1	Tuesday, 15 October 2024
2	(10.00 am)
3	LADY JUSTICE THIRLWALL: Good morning.
4	Ms Langdale.
5	MS LANGDALE: Good morning. May I call, please,
6	Nicola Lightfoot.
7	MS NICOLA LIGHTFOOT (affirmed)
8	Questions by MS LANGDALE
9	LADY JUSTICE THIRLWALL: Do sit down.
10	A. Thank you.
11	MS LANGDALE: Ms Lightfoot, you have prepared
12	a statement for the Inquiry dated 31 March 2024.
13	Can you confirm the contents are true and accurate
14	as far as you are concerned?
15	A. Yes, that's correct.
16	<b>Q.</b> Have you got it with you?
17	A. I have, yes.
18	<b>Q.</b> So if I refer you to paragraphs you have it
19	there?
20	A. Yes.
21	<b>Q</b> . You tell us that you worked as a Band 6 deputy
22	ward manager during 2011 to 2015 on the children's unit.
23	Can you tell us what that role entailed and also set
24	out, as much as you would like to, your experience
25	before taking that role; how long you had been a nurse
20	1
1	<b>0</b> So in 2011 how long had you been working as
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1	and your experience?
2	A. Okay. So I completed my nurse training '93 to
3	'96. It was specific in paediatrics. I started my role
4	on the children's ward at Chester in January '97 as
5	a junior staff nurse at that point.
6	After a few years I took on a role as senior staff
7	nurse and then after that, I also took on the deputy
8	ward manager role which was classed as a sort of Sister
9	role.
10	I have been an acting manager on the unit for
11	a short period of time as well. I have worked on that
12	unit ever since.
13	My role involves day-to-day clinical management of
14	my own patient workload at times. I am responsible for
15	running the unit which is across three areas. I have
16	management responsibilities on day-to-day runnings of
17	the ward, managing patient flow from the admissions that
18	we have in, supporting my colleagues and junior staff.
19	Part of my deputy ward manager role is also
20	completing appraisals, sickness reviews, any
21	disciplinaries with any staff, dealing with parent
22	complaints.
23	So it's two-fold really. There is some management
24	of the staff and then the day-to-day runnings of
25	clinical duties as well.
	2
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1 2	Eirian Powell. Usually, if I was representing the manager the manager would usually go to these
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and a number of assessments. It was an official 1 2 qualification at that time. 3 It's since changed since. There isn't actually the 4 formal training and qualification now. 5 So I completed that. That was something that was 6 routine for senior nurses at a certain point into their 7 career. It was a sort of natural progression as you became a senior staff nurse that you would complete that 8 9 course to enable you to support and mentor students. 10 And support and mentor students, was that Q. their way of achieving qualification, you were helping 11 them to achieve their qualification and develop into 12 13 independent nurse practitioners? Absolutely. So throughout, obviously, the 14 Α. nurse training at that point was a three-year course and 15 16 students would have various placements across different 17 specialties, some community placements, some hospital 18 placements. 19 Towards the end of their third year we expected 20 a bit more autonomy, them to be able to work a little 21 bit more independently, and in the placement that I was 22 mentor to Lucy, and it was her final placement, so that 23 is the placement prior to becoming a qualified nurse. So it's quite pivotal and particularly important to 24 25 ensure that that student is ready to qualify because as

- 20 ensure that that student is ready to qualify because as 5
- 1 then, under support, completing that task yourself.
- 2 By the time they are in the third year, we would
- 3 allocate our third year students their own patient
- 4 workload of two or three patients. They would
- 5 independently plan that care, with your supervision,
- 6 based on their nursing assessments, the condition of the
- 7 child, you are observing their interaction with the
- 8 family and other members of the multi-disciplinary team.
  9 But we are expecting them, as I said before, to
- 10 work more autonomously, come back, touching base every
- 11 so often, but I would expect a third year to be able to
- 12 go and plan their own care for their patients,
- 13 recognising their priorities, delivering that care and
- 14 assessing and evaluating how that care has impacted on15 the condition the child.
- 16 **Q.** And what kind of mentor were you, certainly in
- 17 final placements? Had you mentored many third year18 students?
- 19 A. Yes, so at that point, I -- I had been
- 20 qualified sort of almost 15 years. We have -- we all
- 21 have had a number of students over, over every year.
- 22 I had mentored an awful lot of students, first years,
- 23 second years, third years.
- 24 I think I personally in the first year perhaps the
- 25 expectations I would have are not quite so high because 7

- 1 a student, you do obviously have your own
- 2 responsibility, however you are supported and the main
- 3 responsibility lies with your mentor and the qualified
- 4 staff you are working with.
- 5 Obviously that transition to go from that to
- 6 an independent worker although albeit under still
- 7 supervision we have a sort of preceptorship programme
- 8 that we support newly-qualified staff in is really quite9 a change.
- 10 So you have to be absolutely sure that that person
- 11 is at that point ready to qualify and take on that
- 12 responsibility.
- 13 **Q.** So in the first year, then, so first year
- 14 students you say need basic orientation to the role and
- 15 you teach basic skills like ward routeing, observations,
- 16 and completing documentation but by the time of the
- 17 third year, they are about to qualify so expectations
- 18 are different, as you have just said.
- 19 A. Absolutely, absolutely, and you work almost
- 20 more remotely, you allow that independence.
- 21 They -- in the first and second year often they are 22 on your shoulder, they are behind you, they are
- 23 observing a lot. Obviously we would try and encourage
- 24 participation in those skills and that is how you learn,
- 25 you know, often, you know, watching what is done and 6
- 1 they have got time to develop. By the time they get to
- 2 third year, my professional responsibility and my duty
- 3 of care as a nurse is to ensure that that student
- $4 \quad \ \ {\rm qualifies \ and \ is \ safe, \ can \ deliver \ effective \ care; \ that}$
- 5 I am happy that that protects them as a practitioner.
- 6 I am happy that that protects their colleagues as
- 7 a safe practitioner and, more importantly, the children
- 8 and the families that they are looking after and that's9 is my primary focus.
- 10 It doesn't always make you very popular especially
- 11 I have found in my experience that students that have
- 12 been weaker or I have felt were lacking in some areas
- 13 are often quite defensive. Often may have said, "Oh,
- 14 I find, I find you difficult" or "I find you
- 15 intimidating", but my primary responsibility is to
- 16 ensure that that person is safe for all of those reasons
- 17 I have just, I have just said.
- 18 **Q.** And how many had you failed? When you are
- 19 asked about this with the police in 2018, how many third
- 20 year students had you failed at that time, would you
- 21 say, roughly?
- 22 A. Yes, I couldn't, I couldn't put a number on it
- 23 but I have, I have failed a few. And as you probably
- 24 have seen and for anybody that isn't aware, any student
- 25 that is failed in that final placement has the

opportunity to repeat that placement to try and achieve 1 2 the competencies that they have not met. 3 So the student training and the placements have a number of competencies that we expect the nurse to 4 5 achieve. If, as we go through the time of that 6 placement, we are finding that that member of staff is 7 struggling to meet some of those objectives, at that 8 point we will action plan for it, we will raise issues 9 as we go along -- it's unfair to put them all at the end 10 and that student have no awareness of what areas that they need further work and support in. 11 12 And you do the marking, don't you? As Q. 13 a mentor you mark --14 Α. Yes 15 Q. -- it is fed back to the University of Chester 16 and then they pass or fail or they give them feedback as 17 appropriate? 18 Α. Absolutely. So at that point there was what 19 we called an OSCE, which was a practical test, and basically it was to assess that student's ability to 20 21 co-ordinate care for a number of patients. It included 22 a medication ward round, which obviously has to work 23 within the -- the Nursing and Midwifery Council guidance 24 for administration of medicine. 25 So there is right and wrong ways of completing it; 9 1 position to provide care to sick children and their 2 families and they come as a whole. 3 We expect our students and our staff to be able to 4 establish a working relationship with that family. They 5 need to be able to trust that you know what you are 6 doing, that you are going to provide the best care 7 possible for their child in a very distressing and 8 anxious situation. 9 They want to feel supported in that they feel that 10 you know what they are doing. 11 So, actually, those kind of traits are really vital 12 in becoming a competent practitioner. 13 Q. What were your concerns about those traits as 14 far as Lucy Letby was concerned? So, as I said, I have mentored a number of 15 Α. students over the years. I am well aware that actually 16 when you are under assessment, it can feel intimidating 17 so I very much tried to stand back and allow Lucy to 18 perform without feeling I was over her shoulder putting 19 20 that pressure on, that perceived pressure that she had, and I would allow her to go and establish these 21 22 relationships and perform the duties that we have talked 23 about previously and then I would just touch base and 24 reassess.

25 Sorry, could you just repeat the question again?

11

1 that's not a subjective assessment.

2 The competency-based assessment is a little bit

3 more subjective. But I would say that in my experience

4 I have seen sufficient students in practice to know what

5 students perhaps need additional support.

6 **Q.** You tell us at paragraph 15 that you were 7 Letby's mentor during her final placement 23 May to

8 31 July and you say:

9 "... it became apparent to me that Lucy didn't have
10 overall characteristics to be a successful registered
11 nurse."

12 What did you mean by that?

13 A. So obviously students have to have a certain

14 academic ability which is assessed by the university.

15 They have assignments that they have to pass and they

16 also obviously have their ward assessments to pass as17 well.

18 We see students that actually are extremely

19 academic but actually from a personality and

20 characteristic point of view they don't seem to blend

21 into the role of being a children's nurse, which

22 includes characteristics of empathy, being kind, being

23 friendly, being able to establish good relationships

24 with our families.

25 This is a position of trust. It is an honoured 10

- 1 **Q.** No, you have answered it, I think.
  - A. Okay.

2

3 Q. If you answer this question, please. Did you
4 discuss any concerns you had with her directly about her
5 communication with patients or families?

6 A. Yes, absolutely. So as I say, we address

7 things that we -- we do -- at that point we have an

- 8 initial interview, we class it, and that's where we
- 9 would say to the student: this is what we expect you to
- 10 have achieved by the end of this placement. What would
- 11 you like to achieve? What areas do you feel you haven't
- 12 had opportunity to experience yet?

13 We then do a halfway interview and we will assess

14 where they are with those competencies: is there

15 anything flagging up that we need to do further work on

16 that we need to put additional support in with, and at

17 that point if we feel there are things that need working

18 on we will liaise with the university which is what we19 did.

20 We also had our practice facilitators who worked

21 within the hospital and they would also provide support

22 to you as the mentor to complete an action plan, if

23 necessary, at that point for that student to achieve the

24 competencies they were lacking in.

25 Q. If we go to your final report, we see what you12

said at the time. So it's INQ0014042, page 163. So 1 2 0014042 0163? 3 Α. I think I have from 0164 onwards, sorry. 4 That's fine. It will come on the screen O. 5 anyway so everyone can see it. 6 We see the front page, the final outcome for you of 7 that placement in the third year was a fail, "has not 8 provided sufficient evidence to demonstrate the common 9 foundation programme outcomes". 10 If we go over the page, beginning 164, your final report, you start by saying: 11 "Since the mid-point interview Lucy worked hard to 12 13 address the areas of concern highlighted by myself." 14 Had you failed her at the midpoint of the 15 placement? 16 Α. There was some -- so it's not classed as 17 a fail. 18 Q. Right. 19 There was some competencies that you could say Α. 20 at that point "you haven't achieved these yet". 21 Q. Right. 22 Α. Sometimes it's because of lack of opportunity, 23 but the things -- one of the things that I felt she wasn't achieving at that point was under the very broad 24 25 banner of "professionalism". And the things that I have 13 1 responding to you, how they are feeling, you know, 2 understanding and empathising with their anxieties and 3 responding appropriately to reassure them, as I said 4 earlier, as part of that building a trusting 5 relationship. 6 Q. Page 165, please. If we go to that. 7 And the fifth paragraph, go further down if we can. 8 Α. Yes. 9 Page 165, we are still not there. Q. 10 "Lucy does demonstrate drug calculations" -- there we are, it is the penultimate paragraph on the one 11 12 that's there now 13 She "does demonstrate drug calculations on 14 a regular basis", did that mean how to calculate the amount of drugs, she knew -- she was competent at that? 15 16 Absolutely. So within children's nursing we Α. would always have two registered nurses to sign 17 medications. Children's medications are often very 18 different, they are weight-based, they are often very 19 20 variable, sometimes the doses are very complex to work out, hence we would always have two people to check that 21 22 that dose is correct, that that dose is appropriate, 23 that it's been given at the right time and that there's 24 no drug interactions or, sort of, allergic responses the child has previously had that would affect how you are 25

documented in this report and that I have said in my 1 2 previous statements that I was concerned about was her 3 interaction, how she communicated. 4 I felt it was lacking, it wasn't where it should be. I felt her clinical knowledge was not where it 5 6 should be. 7 Q. If we look at paragraph 3 on that page --8 Α. Yes. 9 Q. -- you say she: 10 "... needs more experience at observing and picking up on non-verbal signs of anxiety/distress from parents 11 and recognising when to change her approach." 12 13 I found -- I found Lucy to be quite cold, Α. I didn't find a natural warmth exuding from her that 14 I expect from a children's nurse. I appreciate as 15 16 a student you feel like you are being assessed all the 17 time. But I didn't feel it was a natural characteristic 18 that she showed. 19 Non-verbal signs are absolutely crucial as a nurse. 20 The verbal signs are obviously clear as they are 21 verbalised to you from parents or children. But a lot 22 of our job is interpreting those non-verbal signs that 23 a child is distressed that -- and it perhaps might not be as obvious as crying, it could involve looking at 24 25 their body language, assessing how that parent is 14 1 administering drugs. 2 We would ask the third -- the student to be the 3 third checker. They would take no legal responsibility, 4 obviously, for signing those medications but we would 5 expect them to be able to calculate the volume of drug 6 that they needed, to check that the dose is appropriate 7 for that child's age or weight, and a lot of the drugs 8 we regularly do, the students very quickly have awareness for because we are giving them all the time 9 10 such as paracetamol. 11 O. Just pausing there, the checker, is the checker checking that the infusion or the drugs being 12 administered at the right rate? In other words, so one 13 14 person puts the infusion on or sets it up and the 15 checker comes to check the calculation and it looks the right amount? 16 17 So both of the people will go to complete that Α. drugs round. We would ideally take the medication to 18 the child's bedside. We would, as I say, ascertain that 19 20 it's the right dose, that it is the right time and it's not being given too early and that it's due, and 21 22 actually that it's been prescribed correctly because 23 obviously there are occasions where human error occurs 24 and prescriptions are incorrectly prescribed. So our responsibility is to check against our recommended 25

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(4) Pages 13 - 16

medication guidance that that is the correct dose for 1 2 that child as well. 3 When we are then administering that, so we are 4 independently checking even though we are alongside each 5 other, we are independently checking all of those 6 things. We are then ascertaining that we are giving it 7 to the correct patient, so we are checking their name 8 band, we are confirming verbally with the parents, 9 asking them to confirm the name and the date of birth 10 and any allergies, we would confirm with the child, if appropriate, and then only if we were happy with all of 11 those things we would administer that medication and the 12 13 two registered nurses would sign the drug chart which was paper at that time. 14 15 So we didn't expect Lucy to sign any drugs. But we 16 would ask her to independently try and check to 17 ascertain that she gets the correct dose and volume and I found that even doing the same kind of medication that 18 19 she struggled to retain that information and we had to 20 do a lot of repeating and asking her to look up and clarify for herself, which we would always recommend 21 22 anyway, if you are unsure, you would check it, you know, 23 that's where mistakes happen. But she did struggle to 24 retain that information. 25 O. You say there -- sorry, just to go back, she 17 1 Q. Can we go over the page, please, to 166. 2 You in that second paragraph highlight the -- what 3 you said already, I don't need you to go back on that 4 about the non-verbal cues. We heard from Nurse T

5 yesterday, who had Lucy for the first period in that
6 third year, that she felt her communication skills were
7 very positive, and something that was raised by Letby

- 8 was that at the midpoint she found it -- was anxious --9 you made her feel anxious.
- Do you want to just comment on that, the impact ofdifferent people and the assessment of things like

12 communication skills by different people?

13 A. Yes, I mean, obviously, we are all

- 14 individuals, we all have various amounts of experience.
- 15 We all -- we -- I would say my professional manner has
- 16 always been trying to keep safety at the forefront of
- 17 what I am doing, in a kind way, I would try to be
- 18 encouraging. There were a number of positives that
- 19 I mentioned throughout this report that I felt Lucy had
- shown improvement in and there were areas that I feltdidn't naturally come to her.
- 22 When I was -- when you are trying to ascertain
- $\ensuremath{\texttt{23}}$   $\ensuremath{\,}$  people's knowledge base, that involves having to ask
- 24 questions. On occasions, as I say, I would sort of
- 25 stand back and allow Lucy to go and provide care for
  - 19

- 1 struggled to retain the information about side-effects
- 2 and drug usage for common drugs given.
- 3 Is that a different struggling to retention rather
- 4 than calculations; do you see how you have set it out
- 5 there that's what you say -- (overspeaking) --
- 6 A. So calculations -- so we have a certain drug
- 7 calculation to work out the volume and that is based on
- 8 how many milligrams or micrograms of that drug there are
- 9 in a certain volume. So that is one part of it.
- 10 So there is a calculation to ascertain the correct
- 11 volume that you are going to give and that the strength
- 12 of the drug you are giving is correct because many drugs
- 13 come in various strengths, so you have to ascertain
- 14 because 5 millilitres of one drug would be a different
- 15 strength than 5 millilitres of another drug.
- 16 As I say, there are, there are a number of very
- 17 basic medications we give all the time in paediatrics,
- 18 such as paracetamol, ibuprofen, basic antibiotics, stuff
- 19 that, actually, after you have given a couple of times
- 20 I would expect you to remember the side-effects because
- 21 actually they are fairly generic and the same and
- 22 actually when we would ask Lucy to verbalise during any
- 23 practices, and including her official OSCE practice, to
- 24 clarify some of those side-effects she couldn't
  - verbalise them.

- 18
- 1 a group of patients. When I had then reconvened with her a few hours later to say, "Tell me about this", she 2 3 actually couldn't verbalise what conditions they were, 4 what signs of deterioration she would be looking 5 out for. 6 So I had deliberately tried to stand back so 7 I didn't -- so she didn't feel I was putting any 8 pressure on her, but even in that situation I found she 9 struggled to provide me with that information. 10 I know in Ruth Sadik, her link lecturers, one of 11 her statements, she had also found that Lucy struggled 12 to verbalise some, some of the questions that she had 13 and that's very difficult to determine that person's 14 level of knowledge. If they can't verbalise it and 15 can't show it, then in essence it's not happening. 16 Q. Look at the last paragraph. You say: 17 "At the moment Lucy is requiring much more support, prompting and supervision than I would expect at this 18 stage to allow her to qualify as a competent 19 20 practitioner. However, I strongly feel if Lucy continues to take on board feedback and continues to 21 22 work on her weaker areas and develop her practice
- 23 accordingly then this is achievable in the future."
- 24 We know -- that can be taken down from the screen25 now.

In terms of achievable, what did you think should 1 2 happen next and we know there was discussion between 3 yourself, Ruth Sadik and others about next steps and, 4 indeed, Ruth Sadik spoke with Letby about the next steps 5 as well, didn't she? 6 Α. Yes. 7 Q. If you go to paragraph 19 of your statement, 8 you set out there the options that were documented by 9 Ruth Sadik which were for Lucy to repeat her practical 10 OSCE assessment at a later date, for Lucy to see her GP and get signed off sick for four weeks or for an 11 interruption of her studies and go back and repeat a 12 13 portion of her training. 14 What actually happened? There was a discussion between all of you, wasn't there, about next steps? 15 16 Α. Yes. 17 Q. And it looks as though there was a retrieval placement put in place; is that right? 18 19 Α. Absolutely. 20 Let me take you to a document so you can see Q. it, because I think it is signed by both you and 21 Ms Sadik, INQ0014042 0171. 22 23 Α. Yes. 24 So that should come on the screen. So an Q. 25 action plan agreed, obviously with Letby's input too, 21 1 Q. We know that Letby went on to do a retrieval, 2 four-week placement, with Sarah Jayne Murphy and we will 3 read that in, my Lady, after this evidence. 4 Were you aware that she then subsequently achieved 5 the competencies and passed? 6 Α. Yes, absolutely. As I said before, I stand by 7 the decision I made at the time based on my experience 8 and, actually, when you are a mentor you are not the only person making an assessment on this person. Often 9 you do have to consider, is there a personality clash, 10 we don't all get on with everybody we work with, we have 11 to form professional working relationships. So I had 12 sought other colleagues' opinions of Lucy just to 13

14 reinforce to myself that I was happy I was making

a non-judgmental assessment of her skills and how she 15 16 was as a nurse.

- 17 Did you feel criticised by her in that Q.
- 18 process?
- 19 Α. No. I think at one point during
- 20 a conversation Ruth had said, "Oh, she says she finds
- you intimidating", you know, but I think that was 21
- 22 because I was professionally challenging her knowledge 23 and her skills.
- 24 Often, I think I said earlier, students that are
- lacking in where they should be often you find provide 25

23

- and decisions. There we are. 1
- 2 This is the note on 7 August, it's actually the
- same date as your report, setting out she's made great 3
- 4 progress in clinical practice and retrieved
- five proficiencies. However, still has three 5
- 6 outstanding.
  - What are AI, DI, and JI?
  - So each of the proficiencies or the Α.
- competencies that I mentioned before are alphabetically 9
- 10 ordered and in each section the A, the B, the C, the D
- section there is a number of competencies within each 11
- 12 section.

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- 13 Some of them are practical things, practical skills
- 14 that we would expect them to achieve but from my
- recollection, A1, as I say, was a broader competency, 15
- 16 proficiency, based on professionalism and that was one
- 17 of my main concerns, that I still felt that she had some 18
- way to go.
- 19 All students develop, we all learn at different
- 20 rates, you know, and we do take that into consideration.
- 21 But by the third year, most of these should be
- 22 achievable. From their first year it's very much
- 23 filtered from university and from us on the ward that,
- actually, professionalism is, is key and how you build 24
- 25 those professional working relationships.
  - 22
- 1 negative feedback almost to try and get their side in first. So I wasn't surprised she found that approach, 2 3 in her words, intimidating. But I was trying to 4 ascertain her level of knowledge and skills to ensure 5 that she was safe, partly for her benefit as 6 a practitioner. 7 Q. And Sarah Jayne Murphy, in her statement, 8 refers to she thought that Letby had initiated an appeal process -- I don't think there was an -- we can't see 9 10 any evidence of an appeal process. Α. 11 No. 12 Q. It was more the comments appealing to the fact 13 that she felt intimidated by you, or something similar. 14 So all students, if they failed a placement, Α. 15 had the opportunity to do a retrieval placement. It is only a very short placement. It is -- at that point it 16 was only a further four weeks. I also verbalised that 17 I felt I couldn't objectively continue as Lucy's mentor, 18 she felt the same, because I genuinely didn't think that 19 20 in four weeks she would be at a level that I would be 21 happy to sign her off. 22 That previous document that you showed me where 23 you -- where I had circled the fail and I had signed it,
- 24 that is my professional responsibility as well. That is
- my professional registration. I have to be sure that 25

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I am saying that this person is ready and safe to 1 2 practise and I wasn't prepared to put my professional 3 reputation and my professional registration on the line 4 at that point. 5 It looks like the second document I showed you Q. 6 written by Ruth Sadik but signed by you both, I think, 7 so you were on board with the discussions about what 8 happened next? 9 Α. Absolutely. 10 Q. But she went to different nurses and different experiences? 11 12 Α. Okay. 13 Moving on then to the deaths of Child O and P, Q. the -- two of the triplets. You tell us that you heard 14 Letby say something. Can you set that out for us, 15 16 please? 17 Α. Yes. So as I said earlier, actually we work 18 really as two independent units from a nursing 19 perspective. We do help each other out when we need to 20 but we are predominantly fairly independent. The medics 21 cross between the two. 22 So we have -- I personally had guite limited 23 information as to what had been happening. I couldn't say that I had any awareness as to what their normal 24 level of mortality was on the unit. I didn't have 25 25 1 mention it to Eirian Powell or somebody who was 2 responsible in the workplace for Letby? 3 Α. At that point, when I had heard about that 4 second triplet, I thought, oh gosh, that's strange 5 because there was a passing yesterday and I think that 6 was my -- a moment where I thought perhaps there was 7 something significant happening that I hadn't been aware 8 of. I didn't realistically think anything more about 9 this response other than it was inappropriate. 10 I think I probably will have mentioned it to somebody when I came back on the ward, another 11 12 colleague, because I was quite shocked. But in 13 hindsight, you know, perhaps I -- I could have escalated 14 it but I -- there was nothing substantiated. There was just an inappropriate response and I didn't have the 15 full awareness of what had been happening on the unit 16 17 and their mortality rate for me to put two and two 18 together. 19 Nurse ZC, who has a cipher so remember that, Q. 20 says that in the resource room after the death of the triplets, and it was after an afternoon safety brief, 21 22 you were working at one of the computers, and you were 23 somebody she felt able to talk to at that time, and she 24 said, "Is it not concerning that she is involved and she

25 is always there?" enough experience in working that neonatal unit to know that. And the first triplet sadly passed away on one day,

- 3 4 and on the second day, I heard that the second triplet
- had also passed away and as I was coming out of the 5
- break room I passed Lucy, who didn't see me, she was
- 6 7 coming out of her unit and greeting a member of the
- night staff that was coming on and I heard her say 8
- 9 something along the lines of, "You never guess what just
- 10 happened".
- 11 And I felt, I felt -- I felt it was inappropriate
- in light of what had happened. The way she had said it 12
- seemed like she was talking about some exciting event or 13
- something, you know, that she had witnessed or seen on 14
- the unit. It wasn't an appropriate response to the 15
- 16 death of a child. The death of a child is distressing
- 17 for everybody involved whether it's expected or not.
- 18 And it has a profound effect on the whole team looking
- 19 after that child, and I have never, and I have never
- 20 since seen a response like that to a nurse involved in
- 21 a patient's passing.
- 22 Q. And Melanie Taylor who you thought she said it 23 to confirms that was said, she described in an excited
  - manner
- 24

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25 Did you take that up with anyone at the time or 26

1 And she describes you as shrugging your shoulders 2 and not saying anything in response. Can you remember 3 that, her saying that to you?

- 4 I don't recall those specific words and that Α.
- 5 conversation. The resource room, for some clarity, is
- 6 a public area where the medics and the nurses work.
  - Q. Do you have safety briefs in there sometimes?
  - Α. Yes, yes, we do.

Which is what she is describing, so maybe not Q.

the public there after a safety brief. 10

- 11 Δ Yes, but it's not the privacy of the office
- that I would expect any concerns to be escalated. 12
- That is not the first time that I have heard 13
- 14 Nurse ZC comment about Lucy. I had heard her and
- a couple of medical colleagues on a number of occasions 15
- discussing that Lucy must be involved. I felt it was 16
- 17 quite malicious, it was gossip. It was, at that point
- as far as I was aware, unsubstantiated. 18

19 Did you think that even after the triplets Q.

- 20 when you yourself had heard her say that, when another
- nurse says to you, "She seems to be around a lot"? Did 21
- 22 you still think it was malicious then?
- 23 Α. If a member of staff had come to me with
- 24 a professional concern, it is -- it would be my
- 25 professional practice, and it has been previously, to 28

away by Dr Barrett on the corridor to myself -escalate that concern appropriately. 1 At that point, I thought it was nothing more, 2 Q. Right. still, than a member of staff that disliked Lucy making 3 -- when she passed me and she said, "I see Α. ongoing unprofessional comments and judgments and 4 Nurse Death's on again." Right. 5 Q. I am aware that there was also a separate complaint 6 Α. So I didn't hear a conversation per se. 7 Q. So you had had Dr Barrett say to you Well, let's just pause there. I am focusing "Nurse Death" and you had had Nurse ZC saying the 8 on Letby. We know that you said, for example, comment "Isn't it concerning she's involved and she's 9 Dr Barrett and Nurse ZC had used a derogatory term about 10 always there?", or something similar. So you had had Letby, both of them say that conversation didn't happen two people raise with you concerns about Letby at that 11 although Dr Barrett accepts she did say "Nurse Death", point. 12 she said, "I didn't have that conversation with Dr ZC". 13 But you thought they may still be gossip or So who else, apart from Dr ZC, when you say you 14 malicious or what is your evidence? I don't know what were aware of people -you thought. 15 LADY JUSTICE THIRLWALL: Nurse ZC. 16 Α. I did, I did, because Nurse ZC and Dr Barrett MS LANGDALE: Nurse ZC, sorry. 17 and Dr Mayberry, who I had also mentioned in my Who else, apart from her, were you aware was statement, were very friendly, they were often together, 18 talking about Letby when you say you were aware and 19 they were often sending text messages between each thought people were gossiping or it was malicious? 20 other. So the conversations that I am aware other staff May I just clarify. In my statement I didn't 21 had also witnessed were between those three. So hear a conversation between Nurse ZC --22 I didn't feel they were independent concerns. 23 Q. Did you speak to Dr Mayberry about them at 24 all? Did you tell him that she didn't seem engaged as -- and Dr Barrett talking about Nurse Death. a student or anything like that, or not? The comment was made after the second triplet passed 25 29 30 I don't recall saying that to him. I didn't 1 allegations that they had heard her make that she would have that kind of relationship with him. 2 be -- she would be involved. Nurse ZC tells us that there were briefings at 3 Q. So would you have been part of the briefings this point that staff were told they shouldn't be 4 to staff to say: do not discuss her otherwise discussing deaths on the neonatal unit, infant deaths, 5 disciplinary measures would follow? or Letby, or disciplinary measures might be considered. 6 Absolutely, because at that point it was, it Δ. Was that the case because there was concern that this 7 was -- there was nothing substantiated from our was malicious gossip --8 perspective on the children's unit that we had awareness So the malicious gossip, as I said, was 9 of. witnessed by a number of colleagues, as well as myself, 10 But you had concerns yourself about her Q. communication and you had heard something that you 11 thought was inappropriate, didn't that ring --Which colleagues? 12 So there were colleagues that I am aware of 13 Α. Absolutely. made a formal complaint. 14 Q. Didn't that ring bells for you that it might Yes, who were they? Tell us who they were. 15 be concerning? (Redacted). 16 Α. No, I didn't have any other evidence other (Redacted)? than concern about an inappropriate response. The 17 (Redacted). briefings were not to silence anybody, the briefings 18 Yes, about -- in support of Letby, malicious were: this is damaging unsubstantiated, from our 19 comments about Letby? 20 perspective, discussions about a neonatal colleague that Yes, part of the complaint was about were very damaging. So please do not gossip and discuss 21 Nurse ZC's general professional behaviour. 22 anything that we have no involvement in, that we know I'm not asking about her, I want to move on 23 nothing about. 24 Q. Were you curious after hearing the comment about the triplets to know more about it? Did you have But part of it was about Lucy Letby and 25 32

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supposition

about Nurse 7C

Q.

Α.

Q.

Α.

Α.

Q.

Α.

and it was --

Q.

Α.

Q.

Α.

Q.

Α.

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Α.

Q.

Α.

and ask about --

Right.

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any curiosity yourself about how they died, was it of deaths. So I presumed at that point she must have 1 1 2 unexpected, was it expected, what were the 2 had some kind of involvement. 3 circumstances, or did you think that wasn't any of your I would have said, and I think I have said in my 3 4 business on the children's unit? 4 police statement, that I perhaps wouldn't have been 5 I didn't recall how I felt. As I say, I feel surprised to hear that her lack of knowledge or her lack Α. 5 6 like that was the first point I actually had some 6 of skills may have led to a failure to recognise 7 understanding of actually this seemed unusual to have 7 deterioration. But I absolutely would not have thought, 8 two deaths in two days. But that was based on, as knowing her as I did, that that would have been 8 9 I say, my lack of knowledge and awareness of what is 9 a deliberate act. 10 usual on the neonatal unit. 10 You spoke, did you, with Eirian Powell much Q. So when did you first start to think the about Letby at the time? Were you aware Eirian Powell 11 Q. 11 unthinkable, as some nurses have described it, that was describing her as a competent nurse? 12 12 13 someone, or Letby, might be harming babies on the unit? 13 Α. Sorry, could you repeat. 14 I imagine it will have been when I heard she 14 Were you aware that Eirian Powell was Α. Q. had been redeployed to another department. describing her as a competent nurse at this time? 15 15 16 Q. When she went to the risk department? 16 Δ. Not that I recall. 17 Α. Absolutely. 17 Q. We know she moved to the risk department 18 Q. What did you think was going on then? 18 in July 2016. That must have been a matter of 19 Α. I assumed that she had been removed because 19 conversation for lots of people in the hospital, mustn't 20 there was concern that she was involved in what had been 20 it? It is a significant event. You had made a link by happening. then that there must be something that associated her 21 21 22 Q. In what way did you think she was involved or 22 with deaths on the neonatal unit at least; yes? 23 may have been involved in what was happening? 23 Α. (Nods). 24 Α. As I say, my limited information that I had at 24 Q. So were there still instructions that people 25 the time was that there had been this unexpected number 25 shouldn't discuss this at all? Did that continue, 33 1 concerns that people shouldn't be discussing it and it 1 it, take it forwards through a process. 2 would be a disciplinary matter if they did? 2 Actually, a trusted colleague where you can just 3 Α. I don't recall specifics but I would imagine 3 say, "I am worried about this", isn't that a very 4 that absolutely would have been the message to -- to not 4 valuable way of hearing concerns and complaints? It's 5 discuss it. 5 not simply gossip because it is done informally, it may 6 Q. How do you think that sits by policies such as 6 weigh heavily with the person that tells you something. 7 7 Freedom to Speak Up and speaking up about concerns when Α. And I think that if that had been brought to 8 all these people who may have different pieces in 8 me in a professional manner, in a professional -- as the jigsaw aren't supposed to speak up or talk about it 9 9 a professional complaint, I would have dealt with it as or talk about it with each other? Do you think there 10 10 a professional complaint. was a conflict there? 11 11 We were -- our usual practice and my usual practice 12 Α. I think there's obviously always room to 12 to anything like that would be to have a conversation 13 professionally challenge. I think if we have concerns 13 with that person in a private room, I would document 14 we should escalate them and we have and I have been 14 that conversation I would document that person's involved in escalating concerns previously, as I did concerns. And I would have escalated it to my manager 15 15 when I had concerns about Lucy as a student. However, or my head of service at that point. 16 16 these have to be in a professional manner and the gossip 17 This colleague ZC, ZC, I -- it was not a colleague 17 and tittle-tattle and unsubstantiated talk such as that, 18 that I --18 is not usually part of a formal professional response to 19 Q. I'm not asking for comments --19 20 concerns. 20 Α. I thought you asked me --21 Sometimes it's in the most informal settings 21 Q. Q. No. no --22 22 that people tell us, when you are in a management role Α. -- if a trusted colleague came to you, 23 or a senior role, what's really troubling them. It's 23 I thought that's what you meant. 24 a big deal to make a formal complaint or come in and 24 Q. Yes, that's what -- well, you -- any make -- to a meeting, and you use the term "escalate" colleague, I am talking about the principle now of --25 25 35

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1 Α. Okay. 2 Q. -- freedom to speak up generally. How does it 3 work for you that someone might tell you in an informal 4 setting, not just that one? You indeed tell us you went back to the children's unit and would have probably said 5 6 to somebody what you'd heard Letby say because it 7 shocked you. 8 Α. (Nods). 9 Q. Again, that would be natural for you to go 10 back and say, "I have just heard someone say this." Do you think if you said it in an informal way like that, 11 there wouldn't be a responsibility on the receiver of 12 that comment to take it forward if they thought 13 "Actually, that's really troubling"? 14 15 Α. Yes. 16 Q. If they knew something else, another piece? 17 Α. I think obviously, as you said before, this was a small piece of a puzzle that in hindsight --18 19 Q. Yes 20 -- perhaps I -- I could have escalated it. Α. 21 But with the limited information I had at that point, 22 I didn't feel professionally I had a need to raise it 23 further. 24 We have -- we encourage all of our staff to speak 25 out, to bring any concerns, as you say, professionally 37 1 other units if it was an internal issue. 2 And so by the time she had moved to the risk Q. 3 patient safety unit, did you think that was a matter 4 that shouldn't be discussed because it obviously 5 affected an employee and she was moved to another unit; 6 is that broadly where you were at with that? 7 Α. Absolutely. Absolutely. Obviously, you know, 8 personal thoughts aside, you know, it's my job to try and maintain professionalism and set an example of as 9 a role model, as a deputy manager, so we would 10 discourage as much as we could general gossip about 11 12 a colleague that, as I say, at that point was 13 unsubstantiated. 14 Q. We know that nurses on the neonatal unit were all e-mailed with information about secondments or being 15 able to move around the hospital for secondments. Was 16 17 there any conversation like that on the children's unit about people wondering about those opportunities or 18 generally talking about secondments at that time? 19 20 Α. Not that I can recall. 21 MS LANGDALE: Just give me one moment. 22 Thank you, I have got no further questions. 23 Okay. Thank you. Α. 24 MS LANGDALE: My Lady, there are no further 25 questions from the Bar. 39

or personally to us as managers. I felt I had a good 1 2 relationship with all of our members of staff and that they could do that and I, as I say, it is my 3 4 professional practice to raise concerns if I feel it appropriate. But at that point, I didn't have all of 5 6 the information that I am now aware of. 7 Q. Understood 8 You also refer to an internal investigation being conducted, I think. Do you know what investigations 9 10 were being done? Whether it was the RCPCH or internally, what did you think was happening? 11 12 I didn't really have much information about Α. 13 that. I knew that the Trust was looking at the mortality rate and the collapses on the neonatal unit. 14 I really knew very little about it as I say, because we 15 16 are a separate unit. 17 Q. Do you think you should have known? Someone should have told you, you are working in a children's 18 19 unit. 20 I suppose we -- we are separate units. We are Α. 21 separate teams of nursing staff. Again, I imagine if it 22 was our unit that it would be dealt with within our unit 23 and escalated appropriately within our management hierarchy. I wouldn't necessarily expect it to be 24 25 shared with the neonatal unit or midwifery or any of the 38 1 LADY JUSTICE THIRLWALL: Thank you very much 2 indeed. 3 No, I have no questions either. Thank you very 4 much indeed, Nurse Lightfoot, you are free to go. 5 MS LANGDALE: My Lady, I am going to ask Ms Bennett 6 to read in sections of Sarah Jayne Murphy's statement to 7 complete the mentoring. 8 LADY JUSTICE THIRLWALL: Thank you very much. 9 Ms Bennett. 10 Statement of SARAH JAYNE MURPHY MS BENNETT: My Lady, the Inquiry has received 11 a statement from Sarah Jayne Murphy, nurse practitioner, 12 13 which reads as follows: 14 My full name is Sarah Jayne Murphy. After studying 15 at Chester University for a diploma in higher educational nursing studies, I qualified as a registered 16 17 children's nurse in February 2004. A few week after I qualified, I went to work on the Children's Unit at 18 the Countess of Chester Hospital where I worked 19 20 until September 2013. 21 Whilst working at the Trust I completed the 22 Teaching and Assessing in Practice module enabling me to 23 become a mentor and an assessor for student nurses. 24 As part of the mentoring and assessing role, 25 I became a sign-off mentor, meaning that I could work

with students during their final placement and their 1 2 OSCEs, the Observed Structured Clinical Examination. 3 My day-to-day duties on the ward included managing 4 the care of a small group of patients, assessment of 5 patients' needs, planning, implementing, and evaluating 6 care delivery according to changing health needs. 7 I worked collaboratively with the wider 8 multi-disciplinary team to ensure health needs were met 9 and contributed to the development of services for children and young people, supervision of others 10 including being a shift leader, development and 11 12 education of student nurses. 13 In September 2013 I left the Trust to work as part of a nurse-led community continence team with the Wirral 14 Community NHS Foundation Trust where I worked for 15 16 a further five years as a Band 6 children's bladder and 17 bowel nurse. 18 During this time, I completed a Bachelor of Science 19 professional practice degree and the V300 independent 20 non-medical prescribing modules. 21 I left Wirral Community Trust in September 2018 and 22 came to work for the Wirral Teaching University Hospital 23 NHS Foundation Trust at Arrowe Park Hospital with the 24 epilepsy team. 25 Currently, I am a Band 7 children's epilepsy 41 1 I do not have complete recollection of assessment 2 and grading of students during placement, students had 3 a large amount of paperwork to complete and were 4 expected to arrange an initial meeting with their mentor 5 to think about how their learning needs could be 6 facilitated during the placement and to make a plan to 7 achieve set placement outcomes. At the midway point, a second meeting would look at 8 9 progress so far and what might still need to be achieved in the second half of the placement and where the 10 student might need further support and learning to 11 12 achieve outstanding outcomes. 13 At the final meeting, the mentor and student would 14 complete outstanding paperwork. The mentor would write a small report and if the outcomes were achieved then 15 sign off the placement as complete. 16 17 There was also a section of this documentation for 18 the student to complete. During the student's placement their mentor would 19 20 be expected to gather feedback from other nursing staff and nursing support staff that their allocated student 21 22 had worked with. This might be done informally, for 23 example if your student had worked a night shift with 24 a colleague you might ask them for feedback at handover. 25 As registered nurses and mentors, we had support

- 1 specialist nurse. I am the lead nurse in a small team
- 2 of nurses working closely with two paediatricians who
- 3 specialise in epilepsy.
- 4 I am an independent nurse prescriber, run nurse-led
- 5 first seizure and teenage clinics, gather clinical data
- 6 for national epilepsy audit and work to develop epilepsy
- 7 services for children and young people locally and
- 8 regionally. I continue to work at Arrowe Park Hospital9 in the same role.
- 10 Mentorship of nursing students.
- 11 During the last year or so that I worked on the
- 12 children's ward at the Countess of Chester Hospital,
- 13 I became the link nurse for students. The role included
- 14 planning student off-day rotas allocating each student
- 15 with a named mentor, liaising with the university
- 16 lecturers to ensure effective learning experiences for
- 17 students. The Nursing and Midwifery Council state that
- 18 a mentor is a mandatory requirement for pre-registration
- 19 nursing students.
- 20 All student nurses were assigned a mentor and
- 21 a back-up mentor and expected to work 40% of their
- 22 placement time with their mentor. It was
- 23 a responsibility of the mentor to get feedback from
- 24 other nurses and professionals who had worked with their
- 25 allocated student.
  - 42
- 1 from Practice Education Facilitators, PEFs, and could
- 2 speak to them for advice and support. This included if
- a student was failing to meet learning outcomes fortheir placement.
- 5 Students would have support from their mentor from
  6 their peers and from university lecturers who would make
  7 visits to the ward during the placement.
- 8 As a sign-off mentor I worked with third year
- 9 students in their final placement. A big part of the
- 10 final placement, and always stressed to the student and
- 11 mentor, was a final placement of the Observed Structured
- 12 Clinical Examination. On this day, the student would be
- 13 given a small group of patients to manage and would be
- 14 expected to be involved in patient allocation, arranging
- 15 of staff breaks, asking for updates from their
- 16 colleagues about their allocated patients.
- 17 A drug round was also part of the assessment where
- 18 the student would be expected to calculate the dose,
- 19 prepare, administer medications.
- 20 I worked with a very capable third-year student who
- 21 during her OSCE, made a drug calculation error and
- 22 failed. We arranged for this examination to be redone
- 23 the following week and made use of lots of opportunities
- 24 for drug calculation practice. On her second attempt
- 25 the student passed and was signed off. This was an 44

- experience of failing the student that stands out for 1
- 2 me. I can't recall failing other students during my
- 3 time as a mentor.
- 4 I believe I was nurturing and encouraging -- and an
- encouraging mentor. I believe that I am approachable 5
- 6 and friendly but always maintain a professional
- 7 relationship with the students.
- 8 I tried to maintain a mix of working closely with
- 9 my students whilst facilitating and encouraging them to
- 10 arrange their own learning opportunities, practice and
- improve clinical and interpersonal skills. 11
- 12 I cannot be certain, however, having now reviewed
- 13 the Royal College of Nursing's guidance for mentors,
- nursing students and midwives, I cannot say for certain 14
- whether this was the toolkit that I would have used. 15
- 16 However, having said that, I might have used a toolkit
- 17 that the university directed the students to use.
- I would have used Nursing and Midwifery Council 18
- 19 standards to support learning and assessment in
- 20 practice.
- 21 Mentorship of Letby.
- 22 I mentored Letby in her first year as a student
- 23 nurse. I believe it was her first ward placement.
- I cannot recall the year. The nurse in charge of 24
- 25 student allocation would have allocated Letby as my 45
- 1 families.
- 2 I presumed that this would come with practice and 3 experience. I cannot recall Letby's reaction to my 4 feedback. My conversation with Letby would have been
- 5 documented in her student paperwork which I presume is
- 6 held by the university.
- 7 In terms of my role as a mentor when working with
- Letby, I was responsible for ensuring that she had 8
- 9 available to her the necessary learning opportunities
- 10 and to ensure that she was able to achieve the required
- competencies and learning outcomes as part of the 11
- 12 placement. Also, my role was to make sure that her
- 13 off-duty rota allowed her to work at least 40% of her 14 time with me.
- During the time that she was working with other 15
- members of the team I would keep track of her progress 16
- 17 by asking for feedback from those members of staff at handover or other times. 18
- 19 In terms of Letby's responsibilities she was
- 20 required to make sure and take the initiative to
- facilitate her own learning. For example, if a student 21
- 22 nurse felt that they would benefit from observing a ward
- 23 round then it would be their duty to ask for this to be
- 24 arranged for them. In addition, it was Letby's
- responsibility to ensure that she proactively arrange 25

- student. I cannot recall who that was but this was the 1 2
- usual process.
- 3 I did not mentor Letby again during her training
- 4 until I was asked to work with her at the end of her
- 5 third year when she had failed her final placement and
- 6 still had three elements of practice proficiencies to
- 7 complete. I monitored and assessed her over a four-week 8 period.
- 9 During her first placement I remember Letby being
- 10 quiet and, I thought, shy. She did not show good
- interpersonal skills with children, parents, nurses or 11
- the wider team. I believe this to be Letby's lack of 12
- confidence and experience as she was very young and an 13
- only child away from home. 14
- 15 There was a tendency among some students to hang
- 16 around the nurses station and the desk area. Letby was
- 17 one of these students and often had quiet an
- expressionless look. I and other staff members found it 18
- 19 awkward and quiet. I think she felt comfortable working
- 20 with me but she remained quiet and never appeared
- 21 particularly animated or to be enjoying herself.
- 22 At the end of the first placement I remember
- 23 telling Letby that although she had passed the
- 24 placement, it was important that she develop her
- 25 communication skills, especially with the children and 46
- 1 the initial, midpoint, and final assessment interview
- 2 dates and times.
- 3 Although the assessment date and times were often 4 agreed between students and mentors, the student was 5 required to communicate their schedule and availability 6 with their mentors so that the arrangements could be 7 agreed upon.
- 8 Letby did not work with me again until the end of her third year after she had failed her final placement 9
- with Nurse Nicola Lightfoot. As Letby had requested to 10
- 11 work with me I had concerns that she might not work
- equally as well and with confidence if asked to work 12
- 13 with another member of staff. I do understand that we
- 14 can't get along with everyone but it is important
- 15 professionally to be able to do this.
- 16 I discussed this with one of the PEFs, I think it
- 17 was Anita Hargreaves, we agreed that Letby would work
- a shift with each of two other colleagues Anne Murphy 18
- and Azra Eccles. 19
- 20 Documentation from when Letby worked with me will
- be in her student paperwork which will be held by the 21
- 22 university. This will include my comments in the first
- 23 year about her need to develop her communication skills
- 24 and from when we agreed that she would work alongside
- 25 two of my colleagues as part of her retrieval process.

This was at the end of her first year. However, I do

- 2 not have the documentation in my possession now.
- 3 There would have been documents in relation to
- 4 Letby's final assessment as well but, again, I do not
- 5 have access to these documents.
- 6 Nurse Lightfoot was already a very experienced and
- 7 senior member of the nursing team when I joined the
- 8 Trust in 2004. In her statement, university lecturer
- 9 Ruth Sadik states that in her mentorship of Letby
- 10 Nurse Lightfoot was "very supportive but very
- 11 forthright".

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- 12 I would agree with this statement and whilst it is
- 13 important to have high standards and expectations from
- 14 students, especially in their third year, I think that,
- 15 unintentionally, Nurse Lightfoot may have been a little
- 16 overwhelming or intimidating at times. This would not
- 17 have been with Letby in particular.
- 18 I do not have a good recollection of the
- 19 proficiencies passed and failed but looking at the
- 20 documentation provided in Letby's student file, Letby
- 21 had eight proficiencies still outstanding. Five of
- 22 these had been and progress made over the previous weeks
- 23 but three were still outstanding when Letby began the
- 24 retrieval process with me.
- I have set out the relevant proficiencies and what49
- 1 personalities between them. I felt awful as I had been
- 2 approached due to Lucy requesting me to be her mentor
- 3 for her final placement and she felt that we had a good
- 4 relationship during her first year placement."
- 5 I have no recollection of the actual shift when
- 6 Nurse Lightfoot failed Letby but I was fully aware that
- 7 this had happened and at some point was made aware that
- 8 Letby had asked for me to be her mentor for the
- 9 retrieval of the final three competencies.
- 10 I do not know how the appeal process works and I do
- 11 not know if it is normal practice for students to be
- 12 able to request a mentor. I cannot recall who
- 13 approached me about being a mentor for Letby's retrieval
- 14 placement. On reflection of events, I do not think
- 15 I would have been given a choice to refuse. I do not
- 16 recall Letby herself discussing anything with me
- 17 directly about being her mentor during her retrieval18 placement.
- 19 In terms of my police statement where I stated
- 20 I felt awful, I do remember being worried about this, as
- 21 the general feeling on the ward was that if
- 22 Nurse Lightfoot, who is very experienced, had failed
- 23 Letby, then that decision should stand. I think at the
- 24 time I personally also believed that if Nurse Lightfoot
- 25 had failed a student that decision should stand.

- 1 they mean.
- 2 A1: demonstrating professional integrity, working
- 3 with patients and families to review and monitor
- 4 progress in care, timely documentation of care outcomes
- 5 to ensure continuity of care.
- 6 D1: development of therapeutic relationships with
- 7 children and family showing an appropriate level of
- 8 communication, employing interpersonal skills of
- 9 effective listening and communication, demonstrate
- 10 evidence of being able to interpret verbally and
- 11 non-verbal signs from patients and families, able to
- 12 reflect on performance.
- 13 J1: evaluate and document outcomes of nursing and
- 14 other interventions, working with the child and family
- 15 to review and evaluate progress, ensure continuity of
- 16 care for the patient, documentation actions, outcomes17 and progress.
- 18 The above is what was meant by the comments "Has
- 19 made great progress in clinical practice and achieved
- 20 five proficiencies. However, still has three
- 21 outstanding AI, DI and JI".
- 22 I note my comments in the police statement where
- 23 I stated:
- 24 "I believe that Lucy appealed Nicky's decision to
- 25 fail her reasoning that there was a clash of 50
- I cannot specifically recall the individuals who
   believed Nurse Lightfoot's decision should prevail.
- 3 However, I do think it was reasonable to hold that view.
- 4 This is because Nurse Lightfoot was an experienced
- 5 and professional nurse and regardless of her direct
- 6 approach to dealing with certain matters, she would
- 7 never fail a student without good reason.
- 8 I only have vague recollection of my discussion of
- 9 Anita Hargreaves about postponing the retrieval process
- 10 as I thought Letby may need time to process the events
- 11 of recent days, ie failing her final assessment.
- 12 However, from the documentation provided I can see
- 13 that it was agreed with the university that the
- 14 retrieval process would start the next day.
- 15 I cannot remember whether Letby spoke to me at all
- 16 before this final few weeks that we worked together.
- 17 I do not think it was common for students to fail
- 18 in their final year. The student I mentioned earlier
- 19 that failed with me had achieved all her competencies,
- 20 it was just that the final OSCE placement was extremely
- 21 stressful for students and sometimes mentors too. We
- 22 were able to repeat that after a few days with some drug

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- 23 calculation practice.
- 24 I do not remember conversations with
- 25 Nurse Lightfoot and/or Ruth Sadik with regards to 52

1	concerns about Letby. I do not remember the exact	1	It would be usual for the retrieval placement to be
2	nature of conversations with the PEFs, but I do remember	2	documented but I cannot remember exactly where or how.
2	feeling very supported by them.	2	I would imagine the school of nursing would have a
4	Due to the lapse of time, I cannot recall	4	record of the documentation.
5	a conversation with Nurse Lightfoot or anyone else	5	During her police interview Ruth Sadik discussed
6	stating that Letby would not be ready to qualify as	6	her thoughts about Lucy passing these final
7	a nurse in four weeks' time, which was the length of the	7	proficiencies and her comments relate to a conversation
8	retrieval placement.	8	that she had with me. She stated:
9	My concerns about Letby during her retrieval	9	
9 10	placement were whether she would be able to demonstrate	9 10	"I spoke to Jayne to ask why she was passing her and Jayne had a lot of a lot of soul searching. It
11	the ability to work with other members of the nursing	10	wasn't something she did easily but she felt that it was
12	team, not just with me and so I arranged for her to work	11	right to do. Now, my personal thoughts at that time
12	with Anne Murphy, who was a ward manager at the time,	12	were that Jayne was conflicted but that bit is because
			-
14	and with Azra Eccles, who was working as a Band 6 nurse	14	Nicky is quite a powerful person. She wanted to please
15 16	in the children's assessment unit. I believe it is documented that I received positive	15	Nicky but also that she her conscience wouldn't allow her to, and she had seen what she saw."
	feedback from them but I cannot remember what the	16	
17		17	I cannot remember the conversation above with
18	feedback was.	18	Ruth Sadik but I did feel conflicted at the time as
19	Letby worked with me and with other nurses when	19	Nurse Lightfoot had felt that Letby was not competent to
20	I was not on shift to achieve the three proficiencies documented above. I cannot remember the actions	20	pass the final placement. But after observing and
21		21	working with Letby for a number of weeks, I had felt
22	planned made for how these competencies might be	22	that she had achieved the three outstanding
23	achieved, but I do know that I would have monitored	23	proficiencies.
24	Letby very carefully and asked for feedback both from	24	I cannot recall a conversation with Ruth Sadik, but
25	her and from other nurses that she worked with. 53	25	from my perspective, I was asked to assess Letby based 54
1	on the three proficiencies and whether she had met	1	My Lady, that concludes the statement.
2	those. From what I had observed during my assessment	2	LADY JUSTICE THIRLWALL: Thank you very much
3	I could not say that she did not meet those three	3	indeed, Ms Bennett. Is that a convenient moment for the
4	proficiencies. Also, I would like to reiterate that	4	break.
5	I sought feedback from other members of staff that she	5	<b>MS LANGDALE:</b> It is, my Lady, 11.30?
6	worked with and so I had no reason to believe that she	6	LADY JUSTICE THIRLWALL: So we will rise now and
7	was performing well only just during my assessments.	7	start again at half past 11.
8	If, however, the feedback I received was negative	8	(11.13 am)
9	and raised concerns about Letby, this would have of	9	(A short break)
10	course impacted my assessment on whether or not she had	10	(11.30 am)
11	passed those proficiencies. I cannot recall what was	11	LADY JUSTICE THIRLWALL: Ms Brown.
12	meant by the quote, "she had seen what she saw."	12	<b>MS BROWN:</b> If we could call the witness, please.
13	Friendship.	13	JULIE CAROLE FOGARTY (sworn)
14	I don't recall that Ruth Sadik and Letby were	14	Questions by MS BROWN
15	friends and I am not aware that they socialised	15	LADY JUSTICE THIRLWALL: Do sit down.
16	together. My relationship with Letby was purely	16	A. Thank you.
17	professional. I would not count her as a friend or	17	<b>MS BROWN:</b> Could you please give your full name.
18	someone that I would socialise with. Louise Newman(?)	18	A. I am Julie Carole Fogarty.
19	in her statement talked about friendships on Facebook	19	<b>Q.</b> Mrs Fogarty, you provided a witness statement
20	which I do not use so I would not be aware of	20	to the Inquiry dated 30 May 2024. Is that statement
21	a friendship between Ruth and Letby.	21	true to the best of your knowledge and belief?
22	Concerns or suspicions.	22	A. Yes, it is.
23	I left the Trust in 2013. I was never made aware	23	<b>Q.</b> And turning to your qualifications, it is
24	of any suspicions or concerns about the conduct of Letby	24	correct, is it, that you qualified as a registered
25	at any time.	25	general nurse in 1985, as a registered midwife in 1988,
	55		56

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and as a supervisor of midwives in 1996? 1 2 Α. That's correct. 3 Q. And you also have a degree in midwifery and 4 a postgraduate certificate in leadership behaviours. 5 Α. That's correct. 6 Q. And turning to your career history, when did 7 you first start working at the Countess of Chester 8 Hospital? 9 Α. So in 1987 I commenced my midwifery training 10 as a student midwife. And when was your first role as a midwife? 11 Q. So that would be in 1988, upon qualification 12 Α. 13 as midwife. Q. And that was at the Countess of Chester? 14 15 Α. Yes 16 Q. And I think approximately 12 years later, you 17 were appointed Head of Midwifery in July 2010? Yes, that's correct. 18 Α. 19 And in that intervening period you worked Q. 20 solely at the Countess of Chester Hospital, did you? Α. 21 Yes 22 Q. And you moved, I think, from your role of Head 23 of Midwifery to that of Associate Director of Risk and 24 Safety in April 2017, is that correct? 25 Α. That's correct, yes. 57 1 Α. That's correct, yes. 2 And you also say that within your area of Q. 3 responsibility, was the quality of the patient 4 experience. Can you just expand a little on what you 5 mean by that phrase? 6 Δ So it's making sure that women had a voice and 7 their views were listened to and that the care they 8 received was to the best of the ability of the staff and 9 the services available, and that it moved in time with new initiatives as they developed within midwifery. 10 11 And you say in paragraph 9 of your statement: O. "I had lead responsibility for co-ordinating 12 clinical risk activities with maternity services." 13 14 In practical terms, what does that mean? So it's making sure that the midwives were 15 Α. trained, so they knew how to report incidents using the 16 Datix system; that any reports that were produced were 17 received at the Women & Children's Care Governance Board 18 and that as a, as maternity services we reviewed any new 19 20 guidance that came out, issue -- and things like the NICE guidance, that if anything new came out that they 21 22 were reviewed within a timely manner and that anything 23 that needed changes in practice that they were 24 implemented. 25 Q. And your role as Head of Midwifery, did that 59

Q. And having worked in midwifery for all of your 1 2 career up to that point, why did you make that move? I was asked by the Director of Nursing at the 3 Α. time to go and oversee that department because the 4 5 previous postholder had left. 6 Q. And who was the previous postholder? 7 Α. Ruth Millward. And I think it is correct that you retired 8 Q. from the NHS in April 2020? 9 10 Α. Yes, that's correct. 11 Q. So that was after three years of Director of Risk and Safety but how long in total did you work at 12 the Countess of Chester Hospital? 13 So from 1987 to 2020, so 33 years. 14 Α. 15 Q. And how did you find the Countess of Chester 16 as a place to work? 17 Α. It was a happy place to work, people were proud to work within maternity services which is where 18 19 was the bulk of my career. 20 And in your role as Head of Midwifery -- you Q. 21 set out in your statement at paragraphs 8, 9 and 10 what 22 your role involved. But it's correct that included in 23 your responsibilities was ensuring midwifery care was delivered by competent midwives and best practice was 24 25 followed? 58 1 ever involve actually working on the ward as a midwife 2 if -- filling in if the ward was short-staffed? 3 Α. No, not clinically no. 4 Q. So there was no -- from when you took over as 5 Head of Midwifery, there was no clinical aspect to your 6 role? 7 Α. No. 8 Q. And you say in your statement as well at paragraph 9 that you participated in the Trust managers 9 on-call rota? 10 Α. 11 Yes 12 Q. Can you explain what that was? 13 Α. So out of hours there was always someone on 14 duty for the clinical psych ward, who managed the Trust, to contact someone if there were issues with ambulance 15 delay, staffing. So it was making decisions to try and 16 keep the Trust safe out of hours and we reported 17 directly to the -- there was always an executive on-call 18 that we would escalate if we had concerns. 19 20 Q. So the on-call rota would be the most senior person on site subject to access to an executive 21 22 director, is that --23 We wouldn't be on site, we would be at home, Δ. 24 as would the executive but we would attend if we needed 25 to.

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1	<b>Q.</b> And how often would you be asked to be on that
2	call rota?
3	A. Probably a couple of times a month.
4	<b>Q.</b> And in terms of your physical presence on the
5	ward, how often would you, you said you didn't have
6	a clinical role, but how often would you be physically
7	present on the maternity ward, walking around?
8	<b>A.</b> Probably three, four times a week.
9	<b>Q.</b> And where was your office in relation to the
10	maternity ward?
11	A. It was in the Long House Building, which was
12	the building virtually next door to the maternity unit.
13	<b>Q.</b> So did you have to leave one building and go
14	into another or did you just
15	A. There was a corridor, so it, it was just
16	a corridor but I did have to leave one building, so
17	I was based in what was known as the Long House, but it
18	was literally next door.
19	<b>Q.</b> And in terms of the neonatal ward, would you
20	ever have cause to visit the neonatal ward to actually
21	walk on to that ward?
22	A. No, no, it wasn't in my remit, so no.
23	Q. And just looking at where the Head of
24 25	Midwifery fitted into the divisional structure. Midwifery was part of the Planned Care Division?
20	61
1	Q. And did you feel that this management
2	structure, with those three well with your four
2 3	structure, with those three well with your four posts sitting at the top of the Planned Care Division
2 3 4	structure, with those three well with your four posts sitting at the top of the Planned Care Division was that a management structure that worked effectively?
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quir	У	15 October 2024
1	Α.	Yes.
2	Q.	And then at the top of the Planned Care
3	Division th	nere was a divisional director of Planned
4	Care, who	was that?
5	Α.	Linda Fellowes.
6	Q.	And then again, looking at Planned Care, there
7	would be a	a Head of Nursing for Planned Care and that was
8	Carmel He	ealey?
9	Α.	That's correct, yes.
10	Q.	There was your role, obviously, as Head of
11	Midwifery,	and then there would be a Medical Director
12	for Planne	ed Care and that was David Semple, I believe?
13	Α.	Yes.
14	Q.	And what was his specialty as a doctor?
15	Α.	So he was an obstetrician.
16	Q.	And in terms of that management structure of
17	the Planne	ed Care Division, David Semple and Carmel
18	Healey, di	d they continue in practice or were those
19	full-time m	nanagement roles?
20	Α.	So Mr Semple continued clinical practice.
21	Carmel He	ealey was like myself; it was a management role.
22	Q.	And who did you report to?
23	Α.	So I reported directly to Alison Kelly, the
24	Director o	f Nursing, and Linda Fellowes, the divisional
25	director.	
		62
1	and if her	baby had cause to be admitted to the neonatal
2	unit, the b	aby would then be under the Urgent Care
3	Division?	
4	Α.	Yes.
5	Q.	And what were the problems that you saw with
6	that struct	ure?
7	Α.	I just felt that if the two areas of care had
8	been with	in the same division, there would have been
9	more joint	working, there would have been better
10	communic	cation and we would have been on the same journey

11 together at the start of projects.

- 12 **Q.** And Dr Brearey raised this issue and you refer
- 13 in fact to 20 July 2015 in your statement, at
- 14 paragraph 21 as well, that the divisional structure with
- 15 Urgent and Planned Care split, obstetrics, gynaecology
- 16 and midwifery on one side, paediatrics and neonatal
- 17 within Urgent, and that was discussed at the Quality,
- 18 Safety, and patient Experience Committee that you sat
- 19 on, I think, as well?

20

- A. Yes, I did.
- 21 **Q.** And Dr Brearey said at that meeting that he
- 22 considered the split would hinder the improvement of
- 23 maternity, neonatal and paediatric services. Did you
- 24 agree with that view?
  - A. I did, yes.
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And I think you have explained, but did you --1 Q. 2 what did you understand was Dr Brearey's concern and 3 objections to the structure? 4 Δ It was similar to mine. The fact that we were both reporting through two different divisional lines 5 6 instead of through one joint divisional line. So 7 methods of communication sometimes were delayed. 8 Q. And just staying on communication there. You 9 say that you felt that being, as you have explained now, 10 you say in your statement that if you had been in the same division you felt there would be improved 11 communication. Just so I am clear. You are talking 12 there, I think, about communication in terms of the 13 management structures, or are you also talking about 14 communication at a nursing and doctor level? 15 16 Α. More as --17 Q. Nursing and midwives, I should say. 18 Α. More as the management structure. 19 Q. And in terms of this Inquiry, do you feel if 20 there had been one Women's and Children's division, as I think there was before --21 22 Α. Yes 23 Q. -- and I think as there is now, do you think 24 that you and your colleagues in the midwifery obstetrics and gynaecology might have been alerted at an earlier 25 65 1 literally went through a door and that's where the 2 neonatal was. And also from the Consultants' point of 3 view they were based in the same building as myself. So 4 that eased communication as well. 5 So just to be completely clear, the labour Q. 6 ward and the neonatal units weren't on different floors? 7 Α. No 8 Q. They were on the same floor. And when you said about offices, did that mean that on a daily basis 9 you would be walking past colleagues who worked on the 10 neonatal unit? 11 No. No. So the Consultants were in the same 12 Α. 13 building but not the, not the neonatal nurses. 14 Q. So you worked in a different building to the 15 Consultants? 16 Α. No, my office was in the same building as the paediatricians, obstetricians and myself, we were all 17 based in the Long House Building. 18 19 Q. I see, thank you. And the Inquiry has heard some characterisations of 20 there being hostile relationships between midwives and 21 22 those working on the neonatal unit, doctors not feeling 23 welcome on the maternity ward, tensions between nurses 24 and midwives. Is that something you recognise? 25 It's not something that was ever escalated to Α.

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1 stage to the concerns that we know there were in the

neonatal unit?

Α. Yes.

- O. And related to that, and maybe if you can just
- expand on that -- it might seem obvious to you, but why 5
- 6 do you say that you think you would have been alerted to 7 those issues earlier?
- 8 Α. We would have been at meetings where they
- 9 would have been potentially discussed.
- 10 And related to that question, do you think Q.
- that divisional split also had an effect on how the 11
- management responded to the issues because they had two 12
- chains of command going to them? 13
- 14 I don't -- I don't feel that I can comment on Α.
- 15 how the management responded.
- 16 I'm just staying with communication then for Q.
- 17 a moment. In terms of the practical aspects of
- communication, you have explained that at management 18
- 19 level the two units meant that you were in different
- 20 meetings, but you say that the labour and neonatal units
- 21 were positioned next door to one another.
- 22 Can you just explain the geography as to where the
- 23 labour ward and the neonatal unit was?
- 24 Α. So from a clinical position of wards, it was
- 25 literally through a door. So the labour ward, you 66
- 1 me and not something that I recognised from my time 2 clinically working.
- 3 Q. And what was your view, your personal view of 4 relations between midwives and nurses? You obviously 5 worked as a midwife for a long period before you went 6 into a management role.
- 7 Α. Yes. So there -- there never seemed to be 8 a problem, you know, there was always good
- 9 communications so the minute somebody came into the
- labour ward and there was a potential that they may need 10
- 11 neonatal services, you would go through as a shift
- leader and alert the neonatal unit to that fact so they 12
- 13 could start to prepare.
- 14 Q. So that's at the level of midwives and nurses. 15 Α. Nurses.
  - Q. At your level, at the management level, if you
- 16 17 wanted to speak to someone on the neonatal unit about
- a common issue, who would be your point of contact? 18
- So I would go to see the manager at the time 19 Α. 20 so that was Eirian Powell.
- 21 And what sort of working relationship did you Q.
- 22 have with Firian Powell?
- 23 Δ. We didn't have a problem. We didn't see each
- 24 other very much but if I needed to speak to her she
- was -- she always made herself available and we always 25 68

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agreed on a plan going forward. 1 2 Q. And in practice, how would that take place, 3 would you walk to her office, call her on the phone, 4 just a feel of how often you would be in communication 5 with Eirian Powell? 6 Α. So it would be very, very infrequent. But 7 normally I would email her to see if she's free. 8 And in relation to Dr Brearey who was the Q. 9 clinical lead of the neonatal unit, what was the extent 10 of your contact with him? So, again, I would see him very infrequently 11 Α. because he wasn't working in the same sphere of practice 12 13 as myself. And how would you describe your working 14 Q. relationship with Dr Brearey, or was it minimal? 15 16 Α. Very -- if ever I needed to engage with him 17 there was no issues whatsoever. 18 Q. And presumably you would have a great deal 19 more contact with the Consultant obstetricians? 20 Daily. Α. 21 Q. Just staying with the culture of the hospital 22 for a moment. Generally the relationship with doctors 23 and nurses, how would you have observed that, how would you characterise that? 24 25 Α. I can only comment on the relationship between 69 1 on the corridor if I went to the execs' office to 2 escalate or to drop a report off, then I may see her 3 there. 4 Q. And what could you or -- could you comment 5 about Alison Kelly's level of engagement with the issues 6 on the maternity ward and the issues that you were 7 dealing with? 8 Α. So she was always engaging, if ever I had 9 anything I need today escalate I always had access and she listened. 10 11 O. And in relation to Tony Chambers and Ian Harvey would you have cause to have much contact 12 13 with either of those? 14 Α. I didn't see them on a regular basis but there would be meetings that they would be present at that 15 I would also be present at. 16 17 And members of the board. Sir Duncan Nichol Q. would you come into contact with him? 18 Α. So again, I didn't see him on a regular basis, 19 20 but he may be there in the execs' office. He came to visit maternity unit when we won an award. So he was 21 22 aware of what was happening but I didn't see him on 23 a regular basis at all. 24 Q. And the non-executive board members, would you 25 have known who they were?

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1 doctors and midwives.

Q. Of course.A. And I felt the

A. And I felt there was excellent teamworking.Q. And relationships between staff and senior

management, again, you will be dealing with staff within

6 your unit, but what were the relationships like between

7 staff and senior management?

8 A. I mean, I can -- again, I can only really

9 comment for within maternity services and there didn't

10 appear to be a problem. It wasn't anything that was

11 ever escalated to me or anything that came out through

- 12 any incident reporting or -- there were lots of
- 13 different channels that people could go to if they

14 needed to and they were never, they were never used.

15 Q. Why was that? Why were these channels never16 used?

17 **A.** Because obviously people didn't feel there was

18 a need to escalate. They felt that if they wanted to

19 speak to managers they had access.

20 **Q.** And in relation to access to managers, your

21 relationship with Alison Kelly as the person who you

22 reported to, or one of the people you reported to, how

23 often would you see her?

24 A. So I had a monthly one-to-one with her but

- 25 I would also see her at meetings and I may bump into her 70
- 1 Α. Yes. 2 Q. Did they ever visit? 3 Α. Yes, I mean, some of them were -- some of them 4 were on QSPEC and there were a number of meetings that 5 I attended that they represented -- you know, 6 represented the non-execs on. 7 Q. Just one final point looking at the divisional 8 structure, you gave an interview, I think you'll recall, to Facere Melius in -- on 14 July 2020. You recall that 9 interview? 10 Α. 11 Pardon? Sorry? 12 You had an interview --Q. 13 Α. Yes, yes. 14 Q. -- on 14 July? And one of the points you made 15 in that interview was you felt the fact that neonatal unit being in Urgent Care and the fact that A&E also 16 17 clearly was part of Urgent Care with the four-hour target that they work to, meant that the neonatal unit 18 was swamped, what did you mean by that? 19 20 Α. Well, the fact that that was a big division 21 with a lot of competing priorities. 22 Q. And you also say --23 LADY JUSTICE THIRLWALL: Sorry, I wonder, could you 24 just -- I am sorry, Ms Brown.
- 25 But the neonatal unit was swamped, do you mean sort 72

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of overlooked or do you mean too much to do? I wasn't 1 2 ... 3 Yes, the fact that there was a lot of Α. 4 competing, so A&E had the four-hour target and I, mean that may have not been the fact, that was just my 5 6 personal opinion. LADY JUSTICE THIRLWALL: Yes, and that's what you 7 8 are being asked about. 9 Α. That that, you know, potentially because that 10 division was very big and had a lot of competing pressures, because of the nature of the work, then the 11 neonatal unit potentially suffered because of that. 12 13 MS BROWN: And you go on to say in that interview, which I think is what you are explaining now, that you 14 felt it wasn't given the attention it deserves and 15 16 people weren't aware of the issues in the neonatal unit. 17 Who are you referring to there as -- who are the 18 people who weren't aware of the issues? 19 So the -- the Urgent Care management. But Α. 20 that, that may have not been correct. That was just an assumption I was making but that may not have been 21 22 correct. I didn't have any hard facts. It was just 23 a feeling. 24 Q. And when you are saying there people weren't 25 aware of the issues in the neonatal unit, what issues 73 1 Women's & Children's Care Governance Board that the 2 chair was Dr McCormack who was a consultant obstetrician 3 and gynaecologist. How would you describe your 4 relationship with him? 5 I would say I had an excellent working Α. 6 relationship with Mr McCormack. 7 Q. And you were the deputy chair? 8 Α. That's correct, yes. 9 And what did the role of deputy chair of the Q. Women's & Children's Care Governance Board involve? 10 Α. So if Mr McCormack was on leave, so unable to 11 attend the meeting, then I would chair the meeting. 12 13 Q. And did you have an input into, for example, 14 what would go on to the agenda? Not, not unless I was actually going to chair 15 Α. 16 the meeting. 17 Would you discuss the agenda with Q. Mr McCormack? 18 Not before the meeting, no. 19 Α. 20 Q. But presumably if you had something you felt would be on it you would be able to raise that with him? 21 22 Yes, we had a standard agenda item but any Α. 23 items you wanted to be received, you referred them to 24 the risk and safety lead and she put the agenda 25

together.

- are you referring to there, are you talking about the 1
- 2 issues of increased mortality or --
  - Α. Yes.
  - Q. -- more generally?
  - Yes, because obviously I was interviewed in Α.
- 6 2020 and I was aware then of the mortality issues.
- If we can look now at some of the committees 7 Q.
- that you sat on. We are looking first at the 8
- 9 Women's & Children's Care Governance Board, and if I can
- 10 call up INQ0015325.
- 11 My Lady, this is tab 13 of your bundle.
- 12 LADY JUSTICE THIRLWALL: Thank you.
- 13 MS BROWN: This is going to show up the Terms of
- 14 Reference, I hope.
- 15 So this is a document that's the Terms of
- 16 Reference. This document, Ms Fogarty, was actually --
- 17 is dated February 2016 but it appears they were updated
- 18 on a, on a sort of annual basis, the Terms of
- 19 Reference --
- 20 Α. Yes.

21 Q. -- so would it be right to say that this, this 22 document would be reflective of the year before and 23 probably the year after?

- 24 Α. Yes
- 25 Q. And we can see there in terms of the 74

1 Q. And if we just look down that list, we can see, as one would expect, there are representatives from 2 3 the Planned Care Division, from Midwifery, so you, 4 Mr McCormack, the Head of Nursing for Planned Care, and 5 then also there's representatives from the Urgent Care, 6 Dr Jayaram, Dr Brearey, the Head of Nursing of Urgent 7 Care. 8 So this was a committee that brought together -whereas there was a division in management structures, 9 this was the committee that brought both units together 10 in terms of the care of women and children? 11 12 Α. Yes 13 Q. And if you can just in overview, what would 14 you say the primary role was of the Women & Children's 15 Care Governance Board? 16 So we were monitoring, so from a midwifery Α. aspect I was there to ensure that reports that had been 17 received in the Trust were reviewed and then received in 18 the board. Any serious incidents that had action plans, 19 20 that they were monitored until they were completed. If we had had an inspection by the CQC and there were 21 22 action plans, that they were received at this board and 23 then they were monitored until actions were completed. 24 Q. And presumably as deputy chair, whilst you 25 obviously came to it with a midwifery perspective, your

If, if that information was brought to the

And going down the next bullet point, so the

So every area had a risk register and if a new

And obviously the trend that this Inquiry is

Yes, we would be looking at the data.

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You would expect them to bring those concerns,

So turning now to another committee that you

So there was a hierarchy here, correct me if

And we see, just picking out some of what they

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And what about concerns about some commonality

Yes.

It could be, yes.

Yes.

Yes

1 position on the committee, as with everyone on the 1 meeting? 2 committee, was to see that this looked at things 2 Α. 3 holistically, that the committee looked at both 3 meeting, yes. 4 midwifery and the neonatal care? 4 Q. 5 Yes. Α. 5 third bullet point: 6 Q. That was the purpose of the board presumably? 6 "Review and monitor the risk registers, escalate 7 Α. So we were responsible so the -- everybody who 7 risks to the divisional and organisational risk was a member was responsible for bringing documents to 8 8 registers". 9 the meeting and at that meeting, we all would review and 9 Again, just can you explain in simple terms what 10 challenge. However, we were aware that because it is 10 that actually in practice meant? such specialised work, we were dependent on the 11 11 Α. specialist to provide the overview. risk was identified, they would be discussed at 12 12 13 And I think if we could go over the page to a divisional level and then brought to this meeting for Q. 13 page 2, we will just see the duties and responsibilities noting and escalating further. 14 14 there. And we see the second bullet point down, that Q. And then finally, not quite finally, the next 15 15 16 one of those was to: 16 but one down says: 17 "Provide assurance to the board lead executive of 17 "Review and monitoring ..." effective risk management". 18 And one of the things you were reviewing and 18 19 Again, what does that mean in practice? 19 monitoring was incident trends. 20 So if we had any concerns that were identified 20 Α. Α. 21 21 or any gaps or risks that we then made sure that we Q. 22 escalated them through this meeting. 22 concerned with is the trend of increased mortality, so 23 Q. So if you had a concern, for example, about 23 that would fall -- should that be the trend that would increased mortality rates, this would -- that would be 24 fall within the remit of this? 24 the sort of thing that should be escalated through this 25 25 Α. 77 1 Q. When you say you are looking at the data, what 1 Α. 2 data would you be looking at on a regular basis? 2 yes. 3 Α. So, so every month we would be looking at any 3 Q. 4 new Level 1, 2 or 3 investigations, progress of action 4 in terms of a member of staff being connected to deaths 5 plans and any trends that were being identified that 5 or collapses, would that be something that you would consider could be raised in this forum? 6 were being flagged up to us. 6 7 Q. And then just the last one that has particular 7 Α. 8 relevance, three from the bottom: 8 Q. 9 "Also duties and responsibilities to ensure that sat on, and if I could go to INQ0002639. 9 clinical performance, quality monitoring and reporting So this is the Quality, Safety & Patient Experience 10 10 11 mechanisms are working effectively". 11 Committee and this, we can see there at the top, was So that would be one of the responsibilities of a committee that reported to the Board of Directors? 12 12 13 this board. 13 Α. 14 Α. Yes Yes 14 Q. So in terms of -- I think you have accepted I have this wrong, Mrs Fogarty, where the 15 Q. 15 that this would be an appropriate forum to discuss Women's & Children's Care Governance Board would take 16 16 concerns about increased rates in mortality, more babies the views from the neonatal and the midwifery and look 17 17 dying; this would be something that would fall -at things from the perspective of women and children and 18 18 babies and then their concerns would be escalated to Α. Yes 19 19 20 Q. If there were concerns about this, this would 20 QSPEC? be the place to discuss it? 21 Α. 21 22 Α. Yes 22 Q. 23 And this would be the place that you would 23 say the purpose was in the Terms of Reference there, Q. 24 bring, you would expect people to bring those concerns 24 four bullet points down: 25 "To monitor serious untoward incidents". 25 to you?

How would the committee do that? 1 2 Α. So the -- Ruth Millward would produce a report 3 for that committee on numbers and progress, et cetera. 4 O. So if there was a serious incident on the neonatal unit, you would expect that to come up 5 6 to QSPEC? 7 Α. So if it meets the STEIS Level 2 or 3 8 reporting then, yes. 9 And it says there as well, the next bullet Q. 10 point: 11 "To review the risk register." There seems to be some overlap here with who is 12 looking at risk registers. Can you just explain that, 13 was there an overlap or was this forming a different 14 function? 15 16 Α. So the review of the risk registers is when 17 the divisions have escalated a risk that cannot be managed at divisional level and the executives need to 18 19 be aware of. 20 And it says then, three bullet points up, Q. 21 under the section 1 on purpose: 22 "To gain assurance from divisions in all matters to 23 do with risk governance, quality, and patient 24 experience." 25 How, in practice, did QSPEC gain assurance from the 81 1 Trust Safeguarding agenda. What was the Trust's 2 Safeguarding agenda? 3 Α. I don't know that in detail. So I can't 4 answer. 5 LADY JUSTICE THIRLWALL: So what did you think was 6 the purpose of the board? 7 Α. So the purpose of the board was to make 8 sure --9 LADY JUSTICE THIRLWALL: In practical terms. 10 In practical terms, they monitored things like Α. mandatory training for safeguard to make sure that staff 11 were getting the training. If there had been a serious 12 case review that the Trust had looked at it and looked 13 14 at the implications for the Countess and addressed any action. That there was --15 16 LADY JUSTICE THIRLWALL: Let's take that example. 17 Α. Yes LADY JUSTICE THIRLWALL: Where would the outcome of 18 the review have been sent? 19 20 Α. So, so an example being so Victoria Climbié, when that report came out, I met with Karen Milne from 21 22 a midwifery perspective to look if there were any, any 23 actions we needed to take, but that report would come at 24 that meeting. 25 LADY JUSTICE THIRLWALL: To the Safeguarding Board? 83

divisions? 1 2 Α. So if there was something that was a concern they would invite the lead Consultant or manager to 3 4 QSPEC to present assurance. And if I could just turn to paragraph 33, then 5 Q. 6 of your statement, where you at the end of that you 7 refer to one other board you sat on and that was the Trust Safeguarding Board, and you say that met four 8 9 times a year. 10 What dates were you a member of this board? 11 Throughout my time as Head of Midwifery. Α. 12 And who chaired that board? Q. 13 Α. That was chaired by Alison Kelly. 14 And if you can recall, other than yourself and Q. Ms Kelly, who else sat on that board? 15 16 So Karen Milne sat on there, she was the lead Δ 17 midwife for Safeguarding, her deputy, there were members from external agencies. 18 19 So approximately how many members on that Q. 20 board, from recollection, sitting at the table? 21 Α. About 20, if I recall. 22 Q. And who did that board report to? 23 Α. I can't, I don't know that answer. 24 Q. And you say in your statement there were 25 quarterly meetings to support effective delivery of 82 1 Α. To the Safeguarding Board, yes. LADY JUSTICE THIRLWALL: Then does that mean --2 just reflecting on what the practicalities were, does 3 4 that help you remember who the board was accountable to? 5 It, it sorry, it doesn't. Α. LADY JUSTICE THIRLWALL: Where would we be able to 6 7 find that out? It should be in the Terms of Reference of the 8 Α. Safeguarding -- because they had Terms of Reference so 9 10 it should be in that. 11 LADY JUSTICE THIRLWALL: It may be that we have 12 them but you can't remember --13 I can't remember, no. LADY JUSTICE THIRLWALL: All right. 14 15 MS BROWN: And you speak there, and you have spoken in response to a question there about the mandatory 16 17 training you are referring to. Did the Safeguarding 18 Board, did they look at the content of that mandatory training, was that something that you would consider 19 whether the content of the training was adequate? 20 21 I don't recall us -- it ever being an agenda Α. 22 item to actually look at the contents of the training. 23 It only looked at the delivery, ie percentage of staff 24 that had attended. 25 Q. And in terms of turning to that, if you are

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unable to -- so what I was intending to ask is whether 1 2 you were aware whether the training made clear who 3 Safeguarding issues should be raised with and what the level of concern was needed before a concern was raised 4 with the Safeguarding Board -- are you able to help with 5 6 that? 7 Α. Yes, I mean I attended the same mandatory 8 training as my clinical midwives and we were always told 9 that you could go to the Safeguarding team if you had 10 a concern and it was better to escalate and it be found not to be a concern than to not escalate at all. 11 12 And you said just earlier about the list of Q. people who were trained. The Inquiry has heard evidence 13 that there were a large number of doctors training with 14 their six-month placement. How did you, as a hospital, 15 16 approach Safeguarding training for those doctors who 17 were rotating through the system being --I -- I wasn't responsible for any, any part of 18 Α. 19 doctor training. I only know from the Consultant obstetricians' point of view they attended the midwifery 20 training alongside the midwives for Safeguarding. 21 But I am unable to provide information about the 22 23 rotational doctors. But I am asking you here not in relation to 24 Q. 25 your Head of Midwifery role but as sitting on the 85 1 why that was? 2 No. I, you know, I have never been asked as Α. 3 to why that was. 4 Q. Well, sitting on the Safeguarding Board, you 5 have told us about your training, that you understood if 6 there was any suspicion, even if you weren't sure, to 7 raise it. Why, why do you think no one took that view 8 about the concerns they had about Lucy Letby? 9 I can't answer why colleagues didn't, didn't Α. escalate through those channels. 10 At what point did you have suspicions, 11 O. 12 Mrs Fogarty? 13 Α. So I became aware -- so, obviously, I was 14 aware of three neonatal deaths in July of 2015 because I attended a Trust Serious Incident Panel but I then 15 next became aware in June 2016. 16 17 And at that point, in June 2016, you were Q. aware of suspicions about -- a member of staff about 18 Letby? 19 20 Α. I didn't know the name but I knew there was 21 suspicions following the death of the triplets. 22 Q. So whilst you may not be able to answer on 23 behalf of other people, why, why did you not raise that 24 as a Safeguarding concern at that point? 25 Because I didn't have enough data. I didn't Α. 87

Safeguarding role, how did you assure yourself as 1 2 a member of a board that the doctors working there, part of the staff, were properly trained? Was there a system 3 4 for seeing --They were part of the statistics and it, it 5 Α. 6 demonstrated that there was compliance for all members 7 of staff. They were broken down into staff groups, the report, so you knew that doctors were getting the 8 9 training. 10 Q. So as far as you were aware --So as far as I was concerned, everybody had 11 Α. access to Safeguarding training. 12 13 Having access is not quite the same as doing Q. Safeguarding training. Were you looking at who had 14 actually completed their Safeguarding training? 15 16 Α. Sorry, can you repeat? 17 Q. Were you looking at who had actually completed Safeguarding training as opposed to simply had access 18 19 to it? 20 Α. No, it is who has completed. 21 Q. Mrs Fogarty, it appears that the suspicions 22 about Letby harming babies were not in fact treated as 23 a Safeguarding concern and it was not raised through Safeguarding channels. Given your role on the 24 25 Safeguarding Board, have you got any reflections as to 86 1 have the information, I didn't have the clinical information that was required. And I was also aware 2 3 from the workstreams by the executives that there were, 4 there were people who were appropriately trained 5 reviewing the clinical care of the babies. 6 O. You did go on, and we shall come to this in 7 due course, but there was a point where you were the 8 day-to-day manager of Letby -- (overspeaking) --9 Α. That is correct. 10 Q. At that point, clearly you knew exactly the 11 person involved and the suspicions that were being raised. At that point did you not think this should be 12 raised as a Safeguarding concern? 13 14 So I wasn't Lucy's direct line manager until Α. 15 2018 when the police were already involved. 16 Q. Prior to the police being involved, did you not -- you were aware at that point that Lucy had been 17 moved -- Letby had been moved off the unit? 18 Α. No. 19 20 Q. Did vou --21 No, I wasn't aware that she had been moved off Α. 22 the unit until the -- July, July '16. 23 And at that point, why did you not raise Q. 24 a Safeguarding issue at that point? 25 Because I didn't have any further information Α. 88

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to back up. 1 2 Q. And you are aware, were you, Mrs Fogarty, that 3 the guidance on Working Together is that Safeguarding is 4 everybody's responsibility? 5 Α. Yes 6 LADY JUSTICE THIRLWALL: Sorry, Ms Brown. 7 So did you think of raising it? 8 No, because --Α. 9 LADY JUSTICE THIRLWALL: You have given a lot of reasons why you might not have done it. But I just want 10 to see whether you actually thought of it in the first 11 12 place. 13 I didn't think of it in the first place. Α. 14 LADY JUSTICE THIRLWALL: And I just wonder if you might reflect now and think I wonder why that was that 15 16 you didn't think of it as a Safeguarding issue. 17 Α. I think at the time I felt that the Executive Board had initiated actions to try and review the whole 18 19 situation and I didn't have the clinical component. 20 So my work with Sian Williams had demonstrated that Lucy was a common denominator though not involved in 21 22 every collapse, but I didn't have the clinical situation 23 because I have not got the clinical expertise to 24 interrogate neonatal data. LADY JUSTICE THIRLWALL: No, you have explained 25 89 1 from the first point of contact with maternity services 2 to delivery or to the postnatal period, if there's 3 a complication with the mum. 4 So what we are trying to do is make sure that the 5 correct pathways were followed, the correct escalation, 6 correct documentation, and that care met our pathways 7 and what was expected. 8 Q. And in what circumstances would there be 9 a OSR, obstetric secondary review, what would trigger 10 one? 11 Α. Anything where there was a poor outcome or 12 concerns about care 13 Q. And when you say poor outcome, that would be 14 poor maternal outcome or maternal complications? Maternal or neonatal outcome. 15 Α. 16 Q. And what was the procedure that you followed to conduct an obstetric secondary review? So one 17 assumes you would examine the notes, but what else would 18 go on? In terms of speaking to the midwives or doctors, 19 20 what was the process of the review? 21 So it was purely a review of the, the case Α. 22 notes and the handheld record that the mum and 23 electronic notes, if required, for the obstetric, for 24 the OSR, the obstetric secondary review. 25 If we decided that it needed a further deeper 91

that. I just wondered why you didn't think it was 1 a Safeguarding issue. You didn't get as far as thinking 2 of the other things, I understand that. 3 4 Δ. Yes LADY JUSTICE THIRLWALL: But it just didn't occur 5 6 to you. 7 Α. It didn't occur to me. LADY JUSTICE THIRLWALL: Do you think, on 8 reflection, that this is something that ought to be 9 10 considered a Safeguarding issue? 11 Definitely, definitely, on reflection it is Α. something that I would have done. 12 13 MS BROWN: And turning now, then, Mrs Fogarty to the involvement that you had with reviewing the deaths 14 of some of the babies on the indictment from a maternity 15 16 aspect, you were involved in obstetric secondary 17 reviews, and I think you confirm in your statement that you were involved in a number of the indictment babies, 18 19 certainly you were involved in the obstetric secondary 20 reviews of Child A, Child C and Child D. 21 Can you just explain, assist with what an obstetric 22 secondary review was? 23 Α. So it is a review purely of the obstetric and midwifery care provided to a mother and it involves 24 25 a comprehensive critical analysis of all care provided 90 1 comprehensive review then obviously that would be then 2 notifiable and it would be a root cause analysis and 3 that would involve interviewing staff. 4 Q. So this was an initial paper exercise? 5 Α. Definitely, yes. 6 Q. And who would generally make up the review 7 panel? So there would always be an obstetrician, 8 Α. a senior midwife and a risk and safety lead as 9 10 a minimum. 11 O. And how would you reach conclusions about whether the standards of care had been set? 12 13 Α. Benchmark it against practice and get clinical 14 guidelines. 15 And what was the system to ensure that any Q. issues you did identify were followed up, followed up? 16 17 So if we found an issue with an individual Α. they would be spoken to. If we found a theme that would 18 be included in the mandatory training, it would be 19 20 escalated at handover so that all staff received that 21 information. 22 Also we had a resource room on the labour ward 23 where anything that we had identified from reviews, 24 there was a poster presentation and the staff used to go in there and read those so that they were familiar with 25

the findings. But the most important things was that if 1 1 2 2 an individual had not followed policy or their 3 3 documentation wasn't accurate, that they were informed, 4 4 because otherwise you are never going to improve 5 practice if the individual wasn't aware. 5 6 Q. So as I understand it, you were looking at any 6 7 individual poor practice but that the method of doing 7 8 these obstetric secondary reviews would or should have 8 9 picked up if there was a trend of a problem? 9 In maternity, yes. 10 Α. 10 And would families be involved if an obstetric 11 11 Q. secondary review had been triggered? 12 12 13 Α. No. 13 14 Q. And in terms of the notification of the 14 deaths, Mrs Fogarty, in your role as Head of Midwifery, 15 15 16 would you always be informed if a baby had died either 16 17 on the maternity unit or after transfer to the neonatal 17 unit? 18 18 19 Α. 19 No 20 Q. Why was that? It was not something as Head of 20 Midwifery you would need to be made aware of if there 21 21 22 was a death on the unit? 22 23 Α. It would be good practice but if a baby died 23 in the neonatal unit it, it wasn't within my remit, the 24 24 25 service didn't belong to me. 25 93 1 Q. And how were you able to say that, that it was 1 2 unusual to have three deaths? 2 3 Α. Because you -- we wouldn't be doing that 3 4 number of obstetric secondary reviews in such a short 4 5 5 period of time in relation to neonatal deaths. 6 And you have talked at the outset a little bit 6 O. 7 about the communication and there would be, because of 7 8 the geography you would see people who worked in the 8 9 other units. Did you, did you go and speak to your 9 colleagues in the NNU, did you raise it and say, "This 10 10 seems very unusual"? 11 11 12 Α. No, no. 12 13 Q. Why was that? 13 14 Α. Because we had gone to a -- there had been 14 a paediatrician present at the Serious Incident Panel 15 15 and he didn't escalate any concerns. 16 16 Did you think, having made the observation 17 17 Q. that you had made, that it was unusual that there were 18 18 three deaths on the neonatal unit, and we will come to 19 19 20 it in a minute, but the obstetric secondary reviews 20 didn't, as I understand it, didn't flag a problem from 21 21 22 the maternity side; that is correct, is it? 22 23 Α. Yes, that's correct. 23 24 Q. So you've got three deaths which is unusual, 24 you are not aware or no problem has been identified from 25 25 95

So I didn't always get notified of neonatal deaths. Q. But as I understand it, if there was a poor outcome of the child, or of the mother, that would trigger an obstetric secondary review, so didn't you need to know if there was a baby that had died to trigger the review? Α. So we would know from Datix that, that -- from the Datix incident, and that would initiate our review. But I wasn't -- there wasn't a formal process where I was informed of every review. But you would always come to know, is that Q. correct, because you would always need to do an obstetric secondary review if a baby had died? Yes, providing we were aware. Α. Q. And in fact that clearly did happen in the case of Child A, Child C and Child D? Α. Yes. You became aware that they had died because Q. you were involved in all three of those obstetric secondary level reviews? Yes. Α. Q. And you say in your -- you accept in your statement, this is paragraph 69, that it was unusual to have three deaths on the NNU within two weeks. Δ. Yes 94 the maternity point of view and we've got the existence of the Women's & Children's Care Governance Board. Did you think it was appropriate for that to be raised and then discussed at that meeting? So that would be something that would be Α. required, that would be tabled by the paediatricians because they are the experts in neonatology and when we attended the Serious Incident Panel in the July, Dr Brearey hadn't escalated any concerns. So, therefore, I was assured because he was the -he was the expert in neonatology. We are going to come to the meeting in just Q. a moment. Α. Yes But just dealing for a moment with the Q. obstetric secondary reviews of Child A, Child C and Child D, I just want to be clear so that there is no misunderstanding. There is no reference in any of the obstetric reviews of any issue of infection on the maternity ward and from your perspective on the maternity ward, that played no part in the death of these three babies? Α. No, we never had any issues with infection at all. Q. And where you have, as you have explained, you 96

came to a conclusion that at the end of the obstetric 1 2 secondary review that there weren't any concerns from 3 a maternity/obstetric perspective, in that situation as 4 a matter of course, we will come to the 2 July meeting in a moment, but as a matter of course would you then 5 6 have a meeting with your neonatal colleagues in order to 7 understand the overview of the picture and of why in 8 fact that baby had died? 9 Α. No. What we would, we always recommend that 10 they did their own review with the same intensity that we, we did for the obstetric element. 11 But there would, as matter of course, be 12 Q. 13 a roundtable discussion, so to speak? So all, so they, they would be discussed at 14 Α. the perinatal mortality meeting that were held quarterly 15 16 and -- and someone attended from Alder Hey as well, a 17 pathologist attended from Alder Hey, and all neonatal deaths and stillbirths were discussed at that meeting 18 19 and it was a joint meeting between the obstetricians and 20 paediatricians. 21 Q. Thank you. 22 So coming now to the meeting of 2 July and it 23 appears that there was a Serious Incident Panel meeting on 2 July and this was to discuss the three neonatal 24 25 deaths and at paragraph 55 of your statement, you quote 97 1 Williams, the deputy director of nursing, so the deputy 2 of Alison Kelly? 3 Α. (Nods). 4 Q. And what did you understand to be the purpose 5 of this meeting? 6 Α. To try and explore whether there was a concern 7 that needed further escalation and investigation. 8 Q. And can you recall the meeting itself, how you 9 went about that? Did you look at the medical notes, 10 what was the process? 11 Δ So, no. So before I went because I knew why

- I was going, I reviewed the three OSR and I made 12
- 13 a summary note in my Head of Midwifery notebook that
- 14 I was able to take so that I was assured that for the
- three cases the mother's care had been looked at and we 15
- had no concerns, and that's how come I know who was in 16
- 17 the meeting because I made, in my summary notes, who was 18 present.
- 19 Q. Yes. I think --
- 20 Α. I made no notes from the paediatrician
- element. So therefore that tells me that no concerns 21
- 22 were escalated, otherwise I would have written that in
- 23 my notes.
- 24 Q. And we have seen a copy of your handwritten
- 25 note --
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- helpfully there, the extract from the case review of 1
- 2 Child D and it's within that case review that this
- Serious Incident Panel is mentioned. 3
- 4 And it says:
- 5 "... the Executive Serious Incident Panel on
- 6 2 July 2015; there had been three neonatal deaths in
- 7 a short period of time and the circumstances were
- discussed to identify if there was any commonality which 8 linked the deaths ..." 9
- 10 And going then at paragraph 17, you explain that
- that meeting was called by Alison Kelly, the Director of 11
- Nursing? 12

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- Α. Yes, that's correct.
- 14 Q. And was that -- did she discuss that with you
- 15 in advance or --
- 16 Α. No.
  - Q. -- were you just asked to attend?
- 18 Α. No, I was just asked to attend.
- 19 And you helpfully, in your statement, you set Q.
- 20 out at paragraph 71 confirming that you attended the
- meeting and setting out who else attended. Alison 21
- 22 Kelly, the Director of Nursing, Ruth Millward, the Head
- 23 of Risk and Safety, Stephen Brearey, Dr Brearey, as the
- clinical lead of neonatal unit, Debbie Peacock, who was 24
- 25 the Risk and Patient Safety Lead, and then Sian
- 98 Α. Yes. -- listing who was there. Q. And had you -- Mrs Fogarty, had you ever been involved in a meeting to look at commonality of three neonatal deaths in this way before --Α. Never. Q. -- or was this a --Α. No. Q. So this was a unique experience? 10 Α. This was, yes. O. And did you have or was there discussion at the meeting of any form of checklist or agenda to assist 12 13 with approaching, in a consistent way, whether there was 14 any commonality? 15 Α. No. 16 Q. So at the meeting you were looking for a common feature. Had there been a common feature identified, clearly that was going to be a very serious issue, potentially a very serious issue? 19 20 Α. Yes. So was there any consideration, or did you Q. 22 raise at the meeting, or did anyone raise at the 23 meeting, given the potential seriousness of what was being discussed, whether this meeting should be attended
- by the Consultants who were involved in the care of the 25

babies and were present at the -- failed in this case --1 2 resuscitations of Child A, Child C, and Child D? 3 The paediatricians had elected to send Α. 4 Stephen Brearey to represent them so there was no discussion about other paediatricians. They didn't go 5 6 in great detail about each individual case, you know, 7 Dr Brearey, you know, provided a summary report, verbal 8 report, and he didn't identify, as far as I recall, any 9 issues that he felt warranted any further action at that 10 time. 11 Looking back now, given sort of the unusual Q. nature of this meeting, looking at whether there are any 12 common features, do you think you would have -- as 13 a member of that meeting would you have been assisted by 14 hearing from the Consultants who were the treating 15 16 Consultants? 17 Α. So with hindsight, really what should have happened is there should have been a total review of all 18 19 three cases by someone external from the Trust. 20 And I think you may be aware Ruth Millward, Q. 21 her view is that at that point, there should have been 22 a review and so I understand, Mrs Fogarty, you are 23 agreeing with her? 24 Α. I agree, yes. 25 Q. And in addition to the issue of whether the 101 1 Q. Because the conclusion of that meeting that 2 you were at, you participated in, was that there was 3 going to be no further investigation at that stage. Can 4 you assist us with how did you come to that conclusion? 5 Α. That decision was made by the Director of 6 Nursing. 7 Q. And it was -- so your evidence is, is it, that 8 it was Alison Kelly who took the decision that no 9 further investigation was required? Α. Yes. 10 11 O. Did anyone dissent from that at the meeting? 12 Α. Not at the meeting, no. 13 Q. And you say in paragraph 74 of your statement 14 that you are unable to comment on the possibility that staffing factors might have anything to do with the 15 deaths of Child A, Child C, or Child D. Was that 16 17 something that was discussed as a possibility --18 Α. No. 19 -- at the meeting? Q. 20 Α. No, it wasn't, it wasn't discussed at that 21 meeting. 22 Q. And just to be clear. I've been asked to 23 clarify, you say at paragraph 75: 24 "The common factor of Letby as a nurse on duty was not discussed at this meeting." 25 103

Consultants, the treating Consultants should have been 1 2 considered or consulted, and attended the meeting, you were looking at commonality of deaths over a two-week 3 4 period. 5 Did anyone raise or was it considered at the time 6 whether it was also relevant to look over that two-week 7 period whether there had been any collapses, so near deaths? We know, of course, there was -- child B, the 8 twin of Child A, collapsed in that period. 9 10 Did anyone say, well, we should be looking, if we are looking at commonality not just at deaths but any 11 incidents? 12 13 Α. The death of Child B wasn't mentioned at all. 14 Q. Child B survived, fortunately, but the 15 collapse --16 Α. Yes, but the collapse wasn't mentioned at that 17 meeting at all. And again, looking back, that would have been 18 Q. 19 a relevant thing to take into account, wouldn't it? 20 Definitely. Definitely. Α. 21 Q. And as well, just so we are clear on what was 22 discussed at this meeting, do you recall whether unusual 23 rashes were discussed at the meeting of 2 July? There was no clinical, no detailed clinical 24 Α. 25 information given. 102 1 Are you clear in your recollection about that? 2 I am very clear that that, that that was not Α. 3 discussed. 4 Q. What action would have been taken if you had 5 been given a name, do you think? 6 Α. Well, we -- you would need to -- if you've got 7 a name then there is a concern that's attached to one 8 person so therefore you would, you would want to 9 escalate that and take further action. Q. 10 So you are confident in that recollection? 11 Δ. I am confident in that recollection, yes. And just again to clarify as well, before we 12 Q. 13 move on, you say at paragraph 36 about this meeting: 14 "The paediatricians did not raise any concern at 15 that meeting ..." You say "paediatricians" but it was -- Dr Brearey 16 17 was the only paediatrician at that meeting? 18 Α. Yes. And you are saying that he didn't raise 19 Q. 20 concerns about looking at the commonality of those 21 deaths. 22 Α. That's correct, yes. 23 If we can turn on now, you say in paragraph 52 Q. 24 of your statement, that it was also at that meeting, the

25 meeting of 2 July that was looking at the commonality,

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that a full case review of Child D would be conducted to 1 2 look at the obstetric and the neonatal notes. So the 3 point we were discussing before about the obstetric 4 review being done and then separately the neonatal 5 review, for Child D this process was put together. 6 Α. Yes. 7 And given that Child A and Child C, from the Q. 8 obstetric point of view there was no explanation for 9 those, those deaths, did you feel that in fact that 10 should have been done not only for Child D but also for Child A and Child C? 11 12 Α. With hindsight definitely, that, that should 13 have been done. And would you go as far as to say that as 14 Q. a matter of course when the obstetric review didn't 15 16 reveal a cause of death, or an explanation for the 17 death, that there should be this, this sort of joint 18 process? 19 Well, from the obstetric point of view we are Α. 20 looking at if anything contributed to the outcome. So it wasn't always relevant to, necessarily, do a -- put 21 22 the two together if the standalone paediatric review is 23 comprehensive. But it is good practice. 24 And if we could go to INQ0003299, we are just Q. 25 going to look at the cover page of the review for 105 1 review the care, that doesn't impact on the quality of 2 the report and the judgments. 3 What should really happen is the two meet 4 separately and then when the conclusions are drawn then 5 meet together to review the conclusions and next steps 6 and that's what didn't happen. 7 Q. Didn't happen? 8 Α. Didn't happen. 9 There was -- so that didn't happen in terms of Q. 10 the first review. There was then, we see, an addendum because after the results of the post-mortem from 11 Child D were supplied, there was then a further meeting 12 which was attended by Dr Davies, Dr Newby --13 14 Α. Yes 15 -- you, Ms Powell and Debbie Peacock. Was Q. that an actual meeting? 16 17 Α. That was an actual physical meeting, yes. So whilst paper initially, this concluded, 18 Q. when we look at the report, with a physical meeting --19 20 Α. Yes. 21 Q. -- of both obstetricians and a paediatrician? 22 Α. Yes 23 Q. And at the time that this review was done, the 24 initial review of 28 August, and certainly by the time that meeting was held, which was 12 October, sadly there 25

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- Child D because this really makes the point clearly that 1 2 this is a review and we can see just by the investigation team that we have got present there, the 3 4 obstetric secondary review team, including you and a Consultant, Dr Davis, and then we've got the neonatal 5 6 review team, Dr Brearey, and Ms Powell, the neonatal 7 unit manager, and there is -- we won't go through it but 8 what follows is an 18-page report with appendices, an 9 11-page report. 10 Α. But these were actually two separate reviews 11 put into one report. Q. So that's my next question. 12 13 Α. Yes. 14 Did you physically meet to discuss this or was Q. this compiled out of two reviews? 15 16 Α. So it was compiled from the two reports, two 17 separate assessments. And back to where we started with the two 18 Q. 19 divisions, and you saying about meetings being held 20 together. In retrospect would it have been more helpful 21 if you had all physically sat around the same table? 22 Α. I mean, being in two divisions shouldn't 23 affect work such as this because that's -- this is very specific and, and because of the nature of the work and 24 25 the terminology the fact that the two meet separately to 106 1 had been more deaths on the neonatal unit. There had 2 been the death of Child E on 4 August 2015. Were you 3 aware of that death? 4 Α. No. 5 Q. Would that not have come to you by the same 6 process of needing an obstetric secondary review? 7 Α. I don't even recall doing an obstetric 8 secondary review on that case. Yes, but it wouldn't have come to you in your 9 Q. role of Head of Midwifery? 10 11 Δ. It wasn't escalated to me. 12 Q. And had it been, had there been a system where you were aware of the fact that one of the children, 13 14 another child had died within August, do you think that would have made you reconsider that decision on 2 July 15 that there was no reason for further investigation at 16 17 that stage because we now have a new component --18 Α. Yes. 19 Q. -- we have another death within a short 20 period? 21 Definitely. Α. 22 Q. And Ruth Millward, she, in her statement to 23 the Inquiry says that was a further missed opportunity 24 to trigger a comprehensive investigation. Are you
- 25 agreeing with that?
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Child I died on 23 October. So the fifth death in 1 2 approximately four months. 3 At that stage, were you -- first, were you aware of 4 the death of Child I? 5 I don't recall being aware of the death of Α. 6 Child I. 7 Q. We know from some other evidence, Mrs Fogarty, 8 that there were or there appeared to have been rumours 9 at this stage within the neonatal unit. 10 Were you aware of any concerns about a commonality of staffing or concerns that something was strange about 11 the increased mortality rates? 12 13 Α. No. 14 Q. When did you first become aware that staff on the NNU had concerns that a member of staff might be 15 16 involved in harming babies? 17 Α. So I first became aware in the June '16 after the death of the triplet, the second triplet. 18 19 Q. Can I just --20 And it wasn't concern that the staff on the Α. 21 neonatal. It was concern that the paediatricians had 22 concerns. That's when I became aware of that. 23 Q. And prior to that, just so that I can be clear, prior to that, so prior to you becoming aware of 24 25 the paediatricians' concerns after the death of O and P, 110 1 LADY JUSTICE THIRLWALL: So I just wondered why it 2 was called a "perceived" increase? 3 Α. It's the terminology that Dr Brigham put in 4 her report in response to a perceived increase. So it 5 was --6 LADY JUSTICE THIRLWALL: But so far as you were 7 concerned, everyone understood it was a --8 But we knew, we knew that that -- that there Α. 9 was because that's why we were meeting and we had all the records. We had the data to back it up. 10 11 LADY JUSTICE THIRLWALL: All right, thank you. 12 MS BROWN: And we can see there that the title is "Review of neonatal deaths and stillbirths at Countess 13 14 of Chester Hospital, January 2015 to November 2015" and I think you accept in your statement, you say the title 15 does not best describe the remit of the review. 16 It may be very obvious but can you just explain why 17 that's not an appropriate title? 18 19 Α. I think it should be explicit that it was 20 purely the midwifery and obstetric care that was reviewed because that is the area of clinical practice 21 22 and the expertise of the panel. 23 And reading that without that knowledge, it's Q. 24 misleading, isn't it, that title? 25 It, it could be for people outside of the Α. 112

1 I agree, yes. Α. 2 Q. The case review of Child D has a distribution 3 list that has gone down, so we needn't turn to it. But 4 page 11 of the report shows there is a distribution list of Child D's -- we don't need to go to it, thank you --5 6 that it would be referred to the Women's & Children's 7 Care Governance Board as well as QSPEC and so again the 8 same question: did you, as deputy chair, did you at that 9 stage or it having been referred, think that this was 10 a matter that should be tabled on the agenda having been prompted not only by 2 July but now by the review of 11 12 Child D --13 Α. Definitely, yes. It should have been, yes. 14 And why did you not raise that because you had Q. been present at the Child D's review, so you were aware 15 16 of the three deaths, you had now attended that review 17 after the post-mortem. 18 At that point, did that prompt you to think this is 19 something we should be discussing as --20 I mean, I was dependent on my paediatric Α. neonatologist specialists to be escalating concerns 21 22 to -- to myself and, and they didn't. 23 Q. Moving forward then. So two weeks on from after the meeting after the post-mortem, the meeting, 24 the physical meeting when Child D was discussed. 25 109 1 were you aware of any rumours? 2 Α. No. 3 Q. If I could turn now to the review that was 4 conducted of neonatal deaths and stillbirths from an 5 obstetric point of view, Dr Brigham's review. 6 If we could turn up INQ0003222 and this is tab 7, 7 my Lady, in your bundle. 8 So this was a review that was done in November, so 9 about four months after that 2 July meeting that we have talked through in some detail, and at this stage we have 10 gone through I. You say you weren't aware of I, but 11 there had been five deaths on the neonatal unit 12 13 from June 2015. 14 Whose idea was it to conduct this review that was 15 looking at the obstetric situation? 16 Α. So the -- so the obstetric risk leads and 17 myself. 18 Q. Why did you decide to do that review? We had had a perceived increase in our 19 Α. 20 stillbirth and neonatal death and so we wanted to be assured that we didn't have a problem with our practice. 21 22 Q. You say "perceived" increase, but presumably 23 there was an increase in stillbirths, is that --24 Α. We knew from our data that there was

25 an increase.

25

Q.

-- department?

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Trust that don't know that that was the remit of the 1 2 people involved or anybody who didn't receive a verbal 3 update, where it was made clear at a verbal update. 4 And you say at paragraph 88 of your statement O. 5 that not only the title but on -- it's not apparent on 6 reading the report that the review is confined to 7 obstetric care? 8 Α. Yes. 9 Q. I think in fairness, if one looks at the 10 review team, we can see there are no neonatologists or paediatricians on that review team? 11 12 Α. Yes 13 Q. So that might be a clue. But it is certainly, on the face of the title and the content --14 15 Α. Yes 16 Q. -- it is not clear that this is not a complete 17 review. And you looked at the deaths from January 2015 so 18 19 that included, this has been checked, that it included 20 the deaths of Childs A, C, D and E. 21 Was -- that was in terms of the neonatal deaths. 22 Was there also concern about the stillbirths in the 23 obstetric departments? What was the concern there? 24 Α. Yes, we felt we had an increase so we wanted 25 to know was it because of poor practice. 113 1 hadn't already addressed so we knew therefore that that same level of investigation needed to be undertaken by 2 3 the paediatricians. 4 Q. Thank you, Mrs Fogarty. 5 So as I understand it, there was a sense in the 6 obstetric department and the midwifery department that, 7 having done your review, it was now really for the paediatricians and the NNU to --8 9 Α. Yes. 10 Q. -- examine their side? Α. Yes. 11 12 Because we have got a situation here where the Q. maternity unit, and you have been looking at it from 13 14 an obstetric point of view, you have identified clearly that we need to look at the neonatal side and it's 15 difficult to understand why given your understanding 16 17 that we needed the neonatal aspect why that wasn't raised at the Women's & Children's Care Governance Board 18 to say, "We have done this review, we need input from 19 20 our neonatal colleagues." 21 Was that not the very purpose, the very aim of that 22 governance board to bring the departments together? 23 Α. So they were already planning their review 24 which they did in the beginning -- at the beginning of 25 2016.

1 Q. And did you inform the Consultant paediatricians and the NNU senior nurses that you were 2 doing this obstetric review? Did they know you were 3 4 doing this? So the paediatricians were aware, yes. One of 5 Α. 6 my Consultant colleagues had informed them. 7 Q. And once you had done this review, that review did not identify the causes of increased mortality 8 9 because you didn't identify a cause from the --10 We were only looking at the obstetric and, Α. actually, we had already -- what the report demonstrated 11 was we had already done comprehensive reviews of all the 12 cases anyway and it didn't, it didn't pick up anything 13 that we hadn't already looked at. It was more of 14 a thematic review. 15 16 Q. And so what did you understand was the plan to 17 try and understand the cause or causes of the neonatal deaths? Clearly the stillbirths were completely within 18 19 your remit but in terms of the neonatal deaths, you 20 hadn't reached a conclusion. What did you understand 21 was the plan? 22 Α. So we were purely looking from an obstetric 23 point of view to see if it was anything in our practice 24 that had contributed to a poor outcome for a baby, and we didn't find any commonality or anything that we 25 114 1 Q. And that's Dr Brearey's thematic review --2 Α. Yes 3 Q. -- is how we have been referring to it. And 4 so you -- at what point were you aware that that was 5 planned, are you able to assist? 6 Α. I think it was when this report was produced. 7 Q. And in terms of this report we see it's 8 dated November. In terms of the circulation of that report, we know that it wasn't e-mailed, in fact more 9 widely circulated, until 9 February. Do you know what 10 the delay was for the --11 So the actual report, in fact the email that 12 Α. 13 circulates the report states: This is a poster 14 presentation in the resource room. 15 So as soon as the report was produced, it was always the practice that the resource room would have 16 17 a copy of this for staff to go and be familiar with. So it would already -- it had already been actioned and all 18 the actual incidents when they were reviewed initially 19 20 that information was in the resource room. So ... 21 So regardless of that email, you are fairly Q. 22 confident that this was properly distributed certainly 23 within your --24 Α. Yes.

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And it actually states that on the email, that 1 Α. 1 2 it's -- it's up, it's already up as a poster 2 3 presentation which was our format. 3 LADY JUSTICE THIRLWALL: Sorry. Does that mean 4 4 5 that it was, the report was in the resource room? 5 6 Α. Yes. Visible, visible for staff to look at. 6 7 LADY JUSTICE THIRLWALL: So every page was there? 7 8 8 Α. Yes, yes. 9 LADY JUSTICE THIRLWALL: Thank you. 9 10 And staff also knew to go to the resource room 10 Α. every week because that's where we -- that was our 11 11 training method that we used. It was very effective. 12 12 13 MS BROWN: So if we can just look now and go 13 through and see what was being discussed at the 14 14 Women's & Children's Care Governance Board. 15 15 16 So if we could put up, please -- that report can go 16 17 down and just maybe one more question regarding that 17 report, Mrs Fogarty, before we take it down. 18 18 19 That report didn't highlight within the report 19 20 itself that a neonatal review was needed and my 20 understanding is that's because you understood that that 21 21 22 was going ahead in any event? 22 23 Α. Yes. 23 24 So, yes, if we could pull up INQ0004235. So Q. 24 25 this is tab 14, my Lady, of the bundle. 25 117 1 three unexpected neonatal deaths. There had in fact 1 2 been four then, taking into account Child E, but it 2 3 refers to three unexpected deaths, but there is no 3 4 discussion in the agenda of unexpected deaths. 4 5 Was that something that on reflection should have 5 6 been something that was discussed or would normally have 6 7 been something that was discussed? It's the fact that 7 8 they are unexpected deaths. Clearly on occasions there 8 9 would be deaths, but the unexpected deaths, would that 9 not be something that should have prompted discussion? 10 10 11 Α. She would have expected the paediatricians to 11 have said, to have brought some information regarding 12 12 13 their reviews of those cases. But that was in 13 14 the October when we were aware of the increase and 14 that's why we then did our review in the November. 15 15 16 So you say that it was for the neonatologist Q. 16 17 or the paediatrician to bring that. But as the deputy 17 chair and as observing this from a critical standpoint, 18 18 knowing that the role of the committee is to flag any 19 19 20 issues, should you not have been asking your colleagues 20 and saying: These are unexpected deaths. We don't have 21 21 22 a solution, is there an explanation? 22 23 There seems a lack of curiosity. 23 24 Α. With -- with hindsight then, yes there should 24 25 have been more probing of the paediatric staff. 25

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This was 18 June, so right -- just shortly after the death of Child A, a meeting there and if we could go to page 3 of that. It records there that JCF, so that's and you -- your initials, sorry, yes, JCF, your initials and the Consultant obstetrician reviewed a twin death and that's referring to Child A. If we go down: "No issues with any element of care provided. Will be subject to neonatal review." So that's as you were explaining to us --Yes. Α. Q. -- recording that there would be an obstetric secondary review. There were no issues there, but there would be a neonatal review? Α. Yes Q. Was there a system for following up matters like that on the minutes to check that -- it says there's going to be a neonatal review --Α. Yes Q. -- that a neonatal review was done? Α. Yes. So at the next meeting they looked at the actions to make sure that they had been completed. Q. That can come down then, please. We don't need to turn to this, but there was another meeting on 22 October and that referred, just very briefly, to 118 Q. If we can go -- thank you. If we can go to the meeting of 18 December and we can call this one up. It's INQ0004371, and page 2 of that. Here we see -- so this is December. We know the Brigham report, the obstetric report we have seen was November, and we see this report came to the meeting here as one would expect? Α. Yes. And we see stillbirth and early neonatal death Q. review and action plan: "Panel set up to review each case individually. No themes identified. Overall the process showed we have a good record-keeping, good escalation. The outcomes would not have been any different." Now, we know that these minutes then went up to QSPEC? Α. Yes Q. And reading that now, I know obviously you have the knowledge that this was an obstetric review but if one was reading that without that knowledge, that would appear to allay concerns about neonatal deaths because it's not clear from that that's just the obstetric care that's being looked at?

- 24 A. But I presented that report at QSPEC and was
- 25 very clear in my verbal presentation that it was

a maternity and obstetric review of care. 1 2 Q. We will come to that in a moment. But from 3 this minute, if one was reviewing the minutes, it's not 4 clear from those minutes -- it would obviously have been clear to those at the meeting, but it wouldn't have been 5 6 clear just on a paper review that there was a problem 7 here? 8 Α. Yes. Yes. 9 Q. Picking up on that point, did that provoke any 10 discussion from Dr Brearey, who was in fact present at that meeting, about the situation on the neonatal unit? 11 Not that I recall. 12 Α. 13 If we can just turn to some emails, this is Q. tab 9, my Lady, in your bundle. 14 There were some -- there was an email exchange 15 16 between Alison Kelly, and this rather just demonstrates 17 the slight confusion, I think, possibly due to the titling of Brigham's report. 18 19 We see, and we could call this up, it's INQ0003220. 20 So if one starts at the bottom the page, this is from Alison Kelly: 21 22 "Hi, where are things up to re the thematic review? 23 I am keen to get the paper to December QSPEC." 24 So she is referring there to the Brigham review, 25 the obstetric review because Dr Brearey's review 121 1 Alison Kelly's understanding that there was at that 2 stage one review that combined the two. But that's not 3 the case, is it? 4 Α. No, no, and Alison Kelly knew that it wasn't 5 one report that -- she knew that from my one to one and 6 my, my verbal. She knew we were doing the thematic 7 review in obstetrics before it had taken place because 8 I had escalated that to her. 9 Just looking at that, your discussions with Q. Alison Kelly then about your review. Did you discuss 10 the obstetric review with Alison Kelly --11 12 Α. Yes 13 Q. -- and say we are waiting for the paediatric? 14 Α. Yes. Yes, I had discussed that at my one to one with her. 15 Q. And can you recall what her view was about the 16 fact that the paediatric -- the neonatal unit, you were 17 awaiting that report, did she --18 Α. I think she said she would chase it up. 19 20 Q. So she was aware that there was -- that the neonatal review of the increased mortality hadn't taken 21 22 place? To my knowledge, yes. 23 Α. 24 Q. And if we can go now. Sorry, just to be clear then. You were aware that Dr Brearey had done 25

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1	hasn't was that your understanding anyway?
2	A. My understanding is she is referring to two
3	reviews because she copied Ruth Millward in and
4	Ruth Millward played no part in the obstetric, but would
5	be looking for the neonatal one. And that's why
6	I responded to say I had sent the papers in November
7	ready for the next QSPEC meeting.
8	It was the paed update that was missing.
9	<b>Q.</b> Yes, and you then make it clear your
10	understanding
11	A. Yes.
12	Q from your response is it is clear that
13	there were two elements
14	A. Yes.
15	Q the midwifery element, which we have seen
16	and looked at?
17	A. Yes.
18	Q. And then it's the paediatric
19	A. Yes.
20	<b>Q.</b> update that's missing?
21	A. Yes.
22	<b>Q.</b> Then Ms Kelly replies:
23	"Sorry if I hadn't been clear. I mean the thematic
24	review of neonatal deaths recently undertaken."
25	So you may not be able to assist but it seems to be
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1	a thematic review and we know that was in February 2015
2	and re-issued in March 2015.
3	Did you, did you receive a copy of that, can you
4	recall?
5	<b>A.</b> No.
6	<b>Q.</b> Would that be something that you would have
7	expected him to have raised as soon as it was issued at
8	the women and children's governance board?
9	A. I would have expected it to have come sooner
10	than it did to the women and children's governance
11	board, yes.
12	<b>Q.</b> I think we will look now at when it did come
13	on 16 June. So if you go to INQ0003212. This is
14	tab 18. If we could go to page 5, please.
15	So we've had the Brigham review back in December.
16	We are now at June, mid-June, and the neonatal aspect of
17	the same issue, increased mortality rates, is being
18	reported here. It is entitled "NNU Thematic Review":
19	"There was a higher than expected mortality rate on
20	the NNU in 2015."
21	And it goes on:
22	"An obstetric thematic review did not identify any
23	common themes that might be responsible for the rise in
24	mortality in 2015."

25 That's a reference to the Dr Brigham report? 124

1	A. Yes.
2	<b>Q.</b> And it said the aim of the neonatal meeting,
3	that was the meeting that was held on 8 February was to:
4	" review the cases as a multi-disciplinary team
5	with an external reviewer to assess."
6	And it says there:
7	"There was no common theme identified in all the
8	cases."
9	A. Yes.
10	Q. Do you recall any other discussion taking
11	place at that meeting surrounding that report?
12	A. I due to the time lapse, I don't.
13	MS BROWN: My Lady, I don't know if that would be
14	a convenient moment.
15	LADY JUSTICE THIRLWALL: Yes, certainly.
16	So we are going to adjourn now for lunch so if you
17	will come back please and be ready to start again at
18	2 o'clock.
19	A. Right.
20	LADY JUSTICE THIRLWALL: Please don't talk about
21	your evidence.
22	(1.00 pm)
23	(The luncheon adjournment)
24	(2.01 pm)
25	LADY JUSTICE THIRLWALL: Ms Brown.
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1	effective in relation to maternity services, the fact
2	that the issues relating to the NNU mortality was not
3	presented at this board by the NNU Team demonstrates
4	a gap in its overall effectiveness.
5	Just clarify what you mean by the gap in its
6	
	overall effectiveness, please?
7	A. Well, the whole purpose the board is to, you
7 8	
	A. Well, the whole purpose the board is to, you
8	<b>A.</b> Well, the whole purpose the board is to, you know, receive information and where there is risk to
8 9	<b>A.</b> Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in
8 9 10	<b>A.</b> Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.
8 9 10 11	<ul> <li>Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.</li> <li>So it was a gap that the increase in mortality</li> </ul>
8 9 10 11 12	<ul> <li>Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.</li> <li>So it was a gap that the increase in mortality wasn't flagged by the paediatric team for discussion,</li> </ul>
8 9 10 11 12 13	<ul> <li>A. Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.</li> <li>So it was a gap that the increase in mortality wasn't flagged by the paediatric team for discussion, noting and escalating.</li> </ul>
8 9 10 11 12 13 14	<ul> <li>A. Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.</li> <li>So it was a gap that the increase in mortality wasn't flagged by the paediatric team for discussion, noting and escalating.</li> <li>Q. And obviously you have had some time to</li> </ul>

17 Q. -- about this. And what is your explanation18 for that, why a meeting that was convened for that

- 19 purpose with neonatal and midwifery and obstetric
- 20 representatives, concerns that did exist, why was that
- 21 not being debated in that forum?
- 22 A. I have no explanation as to why the
- 23 paediatricians didn't bring that information forward or
- 24 raise it for a topic of discussion.
- 25 **Q.** Do you feel that whilst, as you have made 127

1	MS BROWN: Ms Fogarty, we were just looking at the
2	8 February thematic report that had been presented to
3	the Women's & Children's Care Governance Board on
4	16 June and the fact that on the entry for that it said
5	there was no common theme identified in all the cases.
6	So having completed that, that review going through
7	those board meetings of the Women's & Children's Care
8	Governance Board, at no point between June 2015
9	and June 2016 did the Women's & Children's Care
10	Governance Board have any minuted discussion about the
11	cause of serious concerns of rising unexpected and
12	unexplained neonatal deaths; that the case, isn't it?
13	A. It would be apparent from the minutes, yes.
14	Q. So it's not a case that it's not minuted, you
15	would have recalled that discussion as well?
16	A. Yes.
17	Q. And consequently, no concerns about rising
18	unexpected and unexplained deaths rose from there to
19	QSPEC?
20	A. That's correct, yes.
21	<b>Q.</b> That follows as a matter of course.
22	And at paragraph 31 of your statement you address
23	this frankly and you say that whilst, during your time
24	as Head of Midwifery you felt that the WCCGB, the
25	Women's & Children's Care Governance Board, was
	126
1	clear, you weren't a paediatrician, you weren't from
2	neonatal expertise, but did you think there was
3	sufficient that you maybe should have raised it yourself
4	as a concern?
5	A. I have no neonatology experience whatsoever.
6	I have never ever reviewed a neonatal care case because
7	it's not my area of clinical expertise. So I am not
8	able to interrogate the data.
9	But certainly, you know, in hindsight then, just
10	the fact that, you know, I was aware of the from our
11	own review, our own obstetric review, there should have
12	been some escalation at that time.
13	<b>Q.</b> And that's, in a sense, a question of
14	hindsight. At the time you knew that there wasn't an
15	obstetric cause and that's something you could have
16	raised at the meeting.
17	<b>A.</b> Well, I knew that there wasn't an obstetric
18	cause but I would I was being guided by the
19	paediatricians who are the experts in neonatology.
20	<b>Q.</b> Thank you. And just on a related issue in
21	terms of the reporting culture within the NNU. Again,
22	you said in your Facere Melius interview that you felt

- $\label{eq:constraint} 23 \quad \text{there was a good reporting culture in midwifery, and} \\$
- 24 that's the case, is it?
- 25 A. I would say yes.
  - 128

But you said that you considered that neonatal Q. 1 incidents were not always reported. What was the basis 2 issue? for that? 3 Α. Α. 4 aware of it. That was just a feeling I had of the fact that not all the incidents were Datixed so therefore weren't 5 Q. fed through, they were put in -- my understanding was 6 some of the incidents were put in retrospectively. 7 And that was a concern that you had at the Q. 8 time about neonatal --9 Α. Not at the time. no. because it wasn't 10 something that I was looking for at the time because 11 neonatal services didn't sit in my portfolio, so 12 I therefore wasn't looking and challenging the data on 13 Α. a regular basis. 14 Q. Q. So is that, that concern about neonatal 15 reporting, was that something that occurred once you 16 took on your new role as the Associate Director or when 17 reports? did that occur to you? 18 Α. No, it was from when -- obviously when the 19 Α. execs started their investigation work. That was one of 20 Q. 21 the things that I had heard. Α. Q. So it wasn't something that you considered at 22 Q. the time, at the time of these events, 2015 to 2016, 23 June 2015 to June 2016, that you should have raised 24 within the context of the Women's & Children's Care 25 129 what QSPEC were doing and back to the meeting of 1 14 December 2015. 2 So that's INQ0003204. 3 This is, my Lady, tab 21 of your bundle. Sorry --4 5 yes, 21. If we can get, yes, page 5. 6 So this was very close in time to the meeting when 7 you were presenting your report as well to the 8 Α. Women's & Children's Care Governance Board, you were Q. 9 reporting it also to QSPEC, and we see here at point 11, 10 neonatal and stillbirth review: 11 "Ms Fogarty presented a review of neonatal deaths 12 and stillbirths at the Trust during January to 13 November 2015. It had been recognised that there had 14 been an increase during the period and therefore a panel 15 was set up to independently review all the cases again 16 on an individual basis to identify any common themes or 17 trends and lessons to be learned." 18 And then going down: 19 Α. "The review team had also included an external 20 Q. reviewer who had felt the Trust review process was 21 22 extremely robust, open and transparent." Α. And then going down: 23 Q. "The report will now be received at the Women's & 24 Children's Care Governance Board where the action plan 25 131

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Governance Board that you felt there was a reporting No, because at that time I didn't -- I wasn't Just dealing briefly with QSPEC then. Before turning to the specific meetings, you say and this is paragraph 27 of your statement, that QSPEC had a role that included monitoring the implementation of recommendations from national reports such as Francis. Can I just be clear there. You are referring there, are you, to the February 2015 Freedom to Speak Up report by Sir Robert Francis? Yes. And in general terms -- you sat on QSPEC, can you recall what work was being done in 2015 into 2016 to implement recommendations from the Freedom to Speak Up So they were getting Freedom to Speak Up Guardians within the Trust and implementing those. And can you recall when those came in? I couldn't be exact as to when they came in. And if you could turn then to a meeting -- we are going back in time now because we have looked through the Women's & Children's Care Governance string of minutes and we are going to go back in time now to 130 will be monitored." So looking at that from the -- we will hear what you said about -- what you actually said to the meeting but from the notes of that meeting, that, from someone reading it, an outsider reading it who wasn't involved in that review, it wouldn't be apparent to them that that is purely an obstetric review? No, no. And if we go over the page to the end of that entry, it says: "Mrs Kelly thanked Ms Fogarty and the team for the report and the assurance it had provided to the committee." Now, just dealing with Mrs Kelly first of all, the Director of Nursing. I think your evidence was before, but correct me if I am wrong, was that Mrs Kelly was aware that this was just -- you were presenting just an obstetric report? Definitely, yes. And, of course, she was your line manager so she was very well aware of what your remit was? Yes But having accepted that that's misleading to the uninitiated reading that, what is your recollection

25 of what you in fact presented at that meeting?

I mean, during the verbal report I was, I know 1 Α. 2 I was clear that it was obstetric and maternity care 3 that are being reviewed. The members of the meeting 4 also knew that that was my remit. 5 Q. And did you consider raising at that meeting, 6 or indeed subsequently, that there was a need for the 7 neonatal care aspect to be brought back to QSPEC because 8 they were just seeing half the picture, in effect? 9 I mean, it was my understanding that when they Α. 10 had done their review that it would go to QSPEC. So I didn't raise it at that meeting because I already knew 11 that that's -- that's what would happen. 12 13 And I think you have explained but did you Q. review these minutes and have a concern at the time 14 about how it was -- (overspeaking) --15 16 Α. Not at the time, no. 17 Q. Had you had a concern about the minutes or whether it was an accurate reporting, what was the 18 19 process for approval of minutes and raising objections? 20 So at the start of each meeting you agreed the Α. 21 previous set of meeting minutes were correct and that 22 if, if -- in hindsight I would have said no, we need 23 further clarity that it was an obstetric and midwifery 24 review not neonatal, but at the time --25 O. That wasn't something you raised --133 1 care in a Neonatal Network meeting. 2 And you say that the issue of neonatal deaths Q. 3 at the Countess of Chester, that's the increase in 4 mortality, was not raised as far as you recall by 5 Dr Brearey or Eirian Powell at that meeting? 6 Α. No, and the notes confirm that. 7 Q. And did you, whether in the context of going 8 to this meeting or at any other time, did you ever 9 discuss with Dr Brearey or Eirian Powell the facts -the topic of neonatal mortality --10 Α. 11 No. 12 Q. -- and the need to flag that to this or any 13 other committee? 14 Α. No If we could just look at the deaths of 15 Q. Child O, and Child P, which cover 23 and 24 June 2016. 16 17 When were you informed of those deaths? Do you recall how you became aware of those? 18 I can remember being at a Consultant meeting, 19 Α. 20 a Tuesday lunchtime meeting, and someone coming in and saying that, you know, another triplet had died. 21 22 Q. And I think that's the meeting that you look 23 at in paragraph 115 of your statement and you say you --24 that the obstetrician said "something's going on". 25 Α. Yes. 135

But at the time I had verbalised that but Δ. 1 2 I didn't appreciate the significance. 3 Q. And at paragraph 106, then, just moving on to 4 a slightly different topic in your statement, you talk about yet a different type of meeting, this time the 5 6 Cheshire and Merseyside Neonatal Network Steering Group. 7 Just very briefly, can you explain what that group 8 was? 9 Α. So I only attended one of those meetings. 10 I don't know how I came to go to that meeting. Yet the minutes are clear that I was there. When I look at the 11 contents, there was no other midwifery representative 12 there and I didn't attend another meeting because the 13 discussions at the meeting I couldn't contribute. It 14 was all related to neonatal practice of which I had no 15 16 information. 17 Q. You have answered my question. You don't recall why you were at this meeting? 18 19 Α. No. 20 Q. Could it have been that you were asked to go 21 along to this meeting because there was a thought that 22 the issue of neonatal deaths or deaths of babies was 23 going to be discussed and you would contribute in 24 relation to the obstetric aspect? 25 Α. No, because they wouldn't look at obstetric 134 1 Q. Do you know who that obstetrician was? 2 I can't remember who said it and then whoever Α. 3 chaired the meeting at the time came into the room and 4 we then went -- proceeded to have the meeting. However, 5 the person who had said about the triplets had also said 6 that the paediatricians had gone to the executive team 7 so I was aware that they had escalated to the executive 8 team. Q. So rather like the Consultant obstetrician, by 9 the end of that meeting you certainly knew there was 10 something going on? 11 12 Α. Yes 13 Q. Any more than that? What was your 14 understanding of the situation at that point? I, I didn't have any further explanation. All 15 Α. we knew was there had been an increase in deaths. But 16 17 I didn't have any detail behind that. And was there either a suggestion that one 18 Q. member of staff was involved? 19 20 Α. Not at that meeting, no. 21 And mention of Letby wasn't made, I think it Q. 22 follows 23 Α. No. 24 Q. We come then to the 11 July, so just 25

two weeks, just over two weeks after the death of 136

(34) Pages 133 - 136

Child O and Child P, and you describe something that you 1 say you have a clear recollection of and that's a recollection of you and Sian Williams undertaking an exercise to do a staffing matrix analysis. Can you, first of all, explain who asked you to do this? Α. So it was at the executive meeting as a result of the, the increase in the mortality that had been escalated and so I can't remember which member of the executive team but it was a member of the executive team had asked, had -- a management request for myself and Sian Williams to work together to do this piece of work. So just going back to that meeting, what was Q. the discussion at that meeting? What was the date of that meeting and what was the general discussion at that meeting? Α. I can't recall the exact date of that meeting because there were several meetings that were called. But it was, it was probably the day of, if not the day before this work was undertook. Q. And the discussion about that meeting was -well, explain what was being, what was the general topic of discussion? It may seem obvious to you but can you just explain to us what was being discussed at that meeting that led to this review? 137 we were given the case number for, and we simultaneously went through a record and any time there was the word "sudden collapse", we would then look at who was caring for that baby, who was on duty, and who had been on duty the shift before. So we didn't look at any clinical care because we are not trained to do that. We were simply looking at who was on duty and then we compiled a list of each of those -- for each baby a list of the carer and who was on duty before and during the actual shift of the collapse. Q. So the product of your work was a number reference that would have related to a child? Α. Yes. So we used the cc number of the child, and then it was typed in, the name, so we cross-referenced it with the off-duty from the neonatal unit of the nursing staff. And in what format was that off-duty? Was Q. that a paper register? Α. It was a paper copy. So you've got computer records which you are Q. going through looking for the words "sudden collapse"? Α. Yes. Q. When you find the words "sudden collapse" you are noting down the cc reference that could be -- would 139

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Α. Yes, yes, it was the increase in the mortality 2 that had led to the need to undertake a series of pieces 3 of work. 4 O. And at that meeting and when you took this work at that point you understood that the Consultants 5 6 had serious concerns about the --7 Α. Yes --8 -- cause of these deaths? Q. q -- and that's why --Α. 10 And I think it is evident by the nature of the Q. task we are going to go on to explaining but you 11 understood there was at least concern that a member of 12 13 staff may have been involved in --14 I didn't at that time know it was a particular Α. member of staff but we knew that they had concerns about 15 16 the increase in mortality. 17 Q. And that that was, to go back to what we were discussing, on 2 July, that was an area of commonality 18 19 they were looking at? 20 Α. Yes. 21 Q. So having established that, you are set with Sian Williams to do this task. What exactly was the 22 23 task? 24 Α. So we were tasked with looking through the 25 Meditech, which is the computer records of babies that 138 1 identify the baby concerned? 2 Α. Yes. 3 Q. And then you would be typing up which staff 4 were on duty? 5 Α. Which staff was looking after the baby. 6 Q. Right. 7 Α. Because that would be derived from the 8 Meditech note and then the off-duty would provide us 9 with everybody on duty. Q. 10 And when you say who was looking after the 11 baby, that's the designated nurse? 12 Α. The designated nurse, yes. And staff on that shift or the shift before, 13 Q. 14 the shift after, just to be precise? 15 So we did the shift before, including who was Α. looking after the baby, and the actual shift of the 16 17 collapse. Who was looking after, who was on duty. 18 And when you say "the shift" we are talking Q. 19 about what periods there? 20 Α. I can't -- I am not familiar with the neonatal shift pattern but it would state on the off-duty early, 21 22 late, long day, so that's what we would write. 23 And I think it's because you were providing Q. 24 a check to each other, but correct me if I am wrong, why were there two of you doing the task? 25

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(35) Pages 137 - 140

So that we didn't miss anything and to confirm 1 Α. 2 that we both got the same numbers of collapses and the 3 same staff looking after that person. 4 Q. And how long did this exercise take? Was 5 it -- were you in the room for a day doing this or? 6 Α. We did it over more than one day. 7 And how did you -- how did you check your Q. 8 work? Did you produce one report? Did you confer at 9 the end of the day? 10 A. When we -- after each baby we would confer, we wrote it down on some paper, and then we would confer. 11 When we agreed we got identical information Sian then 12 would type it up and send it, return it back to whoever 13 she had been asked to return it to, because it was Sian 14 who received the -- the case numbers for the baby, not 15 16 myself. 17 Q. And did you have parity between you and Sian Williams about what you were picking up? 18 19 Α. Yes 20 Q. And at paragraph 124 -- you might want to turn 21 that up -- what did your analysis show? 22 Α. That Nurse Letby was a common denominator. So 23 she wasn't present for all of the collapses, but a large proportion, disproportionate portion to everybody else. 24 25 And did that lead you to suspecting that Letby Q. 141 1 at the meetings? 2 We were aware of Consultants and we were also Α. 3 aware that there were Consultant paediatricians and 4 children's nurses looking at the clinical aspect of 5 care. 6 Q. And I suppose the added bit of the picture 7 that you had was that you knew from Dr Brigham's report, 8 certainly up to during 2015 anyway, that there were no 9 obstetric concerns --10 Α. Yes 11 O. -- about these babies? 12 Α. Yes 13 Q. Did you make that connection? 14 Α. And Sian was aware of that as well because she -- Sian Williams, because she sat on QSPEC, so she 15 was aware of the obstetric report and work as well. 16 17 So in addition to going to -- or Sian Williams Q. going to Mr Harvey and you said she reported back to you 18 that that had been done, did you discuss with 19 20 Sian Williams, or indeed with anyone else, the idea of going to the police. We know you didn't, but did you 21 22 discuss the idea of --23 I personally didn't, no, because I was never Α. 24 fed back the outcome of the paediatric and neonatal nurse review of the care provided to the babies. That 25 143

was involved or could have been causing harm to the 1

2 babies?

Α. Yes, and so that's why we escalated to the 3 4 execs.

And you say in fact at paragraph 125 that 5 Q.

6 "a concern we both shared".

7 Α. Yes.

> Q. Is that a concern you are sharing with

Sian Williams? 9

8

10 Α. Yes

11 Q. Were you sharing that concern with anyone 12 else?

13 Α. No, just myself and Sian, and then she

escalated that to Ian Harvey on both our behalves and 14

she confirmed that she had done that verbally to me. 15

16 And escalated, what practically did she do? Q.

17 What did she do in terms of Ian Harvey? Did she go and see him? 18

19 Α. So she went to see him and she escalated the

20 fact that during our staffing check that the name

Lucy Letby had come up as being a common denominator and 21

- that both myself and her were escalating our concerns to 22 23 him.
- 24 Q. And you were aware that there were
- 25 Consultants' concerns as well at this point having been 142

1 information was never given to me.

2 And at paragraph 126 you say that you accept Q. 3 now that you should have reported the findings to the police. 4

> Α. Yes.

6 O. And we know in fact that Letby wasn't reported to the police for some time after this.

Looking back now, as you said, you were aware of 8

the Consultants' concerns, you had drawn a concern that 9

Letby may be causing harm, why do you think, doing the 10

best you can, why do you think it was, having accepted 11

now that's what you should have done, why did you not --12

what was inhibiting you going to the police at that 13

14 stage?

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15 I think I had trust in the executive team that Α. they were, were -- not -- when I say control, I don't 16

17 mean stopping people from doing things but they had the

range, so they were receiving all the information, so 18

therefore they were making decisions based on 19

20 information that was being fed back from all the

21 different workstreams.

22 Q. And just considering the other steps, your

23 answer may be similar, but did you, did you consider

24 first of all whether internally you needed -- other than

going to Mr Harvey, did you, for example, consider that 25 144

(36) Pages 141 - 144

#### The Thirlwall Inquiry

1 you needed to raise this on one of your committees, on 2 the Women's & Children's Care Governance Board or on 3 QSPEC, that you had to share what your concerns that 4 were now heightened with either of these committees? 5 I felt that I had shared, you know, we'd Α. 6 shared it with the executive team which is the, you 7 know, they are the most senior team in the Trust and, 8 and at the time, you know, they appeared to be liaising with, with different bodies to take best advice. 9 10 And you are a midwife but you are also Q. a registered nurse. Did you consider referring Letby to 11 the NMC? Did you think about restrictions on her 12 13 practice? Was that a thought process you had? Again, no, because I felt that that was --14 Α. 15 I didn't at the time because I didn't have enough detail 16 because I, whilst I knew she was a common denominator, 17 I didn't have the clinical knowledge to know whether the collapses, even though they were sudden, whether they 18 19 fitted within a picture of the baby's health, I didn't 20 have that clinical insight. 21 Q. And I think we have addressed Safeguarding. 22 That was something that didn't occur to you at the time? 23 Α. Not at the time, no. 24 And in terms of the obstetric secondary Q. 25 reviews, I think you carried out the obstetric secondary 145 1 at tab 19, and just looking at, first of all, who was 2 there, there's an awful lot of apologies for this 3 meeting but we can see that you were present and 4 Dr Jayaram was present at this meeting along with 5 Sara Brigham, a Consultant -- the lead for obstetrics. 6 So we had the lead for obstetrics and the lead for the 7 paediatricians, the clinician for children's services. 8 If we go over to page 3, we see at the top there 9 that Child O and Child P, it was being recorded there, 10 it was unexpected neonatal deaths. And then turning over the page again -- actually, just, we don't need to 11 go back but just dealing with the fact that those were 12 13 reported. 14 You say, I think in relation to this meeting, that there wasn't any discussion, as far as you recall, about 15 Letby's suspected involvement in the death of the 16 babies. Clearly that was something that was present in 17 your mind at this time. Are you able to give an insight 18 as to why that wasn't discussed at this meeting? 19 20 Α. So this meeting was in May and I didn't become aware -- was it May? 21 22 Q. No, this is 21 July. 23 Oh sorry, I thought it said May. So I think Α.

- 24 that the -- sorry, can you just ask me the question
- 25 again?

- 1 reviews on 20 July for Child P and Child Q; is that
- 2 correct?

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- A. Yes.
- Q. And when we looked at Child A, Child C and
- 5 Child D, they were done, those reviews, very shortly
- 6 after the deaths -- in fact, I think in the case of
- 7 Child D, within 24 hours.
- 8 This obviously is some time afterwards. Is there
- 9 a reason for that?
- 10 A. Possibly annual leave because of the time of
- 11 year. Also, I think that the Consultant obstetrician
- 12 had had a brief look at the maternal care for the mum
- 13 and didn't have any initial concerns. But I think it
- 14 could have just purely been annual leave that there was15 a slight delay.
- 16 **Q.** When you say didn't have concerns, you are
- 17 talking about the maternity -- (overspeaking) --
- 18 A. Maternity care, yes.
- 19 Q. Because we know there were very serious
- 20 concerns --
- A. Yes. No, no, this was purely the maternityand obstetric care.
  - Q. And if we could just go to the
- 24 Women's & Children's Care Governance meeting, the last
- 25 one we are going to look at, at INQ0003214, and that's 146
- 1 **Q.** Yes. So we know that by 21 July concerns were 2 in your mind --
  - Definitely yes.
  - Q. -- because we have discussed the exercise you
- 5 did with Sian Williams, and we know that Dr Jayaram had
- 6 concerns and we know that the topic of the death of
- 7 Child O and Child P was at least referred to at the
- 8 meeting.
- 9 Was there any discussion that you can recall about
- 10 the issue of Letby, whether the police should be called,
- 11 whether there should be restriction on her practice; any
- 12 discussion about the issue that must have been at the
- 13 forefront of, presumably, Dr Jayaram's and your mind at14 this meeting?
- A. I don't recall there being a discussion about,
  about that at all because at that time the Trust
- 17 Executive team were still, still had a working group,
- 18 I was aware of that, that were looking at all the
- 19 issues.
- 20 Q. So you, you didn't feel the need to minute it
- 21 or raise it at this meeting?
- 22 **A.** No.
- 23 Q. And sorry, if we could go to a page where we
- 24 have gone already, to page 4 of that document.
- 25 Sorry, that's why I am confused. It should be 148

1	3213. Sorry. I must have said 3214.
2	So if we could go to page 4 of 3213, page 4.
3	Looking at page 4 of that. So maybe if we can just go
4	back to page 3. So that's where we see the unexpected
5	neonatal deaths that were raised can you see at the
6	top of the page but no discussion underneath that?
7	A. No, because at that time it says it's an
8	incident. I'm not sure if that is the receipt of
9	a report or whether it's just the incident being logged.
10	<b>Q.</b> But
11	A. It's not clear.
12	<b>Q.</b> But this is the meeting on the 21 July
13	A. Yes.
14	<b>Q</b> and the point is that there's no minuted
15	discussion of Letby or steps that could be taken?
16	A. No. She was definitely never discussed in any
17	Governance Board. I know that.
18	<b>Q.</b> Yes, that is the point
19	A. I am very clear about that.
20	<b>Q.</b> Thank you very much.
21	If we could go then on to page 4, and we see there
22	under "Risks", "New Risk for Escalation in the Month"
23	and we see:
24	"Potential damage to reputation of neonatal service
25	and wider Trust due to apparent increased mortality 149
	145
1	something that was raised in the risk register in terms
1 2	something that was raised in the risk register in terms of the planned
2	of the planned
2 3	of the planned A. No, because the stillbirths, unfortunately in
2 3 4	of the planned <b>A.</b> No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you
2 3 4 5	of the planned <b>A.</b> No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually
2 3 4 5 6	of the planned <b>A.</b> No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and
2 3 4 5 6 7	of the planned <b>A.</b> No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that
2 3 4 5 6 7 8	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned
2 3 4 5 6 7 8 9	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided.
2 3 4 5 6 7 8 9 10 11 12	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant. Q. Thank you.
2 3 4 5 6 7 8 9 10 11 12 13	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant. Q. Thank you. And just before we are going to move now to your
2 3 4 5 6 7 8 9 10 11 12 13 14	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant. Q. Thank you. And just before we are going to move now to your period as the Associate Director of Risk and Safety.
2 3 4 5 6 7 8 9 10 11 12 13 14 15	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant. Q. Thank you. And just before we are going to move now to your period as the Associate Director of Risk and Safety. But just to be clear, there was a CQC review
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	of the planned A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided. So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant. Q. Thank you. And just before we are going to move now to your period as the Associate Director of Risk and Safety. But just to be clear, there was a CQC review in February 2016 and I think you didn't have any
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ry	15 October
within the	e neonatal unit."
Sov	what seems surprising there is that the risk
that is be	ing identified is the potential risk to
reputation	n. Wasn't the more important risk the risk to
patients o	lue to the increased mortality?
Α.	I mean, certainly. However, this risk was
a plan, ar	n Urgent Care risk so that, that division will
have had	the discussion and they have decided what they
were goir	ng to include on their risk register.
lt's⊸	it's come here for noting and escalation to
QSPEC t	o follow a process.
Q.	And did that discussion, the discussion about
risk regis	ters and the damage to reputation based on
-	d mortality, did that cause you to reflect as to
	he risk registers needed to be or should have
	lated to reflect the risk to patients due to
	I mortality? Because that doesn't appear to
	n added to the risk registers at any time
	e 2015 onwards.
<b>A</b> .	I mean, certainly the risk registers, there
	ave been something in it far sooner within the
-	are Division.
Q.	And was it something, because obviously there
	tillbirths and the identified increased
neonatal	deaths from the maternity aspect. Was that 150
А.	No.
Q.	So moving forward to April 2017. You took
over a ne	w role now as Associate Director of Risk and
Safety. V	Vho did you and you took over from
Ruth Milly	ward, I think you have told us.
А.	Yes.
Q.	Who did you report to in that role?
Α.	Alison Kelly, Director of Nursing.
Q.	So you had the same reporting structure?
<u>а</u> .	Yes.
Q.	Was it a more senior role in fact?
<u>ц</u> . А.	No. It's probably parity, just a different
remit.	No. It's probably parity, just a different
Q.	And you gov and this is percerent 127 of
	And you say and this is paragraph 137 of
•	ement that you first met Letby in April 2017
	n moved to the new role?
A.	Yes.
Q.	And what was Karen Rees' role in relation to
Letby?	
А.	So she was her manager.
Q.	And what was your role? You had, as
I understa	and it, you were the, what's referred to as the

- day-to-day manager of -- (overspeaking) --
- A. Yes.
- Q. What's that?

#### The Thirlwall Inquiry

When I moved down to the risk and safety team, 1 Α. 2 Lucy was, was working within the patient experience team 3 but their line manager post was -- the person hadn't 4 commenced their post. So it was being, they didn't have 5 clear supervision from somebody senior within the Trust. 6 So I was asked to provide some day-to-day, just 7 support, whilst Karen Rees, who was the Head of Nursing 8 for Urgent Care, so was responsible for neonatal unit, 9 had kept the management of Letby insomuch of all the 10 meetings with the executives, the unions, and any other meetings that Lucy attended, it was Karen who dealt with 11 that. 12 13 I just dealt with her when she joined my team and I provided the day-to-day support of insomuch that she 14 was working within risk and safety. 15 16 Q. And we know, because you have explained to us 17 your thought process after doing your correlation exercise with Sian Williams. What did you think about 18 19 the appropriateness of Letby being employed in that role 20 at the time and the position that you were put into as being her day-to-day manager? How did you feel about 21 22 that? 23 Α. I mean, she was in a non-clinical role so she 24 was not a risk to patients and at that time, we were 25 still awaiting the next steps from the executive 153 1 of swipe access. So you can't get into any areas of 2 midwifery or neonatology without having swipe access and 3 she didn't have access to get in. 4 Q. Was that something you checked or was it 5 something --6 Α. She's had that access taken. I knew she had 7 had that access taken away from her. 8 Q. So you knew that access had been taken away. 9 Do you know who made that decision to take that access 10 away? 11 Α. No, I don't. But I checked when she joined my team because we had -- she needed access to join the 12 office that one of my teams were based in where her desk 13 was going to be, so I checked where her access was for 14 and that's how come I know she did not have any access 15 16 to --And related to that but on a rather wider 17 Q. scale, is, any restrictions on her practice by the NMC. 18 Did you make any enquiries as to whether there were --19 20 any restrictions had been placed on her practice, whether she would have been able to go and get a job 21 22 somewhere else, for example? 23 Well, she wasn't -- when she was working for Α. 24 me she wasn't working clinically, she was in 25 a non-clinical role.

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management plan of their reviews of all of the care and 1 2 what their next steps were going to be from external 3 reviews, et cetera. 4 O. And you say not a risk to patients. Were you aware of whether there were any restrictions on her 5 6 movements within the hospital? 7 Α. So when she worked for me in risk and safety, she was office-based, she didn't need to attend, but 8 I had her working with nothing to do with women and 9 10 children's services whatsoever because I didn't feel 11 that was appropriate. 12 Q. But in relation to her physical access to 13 other areas of the building, was that something you 14 ensured that she --15 I -- I wasn't responsible for that aspect of Α. 16 her, her work. 17 Q. But given your -- given the concerns --18 Α. Yes. 19 Q. -- that had occurred to you after your 20 exercise with Sian Williams and given your post of 21 Director of Risk and Safety, was it not a matter of 22 concern to you that you had someone who was still 23 working in the hospital who potentially could have gone 24 back to the neonatal unit? 25 Α. Well, she wouldn't be able to get in because 154 1 Q. But did you think about making those checks or 2 did you discuss whether those checks had been made with 3 anybody else on restrictions on her practice? 4 Do you mean when she was in my team? Α. Yes, so you became involved with her 5 Q. 6 from April 2017. From that point, did you make any 7 enquiries as to whether there were any restrictions on 8 her practice or suggest that there should be 9 restrictions on her? Well, at that time she was just -- she was 10 Α. working in an administrative role. She wasn't working 11 12 in a clinical role. 13 Q. So is the answer to the question you didn't 14 check? 15 So I didn't check because I knew where she was Α. working. She was office-based. 16 17 And where was she physically working relative Q. to you? Was it in the same room or just in the same --18

19 **A.** Not as myself, but she was working in an

20 office with the risk and safety leads.

21 **Q.** And were you aware then that she was leaving

- 22 on occasions to go to visit Alder Hey hospital?
- 23 A. That was before I joined. So when that was
- 24 happening I was still Head of Midwifery. That was prior
- 25 to my movement to risk and safety. So I had no

1	knowledge of that until I was in my questioning for the
2	Inquiry.
3	<b>Q.</b> And once did you come to learn of that?
4	A. Only when I received my pack
5	<b>Q</b> . From the Inquiry?
6	A to do with the Inquiry. I didn't have any
7	knowledge of that prior.
8	<b>Q.</b> What would have been your view as her
9	day-to-day manager had she expressed the fact that she
10	was taking leave to visit another hospital?
11	A. Well, I wouldn't have I wouldn't have
12	allowed I wouldn't have allowed that to happen.
13	I would have had to escalate that to Alison Kelly.
14	<b>Q.</b> And why wouldn't you have allowed that to
15	happen?
16	A. Well, because I had done a, you know,
17	a staffing analysis where, you know, there was an index
18	of suspicion and so therefore you don't want someone, if
19 20	they have been removed from clinical practice in our
20	neonatal unit, I don't want them to go into another clinical area.
21 22	So that's why I wouldn't have wanted that to have
22	happened.
23 24	<b>Q.</b> And did you consider that from your
24 25	perspective, while she was within your team sufficient,
20	157
1	referring to there?
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2 3	<b>A.</b> Yes. So all policies within the Trust have an end date on them because practice changes and they have
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consideration had been given to patient safety and 1 2 safeguarding risks? I felt that had been given prior, yes. 3 Α. You were then present at Tony Chambers' 4 O. briefing on 16 May, and we see -- we don't need to turn 5 to it, but we see that you are recorded as having 6 7 attended that? 8 Α. Yes. Q. 9 You recall that briefing, I imagine? 10 Α. Yes, yes. And you understood from that point that there 11 Q. was a police inquiry? 12 Α. 13 Yes. And you understood that Letby was clearly 14 Q. going to be involved in that inquiry? 15 16 Α. Yes. 17 Q. Can we just look at the issues you found when you came to the role of being the Associate Director of 18 19 Risk and Safety. In paragraph 152, you set these out. 20 I am not going to go through them all, but just to highlight some of those. 21 22 You say that: 23 "Hundreds of policies were out of date." 24 Can you just expand a little bit on that, that 25 sounds quite a dramatic statement. What are you 158 1 that hadn't been reviewed. 2 Q. And you said before that it was only subsequently, but it wasn't that review that led you to 3 4 your comment that you felt the neonatal unit weren't 5 reporting things properly, this was a more general --6 Α. These were actual incidents that had been 7 reported so they are in the Datix system but they had 8 never been reviewed. And that was -- there was no one unit that 9 Q. stood out in that? 10 Α. 11 It was, it was -- it was across the --12 Across the board? Q. 13 Α. Yes, apart from within midwifery but then we 14 only had small -- we had small numbers. So it was much easier for us to keep on top of things whereas some 15 areas, just by the nature of the work, had more 16 17 incidents. 18 And then going down a bit further, you say: Q. "Inconsistent approach to risk across the Trust." 19

the governance boards, the items that went -- were received within Urgent Care and Planned Care, they

25 weren't consistent. There were, were -- minutes were 160

Can you just give a little bit more -- develop that

Yes. So just in the make up of things like

20

21

22

23

24

a little bit.

Α.

4			
1 2	received.		
2 3	The way that the risk and safety leads maybe worked within the divisions wasn't consistent. Who attended		
4	what meetings. So someone from audit may attend one		
5	meeting but the the next division may not have		
6	somebody there.		
7	<b>Q.</b> Underneath that, you refer to:		
8	"Out of date mandatory training package."		
9	A. Yes.		
10	<b>Q.</b> Is that we looked at mandatory training		
11	used in the context of safeguarding before. Could that		
12	be a reference to that, is that		
13	A. So this was the risk and safety, so all staff		
14	had risk and safety training as part of their annual		
15	mandatory training and the data and the statistics and		
16	some of the information that was in there was out of		
17	date.		
18	<b>Q.</b> So that's not a reference to safeguarding?		
19	A. It is not safeguarding, no. It's the Trust.		
20	<b>Q.</b> You say at the bottom:		
21	"Poor management of the risk register."		
22	A. Yes.		
23	<b>Q</b> . Did that have any bearing specifically on not		
24	updating a risk register relating to neonatal deaths or		
25	is that not something you can recall?		
	161		
1	<b>A.</b> Who's who is he referring to? He is		
2	referring to Ruth Millward.		
2 3	referring to Ruth Millward. <b>Q.</b> And it says risk and complaints team. This is		
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It is -- across the board in the Trust there 1 Δ. wasn't consistency when risks registers were reviewed. 2 And I think you end your list by saying: 3 Q. "This list is not all inclusive ..." 4 5 Α. No. 6 Q. And if we could just see -- pull up 7 INQ0006771. 8 My Lady, this is tab 12. 9 This rather shows that whilst you have put it in 10 your witness statement what was happening at -- in real-time, so to speak, because this is a message from 11 David Semple on 16 June 2017, so about a month or so, 12 six weeks or so after you were in post; is that correct? 13 14 Yes, about that. Yes. Α. 15 Q. It says: 16 "Please be assured that Julie Fogarty (Interim 17 Associate Director of Risk and Safety), Mel Kynaston (Associate Director of Nursing ...) and I are acutely 18 19 aware of ongoing concerns around clinical risk within 20 the Trust. To put it mildly, we have inherited a mess 21 and the issues include to name but a few ..." 22 So again, this is not an inclusive list, "previous 23 poor leadership within the risk." 24 Who are you referring to as previous poor 25 leadership? 162 1 Surely that, in logic, must have contributed? 2 The reason I came to that conclusion was that Α. 3 it is obvious, though I didn't know it at the time, but 4 it was obvious from the reports in the media and 5 information within my pack, that the paediatricians had 6 concerns for a long time and they had taken them to the 7 Executive team to escalate their concerns and so even if 8 you had all these processes, they had taken them to the 9 Executive team. So that's why I felt -- possibly that's why I felt 10 that at the time when I wrote my statement. 11 But having gone through the exercise we have 12 Q. 13 gone through today, would you accept that these issues 14 with risk were a contributory factor --15 Oh certainly. Α. 16 Q. -- to an environment where this was allowed to 17 happen? 18 Yes, certainly as time has gone on and since Α. I have produced my statement I've been aware of more 19 20 facts. Then yes. 21 And yes, yes, it was part of the environment Q. 22 that allowed these circumstances not to be investigated 23 earlier? 24 Α. Yes, yes.

25 Q. Is that a correct --

# The Thirlwall Inquiry

1	A. I would agree, yes.		
2	Q. You talked very, very briefly and we may have		
3	covered this sufficiently but about your annual		
4	safeguarding. Can I just be clear that this was		
5	training that you were having in 2015 and 2016?		
6	A. Yes.		
7	<b>Q.</b> And you say, as well, when you are dealing		
8	with the safeguarding that you were trained in SUDiC, so		
9	that's Sudden Unexpected Death in Childhood.		
10	Was it your understanding that that process,		
11	referring to the SUDiC process, would be used if there		
12	was a sudden unexpected death of a baby in hospital, so		
13	a baby that's born in hospital and has never gone home?		
14	A. So my understanding is that the neonatal team		
15	would refer that baby to that, that person.		
16	Q. So that would be your understanding that		
17	<b>A.</b> That would be my understanding.		
18	<b>Q.</b> albeit it is not a death at home so there		
19 20	is no suggestion		
20 21	A. But because it was unexpected then I would		
21	<ul><li>still expect that that was the process they follow.</li><li>Q. And did you in your work ever have to refer</li></ul>		
22	a baby on		
23 24	<b>A.</b> No, because it wouldn't be in my, my sphere of		
25	practice.		
20	165		
1	<b>Ο</b> Mrs Fogarty my name is Alex Jamieson I ask		
1	<b>Q.</b> Mrs Fogarty, my name is Alex Jamieson. I ask you questions on behalf of some of the Families		
2	you questions on behalf of some of the Families.		
	you questions on behalf of some of the Families. <b>A.</b> Right.		
2 3	you questions on behalf of some of the Families. A. Right.		
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1	<b>Q.</b> And then, finally, if we can just go to your
2	reflections that you helpfully set out at the end of
3	your statement, and at paragraph 169 you say:
4	"The steps I consider could have been taken to
5	potentially identify earlier that Letby was harming
6	babies on the NNU was a more comprehensive deep dive
7	into the initial increase in mortality, including
8	staffing analysis by an external team."
9	Is there anything you want to add to that by way of
10	detail so that we can understand exactly what, as
11	I understand it, where you feel a wrong turn was taken?
12	A. No, I think, I think I am fairly clear there.
13	I felt that right at the very beginning the Trust should
14	have engaged an external team to do a comprehensive
15	review of the three cases involving in that review
16	staffing involved, et cetera, to try and see if they
17	could find a potential issue.
18	MS BROWN: Thank you very much, Mrs Fogarty, those
19	are all my questions.
20	Mr Jamieson will now have some questions.
21	LADY JUSTICE THIRLWALL: Very well.
22	Questions by MR JAMIESON
23	MR JAMIESON: Is it Mrs Fogarty or would you prefer
24	some other title?
25	A. Yes, that's fine.
	166
	166
1	166 <b>A.</b> Yes.
1 2	
	A. Yes.
2	<ul><li>A. Yes.</li><li>Q. And so you very personally felt that</li></ul>
2 3	<ul> <li>A. Yes.</li> <li>Q. And so you very personally felt that reorganisation because after it had happened, your</li> </ul>
2 3 4	<ul> <li>A. Yes.</li> <li>Q. And so you very personally felt that reorganisation because after it had happened, your responsibility for neonatal services was taken away.</li> </ul>
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25 "Silo working. It was true silo work." 

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Q.

Α.

Q.

Α.

Q.

Α.

Q.

Α.

Q.

Α.

Yes

No.

Yes.

Is that what that is?

And that there were no M -- is that MW issues?

So this note, the bottom bit with -- it didn't

It will have had the date -- it will have had

172

And that section underneath was written before

Yes

And you go on to explain that on the staff -- on 1 1 2 the shop floor, on the clinical floor, the neonatal 2 all of the relevant information, wherever it may be, and 3 staff and midwifery staff were doing well but as soon as if that information is in different silos I need to be 3 able to get hold of it; is that accurate? 4 you got above that into the governance structures it was 4 5 complete silo working. 5 6 And I'm just wondering that phrase "silo working", 6 the arrangements that had been made in the Countess had 7 what did that mean to you, why did you use that? 7 8 So instead of working jointly like we would do led to the information being siloed? Α. 8 9 previously in the old -- when it was a women and 10 children's services, we were working independently and feeding up through a different structure. So maternity 11 services were feeding up through Planned Care and a 12 Planned Care Board and the neonatal services sat on --13 so it was a change in practice. Whereas we were used to 14 all being sat round the table and reviewing and 15 16 discussing, that's not how it was in the future. It was 17 two completely separate divisions. 18 And by this point, that is 2020, your job in Q. 19 the Trust has been this Director of Risk and so it's 20 well known in the management of risk that silos of information are dangerous; am I correct? 21 22 Α. They are not -- they are not beneficial. 23 Q. No. 24 Α. They are not necessarily dangerous. But they 2 25 are not beneficial. 2 169 1 unexpected. Those are Children A, C, and D. 1 not a neonatologist, you didn't have any expertise in 2 Another child, Child B, the twin of Child A, has 2 that area and what I am interested in, please, is your 3 also seriously collapsed and required resuscitation 3 understanding of what your purpose and role was in this 4 within that period. The other fact that we need to 4 meeting. 5 5 build in is that the cause of death for each of those 6 three children was at that stage uncertain. They had 6 that you have taken is a line or a section for each 7 all been referred for post-mortem and indeed a Datix had 7 child, they are identified on the left as Child A, 8 been raised for each death. 8 Child C, and Child D, a short description of some 9 Okay? particulars and then on the right-hand side of the page, 9 10 Α. in relation to each one you have recorded the OSR -- is Yes. 10 that the obstetric secondary review? 11 O. So that's the situation --11 12 12 Α. Yes 13 Q. -- as you come to deal with the issue on 13 14 2 July 2015. 14 I wonder if next, please, we could have on the 15 15 have Child A, C, D. screen your notes of that meeting. Those are 16 16 17 INQ0003530. Thank you. Please may we just zoom in on 17 that top bit of the page. Thank you. 18 18 So we can see this is dated "SUI Review, a Datix number. 19 19 20 2 July '15" and to the right of that you have given the 20 21 initials of the attendees. Yes? 21 22 Α. Yes 22 I went to the meeting because I knew what I was going to 23 Q. Yes, okay. So we have got the right document. 23 discuss and I had to review the care from a midwifery 24 Now, just before I ask my question, you have said 24 aspect because that was my role at this a number of times to us in your evidence that you were 25 25 take the midwifery aspect.

171

meeting; was to
(43) Pages 169 - 172

9	Α.	Yes.		
10	Q.	I think what I and The Families would be		
11	grateful fo	or your reflections upon is how that siloed		
12	approach	was relevant to the risk that was presented by		
13	Letby in 2015 and 2016.			
14	So I	would just like to ask you some questions		
15	about that, if I may.			
16	That can come down, thank you, Mrs Killingback.			
17	Can	we move, please, to the 2 July Serious Incident		
18	Panel.			
19	Α.	Yes.		
20	Q.	I know you have answered quite a lot of		
21	questions	about that already. Just before I ask you my		
22	questions	, can I just contextualise that moment in time.		
23	Wha	at has happened in the lead up to that meeting is		
24	that three	children have died in two weeks in June, all		
25	of those of	leaths were sudden, all of those deaths were 170		

Because what we can see when we look at the records

Well, if I am going to manage a risk I need

And so what you were reflecting here is that

1 I obviously added who was there when I got there. 2 Q. Yes 3 LADY JUSTICE THIRLWALL: So when you were asked 4 what does "MW" stand for --5 Α. It's midwifery, no midwifery issues. 6 MR JAMIESON: Really it is that answer that you 7 have just given that I am particularly interested in. 8 Your role at this meeting, as you understood it, 9 was to take the midwifery information --10 Α. Yes. Q. -- and to come back with any midwifery 11 actions? 12 13 Α. Yes. 14 Right. So does that mean you did not Q. understand it to be any part of your role to challenge 15 16 professionally or evaluate the information that the 17 other specialists were bringing? 18 Α. Obviously if I had concerns then yes, but at 19 this time I trusted the information, as did everyone 20 else at the meeting, that was being provided by 21 a neonatologist. 22 Q. Yes. I just, if I may, I would value your 23 reflections on this issue because it's clear from what you have written that we have read that there were no 24 25 midwifery issues identified or present in relation to 173 1 present in that meeting, I would say. Though it's 2 nine years, it's a long time ago. 3 Q. Okay. There is one document that may help. 4 That can come down, thank you very much. 5 It's the Datix report for Child D, that is 6 INQ0002658. 7 Just while that's coming up, were those Datix 8 reports available to you in the meeting? Were they 9 considered by the attendees beforehand? So the Datix were not brought up in that 10 Α. meeting. 11 12 No. Had you seen them beforehand? Q. So I wouldn't have seen -- I hadn't seen the 13 Α. 14 baby element but obviously the mother, yes, because we would have done the review that would have then gone 15 into the Datix. But no, not the -- not the baby 16 17 information. 18 Okay. How does that work? So you log on to Q. the system to see the Datix. 19 20 Α. The risk and safety lead, they, they pull the incidents. So, for us, once there is an incident we 21 22 look at all of the midwifery care. 23 And so, going back to my question about your Q. 24 reflections on silos, even as you prepare for this meeting, even as you look at the Datixes, you are only 25

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the tragic deaths of these three children, right? 1 2 Seen from the midwifery perspective, that is 3 a reassuring fact, isn't it, because it means we haven't 4 done anything wrong? It means the care provided didn't -- yes. 5 Α. 6 Q. But if I am standing back and looking at it in 7 the round, holistically, I have three deaths that have all been sudden and unexpected, no cause of death is 8 identified, and there is nothing in the midwifery care 9 10 that can have explained why these children died. 11 That's a concern, isn't it? 12 It is now but obviously, you know, nine years Α. down the line when I am looking at this, my actions 13 would be different than they were taken at that time. 14 15 Q. To be clear, this is not -- this questioning 16 is not directed at you personally, I am trying to 17 understand what is going on in the meeting. 18 Α. Yes. 19 All right? So that thought process that Q. 20 I have just set out for you, if there are no 21 shortcomings in the midwifery care, that raises at least 22 the possibility that there is something else that we are 23 not seeing; was that thought process present in the 24 meeting and, if so, who was it voiced by? 25 Α. I would say that thought process wasn't 174 1 looking at the bit that relates to midwifery care? 2 Well, that's because you can't look at Α. 3 something you have not got the clinical expertise to 4 interrogate data. So that isn't silo working, that is 5 just a specialty reviewing care, that it's got the 6 expertise to be able to interrogate and challenge. 7 Q. Okay. Well, let's, if we may please, look at 8 page 2 of this document, and just zoom in on the top 9 half of that page, please. Thank you. Now, can you see -- this is a little involved, so 10 bear with me. Under "Incident investigation" there are 11 a number of entries that have been made by Debbie 12 13 Peacock that are and then Dean Bennett that have been 14 timestamped. Can you see the third one of those that's timestamped 23 July '15, if you look over on to the 15 right-hand side there are in fact a number of earlier 16 17 timestamps and it's the earliest one of those that I am 18 interested in. 19 24 June 2015, 10:45:05 Debbie Peacock. So it is on 20 that line just across to the right-hand side in the body of the text. And Debbie Peacock was an attendee of the 21 22 SUI meeting, wasn't she? 23 Α. Yes.

- 24 **Q.** What she's recorded is:
- 25 "Just to confirm that I have met with Eirian and 176

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reviewed the case notes of Child D who died in the early 1 2 hours of this morning. We have also discussed whether 3 there are any other issues to address in the view of the 4 two other recent sudden deaths on the NNU so all deaths 5 are brought together. In regard to those three deaths, 6 all deaths occurred in Room 1, our intensive care room 7 but in a different cot space, all microbiology results 8 have been negative to date, initial post-mortem result 9 for Child A did not identify a definite cause of death." 10 A point that I have made with you already. There is a bullet point about a TPN bag and why 11 that makes a particular infection unlikely, but then the 12 13 fourth bullet: "There does not seem to be any staff, medical or 14 nursing members present at all three episodes other than 15 16 one nurse, who was not the nurse responsible for Child D 17 on that shift." 18 Or putting that the other way round, there was 19 a member of staff who was common to all of those three 20 deaths and that entry, as I understand this record, is timestamped as having been made on 24 June '15, so 21 22 a week or so before your meeting. 23 I take it from your answer that you didn't read 24 that before the meeting? 25 No. No, because that is a neonatal entry so Α. 177 1 Registrar concerns, that before this meeting Registrars 2 had or a Registrar had visited a Consultant and said: we 3 are concerned about these sudden collapses, we are 4 concerned that there is a common and unusual rash that 5 none of us have seen before but it's happened in three 6 of these cases. We don't know what's happening here. 7 Was that information brought to your meeting? 8 This is the first time I have even heard of Α. 9 that. 10 Q. Okay, thank you. Those are the end of my questions then about that meeting. 11 Can I just please then move briefly to talk to you 12 about QSPEC, the Quality, Safety and Patient Experience 13 14 Committee Could we look very briefly at the 15 20 July 15-minute, so that's INQ0003211, and I am 16 17 looking at page 2 to begin with, please. 18 So I'm just going to note in passing, again for the transcript and for my Lady's note, that Dr Brearey has 19 20 attended this meeting -- it's at the bottom of this page -- particularly to talk about the Morecambe Bay 21 22 Kirkup report and about the risks to neonatology that 23 were presented by the current divisional structure, 24 okay? 25 So that was a topic for discussion at that meeting. 179

1 I read the obstetric elements.

2 **Q.** But does one need to be a neonatologist to

3 look at that and say: well, that is a common factor, we

4 don't know if that's relevant or not. We had better

5 think about it?

- 6 **A.** Well, I would have expected this level of
- 7 information to have been -- to have been presented by
- 8 either Debbie Peacock who wrote it or the paediatricians
- 9 who were aware of this information. That was the
- 10 purpose of the meeting. I was given the remit of
- 11 looking at the obstetric, I wasn't asked to review
- 12 neonatal records. I was asked to take the obstetric
- 13 element and that's what I did.
- 14 **Q.** Just with your Director of Risk hat on, if
- 15 I can use that vernacular, is that the right approach?

16 A. It obviously isn't now, but at the time I did

- 17 the task I was given, so I was given the task of
- 18 reviewing and bringing the obstetric information and
- 19 that's what I took to the meeting. However, hindsight
- 20 is a great thing.
- 21 **Q.** Yes. Okay. And the final question just to 22 ask you to confirm this, please. We know from other
- 23 evidence, I am not going to ask that it comes up on the
- 24 screen, but for the record of the transcript,
- 25 INQ0025743, it is the email from Dr Gibbs reflecting 178
- 1I don't have a question for you about it. Thank2you.

But may we go, please, to page 5 of this document.
At item 11, the agenda item is "SUI update and other
incidents" and there are a discussion of a number of

6 incident reviews that have been raised to this meeting7 and taken place.

8 Now, the 2 July '15 meeting was a Serious Untoward
9 Incident Review. That does not seem to have been
10 discussed at this meeting, some three weeks later.

- 11 Should it have been?
- A. I mean, it obviously wasn't, but I can't, you
  know, I don't know why that wasn't tabled at that

14 meeting.

- 15 Q. I didn't work in this hospital. Was that the16 sort of reports, the sort of meeting that should have
- 17 been tabled here?

18 A. I mean, certainly it should, the, the concern19 should have been escalated further.

- 20 **Q.** I mean, in terms of escalation, Alison Kelly,
- 21 the Director of Nursing, was in that meeting, so she
- 22 would have had --
- A. She called that meeting.
- 24 **Q.** She called the meeting?
- 25 **A.** Yes.
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1	<b>Q</b> . She was aware of everything that was
2	discussed. Could she have brought that to this meeting?
3	She wouldn't have had to escalate it to anybody, she
4	knew about it. Is that a fair inference?
5	A. Sorry, can you
6	<b>Q.</b> Is that a fair inference, is that a fair
7	comment that I have just made that she was aware of
8	those
9	A. Yes, she was aware. Yes, she called the
10	meeting. She was fully aware.
11	<b>Q.</b> Okay. Thank you. That can come down.
12 13	In relation next to the Brigham report as it's been called.
13 14	A. Yes.
14	<ul> <li>A. Tes.</li> <li>Q. You told us that there was an awareness that</li> </ul>
16	there had been an increase in the number of deaths from
17	your perspective, stillbirths and neonatology deaths,
18	and so the review had been commissioned. What I was
19	interested in, please, is how did you capture that
20	information that there had been an increased rate of
21	mortality?
22	A. Data.
23	<b>Q.</b> What does that mean? What did you actually do
24	or who did it?
25	<b>A.</b> So within data well, for a start the
	181
1	• Because do you see what the direction of my
1 2	<b>Q.</b> Because do you see what the direction of my question? The data might be there on the Datix
2	question? The data might be there on the Datix
	question? The data might be there on the Datix A. Yes.
2 3	<ul> <li>question? The data might be there on the Datix</li> <li>A. Yes.</li> <li>Q but somebody has to be prompted to go and</li> </ul>
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1	Consultant obstetricians would be aware from being based	
2	on the labour ward, but from Datix.	
3	<b>Q.</b> Okay. So who is it who is going into Datix on	
4	your side to notice those trends, to identify them and	
5	5 to action them with the review. Who's doing that work	
6	A. So not only the risk and safety leads but all	
7	of the ladies who have stillbirth, they have	
8	a Consultant review, they go to the Pregnancy Risk	
9	Clinic, and also the neonatal deaths were having	
10	an obstetric secondary review.	
11	So because of an index of suspicion, we ran a Datix	
12	report.	
13	<b>Q.</b> So but so you have identified I think the	
14	risk leads on the unit, they were the people who were	
15	actually doing this?	
16	<b>A.</b> There is one risk lead for women and	
17	children's service, and they were asked to pull a report	
18	for us.	
19	<b>Q.</b> Okay. And who made that request?	
20	A. I can't remember.	
21	Q. But it sounds like it was a matter of	
22	discussion between you and the clinicians?	
23	A. It was it was myself and the Consultants	
24	but I couldn't tell you exactly who will have said pull,	
25	pull the list, due to the time lapse. 182	
4		
1 2	join your review? A. No. because it was purely a review of	
3	obstetric care, so they wouldn't be able to contribute	
4	to reviewing whether people were on the right pathway or	
5	had the right drugs, et cetera.	
6	We were also aware that they would be doing	
7	a review of their own.	
8	<b>Q.</b> How did you have that awareness?	
9	A. One of the one of the Consultants had said,	
10	"Well the paeds are doing a review as well." So it was	
11	a verbal that we had been told verbally.	
12	<b>Q.</b> But the Brigham review, as I understand it, is	
13	finished in November?	
14	A. Yes.	
15	Q. It's presented	
16	A. In December.	
17	<b>Q.</b> in December.	
18	A. Yes.	
19	<b>Q.</b> And there is nothing from the neonatology side	
20	in November, there is nothing in December.	
21	A. I can't account for the practices within the	
22	neonatology unit.	
23	<b>Q.</b> No. You have been asked you have already	
24	candidly conceded, and I am grateful, that on reflection	
25	looking at that Brigham report it is potentially	
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says:

committee."

Α.

Q.

Α.

O.

neonatal side.

Yes

Α.

or our review

Q.

Α.

Q.

Α.

Q.

update that's missing.

Yes.

No, because Alison Kelly emailed myself and

Yes. So you have said that in terms, haven't

Ruth Millward on 2 December. So myself, for the

obstetric, and Ruth Millward, for the neonatal, because

Ruth Millward played no part in our decision to review

So that's why I said it was the paed element that was

missing and so that's why Ruth was copied in because

you, on 2 December, the updated midwifery element was

received in November, that document that I gave you

in November was the midwifery element, it's the paed

But her reply at the top of that:

"Hi, sorry if I haven't been clear. I mean the

thematic review of neonatal/deaths recently undertaken

I don't, in fact, think I can put any particular --

So that, that is the neonatal review.

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LADY JUSTICE THIRLWALL: I hadn't noticed that.

Right. Now, my learned friend Ms Brown took you to

"Mrs Kelly thanked Ms Fogarty and the team for the

this paragraph and I am not going to repeat what she's

done already. It is the minute of your presentation of

the neonatal and stillbirth review. What I would like

to do, though, is having orientated us there, just go

over the page to page 6, because the final sentence

Now, as I understand your evidence, your

explanation to QSPEC had been: this is our report, it

shortcomings with it, we have an action plan to pick up

only deals with maternity, we have not found any

the items of improvement that we have identified.

That's correct, yes.

That's accurate?

report and the assurance it had provided to the

MR JAMIESON: And my Lady is quite right. It is

is midwifery element only, and just to bottom this topic

Yes. Which you have said in the email below

it will be for her to explain what that meant.

out, please, can we go to the minutes.

paragraph 11, not page 11.

It is page 5, please.

then she would be chasing up the neonatal element.

And she's also copied Ian Harvey into the email.

misleading. 1 2 Α. Definitely, definitely. Q. 3 Right. And may we please just look at -- it 4 is a document we have looked at before but we are going to look at it again briefly, if we may. It is the 5 6 emails with Alison Kelly. 7 Α. Yes 8 INQ0003220. Q. 9 So we start at the bottom. So the question is 10 coming to you on the 2 December by which time the Brigham report has been produced but it has not been 11 presented. 12 13 Α. Yes. Q. "Hi, where are things up to with the thematic 14 review? I am keen to get a paper to the 15 16 December QSPEC." 17 Now -- and you reply: "Hi, the updated midwifery element was received 18 19 in November at QSPEC. It was the paed update that was 20 missing." 21 Now, it may be suggested that Alison Kelly was one 22 of those who received the report and was misled by it to 23 begin with, thought it was a comprehensive document --24 Α. No. no. 25 Q. -- rather than just obstetrics? 185 1 Α. Because Alison Kelly has written at the top: 2 "Despite terminology below this was an 3 obs/maternity review." 4 That's Alison Kelly's handwriting. 5 Q. That's her handwriting? That's really 6 helpful. Thank you. So that's the manuscript --7 Α. That's Alison Kelly's handwriting at the top, 8 I recognise that. 9 That's really helpful. Thank you. Q. Because I just -- in that light, I would just like 10 to look at the minute of the December QSPEC, please. 11 That is INQ0003204, and can we start at page 11. 12 13 It may be that I have given you the wrong --14 LADY JUSTICE THIRLWALL: Do you mean page 11 or 15 paragraph 11? MR JAMIESON: I mean page 11 but that was not the 16 17 document I was expecting. LADY JUSTICE THIRLWALL: I think you might mean 18 paragraph 11, 0005. 19 20 MR JAMIESON: So what I was hoping to see was the minutes of the QSPEC committee. 21 22 LADY JUSTICE THIRLWALL: Yes. 23 You have given the right reference. 24 MR JAMIESON: I have, okay, it is just not what has 25 come up in front of me.

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And so nobody listening to that should have taken assurance that it answered concerns on the

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(47) Pages 185 - 188

1 Α. No, because they were aware of my remit. 2 I made it clear it was obstetric and maternity only and 3 Sian Williams in her statement makes reference to the 4 fact that this report was an obstetric report only which confirms that that's what I verbally said at the 5 6 meeting. 7 Q. Yes. There are no -- what you had also said 8 in that email that we looked at a moment ago was that 9 the neonatal review was still outstanding. 10 Α. Yes. Q. But there is nothing here in terms of an 11 action or a plan taking forward that suggests the 12 committee were awaiting that report or expecting that 13 14 report. 15 No, it's not evident in that and I -- no, it's Α. 16 not evident in these minutes. But that would be 17 something for Alison Kelly and Ruth Millward to chase 18 outside of the meeting. 19 Q. That was your expectation? 20 Α. That would be my expectation. 21 Q. But didn't QSPEC have a role in monitoring 22 these issues, making sure that actions were completed? 23 Α. Definitely, yes. 24 So if, on this very serious issue an increase Q. 25 in neonatal deaths and stillbirths, half of the review 189 1 position of Director of Risk, okay? 2 So the risks that are or have been identified by 3 Mother E/F in the evidence that she has heard, in the 4 criminal trial and here, in staff using their mobile 5 phones on the unit is principally a blurring of the 6 lines between the personal and the professional because 7 this Inquiry and indeed the criminal trial have received 8 evidence of messages between clinicians, of friendly 9 run-of-the-mill conversations, lighthearted social 10 conversations, that then have interwoven an exchange of deeply personal and often tragic personal data that 11 related to the children who died. 12 13 And the question is: was that a risk that the Trust 14 was aware of at the time that you were Director of Risk Management? 15 16 Α. So this is the first time I have heard that piece of information. 17 18 Okay. Q. It wasn't something that I was familiar with. 19 Α. 20 Q. Okay. Were there any policies or rules that governed the use of personal mobile telephones on the 21 22 NNU? 23 Α. Not on the NNU, no. I would say that mobile 24 personal phones were used not only in the Countess but widely throughout all of the NHS because staff are not 25

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has been completed but the other half hasn't, shouldn't 1 2 that have been formally on the agenda for future QSPECs? Well, I don't know whether, aside from the 3 Α. 4 meeting, whether there were any emails being sent to the 5 relevant people asking where the reports were. Because 6 I wouldn't be privy to that information. 7 But as somebody who sat on this board, if Q. I come to the next meeting of this committee and I am 8 9 asked to review the minutes, I am not going to be 10 looking, I am not going to be prompted to look for any additional review from the NNU in relation to these 11 deaths. I am going to read that and it says, "Assurance 12 has been provided, no further actions." 13 14 I suppose that Alison Kelly knew that there Α. 15 was a need for a neonatal review as did Ian Harvey, the 16 Medical Director. 17 Q. Okay, thank you very much. That can come 18 down. 19 The final topic is different to everything that we 20 have talked about before and it comes from one of the 21 Families that I represent and the concern that's raised 22 is about the use of mobile telephones on the NNU. 23 Now, I know that you didn't work on the NNU --24 Α. Yes 25 O. -- and so I am asking you really from your 190 1 issued with a works telephone. 2 But if that risk that I have identified is Q. 3 present, that measure that you have just mentioned, the 4 issuing of a staff telephone, might be an effective one 5 to reduce that risk? 6 Δ. I mean, it's very sad to hear what you have 7 said about the, you know, the messages. I can say I had 8 no personal knowledge of that until you have just raised 9 it now. 10 MR JAMIESON: Thank you very much. Those are all 11 my questions. 12 Thank you, my Lady. LADY JUSTICE THIRLWALL: Thank you very much, 13 14 Mr Jamieson 15 I have no questions for this witness. We are finished now? 16 17 MS BROWN: Yes. LADY JUSTICE THIRLWALL: Thank you very much 18 indeed, Mrs Fogarty, you are free to go. 19 20 Are we going to take the break now? 21 MS BROWN: I think that's the suggestion and then 22 there is going to be a summary of evidence after the 23 break. 24 LADY JUSTICE THIRLWALL: Very good. We will

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recommence at quarter to 4.

1	(3.28 pm)
2	(A short break)
3	(3.46 pm)
4	LADY JUSTICE THIRLWALL: Yes, Ms Lyons.
5	MS LYONS: My Lady, this is the summary of the
6	evidence of nurses and midwives.
7	LADY JUSTICE THIRLWALL: Thank you.
8	Summary of Evidence of NURSES AND MIDWIVES
9	MS LYONS: My Lady, the Inquiry local team sent
10	Rule 9 requests to 30 nurses who were involved in the
11	clinical care or management of babies on the indictment
12	at around the time of collapse and/or death.
13	20 other nurses who worked on the neonatal unit and
14	all 14 midwives who appeared in the hospital staff list
15	were sent questionnaires. Any individual who worked
16	there during 2015 and 2016 and who considers they might
17	have relevant evidence to give the Inquiry should
18	contact the Inquiry. It remains the case that the
19	Inquiry remains open throughout the course of these oral
20	hearings to receive such evidence.
21	This is a summary of the evidence of nurses who are
22	not being called to give oral evidence. Collectively,
23	they have provided 22 witness statements and completed
24	20 questionnaires. This summary also incorporates the
25	evidence of the midwives. The nurses and midwives have 193
1	providing clinical care to special care babies since
2	2008. She described this period as:
3	" very busy and stressful on the unit. We would
4	sometimes miss breaks because it was that busy. Staff
5	morale was low because everyone was tired. However,
6	I always felt supported and valued."
7	Most of the nurses commented positively about the
8	quality of management, supervision and/or support that
9	they received during this period from the NNU ward
10	manager Eirian Powell and the deputy ward manager
11	Yvonne Griffiths.
12	Of the Band 6 nurses concerned, Laura Eagles
13	described the ward manager and deputy ward manager as
14	"very present, approachable and strong in their
15	leadership".
16	Caroline Oakley also described Eirian Powell as
17	"approachable, helpful and supportive", as did Ailsa
18	Simpson who stated that Eirian Powell was "supportive
19	and appreciated all our hard work as a team during an
20	extremely difficult period."
21	Other Band 6 nurses such as Caroline Bennion
22	described Eirian Powell and Yvonne Griffiths as "very
23	supportive, approachable and proactive with personal
24	development. Learning opportunities, study days, and

- 24 development. Learning opportunities, study days, and
- 25 courses were often recommended and encouraged".

- responded to specific questions in connection with the 1
- 2 issues under investigation. We are grateful for their
- co-operation which is of assistance to the Inquiry's 3
- 4 work
- This summary sets out their responses to questions 5
- 6 about the culture and atmosphere on the NNU between 2015
- 7 and 2016, suspicions or concerns about Letby, the
- mortality rate, and what changes should be made to keep 8
- babies in the NNU safe from deliberate harm. 9
- 10 Culture and atmosphere on the NNU at the hospital
- from 2015 to 2016. 11
- Many of the nurses concerned described June 2015 to 12
- June 2016 as a particularly busy period on the NNU. 13
- Christopher Booth, a Band 6 nurse, who had been working 14
- on the NNU since 1993 recalled it being: 15
- 16 "... an incredibly busy period with high acuity and
- 17 it was a demanding time for all team members. As so
- much time has now passed my memory is somewhat sketchy 18
- 19 but I do remember team members being asked to show
- 20 greater flexibility with shifts worked and indeed even
- 21 being asked to work extra shifts on a regular basis.
- 22 I do remember grumblings of us needing more registered
- 23 nurses to help cope with the increased workload but that
- 24 did not seem to be forthcoming."
- 25 Lisa Walker, a Band 4 nursery nurse, had been 194
- 1 Both Joanne Williams and Amy Davies said they felt 2 supported within the nursing team and were encouraged to 3 further their qualifications and training.
- 4 Nurse X noted that Eirian Powell was "open to 5 general concerns or issues being raised". She also
- 6 said.

7 "Eirian Powell could be defensive of nurses on the 8 unit and would generally support nurses if issues were

- raised by doctors, for example. That said, she had 9
- obvious favourites amongst the staff as well as a couple 10
- of staff that she clearly did not like. This meant that 11
- her response to issues, incidents varied depending on 12 13 who was involved."
- 14 Belinda Williamson described Firian Powell as
- 15 "generally very supportive and fair". She also stated: 16
- "If I had a problem she was approachable and would
- generally work with me to solve the problem. She would 17
- often ask for the problem to be put in writing if she 18
- felt it was necessary to have a record of the issue. 19
- 20 She encouraged the team to actively fill out Datix.
- Eirian supported us with trying to ensure we had 21
- 22 adequate staffing levels and often asked us to enter
- 23 a Datix if staffing levels were insufficient."
- 24 As regards the deputy ward manager Yvonne Griffiths
- Belinda Williamson commented that she worked well with 25

Eirian Powell: 1 2 "They balanced each other out and appeared to work 3 well together." 4 She expressed the view that: 5 "At times it did feel that some staff were given 6 opportunities based on who they were, not their 7 abilities and/or experience. Staff were encouraged to 8 improve their knowledge and skills through further 9 training and education as well as secondments at 10 tertiary centres. At times it felt staff were allocated infants above their capabilities due to the workloads 11 occurring within the unit, relying on the nurse in 12 13 charge or senior nurses to oversee their work." 14 Anne Murphy was the "matron of the women and children's ward", known in the Inquiry as the Lead Nurse 15 16 for Children Services. Ailsa Simpson described 17 Anne Murphy's management style as "very supportive". Nurse Y gave similar evidence. She said that 18 19 Anne Murphy was: 20 "Always contactable and supportive in the absence 21 of management on the NNU". 22 Minna Lappalainen was less positive about the 23 hospital's senior management who she felt "didn't support us or listen to staff or the NNU manager". She 24 25 expressed the view that "our staffing levels remained 197 1 supportive and did pass on any concerns I raised 2 regarding staffing levels to her manager. I found the

- 3 unit very stressful during this period due to increasing
- 4 staff shortages and the increasing workload that was
- 5 being expected of a Band 4. Even though I was
- 6 an experienced Band 4 nurse I had not seen the staffing
- 7 issues as bad as I had in 2015 to 2016. I was being
- 8 asked to complete tasks that I was under qualified for,
- 9 ie babies that required a Band 5/6 nurse. When I raised

10 these concerns to fellow colleagues I felt very under11 supported."

- 12 In 2015 to 2016 Claire Bevan worked predominantly
- 13 night shifts as a Band 6 bank nurse on the NNU. During
- 14 these shifts she described either being in charge or
- 15 second in charge of the NNU, co-ordinating staffing and
- 16 care and allocating patients and staff for the shift as
- 17 well as supporting staff. As to the quality of the
- 18 management of the NNU between June 2015 and June 2016,19 she said:
- 20 "Some staff found management more approachable than
- 21 others. The unit generally felt neglected by senior
- 22 management as we were constantly short-staffed and it
- 23 appeared they weren't listening to our requests for
- 24 help. If we had sickness on shifts it was always very
- 25 hard to get help from other areas of the hospital. We

- 1 poor at times especially during busy periods. This
- 2 period was stressful and exhausting at times."
- 3 Bernadette Butterworth, Mary Griffith,
- 4 Sophie Ellis, and Samantha O'Brien were Band 5 neonatal
- 5 nurses in 2015/2016. They all describe the management
- 6 on the NNU as supportive.
- 7 As a junior Band 5 nurse working on the NNU between
- 8 2015 and 2016, Sophie Ellis found the nursing managers
- 9 "supportive, approachable and knowledgeable". She felt
- 10 able to talk about personal and professional matters
- 11 with the nursing managers and felt "they listened to
- 12 [her] with compassion".
- 13 Bernadette Butterworth recalled there being a good
- 14 team spirit where the nurses would all support each15 other.
- 16 Of the Band 4 nursery nurses who had dealings with
- 17 the NNU managers the majority reported feeling largely
- 18 supported. Jean Peers said:
- 19 "I would describe the quality of management and
- 20 supervision as supportive, close and caring, as were the21 nurses on the NNU."
- 22 However, Cherryl Cuthbertson-Taylor experience of
- 23 the culture and atmosphere on the NNU differed. She
- 24 said:
- 25 "My line manager between 2015 and 2016 was 198
- 1 felt like we were on our own. I think people were
- 2 frightened to come and help because it was such a niche3 area of nursing."
- 4 Each of the nurses was asked to describe the
- 5 relationship between (1) clinicians and managers, (2)
- 6 nurses, midwives and managers, and (3) between medical
- 7 professionals -- doctors, nurses, midwives and others --
- 8 at the hospital between June 2015 and June 2016.
- 9 Several of the Band 6 nurses gave evidence that
- 10 there was a good relationship between the neonatal
- 11 nurses and the doctors.
- 12 Laura Eagles recalled that the nurses worked well
- 13 with the doctors, particularly the Registrars and senior
- 14 house officers. She describe the Consultants as
- 15 approachable. Joanne Williams also commented on the
- 16 close working relationship the nurses had with the
- 17 Registrars who she recalled were present on the NNU most
- 18 of the time when acuity was high. She described the
- 19 relationships across the different professions as
- 20 professional.
- 21 Nurse Y described the Registrars who were allocated
- $\ensuremath{\text{22}}$  to the NNU as very experienced and appeared to have
- 23 a good rapport with the nurses.
- 24 As regards the nature of the relationships with the
- 25 Consultants she said she had "worked on the unit for 200

1 a long time" and that she felt she had "a good rapport

2 with Consultants".

- 3 Ailsa Simpson recalled there being stressful4 periods at times. She stated:
- 5 "Sometimes when a baby required a review by
- 6 a doctor they wouldn't always be available to attend
- 7 straight away as they would be reviewing patients on the
- 8 children's ward first. Overall, despite the [busyness]
- 9 of the NNU, the doctors and nurses on the NNU
- 10 collaborated well together as a team and the atmosphere
- 11 was happy at times despite the stressful phases."
- 12 Belinda Williamson noted:
- 13 "There was frustration with the medical team at
- 14 times due to lack of cover for neonates, especially
- 15 overnight, or if the team became busy on A&E or on thepaediatric unit."
- 17 Christopher Booth described the relationship
- 18 between the medical professionals during this period as19 good. He also said:
- 20 "We were a strong, mutually supportive team and all
- 21 worked well together for the well-being of our babies
- 22 and their families. My only slight concern though, and
- 23 it is a concern that I have held for some time, is that
- 24 we at the Countess of Chester Hospital really could have
- 25 benefited from the expertise of a neonatologist who

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- 1 with midwives. There was very little communication
- 2 between us and the obstetricians. If we had challenging
- 3 conversations to have, we would ask our Consultants to
- 4 speak with them. We would sometimes face discord from
- 5 some senior midwives and ourselves. This would be in
- 6 relation to when we were heading to full capacity or
- 7 already at it and the midwifery team not valuing our
- 8 concerns. It could be quite a struggle sometimes when
- 9 we were full and then wanting to deliver a baby that
- 10 would need our care and us not having room. We would
- 11 ask them for help and some appreciation of our situation
- 12 but would not get it. I cannot say this was all the
- 13 time but it was quite common to have a struggle when we
- 14 were getting full and/or closed. If we as an NNU team
- 15 felt the best thing for the pending admission was
- 16 a transfer out, it would be very difficult to make this
- 17 heard by the obstetric team."
- 18 In her evidence to the Inquiry, Caroline Oakley
- 19 discussed the strain in the relationship between the NNU
- 20 and obstetric teams when the midwives/obstetricians did
- 21 not accept that the NNU was at full capacity and could
- 22 not admit any more babies. She said that neonatal
- 23 nurses would report such incidents via an online
- 24 reporting system, Datix.
- 25 Susan Morton was employed by the hospital as a 203

- 1 could offer more specific, focused and cutting-edge
- 2 expertise in this very specialised field."
- 3 Abigail Lever, a Band 5 neonatal nurse stated that
- 4 there has "always been a really good relationship
- 5 between doctors and nurses."
- 6 In 2015 to 2016, Band 5 neonatal nurse Satasha
- 7 Culshaw worked ad hoc shifts on the NNU that required
- 8 cover. She cared for special care and high dependency
- 9 care babies. She said:
- 10 "The staff I worked with all had a strong sense of
- 11 teamwork ... I felt there was a good sense of teamwork
- 12 between all members of staff that I worked alongside.
- 13 I never got a feeling that there were any issues between
- 14 colleagues."

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- 15 Janet Cox, a Band 4 nursery nurse who had worked at
- 16 the hospital from 1986 to 2022 stated that she did not
- 17 have a clear memory of the relationships between
- 18 clinicians and managers and medical professionals. She
- 19 also stated that she did not wish to comment "as [her]
- 20 view the Trust and various so-called medical
- 21 'professionals' is prejudiced by the horrendous way they
- 22 treated Lucy, (Ms Letby)".
- As to the relationship between neonatal nurses andmidwives, Laura Eagles described this as:
- 24 Iniuwives, Laura Eagles described this as.
- 25 "More complex. "We as nurses would directly liaise 202
- 1 Band 6 rotational midwife in 2015 to 2016. She worked
- 2 on the central labour ward, antenatal/postnatal ward and
- 3 within the maternity day unit. She described the extent
- 4 to which she carried out work on or in connection with
- 5 the neonatal unit between 2015 and 2016 as follows:
  - "If I was working on the labour ward and a baby
- 7 required any care or observation on the neonatal unit
- 8 immediately following birth, the baby may have been
- 9 transferred to the unit by the neonatal team. I would
- 10 complete a situation background assessment and
- 11 recommendation handover to a member of the NNU team.
- 12 This is a recognised tool we use in medicine to give
- 13 a clear and concise handover and would detail any
- 14 relevant risk factors from the mother's pregnancy,
- 15 labour and delivery. When working on the postnatal ward
- 16 a nursery nurse from the NNU would be allocated to the
- 17 ward's transitional care room. This was a 3-bedded bay
- 18 and may include, for example, babies who were slightly
- 19 premature requiring additional observation, feeding,
- 20 support, temperature monitoring, or phototherapy. As
- 21 midwife I would be caring for the mother and the nursery
- 22 nurse would be responsible for the care of the baby. In
- 23 these situations I liaised with the neonatal nursery
- 24 nurse who was caring for the baby. If a baby was being
- 25 cared for on the NNU, mum may be staying in a single 204

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- 1 room on the postnatal ward. If mum was unable to
- 2 mobilise independently then a member of ward staff, on
- 3 occasion a midwife, would transfer mum to the NNU in
- 4 a wheelchair to feed and spend time with her baby. At
- 5 that time any baby born on antibiotics had to be
- 6 transferred from the ward to the NNU each time their
- 7 medication was due as the drug and dose required
- 8 checking by two of the registered nurses. On occasions
- 9 that the parents or a member of the neonatal staff were
- 10 unable to transfer the baby they sometimes asked
- 11 a midwife or a midwifery assistant to take the baby to
- 12 the unit. I cannot recall if I did this as during this
- 13 time period I had completed six months' experience as
- 14 a labour shift leader then went back to being a Band 615 midwife."
- 16 Susanne Boggan qualified as a registered midwife in
- 17 2014 and commenced work at the hospital between
- 18 October 2014 and November 2015 as a Band 5 rotational
- 19 midwife. She described the extent to which she carried
- 20 out work on or in connection with the neonatal unit
- 21 between 2015 and 2016 as follows:
- 22 "I would primarily have contact with the neonatal
- 23 team if their attendance was required at a birth where
- 24 it was anticipated the baby may need assistance or
- 25 monitoring outside of midwifery scope of practice, for 205
  - 200
- 1 whistle-blowing formally. However, I am aware of how to
- 2 raise concerns. The process would be to inform the
- 3 manager, or higher, if necessary, and to complete
- 4 a Datix incident form depending on the type of
- 5 concerns."

- 6 Caroline Bennion:
  - "We had a good relationship with our immediate
- 8 management team to feedback any concerns we may have had
- 9 regarding colleagues, unsafe practices and not adhering
- 10 to policies. The manager at the time Eirian Powell was
- 11 very keen for staff to openly report incidents through
- 12 Datix and log concerns with a no-blame culture. I was
- 13 aware of the Freedom to Speak Up but at the time I would
- 14 not have known who to approach or the process for
- 15 doing so."
- 16 Bernadette Butterworth:
- 17 "With regards to any training we had been given
- 18 regarding reporting concerns involving fellow members of
- 19 staff I cannot recall what training we received at the
- 20 time apart from discussing concerns with the manager.
- 21 We now receive Speak Up core training for all workers
- 22 which is mandatory for all staff."
- 23 Amy Davies:
- 24 "I cannot recall whether we had specific training
- 25 on how to report concerns about members of staff at the

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- 1 example instrumental or operative births, premature
- 2 babies, or babies who required resuscitation at birth.
- 3 In such cases it was usually a neonatal doctor who would
- 4 attend first and the team would include senior neonatal
- 5 nurses if their assistance was required. I would also
- 6 come into contact with the neonatal nurses if a baby in
- 7 my care was receiving intravenous antibiotics as it was
- 8 the neonatal nurses who would come to administer those.
- 9 If a baby required admission to the NNU after birth,
- 10 I would often accompany the parents to the NNU to see
- 11 their baby once the mother was well enough.
- 12 Occasionally, I would see the NNU shift leader when they
- 13 would come to the labour ward to ask for updates on any
- 14 anticipated birth that might require their presence. On
- 15 one occasion I cared for a family in the bereavement
- 16 suite after their baby had unexpectedly passed away and
- 17 two neonatal nurses attended to help with bathing the
- 18 baby and memory making, taking photos, hand and
- 19 footprints."
- 20 Concerns or suspicions.
- 21 While few of the nurses could recall receiving
- 22 specific training on how to report concerns about fellow
- 23 members of staff, they were all aware of how to do so.
- 24 Laura Eagles:
- 25 "I do not recall ever having any training on 206
- 1 time. However, I know I knew about whistle-blowing and
- 2 I felt confident that I could report any concerns to my
- 3 line manager or higher management if I had concerns and
- 4 I would have done so if I had any concerns."
- 5 Nurse Y:

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- "As a senior member of staff if I had concerns
- 7 regarding another member of staff I would report this to
- 8 my line manager in confidence or raise my concerns via
- 9 email if they were not available at that time. As
- 10 a registered nurse, it would be my responsibility to
- 11 escalate any concerns about patient safety to the unit
- 12 manager, or matron in her absence. This is the
- 13 ethically correct course of action and follows the
- 14 standard set by the NMC Code of Conduct."
- 15 Caroline Oakley:
- 16 "To the best of my knowledge I was not given any
- 17 training on how to report concerns about fellow members
- 18 of staff. As a senior member of the nursing team and
- 19 depending on nature of my concerns, I would either speak

training about how to report concerns about another

member of staff although if I did have any general

"I cannot remember whether we received any formal

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- 20 to the member of staff or escalate the issue to my
- 21 manager."

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22 Sophie Ellis:

- 1 concerns, I know that I could speak to my line manager
- 2 and escalate as appropriate if needed."

3 Mary Griffith:

- 4 "I would have been aware of how to report concerns
- 5 about fellow members of staff. I knew that concerns
- 6 should be reported to the unit manager."
- 7 Valerie Thomas:
- 8 "I cannot remember ever attending formal training
- 9 on reporting concerns but I knew I could go and report
- 10 at any time with my ward manager."
- 11 Claire Bevan:
- 12 "Annual training updates included whistle-blowing
- 13 updates. I cannot remember the detail but throughout my
- 14 training and career as a nurse, I was always taught that
- 15 any concerns about staff, procedures, protocol not being
- 16 followed, et cetera, should always be raised. There was
- 17 lots of information on the intranet about how to do it.
- 18 I believe that most senior staff on the neonatal unit
- 19 were approachable. Even if a junior member of staff
- 20 felt uncomfortable approaching management directly, the
- 21 friendship groups within the neonatal unit were such
- 22 that all staff, either directly or indirectly, had
- 23 a route to raise concerns. I cannot think of any member
- 24 of staff on the unit that if they felt for whatever
- 25 reason they couldn't follow official channels didn't 209
- 1 "Yes, I have had training and am aware of processes
- 2 such as Datix incident reporting and whistle-blowing.
- 3 From what I can remember any concerns to be reported
- 4 between 2015 onwards were to be reported, as always,
- 5 through Datix incident reporting or, if this was not
- 6 suitable or feasible to do so, there was the option to
- 7 use the Freedom to Speak Up policy -- I'm not sure
- 8 whether it was called this at the time -- and report to9 higher-ranking person."
- 10 Overwhelmingly none of the nurses had any concerns
- 11 or suspicions about the conduct of Letby while she
- 12 worked on the NNU.
- 13 Ailsa Simpson had no concerns but felt that Letby
- 14 involved herself more -- with more babies than she
- 15 needed to be involved in:
- 16 "For example, if a baby collapsed or required
- 17 cardiopulmonary resuscitation but [Letby] wasn't caring
- 18 for that baby she would involve herself anyway despite
- 19 being told by a shift leader that she needed to look
- 20 after her own babies."
- 21 Ailsa Simpson also recalled:
- 22 "After the death of the third or fourth baby it was
- 23 generally noted that she (Lucy Letby) was involved in
- 24 each case. This was the only point that the NNU staff
- 25 observed. At that point, I did not consider that she

- 1 have someone relatively senior to discuss concerns with,
- 2 that then would have been formally reported."
- 3 The majority of the midwives had no recollection of
- 4 having received any training on how to report concerns
- 5 about a fellow member of staff. However, they all knew
- 6 how to escalate concerns to their line management or any
- 7 other manager that was felt appropriate.
- 8 Some midwives would have also reported any concerns
- 9 regarding patient care via the Datix system. Those
- 10 midwives who had received training said. Susan Morton:
- 11 "Training on how to escalate and report any
- 12 concerns about fellow staff members was disseminated as
- 13 part of mandatory study days via training modules,
- 14 emails and campaigns, such as the 6 Cs which were the
- 15 core values of the hospital at the time: care,
- 16 compassion, commitment, courage, communication and
- 17 competence."
- 18 Rachel Wright:
- 19 "I was given training on how to report concerns
- 20 about fellow members of staff during midwifery training
- 21 in university and at the start of my career within the
- 22 mandatory study days that I attended. Any concerns were
- 23 to be reported with the member of staff, shift leader or
- 24 manager."

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25 Deborah Moore:

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- 1 was the cause of the issues and I thought that her
- 2 involvement might just have been a coincidence."
- 3 Vicky Blamire said:
- 4 "It wasn't until finding out about more and more
- 5 fatalities that questions were asked about which members
- 6 of staff were present at the time as this would have had
- 7 a big impact on their mental health. Hearing Lucy's
- 8 name with every occasion made me feel very uncomfortable
- 9 as she didn't show any kind of emotion. I remember
- 10 feeling very shocked and confused as to why she didn't
- 11 seem to be upset. This was very unnerving."
- 12 Cherryl Cuthbertson-Taylor did not have any
- 13 concerns or suspicions about Letby's care of the babies
- 14 or as a nurse. She did, however, find Letby a little
- 15 odd and said she was aware of several staff who felt the
- 16 same way about her.

17 Nurse Y had no concerns about Letby and was not18 aware of any. She explained:

- 19 "As a full time Band 5 neonatal practitioner who
- 20 also worked regular overtime shifts with the relevant
- 21 qualifications to care for intensive and high dependency
- 22 care patients, Letby was regularly allocated the sicker
- 23 infants on shift. Band 5 nurses do not take charge of

the NNU, I remember her being taken off night shifts to

work only day shifts at some point. I had presumed this

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was to protect her own well-being as she had been 1 2 present for a number of deaths on the unit." 3 Janet Cox had no concerns or suspicions about 4 Letby's conduct. In her view, Letby was "An exemplary 5 nurse who is completely innocent of all the alleged 6 crimes." 7 Ms Cox could not recall the precise dates when she 8 became aware of the suspicions or concerns of others 9 about Letby but she does recall "gradually becoming 10 aware that certain Consultants, in particular Brearey, appeared to be trying to make Lucy a scapegoat for the 11 12 increased number of deaths/collapses". 13 Joanne Williams did not have any concerns or suspicions that Letby was deliberately harming babies on 14 the NNU. However, following the collapse of Child K on 15 16 17 February 2016, Dr Ravi Jayaram approached 17 Joanne Williams wanting to know what had happened to Child K. She said: 18 19 "After this I thought he may have had concerns 20 about Letby." 21 Other nurses were only aware of the concerns or 22 suspicions of others regarding Letby's conduct after 23 July 2016 when she was seconded to another department 24 and the NNU was downgraded. 25 None of the midwives had any concerns or suspicions 213 1 a death and collapse of a baby. All staff involved 2 including the midwifery and obstetric staff, where 3 appropriate, would be invited too. A formal meeting 4 would be arranged and sent out by the Consultant to all 5 staff involved later." 6 Christopher Booth gave similar evidence. He said: 7 "After the death of a baby formal debriefs did 8 occur usually a few days after the event. I did not 9 attend any formal debriefs as either I was working on a night shift or chose not to attend. I did, however, 10 11 make use of informal debriefs with colleagues where we would talk, discuss, assimilate, and try to rationalise 12 13 what had happened." 14 Belinda Williamson said: 15 "[Debriefs] depended on the circumstances of the death as to when or if a debrief occurred. It was 16 17 voluntary for nursing staff to attend. If the ward

- 18 manager or medical staff wanted us to attend it was
- 19 generally arranged for a day when we were back on shift
- 20 and available to attend. As a member of staff you could
- 21 ask for a debrief with the medical team and raise any
- 22 questions you had regarding the event even if the
- 23 medical team did not necessarily know the answer. We
- 24 could also ask verbally for the post-mortem results once
- 25 they were completed. Nurses tended to discuss the

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- 1 about Letby's conduct. Most of the midwives did not
- 2 know Letby or had not worked with her. They became
- 3 aware of the increase in the number of deaths on the NNU
- 4 as a result of the police investigation and/or from the
- 5 media following Letby's arrest.
- 6 The nurses were asked whether discussions or
  - debriefs, formal or otherwise, with or between nurses or
- 8 between nurses and doctors, took place following the
- 9 death of a baby. Most of the Band 4 nursery nurses said
- 10 they did not participate in these types of discussions
- 11 or debriefs. Vicky Blamire explained that this was not
- 12 unusual because Band 4 nurses only cared for special
- 13 care babies and babies who were getting ready to be
- 14 discharged.
- 15 Caroline Oakley's evidence is that there was and
- 16 still is no formal protocol for debriefs.
- 17 Laura Eagles described then as "informal and
- 18 ad hoc".

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- 19 There would be discussion led by a Consultant about
- 20 the case and how everyone felt. Amy Davies explained
- 21 that there was no formal process to discuss an
- 22 unexpected event or unexpected response from a baby to
- 23 treatment.
- 24 Caroline Bennion stated:
- 25 "There were always informal hot debriefs after 214

1 events amongst colleagues if we felt we needed to." 2 Susan Needham, who worked at the hospital as 3 a midwife, said discussions with or between midwives 4 after the death of a baby at the hospital would depend 5 on how much input the midwives had had with the baby and 6 their family and whether the labour and delivery were in 7 some way significant to the demise of the baby. 8 She said: 9 "Midwives are always given the opportunity to discuss the demise of a baby that dies at or soon after 10 birth. They will be given the opportunity to go through 11 the labour, to try and pinpoint any problem with their 12 13 care, and there was usually a multi-disciplinary meeting 14 held for midwives and doctors to attend and this had 15 been the process prior to, during, and after 2015 to 16 2016." 17 The mortality rate. 18 Most nurses described being aware of or worried about the increase in the number of deaths on the NNU. 19 20 Laura Eagles: 21 "I was aware of the increase in mortality rate. 22 Obviously all deaths are concerning and it is important

- 23 to ensure that all clinical care has been reviewed to
- $\ensuremath{$  24  $\ensuremath{}$  make sure that it was correct. As far as I can recall,
- 25 the Coroner was informed of all the deaths. As I have 216

- 1 previously mentioned, there was an increase in activity
- 2 on the unit and it felt there were more sick babies than
- 3 is usual. This could then explain why perhaps that
- 4 there were more deaths, in my opinion."
- 5 Christopher Booth:
- 6 "I was of course worried about the increased number
- 7 of deaths on the NNU. It was extremely harrowing and
- 8 emotionally exhausting. As I have outlined earlier, in
- 9 my mind the collapses and deaths could all be rationally
- 10 explained as we were experiencing an unprecedented level
- 11 of acuity with the NNU being at capacity or close to
- 12 capacity for such a long time. Water pressure was low,
- 13 which was not ideal for hand washing. It took time for
- 14 the issue to be resolved and it is only since the events
- 15 were investigated that I reflected upon it and saw it as
- 16 a potential factor in perhaps cases involving sepsis."
- 17 Caroline Bennion:
- 18 "I was personally alarmed or alerted to the number
- 19 of child deaths when one of the triplets died on
- 20 21<sup>st</sup>(sic) June 2016. I can remember asking my
- 21 colleague, although I can't recall who, about what had
- 22 happened. It was completely unexpected. They were
- 23 mature babies, born at 33 weeks, good weights, and
- 24 although they were receiving respiratory support they
- 25 were very stable. I wondered if there was a significant
  - 217
- 1 the consequence of the gravity of the babies' conditions
- 2 and the increased number of admissions."
- 3 Caroline Oakley:
- 4 "I was aware that 2015 to 2016 was a very busy year
- 5 and we had more vulnerable babies coming in from the
- 6 labour ward. I was aware of more deaths but due to the
- 7 increase in the number of vulnerable babies we were
- 8 caring for I did not think it was an unnatural result
- 9 that there were more deaths.
- 10 Janet Cox:
- 11 "Obviously any death is a worry, but I did not
- 12 think this at the time, nor do I think now, that there
- 13 was anything sinister about the increase in the number
- 14 of deaths/collapses. I do not see how you can set
- 15 a figure on how many deaths are acceptable in one
- 16 particular time frame. The very reason these babies
- 17 required admission to an NNU was because they had a high
- 18 chance of dying or collapsing."
- 19 Jennifer Jones-Key:
- 20 "I discussed with nursing staff about how busy we
- $21 \quad had \ been \ and \ how \ sad \ it \ was \ with \ the \ run \ of \ babies$
- 22 passing away. I was not concerned by the number of
- 23 deaths as we had had a very busy time and had been full
- 24 most of the time."
- 25 Claire Bevan:
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- 1 infection on the unit that we were missing. This was
- 2 a discussion with nursing staff although I cannot recall
- 3 their names, given that infection is always a concern in
- 4 relation to preterm babies. This was not a conversation
- 5 I had with the medical staff or outside the unit but it
- 6 was more of a speculation between the nursing staff."7 Ailsa Simpson:
- 8 "The increase in the number of deaths on the NNU
- 9 during the period 2015 to 2016 was very concerning. It
- 10 is usually very rare for a baby to die and even if they
- 11 do, it's usually in cases where the babies are extremely
- 12 unwell, either with sepsis or if there is a congenital
- 13 abnormality."
- 14 Joanne Williams:
- 15 "I was aware and concerned about the increase in
- 16 the number of deaths on the NNU. I cannot recall
- 17 specifically when I became aware of the increase or what
- 18 I thought. At the time the acuity on the unit was
- 19 always high and we were caring for vulnerable patients.
- 20 It was very difficult for the team dealing with numerous
- 21 deaths feeling overworked and at times under
- 22 appreciated."

- Mary Griffith: "All staff on the NNU were concerned about the
- 24 "All staff on the NNU were concerned about the25 number of deaths on the unit but regarded this as being
  - 218
- 1 "The increase was concerning but nobody to my 2 knowledge expressed any concerns including doctors. As 3 far as I am aware, although the deaths were unexpected 4 and some apparently unexplainable, nobody voiced any 5 concerns. In my recollection staff were discussing how 6 odd it was but there was never any suggestion of 7 anything untoward." 8 Nicola Dennison: "I was not particularly worried about the increase 9 of the deaths on the neonatal unit because we had lots 10 11 of babies who were very poorly, some of which were born 12 to very poorly mothers, and as such our statistics 13 naturally increased. We also had a high instance of 14 congenital abnormalities, which included heart
- 15 conditions and gastroschisis, for example. We were at
- 16 maximum capacity for the majority of the time. However,
- 17 I do not feel that care was ever compromised."
- 18 Susan Morton:
- 19 "I remember being worried and concerned about the
- 20 high number of deaths in 2016. This was when I was
- 21 undertaking my developmental Band 7 labour ward shift
- 22 leader role. I was the shift leader on a day shift when
- 23 two of the three triplets died within a short period of
- 24 time. I recall hearing that the transport transfer team
- 25 were present when the second baby died and the parents 220

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1	had requested that the third baby be transferred to	1
2	another unit.	2
3	"I also recall that day that a decision was made to	3
4	halt any elective inductions of labour and not commence	4
5	any new inductions at that time. I don't however recall	5
6	who this decision was made by. I remember feeling	6
7	incredibly upset and shocked at the recent events and	7
8	that morale was becoming increasingly low."	8
9	Recommendations.	9
10	The nurses were asked whether Letby's crimes could	10
11	have been prevented if the babies had been monitored by	11
12	CCTV. The majority doubted the efficacy of CCTV in	12
13	preventing Letby's crimes.	13
14	Ailsa Simpson expressed the view that even if CCTV	14
15	had been in place at the time Letby would have found	15
16	a way:	16
17	" as she had the intention to harm the babies."	17
18	Christopher Booth stated that CCTV:	18
19	"Would have little impact or effect. If a person	19
20	is determined to commit any unlawful deed the CCTV	20
21	camera system could be easily circumvented."	21
22	Amy Davies pointed out that babies are not always	22
23	in full view due to the incubators and incubator covers	23
24	and the position of staff.	24
25	She did not think CCTV would help.	25
	221	
1	a nurse. On the issue of CCTV monitoring, she said:	1
2	"I am undecided whether having the babies monitored	2
3	by CCTV could have prevented the crimes of Letby. On	3
4	the one hand, it could have prevented any harm coming to	4
5	any baby by deterring her entirely. It could also have	5
6	prevented some of the later crimes as perhaps once the	6
7	medical team started to suspect Letby she may have been	7
8	either deterred by knowing she was being monitored or	8
9	caught via the CCTV.	9
10	"Some of her crimes, such as injecting insulin into	10
11	TPN bags and failing to act or request help when a baby	11
12	was 'crashing', would have been detectable by CCTV.	12
13	However, some of the ways in which she murdered or	13
14	attempted to murder the babies were by using equipment	14
15	that nurses handled all the time and by doing things	15
16	which were very similar to routine tasks. What I am	16
17	referring to here is when she used feeding tubes to	17
18	overfeed the babies or insert air and intravenous lines	18
19	to inject air.	19
20	"On camera these actions might be indistinguishable	20

- 20 "On camera these actions might be indistinguishable
- 21 from routine and correct procedures. For instance, it22 might not be possible to tell from CCTV whether
- 23 a syringe has air or clear fluid in it or whether a baby
- 24 is receiving more milk than their usual feed amount.
- 25 These crimes may have been detectable later on once the 223

- Nurse Y, Minna Lappalainen, Joanne Williams,
- 2 Mary Griffith, Lisa Walker and several other nurses
- 3 expressed concern that the use of CCTV in clinical areas
- 4 of the NNU was not appropriate and would interfere with
- 5 the privacy rights of babies and their families.
- 6 Belinda Williamson felt it would inhibit mothers
- from breastfeeding or expressing milk or having
- 8 skin-to-skin contact, which would be detrimental to both
- 9 babies and their parents.
- 10 Nurse Y also considered it inappropriate to have
- 11 CCTV monitoring of babies:
- 12 "... during procedures or examinations when their13 private areas may be visible."
- 14 It concerned her who might have access to these
- 15 images. Nurse Y also stated:
- 16 "As a practitioner, I would strongly object to CCTV
- 17 monitoring and I feel it is an intrusion. It is not
- 18 used in general nursing wards or in paediatric care so
- 19 I feel it would be unnecessary and inappropriate."
- 20 Satasha Culshaw pointed out the use of CCTV
- 21 monitoring as a deterrent might be more effective in the
- 22 drug dispensary where it might also be capable of
- 23 capturing the commission of a crime.
- 24 Shelley Tomlins was employed as a Band 5 neonatal
- 25 nurse on the NNU before moving abroad to work as 222
- 1 CCTV was scrutinised closely and people had an idea what
- 2 they were looking for. By that point, it would have
- 3 been too late to catch her in the act and therefore too
- 4 late to prevent harm happening to the babies.
- 5 "Overall though I do feel that perhaps the presence
- 6 of CCTV might have been enough of a deterrent and
- 7 therefore could have prevented Letby's crimes."
- 8 Other neonatal nurses and nursery nurses such as
- 9 Pauline Fong, Abigail Lever, Adele McGarry,
- 10 Cherryl Cuthbertson-Taylor and Faith Chidongo all
- 11 considered that if the babies in the neonatal unit had
- 12 been monitored by CCTV the crimes of Letby could have13 been prevented.
- Janet Cox considers that if there had been CCTVmonitoring, it would have proved Letby's innocence.
- 6 Finally, as to the recommendations which the nurses
- 17 think my Lady should make to keep babies in NNU safe
- 18 from any criminal actions of staff, they said as
- 19 follows: Christopher Booth:
- 20 "I think using the utmost vigilance in the
- 21 screening of potential staff members at the time of
- 22 recruitment would be a good place to start. This could
- 23 involve possibly conducting personality tests as part of
- 24 the recruitment process to seek to identify any
- 25 personality disorders which would mean such people would 224

probably be incompatible with working in such 1 2 a stressful environment. That is not to say that I feel 3 Letby necessarily suffered from such a disorder, but it 4 seems to be a glaring oversight in the recruitment 5 process 6 "Improving staffing numbers would always have 7 a positive effect on neonatal nursing teams' well-being 8 as throughout this period between 2015 to 2016 we were 9 almost constantly short-staffed with team members being 10 asked to change shifts at short notice or work extra shifts. This is not good for staff mental health or 11 morale." 12 13 Paula Baden: 14 "Parents should have more and better equipped facilities to enable a parent to stay at the bedside 15

- 16 throughout their baby's stay. While I am unsure of the
- 17 procedures around neonatal deaths and reporting, I feel
- that if there is more than one, regardless of reason, 18
- 19 this should have a thorough investigation.
- 20 "Medication must always be kept securely and
- regular medication audits should also be carried out to 21
- 22 identify any anomalies."
- 23 Joanne Williams:
- 24 "I do appreciate staffing is a main priority for
- 25 all those in the NHS. Having safe staffing levels to 225
- 1 for doing this should be straightforward, dealt with
- 2 much more quickly than it was for Letby, take the
- 3 concerns of the whistleblower seriously and should put
- 4 the safety of the babies as a priority rather than the
- 5 feelings of staff members.
- 6 "I am sure there are ways to deal with serious
- 7 concerns that are fair and sensitive to the staff member
- 8 whilst also making patient safety the top priority.
- 9 There should be no red tape to get through and never any
- hesitation or delay in contacting the police." 10
- Sophie Ellis: 11
- 12 "There should be an open and honest culture with
- 13 a freedom to speak up within all staff groups.
- 14 Individuals who raise concerns should have guaranteed
- support from management and/or a dedicated team to 15
- support whistleblowers. A clear process of how to 16
- 17 report concerns specifically about criminal actions of
- staff needs to be created and outlined. This should be 18
- 19 streamlined within all Hospital Trusts.
- 20 "Staff may then be more likely to raise concerns
- without fear of negative judgment and instead be 21
- 22 commended for their courage. This can be very difficult
- 23 to do even with a positive culture. Some of these
- 24 aspects may already be in place in some Hospital Trusts.
- If so, there needs to be consistency amongst all 25

- deliver high-quality care is paramount. General 1
- 2 District Hospitals with NNUs should ensure they
- understand the challenges, difficulties in working in 3
- 4 such a specialist area and provide appropriate support.
- Parents and primary carers should be able to be with 5
- 6 their babies 24 hours, if they wish to be, with NNUs
- 7 designed to facilitate this."
- 8 Minna Lappalainen:
- 9 "Appropriate professional staffing levels on
- 10 neonatal units and open communication between all
- professional disciplines would improve the way concerns 11
- are addressed. Hospital executive management must 12
- respond promptly to concerns raised by nursing and 13
- 14 medical managers."
- 15 Nurse X:
- 16 "Swipe card access to drug storage areas and CCTV
- 17 would track access to these areas more accurately."
- 18 Ailsa Simpson:
- 19 "I believe a culture where members of staff can
- 20 freely express their concerns without the fear of
- repercussions is necessary." 21
- 22 Shelley Tomlins:
- 23 "I think the Inquiry should make recommendations
- 24 about the ways in which members of staff can voice
- 25 concerns they have about staff members. The procedure 226
- 1 hospitals."
- 2 Stephanie Terry:
- 3 "As a clinical educator for student midwives,
- 4 I feel that the Inquiry should investigate the practical
- 5 element of when students study to become nurses. In my
- 6 experience, behavioural or personal attributes can be
- 7 difficult to fail a student on. This, in my opinion,
- 8 needs to change. We need to ensure that students are
- 9 safe to be working with vulnerable babies and people
- going back to basics with recruitment and education." 10
- 11 My Lady, that concludes the summary of the evidence 12
- of the nurses and midwives.
- 13 This summary is intended to assist the oral
- 14 hearings insofar as it provides some indication of the
- themes that run through the evidence from nurses and 15
- midwives who have provided written evidence to the 16
- 17 Inquiry and will not be called to give oral evidence.
- 18 The witness statements and questionnaires
- summarised today will be published on the Inquiry's 19
- 20 website in due course.
- 21 LADY JUSTICE THIRLWALL: Thank you.
- 22 Thank you very much indeed, Ms Lyons.
- 23 MS LYONS: Thank you.
- 24 LADY JUSTICE THIRLWALL: I think that concludes the
- proceedings for today. We will start again tomorrow 25 228

1	morning at 10 o'clock. Thank you all very much.	1	
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3	(The Inquiry was adjourned until 10.00 am,	3	
4	on Wednesday, 16 October 2024)	4	Stater
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therefore [12] 96/10 99/21 104/8 115/1 129/5 129/13 131/15 144/19 151/10 157/18 224/3 224/7 these [46] 4/2 11/21	165/21 166/16 169/22 169/22 169/24 169/24 171/6 172/7 174/14 175/8 175/20 175/20 182/7 182/8 182/14 182/17 184/3 184/6 189/1 193/16 193/23	167/10 170/10 178/5 182/13 186/20 187/18 192/21 200/1 209/23 219/8 219/12 219/12 221/25 224/17 224/20	95/24 96/22 97/24 98/6 99/12 99/15 100/4 101/19 109/16 119/1 119/3 166/15 167/8 170/24 171/6 174/1 174/7 177/5 177/15 177/19 179/5	207/13 207/20 208/1 208/9 209/10 210/15 211/8 212/6 212/19 217/12 217/13 218/18 219/12 219/16 219/23 219/24 220/16 220/24 221/5 221/15 223/15
therefore [12] 96/10 99/21 104/8 115/1 129/5 129/13 131/15 144/19 151/10 157/18 224/3 224/7 these [46] 4/2 11/21 13/20 22/21 35/8	165/21 166/16 169/22 169/22 169/24 169/24 171/6 172/7 174/14 175/8 175/20 175/20 182/7 182/8 182/14 182/17 184/3 184/6 189/1 193/16 193/23 195/9 196/1 197/2	167/10 170/10 178/5 182/13 186/20 187/18 192/21 200/1 209/23 219/8 219/12 219/12 221/25 224/17 224/20 226/23 228/24 thinking [1] 90/2 third [23] 5/19 6/17	95/24 96/22 97/24 98/6 99/12 99/15 100/4 101/19 109/16 119/1 119/3 166/15 167/8 170/24 171/6 174/1 174/7 177/5 177/15 177/19 179/5 180/10 220/23	207/13 207/20 208/1 208/9 209/10 210/15 211/8 212/6 212/19 217/12 217/13 218/18 219/12 219/16 219/23 219/24 220/16 220/24 221/5 221/15 223/15 224/21
therefore [12] 96/10 99/21 104/8 115/1 129/5 129/13 131/15 144/19 151/10 157/18 224/3 224/7 these [46] 4/2 11/21 13/20 22/21 35/8 35/17 46/17 49/5	165/21 166/16 169/22 169/22 169/24 169/24 171/6 172/7 174/14 175/8 175/20 175/20 182/7 182/8 182/14 182/17 184/3 184/6 189/1 193/16 193/23 195/9 196/1 197/2 197/6 198/5 198/11	167/10 170/10 178/5 182/13 186/20 187/18 192/21 200/1 209/23 219/8 219/12 219/12 221/25 224/17 224/20 226/23 228/24 thinking [1] 90/2 third [23] 5/19 6/17 7/2 7/3 7/11 7/17 7/23	95/24 96/22 97/24 98/6 99/12 99/15 100/4 101/19 109/16 119/1 119/3 166/15 167/8 170/24 171/6 174/1 174/7 177/5 177/15 177/19 179/5 180/10 220/23 three weeks [1]	207/13 207/20 208/1 208/9 209/10 210/15 211/8 212/6 212/19 217/12 217/13 218/18 219/12 219/16 219/23 219/24 220/16 220/24 221/5 221/15 223/15 224/21 timely <b>[2]</b> 50/4 59/22
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therefore [12] 96/10 99/21 104/8 115/1 129/5 129/13 131/15 144/19 151/10 157/18 224/3 224/7 these [46] 4/2 11/21 13/20 22/21 35/8 35/17 46/17 49/5	165/21 166/16 169/22 169/22 169/24 169/24 171/6 172/7 174/14 175/8 175/20 175/20 182/7 182/8 182/14 182/17 184/3 184/6 189/1 193/16 193/23 195/9 196/1 197/2 197/6 198/5 198/11 199/23 201/6 201/7 202/21 205/10 206/12	167/10 170/10 178/5 182/13 186/20 187/18 192/21 200/1 209/23 219/8 219/12 219/12 221/25 224/17 224/20 226/23 228/24 thinking [1] 90/2 third [23] 5/19 6/17 7/2 7/3 7/11 7/17 7/23 8/2 8/19 13/7 16/2 16/3 19/6 22/21 44/8	95/24 96/22 97/24 98/6 99/12 99/15 100/4 101/19 109/16 119/1 119/3 166/15 167/8 170/24 171/6 174/1 174/7 177/5 177/15 177/19 179/5 180/10 220/23 three weeks [1] 180/10 three years [1] 58/11	207/13 207/20 208/1 208/9 209/10 210/15 211/8 212/6 212/19 217/12 217/13 218/18 219/12 219/16 219/23 219/24 220/16 220/24 221/5 221/15 223/15 224/21 timely [2] 50/4 59/22 times [18] 2/14 18/19 47/18 48/2 48/3 49/16
therefore [12] 96/10 99/21 104/8 115/1 129/5 129/13 131/15 144/19 151/10 157/18 224/3 224/7 these [46] 4/2 11/21 13/20 22/21 35/8 35/17 46/17 49/5 49/22 53/22 54/6 70/15 93/8 96/22	165/21 166/16 169/22 169/22 169/24 169/24 171/6 172/7 174/14 175/8 175/20 175/20 182/7 182/8 182/14 182/17 184/3 184/6 189/1 193/16 193/23 195/9 196/1 197/2 197/6 198/5 198/11 199/23 201/6 201/7 202/21 205/10 206/12 206/23 208/9 209/24	167/10 170/10 178/5 182/13 186/20 187/18 192/21 200/1 209/23 219/8 219/12 219/12 221/25 224/17 224/20 226/23 228/24 thinking [1] 90/2 third [23] 5/19 6/17 7/2 7/3 7/11 7/17 7/23 8/2 8/19 13/7 16/2 16/3 19/6 22/21 44/8 44/20 46/5 48/9 49/14	95/24 96/22 97/24 98/6 99/12 99/15 100/4 101/19 109/16 119/1 119/3 166/15 167/8 170/24 171/6 174/1 174/7 177/5 177/15 177/19 179/5 180/10 220/23 three weeks [1] 180/10 three years [1] 58/11 through [35] 9/5 36/1	207/13 207/20 208/1 208/9 209/10 210/15 211/8 212/6 212/19 217/12 217/13 218/18 219/12 219/16 219/23 219/24 220/16 220/24 221/5 221/15 223/15 224/21 timely [2] 50/4 59/22 times [18] 2/14 18/19 47/18 48/2 48/3 49/16 61/3 61/8 82/9 171/25
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199/12 200/12 200/25	0/13 0/13 0/17 0/21	157/8 157/24 157/25		
201/21 202/7 202/10	7/2 7/3 7/11 7/17 7/21 7/24 8/2 8/20 13/7	159/12 160/4 162/3		
202/12 202/15 204/1	19/6 22/21 22/22	162/10 163/18 165/3 165/10 165/16 165/22		
211/12 212/20 214/2	42/11 44/8 44/20	166/1 166/3 167/9		
216/2 worker [1] 6/6	45/22 45/24 46/5 48/9	167/13 168/3 168/11		
workers [1] 207/21	48/23 49/1 49/14 51/4 52/18 74/22 74/23			
working [60] 3/1 6/4	82/9 146/11 219/4	171/16 171/25 172/2 172/3 173/8 173/15		
11/4 12/17 22/25	years [14] 2/6 3/4	173/22 175/23 177/22		
23/12 26/1 27/22 38/18 40/21 42/2 45/8	7/20 7/22 7/23 7/23	177/23 178/14 179/7		
46/19 47/7 47/15 50/2	11/10 41/10 57/10	181/17 182/4 183/7		
	58/11 58/14 168/21	184/1 188/7 188/15		
				(95) Women's zo