1 Wednesday, 4 December 2024
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Ms Langdale.
4 **MS LANGDALE:** My Lady, may I call Mr Browne,
5 King's Counsel.
6 **LADY JUSTICE THIRLWALL:** Come forward, Mr Browne.
7 MR LOUIS BROWNE (sworn)
8 Questions by MS LANGDALE
9 **LADY JUSTICE THIRLWALL:** Do sit down.
10 **MS LANGDALE:** Mr Browne, you have prepared
11 a statement for the Inquiry dated 22 November 2024 and
12 could you confirm the contents are true and accurate as
13 far as you are concerned?
14 **A.** I do confirm.
15 **Q.** You tell us your educational background. You
16 hold a first class honours degree in law and the
17 postgraduate degree of Bachelor of Civil Law. You were
18 called to the Bar in November 1988 initially commencing
19 practice at the Chambers of David Harris QC in
20 Harrington Street, Liverpool and then moving to
21 Exchange Chambers, Liverpool, in January 2000 and you
22 have practised from Exchange Chambers since that date.
23 That's correct?
24 **A.** That is correct.
25 **Q.** You took silk in February 2017, and from 2000

1 until you took silk you were on the list of Treasury
2 Counsel who represented the Government and you remained
3 on that panel for silk work and were appointed as
4 a Recorder in 2004 and sat in Crown and County Courts in
5 that capacity?
6 **A.** That is correct.
7 **Q.** What's -- paragraph 4 and tell us now,
8 please -- your particular areas of specialism in
9 practice?
10 **A.** They fall predominantly into three areas:
11 Personal injury claims of the utmost severity, so those
12 are claims involving serious brain injury or serious
13 spinal injury, Inquests and Public Inquiries.
14 **Q.** You set out at paragraph 5 the chronology of
15 events we are interested in in the Inquiry, which is
16 your instruction for an Inquest hearing for
17 10 October 2016 in the death of Child A, a conference on
18 8 September booked in on 5 September, a further
19 conference for 6 October and an Inquest which took place
20 on 10 October and you say papers were returned on
21 12 October?
22 **A.** That's correct.
23 **Q.** Very briefly, can you just tell us the
24 hours -- I think it's at paragraph 20, the time taken on
25 those instructions and the work undertaken?

1 **A.** Yes. So it appears that I advised twice in
2 conference. The first occasion was 8 September 2016,
3 the second occasion was 6 October 2016 and then
4 I represented the hospital at the Inquest itself on
5 10 October 2016 at Warrington Coroner's Court. In terms
6 of the preparation for each of those conferences, I have
7 taken that from the fee note which was sent out shortly
8 after the conferences and that shows that in relation to
9 the first conference it appears that my preparation time
10 was three hours and the conference lasted one and a half
11 hours.
12 The 6 October conference was a telephone conference
13 and it appears my preparation time was one hour
14 50 minutes and the telephone conference lasted
15 50 minutes.
16 The Inquest itself, my preparation time was four
17 hours and the Inquest lasted three and a half hours.
18 **Q.** Your professional relationship with the
19 hospital prior to instruction in respect of the Inquest,
20 and particularly with Mr Cross, and you deal with that
21 from paragraph 17 onwards?
22 **A.** Yes.
23 **Q.** Can you tell us what that was, both the
24 professional relationship with the hospital and any
25 relationship with Mr Cross?

1 **A.** Yes. So far as work that I had undertaken on
2 behalf of the hospital when instructed by Mr Cross, it
3 appears that I represented the hospital when instructed
4 by him on five occasions prior to the Inquest into the
5 death of Child A.
6 The 14 May 2012, which was a three-day Inquest and
7 it appears that I was instructed for that in April 2012.
8 The 19 June 2013, that was a three-hour Inquest,
9 instructions received on 4 June 2013.
10 The 7 October 2013 a one-day Inquest, instructions
11 received in September 2012.
12 The 11 November 2013, that was a three-day Inquest,
13 I was instructed in May 2013.
14 And on 23 August 2016, I advised by telephone.
15 It also appears that I advised in conference on two
16 occasions in December 2015 and on one occasion by
17 telephone in January 2016 with Mr Cross and Mr Chambers.
18 **Q.** We don't need to ask you details about those
19 matters or the names of those.
20 You then say you have been instructed by Mr Cross
21 in relation to a possible injunction in November 2012?
22 **A.** Yes.
23 **Q.** You say save for the instruction in relation
24 to the Inquest into the death of Child A, so far as you
25 can recall, none of your instructions related to matters

1 with which the Inquiry is concerned?
2 **A.** (Nods)
3 **Q.** In terms of Mr Cross what was your
4 relationship -- professional relationship with him?
5 Could he phone you directly to discuss case, did he do
6 that regularly, irregularly, or how was it?
7 **A.** I thought I had a good professional
8 relationship with Mr Cross and on occasion he might
9 telephone me directly without my having been instructed
10 to run an issue by me. On other occasions where more
11 formal instructions were received he would contact my
12 then Chambers' senior director, Tom Handley, and
13 instructions would be received via Mr Handley, by which
14 I mean Mr Handley would speak with Mr Cross, would
15 identify the issue that my assistance was being sought
16 in respect of and then the matter would be taken
17 forward, either by Mr Handley making a booking, or by
18 that being delegated to the clerks and instructions
19 being received in writing.
20 **Q.** When you were actually instructed on the dates
21 you have provided for us, in relation to the Inquest for
22 Baby A, you were a senior junior who took silk in the
23 February, I think, didn't you?
24 **A.** Yes.
25 **Q.** So you were still working as a senior junior

1 at the Bar?
2 **A.** That is correct.
3 **Q.** Would you have known of the appointment to
4 silk that was happening in the February?
5 **A.** Did I know --
6 **Q.** Did you know, yes, at that time?
7 **A.** I knew the silk appointments would be
8 announced in early January 2017.
9 **Q.** Right. But when you were instructed as
10 a senior junior to do the Inquest, what did you
11 understand you were instructed to do? Before you answer
12 that, Mr Browne, if I make clear you say you have no
13 recollection of the two conferences now but you have
14 attempted with the notes of the conferences to put
15 together what happened in them; is that right?
16 **A.** That -- that is correct.
17 **Q.** You also say you weren't given the notes we
18 are going to go to approve but broadly -- and we can
19 deal with the details when we get there -- are you
20 content that those notes are accurate?
21 **A.** I have no reason to doubt the accuracy of the
22 notes.
23 **Q.** So doing what you could around the notes, and
24 with that caveat you state at paragraph 29, what were
25 you instructed to do as far as you are aware in the

1 context of Baby A's Inquest?
2 **A.** Without the instructions and relying upon the
3 notes of the conferences and the note of the Inquest,
4 I expected I was instructed to advise at conference with
5 the clinicians as to the purpose of an Inquest, what an
6 Inquest was, what it was not, and to consider with them
7 the records in relation to Child A and to consider the
8 evidence with them and then to represent the hospital at
9 the Inquest itself.
10 **Q.** You set out at paragraph 37 what you are sure
11 you were not instructed to do. Would you like to tell
12 us that?
13 **A.** Yes.
14 **LADY JUSTICE THIRLWALL:** Just while you are finding
15 your place, I just wonder if I might check that people
16 in the public gallery can hear the evidence? Yes.
17 Sorry, Mr Browne, I'm sorry to interrupt you,
18 I just was slightly concerned.
19 **A.** I will speak up a little bit.
20 **LADY JUSTICE THIRLWALL:** It is to do with the
21 position of the microphones, they are obviously working,
22 so that's fine.
23 **A.** Thank you.
24 I'm -- based upon the work particularised in the
25 fee note and the absence of any follow-up after

1 October 2016 with me, I am sure that I was not
2 instructed to do any of the following: draft proofs of
3 evidence for any witness from the hospital who was to
4 give evidence, and in fact I had been reminded, having
5 seen the statements that were provided to me yesterday
6 from the clinicians, that those statements pre-dated by
7 a substantial degree the -- my instruction. So they
8 were in finalised form when I saw them.
9 I was not advised -- I was not instructed to advise
10 on the terms of any draft of any statement.
11 I was not instructed to advise on any matter that
12 was not directly connected with the death of Child A.
13 I was not instructed to advise in relation to any
14 matter concerning the appointment of Dr Jane Hawdon to
15 undertake her review and that includes not being
16 instructed to advise on the Terms of Reference for that
17 review, or the Terms of Reference of any other review or
18 indeed to advise on any other review whether in --
19 whether relating to reviews that had been undertaken or
20 that remained to be undertaken.
21 I was not advised to -- I was not instructed to
22 advise on other neonatal deaths on the unit and how or
23 why they had occurred, nor was I instructed to advise on
24 any other matter.
25 So -- forgive me, Ms Langdale. So put shortly, my

1 role was solely in relation to advising in respect of
2 the Inquest into the death of Child A.
3 **Q.** Again, in the context of your instructions,
4 were you told at any time there was any suspicion that
5 Child A or any other babies in the neonatal unit had or
6 might have been deliberately harmed by a nurse?
7 **A.** I am sure that I was not told of that.
8 **Q.** Why are you sure of that?
9 **A.** Because had I been told of that, I would have
10 taken action and advised in respect of it.
11 **Q.** What would your advice have been had you been
12 told that?
13 **A.** If I had been told that there was a suspicion
14 that any nurse on -- on the neonatal unit had
15 deliberately harmed babies, then I would have told the
16 Trust in no uncertain terms that they must inform their
17 own safeguarding unit of that and the police should be
18 informed.
19 **Q.** You tell us in your statement at paragraph 41
20 of the relevant guidance for witnesses provided in the
21 Good Medical Practice for Doctors including Inquests.
22 We know, and we are going to come on to it, you met
23 with some of the doctors. What's your understanding of
24 the applicable guidance that you may or may not have
25 imparted?

1 **A.** Well, I expected that the doctors who were to
2 give evidence would give truthful and complete evidence.
3 Whilst I may not have had in mind the NMC guidance or --
4 forgive me, the GMC guidance, it should not have needed
5 repeating that witnesses who give evidence in court
6 should tell the truth and the complete truth and so far
7 as clinicians are concerned, they should comply with the
8 duty of candour.
9 **Q.** But you didn't -- I mean, you have for the
10 purposes of our statement, set that out, the relevant
11 paragraphs, but that's not something as a matter of
12 course that you would take doctors to in one of these
13 pre-Inquest meetings when you are supporting clinicians?
14 **A.** No, I wouldn't as a matter of routine take
15 them to the GMC guidance on that.
16 **Q.** What were the sort of general issues that you
17 might state before we go to the specifics, when you are
18 meeting doctors who are due to give evidence in an
19 Inquest?
20 **A.** Well, typically I would explain at the outset
21 that they would be required to give evidence and they
22 would -- they would either take an oath and affirm and
23 that would be a matter for their conscience and they
24 would then be asked questions by the Coroner and then
25 interested persons' representatives could also ask

1 questions. If there was a jury -- there wasn't at this
2 case, if there was a jury, the jury might have the
3 opportunity to ask questions.
4 **Q.** If we go, please to INQ0108406, page 3, we
5 will see a note from a hospital paralegal at the time,
6 Mr Joshua Swash, of the pre-Inquest meeting on
7 8 September 2016 --
8 **A.** Yes.
9 **Q.** -- between yourself and Drs Ogden and Wood?
10 My Lady, we have short statements from those
11 doctors too which we will read in at the end of this
12 witness' evidence.
13 So here we have a note, Mr Browne, of the
14 pre-Inquest meeting which you have seen. And we see at
15 the beginning at the top:
16 "Adjustment of the line but as PM suggesting it had
17 an impact"?
18 **A.** Yes.
19 **Q.** So we know Baby A's Inquest spent some time
20 considering a long line insertion, that would appear to
21 refer to that, do you agree, the long line?
22 **A.** Yes.
23 **Q.** Adjustment to the long line.
24 Then this appears:
25 "Was nurse involved in Child A's care?"

1 **A.** Yes.
2 **Q.** "Re wider review where Child A's death fit
3 into the sequence."
4 First of all, wider review. What did you
5 understand was being referred to as a wider review?
6 **A.** At that stage, whilst I had not seen the neo
7 -- the Thematic Review, nor had I seen the Royal College
8 of Paediatrics review, I must have been informed that
9 there had been reviews into neonatal deaths at the
10 hospital but I can't recall precisely which review that
11 references.
12 **Q.** Then we see below:
13 "Sequence Nurse L, if yes disclose, disclosure to
14 family."
15 **A.** Yes.
16 **Q.** And then:
17 "Spike in deaths not just nurse [equals]
18 disclosure."
19 Can you help us with that, please?
20 **A.** Yes. That is advice that I will have given
21 and it will have been based, so far as I am able to
22 answer that -- this now, it will have been based upon
23 information that I had been provided that the wider
24 review had identified a spike in the number of deaths on
25 the unit and that consideration was being given as to

1 nurses who were on duty at the time of those deaths.
2 Without sight of the -- of either the RCP report or
3 the thematic review, at that time I wouldn't have been
4 able to identify an issue regarding any particular nurse
5 but I suspect for -- for the fact that I've referenced
6 nurse or there is a reference to "nurse" probably
7 indicates that I had been told that there was a nurse
8 where there was consistency of -- that nurse being on
9 duty at the time of some of these neonatal deaths. And
10 I will then have advised: well, if that nurse was on
11 duty at the time of Child A's death, then that fact must
12 be disclosed to the Family. And whether or not that
13 nurse was on duty, the fact of a spike of, in deaths
14 should be disclosed to the Family.
15 **Q.** If you go down to the next contribution:
16 "Dr Ogden: short period of time from the birth
17 until the patient died. Louis explaining Inquest
18 thoroughly."
19 Is that reference the hospital pre-Inquest pack?
20 **A.** It does seem to reference that.
21 **Q.** What is the hospital pre-Inquest pack? We
22 have seen guidance offered to doctors. Was that part of
23 this pack or what?
24 **A.** That -- at's all I have seen and I don't know
25 whether that's the complete pack but it looks as though

1 that was likely part of the pack and that will have been
2 what I have been referencing, I suspect but not having
3 seen it recently, I couldn't, I couldn't confirm that.
4 **Q.** So was it, having advised on other Inquests,
5 something you were familiar with, the hospital
6 pre-Inquest pack?
7 **A.** Yes, I suspect that's --
8 **Q.** What's the messaging in that pack? You had
9 read it presumably and satisfied yourself it was
10 appropriate, had you?
11 **A.** Well, I will have read it at some point.
12 Whether I read it in advance of this consultation
13 I -- I can't recall. Without sight of it, it's
14 difficult for me to say but I -- I expect it would
15 explain what a Coroner's court was, it would explain the
16 role of clinicians at a Coroner's court and nursing
17 staff who were to give evidence. How much further than
18 that it went, I just can't recall.
19 **Q.** It records here:
20 "Coroner thinks issues are relatively discrete."
21 What did you mean by that?
22 **A.** I understood what I meant by that was it was
23 listed for half a day.
24 **LADY JUSTICE THIRLWALL:** A half a day, that is the
25 first part of the sentence.

1 **A.** Yes, it was listed for half a day and that
2 I considered was indicative of the range of issues which
3 the Coroner was wanting to explore which suggested to me
4 that they were in a relatively discrete compass.
5 **MS LANGDALE:** Did you see at any stage at the
6 Countess the guidance to preparing written statements
7 for doctors, was that part of the Inquest pack or not,
8 was the Inquest pack about giving evidence or preparing
9 witness statements as well?
10 **A.** It may have been, I can't recall.
11 **Q.** Can I ask you to have a look at this,
12 Mr Browne. You may or may not recognise it. We can
13 come back to this document. INQ0108392, page 1.
14 **A.** Yes.
15 **Q.** This is a general letter, do you recognise
16 that letter or would you have seen that at the time or
17 considered it appropriate, not appropriate?
18 **A.** I -- I can't recall either way whether I will
19 have seen this or not.
20 **Q.** The guidance on written statements,
21 INQ0008638, page 1 to 4. You have made it very clear
22 that you weren't asked to advise on written statements
23 but just looking at this guidance is this something you
24 recognise in the context of your work for the Trust,
25 take your time to read page 1.

1 (Pause)
2 **A.** Yes, I have read that, thank you.
3 **Q.** Page 2, there it's only four pages.
4 (Pause)
5 **A.** Yes, thank you.
6 **Q.** Page 3?
7 (Pause)
8 I am particularly interested in the third bullet
9 point:
10 "Avoid criticism of colleagues other departments."
11 **A.** Yes, I note that this document says:
12 "Your statement should be accurate and complete you
13 must tell the truth and the whole truth."
14 **Q.** At page 4 if we go to the end.
15 **A.** Yes. Yes, thank you, sorry you were
16 highlighting for me --
17 **LADY JUSTICE THIRLWALL:** Can we go back to page 3
18 so that the witness can finish his answer.
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** Under "Hints and Tips", is
21 that the highlighted part you are referring to? Did you
22 want to say something about that?
23 **A.** I don't recall seeing this. I wouldn't regard
24 that as being a sound position to take in all cases.
25 I can understand why that might be included but if there

1 were -- if there was a case where a clinician or a nurse
2 was criticising a colleague, or another department, for
3 reasons that were connected with the Inquest I would
4 expect that matter to be addressed.
5 **MS LANGDALE:** It does say, if we go back to page 4:
6 "Do not leave out significant information."
7 But as a standalone, the bit that was highlighted
8 doesn't encourage openness, does it: don't avoid
9 criticism of colleagues?
10 **A.** If -- if a clinician or a nurse was reading
11 this document, and landed on that bullet point, then no,
12 it would not necessarily encourage openness and
13 transparency, I agree with that.
14 **Q.** But in any event you don't know if that was in
15 their pre-Inquest pack now but they had -- this is
16 reference to guides for writing statements.
17 But in terms of advice you give in a meeting if we
18 go back to INQ0108406, page 3, what's your general
19 advice around that?
20 **A.** Well, I would -- I would normally begin, as
21 I said, by explaining why all of the clinicians were
22 there in conference with me and I then begin by
23 explaining the purpose of the Inquest and I would
24 expressly say: you will be required to give evidence and
25 that will require you to take an oath or make an

1 affirmation, that will be a matter for you, and then
2 I would move on to dealing with the sequence of
3 questioning.
4 I -- I would not routinely feel the need to tell
5 a clinician or a nurse you must tell the whole truth.
6 I -- I would expect that that would be a given.
7 **Q.** If we go back to this page 3:
8 "Postmortem, page 9, re long line."
9 Just below halfway down the page.
10 "In summary ..."
11 **A.** Yes.
12 **Q.** "... [Louis] final page, CVL related to death,
13 cannot say unascertained."
14 Then it appears:
15 "As long as we as a team don't contradict these
16 findings, there shouldn't be a problem"?
17 **A.** Yes.
18 **Q.** Do you know who said that "as long as we as
19 a team" or in what context that was said?
20 **A.** I -- I don't know who said that. I don't
21 believe it was me.
22 **LADY JUSTICE THIRLWALL:** Ms Langdale, when you were
23 reading that I think you said "Louis" and I can't see
24 that. Or maybe you -- it's:
25 "In summary, PM has failed ... "

1 Then "Very important".
2 Just so that I can understand, is that -- I assume
3 that was an arrow:
4 "Final page, CVL related to death ..."
5 **MS LANGDALE:** "... cannot say unascertained."
6 **A.** Yes.
7 **MS LANGDALE:** The "L -- final page", so do we think
8 you said --
9 **LADY JUSTICE THIRLWALL:** You see that as an "L",
10 thank you, I didn't see that.
11 **MS LANGDALE:** Is that L:
12 "... Louis -- final page, CVL related to death,
13 cannot say unascertained."
14 We know that it was -- well, you tell us, you were
15 there?
16 **A.** I don't think that is an "L", I think that's
17 an arrow. Are you referencing what appears on the
18 left-hand side of "final page"?
19 **Q.** Yes.
20 **A.** I think that's an arrow.
21 **Q.** So who's likely to be summarising the
22 postmortem, "postmortem has failed"?
23 **A.** I -- I don't doubt -- there's no reason for me
24 to consider that I wasn't addressing the postmortem
25 findings.

1 **Q.** Right. Yes.
2 **A.** So I am not suggesting that that will not have
3 been something I wouldn't have addressed.
4 **Q.** Yes, might you have said:
5 "... CVL related to death, cannot say
6 unascertained"?
7 **A.** Yes.
8 **Q.** Because that is --
9 **A.** It's likely --
10 **Q.** -- what was the subject of the Inquest
11 hearing, wasn't it?
12 **A.** It was.
13 **Q.** The long line, could that explain the death or
14 was it unascertained?
15 **A.** Yes.
16 **Q.** So whether that L is referring to you or not
17 that would have been, as far as you were concerned, the
18 issue?
19 **A.** Yes.
20 **Q.** You are meeting the doctors to discuss the
21 issue and are you dealing with the long line issue
22 there, or referring to it, can you remember doing that?
23 **A.** I can't recall doing that. But I have no
24 reason to think I wouldn't, because as you say, that was
25 a key part of the conference to consider potential

1 causes of death.
2 **Q.** And you say the bit below, and it's not clear
3 at all: as long as we as a team don't contradict these
4 findings, there shouldn't be a problem?
5 **A.** Yes.
6 **Q.** Whoever said that, "a problem", what's viewed
7 as a problem in terms of an Inquest?
8 **A.** Well, as I say, I don't think I said that.
9 And the reason I don't think I said it, but forgive me,
10 just to explain before dealing with the question, the
11 reason I don't think I said it is because it's not
12 something I would say.
13 Secondly, this is a meeting of clinicians. I was
14 not part of a clinical team, nor would I be giving
15 evidence.
16 So in the circumstances I personally wouldn't be
17 doing anything to contradict the findings.
18 Looking at it, and trying to interpret it now,
19 it -- it might, it might mean that if clinician was
20 seeking to give an explanation as to a cause of death
21 that had not been raised they might be questioned about
22 it and asked why has it not been raised earlier. But
23 beyond that, I couldn't, I couldn't say why that's
24 referenced.
25 **Q.** We see at the bottom of the page:

1 "Dr Ogden, first check. On first check, nothing to
2 suggest that Child A had any problems. Needed a central
3 line for nutrition necessary."
4 We go over to page 4. Continued discussion --
5 **A.** Yes.
6 **Q.** -- of the long line.
7 Then if we can go to page 5, please.
8 **A.** Yes.
9 **Q.** There's discussion there of staffing levels.
10 Can you tell us -- I mean, I can see that and read that,
11 we can perhaps expand that bit. But tell us what the
12 discussion was there, please?
13 **A.** I will have been interested to and I will have
14 wanted to know because the Coroner would have wanted to
15 know whether issues regarding staffing levels had any
16 part to play potential part to play in the death of
17 Child A. So that would include issues such as the
18 number of staff on duty and the skill mix of that -- of
19 the members of staff on duty.
20 **Q.** So we see there:
21 "Staffing levels and nursing and care given. No
22 impact on his care."
23 **A.** Yes.
24 **Q.** Do you know who said that?
25 **A.** I -- I -- given that it features -- I think

1 I am right in saying -- in notes at a point in time when
2 Dr Ogden is recorded as having been speaking, it may
3 have come from Dr Ogden.
4 **Q.** If we see then that -- was it an arrow, was it
5 an L? It looks like here it is an arrow, isn't it:
6 "... potential impact on Dr Harkness, would have to
7 ask him ..."
8 Or would you have said anything, "potential impact
9 on Dr Harkness"?
10 **A.** I can't recall, but I think that would
11 probably reference potential impact on Dr Harkness and
12 his evidence and a need for me to understand from
13 Dr Harkness that doctor's perspective on staffing levels
14 and care and nursing.
15 **Q.** So might that 'L' be "potential impact on
16 Dr Harkness", you saying that; you need to ask him?
17 **A.** Yes.
18 **Q.** It could be Louis saying "potential impact on
19 Dr Harkness, would have to ask him".
20 We then get to the bottom of the page, if we can
21 just highlight "Actions"?
22 **A.** Yes.
23 **Q.** It appears that you at the bottom say:
24 "Would you be kind enough to identify relevant
25 policies for neonates and are you able to send me [if we

1 go to the last page then, page 7] a copy."
2 Then it says:
3 "Check through medical notes re was nurse involved
4 in care?"
5 **A.** Yes.
6 **Q.** So, first of all, do you remember requesting
7 the policies, relevant policies for neonates?
8 **A.** I -- I did request them but I don't think
9 those notes are notes that were made at the time when
10 the conference was taking place.
11 **Q.** So these actions in a different pen you think
12 have been made subsequently by Mr Swash?
13 **A.** I do. You will see on the first page of that
14 note of conference that there's a reference I think to
15 policies and protocols at the very top.
16 **Q.** On the first page?
17 **A.** I think on the first page.
18 **Q.** So page 3.
19 **A.** Yes. So in the box on the top right-hand
20 corner "policies" underneath "protocols". So I will
21 have asked then for those policies and protocols.
22 **Q.** Right. So if we go back to page 7, and we see
23 then there is in red notes, red pen:
24 "Yes, nursing notes 9 June, 9 June."
25 Where those actions are followed through, it would

1 appear?
2 A. Yes.
3 Q. Do you remember mentioning was nurse -- or
4 asking "was nurse mentioned in care"? Was that
5 something you would have said in the meeting or not?
6 A. Well, I will have wanted to have known that,
7 that's why I was asking that what action plan be to
8 consider; whether the nurse had been on duty I mean,
9 looking at this recently, I note the date is
10 9 June 2015, I understand Child A in fact died on
11 8 June 2015. So these would be entries from the
12 following day from but it matters not because I was
13 being -- I was asking: was the nurse on duty, I was
14 asking could that be checked and subsequently I was
15 informed that she had been on duty.
16 **LADY JUSTICE THIRLWALL:** I think it reads "was
17 nurse involved in care"?
18 A. Yes.
19 **MS LANGDALE:** If it assists, Josh Swash's
20 statement, my Lady, at paragraph 24:
21 "Regarding the note 'checked through medical notes
22 re was nurse involved in care', I recollect being asked
23 by Stephen Cross to examine the medical records of
24 Child A to establish whether Lucy Letby was involved in
25 the care of Child A. The red writing stating yes, and

1 the associated times and dates are referenced in the
2 nursing notes which were attributed to Lucy Letby and
3 therefore confirming her involvement in the care of
4 Child A. I would have written the red part of the note
5 on return to the Legal Services office when I will have
6 reviewed the medical records."
7 That can go down and if we can go to some emails
8 now, please, Mr Browne. INQ0052593, page 1. If we look
9 at the bottom email first.
10 A. Yes.
11 Q. "Dear Louis", this is from Joshua Swash:
12 "Following on from our pre-Inquest meeting on
13 8 September to discuss the above Inquest, I have
14 attached the policies that were mentioned in the
15 doctors' reports ... infection, antibiotics and newborn
16 life-support. I have also spoken to Dr Harkness who we
17 would like to meet with. He is currently working at
18 Alder Hey A&E and says if he is given dates he should be
19 able to get off in order to have a pre-Inquest meeting."
20 And then over the page, at page 2:
21 "Stephen also asked me to get availability for
22 a pre-Inquest telephone conference with a lunch time
23 most likely to be a suitable time for this. Dr Jayaram
24 and Dr Saladi have given me availability for this week
25 and are available ..."

1 It gives various dates.
2 "Finally, following on from our conversation prior
3 to the pre-Inquest meeting on 8 September surrounding
4 the nurse's involvement in the care of Child A, having
5 investigated the records I can confirm she was involved
6 in the care of Child A. Stephen has suggested that it
7 would be helpful if we could have a conversation with
8 you regarding this issue this week if possible."
9 So the conversation pre-Inquest meet about
10 a nurse's involvement, can you remember anything about
11 that conversation?
12 A. I can't and I have, I have not found anything
13 in my diary to suggest I had a -- forgive me -- it
14 refers to a conversation prior to the meeting. I can't
15 recall any conversation prior to the first conference.
16 Q. Do you remember having one with Mr Cross, he
17 having suggested it would be helpful if he could have
18 a conversation with you regarding this issue?
19 A. I don't recall specifically having
20 a conversation with him.
21 Q. We then, if we can go back to the previous
22 page, page 1, the other email should be at the top of
23 that page, so INQ0052593, page 1.
24 This is an email that Mr Swash sends to Mr Harvey,
25 on the 27th:

1 "Dear Mr Harvey, Stephen Cross has asked me to
2 forward this email to you which I have today sent to
3 counsel regarding the above Inquest and you will note
4 that the nurse who has recently been moved out of the
5 neonatal unit was involved in the care of baby Child A.
6 You will also note that Stephen is going to speak with
7 counsel about disclosure to the Coroner on this matter."
8 We also -- do you remember at that time, ie after
9 that pre-Inquest meeting, having a conversation about
10 this?
11 A. No, I -- I don't recall that.
12 Q. About disclosure. We see the note about
13 disclosure in the pre-Inquest meeting, but subsequently?
14 A. I -- I don't recall having any conversation
15 with Mr Cross in which he informed me that the nurse had
16 been moved out of the neonatal unit, nor do I recall
17 being told that by anybody else at the hospital.
18 Had I been told that, it would have led me to ask
19 questions about it because it would have been important.
20 Q. We then go to the next conference you had,
21 I think it was a telephone conference on 6 October,
22 INQ0108406, page 10. In fact, perhaps we should look
23 first at page 9 because that sets out who's there
24 attending.
25 Mr Cross, Mr Browne, Drs Jayaram, Saladi, Harkness,

1 McCarrick.
2 That seems to be Mr Swash's note on the left. And
3 there's reference there, do you remember this, five
4 lines down, it's underlined in red zigzag:
5 "Louis Browne [plus] usually takes original records
6 but away being examined".
7 I think the first bit may relate to when they are
8 meeting you but can you help with what was being away
9 examined?
10 **A.** I don't read those, I don't read the two lines
11 together.
12 I think the first line is referencing transport
13 arrangements for the doctors on the day and the
14 possibility to meet with me on the day. And then the
15 line below refers to plus usually takes original records
16 but away being examined. I have never taken original --
17 **Q.** No.
18 **A.** -- medical records to any hearing, I wouldn't
19 expect to be in possession of them so I don't -- I don't
20 read those two lines as being related. But I don't
21 recall that, I have to say.
22 **Q.** We know of course there were various reviews?
23 **A.** Yes.
24 **Q.** So it may refer to what the hospital was doing
25 with the records but you have no recollection of being

1 involved --
2 **A.** I don't.
3 **Q.** -- with records?
4 If we can go to page 10, then. We see at the top:
5 "Listed for half a day. Coroner believes issues
6 are relatively discrete. Insertion of line,
7 replacement, did it have any impact?"
8 Is this you? It says you explaining at the
9 beginning and again with the assistance of the note, can
10 you tell us what you said at the beginning of the
11 meeting?
12 **A.** Forgive me, can you repeat the question,
13 please?
14 **Q.** Can you, with the assistance of this note,
15 tell us what you said at the beginning of the meeting?
16 It appears to be you explaining the Inquest and the
17 objective. Can you set out what you said here?
18 **A.** Yes, I -- I expect based upon my practice that
19 I would have said the purpose of the Inquest is
20 a fact-finding Inquiry to identify four limited
21 questions, the answers to four limited questions. It
22 isn't a trial, either civil or criminal. You have been
23 asked by the Coroner to come along and give evidence.
24 Before you give your evidence you have to take an oath
25 or you affirm and that is a matter for your conscience

1 and then you will be asked questions by the Coroner and
2 then possibly questions by the representatives for the
3 other interested persons.
4 It is not recorded, but that would be my normal
5 practice.
6 **Q.** If we go over the page to page 11, we see what
7 Dr Jayaram says, halfway down:
8 "Still to this day Ravi doesn't know why this
9 happened"?
10 **A.** Yes.
11 **Q.** "In 27 years in paediatrics never seen this
12 kind of situation."
13 This was over the telephone, was it --
14 **A.** It was.
15 **Q.** -- for Dr Jayaram?
16 Do you remember him saying that?
17 **A.** I don't specifically recall that. But I have
18 no reason whatsoever --
19 **Q.** So has everybody phoned in, or some of you in
20 person and some phone in?
21 **A.** I will have done this remotely. I anticipate
22 that the clinicians and the legal team will have been in
23 the same room but I can't -- I can't recall.
24 **Q.** What's the advice just below that, attributed
25 to you "Louis", what do you say there?

1 **A.** "If you don't know the answer say, no
2 speculation, we can't say."
3 **Q.** Then "Family questions", what's that? Do you
4 know what that note --
5 **A.** I don't, but to deal with the first point.
6 I would routinely advise witnesses who were giving
7 evidence at a fact-finding hearing, whether it's an
8 Inquiry or a trial, that a court will be interested in
9 the facts, not interested in speculation.
10 So that would be not unusual for me to say that: if
11 you don't know, say you don't know.
12 As to Family questions, I -- I -- I don't -- but
13 I suspect insofar as I can comment upon that that I was
14 identifying that the Family may well ask questions.
15 **Q.** We know, and we don't need to take you to it,
16 Mr Browne, Dr Jayaram did say at the Inquest he has to
17 confirm the events that happened to Child A do not make
18 any clinical sense to him at all.
19 Do you remember now --
20 **A.** Well.
21 **Q.** -- him setting out that he didn't know, he
22 didn't have an understanding?
23 **A.** I have no specific recollection of the inquest
24 but it's quite clear from this note and from having
25 re-read the note of the Inquest that Dr Jayaram has gone

1 through a list of considerations that were operating on
2 his mind as to potential reasons for the sudden
3 deterioration. Has there been an acute haemorrhage?
4 Could the line have gone into the heart? What was the
5 reason for lack of response to CPR? And he didn't know
6 why it happened. What he didn't say was that there was
7 a potential sinister cause.
8 **Q.** Well, did you ask him when he said that, did
9 you say: are you suspecting foul play or anything like
10 that?
11 **A.** No, I didn't.
12 **Q.** You didn't ask him either?
13 **A.** I didn't ask him because I had no reason to
14 consider that foul play was a potential cause.
15 **Q.** But he explains that he didn't know and he
16 said in the Inquest he didn't have the cause of death,
17 he couldn't clinically explain it.
18 Dr Saladi, if we go to page 12, he says records
19 here if the Coroner asks "how did it inform future
20 practice?" Dr Saladi has given evidence, if the Coroner
21 asks that kind of question and he referred to the Royal
22 College of Paediatrics review.
23 He says:
24 "Pattern of deaths appear unusual, further enquiry
25 required, forensic review."

1 Did you know this information before Dr Saladi gave
2 it you here?
3 **A.** I will have known that the Royal College of
4 Paediatrics had carried out a review. I -- I had not
5 seen that review. And indeed until the disclosure
6 yesterday of the final report which I understand was
7 sent to the Coroner in January 2017, I had not seen that
8 review but I will have been informed that the
9 Royal College had considered that there was a pattern of
10 deaths that appeared unusual and I likely will have
11 known that at the 8 September even though I may not have
12 known that the source was the Royal College.
13 And that because of the view of the Royal College,
14 a further review was required.
15 **Q.** We see here:
16 "If review is outside of the remit of your
17 knowledge, then say so. Don't say anything unless you
18 know. Review is ongoing."
19 So were you aware that the review was ongoing or
20 some review was ongoing, but there were no conclusions
21 from it yet?
22 **A.** I suspect I was aware of that. And -- and by
23 this date, by 6 October, while I can't precisely
24 remember the timeline, on that same day Mr Cross sent to
25 me the letter of instruction to Dr Hawdon.

1 **Q.** Yes, we can go to that next, unless there is
2 anything else you want to refer to there --
3 **A.** No, thank you.
4 **Q.** -- Mr Browne, I think we have gone to the
5 references I sought to.
6 If we go to INQ0053069, page 1, you see the email
7 makes more sense actually to look at the bottom one
8 first.
9 This is an email first of all at the bottom from
10 Mr Cross to Mr Rheinberg, where he says:
11 "You will recall that in your absence I advised
12 your deputy that the Countess was undertaking a review
13 of neonatal deaths by the Royal College of Paediatrics
14 and Child Health which was undertaken at the beginning
15 of September and the Trust is awaiting their report.
16 "The Review Team have indicated that they were
17 entirely satisfied with the care within the neonatal
18 unit and raised no concerns. However, they recommended
19 that a detailed forensic Casenote Review of each of the
20 deaths from July 2015 should be undertaken so
21 consequently this is still work in progress."
22 Over the page, please, page 2:
23 "I have instructed Louis Browne of counsel in this
24 matter and he is fully aware of the review and Dr Ravi
25 Jayaram as the lead Consultant is also fully aware of

1 this matter. He is called to give evidence at this
2 Inquest and will be able to answer any questions
3 regarding the review."
4 If we go back to page 1, Mr Cross sends on the same
5 date to you:
6 "Dear Louis, thank you for the case conference
7 which was most helpful.
8 "Further to our conversation regarding disclosure
9 to the Coroner regarding the current review being
10 undertaken at the Countess, please see email below.
11 "I attach for your information our letter of
12 instruction regarding the continuation of the review.
13 I have not sent a copy to the Coroner but rather
14 explained it in the email below and I copied Ravi into
15 the email for his information."
16 So you see the email that's been sent to
17 Mr Rheinberg describing the RCPCH review as entirely
18 satisfied with the care but requesting a detailed
19 forensic Casenote Review. Attached to this for you at
20 INQ0003101, page 1, I think is that letter of
21 instruction; is that right?
22 **A.** Yes.
23 **Q.** Did you read that at the time?
24 **A.** Forgive me, did I read it at the time?
25 **Q.** Yes, did you read it?

1 **A.** Yes, I will have done.
2 **Q.** We see it says at paragraph 2:
3 "The Review Team agreed that the pattern of recent
4 deaths and the mode of deterioration prior to death in
5 some of them appeared unusual and needed further inquiry
6 to try to explain the cluster of deaths."
7 Further down at D:
8 "Details of all staff with access to the unit from
9 four hours before death of each infant is one of the
10 matters that were included that required investigation,
11 although that is not something Dr Hawdon was able to
12 do."
13 When you looked at that letter, did you have any
14 concern that there was suspicion around a nurse or
15 some --
16 **A.** A suspicion that a nurse was deliberately
17 harming babies?
18 **Q.** Yes.
19 **A.** Absolutely not. No. I will have read
20 subparagraph D in the context of the Thematic Review
21 that I had been provided with by that date and from
22 recollection I think one of the recommendations of the
23 Thematic Review was that there should be a consideration
24 of precisely that issue.
25 **Q.** Did you get the Thematic Review with the copy

1 of a table, perhaps we can go to that email, which is
2 also 27th of the 9th, so INQ0052602, page 1. So this is
3 also the 27th:
4 "Please find attached the documents we have
5 disclosed to the Coroner regarding the ... Inquest."
6 So the Mortality Review for Child A, obstetric
7 secondary review and a Thematic Review of neonatal
8 Mortality 2015 to January 2016, which we take to be
9 Dr Brearey's Thematic Review.
10 Is that right?
11 **A.** Yes.
12 **Q.** Then a perinatal Mortality Morbidity Review.
13 So you saw that on 27 September?
14 **A.** Yes.
15 **Q.** When you were sent the Mortality Review, did
16 you have an appendix to it with names on and who was
17 present at different --
18 **A.** I can't recall but I suspect I will have done.
19 **Q.** So you may have seen that table of names and
20 who was on duty?
21 **A.** Yes.
22 **Q.** Was it a version with Lucy Letby's name in red
23 or not? Can you remember?
24 **A.** Well, I -- I can't recall.
25 **Q.** Did you pick up on her name?

1 **A.** No, I can't recall ever having been given the
2 name of a specific nurse at any time while I was
3 instructed.
4 **Q.** When did you read of her arrest, when did you
5 first know she had been arrested?
6 **A.** Again I can't recall precisely but I suspect
7 it was at the time that became public.
8 **Q.** 2018?
9 **A.** Some time in 2018.
10 **Q.** Did you make a link in your mind at that time
11 between this Inquest and that or not?
12 **A.** I didn't. Because there had been -- firstly,
13 I suspect it was a very short -- it was a very short
14 Inquest and meaning absolutely no disrespect whatsoever,
15 in the context of Inquests that I was being instructed
16 in, at the time it carried no additional significance to
17 me because there was no indication whatsoever from
18 anybody at the hospital that there was a suspicion that
19 Child A had been murdered.
20 **Q.** When you saw the --
21 **A.** Forgive me, or -- or may have been
22 deliberately harmed that led to his death.
23 **Q.** Did you regard the reference to a detailed
24 forensic Casenote Review in Dr Hawdon's letter of
25 instruction, the reference to a forensic Casenote

1 Review, did you -- did that raise any alerts for you?
2 **A.** It didn't. I would have interpreted forensic
3 in the context of a letter of instruction as meaning
4 a thorough review, having regard to the records within
5 the scope of what she was being asked to do as the
6 expert. But again, this was not a matter that I was
7 being asked to consider expressly. It was part of the
8 wider picture as to what the Trust were doing to deal
9 with the findings as I understood them to be of the
10 Royal College of Paediatrics.
11 **Q.** You say clearly in your statement at the end:
12 "If at any time when I was instructed a member of
13 hospital staff had told me of any concerns/suspicions
14 they had that Child A's death may have been caused by
15 the deliberate actions of a nurse ..."
16 You would have given the advice you suggested
17 earlier.
18 From the information that was given to you, were
19 you able at the time to piece it together, that there
20 were concerns that Child A's death may -- the nurse may
21 have been relevant to Child A's death?
22 **A.** Forgive me, the nurse may?
23 **Q.** May have been relevant to the child's death in
24 the consideration of the cause for the death?
25 **A.** No, there was nothing known to me that

1 suggested the nurse was in any way responsible for that
2 child's death. I -- having read the Thematic Review,
3 I will have seen that in relation to cluster of deaths
4 a number of them occurred in the early hours of the
5 morning between 12 and 4 am, I think.
6 Child A had an unexpected collapse at about 8.30 pm
7 from recollection from the records. And there was
8 simply nothing known to me, at the time, to suggest that
9 any nurse had had acted in a way that might have caused
10 or contributed to Child A's death. I wanted to know
11 about staffing levels. I wanted to know about what,
12 what the skill mix was because one of the issues that
13 the Coroner would need to explore was precisely that.
14 If -- if there was culpable behaviour, not, not
15 criminal behaviour but if, for example, there was
16 substandard nursing care, it would be important for me
17 it know that and it would be important for the Coroner
18 to know that because I would have explored that with the
19 witnesses and they -- a potential might have been to
20 have asked the Coroner to consider obtaining evidence
21 from that nurse or from colleagues.
22 But that was never known to me and there was
23 nothing available to me that would put me on notice.
24 **MS LANGDALE:** Thank you, those are my questions,
25 my Lady. Mr Skelton and then Mr Baker have some

1 questions.
2 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.
3 Mr Skelton.
4 Questions by MR SKELTON
5 **A.** Good morning.
6 **Q.** Mr Browne. I ask questions on behalf of one
7 of the groups of Families, including of course Family A.
8 Can I ask you just first of all -- and I don't want
9 to go over ground Ms Langdale has thoroughly covered --
10 but you had done five Inquests, I think, for the
11 hospital?
12 **A.** Yes.
13 **Q.** Were those all direct instructions or were
14 they via sort of NHSLA instructions?
15 **A.** From recollection, they were all direct
16 instructions.
17 **Q.** Why were the hospital directly instructing you
18 as opposed to going via the conventional channel?
19 **A.** I don't know the answer to that, but I think
20 as time went on, Mr Cross and I had what I regarded as
21 a good professional working relationship. He would be
22 able to instruct me directly because he was a lawyer
23 himself working in the legal department of a hospital.
24 But other than that, I -- I can't say.
25 **Q.** In your chronology, paragraph 17, you mention

1 giving advice on the telephone on 23 August?
2 **A.** Yes.
3 **Q.** Was that to do with Child A's Inquest?
4 **A.** No.
5 **Q.** It was a separate matter?
6 **A.** Yes.
7 **Q.** So prior to getting your instructions, had you
8 not had any contact with the hospital about the nature
9 of the case that you were accepting?
10 **A.** No, I hadn't.
11 **Q.** Was that standard practice again, that
12 something would simply go in your diary and you would be
13 told you are off to do a conference for an Inquest in
14 a few weeks' time?
15 **A.** Yes.
16 **Q.** As I understood your answers to Ms Langdale,
17 you can't remember anything about the instructions at
18 all; is that correct?
19 **A.** I can't. I have not seen them, they have not
20 been provided to me and the evidence I have given both
21 in my statements and this morning is based upon a -- my
22 recollection from the notes.
23 **Q.** How would those instructions have been
24 received, via email to your clerks or directly to you?
25 **A.** I think they will have been received hard copy

1 because the return of them, the chronology I think
2 references an earlier -- references the return of them
3 on 12 October which suggested they were received in hard
4 copy form and then they were sent back by one of my
5 clerks.
6 **Q.** So the standard procedure would be a folder?
7 **A.** Yes.
8 **Q.** Or a number of folders plus a covering form of
9 instructions?
10 **A.** Yes.
11 **Q.** You and your clerks have been unable to locate
12 those instructions because they would have been sent
13 back?
14 **A.** Yes.
15 **Q.** Can I ask you a bit more about the
16 conversation you had with Joshua Swash on 8 September
17 and can we go back, please, to the document INQ0108406.
18 While that's coming up, Mr Browne, it is common
19 practice, isn't it, to have a pre-meet conversation with
20 those instructing you?
21 **A.** Yes.
22 **Q.** In this case it's Mr Swash, he is the sort of
23 instructing solicitor for these, for the purpose of that
24 day's conference; that is correct?
25 **A.** Yes.

1 **Q.** So before the con you have a meeting with him
2 alone, do you remember doing that?
3 **A.** I -- I don't. I -- I don't remember Mr Swash,
4 forgive me, I don't remember what he looked like.
5 I don't know whether Mr Cross was present at that
6 8 September conference. I can't recall.
7 I -- I don't think it identifies who from the Trust
8 was present.
9 **Q.** So you can't remember Mr Swash and you can't
10 remember where it was?
11 **A.** I can't. I suspect it will have been at the
12 hospital, I don't -- I don't recall it being in my
13 Chambers.
14 **Q.** Okay. And it's Mr Swash who I think mentioned
15 the nurse and it's that conversation I think which is
16 quite critical and you really must rack your brains as
17 to what he said about it, if you can.
18 But on page 3 you can see, just so we have it on
19 screen, and we can try and anchor this again.
20 "Was nurse involved in Child A's care?"
21 So why is a single nurse being mentioned in the
22 context of Child A?
23 **A.** I suspect that I will have been informed that
24 there had been a review -- reviews and that there was
25 an investigation into a cluster of unexpected deaths and

1 one of the matters that the hospital were considering
2 was who was on duty at the time of those deaths and in
3 that context, I suspect that it was said that a nurse --
4 a nurse -- appeared to have been on duty at the time of
5 some of these deaths.
6 **Q.** So there's obviously some implicit concern
7 there that she might have done something or failed to do
8 something in respect of Child A and potentially the
9 other children?
10 **A.** Yes, I was interested in that.
11 **Q.** Where in the meeting do you pursue that
12 interest --
13 **A.** Well, at that --
14 **Q.** -- with Mr Swash or with anyone else?
15 **A.** At that stage I had no reason to because
16 I knew no more than what I had been told about the
17 reviews and of the concern. I was then told by Dr Ogden
18 expressly that issues relating to nursing and care were
19 not relevant to the care received by Child A. They were
20 not, they were not causative.
21 **Q.** I understand that point but there's
22 a difference between staffing levels and overall care
23 and a particular focus on a particular nurse who may be
24 connected to Child A and the sequence of deaths. Is it
25 your evidence that you pursued your interest in that by

1 asking questions of Mr Swash or Stephen Cross or anyone
2 else about Nurse A's involvement -- this nurse's
3 involvement in Child A's care?
4 **A.** I will have wanted to have known whether that
5 nurse was involved in the care and, if so, why that was
6 relevant.
7 **Q.** You do set in motion that question. You can
8 see that written down. "If yes, disclosure to family",
9 which I will come on to. The answer you get back at
10 some point -- we will come to that as well -- was yes,
11 the nurse was involved. But what about that second
12 question that you have just put?
13 **A.** Where Child A's death fit into the sequence?
14 **Q.** No, the nurse's involvement with Child A's
15 death?
16 **A.** Yes.
17 **Q.** What specific questions did you ask about that
18 and of whom?
19 **A.** At that stage I didn't ask any questions
20 because I was waiting for further information as to
21 whether it was or was not relevant. I was told
22 subsequently by Dr Ogden at that meeting that her
23 involvement, if she had involvement, would not have been
24 implicated because I was being told that the staffing
25 levels and the nursing and the care delivered were not

1 impactful.
2 **Q.** I will come back to that, if I may, when we
3 get to the meeting, but for these purposes you were
4 asking about a nurse but you weren't, there is no record
5 of you saying what did the nurse actually do and there's
6 no record of what you were told about what the nurse is
7 alleged to have done?
8 **A.** No.
9 **Q.** You can't remember either of those things?
10 **A.** Well, I can -- I can recall, what I can say
11 with absolutely certainty is if anybody had said to me
12 there was -- that it was suggested that any nurse had
13 behaved in a way whereby they were deliberately harming
14 babies, that would have been the first time in my
15 professional career that that would have been said --
16 **Q.** I understand that, and you say that repeatedly
17 in your statement, and you have said it today?
18 **A.** But it is very important, Mr Skelton.
19 **Q.** It is important but I am not asking you about
20 that just yet.
21 What I am asking you about really is: isn't the
22 very fact that there is a nurse who is potentially
23 involved in all of the sequence of deaths, isn't that
24 fact itself significant and warrants your attention and
25 potentially disclosure?

1 **A.** Well, I didn't know that she was involved in
2 all of the cluster of deaths at that stage. I didn't
3 know she was involved in any of the cluster of deaths
4 from any evidence base. I was told that there was
5 consideration being given to that by the hospital.
6 I didn't know that. I didn't have any evidence
7 available to me to establish that.
8 **Q.** Why -- why were you saying that this issue to
9 do with the nurse needed to be disclosed to the Family?
10 What was triggering the disclosure, if there was nothing
11 to it?
12 **A.** Because it -- well, it, it would potentially
13 be relevant if there was --
14 **Q.** How?
15 **A.** Well, if there was a nurse on duty at the time
16 of Child A's death and there was a suspicion, if there
17 was a suspicion, that her care had not been adequate
18 then the Family would need to know about that and the
19 Coroner would need to know about that. But I didn't
20 know at that stage whether that nurse had been involved
21 in providing care.
22 **Q.** I may as well ask this question now: it is the
23 reality that the Family were never given any disclosure
24 about the nurse at all?
25 **A.** Well, they should have been.

1 **Q.** But as far as I can see this advice that you
2 give on the first conference is not repeated later on
3 and I wonder if you can answer why that might be the
4 case?
5 **A.** I -- having worked with Mr Cross on a number
6 of occasions, there had not been an occasion to my
7 memory where he had failed to follow my advice.
8 **Q.** So you were communicating this to Mr Swash and
9 the expectation was Mr Swash would communicate this to
10 Mr Cross or action it himself?
11 **A.** Yes.
12 **Q.** Likewise, the spike in deaths, presumably you
13 were very aware that a Family would want to know that
14 they are part of a cluster of untoward deaths and they
15 could therefore ask the appropriate questions at the
16 Inquest about that?
17 **A.** Absolutely.
18 **Q.** That needed to be disclosed as well?
19 **A.** Yes, it should have been.
20 **Q.** Were you aware about the Coroner's request for
21 a Serious Untoward Incident report?
22 **A.** I can't recall that I was.
23 **Q.** I won't take you to it, because it will take
24 far too long, but there is a series of emails and there
25 is also a phone call to Mr Swash on 27 September in

1 which the Coroner is chasing or asking for a report to
2 be produced and chasing it?
3 **A.** Yes.
4 **Q.** There's also private correspondence he has
5 with prior solicitors, who at that point represented the
6 Family, about his frustration. Is it your recollection
7 that you were unaware of the Coroner's request for
8 a Serious Untoward Incident report into this child's
9 death?
10 **A.** I was unaware of that and I saw that
11 correspondence for the first time when I read the
12 Coroner's papers yesterday.
13 **Q.** Sorry, but at the time you were unaware?
14 **A.** I was unaware of it.
15 **Q.** Because it's something again you would have
16 advised on --
17 **A.** Absolutely.
18 **Q.** -- and sought to ensure that it would have
19 been disclosed?
20 **A.** Yes.
21 **Q.** So far as the substantive meeting is
22 concerned, Ms Langdale has asked you about this. You
23 talk about the issues being relatively discrete and
24 I think at that point the main concern was the long line
25 insertion; is that correct?

1 **A.** Yes.
2 **Q.** Why didn't you ask any of the doctors present
3 about the nurse you had been told about by Mr Swash just
4 before the meeting started?
5 **A.** Well, I clearly did ask about nursing care
6 because it's referenced by Dr Ogden.
7 **Q.** That's quite a different question though.
8 If you ask them an open question: "is there
9 anything wrong with the nursing care that you can
10 recollect or was there anything about the nursing
11 staffing levels?", that is a general question. But why
12 didn't you ask the specific question of there is
13 a particular nurse who is said to have been connected to
14 these deaths, can you tell me anything about her?
15 **A.** Well, there are two reasons for that.
16 Firstly, I was not instructed to consider issues more
17 widely and with the benefit of hindsight of course the
18 pieces of the jigsaw fit together that Letby was
19 deliberately harming children.
20 But that was not a matter that I was aware of or
21 had ever been told. So the first reason is there was no
22 basis for me to ask the clinicians about particular care
23 given by a particular nurse because of a suspicion of --
24 of that nurse deliberately harming.
25 But the second reason is in the context of this

1 Inquest I had no evidence available to me to suggest
2 that that nurse's conduct, whether viewed from
3 a perspective of competence or from any other
4 perspective, was called into question. I wanted to know
5 whether that nurse had been on duty and I will have
6 wanted to have known that so I could explore if it
7 became relevant.
8 **Q.** Why didn't you just ask the doctors?
9 **A.** Well, I -- because at that, at that stage
10 I was being told that there was no issue with care. So
11 clearly I did ask the doctors about the level of care
12 being delivered by the nurses because it's specifically
13 referenced by Dr Ogden.
14 **Q.** Did you not think, though, that that very fact
15 itself is quite significant. So you are told about
16 a nurse's connection with the deaths, the sequence of
17 deaths and in particular Child A. You ask about whether
18 there is any question about the nursing care and you are
19 told no.
20 The next question is: well, what is it about this
21 nurse that you are concerned about?
22 **A.** Well, at that stage, nothing other than the
23 fact that the hospital had expressed to me that there
24 was a consideration as to the involvement of a nurse in
25 a number -- in -- in looking after a number of babies

1 who had died suddenly and unexpectedly and I was --
2 **Q.** Was it?
3 **A.** Forgive me. I was probing to say: well,
4 please let me know, was she involved? Where does it fit
5 into the wider review?
6 **Q.** Just before I move on from that meeting, was
7 it apparent from Mr Swash's contact with you before the
8 main meeting started, either implicitly or explicitly,
9 that the issue to do with the nurse was not something to
10 be dealt with in the open meeting?
11 **A.** No and I wouldn't entertain that. It's not
12 how -- it's not how I have ever practiced and it will
13 not be how I ever practice.
14 I -- I don't -- I wouldn't tolerate private
15 conversations where I'm asked to keep matters to myself
16 and not share them. It's not how I work; it is not part
17 of my professional duty.
18 **Q.** Ms Langdale led you through the evidence about
19 Letby being found or the nurse being found as having had
20 contact with Child A.
21 There's then a conversation -- or, sorry, contact
22 with Mr Harvey who you will know is the Medical Director
23 who indicates that you needed to be told this. So
24 a decision by the Medical Director to tell you that the
25 answer is yes, the nurse was involved.

1 Mr Swash sends two emails to you on 27 September,
2 and I will quote it -- unless you would like me to bring
3 it up again, but:
4 "Finally, following on from our conversation prior
5 to the pre-Inquest meeting on the 8th surrounding the
6 nurse's involvement in the care of Child A, having
7 investigated the records I confirm she was involved in
8 the care of Child A. Stephen has suggested that it
9 would be helpful if he could have a conversation with
10 you regarding this issue this week if possible."
11 So you set in motion a request. You get the
12 answer. At that point, the disclosure obligation that
13 you have already indicated or advised on should have
14 triggered shouldn't it?
15 **A.** Yes.
16 **Q.** But instead they are saying: can Stephen Cross
17 have a chat with you?
18 **A.** Yes.
19 **Q.** Why did you think that was?
20 **A.** I don't recall -- I don't recall ever having
21 had a conversation with Mr Cross because if we had
22 a conversation about the issue of disclosure I would
23 have reminded him what I had already said that both the
24 Family and the Coroner should be informed. Not because
25 it is potentially causative but because it seemed to be

1 a matter that they would, if I can put it this way, be
2 interested in.
3 **Q.** The same day you are sent the documents you
4 have been asked about, the Mortality Review --
5 **A.** Yes.
6 **Q.** -- the obstetric secondary review, the
7 Thematic Review. As you are aware in this Inquiry there
8 are unfortunately a number of different versions of the
9 Thematic Review. Can I just ask you: you read it, as
10 I understand it, as you would have done with all the
11 attachments?
12 **A.** Yes.
13 **Q.** The one dated 8 February 2016 or one of the
14 versions dated 8 February has themes in it. Can I just
15 put those themes in front of you.
16 **A.** Of course.
17 **Q.** Thank you, INQ0003217 at page 7. So you can
18 see there that there's a number of issues which are to
19 do with clinical care that needed to be looked at. But
20 the final bit is the timing of arrests: six babies had
21 arrests between that time and then there is an action
22 to:
23 "Review all cases focusing on nursing observations
24 in the four hours before.
25 "Aim to identify if unwell babies could have been

1 identified earlier.
2 "Identify any medical or nursing staff association
3 with these cases".
4 So do you remember if you saw the version with that
5 paragraph? I appreciate this is very difficult.
6 **A.** I can't, but I will have read carefully
7 whatever version it was I received.
8 **Q.** Well, within -- attached to this version is
9 the appendix which does have the staff and in that
10 Child A, if we come on to page 9, please, so two pages
11 on, you can see on the far -- the penultimate right-hand
12 column care handed to Lucy Letby as being the nurse on
13 duty.
14 As you know, her name reappears in a number of the
15 children's cases in the rest of this?
16 **A.** Yes.
17 **Q.** Would you have picked that up, did you pick
18 that up?
19 **A.** Well, I -- I don't recall ever having heard
20 the name Lucy Letby until news of her arrest was made,
21 I don't recall her being named as the nurse.
22 **Q.** But the reason I ask is that Mr Swash had put
23 you on notice that a nurse was potentially connected
24 with Child A and the other deaths?
25 **A.** Yes.

1 **Q.** You by this stage had asked for checks to be
2 made to see if the nurse was involved?
3 **A.** Yes.
4 **Q.** The answer had come back: yes. You are being
5 given a table in which it's obvious which nurse is being
6 talked about and Child A of course Letby's name is the
7 very first one mentioned?
8 **A.** Well, with respect, it is not obvious because
9 I didn't know that the name of the nurse was Letby. And
10 it's also the case that there are five other nurses on
11 duty, according to that roster.
12 **Q.** There are, but if you go through this you will
13 see that her name comes up far more than anyone else's?
14 **A.** But it is important I think to put into
15 context what I was instructed to do.
16 I was not instructed to enquire whether any one or
17 other of these nurses was deliberately harming babies.
18 Had I been told that there was any suspicion of that, my
19 approach to advising and representing the hospital would
20 have been fundamentally different.
21 What I will have taken in part from this Thematic
22 Review, that there's no suggestion of criminality on the
23 part of any person in the review. It specifically says
24 as I recall that there was no unifying theme to explain
25 the spikes in deaths. So I will have read all of that.

1 I won't have focused on appendix 1 and looked at that
2 name and thought: well, there may well be some issue
3 there. I was being reassured that there was not
4 an issue about the level of care provided by this nurse
5 or any nurse and nobody indicated that there was
6 a suspicion that that named nurse was deliberately
7 harming babies. Had that been even remotely suggested,
8 events --
9 **Q.** But Mr Swash in the email I have quoted from
10 is saying to you: the nurse that we talked about a few
11 weeks ago --
12 **A.** Yes.
13 **Q.** -- was in fact involved in her care?
14 **A.** Yes.
15 **Q.** He is providing you a table in a review in
16 which the nursing staff are set out. I just wonder why
17 you are not trying to put together or understand why you
18 are talking about the nurse. She's being raised with
19 you repeatedly, but you don't seem to know why?
20 **A.** Well, I have asked the question: is there
21 an issue about skill mix and the level of care
22 delivered? I have asked the question that would, based
23 upon what I knew at the time, be directly relevant to
24 the Coroner's Inquest.
25 **Q.** But it's still coming back, the issue is still

1 coming back. Despite your con that you have had
2 previously, you now have data that shows there was
3 a particular nurse and Mr Swash has checked the records.
4 There is still questions about why you are being told
5 this information and I am struggling to understand what
6 you were told about the nurse and why they were
7 interested in her?
8 **A.** I was told no more than I have set out.
9 I understood that there was going to be a further
10 investigation as to the events on the neonatal unit
11 which went to the issue of the spike in the number of
12 deaths.
13 **Q.** As I understand it, you can't remember any
14 conversations with Mr Cross at all?
15 **A.** No, I can't. And -- and if he had explained
16 to me that there was a -- if I can put it this way,
17 a suspicion of whatever nature about that particular
18 nurse or any other nurse, I would have asked questions
19 about that and I would have asked questions about it
20 because it would have been directly relevant to the
21 matters I was considering for the purpose of the
22 Inquest.
23 **Q.** He was present on the telephone conference.
24 Was there no -- was there no pre-meet from that
25 conference on the phone?

1 **A.** Not that I can recall.
2 **Q.** You have checked your diary and so on to see
3 if there's any phone call that you have had?
4 **A.** I have and there isn't.
5 **Q.** As you know, and Ms Langdale led you through
6 this, the two senior Consultants were there, Dr Saladi
7 and Dr Jayaram are at that meeting and they -- Dr Saladi
8 in particular raises the Royal College Review and also
9 that a further review is going to go on, the forensic
10 review which was Dr Hawdon.
11 **A.** (Nods)
12 **Q.** Did you ask then them is there anything about
13 the nursing care that was provided to this child that
14 you are concerned about?
15 **A.** I can't recall asking that expressly. But by
16 virtue of the fact that Dr Jayaram had gone through, if
17 I might put it this way, a checklist of potential causes
18 of a sudden unexpected deterioration, and hadn't
19 highlighted any issue about any other matter on the
20 unit, I wouldn't have felt it necessary to explore with
21 him whether felt that a failure of one or more nurses
22 might have been contributory to Child A's death.
23 I mean, I would also point out that -- that again
24 at no stage did Dr Jayaram explain any concerns or
25 suspicions.

1 But also he -- there was other material that he
2 didn't tell me that I have now found out that might have
3 been a matter that I would have wished to have explored.
4 So, for example, issues of discolouration of the
5 child's body. I would have wanted to have known if that
6 had been if that was information I had been given.
7 Well, does that help at all in understanding why there
8 is a sudden deterioration? But I wasn't -- but I wasn't
9 informed of that either.
10 **Q.** It's fair to you, Mr Browne, I think, isn't
11 it, that you would have wanted to know that the
12 consultants were in fact concerned that Lucy Letby had
13 killed Child A?
14 **A.** Forgive me, I didn't hear?
15 **Q.** You would have wanted to know that the
16 Consultants were concerned Lucy Letby had in fact killed
17 Child A?
18 **A.** Yes.
19 **Q.** Which had been raised explicitly in a number
20 of meetings prior to this date?
21 **A.** Yes, and frankly I don't understand why
22 I wasn't told it.
23 **Q.** You could have been told that directly by
24 Mr Swash, by Mr Cross or anybody?
25 **A.** I am absolutely sure that I was not told that

1 by anybody.
2 **Q.** You were sent an email by Mr Cross directly,
3 which included Jane Hawdon's instructions?
4 **A.** Yes.
5 **Q.** Can I just ask you about that. I know you
6 have touched on this already to some extent but you
7 were, if we look at INQ0012066, just that second
8 paragraph first of all. So they have -- it follows the
9 Royal College Review and then it says:
10 "The Review Team agree that the pattern of recent
11 deaths and the mode of deterioration prior to death in
12 some of them appeared unusual and needed further inquiry
13 to explain the cluster of deaths."
14 So there is something unusual about the pattern
15 that needs investigation because you haven't they
16 haven't got to the bottom of the causes of the
17 children's deaths. It doesn't say anything about
18 criminal suspicion?
19 **A.** No.
20 **Q.** Although we know of course that that was in
21 fact behind this, to some extent at least.
22 Then in paragraph C underneath that:
23 "Examination with the relevant paediatric
24 pathologist at the postmortem findings and any
25 additional information available on their files which

1 might identify cause of death including rare conditions
2 such as air embolism and severe metabolic derangement",
3 so they were looking for the unusual?
4 **A.** Yes.
5 **Q.** You were aware of this, I think, by the time
6 you had your meetings, weren't you, or certainly by the
7 time of the Inquest?
8 **A.** I was aware that Dr Hawdon had been instructed
9 to carry out that review.
10 **Q.** If you just look at that information there,
11 just in terms of the way that the review advice is
12 summarised, that is information the Coroner needs to
13 know, isn't it?
14 **A.** What, sub-paragraph (c)?
15 **Q.** Well, the second paragraph in its totality
16 contains information including that first bit I read out
17 about the pattern of deaths, the mode of deterioration,
18 and the unusual nature of them; that's something the
19 Coroner needs to know, isn't it?
20 **A.** Well, my understanding is that the Coroner did
21 know that there was going to be a further review to
22 investigate the spike in deaths.
23 **Q.** He did. But if we look at the email from
24 Mr Cross, INQ0053069, so your email is at the top
25 attaching -- there is something odd about the timing of

1 this, which I know you have picked up in your statement
2 but it does appear the Coroner was told something first
3 and you were told afterwards?
4 **A.** Yes.
5 **Q.** But I don't think it is a material difference.
6 You are given the letter of instruction, which
7 I have just taken you to, which contains that
8 information I have focused on.
9 Then you look down at Mr Rheinberg -- the email to
10 Mr Rheinberg from Mr Cross. So he describes the review
11 in paragraph 1, then he says:
12 "The Review Team have indicated that they were
13 entirely satisfied with the care within the neonatal
14 unit and raised no concerns. However, they recommended
15 that a detail forensic Casenote Review of each of the
16 deaths from July should be undertaken, so consequently
17 this is a work in progress".
18 So he isn't being given the letter of instruction,
19 Mr Rheinberg, and he isn't being given the reasons for
20 the recommendation. And what I am putting to you is
21 that those reasons are actually quite significant, do
22 you recognise that? We have -- children are dying for
23 reasons we can't determine and there's a pattern to it
24 and a cluster. That is significant information for the
25 Coroner?

1 **A.** In relation to the death of Child A?
2 **Q.** Yes, because, I mean, you are being given this
3 in the context of Child A's Inquest, aren't you, there's
4 no question of that?
5 **A.** Well, the wider context is the -- is the wider
6 review. What I knew at that date was that Dr Hawdon had
7 been instructed as per the letter of instruction.
8 **Q.** That is not my question. My question is you
9 are being sent by Mr Cross in the context of Child A's
10 Inquest the letter of instruction to Dr Hawdon and you
11 are being told what the Coroner has been told but the
12 Coroner hasn't been told the full story because
13 Dr Hawdon's instructions contain more information that
14 you are in possession of that he isn't?
15 **A.** Well, I am not sure that it would have
16 affected the outcome but insofar as the obligation it
17 provide the letter of instruction is concerned, if there
18 was an obligation it would fall on the Trust, it
19 wouldn't fall on me. I wasn't looking at this email
20 correspondence and asking myself: should the Coroner
21 have been informed? Should the Coroner have received
22 a letter of instruction?
23 **Q.** I am not putting that to you. I am just
24 putting to you that there is a significant difference
25 between the two pieces of information. You are being

1 told what the Royal College actually thought justified
2 the forensic review, the Coroner is not?
3 **A.** I think the Coroner knew that there was
4 a review because there was a pattern of unexplained
5 deaths in the neonatal unit.
6 **Q.** We will come on to the Inquest then itself.
7 Dr Jayaram at the Inquest describes Child A's care in
8 detail, I won't take you through that, you are very
9 familiar with it and you have seen the note from Pryers
10 which I think is the fuller and more accurate account.
11 The child had been stable, nothing to explain the sudden
12 deterioration, timely resuscitation didn't work, which
13 was unusual. There had been similar cases of other
14 neonates dying and he mentions cryptically the potential
15 issue with staffing but doesn't describe any concerns
16 about anyone in particular and also mentions the
17 independent review but there is no mention of the
18 Royal College explicitly.
19 What both he and Dr Saladi don't mention was the
20 concern about a specific nurse; correct?
21 **A.** (Nods)
22 **Q.** A in particular they definitely don't say that
23 there was a concern, a suspicion that the nurse may have
24 deliberately harmed Child A, or the mechanism of how
25 that might have occurred, air embolism, or the fact that

1 she may have harmed other children. None of those
2 things were mentioned?
3 **A.** I absolutely agree, Mr Skelton, nor is there
4 any mention that potential substandard care was
5 implicated. So there is no reference to the quality of
6 care being delivered by nursing as being causally
7 connected with Child A's death.
8 **Q.** You don't ask any questions of Dr Jayaram --
9 **A.** No.
10 **Q.** -- or Dr Saladi?
11 **A.** No.
12 **Q.** You don't ask either of them to explain the
13 nature of the Royal College Review?
14 **A.** No, I hadn't seen the Royal College Review.
15 I -- I knew only that there was a review which was going
16 to be undertaken by Jane Hawdon, and I knew why she was
17 being instructed. That was as much as I knew about the
18 Royal College.
19 **Q.** You don't lead into evidence the Jane Hawdon
20 review either in terms of what you knew about it. You
21 knew her instructions and the reason she had been asked
22 to review and you knew I think implicitly from
23 Mr Cross's email that he was in fact going to look at
24 Child A.
25 **A.** There was no suggestion -- there was no

1 evidence known to me or any indication that Child A's
2 death was caused or might have been caused by failures
3 of medical and/or nursing staff or might/was caused by
4 a deliberate act.
5 And so in the circumstances, that -- that there is
6 a wider context of the Trust asking Dr Hawdon to carry
7 out a review into these cluster of deaths, I -- I --
8 I am not a clinician. I was there to represent the
9 Trust at that Inquest and my focus was on the material
10 available to me that was available to the Coroner, to
11 understand how Child A might have come by his death.
12 That was the focus of my --
13 **Q.** I understand that.
14 **A.** -- my -- my role and my instructions. It was
15 not to go beyond that --
16 **Q.** But why -- when Mr Cross sent you Dr Hawdon's
17 instructions, why didn't you ask him: is she looking at
18 Child A's death as being one of these unusual
19 deteriorations that can't be explained?
20 **A.** I don't know.
21 **Q.** Why didn't you ask him?
22 **A.** Well, I had no reason to ask that question.
23 **Q.** Well, you were sent it in the context of
24 Child A's Inquest --
25 **A.** Yes.

1 **Q.** -- by Mr Cross so the obvious question is: is
2 there investigation, a forensic Casenote Review of this
3 child going on now?
4 **A.** Even had I asked that question and even if the
5 answer was yes that is one of the deaths that's being
6 investigated, at that point in time, where would that
7 have led me? I had no information to suggest that there
8 was going to -- that there was anything about any nurse
9 on the unit or any clinician on the unit doing something
10 that materially affected Child A and led to his death.
11 **Q.** No, but what you could have said to the
12 Coroner in front of the Family was: this child's death
13 is now being included as part of a detailed forensic
14 Casenote Review by a senior neonatologist and we await
15 the answers to that. And that is information they would
16 have wanted to know, both the Coroner and the Family?
17 **A.** Well, the Coroner knew there was to be this
18 review. It would have been open to the Coroner, if he
19 had wished to have done so, to have adjourned the
20 Inquest until the review had been received. In fact, as
21 I understand it, he had been invited to adjourn the
22 Inquest by the solicitors then representing the Family
23 of Child A a few days before and had refused to do so
24 considering he had sufficient information available to
25 him to answer the statutory questions.

1 Now, with the benefit of hindsight, should
2 Child A's Family have known about the Hawdon Review?
3 Yes, they should. But I think the obligation to provide
4 that information didn't come from me, it was very clear
5 from what I said on 8 September that I wanted the Family
6 to have disclosure of the detail, of the potential
7 relevance of a nurse and of the spike in deaths.
8 If I had considered there was other material that
9 I thought they should have known, then I would have
10 advised on that.
11 **Q.** But you got to the Inquest, the evidence
12 proceeds, you have no basis for concluding that the
13 Family know anything about the concerns relating to
14 a nurse and they certainly don't know anything about the
15 instruction of Dr Hawdon which might relate to their own
16 child?
17 **A.** Well, they should have done.
18 **Q.** Those are both things that you could have and
19 should have advised them?
20 **A.** The obligation to do that fell on the Trust.
21 The Trust set up the review, I didn't set up the review.
22 The Trust define the Terms of Reference for the review,
23 chose the expert, drafted the letter of instruction to
24 the expert and was paying the expert. The obligation to
25 tell the Family was an obligation on the Trust, not on

1 me.
2 **Q.** Well, the difficulty with that suggestion,
3 Mr Browne, if I may say so, is that this is the only
4 Inquest, this is the Inquest which takes place and once
5 it's over, it's over, as you know: it can only be
6 re-opened with order of the High Court.
7 The Coroner is struggling to find out how this
8 child died; that is what the whole Inquest was about.
9 But you know that Dr Hawdon, an expert
10 neonatologist, is about to undertake a review of that
11 child's death which may or may not find out how that
12 child died, including possibly by air embolism. As it
13 turned out, that was the mechanism of death.
14 The Coroner isn't fully aware of that. The Coroner
15 and the Family do not know that investigations are still
16 going on and those are obviously going to be relevant to
17 the cause of death, aren't they, I mean, unquestionably?
18 **A.** Well, Dr Jayaram knew that the review was
19 going on.
20 **Q.** No, I am talking about your obligation?
21 **A.** Yes, well, I don't consider I had
22 an obligation at that stage to advise. In retrospect,
23 do I wish that the Family had been informed? Of course
24 I do.
25 But as matters stood at the time that I was

1 representing the Trust, what -- what I knew was what
2 I was being told by the clinicians and what I knew from
3 the postmortem and at that stage there was no suggestion
4 that there was a sinister cause for Child A's
5 deterioration and death.
6 **Q.** I understand that, but the obvious risk was
7 that Jane Hawdon can finish her investigation and find
8 a cause of death which would mean that the Inquest had
9 proceeded on a wrongly informed basis and that risk was
10 a risk that you needed to address?
11 **A.** I don't accept that. I don't accept that was
12 a risk I needed to address.
13 I didn't know precisely what the parameters were
14 that were going to be considered by Dr Hawdon and so --
15 **Q.** Well, you did from her instruction, it was
16 exactly what was set out. I have just read it out to
17 you?
18 **A.** She is not being asked to investigate the
19 potential for suspicious activity.
20 **Q.** She is being asked to find the cause of
21 death --
22 **A.** Yes.
23 **Q.** -- which includes rate conditions such as air
24 embolism?
25 **A.** To try to find a cause of death and as matters

1 transpired, she couldn't find one, as I understand it.
2 **Q.** No.
3 **A.** So even had I -- even had I suggested that the
4 Inquest be adjourned pending Jane Hawdon's review, it
5 wouldn't have assisted because that review didn't tell
6 us anything more about Child A's death than we knew at
7 the time of the Inquest.
8 **Q.** But you must also have been aware that they
9 knew nothing about the nurse because it never gets
10 raised at the Inquest?
11 **A.** I didn't know that they didn't know nothing
12 about the nurse. I had given advice, clear advice that
13 that was to be disclosed. I had a relationship with
14 Mr Cross, whereby I expected that he would act on my
15 advice. I had that expectation because he had not --
16 he -- he hadn't failed to do so before.
17 So I assumed that he would have informed the Family
18 of that. It's not something that was necessarily needed
19 to be raised at the Inquest but I would have assumed he
20 would have acted on my advice.
21 **Q.** Mr Browne, just stepping back and considering,
22 you represent families, I know, at Inquests?
23 **A.** (Nods)
24 **Q.** They are going in trying to find out why this
25 child died and they are suspicious about it because they

1 have already intimated a civil claim. So they think
2 something untoward has happened, they obviously think
3 it's inadvertent harm as opposed to deliberate harm at
4 that point. But there is an awful asymmetry between the
5 knowledge that you have and your clients had and what
6 they have.
7 The knowledge that you have is that there is
8 something going on with a nurse that is causing concern,
9 that's being looked at, there is a connection with
10 between her and the sequence of death, which includes
11 Child A, you have been told that explicitly and there is
12 further investigation on forensically of Child A's case
13 which they don't know about. That asymmetry of
14 knowledge needed correcting by you at the Inquest and
15 you should have done it?
16 **A.** No, Mr Skelton, if there is asymmetry of
17 knowledge, the asymmetry of knowledge is between the
18 clinicians and the Trust on the one hand and the
19 Coroner, the Family of Child A and me on the other. The
20 Trust knew of the suspicions of the clinicians that
21 a nurse was deliberately harming those children.
22 Neither the Coroner, nor the Family of Child A, nor
23 I knew of those concerns. That's where there is an
24 asymmetry.
25 **MR SKELTON:** Thank you, my Lady.

1 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
2 We will take a 15-minute break now and we will
3 start again at 5 to 12.
4 **(11.40 am)**
5 **(A short break)**
6 **(11.55 am)**
7 Questions by MR BAKER
8 **LADY JUSTICE THIRLWALL:** Mr Baker.
9 **MR BAKER:** Mr Browne, I ask questions on behalf of
10 the other Family groups.
11 You mentioned that you didn't hear or don't recall
12 hearing the name Lucy Letby at all during the time when
13 you were instructed in respect of Child A. Could I just
14 ask for INQ0108406 to be brought on screen, please, and
15 page 8. Sorry, page 9. Sorry, page 7. Forgive me.
16 Sorry.
17 Yes. This is part of a note made by Josh Swash of
18 a pre-Inquest review meeting and it contains an action
19 plan at the end, which makes a specific reference to
20 Lucy Letby by name.
21 Does that help refresh your memory as to whether
22 her name was mentioned at any point?
23 **A.** No, it doesn't. It doesn't, Mr Baker, and
24 these notes were not taken, as I recall, during the
25 course of the conference.

1 My understanding from the evidence is that Mr Swash
2 went back to the office, checked the notes and on
3 checking the notes, made that entry. So I have no
4 recollection of knowing the name Lucy Letby before her
5 name came to prominence in the press.
6 **Q.** In a different way, then, you had been
7 provided with the Thematic Review, you had been provided
8 with other documentation and there was mention of
9 a single nurse being involved. In order to navigate
10 your way around those documents and to understand them,
11 would it not have been natural to ask: what is the name
12 of this nurse?
13 **A.** The -- the name, there were many other names
14 referenced on appendix 1 of the Thematic Review in
15 connection with those other children who were within the
16 cluster of sudden and unexpected deaths. The name Letby
17 didn't stand out to me in the same way that none of the
18 other --
19 **Q.** I understood that to be your evidence, but the
20 notes are clear that there was a discussion around
21 a single nurse being involved, so notes of the
22 conferences taken by Mr Swash, by Mr Cross, again clear
23 that you were aware that there was an issue in relation
24 to a single nurse being involved.
25 Now, to make sense of the Thematic Review and the

1 other documentation, would it not have been natural to
2 ask: what is that nurse's name so that I can
3 cross-reference it myself?
4 **A.** Well, when I went through the appendix, as
5 I will have done, I will have noticed that Letby's name
6 was mentioned in relation to a number of the children,
7 but I will also have noticed in relation to other
8 children she wasn't referenced and bear in mind at this
9 stage, I repeat -- forgive me for doing so, but
10 I repeat, the other names referenced in appendix 1 are
11 children who tragically died, meant only to me at that
12 stage that they were part of a cluster of Sudden and
13 Unexpected Deaths. It had no wider significance for me
14 either in the context of the review overall or in the
15 context of the death of Child A.
16 **Q.** If you were told that there was concern or
17 some relevance in the commonality between a single nurse
18 and a number of cases or indeed all of the cases that
19 were considered to be part of the spike, what
20 explanation could you have thought of as to the
21 relevance of that involvement, other than that there may
22 be some questions of competence surrounding that nurse
23 or the more extreme end of the scale: some suggestion of
24 deliberate harm?
25 **A.** I don't recall ever being told that there was

1 a concern over a nurse in any respect. Insofar as
2 I have a recollection, my recollection is that the
3 hospital had identified that there was a nurse who had
4 been on duty at the time of a number of these neonates'
5 deaths.
6 And in the context of that information, at the
7 first pre-Inquest conference, I wanted to know whether
8 that nurse was on duty at the time of the death of
9 Child A because at that stage I had not seen the
10 Thematic Review and I wanted to know where that fell in
11 the spike of deaths.
12 **Q.** Well, I -- I won't go over the documents and
13 the emails again but the action plan we have on screen
14 involves Joshua Swash going off and investigating
15 whether the single nurse was involved in this case, ie
16 the one who had been associated with the deaths that
17 were being investigated. And he has written
18 "Lucy Letby", it may be because he wrote that afterwards
19 or because her name was mentioned.
20 But that was followed up in an email that we were
21 taken to -- the Inquiry was taken to, where you were
22 informed that that is the nurse who is involved in this
23 case as well?
24 **A.** That a nurse -- a nurse -- had been on duty at
25 the time of Child A's death.

1 **Q.** Well, it's obviously the relevant nurse. It's
2 a relevant nurse, it is not just a general nurse. It is
3 a relevant nurse who is common to the other cases, that
4 is the obvious implication from the notes?
5 **A.** As I recall, what appendix 1 actually says was
6 that the care was handed over to her at 2000 hours and
7 the child had a sudden unexpected collapse shortly
8 thereafter.
9 **Q.** Yes.
10 **A.** That is what I knew, but there were other
11 nurses on duty and, at that stage -- by "that stage"
12 I mean when I had the Thematic Review -- I already had
13 my first conference and I was shortly thereafter to go
14 into the second conference. But I had been reassured at
15 that first conference that there was no issue about
16 nursing care, et cetera, that was involved in the death,
17 was implicated in the death of Child A. That is what
18 I knew on 8 September.
19 Having re-read -- having read the Thematic Review
20 when I received it later that month, there was nothing
21 further in that Thematic Review that led me to probe
22 that any further so I was not being told by any nurse
23 that there was an issue, not being told by the
24 clinicians that there was an issue. So the evidence
25 I had at that stage was that Dr Ogden, in response to

1 questioning from me, I suspect, had provided reassurance
2 that there was no concern over the level of nursing
3 care -- nursing or care or staff mix or levels that were
4 involved in Child A's death.
5 **Q.** This is, however, based upon your piecing
6 together what's written down in the notes; you have no
7 direct memory of this discussion?
8 **A.** I don't. But piecing together what's in the
9 notes and based on my -- what my normal practice would
10 be in the context of a death in hospital I will have
11 wanted to have known whether there was any act or
12 omission on part of the nursing or clinical staff that
13 potentially in the context of a wider Coronial
14 investigation, that potentially could be implicated in
15 this child's death or that adult's death.
16 **Q.** And --
17 **A.** Forgive me, that is the context in which
18 I will have been asking those questions. And whilst
19 I have no direct recollection that is based upon my
20 experience of having done a number of these deaths in
21 hospital beforehand. That is what I will have been
22 interested in.
23 **Q.** And again, sorry to go back to my earlier
24 question, but in general terms, if there is a common
25 link between a nurse and unexpected, unexplained deaths

1 can you think of another concern it would have caused
2 you other than the possibility of incompetence or at the
3 more extreme end, deliberate harm by that nurse?
4 **A.** Under no circumstances would it have entered
5 my head at that stage to think that Letby or any other
6 nurse was responsible for deliberately harming Child A
7 or any other children. It simply was not on my radar.
8 **Q.** But to ask the question again: is there
9 another explanation for that being a relevant issue that
10 might be discussed other than concern about that nurse's
11 competence or at the more extreme end of the scale,
12 deliberate harm?
13 **A.** What might that be? If it's not -- if it
14 doesn't go to the level of care delivered and go to
15 their competence, and is not at the other end of the
16 extreme scale deliberate harm --
17 **Q.** Yes.
18 **A.** -- I don't know what other issue that might go
19 to.
20 **Q.** No, so the answer is there couldn't be any
21 relevance in discussions surrounding that other than
22 concerns regarding competence or?
23 **A.** I -- at that stage, I was -- I -- I did not
24 consider for a moment based upon the information
25 available to me.

1 **Q.** I understand your evidence around that.
2 **A.** Thank you.
3 **Q.** Your witness statement says you had no
4 involvement at all after October 2016 in any of the
5 cases relating to Lucy Letby?
6 **A.** Sorry, can you repeat that?
7 **Q.** You had no involvement beyond October 2016 in
8 Child A's case or indeed in any other issues relating to
9 Lucy Letby?
10 **A.** That is correct, to my recollection.
11 **Q.** Could we go please to INQ0106817, please, and
12 particularly to page 31. These are notes slightly less
13 clear on this screen than they are on my page but on the
14 right-hand page towards the bottom, there is an entry
15 that is dated 6 February 2017. You will have to take my
16 word on the date it is clearer on my version than it is
17 here and it is a meeting between or involving Helene and
18 Josh and it is at 11 am and it is a discussion regarding
19 the legal position.
20 This first entry is to contextualise the
21 discussions that are occurring in the week of
22 6 February 2017. There is a reference here to a letter
23 of claim regarding Child D, there is a reference to
24 Inquests, and it says "Child A done, cause
25 unascertained". 10 October 2016. Then:

1 "Inquests for Child D and Child O. No Inquest for
2 ..."
3 That's a non-indictment baby.
4 So there is a reference at the bottom:
5 "Actions: Josh to prepare a schedule of Inquest
6 claims, potential claims, SAR requests for neonatal
7 report."
8 If we go on to the following page, again, this note
9 is less clear on this screen than it is on mine but
10 there's a further note at the top it says:
11 "Monday, 6 February 2017 continued."
12 There is a reference to Sian Williams speaking to
13 the Families, Child A, Child D and a number of
14 non-indictment babies.
15 Then at 4.45, the next part down, there is
16 a meeting with Tony Chambers and it's a neonates update
17 meeting.
18 If we go on then to page 34. There's a further
19 meeting here which begins on Thursday -- sorry,
20 Wednesday 28 February, reference at the right-hand page,
21 it's about the third line down, begins:
22 "Wednesday, 8 February 2017, meeting with Coroner".
23 Can you see that?
24 **A.** Yes.
25 **Q.** Then the next meeting begins: "Thursday",

1 halfway down the page:
2 "Countess of Chester Hospital. Present
3 Stephen Cross, SHL" and others.
4 Then there's a reference just below I&S, it says:
5 "Inquest update: SHL."
6 And to the right of that:
7 "Claire to speak with Rachel Exchange."
8 Can you see that?
9 **A.** No.
10 **Q.** No, you can't, it's not clear on your screen?
11 **A.** Not at the moment.
12 **Q.** Just below the letters "I&"S, you will have to
13 take my word for it, it says:
14 "Claire to speak to Rachel Exchange."
15 **A.** Yes.
16 **Q.** Is Rachel at Exchange somebody you will be
17 familiar with?
18 **A.** She was one of the clerks.
19 **Q.** So she was one of the clerks. There's
20 reference again "Inquest update SHL". There's
21 "Hill Dicks neonates". Above that, it says "C-2 email
22 to Ian Benton re Coroner" and then "Countess brief to
23 NEDs and governors" and to the right of that circled it
24 says "Ring Louis", can you see that?
25 **A.** Yes.

1 **Q.** So it appears to be a note regarding over the
2 course of several days discussions relating to Inquests
3 including the Inquest into the death of Child D which
4 was ongoing at the time and then later in the week,
5 a further reference to Inquests and a reference to "ring
6 Louis".
7 Given that there is a reference to your clerk and
8 Louis is a relatively uncommon name I'm assuming that
9 must be a reference to ringing you?
10 **A.** I assume so.
11 **Q.** On the following page, again less clear on
12 this screen than on mine, Friday, 10 February 2017, it
13 says, first two words are "Rachel Exchange", they are
14 clear on my page and then it says "MT", which I assume
15 is meeting, and then it says "with Louis Browne".
16 The next line is "Capito contract novation" and
17 then it says "Neonates Hill Dicks (Richard NHSLA) and
18 then it says "[something] for Sian" at the bottom of
19 that, next to "I&S".
20 So it would appear, wouldn't it, in the context of
21 discussions regarding Inquests and neonates, during the
22 course of this week, there is a reference to ringing
23 Louis and then there is a meeting with you in
24 February 2017. Would you agree that that's likely to be
25 what occurred?

1 **A.** No, I have checked my diary for the entire
2 period. I -- I saw this yesterday and I checked my
3 diary for 2017. There is no record of my having had
4 a meeting with Mr Cross or anyone else from
5 Hill Dickinson about other neonatal deaths.
6 In fact, I looked again at Mr Rheinberg's statement
7 to remind myself of what he said about Child D to see if
8 that jogged my memory and there is nothing in that
9 statement concerning Child D -- Child D's death and the
10 progress of any investigations thereafter.
11 **Q.** When you talk --
12 **A.** Sorry, forgive me.
13 **Q.** When you talk about your diary, can you just
14 say what you mean by your diary?
15 **A.** I mean, I have looked through the LEX system
16 to identify if there is any meeting around that date
17 with Mr Cross and the Trust and there isn't. There
18 are --
19 **LADY JUSTICE THIRLWALL:** The LEX system is the
20 software in your Chambers, is it?
21 **A.** It is.
22 **LADY JUSTICE THIRLWALL:** The electronic diary?
23 **A.** It is, my Lady. And furthermore I have no
24 documentation at all evidencing the desire to have
25 a conversation with me so I have never -- I have never

1 instructed there are no emails on the system that we
2 have been able to find.
3 As I have explained in the statement that show that
4 I had that meeting, I have no recollection of it and
5 based upon what I have looked at, I just -- I have no
6 recollection of it taking place. But my -- insofar as
7 I am able to say so, I do not believe that I was
8 instructed to advise in any way in relation to any other
9 neonatal deaths after Child A.
10 **MR BAKER:** So if a solicitor or legal
11 representative from a client telephoned you directly
12 rather than speaking with your clerks, and said: can we
13 have a conversation, a meeting by telephone, regarding
14 a case, and you were to say: that's fine, I have a space
15 in my diary tomorrow and we could have a conversation,
16 it entirely bypassed the clerking system, would it be
17 uncommon for that not to be recorded then in the LEX
18 diary?
19 **A.** It would be uncommon for me not to bill for it
20 if I had had a conversation of this nature and there is
21 no record of my having billed for it. There is no
22 record on the system of my having been instructed.
23 If it's a conversation on a matter, so a solicitor
24 rings me and wants to have a chat about they have a case
25 in which whatever the issue, can we just have

1 five minutes, then that probably wouldn't be diarised.
2 But in circumstances where Rachel has been expressly
3 mentioned as a contact, if this took place I would have
4 expected that contact would have been made via her and
5 a date would have been placed in my diary for that
6 conversation to take place and there wasn't any date
7 recorded.
8 **Q.** If advice or discussions were occurring on an
9 informal basis as a potential prelude to being
10 instructed in a case, would you always bill for those
11 conversations?
12 **A.** Not necessarily, no.
13 **Q.** So the absence of billing in relation to it,
14 the absence of a diary entry and indeed the absence of
15 emails, because it appears to have been done by
16 telephone, wouldn't necessarily exclude the possibility
17 that a conversation had taken place, would it?
18 **A.** By itself it would not. However, as I say
19 I have no recollection of that and there is nothing at
20 all to indicate to me that a conversation about other
21 neonates in February 2017 took place.
22 **Q.** You would, however, have been a counsel who
23 the Countess of Chester knew, through your involvement
24 in the case of Child A, had knowledge of the broader
25 issues, the RCPCH report, the Jane Hawdon report and so

1 would have been aware of you as being somebody who they
2 might contact about this, hence perhaps "ring Louis"?
3 **A.** Well, there is a logic to that. But the fact
4 remains that I have no recollection of it and there's
5 nothing to indicate that that call was made other than
6 this. Certainly no information was provided to me that
7 I have been able to identify or locate to suggest that
8 that conversation took place.
9 **Q.** Finally, paragraph 13 and 14 of your statement
10 you describe meeting with Stephen Cross in the autumn of
11 2018 regarding a criminal matter which was hanging over
12 the Countess of Chester Hospital.
13 **A.** Yes. I don't recall that meeting but the
14 notes suggest that that meeting took place, yes.
15 **Q.** Yes, so there is a clerking note saying that
16 it is being arranged and that the meeting took place?
17 **A.** Yes.
18 **Q.** Yes. You didn't bill for that meeting?
19 **A.** I have not been able to find any billing for
20 it, no, and that would have been -- I am -- I am
21 assuming -- I have no direct recollection of it, that
22 that would have been a meeting in which Mr Cross might
23 have told me of concerns he had. In the light of events
24 that happened because by then of course Letby had been
25 arrested this was three months after she had been

1 arrested.
2 **Q.** Yes, so she was arrested in July 2018 and you
3 are not a criminal barrister?
4 **A.** I'm not.
5 **Q.** No, so you would not take offence at me saying
6 you wouldn't be the first port of call for a hospital
7 Trust in relation to a criminal issue?
8 **A.** I would not.
9 **Q.** Do you accept that this contact probably
10 relates to Lucy Letby, given its timing?
11 **A.** Well, the reference I think specifically was
12 to a criminal investigation hanging over them.
13 **Q.** Yes.
14 **A.** So yes.
15 **Q.** Yes. And that connection must -- contact was
16 likely made because of your prior knowledge of issues or
17 involvement in neonatal issues in the Trust?
18 **A.** I suspect it was because I had represented the
19 Trust at the Inquest into death of Child A.
20 **Q.** Does it not feel, though, part of more of
21 a substantial continuum, the reference to "ring Louis"
22 in February 2017, Stephen Cross being in touch with you
23 following the arrest of Lucy Letby?
24 I mean doesn't it feel like more of a part of
25 a continuum than just simply an isolated link back to

1 an inquest you did, a half day Inquest in October 2016?
2 **A.** No, no, it doesn't. I would have distinctly
3 remembered if there had been further instructions to me
4 from the Countess of Chester Hospital from Hill
5 Dickinson on their behalf in relation to deaths of
6 neonates. Bear in mind the death -- the Inquest into
7 the death of Child A was held in October 2016.
8 A few months later, in February 2017, if I was
9 being telephoned to discuss other neonatal deaths at
10 that hospital, I would have remembered.
11 **Q.** Thank you.
12 **A.** Because I would have said: hang on, what,
13 what's the issue with Child D?
14 **Q.** But your evidence to the Inquiry is that you
15 never made any connection between Child A and the arrest
16 of Lucy Letby but if you were having a conversation with
17 Stephen Cross about the criminal charges hanging over
18 the Countess of Chester probably relating to Lucy Letby
19 in September -- sorry, October 2018, and you now piece
20 it together in the way that you do, you must have made
21 a connection?
22 **A.** I -- I didn't make the connection at that
23 time. Or if I did, I have no recollection of it. Bear
24 in mind that Simon Medland from Chambers had been
25 instructed so there was -- there was an issue about his

1 involvement. I don't know when he first became involved
2 or when he ceased to become involved. But there was
3 a connection that went beyond my representing the Trust
4 at the Inquest into Child A. But I can assure you that
5 I have no specific recollection of that meeting with
6 Mr Cross in autumn 2018. It was a particularly busy
7 time in my practice and I -- I made no note of it and
8 was supplied with no note of it.
9 **Q.** Yes. You have had no contact with
10 Stephen Cross since 2019?
11 **A.** No, not -- he telephoned me to let me know he
12 was retiring and I have referenced that in the statement
13 and subsequent to that, I have no recollection of having
14 any contact with him.
15 **MR BAKER:** Okay. Thank you, my Lady, I have no
16 more questions.
17 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
18 **MS LANGDALE:** No further questions from me,
19 my Lady.
20 **LADY JUSTICE THIRLWALL:** Thank you very much, and
21 I have no questions for you, Mr Browne. Thank you for
22 coming to give your evidence and you are free to go.
23 **A.** Thank you.
24 **LADY JUSTICE THIRLWALL:** I think we are going to
25 move to the next -- no, we are going to have some

1 statements read, thank you.
2 Statements read by MS BROWN
3 **MS BROWN:** My Lady, Dr Wood and Dr Ogden were asked
4 to provide additional statements to the Inquiry to deal
5 specifically with their evidence to the Coroner in
6 relation to the Inquest of Child A and I will now read
7 extracts from their statements.
8 Extract from the statement of Dr Christopher Mark
9 Wood, dated 10 November 2024.
10 "I have been asked to explain my involvement in the
11 Inquest into the death of Child A. My understanding of
12 why an Inquest was taking place was that it was to
13 investigate the cause of death which I vaguely recall
14 was unclear.
15 "This was the first and only Inquest that I have
16 attended. The pre-Inquest meeting and Inquest took
17 place after I had left the Countess of Chester Hospital.
18 "I recall visiting the hospital after I had left
19 which must have been for this pre-Inquest meeting but do
20 not recall any specifics of the meeting itself and have
21 no written notes from this.
22 "I have been asked to consider the following
23 specific events as recorded in the notebook of
24 Joshua Swash.
25 "I recall having a hard copy of the pre-Inquest

1 bundle which I believe contained all the statements and
2 medical records. I do not have a copy of that
3 pre-Inquest bundle.
4 "Whilst working at the Countess of Chester Hospital
5 I recall being aware that the neonatal unit had a higher
6 than usual mortality rate. At the time, I recall
7 thinking that this might have been due to the types of
8 patients being cared for, but as a junior doctor, would
9 not have been involved in those discussions. I was not
10 aware of any concerns regarding deliberate harm by
11 a member of staff until they were in the media.
12 "I was not aware of any external investigations
13 being undertaken into the mortality rate until they were
14 mentioned by Dr Jayaram as part of the Inquest process.
15 I do not recall ever having discussions with
16 Stephen Cross, Claire Raggett, Ian Harvey or
17 Louis Browne about this Inquest. I do not believe that
18 I knew at the time who they were, only being aware of
19 their identities now following media coverage.
20 "I recall that Joshua Swash was probably the
21 Trust's representative from the legal department. I do
22 not recall any discussions with him.
23 "I do not recall it being suggested by anyone,
24 whether expressly or implicitly, that the Coroner should
25 not be told about the concerns relating to Letby.

1 "I cannot comment on the attitude of Stephen Cross
2 or Louis Browne in relation to the Coroner being made
3 aware of the concerns relating to Letby.
4 "My understanding of Dr Jayaram's attitude in
5 relation to the Coroner being made aware of the concerns
6 relating to Letby is based on the evidence he gave at
7 the Inquest. I recall the gist of his evidence focusing
8 on how genuinely interested he was in getting to the
9 bottom of what was going on. My impression was that he
10 did not like being unable to give the parents and
11 Coroner an answer about how Baby A had died and he
12 seemed to have a genuine willingness to look at all
13 possibilities. I was not aware that he had any concerns
14 about any specific members of staff, however.
15 "I am aware of Dr Saladi's name but cannot recall
16 any details about his attitude in relation to the
17 Coroner being made aware of the concerns relating to
18 Letby."
19 Then he turns to the pre-Inquest meeting of
20 8 September 2016:
21 "As recorded in Joshua Swash's notebooks,
22 I attended a pre-Inquest meeting on 8 September 2016.
23 I vaguely recall attending this but do not remember any
24 detail. I have a vague recollection of colleagues
25 attending, but do not know who. I believe that the

1 purpose of the meeting was to support us as witnesses
2 through the Inquest. This was the first and only
3 Inquest I have attended. I believe we were told about
4 the process at the Inquest that we would read our
5 statements and then be asked questions about the medical
6 care provided."
7 I will now read extracts from the witness statement
8 of Dr Sally Rebecca Ogden dated 11 November 2024.
9 "Inquest into the death of Child A.
10 "My understanding of why an Inquest was taking
11 place was due to Child A's death being unexplained.
12 When I was asked to write my statement for the Inquest
13 I believe I was given a copy of the medical notes for
14 Child A. I recall receiving a communication inviting me
15 to a meeting to prepare for the Inquest. I cannot now
16 find what I presume was an invitation via email.
17 I recall attending at the Countess of Chester Hospital
18 and sitting in a room with a number of other junior
19 doctors with whom I had worked on the neonatal unit.
20 "I believe the others that might have been present
21 were Drs Lambie and Wood, but I cannot now remember.
22 I have located a copy of the Inquest preparation
23 pack that I believe I was given. I exhibit this.
24 I have reviewed the handwritten notes of the meeting
25 which I understand was made by Joshua Swash. This does

1 not record those in attendance or the date. I recall
2 someone was present from the Trust's legal team but I do
3 not recall Joshua Swash, Stephen Cross or Louis Browne
4 specifically. I do not recall making my own notes.
5 I do not recall receiving any briefings from the
6 meeting. I do not recall receiving any briefings before
7 the meeting.
8 "I was not aware of any suspicions or concerns
9 about a particular member of staff at that time. I was
10 aware that there had been a number of deaths that were
11 higher than expected for the unit but I was not aware of
12 any issues beyond that, investigations being undertaken,
13 for example.
14 "I left the Countess of Chester in September 2015.
15 "I only recall attending one meeting to prepare for
16 the Inquest. I recall that the purpose was to explain
17 the Inquest process, what would happen on the day and
18 discuss the issues we might be asked about. My main
19 involvement related to the insertion of a UVC.
20 "I do not recall the detail of any discussions
21 I might have had with Stephen Cross, Claire Raggett,
22 Joshua Swash, Ian Harvey or Louis Browne. I do not
23 believe I knew who they specifically were. I do not
24 recall it being suggested by anyone, whether expressly
25 or implicitly, that the Coroner should not be told about

1 the concerns relating to Letby. I was not aware of them
2 at the time.
3 "I am unable to comment on the attitude of
4 Stephen Cross, Louis Browne, Dr Jayaram or Dr Saladi's
5 attitude in relation to the Coroner being made aware of
6 the concerns relating to Letby."
7 Dr Ogden continues:
8 "The focus of my evidence at the Inquest was the
9 UVC insertion. It was mispositioned and I had asked
10 a trainee to replace it. Most of the questions at the
11 Inquest focused on the technicality of this. I have
12 been provided with an email from Sarah Harper-Lea to
13 myself dated 19 May 2016. The email trail begins on
14 12 April 2016 and asks for clarification on the UVC
15 insertion. I reply with a clarification on
16 26 April 2016 advising that for the first insertion,
17 both Dr Teresa McCarrick and I scrubbed to insert the
18 line as I was teaching her how to do this and that
19 I would therefore say it was inserted jointly.
20 I clarify that the second was inserted by Dr McCarrick.
21 "The final email in the trail is from 19 May 2016
22 which attaches my statement for the Inquest and asks
23 whether I have posted a signed version to the Legal
24 Services Team. This is the only email that I have sight
25 of in relation to Child A's Inquest. At the time I was

1 not aware of any suspicions regarding any member of
2 staff."
3 Mr Swash, Legal Services Assistant at the Countess
4 of Chester, was also asked to provide a statement to the
5 Inquiry and again I will read extracts.
6 Extracts from the witness statement of Joshua
7 Anthony Swash dated 12 November 2024:
8 "I have been asked to explain my role as a Band 3
9 Legal Services Assistant (Inquests) at the Countess of
10 Chester Hospital in July 2016. I started in that role
11 on Monday, 6 June 2016 for induction, joining the legal
12 team on Wednesday, 8 June 2016.
13 Mr Swash continues:
14 "I was responsible for the day-to-day management of
15 any Inquests that had been notified to the Trust. I was
16 not specifically allocated Baby A's Inquest but would
17 work on all Inquests involving the Trust. I understood
18 that an Inquest was taking place because the cause of
19 Baby A's death was unknown. The Inquest had been opened
20 and notified to the Trust before my employment began.
21 "I do not recall being given any specific form of
22 briefing about this Inquest. I do not recall ever
23 receiving a briefing ahead of an Inquest but would
24 receive the information and requests sent by the Coroner
25 which we would then action to collate the required

1 evidence and statements.
2 "I understood that Louis Browne was instructed by
3 Stephen Cross. We normally instructed the Trust
4 solicitors via the then NHSLA's Inquest Funding Scheme,
5 it may have been that because this was a fairly last
6 minute instruction that Stephen Cross decided to
7 instruct Louis Browne. The Trust's approach to legal
8 representation at Inquests was only to do so if the
9 Family had instructed legal representation.
10 "Once it had been established that the Family of
11 Baby A had instructed legal representation as per the
12 email of Denise Millard, the Trust would have then
13 instructed legal representation. This is referenced in
14 the email from Heidi Douglas. Stephen Cross knew
15 Louis Browne personally. I do not know how.
16 "The first time I became aware of issues about
17 Letby was when Stephen Cross asked me to check a set of
18 medical records to see if she was involved. I cannot
19 now recall the date and I do not know why this request
20 was made.
21 "I was aware something was going on as it was
22 discussed in the pre-Inquest meetings as described
23 below. I understand that investigations were being
24 undertaken into a rise in mortality rates on the
25 neonatal unit. Having reviewed the available emails,

1 I can see that I emailed Ian Harvey directly about
2 Baby A in Stephen Cross's absence. In this email I call
3 him 'Mr Harvey'; I think that this was the first time
4 I contacted him due to the formality of my addressing of
5 him."
6 Mr Swash goes on:
7 "I do not recall any discussions with
8 Claire Raggett about Letby, the rise in mortality rates
9 or the Inquest into the death of Baby A. I would speak
10 to Claire Raggett only as a go-between to speak to
11 Stephen Cross. I wouldn't necessarily have recorded
12 those discussions in writing in my notebooks.
13 "I have been asked to explain all discussions I had
14 with Ian Harvey about Baby A's Inquest. I do not
15 believe I had made Ian Harvey's acquaintance until
16 27 September 2016 when I emailed him at the request of
17 Stephen Cross which forwarded an email that had been
18 sent to counsel, Louis Browne, that day.
19 "The email also advised him that Letby had been
20 involved in the care of Baby A. I advised Ian Harvey in
21 this email that Stephen Cross was going to speak with
22 counsel, Louis Browne about disclosure to the Coroner on
23 this matter. I have been unable to find any email
24 response from Ian Harvey.
25 "I do not recall any discussions with Louis Browne

1 outside of formal pre-meets. I would not have spoken to
2 him directly as part of my role unless to make
3 logistical arrangements. Any communication with him
4 would have been by email. Stephen Cross led all
5 discussions with Louis Browne.
6 "I do not recall it being suggested by anyone,
7 expressly or implicitly, that the Coroner should not be
8 told about the concerns relating to Letby. I cannot
9 comment on the attitude of Louis Browne, Ian Harvey,
10 Stephen Cross, Dr Saladi or Dr Jayaram towards the
11 Coroner being made aware of the concerns relating to
12 Letby as I do not recall any discussions about that
13 beyond what is written in my notebook.
14 "I can picture the pre-meetings taking place in my
15 mind but not the detail of any discussions. My role was
16 to deal with logistics such as transport for the
17 Inquest, arrange pre-meets and make a note."
18 Mr Swash then continues to deal with the
19 pre-Inquest meeting on 6 October 2016:
20 "The pre-Inquest meeting on 6 October 2016 was
21 a telephone conference and those that attended or
22 dialled in were Stephen Cross, Louis Browne,
23 Dr Ravi Jayaram, Dr Murthy Saladi, Dr David Harkness and
24 Dr Teresa McCarrick.
25 "I have been asked to explain the following entries

1 made at the pre-Inquest meeting to prepare for the
2 Inquest and support witnesses.
3 "'Not anticipating any difficulties', which appears
4 to be attributed to Louis Browne, this will likely have
5 been said by Louis Browne. This was his opinion on
6 whether he expected any difficulties at the Inquest.
7 "'Listed for a half day. Coroner believes issues
8 are relatively discrete', which appears to be attributed
9 to Louis Browne. Similar to above this will likely have
10 been said by Louis Browne to signify to witnesses that
11 the length of time the Coroner had set aside in his
12 opinion was indicative of the Coroner believing the
13 issues were relatively discrete.
14 "'Mention of line and replacement, did it have any
15 impact.' This appears to be attributed to Louis Browne.
16 I think this was simply Louis raising the next topic of
17 conversation.
18 "'Still to this day Ravi doesn't know why this
19 happened in 27 years in paediatrics, never seen this
20 kind of situation.' This is my note-taking of what
21 Dr Ravi Jayaram would have said at the pre-Inquest
22 meeting, namely that he had never seen this kind of
23 situation before in 27 years in paediatrics. My
24 recollection is that he was referencing the
25 circumstances surrounding Baby A's death.

1 "'If you don't know the answer, say, no
2 speculation, we can't say.' This comment would have
3 been made by either Louis Browne or Stephen Cross. This
4 was not an unusual comment to be made at pre-Inquest
5 meeting during my time in the role. An Inquest is
6 a fact-finding inquiry and therefore witnesses would be
7 advised to stick to the facts. To demonstrate this
8 point, Stephen Cross would regularly give the example of
9 an ICU [Intensive Care Unit] Consultant who is asked
10 a simple 'yes' or 'no' question by the Coroner and was
11 still in the witness box an hour later.
12 "'Dr Saladi, Coroner asked how did it inform future
13 practice. Review Royal College of Paediatrics pattern
14 of death appear unusual. Further inquiry required,
15 forensic review. Is aware we have had a review but not
16 that we are having further reviews. Review is outside
17 of the remit of your knowledge, then say so. Don't say
18 anything unless you know review is ongoing.' These are
19 my notes in regard to Dr Saladi's question and the
20 subsequent response which would have been made by
21 Louis Browne or Stephen Cross. The advice given to
22 Dr Saladi was that there had been a review. This had
23 identified a pattern of death which was unusual and that
24 further inquiry/forensic review was required.
25 "I cannot be certain who is aware we had a review

1 but not that we are having further reviews is
2 referencing.
3 "The Inquest hearing. The Inquest hearing took
4 place on 10 October 2016. I do not recall any
5 discussions before or after the hearing in relation to
6 the concerns about Letby. I do not recall her name
7 being specifically mentioned during preparations for the
8 Inquest. The only time I was made aware of her name was
9 when Stephen Cross asked me to review the set of medical
10 notes referred to above. I do not recall feeling at any
11 time that any answer given by any witness was misleading
12 or was capable of misleading the Coroner connected to
13 the concerns about Letby.
14 "Had I been concerned I would have raised it with
15 my line managers. I was not aware of all of the
16 information which was being dealt with by Stephen Cross
17 and the Trust's Executives."
18 That concludes the reading of those extracts.
19 **LADY JUSTICE THIRLWALL:** Thank you very much,
20 Ms Brown.
21 Mr De La Poer.
22 **MR DE LA POER:** My Lady, thank you the next witness
23 for today is Mr Alan Moore, please.
24 **LADY JUSTICE THIRLWALL:** Thank you, is Mr Moore
25 here?

1 Do come forward, Mr Moore.
2 MR ALAN MOORE (sworn)
3 Questions by MR DE LA POER
4 **LADY JUSTICE THIRLWALL:** Do sit down.
5 **A.** Thank you, my Lady.
6 **MR DE LA POER:** Please could you give us your full
7 name?
8 **A.** Alan Gordon Moore.
9 **Q.** Mr Moore, is it correct that you provided to
10 this Inquiry a witness statement dated 16 May of this
11 year?
12 **A.** That's correct.
13 **Q.** Is the content of that witness statement true
14 to the best of your knowledge and belief?
15 **A.** It is.
16 **Q.** Dealing with your background first. Did you
17 qualify as a solicitor in 1989?
18 **A.** I did, yes.
19 **Q.** Did you then become an officer in the
20 British Army serving in the Army Legal Services branch?
21 **A.** I did.
22 **Q.** Did you retire at the rank of colonel after
23 23 years of service?
24 **A.** Correct.
25 **Q.** Were you appointed Assistant Coroner in

1 Cheshire in 2009?
2 **A.** I was.
3 **Q.** And were you one of two Assistant Coroners
4 supporting the Senior Coroner Mr Nicholas Rheinberg?
5 **A.** I was one of a number of Assistant Coroners,
6 perhaps five.
7 **Q.** In terms of the role of Assistant Coroner, was
8 that a full-time position?
9 **A.** No. I worked on designated days each week.
10 **Q.** Completing your CV, did you become the
11 Senior Coroner for Cheshire on 10 March 2017?
12 **A.** That's correct.
13 **Q.** Did you retire from that position in June of
14 2022?
15 **A.** I did.
16 **Q.** Now, just to clear up some of the language
17 that we see used. Do you recognise that on some
18 occasions, people have described you as the Deputy
19 Senior Coroner?
20 **A.** That's right.
21 **Q.** That wasn't formally your title, but you
22 recognise that on those occasions it's you who is being
23 referred to?
24 **A.** Yes. Mr Rheinberg, the Senior Coroner at the
25 time, nominated me as his deputy but it was a nomination

1 rather than a formal appointment.
2 **Q.** Now, as you are the first of the two Coroners
3 that the Inquiry is going to hear from, I wonder if we
4 can just briefly introduce the Coronial process?
5 **A.** Yes.
6 **Q.** We will begin, just if you don't mind, please,
7 by giving us a summary of what a Coroner is and what
8 their function is?
9 **A.** Of course. Coroners are independent judicial
10 officers. Their legal powers are derived from statute,
11 they have a statutory duty to investigate certain
12 deaths, namely where the deceased died a violent or
13 unnatural death, where the cause of death is unknown or
14 where the deceased died in custody or otherwise in state
15 detention.
16 There is, I should say, something of
17 a misconception about the role of a Coroner. The public
18 don't often understand the role particularly well. It's
19 worth making clear that a Coroner doesn't investigate
20 criminal offences and has no power to make
21 a determination which would appear to determine an issue
22 of criminal liability on the part of any named
23 individual or to determine an issue of civil liability.
24 So the Coroner's legal duties are quite narrowly
25 defined by statute.

1 **Q.** As part of that duty, where a relevant case
2 and we will come to the procedure as to how it arrives
3 to this point. But where a relevant case is before
4 a Coroner, is the Coroner expected, where possible, to
5 identify the cause of death?
6 **A.** Yes.
7 **Q.** Is that cause of death a formal, national
8 recording in relation to that individual, in other words
9 that is the official record of the cause of death?
10 **A.** Yes.
11 **Q.** So does it follow from that, and perhaps
12 obvious, that it is extremely important that that is
13 right?
14 **A.** Indeed, yes.
15 **Q.** Now, in terms of the procedure as to how
16 a particular individual's death may come before
17 a Coroner, you deal with this at your paragraphs 9 and
18 following, and this is the process specific to Cheshire
19 during the period we are focused on, is that right?
20 **A.** That's correct.
21 **Q.** So is the expected beginning of the journey of
22 that individual's case to the Coroner that a doctor will
23 contact the Coroner's office?
24 **A.** In the case of a hospital death, it would be
25 a doctor.

1 **Q.** What, at that first stage, is a doctor
2 expected to communicate to the Coroner's office?
3 **A.** Well, in the first place the doctor would not
4 contact the Coroner directly. The doctor would contact
5 a Coroner's officer within the Coroner's office and the
6 doctor would report the death to the Coroner's officer
7 and would provide details of the deceased person, in
8 this case the deceased child, that would include the
9 circumstances of the death, the clinical picture, the
10 clinical information from the doctor and the doctor's
11 assessment of the medical cause of death if a doctor
12 were able to give one. And that's not always the case.
13 **Q.** So at that point, once that initial
14 information is provided, is that individual's case then
15 going to be set upon a number of potential pathways
16 depending on the nature of the information?
17 **A.** Correct.
18 **Q.** Now, you deal with these different options at
19 your paragraph 11. If the reporting doctor is confident
20 of a naturally occurring death, to what extent would the
21 Coroner be involved?
22 **A.** Well, the Coroner's officer would report the
23 death to the Coroner. Following on from what we have
24 just discussed, the Coroner's officer would send a form
25 called, in Cheshire, called an HMC1, which would contain

1 all of the information that I described to you. So the
2 Coroner would get to see that form.
3 The Coroner's officer would also speak directly to
4 the Coroner about the death that's been reported and if
5 the reporting doctor was able to offer a naturally
6 occurring cause of death and was confident of that, and
7 if the Coroner had made all necessarily -- forgive me --
8 all necessary preliminary enquiries in relation to that
9 death the Coroner would issue what's called a form 100A
10 and that would end the Coroner's involvement in the
11 case.
12 **Q.** Now, the next potential scenario, and we are
13 again just speaking generally here, would be the
14 circumstances in which a doctor is not able confidently
15 to offer a cause of death.
16 What options are available at that stage?
17 **A.** In, in such a case, the Coroner would direct
18 a postmortem examination to take place carried out by
19 a pathologist in order to establish what was the cause
20 of death.
21 In the case of a neonatal death, that postmortem
22 examination would be carried out by a paediatric
23 pathologist.
24 **Q.** In the event that the pathologist is able to
25 offer a cause of death which would be described as

1 natural, what then?
2 **A.** Well, again, if the pathologist provided
3 a natural cause of death and, following all preliminary
4 enquiries by the Coroner, the Coroner was happy with
5 that cause of death as being natural, and there were no
6 concerns regarding medical care or treatment then a form
7 100B would be issued and that would end the Coroner's
8 involvement in the case.
9 **Q.** Now, we have used the phrase "natural death".
10 It's perhaps important to understand what unnatural
11 death might encompass. Plainly, it encompasses
12 deliberately caused death or murder?
13 **A.** Absolutely.
14 **Q.** But does it also encompass matters which are
15 perhaps not as serious as that; in other words,
16 occasions where medical care may have been deficient --
17 **A.** (Nods)
18 **Q.** -- or other scenarios such as that?
19 **A.** Indeed. Clinical mismanagement and matters of
20 that nature, yes.
21 **Q.** So the fact that a death for a Coroner might
22 be described or suspected as being unnatural, it doesn't
23 follow that it is immediately moving to thoughts of that
24 person must have been murdered?
25 **A.** Absolutely not. That's correct.

1 **Q.** In the event that the postmortem and the
2 pathologist who's conducted it cannot offer a natural
3 cause of death, what then for the Coroner?
4 **A.** Well, excuse me. What would then happen is
5 the Coroner would likely open what's called a Coroner's
6 investigation. And I should say that in, in most cases
7 where the deceased is a baby -- and I have already said
8 the paediatric pathologist would be carrying out the
9 postmortem -- that paediatric postmortem examination and
10 the subsequent report can take many, many weeks,
11 sometimes months because the pathologist will also often
12 carry out other investigations such as microbiology,
13 toxicology, virology and investigations of that nature.
14 So it takes a long time.
15 So the Coroner would open an investigation pending
16 the outcome of that postmortem examination and the cause
17 of death would be described in the interim as
18 "withheld".
19 **Q.** So if, at the end of that postmortem
20 investigation stage, there is no natural cause of death
21 or there is concern that the death may not be natural,
22 what then?
23 **A.** If there is a concern that the death may not
24 be natural then the case would proceed to Inquest. An
25 Inquest would be opened.

1 **Q.** So far as Inquest is concerned, is the end
2 point of an Inquest that there will be an oral hearing
3 which the Coroner will preside over and reach
4 a conclusion at the end of it?
5 **A.** That's absolutely correct. There is one, if
6 I may, there is one element we may have missed out.
7 It's if the Coroner's investigation leads to
8 a postmortem examination which -- forgive me --
9 a postmortem examination report which reveals a natural
10 cause of death and there are no concerns regarding care
11 and treatment the Coroner would discontinue the
12 investigation rather than proceeding to the Inquest.
13 **Q.** I understand.
14 **A.** Just for completeness.
15 **Q.** So those are the procedures available in any
16 given case.
17 **A.** Yes.
18 **Q.** I am going to turn now to look at your
19 involvement in the deaths of the children named on the
20 indictment, which you deal with at paragraphs 14 and
21 following.
22 The first point, just to remind everybody, I am
23 sure that you would agree with this, Mr Moore, is that
24 when you are dealing with these cases, up until 10 March
25 of 2017, you are doing so as an Assistant Coroner

1 effectively on a part-time basis supporting
2 Mr Rheinberg, is that correct?
3 **A.** That's correct, yes.
4 **Q.** So Child A., did you open and adjourn an
5 Inquest on 23 December 2015?
6 **A.** I did, yes.
7 **Q.** Child D, did you open a Coroner's
8 investigation on 26 June of 2015?
9 **A.** Yes.
10 **Q.** And did you subsequently and immediately
11 adjourn an Inquest on 8 January 2016?
12 **A.** That's correct.
13 **Q.** Was Mr Rheinberg the person with overall
14 responsibility for investigation of Child D's death?
15 **A.** That's correct. My involvement was the two
16 procedural stages; namely, to open the investigation and
17 then subsequently to open the Inquest.
18 **Q.** The Inquest hearing was scheduled in Child D's
19 case before you as then the Senior Coroner on 25 May of
20 2017, is that right?
21 **A.** That's correct. Mr Rheinberg had prepared the
22 case for Inquest, he had prepared the witness list and
23 dealt with all of the disclosure and he was attempting
24 to hear the Inquest before he retired. Unfortunately,
25 he wasn't able to do that, so he handed me the file and

1 the case had been set down for hearing on the date you
2 just mentioned.
3 **Q.** In fact, that hearing never took place because
4 on 3 May, so some 22 days before it was scheduled to be
5 heard, you were notified of a police investigation, is
6 that right?
7 **A.** That's correct.
8 **Q.** Just help everybody to understand this. Is it
9 appropriate for an Inquest to take place in the event
10 the police are investigating a death?
11 **A.** No.
12 **Q.** So is the inevitable response to learning that
13 a police investigation is taking place for an Inquest to
14 be suspended or adjourned?
15 **A.** That's correct, so as not to prejudice any
16 criminal investigation or subsequent criminal
17 proceedings.
18 **Q.** At the conclusion of a police investigation,
19 are there circumstances in which the case will be
20 re-opened or continued once the outcome of any criminal
21 proceedings are concluded?
22 **A.** That's correct, that can be the case, yes.
23 **Q.** So that's Child D.
24 In the case of Child I, was Child I's death
25 reported to you on 23 October of 2016 upon which you

1 directed that a postmortem take place?
2 **A.** I -- I think it was 23 October 2015.
3 **Q.** '15, my mistake. That's an error in my notes.
4 2015?
5 **A.** No problem.
6 **Q.** Finally, in relation to Child O and Child P,
7 did you open an investigation on 30 June of 2016?
8 **A.** I did in respect of both children, yes.
9 **Q.** And did the case then proceed under the
10 stewardship of Mr Rheinberg until you became the
11 Senior Coroner on 10 March?
12 **A.** That's correct.
13 **Q.** And have you seen -- and we will hear on
14 Friday from Mr Rheinberg -- correspondence to the effect
15 that in the course of the period that Mr Rheinberg was
16 managing the investigations into Child O and Child P's
17 deaths, that he had been minded to close those
18 investigations but in fact by the time that you became
19 Senior Coroner they were still live investigations and
20 you took them over?
21 **A.** That's correct. He was, he was minded to
22 discontinue the investigation, to use the correct term.
23 But you're absolutely right, yes.
24 **Q.** As with the case of Child D, upon being
25 informed on 3 May of the police investigation, did you

1 suspend the Coroner's investigation?
2 **A.** I did in both cases for the -- for the same
3 reason that we discussed in relation to the other case,
4 so as not to prejudice the police investigation.
5 **Q.** Turning to your communication with staff from
6 the Countess of Chester Hospital.
7 **A.** Yes.
8 **Q.** The first event that I wish to ask you about
9 is a telephone call from Stephen Cross, which I think we
10 can date as some time around the 6, 7 or 8 July?
11 **A.** I -- I don't remember the exact date, but
12 I wouldn't dispute that.
13 **Q.** No, we have some notes to that effect.
14 **A.** Yes.
15 **Q.** Now, were you the intended recipient of that
16 call?
17 **A.** No.
18 **Q.** Who was?
19 **A.** Mr Rheinberg.
20 **Q.** But was it the position that Mr Rheinberg
21 wasn't available?
22 **A.** That's correct, he wasn't in the office.
23 **Q.** So doing the best you can, just tell us what
24 Mr Cross told you in the course of that telephone call?
25 **A.** Sure. The admin staff put the call through to

1 me and they said, "There's a call for Mr Rheinberg, he
2 is not here. Will you take it?" "Yes", I said. I took
3 the call. Mr Cross introduced himself as the director
4 of Corporate and Legal Services.
5 I didn't know Mr Cross prior to that. He indicated
6 that the Countess of Chester Hospital had experienced
7 a number of neonatal deaths in, in recent times and that
8 the Trust had therefore commissioned an independent
9 review by the Royal College of Paediatrics and Child
10 Health. He said the review would look at the neonatal
11 unit and he said, "We will send a copy of the report
12 once it's available through to Mr Rheinberg."
13 **Q.** Now, we know that a driving factor behind the
14 RCPCH review was the fact that the Consultants raised
15 concerns in a number of meetings that they had suspicion
16 that a member of staff may be responsible for some or
17 all of the deaths.
18 Was that information communicated to you by
19 Mr Cross?
20 **A.** No.
21 **Q.** Just to consider that. If, if you had been
22 told that, what, if anything, would have been your
23 reaction?
24 **A.** Well, I wouldn't have waited for
25 Mr Rheinberg's return. I would have explored exactly

1 what the concerns were that Mr Cross or the Trust or
2 both had and, if necessary, would have spoken with the
3 police.
4 **MR DE LA POER:** Now, there's one further meeting to
5 ask you about, Mr Moore. We will need to take a little
6 more time over it. My Lady, I wonder if this might be
7 a convenient moment.
8 **LADY JUSTICE THIRLWALL:** Yes, certainly. So we
9 will take the break now and we will start again at
10 2 o'clock.
11 **(1.00 pm)**
12 **(The luncheon adjournment)**
13 **(1.59 pm)**
14 **LADY JUSTICE THIRLWALL:** Do sit down.
15 **MR DE LA POER:** Mr Moore, we are going to move
16 forward in time from early July 2016 to a meeting on
17 15 February of 2017. Before we come to the detail of
18 that, obviously you had been told about the RCPCH report
19 the previous year.
20 Do you think that by the time you came to that
21 meeting on 15 February you had seen a copy of that
22 report?
23 **A.** No, I hadn't.
24 **Q.** Had you before that meeting been given any
25 other information about the Countess of Chester, how

1 their investigations were progressing, or anything like
2 that?
3 **A.** No. The only information I had was that in
4 the summer of 2015, Mr Rheinberg had taken a death
5 report where he had noticed from the text on the death
6 report form that there had been three deaths in a very
7 short period of time and then subsequent to that the
8 information about the report -- forgive me, the review
9 having been commissioned. That's all.
10 **Q.** So to some degree you went into that meeting
11 cold, is that fair to say, in terms of the issues that
12 were about to be discussed?
13 **A.** Absolutely, yes.
14 **Q.** Now, we are going to look at firstly an email
15 that you sent about that meeting close to the time.
16 This is to be found at INQ0002048, at page 110. As that
17 will come up on your screen in a moment, but --
18 **A.** Yes, I have it.
19 **Q.** As you will understand, what was or was not
20 said at that meeting is a matter of some importance so
21 we will begin by looking at your record of that meeting
22 on 3 May, so about two and a half months later and
23 I will just draw your attention, please, to the second
24 paragraph.
25 You say:

1 "On 15 February this year Mr Rheinberg met with
2 Dr Harvey, Medical Director at the Countess of Chester
3 Hospital (COCH), and Stephen Cross its Director of
4 Corporate and Legal Services. The meeting, which was
5 held at the coroner's office, had been called by
6 Dr Harvey and Mr Cross. I was asked to join in part way
7 through the meeting.
8 "Briefly, Mr Cross referred to a number of neonatal
9 deaths at the Countess of Chester. Seemingly there had
10 been some form of 'internal' reviews by the COCH. There
11 had also been an external review by the Royal College.
12 "Following these reviews clinicians from the
13 neonatal unit at the COCH had written to the Chief
14 Executive of the COCH, aggrieved regarding some of the
15 findings. They asked whether the Coroner could hold an
16 Inquest in each case.
17 "Mr Rheinberg explained that the Coroner may only
18 hold an inquest where he has jurisdiction to do so, in
19 other words where there are proper legal grounds to hold
20 an inquest. The inquest process, he said, is not a form
21 of governance for the hospital trusts and the like."
22 Then you go on to say what happened following the
23 meeting.
24 Now did you refresh your memory from any notes or
25 records before you wrote this or was this just from your

1 recollection at that time?
2 **A.** I believe it was from my recollection at that
3 time.
4 **Q.** Now, I am sure you will identify with this,
5 one matter that you haven't included in that email is
6 any suggestion made to you and Mr Rheinberg that
7 a member of staff had been identified as being
8 potentially responsible for some or all of the deaths?
9 **A.** Yes.
10 **Q.** Do you agree? That's not there in your
11 summary, is it?
12 **A.** No, it's not.
13 **Q.** So we will move on from that note and we will
14 come to a note which the Inquiry understands was made by
15 Mr Rheinberg at or very close to the time. This is at
16 page 102 of the same document. Is that a document you
17 recognise from your preparation for this Inquiry?
18 **A.** Yes, yes.
19 **Q.** Are we right in understanding that "AGM",
20 which we see in the top line, will be a reference to
21 you?
22 **A.** That's correct.
23 **Q.** Now, it may not be an important point, but in
24 your email a couple of months later you indicated that
25 you attended the meeting part way through. This record

1 doesn't appear to acknowledge that fact or draw
2 attention to it because it begins with you and
3 Mr Rheinberg attending the meeting.
4 Doing the best you can, do you think you did attend
5 late or that you didn't, or can you just not say now?
6 **A.** I have thought about this. My recollection is
7 that I was called into the meeting by Mr Rheinberg in
8 the sense of: oh, I am having a meeting, would you come
9 and join us in that sense.
10 So I can't say how long the meeting had been going
11 on when I joined.
12 **Q.** Does that recollection tend to suggest that it
13 was a spontaneous decision once the meeting had been
14 convened for you to join?
15 **A.** That is my recollection, yes.
16 **Q.** Before we come to the detail of this, what was
17 your understanding about why you were invited to join
18 that meeting?
19 **A.** To be honest, I don't know. My assumption was
20 afterwards that Mr Rheinberg felt that as he was due to
21 retire quite shortly after this meeting, some weeks
22 after this meeting, he thought it might be prudent for
23 me to attend, but that's just my assumption.
24 **Q.** But at all events were you happy to follow the
25 request made of you by the Senior Coroner and join the

1 meeting?
2 **A.** Yes, I was, yes.
3 **Q.** So let's turn and have a look at some of the
4 details here. At item 1 towards the top:
5 "Letter of 15 February 2017 handed to me with
6 enclosures."
7 Now, "me" will be Mr Rheinberg because this is his
8 note.
9 Do you recall whether there was a copy of those
10 materials for you or not?
11 **A.** My recollection is that there wasn't, I don't
12 recall seeing any documentation at that meeting.
13 **Q.** We will have a look at what documentation was
14 handed over because we have a cover letter and that
15 documentation. Do you think at any point after this
16 meeting you saw that documentation or any of it?
17 **A.** I have seen the documentation in preparing to
18 give evidence at this Inquiry. Yes.
19 **Q.** But at the time when you were either Assistant
20 Coroner or Senior Coroner, do you think you saw that
21 material?
22 **A.** I don't believe so.
23 **Q.** Well, we will have a look at it just to work
24 through it briefly, but it may be that that is the
25 resting position we reach.

1 So item 2 refers to:
2 "... a bundle of in-depth reviews into the baby
3 deaths in question and towards the end of the bundle is
4 a sheet indicating which reviews relates to which baby.
5 In the case of each review a document will be expanded
6 and written in an easily comprehensible form to be
7 delivered to the parents. We will be given a copy."
8 Now, do you have any recollection of having
9 received a document after this meeting, which is a more
10 easily comprehensible form of the review that is being
11 spoken about?
12 **A.** I don't. I can -- I can possibly speculate
13 but I don't want to do that.
14 **Q.** Well, if you don't have a recollection, you
15 don't have a recollection --
16 **A.** No.
17 **Q.** -- and that will be where we reach.
18 **A.** Very well.
19 **Q.** The note in the unnumbered paragraph then goes
20 on to talk about a letter which had been written to the
21 Chief Executives as -- and that that was one of the
22 enclosures. Do you recall whether the letter was
23 brought out of the bundle and that you went through it
24 or talked about its content or was it the case that the
25 bundle was to one side, and there was just an oral

1 discussion without reference to documents?
2 **A.** My recollection is that when I joined the
3 meeting, Mr Rheinberg had a bundle of hard copy
4 documents which I assumed had been provided to him by
5 either Mr Cross or Mr Harvey.
6 **Q.** Were those documents ever opened up in the
7 course of the meeting to look to any of the particular
8 documents as they are being spoken about, do you recall?
9 **A.** I can -- I can recall the letter from the
10 Consultants having been spoken about but I -- I couldn't
11 say whether Mr Rheinberg had it in front of him at the
12 time.
13 **Q.** At all events, you didn't have it in front of
14 you?
15 **A.** No.
16 **Q.** The summary given to the meeting presumably by
17 either Mr Harvey or Mr Cross was that they, ie the
18 Consultants, are asking for the Coroner to hold an
19 Inquest in each case which prompts Mr Rheinberg to draw
20 attention to the fact as per the statute that an Inquest
21 can only take place when the Coroner has jurisdiction to
22 do so?
23 **A.** (Nods)
24 **Q.** Presumably you would understand that to be
25 a reference to what we talked about this morning, ie,

1 the procedure that allows for the Coroner to take
2 control of and investigate a death?
3 **A.** Correct.
4 **Q.** It goes on, and we don't need to read all of
5 that paragraph out, but you will have refreshed your
6 memory from it with Mr Rheinberg providing some further
7 information about the function of a Coroner?
8 **A.** (Nods)
9 **Q.** Having read that now, would you agree with
10 that summary of the role of a Coroner as recorded by
11 Mr Rheinberg here?
12 **A.** Yes.
13 **Q.** So he then gives a number of examples, perhaps
14 rather like the examples that we discussed this morning
15 but the first is:
16 "Cases in respect of which an inquest has already
17 been held. If that is the case then the Coroner is
18 functus officio."
19 In other words they do not have a jurisdiction any
20 longer?
21 **A.** Correct.
22 **Q.** "Deaths, which although reported were dealt
23 with under a Part A with jurisdiction never formally
24 taken. With no body within the jurisdiction, following
25 a funeral, the Coroner could not hold an Inquest without

1 permission from the Chief Coroner which could only be
2 sought if there were proper grounds for doing so."
3 Would you agree with that as an accurate summary of
4 the position?
5 **A.** Yes.
6 **Q.** "Deaths where a natural cause of death was
7 shown following a postmortem/investigation was
8 discontinued. Should new facts emerge indicating an
9 unnatural death then an Inquest will be listed."
10 Again would you agree that is an accurate summary
11 of the law?
12 **A.** Yes.
13 **Q.** Of course those deaths already listed for
14 Inquest, which as we know at this time was Child D,
15 Child O and Child P?
16 **A.** I think Child O and Child P were still
17 Coroner's investigations.
18 **Q.** They were still investigations at that time?
19 **A.** Yes.
20 **Q.** Had not -- an Inquest had not been opened.
21 Then we have the deaths currently under
22 investigation, presumably that's a reference to Child O
23 and P then?
24 **A.** Correct, that's right.
25 **Q.** Given the word "investigation", where either

1 an unnatural cause is found, no cause is found or where
2 there is an element of neglect?
3 **A.** (Nods)
4 **Q.** Now, no doubt you would agree with 5 as far as
5 it goes. One potential circumstance which isn't
6 included is where a death was deliberately caused and
7 would you say that that could be added to that list and
8 for it still to be legally accurate?
9 **A.** Well, if a death had been deliberately caused
10 by a criminal act, the Coroner wouldn't be
11 investigating, it would be a police matter.
12 **Q.** Was there any discussion in this summary of
13 the law given by Mr Rheinberg about what ought to happen
14 if a deliberate act, so murder was suspected?
15 **A.** No.
16 **Q.** Then just completing the note, we have
17 a remark attributed to you. You asked according to the
18 note, what the clinicians hoped to achieve by seeking
19 Inquests and wondered whether there were reputational
20 motives, there being no right of appeal from the Royal
21 College's findings. That is the first bit. The next
22 bit appears to be a summary of a response.
23 So just help us. Do you have a recollection of
24 saying that?
25 **A.** I asked that question, yes.

1 **Q.** Why did you say that?
2 **A.** Well, although I hadn't seen the letter from
3 the Consultants at this meeting, it was discussed
4 between Mr Cross, Mr Harvey and Mr Rheinberg and I could
5 only gauge from the discussion that the Consultants
6 appeared to have some degree of issue with the
7 Royal College report and I didn't know exactly what.
8 And this is a letter from the Consultants to the --
9 I believe the Chief Executive at the hospital and
10 I thought this is somewhat unusual. Why would the
11 Consultants be writing to the Chief Executive?
12 So in my own mind I am asking the question: what
13 could be the motivation behind that? There must be some
14 reason. And I asked that question at the meeting.
15 And I -- I think I -- I asked: is it perhaps that
16 they have suffered reputationally from something in that
17 report which of course I hadn't seen? Or is there some
18 kind of issue that they would wish to challenge in
19 another forum? And bearing in mind that the context of
20 this meeting was asking Mr Rheinberg to conduct some
21 form of review of the neonatal deaths, including perhaps
22 holding an Inquest in those cases, as we have just
23 touched on.
24 So I was trying to get to the bottom of: what's the
25 motivation behind this?

1 **Q.** By the time that you came to make that
2 comment, had you formed any impression about the
3 attitude of either Mr Cross or Mr Harvey about the
4 Consultants or the validity of their concerns? You have
5 said that there was a discussion about their letter --
6 **A.** Yes.
7 **Q.** -- with Mr Rheinberg.
8 What we are really looking for, so far as you can
9 tell and recall, is had you formed an impression about
10 whether they thought that this was a really important
11 thing, that absolutely needed Mr Rheinberg to take
12 a grip of or that they were there reluctantly or
13 somewhere in between? Just your impression, please?
14 **A.** I follow. Somewhere in between. There was --
15 there was certainly no particular impetus one way or the
16 other. They were presenting this letter to
17 Mr Rheinberg, this request.
18 **Q.** Yes. One interpretation of the suggestion you
19 made is that you are potentially ascribing bad faith
20 motivation to the doctors, that they are wishing to
21 complain because they are worried about their
22 reputation, that's -- did you mean it in that way?
23 **A.** No, I meant it in quite a different way.
24 **Q.** Could you just explain for us --
25 **A.** Yes.

1 **Q.** -- the way in which you meant it?
2 **A.** If I can be frank, I -- I had some sympathy
3 with the Consultants. I thought -- well, there are
4 a number of Consultants apparently had signed the letter
5 and I thought, well, there must be some reason why they
6 are unhappy with the Royal College report and I was just
7 trying to establish at the meeting what that might be.
8 **Q.** So that brings us, if we just go over the page
9 here, please. As you can see that brings us to the end
10 of Mr Rheinberg's note of the meeting.
11 **A.** Yes.
12 **Q.** To the best of your recollection, is that an
13 accurate note of what was discussed?
14 **A.** It is. There's one element of this note that
15 we haven't discussed in evidence, if I may just take the
16 Inquiry to it. It's the bit where --
17 **Q.** Is it the governance remark?
18 **A.** Yes.
19 **Q.** Well, I was going to ask you about that in
20 just a moment. But, yes, in terms of the overall
21 accuracy of this note, do you think it captures the
22 substance of what was discussed?
23 **A.** I do, yes.
24 **Q.** So my question about the governance remark is
25 that that is a remark that you yourself recalled having

1 been made some two and a half months later when you are
2 emailing the police about this, because you used that
3 very same word?
4 **A.** Yes.
5 **Q.** So plainly it stuck in your recollection?
6 **A.** It did.
7 **Q.** Just tell us what was being said about
8 governance?
9 **A.** Yes. Mr Harvey and Mr Cross were essentially
10 saying to Mr Rheinberg, the Coroner: here's a letter
11 from the Consultants, they would like you to conduct
12 an -- a review of -- of these neonatal deaths.
13 He explained in some detail the legal position
14 which we have already touched on in evidence and he made
15 it clear that he had no legal powers either a) to carry
16 out some form of broad review of the deaths, that's
17 outside of his statutory powers as a Coroner; and b) he
18 couldn't revisit the cases in a Coronial context because
19 many of them had already been through the Coronial
20 process and he would have to have special reasons to do
21 that. For example, he said at the meeting: I would
22 need, for example, fresh evidence or new facts which he
23 was not already aware of to be able to prompt him to
24 revisit those cases in a Coronial context.
25 And I think the governance remark -- well, I can

1 tell you what my interpretation of it was. I think he
2 was basically saying: you are asking me to conduct
3 a review, I have no legal power to do that at all, you
4 are asking me to revisit the cases and hold Inquests,
5 I have no statutory powers as a Coroner to do that and
6 almost finally, the Coroner is not or he, Mr Rheinberg,
7 is not a form of governance for the Countess of Chester
8 Hospital to review those cases in any other form.
9 I -- I think my impression was he felt -- and you
10 can ask him of course this question, but my impression
11 was that he felt that Mr Cross and Mr Harvey and perhaps
12 the Consultants had completely misunderstood the role of
13 a Coroner and his legal powers.
14 **Q.** Now, an important question for the Inquiry is
15 whether or not you and Mr Rheinberg were told in this
16 meeting that there was a concern that a member of staff
17 may be responsible for some of the deaths or all the
18 deaths that were under discussion. We have looked at
19 your email of two months later, we have looked at this
20 note, we don't see in either of those a reference to
21 that. What is your recollection?
22 **A.** There was no mention whatsoever of anything of
23 that kind. If there had been, the outcome of this
24 meeting would have been very different, I assure you.
25 Mr Rheinberg is a very experienced, diligent and

1 thorough Coroner and I have no doubt that he would have
2 contacted the police probably before Mr Harvey and
3 Mr Cross had left the room.
4 **Q.** Had he not been immediately inclined to do
5 that, what would you have said?
6 **A.** I would have made that call.
7 **Q.** I would like to take you to an internal email
8 and what you have told us may already provide us with
9 the answer but it's important that you have the
10 opportunity to comment upon what is being said about
11 this meeting.
12 **A.** Yes.
13 **Q.** We will find that at INQ0014268 at page 2.
14 So if we go up to page 1, the relevant part is on
15 page 2 but I just want to help you understand. This is
16 an email, as we see, towards the bottom of the page from
17 Dr Gibbs one of the Consultant paediatricians?
18 **A.** Yes, I have it.
19 **Q.** Sent 24th and it is sent to Dr Jayaram, also
20 a Consultant paediatrician. And we can see that he is
21 sending Dr Jayaram an update about what he has
22 understood to be the position following various
23 discussions that he's had. And we can see in the second
24 paragraph he is saying:
25 "Managed to get to see Ian this evening -- and it

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1 was just Ian."
2 That is a reference to Mr Harvey?
3 **A.** Yes.
4 **Q.** He then sets out what he has been told in that
5 meeting as he recalls it.
6 And if we go over the page, and look at the second
7 full paragraph, what is said:
8 "Ian felt that he and Stephen Cross had made our
9 concerns clear to the Coroner. As Tony Chambers had
10 said in his letter to each of us, our letter in which we
11 gave our view that the deaths and non-fatal collapses
12 had not been adequately addressed through the two
13 reviews so far, and that we felt some of these were
14 unnatural, was given to the Coroner.
15 "Also, Ian and Stephen Cross discussed our concern
16 that one particular nurse featured more often than any
17 other nurse in the resuscitation/immediate care of the
18 deaths and collapses. Also, as we already knew, the
19 Coroner has the 'full' College review (where our
20 concerns are again covered) and also Dr Hawdon's
21 review."
22 Now, to be clear, "our concerns", as the Inquiry
23 understand them to be as at this date, is that
24 Nurse Letby may have murdered babies?
25 **A.** Yes.

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1 **Q.** Is this an accurate summary of what you were
2 told?
3 **A.** Absolutely not.
4 **Q.** Thank you. The penultimate document, or set
5 of documents, to take you to is just as I said I would
6 to Mr Cross's covering letter, just to remind you of the
7 documents that were provided. INQ0002048, so that is
8 the document we were looking at before and we will go to
9 page 34, please.
10 **A.** Yes, I have it.
11 **Q.** So we see the date, the 15th, the same date as
12 your meeting, and as the Inquiry understands it, this is
13 the letter and documents that sit behind it that were
14 handed over at the start of that meeting.
15 We can see listed are three enclosures, a report by
16 Dr Hawdon, the letter from the paediatric Consultants
17 dated 10 February that we have already covered was
18 discussed, and observations additional to the RCPCH
19 review of neonatal services at the Countess of Chester
20 Hospital.
21 I just wanted, this was obviously addressed to
22 Mr Rheinberg and rightly so, as he was the
23 Senior Coroner and you weren't at this time. But
24 I would just like to show you some features of these
25 documents to see if it prompts your recollection in any

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1 way.
2 So if we go to page 89 of this same document, we
3 will see Dr Hawdon's summary page at the conclusion of
4 her report. So this sits at page 55 of Dr Hawdon's
5 report, and we can see that at paragraph 2, she -- her
6 second group, as she describes it, is the death or
7 collapses is unexplained. It is the investigation of
8 these cases which would potentially benefit from a local
9 forensic review as to the circumstances, personnel
10 et cetera, date of first collapses noted.
11 We can see that a number of children are listed
12 there including Child A who had been the subject of
13 a full Inquest in October and Child O and Child P, both
14 of whom were at that time the subject of Coronial
15 investigation?
16 **A.** Yes.
17 **Q.** Do you think, Mr Moore, that you ever saw this
18 report in the time that you were either Assistant
19 Coroner or a Senior Coroner?
20 **A.** I -- this is Dr Hawdon's report?
21 **Q.** This is Dr Hawdon's and this is just the
22 penultimate page of it?
23 **A.** I think I might have seen it in the course of
24 preparation for the Inquest into the death of Child D.
25 But I can't be sure. I say that because it might have

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1 been placed in the file by -- by Mr Rheinberg.
2 **Q.** Do you have any recollection of reading this
3 page in particular where it is recommended that a local
4 forensic review take place in relation to four
5 particular deaths?
6 **A.** I remember hearing that there was going to be
7 further investigations by the Trust in the lead-up to
8 the Inquest into Child D because I received a letter
9 from the Trust's solicitors, very shortly before the
10 Inquest, which, as you have said, didn't take place
11 because of the police involvement. And in that letter,
12 they, they said -- forgive me, I can't quote the exact
13 words, but: our investigations are not yet complete.
14 There is still more work to do.
15 I responded by asking broadly because I didn't know
16 what they were talking about: are you seeking an
17 adjournment because we were right on top of the Inquest?
18 So I don't know whether that, that further work to
19 do might relate to this paragraph that you are showing
20 me, but I can't be sure.
21 **Q.** In terms of as a trained solicitor and person
22 who's practiced law for your entire professional career
23 in one form or another, what significance, if any, would
24 you ascribe to the use of the word "forensic" in this
25 context and the fact that "personnel", as we see later,

1 are to be the subject of that review?
2 **A.** Well "forensic" doesn't necessarily imply
3 criminal. For instance, it could -- it could mean
4 a broader, more detailed in-depth review than whatever
5 has already taken place.
6 **Q.** So does it follow from that that if you read
7 that word your brain wouldn't necessarily interpret it
8 as meaning: this person wants some kind of
9 quasi-criminal review to take place?
10 **A.** No, no, I wouldn't.
11 **Q.** We don't need to go to the Consultants' letter
12 of course. That letter expressly mentions the fact that
13 Dr Hawdon had identified four cases. So any
14 consideration of that letter would have led to the same
15 understanding that there were four children whose cases
16 were, according to Dr Hawdon, requiring a further
17 investigation.
18 The other document that was an enclosure we will
19 find at page 93. Now, this is the observations
20 additional to the RCPCH report and we can see perhaps
21 capturing part of the substance of it, the third line
22 down:
23 "Subsequently, the paediatric lead and all the
24 Consultant paediatricians had been convinced by the
25 link."

1 The link being between the deaths and the nurse
2 which we see in the preceding sentence.
3 Is this a document that you have any recollection
4 of having seen?
5 **A.** No. I have only seen this in preparing for --
6 for the Inquiry.
7 **Q.** Just so that you understand what we are
8 looking at here. The Royal College report, the
9 confidential version, had a number of passages in it
10 which were removed from the dissemination copy, there
11 were two versions of them. These are the comments that
12 marked the difference between the two versions and they
13 have been extracted into a single document?
14 **A.** I follow.
15 **Q.** If you had seen this document, would it have
16 prompted you, do you think, to do anything?
17 **A.** Absolutely. Yes.
18 **Q.** And why is that?
19 **A.** Well, it's suggesting that there may be at
20 least a suspicion that a person or persons may have been
21 responsible for a death.
22 **Q.** Just to spell it out, why is that of relevance
23 to you as Coroner?
24 **A.** Because that takes straight away from the
25 Coroner any jurisdiction to deal with the case and it's

1 a red flag to alert the police, at least for them to
2 examine it and look at it.
3 **Q.** No doubt Mr Rheinberg will be able to address
4 this on Friday, but can you think of any good reason why
5 this wouldn't have been handed over to you? Or are you
6 even able to say that it wasn't part of all of the
7 documentation that became yours when you became
8 Senior Coroner?
9 **A.** No.
10 **Q.** Is it a documentation that if Mr Rheinberg had
11 read it and appreciated its significance, that you would
12 have wanted to have drawn to your attention?
13 **A.** Yes.
14 **Q.** Thank you. That can come down.
15 At the conclusion of your statement, you say at
16 paragraph 41, page 10:
17 "The provision of timely, accurate and truthful
18 information is fundamental to the Coronial process".
19 At paragraph 42:
20 "If the Countess of Chester became aware of any
21 information which had not already been disclosed to the
22 Coroner's office that would impact upon a death, the
23 Countess of Chester would have been required to disclose
24 that information immediately."
25 Then you go on:

1 "This applies to cases which had already been
2 through the Coronial process as well as to any case that
3 was still subject to Coronial process. The Countess of
4 Chester would have been expected to notify the police
5 immediately if it had any reason to suspect that
6 a person or persons may have been criminally responsible
7 for causing a death. It goes without saying that the
8 bereaved Families ought to have been appropriately
9 informed in any of the above circumstances."
10 You have set that out. I just want to ask you
11 about this. On the one hand, there is an understanding
12 that witnesses who have taken an oath to tell the truth
13 must do so and that they must not speculate and they
14 must be scrupulously accurate. On the other hand, we
15 know here there was a body of Consultants who had
16 a sincere belief that there may be a criminal
17 explanation for these deaths.
18 Are you clear in your own mind, Mr Moore, that even
19 though it wasn't a fact, as far as they were concerned,
20 nevertheless you should have been told?
21 **A.** Absolutely. The Coronial process is
22 a judicial process. It demands complete candour from
23 healthcare professionals, clinicians, nurses and from
24 hospital staff and also from Trust management and
25 a failure to disclose to the Coroner any information

1 which may have a material bearing on a Coronial case,
2 whether it's been through the Coronial process already
3 or is pending, is to mislead the Coroner and to mislead
4 the court.
5 **MR DE LA POER:** Mr Moore, thank you, those are my
6 questions for you. I understand there is brief further
7 questioning from Mr Baker.
8 **LADY JUSTICE THIRLWALL:** Mr Baker.
9 Questions by MR BAKER
10 **MR BAKER:** Mr Moore, I ask questions on behalf of
11 a number of the Family groups. In your evidence to the
12 Inquiry, you described the effect of a finding of
13 natural causes following a postmortem and in effect
14 bringing an end to the Coroner's jurisdiction.
15 **A.** Yes.
16 **Q.** I think that there is a caveat to that,
17 I think you will appreciate that where an unnatural
18 death -- sorry, where a death by natural causes is made
19 unnatural by the failure to intervene?
20 **A.** Absolutely, to situation.
21 **Q.** Yes, so a death by natural causes can
22 nonetheless be unnatural and can therefore trigger the
23 Coronial jurisdiction in certain circumstances?
24 **A.** In those circumstances, yes.
25 **Q.** The classical example of that would be

1 circumstances where there was a failure by doctors or
2 other medical professionals to intervene and to avert
3 an actual cause of death?
4 **A.** Correct.
5 **Q.** Now, there have been discussions within this
6 Inquiry and evidence in this Inquiry about the need for
7 candour with patients?
8 **A.** Sorry, I can't quite hear you?
9 **Q.** It is the microphone.
10 There's been evidence in the Inquiry about the need
11 for candour with patients and Family members?
12 **A.** Yes.
13 **Q.** You were giving evidence a moment ago about
14 the need for candour with the Coroner as well?
15 **A.** (Nods)
16 **Q.** If a Trust became aware of evidence to suggest
17 that there was negligence or failings in care provided
18 to a patient that caused or contributed to their deaths,
19 would you expect that to be made clear to the Coroner?
20 **A.** Absolutely. Yes.
21 **Q.** The relevance in this case is that a report
22 was obtained from Jane Hawdon in October 2016, which
23 identified failures in care provided to Child D and that
24 that was probably relevant as to her death or a cause of
25 her death?

1 **A.** Right.
2 **Q.** Would you have expected that to be
3 communicated straight away to the Coroner and indeed to
4 have been made clear within the witness statements that
5 were provided by the Trust to the Coroner?
6 **A.** Both of those, yes.
7 **MR BAKER:** Thank you, my Lady I have no more
8 questions.
9 **LADY JUSTICE THIRLWALL:** Thank you very much,
10 indeed, Mr Baker. I have no questions for you,
11 Mr Moore, thank you very much for coming and you are now
12 free to go.
13 **A.** Thank you, my Lady.
14 **LADY JUSTICE THIRLWALL:** I assume we are going to
15 move straight to the next witness?
16 **MR DE LA POER:** Yes, and I am going to hand over,
17 if I may, to Mr Bershadski.
18 **LADY JUSTICE THIRLWALL:** Thank you. Do come
19 forward.
20 Just a minute. Everybody is getting themselves
21 sorted out. I think we are ready. Would you take the
22 oath, please.
23 MS HELENE DONNELLY (sworn)
24 Questions by MR BERSHADSKI
25 **LADY JUSTICE THIRLWALL:** Thank you very much

1 indeed, Ms Donnelly. Do sit down.
2 **A.** Thank you.
3 **LADY JUSTICE THIRLWALL:** Mr Bershadski.
4 **MR BERSHADSKI:** Could you state your full name
5 please for the Inquiry.
6 **A.** Yes, Helene Elizabeth Claire Donnelly.
7 **Q.** Ms Donnelly, you have prepared a statement
8 dated 11 April 2024; is that correct?
9 **A.** Yes, that's right.
10 **Q.** Is that statement true and accurate to the
11 best of your knowledge and belief?
12 **A.** Yes.
13 **Q.** Ms Donnelly, is it correct that you worked at
14 the Mid Staffordshire NHS Foundation Trust from 2002 to
15 2008 and that you were one of the members of staff there
16 who raised concerns?
17 **A.** Yes, that's right.
18 **Q.** Ms Donnelly, I am not going to ask you about
19 any of the matters that you raised concerns about. You
20 have discussed those matters in the public domain and
21 interested persons can look those up for themselves.
22 Is it right that from 2013 to 2022, you were an
23 Ambassador for Cultural Change and Lead Freedom to Speak
24 Up Guardian for the Midlands Partnership NHS Trusts?
25 **A.** Yes, that's right.

1 **Q.** I believe you were involved with the
2 Sir Robert Francis Freedom to Speak Up Review; is that
3 correct?
4 **A.** Yes.
5 **Q.** Now, the Inquiry has seen a policy that was in
6 place at the Countess of Chester Hospital in 2015 and
7 2016 called a Speak Out Safely policy and it's the
8 Inquiry's understanding that that pre-dated a Freedom to
9 Speak Up policy so I am just going to ask you a few
10 questions about the earlier type of policy and the
11 transition to Freedom to Speak Up, if I may?
12 **A.** Yes.
13 **Q.** How developed in your experience was the
14 notion of speaking out safely in 2015/2016?
15 **A.** You mean across the NHS as a whole?
16 **Q.** Yes.
17 **A.** Yes, not very. I think certain Trusts
18 probably were slightly more proactive than others and
19 I think different cultures existed which probably
20 provided an environment where some people felt more
21 unable to speak up and then had better experiences when
22 they did but I think it was very, varied and certainly
23 wasn't consistent across the NHS.
24 **Q.** When in your experience did Trusts start
25 appointing Freedom to Speak Up Guardians?

1 **A.** Well, it became part of the NHS standard
2 contract I believe in 2017, so the creation of the
3 National Guardian's Office started around 2016 and then
4 they helped to sort of guide and influence how
5 organisations were to appoint and implement Freedom to
6 Speak Up Guardians.
7 **Q.** Just thinking back to 2015/2016, in the Trust
8 policy there was a list of designated officers under the
9 Speak Out Safely policy?
10 **A.** Yes.
11 **Q.** So at that point they weren't called Freedom
12 to Speak Up Guardians. What was their obligation as far
13 as you are aware to report serious concerns to external
14 bodies, such as regulators or police?
15 **A.** Well, we had the Public Interest Disclosure
16 Act in place then so there was a broader understanding
17 I suppose for the public as a whole that if people
18 raised concerns that fitted within the public interest
19 then there was an obligation for that to be acted upon
20 and addressed but I don't think that was something,
21 certainly not a lot of colleagues I -- at that time
22 would have been familiar with and it doesn't really
23 translate into every day life so I don't think people
24 would have known necessarily what designated officers
25 were there to do, what their remit was and I don't think

1 it would necessarily encourage people and give
2 confidence.
3 **Q.** Now, you say in your statement I think that in
4 your experience since the introduction of Freedom to
5 Speak Up Guardians, more NHS workers are speaking out
6 and I just wanted to ask you a few questions about that.
7 The Inquiry has received a statement from the legal
8 director of a charity called Protect which is
9 a whistleblowing charity that you may be familiar with.
10 That statement suggests that it is still the case that
11 a majority of NHS workers, certainly who contact the
12 Protect charity, feel that they have been negatively
13 treated as a result of speaking out. Examples that have
14 been provided of the ways that workers have been
15 negatively treated is with the Datix system being used
16 maliciously against them and with retaliatory referrals
17 being made to regulatory bodies.
18 Are those problems that you are aware of and what's
19 your experience of them?
20 **A.** Yes, very aware. I mean, I don't have exact
21 figures but I think we have now -- well, I know we have
22 exceeded over 100,000 people speaking up to Freedom to
23 Speak Up Guardians since their introduction in 2017 and
24 that's been collected through the National Guardian's
25 Office data.

1 Now, I don't think the majority of those over
2 100,000 people have had a negative experience. I would
3 argue that probably the majority have had a good
4 experience. However, for those who have had a poor
5 experience and for those who, whatever they were
6 speaking up about was not addressed and then harm
7 occurred to patients, to colleagues, that's clearly, you
8 know, not acceptable and so whatever the number it's --
9 it's too many and we need to address it.
10 **Q.** So in your experience it is something that
11 still happens on occasion?
12 **A.** Yes, yes, very much agree with that.
13 **Q.** I am just going to ask you a few questions
14 about the role of a Freedom to Speak Up Guardian, if
15 I may.
16 Could you begin by just explaining to the Inquiry
17 what sort of person is typically in your experience
18 appointed to a Freedom to Speak Up Guardian role?
19 **A.** They are people generally who work within the
20 NHS organisation and they can be kind of a --
21 professionally regulated as nurses doctors, allied
22 health professionals and so on. Or they could be
23 clerical staff, admin staff, it doesn't really matter.
24 What does matter is their sort of personal
25 attributes, their confidentiality, their compassion,

1 engaging, making sure that people feel safe to come to
2 them but crucially also making sure that they can
3 challenge and escalate where necessary. And if they
4 feel and have a reasonable belief that the concerns that
5 they are escalating to leaders for their action, if they
6 feel that those are not being responded to in the right
7 way, then the Guardian has to understand that they are
8 duty-bound to escalate further and that might be
9 externally outside of the organisation.
10 And it's really important that they do that and
11 they feel able to do that and I am not convinced that
12 all of them do.
13 **Q.** The Inquiry has seen some evidence that the
14 typical appointee to a Freedom to Speak Up Guardian role
15 is a member of mid-level management who will typically
16 have many other responsibilities as well?
17 **A.** Yes.
18 **Q.** Does that chime with your experience?
19 **A.** Yes, and has come about because there was
20 never any clear directive in terms of the -- the time
21 given, the ring-fenced time given to individuals in that
22 role. So I don't believe they have to do the role
23 solely full time but I do believe that if, if it
24 conflicts with other roles then -- or there is even
25 a perception of a kind of conflict of interest then they

1 shouldn't do it but equally if their -- their capacity
2 is such in their sort of substantive role, for example,
3 that they are not going to be able to give enough
4 appropriate time and attention to the role of Guardian
5 and they also shouldn't do it.
6 But they also need that kind of clear directive as
7 to what the ring-fenced time should be or at least
8 a range of what that should be because it will differ,
9 of course, from Trust to Trust, organisation to
10 organisation. But there needs to be at least some sort
11 of remit and we still haven't got that.
12 **Q.** If we set aside for a second the issue of the
13 amount of time that Guardians typically have for their
14 role, if it is right that the typical appointee to that
15 role is a member of mid-level management, then how
16 frequently in your experience can such a person feel
17 that it's difficult for them to challenge senior
18 management if they feel that senior management haven't
19 dealt adequately with a concern?
20 **A.** It really just varies from Guardian to
21 Guardian. They are trained in a -- in a consistent way
22 by the National Guardian's Office, each Guardian has
23 been to be registered that National Guardian and have
24 training through the National Guardian's Office, which
25 they have to refresh every year as well. And that is

1 really clear, that -- that responsibility that I have
2 just set out around that need to challenge and need to
3 escalate further. So no matter what level you are at in
4 the organisation, you should feel able to do that.
5 I would argue that those already in possibly
6 a middle management sort of structure or role they
7 should feel more able to do that because they are
8 already in a management position so I think this speaks
9 to the broader issue we have around managers not
10 responding necessarily or feeling empowered and enabled
11 to respond when people speak up, because of course
12 obviously you are questioning me at the moment around
13 the Freedom to Speak Up Guardians, but it's a much
14 broader responsibility for everyone in the NHS, no
15 matter what your role or position, but especially for
16 those with any sort of leadership or management
17 responsibility to be able to know how to escalate
18 concerns, to crucially be able to recognise them in the
19 first place, know how to escalate and know where to go
20 if you are met with resistance.
21 So I think it speaks to the broad problem we have
22 around managers and some of those may be Guardians, who
23 don't actually feel then able to speak up because of the
24 culture that exists.
25 **Q.** What is it that you think is wrong with the

1 culture that exists around -- that's preventing them
2 from taking adequate action?
3 **A.** Because of the response that they usually get
4 from colleagues at peer level but certainly from more
5 senior managers and that is not necessarily at Exec and
6 board level because as you are aware there is lots of
7 different levels of that kind of middle management
8 structure.
9 And, I mean, I am speaking generally because there
10 are clearly some organisations, some Trusts, some
11 pockets within some Trusts, that do this really, really
12 well. However, there are obviously areas where it's not
13 done well and it's that toxic negativity of if you are
14 speaking up, if you are raising concerns, you are being
15 difficult, you are not being a team player, you are
16 causing problems rather than solutions and that sort of
17 negativity.
18 And that I think comes from a system and -- and,
19 you know, an absolutely overstretched National Health
20 Service where everybody is firefighting, everybody is
21 under pressure. So that knock on your door or that
22 email that presents a problem is -- you just haven't got
23 the time and the capacity to be able to deal with it.
24 If as a manager it's not within your gift to be
25 able to resolve the issue, you have got to be open and

1 honest about that but you have also got to escalate it
2 further up the chain so that somebody can possibly do
3 something about it. But you are met with either being
4 told: well, it's your problem, it's your team, it's your
5 area, you sort it out, even though it might not be
6 within your gift, or: why are you bringing me this?
7 Don't bring me problems. Bring me solutions. Or that
8 sort of thing of: well, look, what's the bigger picture
9 here, what is the problem? Just make it go away, shut
10 it down.
11 And that is still people won't admit it, but that
12 is absolutely a real theme that exists through all of
13 the cases that I have been aware of where people are
14 speaking up and they get a negative response. Obviously
15 I am setting aside the ones where people do get a good
16 response because every day people are speaking up in the
17 NHS and they don't even know what -- that's what they
18 are doing, they are just raising an issue to their
19 manager or speaking about something in a team meeting
20 and they get a good response so we never hear about it.
21 But on those occasions where it doesn't go well,
22 that ripple effect then goes out which then suppresses
23 other people from speaking up and it also suppresses
24 other managers in terms of knowing how to do the right
25 thing because the role modelling isn't there and the

1 culture is such that you -- it creates apathy and
2 a feeling of futility because people think what is the
3 pointing in speaking up and even managers feel: what is
4 the point in escalating, what is the point in speaking
5 up because either I will get it in the neck or nothing
6 is going to change anyway, so I might as well just keep
7 my head down even as an advocate for somebody else who
8 is speaking up. So that broadly is the culture that
9 exists.
10 **Q.** One of the suggested changes that you mention
11 in your statement is around expanding the role
12 potentially of the National Guardian's Office?
13 **A.** Yes.
14 **Q.** Now, could you just describe, please, what is
15 your understanding and experience of the current role of
16 the National Guardian's Office in the Freedom to Speak
17 Up Guardian system?
18 **A.** So basically the National Guardian's Office is
19 there to help set out guidance -- and it's only
20 guidance, for individual Guardians, so as I said earlier
21 the Guardians have to be registered with them, so we
22 have a database of who is who and what is what. They
23 have to be trained by the National Guardian's Office, so
24 there is some degree of standardisation which is very
25 good.

1 And then they are there to collect data so each
2 Guardian has to return reporting data on set categories
3 and obviously the Guardian's Office expands that out and
4 looks at other things and they do Guardian surveys as
5 well, so the Guardian returns sort of information on how
6 they are being responded to as a Guardian and so on so
7 forth.
8 So they are there to collect a lot of data and
9 information which is of course useful.
10 They are there to offer guidance to Trust boards
11 and other organisations that have Freedom to Speak Up
12 Guardians on best practice and how it should look. But
13 that's about it. They don't have any statutory power to
14 enforce anything. They were conducting a small section
15 but they were -- a small portion, sorry, but they were
16 conducting some case reviews.
17 So anybody could contact the Freedom to Speak Up
18 Guardian and say that they had raised a concern or
19 a Guardian could contact the Guardian Office and say:
20 I had a case brought to me, I am not convinced it was
21 handled in the best way, could you do sort of
22 independent review of that so that we can see if things
23 could have been dealt with better? And obviously there
24 is learning, improving and shared more broadly.
25 But they have had to really reduce doing that

1 because they don't have capacity, their funding and
2 budget has been cut and they can't necessarily do these
3 in the way that they -- they possibly could and should.
4 What I wanted the Guardian Office to become was
5 a body that would be sort of centrally funded but it
6 would have a degree of independence and autonomy to be
7 able to really influence the culture change we needed
8 around speaking up practices and within that they would
9 have statutory power to enforce rather than just give
10 guidance and I also wanted them to be able to
11 essentially employ Guardians who would then effectively
12 be kind of deployed into Trusts and organisations so
13 that the Guardians themselves would have a genuine
14 degree of independence because obviously most Guardians
15 are employed by their organisation so there is
16 a perception, even if it's only a perception rather than
17 a reality, that that Guardian can't necessarily be fully
18 independent because they are on the payroll and
19 ultimately, you know, they have got to do what their
20 bosses, managers, are telling them to do.
21 So they don't have that real independence and
22 autonomy to act freely. So if they were employed
23 outside of the organisation via the National Guardian's
24 Office that for me would have helped prevent that.
25 **Q.** One of the other suggestions is for the

1 National Guardian's Office or some other body to itself
2 be an organisation to which potential whistleblowers
3 could turn and --
4 **A.** Yes.
5 **Q.** -- for that organisation then to have the
6 power --
7 **A.** Yes.
8 **Q.** -- to see that that concern is dealt with
9 appropriately?
10 **A.** Yes.
11 **Q.** What is your view of that sort of model?
12 **A.** Absolutely agree and that was the other thing
13 I wanted at the time, I wanted the National Guardian's
14 Office to be able to independently investigate concerns
15 that came through to them. I mean, obviously not all
16 concerns would have to be because again if concerns are
17 being dealt with appropriately within an organisation
18 and there's a degree of confidence in that, then that's
19 fine. But for those cases that are more difficult, more
20 tricky, that are involving more senior people in the
21 organisation, you know, all of those issues that could
22 arise I think there you need somebody you can go to to
23 offer real independence but also some expert sort of
24 advice and investigative responses to.
25 And there are obviously independent investigators

1 out there that for a fee will come in and do an
2 investigation. But they are essentially just being told
3 by the Trust: well, these are our Terms of Reference,
4 this is what we want you to investigate, you go and
5 investigate, tell us what you think. The investigator
6 goes away and then the Trust then sits with it and
7 decides what to do or not to do with the information.
8 So I wanted there to be more oversight than that
9 and, and that sort of responsibility would then sit with
10 the National Guardian's Office to not only investigate
11 and hand it back over but to then follow up and make
12 sure what's happened and follow through it make sure
13 that's appropriate and that all parties involved have
14 had the -- the necessary feedback and information what
15 the outcomes are and crucially what's the learning,
16 because we see this time and time again in the NHS when
17 even if good investigations have been conducted, the
18 learning and the improvement from that is not shared
19 widely enough so the same problem then happens further
20 down the corridor or down the road and neighbouring
21 organisations.
22 So I wanted there to be a body that would be able
23 to oversee all of that.
24 **Q.** The Inquiry understands that a slightly
25 different model operates in Scotland, where there is

1 an independent National Whistleblowing Officer that can
2 investigate how concerns have been dealt with.
3 **A.** Yes.
4 **Q.** Is that a body that you have any experience
5 of?
6 **A.** Yes, I have spoken to some individuals who
7 have worked within that system and escalated concerns to
8 that system so, I mean, as with all information
9 nothing's perfect, is it, and I think their model has
10 got so some real bonuses to it and I think that is
11 probably something we should in England be edging
12 further towards. But I wouldn't necessarily think that
13 their system is absolutely what we should adopt, I think
14 there are -- it needs to be worked through and I think
15 there are things that we could take from it definitely
16 and there should be some learning across.
17 Although I think -- I mean, this is a much bigger
18 issue in terms of the devolved nations and it's obvious
19 that we have the different systems across the different
20 devolved nations but that in itself causes confusion as
21 well. We have lots of differences within the
22 NHS England structure as it is, there's so much
23 variation from organisation Trust to Trust, but you go
24 over the border and there is even more variation.
25 So if we think about a lot of our workforce,

1 particularly medics who move around a lot and will go
2 and work in different places on rotations, they can go
3 to one Trust and have a completely different system and
4 model and Freedom to Speak Up than a Trust down the road
5 and that clearly varies again if you go north of the
6 border.
7 So I think that again causes a lot of confusion.
8 We need much greater standardisation and clarity on it
9 all.
10 **Q.** Now, one of the issues with the current
11 Freedom to Speak Up policy and Guardian role that the
12 Inquiry has read about is that because the policy, the
13 national policy asks that all concerns be raised under
14 that umbrella that actually all sorts of interpersonal
15 difficulties are raised through that and that sometimes
16 therefore the more serious concerns raised under Freedom
17 to Speak Up might not achieve the prominence that they
18 should do.
19 Is that a problem that you have experienced?
20 **A.** No. I think what happens though is concerns
21 that relate to the interpersonal relationships get
22 dismissed because they are just "grievancee", person A
23 not getting on with person B and it's all -- it's all
24 dumbed down to just those kind of personality
25 differences or somebody doesn't like the way somebody is

1 managing them and those sorts of things.
2 Now, often that can be the case, of course it can.
3 But what then happens is that those things get dismissed
4 and there is a real failure to actually acknowledge that
5 certainly in the health and social care sector that
6 those issues may not be a direct safety issue, they may
7 not be directly relating to patient safety, but they
8 absolutely are indirectly and we know this through
9 sickness rates, through retention rates, through studies
10 and research done such as Civility Saves Lives which has
11 shown the cognitive impairment when colleagues are rude
12 to you and you are going into situations that could be
13 bullying and toxic. That cognitive reduction when you
14 then might go out from the staffroom or the staff area
15 to treat a patient could clearly be catastrophic.
16 So this failure to acknowledge that those
17 interpersonal relationships and issues that are raised
18 are just as important, in my view, as some of the more
19 obvious and more direct patient safety issues.
20 So what then happens is that either the sort of the
21 two things get conflated and not really resolved
22 properly or they get separated which is what should
23 happen but one precedes the other and vital things are
24 missed and/or things are forgotten so we need a much
25 better system of addressing those things sort of

1 simultaneously but giving them both the importance that
2 they deserve, because they are really important.
3 I don't necessarily think though that concerns that
4 are raised through Freedom to Speak Up as it were
5 through a Guardian are any more likely to be dismissed
6 than anything else. In fact, I would argue they are
7 more likely because if a Guardian is doing what they
8 should be doing, they should be following that through
9 to its conclusion and if they are not happy that it's
10 been concluded appropriately then they should be
11 escalating further so I would argue by raising it
12 through a Guardian there is much more oversight and it's
13 less likely to be lost in translation than otherwise.
14 However, I would also say that we shouldn't have to
15 have every concern going through a Freedom to Speak Up
16 Guardian, I believe we shouldn't have to have Freedom to
17 Speak Up Guardians. Clearly I am a huge advocate for
18 them, and I still am, but I think we should have a
19 culture where people are speaking up to managers or
20 their manager's manager and getting the right responses
21 in the first place so that they never have to go to
22 a Guardian.
23 **Q.** Can I ask you a few questions about
24 training --
25 **A.** Yes.

1 **Q.** -- because it seems to me that if your
2 evidence is that there is a culture still lacking of
3 speaking up and dealing with Speak Up appropriately,
4 then it may be that training is one of the issues that
5 leads to that?
6 **A.** Yes.
7 **Q.** Now, I think you say in your statement that
8 there is now in principle training on Freedom to Speak
9 Up for all NHS workers?
10 **A.** Yes.
11 **Q.** In your experience, is that mandatory and is
12 it delivered to all NHS workers?
13 **A.** In my experience, most Trusts have mandated at
14 least the first level so it's sequential. There is
15 three tiers to it: the first is for all workers; the
16 second is for anybody with any leadership and management
17 responsibility; the third and final is for senior
18 leaders including the Execs at board level and Non-Execs
19 as well. And they have to be done sequentially so all
20 the way through, but obviously "workers" just have to do
21 the first tier.
22 Many organisations have mandated that tier, some
23 have even mandated the sort of middle tier. I don't
24 know of any, but there may be some that have mandated
25 all three.

1 So it's good that it's there, it's actually quite
2 good training. It was first developed through Health
3 Education England and well -- actually, no, it was first
4 developed through Public Concern at Work, formerly and
5 now Protect and then Health Education England have
6 helped develop this current suite of training.
7 But it's not enough. For me that is just a toe in
8 the water, that is a -- that is giving all workers an
9 understanding of what Freedom to Speak Up is, what it
10 isn't, how you can access help, what Freedom to Speak Up
11 Guardians are there for and then there's lots of
12 different links and information provided but that is
13 just the start for me.
14 We need to go further. And I feel that because
15 that's you know e-learning and e-training, people just
16 click through it and you don't necessarily fully engage
17 with it.
18 I have been reliably told that some organisations
19 senior and manager level people who have assistants, get
20 their assistants to log in for them and just click
21 through it, and essentially do the training for them so
22 they didn't even look at it.
23 So again it's just, you know, the standard of it
24 and we can't sort of put all our eggs in that basket and
25 say: right, we have sorted training, we've got that,

1 because we haven't.
2 So I think it needs to be followed up and we need
3 to have much more robust and face-to-face training for
4 leaders. I am encouraged by NHS England's -- some of
5 the work they have done recently around the fit and
6 proper persons test leadership capabilities and also
7 I understand there's a leadership and development
8 programme that's due out I think next summer, so that
9 all looks great, but I reserve judgment until we see how
10 it is brought to life and how it is implemented.
11 **Q.** Do you think that managers in the NHS need to
12 be regulated?
13 **A.** Yes.
14 **Q.** Do you think that the issues you have
15 identified of some managers not taking the training
16 seriously and indeed not doing it themselves, delegating
17 it to an assistant to click through; do you think that
18 is the sort of issue that needs to form part of --
19 **A.** Yes.
20 **Q.** -- their statutory and regulatory obligations?
21 **A.** I do. There is two things, though. Firstly
22 the -- that will only ever be known if the people who
23 know about it feel safe enough to speak up and expose it
24 and they don't. So the people who have told me that
25 happens, they told me -- I have no reason to not trust

1 what they are telling me, but they have said to me: oh,
2 my God, don't tell anybody I have told you that though,
3 because oh my God! So nobody feels safe to go on the
4 record and call these bad behaviours out.
5 The second thing is that whilst I do agree that we
6 need regulation, I know the government -- was it last
7 week or the week before? -- launched the most recent
8 consultation on that and how we are going to potentially
9 regulate managers and so on. I agree with that, I think
10 we should have it. The Kark review pointed this out
11 years ago and we are still waiting.
12 However, how that is done also has to be done in
13 a really just way and in a way that's supportive because
14 I fear that a lot of managers could be thrown under the
15 bus for failures that are not solely theirs and it's
16 actually a system failure, it is a cultural issue coming
17 from the top and that might not get exposed but certain
18 individual managers within those middle tiers we have
19 already discussed could really feel quite vulnerable
20 because they are not given the support and the training
21 and the ability and the capacity to be able to deal with
22 concerns or issues or whatever it might be, and then
23 they are exposed and they are made an example of but
24 others who are more senior to them and have presided
25 over that behaviour are not necessarily also held to

1 account.
2 So how that is done and how it's regulated we need
3 to be really, really clear on and make sure it's done in
4 the right way.
5 **Q.** I am just going to ask you a few questions
6 about investigations which you deal with from
7 paragraph 31 of your witness statement. You say that an
8 appropriate investigating officer should be appointed
9 where a Freedom to Speak Up concern has been raised and
10 that you have heard of very busy managers being tasked
11 with undertaking complex investigations?
12 **A.** Yes.
13 **Q.** Could you just talk about that a little bit
14 more and the extent to which that's a problem in your
15 experience?
16 **A.** In my experience it happens frequently, daily
17 across the NHS where you have a manager who is already
18 running a team or a department or an area and they are
19 very, very busy and they suddenly get told: we have got
20 an investigation that's happening over there, nothing to
21 do with them so there is a degree of independence but we
22 need you to investigate. And often they are not trained
23 and have no idea how to do an investigation. I have
24 spoken to many managers over the years who said to me:
25 I was asked to investigate something and I had no idea

1 how to do it, I have never had any investigation
2 training, I didn't even really know what the Terms of
3 Reference were or how to establish that. Some of the
4 things I was investigating I had no clue. So some
5 people who have had to investigate fraud, for example,
6 or alleged fraud had no idea what to do, so you have got
7 to question the -- you know, how thorough and
8 appropriate that investigation would be.
9 But in addition to that, they are obviously running
10 a department or a team or an area and are very, very,
11 busy. They are not given any more time or not taken
12 away from that to be given ring-fenced time to conduct
13 an investigation.
14 So two things happen: their team and their area
15 suffer, but also the investigation, the quality of the
16 investigation suffers and also can be -- it can take
17 much longer than it perhaps should take to complete
18 because they are not given the appropriate time and
19 support. So for me this, again, just -- I just can't
20 understand why we haven't really tackled that.
21 Now, I know of some Trusts that have a sort of bank
22 or a pool of investigators and they specifically appoint
23 them to be investigators who can be sort of drafted in
24 and move around to conduct investigations and that seems
25 like quite a good model.

1 But, equally, you have still got the issue around
2 genuine impartiality and independence because if they
3 are still employed by the organisations they might not
4 have that. So I think we need a central pool who can be
5 dropped in. But again it needs to be central because
6 there are lots of organisations, as I said earlier, who
7 are quite happy to charge the NHS a fee to bring in
8 independent investigators -- and many do a very good
9 job -- but for me it's not robust enough and we don't
10 have that kind of central oversight to make sure that
11 they are conducted in the right way and there's too much
12 variation again.
13 **Q.** So is it your proposal that there be a central
14 body to which all Trusts can turn for conducting
15 investigations?
16 **A.** Yes, at a certain level. I mean, as I said
17 earlier I think low-level investigations, there are
18 investigations that are happening every day across the
19 NHS, that wouldn't necessarily tip into that sort of
20 threshold of needing that.
21 But I think those that do or where you have had an
22 investigation and people are appealing it or they want
23 another investigation or there's new evidence comes to
24 light, or whatever, I think sometimes you need to take
25 it up a notch and make sure that it's done

1 appropriately. And there just isn't anywhere really to
2 turn or there isn't a standardised approach to it.
3 So I think again that could and should have been
4 something that could have been incorporated into the
5 National Guardian's Office potentially or we needed
6 another separate body that is there across NHS and
7 social care to investigate concerns and not just the
8 ones that are overtly about patient safety but the ones
9 that are around bullying and harassment and
10 discrimination and all those other kind of poor
11 leadership. Those need to be investigated very
12 thoroughly to ensure that those people don't go on to
13 just continue to do what they have been accused of doing
14 and are not held to account.
15 **Q.** I am just going to ask you a few questions
16 about human resources departments, which is a topic that
17 you deal with in your statement from paragraph 35.
18 You make the point you say that it's alarming the
19 number of times that you have heard inappropriate advice
20 being given by HR or by HR workers not paying due
21 diligence.
22 Can you just expand on what you meant by that?
23 **A.** So again, I just you know give the caveat that
24 there are some really good HR practitioners out there
25 and some really good HR departments, so I don't want to

1 appear to be, you know, tarring them all with the same
2 brush.
3 But I frequently hear about poor advice that is
4 given around -- and conflicting advice as well and again
5 some very open and honest HR practitioners have come to
6 me and owned up and said, "I don't really know" or "I's
7 being told by somebody senior in my team to advise this,
8 but I don't actually think that's the right thing to do"
9 or "I don't feel I have got the skills or the required
10 competency to be able to deal with this particular case"
11 because it seems quite convoluted or really difficult to
12 unravel. And they themselves can feel out of their
13 depth, but they would never admit that and say, "I don't
14 think we are handling this well."
15 So you then lead on to, you know, inappropriate
16 advice or conflicting information. One person is told
17 one thing, somebody then is told something different.
18 The way that some things are decided that they will be
19 investigated but other things are not and there is that
20 lack of consistency.
21 Again going back to the investigation. Who was
22 appointed to investigate? How is that decision made?
23 Are they genuinely impartial? The amount of times --
24 and this happened in my own personal case at
25 Mid Staffs -- but the amount of times I still hear about

1 investigating officers who are appointed to investigate
2 and are known to be good friends with the person they
3 are investigating or have worked very closely with them.
4 Now, they might believe that they can separate it
5 and they genuinely would come at it with a degree of
6 impartiality and objectivity. But even -- but the
7 perception of that, the optics don't look good. So why
8 do? That there must be an alternative. Don't even do
9 it.
10 And that's not bringing the credibility of that
11 individual investigator into question to say, "Well,
12 they can't be impartial" but it's just -- it just
13 doesn't look good. It doesn't give anybody confidence
14 in what's going to then happen. So, why start from that
15 basis?
16 So I really feel that again HR practitioners
17 themselves are often very disadvantaged. They are under
18 the cosh, they are under pressure to keep costs down, to
19 not investigate certain things because it's going to be
20 too time-consuming or it's going to cost too much. Then
21 they give that advice to the manager who then delivers
22 the information. The way that information is delivered
23 as well can be awful. There is just that lack of
24 compassion and a genuine sort of just and fair response
25 to it, which I hear consistently.

1 **Q.** Now, you say at paragraph 49 that when people
2 speak up about something they are worried about but not
3 sure they are often expected to provide evidence to
4 support their concerns. Too often concerns are never
5 acted upon until it is too late because there was
6 apparently insufficient evidence.
7 Now, the Inquiry has heard from a number of
8 witnesses who have testified that this was a case where
9 they were presented with apparently insufficient
10 evidence. Can you just expand on the sorts of
11 situations that you have come across where an evidential
12 threshold, without giving any details of course --
13 **A.** Yes.
14 **Q.** -- that have been applied inappropriately in
15 your view?
16 **A.** So I mean it can, it can range. I've heard of
17 lots and experienced lots myself.
18 So sometimes again it's more around the
19 interpersonal behaviours because we can't get away from
20 that. That's the thing that people speak up about the
21 most. The thing that people go to Freedom to Speak Up
22 Guardians the most is about inappropriate attitudes,
23 behaviours and potential bullying and harassment as
24 well.
25 So -- and the two things don't necessarily cancel

1 out the other. So they might be raising that, but, at
2 the same time, raising patient safety concerns or
3 whatever. So often they are asked to provide evidence
4 that they don't necessarily have and sometimes it's
5 hearsay, sometimes it's just rumour, but there's enough
6 there to worry people. But nothing -- there's a lack of
7 curiosity from managers and HR to go and find out more
8 information or that the burden of proof is placed back
9 on that person to say, "Well, you've got to find me
10 evidence, you've got to find me witnesses."
11 Rather than them actually, as managers and as HR
12 professionals, to go out and actually go and find the
13 information themselves if it's there. And then when
14 I raise that question, I get told, "Well, we can't be
15 seen to be doing that because we'll look like we are
16 going on a witch hunt." I don't agree with that at all.
17 If the evidence is there, you will find it. If it
18 isn't, then fine, but at least you've satisfied
19 yourself, and everybody else involved, that you have
20 robustly looked into it and investigated it.
21 Also if people see people going and looking
22 actively, if there is any information or evidence, that
23 will give confidence to other bystanders who may have
24 that crucial piece of information but have been too
25 afraid or have thought that they wouldn't be believed,

1 or nobody is going to listen and they might then come
2 forward because they can see that issues are being taken
3 seriously.
4 So that can range from anything from those kind of
5 interpersonal behaviours and incivility and rudeness and
6 aggressive toxic cultures to really serious concern and
7 allegations or just a worry that an individual health
8 professional is not behaving in the right way. They
9 might not have the evidence to prove it, but they have
10 got enough there that concerns them.
11 The responsibility I believe then sits with the
12 managers and HR and the senior leadership of the
13 organisation to go out and find that evidence rather
14 than just turn round and say, "Well, you've told me
15 this, but you just -- it's just rumour, I can't do
16 anything." I think that's abhorrent and, as we have
17 seen in this most tragic of cases, we know what then can
18 happen if people don't take action and it cannot be
19 allowed to continue.
20 **Q.** Now, in this case, the suspicion that was
21 raised was of course one of deliberate harm by
22 a healthcare worker and indeed deliberate killing by
23 a healthcare worker. In your experience, how aware are
24 Freedom to Speak Up Guardians and to what extent is that
25 possibility covered in their training?

1 **A.** I believe, I mean, I haven't been on the
2 training recently, but I believe it is, it is covered.
3 You know, these -- this is obviously one of the most
4 recent and most horrific cases, but Mid Staffs,
5 Harold Shipman, Ian Paterson, the baby maternity deaths
6 that have happened that Donna Ockenden looked into, the
7 Kirkup Review, all of these things are referenced and
8 talked about to Guardians so that they understand the
9 ramifications if these things are not addressed
10 appropriately.
11 I mean, this is partly why I still do what I do
12 because I'm asked to go and talk about my own personal
13 experience at Mid Staffs, which is, you know, 10,
14 15 years ago now but, sadly, it is still ever relevant
15 and pertinent and we hadn't moved on enough. You could
16 argue we've actually gone backwards. So I still go
17 around the country supporting Trusts and organisations
18 but also sometimes individuals around what really good
19 Speak Up practices and culture should look like in my
20 opinion and in my experience.
21 So for me the Guardians are acutely aware. But the
22 Guardians can only be effective if they are working
23 within a system and an organisation and a culture which
24 is not only receptive to that, but is encouraging it and
25 is doing -- you know, everybody has got to play a part

1 and if you have people blocking it along the way then it
2 won't work as it should.
3 And when I pioneered the role back in 2013, I saw
4 it as a conduit for the frontline to raise issues with
5 the Guardian who could then get direct access to the CEO
6 and board if necessary. And that came about because of
7 the evidence that was given at the Mid Staffs Inquiry by
8 the Chair of the board at the time and other senior
9 leaders saying, "We didn't know. We weren't told how
10 bad it was." And I have seen throughout this Inquiry
11 that you have heard similar evidence from very senior
12 board level individuals saying, "We didn't have full
13 sight of all the information." Well, you should have.
14 And actually a Guardian can and should be utilised
15 as an -- as an ally really for that most senior tier of
16 leadership to be asking and to be telling them where the
17 problems are, where the hot spots are, what's the noise,
18 what are the issues and if there are specific cases that
19 are really concerning, and potentially quite extreme,
20 that should be brought directly to the board and not be
21 distilled. It shouldn't be dulled down.
22 Obviously a lot of what comes across the boardroom
23 is quite sanitised and is reduced because they have
24 overwhelming amounts of information to go through and
25 I understand that. But where these cases do crop up,

1 the Guardians should have the confidence to go to the
2 CEO, to the chair of the board, to the Non-Exec director
3 responsible for Freedom to Speak Up and the Exec
4 Director responsible for Freedom to Speak Up and say,
5 "I am really concerned because of X, Y and Z" and then
6 they should again have the curiosity and the leadership
7 skills required to go and find out more information and
8 assure themselves that actually everything that could be
9 being done is being done and if not, why not and does it
10 need to go further.
11 The fact that we are still hearing of cases where
12 that's not happening and we are still hearing of
13 Guardians being blocked and not being given access or
14 regular access or meaningful access to those senior
15 tiers is really concerning.
16 **Q.** You talk about --
17 **LADY JUSTICE THIRLWALL:** Sorry, Mr Bershadski, is
18 now a good time for the break?
19 **MR BERSHADSKI:** Yes, certainly.
20 **LADY JUSTICE THIRLWALL:** So we will take a break of
21 15 minutes, so that's back in at 20 to.
22 **(3.24 pm)**
23 **(A short break)**
24 **(3.39 pm)**
25 **LADY JUSTICE THIRLWALL:** Yes, Mr Bershadski.

1 **MR BERSHADSKI:** Thank you, my Lady.
2 Ms Donnelly, just three more questions from me.
3 The first: we have heard from a number of witnesses
4 about there being a lack of specific policies on what to
5 do when there is a suspicion of deliberate harm by
6 a healthcare worker.
7 Do you have any experience of whether policies are
8 sufficiently clear on what to do in that scenario?
9 **A.** No. I mean, I think the policies could be
10 more explicit. There is certainly in the Freedom to
11 Speak Up training and in the Freedom to Speak Up policy
12 there is reference to the fact that if you have got
13 significant concerns and you do not feel that they are
14 being appropriately addressed within the organisation,
15 then it signposts you to other external bodies such as
16 the CQC, the National Guardian's Office, Health
17 Education England, et cetera, et cetera, and not least
18 the police as well. If there are any significant
19 concerns around harm, possible deaths, safeguarding
20 then -- and if people believe they have, they have got
21 a legitimate concern then they should be encouraged
22 to -- to access that.
23 But I think again it should be done through, where
24 possible, and best practice would be that somebody can
25 speak up to their manager, their manager escalates it

1 and the organisation, if they believe there is even
2 potential for that, they should be getting external
3 professional support to look at that.
4 And I don't just mean pulling in an independent
5 investigator necessarily. I mean going to the police or
6 other bodies that are appropriate and I think we could
7 strengthen the policy and the guidance and the training
8 to possibly be more explicit in that.
9 **Q.** Is it your experience that Trust managers, on
10 occasion, are resistant to taking such a step?
11 **A.** Yes.
12 **Q.** Based on concerns around the reputations of
13 either themselves or the Trust, is that a problem?
14 **A.** Yes, absolutely. I do think that this harks
15 back to my concerns around HR practice as well, is that
16 the focus is on the reputational damage of the
17 organisation and protecting the organisation and not
18 necessarily on just doing right thing and having
19 transparency and openness to make sure that we can all
20 be assured that either there is a problem and therefore
21 it needs to be addressed through the appropriate routes
22 and channels or actually there isn't a problem but we
23 looked into it robustly and thoroughly and transparently
24 and everybody can then be assured. And those things
25 don't necessarily happen. Again this case is extreme,

1 so I haven't had personal experience of something on
2 that kind of magnitude.
3 But certainly my experience at Mid Staffs was that
4 nobody wanted to hear because it was just -- it was too
5 difficult, it was too difficult to do, it was too
6 difficult to look into. It would expose the
7 organisation for not hitting its targets and not
8 performing and the pressure now on all of our NHS Trusts
9 is, is so extreme that that pressure is even more acute
10 and although now, as opposed to when I was raising
11 concerns at Stafford Hospital, there is more talk of
12 patient safety and quality coming first and not the
13 reputation and not hitting the target.
14 But that's not necessarily borne out in practice.
15 It's not lived and breathed and really encouraged
16 because ultimately, even within an organisation, teams
17 are pitted against each other, wards are pitted against
18 each other in terms of their -- the targets they are
19 hitting internally within the wider macro-organisation.
20 So instead of people again feeling empowered to
21 speak up, and I include managers in this, to say, "We
22 are struggling", the onus is on them to either fix it
23 and make it look good or just make the problem go away.
24 And then you extrapolate that up and out and that's
25 the culture in the NHS. So I don't think we have learnt

1 from it.
2 And this is the problem with some of the HR
3 practices we have. And by that I also mean the
4 employment law as it currently stands; I think we need
5 legal reform in terms of employment law and legislation
6 around whistleblowing specifically. But the sort of --
7 the cloak of secrecy that is shrouded over
8 investigations and so on leads to, at best, things not
9 necessarily getting addressed as they appropriately
10 should and thoroughly should and therefore giving
11 confidence to people that it's been addressed and, at
12 worst, actually gives dark places for dark things to
13 hide deliberately.
14 And I think that's rare and usually it's not
15 a deliberate thing that things are hidden, but because
16 of that lack of transparency and openness it just leaves
17 that, that possibility for things to not be clear and
18 that leads again in terms of whistleblowing for people
19 speaking up it doesn't give people confidence because
20 they can't see what's happened.
21 Even if I go back again to concerns that relate to
22 interpersonal relationships and behaviours and conduct
23 and grievance-type issues, even if a finding is upheld
24 that somebody has been found to be bullying, whatever,
25 that's not necessarily disclosed because it's private

1 and confidential for that individual.
2 So a) where is the accountability? And even if
3 this person is dismissed from that organisation they
4 sort of leave quietly by the backdoor. Nobody really
5 knows what's happened and there is no learning from it
6 and it doesn't give the people who spoke up and the
7 people who were witnessing that any confidence for the
8 future and then what that individual often then does is
9 go down the road and get a job somewhere else.
10 Now, I know, as we talked about earlier, the
11 current consultation into regulation of managers and so
12 on will go some way to hopefully prevent that and
13 certain individuals may be barred from working in the
14 NHS and, I hope, the wider health and social care
15 sector.
16 But I still worry that if the HR practice and if
17 employment law doesn't change to enable that then we
18 still won't be any further forward and my real fear is
19 we will be here again in another five, 10 years having
20 seen another scandal and discussing the same things.
21 **Q.** I was going to ask you a question relating to
22 employment law, so that leads neatly on to that.
23 The Inquiry has heard some evidence that decisions
24 relating to Letby were, in part, matters that were taken
25 into account were legal risk, ie a potential grievance

1 that she may have brought or Employment Tribunal
2 proceedings and that that may have had some impact on
3 decisions people made.
4 Is that a problem that you are aware of?
5 **A.** Yes. I mean, again, this was a really extreme
6 case and the ramifications were huge and I hope -- well,
7 I know that they're not -- they are not every day.
8 But what is every day again is going back to the
9 sort of the potential issues around conduct, behaviour,
10 attitudes, potentially bullying and the person that's
11 had an allegation made against them brings
12 a counter-allegation and the organisation doesn't want
13 that. So they just want it to go away and they don't
14 want it to go to an Employment Tribunal or whatever.
15 So they mitigate risk and they either pay people
16 off so again they leave quietly by the backdoor. But
17 they are not held to account.
18 Equally, though, I would argue -- and I have spoken
19 to many managers who have been wrongly accused of
20 bullying when they have just been trying to manage
21 somebody and, you know, people are difficult to manage
22 and there are a lot of people who will claim that they
23 are being bullied or they are being victimised. They
24 will claim they're a whistleblower to try and avoid some
25 potential disciplinary action being taken against them

1 or whatever and it just becomes, it just -- it just
2 becomes a free-for-all and just everything becomes
3 muddied.
4 So we have got to get better at separating those
5 things out and dealing with them really clearly and
6 robustly and transparently.
7 But also for when people have been accused of
8 bullying and it's not upheld, then that should also be
9 transparent. Because that person -- there's a rumour
10 mill. Even though people are told "You mustn't talk
11 about it", everybody talks about it. Everybody knows
12 that that person over there has been accused of bullying
13 and then there's the whole thing of "Well, there's no
14 smoke without fire" and for some people that's terrible
15 because it damages their reputation and potentially
16 their career.
17 So being open and honest in both, you know,
18 eventualities -- a finding is upheld and somebody has
19 been found to be a bully, well, let's expose them. If
20 somebody has been accused of it but then there was no
21 evidence and they were not found to be a bully then that
22 also needs to be made transparently made clear but in
23 defence of that person. And although I believe this to
24 be rare, but if there is sufficient evidence that
25 claim was made maliciously or vexatiously, then that

1 person should then go through some sort of process of
2 disciplinary action. Because too often people, you
3 know, don't get held to account for making malicious and
4 vexatious claims.
5 But it has to be done robustly and transparently so
6 that there is confidence on both sides of it and I think
7 what happens is these threats are made or people --
8 these sort of counter-allegations are made and nobody
9 really investigates it thoroughly and robustly and then
10 nobody transparently tells the outcome of that and if
11 there is still doubt, well, it can go through appeals or
12 whatever. But there just -- there needs to be greater
13 transparence, just like we have in criminal law.
14 I don't understand why employment law is so very
15 different. I think we just need to have much more
16 openness and honestly. And I understand the
17 confidentiality element whilst an investigation is
18 happening, but the outcome of that should be made clear
19 and honest.
20 **Q.** A final question. One of the features of some
21 of the evidence in this Inquiry has been around whether
22 there was adequate communication with Families when
23 concerns were raised. Can you just tell us about the
24 extent to which the Freedom to Speak Up system and
25 training incorporates duty of candour?

1 **A.** Yes. It is certainly discussed and talked
2 about and, again, guardians should be aware of both the
3 statutory and the professional duty of candour that
4 exists and if they don't feel that that's being upheld
5 that again is something the Guardian should be
6 escalating to the people who need to know it. And that
7 might be, as I said earlier, going to the most senior
8 people in the organisation, the Trust board, the
9 Executive leadership and potentially beyond if
10 necessary.
11 I think we are making some progress in that area
12 with the introduction of PSIRF, so the Patient Safety
13 Incident Response Framework, which I believe was brought
14 in in September last year that there's a really clear
15 framework for organisations to work from where they
16 absolutely engage with and involve the families and/or
17 relatives and/or individuals who, who sort of harm has
18 occurred to or could have occurred to because an error
19 has been made.
20 And, first and foremost, an apology needs to be
21 made. And I know that there is, in the guidance that
22 comes through from NHS England and others and the CQC,
23 there are real -- it's really clear that that apology is
24 not an admission of liability. But I don't think that
25 actually is widely thought or believed to be the case

1 because I still hear people -- and again this comes back
2 to some HR advice that I have heard given -- where HR
3 have said, "Don't apologise, don't apologise" when they
4 are talking to families and relatives but also to
5 employees in relation to employee concerns and that
6 failure to apologise actually makes things escalate
7 ultimately.
8 But there is -- so there is -- so that messaging
9 which is very clear if you take the time to go and look
10 and read about it, but I'm not sure how explicitly we
11 make that clear to our general workforce around the fact
12 that an apology is absolutely what you should do to
13 patients and relatives but also to employees where
14 things haven't gone as they should.
15 So I think duty of candour is talked about.
16 Certainly guardians should be aware of it. But again
17 you are beholden on the organisation to do the right
18 thing and uphold it and if they are not doing it, any
19 individual, but certainly a Guardian, needs to have the
20 courage of their convictions to take it further and
21 escalate it further. And I still don't think we have
22 got a culture that really enables that and encourages
23 that to happen.
24 **MR BERSHADSKI:** Thank you. My Lady, those are my
25 questions. I don't believe there are any questions from

1 the bar.
2 Questions by LADY JUSTICE THIRLWALL
3 **LADY JUSTICE THIRLWALL:** Right. Thank you.
4 I've just got a couple, if I may. Thank you very
5 much for coming to speak to us today. I don't imagine
6 you thought, when you were first speaking up all those
7 years ago, that this would be where it would lead?
8 **A.** Absolutely not.
9 **LADY JUSTICE THIRLWALL:** No, or that it would take
10 so long.
11 You mentioned a couple of times that there are
12 places where Freedom to Speak Up/open culture actually
13 does exist and people are able to bring their concerns
14 to the Guardian and it's dealt with appropriately.
15 I'm not asking you to do this now, but would you be
16 prepared to say which Hospital Trusts that applies to so
17 that we could perhaps approach them with a view to
18 finding out how they do it?
19 **A.** Yes, yes.
20 **LADY JUSTICE THIRLWALL:** Would you mind doing that?
21 **A.** Absolutely.
22 **LADY JUSTICE THIRLWALL:** Thank you. One of the
23 other things that you talked about was people being
24 asked to investigate things without the right skills or
25 training and that sounded to me like that was quite

1 a recurring problem.
2 **A.** Yes, very much so.
3 **LADY JUSTICE THIRLWALL:** Then there is one option
4 which we have seen here, is that you bring in an
5 external body and then you give them Terms of Reference
6 and then you decide what to do with it and you have made
7 your observations about that.
8 **A.** Mmm mm.
9 **LADY JUSTICE THIRLWALL:** One of the Non-Executive
10 Directors at the Countess gave evidence yesterday who
11 felt that actually, on reflection, that they really
12 didn't have the skills themselves as a board --
13 **A.** Yes.
14 **LADY JUSTICE THIRLWALL:** -- properly to investigate
15 this, which I think it seemed hadn't been obvious at the
16 time --
17 **A.** Mm-hm.
18 **LADY JUSTICE THIRLWALL:** -- but is now obvious to
19 him. I just wondered whether you had thought about the
20 situation where, and obviously this is and the extreme
21 case, I appreciate that, but a case where concerns are
22 being raised about possible criminal conduct, whether
23 there's anything wrong with that being raised straight
24 up to the board for them to consider safeguarding and
25 the police?

1 **A.** I don't think there is anything wrong with
2 that. I think it's essential because if it's -- if it's
3 then looked at relatively thoroughly and robustly and
4 it's sort of de-escalated, then that's okay. But the
5 opportunity, if you don't do it in terms of escalating
6 upwards first, then the opportunity could be missed and
7 then harm can happen.
8 So for me it should be, well, if in doubt escalate
9 up. If it then needs to trickle back down to be
10 resolved, which is often what happens anyway, then so be
11 it, but at least you have had some oversight and you
12 have had some assurance and then they can keep tapping
13 in and looking at it. And essentially that again is how
14 the Freedom to Speak Up Guardian role should work.
15 So when it's relatively minor low-level stuff, the
16 Guardian will escalate to the most appropriate manager
17 or actually, in the first instance, the Guardian will
18 encourage the individual who's come to them to go back
19 to their line manager or their manager's manager and
20 have it dealt with through the line. But if that's
21 either been tried and/or it's not appropriate for
22 whatever reason then the Guardian can escalate up
23 to whatever tier.
24 If the Guardian has been presented with information
25 that would, would concern them enough to think there is

1 some issue around potentially patient or public safety
2 or safeguarding, then they should escalate up if in
3 doubt.
4 I mean, if they have got a good relationship with
5 their safeguarding lead, with their Patient Safety Lead
6 and whoever and they feel absolutely confident that if
7 they escalate to them, it will be looked at
8 appropriately then there's no need to necessarily
9 escalate it up.
10 **LADY JUSTICE THIRLWALL:** Understood.
11 **A.** But I think you need to -- but this is the
12 other point as well I made earlier around you have to
13 have a Non-Exec lead and an Exec lead for Freedom to
14 Speak Up. Now, those two people should be meeting
15 separately with their Freedom to Speak Up Guardian or
16 guardians regularly; at least every sort of month to
17 two months, I would say, but also have a direct point of
18 contact in between that time so that if the Guardian is
19 really worried about any particular cases, they can --
20 they can just sight it to them.
21 They might not give them the full detail at that
22 point but they can put on those individual's radar the
23 fact that: We've got this case that is bubbling in
24 whatever department, I'm a little bit worried. So and
25 so is looking into it. We'll give them time to look at

1 it but I will come back to you when I know what's
2 happening and/or if I have got further concerns.
3 And then that should be that kind of two-way
4 conversation so that everybody ultimately has some sort
5 of degree of understanding what the outcomes have been.
6 But again often -- and this goes back to my HR
7 concerns -- is that even the Guardian is often told that
8 they are not allowed to know the outcome of the
9 investigation. It's handed over to the investigator, to
10 HR, and then it's: Thank you for that, you know, don't
11 call us, we'll call you.
12 But that shouldn't be what happens. The Guardian
13 is a trusted individual who is trained to know that
14 there are, there are, you know, restrictions on the
15 information they can share, but they themselves have to
16 have assurance that the concerns have been dealt with
17 robustly because if not then it's farcical. There is no
18 point in having the Guardian role in existence. It is
19 literally just a tick box exercise.
20 So that route up to the top and to the Non-Execs is
21 really important as well, but it needs to be two way and
22 I often hear of guardians constantly trying to chase the
23 execs or the non-execs to say: Can we have our meeting?
24 and it just keeps getting cancelled and moved and
25 whatever and it just, you know, it's just clear that

1 it's not a priority.
2 **LADY JUSTICE THIRLWALL:** Thank you. Does anybody
3 want to ask anything arising out of that? No.
4 Well, in that case, thank you very much indeed for
5 coming to help us and you are now free to go.
6 **A.** Thank you very much. Thank you.
7 I think tomorrow, Mr Bershadski, you are calling
8 the first witness.
9 **MR BERSHADSKI:** Yes, that's right, my Lady.
10 **LADY JUSTICE THIRLWALL:** Very good. So we will
11 rise now until 10 o'clock tomorrow morning.
12 **(4.00 pm)**
13 **(The Inquiry was adjourned until 10.00 am,**
14 **on Thursday, 5 December 2024)**
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