earlier that  
 23 Serious Untoward Incidents are reflected back into that  
 24 committee. This is a sort of standalone but it looks as  
 25 though the Datix, or rather the deaths of Child A

21

1 point.

2 Q. In this point, July 2015 you are talking about  
 3 that?

4 A. No.

5 Q. Just focus on this document --

6 A. I don't remember that.

7 Q. Right, so you don't remember this at all?

8 A. No.

9 Q. I am going to take you to later documents,  
 10 don't worry, you will get a chance to comment.

11 A. Sorry, I don't remember this one.

12 Q. So you don't remember this, although it looks  
 13 like you are present when three deaths in a very short  
 14 period are being discussed?

15 A. Yes.

16 Q. But you don't remember it?

17 A. I don't.

18 Q. Looking now at that cluster, does that look  
 19 like to you as though this Serious Untoward Incident  
 20 should have been followed up and followed through QSPEC  
 21 and analysed?

22 A. If depending -- I'm not sure what the outcome  
 23 of the Serious Incident Review was, so it depended on  
 24 the outcomes as to whether then it was escalated.

25 Q. You tell us at paragraph 31 of your statement,

23

1 Child C and Child D are being referred to in combination  
 2 and we know those three deaths all happened in a rapid  
 3 successive period within three weeks?

4 A. (Nods)

5 Q. So the three of you are talking about that.

6 Can you remember now what was being said about that?

7 A. I can't. I have racked my brains, I can't  
 8 remember it at all. That's the ...

9 Q. You told the police in a police statement --  
 10 you don't need to turn that up -- that it was more in  
 11 relation to an overview, not an individual?

12 A. Right. So I am not convinced they are the  
 13 same. I think in my police statement I talk about where  
 14 Stephen Brearey, Ruth Millward, Alison Kelly, myself and  
 15 I think Ian Harvey may have been on leave.

16 He had done a review of deaths and he -- we met him  
 17 to go through it and --

18 Q. Was that with the Triplets or two babies that  
 19 had died together?

20 A. I -- I can't remember. I think, you know, it  
 21 might have been -- it might have been -- I don't know,  
 22 it might have been a bit wider than that, I don't know.  
 23 I can't remember.

24 But at that point, you will have read, Dr Brearey  
 25 didn't really come across as that concerned at that

22

1 we asked you whether the meeting considered the NHS  
 2 revised Serious Incident Framework published in 2015?

3 A. Yes.

4 Q. You tell us you couldn't recollect the meeting  
 5 so you can't comment on it.

6 A. Yes.

7 Q. Who was responsible for compiling reports on  
 8 Serious Untoward Incidents, it is clearly not you from  
 9 what you are telling us?

10 A. No.

11 Q. So who was?

12 A. So it would be members of the Risk Team that  
 13 were specific for that area alongside the -- the  
 14 Consultants who would then because, you know, sign off  
 15 the content that they were happy with everything that  
 16 went in and --

17 Q. So Ruth Millward is present for that one --

18 A. Yes.

19 Q. -- on 2 July so it would be in your view her  
 20 responsibility?

21 A. Yes.

22 Q. Those -- just let me finish, those three  
 23 deaths having been identified, her responsibility to see  
 24 that was managed through the Risk Team; is that the  
 25 position?

24

1 A. Yes and -- and Debbie Peacock's, that is if --  
 2 if Steve Brearey agreed that, you know, there were  
 3 lessons to be learned, that type of thing.  
 4 Q. They would need to have information from him  
 5 but presumably from what you are saying this management  
 6 of risk is what they are there for. That is their day  
 7 job, isn't it --  
 8 A. Yes.  
 9 Q. -- so to speak. Just pausing there, so the  
 10 doctors are doing the day job of the doctors, they give  
 11 information and then is it carried on through the  
 12 management team and for those who have management  
 13 responsibilities and risk management responsibilities?  
 14 A. Yes, it's worked alongside together, yes.  
 15 Q. So in your experience, who should be filling  
 16 in the forms and the details and the documents where  
 17 they are required and we see a number are required?  
 18 A. I would say it should be the Risk Team.  
 19 Q. So it is not the doctors who finished with one  
 20 patient, go to the next. They can hand over information  
 21 verbally and the Risk Team have to deal with it?  
 22 A. Hand over information, go through it from the  
 23 assurance purpose, go through the detail as well and  
 24 check the interpretations are correct.  
 25 Q. Paragraph 34, you tell us:  
 25

1 Chester have to report something to safeguarding or to  
 2 the designated people within the hospital doctors or  
 3 nurses?  
 4 A. I may have had some of the adult, because the  
 5 adult safeguarding, I may have used her for advice and  
 6 reporting on a number of occasions.  
 7 Q. How did it work on the ground for adults, did  
 8 you know who would you take a concern to about an adult?  
 9 A. You take to the adult safeguarding nurse.  
 10 Q. Who was that?  
 11 A. Tracey -- I can't remember her surname.  
 12 Q. Right, okay, but you knew who she was, you  
 13 knew who to go to?  
 14 A. Yes.  
 15 Q. Would you hesitate about doing that?  
 16 A. I think I would get the information to go  
 17 there.  
 18 Q. You tell us at paragraph 45 of your statement:  
 19 "I cannot recall being provided with, or reading  
 20 the report compiled by Dr Brearey considering the  
 21 neonatal deaths ..."  
 22 As opposed to obstetric deaths.  
 23 If this helps, at enclosure 4, if we can go,  
 24 please, to INQ0003138, page 1.  
 25 A. Yes.

27

1 "I do not know if the deaths of Child A, Child C or  
 2 Child D were reported to the Child Death Overview Panel  
 3 or whether they were reported as Sudden Deaths In  
 4 Infancy ... (SUDIC) ..."  
 5 As that wouldn't fall within your remit. Who would  
 6 be responsible for reporting to the Child Death Overview  
 7 Panel?  
 8 A. I am not a paediatric nurse and I -- I am  
 9 unsure to give the correct answer there. I don't know.  
 10 We did have a safeguarding paediatric nurse, so possibly  
 11 from there. The Consultants take some -- and maybe the  
 12 Risk Team but I am -- I couldn't say for sure because.  
 13 Q. So risk or safeguarding?  
 14 A. Yes.  
 15 Q. Did you have any involvement with the  
 16 paediatric department, the children's department, or  
 17 just the NNU?  
 18 A. No, I had no with the paediatric no. The  
 19 paediatric safeguarding nurse reported to Alison Kelly.  
 20 Q. Right and you tell us later you didn't  
 21 actually have safeguarding training yourself or child  
 22 protection?  
 23 A. No, just the general safeguarding training  
 24 that the hospital has.  
 25 Q. Did you ever in your time at the Countess of  
 26

1 Q. For you it's just behind enclosure 4, the  
 2 first two emails.  
 3 A. Yes.  
 4 Q. If we look there, we see Alison Kelly in the  
 5 middle email, 4 May, sending an email to Karen Rees  
 6 cc'ing you.  
 7 "Please see attached. Not sure you will have had  
 8 previous sight of this. Lucy Letby highlighted in red!  
 9 I have not noticed this when I first reviewed. Can you  
 10 please look into this as per my previous email, many  
 11 thanks."  
 12 Then further down another email:  
 13 "Can you please look into this with Anne. If there  
 14 is a staff trend here, we have already changed her shift  
 15 patterns [which we know they had in April] because of  
 16 this, then this is potentially very serious."  
 17 Do you remember receiving that and seeing that  
 18 table with her name in red?  
 19 A. I don't remember, now I -- I don't remember  
 20 seeing it. I was copied in to it, I think it went  
 21 direct to Karen, I don't remember seeing it.  
 22 Q. Would you have looked at it when you were  
 23 cc'd?  
 24 A. I may have, yes, I might have done, but  
 25 I don't remember I don't recall seeing it. Because

28

1 Karen reported direct to Alison it was left very much  
 2 with Karen. I might have been on leave. I don't know.  
 3 Q. She sounds pretty alarmed, doesn't she, with  
 4 her exclamation marks "Lucy Letby in red!"  
 5 A. Yes.  
 6 Q. That is a concerned email, isn't it, would you  
 7 say?  
 8 A. Yes.  
 9 Q. So is it the kind of email that you wouldn't  
 10 have looked at the attachment just to see what she meant  
 11 and how important it was?  
 12 A. I might have looked at it I might have not  
 13 looked at it at that time if I wasn't around.  
 14 Q. Right, so at some point you looked at it?  
 15 A. Yes.  
 16 Q. Do you know when you will have looked at it?  
 17 A. I don't, no.  
 18 Q. We know that on 23 and 24 June two babies  
 19 died, two of three Triplets. If we just go further on  
 20 in that enclosure for you a couple of emails on  
 21 INQ0047571 -- it is a different INQ number  
 22 Ms Killingback sorry, INQ0047571, page 1.  
 23 A. Yes.  
 24 Q. So it is INQ0047571, 0001. It's not there?  
 25 Well, we have got a hard copy so I will read out

29

1 Q. The two Triplets?  
 2 A. I don't remember having that conversation with  
 3 her. I am unsure if it was after the reviews of the  
 4 Triplets, I don't think --  
 5 Q. No, that is before, I am going to take you to  
 6 the reviews of the Triplets which actually happens on  
 7 5 July. So this predates that?  
 8 A. Yes.  
 9 Q. But the Triplets have died, so she says she's  
 10 briefed you?  
 11 A. Yes.  
 12 Q. What has she told you about them?  
 13 A. I don't remember having this conversation with  
 14 her. Obviously I -- it looks to me as though I was  
 15 covering her for not being at the meeting, so I don't  
 16 remember what she had said, to be honest.  
 17 Q. When you say "not being at the meeting", what  
 18 meeting do you mean there?  
 19 A. Is it something to do with Execs or something  
 20 it says.  
 21 Q. No she is saying "I am not at Execs this  
 22 morning"?  
 23 A. Yes.  
 24 Q. So she is not going to be at the meeting but  
 25 she's briefed you?

31

1 Mrs Williams, so people can see what the email says.  
 2 A. Yes.  
 3 Q. We see there is an email from Alison Kelly on  
 4 29 June sent to Ian Harvey and she says this:  
 5 "Hi Ian, I am not at Execs this AM but have briefed  
 6 Sian fully. I have discussed the actions we are taking  
 7 with her and I know we are commissioning an extra  
 8 clinical review, but Sian and I did also discuss the  
 9 police. I know this is a big step but it is something  
 10 we need to consider in light of heightened concerns.  
 11 Can we double-check that the babies have had a PM yet?  
 12 I am assuming the Coroner was made aware. Sian said she  
 13 would try and speak with Stephen C prior to Execs for  
 14 his thoughts but this also needs to be considered in the  
 15 Exec conversation."  
 16 Then we see further emails between Alison Kelly and  
 17 Ian Harvey which they will be asked about but looking at  
 18 what she says about you, you have that in front of you,  
 19 it looks -- well, that she's saying that you have both  
 20 by 29 June, had a conversation about calling the police  
 21 and she's briefed you fully. What can you remember she  
 22 said to you about that time?  
 23 A. I don't.  
 24 Q. So this is after the Triplets have died?  
 25 A. Yes.

30

1 A. Yes. So she obviously was concerned about  
 2 something, about the deaths being brought to her  
 3 attention. She -- she quite probably briefed me but  
 4 I can't remember having the conversation with her.  
 5 I do recollect on a number of occasions having  
 6 a conversation with Alison Kelly and the other Execs  
 7 about going to the police.  
 8 Q. About what time?  
 9 A. I -- I can't -- I can't remember. I --  
 10 a couple of times I, you know, said I think it was more  
 11 when they had done the review, that type of thing.  
 12 Q. Let's go have a look at the mortality review  
 13 now of the Triplets. If we go -- continue for you in  
 14 that same enclosure, but it is INQ0005121, so 0005121,  
 15 page 1.  
 16 A. Yes.  
 17 Q. We actually see on page 3?  
 18 A. Yes.  
 19 Q. Go to page 3 you see the reviewers. There is  
 20 Dr Brearey -- just the reviewers' names at the bottom,  
 21 if we may, further up. Dr Brearey, Eirian Powell,  
 22 yourself, Yvonne Griffiths, Dr U, Dr ZA and  
 23 Hayley Cooper. So this is where -- and the Inquiry has  
 24 heard a lot of evidence about the collapse and death of  
 25 Baby O and then Baby P.

32



1 This is when the people named come together. What  
2 do you remember now about this meeting on 5 July and the  
3 concerns that were being expressed at that meeting?

4 **A.** I remember the meeting because Ruth Millward  
5 was meant to go and couldn't, so I stepped in and did it  
6 for -- with her, for her and Steve Brearey led it. It  
7 was a mortality review if I -- you know, rather than  
8 a serious -- it was a mortality review that the hospital  
9 did on any death, be it adult or child.

10 So I -- I don't have access to a lot of the  
11 record-keeping because they have different systems in  
12 the neonatal unit. I don't recollect a specific name  
13 coming up, a nurse involved. I do recollect there was  
14 some small areas of lessons learned, you know,  
15 sub optimal care you know, so that, that's basically the  
16 meeting itself and it was late to finish. So ...

17 **Q.** Dr ZA gave evidence to say that at that  
18 meeting, Letby's presence was referred to and Letby  
19 having something to do with the deaths, her continued  
20 association and that things had gone beyond  
21 a coincidence and she must have been involved in some  
22 way, either deliberately or through incompetence was  
23 made very clear at this meeting. Would you agree with  
24 that?

25 **A.** I -- I don't recollect that level of him

33

1 what to do with them so I phoned the Trust secretary,  
2 Stephen Cross, who has a legal background. He informed  
3 me that given there was a suspicion of foul play  
4 I should ensure they were kept".

5 Do you remember that conversation with  
6 Stephen Cross?

7 **A.** (Nods)

8 **Q.** So it is clear at this meeting that was  
9 discussed, the retention of a sample, and you followed  
10 that up with him and he said --

11 **A.** I did.

12 **Q.** -- suspicion of foul play. So the suspicion  
13 was clear, wasn't it?

14 **A.** It wasn't specific -- so there was  
15 a suspicion. I don't remember Letby coming up a great  
16 deal during the -- the review. However, there was  
17 a suspicion by -- by some of the clinicians then and  
18 because they kept the bag I didn't know what to do. It  
19 was 10 days after the event now so it had been sitting  
20 on what we class as the sluice for 10 days and I think  
21 the Executives were more aware of issues by then so they  
22 were keeping it very close to themselves.

23 **Q.** Well, not so close that it wasn't clear to you  
24 there was a suspicion of foul play; that couldn't be  
25 clearer, could it, what Stephen Cross had said to you

35

1 making that -- I don't recollect him, to be honest.

2 I don't recollect that level of detail of highlighting  
3 a specific nurse at that point.

4 **Q.** It may help to see your police statement  
5 nearer the time, INQ0001996, page 4. So if you go back  
6 it's behind your Inquiry statements, Mrs Williams?

7 **A.** Yes.

8 **Q.** And it is page 4 of it. We will go to  
9 paragraph 2.

10 **A.** Yes. Yes.

11 **Q.** Actually it starts on the page before, page 3,  
12 if I may. You see at the bottom:

13 "I recall working on a couple of mortality reviews  
14 ..."

15 **A.** (Nods)

16 **Q.** "... around the same time. I can't remember  
17 the names of the babies. I think it was two of the set  
18 of Triplets. Stephen Brearey was involved and it was  
19 clear that the clinicians were become twitchy about the  
20 situation. Nurse Letby's name came up again during the  
21 review. It is clear they were concerned the mortality  
22 review was about 10 days after the event but the  
23 clinicians had kept a bag of fluids that one of the  
24 babies had been fed with at the time of death. This was  
25 highlighted to me during the meeting and I was unsure

34

1 there?

2 **A.** That is what he -- well, he came -- used that  
3 term to me.

4 **Q.** Yes.

5 **A.** Yes.

6 **Q.** So when he said that to you, what do you take  
7 "suspicion of foul play" to mean?

8 **A.** That she was on duty a bit of the time, that  
9 was it. So --

10 **Q.** Really? Just that she was on duty? Suspicion  
11 of foul play, that's not about --

12 **A.** They were his term --

13 **Q.** Yes.

14 **A.** Foul play.

15 **Q.** So what do you think that means?

16 **A.** Just because he's got a police background and  
17 he said to keep it, it could be evidence and that's it.

18 **Q.** Evidence of what?

19 **A.** Well, that's what he said, of foul play.

20 **Q.** So you knew there was suspicion from the  
21 Consultants and from the Executives around babies being  
22 deliberately harmed?

23 **A.** After that meeting and there at that point.

24 **Q.** That can come off the screen, please. If we  
25 go -- for us it's enclosure 4, and it's a handwritten

36

1 note of Stephen Cross before the mortality review,  
 2 Mrs Williams.  
 3 **A.** Yes.  
 4 **Q.** The reference electronically is INQ0004314,  
 5 page 1. So if you go back to enclosure 4, it's  
 6 a handwritten document a couple of emails in. And it's  
 7 got at the top Monday 4 July 2016?  
 8 **A.** Yes.  
 9 **Q.** You have got that, thank you. So this is  
 10 a meeting where discussion of the downgrading of the NNU  
 11 was happening and this is 4 July, so the day before --  
 12 **A.** Yes.  
 13 **Q.** -- the meeting you have just had. So they are  
 14 discussing here downgrading the unit and there are many  
 15 pages of contributions. If you look at page 3, there is  
 16 discussion, isn't there, about getting the  
 17 communications right for the families. Can you see  
 18 that, Tony Chambers?  
 19 **A.** Yes.  
 20 **Q.** Tony Chambers talking about getting  
 21 communications right?  
 22 **A.** Yes.  
 23 **Q.** Dr Brearey above, "Difficult issue re comms  
 24 for parents whose babies have died".  
 25 Do you remember anything about this meeting and

37

1 **A.** So myself and Julie, there was a meeting in  
 2 the organisation where the Execs had pulled together  
 3 a meeting and a number of us were tasked to look at  
 4 specifics.  
 5 My understanding and my recollection is the  
 6 Consultants had done a bit of a staffing review  
 7 themselves and come up with the name Letby. So we were  
 8 tasked to go back and go through that which -- which is  
 9 what myself and Julie Fogarty did, we did it, we did it  
 10 in my office but separately looking at it and we looked  
 11 at using Meditech like electronic notes of, you know,  
 12 collapses, that -- you know the babies there.  
 13 And we came to this, a similar to the -- to the  
 14 doctors that she was, and I did a quick calculation, 80%  
 15 more likely to be on duty either during or before a baby  
 16 collapsed.  
 17 **Q.** What Julie Fogarty says is that at the time of  
 18 the analysis you were both aware appropriately trained  
 19 professionals were undertaking a review --  
 20 **A.** Yes.  
 21 **Q.** -- of all aspects of the sudden collapses, is  
 22 that what you understood?  
 23 **A.** Yes.  
 24 **Q.** That the sudden collapses, so the doctors were  
 25 looking at --

39

1 discussion of communications with families?  
 2 **A.** Not to any level of detail, no. I don't.  
 3 I have obviously contributed, there is my comment there  
 4 about some babies coming back.  
 5 **Q.** Did this feel a significant event in your  
 6 mind, that the unit was being downgraded and families  
 7 needed to be informed of things, did that feel  
 8 significant at the time or not?  
 9 **A.** I can't remember.  
 10 **Q.** You can't remember?  
 11 **A.** No.  
 12 **Q.** Had you been involved at all in another  
 13 setting where units were downgraded?  
 14 **A.** No, the only time where a unit may close if is  
 15 if an ITU is full or it has got poor staffing and you  
 16 can't risk putting another patient in there. So there  
 17 might be a temporary closure.  
 18 **Q.** If we go back to your statement, if we could,  
 19 thank you, at paragraph 52, we come to your staffing  
 20 analysis and you tell us: on 11 July 2016, Julie Fogarty  
 21 and I completed a staffing analysis and fed back the  
 22 findings to the medical staff.  
 23 Can you just tell us in your own words what that  
 24 piece of work was about, what you both did and how you  
 25 set about it?

38

1 **A.** Yes.  
 2 **Q.** -- first and foremost what had happened to the  
 3 babies, what might have caused their death. That was  
 4 the main need for inquiry, wasn't it?  
 5 **A.** Yes.  
 6 **Q.** Then when you looked at that and if you had  
 7 concerns about that there is questions about who is  
 8 present. Is that how you understood the sequence of  
 9 events?  
 10 **A.** I don't recollect specific sequence. We were  
 11 just given this piece of work to do. My understanding  
 12 is that John Gibbs was looking at the case note side of  
 13 it with -- with -- I am going to say Anne Martyn, but  
 14 I could be wrong.  
 15 **Q.** Which babies were you looking at, those where  
 16 there had been unexpected deaths or unexpected  
 17 collapses?  
 18 **A.** Yes, both.  
 19 **Q.** Right so you were looking at events that had  
 20 been unexpected?  
 21 **A.** Yes.  
 22 **Q.** So you weren't looking at every baby that had  
 23 deteriorated or died?  
 24 **A.** No.  
 25 **Q.** You were looking at unexpected events; is that

40

1 what you remember?

2 **A.** Yes, I -- if I recollect it was the ones that  
3 the doctors had already looked at. We were just going  
4 over that again.

5 **Q.** So you wouldn't recollect precisely which ones  
6 but you were going over a number?

7 **A.** Yes, and we also added another column of which  
8 medical staff were involved as well.

9 **Q.** You tell us at paragraph 55:

10 "We reported our findings back to one of the  
11 Executive Team, [you] think it was Sue Hodgkinson ..."

12 **A.** Yes.

13 **Q.** But you can't be sure and you recall also  
14 telling the Medical Director, Ian Harvey, that you were  
15 concerned?

16 **A.** Yes.

17 **Q.** Again, do you remember that or --

18 **A.** I do. I do remember that.

19 **Q.** So tell us about what you said to both of  
20 those?

21 **A.** So there were three babies that had collapsed  
22 that were fine during the day and then overnight they  
23 had collapsed. So I was concerned when I saw that as we  
24 checked it out with Julie Fogarty.

25 **Q.** Just pausing there, three babies or one baby

41

1 had experience before in an adult area where  
2 an allegation had been made and calling the police and  
3 that you told the Executives about that?

4 **A.** I did on a number of occasion.

5 **Q.** Can you expand on that?

6 **A.** A previous Chief Executive.

7 **Q.** We don't need any names.

8 **A.** I am not going to. A previous

9 Chief Executive, I was Head of Nursing then and the  
10 chief nurse and the deputy were away at conference or  
11 something so I was there and I got a phone call saying  
12 could I come down.

13 So I went down to see him. He said that somebody  
14 had brought -- I don't know who the somebody was, had  
15 brought this concern that somebody may be switching off  
16 pumps, pumps are what you deliver fluids to patients in  
17 I think it was the high dependency setting.

18 So we had a very brief conversation and said that  
19 we both believed we should inform the police and the  
20 police would make their decision then as to what they  
21 would do. They would either come in, say "do your own  
22 investigation and keep us informed" or not be bothered.  
23 So they were the three things.

24 So he rang the police and they came in that night  
25 and I stayed until about 4/5 o'clock in the morning with

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1 three times collapsing?

2 **A.** Sorry yes, one baby three times, I apologise.

3 **Q.** One baby had collapsed in the night, not in  
4 the day?

5 **A.** Three times, yes. So I -- when we fed it back  
6 we raised it there and I also took it to Ian Harvey as  
7 the Medical Director specifically and said I was  
8 concerned about that and he said he was going to check,  
9 if I recollect. So that's what we did.

10 **Q.** Now, the email I took you to earlier, the  
11 29 June, is where Alison Kelly said she would brief you  
12 and they were discussing the police.

13 She was telling -- discussing the police in those  
14 emails. Was Ian Harvey -- did you and Ian Harvey  
15 discuss around this time when you had done the review  
16 going to the police or not?

17 **A.** I don't recollect.

18 **Q.** You can't remember?

19 **A.** No.

20 **Q.** But do you remember around this time in July  
21 there being conversation about going to the police  
22 generally amongst the Execs, in your own mind or you and  
23 Julie Fogarty?

24 **A.** Yes. Yes. I do recollect.

25 **Q.** You also set out at paragraph 57 that you had

42

1 the staff going through, supporting staff and going, you  
2 know, supporting the police.

3 **Q.** Which Executives did you give that account to?

4 **A.** I recollect telling Ian Harvey. I recollect  
5 telling -- well, I recollect if it was mentioned at any  
6 meetings, the Executive meetings, I am pretty confident,  
7 well, you know, I can't be 100% sure but I brought it up  
8 on a number of occasions definitely because I thought it  
9 was a piece of information that could be utilised.

10 **Q.** Why did you think that?

11 **A.** Because of my experience.

12 **Q.** Sorry, why did you think it was a useful piece  
13 of information for them to hear?

14 **A.** Because I felt that, you know, they needed to  
15 consider the police. I did tell them I spoke to  
16 Alison Kelly on a number of occasions, one I remember  
17 with Karen Rees in my office saying that you need to go  
18 to the police and she said "I have taken advice" and  
19 that was it and she wouldn't listen.

20 **Q.** By the time you and Julie Fogarty were doing  
21 this analyses and then there was other reviews going on,  
22 did it at any time feel as though you were taking on the  
23 role of the police trying to look formal information and  
24 retaining fluid bags and doing things without really the  
25 resources or the knowledge or the expertise --

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1 A. I think we were just tasked in a management  
2 responsibility to do it. Yes.

3 Q. Did that sit comfortably at the time?

4 A. It -- it was uncomfortable given what I had  
5 been through in the past which is what I kept saying to  
6 them.

7 Q. Do you see referral to the police as  
8 essentially a neutral act just that an investigation is  
9 needed where there is concerns for a child that may be  
10 harmed or may not be harmed, that is the point of the  
11 referral?

12 A. I personally say that, yes.

13 Q. So you understood you don't need conclusive  
14 evidence or evidence of guilt, that is what the police  
15 look for if there is evidence one way or another?

16 A. But the Executives said that they were -- had  
17 taken advice and they need that we had to do our own  
18 investigation first.

19 Q. So your staffing analysis fed into that  
20 investigation?

21 A. Yes.

22 Q. You say:

23 "I did consider going to the police myself but as  
24 I had been told by the Executive Team that they needed  
25 to do their own investigation and as Stephen Cross was

45

1 Q. So the Triplets?

2 A. Yes.

3 Q. The O and P Triplets, so by July?

4 A. Yes.

5 Q. There was a meeting, wasn't there, on 13 July.  
6 If we go to enclosure 5 -- sorry, it's actually  
7 enclosure 4, Mrs Williams, the last document, and it's  
8 INQ0003365, page 4. 3365, page 4.

9 A. The handwritten notes.

10 Q. Exactly.

11 A. Yes.

12 Q. This is about a discussion around Letby having  
13 supervised practice?

14 A. Yes.

15 Q. Moving down to the meeting on 13 July,  
16 reference from Ian Harvey, we are aware of your concerns  
17 re one member of staff.

18 Over the page, page 5. There is correlation with  
19 a nurse but we know a change in acuity and activity.

20 That is Tony Chambers.

21 Further down:

22 "Dr ZA, nurse worrying correlation. One  
23 possibility criminal, it could be something else. Not  
24 necessarily criminal."

25 "Dr Jayaram: data is good. How do I feel?

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1 an ex-police officer and had a legal background coupled  
2 with the fact that the Consultants didn't see the need  
3 to do this, I didn't take it forward as I was not privy  
4 to all of the information."

5 A. No.

6 Q. Just pausing there. With the Consultants'  
7 position, you have said earlier that when the  
8 Consultants had raised the concerns, it is for the Risk  
9 Team to manage that through the risk process. Where the  
10 Consultants had raised concerns about the babies and  
11 very clearly in that mortality review and subsequently,  
12 who do you think was responsible for making decisions  
13 about going to the police?

14 A. I think you could argue everybody should have  
15 that responsibility.

16 Q. Including you?

17 A. Yes. Yes, I put that in my statement,  
18 I regret not doing it --

19 Q. Do you?

20 A. -- at that point. Yes.

21 Q. When would you have done it if you were going  
22 to do it?

23 A. I think by the time I had gone through the  
24 mortality reviews and there was a name then, yes, then  
25 definitely.

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1 A doctor would have been suspended."

2 Over the page, Mr Chambers:

3 "A week ago only option to ring the police."

4 Do you understand why he was saying: but there was  
5 not a need now to do that at this meeting on 13 July,  
6 because we have seen the emails about the discussions  
7 and at this point he's suggesting that is not the only  
8 option. Can you remember why that was the case?

9 A. I can't remember, no. There is no detail to  
10 say why he's come to that conclusion.

11 Q. Well, he carries on, doesn't he, two lines  
12 down:

13 "We can create harm to nurse, fragile, toxic, need  
14 to protect it."

15 I think that says "need", anyway, he will deal with  
16 that in his own evidence.

17 But you see there is focus, isn't there, on Letby  
18 herself, do you remember that?

19 A. I don't, no, sorry.

20 Q. If we go further down:

21 Dr Gibbs: not discussed with nurse, only nursing  
22 lead Eirian. How can we Consultants accuse nurse but do  
23 not know if it is that nurse?"

24 So some discussion around: well, we don't know for  
25 sure it is her, we are worried about that; you see that?

48

1 We don't know?  
 2 A. That's what John Gibbs is saying here.  
 3 Q. Yes, and then if we go over to the next page,  
 4 page 7:  
 5 "Dr Jayaram: should not be blinkered to the  
 6 unspeakable. Fine balance, my objectivity compromised.  
 7 Clarity re supervision and cameras."  
 8 There is discussion about having cameras, isn't  
 9 there, at this stage?  
 10 A. (Nods)  
 11 Q. Sorry, you nod; that doesn't get picked up?  
 12 A. Yes. Sorry.  
 13 Q. Yes. So there is discussion about to achieve  
 14 security on the unit, you need CCTV at this point, yes?  
 15 A. That's the impression, there yes.  
 16 Q. We see further down:  
 17 "Dr Gibbs: Cameras good. Corridors, deterrent.  
 18 Someone killing babies but don't know this, I do not  
 19 feel we need to whistleblow, how do we sell cameras?"  
 20 If we go over the page, to page 8:  
 21 JG [Dr Gibbs]: main worry is nurse therefore must  
 22 be totally supervised. Cast iron assurance total  
 23 supervision."  
 24 Then there is notes there:  
 25 "Mass murderer, coincidental, not involved."  
 49

1 A. Other organisations having it routinely.  
 2 Q. Yes, other organisations?  
 3 A. Yes.  
 4 Q. But you as a group of doctors and nurses  
 5 hadn't been having that conversation until this meeting  
 6 or had you?  
 7 A. No.  
 8 Q. No. So that can come down.  
 9 You tell us that in your statement going back to  
 10 that at paragraph 61:  
 11 "The Executive Team had made the decision that  
 12 Letby was to be allowed to work in a supervised  
 13 capacity."  
 14 So it looks as though you were tasked with writing  
 15 a letter to her, to that effect, enclosure 5, and the  
 16 document reference is INQ0003147, page 1.  
 17 A. Yes.  
 18 Q. We see there when it comes up, your letter.  
 19 If we look at the last two paragraphs on the first page  
 20 you explain:  
 21 "The review which has been undertaken to date has  
 22 been unable to explain the collapse or deterioration of  
 23 babies in a number of cases ... serious concern to the  
 24 Trust. The review which has been undertaken has  
 25 revealed that a small number of staff were regularly  
 51

1 You say, this is your contribution to this meeting:  
 2 "Will affect staffing levels"?  
 3 A. That's right.  
 4 Q. So what was your thinking when you say "will  
 5 affect staffing levels"?  
 6 A. So if it -- the conversation is -- I mean  
 7 I can't remember the detail, but if there was  
 8 a competency issue with an individual and you have to  
 9 supervise them, then it does affect it because you  
 10 have -- somebody has to work in a pair so there wouldn't  
 11 be sufficient staff then to staff the rest of the cots.  
 12 Q. So that meeting taking place as it does on the  
 13 13th, you are aware that it's Letby that they are  
 14 worried about but they don't know and they are worried  
 15 about her being upset by it and it's a difficult  
 16 situation; yes?  
 17 A. I don't remember the detail, but clearly  
 18 that's what it says.  
 19 Q. They are so worried about foul play they are  
 20 talking about CCTV being introduced for security on the  
 21 wards?  
 22 A. Yes, that was a general belief anyway that  
 23 neonatal units and areas need CCTV. So ...  
 24 Q. You say a general view. Where was that  
 25 discussed between doctors and --  
 50

1 involved in the care. Their involvement was either on  
 2 the shift or on the shift before a baby had unexpectedly  
 3 collapsed or deteriorated. As we discussed during our  
 4 meeting, you have been identified as one of these  
 5 members of staff. The review has identified you as  
 6 being more regularly involved in the care of babies  
 7 concerned."  
 8 And you continue.  
 9 The next paragraph:  
 10 "A decision has been made to provide additional  
 11 support to all of the staff including you" --  
 12 **LADY JUSTICE THIRLWALL:** I'm not sure you have the  
 13 right passage on there on the screen.  
 14 **MS LANGDALE:** Sorry. Page 2. Top paragraph. That  
 15 is fine.  
 16 "The review has identified you as being more  
 17 regularly involved in the care of babies concerned."  
 18 And the next paragraph:  
 19 "As we discussed patient safety is of paramount  
 20 importance."  
 21 In the middle of that paragraph:  
 22 "Therefore a decision has been made to provide  
 23 additional support to all of the staff, including you,  
 24 who have been identified in the review. I explained you  
 25 will be the first nurse to undergo this process due to  
 52

1 you being identified in the review as being the most  
 2 regularly involved."

3 Who drafted this letter with you?

4 A. Sue Hodgkinson, if I recall.

5 Q. It then says in the next paragraph:

6 "The Royal College of Paediatrics and Child Health  
 7 are undertaking an external review commencing on  
 8 18 August. The Trust has decided you will remain  
 9 subject to clinical supervision until the Trust has  
 10 received feedback from the external review. Other staff  
 11 who have been identified as being regularly involved in  
 12 the care of babies will also undergo a similar process."

13 Do you think this letter was transparent with the  
 14 concerns that had been raised and the true situation?

15 A. No.

16 Q. Why not and whose suggestion was it that it  
 17 should not be?

18 A. It was the Executive decision. They proofread  
 19 the letter and edited anything that was ...

20 Q. When you say "the Executive", which ones?

21 A. I am pretty sure it was Sue Hodgkinson.  
 22 Whether Alison Kelly also had input I'm not sure but  
 23 I am pretty sure it was Sue Hodgkinson with an HR  
 24 background.

25 Q. Did she give you any sense of why that was the

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1 decided that all members of staff need to undertake  
 2 a period of clinical supervision. Due to our staffing  
 3 issues it has been difficult to determine how we  
 4 undertake this process. We can only support one member  
 5 of staff at a time."

6 So this is an email to be sent to everyone on the  
 7 NNU, isn't it, by -- we know it is sent by Yvonne  
 8 Griffiths for clinical supervision, but it looks like  
 9 you or Eirian Powell have had an input into this letter.  
 10 You have certainly seen this?

11 A. I don't recall having input but I clearly did  
 12 see it, so I must have known about it, yes.

13 Q. So you knew that this is what all of the staff  
 14 were going to be told?

15 A. Oh, yes.

16 Q. Yes?

17 A. Yes, my understanding was that was going to  
 18 happen, they were going to do some supervised practice  
 19 for other staff as well, just to give people additional  
 20 training to make sure.

21 Q. Again, do you think that letter was  
 22 transparent with the neonatal unit staff that in fact  
 23 there was suspicion of foul play and there was going to  
 24 be an investigation?

25 A. With hindsight probably not, however --

55

1 case, why it should be sugar-coated or set out in this  
 2 way?

3 A. Because at that point, the -- the Executives  
 4 were still of the belief it wasn't a single person.

5 Q. Right. Which Executives didn't think it was  
 6 a single person?

7 A. I am -- I'm not sure if you could say  
 8 individual ones. I think it was a group.

9 Q. And did you truly believe when you sent that  
 10 letter that she was going to be supervised and then  
 11 others would be or did you know that just would never  
 12 happen?

13 A. Well, I was confident that they were going to  
 14 do some supervision of the nurses there, not  
 15 supervision, retraining, skills updates, that type of  
 16 thing.

17 Q. There's another letter, the next page for you,  
 18 and if we can go, please, to INQ0002731, page 1. You  
 19 here are sending to Eirian a draft, is that right? Have  
 20 a look at this.

21 One says "It is good to go". Have a look at this  
 22 email. Have you seen this or had input into this draft?

23 A. I don't recall having any.

24 Q. It says:

25 "In preparation for the external review it has been

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1 Q. What do you think with hindsight that  
 2 communication should have said at this point?

3 A. I think it's very difficult because at that  
 4 point you know, naming a name wasn't an option according  
 5 to the Executives, so I think there was going to be some  
 6 training definitely. I think that was the belief; that  
 7 they did need some additional training.

8 Q. When you say naming names wasn't an option,  
 9 why was that?

10 A. Because it was an Executive decision. They  
 11 felt it wasn't the right thing to do.

12 Q. Do you think that was realistic given that her  
 13 name was coming up in mortality reviews, at meetings,  
 14 discussion around her commonality with all the internal  
 15 reviews being done?

16 A. It depended on who they wanted to talk to,  
 17 basically.

18 Q. Were people told not to mention her name and  
 19 not to talk about her individually?

20 A. I -- I don't recollect that specifically, no.

21 Q. Well, you don't refer to her name anywhere in  
 22 your communications, as I have seen it. Do you remember  
 23 that, do you remember having conversations?

24 A. No.

25 Q. You were at pains to say you don't remember

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1 seeing that mortality review with her name in red. Was  
2 there a sense that you couldn't mention her name or you  
3 should not mention her name?

4 **A.** I think the Executives were of the -- still of  
5 the impression that or the opinion that you -- you  
6 couldn't mention her name yet. It wasn't cut and dry,  
7 if you like. I don't want to use that saying, but --

8 **Q.** It wasn't crystal clear, "cut and dry", your  
9 expression?

10 **A.** Thank you.

11 **Q.** It wasn't cut and dry, so don't mention her  
12 name because it is a serious allegation?

13 **A.** Yes.

14 **Q.** In that, there is a line, isn't there, between  
15 being misleading, not mentioning a name and being  
16 misleading about the true circumstance; would you agree?

17 **A.** Looking back at it, yes.

18 **Q.** When the police were eventually contacted, did  
19 her name become known then?

20 **A.** I don't know, because I had left by then.

21 **Q.** Okay. If we go to another document in the  
22 same enclosure, 5 for you, it is INQ0005769 at page 2,  
23 this is a letter 14 July -- sorry, an email, 14 July and  
24 you are sending it to Sue Hodgkinson to run it by her.  
25 Page 2.

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1 **Q.** Did you share that concern about her being in  
2 the Risk and Patient Safety Team?

3 **A.** I am -- I can't 100% be sure but I am fairly  
4 sure I did say to Alison it was not the best move. But  
5 I didn't have an option, so ...

6 **Q.** Were you concerned that she would have access  
7 to material about the babies on the unit or generally or  
8 what?

9 **A.** I did raise that concern but she sat in the  
10 other office, she wasn't in with the rest of the Risk  
11 Team.

12 **Q.** Is there a computer system where you have  
13 access to?

14 **A.** There is, I'm not sure whether or not she had  
15 access because not everybody has access to it.

16 **Q.** At paragraph 74 of your statement, you say:  
17 "I personally did not consult with Stephen Brearey,  
18 about his view regarding patient safety if Letby  
19 returned to the ward. The Executive Team undertook all  
20 discussions with the paediatricians and Dr Brearey."

21 Looking back, do you think you could have had more  
22 discussions with Dr Brearey or Dr Jayaram or did that  
23 not seem appropriate?

24 **A.** It would have been a viewed as inappropriate  
25 by the Exec Team because they were holding the ring on

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1 **A.** Yes.

2 **Q.** It's just above. You send this and you want  
3 her to have a look at it and if we go to page 4:

4 "Security. Sue outlined the proposal to install  
5 cameras in the NNU following a recent security review.  
6 Can you please make sure you meet with Tim Lister to  
7 discuss the best place to put them."

8 Do you know if they were ever put in or why they  
9 weren't put in, if they weren't put in?

10 **A.** I don't think they were ever put in.

11 **Q.** But it was being followed up by you, wasn't  
12 it, the need for cameras at this time in the unit?

13 **A.** It was being followed:

14 "Action; Eirian Powell to meet with Tim Lister."

15 **Q.** In fact, we know -- that can come down --  
16 Letby was removed from the unit and she was moved into  
17 the Risk Department. What was your view about that move  
18 to her into the Risk Department?

19 **A.** I didn't have -- my view is it was probably  
20 not appropriate. I didn't have the -- I didn't have  
21 an option as to where she was going so I made the --  
22 I made the decision to keep her in Patient Experience  
23 and PALS, you know, counting patient experience cards  
24 and making, you know, pulling the comments out, rather  
25 than have her with the Risk Team per se.

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1 it.

2 **Q.** Because they were?

3 **A.** Holding -- they were holding it, if you like.

4 **Q.** Holding it, holding the reigns of the  
5 situation?

6 **A.** Yes, yes.

7 **Q.** Were you all aware of that, that it wasn't --  
8 you weren't free to do whatever you each wanted; there  
9 was a -- I don't want to say "party line" but a process  
10 that was going on? How would you describe it?

11 **A.** That any conversations around that went via  
12 them first.

13 **Q.** Who's "them"?

14 **A.** The Execs.

15 **Q.** Right. Which Execs? Sorry to push you on  
16 that.

17 **A.** Ian Harvey and Alison Kelly, really.

18 **Q.** Right. Ian Harvey and Alison Kelly.

19 What about Tony Chambers was he very directly  
20 involved as far as you were aware?

21 **A.** He attended the meetings as you can see. I'm  
22 not sure he was as close to it as Ian Harvey and  
23 Alison Kelly.

24 **Q.** Right. You tell us the Royal College of  
25 Paediatrics and Child Health report, you don't recall,

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1 paragraph 79, ever seeing the Terms of Reference --  
 2 **A.** No.  
 3 **Q.** -- for that review.  
 4 What did you understand that review was going to  
 5 do?

6 **A.** I never saw the Terms of Reference. We  
 7 weren't privy very to them. My understanding is they  
 8 were going to look at general staffing levels, care,  
 9 just those sort of things.

10 **Q.** Looking at the babies, presumably? You  
 11 realised they were getting some review of the babies'  
 12 care?

13 **A.** My understanding was that they would look at  
 14 the care of infants in there per se. I don't know if  
 15 they were given specific details to look up this baby or  
 16 that baby or ...

17 **Q.** So you didn't know which baby, but you thought  
 18 they were looking at babies?

19 **A.** No.

20 **Q.** What -- if you were going to guess at that  
 21 time, did you think about that at that time, what babies  
 22 they would be looking at?

23 **A.** I thought that it would be covered in their  
 24 Terms of Reference; they would look at the care of  
 25 individual babies.

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1 **A.** That they should know that it was happening,  
 2 that we were reviewing the care.

3 **Q.** And that they should know when a report comes  
 4 back and --

5 **A.** Yes.

6 **Q.** -- what it says?

7 **A.** Yes.

8 **Q.** Was there ever a discussion about that --

9 **A.** I don't think there was.

10 **Q.** -- that you were involved?

11 **A.** Well, obviously when it came back, I think  
 12 there was some, you know, area communication to the  
 13 families.

14 **Q.** Moving on to the topic of the grievance.

15 We know Letby took out a grievance subsequently and  
 16 Dr Christopher Green was the investigating officer as  
 17 part of the grievance investigation and you had an  
 18 interview with him. What did you think the grievance  
 19 was about?

20 **A.** I never saw -- I have -- I never saw the  
 21 terms, the grievance, I never even saw the outcome of  
 22 the grievance until the bundle came to be fair.

23 I was led to believe it was to do with how  
 24 Lucy Letby was being treated by the Consultants, that's,  
 25 you know, the allegations that were being made. That's

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1 **Q.** And at the time, would you have expected that  
 2 the parents of the babies they were looking at would be  
 3 informed that that was going to happen at the time that  
 4 instruction was made?

5 **A.** I think it would have been fairer to have told  
 6 them at the time because often parents can share  
 7 concerns or bring information that can contribute.

8 **Q.** As far as you were aware, had any of the  
 9 parents of the babies named on the indictment who died  
 10 had any input or conversations with the Exec Team?

11 **A.** I don't know. And as far as I am aware  
 12 probably not, but I couldn't say one way or the other.

13 **Q.** Did you ever ask that and say: Look, you  
 14 know, we have seen there was discussion about  
 15 communication with families. Look, these families need  
 16 to know if their babies are being reviewed?

17 **A.** I don't recollect saying that, no.

18 **Q.** Did you ever think it?

19 **A.** I can't remember at the time. I -- it was  
 20 very much left with the Executive Team to -- to deal  
 21 with that. I would have expected Alison possibly to  
 22 have said it.

23 **Q.** If you were asked what your view was at the  
 24 time, what would you have said in terms of what they  
 25 should know?

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1 all.

2 **Q.** Okay. So can you remember who told you that?  
 3 Was that --

4 **A.** I'm not sure. I -- I -- I can't remember.

5 **Q.** But before you were interviewed, you thought  
 6 it was about her complaints about how the Consultants  
 7 had treated her?

8 **A.** That she had raised a grievance is what I had  
 9 been told. But I didn't know the level of detail, so  
 10 I would just be assuming.

11 **Q.** You say at paragraph 83:

12 "I recall asking the Director of Nursing,  
 13 Alison Kelly, if it was appropriate to continue with the  
 14 grievance process given investigations such as that by  
 15 the RCPCH were ongoing."

16 **A.** Yes.

17 **Q.** So can you expand upon that, please? What did  
 18 you say about that?

19 **A.** I did recall, when the grievance was issued,  
 20 that a number of staff were having to be interviewed and  
 21 I recall saying to Alison that I didn't feel it was  
 22 appropriate and would it not be better to wait until we  
 23 had all the information together because we had not got  
 24 the Royal College position report and it's -- it just  
 25 felt it wasn't the right thing.

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1 Now, if I recall right, she said she had taken  
 2 advice and it was going ...  
 3 **Q.** What were you thinking was the right thing?  
 4 **A.** To wait for the outcome of the rest of the  
 5 information.  
 6 **Q.** The investigation, effectively --  
 7 **A.** Yes.  
 8 **Q.** -- as you thought it may be with the RCPCH?  
 9 **A.** Yes.  
 10 **Q.** So have the results of the investigation. Why  
 11 was that necessary to have that before looking at  
 12 a grievance? It may seem obvious, but can you explain  
 13 your thinking?  
 14 **A.** My thinking would be that they had made -- you  
 15 know, until you get it all together and you look at the  
 16 bigger picture sometimes people make decisions that, you  
 17 know, they haven't seen it and they miss something and  
 18 miss the opportunity if you like.  
 19 So my -- I would have waited until it all came  
 20 together, got the bigger picture and then you can decide  
 21 the most appropriate course of action at that point.  
 22 **Q.** Did you think she needed to be investigated?  
 23 **A.** Do I... ?  
 24 **Q.** Did you think there needed to be an  
 25 investigation into Lucy Letby, whether it was

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1 days."  
 2 **A.** Yes.  
 3 **Q.** "As a result of that, I would have expected an  
 4 investigation."  
 5 **A.** Yes.  
 6 **Q.** So that was in April 2016. So when she was  
 7 moved to day shifts, you would have expected  
 8 an investigation, you tell Dr Green that. Did he ask  
 9 you why or what your thinking was about that?  
 10 **A.** I don't know. If it's not in the transcript,  
 11 you know, probably not.  
 12 **Q.** If we go over the page, the top box, so  
 13 page 2, top box?  
 14 **A.** Yes.  
 15 **Q.** "There were no red flags", you say:  
 16 "Sudden deterioration in neonatal babies is  
 17 apparently common. Although I am not neonatally trained  
 18 I didn't find anything more than that. I asked how the  
 19 sudden deterioration could happen and was told they are  
 20 more unstable than adults. I met Lucy in my office with  
 21 EP and explained that she featured in terms of  
 22 attendance so we will start with her doing supervision  
 23 clinical competencies then work down the list of staff  
 24 and finish with the ones that only work one shift."  
 25 You don't mention here -- you say there is

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1 disciplinary or a police investigation?  
 2 **A.** I -- as I said on a number of occasions,  
 3 I felt the police needed to be involved, not -- to look  
 4 at the deaths and make that decision as to whether it  
 5 was an issue or not.  
 6 **Q.** Because there was suspicion around these  
 7 deaths and they needed to find out who it was if someone  
 8 was causing the deaths?  
 9 **A.** Yes. There was -- they were unexplained and  
 10 there were a number of unexplained collapses, yes.  
 11 **Q.** Your interview with Dr Green is at  
 12 enclosure 9, which is INQ 0003164, page 1. So you are  
 13 being interviewed by him because you now understand from  
 14 what you have said that it is a grievance she's raised  
 15 about how the Consultants have treated her. Did you  
 16 think you were particularly being asked about one topic  
 17 or did you feel it was quite an open interview when you  
 18 look back?  
 19 **A.** I can't really remember to be honest. When  
 20 you mean one topic?  
 21 **Q.** Okay. If we go to the first box, you say:  
 22 "I was told that Lucy was swapped from nights to  
 23 days. I would have expected..."  
 24 No, it's further up -- there we go, thank you:  
 25 "I was told that Lucy was swapped from nights to

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1 increased deaths, you don't mention there was suspicion  
 2 of foul play and the Consultants were really worried  
 3 about that. You don't say that, do you?  
 4 **A.** No.  
 5 **Q.** Why not?  
 6 **A.** I cannot recollect as to why not. I don't  
 7 think it was a specific question that was asked, so ...  
 8 **Q.** You don't think you were asked whether the  
 9 Consultants had concerns, whether they were worried or  
 10 whether it was genuine?  
 11 **A.** Not unless it appeared on here, no.  
 12 **Q.** You were asked by Dr Green: did you tell her  
 13 that there had been allegations from the Consultants  
 14 about her specifically? And you say: I was using the  
 15 phrasing I was asked to by SH and AK.  
 16 So Sue Hodgkinson and Alison Kelly had told you what  
 17 you could say to her; is that right?  
 18 **A.** Yes, yes.  
 19 **Q.** Did you feel a bit like you were the messenger  
 20 in this?  
 21 **A.** Yes.  
 22 **Q.** Did you think it was the right thing to do,  
 23 what you were telling her?  
 24 **A.** With the benefit of hindsight, I should have  
 25 stood up a bit more to her.

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1 Q. With the benefit of hindsight should you have  
2 told Dr Green the Consultants had genuine concerns they  
3 were worried and indeed you thought the police should  
4 have been contacted and they had -- if they had, as far  
5 as you were concerned?

6 A. (Nods) Yes.

7 Q. Do you think you should have told him that?

8 A. Possibly. I -- I have a feeling he probably  
9 knew.

10 Q. What's that?

11 A. You know, the -- about the -- the -- because  
12 he knew, the allegations had come forward so I think he  
13 probably knew that there were allegations but I wasn't  
14 specifically asked.

15 Q. Do you think he knew that the Consultants were  
16 genuinely worried about babies unexpectedly dying and  
17 collapsing and one person being present?

18 A. Maybe not the one person being present but  
19 yes, I think he probably knew about the deaths.

20 Q. Why do you think he knew?

21 A. Because I -- this was after the meeting. This  
22 date here is October 2016 and we had that meeting where  
23 Sue Hodgkinson pulled it together in the boardroom that  
24 time and he was part of that meeting. So, yes, I think  
25 he probably knew.

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1 speaking like that?

2 A. I didn't, no. No. I personally didn't.

3 Q. So of all the things when he asked you about  
4 allegations about Lucy, why is it that you come up with  
5 that, which you had never heard and you had sat in  
6 mortality reviews and heard Dr ZA express concerns about  
7 what had happened to the babies?

8 A. Because at the mortality reviews, you know,  
9 would name -- sort of harp on about a specific name of  
10 those things, I don't remember those specific things,  
11 just the care of the babies.

12 Q. If you go to the end, page 3:

13 "Is there anything else you want to tell me? If  
14 the Consultants really believed she had done it why  
15 didn't they go to the police and why have they come to  
16 that conclusion?"

17 You didn't go to the police either?

18 A. No.

19 Q. You thought you should do. So again do you  
20 think you have you are having a pop at the Consultants  
21 there for something that you say you could have done and  
22 should have done?

23 A. I think they were much closer to it than  
24 I was. They had done quite a lot themselves, but  
25 I agree, with the benefit of hindsight, I should have

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1 Q. He does ask you, doesn't he, near the bottom  
2 of the page, the last but one:

3 "Have you heard about any allegations about Lucy?"

4 You say:

5 "I am aware that they feel she is to blame. I was  
6 told by someone else that one of the doctors had  
7 referred to her in the context of there's a murderer on  
8 the loose out there in one of the outpatient clinics,  
9 but not by name."

10 Pausing there, did you ever have a name of anybody  
11 who had heard that allegation given to you? Heard that  
12 suggestion that there is a murderer on the loose out  
13 there was said?

14 A. That was a second -- the conversation somebody  
15 had said they had overheard it and told me but I never  
16 heard it firsthand.

17 Q. Hearsay?

18 A. It was just hearsay.

19 Q. Who told you that?

20 A. I can't remember who it was --

21 Q. A nurse?

22 A. -- to be honest.

23 It could have been or it could have been one of the  
24 other managers, I don't know.

25 Q. In all your time there did you hear anyone

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1 gone to the police.

2 Q. Do you think this interview, you might have  
3 communicated what you communicated in your police  
4 statement subsequently a number of issues?

5 A. I don't know what --

6 Q. Let's go to -- that can come off the screen  
7 INQ0001996, page 4. It's at the back of your Inquiry  
8 statement, the police statement and it's paragraph 3.

9 "I remember being at another meeting ..."

10 Sorry, it is just up on the screen now at the top,  
11 do you have it, Mrs Williams?

12 "I remember being at another meeting after the  
13 review I had done, with the Consultants and the Medical  
14 Director, the clinician staff were clearly twitchy about  
15 the whole situation. I recall one of the female  
16 Consultants, possibly Dr ZA, suggesting the deaths might  
17 have been caused by the injecting of air. The meeting  
18 was very upsetting."

19 So you knew when you told the police that at least  
20 one doctor you had heard that being said?

21 A. It was the meeting that was referred to --  
22 I am pretty sure this is the meeting that is referred to  
23 where the Exec Team were there, Tony Chambers was there,  
24 everybody was there. I think it was one of the big  
25 meetings where one of the Consultants walked out who was

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1 upset, so I think it was that one.

2 **Q.** Okay. Do you think that was before the  
3 grievance on 24 November 2016 or after?

4 **A.** I think it probably was before the grievance.

5 **Q.** Before, okay. So you had that information  
6 before you spoke to Dr Green?

7 **A.** (Nods)

8 **Q.** Was there an atmosphere in the context of that  
9 grievance, you say you knew it was raising concerns  
10 about the Consultants and how they treated her was the  
11 atmosphere that that is what you were there to talk  
12 about what the Consultants had done or said or behaved  
13 like rather than what had happened to babies?

14 **A.** It -- it was what their behaviour was, rather  
15 than the babies.

16 **Q.** You agree from what you have said before that  
17 what was needed at that point was either a disciplinary  
18 or police investigation, a police investigation?

19 **A.** Yes.

20 **MS LANGDALE:** Contact with parents. You set out at  
21 paragraph -- I see the time actually, my Lady. It might  
22 be a good place to stop. We've been going for an hour  
23 and a half, Mrs Williams.

24 **LADY JUSTICE THIRLWALL:** Very well. So we will  
25 take a break now and we will start again at quarter to

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1 **Q.** If we go now, please, to enclosure 6 for you,  
2 the second document and INQ0012622, page 3. This is  
3 a letter sent from Mr Harvey in February 2017 and this  
4 is a letter intended for parents of the bereaved  
5 children and we see he sets out there:

6 "Following on from your conversation please find  
7 enclosed a copy of our report ... explain to you we  
8 asked for this external assessment from the  
9 Royal College. This step was taken because we wanted to  
10 better understand why there had been a greater number of  
11 deaths than we would normally expect. In the report it  
12 describes no single cause or factor to explain the  
13 increase we have seen in our mortality numbers."

14 It continues:

15 "You will see in the report one of the  
16 recommendations includes a thorough review of the  
17 specific care and treatment each baby received. This is  
18 personal and confidential to you and your family and we  
19 would welcome the opportunity to meet and discuss with  
20 you the care your baby received."

21 The -- you tell us that you were involved in  
22 contacting families and indeed just before that letter  
23 on a page dated 3 February 2017, we see ciphered names  
24 and ticks where you have presumably indicated things by  
25 your ticks. If we have that page, INQ0012622, page 1.

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1 12.

2 **(11.28 am)**

3 **(A short break)**

4 **(11.45 am)**

5 **MS LANGDALE:** Mrs Williams, before I move to  
6 contact with parents, can I just take you back to  
7 paragraph 19 of your Inquiry statement and you are  
8 speaking of July 2015 and the Serious Untoward Incident  
9 review we went to and you think it was around that  
10 time -- you say at that time where the mortality rates  
11 were discussed Dr Brearey was not overly concerned at  
12 that stage and indicated that peaks in deaths can  
13 sometimes occur.

14 You can't recall the date but it looks as if it is  
15 around that A,C,D, time; do you remember him raising  
16 that with you?

17 **A.** I -- I am not convinced it's the 2 July one.

18 I think it's like a neonatal review that he did  
19 separately. I am not 100% convinced of the date. It  
20 might have been late in 2015, October time round. But  
21 I couldn't swear to it.

22 **Q.** You remember he wasn't overly concerned but  
23 you say as things continued he became more concerned; is  
24 that your evidence?

25 **A.** Yes, yes, basically.

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1 People will see what that means.

2 That's something you had pulled together and you  
3 were using that, were you, as you made telephone calls  
4 and the like when you contacted parents; is that right?

5 **A.** Yes. I think the -- the admin team pulled it  
6 together and supported me in the process as well.

7 **Q.** So the admin team supported you and you were  
8 making the calls. That can come down?

9 **A.** Yes.

10 **Q.** The Inquiry has heard evidence from the  
11 parents of the babies named in the indictment and there  
12 are two stages where they were not informed where I am  
13 sure you would agree they should have been and the first  
14 was when there was a press statement announcing the  
15 RCPCH review, the parents should all have known about  
16 that review, shouldn't they, before that announcement  
17 was made in the media?

18 **A.** Yes, we discussed that before because  
19 I believed they should have been part of the process.

20 **Q.** Then there was the occasion of the report  
21 itself being leaked to a newspaper and the parents being  
22 contacted by you on a Friday evening to tell them it was  
23 about to be leaked in a newspaper. Deplorable, isn't  
24 it, that that's how they should hear about it?

25 **A.** Yes, I can't disagree with that.

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1 Q. We heard from different parents, we heard from  
 2 Mother C who was expecting another child and was still  
 3 in contact with the Countess of Chester, her mobile  
 4 details, her presence at those antenatal visits and no  
 5 effort made to tell her about that which she did not  
 6 know; that the RCPCH report was being conducted, and  
 7 I think it was you and Alison Kelly who spoke to her  
 8 about that when she found you and came to speak to you  
 9 about it?

10 A. Yes.

11 Q. Do you remember that?

12 A. I -- I don't remember it but I have seen her  
 13 recollection --

14 Q. It's right that she came and spoke to you  
 15 both?

16 A. Yes.

17 Q. She says that you were apologetic at that time  
 18 and she assumed there would be good communication moving  
 19 forward and yet she was one of the number who were not  
 20 told about that report when it was available to the  
 21 Countess and learned about it in the run-up to the  
 22 publication?

23 A. (Nods)

24 Q. Why was it that that level of communication or  
 25 lack of communication took place?

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1 should have -- you know the Trust should have -- if  
 2 there's nothing to say at that point then the Trust  
 3 should have said nothing, we have got nothing to update  
 4 you but, you know -- that's, you know, how it should  
 5 have been dealt with.

6 Q. When did you learn, if at all, that babies had  
 7 been administered insulin, deliberately administered  
 8 insulin? Did you know which babies?

9 A. No.

10 Q. Were you ever asked to communicate that to the  
 11 parents of those babies?

12 A. No.

13 Q. Mother I, she had no idea that the review or  
 14 RCPCH was ongoing and even being conducted until she  
 15 received a letter, did she, again?

16 A. No. I think I -- we had tried on a number of  
 17 times to ring but sometimes there were no numbers or we  
 18 got, you know -- you know more, worryingly out-of-date  
 19 numbers, that type of thing.

20 Q. Well, that is challenged in some cases,  
 21 Mrs Williams, and it's often said, isn't it: you have  
 22 moved house, it is the wrong number and that is  
 23 certainly challenged in one case, someone who hadn't  
 24 moved house, Mother C, and it depends how hard we try to  
 25 find people doesn't it?

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1 A. I am unsure as to why the Exec Team made that  
 2 decision. I recollect -- well, I don't physically  
 3 remember it, but I have looked at my notes and I did  
 4 call members of families. I don't recollect as to why  
 5 they -- the Executive Team weren't more proactive.

6 I do, looking at an email which I have seen, here  
 7 email them in February because I left the Trust at the  
 8 end of March and in February I emailed Stephen Cross to  
 9 say I was concerned that the communication wasn't as it  
 10 should be and, you know, we desperately needed to try  
 11 and improve it and that, you know, I couldn't emphasise  
 12 how anxious the parents were when I spoke to them on the  
 13 phone.

14 Q. You do communicate that. We have seen  
 15 an email that you say they are anxious. You were  
 16 contacted by Mother D, she was waiting for an Inquest,  
 17 pushing for an Inquest, wanted to know what was being  
 18 done about her baby girl. She shouldn't have had to  
 19 phone you to find that out?

20 A. Yes, I mean the Trust don't do the Inquest  
 21 per se, it is for the -- the Coroner. But however, yes,  
 22 we there's little doubt in -- with the benefit of  
 23 hindsight, and I hate to keep saying that word --

24 Q. Mother E and F as well?

25 A. We should have been more proactive and we

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1 A. Yes, I agree. I -- I cannot dispute sitting  
 2 here defending the communication because it was poor,  
 3 little doubt it was poor.

4 Q. With little compassion or understanding of  
 5 their anxiety and their position?

6 A. I -- I -- I can't dispute that, I have not  
 7 been in their position. You know, on reflection that's  
 8 the one area -- sorry, we could have improved. Sorry.

9 Q. It sounds as though you and Alison Kelly when  
 10 you first met Mother C recognised that and apologised so  
 11 why was it -- obviously a question for Alison Kelly  
 12 too -- that there wasn't more proactivity, you had seen  
 13 someone in the flesh, it is often very different when we  
 14 meet them directly, isn't it, you have them in mind, you  
 15 understand the suffering --

16 A. Yes.

17 Q. -- better, arguably, than when you don't have  
 18 a person in mind and these parents were reaching out to  
 19 you?

20 A. Yes.

21 Q. So why was it that wasn't proactive from you  
 22 and her?

23 A. Because that was the Exec decision that I was  
 24 being told what to do and how to do it and that type of  
 25 thing, so it was down to that.

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1 I was actually away a significant part of February.  
2 I had gone on holiday and I didn't come back until sort  
3 of mid-March and then was only there for 10 days after  
4 that. So, you know, I didn't ...

5 **Q.** You took a call, didn't you, from Father O, P  
6 and R, bereaved Father, both O and P we now know  
7 murdered, and he was not happy, was he, with the  
8 follow-up? No contact since the death of his boys, no  
9 bereavement support, and made the point too it wasn't --  
10 the support there wasn't like at Liverpool Women's just  
11 generally when he had been there.

12 Do you remember that conversation?

13 **A.** I -- I don't remember the call but I have seen  
14 some notes. Yes.

15 **Q.** So you agree that level of communication was  
16 coming in at that time from the parents of bereaved  
17 families?

18 **A.** Mmm and it was not recognised and not dealt  
19 with appropriately.

20 **Q.** When you say it was an Executive decision,  
21 which Executives -- sorry to keep pressing you on this,  
22 but there is a number, so who do you say was the most  
23 sighted on that issue and made those decisions?

24 **A.** Probably Alison Kelly.

25 **Q.** Right. So it's for her to explain to us what

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1 **Q.** Is that the case that at the time you weren't  
2 aware of the child protection or safeguarding measures  
3 that applied?

4 **A.** Not to that level of detail. No.

5 I didn't work with children, like I say, and as  
6 Alison Kelly led the Safeguarding for Children Team, you  
7 know, she knew the level of detail and used to attend  
8 the meetings.

9 **MS LANGDALE:** Yes, thank you. I have no further  
10 questions, Mrs Williams.

11 There are some questions, my Lady, from Mr Sharghy  
12 first and then Mr Baker.

13 Questions by MR SHARGHY

14 **MR SHARGHY:** Mrs Williams, good -- I think it is  
15 still just about morning and I am going to be asking you  
16 questions on behalf of a number of Families. Although  
17 I represent the Families of Child I, I am also going to  
18 be asking questions on behalf of Child A, B, L, M, N and  
19 Q.

20 You have been taken through a lot of documentation  
21 and in particular focusing on your staff matrix review  
22 that you carried out with Mrs Fogarty which was  
23 completed on 11 July 2016?

24 **A.** (Nods)

25 **Q.** I am not going to go through the background to

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1 the reasoning was behind that. As far as you were  
2 concerned, would you have made calls at any time if you  
3 had been asked to do so and provided information that  
4 you were told to provide?

5 **A.** I would like to have thought I would, I -- you  
6 know I'm -- yes, I am the type of person who likes to --  
7 if there is nothing to say, like I say, ring them up and  
8 say "there is nothing to say"; at least then you  
9 maintain contact.

10 **Q.** One more document, please, at appendix 8, for  
11 you, enclosure 8, and it is INQ00028790120.

12 This is the safeguarding guidance and consideration  
13 of referral to the LADO, Local Authority Designated  
14 Officer, when it comes up.

15 We just see in the top two bullet points, if there  
16 is a concern raised or an allegation made about a person  
17 who works with children, whether a professional staff  
18 member, foster carer or volunteer that they may have  
19 behaved in a way that has harmed a child or may have  
20 harmed a child, possibly committed a criminal offence,  
21 what should happen.

22 You tell us you weren't aware of that policy, you  
23 tell us also that you hadn't worked with children other  
24 than your contact with the neonatal unit?

25 **A.** No.

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1 what it was and why you were asked to carry out that  
2 role but I would like to know a little bit more about  
3 the reporting you made to the Executive Team but you  
4 specifically highlighted Alison Kelly, Ian Harvey and  
5 Sue Hodgkinson.

6 When you reported your findings to those  
7 individuals, and perhaps at some point to the entire  
8 Executive Team, how clearly and forcefully did you  
9 present your findings and in particular your concerns?

10 **A.** So there is two answers. I reported it to,  
11 like you say, the Executive Team and myself and Julie  
12 were clear, we had worked out the percentage of how  
13 often Letby appeared during that shift or leading up to  
14 a collapse, so we reported that in that clarity.

15 And -- what was the other one I was going to say?  
16 The other one is I spoke to Ian Harvey independently  
17 before because when we had looked at the collapses,  
18 I don't know if the meeting was the next day or later on  
19 but it might have been the next day, I was concerned and  
20 I went to Ian Harvey and I escalated it to him and said  
21 that this is what we had found. So he and I used the  
22 percentage again of those.

23 So I was as clear as that.

24 **Q.** Can I just ask you two follow-up questions  
25 from that?

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1 A. Yes.  
 2 Q. Was Mr Harvey present at the Executive Team  
 3 meeting approximately a day before when you presented  
 4 your findings?  
 5 A. I think he was around but I couldn't swear to  
 6 it. I couldn't swear to it.  
 7 Q. Okay, was there something in particular that  
 8 led you to go and seek him out for a further meeting  
 9 which was a one-to-one meeting?  
 10 A. So I think I told him, I think we would just  
 11 happen to cross paths and I think we were down in the  
 12 Executive office and that's when I told -- well, no,  
 13 I would seek him out, actually, I went down to tell him  
 14 specifically -- I went down to tell -- I think it was  
 15 just him that was down there so I told him and, you  
 16 know, he said he would check it out as well.  
 17 Q. Would it be fair to describe your concerns as  
 18 quite significant for you to have taken those steps?  
 19 A. Yes.  
 20 Q. It would perhaps have gone in terms of what  
 21 you discovered beyond what in your experience would have  
 22 been coincidence?  
 23 A. I mean, yes, I -- to have a member of staff on  
 24 that percentage of time, and we could look too and say  
 25 she did -- over time she did this that and the other,

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1 Team seem surprised or indeed worried by what you had  
 2 told them about your findings?  
 3 A. I don't recall them being -- saying anything  
 4 that would give me that impression.  
 5 Q. Did they express any concern either for  
 6 the families of the babies who you had looked into or  
 7 indeed babies who were still being cared for on the  
 8 neonatal unit?  
 9 A. I don't recollect anything to do.  
 10 Q. You say in your witness statement, and I won't  
 11 take you to it, because I will read the section that is  
 12 relevant at paragraph 83 that you felt that the  
 13 Executive Team were clear in their minds that the deaths  
 14 were due to poor care and that Letby was not  
 15 deliberately harming babies.  
 16 What led you to that belief?  
 17 A. I will need to look at my statement, is that  
 18 okay?  
 19 Q. Yes, paragraph 83.  
 20 A. So this is where the conversation about the  
 21 grievance procedure and that type of thing. I had  
 22 spoken to Alison about it and I think Karen Rees, that  
 23 might have been the occasion that Karen Rees was with me  
 24 at that point and we had both said and she was adamant  
 25 that she had taken advice and they were to carry on with

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1 but I was still -- and myself and Julie were concerned.  
 2 Q. I believe I caught your answer in terms of  
 3 what Mr Harvey's reaction or response was to what you  
 4 had told him and I believe you said that he had  
 5 indicated to you that he would go and check?  
 6 A. Yes.  
 7 Q. Did he say what he was going to check?  
 8 A. He said he was going to check it, check the  
 9 information and look himself because I think he was  
 10 going to look at some of the notes as well.  
 11 Q. But by this stage, and again I hope  
 12 I understood your evidence correctly, one of the  
 13 purposes of you and Ms Fogarty carrying out the review  
 14 was to check the same sort of process that the  
 15 Consultants had already undertaken?  
 16 A. It was, it was.  
 17 Q. So in other words, this is now a further  
 18 opportunity --  
 19 A. Yes.  
 20 Q. -- that you believed Mr Harvey was looking to  
 21 check that --  
 22 A. Yes.  
 23 Q. -- same information?  
 24 A. Yes.  
 25 Q. Did he or any other member of the Executive

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1 what the course of action they were taking.  
 2 Q. But in particular, what was it about the  
 3 Executives' belief that you felt had effectively  
 4 dismissed the concept of deliberate harm and it could be  
 5 more incompetence in care?  
 6 A. Because I think by then I think if they  
 7 believed that, they would have gone to the police.  
 8 Q. You have told the Inquiry that you were in  
 9 a rather unique position because you had already had  
 10 some experience in a clinical setting where deliberate  
 11 harm had been suspected and the police had been called.  
 12 A. Yes.  
 13 Q. You gave the circumstances in relation to  
 14 that. Was that why you continued on a number of  
 15 occasions to press for the police to be contacted?  
 16 A. Yes. Yes.  
 17 Q. Did you accept that what the Trust had  
 18 indicated they wanted to do, which is carry out their  
 19 investigations first, sufficient not to call the police?  
 20 A. No. I don't accept that.  
 21 Q. Can you elaborate on why not?  
 22 A. Because of the information, because of the  
 23 position I had been in before and that's not the  
 24 information, the police -- they were quite -- came in  
 25 straight away. They didn't want you to do your own

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1 investigation or anything like that.  
 2 **Q.** Who discouraged you from going to the police  
 3 yourself?  
 4 **A.** Well, I would like to -- I just -- I wasn't  
 5 privy to all the information because the Executives  
 6 kept -- and there is stuff that's come to me since that  
 7 I had never seen before. And I -- I reflected on it:  
 8 why didn't I go and I should have gone? However, you  
 9 know, the Exec, the -- the Consultants who were, didn't  
 10 do it, you know, all those type of things so that's what  
 11 stopped me from doing it, to be honest.  
 12 **Q.** Did you know, because either of your  
 13 experience on the previous occasion or just generally in  
 14 everyday life, that you could have contacted the police  
 15 but anonymously?  
 16 **A.** I never even thought about doing it  
 17 anonymously.  
 18 **Q.** That never crossed your mind?  
 19 **A.** No.  
 20 **Q.** In terms of the number of times you raised  
 21 this issue about calling the police and it not being  
 22 accepted, did you feel that there was something wrong  
 23 with the structure or the system within the Trust, that  
 24 effectively didn't listen to concerns --  
 25 **A.** Yes.

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1 court so you should be able to see her behind me, so do  
 2 you recognise her?  
 3 **A.** I don't, no.  
 4 **Q.** Okay. Well, let me assist you with some  
 5 context. Your first meeting with Mother C was in the  
 6 summer of 2016?  
 7 **A.** Okay.  
 8 **Q.** When she became aware of a leak or a potential  
 9 leak of a news story and got in touch with the Trust?  
 10 **A.** Yes.  
 11 **Q.** And came into the hospital and met with you  
 12 and Alison Kelly?  
 13 **A.** Yes.  
 14 **Q.** Now as of the summer of 2016, you have been  
 15 through it already quite a few times with other people  
 16 asking questions, but you had recently completed an  
 17 investigation yourself or a staffing rota analysis  
 18 yourself?  
 19 **A.** Yes.  
 20 **Q.** You had concerns not just about the  
 21 association between Lucy Letby and these collapses, but  
 22 also the nature of these collapses as well, that they  
 23 were occurring in babies who appeared to be stable?  
 24 **A.** Yes.  
 25 **Q.** I want to take you to a quote from your police

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1 **Q.** -- of senior individuals such as yourself?  
 2 **A.** Yes. I -- I just think that they were -- they  
 3 had taken -- I got the impression they had taken advice,  
 4 where from I couldn't say, and that they firmly believed  
 5 they were following what they should have been doing and  
 6 didn't listen either side, you know.  
 7 **Q.** You are clear that you believed or you were  
 8 told that they had taken advice --  
 9 **A.** Yes.  
 10 **Q.** -- specifically about --  
 11 **A.** Yes, yes.  
 12 **MR SHARGHY:** Mrs Williams, thank you so much that  
 13 is all my questions.  
 14 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy.  
 15 Mr Baker.  
 16 Questions by MR BAKER  
 17 **MR BAKER:** Good morning, Mrs Williams.  
 18 **A.** Morning.  
 19 **Q.** My name is Richard Baker, I ask questions on  
 20 behalf of a number of the Families.  
 21 In this context specifically I want to ask you some  
 22 questions about your interactions with the Mother of  
 23 Child C?  
 24 **A.** Okay.  
 25 **Q.** Now, I don't know if you recall, she's in

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1 interview and what you say there it is reflected in the  
 2 evidence you give but there is a bit more detail given  
 3 and you say to the police officer who's questioning you:  
 4 One of the babies was fine during the day, collapsed  
 5 overnight, fine during the day, collapsed overnight?  
 6 **A.** That's right.  
 7 **Q.** Fine during the day, collapsed overnight. And  
 8 the officer says yes. And you say: it was her that was  
 9 on duty --  
 10 **A.** That's right.  
 11 **Q.** -- overnight. The officer says yes. You say:  
 12 and it -- that spooked me. I have to say that spooked  
 13 me?  
 14 **A.** (Nods)  
 15 **Q.** Do you remember saying that or at least that  
 16 sense?  
 17 **A.** Yes. I remember talking to the police and  
 18 telling them that, yes.  
 19 **Q.** Yes. What did you mean by "spooked"?  
 20 **A.** That during the day that the baby seemed very  
 21 stable but then overnight, there was a sudden collapse  
 22 and back again during the day, that's the concern and  
 23 that's the one that I highlighted to Ian Harvey.  
 24 **Q.** Yes and that when Lucy Letby was there, this  
 25 stable baby suddenly deteriorated and when she wasn't

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1 there, it got better?  
 2 **A.** Yes.  
 3 **Q.** Now, you had had conversations with doctors  
 4 who had said: look, we are keeping a bag of feed behind  
 5 from the most recent case.  
 6 **A.** Yes.  
 7 **Q.** You must have known they were keeping that so  
 8 that it could be checked for poisons?  
 9 **A.** It's 10 days after the event but I think  
 10 Letby's name had come up but not in any great detail in  
 11 there and they said oh, they had kept the bag of fluid  
 12 and I thought what -- by this time I think they were,  
 13 you know, suspicions that ...  
 14 So I that's what I thought: what do I do with that?  
 15 So and it was late, so I rang, came home, I rang  
 16 Stephen Cross and he said get Chris Green to remove it  
 17 and store it.  
 18 **Q.** Yes, but you must have known they were keeping  
 19 it because they thought somebody might have tampered  
 20 with it?  
 21 **A.** Yes, that is what but they never said that,  
 22 they never --  
 23 **Q.** No, but that is the obvious inference, isn't  
 24 it?  
 25 **A.** I think with the benefit of hindsight yes, but

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1 **Q.** So that's the context to the discussion with  
 2 Mother C that I will come on to in a second but we are  
 3 going to hear evidence from Dee Appleton-Cairns, who is  
 4 an HR person.  
 5 She says in her witness statement:  
 6 "I know that we discussed communications which were  
 7 being led by Sian Williams. Sian was to compile a list  
 8 of stakeholders to be informed which was noted as  
 9 a priority for the Executives. I recall that the  
 10 parents of the babies who had died were to be included  
 11 on that list of stakeholders."  
 12 So is it correct, first of all, that you compiled  
 13 a list of stakeholders?  
 14 **A.** I do -- I don't -- I don't recall it being  
 15 part of the parents. The stakeholders I would have put  
 16 on that list were the people like NHS England, local  
 17 CCG, that type of thing. I don't recall it being the  
 18 parents on there.  
 19 **Q.** Well, should the parents have been involved at  
 20 the outset?  
 21 **A.** The -- the parents should have been involved  
 22 at the outset, there is little doubt and I was just  
 23 following the instructions of what to do. They should  
 24 have been involved in looking at the -- the inquiry for  
 25 the Royal College, we should have listened to them

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1 they never specifically said that. You can keep pieces  
 2 of kit that are faulty or what have you, you know, we  
 3 have had areas before we investigated something like  
 4 a piece of kit has been faulty so people have kept it  
 5 behind, that type of thing. But I was a bit surprised.  
 6 **Q.** But if we put it into what Stephen Cross said  
 7 to you about foul play --  
 8 **A.** Yes.  
 9 **Q.** -- and we begin to draw all that together?  
 10 **A.** Yes.  
 11 **Q.** You feeling spooked?  
 12 **A.** Yes.  
 13 **Q.** Doctors keeping feed bags, Stephen Cross  
 14 talking about foul play?  
 15 **A.** Yes.  
 16 **Q.** Bringing all that together, then the suspicion  
 17 that was being voiced was that somebody, Lucy Letby,  
 18 might be deliberately harming babies?  
 19 **A.** Yes, yes.  
 20 **Q.** Yes.  
 21 **A.** Coupled with what the Consultants were saying  
 22 as well, yes.  
 23 **Q.** Yes. Your view was if that's being raised as  
 24 an issue, it's the police who need to look into it?  
 25 **A.** Yes, absolutely.

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1 because they may have had real relevant information,  
 2 that type of thing. Absolutely.  
 3 **Q.** Well, that is a very important point the  
 4 relevant information because it has been spoken about in  
 5 terms of compassion, sort of keeping people informed,  
 6 but actually parents might have really relevant  
 7 information?  
 8 **A.** I -- I -- I lost count of the amount of times  
 9 I have dealt with patients and families who have not  
 10 been happy with the care and we have involved them and  
 11 I am unsure as to why the Executives didn't want to do  
 12 that in this case.  
 13 **Q.** The facts of this case, we know that Mother E,  
 14 if somebody had spoken with her, she would have  
 15 described having an interaction with Lucy Letby and that  
 16 would have suggested that Letby had falsified the notes?  
 17 **A.** Yes.  
 18 **Q.** So that would have been a really important  
 19 piece of information?  
 20 **A.** Without a doubt.  
 21 **Q.** Yes.  
 22 So coming on to your meeting, your first meeting  
 23 with Mother C. This occurs in -- it is in the summer,  
 24 June or July of 2016. So that is when we find out an  
 25 article in the Chester Chronical newspaper about an

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1 investigation.

2 So this meeting occurs shortly after then and it's  
3 with you and Alison Kelly and you were sat in a room  
4 with her and you both advised her that their child,  
5 Child C, was part of the investigation. You have  
6 already been asked about contacting them and how easy it  
7 would have been to contact Mother C, so I won't repeat  
8 that.

9 But Mother C recalls that:

10 "They advised me that the investigation was just  
11 a formality to check staffing levels because there had  
12 been a small increase in the number of deaths but they  
13 didn't think it was significant. They said there was  
14 nothing more to say at that stage and they would find  
15 out more when the report was done."

16 Now, at that time, you knew; in fact you had your  
17 own suspicions, perhaps?

18 A. (Nods)

19 Q. You sat in a room and either said that or  
20 allowed that to be said?

21 A. Allowed it to be said is what I would probably  
22 say.

23 Q. It was untrue, wasn't it?

24 A. It wasn't as clear as it should have been,  
25 I think it should have involved --

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1 your evidence is you were told you couldn't say any  
2 more?

3 A. Yes, I don't see I don't specifically recall  
4 the meeting, so I can't recall what the mum said.

5 Q. There might have been a number of these  
6 meetings but you must recall sitting in meetings with  
7 parents and having to bite your tongue about what you  
8 could and couldn't say?

9 A. I don't recall it, that's the sad bit in all  
10 of this. I wish I could.

11 Q. I mean, you must have a recollection, though,  
12 of being part of a cover-up at this point?

13 A. I recollect when I have looked at some of the  
14 notes -- some of the notes in the parents' things are  
15 not my handwriting. I can see where I have gone in  
16 afterwards, that type of thing and contacted them or had  
17 to because we couldn't do it the first time or there had  
18 been further contact. So ...

19 Q. I know, I can see from the notes that you were  
20 contacting parents, but your own personal view is that  
21 the police should be called?

22 A. Yes.

23 Q. You were communicating with people who --  
24 parents who will say that it was said to them that there  
25 was nothing significant going on. You must have had

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1 Q. No, I will go further than that.

2 You knew that there was a real suspicion that  
3 a nurse had murdered their baby and that your own view  
4 was that the police should be called. It's misleading,  
5 isn't it, not to keep a parent informed if that's a real  
6 concern?

7 A. Yes.

8 Q. So you must have bit your lip, mustn't you?

9 A. It wasn't a -- I don't remember the meeting  
10 but it's not a place I would, you know, want -- want to  
11 be -- we were told what we could and couldn't say, that  
12 type of thing.

13 Q. So I think that's an important point. You  
14 were told what you could and couldn't say.

15 A. Because the inquiry hadn't completed yet, the  
16 Executive Team was still probably of the opinion that it  
17 wasn't foul play, that type of thing.

18 Q. What was being said to Mother C wasn't; there  
19 are suspicions but there's going to be an inquiry and we  
20 can't prejudge that inquiry. What was said to her, if  
21 her words are accepted is that there was -- nobody  
22 thought anything significant was going on, there was  
23 just a small spike in the number of deaths that needed  
24 to be investigated.

25 Now, I appreciate your evidence is that you were --

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1 a sense of being part of a cover-up?

2 A. I was uncomfortable with the whole thing and  
3 that's why I kept going back to the: why don't you bring  
4 the police in?

5 Q. I mean, if it's accepted that those words were  
6 said by you or in your presence to Mother C, in the  
7 summer of 2016, is there anything that you would want to  
8 say to her?

9 A. How desperately, desperately sorry I am for  
10 the lack of communication, for the whole situation, that  
11 on reflection how much it could have been so different.

12 Q. You see, I'm sorry to keep picking you up on  
13 this, but lack of communication is the sort of thing  
14 that is said in an entirely different context. This is  
15 parents who are being misled. And there was a further  
16 meeting in January 2017, when you first of all called  
17 Mother C while she was on holiday, do you remember  
18 calling Mother C while she was on holiday?

19 A. I vaguely do remember, I think, and there was  
20 a conversation about picking the report up, if  
21 I remember right.

22 Q. She made arrangements to pick the report up,  
23 she asked you if it could be emailed to her but you said  
24 it couldn't be emailed, it could be posted, do you  
25 accept that that's what would have been said?

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1 A. I can't recall it but I am not disputing it,  
 2 no.  
 3 Q. Is one of the reasons why it couldn't be  
 4 emailed that it might be easily disseminated beyond the  
 5 parents if it was sent by email --  
 6 A. No.  
 7 Q. -- were the Trust concerned about that?  
 8 A. That wouldn't cross my mind, I don't know why  
 9 it wasn't emailed.  
 10 Q. Do you remember having a meeting with Mother C  
 11 on 6 February 2017, where, again, it was suggested that  
 12 there is a report but again some babies would need  
 13 further investigation, but that Child C was probably not  
 14 one of them?  
 15 A. I don't -- I don't recall that, no.  
 16 MR BAKER: Thank you, my Lady, I have no more  
 17 questions.  
 18 LADY JUSTICE THIRLWALL: Thank you very much  
 19 indeed, Mr Baker.  
 20 MS LANGDALE: My Lady, one question arising if  
 21 I may?  
 22 LADY JUSTICE THIRLWALL: Yes, certainly.  
 23 Further questions by MS LANGDALE  
 24 MS LANGDALE: Mrs Williams, you said to Mr Baker  
 25 that I was uncomfortable with the whole thing.

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1 Lorraine Burnett and I hand over to Ms Brown who will be  
 2 taking her evidence and I think she is ready to start,  
 3 or will be in a moment.  
 4 LADY JUSTICE THIRLWALL: Thank you very much. We  
 5 will let this witness leave the witness box. (Pause)  
 6 MS BROWN: If we could call Lorraine Burnett,  
 7 please.  
 8 LADY JUSTICE THIRLWALL: Ms Burnett, if you come  
 9 forward, please, you will be sworn.  
 10 MS LORRAINE BURNETT (affirmed)  
 11 Questions by MS BROWN  
 12 LADY JUSTICE THIRLWALL: Do sit down.  
 13 MS BROWN: Thank you, can you please state your  
 14 full name.  
 15 A. Lorraine Burnett.  
 16 Q. You provided a witness statement to the  
 17 Inquiry dated 28 June 2024 and is that statement true to  
 18 the best of your knowledge and belief?  
 19 A. It is, yes.  
 20 Q. In terms of your qualifications you qualified  
 21 as a nurse in 1990 and worked as a staff nurse at  
 22 Manchester University NHS Foundation Trust in the  
 23 children's hospital; is that correct?  
 24 A. That's correct.  
 25 Q. I think you continued to work as a nurse for

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1 Can you expand on that?  
 2 A. Well, throughout with the whole, the not  
 3 having the police involved, that's ...  
 4 Q. And not telling the truth, the full truth?  
 5 A. Well, not telling giving them the information  
 6 that we had so far. Yes.  
 7 Q. Was there ever a conversation in those terms  
 8 in the way they have just been put to you with the  
 9 Executives about: we are not telling the truth, we are  
 10 concealing this?  
 11 A. No.  
 12 Q. But that is what you felt uncomfortable with  
 13 that that's what was happening?  
 14 A. Yes.  
 15 Q. Yes, sorry, you nod. We don't pick that up on  
 16 the transcript but yes, that is what you were  
 17 uncomfortable with?  
 18 A. Yes, sorry, yes.  
 19 MS LANGDALE: I understand. Thank you. I have no  
 20 further questions  
 21 LADY JUSTICE THIRLWALL: Thank you very much.  
 22 Mrs Williams, I don't have any further questions  
 23 for you either, so thank you for coming and you are free  
 24 to go.  
 25 MS LANGDALE: My Lady, the next witness is

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1 approximately 10 years?  
 2 A. Yes.  
 3 Q. Did you ever work as a neonatal nurse during  
 4 that period?  
 5 A. No.  
 6 Q. You then decided to move to a management role,  
 7 you obtained a Bachelor's of Science in Child Health and  
 8 then a Master's in Health Service Management in 2010?  
 9 A. Yes.  
 10 Q. Turning to your employment at the Countess of  
 11 Chester, you started employment in March 2013 as the  
 12 Divisional Director for Urgent Care?  
 13 A. Yes.  
 14 Q. At that time, the neonatal unit was part of  
 15 Urgent Care and that fell within your remit?  
 16 A. Yes.  
 17 Q. You continued in your role as Divisional  
 18 Director for Urgent Care until September 2015 when  
 19 Karen Townsend took over the role. Do you recall, was  
 20 that the beginning or the end of September?  
 21 A. My recollection would be the beginning of  
 22 September.  
 23 Q. And you then moved to a temporary role to  
 24 support winter and emergency care plans but by the end  
 25 of January/early February 2016, you had been promoted to

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1 an Executive role?  
 2 **A.** Yes.  
 3 **Q.** And that role was Interim Director of  
 4 Operations, which became permanent in May 2016?  
 5 **A.** Yes.  
 6 **Q.** And I think there was a title change in  
 7 April 2017, to Chief Operating Officer?  
 8 **A.** Yes.  
 9 **Q.** But that role, the role of Interim Director,  
 10 then actual Director and Chief Operating Officer,  
 11 although we have got three titles, that was in effect  
 12 the same role; is that correct?  
 13 **A.** Yes, a slight change in portfolios, things  
 14 I was responsible for, but yes, generally the same role.  
 15 **Q.** So just to recap. Up until September 2015,  
 16 you were the Divisional Director of Urgent Care which  
 17 included the neonatal unit?  
 18 **A.** Yes.  
 19 **Q.** In terms of the matters that this Inquiry is  
 20 considering specifically that meant you were Divisional  
 21 Director at the time of the deaths of Child A, Child C,  
 22 Child D, Child E and the collapses of Child B and the  
 23 deterioration of Child F?  
 24 **A.** I am unsure, but if that was what's in the  
 25 documents then yes.

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1 than reporting to me.  
 2 **Q.** Sorry?  
 3 **A.** It is more that we were both -- we were  
 4 colleagues rather than him reporting directly to me.  
 5 **Q.** Then the Head of Nursing, Jane Evans initially  
 6 and then that became Karen Rees?  
 7 **A.** That's correct.  
 8 **Q.** Just there when you say colleagues, is it  
 9 correct that the Head of Nursing and the Medical  
 10 Director both had a reporting structure, professional  
 11 reporting structure to their Director of Nursing and the  
 12 Medical Director of the hospital but they also reported  
 13 to you as Divisional Director?  
 14 **A.** Yes. There was two reporting lines, a  
 15 professional reporting line and a day-to-day reporting  
 16 line.  
 17 **Q.** For the day-to-day reporting line they  
 18 reported to you as Divisional Director but they also  
 19 reported out, so to speak, to Director of Nursing and --  
 20 **A.** At that time until it changed in -- I think we  
 21 changed it -- it's in my statement but I think it is  
 22 2018 that the structure was changed.  
 23 **Q.** But the time we are looking at --  
 24 **A.** At the time, yes.  
 25 **Q.** -- that was the position.

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1 **Q.** Well, those events occurred between --  
 2 **A.** If those events took place before I moved  
 3 roles, then yes.  
 4 **Q.** Before the beginning of September.  
 5 From the end then of January 2016/beginning of  
 6 February you were promoted to the Executive Team and  
 7 that was the most senior tier of managers in the  
 8 hospital?  
 9 **A.** Yes.  
 10 **Q.** You remained part of the Executive Team until  
 11 you left the Countess of Chester in December 2019?  
 12 **A.** Yes.  
 13 **Q.** What is your current role?  
 14 **A.** I am Chief Operating Officer at Barnsley  
 15 Hospital.  
 16 **Q.** So is that a role of equivalent seniority or  
 17 is that a promotion relative to Countess of Chester?  
 18 **A.** It is equivalent to the role I was doing in  
 19 2019 in Chester.  
 20 **Q.** So turning first to the period when you were  
 21 Divisional Director of Urgent Care and just looking at  
 22 the structure first of all, you were the Divisional  
 23 Director and reporting to you was the Medical Director  
 24 of Urgent Care, who was Dr Sedgwick, I think?  
 25 **A.** It was Dr Sedgwick, we were more colleagues

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1 Looking just at the culture, you were in post as  
 2 a Divisional Director for two and a half years  
 3 approximately. How did you consider the relationships  
 4 between nurses and doctors within the hospital?  
 5 **A.** I felt that they -- we were a single team,  
 6 people worked together as a team and people tended to  
 7 group themselves in their particular specialty or the  
 8 area that they worked. But doctors and nurses within  
 9 that area would be focused on what they were delivering  
 10 for their patients and worked together as a team.  
 11 **Q.** Specifically obviously we are concerned with  
 12 the neonatal unit. Did you perceive doctors and nurses  
 13 working well together within that unit?  
 14 **A.** Yes.  
 15 **Q.** How often would you have visited the unit as  
 16 the Divisional Director approximately?  
 17 **A.** It's hard to say now looking back, but it  
 18 would be something maybe every few months.  
 19 **Q.** We are aware that at this time neonatal was in  
 20 Urgent Care and obstetrics were in Planned Care. How  
 21 did you view the working relationships between  
 22 obstetrics and the neonatal unit or between the  
 23 maternity ward and the neonatal unit?  
 24 **A.** I wasn't aware of any problems.  
 25 **Q.** So that is at management level you weren't

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1 aware of any problems?

2 **A.** No, at management level I wasn't aware of any  
3 problems and nothing was ever told to me that there were  
4 any concerns.

5 **Q.** More at ground level in terms of relationships  
6 between midwives on the maternity ward and nurses and  
7 doctors on the neonatal unit, was that something you  
8 were aware of any -- there being any problems?

9 **A.** I wasn't aware there were any problems.

10 **Q.** Turning now then to Child A, Child C and  
11 Child D specifically. You were the Divisional Director  
12 when these children died and they died, we know, within  
13 a two-week period in June 2015 and you say in your  
14 statement that the then Head of Nursing for Urgent Care,  
15 Jane Evans, informed you of the deaths.

16 Can you just explain how that took place in  
17 practice, how did you come to know in practice?

18 **A.** Yes. So myself and Jane Evans and later  
19 Karen Rees were in the habit of meeting up around about  
20 8 o'clock so at the start of the day so it was  
21 an informal meeting over a cup of coffee, what happened  
22 yesterday, any challenges we have got at the start of  
23 the day and what we -- what our focus was going to be.

24 So in regards to those three deaths, I was told  
25 I think it was probably the following day by Jane Evans

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1 **Q.** So there was a system, was there, for  
2 informing you as Divisional Director of when there were  
3 deaths within your unit?

4 **A.** Not particularly deaths. There were processes  
5 in place for informing me when there are had been any  
6 indents or any concerns.

7 **Q.** Was that a concern to you, that there wasn't  
8 a formal system so that you were always aware of any  
9 increase in mortality rates in any formal system?

10 **A.** In my role as Divisional Director it wasn't  
11 something that concerned me in terms of having a formal  
12 route to know about the increased mortality. My  
13 assumption at that time is that that is something that  
14 would be escalated through the nursing and the medical  
15 route through the professional leads.

16 **Q.** After you had heard obviously in rapid  
17 succession by the time you heard of the third death in  
18 the neonatal unit, presumably that was pretty shocking  
19 and had never happened before in your career at the  
20 Countess of Chester?

21 **A.** It isn't something that I was aware of  
22 happening before. I am not -- I can't recall when there  
23 had been three deaths in such a short space of time.

24 **Q.** What were your immediate concerns after you  
25 had learned of three deaths within a two-week period?

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1 that there had been a death on the neonatal unit, we had  
2 a conversation where I asked was there any learning, is  
3 there anything that we didn't do --

4 **Q.** Just pausing there.

5 **A.** Okay.

6 **Q.** So you were told one death at a time, so to  
7 speak?

8 **A.** Yes.

9 **Q.** Yes, carry on?

10 **A.** So then after each death, so each time I was  
11 told of a death, I asked, you know, was there anything  
12 from that death that was of a concern. Then I would ask  
13 how were the family and had we put support in place and  
14 how were staff and had we put adequate support in place  
15 for those members of staff.

16 **Q.** Just pausing there for a moment. You said  
17 this was an informal update over coffee in the morning.

18 Had it not been for that update, was there any  
19 other means by which you as Divisional Director would  
20 have been informed of this increase in mortality of  
21 these deaths?

22 **A.** We -- we had regular more formal updates  
23 around what was happening in the hospital on a daily  
24 basis so I would have been informed, possibly later than  
25 I was.

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1 **A.** I think my concerns were after each death and  
2 I asked if -- if anything needed to happen. At each  
3 time I was assured that no concerns had been raised and  
4 I think by the third death it was well, we are just  
5 having a bad run and there's -- and there is no concerns  
6 that there has been three deaths in a short space of  
7 time.

8 **Q.** Well, you were the Divisional Director?

9 **A.** Mm-hm.

10 **Q.** You have got three deaths within a short  
11 period, something that had never happened before. Was  
12 it acceptable that you just accepted: we are having  
13 a bad run? Did you not consider -- what did you  
14 consider your role and responsibility was as the  
15 Director of Division once you had been informed of three  
16 deaths within two weeks?

17 **A.** Well, I'm not sure. I don't know whether it  
18 had ever happened before. I wasn't aware. It hadn't  
19 happened while I was there, but that was -- I would have  
20 only been there for a short period of time and it hadn't  
21 happened in that -- since 2013.

22 But I was assured by my Head of Nursing that the  
23 clinicians had looked at the deaths, they had no  
24 concerns and that the relevant processes were in place  
25 and each death would be further looked at through the

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1 mortality review and then they would come back to me if  
2 there was anything that came out of there that I needed  
3 to be aware of.

4 **Q.** Just to return to the question, though.

5 What did you consider your role was as Divisional  
6 Director having heard of the three deaths? Did you  
7 consider there was a role for you as Divisional  
8 Director?

9 **A.** Not a particular role. I felt there was  
10 a role for the Head of Nursing and the clinical lead in  
11 paediatrics and the lead for neonates and that it was  
12 a clinical concern; there would be a clinical review.

13 If there was anything relating to the management of  
14 the unit, that would be brought to my attention later  
15 once an initial investigation had been completed.

16 **Q.** You say in paragraph 25 of your statement:

17 "Jane also assured me the deaths were going through  
18 the internal governance process and that if anything of  
19 concern came out of those reviews it would be escalated  
20 to me ..."

21 What internal governance process did you understand  
22 the deaths were going through?

23 **A.** My understanding was that there was  
24 a Women's and Children's governance process where they  
25 reviewed any deaths or incidents in the unit.

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1 skills to do that.

2 **Q.** Did it occur to you to go to speak to  
3 Dr Brearey, to simply walk to the unit and ask him about  
4 whether he had any concerns?

5 **A.** No because it -- it was being picked up and  
6 followed by my Head of Nursing.

7 **Q.** Because you say you were being assured there  
8 were no concerns. But, in fact, the doctors involved in  
9 fact considered these deaths to be unexplained and  
10 unexpected. Was that communicated to you?

11 **A.** No.

12 **Q.** The fact of three babies dying within  
13 two weeks was obviously a concern to you?

14 **A.** Yes.

15 **Q.** You recognised, did you, that it was something  
16 that needed to be addressed and kept under review?

17 **A.** I recognised that it was unusual.

18 **Q.** And that it needed to be kept under review?

19 **A.** And that the people in charge of the neonatal  
20 unit, so the clinical lead and the nurse manager, needed  
21 to understand if there was any concerns from those three  
22 deaths.

23 **Q.** Was that not something that you also needed to  
24 understand?

25 **A.** I was assured that the process we had in place

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1 So I had -- I was -- had the assumption that all of  
2 those deaths would go through that meeting and would be  
3 reviewed and that if there was any concerns that those  
4 would then be raised further through the risk management  
5 team and through routes that were then managed by the  
6 Director of Nursing or the Medical Director.

7 **Q.** And did you make any proactive moves to  
8 enquire what had happened with those reviews that you  
9 thought were going on? Did you say: I need to be kept  
10 informed. Can I have an update next week", for example?

11 **A.** Not that I recall, but it was -- it's a very  
12 busy job with a lot of responsibilities outside of areas  
13 other than the neonatal unit.

14 **Q.** Well, obviously a very busy job.

15 But this, this has to be at the highest level of  
16 severity of anything that could have crossed your desk  
17 with three deaths in the neonatal unit.

18 Did you not think, as the Divisional Director, you  
19 needed to make sure you were informed about what  
20 investigations were going on and what the result of  
21 those investigations were?

22 **A.** As the Divisional Director, I felt that I had  
23 confidence in my Head of Nursing and my Divisional  
24 Medical Director that they would pick those up and move  
25 take them forward. They had the knowledge and the

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1 in terms of incident reporting, the business and  
2 governance meetings that if there was anything that came  
3 out of there that I needed to be aware of and take  
4 forward that that would be escalated to me.

5 **Q.** You said that it was a concern, it needed to  
6 be something kept under review. Setting aside colours,  
7 numbers, risk ratings, in essence, that's a Risk  
8 Register, isn't it, a list of concerns and an  
9 acknowledgement that that needs to be kept under review?

10 **A.** The Risk Register is -- there are risks that  
11 are reported, there are incidents that are reported,  
12 things that can't be managed or mitigated may find  
13 themselves on to the Risk Management Register and that's  
14 where you are aware of incidents that could occur and  
15 you would manage that.

16 **Q.** Because you have got a concern here, it's  
17 something that needs to be reviewed and it's not  
18 appearing on the urgent care Risk Register. Why is  
19 that?

20 **A.** I was concerned that there had been three  
21 deaths. I was told that each of those deaths had --  
22 were -- had a cause, that there was no concerns about  
23 any of those deaths. It was just --

24 **Q.** Well, just pausing there for a moment.

25 So this was an informal meeting over coffee --

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1 A. Yes.  
 2 Q. -- with Jane Evans?  
 3 A. Yes.  
 4 Q. And is that the extent of the information that  
 5 was given to you about these deaths? You say you were  
 6 assured?  
 7 A. Yes.  
 8 Q. Did you not think that something more was  
 9 needed to reassure yourselves rather than Jane Evans,  
 10 the day after the death, at which point there would have  
 11 been no postmortem, probably no debrief and certainly no  
 12 neonatal mortality review at that point; was that  
 13 sufficient that over coffee the nurse was saying: There  
 14 are no concerns about this death?  
 15 A. At that point, it was. And then there were  
 16 regular business and governance meetings in the  
 17 Women's and Children's division where those things were  
 18 discussed and they were discussed with the people with  
 19 better skills and knowledge than me, so those clinical  
 20 skills, to understand whether there was any concerns.  
 21 For me as Divisional Director in my role it was  
 22 more about the business and the oversight of the -- of  
 23 the division. I don't think I would have had the skills  
 24 to be able to understand what had happened in that  
 25 neonatal unit.

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1 Q. So a concern about increased mortality is not  
 2 something that you considered to be put on the Risk  
 3 Register?  
 4 A. I think it's something that could be put on  
 5 the Risk Register. It didn't need to be me that put  
 6 things on the Risk Register and actually, as  
 7 a Divisional Director, it would be unlikely that you  
 8 would. You would see what went on there, but other  
 9 people would escalate that up.  
 10 Q. Karen Townsend, who obviously succeeded you in  
 11 the role, her evidence was that she would review all  
 12 risks on the Risk Register for Urgent Care. Is that  
 13 something that you would do?  
 14 A. Yes.  
 15 Q. And so you were aware, were you, that the  
 16 increased mortality rate that you were aware of was not  
 17 on that Risk Register?  
 18 A. I wasn't informed there was an increased  
 19 mortality. I was informed there had been three deaths,  
 20 that that was unusual in a short space of time, but  
 21 there had not been a lot of deaths previous to that.  
 22 So I wasn't -- it was never classified to me as  
 23 an increased mortality rate.  
 24 Q. Was that not something you thought you ought  
 25 to find out about as Divisional Director?

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1 Q. And you say you had an oversight role. What  
 2 was the oversight here that you were conducting?  
 3 A. So performance targets, finance.  
 4 Q. Sorry, the oversight of this incident -- of  
 5 these incidents, these deaths?  
 6 A. Of these incidents, so the oversight of these  
 7 incidents. I think it was more I was informed so I was  
 8 aware it had happened.  
 9 The oversight was through the medical, the medical  
 10 and the nursing teams and the infrastructure that was in  
 11 place that went through from the neonatal unit to the  
 12 Women's and Children's division, then up through the  
 13 quality and safety meetings that went through medical  
 14 and nursing.  
 15 Q. We will come to that in a moment.  
 16 But in terms we are discussing as well the Risk  
 17 Register, just to understand why it was that these  
 18 deaths and the concerns about the increased mortality  
 19 were not put on the Risk Register.  
 20 A. You wouldn't put deaths on a Risk Register.  
 21 In a Risk Register would be things such as there was  
 22 a leak in the roof, we can't fix it and therefore there  
 23 is a concern that the environment may not be conducive  
 24 or there -- so they were risks around what might happen,  
 25 not things that actually happened.

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1 A. No, because mortality and management of  
 2 mortality sits within nursing and medical within the  
 3 clinical skill set and, therefore, they would be aware  
 4 of an increased mortality.  
 5 I -- I wasn't in a position to understand the  
 6 difference between a cluster of deaths and those  
 7 happening because, you know, there'd been a number of  
 8 sick people or whether that was unusual. And at the  
 9 time I was told that -- I was never told there had been  
 10 an increase in mortality.  
 11 Q. If it had been put on the Risk Register that  
 12 there were concerns about an increased mortality, what  
 13 difference would that have made?  
 14 A. If a risk is put on the Risk Register then you  
 15 would categorise what the -- the size of that risk and  
 16 you would put actions in place to mitigate it. So you  
 17 would try and reduce the risk to the minimum level.  
 18 Q. One of the results as well presumably would  
 19 have been that when Karen Townsend took over she would  
 20 have been aware that there was a concern about deaths on  
 21 the neonatal unit?  
 22 A. Yes.  
 23 Q. And when you briefed her -- or was there  
 24 a handover period with Karen Townsend?  
 25 A. There wasn't a formal handover because Karen

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1 had been my deputy, so she was aware of what was  
 2 happening in the division before we had a handover  
 3 formally.  
 4 **Q.** Did you brief Karen Townsend about your  
 5 concerns about these three deaths?  
 6 **A.** Not formal because as I was told about the  
 7 deaths from Jane Evans, then that was cascaded. So  
 8 Karen would have been aware, as my deputy, that there  
 9 had been a death in the neonatal unit.  
 10 **Q.** Well, Ms Townsend's evidence was that she  
 11 wasn't aware. How -- just be clear here. How do you  
 12 say she would have been aware? You didn't inform her.  
 13 **A.** I don't remember informing her directly, but  
 14 it was known in the division that there had been three  
 15 deaths. So we were all aware that there had been three  
 16 deaths in that month and the service manager definitely  
 17 was aware.  
 18 **Q.** The case of Beverley Allitt, is that something  
 19 that you were aware of? Was it covered in your Master's  
 20 in Health Service Management for example?  
 21 **A.** Beverley -- I know about Beverley Allitt  
 22 because that case was in the early '90s as I qualified  
 23 as a paediatric nurse.  
 24 **Q.** And Recommendation 13 of the Clothier Inquiry  
 25 into Beverley Allitt was that:

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1 coffee with Jane Evans who wasn't involved directly in  
 2 these incidents.  
 3 So how could you satisfy yourself that there was no  
 4 linking factor between these deaths that was a concern  
 5 that you ought to be investigating?  
 6 **A.** The -- the division of Urgent Care is quite a  
 7 complex and large division. We had layers of -- we had  
 8 a hierarchy and we had layers of management and  
 9 clinicians in there that would manage things to  
 10 a separate level.  
 11 So for me I had a senior manager who liaised  
 12 directly with the unit, with the neonatal unit, with the  
 13 clinicians, who was involved in their regular business  
 14 meetings. I then met with them on a monthly basis where  
 15 they escalated to me if anything had come out of there  
 16 that was out of the ordinary or of concern. And at no  
 17 point was it ever escalated to me that there had been  
 18 unexplained deaths.  
 19 So I was assured by the meeting with Jane Evans  
 20 where she told me that the clinicians had looked at the  
 21 deaths and they had no concerns and --  
 22 **Q.** Sorry. Just stopping you there. The  
 23 clinicians had looked at the deaths. This was the  
 24 morning after the deaths.  
 25 **A.** It was the morning after. But they -- they

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1 "Beverley Allitt's actions should serve to heighten  
 2 awareness in all those caring for children of the  
 3 possibility of malevolent intervention as a cause of  
 4 unexplained clinical events."  
 5 Now, I'm not suggesting you would probably be aware  
 6 of the exact wording or the number of the  
 7 recommendation. But as someone working in hospital  
 8 management and with a qualification in that, were you  
 9 aware of the possibility of deliberate harm as a cause  
 10 of unexplained clinical events?  
 11 **A.** I am aware that this happens, even if it's  
 12 a very rare occurrence, but I wasn't told that any of  
 13 the deaths were unexplained.  
 14 **Q.** But your mind was open to the possibility --  
 15 **A.** Yes.  
 16 **Q.** -- that if you had three deaths in close  
 17 succession that that was one of the things that had to  
 18 be considered?  
 19 **A.** If -- if a clinical -- if a clinician had told  
 20 me there had been three deaths and they were unexplained  
 21 then, yes, that would have been something that I was  
 22 open to.  
 23 **Q.** But, Ms Burnett, you didn't talk to any  
 24 clinicians to find out whether these deaths were  
 25 unexpected or unexplained. You just had a briefing over

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1 were able to give assurance to Jane and the matron or  
 2 the Head of Nursing for paediatrics that they didn't  
 3 have any concerns, but that they would look again at the  
 4 deaths and there would be a better, a more in-depth  
 5 review.  
 6 **Q.** And who did you understand was the clinician  
 7 who was assuring Jane Evans?  
 8 **A.** I don't know exactly, but I would -- my  
 9 assumption was that Steve Brearley(*sic*) as the lead for  
 10 neonatal unit was involved in those conversations.  
 11 **Q.** If we just look at paragraph 26 of your  
 12 statement. You say:  
 13 "The Trust's governance structure was set up  
 14 to provide appropriate avenues for any concerns to be  
 15 reported."  
 16 And you go through in that statement and you go  
 17 through Serious Incident reporting, where there was  
 18 a risk that going on to the Risk Register, that being  
 19 escalated to QSPEC and then in turn any issue raised  
 20 with the Executive Directors group.  
 21 Well, in this case of course we know that that fell  
 22 at the first hurdle in the case of Child A, Child C and  
 23 Child D because it was decided that there was no further  
 24 investigation of commonality between their deaths.  
 25 **A.** (Nods)

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1 Q. Ruth Millward's statement to the Inquiry  
2 accepted that the failure to conduct a full  
3 investigation of that cluster of deaths was a missed  
4 opportunity. Do you agree with that?  
5 A. In hindsight, yes.  
6 Q. Looking back now, do you consider that as  
7 Divisional Director you should have made sure that you  
8 were informed and satisfied yourself that sufficient  
9 investigation had taken place of those three deaths?  
10 A. No. I don't think that is the role, the  
11 overall role of Divisional Director. That was why there  
12 was a Divisional Medical Director and a Head of Nursing  
13 who covered off the clinical aspect of the division.  
14 Q. Turning to Child E, were you informed of the  
15 death of Child E? Child E died on 4 August?  
16 A. Not to my knowledge. Not -- but, again, it  
17 was a long time ago. I don't recollect that.  
18 Q. So you have explained, I think by then it may  
19 have been Karen Rees who had taken over the role, that  
20 you had the informal meetings with Jane before that.  
21 Was there no other -- you said before that there  
22 was a mechanism whereby you would be informed of deaths.  
23 Did that not happen in the case of Child E?  
24 A. I can't recollect. I think that the reason  
25 that the three deaths stood -- stuck in my mind and  
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1 because that could cause you to reconsider the issue of  
2 commonality between the deaths?  
3 A. I was aware that the right people were aware  
4 there had been three deaths. So the clinicians were  
5 aware and they were on the -- they were keeping  
6 a heightened awareness that there had been more deaths.  
7 That was enough to assure me in a non-clinical role that  
8 the right people were looking at the information.  
9 Q. Because Ruth Millward says that the death of  
10 Child E was another missed opportunity to consider in  
11 more detail those deaths. Would you accept that that  
12 was a further missed opportunity?  
13 A. Yes. As I say, I don't recall being informed  
14 of that in August.  
15 MS BROWN: My Lady, I don't know if that would be  
16 a convenient moment because the next section is going to  
17 look at the role of Ms Burnett and the Executive Team.  
18 So I don't know if that would be a convenient moment to  
19 break.  
20 LADY JUSTICE THIRLWALL: Yes, certainly. So we  
21 will break now and we will start again at 5 to 2.  
22 A. Thank you.  
23 (12.55 pm)  
24 (The luncheon adjournment)  
25 (1.57 pm)

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1 being told about them was because it was unusual to have  
2 three deaths in a short space of time.  
3 I don't recollect that anything in, in  
4 the August -- I don't know if I was -- I may have been  
5 on holiday, annual leave, there could have been lots of  
6 reasons why, but the specifics of that do not stick in  
7 my mind.  
8 Q. The unusualness of the three deaths was that  
9 if there was something in common between those deaths --  
10 A. Yes.  
11 Q. -- that was a very serious matter that needed  
12 to be investigated and you recognised that?  
13 A. I recognised that and I asked each time  
14 this -- and on the third death: You know, this is  
15 three. This is a lot. What, what's going on? And  
16 I was again assured that there was no concerns. It was  
17 just unfortunate we'd had three very sick babies in  
18 a short space of time.  
19 Q. Did it also make -- that was the thought  
20 process you had when it got to number 3. Did it also  
21 make you think: I must be very alert to see if there is  
22 another death, which in fact occurred with the death of  
23 Child E?  
24 Were you not very alert to the fact that you needed  
25 to be very aware of whether there was any other death  
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1 LADY JUSTICE THIRLWALL: Sorry to keep you all  
2 waiting. Ms Brown.  
3 MS BROWN: So, Ms Burnett, we are going to turn now  
4 to the period when you were on the Executive Team and  
5 that commenced at the end of January/beginning of  
6 February and that was a team of eight individuals that  
7 included Ian Harvey, Tony Chambers, Alison Kelly,  
8 Stephen Cross, Sue Hodgkinson, Ian -- Debbie O'Neill,  
9 later Mr Holden and yourself; that is correct, is it?  
10 A. Yes, it was a long list.  
11 Q. So there were eight of you and you were the  
12 most senior managers?  
13 A. Yes, and I joined the Executive meetings from  
14 September and then became the Interim Director of  
15 Operations, I think it was it is in here but --  
16 Q. I think you are recorded on a meeting at the  
17 end of January with that title so it would seem from the  
18 end of January 2016 you had the title but you had sat in  
19 on the Executive meetings in fact before then?  
20 A. Yes.  
21 Q. How often approximately did the eight of you,  
22 or the Executive Directors Group, that relatively small  
23 group, how often did you meet?  
24 A. We met weekly. We had a scheduled meeting on  
25 a Wednesday morning.

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1 Q. What was the overarching purpose of those  
2 meetings?

3 A. There was an element of sharing information,  
4 checking in, seeing how things were going but then it  
5 would also serve a step-in where we would hear business  
6 cases and proposals for the hospital. We received  
7 reports et cetera, things of that nature.

8 Q. How would you just briefly describe what your  
9 role was as Director of Operations, what was your  
10 particular remit?

11 A. So my particular remit at that time was around  
12 managing winter, so bed pressures, A&E discharges and  
13 the difficulties we had with discharges working across  
14 with community and Council colleagues.

15 Q. But as you said presumably the weekly meetings  
16 was to try and ensure that most people knew what  
17 everyone was doing, broadly, in a broad fashion?

18 A. Yes, so we shared information, it was also --  
19 it was a gateway where papers would come to that meeting  
20 to be agreed and approved before they went to committees  
21 or to board.

22 Q. At paragraph 20 of your statement, you say:  
23 "From my recollection no one person had a dominant  
24 voice within the EDG [the Executive Directors Group], we  
25 all took turns offering our thoughts and advice

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1 period and over that issue?

2 A. Not particularly. I think there was the  
3 scheduled Executive meeting on a Wednesday where we  
4 would talk about things wider than the neonatal unit.  
5 Then there was significant number of meetings that  
6 were -- every time we would get together we would make  
7 notes of any meetings that we discussed around neonatal  
8 unit and -- and concerns.

9 In a number of cases those would be chaired by  
10 Tony Chambers. So he would introduce why are we meeting  
11 today, what has happened in the last 24/48 hours. But  
12 then there would be elements of Stephen Cross from the  
13 legal perspective, also input from Alison Kelly and  
14 Ian Harvey depending on which elements we were  
15 discussing.

16 Q. So obviously everybody would come in there as  
17 expertise but would you describe even dealing with the  
18 issue of mortality and the issue of Letby, did they  
19 remain collaborative style meetings or was someone then  
20 directing them in a different way?

21 A. No. I mean, they were chaired, they were  
22 chaired and Tony Chambers would in the main chair them,  
23 but I would still think they were collective meetings  
24 where everybody spoke up against their particular  
25 element.

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1 dependent on the topic of discussion and our personal  
2 expertise."

3 So you are describing there a collaborative style  
4 of meeting?

5 A. Yes.

6 Q. One of the areas of expertise that you came  
7 with was that you had previously been Director of Urgent  
8 Care and the neonatal unit, which obviously we are  
9 concerned with here, had been within your area of  
10 responsibility?

11 A. It had. But what I would say is what  
12 I brought to the Executive meetings was my experience in  
13 managing A&E patient flow, bed capacity. The neonatal  
14 unit was a very, very small part of my remit in Urgent  
15 Care.

16 Q. With regard to that comment about no one  
17 person having a dominant voice, obviously we are going  
18 to come to this from the end of June 2016 right up to  
19 the time when the police were involved there were a lot  
20 of meetings of the Executive Directors Group and a lot  
21 of meetings about difficult issues, discussions with  
22 Consultants, issues of downgrading of the unit, dealing  
23 with the concerns about Letby.

24 Did that remain the case, that there was no one  
25 dominant voice or did a dominant voice emerge over that

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1 Q. At paragraph 15 of your statement, you say:  
2 "In my view the structures and processes for the  
3 management and governance of the Trust did not  
4 contribute to the failure to protect babies on the NNU."

5 Just examining that a little bit more. We know  
6 that there were concerns amongst some of the  
7 paediatricians before June 2016?

8 A. Mmm mm.

9 Q. And I think June 2016 we are going to look at  
10 that meeting in a moment, but is it when you say you  
11 first became aware of the concerns about Letby?

12 A. Yes.

13 Q. So we know that there were concerns before  
14 that, certainly by January 2016 when Dr Brearey was  
15 initiating a neonatal review using an external  
16 Consultant, Dr Subhedar, that those concerns were  
17 considerable about the mortality rates?

18 A. Management mm-hm.

19 Q. But that that thematic neonatal review by  
20 Dr Brearey, we know that wasn't raised at the Women and  
21 Children's Care Governance Board until the middle of  
22 June 2016. We know that prior to the end of June 2016,  
23 increased mortality on the neonatal unit wasn't put on  
24 to any Risk Register and we know that it wasn't raised,  
25 the concerns about mortality on the neonatal unit, the

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1 concerns with Consultants didn't reach the Executive  
 2 Team, didn't reach you --  
 3 **A.** (Nods)  
 4 **Q.** -- until the end of June.  
 5 So contrary to what you say at paragraph 15,  
 6 doesn't that in fact indicate there was some failure of  
 7 management and governance and certainly of risk  
 8 management?  
 9 **A.** I think the structures and the processes were  
 10 in place. But as I said in my statement I don't think  
 11 things were reported although structures and processes  
 12 were used as they should have been in, you know, looking  
 13 back what's been said now.  
 14 **Q.** So the system didn't manage to bring the  
 15 concerns up to the Executives?  
 16 **A.** The systems were there. The people involved  
 17 didn't use the systems.  
 18 **Q.** Just looking then at June and July and when  
 19 there were these series of meetings, dealing first with  
 20 29 July, and there was more than one meeting on 29 July,  
 21 you deal with these from paragraph 34 of your statement.  
 22 You attended a meeting just of the Executive  
 23 Directors Group and we don't need to turn to it but we  
 24 can see from a note there that there was reference to  
 25 there being an NNU neonatal update on that day and you

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1 link between her and the deaths that is what was being  
 2 discussed?  
 3 **A.** Yes, so I don't recall exactly when it was  
 4 raised but in the course of those meetings on the 29th,  
 5 we had the conversation about Letby being on duty and  
 6 then the comment was made that she was -- worked  
 7 full-time, that she did extra shifts et cetera.  
 8 **Q.** You say at paragraph 37:  
 9 "The tone of the meeting was very much one of shock  
 10 and concern ..."  
 11 Was the shock there that it was being suggested  
 12 that a member of staff may be involved in harming babies  
 13 which obviously would have been shocking?  
 14 **A.** I think it was a -- it was a combination. So  
 15 it was a shock at the number of deaths that we were  
 16 being informed of, there was shock that that hadn't been  
 17 brought out sooner; and there was a shock that there was  
 18 some concern that somebody was undertaking something  
 19 malicious.  
 20 **Q.** You say there the main focus was being to find  
 21 the cause and I think it goes hand in hand with that to  
 22 find the cause, one of the things that have to be  
 23 investigated was: was that concern about Letby genuine,  
 24 was that a cause, was she a cause of those deaths, that  
 25 was one of the things you would have to investigate to

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1 go on to deal with what was said at that meeting.  
 2 You say -- paragraph 35 this is:  
 3 "Tony confirmed that the Consultants had raised  
 4 concerns regarding increased mortality on the NNU and  
 5 that they felt uneasy about Letby."  
 6 That's the first you are aware of an increase in  
 7 mortality and the concerns of the paediatricians, is it?  
 8 **A.** Yes.  
 9 **Q.** We go on at paragraph 36, you say:  
 10 "There were ... discussions around the fact that  
 11 Letby always seemed to be on duty when deaths occurred,  
 12 however it was also flagged that she worked full-time  
 13 and often picked up extra shifts."  
 14 So the concern here was, it wasn't a conclusion,  
 15 but it was a concern that Letby was involved in some  
 16 ways in those deaths?  
 17 **A.** I don't recall -- excuse me, I don't recall  
 18 the exact conversation. I remember that there was  
 19 concerns raised around the deaths and why they were  
 20 occurring. I remember at some point in the meeting we  
 21 started to talk about Letby, so I make an assumption  
 22 that that had been raised.  
 23 **Q.** Well, you are saying the fact that Letby  
 24 always seemed to be on duty when deaths, so that -- the  
 25 obvious suggestion there is that there was possibly some

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1 find out the cause of the increased mortality?  
 2 **A.** From my perspective it -- everything we did  
 3 was about finding out why and we and keeping an open  
 4 mind as to what that could be from something that was  
 5 very unlikely, to the most likely. But being aware of  
 6 anything.  
 7 **Q.** I think you have accepted already that you  
 8 were aware of Beverley Allitt and were aware that one of  
 9 the possibilities you had to be alert to was a member of  
 10 staff harming -- deliberately harming children?  
 11 **A.** Yes.  
 12 **Q.** You say there:  
 13 "I was shocked by the concerns being raised as  
 14 I was unaware of the increased mortality on the NNU ..."  
 15 At that point did you reflect back on the year  
 16 earlier when you had been informed the three deaths?  
 17 **A.** Not in that particular meeting. It was when  
 18 we heard the information from -- I have forgotten the  
 19 Consultant's name, when they had done the review the  
 20 neonatal unit and they came back with a significant  
 21 number of cases, that was when I put -- realised the  
 22 three deaths in the previous summer.  
 23 **Q.** Then you go on from paragraph 38 to discuss  
 24 the further meeting and then there was a further meeting  
 25 that day at 5.10 pm, when the Consultants also attended.

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1 A. Yes.

2 Q. If we could go to the notes of that meeting,  
3 that is INQ0003371. It's tab 6 in the bundle, my Lady.

4 A. Can you put it up, I haven't got any of the  
5 documents?

6 Q. No, it's going to come on to the screen so you  
7 can see it.

8 LADY JUSTICE THIRLWALL: It will come on to the  
9 screen.

10 MS BROWN: So we see there at the top this is  
11 Wednesday, 29 June 2016 and we see the initials. So  
12 Tony Chambers, Alison Kelly, Ian Harvey, that is Dave  
13 Semple, Steve Brearey, Dr Jayaram, Dr Saladi, your  
14 initials and Stephen Cross who are there?

15 A. Yes.

16 Q. Just picking out a few of those notes. We see  
17 that Dr Brearey four lines down, some PM report but not  
18 all inconclusive, so postmortem reports, some were  
19 inconclusive.

20 Going further down, unexplained collapses. And  
21 then in fact Dr Brearey he does make the connection  
22 between those three earlier deaths. He says: met  
23 July 2015 three cases.

24 That was the Child A, C and D.

25 "Common theme was nurse."

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1 Q. Then if we go on to page 3 there seems to be  
2 a sort of list of concerns, obviously these are just  
3 notes:

4 "Concerns shut unit, Commission review, then police  
5 ..."

6 Or they seem to be listing different orders of  
7 doing things, police and consequences.

8 We see a bit further down there "safety paramount"  
9 and then we see:

10 "Nurse cannot be excluded."

11 Do you recall a discussion there now looking at  
12 that note about suggesting that the nurse couldn't be  
13 excluded, that is a reference to Letby?

14 A. I don't recall that, I recall at the meeting  
15 we were informed that Letby was on leave for two weeks  
16 and therefore we had two weeks to, if you like, get our  
17 thoughts together as to what we should do.

18 Q. Yes. If we can just go back to your statement  
19 then, so that can come down, thank you. Just to be fair  
20 to you, because you also discuss this meeting in your  
21 statement and you say at paragraph 40 that your  
22 recollection in your statement is you recall Tony being  
23 adamant that she could not return to the unit until all  
24 concerns had been resolved.

25 Just fill us out on what your recollection was of

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1 You was that the first that you were aware that  
2 there was a common theme amongst those three deaths A,  
3 C and D that you had been told about by Jane?

4 A. Yes, yes. As I said previously I was told  
5 that they were all unfortunate but not suspicious.

6 Q. Then we see that Dr Jayaram also contributes  
7 to this meeting, he says:

8 "Babies were stable and then deteriorated, why  
9 always this nurse?"

10 Then if we go over the page. Stephen Brearey says  
11 more than -- or the notes say:

12 "More than just an association with this nurse"?

13 A. Mm-hm.

14 Q. Dr Saladi is noted next to his name:

15 "Don't suddenly deteriorate. These babies were  
16 relatively stable, sudden deterioration and collapse."

17 Then next to the initials TC, Tony Chambers:

18 "Why did we call the police?"

19 Then your initials a bit further down, LB:

20 "Unsafe unit agreed."

21 Can you recall what you were saying there?

22 A. I can't and I think that is a paraphrase of  
23 what I was said so I think we were probably discussing  
24 whether the unit was currently safe and what did we need  
25 to do.

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1 what Mr Chambers was saying then?

2 A. My recollection is that the paediatricians  
3 were raising concerns, they were raising concerns about  
4 Letby. Tony Chambers was adamant until we have got to  
5 bottom of this and everybody's agreed that she had no  
6 part to play, then she couldn't go back on the unit and  
7 I recall that being said in a number of meetings.

8 Q. So what you are saying is he was adamant that  
9 until it was decided whether or not she had any  
10 connection with the deaths, she must not be on the unit?

11 A. Yes.

12 Q. This may seem obvious to you but if you could  
13 spell it out: what was the risk that you understood  
14 Mr Chambers to be concerned about?

15 A. I think there was a risk of for her if she  
16 went back on the unit and that was -- that was -- it  
17 hadn't been explained, but the overarching risk for all  
18 of us is that we didn't want any more deaths, we didn't  
19 want any more unexplained collapses.

20 Q. Did you agree with Tony Chambers's adamant  
21 position at that meeting that you were in agreement with  
22 it?

23 A. Yes.

24 Q. At paragraph 41, you say:

25 "I also recall Tony specifically [we have seen this

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1 in the notes] mentioning police involvement ..."

2 We have discussed Beverley Allitt and you have  
3 acknowledged there was a possibility of deliberate harm  
4 here. You go on to say:

5 "I cannot recall that anybody wished for the police  
6 to be called ..."

7 Given that there was a possibility of deliberate  
8 harm, why was it that your recollection is that nobody  
9 wanted the police to be called at that time?

10 **A.** My recollection was that people were open to  
11 there -- to a number of explanations, everybody in the  
12 room, and therefore we needed more information to inform  
13 the next steps.

14 So at that point we needed to understand more about  
15 what was happening, what had -- could happen and then  
16 whether we needed to call the police.

17 **Q.** That's -- your understanding was that was the  
18 tenor of the whole meeting, that there was agreement  
19 that it was that they should not be going to the police  
20 at that stage; is that your recollection?

21 **A.** Yes.

22 **Q.** If you can go down to paragraph 43, you say:  
23 "We talked through all the options available to the  
24 Trust, concerns raised by the Consultants about  
25 increased mortality and something being wrong with

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1 know, people are talking because something was said in  
2 a queue at the coffee shop.

3 **Q.** First of all you discuss that words those  
4 words were inappropriate?

5 **A.** Mmm mm.

6 **Q.** But then you say:

7 "I remember saying that we had now initiated  
8 a process to get to the bottom of [this] issue ..."

9 The "we" there is the Executive Directors Group,  
10 that is the Executive Team, is it?

11 **A.** No I think I included the clinicians and the  
12 Women's and Children's in that statement, because we had  
13 all been in the room and we had agreed our way forward.

14 **Q.** So the "we" there is really the "we" from that  
15 meeting on 29 June, the one where the Consultants were  
16 present too?

17 **A.** Yes, yes.

18 **Q.** You said "we had initiated a process to get to  
19 the bottom of the issue", so we had the reference to the  
20 "angel of death" and "the bottom of the issue" and you  
21 are talking there are you about getting to the bottom of  
22 the issue about whether Letby was or was not responsible  
23 for the deaths?

24 **A.** I was talking about getting to the bottom of  
25 what had happened, to the babies that had died and one

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1 Letby."

2 What do you mean there by "something being wrong  
3 with Letby"?

4 **A.** That was how it was described by Dr Brearey  
5 and Dr Jayaram, they -- they couldn't give an example or  
6 anything that may have happened. But they described it  
7 as she's not right, there's something wrong, things  
8 don't feel right with her.

9 **Q.** But you were clear that when Tony Chambers was  
10 adamant she be removed that was because there was  
11 a concern that she could be harming babies and she had  
12 to be removed from the unit?

13 **A.** I think it was two-fold. One, if she had been  
14 harming babies -- and that was the concern from the  
15 clinicians -- we needed to take a seriously; but two, if  
16 she hadn't and we left her on the unit and anything else  
17 happened we wouldn't have been able to define what had  
18 occurred.

19 **Q.** At paragraph 44 you then say following the  
20 meeting you had a conversation with Dr David Semple who  
21 informed you that medical staff had been overheard using  
22 the phrase "angel of death".

23 First of all, are you aware who those staff were,  
24 were you given names?

25 **A.** No, it was kind of -- the comment was, you

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1 cause could be Letby, so it was the whole thing. Let's  
2 find out, we have initiated a process, we will follow  
3 that process through until we get to the end conclusion.

4 **Q.** But you were clear that one of the things that  
5 had to be sorted out was: was Letby involved in these  
6 deaths or was she not?

7 **A.** Yes, but because I was open to there have been  
8 any -- could be a number of reasons.

9 **Q.** Yes. We then come to the issue of downgrading  
10 of the unit. You say at paragraph 48 you were required  
11 to focus on many responsibilities in your role as Chief  
12 Operating Officer, including the downgrading of the NNU.

13 Can you just explain what your role was in terms of  
14 the downgrading of the unit?

15 **A.** Yes. So following the meetings late  
16 June/early July one of the things we agreed was to  
17 minimise the risk to the neonatal unit going forward  
18 until we knew actually what was happening.

19 So one of those things, and I spoke to Dr Brearey  
20 was in the meeting where we discussed this, was to  
21 reduce the acuity of the babies on the unit. So working  
22 with Dr Brearey and Dr Jayaram, we wrote the protocol  
23 around what the threshold was for babies being in our  
24 unit, I took on the role of linking in with the neonatal  
25 network to inform them that we were moving to not quite

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1 Level 1 but Level 1 unit and also spoke to some of my  
2 colleagues in neighbouring Trusts around the impact that  
3 might have on their unit.

4 **Q.** In that liaison with other hospitals, which  
5 obviously was something that would have to be done, what  
6 reason were you giving and what reason did you  
7 understand for the downgrading of the unit?

8 **A.** The reason that I gave was that we had had  
9 increased mortality, a number of deaths that we didn't  
10 have full explanations for, we were investigating and  
11 until we had an answer for that, we wanted to minimise  
12 any risk to babies on the unit and therefore we were  
13 going from a Level 2 to a Level 1.

14 **Q.** So you were clear that you were downgraded  
15 because of the increase in neonatal deaths and you were  
16 clear that it was unsure why those deaths had happened,  
17 they were unexplained?

18 **A.** Yes, I was clear that the action was being  
19 taken on the grounds of patient safety.

20 **Q.** Did you in any of your communications with the  
21 other hospitals mention the fact that there was  
22 a concern that a staff member may be involved?

23 **A.** No. Not that I recollect.

24 **Q.** In relation to that communication with other  
25 hospitals, what about communication with parents, was

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1 staff, have a look at what was happening on the unit and  
2 come back to us with, with their view in terms of what  
3 they thought might be happening.

4 **Q.** Because we looked before a bit at the comment  
5 of "angel of death" and a phrase you used was "getting  
6 to the bottom of the issue". The RCPCH was not going to  
7 get to the bottom of the issue of whether Letby was  
8 responsible; you understood that, did you?

9 **A.** That -- I think -- what I thought was that the  
10 College review would potentially come to: we do agree  
11 that there are concerns being raised around Letby and  
12 therefore we think, you know, that's what we would say.  
13 And I think that would have then directed the next steps  
14 for us.

15 **Q.** Because I think you accept at paragraph 51 you  
16 say it would have been your practice to read the emails,  
17 you don't recall them specifically now, but in terms of  
18 the Terms of Reference for the RCPCH, there's no mention  
19 of Letby in those Terms of Reference. But your  
20 understanding was, was it your understanding that they  
21 were going to be looking at whether Letby was or was not  
22 involved in these deaths?

23 **A.** My understanding was that they were going to  
24 look at the increased mortality, the unexplained causes  
25 of the deaths and the concerns that were being raised by

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1 that something that came under your responsibility?

2 **A.** No. We -- there was a sheet produced that we  
3 put all the actions on and we put people's names against  
4 them.

5 **Q.** So you didn't get involved --

6 **A.** I wasn't involved in that at all, no.

7 **Q.** -- in discussing that aspect.

8 Just turning to the RCPCH, then. You deal with  
9 this at paragraph 49 and you say it was discussed --  
10 this is paragraph 50 of your statement -- by the  
11 Executive Team as a method of trying to ascertain  
12 an answer to rising mortality on the NNU and address the  
13 concerns raised by the paediatric Consultants.

14 We have looked at what their concerns were, one of  
15 their concerns was that Letby had an involvement in  
16 these deaths. How did you think the RCPCH review was  
17 going to address the concerns about Letby?

18 **A.** So I think at that point it -- the concerns  
19 that were being raised were more generic. So there was  
20 concerns about the number of deaths, there was concerns  
21 that Letby had been around on the unit, there was not --  
22 it wasn't a consolidated view of this is what's been  
23 happening.

24 So my view was that the Royal College would give us  
25 an independent view, would collect information from the

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1 the paediatricians.

2 **Q.** How did you think the issue of whether Letby  
3 was or was not involved in these deaths was going to be  
4 resolved?

5 **A.** I think --

6 **Q.** She was -- you were aware that she had been  
7 taken off the unit?

8 **A.** Yes.

9 **Q.** So you have got a member of staff who has been  
10 taken off the unit because of concerns. Somebody has to  
11 resolve that concern at some point and as a member of  
12 the Executive Team, what was your understanding of how  
13 you were trying to resolve that?

14 **A.** So it all comes back to keeping an open mind  
15 and making sure that we were open to any cause from  
16 Letby to an issue in the unit.

17 So I think, you know, for me, the Royal College  
18 review would have kind of narrowed that scope down  
19 a little bit and allowed us to sort of think what our  
20 next steps might be. So, no, they were never going to  
21 be able to tell us: Letby did X, Y and Z, but they could  
22 have told us: we feel that, you know, that is a likely  
23 route you need to go down or, or not.

24 **Q.** When you appreciated that, if you appreciated  
25 that that at the time that RCPCH were conducting their

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1 review, did you reconsider: at this point we are going  
2 to have to get the police involved, because it's the  
3 police who can conduct an investigation of Letby back in  
4 September when the RCPCH were doing the review?

5 **A.** I think at that point my overriding concern  
6 was to make sure that there was no further deaths on the  
7 unit and that was what I was most concerned about and  
8 then it following the process so that we eliminated or  
9 narrowed the number of reasons why those -- those deaths  
10 had happened.

11 **Q.** Yes. If we could just go to INQ0004327,  
12 I might have given too many zeros there, 0004327, and it  
13 is tab 14, my Lady, in your bundle.

14 This is a meeting that was on 14 July 2016, so  
15 a few weeks after the one where the problems and the  
16 concern about Letby has been brought to your attention.

17 Halfway down there, so it is Thursday 14 July we  
18 see at the top, and we see your initials along with  
19 Tony Chambers, Mr Nichol, Stephen Cross, and the other  
20 initials we have got there at the top. But the middle  
21 of the paragraph is the point I want to come to where it  
22 says under your initials:

23 "Culture and obstets paedts broken plus breakdown  
24 between doctors and nurses".

25 So you told us at the beginning of the evidence  
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1 nurses felt strained, but I wouldn't have said culture  
2 was broken or breakdown between doctors and nurses.

3 **Q.** So insofar as that's a note you don't think  
4 that was something attributable to something that you  
5 said?

6 **A.** I don't think it is something that I said.  
7 I think it's likely a paraphrase of the conversation  
8 that was taking place at the time.

9 **Q.** If we could just take that down, please, and  
10 go to INQ0007197. This is tab 17.

11 Just one point on this document right at the bottom  
12 of that page. Sorry, have I given the wrong number?  
13 0007197. That is the number on there. Sorry, it is  
14 page 132. That is page 1 we have got there and it's  
15 page 132.

16 Right at the bottom of that we just see a reference  
17 to neonatal dashboard:

18 "LB presented the dashboard, the daily record of  
19 key activities and risks, the number of deliveries to be  
20 added to give overall denominator and the [going over  
21 the page] number of Datix incidents. Staffing to be  
22 increased."

23 And so on.

24 Can you just explain what the neonatal dashboard  
25 was, when it was introduced and what it was aimed at  
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1 that when you were the Divisional Director you didn't  
2 perceive there to be any problems between doctors and  
3 nurses and here you are talking about a breakdown  
4 between doctors and nurses.

5 What was -- what led to that? What led you to that  
6 view?

7 **A.** I am not -- I'm not sure that I actually said  
8 this so I think I probably did say staffing issues and  
9 we need to understand the vacancies.

10 So we knew that we had issues with the trainee  
11 doctors that were coming into the unit because there  
12 weren't enough in training, we knew that, you know, we  
13 had business case in train for additional  
14 paediatricians, we knew that we weren't compliant with  
15 BAPM standards for nursing. So I recall at that --  
16 I recognise that, but the bit underneath I don't  
17 recognise.

18 So whether that was a paraphrase of a conversation.

19 **Q.** But they are only notes --

20 **A.** Yes.

21 **Q.** -- of course. But looking from this angle  
22 then was it your view at that time that there were there  
23 was a breakdown between doctors and nurses?

24 **A.** No. I think that was -- it was at this point  
25 when Letby had been removed from the unit, I think the  
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1 achieving?

2 **A.** So following the meeting on the 29th and then  
3 the subsequent meeting where Dr Gibbs -- it was Dr Gibbs  
4 presented his review of the neonatal unit, it became  
5 clear that there was a bit of a disconnect and we  
6 weren't aware of exactly what was happening in the unit.  
7 I think that was more pronounced for me because when  
8 I had been Divisional Director in 2013/14, we only had  
9 three or four babies on the unit, it was empty a lot of  
10 the time. So then to find out it was often over  
11 occupancy I think we recognised there was a gap in our  
12 knowledge and understanding, so we introduced a daily  
13 report that was emailed into the Exec suite by 10 clock  
14 in the morning telling us what had happened the day  
15 before, how many babies on the unit, any transfers out,  
16 any incidents, any collapses, any deaths. So then we  
17 could look closer if there had been any concerns.

18 **Q.** So going back to the evidence we had about  
19 when you were Divisional Director and you say then that  
20 you couldn't recall being made aware of the death of  
21 Child E, with the neonatal dashboard that would have  
22 been impossible?

23 **A.** Yes.

24 **Q.** Because the death would have been recorded on  
25 the --  
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1 A. Yes, by 10 o'clock the following morning we  
2 would have known anything that had happened the previous  
3 day at an Executive level.

4 Q. That was -- the neonatal dashboard was just  
5 introduced post 29 June --

6 A. Yes, when we were --

7 Q. -- 2016?

8 A. When we were aware there was an increased  
9 mortality and there were concerns around the neonatal  
10 unit.

11 Q. And that -- was it successful, did it carry on  
12 while you were on the Executive Team?

13 A. Yes, it continued up I think until about 2018,  
14 maybe longer. Originally it was two sections to it;  
15 there was the maternity section and a neonatal section.  
16 After the first few months the maternity section was  
17 stepped down.

18 Q. Yes, if we could just turn then to a meeting  
19 that was on 30 December and this is INQ -- take that one  
20 down, INQ0004299. So if we wait for that meeting to  
21 come up but this was a meeting that was held on  
22 30 December, while we are waiting for it to come up.

23 It was attended by Duncan Nichol, Tony Chambers,  
24 Ian Harvey, yourself, and Mr Cross and we see those  
25 initials halfway down, we see Friday, 30 December and  
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1 concern which was the upgrading or the downgrading of  
2 the unit?

3 A. Yes.

4 Q. That was under your remit?

5 A. Yes. At some -- at some point I did see the  
6 Royal College report. I don't know if it was here and  
7 then or whether it was later, but I do recall that I did  
8 see that report.

9 Q. That report didn't answer the question, did  
10 it, of whether Letby was or was not responsible for the  
11 deaths on the unit or the collapses?

12 A. No, it didn't.

13 Q. So running through as well what stage we have  
14 reached by now, so the RCPCH have visited, they have  
15 reported, Jane Hawdon has been instructed and she sent  
16 out her advisory report to Ian Harvey recommending  
17 a broader forensic review of Child A, Child I, Child O,  
18 and Child P because those deaths remained unexpected and  
19 unexplained.

20 Were you aware of that?

21 A. I was aware that one of the recommendations in  
22 the Royal College report was that there was  
23 a pathologist review of certain cases.

24 Q. Were you aware that Jane Hawdon had been  
25 instructed initially?

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1 then there is passage blocked out and then 10.15  
2 neonates and then the initials, including your initial,  
3 there.

4 Just to recap of where we were at this stage. So  
5 by this stage, the RCPCH had conducted their visit on  
6 1 and 2 September, they had reported dealing with that  
7 report, had you seen the full unredacted report of the  
8 RCPCH?

9 A. I can't recall.

10 Q. Were you aware there were two: an unredacted  
11 and a redacted version of the report?

12 A. I was aware there was two because in the  
13 unredacted version I think there was some names  
14 included.

15 Q. So that seems to suggest you had seen the  
16 unredacted version even if you can't specifically recall  
17 it?

18 A. I -- I recall the conversation about why there  
19 was a redacted version, I can't recall whether  
20 I absolutely saw both versions or not.

21 Q. I mean, that would have been a very  
22 significant report, wouldn't it, because you were  
23 looking at that report to potentially answer some of  
24 your questions about why there had been an increase in  
25 mortality and that related to your particular area of  
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1 A. I was aware of her having been instructed but  
2 it was just a name to me. I didn't know who Jane Hawdon  
3 was.

4 Q. And so can you recall whether you had or had  
5 not seen her report?

6 A. I didn't see her report.

7 Q. Letby's grievance had been heard on  
8 1 December, that was the other significant event that  
9 had taken place?

10 A. Mm-hm.

11 Q. Also on 22 December, Letby and her parents had  
12 met with Hayley Cooper, Karen Rees, Tony Chambers  
13 Ian Harvey Alison Kelly and Sue Hodgkinson.

14 Were you aware of that meeting, you weren't at it  
15 but were you aware that meeting had taken place?

16 A. I was aware possibly afterwards but I wasn't  
17 sort of aware at the time it was happening.

18 Q. So that's the context and now let's just look  
19 at what was discussed at this meeting in December. So  
20 can we have that back up on the screen, sorry.  
21 INQ00004299.

22 So in the bottom part section of the third of the  
23 page we have got:

24 "Unredacted version, should it go anywhere?" and  
25 then "distribution".

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1 It seems what was being discussed there at this  
2 meeting at which there were the five Executives present,  
3 was what should be done with the RCPCH report. Do you  
4 recall that discussion?

5 **A.** I recall a discussion about where the report  
6 should go to.

7 **Q.** What discussion was had, what was the  
8 discussion that was had at that meeting?

9 **A.** I don't -- I don't recall the outcome of the  
10 discussion. I just remember there was a general  
11 discussion of the Royal College report, where it went  
12 to, whether it was redacted or unredacted and how did we  
13 keep the right people informed.

14 **Q.** What were your views about first of all the  
15 Consultants seeing an unredacted version of that report,  
16 did you feel that they should be seeing that?

17 **A.** I think at that point I didn't -- I didn't  
18 have -- I think I was listening to what people were  
19 saying. I don't think I had a strong view one way or  
20 another. I didn't -- I didn't feel that I could fully  
21 make a decision on whether it should be redacted or  
22 unredacted.

23 **Q.** What about we have seen there under the  
24 heading "Distribution -- parents", what about your  
25 view -- you obviously had a background in nursing as

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1 Commitment to them at meeting."

2 Was it explained to you what commitment had been  
3 made to Lucy and her family at that meeting?

4 **A.** I don't recall the -- the details of that  
5 meeting. But I just recall that our priorities were  
6 around making sure the unit was safe and there was no  
7 more deaths.

8 **Q.** We see then next to that "Safety of babies".  
9 Was that still something that you were very alert  
10 to?

11 **A.** Yes.

12 **Q.** The safety of babies in the unit?

13 **A.** Yes, yes.

14 **Q.** And further down it says.

15 "Challenge of return of Lucy to unit. Trust will  
16 manage this return."

17 Why did you understand it being said, and it seems  
18 to have been decided at this meeting, that Letby should  
19 be being returned to the unit when the RCPCH hadn't  
20 concluded whether or not she was responsible for the  
21 deaths and you had supported Tony Chambers and said she  
22 had to be moved off the unit, the priority was safety?

23 Why now was it being decided that Lucy should be  
24 returned to the unit?

25 **A.** I think again these are just somebody's notes

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1 well as your qualifications in management.

2 What was your view about whether performance should  
3 be seeing what report; did you have a view on that?

4 **A.** I think my view was that parents needed to be  
5 given -- kept up to speed on all information. My  
6 understanding of when we initially contacted the parents  
7 where parents were initially contacted at the end  
8 of June/early July is that part of that conversation was  
9 about how the parents wanted to be communicated with and  
10 the level of information that they wanted to receive.

11 So again I think that I probably could see both  
12 sides of what was being discussed. I didn't have  
13 a strong view and therefore I was comfortable with  
14 people who were more -- who were closer to it than me.

15 **Q.** Just in terms of the people who were at this  
16 meeting, we have got Duncan Nichol, Tony Chambers,  
17 Ian Harvey, Stephen Cross. Do you know why there were  
18 only five at that meeting, there weren't the full eight  
19 Executives, I mean?

20 **A.** I would imagine it was who was available at  
21 that particular time.

22 **Q.** Just going over the page, then, to page 2 of  
23 this document, there is a reference then sort of a third  
24 of the way down the page:

25 "Difficult meeting with Lucy and family.

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1 and I think I recognise there was a challenge of  
2 returning her to the unit and we would have to manage it  
3 if she did return.

4 So I -- I read it that this isn't saying we were  
5 looking to return her to the unit at that time. But by  
6 this time, my focus was on the day-to-day functioning of  
7 the unit and babies that may need neonatal care moving  
8 forward.

9 In terms of Letby and what was happening with the  
10 HR, I left that with that department and in terms of the  
11 reviews and understanding mortality, I left that with  
12 Alison Kelly and Ian Harvey.

13 **Q.** If we go over to the next page, page 3, we see  
14 against your initials and as you said your involvement  
15 was particularly with the level of the unit, next to  
16 your initials it says:

17 "Business case, do we need Level 2? Looking at the  
18 last six months, no deaths."

19 You were tasked with looking at the level of the  
20 unit and in discussing the level of the unit you had to  
21 be sure, did you, that it was safe, that was one of the  
22 considerations you -- that fell within your remit in  
23 terms of what level it should be?

24 **A.** So it was part of -- the role that I was given  
25 in managing this was keeping that unit safe.

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1 My personal view was that we -- we had done that  
2 because we hadn't had any more deaths and therefore  
3 until we had the absolute answer we should stay at that  
4 level.

5 **Q.** If we could just go down, then. We see  
6 further down next to TC, next to Tony Chambers's  
7 initials, "Sequence". It says Lucy meeting, board  
8 meeting, then meeting with paediatric Consultants.

9 So it seems to be setting out the next steps of  
10 what was going to occur.

11 Then over to the right-hand side of the page, it  
12 says:

13 "Formal acceptance of reviews."

14 And then:

15 "Action plan: reserve its position on Level 1 or  
16 Level 2. Endorse transition of Lucy back into the  
17 unit."

18 So this meeting, at which you were one of five  
19 people present, seems to be making a decision to endorse  
20 the transition of Lucy back into the unit.

21 **A.** Again, I think this is the way I did -- these  
22 handwritten notes are written, I think it was more of  
23 a discussion and, you know, do we endorse the unit --  
24 Lucy back into the unit rather than is that, where do we  
25 get to that in that being a step rather than this

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1 expressed at the meeting?

2 **A.** I can't recall exactly what my views were and  
3 what I actually said in this meeting or if I said  
4 anything, because I was still quite new to the Executive  
5 Team and sort of understanding the role of an Executive  
6 but my view was always just to maintain the safety of  
7 the unit and it seemed very safe to me at that point.  
8 So I was more -- I felt comfortable about where we were  
9 at that point in time.

10 **LADY JUSTICE THIRLWALL:** That was without  
11 Lucy Letby on the unit?

12 **A.** Yes, and without the very sick babies on the  
13 unit.

14 **LADY JUSTICE THIRLWALL:** Yes, there were two  
15 things.

16 **A.** Yes.

17 **LADY JUSTICE THIRLWALL:** But one of them was  
18 Lucy Letby not being on the unit?

19 **A.** Yes, yes.

20 **LADY JUSTICE THIRLWALL:** Looking back, do you think  
21 you said anything about that?

22 **A.** I'm not sure that I did because I -- I kept  
23 separate from any of the conversations that were going  
24 on. I don't recall ever meeting Lucy Letby, I don't  
25 remember having ever having read anything around her or

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1 meeting having made that decision.

2 **Q.** What was your view about whether Lucy should  
3 be returned to the unit?

4 **A.** My view was that until we knew exactly what  
5 has happened, we should maintain where we were right  
6 then. So Lucy wasn't on the unit, we were a Level 1  
7 unit, there had been no more collapses, been no more  
8 deaths, that seemed to me to be a safe position and one  
9 that we needed to continue until we got to the end, and  
10 the end was everybody agreeing.

11 **Q.** Because we know in fact what went on from this  
12 is that there was a decision and Lucy Letby had been  
13 informed that she would go back to the unit and the  
14 Consultants then raised their concerns about this but  
15 the Executive decision following this meeting was that  
16 Letby should go back to the unit and you were one of  
17 five people at this meeting.

18 Why do we not see your views expressed here that at  
19 all costs Letby must not go back on the unit?

20 **A.** So again, I don't know why -- why it doesn't  
21 say that I wasn't concerned, but it was a collective  
22 decision. So there were a number of people in there and  
23 people had different -- different views. It isn't  
24 a transcript. It's somebody's notes.

25 **LADY JUSTICE THIRLWALL:** What were your views  
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1 what had happened. So I think that was probably  
2 something that I felt other people in the room were  
3 better informed.

4 **LADY JUSTICE THIRLWALL:** So you didn't say anything  
5 about that, you don't think?

6 **A.** It's difficult to say. I can't remember  
7 exactly what I said in the meeting, but if I think about  
8 my thoughts, my thoughts were that by Lucy not being on  
9 the unit and it being at a Level 1, that it was safe.  
10 We hadn't had any more concerns raised, we hadn't had  
11 any more collapses or deaths and I felt assured that the  
12 risk had been minimised.

13 **MS BROWN:** Did you understand at that meeting the  
14 import of the meeting, this was the five most senior  
15 people in the hospital of which -- at that meeting of  
16 which you were one and a decision was being made about  
17 whether to return Letby to the unit.

18 Did you understand how significant that decision  
19 was?

20 **A.** I don't recall that the decision was made in  
21 that meeting to return Lucy to the unit.

22 **Q.** Looking back now, you were involved as  
23 a Divisional Director when the first cluster of deaths  
24 occurred, that was in the neonatal unit, and you then  
25 sat on the Executive Directors Group meetings from

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1 September through to the point where there was a report  
 2 of Letby to the police.  
 3 Looking back now, why do you think it took so long  
 4 for the Executives to refer Letby to the police?  
 5 **A.** Looking back now, and having read some of the  
 6 transcripts from the Inquiry, at no point were the  
 7 Executives made aware of any insulin results or any  
 8 concerns about any of the blood results. We were told  
 9 that there was no explanation for the deaths.  
 10 I think if some -- if some of those concerns that  
 11 have since come to the forefront had been made known to  
 12 the Executive Team, then we would have taken a different  
 13 course of action.  
 14 **MS BROWN:** Thank you, I have got no further  
 15 questions and I don't believe there are questions from  
 16 any of the Core Participants.  
 17 Questions by LADY JUSTICE THIRLWALL  
 18 **LADY JUSTICE THIRLWALL:** Just one from me, if  
 19 I may.  
 20 You said you were asked some questions about  
 21 systems which obviously did not result in the issue of  
 22 Lucy Letby coming to your attention or to the board's  
 23 attention and you say the systems were there but people  
 24 didn't use them?  
 25 **A.** Mmm mm.

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1 had been the Inquiry into Morecambe Bay, one of the  
 2 recommendations was that Women's and Children's services  
 3 should sit back together. So I had spoken to my  
 4 counterpart in Planned Care and we put a proposal to the  
 5 Executive Team for the Women's and Children's to come  
 6 back together, not in its own division, but as  
 7 a directorate mindful the resources that we had  
 8 available to manage the services.  
 9 So I think so that would suggest that the answer  
 10 could be yes, but I think we recognised there was  
 11 recommendation from the Kirkup Report and that it would  
 12 be in the best interests for them to sit together.  
 13 **LADY JUSTICE THIRLWALL:** Yes, those are my  
 14 questions. Thank you very much indeed, you are free to  
 15 go.  
 16 **A.** Thank you.  
 17 **LADY JUSTICE THIRLWALL:** I think we are waiting,  
 18 Mr Bershadski, for the next witness, Ms Appleton-Cairns.  
 19 **MR BERSHADSKI:** Yes, my Lady.  
 20 **MS DEE APPLETON-CAIRNS** (affirmed)  
 21 Questions by Mr Bershadski.  
 22 **LADY JUSTICE THIRLWALL:** Thank you, do sit down.  
 23 **A.** Thank you.  
 24 **MR BERSHADSKI:** Good afternoon, could you state  
 25 your full name, please, for the Tribunal?

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1 **LADY JUSTICE THIRLWALL:** I just wondered if that's  
 2 the case, does that mean that the systems perhaps  
 3 weren't appropriate for this situation?  
 4 **A.** I think that's a possibility. I think that  
 5 the hospital was very much focused, it was -- it is  
 6 a district general hospital, there was a significant  
 7 focus at that time on urgent emergency care, the  
 8 pressures around beds, so that bigger part of the  
 9 hospital, rather than neonates Women's and Children's.  
 10 So I think that is a possibility; that those  
 11 systems weren't appropriate for the neonatal unit and  
 12 could have been different.  
 13 **LADY JUSTICE THIRLWALL:** Thank you. Just arising  
 14 out of your answer, we know there was a restructure  
 15 which meant that women and children were effectively in  
 16 a management sense sort of downgraded in terms of their  
 17 representation on the board.  
 18 Is that something that may have contributed, do you  
 19 think, to them being a bit disconnected?  
 20 **A.** So I wasn't in -- when I joined the  
 21 Countess --  
 22 **LADY JUSTICE THIRLWALL:** I know you weren't.  
 23 **A.** -- it had already happened.  
 24 **LADY JUSTICE THIRLWALL:** Yes.  
 25 **A.** I think it was around 2016, 15/16, when there

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1 **A.** Deborah Lynne Appleton-Cairns.  
 2 **Q.** Thank you. I think you have made a statement  
 3 for the Inquiry dated 30 July 2024; is that right?  
 4 **A.** Yes.  
 5 **Q.** Have you had an opportunity to consider that  
 6 statement recently?  
 7 **A.** Yes.  
 8 **Q.** Is it true and accurate to the best of your  
 9 knowledge and belief?  
 10 **A.** Yes.  
 11 **Q.** Thank you.  
 12 Ms Appleton-Cairns, is it right that you started  
 13 working in the human resources sphere in 1999?  
 14 **A.** Yes.  
 15 **Q.** So by the time of 2016/2017 you had some 17  
 16 years' experience in HR; is that right?  
 17 **A.** That's correct.  
 18 **Q.** I think you have got some professional  
 19 qualifications in HR as well; is that correct?  
 20 **A.** It is, yes.  
 21 **Q.** Thank you.  
 22 I am just going to begin, Ms Appleton-Cairns, by  
 23 asking you about some of the HR policies that may be  
 24 relevant to some of the issues we are going to discuss.  
 25 Could I first ask you to turn to the disciplinary

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1 policy and if we could have that up on the screen, it's  
2 INQ0108329.

3 It can take a little bit of time for documents to  
4 present themselves on the screen.

5 A. Okay.

6 Q. Ms Appleton-Cairns, I think you have provided  
7 the Inquiry with this copy of the disciplinary policy;  
8 is that correct?

9 A. Honestly, I don't know, because there were  
10 a number of versions and I did provide an additional one  
11 to the Inquiry that I had.

12 Q. Thank you. Is there anything within this  
13 policy that as far as you can recall is significantly  
14 different from the policy that you think would have been  
15 in place in 2016?

16 A. Not of significant difference, no.

17 Q. Thank you. I am not going to take you through  
18 the entirety of this policy but if we could just turn,  
19 please, to page 15 of the policy. Were you familiar in  
20 2016 with this part of the policy, appendix 6,  
21 consideration of referral to the Local Authority  
22 Designated Officer?

23 A. Yes.

24 Q. What was your understanding of, in essence,  
25 the purpose and effect of this aspect of the

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1 being disciplined at that stage. However, I think that  
2 if there was evidence with regard to somebody who was  
3 harming a child, if something had been raised in that --  
4 in that context then the person who was the conduit  
5 between the Trust and the local authority could have  
6 made that referral, yes.

7 Q. Would it be fair to say that you as the deputy  
8 director of HR at that time would be expected to have  
9 a particularly sound knowledge of this policy and other  
10 HR policies within the Trust?

11 A. Yes.

12 Q. Now, is it right that within this section of  
13 the policy, it doesn't talk about any particular  
14 evidence being provided or of any evidential threshold  
15 for a referral to be made; it simply says that if  
16 a concern is raised, a referral should be made; is that  
17 right?

18 A. Yes.

19 Q. Is it right that the disciplinary policy isn't  
20 the only policy which discussed referrals of this  
21 nature?

22 A. I would have to see the other -- the other  
23 policies to which you are referring.

24 Q. Okay. If we could please turn up the Speak  
25 Out Safely policy, it is INQ0003012. Now, is this

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1 disciplinary policy?

2 A. So this is if somebody was being disciplined  
3 under this policy, then there would be consideration,  
4 this was an appendix to that.

5 Q. Yes.

6 A. And that if there was something that required  
7 -- so if they were under disciplinary and it was  
8 something to do with harming children, then there would  
9 be consideration to refer that to LADO.

10 Q. The way it's phrased, if we can take it at the  
11 top, it says if there is a concern raised or

12 an allegation made about a person who works with  
13 children, whether a professional staff member, foster  
14 carer or volunteer, that they may have done various  
15 things, including possibly harmed a child, then  
16 a referral should be made; is that right?

17 A. Yes.

18 Q. So would it be fair to say that the very fact  
19 of a concern being raised or an allegation about  
20 somebody who works with children that they may have  
21 harmed a child, that that would be sufficient to trigger  
22 a referral to be made to the Local Authority Designated  
23 Officer?

24 A. I guess there is a couple of things. First of  
25 all it's under the disciplinary policy and nobody was

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1 a policy that you would have been familiar with in 2016?

2 A. No.

3 Q. Why is that?

4 A. Because the Speak Out Safely policy was dealt  
5 with entirely by Alison Kelly and Sue Hodgkinson.

6 Q. Are you saying you would never have looked at  
7 it --

8 A. No.

9 Q. -- in 2016?

10 A. No, I am not saying that at all. But I wasn't  
11 involved in the -- there was numerous versions of this  
12 policy that were going backwards and forwards.

13 Q. Yes.

14 A. And at that particular time, I was overseeing  
15 two very major jobs and that's why they were doing this  
16 policy --

17 Q. Right.

18 A. -- with the Union.

19 Q. Well, let's just try and establish if we can  
20 whether this is the policy that would have been in place  
21 at the time. We can see on this page the Trust policy  
22 statements on the screen and it is dated November 2013?

23 A. Mm-hm.

24 Q. Yes. Now if I could just ask you if we could  
25 flip through to page 12 of this document, please. We

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1 can see it says "Review" in the middle of the screen  
 2 then:  
 3 "This policy will be reviewed every three years in  
 4 consultation with the Trust's partnership forum, it can,  
 5 however, be reviewed earlier if the need arises?"  
 6 **A.** Yes.  
 7 **Q.** So is it right to say that the prima facie  
 8 position would be that this is the policy that would  
 9 have been in place probably until November 2016 unless  
 10 a particular situation had arisen that required a review  
 11 before then?  
 12 **A.** I think it was reviewed before that review  
 13 period because of the campaign that was run by the RCN.  
 14 But as I say, it was -- it was something I had very  
 15 little to do with.  
 16 **Q.** Okay. If we can please turn one page back to  
 17 page 11, can you see "Monitoring arrangements" --  
 18 **A.** Yes.  
 19 **Q.** -- sort of two-thirds of the way down on the  
 20 screen and if we look there, it says:  
 21 "Process for monitoring and annual audit is  
 22 undertaken to ensure compliance with the policy current  
 23 legislation and best practice."  
 24 Then underneath that it says:  
 25 "Responsible individual: deputy director for HR and  
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1 undertaking audits to ensure compliance by the Trust  
 2 with this policy; that is what it seems to say?  
 3 **A.** (Nods)  
 4 **Q.** Did you do that or not?  
 5 **A.** The partnership forum that included all the  
 6 unions, that it was a general review. It wasn't just me  
 7 because I had no power to change a policy unless I had  
 8 the partnership forum's agreement. So it would be the  
 9 annual audit was -- was done as a partnership forum just  
 10 with my name on it.  
 11 **Q.** Yes. So were you responsible for it?  
 12 **A.** Yes.  
 13 **Q.** So are you saying that even though you might  
 14 not personally undertake the audit, you would make sure  
 15 that it was done and put your name to it?  
 16 **A.** Yes, if somebody said that they needed to have  
 17 a change or whatever but I also had a head of policy as  
 18 well, because obviously, you know, I had an awful lot of  
 19 other responsibilities including the policies, so I had  
 20 a head of policies who I would maybe give that -- give  
 21 that task to do.  
 22 **Q.** Okay. Would it be fair to say that given that  
 23 you had responsibility for signing off annual audits for  
 24 compliance with this policy, that you should have had  
 25 a pretty good working knowledge of this policy or its  
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1 OD"?  
 2 **A.** Yes.  
 3 **Q.** Was that you at the time?  
 4 **A.** That was me.  
 5 **Q.** Were you undertaking annual audits to ensure  
 6 compliance by the Trust with this policy as it seems to  
 7 state that you should be in the policy?  
 8 **A.** In -- all policies were reviewed and they  
 9 could be reviewed earlier if there was a change in  
 10 legislation or whatever, but I do recall that this one  
 11 was reviewed earlier and one of the things that makes me  
 12 think that is because you have got UCAT as one of the  
 13 unions and UCAT stopped being a recognised union. So  
 14 that makes me think that this isn't what was in place at  
 15 the time.  
 16 **Q.** Okay. But had you at any point between 2013  
 17 and 2016 been undertaking audits to ensure that the  
 18 Trust was complying with the Speak Out Safely policy as  
 19 it suggests you were responsible for? Had you  
 20 undertaken those reviews or not?  
 21 **A.** Sorry, could you say that again?  
 22 **Q.** Okay. I am sure I'm not making myself clear.  
 23 This policy dated 2013 --  
 24 **A.** Yes.  
 25 **Q.** -- states that you are responsible for  
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1 equivalent in 2016?  
 2 **A.** Well, I would like to see the one from 2016  
 3 because, as I say, I didn't have responsibility for the  
 4 one that came after this.  
 5 **Q.** Okay. Well, this is the version that we have.  
 6 If I could ask you if we could turn the page to page 9,  
 7 please, of it, do you see again a section headed  
 8 "Consideration of referral to the Local Authority  
 9 Designated Officer"?  
 10 **A.** (Nods)  
 11 **Q.** So it is a similar title to the bit we just  
 12 looked at from the disciplinary policy.  
 13 **A.** (Nods)  
 14 **Q.** Again we can see it says:  
 15 "In cases where there is concern with regards to  
 16 patient care, the senior manager informed of the  
 17 allegations needs to consider referral of the matter to  
 18 the Local Authority Designated Officer ..."  
 19 **A.** Yes.  
 20 **Q.** "... in conjunction with the head of service."  
 21 Can you see that?  
 22 **A.** Yes.  
 23 **Q.** Then if we skip to the middle of the paragraph  
 24 or in fact seven lines down, we can see it says:  
 25 "A referral must always be made if the employer  
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1 thinks that the individual has harmed a child or poses  
 2 a risk of harm to children."  
 3 **A.** Yes.  
 4 **Q.** Would you -- is it likely, do you think, that  
 5 whichever precise version of this policy was in place in  
 6 2016, that this requirement to make a referral would  
 7 have been in place?  
 8 **A.** I don't know what the other version said.  
 9 However, what I would say is that Alison Kelly was  
 10 the LADO conduit, was the lead person for that. So it  
 11 wouldn't have been me who would have made the referral.  
 12 And I agree, a referral must always be made if the  
 13 employer thinks the individual has harmed a child. Yes,  
 14 I do think if people thought that children were being  
 15 harmed, then they had that responsibility to make  
 16 a referral to the local authority.  
 17 **Q.** Well, do you agree that they had that  
 18 responsibility not just if they thought an individual  
 19 had harmed a child but if they thought that the  
 20 individual posed a risk of harm, that they also had that  
 21 responsibility? Would you agree with that?  
 22 **A.** I think if they had evidence of that, then  
 23 yes, absolutely.  
 24 **Q.** Okay. All right. Thank you.  
 25 I am just going to ask you a few questions about  
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1 Ian Harvey; is that right?  
 2 **A.** Yes.  
 3 **Q.** Okay. Now, can you just give us a summary of  
 4 what your understanding was of the purpose of this  
 5 meeting?  
 6 **A.** The meeting was around -- well, it was, it was  
 7 to understand what was going on on NNU and it was also  
 8 to discuss whether Lucy Letby should be -- be removed  
 9 from that meeting -- from that department and from her  
 10 duties. So that -- that was it in essence.  
 11 **Q.** What was your understanding of the reason why  
 12 consideration was being given to remove Lucy Letby from  
 13 the unit?  
 14 **A.** It was due to the fact that there was a spike  
 15 in -- in the -- in the neonates. But they couldn't  
 16 understand what had happened, but according to two of  
 17 the Consultants, they felt that it could possibly be to  
 18 do with Lucy Letby being on duty. There was  
 19 a commonality between her being on the unit when some  
 20 babies had died.  
 21 **Q.** I am going to just jump straight to the point,  
 22 if I may. Surely already by that point, that was an  
 23 expression of a concern by individuals within the  
 24 hospital that Lucy Letby may pose a risk of harm to  
 25 children and it should have triggered, as you should  
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1 the NNU action plan in meetings and your role within  
 2 that and that is a topic that you cover from  
 3 paragraph 17 onwards of your statement. If we could  
 4 please have up on screen INQ0005196.  
 5 Now, this was an action planning meeting regarding  
 6 the neonatal unit which you attended on 30 June 2016.  
 7 **A.** Yes.  
 8 **Q.** Were you aware of concerns about increased  
 9 mortality on the neonatal unit prior to this meeting or  
 10 is this the first time that you became aware of such  
 11 concerns?  
 12 **A.** The first time I -- and unfortunately I cannot  
 13 get the chronological dates in my head completely right  
 14 because it's a long time ago.  
 15 **Q.** Yes.  
 16 **A.** However, the first time I heard about there  
 17 being a spike in mortality rates and then being drilled  
 18 down into it being neonates, I believe I was at that  
 19 meeting, I can't remember when, and I believe it was the  
 20 Medical Director Ian Harvey that raised it and that he  
 21 was instructed by the Chief Executive Tony Chambers,  
 22 along with Alison Kelly, to go and understand exactly  
 23 what that meant.  
 24 **Q.** Okay. So you think that by the date of this  
 25 meeting, you had already heard about the concerns from  
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1 have known from your knowledge of the policies,  
 2 a referral because it was a concern of a risk of harm;  
 3 would you go with that?  
 4 **A.** Sorry, just say that again, please?  
 5 **Q.** Well, I am suggesting that if this meeting was  
 6 called as a result of a concern that Lucy Letby had  
 7 harmed children, then that was a concern of a risk to  
 8 children which should have triggered a referral under  
 9 the sections I have taken you to from the Speak Out  
 10 Safely policy and also the disciplinary policy.  
 11 And I am just asking whether you agree with that  
 12 analysis or not?  
 13 **A.** It was far more vague than that. So I can't  
 14 give you a yes or a no and I think it's really  
 15 important.  
 16 When the Consultant -- and I was very much on the  
 17 periphery, so forgive me if I am just saying about  
 18 hearsay, but you couldn't pin them down to what, what is  
 19 it or who is it or when is it that you think that these  
 20 that there is something happening and all they could say  
 21 is well, we just think that Lucy's on duty more often  
 22 than not and we had already looked into that and  
 23 certainly the commonality, the spreadsheet that I saw  
 24 and I only saw it for a few moments, did not look like  
 25 the one that was presented to the jury, it was far more  
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1 comprehensive, there was far more dates on there, there  
 2 was far more babies on there, there was as far more  
 3 staff on there including doctors as well. So there  
 4 wasn't that commonality and it wasn't that people were  
 5 looking, that they were trying to avoid the situation.  
 6 We were looking for the answers and -- but with  
 7 regard to your question about should it be referred to  
 8 LADO, that question was raised, as I recall; is this now  
 9 a LADO situation? I didn't raise it. I didn't. But it  
 10 was raised. I can't tell you if it was at that meeting  
 11 or not, but it had been raised and then it was up to  
 12 Alison Kelly to decide whether she went, as that LADO  
 13 lead for the Trust, to refer it.  
 14 **Q.** Who raised that question?  
 15 **A.** I just said I can't remember. It wasn't me.  
 16 **Q.** Was it an Executive, was it a doctor? What  
 17 type of -- do you remember what kind of person it was,  
 18 in roughly what position they occupied?  
 19 **A.** On the basis that I can't remember who it  
 20 is --  
 21 **Q.** Yes.  
 22 **A.** -- then I am not prepared to speculate.  
 23 **Q.** Okay. Do you have any sense of what period of  
 24 time that would have been raised was it around the time  
 25 that you became involved when you were at this action

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1 stands for Karen Rees; is that right?  
 2 **A.** Yes.  
 3 **Q.** "/DAC."  
 4 **A.** Yes.  
 5 **Q.** So with reference to that, what was your task  
 6 as a result of this meeting?  
 7 **A.** Okay. So we had a recruitment section within  
 8 the -- department within the hospital and it was  
 9 a shared service with Arrowe Park Hospital, so it was an  
 10 autonomous subsidiary of both organisations so I was the  
 11 conduit to go into them and say, you know, is -- because  
 12 we had a bank, an agency group that would look -- if  
 13 anybody had any spare shifts or wanted any spare shifts,  
 14 then they would book them through that bank and agency  
 15 department.  
 16 So I went to find out A, if she had been doing any  
 17 additional shifts in any of the departments within our  
 18 Trust, but also to see whether she had actually been  
 19 working at Arrowe Park on any other shifts as well and  
 20 I couldn't find any evidence of that.  
 21 **Q.** What was the purpose of you undertaking that  
 22 exercise?  
 23 **A.** Just -- I guess just to understand exactly  
 24 where she had been working. And, you know, what -- what  
 25 I found at that particular time was that we had nurses

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1 planning meeting or was it significantly later than  
 2 that?  
 3 **A.** It was either slightly before or at this -- it  
 4 probably was around this meeting -- it could have been  
 5 at this meeting. I am trying --  
 6 **Q.** Okay.  
 7 **A.** I'm sorry, it is a long time ago.  
 8 **LADY JUSTICE THIRLWALL:** Sorry. Just so I am  
 9 clear, so it may have been at this meeting that this was  
 10 said?  
 11 **A.** Yes, it could have been.  
 12 **LADY JUSTICE THIRLWALL:** Well, if it were, it would  
 13 have been said by one of the people on the list.  
 14 **A.** Yes.  
 15 **LADY JUSTICE THIRLWALL:** And it wasn't you?  
 16 **A.** It wasn't me.  
 17 **LADY JUSTICE THIRLWALL:** Thank you. Shall we move  
 18 on?  
 19 **MR BERSHADSKI:** Now, your role in this meeting is  
 20 set out at the bottom of this page, isn't it:  
 21 "Actions to be taken: Clarity re LL working in  
 22 other units and [query] bank hours."  
 23 Can you see that?  
 24 **A.** Yes.  
 25 **Q.** Then it says "KR" which I think probably

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1 that were exhausted, that were -- and so if they were  
 2 being asked to work other shifts or they were working  
 3 other shifts, or there could be commonalities with  
 4 Arrowe Park if they had experienced a spike in neonatal  
 5 deaths she had been working there, but there was  
 6 nothing, nothing that I found.  
 7 **Q.** If we go over the page to page 2, we can see  
 8 that -- sorry, if we go to INQ0005101. There were two  
 9 meetings that day, weren't there, and this is now the  
 10 second of those meetings in the afternoon; is that  
 11 correct?  
 12 **A.** Yes.  
 13 **Q.** If we just go over the page. At the top we  
 14 can see that in relation to that action that we looked  
 15 at before --  
 16 **A.** Yes.  
 17 **Q.** -- it's now been filled out:  
 18 "LL not working ..."  
 19 **A.** Yes.  
 20 **Q.** "... anywhere else, ie at another Trust or  
 21 agency."  
 22 **A.** Yes.  
 23 **Q.** "Trained at Chester. Lives alone. Has  
 24 elderly parents"?  
 25 **A.** Yes.

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1 Q. Now, do you think the reason that you were  
 2 checking that she wasn't working anywhere else at  
 3 another Trust or agency would be that if she had been  
 4 that contact would be made to make sure she was no  
 5 longer working at any of those other locations?  
 6 A. I don't know. That's what I was asked, that  
 7 is what I was asked to do is to find out if she was  
 8 working anywhere else because I think the view was that  
 9 they were then going to take her off the unit and put  
 10 her into the governance team and on that basis then we  
 11 would probably have to inform other Trusts that this is  
 12 what we were doing.  
 13 Q. Is that because of a concern that she may pose  
 14 a risk to children at any other units that she was  
 15 working at as well as at the NNU at the Countess?  
 16 A. I can't, who -- are you asking me personally?  
 17 Q. Yes. I am asking you about your knowledge of  
 18 what the purpose was of you establishing whether she had  
 19 been working anywhere else?  
 20 A. My understanding is I was asked to -- to find  
 21 that information out, which I did, I brought it back.  
 22 That was the information that I found. I think  
 23 Karen Rees had put the "Trained at Chester, lives alone,  
 24 has elderly parents", I think that was Karen.  
 25 But the bit about not working at any Trust, that

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1 who is Alison Kelly and it had been raised so there was  
 2 no reason for me to raise it again.  
 3 Q. Do you think that you should have given your  
 4 analysis of what the HR policies said about the criteria  
 5 for making a referral given your particular familiarity  
 6 and role with those policies?  
 7 A. It would not have occurred to me to mention  
 8 the disciplinary policy because nobody was being  
 9 disciplined at that time.  
 10 Q. Well, about the Speak Out Safely policy?  
 11 A. As I have -- as I have explained, I was not  
 12 involved in the review of that policy. Alison Kelly was  
 13 responsible along with Sue Hodgkinson and she was the  
 14 LADO lead so she must have been more than aware of what  
 15 her responsibilities were with that.  
 16 Q. Okay. So you have explained that you had  
 17 checked that Lucy Letby wasn't working anywhere else at  
 18 this point. Did you take any steps to make sure that  
 19 she wouldn't be able to work anywhere else in the  
 20 future?  
 21 A. No, because it was -- it was going to be -- my  
 22 understanding was it was going to be made clear to  
 23 Lucy Letby that if she wanted to work anywhere else then  
 24 she had to declare that to -- I believe it was  
 25 Karen Rees.

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1 was just what I was asked to find out, did I -- did  
 2 I personally believe that there was evidence to show  
 3 that she was harming children anywhere at that time?  
 4 I would have to say no --  
 5 Q. But what?  
 6 A. -- if you are asking me.  
 7 Q. What investigations had you conducted into the  
 8 evidence of Letby harming children by that point?  
 9 A. I had done no investigations at all because  
 10 I wasn't aware there was any evidence --  
 11 Q. Right. Well --  
 12 A. -- at that time.  
 13 Q. On what basis was it your role to come to  
 14 a conclusion about the evidence of Letby harming  
 15 children?  
 16 A. It wasn't. It's just a question you asked me.  
 17 Q. Right. Would you agree looking back on it  
 18 that given that clearly the concern by this point was  
 19 that Letby might pose a risk to children, that if you  
 20 had applied the policies that I have taken you to you  
 21 should have recommended a referral be made to the LADO?  
 22 A. So based on the fact that there was no  
 23 evidence that I was aware of at that time and I didn't  
 24 raise the fact that it should be a LADO referral, the  
 25 person who should make the referral was the LADO lead,

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1 Q. But forgive me, what was to stop her not  
 2 complying with that instruction and seeking work  
 3 elsewhere?  
 4 A. Nothing.  
 5 Q. Were you aware that Lucy Letby visited the  
 6 Alder Hey Hospital on a number of occasions and that she  
 7 was only stopped from doing that in June 2017?  
 8 A. No.  
 9 Q. Were you aware that plans were made for her to  
 10 go on a course to another hospital Glan Clwyd?  
 11 A. No.  
 12 Q. Can we have another document up on screen,  
 13 please, INQ0073053. I am just going to ask you a couple  
 14 of questions about a series of emails to do with this  
 15 issue of Letby working elsewhere and these emails were  
 16 sent a little bit later on in the chronology, in October  
 17 and November 2017.  
 18 If we just go a few pages forward, please, to  
 19 page 3, to pick up the theme. Can you see there  
 20 an email from somebody at Warrington Police Station  
 21 asking -- and it is about a quarter of the way down the  
 22 page:  
 23 "Can I just ask that you can confirm that Nurse  
 24 Lucy Letby is unable to work on any other hospitals at  
 25 present?"

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1 That email is sent to Claire Raggett?  
 2 **LADY JUSTICE THIRLWALL:** Raggett.  
 3 **MR BERSHADSKI:** Thank you, my Lady, and that is  
 4 forwarded on and if we go to page 1, we can see that  
 5 Claire Raggett sends this chain of emails on to  
 6 Sue Hodgkinson. It is then sent on to you on  
 7 3 November 2017 from Claire Raggett to you,  
 8 Dee Appleton-Cairns:  
 9 "Please see below the request from the police"?  
 10 **A.** Okay.  
 11 **Q.** Can you see that?  
 12 **A.** Yes.  
 13 **Q.** Did you respond to this email or do anything  
 14 in response to this?  
 15 **A.** That was 3 November?  
 16 **Q.** Yes.  
 17 **A.** Is that 2017?  
 18 **Q.** 2017.  
 19 **A.** It -- I don't know -- okay. So this is -- so  
 20 Steve GR is Steve Gregg-Rowbury and he was the lead for  
 21 this shared service. So I -- that would that was who  
 22 I had liaised with initially to say is she working at  
 23 any other hospital. And I think he -- no, I don't know.  
 24 I'm sorry. I don't know.  
 25 **Q.** Because it appears to be a concern from  
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1 neonatal or paediatric unit, then please contact us in  
 2 the first instance", is what I would do. But if I did  
 3 that or not I can't tell you, I can't remember.  
 4 **Q.** Okay. I am going to ask you a few questions  
 5 about the legal advice that you obtained from DAC  
 6 Beachcroft and you discuss this within your witness  
 7 statement from paragraph 25.  
 8 Do you recall contacting Ian Pace at DAC Beachcroft  
 9 on 5 July 2016?  
 10 **A.** No, the first time I recalled it was when  
 11 I saw his statement in my bundle.  
 12 **Q.** Okay. Well, you have said in your  
 13 statement --  
 14 **A.** Mm-hm.  
 15 **Q.** -- that you contacted him on 5 July 2016:  
 16 "The purpose of the call was to seek advice from  
 17 Ian as to the organisational risks around removing Letby  
 18 from the NNU."  
 19 **A.** Yes.  
 20 **Q.** So are you able to recall now --  
 21 **A.** Yes.  
 22 **Q.** -- what prompted you to call --  
 23 **A.** Yes.  
 24 **Q.** -- him?  
 25 **A.** Yes.

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1 a police officer to make sure that Nurse Lucy Letby is  
 2 unable to work at any other hospitals which ends up  
 3 making its way to you.  
 4 Did you take any action to address that police  
 5 officer's concerns as far as you can remember?  
 6 **A.** I can't recall this email at all.  
 7 **Q.** Well, can you recall taking any steps to make  
 8 sure that Lucy Letby couldn't work at any other  
 9 hospitals such as making a referral at that point to  
 10 LADO, or taking any other step that you may have  
 11 considered?  
 12 **A.** One of the things that we would -- that  
 13 I would do is we had a Deputy Director of HR Network,  
 14 with all the HR directors, the deputy directors in a --  
 15 in a group for Cheshire and Merseyside. And we had  
 16 a group, an email group and also I was very friendly  
 17 with Claire Scrafton who looked at -- who was -- who was  
 18 the Deputy Director at St Helens and Mersey and they  
 19 dealt with people who, you know, if you had extra shifts  
 20 or whatever, then -- then they would or there was spare  
 21 in some way then they would usually go through  
 22 St Helens.  
 23 So I would likely have sent an email round to all  
 24 the deputy directors to say to them: you know, "If you  
 25 get somebody who wants extra shifts or whatever on your  
 190

1 **Q.** Can you just explain to the Inquiry why it was  
 2 that you decided, what particular concerns you had that  
 3 led you to call him?  
 4 **A.** Yes. So we had -- whenever you are going to  
 5 remove somebody from their role, then you have to have  
 6 grounds, you have to understand, you know, why is it,  
 7 why is it that you are going to be removing this person.  
 8 And ideally you would want some evidence or you would  
 9 want some witness statement that said, you know, they  
 10 had -- they physically had seen somebody do something or  
 11 they had some physical evidence and then you would have  
 12 the grounds then to remove them. At this particular  
 13 point, we didn't. It was quite vague.  
 14 So I was just checking if we were to remove  
 15 Lucy Letby from the unit, then what would be our risk  
 16 from another direction, which is the direction of  
 17 Lucy Letby who was being heavily backed by the RCN and  
 18 what that risk would be if we were to move her. What  
 19 we -- what we came to in the end was that obviously  
 20 the -- that risk was not as big as the risk that she may  
 21 be harming babies and in which case we had to move her.  
 22 **Q.** Were you particularly concerned about  
 23 a possible dismissal and then a claim for constructive  
 24 dismissal from Lucy Letby?  
 25 **A.** It's my role to look at all angles, it is like  
 192



1 playing three-dimensional chess. You have to look at  
2 the players, you have to look at what all the  
3 possibilities are and then you are able to offer an  
4 informed opinion about what can and can't happen.

5 **Q.** Was that a significant concern for you, that  
6 there might be some form of proceedings brought by Letby  
7 in response to her removal?

8 **A.** Yes, yes, for the Trust, yes.

9 **Q.** Is that a scenario that you had come across on  
10 previous occasions or was it a particular problem that  
11 you had to deal with often at the time?

12 **A.** I wouldn't say it happened often but yes,  
13 I had been in that position before.

14 **Q.** The Inquiry has heard evidence from  
15 a professor, Professor Dixon-Woods, who has told the  
16 Inquiry or said to the Inquiry that there can be  
17 a challenge when people who are behaving badly engage in  
18 all kinds of counterclaims, grievances, they may be  
19 strategically advised by their Union representatives on  
20 what to do in order that they essentially don't end up  
21 with a disciplinary outcome.

22 Is that a challenge that you recognise that you  
23 were facing at the time?

24 **A.** Not the exact one but yes, I think there's,  
25 that is the essence of -- of what I was thinking at the  
193

1 Were you aware of the case of Beverley Allitt at  
2 the time that you made this call?

3 **A.** Yes.

4 **Q.** Did you have any concerns that you might be  
5 facing a similar situation at the Trust?

6 **A.** The Beverley Allitt case was where she was  
7 addicted to Code Blue, where she would try and  
8 resuscitate the babies. So it was a different --  
9 I thought that was a different case and she was also  
10 a midwife.

11 **Q.** Yes, well --

12 **A.** So it was a different case.

13 **Q.** Were you making reference to Beverley Allitt  
14 because you were concerned that you might also have  
15 somebody who was deliberately harming?

16 **A.** No, I was saying there's been an instance when  
17 a Consultant has referred to -- referred to a midwife as  
18 Beverley Allitt. I don't think he's written that very  
19 well. "There has been an instance where the Consultant  
20 has referred" and it shouldn't be a midwife, a nurse "as  
21 Beverley Allitt." It was the Consultant, not me.

22 **Q.** Yes. And you go on, it says in the next  
23 sentence:

24 "Dee is satisfied that there are no malicious  
25 issues involved."

195

1 time.

2 **Q.** Were you having to engage quite regularly with  
3 these kinds of claims for constructive dismissal by  
4 employees at the Trust?

5 **A.** There were many and varied ways of prolonging  
6 the inevitable outcome. There were -- you know, people  
7 got to know the policies really well and they would try  
8 and find the loopholes or whatever. So it was -- it was  
9 tricky dealing with so many different unions and quite  
10 strong unions as well.

11 **Q.** If we just look at the note of your call with  
12 Ian Pace, INQ0101934. It is at tab 6 of your bundle,  
13 my Lady.

14 **LADY JUSTICE THIRLWALL:** Thank you.

15 **MR BERSHADSKI:** 0101934. So you call Ian Pace, you  
16 mention issue on the neonatal department. "An alarm",  
17 in quotes, has gone off --

18 **A.** Yes.

19 **Q.** -- due to an increase in death rates. The  
20 alarm has gone again, we can see in the second  
21 paragraph.

22 Four or five lines down:

23 "They are all pointing fingers at each other, the  
24 staff. There has been an instance where a Consultant  
25 has referred to a midwife as Beverley Allitt."

194

1 **A.** Yes.

2 **Q.** How were you satisfied by this point that  
3 there were no malicious issues involved?

4 **A.** Because the -- the Medical Director  
5 Ian Harvey, Alison Kelly, all of the clinical team had  
6 been to look at, had been through this and they had  
7 given me those assurances that there was no -- it wasn't  
8 malicious.

9 The only thing that -- and they -- I kept asking:  
10 have we got anything at all? Have we got any evidence  
11 whatsoever? Has anybody seen anything? Anything  
12 untoward that we can look at? And the answer was always  
13 no.

14 **Q.** Well, were you aware that there had been  
15 a large number of unexplained, unexpected deaths on the  
16 neonatal unit?

17 **A.** At that point it wasn't that, it wasn't that  
18 many because they were talking -- we had had the  
19 Coroner's report that -- I can't remember the date, but  
20 it was they were, they were commissioning a report from  
21 the Royal College of Paediatricians in there. There was  
22 no commonality on the -- on the spreadsheets that I saw  
23 and then there was this, and then there was this  
24 Dr Brearey saying he had a drawer of doom but he  
25 wouldn't let anybody see what was in the drawer and it

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1 was all just very vague and odd.

2 **Q.** Well, were you aware by this point that there  
3 were a number of Consultants who had a genuine concern  
4 that there was a nurse deliberately causing these  
5 deaths?

6 **A.** The only Consultant that I knew of that was  
7 expressing any kind of concern for a long, long time was  
8 Dr Brearey. I wasn't aware that Dr Jayaram had concerns  
9 until quite far along in this process and that just  
10 might have been because I wasn't close enough to it. At  
11 that point there was a lot of people involved and  
12 I wasn't in that kind of inner circle.

13 **Q.** Did you go and speak to Dr Brearey about why  
14 he had these concerns?

15 **A.** No.

16 **Q.** Well, how were you able to tell your legal  
17 adviser that you were satisfied that there were no  
18 malicious issues involved when there had been  
19 an increase in deaths and a Consultant, as far as you  
20 were aware, was concerned that they were being  
21 deliberately caused by a nurse?

22 **A.** Well, I would like to have seen what was in  
23 his drawer of doom, but --

24 **Q.** Did you ask to go and see his drawer of doom?

25 **A.** Well, no, because I had said to Alison Kelly:

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1 Ian Pace has written this note so I don't know what my  
2 exact words were. But I was satisfied that we had no  
3 evidence of any wrongdoing at that time because I kept  
4 asking the question.

5 **Q.** But you knew by this point, because this was  
6 now a number of days after the NNU action planning  
7 meeting, so you knew that Letby had been removed from  
8 shift and that you had undertaken the task of checking  
9 that she wasn't working anywhere else, so there was  
10 surely enough of a concern to have taken those steps  
11 that there might be malicious issues involved?

12 **A.** I -- at that point, my view was if we take her  
13 off the unit, let's see if there is a correlation  
14 between, you know, the -- the spike and there not being  
15 now a spike. But then the unit was downgraded which  
16 muddled the waters somewhat.

17 But the other thing that bothers me though is  
18 regardless of what you think I think, the fact is  
19 Lucy Letby was removed from the unit but those -- and  
20 those Consultants didn't do anything. So it was like:  
21 Well, yes, she's a baby killer but now she's gone, well,  
22 we're just not going to do anything. They didn't do  
23 anything for months.

24 **Q.** Sorry --

25 **A.** From my perspective. That's what I saw,

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1 send somebody down there, this is ridiculous. Somebody  
2 needs to -- he needs to give us whatever he's got.  
3 Why -- why isn't he doing that?

4 **Q.** Right, so --

5 **A.** But -- but to answer your question, Andrew,  
6 I kept asking -- don't forget, I am not an Executive,  
7 I am on the peripheries, I am doing the day-to-day job  
8 and I kept saying, you know, have we got any evidence  
9 yet, is there anything at all we can hang our hat on  
10 here? And I just kept being told: no and that they were  
11 looking into it, that Ian Harvey had gone through every  
12 case, Alison Kelly had gone through every case and  
13 the -- there was nothing untoward from the Coroner.

14 So for me there was -- there was nothing here other  
15 than Dr Brearey saying he had some concerns about  
16 a nurse, a specific nurse.

17 **Q.** How could you be satisfied that there were no  
18 malicious issues if a Consultant was saying as far as  
19 you were aware that there were malicious issues, you  
20 hadn't even spoken to him about his concerns and as far  
21 as you were aware, he had a drawer of evidence of some  
22 description that you hadn't even seen; so how could you  
23 be satisfied that there were no malicious issues  
24 involved despite all of that?

25 **A.** Can I first of all say this is not my note.

198

1 Andrew.

2 **Q.** Yes.

3 **A.** That that didn't happen. And as I say, you  
4 know, my role as a deputy really was the operational  
5 running of the -- of the Trust and I was -- you know,  
6 I had a big -- two big day jobs that I was consumed with  
7 at that time. I was asking for assurance from  
8 Sue Hodgkinson, from Alison Kelly: do we have anything?  
9 Every opportunity, anything at all?

10 **Q.** Just before we leave this document, can you  
11 see towards the bottom Ian Pace is recorded as saying:

12 "I explained my [view this is three lines up in the  
13 last sort of substantive paragraph] was the priority was  
14 to investigate these issues that were arising bearing in  
15 mind the potential consequences and suspicions that have  
16 arisen."

17 Did you initiate an investigation under the  
18 investigation policies, the HR investigation policies,  
19 in response to that advice?

20 **A.** Okay, so this is Ian's view.

21 **Q.** Yes.

22 **A.** Not my view?

23 **Q.** Yes.

24 **A.** Okay. Yes, so when you say about an

25 investigation in a hospital, when it's to do with

200

1 clinical, the HR team is very much advisory. We don't  
2 go in and do the investigation. We don't do that  
3 because what are we looking for? It would be like  
4 asking you to go in and have a look, it's not your  
5 specialism.

6 So you would look to have the Royal College of  
7 Paediatricians go in and review the cases. You wouldn't  
8 get a HR admin person to do, you know, even a senior  
9 one, I wouldn't go and look at that. I wouldn't know  
10 what I was looking for.

11 **MR BERSHADSKI:** My Lady, I think we normally have  
12 a break around this time. Is now a convenient moment?

13 **LADY JUSTICE THIRLWALL:** Yes, certainly.

14 So we will take 15 minutes and we will come back in  
15 at 5 to 4.

16 (3.40 pm)

(A short break)

18 (3.55 pm)

19 **MR BERSHADSKI:** Ms Cairns, just before I resume my  
20 questioning I am going to ask you refer to me as  
21 "Mr Bershadski" rather than by my first name, if you  
22 don't mind.

23 **A.** Sorry?

24 **Q.** I am just going to ask you before we get back  
25 into the questions that you refer to me by

201

1 deaths by the time that you spoke to Ian Pace in  
2 July 2016?

3 **A.** Well, as I said before the break, that was  
4 Ian Pace's notes. I don't recall saying -- could you  
5 bring it up again for me, please.

6 **Q.** Yes, well, I am just asking about your  
7 evidence, not about the note. You told this Inquiry  
8 that you thought there hadn't been that many deaths?

9 **A.** Yes.

10 **Q.** Now, I am suggesting to you that that was  
11 completely wrong and there had been a very high number  
12 of deaths compared to the usual two to three average  
13 deaths per year that the neonatal unit experienced up  
14 until 2015?

15 **A.** There had been a spike in deaths but at that  
16 point when I spoke to Ian Pace, I didn't think that  
17 there had been anything other than that spike.

18 **Q.** Yes, that is a spike of 10 deaths that  
19 Eirian Powell had looked at in her thematic review. So  
20 on any account it was a very significant spike and very  
21 many deaths, wasn't it?

22 **A.** Yes.

23 **Q.** So would you agree that you were then in your  
24 mind minimising the problem compared to what it actually  
25 was when you spoke to Ian Pace?

203

1 "Mr Bershadski" rather than by my first name, if you  
2 don't mind, in your responses?

3 **A.** Sorry.

4 **Q.** Ms Cairns, just before the break, I think you  
5 said that one of the reasons that you thought there were  
6 no malicious issues involved when you spoke to Ian Pace  
7 on 5 July 2016 is because there hadn't been that many  
8 deaths as far as you were concerned.

9 Now, are you aware that there had been 13 deaths in  
10 the space of just a little bit over a year by that  
11 point?

12 **A.** No, I wasn't.

13 **Q.** How many deaths did you think there had been?

14 **A.** I can't remember.

15 **Q.** The --

16 **A.** But that wasn't how many were being looked at  
17 at various stages.

18 **Q.** Yes. Now, the thematic review document that  
19 had been prepared by Eirian Powell had looked at 10  
20 deaths, hadn't it, for which Lucy Letby was on shift at  
21 or just prior to the death for nine out of those 10; is  
22 that right?

23 **A.** I didn't see the thematic review.

24 **Q.** Okay. Well, would you agree with me that it's  
25 completely wrong to say that there hadn't been many

202

1 **A.** I don't believe that was my intention, no.

2 **Q.** I am going to ask you a few questions about  
3 the Silver Control exercise that you took part in on  
4 7 July. If we could have up on screen, please, document  
5 INQ0004319.

6 Now, we can see your name roughly in the middle of  
7 the document. Can you just give a little bit of  
8 background to the Inquiry what this series of meetings  
9 on 7 July 2016, was their purpose was?

10 **A.** Excuse me. Was this Silver Control?

11 **Q.** Yes.

12 **A.** Okay. So Silver Control is when you have an  
13 incident like the -- the only other Silver Control  
14 I have ever been involved in is when there is a doctors'  
15 strike. So it's a hub within the centre of the hospital  
16 where you bring together quite senior people and  
17 information is fed in and out and things are looked at  
18 and it's headed up by the Chief Executive and this one  
19 was to do with NNU.

20 **Q.** I am just going to ask about your role within  
21 that. If we go to page 3, please, of the document. We  
22 can see just one line up from 145 it says:

23 "Dee Appleton-Cairns confirmed review of permanent  
24 files completed"?

25 **A.** Yes.

204

1 Q. So can you just tell us what you did by way of  
2 review of personal files?

3 A. Yes. So every employee within the Trust has  
4 a personal file and it's kept in the HR department.

5 Now, I would like to tell you that there's only one  
6 file and that it's always complete and that's the only  
7 place where information is kept but we had the personnel  
8 files and it would start when you started your  
9 employment with the Trust and then you would add things  
10 to it, pay increases, references and appraisal  
11 information, that sort of thing.

12 So I asked -- I didn't have a lot to do that day,  
13 as I recall, so I felt a little bit like a spare part so  
14 as I thought it would be a good idea to get the porters  
15 to bring me over all of the personal files to do with  
16 NNU, everybody from the -- from the administrators and  
17 the housekeeper right through to the doctors that were  
18 on there and to bring them over to me and for me to go  
19 through them one by one.

20 I can't tell you what I was looking for  
21 particularly but sometimes, you know, whenever there is  
22 a situation I always go to the -- I always go to the  
23 root and that's usually the personnel file and sometimes  
24 you can find things on there and sometimes you don't.

25 Q. Now, by this point, Lucy Letby had been  
205

1 Q. Well, how are you able to be so sure now?

2 A. Because I had never seen it before until it  
3 came in the third bundle, last Friday.

4 Q. Well, this is one of the pages within a file  
5 called "HR Bundle".

6 Now, is it possible that you don't recall having  
7 seen this document --

8 A. No.

9 Q. -- at the time, but --

10 A. No.

11 Q. But if you looked at the HR files for every  
12 single person who worked on the neonatal unit --

13 A. Yes.

14 Q. -- it's surely possible that you simply can't  
15 now recall having looked at this at the time because you  
16 had looked at so many documents?

17 A. No.

18 Q. Very many?

19 A. No.

20 Q. No?

21 A. I did not see this because this is -- I mean,  
22 I don't know much about this because I am not clinical,  
23 but this is drugs error.

24 Q. Yes.

25 A. This goes to when there is a drugs error and  
207

1 identified as a person of particular interest, hadn't  
2 she, because you had attended the meeting on 30 June  
3 where there was a confirmation that she was no longer on  
4 shift, et cetera.

5 So presumably you would have paid particular  
6 attention to her personal file when conducting this  
7 review; is that right?

8 A. I paid particular attention to all of the  
9 files.

10 Q. Is there any reason why you wouldn't  
11 particularly focus on Lucy Letby considering she by that  
12 point was the particular individual?

13 A. I would not -- I wouldn't want to miss  
14 anything.

15 Q. Okay. So did you look at Lucy Letby's HR  
16 file?

17 A. I did, I did.

18 Q. Okay if I can just bring up a couple of  
19 documents from her HR file. If we could pull up  
20 INQ0008961, and page 45 within that. When conducting  
21 your review, you would have seen this document, would  
22 you, relating to a drug error --

23 A. No.

24 Q. -- and Lucy Letby's role?

25 A. No. This was not on her file.  
206

1 they happen quite often in a hospital.

2 LADY JUSTICE THIRLWALL: Where do they go?

3 A. Sorry.

4 LADY JUSTICE THIRLWALL: What were you going to  
5 tell us about where they go?

6 A. They go to the Clinical Governance Department  
7 who then review them and they look at whether it's, you  
8 know, very serious sort of Never Event, that type of  
9 thing, or they go to the education -- Clinical Education  
10 Department where you are looking at, you know, do you  
11 need to re-educate, re -- re -- you know, to check  
12 whether this person knows exactly what they are doing.

13 So this would be -- I wouldn't see this, this  
14 wouldn't necessarily come to HR. This is a clinical  
15 educational matter and pharmacy would have an overview  
16 if it is a drugs error.

17 Q. Yes, well, let's go over the page. If we go  
18 to page 47, please.

19 Now, this relates to the same incident:

20 "Lucy has commenced a continuous infusion of  
21 morphine at the end of her night shift."

22 Now, I am going to suggest that this is likely to  
23 have been within her HR bundle that you would have  
24 looked at because it is within a document called  
25 "HR Bundle" that has been --  
208

1 A. No, I have never seen this document before.  
 2 Q. -- disclosed?  
 3 A. This was not in her HR file.  
 4 Q. And it --  
 5 A. It might be worth asking Dr Christopher Green,  
 6 who is Chief Pharmacist, about these kind of documents.  
 7 Q. Well, let's also look over two pages to  
 8 page 49. Do you recall seeing this document,  
 9 April 2016, a note by Lucy Letby, "Reflection on drug  
 10 error"?  
 11 A. No. I don't recall it.  
 12 Q. Well, do you think it's possible that you  
 13 simply missed these documents contained within  
 14 Lucy Letby's HR bundle when you conducted your review?  
 15 A. No. Absolutely not.  
 16 Q. How can you be so sure if you were looking  
 17 through every single HR -- I mean how many HR bundles do  
 18 you think you would have looked at?  
 19 A. Between 20 and 30.  
 20 Q. Did you look at all of them in the course of  
 21 one day?  
 22 A. Yes.  
 23 Q. Presumably some of them are fairly long  
 24 bundles for people who have been employed by the Trust  
 25 for a significant period of time?

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1 not a drug that was prescribed for a baby to whom Letby  
 2 gave it? Okay.

3 So I am going to suggest to you that it is possible  
 4 because you didn't have a clinical background that you  
 5 yourself looked at these and didn't think they were --  
 6 they didn't particularly jump out at you as being  
 7 significant because you didn't have the clinical  
 8 knowledge to understand that these were both very  
 9 significant incidents?

10 A. I did not see these documents when I looked  
 11 through the personal files.

12 Q. Well, if we go to just page 1 of this document  
 13 and put it into context, does this look like the sort of  
 14 HR file you would see, "Learning contract from 2012"?

15 A. This is more clinical education. So the  
 16 clinical educators would -- would hold this kind of  
 17 information. It should be on ESR as well -- sorry, ESR,  
 18 Electronic Staff Record.

19 Q. If we go to page 23, "Welcome event for  
 20 Lucy Letby". Is that the sort of document you would see  
 21 in an HR record, a document from HR support services  
 22 welcoming her to her position at the Countess of Chester  
 23 Hospital?

24 A. This is -- this is a document we would send  
 25 out to anybody who was starting, yes.

211

1 A. Yes.  
 2 Q. Well, isn't it possible that you would have  
 3 missed some documents if you were looking through 20 to  
 4 30 bundles?  
 5 A. I did not miss these documents. But can  
 6 I just say, even if they had have been there, drugs  
 7 errors occur on quite a regular basis within a hospital.  
 8 Q. Well --  
 9 A. In both hospitals that I have worked at.  
 10 Q. You explained earlier that you don't have  
 11 a clinical background yourself?  
 12 A. No.  
 13 Q. So you wouldn't know yourself necessarily the  
 14 significance or the rarity of any particular drug error;  
 15 is that right?  
 16 A. Yes, that is true.  
 17 Q. Now, we have heard evidence, the Inquiry has  
 18 heard evidence that this was a very significant,  
 19 potentially fatal, drug error.  
 20 A. Okay.  
 21 Q. The 2013 one?  
 22 A. (Nods)  
 23 Q. Also the Inquiry has heard evidence this one  
 24 that is on screen now in April 2016 is an incident that  
 25 should simply have never happened because Gentamicin was

210

1 Q. Yes. So you wouldn't be surprised to find  
 2 that within her HR documents then; is that fair?

3 A. No, I don't think we would. This is the  
 4 letter we would send out and then we would have -- and  
 5 again this is in the Education Centre, I was across the  
 6 campus at the HR Business Partners Department which is  
 7 pretty much at the other side. They would keep a record  
 8 of who had attended and what courses they had done.  
 9 They would then input that into the Electronic Staff  
 10 Record because then there would be a mechanism for if  
 11 there was any reviews or updates or whatever, then that  
 12 would trigger through their system. But it wouldn't  
 13 necessarily come down to HR no, that letter.

14 Q. Okay. By this point, there was clearly  
 15 a particular concern about Lucy Letby. Would you agree  
 16 that it was important for you to carefully scrutinise  
 17 all records that the Trust had in relation to her,  
 18 either yourself or if you didn't understand all the  
 19 documents relating to her because they had a clinical  
 20 element, to make sure that somebody who did understand  
 21 them reviewed them with you?

22 A. Yes. That would have been Sian Williams or  
 23 Karen Rees, but they wouldn't necessarily do it with me.  
 24 They would bring something to me potentially.

25 Q. Now, if we go back to the Silver Control

212

1 document, please, INQ0004319.

2 **A.** Can I just say that says "HR Support Services"  
3 at the bottom.

4 **Q.** Yes.

5 **A.** That is that shared service that I talked  
6 about. So that would have been generated by that shared  
7 service which is autonomous from both Trusts, but  
8 shared.

9 **Q.** Yes. So if we go to INQ0004319, page 5, we  
10 can see your name there towards the top.

11 "Dee Appleton-Cairns: we have been looking at data,  
12 gone through every personal file for everyone on the  
13 unit. As expected we have not really found anything."

14 **A.** Mm-hm.

15 **Q.** Why was it you who said that as expected you  
16 hadn't really found anything?

17 **A.** It -- it was a shot in the dark going through  
18 there. You know, you rarely, what I have found in  
19 personal files in the past has been things like  
20 a reference that says: we have got some concerns about  
21 this person's practice or whatever and it's been  
22 overlooked or it's -- well, there was nobody else and  
23 they were better than -- better than having nobody.

24 But it's rare. But it's still worth checking which  
25 is why I did that. I didn't have anything else to do in  
213

1 I was hearing it second-hand and so I said, okay, if  
2 they have got concerns what are those concerns? And  
3 they were vague.

4 **Q.** Now, you explain in your statement at  
5 paragraphs 39 and 41 that you worked with Sian Williams  
6 to look at shift patterns and, in particular, whether  
7 there was a particular correlation with Lucy Letby; is  
8 that right?

9 **A.** No, I don't think I said that. Sian was  
10 looking at the patterns.

11 **Q.** Yes. Okay. So at paragraph 39 you say that:  
12 "Sian had been analysing the staffing rotas to  
13 identify any commonalities [that can come down off the  
14 screen now, thank you] between the staff on duty and the  
15 time of the neonatal deaths."

16 Were you -- did you speak to Sian Williams about  
17 the exercise that she had conducted?

18 **A.** Just to say, you know, have you completed it  
19 or, you know, have you got any concerns?

20 I had a very brief look at it and it was quite --  
21 and I just remember it being quite large, quite  
22 comprehensive. There was a lot of data on there and  
23 there was Lucy -- the commonality was definitely that  
24 Lucy Letby had been on more shifts than anybody else but  
25 there was also another nurse and there was a doctor that  
215

1 Silver Control that day so that's why I did it but as

2 expected, I didn't really find anything.

3 **Q.** Yes. Well, would it be fair to say that you  
4 weren't expecting to find anything in the personal  
5 records because you personally didn't believe that there  
6 was foul play involved?

7 **A.** I am very open-minded but I wanted to see some  
8 evidence. I wanted to hear something like we have heard  
9 you know, after that about somebody's got an eye witness  
10 account or something. Something that I can then start  
11 an investigation about.

12 **Q.** Well, why can't you start an investigation if  
13 a Consultant or a number of Consultants have come to you  
14 to say that they have got real concerns about  
15 a particular individual, they think that they are  
16 deliberately harming babies? Why isn't that enough for  
17 you to begin an investigation to see whether you can  
18 find any evidence?

19 **A.** No Consultant or anybody else ever came to me  
20 and said that.

21 **Q.** Yes, but you knew by this point that the  
22 Consultants did have those concerns, albeit you didn't  
23 speak to them directly yourself but you knew that they  
24 did have that concern, didn't you?

25 **A.** No. They were speaking to the Executives.  
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1 had -- there was quite a lot of commonality there.

2 If you then factored in the fact that Lucy was the  
3 only full-timer and she had been doing extra shifts it  
4 then -- it then -- it then didn't give you such a clear  
5 picture for me.

6 **Q.** Well --

7 **A.** But that wasn't my decision to make, I just  
8 had a look at it and I just said, you know: have you  
9 found anything? And she went "not really" and then she  
10 went off to speak to Alison Kelly but it wasn't -- it  
11 wasn't my decision to make.

12 **Q.** Sorry, so you are saying that Sian Williams  
13 told you that she hadn't really found anything as  
14 a result of her analysis?

15 **A.** I think she said there was a cluster -- there  
16 was a cluster of three days/nights or babies that she  
17 may have a concern about and that was -- but then she  
18 said she wanted to go and speak to Alison about it so  
19 that was it. It was a passing comment.

20 **Q.** The Inquiry has heard evidence from  
21 Sian Williams this morning who has explained that after  
22 she had conducted her analysis, she had real concerns  
23 about the amount of time that Lucy Letby was on shift  
24 when babies were collapsing and dying and that she  
25 recommended that the police be called in on a number of  
216

1 occasions; that was her evidence to the Inquiry this  
 2 morning?  
 3 **A.** (Nods)  
 4 **Q.** Now, is it possible that you are  
 5 misremembering what Sian Williams told you about her  
 6 concerns following her analysis?  
 7 **A.** It was a passing comment so she probably  
 8 didn't want to confide in me before she had spoken to  
 9 Alison, potentially. But I will accept it's eight years  
 10 ago, I can't remember.  
 11 **Q.** Okay. I am just going to ask you about  
 12 a different topic, Ms Cairns. So you were aware that  
 13 Lucy Letby submitted a grievance in September 2016; is  
 14 that right?  
 15 **A.** Yes.  
 16 **Q.** If we just bring that up on screen, it's  
 17 INQ0002879. If we look at page 3, this is the Letby's  
 18 actual grievance document.  
 19 She was asking why she had been redeployed  
 20 essentially as part of her grievance; is that right?  
 21 **A.** Yes.  
 22 **Q.** Now, if we look at the grievance policy,  
 23 INQ -- if we go to page 99 within that document, you  
 24 would have been familiar with this policy at the time  
 25 presumably?

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1 **Q.** So the policy provided that actually there can  
 2 be circumstances where rather than dealing with the  
 3 grievance as a grievance it's more appropriate to follow  
 4 other policies of the Trust such as disciplinary or the  
 5 whistleblowing policy in the last bullet point?  
 6 **A.** Mmm mm.  
 7 **Q.** Did you consider that the situation that you  
 8 were faced with in September 2016 was precisely the kind  
 9 of situation where it would be better rather than  
 10 dealing with the grievance about the redeployment to  
 11 consider the substance of the matter which was concerns  
 12 that had been raised about Letby under the  
 13 whistleblowing policy or potentially even to investigate  
 14 it under the disciplinary policy and doing it that way  
 15 rather than dealing with the grievance itself?  
 16 **A.** Okay. So this was Lucy Letby's grievance.  
 17 **Q.** Yes.  
 18 **A.** So it wouldn't be appropriate to -- for her  
 19 to -- the whole point of a grievance which is, which is  
 20 partly terms and conditions, it is contractual that you  
 21 are entitled to have a grievance if you are not happy  
 22 about something, is the fact that you are looking for  
 23 a way to move things forward. Somebody is unhappy with  
 24 something, they want it to move forward.  
 25 So I didn't think that -- I think you -- so,

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1 **A.** If this is the policy, yes. But it's --  
 2 the -- my only concern is it's -- it's signed there by  
 3 Susan Young and she was -- she actually left the Trust  
 4 in 2011. So I have just got some concerns. I know it  
 5 says January 2013 but she did leave the Trust.  
 6 **Q.** Yes, well, it says January 13 there --  
 7 **A.** Okay.  
 8 **Q.** -- and this again was a policy that was to be  
 9 reviewed every three years, wasn't it?  
 10 **A.** Yes, okay.  
 11 **Q.** So it would appear that it would be in force,  
 12 unless something else intervened, until November 2016?  
 13 **A.** Mm-hm.  
 14 **Q.** Is that right? Now if we go over the page to  
 15 page 100 the policy provided, in the middle of the  
 16 "Grievances" paragraph:  
 17 "If a grievance can be more appropriately dealt  
 18 with under a different procedure, staff will be advised  
 19 that this is the case. The examples below indicate  
 20 where it is inappropriate to follow the grievance  
 21 procedure as other mechanisms or Trust procedures are in  
 22 place".  
 23 Can you see that? It's been highlighted in yellow  
 24 on the screen?  
 25 **A.** Yes.

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1 forgive me, are you implying that instead I should have  
 2 said: well, I'm sorry, Lucy, you can't -- I am actually  
 3 going to discipline you under this?  
 4 **Q.** Well --  
 5 **A.** Or the fact that, but she wasn't -- she wasn't  
 6 whistleblowing, so this is about Lucy Letby and it was  
 7 her grievance, it wasn't what am I disciplining her  
 8 about? And what, what is she whistleblowing about?  
 9 I don't understand I think you are saying: well,  
 10 shouldn't you follow the policy for somebody else? But  
 11 somebody else didn't raise it. Lucy Letby raised it.  
 12 **Q.** Well, they did raise it, didn't they, because  
 13 a number of Consultants, or on your evidence as far as  
 14 you knew just Dr Brearey had raised a serious concern  
 15 about her and that should have been dealt with under the  
 16 Speak Out Safely policy, shouldn't it?  
 17 **A.** Well, that -- but we are talking which one --  
 18 which policy are we talking about now. Somebody has  
 19 raised a grievance? This is a grievance policy.  
 20 **Q.** Yes.  
 21 **A.** And that is their grievance, that is who we  
 22 are looking at, that is who's in the box. You can't  
 23 turn round and say: well, you have raised a grievance so  
 24 I am going to discipline you over it. That -- that  
 25 doesn't follow. And in the same instance she hadn't

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1 whistleblown. So it is about her, it's not about then  
 2 saying: you have raised this grievance so I am going  
 3 to -- because it is about you, it's not about somebody  
 4 else.  
 5 **Q.** Yes, what I am suggesting is that when  
 6 a grievance came in about the situation from Letby, what  
 7 ought to have happened is that using this section of the  
 8 policy, the actual underlying concern that had been  
 9 raised should have been dealt with under the Speak Out  
 10 Safely Policy?

11 **A.** Well, you could have done that before the  
 12 grievance came in, if that is what -- if that's what  
 13 Sue Hodgkinson, Alison Kelly, the Executives who were  
 14 dealing with that, if that is what they wanted to do,  
 15 then that is what they should have done. But when we  
 16 come down to the grievance then those -- those are not  
 17 appropriate, no.

18 **Q.** Did you consider that the Speak Out Safely  
 19 policy should have been applied to the concerns raised  
 20 by the Consultants?

21 **A.** Well, I did suggest that it should be done in  
 22 tandem. I -- I spoke to Sue Hodgkinson about that and  
 23 she said she was going to raise it with Ian Harvey, the  
 24 Medical Director, but whether that happened or not,  
 25 I don't know. But it would have been good to have that

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1 **Q.** Were you involved with his appointment?

2 **A.** Yes, I made that suggestion along with  
 3 a couple of others.

4 **Q.** Now, I think it was raised with you by  
 5 Sue Hodgkinson that it would be more in line with policy  
 6 to have an independent person, somebody external to the  
 7 Trust investigate the grievance; is that right?

8 **A.** No, I don't recall that. We said about the  
 9 hearing being an independent person, the person, the  
 10 chair, the person who would -- who would hear it.

11 **Q.** Well, did you give any consideration to  
 12 whether Chris Green was sufficiently independent to act  
 13 as the investigating officer for the grievance?

14 **A.** I have always known Dr Chris Green to be an  
 15 extremely honest and honourable man who had a lot of  
 16 experience with grievance investigation -- in fact  
 17 disciplinary investigations.

18 So there was -- there was himself and there was  
 19 a couple of other people that I put forward as  
 20 suggestions but it was again up to the Executive Team  
 21 who they chose.

22 **Q.** Did you know that Chris Green had had  
 23 a disagreement with Dr Brearey about a pharmaceutical  
 24 error in relation to one of the babies prior to this  
 25 grievance?

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1 in tandem from Dr Brearey and Dr Jayaram.

2 **Q.** Well, why?

3 **A.** But they didn't.

4 **Q.** Why didn't you ensure that that happened given  
 5 that you had said it should be done, but then you say  
 6 you simply don't know whether it was done --

7 **A.** No, I escalated it to Sue Hodgkinson, who is my  
 8 HRD, who -- and I said, you know, you need to pass this  
 9 on to Ian Harvey and I understand that's what she did  
 10 and they chose not to.

11 **Q.** It's right that you had operational conduct of  
 12 these HR processes at the time; is that right?

13 **A.** Yes, yes.

14 **Q.** Well, why didn't you -- rather than just  
 15 escalating it if they didn't do it, why didn't you just  
 16 make sure it was done yourself?

17 **A.** I had done what I thought was appropriate.  
 18 I raised -- I escalated it to my HR Director because  
 19 they were -- the Executive Team were dealing with the  
 20 Consultants and suggested that Ian Harvey speak to the  
 21 two Consultants about it.

22 **Q.** Now, I am not going to ask you about the  
 23 grievance investigation itself, that was conducted by  
 24 Dr Chris Green; is that right?

25 **A.** That is correct.

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1 **A.** I did not know that prior to him conducting  
 2 the investigation. However, it is in the notes of the  
 3 grievance and I did read them during the -- when I got  
 4 the bundle and read the hearing notes and it seemed to  
 5 me that that Dr Brearey was supported by his BMA rep and  
 6 the BMA rep had actually come to the conclusion that  
 7 there was no conflict of interest and therefore it  
 8 wasn't an issue.

9 **Q.** Do you think now, looking back on it, that  
 10 given the particular importance of the issues that were  
 11 being investigated as part of the grievance that it  
 12 wasn't best practice to have as the investigating  
 13 officer somebody who had had a disagreement to do with  
 14 one of the babies with the person raising the concern?

15 **A.** I can only reiterate what I have said. I have  
 16 only ever known Dr Chris Green to be an honest and  
 17 honourable person and the fact that I didn't know that  
 18 going -- when I recommended him, and it seemed that it  
 19 was dealt with by Dr Brearey's BMA rep during the  
 20 interview for the investigation and they were happy that  
 21 it wasn't a conflict of interest and that's all I can  
 22 say on it.

23 **Q.** That can come down now off the screen, thank  
 24 you.

25 Now, it's right, isn't it, that you had a meeting

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1 with the chair of the grievance hearing on 1 December  
 2 prior to the grievance hearing itself?  
 3 **A.** Yes.  
 4 **Q.** The chair was Annette Weatherley, I think she  
 5 was the Deputy Chief Nurse at South Manchester; is that  
 6 right?  
 7 **A.** Annette?  
 8 **Q.** Annette Weatherley. She was the person who  
 9 heard the actual grievance; is that right?  
 10 **A.** I don't know.  
 11 **Q.** You don't know.  
 12 **A.** I can't remember now. She was -- that was the  
 13 first time I had met her.  
 14 **Q.** Okay. Well, if we could just put up on screen  
 15 INQ0054483. We can see that a pre-meeting was arranged  
 16 for you to meet with Annette who was the chair who heard  
 17 the grievance, a pre-meet was held with you before the  
 18 grievance hearing took place?  
 19 **A.** Yes.  
 20 **Q.** Now, did you discuss at that pre-meeting that  
 21 you and Annette Weatherley thought that there had been  
 22 a witch hunt against Lucy Letby?  
 23 **A.** No. Not, not to my recollection. The  
 24 pre-meet was exactly like I have had today, been invited  
 25 to this Inquiry. I am invited to come here at a certain  
 225

1 you to Annette Weatherley on 2 December:  
 2 "Hi Annette, sorry for the delay. I have also  
 3 added in about LL's mentor."  
 4 **A.** Yes.  
 5 **Q.** Now, it appears that you had a hand in  
 6 drafting the grievance outcome?  
 7 **A.** Yes.  
 8 **Q.** Why is that, considering that it was supposed  
 9 to be the independent chair who was coming who was  
 10 determining the grievance?  
 11 **A.** Well, you just write what they want. You  
 12 know, you are like a secretary to them. They tell you  
 13 what they -- what they want you to -- to write and you  
 14 do that. Normally you can't get anybody to chair  
 15 a grievance or a disciplinary unless somebody is  
 16 prepared to do that for them, so it would be standard  
 17 practice.  
 18 **Q.** Okay. Well, you have --  
 19 **A.** But it wouldn't be -- it is not for me, so  
 20 what happened was the -- you have got to answer every  
 21 question from the grievance, that's part of the  
 22 template. So there would have been somebody in HR who's  
 23 got the template and then you fill in all the bits and  
 24 then you send it to the chair and the chair will then,  
 25 you know, make any changes, do whatever they want to do,  
 227

1 time, I am shown the room, we meet each other, we chat.  
 2 That's it. There's nothing more sinister about it than  
 3 that.  
 4 **Q.** I am going to suggest that you discussed your  
 5 views about whether the allegations against Lucy Letby  
 6 had any merit or not at that pre-meeting prior to the  
 7 grievance hearing taking place?  
 8 **A.** I have absolutely no recollection of that.  
 9 **Q.** Okay. I am just going to take you to a few  
 10 emails about -- concerning the grievance outcome. Could  
 11 we put up on screen, please, INQ0056138.  
 12 Sorry, Ms Cairns, unfortunately the system can get  
 13 a little bit sluggish at times. There is an issue with  
 14 that INQ reference. I think if we could have instead  
 15 INQ0056150.  
 16 **LADY JUSTICE THIRLWALL:** Is there a hard copy we  
 17 could use?  
 18 **MR BERSHADSKI:** Yes, we seem to have an issue with  
 19 some of the INQ references. Okay.  
 20 **LADY JUSTICE THIRLWALL:** I know the one this  
 21 morning did actually materialise when we thought that  
 22 wasn't there either. Can we ...  
 23 **MR BERSHADSKI:** Okay let's try a third one and see  
 24 if it will improve things. INQ0056173. We have struck  
 25 lucky, Ms Cairns. You can see there is an email from  
 226

1 say what they want to say and then it usually goes back  
 2 two or three times and I remember when I saw the in the  
 3 first bundle there was the outcome letter and it was  
 4 dated 1 December which was the date of the hearing and  
 5 I said I am really sure that that is not the final  
 6 version because I rarely manage to complete it on a day  
 7 because you usually are exhausted and by the time  
 8 everybody's sort of, you know, gone through what --  
 9 what, you know, the Chair's telling you what they want  
 10 in it and the bits not to miss and you are making all  
 11 the notes and then it's the following day that you  
 12 finally get to the letter and then the letter goes  
 13 backwards and forwards and then there is final version  
 14 and then that's the one that goes to the person with the  
 15 grievance.  
 16 **Q.** Now, it's unfortunately in one of the  
 17 documents that we are not able to put up on screen but  
 18 you have seen them, I know?  
 19 **A.** Yes.  
 20 **Q.** My Lady, they are behind tab 16 in the bundle.  
 21 You had actually sent a draft of the grievance  
 22 outcome to Sue Hodgkinson and Alison Kelly --  
 23 **A.** Yes.  
 24 **Q.** -- at the Trust as part of the drafting?  
 25 **A.** Yes.  
 228

1 Q. That's right, isn't it?

2 A. Yes.

3 Q. Alison Kelly then replied to you with some  
4 suggestions to add in a section of conclusions into the  
5 draft which you then added in in the version that you  
6 sent along with the email that we have got here; that's  
7 right, isn't it?

8 A. Well, I think we should -- it's a shame we  
9 can't see it because I think that the Inquiry needs to  
10 know exactly what that was.

11 So basically it was obviously a hot topic,  
12 Sue Hodgkinson, who was my HRD, had asked to see a copy  
13 of the draft, I said: this is the draft but, you know,  
14 it's not -- it's not complete and it had also gone to  
15 Alison Kelly.

16 Alison Kelly had asked me -- had put into that  
17 document that are we going to see Chris Green's  
18 conclusion here, which we always were, because I had put  
19 it's not complete. That conclusion was going to go in  
20 anyway and then there was a bit where she had tried to  
21 suggest we took something out and Annette was really  
22 clear that no, that was not coming out and that stayed  
23 in. So there was no change to it

24 The only other words, because it came back from  
25 Mary Crocombe, who is Alison Kelly's secretary, and she  
229

1 can't. So I think you are right on that point.

2 Q. You added a whole section as part of your  
3 input into the draft. If we can go to INQ0056174 --  
4 unfortunately that document's not working either so I am  
5 going to have to read out the relevant section?

6 A. Okay.

7 Q. You added in a section under question 7 where  
8 you wrote:

9 "I acknowledge that these concerns [ie the  
10 Consultants' concerns] were raised through the  
11 appropriate channels in line with both the Trust's Speak  
12 Out Safely policy and the guidance proffered by the GMC.  
13 However, I do not find that the consultants' concerns  
14 when reiterated to the Executive Team were 'Clear,  
15 honest and objective'. (GMC guidance)."

16 You added that section in; is that right?

17 A. No, I don't believe I did. I would have to  
18 see it. I don't believe I did. I didn't add anything  
19 in. It was all Annette's work. She signed off the  
20 final copy.

21 Q. Yes, well she signed it off but that was the  
22 section that was added by you in response to  
23 a suggestion by Alison Kelly that section 7 be expanded;  
24 that's right, isn't it?

25 A. Well, no, I can't -- I'm sorry, I need to see  
231

1 is a bit of a -- of a grammar police and there was  
2 a couple of words that she was suggesting that I took  
3 out which I remember being a bit sort of -- well, a bit  
4 sort of frustrated about but actually she was right with  
5 regard to the grammar. So they -- those words that said  
6 Lucy or whatever came out.

7 But there was only two things, one was  
8 Chris Green's conclusion which was going in anyway and  
9 the bit that Alison was suggesting that she didn't want  
10 there but Annette insisted that it went in anyway so  
11 there was nothing.

12 Q. Well, do you agree that it's not appropriate  
13 when you have appointed an independent chair to hear  
14 a grievance to start involving Executives at the Trust  
15 and yourself in drafting the outcome?

16 A. It would be absolutely usual for me to draft,  
17 so that is the first thing. To include Alison and Sue,  
18 they wanted a copy of the draft. They weren't being  
19 involved, they weren't being invited to make any  
20 comments and certainly that was curtailed. Should  
21 I have sent it on reflection? No probably I shouldn't  
22 of, because I think you are right, I think that they  
23 thought oh -- well, certainly Alison, Sue wouldn't of,  
24 but Alison thought: oh, here's -- you know, I think  
25 I can add something in and it was like, well, no, you  
230

1 it. Can I see a paper copy?

2 Q. I think you have been -- you have been sent  
3 all of these documents so you would have seen it.  
4 Unfortunately we can't bring it up on screen.

5 A. Well, I think it's unfair to ask me the  
6 question if I can't see it. I need to see it.

7 LADY JUSTICE THIRLWALL: It may be something that  
8 we will have to bring you back to ask you about when we  
9 are able to show it to you more clearly. It is not in  
10 the file you have been provided with, I presume.

11 A. It is downstairs, if somebody wants to go and  
12 get it.

13 LADY JUSTICE THIRLWALL: So you have got it? All  
14 right. Perhaps that might be the way ahead to get  
15 the --

16 A. I don't believe I added anything into -- into  
17 that, that grievance letter. Anything.

18 MR BERSHADSKI: My Lady, I am in your hands about  
19 how to deal with it. We could get a copy or I am happy  
20 to hand up my copy to the witness to simply expedite.

21 LADY JUSTICE THIRLWALL: That might be the quickest  
22 way of dealing with it.

23 MR BERSHADSKI: Yes, it is marked up, I am afraid.

24 LADY JUSTICE THIRLWALL: It has got highlighter on  
25 but you can ignore that.  
232

1  
2 (Document handed to witness).  
3 **A.** Why would you think I have done that?  
4 **MR BERSHADSKI:** Well if you look back, from the bit  
5 I have given you, if you look at the previous draft,  
6 that was annotated by Alison Kelly, wasn't it, to say,  
7 whereas previously section 7 was simply one sentence.  
8 **A.** Section 7 said about adding in -- Alison Kelly  
9 had put: are we adding in Chris's conclusions?  
10 **Q.** Yes.  
11 **A.** Yes, we were always going to add in Chris's  
12 conclusions. We didn't have it at the time, that was  
13 the first draft that she had had. So that went in.  
14 **Q.** You then typed up and added all of that in?  
15 **A.** I typed it all up.  
16 **Q.** Yes, so in response to Alison Kelly's  
17 suggestion you added in that whole page-long section  
18 under section 7; is that right?  
19 **A.** No, no, not according to Alison Kelly, not on  
20 her direction. That, Chris's -- Chris Green's  
21 conclusions was always going to be added in and -- and  
22 that is the -- that's what went to Annette who signed it  
23 all off.  
24 **Q.** Yes, so you added in those conclusions?  
25 **A.** I added it all in, I added it all in.

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1 **A.** Yes. The LADO?  
2 **Q.** The LADO.  
3 **A.** Yes.  
4 **Q.** And that was in July 2018, yes?  
5 **A.** Yes.  
6 **Q.** Now, on reflection, do you think that that is  
7 a meeting that you should have attended and made the  
8 referral to attend that meeting two years previously  
9 when you first heard about concerns about Letby harming  
10 babies?  
11 **A.** No. The only reason I attended that meeting  
12 is because Sue Hodgkinson was off sick and I had stepped  
13 up into her role at that time and I was asked by  
14 Alison Kelly to accompany her. That's the first and  
15 only LADO meeting I've ever been to.  
16 **Q.** You had never previously been to any LADO  
17 meetings?  
18 **A.** No.  
19 **Q.** Had you ever made any LADO referrals before?  
20 **A.** No. Sorry, no.  
21 **Q.** Do you think that that might explain why you  
22 didn't make a referral in this case, because you just  
23 weren't familiar enough with the necessity of doing it  
24 because you hadn't done it before?  
25 **A.** Possibly. If I had wanted to make a LADO

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1 **Q.** And then it went off to Annette Weatherley?  
2 **A.** Yes, but --  
3 **Q.** That's right, isn't it?  
4 **A.** I wrote all of it, you know, I typed all of  
5 it.  
6 **Q.** Yes, and I think you have agreed already that  
7 on reflection, getting the input in --  
8 **A.** I didn't add that in on the direction of  
9 Alison Kelly. She had put that in but it was always  
10 going to be in anyway.  
11 **Q.** Right.  
12 **A.** So I wasn't being directed by Alison Kelly.  
13 I want to make that really clear.  
14 **Q.** Yes. So even though in the previous email  
15 Alison Kelly suggested adding in a section and then in  
16 the next version you have added it in, you're saying it  
17 wasn't because Alison had made that suggestion?  
18 **A.** That's exactly what I am saying.  
19 **Q.** Okay.  
20 **LADY JUSTICE THIRLWALL:** We got that.  
21 **A.** Okay. Sorry.  
22 **MR BERSHADSKI:** I will get it, don't worry.  
23 It's right, isn't it, that you attended a meeting  
24 with the Local Authority Safeguarding Board in 2018, is  
25 that right?

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1 referral, I absolutely would have gone through  
2 Alison Kelly because she was the LADO lead.  
3 I wouldn't have known how to do it because I have  
4 never done it before. So I would have gone to her and  
5 said: Look, you know, I think you need to do this.  
6 I didn't. But then that was -- she was in the inner  
7 circle, the thick -- you know, she could have made that  
8 decision.  
9 **Q.** Do you agree that you should have suggested  
10 that the referral be made if you had taken concerns  
11 about babies being harmed seriously?  
12 **A.** If I had seen or I truly believed there was  
13 evidence then yes, I would have of. But at that point  
14 I was not -- I was too far on the periphery to have that  
15 kind of information.  
16 **MR BERSHADSKI:** Thank you very much, Ms Cairns.  
17 My Lady, I don't have any further questions.  
18 I don't know, there may be some from a Core Participant.  
19 **LADY JUSTICE THIRLWALL:** Mr Baker.  
20 **Questions by MR BAKER**  
21 **MR BAKER:** Ms Appleton-Cairns, my name is  
22 Richard Baker. Can I begin by offering a space at the  
23 start of my questions for reflection.  
24 I represent a number of Families whose children  
25 were murdered or attacked by Lucy Letby. Do you feel,

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1 on reflection, that the HR process and the way in which  
2 you managed it contributed to a delay in bringing Letby  
3 to justice?

4 **A.** No, I do not.

5 **Q.** Even with the benefit of all that you have  
6 seen and heard, you don't think that your actions  
7 contributed at all to a delay in bringing Letby to  
8 justice?

9 **A.** No, I do not. I think that the grievance  
10 procedure was an opportunity for the Consultants to  
11 bring forward and explain in more detail what their  
12 concerns were and any evidence that they had.

13 And there was nothing in that grievance that they  
14 brought, that they brought to the attention of somebody  
15 who was independent, an independent chair.

16 **Q.** Well, I think you have already been asked  
17 questions about how independent that process was.

18 But can I say this: this was a process that was  
19 designed to pander to the whims of a serial killer,  
20 wasn't it, the grievance process, with the benefit of  
21 hindsight?

22 **A.** I don't believe that.

23 **Q.** Do you have any skills or experience at all  
24 that permitted you to understand or interpret the  
25 clinical issues in this case?

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1 by yourself and the nursing staff?

2 **A.** Okay.

3 **Q.** Well, that's "yes", isn't it?

4 **A.** Yes.

5 **Q.** You have already said in evidence that you at  
6 no time went to speak to any of the Consultants who were  
7 making allegations against Lucy Letby?

8 **A.** (Nods)

9 **Q.** That's correct, isn't it? That's what you say  
10 in your witness statement?

11 **A.** Yes.

12 **Q.** So you approached this issue by having  
13 a meeting on the face of it about these issues with the  
14 nursing staff, but didn't seek to balance that by  
15 speaking to any of the Consultants. Why was that?

16 **A.** I was -- I was asked to attend this meeting.  
17 It wasn't my meeting.

18 **Q.** Well, no, that's, I'm sorry, not a very good  
19 answer because you have made various assertions in this  
20 Inquiry about the evidence that was being presented to  
21 you as to the quality of the allegations that were being  
22 made by the Consultants?

23 **A.** Yes.

24 **Q.** Now, if you say before the Inquiry that the  
25 evidence was never presented to your satisfaction, then

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1 **A.** The what, sorry?

2 **Q.** Did you have any skills or experience that  
3 permitted you to interpret the clinical issues in this  
4 case?

5 **A.** No.

6 **Q.** Would you agree you were entirely ill equipped  
7 and unqualified to investigate murder in a healthcare  
8 setting?

9 **A.** Yes.

10 **Q.** Can we look at your witness statement, please,  
11 and to paragraph 17, which I think sets out your first  
12 involvement. You should have a copy of it in front of  
13 you I think, it won't appear on the screens.

14 It's a reference to a meeting on 30 June 2016,  
15 which you attended two neonatal unit action planning  
16 meetings and in attendance to both meetings were  
17 Alison Kelly, Jill Galt, Sue Hodgkinson, Sian Williams,  
18 Ruth Millward, Julie Fogarty and Karen Rees?

19 **A.** Yes.

20 **Q.** And they were meetings arranged to provide  
21 assurance to the Executives as to how the situation on  
22 the NNU was being handled in light of the increase in  
23 neonatal deaths?

24 **A.** Yes.

25 **Q.** So that was a meeting that was attended only

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1 I think it's important that you justify your approach.

2 So you spoke to the nurses. You never spoke to the  
3 doctors?

4 **A.** There was no evidence presented to me at all.

5 **Q.** Well --

6 **A.** By anybody.

7 **Q.** I'm sorry. We are going to come on to a note  
8 in a moment where you make assertions about the quality  
9 of evidence that was available.

10 I think it's quite a simple point. You spoke to  
11 the nurses, but you never spoke to the doctors. Why  
12 not?

13 **A.** Because the doctors would only speak to the  
14 Executives.

15 **Q.** So you are saying that the doctors --

16 **A.** And I knew Ravi. I knew Ravi quite well.

17 **Q.** Are you saying the doctors refused to speak to  
18 you?

19 **A.** The doctors didn't speak to me. You would  
20 have to ask them why they didn't speak to me.

21 **Q.** No. Are you saying that you sought to speak  
22 to the doctors and they refused to speak to you?

23 **A.** No.

24 **Q.** Okay. So the answer is you didn't seek to  
25 speak to the doctors, did you?

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1 A. No.  
 2 Q. No. Now if we go on, please, to INQ0101934.  
 3 This document has worked in the past, so I am reassured  
 4 to see that it's worked again.  
 5 A. That's Ian.  
 6 Q. This is Mr Pace's note of a conversation with  
 7 you.  
 8 A. Mm-hm.  
 9 Q. Now, you have been taken already to a section  
 10 that says:  
 11 "Dee is satisfied that there are no malicious  
 12 issues involved."  
 13 This is 5 July 2016 and I think in response to  
 14 questions from my learned friend, you appeared to  
 15 question whether you used those words by saying, "This  
 16 is Mr Pace's note."  
 17 A. That's correct.  
 18 Q. Can you look, please, at paragraph 30 of your  
 19 witness statement?  
 20 A. 30?  
 21 Q. Yes, paragraph 30. Would you like to read  
 22 that out, please?  
 23 A. Yes:  
 24 "At this stage I was satisfied that there was no  
 25 malicious issues involved."

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1 A. "My understanding that there was only one  
 2 person pointing the finger..."  
 3 Q. No, sorry. We are going back to the telephone  
 4 note.  
 5 A. Okay.  
 6 Q. If we could go on please to read the next  
 7 sentence of the telephone note.  
 8 A. "I asked Dee how ..."  
 9 Q. I'll read it:  
 10 "I asked Dee how she can be sure and she said that  
 11 she did not think there would be any such issues."  
 12 Now, what does that mean?  
 13 A. This is Ian's note. I don't -- I don't know.  
 14 I can't remember.  
 15 Q. "I explained that really the employment  
 16 aspects of the matter pale into insignificance taking  
 17 into account potential issues involved, especially if  
 18 those who are working on the ward and including  
 19 Consultants are pointing the finger at each other and  
 20 the suspicions that the death rate could be attributable  
 21 to one in particular individual."  
 22 Now, isn't that describing a conversation between  
 23 you and Mr Pace wherein you are reassuring him that you  
 24 are satisfied that there's no substance in these  
 25 allegations and him saying: Well, whether there are

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1 I was copying it from Ian's note.  
 2 Q. Right.  
 3 A. "My understanding was that there was only one  
 4 person pointing the finger at Letby and that was  
 5 Stephen Brearey."  
 6 Q. Okay. So if you could stop there.  
 7 A. "However, he had not provided any evidence to  
 8 support ..."  
 9 Q. If you could stop there, please.  
 10 A. Sorry.  
 11 Q. So in quoting "no malicious issues involved",  
 12 you don't seek there, do you, to say: Those weren't the  
 13 words that I used?  
 14 A. I was -- I was -- it's in italics, so I was  
 15 quoting those words.  
 16 Q. Yes. But where in this paragraph does it say  
 17 that: Those are Mr Pace's words and I didn't use them?  
 18 It doesn't.  
 19 A. Well, if it carries on, if I could continue to  
 20 read that paragraph.  
 21 Q. Does it say in that paragraph that those  
 22 weren't your words?  
 23 A. No.  
 24 Q. No. If we could go on, please, to read the  
 25 next sentence.

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1 employment issues in this case or not pale into  
 2 insignificance if there's any reality to the suggestion  
 3 that there is a murderer in this unit.  
 4 Isn't that the interpretation?  
 5 A. Well, I think the interpretation is that he  
 6 explains that:  
 7 "... the employment aspects of the matter pale into  
 8 insignificance taking into account potential issues  
 9 involved especially if those who are working on the ward  
 10 and including Consultants are pointing the finger at  
 11 each other and the suspicions that the death rate could  
 12 be attributed to one in particular individual."  
 13 Q. Well, doesn't this bring us to a key issue in  
 14 your interactions with this case; that employment issues  
 15 are of nothing compared to the seriousness of  
 16 a potential murderer on this ward?  
 17 A. I would agree.  
 18 Q. So in permitting this grievance process to  
 19 proceed, you would accept, wouldn't you, that you did so  
 20 based upon incomplete and un-investigated facts?  
 21 A. No because we had -- there had been the  
 22 Coroner who had looked at each of the deaths and the  
 23 Chief Executive had brought in the Royal College of  
 24 Paediatricians.  
 25 Q. Sorry, which -- which --

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1 A. We had had that --  
 2 Q. Which Coroner?  
 3 A. -- we had had that report --  
 4 Q. Sorry, you keep saying things in your evidence  
 5 that I'm afraid don't appear to have any reality to the  
 6 facts of the case.  
 7 Which Coroner made a determination in which case?  
 8 A. The Coroners had gone -- I was told that the  
 9 Coroner had gone through each of the baby deaths.  
 10 Q. That's untrue.  
 11 A. Oh, okay. That's what I was told.  
 12 Q. Who told you that?  
 13 A. I was told by the Chief Executive and also by  
 14 Alison Kelly.  
 15 Q. So Ian Harvey and Alison Kelly reassured you  
 16 that the Coroner had investigated all of the deaths?  
 17 A. Yes.  
 18 Q. And that there was nothing to be concerned  
 19 about?  
 20 A. Yes -- well, no. They said that there was  
 21 only -- there was two where they couldn't be very  
 22 specific about what the cause of death had been.  
 23 Q. Right.  
 24 A. But they couldn't identify that there was foul  
 25 play either is what they told me.

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1 A. He. Yes.  
 2 Q. No. But it was Letby's representative, wasn't  
 3 it?  
 4 A. Yes.  
 5 Q. Finally, and I am conscious of the time --  
 6 A. But there was -- but there was no chance that  
 7 that was ever going to happen.  
 8 Q. No, but that was what was -- what  
 9 Letby's representative was pushing hard for; that they  
 10 should be disciplined?  
 11 A. There was no -- there was nothing to  
 12 discipline them on.  
 13 Q. If you look at paragraph 75 of your witness  
 14 statement:  
 15 "Letby was concerned that the Consultants thought  
 16 she was lying and said, 'I have nothing to hide.'  
 17 I then said we need to compromise as if you go down the  
 18 disciplinary route with the Consultants --  
 19 A. Yes.  
 20 Q. "I think I was interrupted at this point."  
 21 A. Yes.  
 22 Q. Yes:  
 23 "I did not think the disciplinary route in relation  
 24 to the Consultants would be in any way helpful in  
 25 resolving ..."

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1 Q. And that's information that had come from the  
 2 Coroner?  
 3 A. Sorry?  
 4 Q. That is information that had come to you,  
 5 obviously via Ian Harvey, but from the Coroner?  
 6 A. It wasn't Ian Harvey. It was Alison Kelly and  
 7 Tony Chambers.  
 8 Q. Yes, but they were referring to determinations  
 9 by a Coroner?  
 10 A. Yes, but they had also instigated the  
 11 Royal College of Paediatricians to come in who had  
 12 already completed their investigation and I -- again  
 13 I was told verbally that there was nothing untoward  
 14 within that report and that's the only reason that the  
 15 grievance went ahead when it did.  
 16 Q. But you hadn't been told that by the date of  
 17 your conversation with Mr Pace in July 2016, had you?  
 18 A. I don't recall.  
 19 Q. Well, no because the investigation hadn't been  
 20 concluded by then.  
 21 A. Okay.  
 22 Q. Again, throughout the grievance process, Letby  
 23 via her Royal College of Nursing representative,  
 24 advocated strongly that the Consultants should be  
 25 disciplined, didn't she?

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1 A. Yes.  
 2 Q. That is a reference because Letby was pushing  
 3 for them to be disciplined, wasn't she?  
 4 A. It was her representative that was pushing.  
 5 She -- she wasn't pushing at that point. But there  
 6 was -- you know, with a grievance you are trying to find  
 7 a way forward, for everybody to move forward.  
 8 Going down disciplinary route to me was just  
 9 unimaginable because it would just be making things  
 10 a hundred times worse. So I would not ever have  
 11 supported that, but I don't think she could have done  
 12 anyway because there was no grounds.  
 13 Q. No. But just to be absolutely clear.  
 14 Tony Millea?  
 15 A. Millea.  
 16 Q. Millea was the advocate, the RCN advocate for  
 17 Letby?  
 18 A. (Nods)  
 19 Q. And he was pushing very hard for the  
 20 Consultants to be disciplined on Letby's behalf,  
 21 correct?  
 22 A. That's what he said at the end, yes.  
 23 Q. Yes.  
 24 A. Can I also just make a point because I think  
 25 this is important? It wasn't just Lucy Letby's

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1 grievance that came in. We also got an almost identical  
2 grievance in from the RCN separately, but they were both  
3 together and so we were getting -- it was like a pincer  
4 movement to try and get this, her grievance heard.  
5 So one of the things that I did was to look at the  
6 commonalities between the two so that we only had one  
7 process.

8 So we were under -- I was under pressure to hear  
9 the grievance. The grievance came in in July and it  
10 wasn't heard until December. But at that point we  
11 had -- we did know about the Royal College of  
12 Paediatricians report and so it felt we couldn't hold it  
13 back any longer that then it went, it went ahead.

14 But I wouldn't necessarily disagree with you and  
15 your learned friend that we could maybe have, have  
16 pushed it back further. But it's how far do you keep  
17 pushing it down the road?

18 It was -- there was a lot of pressure from the RCN.

19 Q. Well, what somebody needed to do was call the  
20 police if allegations like this were being made because  
21 they are the people who are equipped to investigate it,  
22 aren't they?

23 A. Do you know what? I couldn't agree with you  
24 more. But I think the people who had all of the  
25 concerns and all of the evidence, they were the people  
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1 who should have called the police and there's no reason  
2 why they shouldn't of.

3 Q. Well, that's a very judgmental thing to say --

4 A. Yes, it is.

5 Q. -- because you didn't interact with them and  
6 you didn't obtain their side of the story.

7 A. (Nods)

8 Q. Finally, and I want to clarify something  
9 Mr Bershadski asked you because I think he asked you two  
10 questions in one and I just wanted to make sure that you  
11 answered both of them.

12 Did you know that Lucy Letby was visiting Alder Hey  
13 Children's Hospital in 2017?

14 A. No.

15 MR BAKER: Okay. Thank you, my Lady, I've got  
16 nothing further.

17 LADY JUSTICE THIRLWALL: Thank you very much,  
18 Mr Baker. I have no questions. Thank you very much,  
19 Ms Appleton-Cairns, you are free to go.

20 A. Thank you.

21 LADY JUSTICE THIRLWALL: So we will start again  
22 tomorrow morning at 10 o'clock.

23 (5.04 pm)

24 (The Inquiry adjourned until 10 o'clock  
25 on Wednesday, 6 November 2024)  
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222/7 222/18	222/7 222/18	250/10	44/16 72/9 72/12	92/17 100/21 134/18	92/17 100/21 134/18	134/20 143/7 228/2	118/7 119/4 125/18
I explained [3]	52/24	250/10	92/17 100/21 134/18	134/20 143/7 228/2	230/3	I reported [1]	125/24 128/15 128/16
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I given [1]	151/12	160/11					
I go [1]	89/8	160/11					
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