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.

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

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

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?

A. Sorry?
Q. Did you notice there was no facility for parents to sleep alongside their neonates?
A. I think I was informed of that, yes.
Q. Was that typical around that time in hospitals as far as you were aware, or you don't know?
A. I couldn't say what other hospitals were -- were like because, you know, I probably spent most of my adult working life there, really.
Q. By this time about 27 years in nursing, weren't you, by 2015/2016?
A. Yes, so I had never worked on the neonatal unit. I had no paediatric experience. When in an adult ward and if a patient relative wanted to stay then we would try and accommodate them with a fold-up bed or a recliner chair or something at the bedside. But I ...
Q. You say at paragraph 4 in the Patient Quality and Safety Team you worked alongside the patient Experience and Complaints Team?
A. Yes.
Q. Did you ever get any complaints at the time around inability to be with babies on the neonatal unit?
A. I don't recollect any specifically. There may have been some but I don't recollect any.
Q. We asked you at paragraph 6 about the culture

and atmosphere on the NNU at the hospital and you say you weren't involved in the day-to-day running of the unit. Did you detect over that year any sense of the nature of the relationships, for example between the nurses and doctors on that unit or generally?
A. No, I detected nothing.
Q. What about between doctors and managers, because you were at meetings, we will come to them later, weren't you, with some of the Executives, Tony Chambers and Alison Kelly, and some of the doctors? We will move on to the details of them in July time in 2016. Did you think the relationships were still not worthy of comment in any way or what did you think?
A. I wasn't aware of any specific issues with the Exec Team at the point of when I was appointed and you know up to 2015, you know mid-2015 or onwards. I wasn't aware of anything.
I wasn't operational so I -- you know, I didn't see them and Alison Kelly tended to, you know, manage that side of it.
Q. Did you get on with all the doctors and nurses, you never had any difficulty with anyone?
A. I never had any difficulties with any of the doctors.
Q. What were they like, if you can comment on

a group in the neonatal unit, doctors?
A. Pleasant. No issues. Constructive often. No, no, nothing that would concern me.
Q. What about the nursing group, did you have much to do with Eirian Powell as the ward manager?
A. Nothing to do with her on a one-to-one basis. I might have seen her in passing if I passed through. She used to come to the ward manager's meetings where Alison Kelly chaired and that's probably it, really.
Q. Your impression of her and unit and the nurses and how they worked together?
A. I -- I couldn't give the impression because I wasn't there.
Q. We asked you about when you first became aware of the increased mortality rate in the NNU. You say you can't specifically remember. Can I take to you a couple of meetings, QSPEC meetings, and let's see where we get to with that.
If we go -- it is in your enclosure 1, for the electronic reference it is INQ0003200, page 3. It is the standing agenda item, Mrs Williams, number 12 --
A. Yes.
Q. -- on page 3 of that hard copy --
A. I have it.
Q. -- document.

LADY JUSTICE THIRLWALL: It is not on the screen yet.
MS LANGDALE: Thank you. We may find ourselves going faster than the screen, Mrs Williams.
A. Sorry.
Q. Not at all. If we look there, this is an Executive Directors Group meeting, Wednesday, 9 September --
A. Yes.
Q. -- in 2015.
A. Yes.
Q. We see there standing agenda item and you have reported that a baby death had been reported to STEIS and an investigation was taking place. We know that that was Baby D, one of the indictment babies, with an unexplained and sudden death.
At the time, do you remember now what you knew about that baby death and why it had been reported to STEIS?
A. I'm afraid I don't remember why it was reported to STEIS. I think at that point I was sitting in for Alison Kelly, who was on leave, and it will be just information that she gave me to tell the team.
So I -- I don't recollect as to why it was reported to STEIS.

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

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

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

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

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

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

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

A. Yes.

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

about what had happened?

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

Q. Do you remember anything of that now?

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

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

A. Yes.

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

A. Yes, I have got it.

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

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

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

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

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

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

A. Yes, yes.

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

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

neonatal deaths and certainly unexplained deaths and their reasons?

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

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

A. Yes, it does look like that.

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

A. No, I can't comment unfortunately.

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

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

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

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

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

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

you know, rather than being a long action plan, it was focused on the key areas is my recollection.

Q. Did you see the CQC inspection report that was done following the visit in February 2016?

A. I -- I -- I can't remember seeing it. I could have done in my role but I specifically can't remember.

Q. How were they received as a hospital, important documents, presumably?

A. Yes.

Q. They get attention from Executives and senior managers, do they?

A. Well, they come via the Executives, definitely, yes.

Q. Is it important to any hospital, but from your experience the Countess of Chester, to get a good rating from the CQC, is that important?

A. I think it's important, it -- for, for a, you know, a good rating. I think it then sends out the right message but, you know, sometimes it can be over focused, if you like, but I think it is important to get a rating that's acceptable.

Q. What do you mean "over focused"?

A. In that people become target driven.

Q. Expand upon that, if you will?

A. Well, just things like A&E targets, that type

of thing.

Q. A&E targets?

A. Yes, that was just an example.

Q. So they wanted to tick a box, just achieve something without thinking about it further, what do you mean?

A. I think sometimes it is just you have to, you know, look at the bigger picture.

Q. Sorry I missed that?

A. You -- sometimes I think it's make sure everybody looks at the bigger picture, not just one single area.

Q. Was that something you found yourself ever saying in discussions with Executives or generally?

A. No, not -- I cannot recollect it. It's just --

Q. More your observation looking back?

A. More from other hospitals' observations as well.

Q. We can see there that there is references again to the maternity neonatal services. As far as you were concerned at this point, what was being discussed in August 2016 about neonatal services, we know you have done your staffing analysis and stuff by then, we will come to that later. But what were they being told in

this discussion?

A. I don't recollect. The only thing I can remember, I would not even remember, I would say possibly the external review.

Q. The RCPCH review?

A. Yes.

Q. So you think they likely just saw that?

A. Sorry?

Q. They likely had access to that but nothing else?

A. Well, I am not sure if it was completed by them, but maybe they were being updated.

Q. Right, when it was completed.

So they would get the external review. Did they ever get your internal review, your staffing analysis from Julie Fogarty?

A. I don't know.

Q. You never gave it them?

A. No.

Q. Were you asked to share that with them?

A. No.

Q. We know, and Julie Fogarty is giving evidence, when you had done that you had concerns that the police should be called?

A. I did.

Q. Yes?

A. Yes.

Q. Is that something you would have thought to share with the CQC in one of these meetings?

A. I think we were guided by the Executive Team as to what to share.

Q. Right. What was that guidance -- that can come off the screen thank you, Ms Killingback -- what was the guidance on this topic?

A. Just that they were undergoing a review. I don't recollect specifically.

Q. Were you told that you could share your concerns about the staffing analysis with anyone or not?

A. I wasn't told one way or the other, if I recollect.

Q. But either way you don't -- you didn't tell the CQC?

A. No.

Q. You tell us at paragraph 18 of your statement that you remember being involved in a mortality review. Can we go, please, to enclosure 2, and it's INQ0003530, page 1.

A. Yes.

Q. We only need the top bit, please, Ms Killingback, which refers to C and D. Just that bit.

Thank you.
So this is described as a Serious Untoward Incident Review and we can see there, Mrs Williams, we have you, Dr Brearey, Alison Kelly and Ruth Millward, Head of Patient Safety, so that is a senior team there, isn't it, meeting?
A. Yes.
Q. Apart from in the context of the neonatal unit did you have many meetings of that level of combination of staff?
A. Not huge numbers. If there was a couple of Never Events in theatre or something like that, then yes, we would get together.
Q. So less than fingers on one hand?
A. I can't -- I can't remember.
Q. But not many?
A. I -- I can't remember this being called a Serious Incident -- to be honest, I can't remember the meeting but I can't remember it being called a Serious Incident Review meeting. I -- you know ...
Q. We don't see this, before we go to the detail, appear again in QSPEC, you know, we saw earlier that Serious Untoward Incidents are reflected back into that committee. This is a sort of standalone but it looks as though the Datix, or rather the deaths of Child A

Child C and Child D are being referred to in combination and we know those three deaths all happened in a rapid successive period within three weeks?
A. (Nods)
Q. So the three of you are talking about that. Can you remember now what was being said about that?
A. I can't. I have racked my brains, I can't remember it at all. That's the ...
Q. You told the police in a police statement -- you don't need to turn that up -- that it was more in relation to an overview, not an individual?
A. Right. So I am not convinced they are the same. I think in my police statement I talk about where Stephen Brearey, Ruth Millward, Alison Kelly, myself and I think Ian Harvey may have been on leave.
He had done a review of deaths and he -- we met him to go through it and --
Q. Was that with the Triplets or two babies that had died together?
A. I -- I can't remember. I think, you know, it might have been -- it might have been -- I don't know, it might have been a bit wider than that, I don't know. I can't remember.
But at that point, you will have read, Dr Brearey didn't really come across as that concerned at that

point.
Q. In this point, July 2015 you are talking about that?
A. No.
Q. Just focus on this document --
A. I don't remember that.
Q. Right, so you don't remember this at all?
A. No.
Q. I am going to take you to later documents, don't worry, you will get a chance to comment.
A. Sorry, I don't remember this one.
Q. So you don't remember this, although it looks like you are present when three deaths in a very short period are being discussed?
A. Yes.
Q. But you don't remember it?
A. I don't.
Q. Looking now at that cluster, does that look like to you as though this Serious Untoward Incident should have been followed up and followed through QSPEC and analysed?
A. If depending -- I'm not sure what the outcome of the Serious Incident Review was, so it depended on the outcomes as to whether then it was escalated.
Q. You tell us at paragraph 31 of your statement,

we asked you whether the meeting considered the NHS revised Serious Incident Framework published in 2015?
A. Yes.
Q. You tell us you couldn't recollect the meeting so you can't comment on it.
A. Yes.
Q. Who was responsible for compiling reports on Serious Untoward Incidents, it is clearly not you from what you are telling us?
A. No.
Q. So who was?
A. So it would be members of the Risk Team that were specific for that area alongside the -- the Consultants who would then because, you know, sign off the content that they were happy with everything that went in and --
Q. So Ruth Millward is present for that one --
A. Yes.
Q. -- on 2 July so it would be in your view her responsibility?
A. Yes.
Q. Those -- just let me finish, those three deaths having been identified, her responsibility to see that was managed through the Risk Team; is that the position?

A. Yes and -- and Debbie Peacock's, that is if -- if Steve Brearey agreed that, you know, there were lessons to be learned, that type of thing.

Q. They would need to have information from him but presumably from what you are saying this management of risk is what they are there for. That is their day job, isn't it --

A. Yes.

Q. -- so to speak. Just pausing there, so the doctors are doing the day job of the doctors, they give information and then is it carried on through the management team and for those who have management responsibilities and risk management responsibilities?

A. Yes, it's worked alongside together, yes.

Q. So in your experience, who should be filling in the forms and the details and the documents where they are required and we see a number are required?

A. I would say it should be the Risk Team.

Q. So it is not the doctors who finished with one patient, go to the next. They can hand over information verbally and the Risk Team have to deal with it?

A. Hand over information, go through it from the assurance purpose, go through the detail as well and check the interpretations are correct.

Q. Paragraph 34, you tell us:

"I do not know if the deaths of Child A, Child C or Child D were reported to the Child Death Overview Panel or whether they were reported as Sudden Deaths In Infancy ... (SUDIC) ..."

As that wouldn't fall within your remit. Who would be responsible for reporting to the Child Death Overview Panel?

A. I am not a paediatric nurse and I -- I am unsure to give the correct answer there. I don't know. We did have a safeguarding paediatric nurse, so possibly from there. The Consultants take some -- and maybe the Risk Team but I am -- I couldn't say for sure because.

Q. So risk or safeguarding?

A. Yes.

Q. Did you have any involvement with the paediatric department, the children's department, or just the NNU?

A. No, I had no with the paediatric no. The paediatric safeguarding nurse reported to Alison Kelly.

Q. Right and you tell us later you didn't actually have safeguarding training yourself or child protection?

A. No, just the general safeguarding training that the hospital has.

Q. Did you ever in your time at the Countess of

Chester have to report something to safeguarding or to the designated people within the hospital doctors or nurses?

A. I may have had some of the adult, because the adult safeguarding, I may have used her for advice and reporting on a number of occasions.

Q. How did it work on the ground for adults, did you know who would you take a concern to about an adult?

A. You take to the adult safeguarding nurse.

Q. Who was that?

A. Tracey -- I can't remember her surname.

Q. Right, okay, but you knew who she was, you knew who to go to?

A. Yes.

Q. Would you hesitate about doing that?

A. I think I would get the information to go there.

Q. You tell us at paragraph 45 of your statement:

"I cannot recall being provided with, or reading the report compiled by Dr Brearey considering the neonatal deaths ..."

As opposed to obstetric deaths.

If this helps, at enclosure 4, if we can go, please, to INQ0003138, page 1.

A. Yes.

Q. For you it's just behind enclosure 4, the first two emails.

A. Yes.

Q. If we look there, we see Alison Kelly in the middle email, 4 May, sending an email to Karen Rees cc'ing you.

"Please see attached. Not sure you will have had previous sight of this. Lucy Letby highlighted in red! I have not noticed this when I first reviewed. Can you please look into this as per my previous email, many thanks."

Then further down another email:

"Can you please look into this with Anne. If there is a staff trend here, we have already changed her shift patterns [which we know they had in April] because of this, then this is potentially very serious."

Do you remember receiving that and seeing that table with her name in red?

A. I don't remember, now I -- I don't remember seeing it. I was copied in to it, I think it went direct to Karen, I don't remember seeing it.

Q. Would you have looked at it when you were cc'd?

A. I may have, yes, I might have done, but I don't remember I don't recall seeing it. Because

Karen reported direct to Alison it was left very much with Karen. I might have been on leave. I don't know.

Q. She sounds pretty alarmed, doesn't she, with her exclamation marks "Lucy Letby in red!"

A. Yes.

Q. That is a concerned email, isn't it, would you say?

A. Yes.

Q. So is it the kind of email that you wouldn't have looked at the attachment just to see what she meant and how important it was?

A. I might have looked at it I might have not looked at it at that time if I wasn't around.

Q. Right, so at some point you looked at it?

A. Yes.

Q. Do you know when you will have looked at it?

A. I don't, no.

Q. We know that on 23 and 24 June two babies died, two of three Triplets. If we just go further on in that enclosure for you a couple of emails on INQ0047571 -- it is a different INQ number Ms Killingback sorry, INQ0047571, page 1.

A. Yes.

Q. So it is INQ0047571, 0001. It's not there? Well, we have got a hard copy so I will read out

Mrs Williams, so people can see what the email says.

A. Yes.

Q. We see there is an email from Alison Kelly on 29 June sent to Ian Harvey and she says this:

"Hi Ian, I am not at Execs this AM but have briefed Sian fully. I have discussed the actions we are taking with her and I know we are commissioning an extra clinical review, but Sian and I did also discuss the police. I know this is a big step but it is something we need to consider in light of heightened concerns. Can we double-check that the babies have had a PM yet? I am assuming the Coroner was made aware. Sian said she would try and speak with Stephen C prior to Execs for his thoughts but this also needs to be considered in the Exec conversation."

Then we see further emails between Alison Kelly and Ian Harvey which they will be asked about but looking at what she says about you, you have that in front of you, it looks -- well, that she's saying that you have both by 29 June, had a conversation about calling the police and she's briefed you fully. What can you remember she said to you about that time?

A. I don't.

Q. So this is after the Triplets have died?

A. Yes.

Q. The two Triplets?

A. I don't remember having that conversation with her. I am unsure if it was after the reviews of the Triplets, I don't think --

Q. No, that is before, I am going to take you to the reviews of the Triplets which actually happens on 5 July. So this predates that?

A. Yes.

Q. But the Triplets have died, so she says she's briefed you?

A. Yes.

Q. What has she told you about them?

A. I don't remember having this conversation with her. Obviously I -- it looks to me as though I was covering her for not being at the meeting, so I don't remember what she had said, to be honest.

Q. When you say "not being at the meeting", what meeting do you mean there?

A. Is it something to do with Execs or something it says.

Q. No she is saying "I am not at Execs this morning"?

A. Yes.

Q. So she is not going to be at the meeting but she's briefed you?

A. Yes. So she obviously was concerned about something, about the deaths being brought to her attention. She -- she quite probably briefed me but I can't remember having the conversation with her.

I do recollect on a number of occasions having a conversation with Alison Kelly and the other Execs about going to the police.

Q. About what time?

A. I -- I can't -- I can't remember. I -- a couple of times I, you know, said I think it was more when they had done the review, that type of thing.

Q. Let's go have a look at the mortality review now of the Triplets. If we go -- continue for you in that same enclosure, but it is INQ0005121, so 0005121, page 1.

A. Yes.

Q. We actually see on page 3?

A. Yes.

Q. Go to page 3 you see the reviewers. There is Dr Brearey -- just the reviewers' names at the bottom, if we may, further up. Dr Brearey, Eirian Powell, yourself, Yvonne Griffiths, Dr U, Dr ZA and Hayley Cooper. So this is where -- and the Inquiry has heard a lot of evidence about the collapse and death of Baby O and then Baby P.

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

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

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

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

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

making that -- I don't recollect him, to be honest. I don't recollect that level of detail of highlighting a specific nurse at that point.

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

A. Yes.

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

A. Yes. Yes.

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

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

A. (Nods)

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

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

Do you remember that conversation with Stephen Cross?

A. (Nods)

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

A. I did.

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

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

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

there?

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

Q. Yes.

A. Yes.

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

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

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

A. They were his term --

Q. Yes.

A. Foul play.

Q. So what do you think that means?

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

Q. Evidence of what?

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

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

A. After that meeting and there at that point.

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

note of Stephen Cross before the mortality review, Mrs Williams.

A. Yes.

Q. The reference electronically is INQ0004314, page 1. So if you go back to enclosure 4, it's a handwritten document a couple of emails in. And it's got at the top Monday 4 July 2016?

A. Yes.

Q. You have got that, thank you. So this is a meeting where discussion of the downgrading of the NNU was happening and this is 4 July, so the day before --

A. Yes.

Q. -- the meeting you have just had. So they are discussing here downgrading the unit and there are many pages of contributions. If you look at page 3, there is discussion, isn't there, about getting the communications right for the families. Can you see that, Tony Chambers?

A. Yes.

Q. Tony Chambers talking about getting communications right?

A. Yes.

Q. Dr Brearey above, "Difficult issue re comms for parents whose babies have died".

Do you remember anything about this meeting and

discussion of communications with families?

A. Not to any level of detail, no. I don't. I have obviously contributed, there is my comment there about some babies coming back.

Q. Did this feel a significant event in your mind, that the unit was being downgraded and families needed to be informed of things, did that feel significant at the time or not?

A. I can't remember.

Q. You can't remember?

A. No.

Q. Had you been involved at all in another setting where units were downgraded?

A. No, the only time where a unit may close if is if an ITU is full or it has got poor staffing and you can't risk putting another patient in there. So there might be a temporary closure.

Q. If we go back to your statement, if we could, thank you, at paragraph 52, we come to your staffing analysis and you tell us: on 11 July 2016, Julie Fogarty and I completed a staffing analysis and fed back the findings to the medical staff.

Can you just tell us in your own words what that piece of work was about, what you both did and how you set about it?

A. So myself and Julie, there was a meeting in the organisation where the Execs had pulled together a meeting and a number of us were tasked to look at specifics.

My understanding and my recollection is the Consultants had done a bit of a staffing review themselves and come up with the name Letby. So we were tasked to go back and go through that which -- which is what myself and Julie Fogarty did, we did it, we did it in my office but separately looking at it and we looked at using Meditech like electronic notes of, you know, collapses, that -- you know the babies there.

And we came to this, a similar to the -- to the doctors that she was, and I did a quick calculation, 80% more likely to be on duty either during or before a baby collapsed.

Q. What Julie Fogarty says is that at the time of the analysis you were both aware appropriately trained professionals were undertaking a review --

A. Yes.

Q. -- of all aspects of the sudden collapses, is that what you understood?

A. Yes.

Q. That the sudden collapses, so the doctors were looking at --

A. Yes.

Q. -- first and foremost what had happened to the babies, what might have caused their death. That was the main need for inquiry, wasn't it?

A. Yes.

Q. Then when you looked at that and if you had concerns about that there is questions about who is present. Is that how you understood the sequence of events?

A. I don't recollect specific sequence. We were just given this piece of work to do. My understanding is that John Gibbs was looking at the case note side of it with -- with -- I am going to say Anne Martyn, but I could be wrong.

Q. Which babies were you looking at, those where there had been unexpected deaths or unexpected collapses?

A. Yes, both.

Q. Right so you were looking at events that had been unexpected?

A. Yes.

Q. So you weren't looking at every baby that had deteriorated or died?

A. No.

Q. You were looking at unexpected events; is that

what you remember?
A. Yes, I -- if I recollect it was the ones that the doctors had already looked at. We were just going over that again.
Q. So you wouldn't recollect precisely which ones but you were going over a number?
A. Yes, and we also added another column of which medical staff were involved as well.
Q. You tell us at paragraph 55:
"We reported our findings back to one of the Executive Team, [you] think it was Sue Hodkinson ..."
A. Yes.
Q. But you can't be sure and you recall also telling the Medical Director, Ian Harvey, that you were concerned?
A. Yes.
Q. Again, do you remember that or --
A. I do. I do remember that.
Q. So tell us about what you said to both of those?
A. So there were three babies that had collapsed that were fine during the day and then overnight they had collapsed. So I was concerned when I saw that as we checked it out with Julie Fogarty.
Q. Just pausing there, three babies or one baby

three times collapsing?
A. Sorry yes, one baby three times, I apologise.
Q. One baby had collapsed in the night, not in the day?
A. Three times, yes. So I -- when we fed it back we raised it there and I also took it to Ian Harvey as the Medical Director specifically and said I was concerned about that and he said he was going to check, if I recollect. So that's what we did.
Q. Now, the email I took you to earlier, the 29 June, is where Alison Kelly said she would brief you and they were discussing the police.
She was telling -- discussing the police in those emails. Was Ian Harvey -- did you and Ian Harvey discuss around this time when you had done the review going to the police or not?
A. I don't recollect.
Q. You can't remember?
A. No.
Q. But do you remember around this time in July there being conversation about going to the police generally amongst the Execs, in your own mind or you and Julie Fogarty?
A. Yes. Yes. I do recollect.
Q. You also set out at paragraph 57 that you had

had experience before in an adult area where an allegation had been made and calling the police and that you told the Executives about that?
A. I did on a number of occasion.
Q. Can you expand on that?
A. A previous Chief Executive.
Q. We don't need any names.
A. I am not going to. A previous Chief Executive, I was Head of Nursing then and the chief nurse and the deputy were away at conference or something so I was there and I got a phone call saying could I come down.
So I went down to see him. He said that somebody had brought -- I don't know who the somebody was, had brought this concern that somebody may be switching off pumps, pumps are what you deliver fluids to patients in I think it was the high dependency setting.
So we had a very brief conversation and said that we both believed we should inform the police and the police would make their decision then as to what they would do. They would either come in, say "do your own investigation and keep us informed" or not be bothered. So they were the three things.
So he rang the police and they came in that night and I stayed until about 4/5 o'clock in the morning with

the staff going through, supporting staff and going, you know, supporting the police.
Q. Which Executives did you give that account to?
A. I recollect telling Ian Harvey. I recollect telling -- well, I recollect if it was mentioned at any meetings, the Executive meetings, I am pretty confident, well, you know, I can't be 100% sure but I brought it up on a number of occasions definitely because I thought it was a piece of information that could be utilised.
Q. Why did you think that?
A. Because of my experience.
Q. Sorry, why did you think it was a useful piece of information for them to hear?
A. Because I felt that, you know, they needed to consider the police. I did tell them I spoke to Alison Kelly on a number of occasions, one I remember with Karen Rees in my office saying that you need to go to the police and she said "I have taken advice" and that was it and she wouldn't listen.
Q. By the time you and Julie Fogarty were doing this analyses and then there was other reviews going on, did it at any time feel as though you were taking on the role of the police trying to look formal information and retaining fluid bags and doing things without really the resources or the knowledge or the expertise --

A. I think we were just tasked in a management responsibility to do it. Yes.
Q. Did that sit comfortably at the time?
A. It -- it was uncomfortable given what I had been through in the past which is what I kept saying to them.
Q. Do you see referral to the police as essentially a neutral act just that an investigation is needed where there is concerns for a child that may be harmed or may not be harmed, that is the point of the referral?
A. I personally say that, yes.
Q. So you understood you don't need conclusive evidence or evidence of guilt, that is what the police look for if there is evidence one way or another?
A. But the Executives said that they were -- had taken advice and they need that we had to do our own investigation first.
Q. So your staffing analysis fed into that investigation?
A. Yes.
Q. You say:
"I did consider going to the police myself but as I had been told by the Executive Team that they needed to do their own investigation and as Stephen Cross was

an ex-police officer and had a legal background coupled with the fact that the Consultants didn't see the need to do this, I didn't take it forward as I was not privy to all of the information."
A. No.
Q. Just pausing there. With the Consultants' position, you have said earlier that when the Consultants had raised the concerns, it is for the Risk Team to manage that through the risk process. Where the Consultants had raised concerns about the babies and very clearly in that mortality review and subsequently, who do you think was responsible for making decisions about going to the police?
A. I think you could argue everybody should have that responsibility.
Q. Including you?
A. Yes. Yes, I put that in my statement, I regret not doing it --
Q. Do you?
A. -- at that point. Yes.
Q. When would you have done it if you were going to do it?
A. I think by the time I had gone through the mortality reviews and there was a name then, yes, then definitely.

Q. So the Triplets?
A. Yes.
Q. The O and P Triplets, so by July?
A. Yes.
Q. There was a meeting, wasn't there, on 13 July. If we go to enclosure 5 -- sorry, it's actually enclosure 4, Mrs Williams, the last document, and it's INQ0003365, page 4. 3365, page 4.
A. The handwritten notes.
Q. Exactly.
A. Yes.
Q. This is about a discussion around Letby having supervised practice?
A. Yes.
Q. Moving down to the meeting on 13 July, reference from Ian Harvey, we are aware of your concerns re one member of staff.
Over the page, page 5. There is correlation with a nurse but we know a change in acuity and activity.
That is Tony Chambers.
Further down:
"Dr ZA, nurse worrying correlation. One possibility criminal, it could be something else. Not necessarily criminal."
"Dr Jayaram: data is good. How do I feel?

A doctor would have been suspended."
Over the page, Mr Chambers:
"A week ago only option to ring the police."
Do you understand why he was saying: but there was not a need now to do that at this meeting on 13 July, because we have seen the emails about the discussions and at this point he's suggesting that is not the only option. Can you remember why that was the case?
A. I can't remember, no. There is no detail to say why he's come to that conclusion.
Q. Well, he carries on, doesn't he, two lines down:
"We can create harm to nurse, fragile, toxic, need to protect it."
I think that says "need", anyway, he will deal with that in his own evidence.
But you see there is focus, isn't there, on Letby herself, do you remember that?
A. I don't, no, sorry.
Q. If we go further down:
Dr Gibbs: not discussed with nurse, only nursing lead Eirian. How can we Consultants accuse nurse but do not know if it is that nurse?"
So some discussion around: well, we don't know for sure it is her, we are worried about that; you see that?

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

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

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

involved in the care. Their involvement was either on the shift or on the shift before a baby had unexpectedly collapsed or deteriorated. As we discussed during our meeting, you have been identified as one of these members of staff. The review has identified you as being more regularly involved in the care of babies concerned."
And you continue.
The next paragraph:
"A decision has been made to provide additional support to all of the staff including you" --
LADY JUSTICE THIRLWALL: I'm not sure you have the right passage on there on the screen.
MS LANGDALE: Sorry. Page 2. Top paragraph. That is fine.
"The review has identified you as being more regularly involved in the care of babies concerned."
And the next paragraph:
"As we discussed patient safety is of paramount importance."
In the middle of that paragraph:
"Therefore a decision has been made to provide additional support to all of the staff, including you, who have been identified in the review. I explained you will be the first nurse to undergo this process due to

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

Who drafted this letter with you?

A. Sue Hodkinson, if I recall.

Q. It then says in the next paragraph:

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

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

A. No.

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

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

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

A. I am pretty sure it was Sue Hodkinson. Whether Alison Kelly also had input I'm not sure but I am pretty sure it was Sue Hodkinson with an HR background.

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

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

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

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

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

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

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

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

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

A. I don't recall having any.

Q. It says:

"In preparation for the external review it has been

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

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

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

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

A. Oh, yes.

Q. Yes?

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

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

A. With hindsight probably not, however --

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

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

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

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

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

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

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

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

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

A. No.

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

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

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

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

A. Thank you.

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

A. Yes.

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

A. Looking back at it, yes.

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

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

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

A. Yes.

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

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

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

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

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

A. It was being followed:

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

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

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

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

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

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

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

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

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

Q. At paragraph 74 of your statement, you say:

"I personally did not consult with Stephen Brearey, about his view regarding patient safety if Letby returned to the ward. The Executive Team undertook all discussions with the paediatricians and Dr Brearey."

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

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

it.

Q. Because they were?

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

Q. Holding it, holding the reigns of the situation?

A. Yes, yes.

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

A. That any conversations around that went via them first.

Q. Who's "them"?

A. The Execs.

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

A. Ian Harvey and Alison Kelly, really.

Q. Right. Ian Harvey and Alison Kelly.

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

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

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

paragraph 79, ever seeing the Terms of Reference --
A. No.
Q. -- for that review.
What did you understand that review was going to do?
A. I never saw the Terms of Reference. We weren't privy very to them. My understanding is they were going to look at general staffing levels, care, just those sort of things.
Q. Looking at the babies, presumably? You realised they were getting some review of the babies' care?
A. My understanding was that they would look at the care of infants in there per se. I don't know if they were given specific details to look up this baby or that baby or ...
Q. So you didn't know which baby, but you thought they were looking at babies?
A. No.
Q. What -- if you were going to guess at that time, did you think about that at that time, what babies they would be looking at?
A. I thought that it would be covered in their Terms of Reference; they would look at the care of individual babies.

Q. And at the time, would you have expected that the parents of the babies they were looking at would be informed that that was going to happen at the time that instruction was made?
A. I think it would have been fairer to have told them at the time because often parents can share concerns or bring information that can contribute.
Q. As far as you were aware, had any of the parents of the babies named on the indictment who died had any input or conversations with the Exec Team?
A. I don't know. And as far as I am aware probably not, but I couldn't say one way or the other.
Q. Did you ever ask that and say: Look, you know, we have seen there was discussion about communication with families. Look, these families need to know if their babies are being reviewed?
A. I don't recollect saying that, no.
Q. Did you ever think it?
A. I can't remember at the time. I -- it was very much left with the Executive Team to -- to deal with that. I would have expected Alison possibly to have said it.
Q. If you were asked what your view was at the time, what would you have said in terms of what they should know?

A. That they should know that it was happening, that we were reviewing the care.
Q. And that they should know when a report comes back and --
A. Yes.
Q. -- what it says?
A. Yes.
Q. Was there ever a discussion about that --
A. I don't think there was.
Q. -- that you were involved?
A. Well, obviously when it came back, I think there was some, you know, area communication to the families.
Q. Moving on to the topic of the grievance.
We know Letby took out a grievance subsequently and Dr Christopher Green was the investigating officer as part of the grievance investigation and you had an interview with him. What did you think the grievance was about?
A. I never saw -- I have -- I never saw the terms, the grievance, I never even saw the outcome of the grievance until the bundle came to be fair.
I was led to believe it was to do with how Lucy Letby was being treated by the Consultants, that's, you know, the allegations that were being made. That's

all.
Q. Okay. So can you remember who told you that? Was that --
A. I'm not sure. I -- I -- I can't remember.
Q. But before you were interviewed, you thought it was about her complaints about how the Consultants had treated her?
A. That she had raised a grievance is what I had been told. But I didn't know the level of detail, so I would just be assuming.
Q. You say at paragraph 83:
"I recall asking the Director of Nursing, Alison Kelly, if it was appropriate to continue with the grievance process given investigations such as that by the RCPCH were ongoing."
A. Yes.
Q. So can you expand upon that, please? What did you say about that?
A. I did recall, when the grievance was issued, that a number of staff were having to be interviewed and I recall saying to Alison that I didn't feel it was appropriate and would it not be better to wait until we had all the information together because we had not got the Royal College position report and it's -- it just felt it wasn't the right thing.

Now, if I recall right, she said she had taken advice and it was going ...

Q. What were you thinking was the right thing?

A. To wait for the outcome of the rest of the information.

Q. The investigation, effectively --

A. Yes.

Q. -- as you thought it may be with the RCPCH?

A. Yes.

Q. So have the results of the investigation. Why was that necessary to have that before looking at a grievance? It may seem obvious, but can you explain your thinking?

A. My thinking would be that they had made -- you know, until you get it all together and you look at the bigger picture sometimes people make decisions that, you know, they haven't seen it and they miss something and miss the opportunity if you like.

So my -- I would have waited until it all came together, got the bigger picture and then you can decide the most appropriate course of action at that point.

Q. Did you think she needed to be investigated?

A. Do I... ?

Q. Did you think there needed to be an investigation into Lucy Letby, whether it was

disciplinary or a police investigation?

A. I -- as I said on a number of occasions, I felt the police needed to be involved, not -- to look at the deaths and make that decision as to whether it was an issue or not.

Q. Because there was suspicion around these deaths and they needed to find out who it was if someone was causing the deaths?

A. Yes. There was -- they were unexplained and there were a number of unexplained collapses, yes.

Q. Your interview with Dr Green is at enclosure 9, which is INQ 0003164, page 1. So you are being interviewed by him because you now understand from what you have said that it is a grievance she's raised about how the Consultants have treated her. Did you think you were particularly being asked about one topic or did you feel it was quite an open interview when you look back?

A. I can't really remember to be honest. When you mean one topic?

Q. Okay. If we go to the first box, you say:

"I was told that Lucy was swapped from nights to days. I would have expected..."

No, it's further up -- there we go, thank you:

"I was told that Lucy was swapped from nights to

days."

A. Yes.

Q. "As a result of that, I would have expected an investigation."

A. Yes.

Q. So that was in April 2016. So when she was moved to day shifts, you would have expected an investigation, you tell Dr Green that. Did he ask you why or what your thinking was about that?

A. I don't know. If it's not in the transcript, you know, probably not.

Q. If we go over the page, the top box, so page 2, top box?

A. Yes.

Q. "There were no red flags", you say:

"Sudden deterioration in neonatal babies is apparently common. Although I am not neonatally trained I didn't find anything more than that. I asked how the sudden deterioration could happen and was told they are more unstable than adults. I met Lucy in my office with EP and explained that she featured in terms of attendance so we will start with her doing supervision clinical competencies then work down the list of staff and finish with the ones that only work one shift."

You don't mention here -- you say there is

increased deaths, you don't mention there was suspicion of foul play and the Consultants were really worried about that. You don't say that, do you?

A. No.

Q. Why not?

A. I cannot recollect as to why not. I don't think it was a specific question that was asked, so ...

Q. You don't think you were asked whether the Consultants had concerns, whether they were worried or whether it was genuine?

A. Not unless it appeared on here, no.

Q. You were asked by Dr Green: did you tell her that there had been allegations from the Consultants about her specifically? And you say: I was using the phrasing I was asked to by SH and AK.

So Sue Hodkinson and Alison Kelly had told you what you could say to her; is that right?

A. Yes, yes.

Q. Did you feel a bit like you were the messenger in this?

A. Yes.

Q. Did you think it was the right thing to do, what you were telling her?

A. With the benefit of hindsight, I should have stood up a bit more to her.

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

A. (Nods) Yes.

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

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

Q. What's that?

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

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

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

Q. Why do you think he knew?

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

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

"Have you heard about any allegations about Lucy?"

You say:

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

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

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

Q. Hearsay?

A. It was just hearsay.

Q. Who told you that?

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

Q. A nurse?

A. -- to be honest.

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

Q. In all your time there did you hear anyone

speaking like that?

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

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

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

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

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

You didn't go to the police either?

A. No.

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

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

gone to the police.

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

A. I don't know what --

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

"I remember being at another meeting ..."

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

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

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

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

upset, so I think it was that one.
Q. Okay. Do you think that was before the grievance on 24 November 2016 or after?
A. I think it probably was before the grievance.
Q. Before, okay. So you had that information before you spoke to Dr Green?
A. (Nods)
Q. Was there an atmosphere in the context of that grievance, you say you knew it was raising concerns about the Consultants and how they treated her was the atmosphere that that is what you were there to talk about what the Consultants had done or said or behaved like rather than what had happened to babies?
A. It -- it was what their behaviour was, rather than the babies.
Q. You agree from what you have said before that what was needed at that point was either a disciplinary or police investigation, a police investigation?
A. Yes.
MS LANGDALE: Contact with parents. You set out at paragraph -- I see the time actually, my Lady. It might be a good place to stop. We've been going for an hour and a half, Mrs Williams.
LADY JUSTICE THIRLWALL: Very well. So we will take a break now and we will start again at quarter to

12.
(11.28 am)
(A short break)
(11.45 am)
MS LANGDALE: Mrs Williams, before I move to contact with parents, can I just take you back to paragraph 19 of your Inquiry statement and you are speaking of July 2015 and the Serious Untoward Incident review we went to and you think it was around that time -- you say at that time where the mortality rates were discussed Dr Brearey was not overly concerned at that stage and indicated that peaks in deaths can sometimes occur.
You can't recall the date but it looks as if it is around that A,C,D, time; do you remember him raising that with you?
A. I -- I am not convinced it's the 2 July one. I think it's like a neonatal review that he did separately. I am not 100% convinced of the date. It might have been late in 2015, October time round. But I couldn't swear to it.
Q. You remember he wasn't overly concerned but you say as things continued he became more concerned; is that your evidence?
A. Yes, yes, basically.

Q. If we go now, please, to enclosure 6 for you, the second document and INQ0012622, page 3. This is a letter sent from Mr Harvey in February 2017 and this is a letter intended for parents of the bereaved children and we see he sets out there:
"Following on from your conversation please find enclosed a copy of our report ... explain to you we asked for this external assessment from the Royal College. This step was taken because we wanted to better understand why there had been a greater number of deaths than we would normally expect. In the report it describes no single cause or factor to explain the increase we have seen in our mortality numbers."
It continues:
"You will see in the report one of the recommendations includes a thorough review of the specific care and treatment each baby received. This is personal and confidential to you and your family and we would welcome the opportunity to meet and discuss with you the care your baby received."
The -- you tell us that you were involved in contacting families and indeed just before that letter on a page dated 3 February 2017, we see ciphered names and ticks where you have presumably indicated things by your ticks. If we have that page, INQ0012622, page 1.

People will see what that means.
That's something you had pulled together and you were using that, were you, as you made telephone calls and the like when you contacted parents; is that right?
A. Yes. I think the -- the admin team pulled it together and supported me in the process as well.
Q. So the admin team supported you and you were making the calls. That can come down?
A. Yes.
Q. The Inquiry has heard evidence from the parents of the babies named in the indictment and there are two stages where they were not informed where I am sure you would agree they should have been and the first was when there was a press statement announcing the RCPCH review, the parents should all have known about that review, shouldn't they, before that announcement was made in the media?
A. Yes, we discussed that before because I believed they should have been part of the process.
Q. Then there was the occasion of the report itself being leaked to a newspaper and the parents being contacted by you on a Friday evening to tell them it was about to be leaked in a newspaper. Deplorable, isn't it, that that's how they should hear about it?
A. Yes, I can't disagree with that.

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

A. Yes.

Q. Do you remember that?

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

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

A. Yes.

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

A. (Nods)

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

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

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

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

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

Q. Mother E and F as well?

A. We should have been more proactive and we

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

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

A. No.

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

A. No.

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

Do you remember that conversation?

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

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

A. Mmm and it was not recognised and not dealt with appropriately.

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

A. Probably Alison Kelly.

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

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

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

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

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

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

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

A. No.

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

A. Not to that level of detail. No.

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

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

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

Questions by MR SHARGHY

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

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

A. (Nods)

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

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

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

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

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

So I was as clear as that.

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

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

but I was still -- and myself and Julie were concerned.
Q. I believe I caught your answer in terms of what Mr Harvey's reaction or response was to what you had told him and I believe you said that he had indicated to you that he would go and check?
A. Yes.
Q. Did he say what he was going to check?
A. He said he was going to check it, check the information and look himself because I think he was going to look at some of the notes as well.
Q. But by this stage, and again I hope I understood your evidence correctly, one of the purposes of you and Ms Fogarty carrying out the review was to check the same sort of process that the Consultants had already undertaken?
A. It was, it was.
Q. So in other words, this is now a further opportunity --
A. Yes.
Q. -- that you believed Mr Harvey was looking to check that --
A. Yes.
Q. -- same information?
A. Yes.
Q. Did he or any other member of the Executive

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

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

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

Q. -- of senior individuals such as yourself?
A. Yes. I -- I just think that they were -- they had taken -- I got the impression they had taken advice, where from I couldn't say, and that they firmly believed they were following what they should have been doing and didn't listen either side, you know.
Q. You are clear that you believed or you were told that they had taken advice --
A. Yes.
Q. -- specifically about --
A. Yes, yes.
MR SHARGHY: Mrs Williams, thank you so much that is all my questions.
LADY JUSTICE THIRLWALL: Thank you, Mr Sharghy. Mr Baker.

Questions by MR BAKER

MR BAKER: Good morning, Mrs Williams.
A. Morning.
Q. My name is Richard Baker, I ask questions on behalf of a number of the Families.
In this context specifically I want to ask you some questions about your interactions with the Mother of Child C?
A. Okay.
Q. Now, I don't know if you recall, she's in

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

interview and what you say there it is reflected in the evidence you give but there is a bit more detail given and you say to the police officer who's questioning you: One of the babies was fine during the day, collapsed overnight, fine during the day, collapsed overnight?
A. That's right.
Q. Fine during the day, collapsed overnight. And the officer says yes. And you say: it was her that was on duty --
A. That's right.
Q. -- overnight. The officer says yes. You say: and it -- that spooked me. I have to say that spooked me?
A. (Nods)
Q. Do you remember saying that or at least that sense?
A. Yes. I remember talking to the police and telling them that, yes.
Q. Yes. What did you mean by "spooked"?
A. That during the day that the baby seemed very stable but then overnight, there was a sudden collapse and back again during the day, that's the concern and that's the one that I highlighted to Ian Harvey.
Q. Yes and that when Lucy Letby was there, this stable baby suddenly deteriorated and when she wasn't

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

they never specifically said that. You can keep pieces of kit that are faulty or what have you, you know, we have had areas before we investigated something like a piece of kit has been faulty so people have kept it behind, that type of thing. But I was a bit surprised.
Q. But if we put it into what Stephen Cross said to you about foul play --
A. Yes.
Q. -- and we begin to draw all that together?
A. Yes.
Q. You feeling spooked?
A. Yes.
Q. Doctors keeping feed bags, Stephen Cross talking about foul play?
A. Yes.
Q. Bringing all that together, then the suspicion that was being voiced was that somebody, Lucy Letby, might be deliberately harming babies?
A. Yes, yes.
Q. Yes.
A. Coupled with what the Consultants were saying as well, yes.
Q. Yes. Your view was if that's being raised as an issue, it's the police who need to look into it?
A. Yes, absolutely.

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

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

investigation.

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

But Mother C recalls that:

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

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

A. (Nods)

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

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

Q. It was untrue, wasn't it?

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

Q. No, I will go further than that.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

a sense of being part of a cover-up?

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

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

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

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

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

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

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

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

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

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

an Executive role?
A. Yes.
Q. And that role was Interim Director of Operations, which became permanent in May 2016?
A. Yes.
Q. And I think there was a title change in April 2017, to Chief Operating Officer?
A. Yes.
Q. But that role, the role of Interim Director, then actual Director and Chief Operating Officer, although we have got three titles, that was in effect the same role; is that correct?
A. Yes, a slight change in portfolios, things I was responsible for, but yes, generally the same role.
Q. So just to recap. Up until September 2015, you were the Divisional Director of Urgent Care which included the neonatal unit?
A. Yes.
Q. In terms of the matters that this Inquiry is considering specifically that meant you were Divisional Director at the time of the deaths of Child A, Child C, Child D, Child E and the collapses of Child B and the deterioration of Child F?
A. I am unsure, but if that was what's in the documents then yes.

Q. Well, those events occurred between --
A. If those events took place before I moved roles, then yes.
Q. Before the beginning of September.
From the end then of January 2016/beginning of February you were promoted to the Executive Team and that was the most senior tier of managers in the hospital?
A. Yes.
Q. You remained part of the Executive Team until you left the Countess of Chester in December 2019?
A. Yes.
Q. What is your current role?
A. I am Chief Operating Officer at Barnsley Hospital.
Q. So is that a role of equivalent seniority or is that a promotion relative to Countess of Chester?
A. It is equivalent to the role I was doing in 2019 in Chester.
Q. So turning first to the period when you were Divisional Director of Urgent Care and just looking at the structure first of all, you were the Divisional Director and reporting to you was the Medical Director of Urgent Care, who was Dr Sedgwick, I think?
A. It was Dr Sedgwick, we were more colleagues

than reporting to me.
Q. Sorry?
A. It is more that we were both -- we were colleagues rather than him reporting directly to me.
Q. Then the Head of Nursing, Jane Evans initially and then that became Karen Rees?
A. That's correct.
Q. Just there when you say colleagues, is it correct that the Head of Nursing and the Medical Director both had a reporting structure, professional reporting structure to their Director of Nursing and the Medical Director of the hospital but they also reported to you as Divisional Director?
A. Yes. There was two reporting lines, a professional reporting line and a day-to-day reporting line.
Q. For the day-to-day reporting line they reported to you as Divisional Director but they also reported out, so to speak, to Director of Nursing and --
A. At that time until it changed in -- I think we changed it -- it's in my statement but I think it is 2018 that the structure was changed.
Q. But the time we are looking at --
A. At the time, yes.
Q. -- that was the position.

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

aware of any problems?
A. No, at management level I wasn't aware of any problems and nothing was ever told to me that there were any concerns.
Q. More at ground level in terms of relationships between midwives on the maternity ward and nurses and doctors on the neonatal unit, was that something you were aware of any -- there being any problems?
A. I wasn't aware there were any problems.
Q. Turning now then to Child A, Child C and Child D specifically. You were the Divisional Director when these children died and they died, we know, within a two-week period in June 2015 and you say in your statement that the then Head of Nursing for Urgent Care, Jane Evans, informed you of the deaths.
Can you just explain how that took place in practice, how did you come to know in practice?
A. Yes. So myself and Jane Evans and later Karen Rees were in the habit of meeting up around about 8 o'clock so at the start of the day so it was an informal meeting over a cup of coffee, what happened yesterday, any challenges we have got at the start of the day and what we -- what our focus was going to be.
So in regards to those three deaths, I was told I think it was probably the following day by Jane Evans

that there had been a death on the neonatal unit, we had a conversation where I asked was there any learning, is there anything that we didn't do --
Q. Just pausing there.
A. Okay.
Q. So you were told one death at a time, so to speak?
A. Yes.
Q. Yes, carry on?
A. So then after each death, so each time I was told of a death, I asked, you know, was there anything from that death that was of a concern. Then I would ask how were the family and had we put support in place and how were staff and had we put adequate support in place for those members of staff.
Q. Just pausing there for a moment. You said this was an informal update over coffee in the morning.
Had it not been for that update, was there any other means by which you as Divisional Director would have been informed of this increase in mortality of these deaths?
A. We -- we had regular more formal updates around what was happening in the hospital on a daily basis so I would have been informed, possibly later than I was.

Q. So there was a system, was there, for informing you as Divisional Director of when there were deaths within your unit?
A. Not particularly deaths. There were processes in place for informing me when there are had been any indents or any concerns.
Q. Was that a concern to you, that there wasn't a formal system so that you were always aware of any increase in mortality rates in any formal system?
A. In my role as Divisional Director it wasn't something that concerned me in terms of having a formal route to know about the increased mortality. My assumption at that time is that that is something that would be escalated through the nursing and the medical route through the professional leads.
Q. After you had heard obviously in rapid succession by the time you heard of the third death in the neonatal unit, presumably that was pretty shocking and had never happened before in your career at the Countess of Chester?
A. It isn't something that I was aware of happening before. I am not -- I can't recall when there had been three deaths in such a short space of time.
Q. What were your immediate concerns after you had learned of three deaths within a two-week period?

A. I think my concerns were after each death and I asked if -- if anything needed to happen. At each time I was assured that no concerns had been raised and I think by the third death it was well, we are just having a bad run and there's -- and there is no concerns that there has been three deaths in a short space of time.
Q. Well, you were the Divisional Director?
A. Mm-hm.
Q. You have got three deaths within a short period, something that had never happened before. Was it acceptable that you just accepted: we are having a bad run? Did you not consider -- what did you consider your role and responsibility was as the Director of Division once you had been informed of three deaths within two weeks?
A. Well, I'm not sure. I don't know whether it had ever happened before. I wasn't aware. It hadn't happened while I was there, but that was -- I would have only been there for a short period of time and it hadn't happened in that -- since 2013.
But I was assured by my Head of Nursing that the clinicians had looked at the deaths, they had no concerns and that the relevant processes were in place and each death would be further looked at through the

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

Q. Just to return to the question, though.

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

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

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

Q. You say in paragraph 25 of your statement:

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

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

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

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

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

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

Q. Well, obviously a very busy job.

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

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

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

skills to do that.

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

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

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

A. No.

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

A. Yes.

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

A. I recognised that it was unusual.

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

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

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

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

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

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

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

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

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

Q. Well, just pausing there for a moment.

So this was an informal meeting over coffee --

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

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

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

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

had been my deputy, so she was aware of what was happening in the division before we had a handover formally.

Q. Did you brief Karen Townsend about your concerns about these three deaths?

A. Not formal because as I was told about the deaths from Jane Evans, then that was cascaded. So Karen would have been aware, as my deputy, that there had been a death in the neonatal unit.

Q. Well, Ms Townsend's evidence was that she wasn't aware. How -- just be clear here. How do you say she would have been aware? You didn't inform her.

A. I don't remember informing her directly, but it was known in the division that there had been three deaths. So we were all aware that there had been three deaths in that month and the service manager definitely was aware.

Q. The case of Beverley Allitt, is that something that you were aware of? Was it covered in your Master's in Health Service Management for example?

A. Beverley -- I know about Beverley Allitt because that case was in the early '90s as I qualified as a paediatric nurse.

Q. And Recommendation 13 of the Clothier Inquiry into Beverley Allitt was that:

"Beverley Allitt's actions should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events."

Now, I'm not suggesting you would probably be aware of the exact wording or the number of the recommendation. But as someone working in hospital management and with a qualification in that, were you aware of the possibility of deliberate harm as a cause of unexplained clinical events?

A. I am aware that this happens, even if it's a very rare occurrence, but I wasn't told that any of the deaths were unexplained.

Q. But your mind was open to the possibility --

A. Yes.

Q. -- that if you had three deaths in close succession that that was one of the things that had to be considered?

A. If -- if a clinical -- if a clinician had told me there had been three deaths and they were unexplained then, yes, that would have been something that I was open to.

Q. But, Ms Burnett, you didn't talk to any clinicians to find out whether these deaths were unexpected or unexplained. You just had a briefing over

coffee with Jane Evans who wasn't involved directly in these incidents.

So how could you satisfy yourself that there was no linking factor between these deaths that was a concern that you ought to be investigating?

A. The -- the division of Urgent Care is quite a complex and large division. We had layers of -- we had a hierarchy and we had layers of management and clinicians in there that would manage things to a separate level.

So for me I had a senior manager who liaised directly with the unit, with the neonatal unit, with the clinicians, who was involved in their regular business meetings. I then met with them on a monthly basis where they escalated to me if anything had come out of there that was out of the ordinary or of concern. And at no point was it ever escalated to me that there had been unexplained deaths.

So I was assured by the meeting with Jane Evans where she told me that the clinicians had looked at the deaths and they had no concerns and --

Q. Sorry. Just stopping you there. The clinicians had looked at the deaths. This was the morning after the deaths.

A. It was the morning after. But they -- they

were able to give assurance to Jane and the matron or the Head of Nursing for paediatrics that they didn't have any concerns, but that they would look again at the deaths and there would be a better, a more in-depth review.

Q. And who did you understand was the clinician who was assuring Jane Evans?

A. I don't know exactly, but I would -- my assumption was that Steve Brearley*(sic)* as the lead for neonatal unit was involved in those conversations.

Q. If we just look at paragraph 26 of your statement. You say:

"The Trust's governance structure was set up to provide appropriate avenues for any concerns to be reported."

And you go through in that statement and you go through Serious Incident reporting, where there was a risk that going on to the Risk Register, that being escalated to QSPEC and then in turn any issue raised with the Executive Directors group.

Well, in this case of course we know that that fell at the first hurdle in the case of Child A, Child C and Child D because it was decided that there was no further investigation of commonality between their deaths.

A. (Nods)

Q. Ruth Millward's statement to the Inquiry accepted that the failure to conduct a full investigation of that cluster of deaths was a missed opportunity. Do you agree with that?

A. In hindsight, yes.

Q. Looking back now, do you consider that as Divisional Director you should have made sure that you were informed and satisfied yourself that sufficient investigation had taken place of those three deaths?

A. No. I don't think that is the role, the overall role of Divisional Director. That was why there was a Divisional Medical Director and a Head of Nursing who covered off the clinical aspect of the division.

Q. Turning to Child E, were you informed of the death of Child E? Child E died on 4 August?

A. Not to my knowledge. Not -- but, again, it was a long time ago. I don't recollect that.

Q. So you have explained, I think by then it may have been Karen Rees who had taken over the role, that you had the informal meetings with Jane before that.

Was there no other -- you said before that there was a mechanism whereby you would be informed of deaths. Did that not happen in the case of Child E?

A. I can't recollect. I think that the reason that the three deaths stood -- stuck in my mind and

being told about them was because it was unusual to have three deaths in a short space of time.

I don't recollect that anything in, in the August -- I don't know if I was -- I may have been on holiday, annual leave, there could have been lots of reasons why, but the specifics of that do not stick in my mind.

Q. The unusualness of the three deaths was that if there was something in common between those deaths --

A. Yes.

Q. -- that was a very serious matter that needed to be investigated and you recognised that?

A. I recognised that and I asked each time this -- and on the third death: You know, this is three. This is a lot. What, what's going on? And I was again assured that there was no concerns. It was just unfortunate we'd had three very sick babies in a short space of time.

Q. Did it also make -- that was the thought process you had when it got to number 3. Did it also make you think: I must be very alert to see if there is another death, which in fact occurred with the death of Child E?

Were you not very alert to the fact that you needed to be very aware of whether there was any other death

because that could cause you to reconsider the issue of commonality between the deaths?

A. I was aware that the right people were aware there had been three deaths. So the clinicians were aware and they were on the -- they were keeping a heightened awareness that there had been more deaths. That was enough to assure me in a non-clinical role that the right people were looking at the information.

Q. Because Ruth Millward says that the death of Child E was another missed opportunity to consider in more detail those deaths. Would you accept that that was a further missed opportunity?

A. Yes. As I say, I don't recall being informed of that in August.

MS BROWN: My Lady, I don't know if that would be a convenient moment because the next section is going to look at the role of Ms Burnett and the Executive Team. So I don't know if that would be a convenient moment to break.

LADY JUSTICE THIRLWALL: Yes, certainly. So we will break now and we will start again at 5 to 2.

A. Thank you.

(12.55 pm)

(The luncheon adjournment)

(1.57 pm)

LADY JUSTICE THIRLWALL: Sorry to keep you all waiting. Ms Brown.

MS BROWN: So, Ms Burnett, we are going to turn now to the period when you were on the Executive Team and that commenced at the end of January/beginning of February and that was a team of eight individuals that included Ian Harvey, Tony Chambers, Alison Kelly, Stephen Cross, Sue Hodkinson, Ian -- Debbie O'Neill, later Mr Holden and yourself; that is correct, is it?

A. Yes, it was a long list.

Q. So there were eight of you and you were the most senior managers?

A. Yes, and I joined the Executive meetings from September and then became the Interim Director of Operations, I think it was it is in here but --

Q. I think you are recorded on a meeting at the end of January with that title so it would seem from the end of January 2016 you had the title but you had sat in on the Executive meetings in fact before then?

A. Yes.

Q. How often approximately did the eight of you, or the Executive Directors Group, that relatively small group, how often did you meet?

A. We met weekly. We had a scheduled meeting on a Wednesday morning.

Q. What was the overarching purpose of those meetings?

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

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

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

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

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

Q. At paragraph 20 of your statement, you say:

"From my recollection no one person had a dominant voice within the EDG [the Executive Directors Group], we all took turns offering our thoughts and advice

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

So you are describing there a collaborative style of meeting?

A. Yes.

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

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

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

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

period and over that issue?

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

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

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

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

Q. At paragraph 15 of your statement, you say:

"In my view the structures and processes for the management and governance of the Trust did not contribute to the failure to protect babies on the NNU."

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

A. Mmm mm.

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

A. Yes.

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

A. Management mm-hm.

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

concerns with Consultants didn't reach the Executive Team, didn't reach you --

A. (Nods)

Q. -- until the end of June.

So contrary to what you say at paragraph 15, doesn't that in fact indicate there was some failure of management and governance and certainly of risk management?

A. I think the structures and the processes were in place. But as I said in my statement I don't think things were reported although structures and processes were used as they should have been in, you know, looking back what's been said now.

Q. So the system didn't manage to bring the concerns up to the Executives?

A. The systems were there. The people involved didn't use the systems.

Q. Just looking then at June and July and when there were these series of meetings, dealing first with 29 July, and there was more than one meeting on 29 July, you deal with these from paragraph 34 of your statement.

You attended a meeting just of the Executive Directors Group and we don't need to turn to it but we can see from a note there that there was reference to there being an NNU neonatal update on that day and you

go on to deal with what was said at that meeting.

You say -- paragraph 35 this is:

"Tony confirmed that the Consultants had raised concerns regarding increased mortality on the NNU and that they felt uneasy about Letby."

That's the first you are aware of an increase in mortality and the concerns of the paediatricians, is it?

A. Yes.

Q. We go on at paragraph 36, you say:

"There were ... discussions around the fact that Letby always seemed to be on duty when deaths occurred, however it was also flagged that she worked full-time and often picked up extra shifts."

So the concern here was, it wasn't a conclusion, but it was a concern that Letby was involved in some ways in those deaths?

A. I don't recall -- excuse me, I don't recall the exact conversation. I remember that there was concerns raised around the deaths and why they were occurring. I remember at some point in the meeting we started to talk about Letby, so I make an assumption that that had been raised.

Q. Well, you are saying the fact that Letby always seemed to be on duty when deaths, so that -- the obvious suggestion there is that there was possibly some

link between her and the deaths that is what was being discussed?

A. Yes, so I don't recall exactly when it was raised but in the course of those meetings on the 29th, we had the conversation about Letby being on duty and then the comment was made that she was -- worked full-time, that she did extra shifts et cetera.

Q. You say at paragraph 37:

"The tone of the meeting was very much one of shock and concern ..."

Was the shock there that it was being suggested that a member of staff may be involved in harming babies which obviously would have been shocking?

A. I think it was a -- it was a combination. So it was a shock at the number of deaths that we were being informed of, there was shock that that hadn't been brought out sooner; and there was a shock that there was some concern that somebody was undertaking something malicious.

Q. You say there the main focus was being to find the cause and I think it goes hand in hand with that to find the cause, one of the things that have to be investigated was: was that concern about Letby genuine, was that a cause, was she a cause of those deaths, that was one of the things you would have to investigate to

find out the cause of the increased mortality?

A. From my perspective it -- everything we did was about finding out why and we and keeping an open mind as to what that could be from something that was very unlikely, to the most likely. But being aware of anything.

Q. I think you have accepted already that you were aware of Beverley Allitt and were aware that one of the possibilities you had to be alert to was a member of staff harming -- deliberately harming children?

A. Yes.

Q. You say there:

"I was shocked by the concerns being raised as I was unaware of the increased mortality on the NNU ..."

At that point did you reflect back on the year earlier when you had been informed the three deaths?

A. Not in that particular meeting. It was when we heard the information from -- I have forgotten the Consultant's name, when they had done the review the neonatal unit and they came back with a significant number of cases, that was when I put -- realised the three deaths in the previous summer.

Q. Then you go on from paragraph 38 to discuss the further meeting and then there was a further meeting that day at 5.10 pm, when the Consultants also attended.

A. Yes.
Q. If we could go to the notes of that meeting, that is INQ0003371. It's tab 6 in the bundle, my Lady.
A. Can you put it up, I haven't got any of the documents?
Q. No, it's going to come on to the screen so you can see it.
LADY JUSTICE THIRLWALL: It will come on to the screen.
MS BROWN: So we see there at the top this is Wednesday, 29 June 2016 and we see the initials. So Tony Chambers, Alison Kelly, Ian Harvey, that is Dave Semple, Steve Brearey, Dr Jayaram, Dr Saladi, your initials and Stephen Cross who are there?
A. Yes.
Q. Just picking out a few of those notes. We see that Dr Brearey four lines down, some PM report but not all inconclusive, so postmortem reports, some were inconclusive.
Going further down, unexplained collapses. And then in fact Dr Brearey he does make the connection between those three earlier deaths. He says: met July 2015 three cases.
That was the Child A, C and D.
"Common theme was nurse."

You was that the first that you were aware that there was a common theme amongst those three deaths A, C and D that you had been told about by Jane?
A. Yes, yes. As I said previously I was told that they were all unfortunate but not suspicious.
Q. Then we see that Dr Jayaram also contributes to this meeting, he says:
"Babies were stable and then deteriorated, why always this nurse?"
Then if we go over the page. Stephen Brearey says more than -- or the notes say:
"More than just an association with this nurse"?
A. Mm-hm.
Q. Dr Saladi is noted next to his name:
"Don't suddenly deteriorate. These babies were relatively stable, sudden deterioration and collapse."
Then next to the initials TC, Tony Chambers:
"Why did we call the police?"
Then your initials a bit further down, LB:
"Unsafe unit agreed."
Can you recall what you were saying there?
A. I can't and I think that is a paraphrase of what I was said so I think we were probably discussing whether the unit was currently safe and what did we need to do.

Q. Then if we go on to page 3 there seems to be a sort of list of concerns, obviously these are just notes:
"Concerns shut unit, Commission review, then police ..."
Or they seem to be listing different orders of doing things, police and consequences.
We see a bit further down there "safety paramount" and then we see:
"Nurse cannot be excluded."
Do you recall a discussion there now looking at that note about suggesting that the nurse couldn't be excluded, that is a reference to Letby?
A. I don't recall that, I recall at the meeting we were informed that Letby was on leave for two weeks and therefore we had two weeks to, if you like, get our thoughts together as to what we should do.
Q. Yes. If we can just go back to your statement then, so that can come down, thank you. Just to be fair to you, because you also discuss this meeting in your statement and you say at paragraph 40 that your recollection in your statement is you recall Tony being adamant that she could not return to the unit until all concerns had been resolved.
Just fill us out on what your recollection was of

what Mr Chambers was saying then?
A. My recollection is that the paediatricians were raising concerns, they were raising concerns about Letby. Tony Chambers was adamant until we have got to bottom of this and everybody's agreed that she had no part to play, then she couldn't go back on the unit and I recall that being said in a number of meetings.
Q. So what you are saying is he was adamant that until it was decided whether or not she had any connection with the deaths, she must not be on the unit?
A. Yes.
Q. This may seem obvious to you but if you could spell it out: what was the risk that you understood Mr Chambers to be concerned about?
A. I think there was a risk of for her if she went back on the unit and that was -- that was -- it hadn't been explained, but the overarching risk for all of us is that we didn't want any more deaths, we didn't want any more unexplained collapses.
Q. Did you agree with Tony Chambers's adamant position at that meeting that you were in agreement with it?
A. Yes.
Q. At paragraph 41, you say:
"I also recall Tony specifically [we have seen this

in the notes] mentioning police involvement ..."
We have discussed Beverley Allitt and you have acknowledged there was a possibility of deliberate harm here. You go on to say:
"I cannot recall that anybody wished for the police to be called ..."
Given that there was a possibility of deliberate harm, why was it that your recollection is that nobody wanted the police to be called at that time?
A. My recollection was that people were open to there -- to a number of explanations, everybody in the room, and therefore we needed more information to inform the next steps.
So at that point we needed to understand more about what was happening, what had -- could happen and then whether we needed to call the police.
Q. That's -- your understanding was that was the tenor of the whole meeting, that there was agreement that it was that they should not be going to the police at that stage; is that your recollection?
A. Yes.
Q. If you can go down to paragraph 43, you say:
"We talked through all the options available to the Trust, concerns raised by the Consultants about increased mortality and something being wrong with

Letby."
What do you mean there by "something being wrong with Letby"?
A. That was how it was described by Dr Brearey and Dr Jayaram, they -- they couldn't give an example or anything that may have happened. But they described it as she's not right, there's something wrong, things don't feel right with her.
Q. But you were clear that when Tony Chambers was adamant she be removed that was because there was a concern that she could be harming babies and she had to be removed from the unit?
A. I think it was two-fold. One, if she had been harming babies -- and that was the concern from the clinicians -- we needed to take a seriously; but two, if she hadn't and we left her on the unit and anything else happened we wouldn't have been able to define what had occurred.
Q. At paragraph 44 you then say following the meeting you had a conversation with Dr David Semple who informed you that medical staff had been overheard using the phrase "angel of death".
First of all, are you aware who those staff were, were you given names?
A. No, it was kind of -- the comment was, you

know, people are talking because something was said in a queue at the coffee shop.
Q. First of all you discuss that words those words were inappropriate?
A. Mmm mm.
Q. But then you say:
"I remember saying that we had now initiated a process to get to the bottom of [this] issue ..."
The "we" there is the Executive Directors Group, that is the Executive Team, is it?
A. No I think I included the clinicians and the Women's and Children's in that statement, because we had all been in the room and we had agreed our way forward.
Q. So the "we" there is really the "we" from that meeting on 29 June, the one where the Consultants were present too?
A. Yes, yes.
Q. You said "we had initiated a process to get to the bottom of the issue", so we had the reference to the "angel of death" and "the bottom of the issue" and you are talking there are you about getting to the bottom of the issue about whether Letby was or was not responsible for the deaths?
A. I was talking about getting to the bottom of what had happened, to the babies that had died and one

cause could be Letby, so it was the whole thing. Let's find out, we have initiated a process, we will follow that process through until we get to the end conclusion.
Q. But you were clear that one of the things that had to be sorted out was: was Letby involved in these deaths or was she not?
A. Yes, but because I was open to there have been any -- could be a number of reasons.
Q. Yes. We then come to the issue of downgrading of the unit. You say at paragraph 48 you were required to focus on many responsibilities in your role as Chief Operating Officer, including the downgrading of the NNU.
Can you just explain what your role was in terms of the downgrading of the unit?
A. Yes. So following the meetings late June/early July one of the things we agreed was to minimise the risk to the neonatal unit going forward until we knew actually what was happening.
So one of those things, and I spoke to Dr Brearey was in the meeting where we discussed this, was to reduce the acuity of the babies on the unit. So working with Dr Brearey and Dr Jayaram, we wrote the protocol around what the threshold was for babies being in our unit, I took on the role of linking in with the neonatal network to inform them that we were moving to not quite

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

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

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

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

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

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

A. No. Not that I recollect.

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

that something that came under your responsibility?

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

Q. So you didn't get involved --

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

Q. -- in discussing that aspect.

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

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

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

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

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

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

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

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

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

the paediatricians.

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

A. I think --

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

A. Yes.

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

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

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

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

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

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

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

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

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

"Culture and obstets paeds broken plus breakdown between doctors and nurses".

So you told us at the beginning of the evidence

that when you were the Divisional Director you didn't perceive there to be any problems between doctors and nurses and here you are talking about a breakdown between doctors and nurses.

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

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

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

So whether that was a paraphrase of a conversation.

Q. But they are only notes --

A. Yes.

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

A. No. I think that was -- it was at this point when Letby had been removed from the unit, I think the

nurses felt strained, but I wouldn't have said culture was broken or breakdown between doctors and nurses.

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

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

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

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

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

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

And so on.

Can you just explain what the neonatal dashboard was, when it was introduced and what it was aimed at

achieving?

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

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

A. Yes.

Q. Because the death would have been recorded on the --

A. Yes, by 10 o'clock the following morning we would have known anything that had happened the previous day at an Executive level.

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

A. Yes, when we were --

Q. -- 2016?

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

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

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

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

It was attended by Duncan Nichol, Tony Chambers, Ian Harvey, yourself, and Mr Cross and we see those initials halfway down, we see Friday, 30 December and

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

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

A. I can't recall.

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

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

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

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

Q. I mean, that would have been a very significant report, wouldn't it, because you were looking at that report to potentially answer some of your questions about why there had been an increase in mortality and that related to your particular area of

concern which was the upgrading or the downgrading of the unit?

A. Yes.

Q. That was under your remit?

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

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

A. No, it didn't.

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

Were you aware of that?

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

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

A. I was aware of her having been instructed but it was just a name to me. I didn't know who Jane Hawdon was.

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

A. I didn't see her report.

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

A. Mm-hm.

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

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

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

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

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

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

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

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

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

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

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

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

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

well as your qualifications in management.

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

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

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

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

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

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

"Difficult meeting with Lucy and family.

Commitment to them at meeting."

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

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

Q. We see then next to that "Safety of babies".

Was that still something that you were very alert to?

A. Yes.

Q. The safety of babies in the unit?

A. Yes, yes.

Q. And further down it says.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Formal acceptance of reviews."

And then:

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

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

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

meeting having made that decision.

Q. What was your view about whether Lucy should be returned to the unit?

A. My view was that until we knew exactly what has happened, we should maintain where we were right then. So Lucy wasn't on the unit, we were a Level 1 unit, there had been no more collapses, been no more deaths, that seemed to me to be a safe position and one that we needed to continue until we got to the end, and the end was everybody agreeing.

Q. Because we know in fact what went on from this is that there was a decision and Lucy Letby had been informed that she would go back to the unit and the Consultants then raised their concerns about this but the Executive decision following this meeting was that Letby should go back to the unit and you were one of five people at this meeting.

Why do we not see your views expressed here that at all costs Letby must not go back on the unit?

A. So again, I don't know why -- why it doesn't say that I wasn't concerned, but it was a collective decision. So there were a number of people in there and people had different -- different views. It isn't a transcript. It's somebody's notes.

LADY JUSTICE THIRLWALL: What were your views

expressed at the meeting?

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

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

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

LADY JUSTICE THIRLWALL: Yes, there were two things.

A. Yes.

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

A. Yes, yes.

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

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

what had happened. So I think that was probably something that I felt other people in the room were better informed.

LADY JUSTICE THIRLWALL: So you didn't say anything about that, you don't think?

A. It's difficult to say. I can't remember exactly what I said in the meeting, but if I think about my thoughts, my thoughts were that by Lucy not being on the unit and it being at a Level 1, that it was safe. We hadn't had any more concerns raised, we hadn't had any more collapses or deaths and I felt assured that the risk had been minimised.

MS BROWN: Did you understand at that meeting the import of the meeting, this was the five most senior people in the hospital of which -- at that meeting of which you were one and a decision was being made about whether to return Letby to the unit.

Did you understand how significant that decision was?

A. I don't recall that the decision was made in that meeting to return Lucy to the unit.

Q. Looking back now, you were involved as a Divisional Director when the first cluster of deaths occurred, that was in the neonatal unit, and you then sat on the Executive Directors Group meetings from

September through to the point where there was a report of Letby to the police.

Looking back now, why do you think it took so long for the Executives to refer Letby to the police?

A. Looking back now, and having read some of the transcripts from the Inquiry, at no point were the Executives made aware of any insulin results or any concerns about any of the blood results. We were told that there was no explanation for the deaths.

I think if some -- if some of those concerns that have since come to the forefront had been made known to the Executive Team, then we would have taken a different course of action.

MS BROWN: Thank you, I have got no further questions and I don't believe there are questions from any of the Core Participants.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Just one from me, if I may.

You said you were asked some questions about systems which obviously did not result in the issue of Lucy Letby coming to your attention or to the board's attention and you say the systems were there but people didn't use them?

A. Mmm mm.

LADY JUSTICE THIRLWALL: I just wondered if that's the case, does that mean that the systems perhaps weren't appropriate for this situation?

A. I think that's a possibility. I think that the hospital was very much focused, it was -- it is a district general hospital, there was a significant focus at that time on urgent emergency care, the pressures around beds, so that bigger part of the hospital, rather than neonates Women's and Children's.

So I think that is a possibility; that those systems weren't appropriate for the neonatal unit and could have been different.

LADY JUSTICE THIRLWALL: Thank you. Just arising out of your answer, we know there was a restructure which meant that women and children were effectively in a management sense sort of downgraded in terms of their representation on the board.

Is that something that may have contributed, do you think, to them being a bit disconnected?

A. So I wasn't in -- when I joined the Countess --

LADY JUSTICE THIRLWALL: I know you weren't.

A. -- it had already happened.

LADY JUSTICE THIRLWALL: Yes.

A. I think it was around 2016, 15/16, when there

had been the Inquiry into Morecambe Bay, one of the recommendations was that Women's and Children's services should sit back together. So I had spoken to my counterpart in Planned Care and we put a proposal to the Executive Team for the Women's and Children's to come back together, not in its own division, but as a directorate mindful the resources that we had available to manage the services.

So I think so that would suggest that the answer could be yes, but I think we recognised there was recommendation from the Kirkup Report and that it would be in the best interests for them to sit together.

LADY JUSTICE THIRLWALL: Yes, those are my questions. Thank you very much indeed, you are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: I think we are waiting, Mr Bershadski, for the next witness, Ms Appleton-Cairns.

MR BERSHADSKI: Yes, my Lady.

MS DEE APPLETON-CAIRNS (affirmed)

Questions by Mr Bershadski.

LADY JUSTICE THIRLWALL: Thank you, do sit down.

A. Thank you.

MR BERSHADSKI: Good afternoon, could you state your full name, please, for the Tribunal?

A. Deborah Lynne Appleton-Cairns.

Q. Thank you. I think you have made a statement for the Inquiry dated 30 July 2024; is that right?

A. Yes.

Q. Have you had an opportunity to consider that statement recently?

A. Yes.

Q. Is it true and accurate to the best of your knowledge and belief?

A. Yes.

Q. Thank you.

Ms Appleton-Cairns, is it right that you started working in the human resources sphere in 1999?

A. Yes.

Q. So by the time of 2016/2017 you had some 17 years' experience in HR; is that right?

A. That's correct.

Q. I think you have got some professional qualifications in HR as well; is that correct.

A. It is, yes.

Q. Thank you.

I am just going to begin, Ms Appleton-Cairns, by asking you about some of the HR policies that may be relevant to some of the issues we are going to discuss.

Could I first ask you to turn to the disciplinary

policy and if we could have that up on the screen, it's INQ0108329.

It can take a little bit of time for documents to present themselves on the screen.

A. Okay.

Q. Ms Appleton-Cairns, I think you have provided the Inquiry with this copy of the disciplinary policy; is that correct?

A. Honestly, I don't know, because there were a number of versions and I did provide an additional one to the Inquiry that I had.

Q. Thank you. Is there anything within this policy that as far as you can recall is significantly different from the policy that you think would have been in place in 2016?

A. Not of significant difference, no.

Q. Thank you. I am not going to take you through the entirety of this policy but if we could just turn, please, to page 15 of the policy. Were you familiar in 2016 with this part of the policy, appendix 6, consideration of referral to the Local Authority Designated Officer?

A. Yes.

Q. What was your understanding of, in essence, the purpose and effect of this aspect of the

disciplinary policy?

A. So this is if somebody was being disciplined under this policy, then there would be consideration, this was an appendix to that.

Q. Yes.

A. And that if there was something that required -- so if they were under disciplinary and it was something to do with harming children, then there would be consideration to refer that to LADO.

Q. The way it's phrased, if we can take it at the top, it says if there is a concern raised or an allegation made about a person who works with children, whether a professional staff member, foster carer or volunteer, that they may have done various things, including possibly harmed a child, then a referral should be made; is that right?

A. Yes.

Q. So would it be fair to say that the very fact of a concern being raised or an allegation about somebody who works with children that they may have harmed a child, that that would be sufficient to trigger a referral to be made to the Local Authority Designated Officer?

A. I guess there is a couple of things. First of all it's under the disciplinary policy and nobody was

being disciplined at that stage. However, I think that if there was evidence with regard to somebody who was harming a child, if something had been raised in that -- in that context then the person who was the conduit between the Trust and the local authority could have made that referral, yes.

Q. Would it be fair to say that you as the deputy director of HR at that time would be expected to have a particularly sound knowledge of this policy and other HR policies within the Trust?

A. Yes.

Q. Now, is it right that within this section of the policy, it doesn't talk about any particular evidence being provided or of any evidential threshold for a referral to be made; it simply says that if a concern is raised, a referral should be made; is that right?

A. Yes.

Q. Is it right that the disciplinary policy isn't the only policy which discussed referrals of this nature?

A. I would have to see the other -- the other policies to which you are referring.

Q. Okay. If we could please turn up the Speak Out Safely policy, it is INQ0003012. Now, is this

a policy that you would have been familiar with in 2016?

A. No.

Q. Why is that?

A. Because the Speak Out Safely policy was dealt with entirely by Alison Kelly and Sue Hodkinson.

Q. Are you saying you would never have looked at it --

A. No.

Q. -- in 2016?

A. No, I am not saying that at all. But I wasn't involved in the -- there was numerous versions of this policy that were going backwards and forwards.

Q. Yes.

A. And at that particular time, I was overseeing two very major jobs and that's why they were doing this policy --

Q. Right.

A. -- with the Union.

Q. Well, let's just try and establish if we can whether this is the policy that would have been in place at the time. We can see on this page the Trust policy statements on the screen and it is dated November 2013?

A. Mm-hm.

Q. Yes. Now if I could just ask you if we could flip through to page 12 of this document, please. We

can see it says "Review" in the middle of the screen then:

"This policy will be reviewed every three years in consultation with the Trust's partnership forum, it can, however, be reviewed earlier if the need arises"?

A. Yes.

Q. So is it right to say that the prima facie position would be that this is the policy that would have been in place probably until November 2016 unless a particular situation had arisen that required a review before then?

A. I think it was reviewed before that review period because of the campaign that was run by the RCN. But as I say, it was -- it was something I had very little to do with.

Q. Okay. If we can please turn one page back to page 11, can you see "Monitoring arrangements" --

A. Yes.

Q. -- sort of two-thirds of the way down on the screen and if we look there, it says:

"Process for monitoring and annual audit is undertaken to ensure compliance with the policy current legislation and best practice."

Then underneath that it says:

"Responsible individual: deputy director for HR and

OD"?

A. Yes.

Q. Was that you at the time?

A. That was me.

Q. Were you undertaking annual audits to ensure compliance by the Trust with this policy as it seems to state that you should be in the policy?

A. In -- all policies were reviewed and they could be reviewed earlier if there was a change in legislation or whatever, but I do recall that this one was reviewed earlier and one of the things that makes me think that is because you have got UCAT as one of the unions and UCAT stopped being a recognised union. So that makes me think that this isn't what was in place at the time.

Q. Okay. But had you at any point between 2013 and 2016 been undertaking audits to ensure that the Trust was complying with the Speak Out Safely policy as it suggests you were responsible for? Had you undertaken those reviews or not?

A. Sorry, could you say that again?

Q. Okay. I am sure I'm not making myself clear. This policy dated 2013 --

A. Yes.

Q. -- states that you are responsible for

undertaking audits to ensure compliance by the Trust with this policy; that is what it seems to say?

A. (Nods)

Q. Did you do that or not?

A. The partnership forum that included all the unions, that it was a general review. It wasn't just me because I had no power to change a policy unless I had the partnership forum's agreement. So it would be the annual audit was -- was done as a partnership forum just with my name on it.

Q. Yes. So were you responsible for it?

A. Yes.

Q. So are you saying that even though you might not personally undertake the audit, you would make sure that it was done and put your name to it?

A. Yes, if somebody said that they needed to have a change or whatever but I also had a head of policy as well, because obviously, you know, I had an awful lot of other responsibilities including the policies, so I had a head of policies who I would maybe give that -- give that task to do.

Q. Okay. Would it be fair to say that given that you had responsibility for signing off annual audits for compliance with this policy, that you should have had a pretty good working knowledge of this policy or its

equivalent in 2016?

A. Well, I would like to see the one from 2016 because, as I say, I didn't have responsibility for the one that came after this.

Q. Okay. Well, this is the version that we have. If I could ask you if we could turn the page to page 9, please, of it, do you see again a section headed "Consideration of referral to the Local Authority Designated Officer"?

A. (Nods)

Q. So it is a similar title to the bit we just looked at from the disciplinary policy.

A. (Nods)

Q. Again we can see it says:

"In cases where there is concern with regards to patient care, the senior manager informed of the allegations needs to consider referral of the matter to the Local Authority Designated Officer ..."

A. Yes.

Q. "... in conjunction with the head of service." Can you see that?

A. Yes.

Q. Then if we skip to the middle of the paragraph or in fact seven lines down, we can see it says:

"A referral must always be made if the employer

thinks that the individual has harmed a child or poses a risk of harm to children."

A. Yes.

Q. Would you -- is it likely, do you think, that whichever precise version of this policy was in place in 2016, that this requirement to make a referral would have been in place?

A. I don't know what the other version said.

However, what I would say is that Alison Kelly was the LADO conduit, was the lead person for that. So it wouldn't have been me who would have made the referral.

And I agree, a referral must always be made if the employer thinks the individual has harmed a child. Yes, I do think if people thought that children were being harmed, then they had that responsibility to make a referral to the local authority.

Q. Well, do you agree that they had that responsibility not just if they thought an individual had harmed a child but if they thought that the individual posed a risk of harm, that they also had that responsibility? Would you agree with that?

A. I think if they had evidence of that, then yes, absolutely.

Q. Okay. All right. Thank you.

I am just going to ask you a few questions about

the NNU action plan in meetings and your role within that and that is a topic that you cover from paragraph 17 onwards of your statement. If we could please have up on screen INQ0005196.

Now, this was an action planning meeting regarding the neonatal unit which you attended on 30 June 2016.

A. Yes.

Q. Were you aware of concerns about increased mortality on the neonatal unit prior to this meeting or is this the first time that you became aware of such concerns?

A. The first time I -- and unfortunately I cannot get the chronological dates in my head completely right because it's a long time ago.

Q. Yes.

A. However, the first time I heard about there being a spike in mortality rates and then being drilled down into it being neonates, I believe I was at that meeting, I can't remember when, and I believe it was the Medical Director Ian Harvey that raised it and that he was instructed by the Chief Executive Tony Chambers, along with Alison Kelly, to go and understand exactly what that meant.

Q. Okay. So you think that by the date of this meeting, you had already heard about the concerns from

Ian Harvey; is that right?

A. Yes.

Q. Okay. Now, can you just give us a summary of what your understanding was of the purpose of this meeting?

A. The meeting was around -- well, it was, it was to understand what was going on on NNU and it was also to discuss whether Lucy Letby should be -- be removed from that meeting -- from that department and from her duties. So that -- that was it in essence.

Q. What was your understanding of the reason why consideration was being given to remove Lucy Letby from the unit?

A. It was due to the fact that there was a spike in -- in the -- in the neonates. But they couldn't understand what had happened, but according to two of the Consultants, they felt that it could possibly be to do with Lucy Letby being on duty. There was a commonality between her being on the unit when some babies had died.

Q. I am going to just jump straight to the point, if I may. Surely already by that point, that was an expression of a concern by individuals within the hospital that Lucy Letby may pose a risk of harm to children and it should have triggered, as you should

have known from your knowledge of the policies, a referral because it was a concern of a risk of harm; would you go with that?

A. Sorry, just say that again, please?

Q. Well, I am suggesting that if this meeting was called as a result of a concern that Lucy Letby had harmed children, then that was a concern of a risk to children which should have triggered a referral under the sections I have taken you to from the Speak Out Safely policy and also the disciplinary policy.

And I am just asking whether you agree with that analysis or not?

A. It was far more vague than that. So I can't give you a yes or a no and I think it's really important.

When the Consultant -- and I was very much on the periphery, so forgive me if I am just saying about hearsay, but you couldn't pin them down to what, what is it or who is it or when is it that you think that these that there is something happening and all they could say is well, we just think that Lucy's on duty more often than not and we had already looked into that and certainly the commonality, the spreadsheet that I saw and I only saw it for a few moments, did not look like the one that was presented to the jury, it was far more

comprehensive, there was far more dates on there, there was far more babies on there, there was as far more staff on there including doctors as well. So there wasn't that commonality and it wasn't that people were looking, that they were trying to avoid the situation.

We were looking for the answers and -- but with regard to your question about should it be referred to LADO, that question was raised, as I recall; is this now a LADO situation? I didn't raise it. I didn't. But it was raised. I can't tell you if it was at that meeting or not, but it had been raised and then it was up to Alison Kelly to decide whether she went, as that LADO lead for the Trust, to refer it.

Q. Who raised that question?

A. I just said I can't remember. It wasn't me.

Q. Was it an Executive, was it a doctor? What type of -- do you remember what kind of person it was, in roughly what position they occupied?

A. On the basis that I can't remember who it is --

Q. Yes.

A. -- then I am not prepared to speculate.

Q. Okay. Do you have any sense of what period of time that would have been raised was it around the time that you became involved when you were at this action

planning meeting or was it significantly later than that?

A. It was either slightly before or at this -- it probably was around this meeting -- it could have been at this meeting. I am trying --

Q. Okay.

A. I'm sorry, it is a long time ago.

LADY JUSTICE THIRLWALL: Sorry. Just so I am clear, so it may have been at this meeting that this was said?

A. Yes, it could have been.

LADY JUSTICE THIRLWALL: Well, if it were, it would have been said by one of the people on the list.

A. Yes.

LADY JUSTICE THIRLWALL: And it wasn't you?

A. It wasn't me.

LADY JUSTICE THIRLWALL: Thank you. Shall we move on?

MR BERSHADSKI: Now, your role in this meeting is set out at the bottom of this page, isn't it:

"Actions to be taken: Clarity re LL working in other units and [query] bank hours."

Can you see that?

A. Yes.

Q. Then it says "KR" which I think probably

stands for Karen Rees; is that right?

A. Yes.

Q. "/DAC."

A. Yes.

Q. So with reference to that, what was your task as a result of this meeting?

A. Okay. So we had a recruitment section within the -- department within the hospital and it was a shared service with Arrowe Park Hospital, so it was an autonomous subsidiary of both organisations so I was the conduit to go into them and say, you know, is -- because we had a bank, an agency group that would look -- if anybody had any spare shifts or wanted any spare shifts, then they would book them through that bank and agency department.

So I went to find out A, if she had been doing any additional shifts in any of the departments within our Trust, but also to see whether she had actually been working at Arrowe Park on any other shifts as well and I couldn't find any evidence of that.

Q. What was the purpose of you undertaking that exercise?

A. Just -- I guess just to understand exactly where she had been working. And, you know, what -- what I found at that particular time was that we had nurses

that were exhausted, that were -- and so if they were being asked to work other shifts or they were working other shifts, or there could be commonalities with Arrowe Park if they had experienced a spike in neonatal deaths she had been working there, but there was nothing, nothing that I found.

Q. If we go over the page to page 2, we can see that -- sorry, if we go to INQ0005101. There were two meetings that day, weren't there, and this is now the second of those meetings in the afternoon; is that correct?

A. Yes.

Q. If we just go over the page. At the top we can see that in relation to that action that we looked at before --

A. Yes.

Q. -- it's now been filled out:

"LL not working ..."

A. Yes.

Q. "... anywhere else, ie at another Trust or agency."

A. Yes.

Q. "Trained at Chester. Lives alone. Has elderly parents"?

A. Yes.

Q. Now, do you think the reason that you were checking that she wasn't working anywhere else at another Trust or agency would be that if she had been that contact would be made to make sure she was no longer working at any of those other locations?

A. I don't know. That's what I was asked, that is what I was asked to do is to find out if she was working anywhere else because I think the view was that they were then going to take her off the unit and put her into the governance team and on that basis then we would probably have to inform other Trusts that this is what we were doing.

Q. Is that because of a concern that she may pose a risk to children at any other units that she was working at as well as at the NNU at the Countess?

A. I can't, who -- are you asking me personally?

Q. Yes. I am asking you about your knowledge of what the purpose was of you establishing whether she had been working anywhere else?

A. My understanding is I was asked to -- to find that information out, which I did, I brought it back. That was the information that I found. I think Karen Rees had put the "Trained at Chester, lives alone, has elderly parents", I think that was Karen.

But the bit about not working at any Trust, that

was just what I was asked to find out, did I -- did I personally believe that there was evidence to show that she was harming children anywhere at that time? I would have to say no --

Q. But what?

A. -- if you are asking me.

Q. What investigations had you conducted into the evidence of Letby harming children by that point?

A. I had done no investigations at all because I wasn't aware there was any evidence --

Q. Right. Well --

A. -- at that time.

Q. On what basis was it your role to come to a conclusion about the evidence of Letby harming children?

A. It wasn't. It's just a question you asked me.

Q. Right. Would you agree looking back on it that given that clearly the concern by this point was that Letby might pose a risk to children, that if you had applied the policies that I have taken you to you should have recommended a referral be made to the LADO?

A. So based on the fact that there was no evidence that I was aware of at that time and I didn't raise the fact that it should be a LADO referral, the person who should make the referral was the LADO lead,

who is Alison Kelly and it had been raised so there was no reason for me to raise it again.

Q. Do you think that you should have given your analysis of what the HR policies said about the criteria for making a referral given your particular familiarity and role with those policies?

A. It would not have occurred to me to mention the disciplinary policy because nobody was being disciplined at that time.

Q. Well, about the Speak Out Safely policy?

A. As I have -- as I have explained, I was not involved in the review of that policy. Alison Kelly was responsible along with Sue Hodkinson and she was the LADO lead so she must have been more than aware of what her responsibilities were with that.

Q. Okay. So you have explained that you had checked that Lucy Letby wasn't working anywhere else at this point. Did you take any steps to make sure that she wouldn't be able to work anywhere else in the future?

A. No, because it was -- it was going to be -- my understanding was it was going to be made clear to Lucy Letby that if she wanted to work anywhere else then she had to declare that to -- I believe it was Karen Rees.

Q. But forgive me, what was to stop her not complying with that instruction and seeking work elsewhere?

A. Nothing.

Q. Were you aware that Lucy Letby visited the Alder Hey Hospital on a number of occasions and that she was only stopped from doing that in June 2017?

A. No.

Q. Were you aware that plans were made for her to go on a course to another hospital Glan Clwyd?

A. No.

Q. Can we have another document up on screen, please, INQ0073053. I am just going to ask you a couple of questions about a series of emails to do with this issue of Letby working elsewhere and these emails were sent a little bit later on in the chronology, in October and November 2017.

If we just go a few pages forward, please, to page 3, to pick up the theme. Can you see there an email from somebody at Warrington Police Station asking -- and it is about a quarter of the way down the page:

"Can I just ask that you can confirm that Nurse Lucy Letby is unable to work on any other hospitals at present?"

That email is sent to Claire Raggett?
LADY JUSTICE THIRLWALL: Raggett.
MR BERSHADSKI: Thank you, my Lady, and that is forwarded on and if we go to page 1, we can see that Claire Raggett sends this chain of emails on to Sue Hodkinson. It is then sent on to you on 3 November 2017 from Claire Raggett to you, Dee Appleton-Cairns:
"Please see below the request from the police"?
A. Okay.
Q. Can you see that?
A. Yes.
Q. Did you respond to this email or do anything in response to this?
A. That was 3 November?
Q. Yes.
A. Is that 2017?
Q. 2017.
A. It -- I don't know -- okay. So this is -- so Steve GR is Steve Gregg-Rowbury and he was the lead for this shared service. So I -- that would that was who I had liaised with initially to say is she working at any other hospital. And I think he -- no, I don't know. I'm sorry. I don't know.
Q. Because it appears to be a concern from

a police officer to make sure that Nurse Lucy Letby is unable to work at any other hospitals which ends up making its way to you.
Did you take any action to address that police officer's concerns as far as you can remember?
A. I can't recall this email at all.
Q. Well, can you recall taking any steps to make sure that Lucy Letby couldn't work at any other hospitals such as making a referral at that point to LADO, or taking any other step that you may have considered?
A. One of the things that we would -- that I would do is we had a Deputy Director of HR Network, with all the HR directors, the deputy directors in a -- in a group for Cheshire and Merseyside. And we had a group, an email group and also I was very friendly with Claire Scrafton who looked at -- who was -- who was the Deputy Director at St Helens and Mersey and they dealt with people who, you know, if you had extra shifts or whatever, then -- then they would or there was spare in some way then they would usually go through St Helens.
So I would likely have sent an email round to all the deputy directors to say to them: you know, "If you get somebody who wants extra shifts or whatever on your

neonatal or paediatric unit, then please contact us in the first instance", is what I would do. But if I did that or not I can't tell you, I can't remember.
Q. Okay. I am going to ask you a few questions about the legal advice that you obtained from DAC Beachcroft and you discuss this within your witness statement from paragraph 25.
Do you recall contacting Ian Pace at DAC Beachcroft on 5 July 2016?
A. No, the first time I recalled it was when I saw his statement in my bundle.
Q. Okay. Well, you have said in your statement --
A. Mm-hm.
Q. -- that you contacted him on 5 July 2016:
"The purpose of the call was to seek advice from Ian as to the organisational risks around removing Letby from the NNU."
A. Yes.
Q. So are you able to recall now --
A. Yes.
Q. -- what prompted you to call --
A. Yes.
Q. -- him?
A. Yes.

Q. Can you just explain to the Inquiry why it was that you decided, what particular concerns you had that led you to call him?
A. Yes. So we had -- whenever you are going to remove somebody from their role, then you have to have grounds, you have to understand, you know, why is it, why is it that you are going to be removing this person. And ideally you would want some evidence or you would want some witness statement that said, you know, they had -- they physically had seen somebody do something or they had some physical evidence and then you would have the grounds then to remove them. At this particular point, we didn't. It was quite vague.
So I was just checking if we were to remove Lucy Letby from the unit, then what would be our risk from another direction, which is the direction of Lucy Letby who was being heavily backed by the RCN and what that risk would be if we were to move her. What we -- what we came to in the end was that obviously the -- that risk was not as big as the risk that she may be harming babies and in which case we had to move her.
Q. Were you particularly concerned about a possible dismissal and then a claim for constructive dismissal from Lucy Letby?
A. It's my role to look at all angles, it is like

playing three-dimensional chess. You have to look at the players, you have to look at what all the possibilities are and then you are able to offer an informed opinion about what can and can't happen.

Q. Was that a significant concern for you, that there might be some form of proceedings brought by Letby in response to her removal?

A. Yes, yes, for the Trust, yes.

Q. Is that a scenario that you had come across on previous occasions or was it a particular problem that you had to deal with often at the time?

A. I wouldn't say it happened often but yes, I had been in that position before.

Q. The Inquiry has heard evidence from a professor, Professor Dixon-Woods, who has told the Inquiry or said to the Inquiry that there can be a challenge when people who are behaving badly engage in all kinds of counterclaims, grievances, they may be strategically advised by their Union representatives on what to do in order that they essentially don't end up with a disciplinary outcome.

Is that a challenge that you recognise that you were facing at the time?

A. Not the exact one but yes, I think there's, that is the essence of -- of what I was thinking at the

time.

Q. Were you having to engage quite regularly with these kinds of claims for constructive dismissal by employees at the Trust?

A. There were many and varied ways of prolonging the inevitable outcome. There were -- you know, people got to know the policies really well and they would try and find the loopholes or whatever. So it was -- it was tricky dealing with so many different unions and quite strong unions as well.

Q. If we just look at the note of your call with Ian Pace, INQ0101934. It is at tab 6 of your bundle, my Lady.

LADY JUSTICE THIRLWALL: Thank you.

MR BERSHADSKI: 0101934. So you call Ian Pace, you mention issue on the neonatal department. "An alarm", in quotes, has gone off --

A. Yes.

Q. -- due to an increase in death rates. The alarm has gone again, we can see in the second paragraph.

Four or five lines down:

"They are all pointing fingers at each other, the staff. There has been an instance where a Consultant has referred to a midwife as Beverley Allitt."

Were you aware of the case of Beverley Allitt at the time that you made this call?

A. Yes.

Q. Did you have any concerns that you might be facing a similar situation at the Trust?

A. The Beverley Allitt case was where she was addicted to Code Blue, where she would try and resuscitate the babies. So it was a different -- I thought that was a different case and she was also a midwife.

Q. Yes, well --

A. So it was a different case.

Q. Were you making reference to Beverley Allitt because you were concerned that you might also have somebody who was deliberately harming?

A. No, I was saying there's been an instance when a Consultant has referred to -- referred to a midwife as Beverley Allitt. I don't think he's written that very well. "There has been an instance where the Consultant has referred" and it shouldn't be a midwife, a nurse "as Beverley Allitt." It was the Consultant, not me.

Q. Yes. And you go on, it says in the next sentence:

"Dee is satisfied that there are no malicious issues involved."

A. Yes.

Q. How were you satisfied by this point that there were no malicious issues involved?

A. Because the -- the Medical Director Ian Harvey, Alison Kelly, all of the clinical team had been to look at, had been through this and they had given me those assurances that there was no -- it wasn't malicious.

The only thing that -- and they -- I kept asking: have we got anything at all? Have we got any evidence whatsoever? Has anybody seen anything? Anything untoward that we can look at? And the answer was always no.

Q. Well, were you aware that there had been a large number of unexplained, unexpected deaths on the neonatal unit?

A. At that point it wasn't that, it wasn't that many because they were talking -- we had had the Coroner's report that -- I can't remember the date, but it was they were, they were commissioning a report from the Royal College of Paediatricians in there. There was no commonality on the -- on the spreadsheets that I saw and then there was this, and then there was this Dr Brearey saying he had a drawer of doom but he wouldn't let anybody see what was in the drawer and it

was all just very vague and odd.
Q. Well, were you aware by this point that there were a number of Consultants who had a genuine concern that there was a nurse deliberately causing these deaths?
A. The only Consultant that I knew of that was expressing any kind of concern for a long, long time was Dr Brearey. I wasn't aware that Dr Jayaram had concerns until quite far along in this process and that just might have been because I wasn't close enough to it. At that point there was a lot of people involved and I wasn't in that kind of inner circle.
Q. Did you go and speak to Dr Brearey about why he had these concerns?
A. No.
Q. Well, how were you able to tell your legal adviser that you were satisfied that there were no malicious issues involved when there had been an increase in deaths and a Consultant, as far as you were aware, was concerned that they were being deliberately caused by a nurse?
A. Well, I would like to have seen what was in his drawer of doom, but --
Q. Did you ask to go and see his drawer of doom?
A. Well, no, because I had said to Alison Kelly:

send somebody down there, this is ridiculous. Somebody needs to -- he needs to give us whatever he's got. Why -- why isn't he doing that?
Q. Right, so --
A. But -- but to answer your question, Andrew, I kept asking -- don't forget, I am not an Executive, I am on the peripheries, I am doing the day-to-day job and I kept saying, you know, have we got any evidence yet, is there anything at all we can hang our hat on here? And I just kept being told: no and that they were looking into it, that Ian Harvey had gone through every case, Alison Kelly had gone through every case and the -- there was nothing untoward from the Coroner.
So for me there was -- there was nothing here other than Dr Brearey saying he had some concerns about a nurse, a specific nurse.
Q. How could you be satisfied that there were no malicious issues if a Consultant was saying as far as you were aware that there were malicious issues, you hadn't even spoken to him about his concerns and as far as you were aware, he had a drawer of evidence of some description that you hadn't even seen; so how could you be satisfied that there were no malicious issues involved despite all of that?
A. Can I first of all say this is not my note.

Ian Pace has written this note so I don't know what my exact words were. But I was satisfied that we had no evidence of any wrongdoing at that time because I kept asking the question.
Q. But you knew by this point, because this was now a number of days after the NNU action planning meeting, so you knew that Letby had been removed from shift and that you had undertaken the task of checking that she wasn't working anywhere else, so there was surely enough of a concern to have taken those steps that there might be malicious issues involved?
A. I -- at that point, my view was if we take her off the unit, let's see if there is a correlation between, you know, the -- the spike and there not being now a spike. But then the unit was downgraded which muddied the waters somewhat.
But the other thing that bothers me though is regardless of what you think I think, the fact is Lucy Letby was removed from the unit but those -- and those Consultants didn't do anything. So it was like: Well, yes, she's a baby killer but now she's gone, well, we're just not going to do anything. They didn't do anything for months.
Q. Sorry --
A. From my perspective. That's what I saw,

Andrew.
Q. Yes.
A. That that didn't happen. And as I say, you know, my role as a deputy really was the operational running of the -- of the Trust and I was -- you know, I had a big -- two big day jobs that I was consumed with at that time. I was asking for assurance from Sue Hodkinson, from Alison Kelly: do we have anything? Every opportunity, anything at all?
Q. Just before we leave this document, can you see towards the bottom Ian Pace is recorded as saying:
"I explained my [view this is three lines up in the last sort of substantive paragraph] was the priority was to investigate these issues that were arising bearing in mind the potential consequences and suspicions that have arisen."
Did you initiate an investigation under the investigation policies, the HR investigation policies, in response to that advice?
A. Okay, so this is Ian's view.
Q. Yes.
A. Not my view?
Q. Yes.
A. Okay. Yes, so when you say about an investigation in a hospital, when it's to do with

clinical, the HR team is very much advisory. We don't go in and do the investigation. We don't do that because what are we looking for? It would be like asking you to go in and have a look, it's not your specialism.

So you would look to have the Royal College of Paediatricians go in and review the cases. You wouldn't get a HR admin person to do, you know, even a senior one, I wouldn't go and look at that. I wouldn't know what I was looking for.

MR BERSHADSKI: My Lady, I think we normally have a break around this time. Is now a convenient moment?

LADY JUSTICE THIRLWALL: Yes, certainly.

So we will take 15 minutes and we will come back in at 5 to 4.

(3.40 pm)

(A short break)

(3.55 pm)

MR BERSHADSKI: Ms Cairns, just before I resume my questioning I am going to ask you refer to me as "Mr Bershadski" rather than by my first name, if you don't mind.

A. Sorry?

Q. I am just going to ask you before we get back into the questions that you refer to me by

"Mr Bershadski" rather than by my first name, if you don't mind, in your responses?

A. Sorry.

Q. Ms Cairns, just before the break, I think you said that one of the reasons that you thought there were no malicious issues involved when you spoke to Ian Pace on 5 July 2016 is because there hadn't been that many deaths as far as you were concerned.

Now, are you aware that there had been 13 deaths in the space of just a little bit over a year by that point?

A. No, I wasn't.

Q. How many deaths did you think there had been?

A. I can't remember.

Q. The --

A. But that wasn't how many were being looked at at various stages.

Q. Yes. Now, the thematic review document that had been prepared by Eirian Powell had looked at 10 deaths, hadn't it, for which Lucy Letby was on shift at or just prior to the death for nine out of those 10; is that right?

A. I didn't see the thematic review.

Q. Okay. Well, would you agree with me that it's completely wrong to say that there hadn't been many

deaths by the time that you spoke to Ian Pace in July 2016?

A. Well, as I said before the break, that was Ian Pace's notes. I don't recall saying -- could you bring it up again for me, please.

Q. Yes, well, I am just asking about your evidence, not about the note. You told this Inquiry that you thought there hadn't been that many deaths?

A. Yes.

Q. Now, I am suggesting to you that that was completely wrong and there had been a very high number of deaths compared to the usual two to three average deaths per year that the neonatal unit experienced up until 2015?

A. There had been a spike in deaths but at that point when I spoke to Ian Pace, I didn't think that there had been anything other than that spike.

Q. Yes, that is a spike of 10 deaths that Eirian Powell had looked at in her thematic review. So on any account it was a very significant spike and very many deaths, wasn't it?

A. Yes.

Q. So would you agree that you were then in your mind minimising the problem compared to what it actually was when you spoke to Ian Pace?

A. I don't believe that was my intention, no.

Q. I am going to ask you a few questions about the Silver Control exercise that you took part in on 7 July. If we could have up on screen, please, document INQ0004319.

Now, we can see your name roughly in the middle of the document. Can you just give a little bit of background to the Inquiry what this series of meetings on 7 July 2016, was their purpose was?

A. Excuse me. Was this Silver Control?

Q. Yes.

A. Okay. So Silver Control is when you have an incident like the -- the only other Silver Control I have ever been involved in is when there is a doctors' strike. So it's a hub within the centre of the hospital where you bring together quite senior people and information is fed in and out and things are looked at and it's headed up by the Chief Executive and this one was to do with NNU.

Q. I am just going to ask about your role within that. If we go to page 3, please, of the document. We can see just one line up from 145 it says:

"Dee Appleton-Cairns confirmed review of permanent files completed"?

A. Yes.

Q. So can you just tell us what you did by way of review of personal files?

A. Yes. So every employee within the Trust has a personal file and it's kept in the HR department.

Now, I would like to tell you that there's only one file and that it's always complete and that's the only place where information is kept but we had the personnel files and it would start when you started your employment with the Trust and then you would add things to it, pay increases, references and appraisal information, that sort of thing.

So I asked -- I didn't have a lot to do that day, as I recall, so I felt a little bit like a spare part so as I thought it would be a good idea to get the porters to bring me over all of the personal files to do with NNU, everybody from the -- from the administrators and the housekeeper right through to the doctors that were on there and to bring them over to me and for me to go through them one by one.

I can't tell you what I was looking for particularly but sometimes, you know, whenever there is a situation I always go to the -- I always go to the root and that's usually the personnel file and sometimes you can find things on there and sometimes you don't.

Q. Now, by this point, Lucy Letby had been

identified as a person of particular interest, hadn't she, because you had attended the meeting on 30 June where there was a confirmation that she was no longer on shift, et cetera.

So presumably you would have paid particular attention to her personal file when conducting this review; is that right?

A. I paid particular attention to all of the files.

Q. Is there any reason why you wouldn't particularly focus on Lucy Letby considering she by that point was the particular individual?

A. I would not -- I wouldn't want to miss anything.

Q. Okay. So did you look at Lucy Letby's HR file?

A. I did, I did.

Q. Okay if I can just bring up a couple of documents from her HR file. If we could pull up INQ0008961, and page 45 within that. When conducting your review, you would have seen this document, would you, relating to a drug error --

A. No.

Q. -- and Lucy Letby's role?

A. No. This was not on her file.

Q. Well, how are you able to be so sure now?

A. Because I had never seen it before until it came in the third bundle, last Friday.

Q. Well, this is one of the pages within a file called "HR Bundle".

Now, is it possible that you don't recall having seen this document --

A. No.

Q. -- at the time, but --

A. No.

Q. But if you looked at the HR files for every single person who worked on the neonatal unit --

A. Yes.

Q. -- it's surely possible that you simply can't now recall having looked at this at the time because you had looked at so many documents?

A. No.

Q. Very many?

A. No.

Q. No?

A. I did not see this because this is -- I mean, I don't know much about this because I am not clinical, but this is drugs error.

Q. Yes.

A. This goes to when there is a drugs error and

they happen quite often in a hospital.

LADY JUSTICE THIRLWALL: Where do they go?

A. Sorry.

LADY JUSTICE THIRLWALL: What were you going to tell us about where they go?

A. They go to the Clinical Governance Department who then review them and they look at whether it's, you know, very serious sort of Never Event, that type of thing, or they go to the education -- Clinical Education Department where you are looking at, you know, do you need to re-educate, re -- re -- you know, to check whether this person knows exactly what they are doing.

So this would be -- I wouldn't see this, this wouldn't necessarily come to HR. This is a clinical educational matter and pharmacy would have an overview if it is a drugs error.

Q. Yes, well, let's go over the page. If we go to page 47, please.

Now, this relates to the same incident:

"Lucy has commenced a continuous infusion of morphine at the end of her night shift."

Now, I am going to suggest that this is likely to have been within her HR bundle that you would have looked at because it is within a document called "HR Bundle" that has been --

A. No, I have never seen this document before.
Q. -- disclosed?
A. This was not in her HR file.
Q. And it --
A. It might be worth asking Dr Christopher Green, who is Chief Pharmacist, about these kind of documents.
Q. Well, let's also look over two pages to page 49. Do you recall seeing this document, April 2016, a note by Lucy Letby, "Reflection on drug error"?
A. No. I don't recall it.
Q. Well, do you think it's possible that you simply missed these documents contained within Lucy Letby's HR bundle when you conducted your review?
A. No. Absolutely not.
Q. How can you be so sure if you were looking through every single HR -- I mean how many HR bundles do you think you would have looked at?
A. Between 20 and 30.
Q. Did you look at all of them in the course of one day?
A. Yes.
Q. Presumably some of them are fairly long bundles for people who have been employed by the Trust for a significant period of time?

A. Yes.
Q. Well, isn't it possible that you would have missed some documents if you were looking through 20 to 30 bundles?
A. I did not miss these documents. But can I just say, even if they had have been there, drugs errors occur on quite a regular basis within a hospital.
Q. Well --
A. In both hospitals that I have worked at.
Q. You explained earlier that you don't have a clinical background yourself?
A. No.
Q. So you wouldn't know yourself necessarily the significance or the rarity of any particular drug error; is that right?
A. Yes, that is true.
Q. Now, we have heard evidence, the Inquiry has heard evidence that this was a very significant, potentially fatal, drug error.
A. Okay.
Q. The 2013 one?
A. (Nods)
Q. Also the Inquiry has heard evidence this one that is on screen now in April 2016 is an incident that should simply have never happened because Gentamicin was

not a drug that was prescribed for a baby to whom Letby gave it? Okay.

So I am going to suggest to you that it is possible because you didn't have a clinical background that you yourself looked at these and didn't think they were -- they didn't particularly jump out at you as being significant because you didn't have the clinical knowledge to understand that these were both very significant incidents?

A. I did not see these documents when I looked through the personal files.
Q. Well, if we go to just page 1 of this document and put it into context, does this look like the sort of HR file you would see, "Learning contract from 2012"?
A. This is more clinical education. So the clinical educators would -- would hold this kind of information. It should be on ESR as well -- sorry, ESR, Electronic Staff Record.
Q. If we go to page 23, "Welcome event for Lucy Letby". Is that the sort of document you would see in an HR record, a document from HR support services welcoming her to her position at the Countess of Chester Hospital?
A. This is -- this is a document we would send out to anybody who was starting, yes.

Q. Yes. So you wouldn't be surprised to find that within her HR documents then; is that fair?
A. No, I don't think we would. This is the letter we would send out and then we would have -- and again this is in the Education Centre, I was across the campus at the HR Business Partners Department which is pretty much at the other side. They would keep a record of who had attended and what courses they had done. They would then input that into the Electronic Staff Record because then there would be a mechanism for if there was any reviews or updates or whatever, then that would trigger through their system. But it wouldn't necessarily come down to HR no, that letter.
Q. Okay. By this point, there was clearly a particular concern about Lucy Letby. Would you agree that it was important for you to carefully scrutinise all records that the Trust had in relation to her, either yourself or if you didn't understand all the documents relating to her because they had a clinical element, to make sure that somebody who did understand them reviewed them with you?
A. Yes. That would have been Sian Williams or Karen Rees, but they wouldn't necessarily do it with me. They would bring something to me potentially.
Q. Now, if we go back to the Silver Control

document, please, INQ0004319.

A. Can I just say that says "HR Support Services" at the bottom.

Q. Yes.

A. That is that shared service that I talked about. So that would have been generated by that shared service which is autonomous from both Trusts, but shared.

Q. Yes. So if we go to INQ0004319, page 5, we can see your name there towards the top.

"Dee Appleton-Cairns: we have been looking at data, gone through every personal file for everyone on the unit. As expected we have not really found anything."

A. Mm-hm.

Q. Why was it you who said that as expected you hadn't really found anything?

A. It -- it was a shot in the dark going through there. You know, you rarely, what I have found in personal files in the past has been things like a reference that says: we have got some concerns about this person's practice or whatever and it's been overlooked or it's -- well, there was nobody else and they were better than -- better than having nobody.

But it's rare. But it's still worth checking which is why I did that. I didn't have anything else to do in

Silver Control that day so that's why I did it but as expected, I didn't really find anything.

Q. Yes. Well, would it be fair to say that you weren't expecting to find anything in the personal records because you personally didn't believe that there was foul play involved?

A. I am very open-minded but I wanted to see some evidence. I wanted to hear something like we have heard you know, after that about somebody's got an eye witness account or something. Something that I can then start an investigation about.

Q. Well, why can't you start an investigation if a Consultant or a number of Consultants have come to you to say that they have got real concerns about a particular individual, they think that they are deliberately harming babies? Why isn't that enough for you to begin an investigation to see whether you can find any evidence?

A. No Consultant or anybody else ever came to me and said that.

Q. Yes, but you knew by this point that the Consultants did have those concerns, albeit you didn't speak to them directly yourself but you knew that they did have that concern, didn't you?

A. No. They were speaking to the Executives.

I was hearing it second-hand and so I said, okay, if they have got concerns what are those concerns? And they were vague.

Q. Now, you explain in your statement at paragraphs 39 and 41 that you worked with Sian Williams to look at shift patterns and, in particular, whether there was a particular correlation with Lucy Letby; is that right?

A. No, I don't think I said that. Sian was looking at the patterns.

Q. Yes. Okay. So at paragraph 39 you say that:

"Sian had been analysing the staffing rotas to identify any commonalities [that can come down off the screen now, thank you] between the staff on duty and the time of the neonatal deaths."

Were you -- did you speak to Sian Williams about the exercise that she had conducted?

A. Just to say, you know, have you completed it or, you know, have you got any concerns?

I had a very brief look at it and it was quite -- and I just remember it being quite large, quite comprehensive. There was a lot of data on there and there was Lucy -- the commonality was definitely that Lucy Letby had been on more shifts than anybody else but there was also another nurse and there was a doctor that

had -- there was quite a lot of commonality there.

If you then factored in the fact that Lucy was the only full-timer and she had been doing extra shifts it then -- it then -- it then didn't give you such a clear picture for me.

Q. Well --

A. But that wasn't my decision to make, I just had a look at it and I just said, you know: have you found anything? And she went "not really" and then she went off to speak to Alison Kelly but it wasn't -- it wasn't my decision to make.

Q. Sorry, so you are saying that Sian Williams told you that she hadn't really found anything as a result of her analysis?

A. I think she said there was a cluster -- there was a cluster of three days/nights or babies that she may have a concern about and that was -- but then she said she wanted to go and speak to Alison about it so that was it. It was a passing comment.

Q. The Inquiry has heard evidence from Sian Williams this morning who has explained that after she had conducted her analysis, she had real concerns about the amount of time that Lucy Letby was on shift when babies were collapsing and dying and that she recommended that the police be called in on a number of

occasions; that was her evidence to the Inquiry this morning?

A. (Nods)

Q. Now, is it possible that you are misremembering what Sian Williams told you about her concerns following her analysis?

A. It was a passing comment so she probably didn't want to confide in me before she had spoken to Alison, potentially. But I will accept it's eight years ago, I can't remember.

Q. Okay. I am just going to ask you about a different topic, Ms Cairns. So you were aware that Lucy Letby submitted a grievance in September 2016; is that right?

A. Yes.

Q. If we just bring that up on screen, it's INQ0002879. If we look at page 3, this is the Letby's actual grievance document.

She was asking why she had been redeployed essentially as part of her grievance; is that right?

A. Yes.

Q. Now, if we look at the grievance policy, INQ -- if we go to page 99 within that document, you would have been familiar with this policy at the time presumably?

A. If this is the policy, yes. But it's -- the -- my only concern is it's -- it's signed there by Susan Young and she was -- she actually left the Trust in 2011. So I have just got some concerns. I know it says January 2013 but she did leave the Trust.

Q. Yes, well, it says January 13 there --

A. Okay.

Q. -- and this again was a policy that was to be reviewed every three years, wasn't it?

A. Yes, okay.

Q. So it would appear that it would be in force, unless something else intervened, until November 2016?

A. Mm-hm.

Q. Is that right? Now if we go over the page to page 100 the policy provided, in the middle of the "Grievances" paragraph:

"If a grievance can be more appropriately dealt with under a different procedure, staff will be advised that this is the case. The examples below indicate where it is inappropriate to follow the grievance procedure as other mechanisms or Trust procedures are in place".

Can you see that? It's been highlighted in yellow on the screen?

A. Yes.

Q. So the policy provided that actually there can be circumstances where rather than dealing with the grievance as a grievance it's more appropriate to follow other policies of the Trust such as disciplinary or the whistleblowing policy in the last bullet point?

A. Mmm mm.

Q. Did you consider that the situation that you were faced with in September 2016 was precisely the kind of situation where it would be better rather than dealing with the grievance about the redeployment to consider the substance of the matter which was concerns that had been raised about Letby under the whistleblowing policy or potentially even to investigate it under the disciplinary policy and doing it that way rather than dealing with the grievance itself?

A. Okay. So this was Lucy Letby's grievance.

Q. Yes.

A. So it wouldn't be appropriate to -- for her to -- the whole point of a grievance which is, which is partly terms and conditions, it is contractual that you are entitled to have a grievance if you are not happy about something, is the fact that you are looking for a way to move things forward. Somebody is unhappy with something, they want it to move forward.

So I didn't think that -- I think you -- so,

forgive me, are you implying that instead I should have said: well, I'm sorry, Lucy, you can't -- I am actually going to discipline you under this?

Q. Well --

A. Or the fact that, but she wasn't -- she wasn't whistleblowing, so this is about Lucy Letby and it was her grievance, it wasn't what am I disciplining her about? And what, what is she whistleblowing about? I don't understand I think you are saying: well, shouldn't you follow the policy for somebody else? But somebody else didn't raise it. Lucy Letby raised it.

Q. Well, they did raise it, didn't they, because a number of Consultants, or on your evidence as far as you knew just Dr Brearey had raised a serious concern about her and that should have been dealt with under the Speak Out Safely policy, shouldn't it?

A. Well, that -- but we are talking which one -- which policy are we talking about now. Somebody has raised a grievance? This is a grievance policy.

Q. Yes.

A. And that is their grievance, that is who we are looking at, that is who's in the box. You can't turn round and say: well, you have raised a grievance so I am going to discipline you over it. That -- that doesn't follow. And in the same instance she hadn't

whistleblown. So it is about her, it's not about then saying: you have raised this grievance so I am going to -- because it is about you, it's not about somebody else.

Q. Yes, what I am suggesting is that when a grievance came in about the situation from Letby, what ought to have happened is that using this section of the policy, the actual underlying concern that had been raised should have been dealt with under the Speak Out Safely Policy?

A. Well, you could have done that before the grievance came in, if that is what -- if that's what Sue Hodkinson, Alison Kelly, the Executives who were dealing with that, if that is what they wanted to do, then that is what they should have done. But when we come down to the grievance then those -- those are not appropriate, no.

Q. Did you consider that the Speak Out Safely policy should have been applied to the concerns raised by the Consultants?

A. Well, I did suggest that it should be done in tandem. I -- I spoke to Sue Hodkinson about that and she said she was going to raise it with Ian Harvey, the Medical Director, but whether that happened or not, I don't know. But it would have been good to have that

in tandem from Dr Brearey and Dr Jayaram.

Q. Well, why?

A. But they didn't.

Q. Why didn't you ensure that that happened given that you had said it should be done, but then you say you simply don't know whether it was done --

A. No, I escalated it to Sue Hodkinson, who is my HRD, who -- and I said, you know, you need to pass this on to Ian Harvey and I understand that's what she did and they chose not to.

Q. It's right that you had operational conduct of these HR processes at the time; is that right?

A. Yes, yes.

Q. Well, why didn't you -- rather than just escalating it if they didn't do it, why didn't you just make sure it was done yourself?

A. I had done what I thought was appropriate. I raised -- I escalated it to my HR Director because they were -- the Executive Team were dealing with the Consultants and suggested that Ian Harvey speak to the two Consultants about it.

Q. Now, I am not going to ask you about the grievance investigation itself, that was conducted by Dr Chris Green; is that right?

A. That is correct.

Q. Were you involved with his appointment?

A. Yes, I made that suggestion along with a couple of others.

Q. Now, I think it was raised with you by Sue Hodkinson that it would be more in line with policy to have an independent person, somebody external to the Trust investigate the grievance; is that right?

A. No, I don't recall that. We said about the hearing being an independent person, the person, the chair, the person who would -- who would hear it.

Q. Well, did you give any consideration to whether Chris Green was sufficiently independent to act as the investigating officer for the grievance?

A. I have always known Dr Chris Green to be an extremely honest and honourable man who had a lot of experience with grievance investigation -- in fact disciplinary investigations.

So there was -- there was himself and there was a couple of other people that I put forward as suggestions but it was again up to the Executive Team who they chose.

Q. Did you know that Chris Green had had a disagreement with Dr Brearey about a pharmaceutical error in relation to one of the babies prior to this grievance?

A. I did not know that prior to him conducting the investigation. However, it is in the notes of the grievance and I did read them during the -- when I got the bundle and read the hearing notes and it seemed to me that that Dr Brearey was supported by his BMA rep and the BMA rep had actually come to the conclusion that there was no conflict of interest and therefore it wasn't an issue.

Q. Do you think now, looking back on it, that given the particular importance of the issues that were being investigated as part of the grievance that it wasn't best practice to have as the investigating officer somebody who had had a disagreement to do with one of the babies with the person raising the concern?

A. I can only reiterate what I have said. I have only ever known Dr Chris Green to be an honest and honourable person and the fact that I didn't know that going -- when I recommended him, and it seemed that it was dealt with by Dr Brearey's BMA rep during the interview for the investigation and they were happy that it wasn't a conflict of interest and that's all I can say on it.

Q. That can come down now off the screen, thank you.

Now, it's right, isn't it, that you had a meeting

with the chair of the grievance hearing on 1 December prior to the grievance hearing itself?

A. Yes.

Q. The chair was Annette Weatherley, I think she was the Deputy Chief Nurse at South Manchester; is that right?

A. Annette?

Q. Annette Weatherley. She was the person who heard the actual grievance; is that right?

A. I don't know.

Q. You don't know.

A. I can't remember now. She was -- that was the first time I had met her.

Q. Okay. Well, if we could just put up on screen INQ0054483. We can see that a pre-meeting was arranged for you to meet with Annette who was the chair who heard the grievance, a pre-meet was held with you before the grievance hearing took place?

A. Yes.

Q. Now, did you discuss at that pre-meeting that you and Annette Weatherley thought that there had been a witch hunt against Lucy Letby?

A. No. Not, not to my recollection. The pre-meet was exactly like I have had today, been invited to this Inquiry. I am invited to come here at a certain

time, I am shown the room, we meet each other, we chat. That's it. There's nothing more sinister about it than that.

Q. I am going to suggest that you discussed your views about whether the allegations against Lucy Letby had any merit or not at that pre-meeting prior to the grievance hearing taking place?

A. I have absolutely no recollection of that.

Q. Okay. I am just going to take you to a few emails about -- concerning the grievance outcome. Could we put up on screen, please, INQ0056138.

Sorry, Ms Cairns, unfortunately the system can get a little bit sluggish at times. There is an issue with that INQ reference. I think if we could have instead INQ0056150.

LADY JUSTICE THIRLWALL: Is there a hard copy we could use?

MR BERSHADSKI: Yes, we seem to have an issue with some of the INQ references. Okay.

LADY JUSTICE THIRLWALL: I know the one this morning did actually materialise when we thought that wasn't there either. Can we ...

MR BERSHADSKI: Okay let's try a third one and see if it will improve things. INQ0056173. We have struck lucky, Ms Cairns. You can see there is an email from

you to Annette Weatherley on 2 December:

"Hi Annette, sorry for the delay. I have also added in about LL's mentor."

A. Yes.

Q. Now, it appears that you had a hand in drafting the grievance outcome?

A. Yes.

Q. Why is that, considering that it was supposed to be the independent chair who was coming who was determining the grievance?

A. Well, you just write what they want. You know, you are like a secretary to them. They tell you what they -- what they want you to -- to write and you do that. Normally you can't get anybody to chair a grievance or a disciplinary unless somebody is prepared to do that for them, so it would be standard practice.

Q. Okay. Well, you have --

A. But it wouldn't be -- it is not for me, so what happened was the -- you have got to answer every question from the grievance, that's part of the template. So there would have been somebody in HR who's got the template and then you fill in all the bits and then you send it to the chair and the chair will then, you know, make any changes, do whatever they want to do,

say what they want to say and then it usually goes back two or three times and I remember when I saw the in the first bundle there was the outcome letter and it was dated 1 December which was the date of the hearing and I said I am really sure that that is not the final version because I rarely manage to complete it on a day because you usually are exhausted and by the time everybody's sort of, you know, gone through what -- what, you know, the Chair's telling you what they want in it and the bits not to miss and you are making all the notes and then it's the following day that you finally get to the letter and then the letter goes backwards and forwards and then there is final version and then that's the one that goes to the person with the grievance.

Q. Now, it's unfortunately in one of the documents that we are not able to put up on screen but you have seen them, I know?

A. Yes.

Q. My Lady, they are behind tab 16 in the bundle.

You had actually sent a draft of the grievance outcome to Sue Hodkinson and Alison Kelly --

A. Yes.

Q. -- at the Trust as part of the drafting?

A. Yes.

Q. That's right, isn't it?
A. Yes.
Q. Alison Kelly then replied to you with some suggestions to add in a section of conclusions into the draft which you then added in in the version that you sent along with the email that we have got here; that's right, isn't it?
A. Well, I think we should -- it's a shame we can't see it because I think that the Inquiry needs to know exactly what that was.
So basically it was obviously a hot topic, Sue Hodkinson, who was my HRD, had asked to see a copy of the draft, I said: this is the draft but, you know, it's not -- it's not complete and it had also gone to Alison Kelly.
Alison Kelly had asked me -- had put into that document that are we going to see Chris Green's conclusion here, which we always were, because I had put it's not complete. That conclusion was going to go in anyway and then there was a bit where she had tried to suggest we took something out and Annette was really clear that no, that was not coming out and that stayed in. So there was no change to it
The only other words, because it came back from Mary Crocombe, who is Alison Kelly's secretary, and she

is a bit of a -- of a grammar police and there was a couple of words that she was suggesting that I took out which I remember being a bit sort of -- well, a bit sort of frustrated about but actually she was right with regard to the grammar. So they -- those words that said Lucy or whatever came out.
But there was only two things, one was Chris Green's conclusion which was going in anyway and the bit that Alison was suggesting that she didn't want there but Annette insisted that it went in anyway so there was nothing.
Q. Well, do you agree that it's not appropriate when you have appointed an independent chair to hear a grievance to start involving Executives at the Trust and yourself in drafting the outcome?
A. It would be absolutely usual for me to draft, so that is the first thing. To include Alison and Sue, they wanted a copy of the draft. They weren't being involved, they weren't being invited to make any comments and certainly that was curtailed. Should I have sent it on reflection? No probably I shouldn't of, because I think you are right, I think that they thought oh -- well, certainly Alison, Sue wouldn't of, but Alison thought: oh, here's -- you know, I think I can add something in and it was like, well, no, you

can't. So I think you are right on that point.
Q. You added a whole section as part of your input into the draft. If we can go to INQ0056174 -- unfortunately that document's not working either so I am going to have to read out the relevant section?
A. Okay.
Q. You added in a section under question 7 where you wrote:
"I acknowledge that these concerns [ie the Consultants' concerns] were raised through the appropriate channels in line with both the Trust's Speak Out Safely policy and the guidance proffered by the GMC. However, I do not find that the consultants' concerns when reiterated to the Executive Team were 'Clear, honest and objective'. (GMC guidance)."
You added that section in; is that right?
A. No, I don't believe I did. I would have to see it. I don't believe I did. I didn't add anything in. It was all Annette's work. She signed off the final copy.
Q. Yes, well she signed it off but that was the section that was added by you in response to a suggestion by Alison Kelly that section 7 be expanded; that's right, isn't it?
A. Well, no, I can't -- I'm sorry, I need to see

it. Can I see a paper copy?
Q. I think you have been -- you have been sent all of these documents so you would have seen it. Unfortunately we can't bring it up on screen.
A. Well, I think it's unfair to ask me the question if I can't see it. I need to see it.
LADY JUSTICE THIRLWALL: It may be something that we will have to bring you back to ask you about when we are able to show it to you more clearly. It is not in the file you have been provided with, I presume.
A. It is downstairs, if somebody wants to go and get it.
LADY JUSTICE THIRLWALL: So you have got it? All right. Perhaps that might that be the way ahead to get the --
A. I don't believe I added anything into -- into that, that grievance letter. Anything.
MR BERSHADSKI: My Lady, I am in your hands about how to deal with it. We could get a copy or I am happy to hand up my copy to the witness to simply expedite.
LADY JUSTICE THIRLWALL: That might be the quickest way of dealing with it.
MR BERSHADSKI: Yes, it is marked up, I am afraid.
LADY JUSTICE THIRLWALL: It has got highlighter on but you can ignore that.

(Document handed to witness).

A. Why would you think I have done that?

MR BERSHADSKI: Well if you look back, from the bit I have given you, if you look at the previous draft, that was annotated by Alison Kelly, wasn't it, to say, whereas previously section 7 was simply one sentence.

A. Section 7 said about adding in -- Alison Kelly had put: are we adding in Chris's conclusions?

Q. Yes.

A. Yes, we were always going to add in Chris's conclusions. We didn't have it at the time, that was the first draft that she had had. So that went in.

Q. You then typed up and added all of that in?

A. I typed it all up.

Q. Yes, so in response to Alison Kelly's suggestion you added in that whole page-long section under section 7; is that right?

A. No, no, not according to Alison Kelly, not on her direction. That, Chris's -- Chris Green's conclusions was always going to be added in and -- and that is the -- that's what went to Annette who signed it all off.

Q. Yes, so you added in those conclusions?

A. I added it all in, I added it all in.

Q. And then it went off to Annette Weatherley?

A. Yes, but --

Q. That's right, isn't it?

A. I wrote all of it, you know, I typed all of it.

Q. Yes, and I think you have agreed already that on reflection, getting the input in --

A. I didn't add that in on the direction of Alison Kelly. She had put that in but it was always going to be in anyway.

Q. Right.

A. So I wasn't being directed by Alison Kelly. I want to make that really clear.

Q. Yes. So even though in the previous email Alison Kelly suggested adding in a section and then in the next version you have added it in, you're saying it wasn't because Alison had made that suggestion?

A. That's exactly what I am saying.

Q. Okay.

LADY JUSTICE THIRLWALL: We got that.

A. Okay. Sorry.

MR BERSHADSKI: I will get it, don't worry.

It's right, isn't it, that you attended a meeting with the Local Authority Safeguarding Board in 2018, is that right?

A. Yes. The LADO?

Q. The LADO.

A. Yes.

Q. And that was in July 2018, yes?

A. Yes.

Q. Now, on reflection, do you think that that is a meeting that you should have attended and made the referral to attend that meeting two years previously when you first heard about concerns about Letby harming babies?

A. No. The only reason I attended that meeting is because Sue Hodkinson was off sick and I had stepped up into her role at that time and I was asked by Alison Kelly to accompany her. That's the first and only LADO meeting I've ever been to.

Q. You had never previously been to any LADO meetings?

A. No.

Q. Had you ever made any LADO referrals before?

A. No. Sorry, no.

Q. Do you think that that might explain why you didn't make a referral in this case, because you just weren't familiar enough with the necessity of doing it because you hadn't done it before?

A. Possibly. If I had wanted to make a LADO

referral, I absolutely would have gone through Alison Kelly because she was the LADO lead.

I wouldn't have known how to do it because I have never done it before. So I would have gone to her and said: Look, you know, I think you need to do this. I didn't. But then that was -- she was in the inner circle, the thick -- you know, she could have made that decision.

Q. Do you agree that you should have suggested that the referral be made if you had taken concerns about babies being harmed seriously?

A. If I had seen or I truly believed there was evidence then yes, I would have of. But at that point I was not -- I was too far on the periphery to have that kind of information.

MR BERSHADSKI: Thank you very much, Ms Cairns.

My Lady, I don't have any further questions. I don't know, there may be some from a Core Participant.

LADY JUSTICE THIRLWALL: Mr Baker.

Questions by MR BAKER

MR BAKER: Ms Appleton-Cairns, my name is Richard Baker. Can I begin by offering a space at the start of my questions for reflection.

I represent a number of Families whose children were murdered or attacked by Lucy Letby. Do you feel,

on reflection, that the HR process and the way in which you managed it contributed to a delay in bringing Letby to justice?

A. No, I do not.

Q. Even with the benefit of all that you have seen and heard, you don't think that your actions contributed at all to a delay in bringing Letby to justice?

A. No, I do not. I think that the grievance procedure was an opportunity for the Consultants to bring forward and explain in more detail what their concerns were and any evidence that they had.

And there was nothing in that grievance that they brought, that they brought to the attention of somebody who was independent, an independent chair.

Q. Well, I think you have already been asked questions about how independent that process was.

But can I say this: this was a process that was designed to pander to the whims of a serial killer, wasn't it, the grievance process, with the benefit of hindsight?

A. I don't believe that.

Q. Do you have any skills or experience at all that permitted you to understand or interpret the clinical issues in this case?

A. The what, sorry?

Q. Did you have any skills or experience that permitted you to interpret the clinical issues in this case?

A. No.

Q. Would you agree you were entirely ill equipped and unqualified to investigate murder in a healthcare setting?

A. Yes.

Q. Can we look at your witness statement, please, and to paragraph 17, which I think sets out your first involvement. You should have a copy of it in front of you I think, it won't appear on the screens.

It's a reference to a meeting on 30 June 2016, which you attended two neonatal unit action planning meetings and in attendance to both meetings were Alison Kelly, Jill Galt, Sue Hodkinson, Sian Williams, Ruth Millward, Julie Fogarty and Karen Rees?

A. Yes.

Q. And they were meetings arranged to provide assurance to the Executives as to how the situation on the NNU was being handled in light of the increase in neonatal deaths?

A. Yes.

Q. So that was a meeting that was attended only

by yourself and the nursing staff?

A. Okay.

Q. Well, that's "yes", isn't it?

A. Yes.

Q. You have already said in evidence that you at no time went to speak to any of the Consultants who were making allegations against Lucy Letby?

A. (Nods)

Q. That's correct, isn't it? That's what you say in your witness statement?

A. Yes.

Q. So you approached this issue by having a meeting on the face of it about these issues with the nursing staff, but didn't seek to balance that by speaking to any of the Consultants. Why was that?

A. I was -- I was asked to attend this meeting. It wasn't my meeting.

Q. Well, no, that's, I'm sorry, not a very good answer because you have made various assertions in this Inquiry about the evidence that was being presented to you as to the quality of the allegations that were being made by the Consultants?

A. Yes.

Q. Now, if you say before the Inquiry that the evidence was never presented to your satisfaction, then

I think it's important that you justify your approach.

So you spoke to the nurses. You never spoke to the doctors?

A. There was no evidence presented to me at all.

Q. Well --

A. By anybody.

Q. I'm sorry. We are going to come on to a note in a moment where you make assertions about the quality of evidence that was available.

I think it's quite a simple point. You spoke to the nurses, but you never spoke to the doctors. Why not?

A. Because the doctors would only speak to the Executives.

Q. So you are saying that the doctors --

A. And I knew Ravi. I knew Ravi quite well.

Q. Are you saying the doctors refused to speak to you?

A. The doctors didn't speak to me. You would have to ask them why they didn't speak to me.

Q. No. Are you saying that you sought to speak to the doctors and they refused to speak to you?

A. No.

Q. Okay. So the answer is you didn't seek to speak to the doctors, did you?

A. No.
Q. No. Now if we go on, please, to INQ0101934. This document has worked in the past, so I am reassured to see that it's worked again.
A. That's Ian.
Q. This is Mr Pace's note of a conversation with you.
A. Mm-hm.
Q. Now, you have been taken already to a section that says:
"Dee is satisfied that there are no malicious issues involved."
This is 5 July 2016 and I think in response to questions from my learned friend, you appeared to question whether you used those words by saying, "This is Mr Pace's note."
A. That's correct.
Q. Can you look, please, at paragraph 30 of your witness statement?
A. 30?
Q. Yes, paragraph 30. Would you like to read that out, please?
A. Yes:
"At this stage I was satisfied that there was no malicious issues involved."

I was copying it from Ian's note.
Q. Right.
A. "My understanding was that there was only one person pointing the finger at Letby and that was Stephen Brearey."
Q. Okay. So if you could stop there.
A. "However, he had not provided any evidence to support ..."
Q. If you could stop there, please.
A. Sorry.
Q. So in quoting "no malicious issues involved", you don't seek there, do you, to say: Those weren't the words that I used?
A. I was -- I was -- it's in italics, so I was quoting those words.
Q. Yes. But where in this paragraph does it say that: Those are Mr Pace's words and I didn't use them? It doesn't.
A. Well, if it carries on, if I could continue to read that paragraph.
Q. Does it say in that paragraph that those weren't your words?
A. No.
Q. No. If we could go on, please, to read the next sentence.

A. "My understanding that there was only one person pointing the finger..."
Q. No, sorry. We are going back to the telephone note.
A. Okay.
Q. If we could go on please to read the next sentence of the telephone note.
A. "I asked Dee how ..."
Q. I'll read it:
"I asked Dee how she can be sure and she said that she did not think there would be any such issues."
Now, what does that mean?
A. This is Ian's note. I don't -- I don't know. I can't remember.
Q. "I explained that really the employment aspects of the matter pale into insignificance taking into account potential issues involved, especially if those who are working on the ward and including Consultants are pointing the finger at each other and the suspicions that the death rate could be attributable to one in particular individual."
Now, isn't that describing a conversation between you and Mr Pace wherein you are reassuring him that you are satisfied that there's no substance in these allegations and him saying: Well, whether there are

employment issues in this case or not pale into insignificance if there's any reality to the suggestion that there is a murderer in this unit.
Isn't that the interpretation?
A. Well, I think the interpretation is that he explains that:
"... the employment aspects of the matter pale into insignificance taking into account potential issues involved especially if those who are working on the ward and including Consultants are pointing the finger at each other and the suspicions that the death rate could be attributed to one in particular individual."
Q. Well, doesn't this bring us to a key issue in your interactions with this case; that employment issues are of nothing compared to the seriousness of a potential murderer on this ward?
A. I would agree.
Q. So in permitting this grievance process to proceed, you would accept, wouldn't you, that you did so based upon incomplete and un-investigated facts?
A. No because we had -- there had been the Coroner who had looked at each of the deaths and the Chief Executive had brought in the Royal College of Paediatricians.
Q. Sorry, which -- which --

A. We had had that --
Q. Which Coroner?
A. -- we had had that report --
Q. Sorry, you keep saying things in your evidence that I'm afraid don't appear to have any reality to the facts of the case.
Which Coroner made a determination in which case?
A. The Coroners had gone -- I was told that the Coroner had gone through each of the baby deaths.
Q. That's untrue.
A. Oh, okay. That's what I was told.
Q. Who told you that?
A. I was told by the Chief Executive and also by Alison Kelly.
Q. So Ian Harvey and Alison Kelly reassured you that the Coroner had investigated all of the deaths?
A. Yes.
Q. And that there was nothing to be concerned about?
A. Yes -- well, no. They said that there was only -- there was two where they couldn't be very specific about what the cause of death had been.
Q. Right.
A. But they couldn't identify that there was foul play either is what they told me.

Q. And that's information that had come from the Coroner?
A. Sorry?
Q. That is information that had come to you, obviously via Ian Harvey, but from the Coroner?
A. It wasn't Ian Harvey. It was Alison Kelly and Tony Chambers.
Q. Yes, but they were referring to determinations by a Coroner?
A. Yes, but they had also instigated the Royal College of Paediatricians to come in who had already completed their investigation and I -- again I was told verbally that there was nothing untoward within that report and that's the only reason that the grievance went ahead when it did.
Q. But you hadn't been told that by the date of your conversation with Mr Pace in July 2016, had you?
A. I don't recall.
Q. Well, no because the investigation hadn't been concluded by then.
A. Okay.
Q. Again, throughout the grievance process, Letby via her Royal College of Nursing representative, advocated strongly that the Consultants should be disciplined, didn't she?

A. He. Yes.
Q. No. But it was Letby's representative, wasn't it?
A. Yes.
Q. Finally, and I am conscious of the time --
A. But there was -- but there was no chance that that was ever going to happen.
Q. No, but that was what was -- what Letby's representative was pushing hard for; that they should be disciplined?
A. There was no -- there was nothing to discipline them on.
Q. If you look at paragraph 75 of your witness statement:
"Letby was concerned that the Consultants thought she was lying and said, 'I have nothing to hide.' I then said we need to compromise as if you go down the disciplinary route with the Consultants --
A. Yes.
Q. "I think I was interrupted at this point."
A. Yes.
Q. Yes:
"I did not think the disciplinary route in relation to the Consultants would be in any way helpful in resolving ..."

A. Yes.
Q. That is a reference because Letby was pushing for them to be disciplined, wasn't she?
A. It was her representative that was pushing.
She -- she wasn't pushing at that point. But there was -- you know, with a grievance you are trying to find a way forward, for everybody to move forward.
Going down disciplinary route to me was just unimaginable because it would just be making things a hundred times worse. So I would not ever have supported that, but I don't think she could have done anyway because there was no grounds.
Q. No. But just to be absolutely clear.
Tony Millea?
A. Millea.
Q. Millea was the advocate, the RCN advocate for Letby?
A. (Nods)
Q. And he was pushing very hard for the Consultants to be disciplined on Letby's behalf, correct?
A. That's what he said at the end, yes.
Q. Yes.
A. Can I also just make a point because I think this is important? It wasn't just Lucy Letby's

grievance that came in. We also got an almost identical grievance in from the RCN separately, but they were both together and so we were getting -- it was like a pincer movement to try and get this, her grievance heard.

So one of the things that I did was to look at the commonalities between the two so that we only had one process.

So we were under -- I was under pressure to hear the grievance. The grievance came in in July and it wasn't heard until December. But at that point we had -- we did know about the Royal College of Paediatricians report and so it felt we couldn't hold it back any longer that then it went, it went ahead.

But I wouldn't necessarily disagree with you and your learned friend that we could maybe have, have pushed it back further. But it's how far do you keep pushing it down the road?

It was -- there was a lot of pressure from the RCN.

Q. Well, what somebody needed to do was call the police if allegations like this were being made because they are the people who are equipped to investigate it, aren't they?

A. Do you know what? I couldn't agree with you more. But I think the people who had all of the concerns and all of the evidence, they were the people

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who should have called the police and there's no reason why they shouldn't of.

Q. Well, that's a very judgmental thing to say --

A. Yes, it is.

Q. -- because you didn't interact with them and you didn't obtain their side of the story.

A. (Nods)

Q. Finally, and I want to clarify something Mr Bershadski asked you because I think he asked you two questions in one and I just wanted to make sure that you answered both of them.

Did you know that Lucy Letby was visiting Alder Hey Children's Hospital in 2017?

A. No.

MR BAKER: Okay. Thank you, my Lady, I've got nothing further.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker. I have no questions. Thank you very much, Ms Appleton-Cairns, you are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: So we will start again tomorrow morning at 10 o'clock.

(5.04 pm)

(The Inquiry adjourned until 10 o'clock on Wednesday, 6 November 2024)