Wednesday, 16 October 2024

(9.58 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, the first witness today is Nurse Yvonne Farmer, please.

LADY JUSTICE THIRLWALL: Would you come to the witness box please, Ms Farmer.

MS YVONNE FARMER (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do have a seat.

MR DE LA POER: Please can we begin with your full name.

A. Yvonne Farmer.

Q. Ms Farmer, can you confirm, please, that you provided the Inquiry with a witness statement dated 7 June of this year?

A. Yes.

Q. And are the contents of that witness statement true to the best of your knowledge and belief?

A. Yes.

Q. Turn to your background. Did you obtain a degree in nursing practice in 2001? I have taken that from your --

A. Oh, yes, yes.

Q. And did you complete a Neonatal Intensive Care

Course in 2000?

A. Yes.

Q. And an Enhanced Neonatal Practice Course in 2002?

A. Yes.

Q. And at around the same time, I think it was 2000, did you also complete the Nurse Teaching and Assessing Course?

A. Yes.

Q. And having completed that course, did you shortly thereafter move to the Countess of Chester Hospital?

A. I did, yes.

Q. Did you begin work on the neonatal unit?

A. Yes.

Q. And so you had been on the neonatal unit for something approaching 15 years --

A. Yes.

Q. -- at the time of the period that we are focused upon?

A. Yes.

Q. And finally, just to complete your background, did you retire in 2019?

A. I did, yes.

Q. Now, Ms Farmer, you held two roles --

A. I did.

Q. -- is this right, in 2015?

A. Yes.

Q. Your first role, as you tell us, was a non-clinical Band 7 with the title Neonatal Practice Development Nurse?

A. Yes.

Q. Had you held that role since 2009?

A. Yes.

Q. We will come back to what that involved in a moment.

A. Okay.

Q. But just to introduce your second role, was that a clinical Band 6 Senior Nurse?

A. Yes, it was.

Q. With responsibilities as a shift leader on occasions or otherwise caring directly for babies?

A. Yes.

Q. So as to your first role, the Neonatal Practice Development Nurse, tell us what that involved you doing.

A. My role was as a neonatal educator based on the unit. So I worked predominantly with students, new staff and existing staff ensuring that they were inducted into the unit, that they attended the courses

that were available.

Basically I constructed a programme of development so I worked with different individuals when they started and I had overall view of the training and education and the staff on the unit.

Q. And how many hours a week were you allocated to that role?

A. I think it was about 21 and a half but it did vary as clinical needs sometimes dictated.

Q. Putting that another way, does that mean sometimes you were needed on the unit clinically --

A. Yes.

Q. -- and so you had to step back from educator role?

A. I did, yes.

Q. I understand. And your second role was, as you have identified, a clinical Band 6 Senior Nurse. Again, just give us an idea of what that required you to do.

A. Yes, I was a shift leader but sometimes I was allocated as shift leader or sometimes I was given a workload. But at that time, as shift leader, we also had a small workload as well.

So I might have a patient, a couple of patients that weren't intensive care. So I had overall view of

all the patients on the unit and allocated staff according to their experience and needs.

Q. So does it follow that you got to interact with your nursing colleagues both in an educational capacity, when appropriate --

A. Yes.

Q. -- but also as a side-by-side colleague --

A. Yes.

Q. -- or in a quasi management role/shift leader?

A. Yes, yes.

Q. What was your view about what the NNU was like as a place to work?

A. I really enjoyed working on the neonatal unit.

It was always an area that was looking to develop, always trying to maintain safe practice. We worked well with the medical team. It was a very small unit so I felt we were a very close team and we did try and support each other when we were on shifts.

Q. And when you say a close team are you speaking there principally about your nursing colleagues?

A. Yes, yes.

Q. So the nursing team was close?

A. Yes, yes.

Q. Well, let's just focus upon the nursing team.

A. Okay.

Q. On the unit, Eirian Powell was the most senior person --

A. Yes.

Q. -- from a nursing perspective. What was she like to work for?

A. I always got on very well with Eirian. I had known Eirian since I started so we did develop into our roles together. So I felt she was an approachable manager.

She would always come in early so that she met with the night staff going off, so she was not only -- she saw both members of staff, day staff and night staff. So in that way she was a very visible manager.

Q. Now, the Inquiry has received some evidence from amongst your nursing colleagues about a "circle of trust" was a phrase that one nurse used. Others have used the phrase "favourites" in terms of Ms Powell.

A. Right.

Q. Is that something that you recognise as applying to the neonatal unit in your experience?

A. I don't think -- no, she didn't have favourites. She ensured that all staff developed. She offered opportunities. If staff approached her about a development role or different opportunities that were within the Trust she was always very willing to listen

to them.

We had always advertised study days so we would allocate and she would make sure that it was divided equally so that not the same people went to study days. So ...

Q. Now, how about the relationships with the doctors? Again, in summary, what was your experience of that?

A. On a personal level I didn't have any problem with the Consultants. The Registrars rotated so -- but during that time, I think we had Registrars that were on for quite some time so we did get to know them and in my role as practice development, I did work quite closely with some of the Registrars if we were introducing a new practice.

On a personal level, I didn't have a problem.

Q. The way you have expressed if, I may just observe, is to say that there wasn't a problem?

A. Yes.

Q. Was it a positive relationship?

A. Yes, yes.

Q. Or was it --

A. Yes, because of the nature of the unit, it had to be a positive experience.

Q. How busy in 2015/2016 was the neonatal unit?

A. As I recall, we had some very busy moments and I feel certain we must have had some quieter moments but you always remember the busy times.

So there were quite stressful shifts. But because of our unit, we weren't an intensive care Level 3 unit so it was peaks and troughs. But it felt busy.

Q. It felt busy?

A. Yes.

Q. Did it feel busy out of all proportion to what had come before, or did it just feel like it was a busier phase?

A. Well, in my experience I did have busy years, some years or some times seemed busier. So I just accepted the fact that we had quite a few babies that year.

Q. One of the things that you comment upon in your statement is about the restructuring of the divisions within the hospital?

A. Yes.

Q. And the fact that paediatrics was placed into the Urgent Care Division.

A. Yes.

Q. Do you want to just tell us what your perception was about the effect of that?

A. Yes. Well, when I first started on the

neonatal unit we were classed as the Women and Children's department. So we worked closely with the maternity team, with ourselves, neonatal and paediatrics, and I personally knew sort of the management tier. But when we were divided into the Planned and Unplanned, we were, the management tier was quite different and it was very adult based. So I felt they didn't really know the needs of our unit.

Q. Can you just help us with who you are speaking about when you say management tier, whether by name or by job description.

A. We had a matron on the children's ward. So if the manager wasn't available I had the matron to refer to if we needed assistance. But after that, there was a management tier that were quite unknown to me, like very senior managers.

Q. The phrase you use in your witness statement is "not as visible to the senior" --

A. Yes, yes, because they were physically based in a completely different building so -- and our previous managers under Women and Children's had been based within the building and I knew who I could contact there.

Q. From your experience during 2015/2016, did that change in structure make any difference, do you

think?

A. It's difficult to say. I think decisions were made that we didn't know anything about. It might have changed communication problems, but I'm not quite sure.

Q. I would like to turn to the topic of policies and procedures and we will start with safeguarding.

Had you received any safeguarding training as to how you should act in the event that you suspected a colleague was causing harm to patients?

A. No.

Q. With all of your experience, do you think that that is properly described as a safeguarding issue?

A. The fact that we didn't have training?

Q. No, no, the fact that a -- the risk from a colleague, if you perceived it, is that a safeguarding issue, do you think?

A. I think it's regarded now at this time, yes. So ...

Q. Was that the way it was being thought about at the time, do you think?

A. I don't think so. No.

Q. And do you have any view on why that might be the case? What's changed, in your perception? I am not inviting you to guess but if you have an opinion about it I am sure we would like to hear it.

A. Not really, no.

Q. Datix.

A. Yes.

Q. When did you understand that it was necessary to fill in a Datix form?

A. We filled Datixes on a variety of areas, usually if there was a drug area, not following policy, an environmental issue.

There was, it was all on the computer so there was, I think -- I can't remember if there was a list or there were different areas where you needed to report. So it was basically identifying a risk that needed to be reported.

Q. Now, we have received a deal of evidence that an unexpected death would be the subject of a Datix with the descriptor "expected" or "unexpected death" being the ...

A. Right. I'll be honest. I don't remember.

Q. You don't remember?

A. Because it's some time since I've seen the Datix reporting system and I can't remember the exact layout or reporting. Sorry.

Q. No need to apologise. We may come back to that.

But the third area of policy and procedure is

debriefs?

A. Yes.

Q. When did you understand that it was necessary to have a debrief? What sort of events should trigger a debrief?

A. Following any neonatal death, ideally a debrief was undertaken. But having re-read all the information, I don't think that occurred on every neonatal death on the unit. But because I wasn't always involved clinically, I can't recall when and which babies were, had a debrief.

Q. And if it is the case that debriefs were not happening, what would be the explanation for that, as far as you are aware? Do you know?

A. I don't know. I don't know.

Q. Would you expect a debrief to take place if a baby suddenly and unexpectedly deteriorated, was the subject of resuscitation but recovered?

A. Not, not always, no.

Q. And if not always, then what would be the trigger for a debrief in that situation, do you think?

A. I suppose if it was for a welfare debrief following a traumatic resuscitation. But because of the nature of our role, we may have resuscitated patients, but it might have been reviewed or discussed as part of

a teaching process, but I don't really remember.
Q. And would that be formally recorded if, if it was used as a teaching --
A. If it was used as teaching, I would imagine so, but it might have been from a medical perspective. So it wasn't something as nurses we did amongst ourselves.
Q. So we are going to turn now to your involvement with Letby and you tell us quite a lot about the period before 2015, starting with the fact that you completed the list of relevant requirements with her on 29 January 2012.
A. Yes.
Q. And at that stage, did you have any concerns about her competence, her attitude or her approach?
A. No. I had met her on the unit as a student and then she was taken on as a permanent member of staff. So that was the first -- we completed that within the first few weeks, so no.
Q. We have heard about her last placement and the fact that there were difficulties upon it. Were you aware of those?
A. No, I wasn't, no.
Q. In your role of inducting Letby into the unit, would you have been expected to be told about any

problems during the student period or, from your point of view, does somebody simply arrive qualified?
A. Because she was interviewed prior -- I wasn't, I didn't interview her. If she was interviewed or if another member of staff had concerns, I would imagine it would be part of her references.
So I had no knowledge that that had occurred, so ...
Q. Now you speak about a requirement of the Nursing and Midwifery Council called the period of preceptorship --
A. Yes.
Q. -- which is a period of approximately six months.
A. Yes.
Q. And during that period, a new starter is allocated a mentor, is that right?
A. Yes.
Q. And did you have some oversight role over that process?
A. She had a clinical mentor.
Q. Yes.
A. And I made sure that she completed, she had a file and I made sure she was completing all the relevant competencies within that six-month period.

Q. And through your involvement with that period, did you arrange for Letby to attend training at the Liverpool Women's Hospital?
A. I did, yes.
Q. Following completion of that NMC requirement, were you aware that Letby attended the Neonatal North-West Induction Programme?
A. Yes.
Q. Was that a standard part of --
A. Yes.
Q. -- the training programme?
A. Yes.
Q. Did that include a further placement at the Liverpool Women's Hospital?
A. It did, yes.
Q. And at the end of all of that process, was there further training and observation leading up to a conclusion that she was safe to practise clinically?
A. Yes, yes, she had a mentor in Liverpool Women's as well as a mentor on our unit during the -- the course of the training.
Q. And so far as you were aware, at the time that she emerged from that training programme, was Letby safe to practise, from your perspective?

A. As far as I was aware, yes.
Q. I think that in your educational role you facilitated Letby's attendance at a number of courses.
A. Yes.
Q. I'll just run you through them: the Cheshire and Merseyside Neonatal Intensive Care Course?
A. Yes.
Q. The neonatal advance life-support course?
A. Yes.
Q. And the mentor and assessing course?
A. Yes.
Q. Now, would that be with a view, that mentor and assessing course, with a view to Letby herself mentoring students?
A. Yes.
Q. And throughout all of those courses, were you available to receive feedback about any concerns?
A. Yes, yes.
Q. And were you informed of any concerns?
A. No.
Q. Now, in March 2012, so if we just recap, it was the end of January 2012 that you completed the list of relevant requirements and that six-month period began --
A. Yes.

Q. -- so after the six-month period. The Inquiry has received evidence from Nurse ZC about an incident in March of 2012 involving a child being transferred back from Arrowe Park. Do you know the incident --

A. Yes, yes.

Q. -- that Nurse ZC has spoken about?

A. Yes, yes.

Q. And in summary, Nurse ZC reports that Letby was quite excited about her involvement in a cardiac arrest; that's the evidence that we have.

A. Right.

Q. And Nurse ZC says that she spoke to you about that; do you have any recollection of that conversation?

A. No, I don't, no.

Q. Would you have expected a Datix form to be completed in circumstances such as that or does it rather depend upon more detail than I have just given you?

A. Yes, yes.

Q. Bearing in mind how you interact with your colleagues and your relationship with Nurse ZC, if she had come to speak to you about such an incident at that early stage of Letby's involvement, would you have expected to remember, or ...

A. I think because of the time I don't remember

the incident. I think it would have been just a conversation, perhaps she needed some support or -- I -- I just don't remember the incident. I've been trying to remember but I just don't, sorry.

Q. But are we to understand from your position, it's that you are not saying it definitely didn't happen --

A. No, but --

Q. -- you are just saying I have no recollection?

A. -- I just don't remember. It has not stuck in my memory.

Q. So that's 2012. Let's move forward, please, to 22 July of 2013 and this is a morphine error?

A. Yes.

Q. So you know the incident that I am speaking about?

A. Yes.

Q. And we will just start, please, by bringing up the first page of the Datix for this, INQ0014469. If we can just crop in right to the centre.

A. Can I expand this? Right. Thank you.

Q. Hopefully that's sufficiently legible. I think it was in your pack before coming here today?

A. Yes, yes.

Q. But here we can see 27 July is the --

A. Yes.

Q. -- date of the Datix of 2013 at 8.40. And we can see the description:

"On carrying out fluid medication checks at the start of the morning shift it was noted that the morphine infusion was running at 1.32 millilitres per hour rather than the correct amount of 0.13 millilitres per hour. The dose was prescribed at 5 micrograms per kilogram per hour and was therefore infusing at 10 times the prescribed amount."

And further figures are given.

Then the action taken is shown a little below:

"Immediately informed the staff nurse who had handed over the baby's care. The dose was rechecked and then changed to the correct infusion rate. The nurse in charge of the shift was also informed as well as the Registrar and the Consultant on the ward round."

If we just scroll down very slightly further. We can see the categories which I think may prompt your memory a little about the sort of dropdown list?

A. Yes.

Q. That the category is medicines, the subcategory, entirely unsurprisingly, administration dose error?

A. Yes.

Q. So that's the Datix -- thank you very much indeed, we can take it down.

A. Okay.

Q. Now, when do you think you first became aware of that incident? And it may be easiest to say by reference to how many hours or days after it had occurred.

A. I don't know how many -- I don't really know the time frame. I assume it would be when I was next on a practice development day that I was told about the error. But I can't pinpoint how long after the incident I was told.

Q. Well, we will come to a record of a meeting that you were involved in --

A. Okay, okay.

Q. -- which was 30 July --

A. Okay.

Q. -- so it was eight days later.

A. Okay, right.

Q. But plainly you knew about it before that meeting.

A. Yes, yes.

Q. Just help us, please, Ms Farmer. Recognising that in the NHS at that time there was a no-blame culture.

A. Yes.
Q. Nevertheless, how serious an error is this in terms of its potential consequences?
A. Well, it is a very serious error, 10 times the dose is not -- it is serious, yes.
Q. And because we are dealing here with a controlled drug --
A. Yes.
Q. -- there were additional safety measures built in to the handling of such controlled drugs; is that right?
A. Yes, yes.
Q. Because, for example, it required two people it sign it out of the locked cabinet?
A. Yes, yes.
Q. And in terms of the training given to nurses, how, how much time is devoted to warning against the risks of dosing errors? Is this something that is not well recognised or is it something part of the --
A. It is well recognised and it formed part of the training, the IV training, always about correcting doses, and part of the course involves drug calculations. So it should be something that she was very familiar with. But it was checked by two nurses, so it was basically an error with two nurses.

Q. So we are here talking about the two nurses who were involved in signing out --
A. Yes.
Q. -- the drug?
A. Yes.
Q. Well, we will come back to that in just a moment.
A. Okay.
Q. But again, it's formed part of the training you have told us?
A. Yes.
Q. And that includes calculation?
A. Yes.
Q. I mean, at this stage, Letby is not far into her career as a nurse?
A. Yes.
Q. But she's well outside the period of formal supervision --
A. Yes.
Q. -- that the NMC requires?
A. Yes.
Q. And what is the expectation about her being able to operate autonomously for things like this?
A. Yes, yes, it would be an expectation, as a Band 5, to work autonomously.

Q. I would just like to consider the timing of this and we know from other documents and we will come to it in a moment --
A. Yes.
Q. -- that the morphine infusion was changed just before the end of the shift.
A. Yes.
Q. That's something that you can recollect?
A. As part of the incident, yes.
Q. Yes.
A. Yes.
Q. And following this, there was a change in policy --
A. Yes.
Q. -- saying that it shouldn't be changed at the end of the shift.
A. Yes.
Q. Just help us to understand a little bit more about those circumstances and what would be going through a nurse's mind at the end of a shift and why they would change a morphine infusion like this?
A. I think if it, if it was a very busy shift it's not really ideal to start setting up infusions, especially morphine. Perhaps they wanted to just get it set up ready for the next member of staff. It's hard to

comment because I wasn't involved in the incident, but ...
Q. So let's just move forward and we are going to go through an event that you weren't present at but which you will have known something about at the time. So let's look at the record, please.
This is INQ0008961, at page 47, and my Lady, you have this at tab 6, page 3 of your bundle, I hope.
LADY JUSTICE THIRLWALL: Thank you.
MR DE LA POER: So I think it will be page 3, my Lady, of that tab, which should have 47 at the bottom right-hand corner.
LADY JUSTICE THIRLWALL: Thank you.
MR DE LA POER: So this is a meeting that takes place the following day with your colleague --
A. (Nods).
Q. -- Yvonne Griffiths?
A. Okay.
Q. Who was the deputy ward manager, is that right?
A. Yes.
Q. Unit manager.
A. Yes.
Q. And is this standard procedure in the NHS and, in particular within the Countess, that if there was

a serious error made that there would be a one-to-one meeting?

A. Yes, yes.

Q. And we can see here the summary of what is recorded from that meeting:

"Lucy had commenced a continuous infusion of morphine at the end of her night shift (7 am) for re-intubated infant. At 8 am on handover infusion noted to be infusing at incorrect rate. Medical staff informed ..."

Not sure what that last -- it appears to be some sort of shorthand involving a triangle. Do you recognise that shorthand?

A. No.

Q. And we can then see recorded:

"Error rectified quickly. No detrimental effect on the infant."

Presumably that's because it was caught very quickly?

A. Yes.

Q. You have described it as very serious. What are the risks of a 10-time dose of morphine into a newborn baby?

A. Well, it's an overdose of morphine, so ...

Q. Potentially very harmful or -- can you comment

on that, you have described it as a "serious error".

A. Yes. Well, morphine, because it was a controlled drug, it's a controlled drug for a reason. So that's why I am saying it's serious.

Q. So we can then -- I think that says "sustain" --

A. Yes, sustain. Yes.

Q. But it may:

"Sustain from checking any intravenous infusions."

I think it may mean "refrain", meaning don't?

A. Yes.

Q. "Any intravenous infusions requiring additives and any control drugs until incident reviewed"?

A. Yes.

Q. And then finally, and this is where you are going to come in:

"Complete intravenous competencies, drug calculation with Practice Development Nurse Yvonne Farmer."

A. Yes, yes.

Q. And that's exactly your educational role in this situation.

A. Yes, yes.

Q. The earlier entry, so the one above with my word, not the word given, "Refrain from checking any

intravenous infusions requiring additives and any controlled drugs until incident reviewed", what were you -- what would you expect the incident review to consist of? Who would do it and when and in what circumstances?

A. Because the ward manager wasn't present at this time, I don't know if it's referring to a review with her or if it was to be reviewed within the risk department.

So it could have been either, referred to either/or.

Q. Now, we will hear about this later from Nurse Griffiths.

A. Right.

Q. But she tells us that Letby was unhappy with the instruction that she had to refrain from administering controlled drugs and that in fact Anne Murphy, the matron in overall charge of the children's, including neonatal, unit was involved.

A. (Nods).

Q. In your position as an educator, would you expect if a senior nurse on the ward is saying you have made an error, you need to take a step back --

A. Yes.

Q. -- would it be normal for somebody in that

situation to say, "I am not happy about that"?

A. Maybe not. Yes.

Q. One of the principles that's very important in medicine and nursing is insight. I am sure you are well familiar with that.

A. Yes.

Q. I am sure you teach upon the subject.

A. Yes.

Q. I mean, how important is insight?

A. Gosh, you mean insight from --

Q. To recognise when you have made a mistake?

A. -- (overspeaking) -- recognise, right, okay.

Well, I would imagine very important, yes.

Q. And can you recall any situation where you, as an educator, have made a recommendation about somebody doing or not doing something for a period of time that they have actually turned round to you and said, "I am not happy about you stopping me doing that"?

A. No.

Q. So we move forward now to your involvement. The meeting was convened on 30 July, so just seven days after this meeting. Before we bring up the note, what had you been told before that meeting that you had about what was expected of Letby following the incident?

A. As regard to checking drugs or?

Q. Yes, I mean, had you been told about her meeting with Yvonne Griffiths and what had been decided at that meeting?

A. I think -- no, I don't think so. I -- when I came on shift I think I was told that this had been decided.

Q. When you say "this", what do you mean "this"?

A. That following the incident, that Lucy wasn't able to check the drugs and that she was going to do further training with myself.

Q. So let's have a look at your meeting.

INQ0008961, page 45, it is the preceding page, my Lady.

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: In tab 6.

So is this a form that you recognise?

A. Yes.

Q. And presumably that's your handwriting?

A. Yes.

Q. And so we can see:

"Review with Lucy and reflect critically on the clinical incident which occurred. Drug calculation was correct. However, infusion pump rate was incorrect."

A. Yes.

Q. Now, would that have emerged from a discussion

you had or is that what you told her had happened?

A. I didn't tell -- because that's Eirian's writing. I didn't tell Eirian that is what had happened, no.

Q. Forgive me, that's Eirian's writing?

A. Yes.

Q. Was this a meeting that you were involved in?

A. It was Eirian's one-to-one form that she must have had with Lucy, and I have added the amendment at the bottom.

Q. I entirely understand. So it's 6th of the 9th 2013 entry only, is it?

A. Yes.

Q. That's your handwriting?

A. Yes.

Q. The other party is Eirian Powell's handwriting?

A. Is Eirian's writing.

Q. So this is a meeting on this date with Ms Powell.

A. Yes.

Q. Again, were you aware of that meeting taking place?

A. I may have been told. But I don't, I don't know.

Q. We can see and we can ask Ms Powell about what it is that she decided about whether or not Letby was allowed to continue --

A. Yes, yes.

Q. -- to care for infants with infusions and whether she's -- can you help us with "is able to check CDs", is that controlled drugs?

A. Yes, yes, controlled drugs. Yes.

Q. So on the face of it that is countermanding what Yvonne Griffiths had said seven days earlier?

A. Yes. I don't know if there was a period of time involved in the rechecking. I don't know. You -- it's not documented but there could have been.

Q. But at all events, by this date, the 30th, she hadn't undertaken her practice calculations with you --

A. No.

Q. -- because that doesn't come until 6 September?

A. Yes, yes. Yes.

Q. Well, no doubt it's a question for Ms Powell but from your point of view, how important was it as an educator, that those practice calculations were performed under supervision before Letby was allowed to be involved with controlled drugs again?

A. I think I gave her a work -- if I recall

I gave her a work booklet as well to go with the practice calculations. And I know I observed her inputting into the pump because that's where the error occurred. So I feel it was important that she demonstrated that she knew how to input into the pump.

Q. But is all of that in September of 2013, not in July?

A. I'm not sure. I have written September, so I can't really disagree with that.

Q. That is likely to be right.

So if we have got our chronology straight --

A. Yes.

Q. -- just looking at this, Yvonne Griffiths appears to have said the incident need a review and she must step back and she needs to undertake the checks.

A. Yes.

Q. We can then see what Ms Powell has written seven days later.

A. Yes.

Q. But the calculation --

A. Yes.

Q. -- practice doesn't in fact happen until six or so weeks later.

A. That's when I have documented, yes.

Q. Now, the last thing, and I just need to check

with the document that's being shown that it's the updated version from yesterday -- I am told it is. I am very pleased to hear that. INQ0012033.

So this is on the 1st August and we don't need to worry about who's sending the message:

"Hi Lucy, how are you? What happened over the drug error?"

So it is talking about what had been happening over the last few days.

A. Right.

Q. To which we can see that Letby replies:

"Thankfully Eirian felt it had been escalated more than it needed to be. Everything is back to how it was. I just have to have more training on using the pumps and it will be on my record for six months. She was very supportive, it is a case of learning to live with it now and getting my confidence back. I am on nights this week. Still feeling a bit vulnerable and thinking about what if, but I'll get there in time. Thanks for asking. Hope you are okay."

So if we can take that down.

Now, from your perspective as someone who was involved in part of this incident, do you think that Yvonne Griffiths escalated it further than it needed to be with her reaction?

A. Well, Yvonne Griffiths was the deputy manager and with the absence of the manager her next level would be the matron. So it was a joint decision and at the time, that was a good decision.

Q. So again, just going back to what you understand about insight. Does it appear from that that Letby is demonstrating insight into the seriousness of what she did?

A. It's difficult to say, really, I would say.

Q. On the subject of errors, and we are going to move to a different error now, and we are going to jump right forward in our chronology to April 2016.

My Lady, you have this at tab 6.

I'm just going to bring up a reflection written by Letby.

INQ0008961 at page 49. It is the final page behind tab 6, I hope.

We might be able to crop into that a little bit.

This is a reference to an antibiotic error.

A. (Nods).

Q. And we can see that what Letby has written was:

"It wasn't due and had not been prescribed."

So giving a drug to somebody who wasn't in need of it?

A. (Nods).

Q. Again, how would you categorise that as an error? Is it a minor error or a major error?

A. It is not a minor error, so possibly a major error.

Q. So if we look down into the large paragraph towards the bottom, so the largest of the paragraphs, we can see the words "on reflection", near the very centre of that text. I am sure it will be highlighted in a moment.

And what Letby has written is:

"On reflection I feel this situation was unavoidable."

A. (Nods).

Q. Now, again, from your perspective as an educator, if you give a patient a drug which was not due and had not been prescribed, is that an unavoidable error?

A. Sorry, could you repeat that again?

Q. Of course, yes. We can see that the drug was not due and had not been prescribed.

A. Yes.

Q. Is that capable of being described as an unavoidable error?

A. No. But if it hadn't been prescribed I don't

understand -- well, I don't understand why it was given if it wasn't prescribed. So I don't know.

Q. Is it always going to be an avoidable error?

A. Yes, yes, if it's not prescribed then ...

Q. You only have to look at what's prescribed to see that it isn't there and you avoid making that mistake.

A. Yes, yes.

Q. Again, it will be my final question about your perception of Letby's insight. Does this show good insight and reflection from somebody following an error or not?

A. She has written that she should have been more aware and greater effort made to ensure that all the checks were made. So she has made some statement there but ...

Q. Yes. Although she has also said it was unavoidable.

A. Yes.

Q. What's your view?

A. It's hard to say really without -- I don't -- I have read the incident. I don't remember the incident, so I think -- obviously it shouldn't have been given, the Gentamicin, so perhaps it is poor insight, you know, it's difficult to say really.

Q. Thank you. We can take that down.

We are now going to focus, please, upon the children named on the indictment who died and in particular what you thought at the time.

And we will just start with an overview which is how you begin in this part of your statement. You begin at paragraph 66 -- you don't need to turn it up unless you want to, I'll just read it to you:

"I was informed by my manager that Dr Brearey and later Dr Jayaram had suspicions about the conduct of Lucy. However, I do not remember when and after which neonatal death this occurred."

A. (Nods).

Q. Right. I just want to see if we can better understand that and the timings.

Obviously, we know, and it's very well established, that there were three deaths in June of 2015.

A. (Nods).

Q. The death of Child E at the beginning of August of 2015 and the death of Child I on 23 October of 2015.

A. (Nods).

Q. So a number of deaths on the neonatal unit and, as we know from other evidence, those weren't the only deaths.

A. (Nods).

Q. But focusing on the children named on the indictment. Just thinking about it now, do you think it was during 2015 that you first heard?

A. Possibly. It might have been following a meeting with Eirian and the doctors. I think they were having lots of -- they reviewed quite a few notes and they were trying to find a commonality, as in a clinical one, and Eirian told me that they were also looking at staffing and there were two nurses and a doctor that seemed to be on for some or the majority of the shifts.

So that's when she told me that they were looking at staff, and Lucy was one of the members of staff.

Q. Was that the occasion, whenever exactly it occurred, that she told you that Dr Brearey was suspicious?

A. Yes, it must have been, yes.

Q. And so just doing the best you can, and we will have a look at some of the detail in moment, do you think that is likely to have been before Christmas 2015, so at some point in 2015?

A. Possibly, possibly, yes.

Q. And when you heard that the neonatal lead Consultant was suspicious of a particular member of staff what did that make you think?

A. I was quite shocked that he thought that a member of staff was directly involved in harming babies. It wasn't something I had ever anticipated hearing or I wouldn't have expected a colleague to purposely harm babies.

So I think it was quite shocking to hear that.

Q. And did you take it upon yourself to speak to Dr Brearey to better understand what it was that he was worried about?

A. No.

Q. Again, just help us to understand what the relationships were at the time. Although you had some managerial responsibilities when you were shift leader --

A. Yes.

Q. -- you weren't the most senior nurse on unit --

A. No.

Q. -- but, nevertheless, you were extremely experienced and had been there a long time?

A. Yes.

Q. Do you think that it would have been appropriate for you to go and speak to Dr Brearey yourself to say, "I just want to better understand this"?

A. No, I didn't feel in a position at that time to go to Dr Brearey directly, no. Because there were lots of reviews and I didn't know where that allegation was going. So no, I didn't take it upon myself at that time.

Q. And you had an awareness that there were lots of reviews going on.

A. Mmm.

Q. Did you have the thought that perhaps the senior managers, so up to the board level, should be made aware of something as potentially serious as that? Was that a thought process that you had at the time?

A. I assumed at some point that they would be.

Q. Was that something you ever discussed with anyone or were told about?

A. No.

Q. So that's, best as you can, the Dr Brearey awareness?

A. Yes.

Q. What you also say is "later Dr Jayaram", so now we have got the most senior --

A. Yes.

Q. -- Consultant in the entire children's department?

A. Mm-hm.
Q. About how far apart was learning about Dr Brearey's suspicions and then learning of Dr Jayaram's? Was it within a matter of days or weeks or was it many months that passed?
A. It may -- it may have been weeks. I don't think it was days. It was just something I overheard. I wasn't told directly. I think it was just sort of hearsay -- well, not hearsay, but I had overheard it that he had mentioned, I think it was after one particular baby.
Q. Do you recall who you overheard talking about it?
A. It may have been my -- Yvonne Griffiths, but I can't be sure.
Q. Having overheard that now the two most senior Consultants had this suspicion, did you speak to Yvonne Griffiths about it to say, "Look, what's all this about?"
A. Not that I recall. But I may have done, but I don't recall.
Q. Dr Lambie, I don't know if you recall Dr Lambie, she was a Registrar until September 2015 so only during the first --
A. Yes.

Q. -- period that we have been focused upon -- told us about seeing a huddle of nurses looking at a rota to see who was on duty and she formed the impression that it was connected to the discussion that was going on at the time about who might be the common nurse.
A. (Nods).
Q. Do you recall any such huddle or did you participate in it?
A. No.
Q. Well, we will just work our way through the timings of things if we may.
You weren't directly involved in the deaths of Child A or Child B --
A. No.
Q. -- in June 2015. You say that you remember attending a multi-disciplinary meeting reviewing the post-mortem of Child A?
A. Yes.
Q. Bearing in mind that you weren't involved in the care --
A. Yes.
Q. -- in what capacity would you have been attending a meeting about the post-mortem?
A. It was, they had meetings, I think they were

monthly, and it tended to be more babies based on that had been on the maternity or it was maternity-based, but because they were reviewing one of our, our babies I thought as part of my professional development that I would attend the meeting and just to see how these incidents or babies were reviewed.
So it was more of a professional development and just to see, really, what was discussed.
Q. And do you have any recollection of any discussion at that meeting about concerns that that, there may be features in common with Child D, for example, a rash or mottling or anything like that?
A. No. I don't, no, sorry.
Q. Was anybody at that meeting raising concerns about the fact that there might be something seriously wrong on the neonatal unit?
A. No, no.
Q. So, again, you weren't involved in the care of Child C when Child C died. But you tell us that you -- something about a debrief in relation to Child C.
What you say is it was not compulsory to attend the debrief and due to workload and staffing issues some staff might not be able to attend.
A. (Nods).
Q. How much encouragement were staff receiving to

attend such debriefs?
A. I think it tended more to be the staff that had been involved in the infant death. It was seen as a welfare and a review of the build-up perhaps to the death.
So it was -- tended to be more the staff that had been looking after the baby or if anyone wanted to raise any -- well, not necessarily concerns, but wanted to talk about what had happened.
Q. Whose responsibility was it to arrange it so that it was convenient for everybody or as many people as possible to attend?
A. It was usually the Consultant but obviously with the managers because they could look at the off-duty and just see when staff were available.
Q. We then come to the death of Child D and we have still not reached the end of June 2015.
A. (Nods).
Q. I mean, at that stage, had you noticed the fact that there were three deaths in very short order? Is that something that you were aware of noticing at the time?
A. No, I didn't. I know, on hindsight, when I look back I am surprised how close they were but at that time, I don't remember having that awareness that

they were so close.
Q. And then a few weeks later, Child E at the beginning of August. Again, do you have a recollection of that being a trigger for you to think, "This isn't a usual period for the NNU"?
A. No.
Q. Just looking back on it, why do you think that that that -- I mean, you can see it laid out now.
A. Yes.
Q. But why at the time do you think that that sort of thought process wasn't triggered in your mind?
A. I think because we were so -- we were busy, everyone was doing their own jobs, and if you weren't there at that time, or you hadn't gone to -- if there was a debrief you hadn't been involved, I think you were just so involved in your everyday working that it didn't really stand out in your mind.
Q. And then in terms of children named on the indictment deaths, towards the end of October 2015, Child I. Might that have been the event that -- the death that you were talking about or do you think it was later than that that the concerns of Dr Brearey or potentially Dr Jayaram started to emerge?
A. Can I check on who Child I is, sorry?
Q. I don't know if we have a cipher --

A. Oh right, okay.
Q. -- list.
Oh, you do have a cipher list. No, I am corrected.
A. Because --
Q. It was quite wrong of me to --
A. Who --
Q. Yes, obviously, it's very important you don't mention the name but by all means, remind yourself.
A. Yes. I do know that baby. I'm not sure, I'm not sure if it was Baby I. I think it was another baby. But I think that was the time that Dr Jayaram had concerns after a different baby.
Q. So let's just try to understand that.
A. Yes.
Q. So do you think that Child I was the trigger for you learning Dr Jayaram's concerns, so Dr Brearey's concerns must have come before Child I's death or -- I'm just trying to understand what you are saying there.
A. Yes, sorry.
Q. No, you don't need to apologise.
A. I can't remember the infant. There was an infant that Dr Jayaram was particular -- talked about, a baby that was ventilated. I think that's after that point, that's when Dr Jayaram was more involved. But I don't remember the date, I'm afraid. But I knew about

Baby I passing away.
Q. The baby you are speaking about for Dr Jayaram, was that a baby who died or a baby who didn't die?
A. A baby that died, I think.
Q. Well, just try one more fact --
A. Okay.
Q. -- that we know to be true, which is that following the death of Child I --
A. Yes.
Q. -- Eirian Powell created a table.
A. Ah, right, okay.
Q. Which -- on the same day, which highlighted Letby's name in red.
A. Right, okay.
Q. Now, she sent that to Yvonne Griffiths and other people, the emails that we have don't indicate that you had received it --
A. No.
Q. -- which is why it hasn't formed part of your evidence pack.
A. Yes.
Q. But were you aware of any table having been created by Nurse Powell identifying each of these deaths and who was on duty and in particular that Letby was

identified?
A. I may have been, but, I can't say for definite.
Q. Well, we will move forward in time, please, to the CQC visit which we know took place between 16 and 19 February 2016, and I think you have had an opportunity to refresh your memory --
A. Yes, yes.
Q. -- from some notes that have been provided.
A. Yes.
Q. By mid-February 2016, do you think you had an awareness that the neonatal unit had been experiencing an increase in the rate of death?
A. Well, I knew there was an increase to the normal amount of infant deaths. Yes.
Q. And was that something that would have been appropriate to raise in your meeting with the CQC, do you think?
A. Not the involvement that I had, no.
Q. Just explain to us why that is.
A. Well, I was -- from the documents, I was shown showing the group round and it just seemed to be like an environmental audit. So you are obviously in an open, with -- on the ward, and it wasn't something that I thought about myself personally discussing with the

CQC. I didn't feel it was my role to discuss that sort of thing.

Q. Do you have any recollection of whether you were thinking at the time somebody else would do it or was it simply not on your mind?

A. It wasn't on my mind.

Q. And do you think it is something that should have been on your mind at that time?

A. It's easy to look back on hindsight and say yes, it should be -- it should have been on my mind but at that time it wasn't on my mind, so ...

Q. We know that on 2 March of 2016, the thematic review of neonatal mortality report in its final version was circulated to a number of people.

A. (Nods).

Q. Did you receive a copy of that report?

A. On an email, yes.

Q. And did you read it?

A. Yes.

Q. And what were your conclusions, having read it?

A. That there were quite, that it was a thorough report and they had looked at all the different clinical reasons. It suggested lots of areas for improving practice, policies, I think I -- my -- I was named as

part of -- in some of the actions which I would have been obviously alerted to. And then there was an addendum, which looked at all the staffing that were involved and then there was an area -- a point that Dr Brearey and Eirian Powell were going to look at specifically, the staffing side of it.

That's what I remember from it.

Q. It is a matter you comment on in your statement but I'll ask it in an open way. Do you think that report alerted you, the reader, to staffing factors and the --

A. Not specifically because there was such a lot of information in the report and I think I would have been looking at all the different actions and obviously the few that I was involved in, not specifically looking at -- because Eirian and Dr Brearey were going to review, that was something that would have followed this review. So ...

Q. By this stage, the thematic review, were you aware of the concerns about Letby that the Consultants had?

A. Amongst the Consultants, I must have been, yes.

Q. And being aware of those concerns, did you look at the appendix to see whether Letby's name

appeared next to the babies?

A. I think I noted that she had been on but hadn't been looking after the babies specifically.

So I believe I was aware that she was on the shift but hadn't necessarily looked after the baby, babies themselves.

Q. What was your own state of mind then about whether there was a problem that needed investigating?

A. Because it was being looked after by senior people, I assumed that that would be looked at.

Q. We know that Letby was moved to day shifts in early April --

A. (Nods).

Q. -- and we know that the thematic review had identified that six out of the nine deaths had occurred between midnight and 4 am?

A. Yes.

Q. Were you aware of Letby being moved to day shifts?

A. Yes. Yes, I think it was discussed with me that that was the plan; that because of all the recent incidents, deaths, that they had occurred during the night, so that's why she was being moved on to days as support for her. If, if it was a training issue or if she needed emotional support, then there were lots of

people around, the managers were around, so ...

Q. Was any part of the explanation that you were told for her move to days, to keep babies safe?

A. No.

Q. Were you aware of the sudden and unexpected collapse of Child M just a couple of days after she was moved to day shifts, on the day shift?

A. Can I refer to who Child M is, please?

Q. Of course.

A. No, I am not familiar with that baby, so, no.

Q. Did you know that there was a meeting with the Executive Directors between Nurse Powell, Dr Brearey on 11 May?

A. No.

Q. That wasn't something that was discussed with you beforehand?

A. No.

Q. Were you -- did you have any discussion about it afterwards?

A. No, I don't remember that at all. No.

Q. We know that following that meeting, an email was sent on 16 May -- you aren't on copy to that email, so let me assure you about that -- indicating that sudden and unexpected collapses should be drawn to the attention of Nurse Powell or Dr Brearey?

A. Okay.
Q. Were you aware of any such instruction having been given?
A. No.
Q. So we reach Child O, and Child P in the latter part of June of 2016. Prior to the deaths of those two children, did you have any suspicions or concerns that any child may have been deliberately harmed?
A. No.
Q. And what was your view at that time of the concerns that had been expressed by the Consultants?
A. I think because there seemed to be lots of meetings going on, that it was being taken seriously and it was being investigated so -- but I wasn't directly involved, so I assumed that's what was happening.
Q. You describe the death of Child O as unexpected.
A. Yes.
Q. And was that also your view of Child P's death?
A. Yes.
Q. I think you were involved in the resuscitation of Child P?
A. Yes.
Q. And so were you aware that Letby was present

at the time of both of those deaths?
A. Yes.
Q. Obviously the death rate has now gone up even higher.
A. Yes.
Q. Was that something that struck you at the time; that before those two deaths, Letby was said by the Consultant to be of concern because of her presence and then two deaths in just two days?
A. Yes.
Q. And there you are seeing for yourself Letby being present again?
A. Yes.
Q. And both of these are unexpected. Did it trigger any thoughts in your mind?
A. I know at the time because they were triplets I thought -- I did query whether it was some underlying infection with the babies. So it was -- I suppose it was only later on when she was taken off that I might have had a suspicion. But I don't really remember. I think it was just such a busy, shocking time and we were all devastated to lose two babies the day after.
I think it just clouded your judgment. I think I was just in shock, really, that that had happened so quickly.

Q. You tell us in your witness statement that you were informed by your colleague Nurse Griffiths that Letby had been taken off-duty for the foreseeable future --
A. Yes.
Q. -- as she was suspected by Dr Brearey as the cause of death in both cases rather than there being a clinical cause.
A. Yes.
Q. You also say what Nurse Griffiths said to you was, "This was for Lucy's protection --
A. Yes.
Q. -- and to give her time out following the two deaths."
A. Yes.
Q. So what was your understanding of Nurse Griffiths' position about whether there was a genuine reason to be concerned at that time?
A. Yes. I think because of confidentiality maybe, I think because if people are making serious accusations, it's not something -- it needs to be taken seriously.
So I assumed they were having discussions with other people, so perhaps it was a way of explaining why she was being removed.

Q. Your report of what Nurse Griffiths said was that it was for Lucy's protection.
A. Right, okay.
Q. Was there any discussion about the need to protect babies?
A. Not that I remember.
Q. What you say is:
"I did not have any suspicions at this time that Lucy had deliberately caused the neonatal deaths."
A. Right.
Q. "There appeared to be no evidence other than that she was looking after Child O and Child P. I and my colleagues believed Lucy to be a competent and excellent neonatal nurse and it seemed to be inconceivable that she was at fault."
A. Right.
Q. That's what you put in your witness statement.
A. Okay.
Q. You earlier told us that perhaps the emotion of events had clouded your judgment.
A. (Nods).
Q. Do you think you may have lost a degree of objectivity in that situation?
A. Possibly. I don't know.
Q. Because you say "it seemed to be

inconceivable" that she was at fault.
A. Yes.
Q. Presumably, given you were highly experienced, you were aware of Beverley Allitt?
A. Yes.
Q. And closer to home geographically, the Stepping Hill nurse who had murdered two patients?
A. Mm-hm.
Q. So it wasn't beyond the realms of what was possible --
A. Yes.
Q. -- that a nurse could be hurting them?
A. I know but it's -- because she was a nurse that worked on the unit and she was very enthusiastic and young, it didn't cross my mind that she then would be deliberately harming babies.
Q. Now, just moving forward through a couple more events.
In July of 2016, you tell us that you were asked by Karen Rees to meet Letby and complete a training update.
A. (Nods).
Q. What did you understand at that time was the plan for whether Letby would be going back to clinical practice?
A. I think I understood that -- I was told that

there was at some point that Lucy was going to come back to the unit. I was never given a date.
It was just that's what I was, the information I was given. So I was asked to, just to, do, like, a refresher with her so that if she did come back then at least we had started to do a refresher.
Q. I think you were able to undertake some training but not the high-dependency or intensive care requirements --
A. No, no.
Q. -- because the training opportunity you were offering didn't involve being on the ward?
A. No, no.
Q. The RCPCH visit on 2 September, you were one of the people interviewed; is that right?
A. Yes.
Q. And what you say is:
"Due to the time lapse since the interview I do not remember the specific questions but I remember we were all very upset and tearful by some of the questions."
A. Yes.
Q. Just help us with what it was that was making people tearful.
A. I -- I just remember it being a very stressful meeting and I think at that time, when Lucy had been

removed we all felt under suspicion. If it wasn't Lucy, it could be one of us, we just didn't know, and I think we felt we hadn't been supported by the senior managers at that time.
I can't remember the specific question or questions that triggered, but we all became upset at the time so ...
Q. You say:
"We had felt let down by the lack of support and communication."
A. Yes.
Q. Who did you perceive had let you down?
A. I think because the Trust removed Lucy and then we didn't hear any communication, we weren't, we were told we couldn't speak to our colleagues about it. It all felt very -- we just felt as if we were just left. We didn't get any support following the deaths, and we were all very stressed and very emotional about it and we didn't feel we had had any well-being support at that time.
Q. Finally, turning to your reflections, you say this:
"I consider a more robust policy and protocol for debriefs amongst the nursing staff and doctors following every neonatal death on the unit may have improved

communication, knowledge, information sharing and discussion at ward level."
And I would just like you, please, to amplify that a little bit and why you have put that in particular in your witness statement.
A. Sorry, could you repeat that again, sorry.
Q. "I consider a more robust policy and protocol for debriefs amongst the nursing staff and doctors following every neonatal death on the unit may have improved communication, knowledge, information sharing and discussion at ward level."
A. Yes. I think we should have -- I think there should be debriefs after an infant death or an incident, so that it would be used as a learning process and it was a better way of communicating between all the nursing, medical staff.
It's all about sharing information. We only knew one small part and you were just part of a jigsaw at that time. So I think with more knowledge, it would have helped.
LADY JUSTICE THIRLWALL: So do you mean debriefs from people other than or in addition to those who would have been involved?
A. No, no, just debriefs on the unit, I meant.
LADY JUSTICE THIRLWALL: No, no, I understand that.

A. Sorry.

LADY JUSTICE THIRLWALL: Just from something you said earlier, you talked about generally debriefs would only be those who had been involved in an incident.

A. Yes, yes.

LADY JUSTICE THIRLWALL: I just wondered, are you suggesting that more than those who had been involved should be invited to the debrief?

A. Yes, maybe more --

LADY JUSTICE THIRLWALL: I don't want to put words in your mouth. I just wondered is that what you meant?

A. Yes. I think so, yes. I think so.

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: Finally, to draw attention to one of the recommendations that you propose. You say:

"I would recommend Safeguarding training for all NHS staff to include a clear process of what to do if there are suspicions or they witness abuse of patients by a member of staff and encourage a culture to speak out."

A. Yes.

Q. Is that something that you thought was lacking during 2015/16?

A. Yes, yes.

MR DE LA POER: Ms Farmer, thank you very much

indeed. Those are my questions.

My Lady, there is a Rule 10 permission in relation to the Family Group 1, Mr Skelton I believe, and I wonder whether it would be convenient if we do that and then take our break.

LADY JUSTICE THIRLWALL: Very well.

Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Thank you.

Ms Farmer, I ask questions on behalf of one of the family groups.

A. Okay.

Q. I am going to ask you first about Child A and Child B, do you remember them, the twins?

A. Yes, I didn't look after them but I do remember them.

Q. But you were around on the unit at the time.

A. Yes.

Q. After they were born, Mother A and B remembers being told that they were in good condition, although Child B, the one that survived, the girl, needed some extra help; do you remember that?

A. Not specifically but ...

Q. But do you remember them being in good condition?

A. Yes, yes.

Q. And do you remember there -- Child A's collapse being unexpected and unexplained at the time?

A. I must have been, yes, yes.

Q. Which is generally speaking an unusual occurrence, so babies without any particular condition that's likely to cause their collapse, don't normally collapse?

A. Well, we were always very vigilant with premature babies. Because of the nature of prematurity, they could be stable but very quickly deteriorate. So it's a difficult one.

You don't expect a death but it's always at the back of your mind that they are very vulnerable babies, so, as such, you are always vigilant to ensure that you pick up on any clinical signs that show that they may be deteriorating, so ...

Q. In the case of Child A, he deteriorated and died very suddenly --

A. Right, okay.

Q. -- and without explanation; were you aware of that?

A. I don't remember at the time how -- I don't know -- no, I don't remember.

Q. Do you remember any discussion about any

rashes or mottling being seen on Child A?

A. No.

Q. So you can't assist on what communications there might have been with Mother A about that?

A. No.

Q. Can I just return to the topic of debriefs. There seemed to be, from your evidence and your statement and today, different purposes for debriefs, one of which is to support staff?

A. Yes.

Q. And the other of which is learning?

A. Yes.

Q. Is that right?

A. Yes.

Q. That's correct?

A. I think so, yes.

Q. And is the initial debrief after a child has collapsed and died to support the staff?

A. Yes. It was -- we did have -- all the staff that were involved following a death, if they were on that unit at that time, following an incident you would have a discussion straight away amongst all the nurses, doctors involved and then a few days later arrange more of a debrief looking through the notes in a more controlled environment.

But again, it was usually with the people that were involved in the incident.
Q. So a debrief is the type of -- the second form of debrief is the type of information sharing --
A. Yes, yes.
Q. -- meeting by the professionals to understand what had happened?
A. Yes.
Q. And if there had been similar factors between collapses and deaths between two children, A and B in particular, would you expect those to be discussed in a debrief?
A. If they followed the same pattern, do you mean?
Q. Yes, if there had been similarities.
A. Possibly.
Q. Can I ask you about the treatment of Mother A and B after Baby A died. Obviously she was in the very difficult position of having to return to the unit because her daughter was still there --
A. Yes.
Q. -- and was still being cared for?
A. Yes.
Q. Do you appreciate now that that's an extraordinarily hard position for a parent to be in --

A. Oh, yes, very much so.
Q. -- one child has just died but the other is still alive?
A. Of course.
Q. And she doesn't feel she was treated, at least by all the staff, with the necessary sympathy and consideration when she returned.
A. I am very sorry to hear that.
Q. Do you appreciate that she should have been treated very sensitively given that she is coming back to the scene of her other child's death?
A. I would have expected her to be treated sympathetically.
Q. Mr De La Poer asked you about your reflections. As I understand your evidence, throughout 2015 and 2016, you had no suspicions about Lucy Letby harming children?
A. No.
Q. Did you ever review any of the babies' notes?
A. No.
Q. So you had no personal understanding of the circumstances in which the children had died --
A. No.
Q. -- or collapsed?
A. No, they weren't available to be reviewed,

so no.
Q. Did you ever speak to Dr Brearey or Dr Jayaram about their concerns?
A. No.
Q. Do you accept now, looking back, that you may have closed your mind to the possibility that she was harming children without any curiosity as to what had actually happened to the children?
A. Well, following the trial, there was a lot of information that I wasn't aware of. I worked with her as a colleague, we had a professional relationship and that was my understanding; that she was a professional.
So I didn't have all the knowledge that we now know about it, so I -- I can't really say more than that, really.
Q. Were you aware of Beverley Allitt? She was a professional nurse.
A. Yes.
Q. And you are aware of Victorino Chua, who was also a nurse, and both of them had killed patients.
A. Yes.
Q. Dr Shipman, of course, famously, killed over 100 patients.
A. Yes, but it didn't cross my mind that that was happening at that time.

Q. Why did you close your mind to the possibility that she was harming patients without having yourself conducted any form of investigation and without having spoken to the two very senior clinicians that did suspect her?
A. I just felt it was unconceivable that a colleague would harm babies. So that was my view at that time.
Q. Do you recognise that that opinion was a mistake, given what you now know?
A. Well, obviously, now I know, it's very devastating. So, yes. Yes.
Q. Have you got any reflections on the fact that you and other nursing staff appeared to have closed your minds to that possibility without taking any active steps to ascertain the truth yourselves?
A. I think that's a very unfair question really because we are all absolutely devastated, it's had a massive effect on us all. So it's a very emotional time. So it's hard to -- of course we have all reflected on it, so -- but we only knew what we knew at the time and could only make decisions on what we knew at that time, so ...
MR SKELTON: Thank you.
Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.
Just to pick up on the last question. Do you think now that it's inconceivable that a nurse would harm babies?
A. Well, not, not with what I have learnt from all the police investigations, no.
LADY JUSTICE THIRLWALL: I'm just thinking, sort of moving on, because I imagine there may have been those who thought like that at the time of Beverley Allitt.
A. Yes, yes.
LADY JUSTICE THIRLWALL: I'm just wondering what it is you think that would make you think the unthinkable, perhaps that's an impossible question to answer but ...
A. Yes, because if a member of staff had had concerns on the unit, we were a very small unit, nobody raised any concerns, like, from -- none of the nurses. I know I have heard evidence that they had a huddle but nobody actually came and spoke to me about it.
LADY JUSTICE THIRLWALL: No one spoke to you about it?
A. Yes.
LADY JUSTICE THIRLWALL: Yes.
A. So I think communication was quite lacking in that respect. If people had suspicions perhaps they should have voiced them. So perhaps we didn't have an

open enough relationship, I don't know.
LADY JUSTICE THIRLWALL: Thank you.
Can I just ask you briefly about the incident with the morphine.
A. Yes.
LADY JUSTICE THIRLWALL: I don't want to take a lot of time on it but I really just want to understand what your role was.
A. Yes.
LADY JUSTICE THIRLWALL: We can see from the document which is INQ0008961, page 45, we have looked at it already --
A. Yes.
LADY JUSTICE THIRLWALL: -- most of it, you told us, in Eirian Powell's writing.
A. Yes.
LADY JUSTICE THIRLWALL: And it looks as though she has a one-to-one with Lucy Letby on 30 July.
A. Yes.
LADY JUSTICE THIRLWALL: And at the bottom she then writes, "Review in six months, January 30th".
A. Yes.
LADY JUSTICE THIRLWALL: So her contribution to the document finishes at that point and then you have written yours above that --

A. Yes, yes.
LADY JUSTICE THIRLWALL: -- for 6 September. And I just wanted to understand whether, when you wrote it on 6 September, you were talking about a process with Letby or whether in fact it was a single occasion --
A. Yes.
LADY JUSTICE THIRLWALL: -- when you completed practice calculations with her.
A. I think it was part of a process because she had a workbook to work through and then the calculations were an addition and we had a competency for the use of the pump, and I know we went through that --
LADY JUSTICE THIRLWALL: Yes.
A. -- and I asked her to input different doses. So she actually knew -- I was confident that she knew how to input the dose, whether it was a mistake, it sounds like it was a mistake in the inputting rather than the actual calculation.
LADY JUSTICE THIRLWALL: Yes, I think we have seen from the documents, it was -- she made a mistake with the pump.
A. Yes, yes.
LADY JUSTICE THIRLWALL: And I presume that all of that had been tested before?
A. Yes, yes. Yes.

LADY JUSTICE THIRLWALL: So was there any discussion about how come she had made a mistake? Did you have any discussion with her about that?
A. No, not really. She did, she was with another member of staff who had checked it as well so we had two people at that time who had made the mistake.
LADY JUSTICE THIRLWALL: Were you involved in dealing with that nurse as well?
A. No, no. No. No, she was a very senior nurse and she almost resigned over the incident, following the incident and so she had more meetings with Eirian --
LADY JUSTICE THIRLWALL: I see.
A. -- rather than myself.
LADY JUSTICE THIRLWALL: Thank you, thank you very much indeed. Actually, there was one other question.
You mentioned that you had gone along to the meeting which was about the post-mortem for Child A.
A. Yes.
LADY JUSTICE THIRLWALL: And the reason that you had gone, I think I have got this correctly, it was for your own professional development.
A. Yes.
LADY JUSTICE THIRLWALL: Was that because you had not previously gone to such an event?
A. Yes. Yes. I think in the past, we, it was

always an open invite if anybody wanted to go.
LADY JUSTICE THIRLWALL: Invitation, yes.
A. As part of, as I have said, my development it's important to have an overview of all the different sort of meetings, areas to go to.
LADY JUSTICE THIRLWALL: Was also a part of your decision the fact that you had been -- you knew about Child A?
A. Yes, yes. Any, any meetings or reviews about different babies on the unit were always something of interest. You might want to go to just to see what -- it was probably a more thorough review or a review that you didn't really know about. Yes.
LADY JUSTICE THIRLWALL: Thank you very much indeed.
A. Okay.
LADY JUSTICE THIRLWALL: Is there anything arising out of that, Mr De La Poer?
MR DE LA POER: No, thank you, my Lady.
LADY JUSTICE THIRLWALL: In that case, thank you for coming to give evidence. You are free to go and we will take a break now until a quarter to 12.
(11.28 am)
(A short break)
(11.48 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.
MR DE LA POER: My Lady, the person sitting in the witness box is Nurse Yvonne Griffiths, our next witness, I wonder if she may be sworn.

MS YVONNE GRIFFITHS (Sworn)

Questions by MR DE LA POER

MR DE LA POER: Please could you give us your full name.
A. Yvonne Griffiths.
Q. Ms Griffiths, you have provided to the Inquiry two witness statements, is that correct?
A. Correct.
Q. The first one is dated 19 June of 2024. With the exception of paragraphs 70 to 77, is the content of that witness statement true to the best of your knowledge and belief?
A. Yes.
Q. And I have excepted those because you provided a second witness statement, dated 15 October of this year -- that is to say yesterday?
A. Correct, yes.
Q. And is the content of that second witness statement, which directly addresses paragraphs 70 to 77, true to the best of your knowledge and belief?
A. Yes, it is.

Q. Did you qualify as a registered nurse in 1985?
A. Correct, yes.
Q. And after a period of further training including in the United States, did you join the Countess of Chester Hospital in 2004?
A. Correct.
Q. Did you complete an Advanced Neonatal Course in 2011?
A. Yes.
Q. And at around that time did you become the deputy ward manager of the neonatal unit?
A. Yes, I did.
Q. And for the entire period that you were deputy ward manager, was the ward manager Nurse Eirian Powell?
A. Yes, correct.
Q. Upon Ms Powell's retirement in December 2017, did you become ward manager for the NNU?
A. Yes, initially acting for six months, and then took over, yes.
Q. Now, as deputy ward manager, which was your role at the time, were you responsible for the nursing rota?
A. I was.
Q. What other responsibilities did you have that were particular to the role of deputy ward manager?

A. At the present time there was a big campaign for Babygrow Appeal so I was a big part of the fundraising activities, and I also deputised if the manager wasn't on duty.
Q. Did you have any responsibility for matters going to staff conduct or the investigation of clinical incidents?
A. Not really no, I was more -- I did work clinically both managerial and clinical, so most of my time was clinical.
Q. When you say clinical that is directly caring for babies on the ward?
A. Yes, I would have about three or four days a month to -- to do the off-duty and I would have additional days if Eirian was off on annual leave.
Q. Now, in your own words, please tell us what the culture and atmosphere on the neonatal unit was around the start of 2015?
A. I found it to be really well. I think we worked cohesive as a team. We were very busy but we all worked really well and I thought it was a good culture.
Q. And when you say "we", are you speaking just about your nursing colleagues or are you including the doctors?
A. I think -- all of us yes, I believe all.

Q. So did you think at that time there were any problems with the culture or atmosphere, whether between individuals or between groups such as nurses and doctors?

A. No.

Q. You do say that you didn't think the relationship between midwives and nurses was particularly strong?

A. (Nods).

Q. Why did you say that?

A. Unfortunately we were in different directives so we never really mixed in any meetings together and I don't think either of us were aware of how busy each other were in our departments because we didn't have that cohesion that we do have now.

Q. In terms of the leadership at the unit level, Dr Brearey was the neonatal lead Consultant and, as you have told us, the ward manager was Nurse Powell.

A. Correct.

Q. What was your perception as to how they worked?

A. I thought they worked really well. They often went to network meetings together. I think they had a common goal. I know our staffing -- they always looked at doing staffing business cases. So I thought

they worked very well. They wanted to make change on the unit.

Q. And did that continue to be the case all the way up until the end of June of 2016?

A. Yes, I think they worked well together.

Q. Once June 2016 was reached and we had the deaths of Child O and Child P towards the end of June was there any change in their relationship that you perceived?

A. Not that I perceived, no.

Q. Now, we have heard something about Nurse Powell's conduct of herself in relation to the nursing staff, so there was a "circle of trust", is something that Nurse ZC has told us, and that some, including Nurse T, have said that Eirian Powell had favourites.

Are those descriptions that you recognise, a club or a clique operating within the neonatal unit?

A. No. I think Eirian was very neutral. She was old school and her famous comment was: these are your work colleagues not your friends.

So she never socialised outside of work with any of, of the nurses, and she was very professional. I think she recognised people who were keen to pursue the career of neonatal nursing because it's a lot of

education, so I think she respected nurses that had the passion to develop their skill set.

Q. In terms of the, as the jargon is, the activity and acuity levels, how busy and how seriously sick were the babies, what was your perception of the busyness of the neonatal unit at that time?

A. I think being responsible for the off-duty, it was very challenging. We were -- we staffed all our budgeted positions within nursing but depending on the acuity then I think the nursing staff had to do a lot of flexibility, work on annual leave, swap days, depending on activity.

So it could range from one day only having seven babies on the unit, and low acuity, to particularly busy periods where we could be full and that's when we would be putting a plea out for additional staff to help.

Q. And you are describing a process where there are particularly busy periods and perhaps less busy periods. Was that true throughout the period of time that you were deputy ward manager or did that change at any point?

A. I think it's reflective of every neonatal unit. You have peaks and troughs. You can have a very busy period or you can have a quieter period, depending, because it is dependent on who delivers and needing our

services.

Q. And as far as those peaks and troughs are concerned, was it a peak or a trough during the period 2015 into 2016? Or neither, it doesn't need to be --

A. I think it continued, yes, yes, busy periods. We would have a quiet spell and then we would be busy, particularly around Christmas, so it just depends, if there is any occasions and we would always have busier times at certain times of the year.

Q. Were you aware of the BAPM standard for staffing?

A. Yes.

Q. And was that aspirational or was it achievable?

A. It was a recommendation from 2010. I think it gave neonatal units the -- the document to say: this is the standard that every neonatal should have. But obviously it was a new document that didn't really come with any additional funding.

So I know we were able to use that document for our business case for additional staff.

Q. And is that the Babygrow business case you are talking about or a different business case?

A. No, the Babygrow was for the new neonatal building that we are in now so that we have got a better

space. The business case was for additional staff.
Q. And when approximately was that business case put forward?
A. I am not aware but I have looked back and it's around about 2013/14. So that was the business case because I think the Kirkup Report came but this is just on my knowledge I have now rather than back in the day.
Q. Well, using the knowledge you have now, provided it is accurate, that's what's important. And what was the response to the business case that was put forward in around 2013?
A. I know Eirian and Dr Brearey and our matron, they got together to compose the business case and I know they would go off to the meeting and would all be excited and then they would come back and it would be refused because it would be on the wrong template and so they would have to do it again. So they never really got anywhere with it.
So following that we were told to Datix if we had any staffing issues, so just so we could highlight that to the Executive team.
Q. We are going to come to Datix in a moment, but is what you are saying that in the event that you felt that you were short-staffed, that should result in a Datix form noting that fact?

A. And I think that was just to recognise -- to have a record of that for the Trust to say that this is why we need that business case to be approved.
Q. And so by the time we get to 2015/2016, had any change been made to the staffing level by reason of the business case?
A. No.
Q. Was patient care ever compromised, in your view, by reason of the staffing level?
A. No, because we all had a very flexible team. I think everybody, if there was a plea for extra staff, the colleagues always came in as they do now. So I think we were very fortunate that we had a good team.
We would have benefited from that additional staff because that would have given us a supernumerary shift leader which would have been better staffing.
Q. Finally before we turn to the topic of policies and procedures, your relationship with Eirian Powell. How did you find working with her?
A. I learnt a lot from Eirian Powell. I think she was a very good manager. She was very passionate about what she did and I think she never, if she had a goal, I think she always went for it, like with staffing she, you know, she persisted to try and get more staff. She encouraged staff to go and do the

courses. We were the first to ever do the R23, which is the Advanced course, because she just wanted all the nurses to be highly skilled, to provide the care.
Q. In your experience of her, did she see herself as an advocate for her staff?
A. Yes.
Q. And was that an appropriate approach for her to take, do you think?
A. Sorry, I don't understand the question.
Q. Well, do you think that her role as manager was to act as an advocate for her staff?
A. I think she was there to represent what the unit needed and it was her voice to take it to the exec level.
But I just feel because we were in Urgent Care, I don't think they appreciated the world of neonatology.
Q. Now, one of the things that you say on more than one occasion in your statement is that you were excluded from major discussions?
A. (Nods).
Q. Or as you describe them, high profile meetings, and you make a reference to your banding saying it is above your banding level.
A. Yes, yes.
Q. Just to try and get underneath what you are

saying by that, was it your view that you were excluded when you should have been included or was it your view that you were excluded and you didn't need to go?
A. I was excluded and didn't need to go because obviously I was working on the shopfloor so we can't just all walk off and go to meetings, you know, my responsibility was to ensure that the safety of the unit was staffed appropriately, and caring for the babies, like any other Band 6.
Q. As somebody with management responsibility who needed to be in a position to step into Nurse Powell's shoes, should she not be available, how important was it that you had a clear understanding of the important workstreams that she was involved in as the unit manager?
A. Eirian always cc'd me in any relevant emails so that if she happened to not be there and I had a question I could read through the thread of emails.
Q. So was it your working expectation that she would always tell you about important things she was doing as the unit manager?
A. Yes, I mean, with the business case and, yes.
Q. Well, we will look at individual events --
A. Okay.
Q. -- but I am talking generally here, so that's

sufficient for now.
A. Yes.
Q. So I said I was going to come on to policies and procedures. The first one is safeguarding. Had you received any training in how to deal with a situation in which a colleague was suspected of doing harm to patients?
A. No, we would do adult safeguarding and children safeguarding and that was specifically around where I worked, it's more the scenarios around making sure that the home was safe for the baby to go home and we never had any scenarios regarding anybody in hospital causing harm because I think it's just, for me, for anyone to do any harm within a hospital setting that's a Trust -- but no, we didn't have any scenarios about staff.
Q. Do you think you should have?
A. In reflection now, yes. Yes.
Q. Do you think the fact that you hadn't had any such training made any difference to how you acted when presented with the events that we are going to look at in more detail?
A. No, but obviously I have read a lot about safeguarding and it is to prevent harm to, to a child, so I suppose now I realise that you could connect the

two but we never had any scenarios regarding staff.
Q. Forgive me, it will have been my question.
I absolutely accept you hadn't had such training, I'm just inviting you to consider that had you had such training, would it have made a difference to how you approached the information you were being given at the time?
A. No, I don't think so.
Q. And why do you say that?
A. Because -- I suppose it was just the commonalities of a certain person on shift rather than witnessing any harm. If I witnessed somebody doing deliberate harm, then I would escalate that.
Q. Well, we will come back to whether it was just commonalities in due course but I'll move on from safeguarding to Datix. What was your understanding about when a Datix form was required?
A. A Datix was so that we could learn from the event.
Q. Now, we know, having seen some Datix forms, and we will look at one or two over the course of your questioning, that there was a category of "Expected and unexpected death".
Does that -- is that something that you recognise as an option on the Datix form?

A. Not from memory, but I believe ...
Q. We will have a look at it. What was your understanding about whether or not a Datix was required if a child died?
A. Looking back, I feel we did Datix any child that had died but I am not 100% back in 2015.
Q. And on what basis were you filling in those Datix forms? Why did you think that they were required? What criteria was prompting that form?
A. I think on the shopfloor at the time in 2015/16, we would just complete a Datix and then we would expect a team to review that Datix.
I wasn't involved in too many reviews of Datixes.
Q. But the thought process of you have just been participating as a nurse in a patient death, did you understand there was an expectation that you would fill in a form about that to record that?
A. Yes, but at the time I just thought it was to -- so the Executive team would be aware that we have had a death.
Q. What about in the event of a sudden unexpected collapse that didn't lead to death? Was your understanding that a Datix was required or wasn't required in that situation?
A. We didn't fill one in at that time.

Q. Has that changed since?
A. No, because we don't tend to have them as often now.
Q. It may be that you don't have them as often but when they do happen, these rare events, would you expect your staff, as the current unit manager, to fill in a Datix?
A. No.
Q. And why is that?
A. Because working within an ITU area, I think it was quite common that that would happen and it was only if it resulted in, in the baby's demise then we would Datix the incident.
Q. Have you, and I readily accept that it wasn't in the pack that you received, have you seen anything of the concerns that were raised at the time by Ruth Millward and others about the fact that the neonatal unit was not filling in Datix forms when they should have been?
A. I wasn't aware of that at the time.
Q. You weren't aware of that at the time?
A. No.
Q. Are you aware of that now or not? Is that news to you, what I have just said?
A. I might have read it in my pack but I can't

remember.
Q. Well, it's certainly not a memory test as far as your pack is concerned.
A. Yes.
Q. But I'm just seeking to understand what your current position is. Have you, as unit manager, had meetings with the risk department about what their expectation is about when Datixes are and aren't filled in?
A. We normally have a Datix drop bar, so that can change depending, you know, as the, as practices change, so usually there is a drop bar that will indicate what we need to Datix.
Q. So that's the form, but I am talking about a sitdown meeting, human being to human being, you and somebody from the risk department so they can say: this is what our expectation is.
A. Oh, sorry, yes. I know back in the day and also now we have NNIRG meetings, which is a neonatal review meeting, and that's with the people from the risk department and the manager and the Consultant would review any Datixes and to see any learning to come from that.
Q. Has any training been provided as to when they are and aren't expected?

A. No. No.
Q. Debriefs.
What was your expectation in 2015/2016 about whether there would be a debrief following a death?
A. A debrief was more for pastoral care for the staff to ensure that they could all come together because obviously it is very traumatic for the staff. We try and do that as soon as the incident was, was -- had happened, but depending on other demands within the team. But I felt that it was -- it's important to just all come together to -- to talk about the incident and how people felt it went and if there was any learning or anything that anybody wanted to bring up.
Q. So if not that first debrief which you have described as occurring as soon as possible and for pastoral purposes, was there any opportunity back in 2015/16 for learning that you were invited to participate in relation to deaths?
A. I might have been present in a few reviews of neonatal deaths. So that would be done by a Consultant that wasn't part of that resus and a nurse, and a manager or, if Eirian wasn't there, then I would, would present. And then I think you would look at all the maternal side and then the neonatal and then they would come together, in my understanding, to review that

case.
Q. So we have heard something about the perinatal mortality and morbidity review meetings that happened approximately every two months. We have also heard something about the neonatal mortality meetings, which were only about deaths, as the name would suggest. Is that what you are referring to?
A. Yes.
Q. So I would like to turn, please, to ask you about clinical incidents before the period that we will focus on in due course, the first being the morphine infusion incident on 22 July 2013.
What you tell us is that you were on a management day on that occasion, but you were made aware that it had occurred.
A. Yes.
Q. And what was it about this incident that would need you, who wasn't on the ward at the time, to be told about it?
A. I believe Eirian wasn't on duty. I think she was on annual leave. I was informed of the incident and because it was a very serious incident with morphine, I did seek help from my matron as well on how to handle the follow-on from the Datix.
Q. Very serious incident?

A. Yes.
Q. Why do you say it was a very serious incident?
A. It was a morphine error on the pump that was infusing. I can't remember the times fold of morphone.
Q. 10.
A. 10-fold, so if that hadn't been picked up as soon as it was, it might have made the baby demise.
Q. It could have been fatal?
A. Yes.
Q. So a very serious error, one requiring you to be contacted when you are not on the ward in the absence of Ms Powell?
A. I was on the ward.
Q. Oh, you were on the ward?
A. It happened -- I think it was handed over at 8 o'clock so the incident occurred at 8 when I was coming on duty.
Q. That's entirely my fault. When you said that I was on a management day --
A. Yes.
Q. -- do you mean you were acting as ward manager that day?
A. Correct.
Q. I'm sorry, that was my misunderstanding entirely.

So you were aware of the incident, and did you speak to Letby immediately after it or had she left for -- at the conclusion of her night shift before you were able to speak to her?

A. I can't remember.

Q. We know that there was a one-to-one --

A. Yes.

Q. -- the next day.

A. That's right.

Q. So I am not asking about that. It's just whether you have any recollection before that one-to-one of seeing Letby, what her demeanour was, what her attitude was to this error?

A. No, sorry, I don't remember.

Q. I'm not going to name the member of staff, but the other member of staff who was involved, you describe as being terribly upset.

A. She was extremely upset.

Q. And that she came to find you.

A. Yes.

Q. Is that right?

A. Yes.

Q. Are you able to say, for sure, whether Letby did or didn't come to find you on that day to talk about it?

A. No, she definitely didn't. No, the only meeting I had with Lucy was on the one-to-one date of the meeting.

Q. So let's have a look at that now, please. It's INQ0008961, page 47 -- it is going to come up on the screen in front of you.

Just so you know, Ms Griffiths, we did look at this with your colleague Ms Farmer earlier today.

So we have read through it already but do you want to just refamiliarise yourself with the content of this document?

A. Yes.

Q. I am sure you have seen it many times.

A. Yes.

Q. What I would like to focus on are the three action points. So the first is happily, because somebody picked it up very shortly after the error was made, no detrimental effect on the infant.

A. Correct.

Q. And had you managed to establish that conclusively by the time of this meeting?

A. Yes.

Q. Now, the next word is, as I read it "sustain", I think that's your handwriting.

A. Yes.

Q. Are you meaning by this that she should not check any intravenous infusions requiring additives and any controlled drugs until the incident review?

A. Correct.

Q. What were you envisaging would occur by way of incident review?

A. I would expect the incident to be, I expected Lucy to be spoken to and, and the pump to be checked. That's what we would normally do for -- to make sure that it wasn't an input error it was a pump error. And I would just expect someone to address it higher than me.

Q. So the incident review, were you expecting that would happen the next day or that it would require a formal meeting, put into people's calendars, what are you expecting by this incident review and when it might take place?

A. Well, I think when I look at the date, 2013, I was pretty new at managing these situations, it was the first incident of a high calibre that I was dealing with, so I did have advice from my matron. And I just thought it was quite a safe practice to stop her from doing any competent, you know, IVs until it was -- somebody more senior could take that lead.

Q. Then we have "Complete intravenous

competencies, drug calculation, with Practice Development Nurse Yvonne Farmer" as your third action point.

A. (Nods).

Q. Were you expecting, when you wrote this, that that competency drug calculation practice would occur before Letby was signed off to go back to administering?

A. Yes. I think we normally have a process. So if a medication error is, is made, depending on the severity, then you would do a reflection and then you would have to do competencies before you are able to carry on.

Q. So you were envisaging a circumstance in which Letby met with Farmer, Nurse Farmer, before she was allowed to go back to being involved with controlled drugs in this circumstance?

A. That's what I would have thought would happen.

Q. Now, what was Letby's demeanour? How was she presenting herself to you in this meeting?

A. I just remember the comparison because I know the other lady was very distraught and very upset, to the point where she was going to leave nursing.

Letby, I think she was upset but not to the same extent.

Q. Now, you have told us that you consulted the

matron who was Anne Murphy.
A. Yes.
Q. The most senior nurse on the Children's Unit, is that right?
A. Correct.
Q. Including neonatology. Let's just think about the order of that. Had you spoken to her before you had this meeting with Letby?
A. Yes. I would have spoken to Anne Murphy the day that the incident occurred.
Q. And so you, you already knew by the time you came into this meeting that what your plan was had been approved by the most senior nurse who worked at ward level?
A. Yes.
Q. What was Letby's reaction to you telling her that she wasn't allowed to be involved in intravenous infusions requiring additives and any controlled drugs until a review had taken place and, as you have told us the third point means, that she wasn't allowed to do any of that until she had completed competencies in drug calculation with Nurse Farmer?
A. She seemed to accept my decision.
Q. Did you at any point have to consult Nurse Murphy about how the situation should be handled

after you had had your meeting with Letby?
A. Yes, we had a meeting after and Anne Murphy was very supportive knowing that this is the first big incident that I had had to deal with.
Q. What degree of insight do you think Letby was showing in that meeting, about the severity of the error and the need for remedial steps to be taken?
A. I can't really remember but I think she accepted it and she did actually sign the form, so ...
Q. And were you involved any further with this incident?
A. No.
Q. I would just like to take you, please, to paragraph 39 of your witness statement just to see if I can prompt your recollection.
A. Is it in the bundle?
Q. It should be in your folder there. You should have your witness statement --
A. Oh, yes.
Q. And if you could go, please, to page 8 and paragraph 39.
A. Yes.
Q. I'll just read it out so you follow along:
"In terms of my discussions with Anne Murphy (Matron for Paediatrics and Children's ward) I remember

showing her the 'One to One' form and discussing my plans on actions, which she agreed. The reason for my discussion with Anne Murphy was due to Letby stating that she was unhappy with my decision following our 1:1 meeting. In response, I stated I would take on board her comments and speak to Anne."
A. Yes, I think perhaps she thought I was being a bit harsh.
Q. So just if we just roll it back a little bit.
A. Yes, yes.
Q. The chronology you have given us to that point was that you spoke to Nurse Murphy before.
A. Yes.
Q. You had an agreed plan, you saw Letby, and Letby was happy with what you decided. The account you have given in your Inquiry witness statement is that in fact your conversation with Anne Murphy happens after your one-to-one, and was only prompted by the fact that Letby was, to use your words, "unhappy" with your decision.
A. Yes. I mean, she wasn't happy but after we discussed it, she, she agreed to sign the paper.
Q. So this is a difficult situation for you to manage as you hadn't, you have told us, done such a review before in such a serious incident. Was it, in

your view, appropriate for Letby to be unhappy with the decision that you had made, bearing in mind the severity of her error?
A. No, and I think it's not that I want to use the word seniority but I think it's, you know, you have to -- she had -- she was only new into her role. I think she had only been on the unit for --
LADY JUSTICE THIRLWALL: I think quite a lot of people in the room didn't hear that because of the noises from outside.
A. She was relatively new on the neonatal unit and I think -- and I think any constructive criticism needs to be taken on board by, by nurses.
MR DE LA POER: Well, I am sure that that's right, but it is just from what you have told us in your witness statement she wasn't, apparently, taking on board constructive criticism unless what you have told us in your witness statement is not correct?
A. I just remember that she did sign the form, so I think after I spoke -- she wasn't happy that it was -- she thought it was a bit severe what I was proposing but then after I explained that this is the normal process that we would do, with any medication error, she did then sign it and then I said she could meet with Eirian the following week when she returned.

Q. Did it give you at the time any cause for concern that her reaction in the face of this error was to question your decision-making which was based on safety grounds?

A. I suppose she was just protecting her reputation. I think she didn't want to think that she -- she was being judged so harshly and I think because it had been picked up so quickly she didn't think that the error had caused any harm.

Q. What does that response say about her insight?

A. Sorry?

Q. What does her response say about her insight into that incident? Did she have good insight?

A. I think she knew the -- how detrimental it would be if that infusion continued, if that's ...

Q. What -- was Anne Murphy supportive of your decision in terms of what you had said should happen to Letby?

A. Yes, and I think the other nurse as well equally had the same, same instructions too.

Q. And did that incident lead to a change of policy, that the infusions would not be made up at the end of a night shift but would instead be made up at the start of the day shift?

A. Correct.

Q. Now, if we look, please, at the same INQ that I gave a moment ago, but page 45. That's INQ0008961.

Just try to understand -- this is a note predominantly written by Nurse Powell, I am sure you recognise the handwriting.

A. Yes.

Q. We can see that the first action is, and there is a symbol I'm not sure that I am able to interpret it:

"To continue for care for infants ..."

"IC", is that including "infusions"?

A. Yes.

Q. Yes.

A. Yes, with, yes.

Q. "Is able to check CDs" -- is that controlled drugs?

A. Yes.

Q. And then to go over with Yvonne Farmer the pump settings, calculations?

A. Yes.

Q. So if we just think about what you had decided, supported by the most senior nurse. It was, as you have told us, that she couldn't do either of those first two things until a review had been carried out and that she couldn't do either of those things until she had done the practice with Yvonne Farmer. This is seven

days later.

A. (Nods).

Q. Do you agree that on the face of it, it's something of a countermand to what you had decided should happen?

A. Yes.

Q. And we can see that it's not in fact until 6 September that those calculations are recorded as having been done?

So was this something that Nurse Powell spoke to you about at the time?

A. No. It's the first time I've seen this one-to-one form.

Q. And I mean, did you have cause to be on the ward and see whether Letby was performing infusions or checking controlled drugs following the incident?

A. I find it difficult to answer that question. I -- I suppose I acted in the best interests in her absence and Eirian then has gone on and done this other -- I don't know where she made these decisions or what her thought process ...

Q. You now sit in her chair on the unit. Was it appropriate that within seven days before the calculations were carried out that Letby was permitted to go back to being involved with controlled drugs and

infusions?

A. We have adapted a new policy within the network, so we have clear indications now if a drug error is made. So we, we have a chart which we grade the severity and depending on the severity then actions follow. And with an infusion like this, that would be quite a high level, so we would ensure that the competencies were done before they resumed.

Q. Under the current protocol this simply wouldn't be permitted.

A. No.

Q. But under the system that you were operating at the time, was it appropriate, do you think?

A. We didn't really have -- not that I am aware, we didn't really have any policies, that's why I seeked help and advice from my matron. There wasn't anything I could pick up to make her -- we just tended to do reflections.

Q. I would just like to show you one more thing. INQ0012033. That's the new version of that document, page 171, the one that was shown earlier.

So this, I hope, is something that you have seen before today?

A. Yes.

Q. And we can see here she's being asked about

the drug error, and this is on 1 August, so this is just after her meeting with Nurse Powell and just over a week after her meeting with you:

"Thankfully Eirian felt it had been escalated more than it needed to be. Everything is back to how it was and I just have to have more training on using the pumps and it will be on my record for six months. She was very supportive. It is a case of learning to live with it now and getting my confidence back. I am on nights this week. Still feeling a bit vulnerable and thinking what if, but I'll get there in time. Thanks for asking."

Just to give you an opportunity, Ms Griffiths, to say, just given what you were told on the ward on the 22nd, given the steps that you took, did you escalate it more than it needed to be?

A. No.

Q. Thank you, we can take that down.

So I am going to turn now to the children named on the indictment and we will start with Child A.

Did you have any involvement in Child A's death?

A. Not that I can recall.

Q. Do you have any recollection of any discussions about Child A's death and anything that may have been unusual that stood out?

A. No.

Q. What you do tell us at paragraph 45 is, you sent what you described as a welfare message to Letby, is that right?

A. Correct.

Q. Just help us to understand why you would have sent that message back in June of 2015.

A. I think -- I like to support staff and she was a very junior staff member and to be involved in a bereavement can be very harrowing for nurses and I felt I just needed to make sure that she was okay because I know she lived on her own and maybe just giving her an opportunity to speak if she needed to.

Q. Were you aware of the collapse of Child A's sibling, Child B?

A. I think at the time -- I mean, I have had the record since but I can't remember the collapses.

Q. And were you aware of any discussion about any similarities between the death and the collapse between the two twins?

A. No.

Q. In paragraph 51 you deal with a message that Letby sent to you on 11 June of 2015. This is your page 10 and very helpfully if I may say --

A. Yes.

Q. -- you have recreated the message in your witness statement so we can look there. This is 11 June, so this is very shortly after the death of Child A and the collapse of Child B:

"Hi Yvonne. Are you okay for staffing over the next few days? I don't have anything on if you need extra or need to change my nights?"

And then you replied and said that staffing was okay until Saturday, the 13th, and Letby replied to that:

"Ok. Think I need to throw myself back in on Sat X."

And you replied saying you hoped things would settle down by Saturday to which she replied:

"Hope so! But I think from a confidence point of view I need to take an ITU baby soon."

So you have already mentioned that she was a junior nurse who you felt it appropriate to send her a welfare message about the death of -- or following the death of Child A, just to check in on her.

In your experience as someone organising the staffing rota, how common would it be that following a pair of traumatic events that a nurse would be volunteering not only to work more but to go on to ITU?

A. I think sometimes young nurses that come into

the neonatal profession, they want to run before they walk, is the expression, and I think they have done all their nurse training, they have done their foundation course, and they feel they have got the skills to -- to work within the ITU unit. But I feel that, you know, you have to have that experience within the unit to -- years' experience, really, to become competent and that's why you need to work alongside more senior nurses.

I appreciate a lot of nurses do want to work within the ITU and that's not unusual because they are all young and enthusiastic. But they do still need that guidance and support and I think that's down to the staff on the unit to recognise that and, you know, and that's why, you know, not to bring her in for an extra shift when they have experienced, you know, a sudden collapse and, and making sure that the allocation is fair.

Q. Accepting entirely that many junior nurses in service are keen to work on the ITU, had you ever experienced a circumstance where a nurse was expressing that eagerness immediately on the back of a death and a very serious collapse?

A. I wouldn't really tend to have a lot of conversations like this over the phone. I think it was

her initiating "I want to get back to ITU", but I wouldn't, I don't have that experience on the unit that people say, "Can I get back into ITU", because of X, Y, Z, you know?

Q. So, to put that another way, you tell me whether you agree or disagree, this is highly unusual?

A. Yes. Yes.

Q. So Child C.

You record within your statement at paragraph 53 a statement made by Child C's father, about something said, and I'll just read it out:

"I remember at one point one of the nurses, I think it could have been Letby, but I am not 100% sure, came in with a ventilated basket, she turned to us and said words similar to 'You have said your goodbyes now, do you want to put him in here?' referring to the basket. The comment shook us, Mother C said, 'he's not died yet!"

Firstly, was the fact that such a remark was made drawn to your attention at the time?

A. No.

Q. Would you have expected that to be brought to your attention or would it have gone to Ms Powell?

A. Ms Powell.

Q. Do you recognise that if such a thing was

said, it was highly insensitive and upsetting?

A. As I said in my statement, it's difficult to interpret if I wasn't there. Obviously, it's a very sensitive and challenging time for both parents and nurses in that situation and sometimes comments are misinterpreted and we do often say, you know, if you would like to pop the baby back into the basket, you know, to the Moses basket, then you can get out for cuddles.

So it just depends on what context and, as I said, sometimes families find it difficult to say goodbye. So until you are actually in the room and you can't generalise because it's very individual and I think you have to be guided by the family.

So I feel very difficult to comment on this because I wasn't there.

Q. You agree that you need to be highly sensitive to the parents at what is an extraordinarily difficult time and if you are acting in that way, presumably it is possible to avoid upsetting people further?

A. Yes. I couldn't envisage anyone saying "put the baby back in the cot", but it all depends how -- the interpretation.

Q. I told you earlier that we would look at a Datix, INQ0000111. This is the Datix for Child C.

I just want to see if you can help us a little bit. If we crop in towards the middle we can see there is a section entitled "Coding" and it's recorded as a clinical incident and then the category, "Neonatal unit pick list", and I think you have told us that there were a list that you could choose from.

A. (Nods).

Q. And the subcategory is recorded as "Expected and unexpected death".

Does that help your recollection at all as to what one of the options was on the list?

A. No.

Q. No. You don't recall ever having filled in a Datix and seeing that as being the appropriate one to record?

A. I don't recall.

Q. Bearing in mind that the incident is expected and unexpected death, can you help us with why the risk grading would have been result: no harm, and the potential for harm: low harm? Are you able to just help how these various fields interact?

A. I wasn't involved in the Datixes back in 2015/16, but now a result of "no harm" means that they don't feel there was anything like a drug error or anything that has caused this death.

Q. So that's a reference to whether or not there is a belief at the time that a clinical error of some kind or a failure to provide good care may have contributed to the incident?

A. Yes.

Q. That's what you understand it to mean. So a person reading this would think this death was either expected or it was unexpected, you can't tell which from that pick list.

A. No.

Q. But that it is not suspected that a failure in clinical care contributed to it.

A. Correct.

Q. That's the interpretation, is it?

A. Yes.

Q. Thank you. We can take that down.

In terms of Datix generally, would you expect that all clinical staff involved in the care at the time of any resuscitation or the death would be recorded within the Datix?

A. Correct.

Q. So Child D.

You tell us in your witness statement that you have vague recall of a discussion re discolouration?

A. (Nods).

Q. Does that fit with your memory of Child D?
A. Yes.
Q. It is your paragraph 58 if you want to just remind yourself:
"I vaguely recall some conversation in respect of Child D's skin discolouration. However, I did not get involved in any of the wider discussions. I think staff were trying to understand why we had suddenly had three episodes so close together, which was unusual. I did not see the rashes in person."
A. Correct.
Q. So when you say staff, are you talking about nursing staff or doctors or both?
A. Nurses.
Q. Nurses?
A. (Nods).
Q. So your belief is that this was a discussion between nurses trying to understand why there had been three episodes so close together.
A. I think everyone was trying to look for, for reasons why we had so many close together and I think Nurse Oakley commented about the skin discolouration. So I never saw anything but often babies do have skin blemishes when they are born.
So I didn't really see any, anything further. It

was just something that she, she noted.
Q. When you say people are trying to find out, how were they trying to find out? I mean, Nurse Oakley is one example. She is saying, well, I saw a skin discolouration.
A. Yes.
Q. What other methods --
A. I think with anything, because I think neonatal nurses are so proud and passionate with what they do, that they always feel they are missing something, why is this happening? So I think, you know, even if you had a cannula and it tissued, you would be worried, you know.
So I think it's just we, we work one-to-one, we get quite close to the families that we work with, and the babies, and we want to find out, are we missing something? Is there anything that we can do? We didn't suspect at that time any harm, but is there something that we are unaware of?
Q. So is this nurses grouped together discussing this between themselves?
A. I don't remember nurses getting together. I mean, we, we only work with about five nurses on a shift so one or two if, the most, but I just remember the conversation being had rather than being involved.

Q. So Dr Lambie, who left in September 2015, told us about a huddle of nurses that she saw who appeared to be looking at the rota to see who was on, and her impression was this was connected to the deaths which had occurred.
Is that the sort of situation that you are describing, with nurses in ones or twos talking to each other and trying to get to the bottom of this or is that something different?
A. No, I was unaware of that being observed. The off-duty is the Bible of the unit because everybody wants to look at the off-duty because it changes that often, so it's not unusual for nurses to look at the off-duty to see who's coming on the next shift.
Q. That's obviously a routine activity. Dr Lambie was suggesting it was not looking forward but it was looking back to see who had been on duty. Were you aware of --
A. No.
Q. Now, you attended on 29 July a Neonatal Mortality Meeting in relation to Child C and Child D.
I'll just bring that up so that you can remind yourself, INQ0003297.
So we can see Child C towards the top left and then Child D, and you are recorded as the penultimate person

in the list, do you see that?
A. Yes.
Q. Now, by the time of this meeting, had you heard Nurse Oakley's comment about the unusual skin discolouration?
A. I can't remember.
Q. Do you know whether anybody at that meeting said anything about Child A and Child B and whether there was any common features between that death and collapse and these two deaths?
A. I have no recollection, I don't think so.
Q. Do you have any recollection of whether Letby's name was mentioned at this meeting?
A. No, she wasn't.
Q. Thank you very much indeed. We can take that down.
You also, in relation to Child D, attended a Level 2 root cause analysis; do you recollect that?
A. Sorry?
Q. A Level 2 root cause analysis in relation to Child D, 28 August. I'll bring it up. INQ0015152.
No. In fact I think I suggested you attended, I would just like you to remind yourself of this document to see whether it's something that you recognise.

You do deal with it in your witness statement at paragraph 65. You are recorded there as the penultimate member of the investigation team.

A. (Nods).

Q. Do you see that?

A. Yes.

Q. And if we look at page 7, it may be I'll need to help you find this, but it records that Child D had become extremely mottled, it is the entry about a third of the way down, 22 June 2015 at 01.40:

"Extremely mottled and had tracking lesions which were dark brown/black across her trunk".

Do you remember any discussion about that presentation?

A. I can't recall. No, I don't remember.

Q. Do you know whether anybody at that meeting drew attention to the fact that Child A and Child B had apparently unusual or unexplained rashes?

A. I really don't remember.

Q. Just to complete it, if we go to -- we can in fact take it down.

You, I am sure, will, having looked at this document, be able to confirm that it concluded that no root cause was identified and a post-mortem was awaited. Does that accord with your recollection?

A. Yes.

Q. Insofar as Child E was concerned, you tell us that you would have been notified -- you believe you would have been notified on your return to work the following day. At that stage, were you struck that you can recall the fact that there had been four deaths in a relatively short period of time, about 10 weeks?

A. Yes, but it was a very busy unit and so I didn't, I wasn't -- it was very sad that they had happened but it wasn't any alarm bells.

Q. You say it was a very busy unit but four deaths in 10 weeks, we know from other data, is nothing like that unit had seen in any of the time that you had been a nurse there. So really what I am asking is whether you noticed at the time that suddenly there were a significant number of deaths taking place in a short period of time by the standard of the unit?

A. Yes, I am sure I would have been at the time. Yes.

Q. I mean, you say you are sure. If I may say so, it doesn't sound as if you have a positive recollection of that.

A. I don't, no.

Q. I am going to turn now to Child I and we just need to go through this carefully, please.

So we will start, please, with the account that you gave the police. We will bring up INQ0000531. And we will go to page 2 at the bottom, please.

So the penultimate paragraph beginning "I think" says this:

"I think that during 14 October 2015 Dr Brearey may have commented to me not to give Lucy child I again for a third night. I cannot remember any specific conversation or decision in relation to this. I'm just speculating regarding anything Dr Brearey said. I think he was suspicious us of her as she had been present when several babies had collapsed."

This, as we see from the front of the statement, is a statement that you gave to the police in the context of a murder investigation into Letby, is that right?

A. Yes.

Q. You understood all that at the time and obviously you knew that you signed a very serious and important declaration at the beginning of it?

A. Yes.

Q. That account was given five years ago, just a bit more than, from today and so it was, do you agree, much closer in time to the events that you were talking about albeit it was still some years after the event?

A. Yes, correct.

Q. So that's what you said first.

Then if we can please bring up your Inquiry statement, INQ0102072, and we go to page 15, please, paragraph 71.

So we can see that in your witness statement, in fact if we just go one page up, you rehearse that extract that I have just read to you, so it's paragraph 70, the preceding page.

Do you see you quote that under Child I there?

A. (Nods).

Q. And then you go on to give the account. So we will look at paragraph 71, please, and you say this to start with:

"With respect to my discussion with Dr Brearey on 14 October 2015, I do recall having to reallocate the nurse allocation as the babies' collapses were causing a few concerns with the medical and nursing staff."

So if we just pause there for a moment.

As it's written, do you agree you are saying that you have a positive recollection of the event?

A. Yes.

Q. And you go on to give some further context:

"Despite all the cases being reviewed there wasn't anything that seemed to connect the deaths or collapses to anything specific and all the care and intervention

seems untoward and obviously the medical team were very confused."

So you are talking about a period of time, do you agree, when the medical team is confused?

A. Yes.

Q. Then you say this:

"Dr Brearey did speak to me about his concern that Letby seemed to be the common denominator to all the incidents which all seemed to happen on nights."

And then:

"This had not been mentioned to me before the conversation but I listened to his concerns and thought it was easier to reallocate care for Letby's protection."

So again, do you agree you appear to be describing a thought process that you had at the time which was to listen to what he had to say and to think, well, the easiest solution to this problem that I am being presented with, for her protection, is to reallocate her?

A. Yes.

Q. And you go on to comment:

"This was a very easy solution and one which seemed to appease Dr Brearey."

So, again, you appear to be describing Dr Brearey's

reaction to what you propose to do?

A. Yes.

Q. Again, is that a fair description of what you have put in there?

A. Yes.

Q. And at 72, your first sentence, you go on to explain your reasoning a bit more:

"I did not change allocation because I had doubts in Letby's practice but more to stop fingerpointing."

So, again, you are describing the circumstances that you have alluded to above namely there is confusion, Dr Brearey has pointed a finger, to use your phrase there, and that you have appeased him?

A. Yes.

Q. And then at 73, following your discussion with Dr Brearey:

"... I did mention my conversation and action as a result to Eirian the next time I saw her on shift which would have been the following week."

And you go on to rehearse what the two of you spoke about in that conversation, which might be summarised as neither of you had any concerns.

A. Yes.

Q. At 74, you consider Nurse T's WhatsApp messages and here we can just summarise what they say:

Letby is telling Nurse T that she has been, on the 14th, reallocated away from the care of Child I.

A. Yes.

Q. And you say:

"I remember looking at the allocation that Nurse T had completed, and I just suggested that she reallocate so that Letby wasn't allocated to Child I."

A. Yes.

Q. So, again, do you agree you appear to be describing a recollection you had of having a look at something and acting upon what you saw?

A. Yes.

Q. And you go on to say:

"This was due to it being her last night and I recall she had busy shifts in the previous nights and it was to give her a lighter load."

So, again, another recollection of exactly what you were looking at and the situation you were dealing with?

A. Yes.

Q. So at 77, just to complete this, you say:

"In respect of Child I's passing, apart from the conversation held on 14 October 2015 with Dr Brearey who raised his concerns around Letby, no other doctor or nurse spoke to me regarding any suspicions or concerns they had."

You then go on to say, as you said earlier, that you discussed the situation with Nurse Powell.

A. Yes.

Q. So that's the account in these paragraphs.

Then if we can bring up your new statement, please, INQ0108335, this, can you confirm, Ms Griffiths, is the statement you gave us yesterday?

A. Yes.

Q. It will come up on screen in just a moment.

A. Yes, that's it. Yes.

Q. And we can see that the purpose of this statement is to correct those passages that we have just looked at in some detail; is that right?

A. Correct.

Q. And you have -- you tell us that you re-read your police statement and you also re-read your Inquiry statement, that's the paragraphs 2 and 3, and then at paragraph 4 you draw attention to a document the Inquiry had provided you with, namely Dr Brearey's account of what had occurred.

And you also say that you consider, at paragraph 5, the neonatal mortality table produced by Eirian Powell.

A. (Nods).

Q. And at 7, you say you believe you were mistaken when you said in your police statement that

you'd had discussions with Dr Brearey about reallocating Letby away from Child I on or around 14 October. And then you go on to say, and we will need to go over the page:

"I believe that this was because I was confused about the time frame of events concerning Letby as I had a number of discussions with Dr Brearey about Letby after she was seconded to the risk team."

So just so we're clear about it, we're talking about therefore conversations with Dr Brearey after 1 July of 2016?

A. Correct.

Q. You go on to say that you didn't fully understand the time frame and you draw attention to the fact that Eirian Powell's table, which we know is dated 23 October, you hadn't appreciated that that postdates 14 October, which was the date you had given?

A. Correct.

Q. And so far as -- and you go on, I will just read it out:

"In other words, the evidence of 'commonality' apparent from Eirian Powell's table was not available to me at the time of the reallocation of Letby on 14 October 2015."

Then you mention the Nurse T WhatsApp messages and

you provide a reason for -- an explanation for that, you think:

"I believe that it is likely that it was decided to reallocate Child I to one of the more experienced Band 6 nurses bearing in mind that Child I was in an ITU cot."

And then paragraph 10 is just correcting a date error.

So hopefully I have reviewed with you all of the relevant parts of each of those three statements and you must say if I have missed out or overlooked anything at all.

A. No, that's very clear. Thank you.

Q. And so I just -- your position when you wrote this statement was that your two previous statements were wrong insofar as the date was concerned?

A. (Nods).

Q. And does it follow that your position is that the correct date must have been some time after 1 July 2016?

A. Correct.

Q. So let's just have a look at the point that you make about Nurse Powell's table. When you gave your witness statement to the police, you didn't have Nurse Powell's table, is that right?

A. Correct.

Q. And so your account to the police, does it follow, cannot have been influenced by any misreading of that table because you didn't have it?

A. Correct.

Q. So far as your explanation for the WhatsApp message for Nurse T, you begin the sentence that explains it with "I believe ..."

Is that you doing your best to try and explain that message based on what you know would be your normal behaviour as opposed to a positive recollection or do you now have a positive recollection of that being the explanation?

A. I believe I remember being on a late shift and looking at the off-duty and often I would intervene because the off-duty is what I do and I would always allocate the more sicker baby to more experienced nurses if I had them.

Q. So you say, "I would always ..."

So the first bit was you remember looking. The second bit is a reference to your standard practice. Does that mean that you don't have a positive record of what you did on that occasion and your reasons?

A. I do have a positive -- it was purely to change the allocation because I had more experienced nurses to look after the ITU baby.

Q. Can you just help us, given that you have that positive recollection sitting there now, how it was that that wasn't your positive recollection when you gave your statement to the police or your Inquiry statement?

A. I think following Baby I's death then we -- a table was produced and that's where the commonality became available and I know there was lots of discussions between Eirian and Steve about who was present at each death and I got confused that that was the cause of my reallocation when actually I didn't have that information until after.

Q. Accepting that memory is a difficult thing to untangle, but really what I am just asking you to consider is you are sitting there now with a positive mental picture of what happened. What my question was just trying to understand is how you didn't have that mental picture when you gave your statement to the police and to the Inquiry.

Are you able to offer any explanation for that?

A. I think after Lucy was removed, I did then have a lot of conversations with Dr Brearey. So I knew that was a concern of his and I just presumed it when I had all the information that perhaps that's influenced my decision.

Q. Just about some of the details that you gave,

just to see if you can help us with your recollection. I mean, the first sentence I read to you was:

"I do recall having to reallocate the nurse allocation as the babies' collapses were causing a few concerns with the medical staff."

I mean, is it right that sitting there right now you simply don't have that recollection?

A. I -- that, that is untrue because it wasn't until after the table had been produced that I realised the severity of, of their concerns.

Q. So can you help us with how you came to write, "I do recall ..." What was in your mind when you wrote the statement?

A. I think because I have given that many statements and I have had lots of conversations since with Dr Brearey about, about the events and I just remember reallocating the nurse assignment and I just brought that in because that's -- I had that information since.

Q. And again if we just look at something else that you said. You said:

"This was a very easy solution and one which seemed to appease Dr Brearey."

Now, do you agree post-July 2016 there was no need to appease Dr Brearey about the staffing --

A. Correct, yes.

Q. -- because Letby was not on the ward?

A. Yes.

Q. So again, just doing the best you can, why do you think that you wrote in your statement that you had appeased Dr Brearey in the course of this conversation that you were recalling?

A. I got confused and thought that the table was pre, but actually it was post Baby I's death when I gave the statement.

Q. But whenever the table was, you appear to be recounting a recollection of an emotional reaction from Dr Brearey that he was appeased.

A. Yes.

Q. I mean, that isn't anything to do with the table, that's just you remembering how he was.

A. (Nods).

Q. But if I have understood, he wasn't appeased when, in fact, you had this conversation because Letby wasn't on the ward.

A. Correct. Yes, I think he wasn't on the ward because I don't recall having a ...

Q. And just finally, and I am not looking to go over it all, but I do want to give you an opportunity to deal with some of these points.

In relation to your conversation with Nurse Powell, you say at 73:

"I did mention my conversation and action, as a result, to Eirian the next time I saw her on shift which would have been the following week. Neither of us had any concerns."

There you appear to be recalling a sequence of events where Dr Brearey told you something which you then relayed was the trigger for you to speak to Nurse Powell and I mean, do you agree that that is how it reads?

A. It does.

Q. And do you agree that in 2016, July 2016, later, that wouldn't reflect the sequence of events that occurred?

A. Correct.

Q. And so, again, just giving you the opportunity to, doing the best you can, how is it you think that that came to be in your Inquiry witness statement given what your recollection is now?

A. I think I have had that many -- that much information because obviously I've been a party since, not even during the trial but after the trial and during the Inquiry, I have had a lot more information and I have had statements given to me that other people have

written, and it's clear there that Dr Brearey had never spoken to me about any concerns over Letby and I think that is more for her -- to be confidential to work colleagues.

And I think it's following that with the chart produced in October 23rd by Eirian that she emailed that to me and that's when I was in the sequence of emails and that's where I saw it, so I got confused thinking that I had -- that Dr Brearey was concerned while I was doing Baby I's statement of allocation.

Q. So after we have undertaken that process, and I accept it's implicit in your last answer, but of the two accounts that you have given, sitting there now, which do you think is correct?

A. The revised account.

MR DE LA POER: My Lady, I have transgressed into the usual lunch period but I just wanted to finish that sequence. So I hope that that was appropriate.

LADY JUSTICE THIRLWALL: Yes, thank you.

So we will rise now for lunch and we will come back in at 10 past 2.

(1.06 pm)

(The luncheon adjournment)

(2.11 pm)

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: Ms Griffiths, we are going to move to that table that you have mentioned a number of times this morning.

We will start with the email that provides it, INQ0003106.

This is dated October 23, 2015, 5.25 in the evening, so this is after Child I has died and you are on copy to this as one the recipients, and it reads:

"Just to say I have discussed the above with Anne Murphy and on reflection it was decided to leave this until Monday. Alison Kelly was not in the hospital and Sian had just left as she was not well."

Would that be Sian Williams, the Deputy Director of Nursing?

A. Yes.

Q. "I have devised a document to reflect the information clearly and it is unfortunate that she was on. However, each cause of death was different, some were poorly prior to their arrival on the unit and others were [question mark] NEC or gastric bleed congenital abnormalities. I have attached the document for your perusal. See you on Monday. I will discuss further with Debbie on Monday."

So this is Friday, 23 October.

Were you aware on that day of any plan to escalate

this to the Director or Deputy Director of Nursing before you received this email?

A. No.

Q. Had you discussed the attachment with anyone before you received it?

A. No.

Q. Let's have a look at it. INQ0003189.

This is a table, it is -- the right-hand column is blank for medical staff but it, we have seen a version of this attached to the thematic review of neonatal mortality, but this is the first iteration, you can see, dated 23 October, bottom left-hand corner, and it comprises eight deaths, the first of which is marked "N/A" in terms of the staffing, the other seven all have Letby either allocated or on duty with her name highlighted in red.

What did you think when you received this document?

A. This is the first time that I had actually seen all the deaths collated in a chart and I think because you come to work and you are busy and you are working, you hear of a baby dying but you don't have that timeline. But I was reassured that the cause of death was actually entered on the chart, so -- and I know they were looking at the commonality and that's when I was aware, after a conversation with Eirian, that

there was a discussion about, you know, the commonality of, of staff on duty.

Q. At the point that you received this had you realised that there were, if you exclude the first death where there's limited information, there were seven deaths since June of 2015 and you were only October?

A. I would have been aware, yes.

Q. So you had had that fact in your mind as you were going about your daily tasks?

A. Yes.

Q. And did you query why it was that Letby's name was highlighted in red, why she had been picked out as opposed to other people?

A. I think following discussion with Eirian, I think there was some discussion between her and the Consultants regarding the commonality.

Q. So your understanding was that Ms Powell and the Consultants, as you have just said, had discussed Letby before this document was created and this document was created highlighting her name as a result, is that --

A. That's what I presume, yes.

Q. What, if anything, did you understand the Consultants were concerned about in connection with Letby?

A. I recollect that they were looking at all possibilities because obviously it was a higher mortality than what we would normally see, so I think they were just trying to really pinpoint and look at everything that they could possibly do.

And I know the nursing staff and the medical staff, I think both, they were looked at.

Q. When you say "all possibilities" does that include deliberate harm by a person who worked there?

A. I -- at the time I didn't think it was deliberate harm I thought perhaps it was lack of knowledge or experience.

Q. Let me be more precise in my question. Did you understand not what your concern was --

A. Okay.

Q. -- but what were the Consultants' concerns, whether they may include the possibility of deliberate harm by Letby as at 23 October?

A. I am unsure if I knew at this point in October. But I was produced, you know, I was cc'd into this email with this chart, so obviously I can't really remember but I think it must have been a concern.

Q. It must have been a concern. So something that needs to be taken extremely seriously?

A. (Nods).

Q. Would that have been your thought process at the time?
A. Yes.
Q. And it would seem from the email that sent this table that it was being taken extremely seriously because there was discussion of going to the Director of Nursing herself about it, we saw that on the email.
A. (Nods).
Q. Did that give you any reassurance or what opinion did you have about the fact that this table was being escalated to the very top of the organisation?
A. I suppose it was just to recognise that, you know, we had recognised there was an increase in deaths and I think they wanted the execs to see if they could -- for some more guidance on how they can deal with this process.
Q. Was the contacting of director level something you discussed with Eirian Powell?
A. No.
Q. So is that an inference that you drew from the information you were given in the email and the table?
A. Yes.
Q. Now, what you tell us in your witness statement, we can turn it up but I am sure it will be familiar to you, is you said you didn't consider

referring it to Alison Kelly yourself.
A. No, that's right.
Q. And your reasoning in your statement was you didn't believe there were any staffing factors?
A. (Nods).
Q. Does that accord with your recollection of your thought process at the time?
A. Yes, and I just thought, you know, I knew that this table had been escalated, so I knew that they were aware of it.
Q. So --
A. -- (overspeaking) -- cc chain.
Q. So did you think that at this time Alison Kelly was contacted?
A. I'm not sure. I just presumed, with Sian Williams being involved that, that it would be.
Q. So did you have a discussion at the time with anyone about whether Sian Williams had in fact been spoken to?
A. No.
Q. Just in relation to your belief at the time that there weren't any staffing factors. I mean, you yourself hadn't carried out an investigation, had you?
A. No.
Q. And you were being brought in to what was

clearly an ongoing conversation which involved the Consultants, is that fair, in terms of how you came to be aware of all of this?
A. Yes, but I wasn't fully aware because -- not fully aware, but I wasn't involved so much in the process of this chart.
During that time I was doing a degree, degree course in university, I was also doing the -- working clinically, so even though I had sight of this email I wasn't really in the major discussions about the processes of what to do with this information.
Q. Do you think at that stage you had an open mind about whether the Consultants might be right, or do you think you made a decision at this stage that they must be wrong?
A. I have always stayed neutral because you never really know staff and I just felt if there was that niggling belief then it needed to be addressed.
Q. When you say "neutral" are you talking about how you presented yourself to the outside world or --
A. Yes.
Q. -- what you thought internally?
A. Yes.
Q. Which was it?
A. How I presented myself to the outside world.

Q. So I am just here focusing not on what you were saying to people but what you were thinking?
A. Yes.
Q. At this stage do you think you had an open mind about whether or not the Consultants might be right?
A. I did, yes.
Q. Now, if we move forward, please, in time to the Tuesday of the following week, so this is 27 October. INQ0003107.
Here we can see the recipients are Dr Brearey and you and Debbie Peacock, and it is a continuation of the previous email, and it reads:
"I have spoken at length with Debbie this morning in relation to the mortality rates for this year. It was decided that it was necessary to create a table that includes all the doctors that was involved with the deceased patients on the unit. This would then ensure that all avenues have been addressed. Debbie was of the same opinion that we did not think there was a connection. However, we would be highlighting the issue once the report has been completed."
And so that's what Eirian Powell is saying.
I mean, did you have your own opinion about how this should be managed at this stage?

A. No.
Q. Because this appears to be the day after it was planned that Alison Kelly or Sian Williams would be contacted. Did you know whether that had happened by the --
A. No, I wasn't aware of these emails until after, you know, I know I've been cc'd, but as I say, often I was cc'd in these emails for -- email threads in case Eirian wasn't there, so I knew that both Steve and Eirian were dealing with this with the help of risk.
Q. So I mean, was it the case that you just weren't really engaging with this because you thought that the only reason you were being cc'd in was in case Eirian was absent in the future?
A. Correct.
Q. Just looking back on it as the deputy ward manager who was provided with this information, do you think you had a responsibility to do more than you did or do you think that you acted appropriately?
A. I felt as a deputy ward manager I am there to support the manager and if she asked me to be involved, I would. But when you, you know, just to clarify my hours as deputy manager was only four to five shifts, you know, seven and a half hour days a month and during that time, I was more concentrating on providing

adequate staff for the unit and constantly juggling staff to accommodate the BAPM standards.
And I just feel, you know, as the role of the manager she had a better understanding and she was actually escalating these things and I was just, I just hoped that there would have been governance and policies in place that this would have been addressed, because you've got two senior people, Eirian and you've got Steve, both highlighting that there is a potential issue so I just presumed that they would both be taking that forward rather than myself as the deputy.
Q. Bearing in mind that you were responsible for the rota, did you think that exactly what Letby may be suspected of or what the concerns may be, was very much your business when it came to the sort of children that she might be caring for?
A. Not at this time because there was no, no staff came and stated that they were concerned about Lucy's practice. Parents seemed to engage and liked Lucy. She was very competent. She was very highly skilled. She had done all the courses. So, you know, perhaps if somebody had come to me and seen something then definitely I would have addressed it.
But actually working on the shopfloor nobody saw anything to implement --

Q. Do you think that the concern of the most senior Consultant on the unit was in itself enough for you to make more enquiries so that you could take into account his concerns when doing the staffing?
A. No, that didn't occur to me.
Q. And just explain for us why do you think that is?
A. I think staffing -- she would never be the most senior nurse on duty. Unless somebody said she wasn't able to work on the shopfloor I would still utilise her within the nursing numbers because she is a Band 5 that's skilled.
So I would have -- really I would wait for direction as to not to allocate her any shifts, but if nobody has actually said that to me then I would be allocating shifts to cover the unit.
Q. Just to complete this and to test it.
If there was a competence concern that would be a reason -- as yet unidentified competence concern --
A. Yes.
Q. -- that would be a reason, for example, not to allocate her to the ITU --
A. Correct.
Q. -- where the sickest -- I was just wondering whether that thought process went through your mind at

the time in terms of taking on board the neonatal leads' concerns, whatever they were, when doing your job?
A. No, not at this point in time.
Q. So we will move forward in the evolution of this to INQ0003190.
My Lady, this is tab 12.
This is a further iteration of the table. It's dated the 19th of the 1st, and it is the same first eight cases as before but there are two more cases added to the end, so we have now got 10 cases in total. Ignoring the first one where no staffing information is provided, of the now nine cases, Letby's name is highlighted in red in either of those two staffing columns, so that's the one change.
So you had seen the earlier version.
A. Yes.
Q. Did you see this version, 19 January?
A. No. Not, not at that time.
Q. Did Nurse Powell discuss with you the fact that she had further developed her table to include two more recent deaths?
A. No. *(Redacted)*. So I wasn't aware of this until I came back to duty.
Q. Now, what you say about these charts is:
"I did not feel I needed to personally take these

charts to Alison Kelly. I was aware that Eirian was in discussion with senior management."

A. (Nods).

Q. And I just wanted to understand how had you become aware, who had told you, or what had you seen that led you to believe that during the period these charts were being produced that Ms Powell was in discussion with senior management?

A. On my return to work I saw the email thread and I could see the email thread between Alison Kelly and Eirian *(redacted)*.

Q. And just so that we can identify that date, you said that you were away for the month of January. Do you recall approximately what your return date was?

A. I looked and I think it was the second week of February.

Q. *(Redacted)*.

A. She did.

Q. You didn't participate in the CQC visit on 16 to 19 February of 2016; that's correct, isn't it?

A. Correct, I wasn't on duty.

Q. We then had the thematic review, final version, and you will know now that there were two versions of that document, the second of which, the final version had the "sudden unexpected deterioration"

part of it.

If we look at INQ0003114, the lower of the two emails is one that you are on copy to, I believe.

A. Yes.

Q. Yes. Left-hand side halfway down.

A. Yes.

Q. Did you read the thematic review when you received it?

A. Yes, I would have. Yes, if it was emailed.

Q. And the last time that you had checked in with the deaths was, you tell us, back on 23 October when you saw the table with those eight. Obviously now there were more deaths in the table. You had seen a version where Letby's name was highlighted in red but this version didn't have that.

Did you look on to those additional deaths to see whether Letby's name appeared for those later deaths as well?

A. I cannot recall.

Q. Just thinking about it. Having already seen a version of that report where her name was highlighted in red, do you think that would have been a natural thing to do, to see whether the updated versions maintained the trend that had been apparent before?

A. As I say, I came back to work *(redacted)* so

I knew the unit was extremely busy and I knew I needed to come in and support my team *(redacted)*.

(Redacted). So she did protect me a lot from this. So I mainly came back to work and concentrated on making sure the unit was safely staffed and as support as opposed to Eirian but -- and worked clinically, so *(redacted)*.

Q. *(Redacted)*. I just wish to understand about a conversation that you report or a state of affairs that you report at around this time in your witness statement. You say:

"Dr Brearey was still adamant that Letby was the common denominator but also could not pin a malpractice on to Letby. I know Eirian was protecting her nursing staff and thought it only right to include medical staff in the reports."

A. (Nods).

Q. So, firstly, I just wanted to ask about what you say about "Dr Brearey was still adamant". Was that a conversation you had with him or was that his view as relayed to you by somebody else?

A. I think Eirian -- obviously, it's all a little bit of a blur but I know Eirian, she really had no one to -- to vent to because I think we were within different directives. I felt that both, in hindsight

now, Eirian and Anne Murphy, they really didn't have the support of the upper exec team, and she really had no one to talk to.

So I think she did discuss with both myself and Yvonne, because we shared an office occasionally with Eirian, about Dr Brearey's concerns and wondered whether we had actually seen anything or had the same thoughts or witnessed anything because Eirian didn't really work on the shopfloor like we would.

And it's very difficult when I think a person is accusing somebody of something so, so huge to actually ask people "what do you think" on the shopfloor.

So it's -- yes, that's all I can say.

Q. The other part I wanted to ask you about was just this phrase that you used, "I know Eirian was protecting her nursing staff".

What do you mean by the word "protecting"?

A. I suppose I didn't mean it in that derogative, I just meant that she was a very caring and compassionate manager and that's how you should be and you should, you know, have -- and she respected her nursing team.

Had she had any clear evidence I am sure that would have been different. She wouldn't have been protecting against an act. I think she just felt more of

supportive of her team rather than protecting them from something they had been accused of.

Q. When it comes to safeguarding, do you need clear evidence?

A. Sorry?

Q. When it comes to safeguarding, keeping babies safe, do you need clear evidence?

A. I think Eirian was -- looked at those charts, and we are a small team, there were a lot of commonalities of staff on the charts, so just to pinpoint one person is very difficult.

Had we had failed competencies, failed courses, lots of Datixes regarding any, you know, abnormal, you know, any incidents, or staff complaints, then we would have had something to work on. But I think it's very difficult just to have a hearsay.

Q. Would you have any of those if the harm was being caused deliberately?

A. Pardon?

Q. Would you have any of those indicators, the competencies, concerns?

A. I didn't have any concerns, no.

Q. No, I understand. But you have given a list of potential pieces of evidence --

A. Yes.

Q. -- but my question really is: if you are contemplating the possibility of something causing deliberate harm, you might not get any of those competency concerns because the person is competent, they are doing it on purpose, and I am just wondering whether you were perhaps thinking too narrowly at that time or -- what do you think?

A. On reflection now that we have got all the information, I think you don't really know the colleagues that you work with and in work we never witnessed anything untoward and it's wonderful in hindsight when you've got all the information. But at that present time I had no concerns myself.

But, as I say, I did keep an open mind, I wasn't, you know, adamant one way or the other.

Q. Now, although you didn't attend the CQC meeting when they came for their inspection in February, I think you were interviewed by a person called Helen Cain on 4 March and hopefully you have had a chance to see the notes of that?

A. I have, yes.

Q. So the 4 March, we remind ourselves, is two days after that email that we just looked at circulating the thematic review. What -- did you draw to Ms Cain's attention the thematic review that had just

been circulated?

A. No.

Q. And looking back on the circumstances of that meeting, was that something that you think you should have done, to tell the CQC that the hospital was in the process of investigating an increase in neonatal mortality and hadn't got to the bottom of it?

A. I think when she, when CQC came and asked, I think we were given a task of things she wanted to specifically ask me about and that was more about the budget, staffing, because obviously I did staffing and I just -- so I didn't think to mention the thematic review.

Q. In terms of how the CQC was viewed at that time, were they seen as an organisation who you could turn to for support when the hospital was facing a difficult time or was there a different view?

A. At that time, being just, you know, not -- just a Band 6 nurse, I didn't really think that they could take things further. I didn't -- no, I just thought they came in to inspect, to grade.

Q. INQ0003089, please.

My Lady, this is tab 18 at page 2.

We are going to look now at an email a little later in March. If we go to page 2, we can see the origin of

this thread which is 17 March.

We have looked at this before in the Inquiry:

"I was hoping that we could arrange a meeting with you to discuss how to move forward with regards to our findings."

This is a reference to the thematic review, as subject line suggests.

Do you know why it took two weeks from when that thematic review was circulated in its final form by Dr Brearey on 2 March for it to be drawn to the attention of Alison Kelly in this email?

A. No.

Q. Just understanding how a hospital works, but also recognising that this is about an increase in the level of deaths, is that two weeks explicable in any way to your mind?

A. Once again, as a deputy manager, I never got involved in timeframes or it was just, as I say, I was often cc'd in these emails just in case Eirian wasn't around and I knew the format.

So I knew that things had been escalated and I was just hoping that obviously the governance and the policies would be in place for this to be acted upon.

Q. Did it strike you at the time that based upon how this email is written, it doesn't appear that this

was an issue that Alison Kelly had a clear understanding of before 17 March, that's certainly one way of reading --

A. I wouldn't have had a comment at that time.

Q. We know -- thank you very much indeed -- that Letby was moved to day shifts around the beginning of April. Did you participate in any way in that decision-making given that you were the person in charge of the rota?

A. I was asked if I could allocate, take Lucy off the night shift and then allocate two months' worth of day shift.

Q. What did you understand to be the explanation for that, and if it helps I will remind you what you said to the interviewer at Facere Melius:

"Steve Brearey said he had concerns but never found any evidence. He said he wasn't happy and we said we would take her off nights so we did that for a month."

So that's the account that you gave --

A. Yes.

Q. -- when interviewed. Does that capture it, that Dr Brearey is saying, "I am not happy" and to make him happy you moved her shift pattern?

A. I think Eirian obviously because of the thematic review, I think it was highlighted that a lot

of the incidents occurred during the night shift and so just to look at that commonality I think the decision was to move her onto days. That's my understanding at that time.

Q. As you describe it there, that's a decision that is being driven by Dr Brearey rather than necessarily coming from you or from Ms Powell. Does that fit with your recollection?

A. I'm not sure. I wasn't at the thematic review.

So I think I was given the report after but I think maybe it was highlighted that a lot of the incidents were during the night shift so, following that, I think maybe, I don't know how it was discussed, the decision was to pop -- to change her to a different duty.

Q. INQ0003185, please. We will look at a new table dated 15 April 2016.

As we bring it up you will know from the top of that email thread that two days after this table is dated, Ms Powell sends a chasing email to Alison Kelly. Do you know the one I mean? That's the 17 April --

A. Yes.

Q. -- so this is just two days before. This is a slightly different format to what we have looked at previously. We can see that on 15 April, Ms Powell goes

back in time to February 2016 and identifies two non-indictment baby deaths and then Child M where we can see -- and Child M didn't die, so I may be wrong about the fact that those too earlier area ones are deaths, but they are certainly two occasions, but Child M, in April of 2016 -- just a few questions about this.

Had you seen this table at the time? We understand it is created by Ms Powell as is indicated at the bottom.

A. I presume I would have been.

Q. Do you know why Dr Gibbs' name is highlighted in red?

A. I presume maybe the commonality of a Consultant.

Q. Child M collapsed just a couple of days after Letby was moved on to day shifts. Was that a connection that you made at the time?

A. Not at the time but when I had all the evidence I made that connection.

Q. And so when would you say you had all the evidence?

A. I think it was the Thirlwall Inquiry.

Q. So it is part of this process that you have seen that connection?

A. Yes.

Q. INQ0014241, please.

This is an email involving Karen Rees in a meeting that took place and I am sure you know which one I am speaking about. You are, again, on copy and there are a number of attachments including that NNU mortality 2015.

Did you have any discussion with Ms Powell about the purpose of this meeting or anything that took place at the meeting, anything that was said?

A. No, I wasn't at this meeting. And I think it was just, as I say, for my own information of what had been discussed.

Q. Thank you.

11 May 2016, so just a few days after this, we know that there was a meeting involving Ms Powell, Nurse Murphy and Ian Harvey and Alison Kelly --

A. (Nods).

Q. -- and of course Dr Brearey. In your witness statement you describe Eirian as being the voice of the nursing staff.

A. (Nods).

Q. Is that how you saw her role in all of this; that she was acting as a spokesperson for nurses?

A. Yes.

Q. So as an advocate, effectively?

A. Yes.
Q. Do you think she also had a role to protect patients?
A. Yes.
Q. And if she is acting as a spokesperson for nurses, what evidence did you see, in what she said and did, that she was also acting to protect patients as she undertook that view?
A. I think Eirian openly took these charts to the Executives and was asking them for their advice and for their help. This is something you don't see ordinarily every day and I don't feel she was hiding the evidence, that these babies were actually -- and created a chart of the staff. But as I say, we had no hard evidence of seeing ill/wrong.
And I feel if, you know, two senior people have taken these concerns forward then there should be that process to -- to look at these.
Q. I am going to move forward now to the deaths of Child O, and Child P. And, again, just to help you I will just read out what you say in your statement.
In relation to the efforts to resuscitate Child O, you say:
"I do remember Dr Brearey looking at me with concern as Letby was present but once again other than

being present, no one raised any other concerns. Dr Brearey never approached me that day to raise any verbal concerns or requests."
Can you just help us just to set the scene for when you are saying that, "Dr Brearey looked at you with concern as Letby was present"?
A. I think it's -- obviously some instance always are ingrained in your, in your mind, and I think I can, I can still visualise holding the father's hand whilst witnessing his child going through this. And I just -- so I just remember that vivid look, but I didn't really think anything at that time.
It isn't until hindsight that I thought, gosh, that's, you know. But had he maybe voiced concerns, I might have done something. But some, some scenarios are just -- are ingrained in your brain forever.
Q. You knew by then that he did have concerns about Letby?
A. Via Eirian yes.
Q. Yes. And there he is giving you this highly memorable look, as you have described it, which you in your mind have connected with the presence of Letby.
A. (Nods).
Q. Do you think at that point, given that what you were all experiencing there was the terrible and

tragic death of that baby, that after that was the time to go and speak to Dr Brearey and say, "What is all of this about?"
A. At that moment in time I didn't think I needed to. My main concern was supporting the family, so I remember sitting in the parents' accommodation, supporting the family who were grieving.
Q. Now, what Dr Brearey has told the Inquiry in his witness statement in relation to the period between the death of Child O and Child P, and I will just read it out to you:
"I had no idea at this point that Letby was returning to work the following day. I could not conceive that senior nursing staff would allocate Letby to care for the surviving triplets. I would have expected senior nursing staff to have given Letby lower acuity babies to care for after the stressful events of Child O's death and I knew at least two senior nurses on the unit [and he names Eirian Powell and Laura Eagles] were aware of the Consultants' concerns."
Now, you were the person in charge of the rota. Do you have any comment upon what you have just heard was Dr Brearey's view about that moment in time?
A. And is he referring to the day after or the day --

Q. Yes, so he is talking about the day of Child O's death, after Child O had died, about the following day. So in other words, he had no idea that Letby was returning to work and could not conceive that senior nursing staff would allocate Letby to care for the surviving triplets.
Obviously, one reading of that, although he doesn't name you, I make that clear, that you might be included within the category of senior nursing staff, and you were responsible for the rota. I just wish to give you an opportunity to comment on what Dr Brearey has said about his state of mind at that time.
A. I know I wasn't on duty on the following day when she was there and, as I say, nobody during that resus, apart from the look, nobody every came to me and said that they had witnessed anything or seen any deliberate harm. And I -- yes. That's all I can say.
Q. If Dr Brearey or Ms Powell had come to speak to you and said, "I don't think that Letby should be caring for the triplets", the two surviving triplets at that stage, "on tomorrow's shift", what would you, as the person in charge of the rota, have done?
A. I think if somebody specifically had said that, then, you know, there would have been other nurses to allocate.

Q. Obviously we know now that Child P died the following day. You report a telephone call that you were aware of after Child P's death that Dr Brearey had called, not you I hasten to add, to say that he wanted Letby removed from the neonatal unit. What was your reaction to that, bearing in mind I think you were away at a social event on that day?

A. Yes, I remember *(redacted)* and I had a phone call when we were walking up to the races off Eirian asking what had happened and had I seen anything untoward about Lucy on shift. So I said nobody had actually said anything to me in regard to having seen anything and it was no different to any of the other, you know, cases and that's where I left the conversation.

Q. You say in your witness statement:

"To believe that Letby had done anything to harm the infants was incomprehensible."

A. That is following, yes.

Q. Did you at any point up to this point reflect upon the cases of Beverley Allitt or the nurse at Stepping Hill, Nurse Chua?

A. No, I didn't.

Q. Do you think that that is something that it would have been appropriate for you to bring into your

thinking at that stage? That there are well-documented cases of nurses deliberately doing harm?

A. Yes, I appreciate, but I feel that it was being looked -- I think, you had two senior people escalating to more senior people and you just entrust that things are, policies are in place for these things to be dealt with.

Q. In the week following the death of the two of the three triplets, and the Inquiry understands that Letby worked three day shifts, that's based upon the records.

A. It is, but actually she never worked, she never came back to the unit.

Q. So was it the case that she was scheduled to work those shifts?

A. She was scheduled to work those shifts and before she -- because I think I messaged her on behalf of Eirian, because I was the person that always messaged to try and get people to work extra shifts whereas Eirian would never message a nursing colleague and it was planned for her to go and meet Eirian in Sian Williams' office.

Q. And is this before the holiday that we know she had booked?

A. Yes.

Q. Just a few more questions about events following.

You describe a meeting on 4 July of 2016 at which senior paediatricians were present, and the way you phrase it in your witness statement was:

"Consultants on a mission to remove Letby based on speculation."

Just reflecting on the way that you were describing the Consultants and what they were trying to achieve, do you think that that is a fair and balanced way of describing what they were saying at that meeting, that they were on a mission to remove Letby based on speculation?

A. Yes, I just -- it was a normal lunchtime meeting that we would all attend with paediatric staff, secretaries, myself -- well, Eirian or myself depending, and I just didn't think it was the format for that conversation.

Q. If we move forward in time to your interview as part of the grievance process -- we can turn it up if we need to -- but on two occasions, you describe the Consultants' approach as a witch hunt.

A. (Nods).

Q. Do you remember using that phrase?

A. Yes.

Q. And again, do you think that that is a fair characterisation of what they were trying to do and how they were doing it?

A. I haven't seen that grievance until the Thirlwall Inquiry, and when I read the questions I just felt -- I had never been part -- I didn't even know what a grievance meeting was. I was told I had to go and do this grievance meeting and when I read back on the questions, I felt they were very loaded and I just felt that they were questioned in such a way that they wanted me to answer to -- to look that Dr Brearey was a troublemaker.

Q. So let's just be clear about the questions you are being asked. Is this the questions being asked by the Thirlwall Inquiry or the questions being asked by the grievance process?

A. By the grievance process.

Q. Well, we have seen a corrected version of that as I am sure you have --

A. Yes.

Q. -- with tracked changes shown on and that phrase appears twice. Is it one that you used?

A. I potentially would have used that because I think there was a real strong element of "it's a nurse" rather than looking at it in a whole and

I think I was just, not angry, at the time but I think it's your whole working profession and you never think a nurse would ever do anything so evil and so harmful.

Q. Do you think it's possible that you had lost objectivity by this point to be speaking about the Consultants in the terms of a witch hunt?

A. Well, I think it was very close to, you know, you see one of your colleagues being told that they can never walk back onto the neonatal unit, that you are going to work in a secondment, you see her grief, you see the grief of, you know, gosh, all those deaths; was there something suspected?

I think I was in a lot of turmoil and now in reflection when I have got more information, because I think as a deputy you only get part of the information, you don't get the whole picture, but I was never derogative to Consultants while I was working with them and I was trying to keep an open mind.

MR DE LA POER: Ms Griffiths, those are all the questions that I have.

I think it is going to be Mr Baker, my Lady, who will be asking the first set of questions on behalf of family groups 2 and 3.

LADY JUSTICE THIRLWALL: Thank you.

MR BAKER: Thank you, my Lady.

Mrs Griffiths, I ask questions on behalf of two of the family groups. I want to begin by asking you something about the drug error issue --

A. Yes.

Q. -- which you were asked about at the very outset of your evidence.

Now, the Inquiry is obviously going to hear evidence from other people about this, but one interpretation of what happened is that Lucy Letby went over your head having, you having made a clear decision about what should happen, she went to Eirian Powell and complained about that decision and you were overruled?

A. (Nods).

Q. Now, if that is the conclusion that is reached, if that is the proper interpretation, would you with the benefit of hindsight regard that as very manipulative behaviour on the part of Letby?

A. I suppose it shows a very over competent -- confident nurse, that she -- because I think part of a nursing journey is to learn from any mistakes potentially. So when I read back and got the two statements, and I think all the text messages between her and her colleagues, I didn't think that was appropriate and I agree, I think it was quite

manipulative.

Q. It is quite grandiose and arrogant as well, isn't it?

A. It is, yes.

Q. I am going to ask you some questions about -- I was going to ask you some questions about Datix forms but I think they have all been covered by Mr De La Poer. So I am going to ask you some questions about suspicions about Letby and in particular your suspicions.

Could we turn up, please, INQ0012986.

So we can see that this is a Facere Melius interview on 30 June 2020. Do you recall that interview? Do you recall attending an interview on 30 June --

A. Yes.

Q. -- 2020?

A. Yes.

Q. If we could go to page 10 of that document, please. So at the bottom of page 10, can you see that you are asked a question by Kay Boyle:

"Okay, I suppose really were you surprised by the arrest of Lucy by that time, bearing in mind it was a year on, after the police had gotten involved?"

And over the page, you respond, if I may say so, by not answering the question but saying something else.

And there is another question from Kay Boyle about the relationship between the nursing staff and Consultants.

You respond and Kay Boyle says:

"So were you surprised?"

And you answer:

"About the police? No, not because I thought -- not because I thought she was guilty but I knew that I didn't have the answers."

Did you think by this point, 2020, that Letby was guilty?

A. No.

Q. You didn't know?

A. Did I think --

Q. You didn't know? You hadn't reached a conclusion?

A. No, I hadn't reached a conclusion.

Q. If we go to your position at the grievance interview, and this is INQ0003167, and if we could go, please, to page 3 of that document.

At the very bottom of that page, it's the section which begins "I have" -- sorry:

"It would be easy for LL to walk away but I hope that she will return to the unit. It's difficult for Letby and me as it's hard when you have lost trust. She has done wrong. However, I would hate anyone to point

the finger with the evidence. She didn't know the allegations. We are looking for a new neonatal lead. Perhaps with progression it would be easier."

What wrong did you think at that point that Lucy Letby had done?

A. I just -- it was just more an accusation or allegations rather than wrong.

Q. Well, it's recorded there --

A. I think it was meant to be "she's done no wrong" rather than --

Q. Oh, you are saying she's done no wrong?

A. Yes, rather than she's done wrong.

Q. Then in the following paragraph -- sorry, at the end of that paragraph:

"It will difficult, however, all the nursing staff are behind her and she is one of the most experienced Band 5s."

And at the final part of that section:

"We would be delighted to have her back. I've only seen her two or three times and told her we are behind her."

So you are describing there that you had had meetings with Letby and told her you were behind her, you were fighting her corner?

A. I don't think fighting her corner because we

weren't fighting for anything but just to let her know, obviously being deputy manager, we were instructed that we had to provide support for Lucy. So, occasionally, we would be asked to go and do a welfare chat/meeting and obviously when she was upset it was just reassuring to tell her that the nursing staff were still behind her, that they weren't talking behind her back negatively.

Q. Well, isn't that saying quite clearly that you were behind her in the sense that not that you were offering her support and well-being as a superior or line manager, but that you were fighting her corner, that you believed her, that you disagreed with the allegations that were being put against her?

A. I think it wasn't until -- we were all in shock as a nursing team. I think to think that one of our colleagues was accused of, of the harm that was allegated (sic) and it wasn't until we went to court that we realised there was a lot more information that we didn't have. All we had was our nursing notes and what we had witnessed whilst working alongside her. We didn't actually see the whole picture so ...

Q. Isn't that rather the point?

A. Yes.

Q. That you must have known then that there were

serious allegations being made against her, that you couldn't possibly know the answer to?

A. Yes.

Q. And rather than standing back as somebody in a position of superiority and saying it is necessary for the safety of babies that this is properly investigated, you in fact are cheerleading for Lucy Letby, aren't you, here, saying you would be delighted to have her back?

A. It sounds like that but obviously, you know, I wanted to have the clear answers as well and I never spoke to the Consultants and said she is completely innocent. But I feel that I tried to keep neutral because obviously we still had to provide a service and work together closely, nurses and doctors.

So in order to do that, you know, we had to work together and at this moment in time she hadn't been arrested for anything. So for me to, I wouldn't have done justice for her if I would have gone and said, "We think you are guilty too."

Q. Are you really saying, though, that you would be delighted to have on the neonatal ward somebody who might be a killer of babies?

A. I know it doesn't sound wonderful. I didn't mean it as in delighted and hindsight is a wonderful thing, and I'm sorry.

Q. Again, Mr De La Poer asked you if you perhaps lost perspective here, that you adopted a polarised position, nurses versus doctors, do you think with the benefit of hindsight that's what had happened?

A. No. I don't think so. I think we still worked together and I think it was just an incomprehensible situation that you never envisage that you are going to be involved in.

Q. If we could go to your Inquiry statement, please, at paragraph 103. I don't know if you can see it in front of you. This is the section where you say, and it's five lines from the bottom:

"I know Eirian was protecting her nursing staff."

A. I can't see that, sorry.

Q. You can't see that. I don't know if the Inquiry statement comes up on the screen but it may be something you have in front of you.

LADY JUSTICE THIRLWALL: I think you've got it in front of you in the folder.

A. Sorry, yes. Which section?

MR BAKER: I don't think we put the Inquiry statement on the screen.

So it is paragraph 103 and you see five lines from the bottom of that paragraph:

"I know Eirian was protecting her nursing staff and

thought it only right to include medical staff in the reports".

I mean, does that not give us a clear indication as to perspectives that you had, that Eirian Powell had, that it was necessary for the senior nurses to protect the nursing staff?

A. I don't think "protect" is the right word. But I suppose it's everyone is innocent until proven guilty and I think it's, it is incomprehensible but nobody refused to give witness statements in support of and everybody wanted to do what was right and they would never have kept anything from any statements to protect anybody. They would tell the truth.

And I think as a manager you would -- hopefully you would want somebody, if you were in a similar situation, to have their support because it could be very isolating as well.

Q. But innocent until proven guilty by whom? I mean, if you take that to its logical conclusion, do you have Lucy Letby working in the neonatal ward up until the point where the jury returns its verdict?

A. Well, no, because she was seconded by then, wasn't she, she wasn't returned to the unit.

Q. That's not my point. What I am saying to you is, at what point do you think the need to safeguard

kicks in?

A. I think it was around the time where she was -- I think February time of '17, I believe, that she was supposed to be coming back to work, or '18, and I know I felt uncomfortable about her return because I knew the Consultants were -- didn't really want her back and I knew that would cause problems between the dynamics of the nursing and the medical team.

Q. Well, in October 2016 you are describing the Consultants as engaged in a witch hunt and that you would be delighted to have Lucy Letby back on the ward. What changes between then and early 2017 that you think there's a need to safeguard?

A. I suppose I have had more conversations perhaps with Dr Brearey and I wanted to keep an open mind. So I didn't have all the information. But I think just looking at the commonalities and the protection, and I think it was just the determination of Lucy wanting to come back to work which struck me as a little bit unusual.

If you are accused of such acts why would you want to go back and work with these people?

So just a whole combination but I tried to keep an open mind because obviously I didn't have all the pieces of the information, just what I had.

Q. So looking then at suspicions about Letby and those that you became aware of, now, how did you come to write a witness statement dated 15 October 2024? What was the process that led to that?

A. Sorry, I have --

Q. How did you come to write a witness statement and sign it yesterday? What process led to that?

A. I was looking at all the information from everybody's statements because I think whilst we were in court we weren't able to discuss anything with our colleagues. We weren't able to see anybody's statements and it wasn't until I received the statements from Dr Brearey and from Eirian that I was able to put pieces together and it's very difficult when you go into court trying to -- and you have only got a small piece of the puzzle and --

Q. So when did you receive those statements?

A. It was two weeks Friday.

Q. And who sent them to you?

A. Hill Dickinson.

Q. Okay. And who did you contact?

A. I received them on a Thursday but I didn't read them until Friday and then on the Monday I contacted --

Q. Did anybody point out to you in sending those

statements particular paragraphs that you needed to read?

A. Pardon?

Q. Did anybody point out to you particular sections of the witness statement that you needed to pay attention to?

A. Yes, we had the Thirlwall's information and we had a short time to actually to get them written down.

I have actually in the year preceding the -- during the court case, I hardly took any annual leave. In August, I did manage to take two weeks annual leave which I have not done in the whole 18 months, I think, this has been going on.

Q. Sorry, why were you --

A. And I think, you know, it was difficult reading while I was -- I had a lot of statements on my phone, I am still working full time, and trying to support the team and I should have spent more time reading the statements.

Q. What I mean is, why were you sent Eirian Powell and Stephen Brearey's reports -- statements two weeks ago? And when you were sent them were you asked to pay any attention to any particular issues within them?

A. Not that I recall, no.

Q. It was only two weeks ago.
A. Yes, yes. No, no.
Q. Your original statements, and indeed your commentary to the police, are very clear in suggesting that you were -- you had a conversation with Stephen Brearey in October 2015.
A. (Nods).
Q. Your evidence this morning, as I understand it, is that Dr Brearey didn't raise any concerns with you at all before the deaths of the triplets, is that correct, in July 2016?
A. He didn't actually physically speak to me, yes.
Q. So to be clear Stephen Brearey, did not say anything to you at all about suspicions or concerns prior to the death of the triplets?
A. Correct.
Q. Can we go then, please, to INQ0003167.
Again, this is the note of the grievance interview, 17 October 2016, so even closer to the events than the Facere Melius interview of 2020.
If you can go on, please, to page 2. We can see here under "YG" -- so "CG" is a person asking you questions and "YG", that's your response. First of all, are these the questions that you were saying are loaded

and intimidating and made you criticise the Consultants?
A. I think it was obviously those questions but the actual -- I just remember, I think, Dr Brearey, I think, spent some time within the Air Force and I think they were using an analogy that sometimes they are tunnel-visioned and I remember that conversation.
And, as I say, this is all new to me. I have never done a grievance before, never been involved in one, and I think there was a lot of exchange but obviously their conversation isn't written down here.
Q. So, I mean, you have answered questions before and the question here is:
"Why were there concerns raised?"
And you say:
"There were some concerns around commonality."
But at the bottom of that paragraph, you say:
"Steve Brearey was the only one with concerns prior to the triplets."
A. Yes.
Q. Yes, so that was your recollection in October 2016.
A. Yes.
Q. Do you agree that's inconsistent with what you are saying now?
A. No, because Eirian actually spoke to me and

said that Steve has said the commonality is Lucy on shift so that's why I was aware that Steve was concerned.
Q. So you are not there recounting what you understood to be the case, namely that Steve Brearey was the one with concerns prior to the triplets?
A. (Nods).
Q. That's not your recollection that's recorded there?
A. Yes, Steve was the only one with concerns and about Lucy, yes.
Q. So you go on to say in the next paragraph:
"After the second triplet passed, Lucy was on shift the next day, then annual leave."
And you talk about a meeting that you attended on 4th July where Steve Brearey voiced his concerns:
"I was there because Eirian Powell couldn't attend. Steve Brearey wanted to go to the chief exec and we said you can't just do that on a gut feeling. He got Ravi and Dr V on board. It's not like Steve Brearey to cause trouble."
I mean, what you are describing here is that Steve Brearey had had concerns prior to the deaths of the triplets, that you were aware of, and that he then brought Ravi Jayaram and Dr V on board?

A. (Nods).
Q. Now, that's in and of itself inaccurate, isn't it, because you knew that Ravi Jayaram had concerns for a lot longer than that?
A. I was just more -- more aware that Steve had, and I think it was in this meeting when they were all there that that's when they all voiced their concerns.
But as I say, I was never in attendance to -- no Consultant ever came to me personally and made their concerns.
Q. Well, let's be clear about the use of the word "concerns" and what that means.
If you can go to INQ0000531. This is your interview with the police and if we could look on page 2, please. At the bottom, you have been taken to this section before and it's:
"During the 14 October 2015 Dr Brearey may have commented to me not to give Lucy Child A (sic) again for the third night."
LADY JUSTICE THIRLWALL: Child I.
MR BAKER: Child I, sorry.
"I cannot remember any specific conversation or decision in relation to this. I am just speculating regarding anything Dr Brearey said. I think he was suspicious of her as she had been present when several

babies had collapsed."
It wasn't concerns, it was suspicions, wasn't it, it was suggesting that she had harmed babies?
A. As I say, this is an error. And I wasn't aware of Dr Brearey's concerns or suspicions until after the table had been created and I think, as you can see, it was more "I think I had a conversation" because since I have had lots of conversations with Dr Brearey and I think it's, there's lots of information. I have given lots of statements. And I think that was an error.
Q. Well, you say you weren't aware of his suspicions until after the table was created. The first table was created in October 2015.
A. Yes.
Q. Again, what you just said now is inconsistent with what you said this morning, isn't it?
A. Well, no, because I was not aware -- because that grievance was in 2016.
Q. You said you weren't aware of his suspicions until after the table had been created.
A. I meant from him, I was aware of the commonality and Steve had raised to Eirian about his concerns that she was on, so to me that was a suspicion.
Q. So when did you become aware that Stephen Brearey had raised with Eirian his concerns

and/or suspicions?
A. After the table was created I was cc'd in that email and Eirian had spoke to me and said that, you know, Steve has got concerns because Letby is on shift at each incident.
But it wasn't until after when Baby O and P, when I was in that meeting that I heard actually Dr Brearey voice that he had concerns.
Q. So you were aware of Stephen Brearey's concerns in or around the end of 2015 when Eirian Powell told you about them?
A. Yes.
Q. So the section of your grievance interview which you suggested I may have misinterpreted, where you said that Stephen Brearey is the only one who had raised suspicions before the deaths of the triplets, in fact that was based upon your firsthand knowledge that he had raised suspicions, dating back from the end of the previous year?
A. Yes.
Q. In fact you also knew, didn't you, that Ravi Jayaram had been copied into emails to Eirian Powell about raising suspicions?
A. As I say, it was just more a conversation with Eirian. Email threads are cc'd to lots of people. But

I knew she voiced that only Dr Brearey, because he was our neonatal lead, spoke to her about the concerns.
Q. Can I very finally deal with the issue that you raised in relation to Child C.
Can I be frank and upfront about what I am about to say to you.
The -- paragraph 53 of your witness statement in which you describe reference to a ventilated basket, you know that a ventilated basket is a cold cot, don't you?
A. Yes.
Q. At paragraph 54, and indeed this morning, you were the only witness who has not expressed horror at the words that were used to Child C's parents.
A cold cot is not something you put a living baby in, is it?
A. No, and I think I just read and I realised that the mother had said, "but she hasn't died", that "the baby hasn't died yet".
Q. Yes.
A. Yes.
Q. So Letby came in with a cold cot, which is designed to keep a dead baby cool so that parents can spend longer with them?
A. Yes.
Q. And said, "You have said your goodbyes now, do

you want me to put him in here?" or "Do you want to put him in here?" and mum said, "He's not died yet."
A. Yes.
Q. That is horrifying, isn't it?
A. It is horrifying.
Q. You would, therefore, correct what you say at paragraph 54 and sharing the horror that is expressed by the other witnesses in relation to that point?
A. Yes.
Q. But can I say as well that you raise here that:
"I do not recall anyone coming to me and complaining about a nurse saying the phrase", which is capitalised above.
I can take you to your police interview, if necessary. In fact, it is INQ0007707, page 20 of that document.
This is a transcript of a recording of an interview that you gave to the police. So page 20 at the bottom. You previously described how you were working on the 12th of --
LADY JUSTICE THIRLWALL: We haven't got the page yet.
MR BAKER: We are not quite there. Yes, thank you, my Lady.

Towards the bottom there is a reference there to:
"Okay, so that was Friday the 12th."
And you have previously described, a few lines up, how mum had enjoyed holding the baby but obviously she was very anxious.
Earlier, you say that when you stopped your shift on the 12th, Baby C was in a stable condition and appeared to be doing, doing well?
A. (Nods).
Q. And that is your recollection, isn't it?
A. Yes.
Q. That is the evidence you gave in the criminal trial. So that was Friday the 12th. He passed away on Sunday but you weren't back in work until the Monday and you say that's right.
A. Yes.
Q. So Baby C died at a little before 6 am on Sunday the 14th of June. You weren't in until the Monday so you weren't there for anybody to complain to you about what had been said?
A. Correct.
Q. So there is nothing unusual at all about the fact that nobody complained to you?
A. No.
MR BAKER: Thank you.

Thank you, my Lady, I have no more questions.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Baker.
Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Ms Griffiths, a few questions first about Mother A and -- Mother A and B.
First of all, information provided to her by the nursing staff. Are you aware that she was told that her children were doing well, albeit they were premature, and that particularly Child A was doing really well?
A. Yes.
Q. And therefore the collapse and death of Child A was a complete shock both to her and to everyone else that was caring for her?
A. (Nods).
Q. What was your explanation for the death of Child A?
A. I didn't recall until I see because --
I wasn't personally involved, I don't think, in the care of Child A.
Q. The reality was, wasn't it, that there was no probable cause for his death found by the clinical staff and indeed that continued to be the case right up to and including the Inquest that took place a year later.

Were you aware of that?
A. No.
Q. Were you aware of the rashes or the mottling that had been found on Child A when he collapsed?
A. No.
Q. Or Child B?
A. No.
Q. So you are not aware of any communications about that either between the staff or between the staff and --
A. Not that I recall, no.
Q. Mother A's evidence is that she arrived, effectively, to a scene where her child had collapsed and was being resuscitated with a lot of staff around him and that during that period a nurse came up to her and asked if she wanted to say a prayer.
This was before she had been told what was going on and whether her child would die. Do you recognise that that is inappropriate to say to a mother who doesn't know if her child is going to die, in fact doesn't know what's going on, if she wants to say a prayer?
A. Yes.
Q. Another point raised by Father M in his evidence to the Inquiry is that he had the impression when he was on the unit that he felt that his child

wasn't his own and he felt that the nurses or the staff were the ones in charge and wanted to care for him rather than the parents.
Do you see that as being problematic?
A. I think when a baby is first admitted often, especially fathers, it's very stressful and distressing and I think initially if the babies do need that care then it can appear that the nurses are doing all that care.
I know now that we have Family Integrated Care, so that has changed dramatically and, you know, the family are really involved in the care.
I can't really say anything regarding that situation but I know the nurses, you know, try and encourage parents to be a part of that but I think if it's busy, the babies are needing attention, then the nurses are more concentrating on, on that. And I don't like to hear that they didn't feel that they were welcomed because that's not what we, you know, want families to feel.
Q. And also that they have contact with the child, you recognise that's important? He --
A. Especially important, and I think, you know, especially fathers, they never -- they feel too scared to hold their babies, but it's so important, so we do --

that loving close relationship, we, we, you know, we do realise that is most important.

Q. So the fact that he didn't feel encouraged to handle his child until he went to Alder Hey, that's something perhaps that shouldn't have occurred?

A. That shouldn't have occurred.

Q. Can I ask you about your reflections about what has gone on at your hospital.

You said to counsel to the Inquiry that by early 2016, you had no concerns yourself and you kept an open mind.

A. (Nods).

Q. But the reality is, from your statement both to this Inquiry and during the grievance process, is that you talk repeatedly about speculation on the part of the Consultants; in other words, they didn't have any particular concrete reason to be concerned about Letby, to be suspicious of her, they were speculating?

A. Yes.

Q. Do you recognise that that is effectively dismissing their concerns?

A. I think if I would have said that the concerns were true then I would have -- and I just don't like sides. You know, there isn't this side or that side. We all want to get to the common goal of finding out

what is the problem.

And I just -- for my own sanity I had to keep that neutral. The nurses were very upset wondering why this nurse was taken away and it was like, it's okay, we are supporting Lucy, the execs were coming in and saying, "Don't worry, Lucy is okay, she's being supported", but then I didn't dismiss, especially the latter part, going to court, the beliefs of the Consultants either.

And I think it's -- hindsight is a wonderful thing and if I would have had all the information that I received following the arrest, then that would have been a bit more clearer and I just feel often you are always in that difficult situation where not being able to disclose information, and I think that's been throughout the whole process for the nurses and for, especially the nurses because it's very difficult to share those concerns that we have about a certain member because obviously you've got to protect their, their confidentiality as well and I don't even know where I am going with this.

Q. Can I just take it in stages. Dr Brearey was a highly experienced senior doctor. He had been treating sick babies for many, many years?

A. (Nods).

Q. And there -- nobody in this Inquiry has

suggested that he was anything other than a caring, competent professional, correct?

A. Correct.

Q. He and other Consultants of similar similarity and experience began to suspect that a member of staff was harming children. That in itself, his seniority, his experience, his concern, is significant, isn't it?

A. Yes.

Q. And ordinarily, if a child comes into hospital and any healthcare professional has a concern that that child is being harmed you have to take active steps to prevent that child from being harmed any further, don't you?

A. Yes.

Q. And it doesn't -- you don't need proof of the harm, you don't need to have had a photograph of the parent injuring the child or the school teacher abusing the child. If you are suspicious you have to act, correct?

A. Correct.

Q. And indeed, that accords with one of the nurse's primary duties as a nurse, as a healthcare professional. Your first duty is to your patients; that's right, isn't it?

A. Correct.

Q. Not to your colleagues or your friends or anyone else but to the patients, the service users in the hospital?

A. Yes.

Q. So when a Consultant comes to you and says, "I am concerned that there is a member of staff harming children", the first duty you have is not to the person who may be harming the children but to the person who may be harmed; do you understand that?

A. Yes.

Q. And it's correct, isn't it?

A. Yes.

Q. It's basic.

A. (Nods).

Q. In this case, what it appears from your statement and from the contemporaneous records is that you thought that Dr Brearey was running a witch hunt against Lucy Letby, you used that word, unprompted, repeatedly, in an interview and you didn't correct it when you had the chance. In other words, there was something malicious about the way she was being treated by this senior experienced doctor.

Is that right?

A. If that's been written down.

Q. Well, you said it.

A. I did but, as I say, at the time I wasn't suspected of anything -- I wasn't suspecting a nurse to do such evil things and I think all the deaths were reviewed by a lot of senior clinicians and everything was gone through and there was a cause of death for the babies.

So I wasn't suspicious that a nurse had actually done deliberate harm.

Q. But there wasn't a cause of death, was there, for all the babies? Child A, who I have just asked you about at the start of my questions, there wasn't a cause of death, right up until the point of the Inquest, no one knew what he died from, and that was the primary problem, wasn't it, these babies had unexpectedly collapsed without explanation?

The Consultants had spent a very long time and a great deal of energy looking to see if they could find what the explanations were and they haven't found them so they were driven to the possibility that it may have been deliberate harm. And presumably they were as unwilling as everyone else to contemplate that possibility because it is horrifying but they needed tod, they had a duty to, didn't they?

A. Mmm.

Q. Now, you had that duty, too. In other words,

you needed to confront that possibility, not to think of protecting Lucy Letby from a witch hunt but to think that actually it might be possible and if it is, what do I need to do?

Do you recognise that?

A. Yes.

Q. And you weren't in a position to be 100% certain at any stage that the Consultants were wrong, were you?

A. No.

Q. Dr Holt gave evidence a few weeks ago and she said that the touchstone that she would use is that if she had to speak to her friends or her family about coming into the unit, what would she want to say to them and she would be concerned to allow anyone to come into a unit where someone was suspected of murdering the patients, and that is an obvious point, isn't it?

A. Yes.

Q. In what way did you protect these babies from being murdered in that situation?

A. I suppose my role, as I say, as the deputy manager, not the manager, taking things forward I just had to ensure that the unit was staffed appropriately, that the staff were confident.

If there was a negative culture on the unit that

didn't embrace change, guidelines, we were a very highly skilled workforce and not one of us saw anything that we would have been suspicious of and I appreciate that the doctors did have -- think of that but all they had was the commonality and I think on that chart there was a lot of commonalities, not just one nurse.

Q. Would you want to send a friend or a family member to a unit in a hospital where the senior Consultants almost unanimously thought that a nurse was killing patients?

A. Personally I wouldn't but, as I say, I didn't think that at that time.

Q. But as I say, your duty was to the patients and you weren't 100% certain they were wrong. So I am putting to you that you should have taken action personally to ensure the safety of the patients on your unit. What is your response?

A. I accept your conversation, your critique.

MR SKELTON: Thank you.

LADY JUSTICE THIRLWALL: We haven't finished yet, I just want to ask you something about the morphine --

A. Yes.

LADY JUSTICE THIRLWALL: -- pump error.

So the morphine was being pumped at 10 times the rate that it should have been, understood. That it was

observed about an hour after that had been done?

A. (Nods).

LADY JUSTICE THIRLWALL: I just would like to know, what are the parents told in that situation?

A. The parents would have been informed of the error at that time.

LADY JUSTICE THIRLWALL: What would they have been told about the reason for the error?

A. They would have just been told that it's been programmed in wrong and it's been administrated at that dose, at that rate, and it was caught within one hour and that that person has been spoken to, the two people, and that things have been put into place.

LADY JUSTICE THIRLWALL: So there would have been a full explanation to the parents?

A. Yes.

LADY JUSTICE THIRLWALL: Thank you very much. I have no other questions.

Did you have anything else, Mr De La Poer?

MR DE LA POER: No, thank you, my Lady.

LADY JUSTICE THIRLWALL: Well, thank you very much indeed for coming to give evidence today.

I realise you have been in the witness box for quite some time *(redacted)*.

Thank you for coming to help.

Now, is there a break for --
MR DE LA POER: My Lady, I am informed we need a full 15 minutes to re-arrange but my expectation is that that will not prevent a 4.30 finish.
LADY JUSTICE THIRLWALL: Very well. If we need 15 minutes, we better take that. So 4 o'clock.
(3.44 pm)
(A short break)
(4.02 pm)
LADY JUSTICE THIRLWALL: Yes.
MR DE LA POER: My Lady, the final witness for today is Nurse Anne McGlade, please.
LADY JUSTICE THIRLWALL: Ms McGlade, will you come forward.
MS ANNE ELIZABETH McGLADE (affirmed)
Questions by MR DE LA POER
LADY JUSTICE THIRLWALL: Do sit down.
A. Thank you.
MR DE LA POER: Two matters of formality before we start. The first is, can you give us please your full name.
A. It's Anne Elizabeth McGlade.
Q. Can you confirm that you provided to the Inquiry a statement dated 3 June of this year?
A. That's correct.

Q. And there are just four matters, which I will just read out to you, that you wish to correct in that statement, I will just run through them, that at paragraph 21 the word "student" should read "staff"; that at paragraph 27, "2017" should be "2016"; that at paragraph 37, in relation to the typed version of the notes that you took for your July 2016 exercise, they were prepared by someone else and the passage in red does not correspond?
A. Yes.
Q. And finally, that at paragraph 39, "2017" should be "2016"; is that right?
A. I think the "2016" should be "2017" for both of them, actually.
Q. Thank you.
Other than those corrections that you have just agreed to, are the contents of that statement true to the best of your knowledge and belief?
A. It is, yes.
Q. So we will start, please, as I understand you want to make a statement.
A. Yes, I would like to.
Before I start I would just like to give my sincere condolences to all The Families that have been affected leading us to be here today. And I am in awe at their

bravery, at the way they are dealing with what has happened to their babies.
Thank you.
Q. Thank you. If we begin with your background, please. Did you qualify as a nurse in 1996?
A. I did, yes.
Q. And did you start that same year at the Countess of Chester Hospital?
A. Yes.
Q. And did you become the children's ward manager in 2012?
A. That's right, yes.
Q. And within the management structure, was your immediate and direct line manager Anne Murphy?
A. That's right, yes.
Q. And effectively, although I daresay your unit was larger than the neonatal unit, you sat in an equivalent position to Nurse Eirian Powell --
A. That's correct.
Q. -- is that right?
A. Yes.
Q. You were both head of your respective parts with Anne Murphy sitting above both of you?
A. That's right, yes.
Q. In terms of which of the two of you, as unit

heads, would act up? Was it the position that you would act up in the event that Anne Murphy was not available?
A. That's right, yes.
Q. And were there a number of occasions over the course of 2014, '15 and '16 when it was necessary for you to act up?
A. Yes, that's right.
Q. And I think we are going to see an example of one of those occasions when it comes to the report that you participated in?
A. Yes.
Q. So having introduced you, tell us please in your own words what your perception was of the sister unit to yours, the neonatal unit; what was your view of the culture and atmosphere?
A. It was a professional relationship with the staff. They were very, they were a busy Level 2 unit and it was -- the culture was like it was on paediatrics, we are very close as a medical and nursing team and we would work together very well.
Q. In early 2015, so before the period that we are going to focus upon, did you perceive any difficulties between any of the relationships between nurses and each other and between nurses and doctors?
A. In early 2015?

Q. Exactly.
A. No, I didn't, no.
Q. No. Did there come a time when you perceived some tensions within the relationships?
A. Yes. I would say that was mid-2016 when there were -- when I initially found out there was some suspicions that a member of staff could be hurting babies on the neonatal unit and I know that my nursing colleagues, Eirian and Anne, did not feel the same way as the medical staff so I think that was potentially causing some issues.
Q. Well, we will come to that in the chronology --
A. Okay.
Q. -- but I would just like to focus on those relationships and how people were before the tensions arose.
A. Yes.
Q. What sort of manager was Eirian Powell?
A. I mean, bearing in mind I work on the Children's Unit, so Eirian, it was a very separate entity, the neonatal unit to paediatrics, but to me Eirian was a good manager.
She was fair with the staff. She had a good relationship with the staff. They had high standards on

that unit that I could see. We would both attend the meeting of managers and we would give regular updates regarding our services and yes, that was the general feel that I had.
Q. We have heard it suggested that she may have had favourites; was that something, a suggestion that you were aware as being made at the time?
A. No, I wasn't aware of that.
Q. Now, did you have a safeguarding role as part of your duties?
A. As ward manager for the children's unit yes, I would have. Part of my role would be to ensure that we adhered to our safeguarding policies and guidelines.
Q. And did that responsibility require you to attend any meetings in that capacity?
A. Yes, I would attend safeguarding meetings both as a manager and as acting up as Anne Murphy for lead nurse, so we would have regular safeguarding meetings that we would attend.
Q. And did Nurse Powell also attend those meetings or was that particular to your role as head of the Children's Unit and when acting up?
A. I can't recall actually. I think because I was acting up for Anne on some of those meetings, Eirian would not have been at those because that would

have been Anne Murphy that would have gone to that and me in turn.
So I can't, I don't recall Eirian being at safeguarding meetings that I attended.
Q. At any of the safeguarding meetings that you attended over the period 2015, '16 and '17, was a concern that a member of staff on the neonatal unit might be harming babies ever raised?
A. No, not that I can recall.
Q. In your view, would it be appropriate even if not naming the member of staff for such a concern to be raised at those meetings?
A. I don't think it would have been appropriate to have raised them at those meetings. But I do think it would have been appropriate to have raised them out of those meetings with the safeguarding team.
Q. Had any of the safeguarding training that you had received helped you to understand what you should do in the event that you suspected that a colleague was deliberately causing harm to a patient?
A. Are we referring to 2015 or now?
Q. 2015.
A. 2015, no.
Q. One thing you do say, and we will need to be clear about when in time you are talking about, you say:

"The training instructs you to report any concerns even if others may not agree or have the same concerns."
So that is quite a general statement about the approach you should take.
A. Yes.
Q. Are you there referring to training which existed in 2015 and '16?
A. So what I am referring to there is if, for example, there was a child on the ward who, for example, a nurse had safeguarding concerns for and maybe the medical staff didn't agree, as a nurse we would still have that responsibility to do that referral to safeguarding regardless of what our medical teams, you know, if they weren't in agreement.
Q. And was that the position in 2015?
A. Yes.
Q. So whilst there was no specific training on particular circumstances involving a colleague --
A. Yes.
Q. -- there was general training that it didn't matter what your colleagues were saying, if you had that concern you should act upon it?
A. Yes. Yes.
Q. Unusually, but I think it will be a helpful way of doing this, I would like to just bring up a part

of your statement on to the screen so everybody can see what you have said about safeguarding.

A. Okay.

Q. So it is INQ0101322, and we are going to go to paragraph 46, please, which is at the bottom of page 10.

This is in your reflections section so we can crop straight into that, please.

I would just like you to just remind yourself of what you said here in your statement and as you just refresh your memory from it once, you are ready I will just draw your attention to one or two elements and ask you to amplify them.

A. Okay.

(Pause)

Okay, thank you.

Q. We will need to tip over the page but I think we can start on this page.

One of the things you say in the fourth line is:

"I do not understand why Lucy Letby was allowed to continue working in a clinical environment when medical colleagues' concerns had apparently been escalated. Anyone who had allegations like these shouldn't have been working clinically."

Can you just tell us, please, why you say that?

A. Because, first and foremost, we are there to

protect patients that we are looking after. And we also have a duty of care to our staff so all allegations need to be investigated and that member of staff, in my opinion, should be removed while those investigations take place.

Q. Can I just explore with you what the threshold for that is. In the event that a doctor or a nurse thinks, "Having thought about it carefully and investigated what I can, I think there is a chance that a colleague of mine is harming babies", is that enough for action?

A. For me as a manager, yes, it would be.

Q. Now, you say two-thirds of the way down the paragraph:

"At the very least Lucy Letby should have been stood down from clinical practice earlier to safeguard the babies."

And then you say this:

"As a senior nurse in my role today I know that any nurse that works with children and faces allegations pertaining to causing harm to a baby or child would be stood down immediately until a thorough investigation had been carried out and any nurse that is accused of harming a baby or [and over the page] child would be referred to the Local Authority Designated Officer".

And you then go on to set out the procedure which is a strategy meeting.

A. Yes.

Q. And then you add this:

"As a Trust we would be expected to say how we would be investigating these issues. This process has been in place since 2013."

So, again, can I just ask you to amplify a little what you have said there?

A. So, actually, when I was putting this statement together, I Googled -- I don't have the policy that was in place at the Trust in 2015/16, but I Googled the process called LADO, so I just Googled to see how long that had been around, and 2013 was the date. So that's how I came to the date.

Q. And did you come across a document which is commonly referred to as Working Together?

A. Yes.

Q. So is it that that you discovered the 2013 version which we know there was one that set out that procedure?

A. I would have to look at the document to absolutely confirm it. But, yes.

Q. In terms of your awareness at the time of the procedure, I appreciate you are sitting here in 2024

Googling --

A. Yes.

Q. -- to just try and reconstruct things, but do you think you knew about that process in 2015/16?

A. No, I didn't. No.

Q. And who, bearing in mind that you had a role that went to safeguarding meetings --

A. Yes.

Q. -- whose responsibility would it have been in the hospital to ensure that you did know about that in 2015?

A. Well, I would have to take some responsibility of that as a manager. But I also cannot remember exactly what was laid out in our safeguarding training at that time. So I would imagine the Trust have a responsibility in terms of the training that was rolled out to ensure that we have the correct information.

Yes.

Q. Thank you. We can take that down.

So I would like to move off the topic of safeguarding and just touch briefly upon the period of Letby's training. So this is her training as a student and then her very earliest period.

Did anybody at any stage make you aware of any

concerns about the period of Letby's training?
A. The only concerns I was aware of was when she was on my ward doing her third-year last placement and she was doing her management OSCE with us, and at that point there were concerns that she potentially wasn't ready and wouldn't pass the OSCE.
Q. And did you have any direct involvement in the management of that or was that something that was taken forward with the deanery?
A. It was the deputy ward manager that was actually mentoring Lucy Letby at that time and I can't remember exactly the conversation that we would have had, but as my deputy she would have informed me there were concerns. It is very unusual for a third-year nurse to get to that stage where they are failing at that point. So it would have been a topic of conversation for us.
Q. So that is all I want to ask you about Letby's training. I want to turn next to the topic of when you first became aware of a number of facts that we now know very well.
So the first fact is: when did you first become aware that there was an increase in the mortality rate on the neonatal unit?
A. I think that would have been when I attended

a Women & Children's Governance meeting. I think that was in November or December of 2015.
Q. We are going to have a look at that document in a moment.
A. Yes.
Q. So you think that is moment in time that you first became aware of it?
A. Yes.
Q. So I won't ask you any more questions about that for now. We will come back to it.
When did you first become aware that a Consultant, or more than one Consultant, was concerned about a particular member of staff?
A. I think, and I cannot recollect exactly, but I suspect that was around June/July of 2015.
Q. If we date stamp a moment in time, you were asked in early July together with Dr Gibbs --
A. Yes.
Q. -- to undertake a review. Do you think it was before or after that request?
A. It was before.
Q. And do you think it was immediately before, as part of your briefing for that, or do you think you had known for some time?
A. No, I don't think I had known for some time.

I think it was around that time.
Q. And when you first learned that a Consultant or Consultants were concerned about a particular member of staff, did you also learn at the same time that their concern was about the possibility of deliberate harm or was it not so clearly defined as that?
A. It's hard to remember due to the passage of time but I think it was around -- the suspicions were that it was related to a member of staff.
Q. And deliberately or incompetently or was it not specified?
A. I think the inference was it was deliberate. Yes.
Q. And doing the best you can, who do you think you learned this from?
A. This would have either been at one of our Monday lunchtime senior clinicians meeting, with the Consultants, or it would have been a conversation with Anne Murphy and Eirian Powell.
Q. Now, we know that on 27 June there was a senior paediatrician meeting --
A. (Nods).
Q. -- the Monday meeting, at which the evidence suggests that the Consultants were speaking openly about their concern that deliberate harm may have been caused.

Does that sound like the meeting that you are recollecting, where there is an open conversation or was it more guarded?
A. I don't think I was at that meeting so I think it was afterwards I found out those concerns.
Q. So we have also heard about a meeting on 4th July, we just heard about that from your colleague Nurse Griffiths. Might that have been the occasion --
A. Possibly.
Q. -- if not the 27th?
A. Yes.
Q. You worked in the same department but on a different unit.
A. Yes.
Q. Do you think you should have been told sooner than that of those concerns?
A. We were, at that time, which is very different to how we work now, we were very, very separate units. So whether I should have been told or not, I wasn't.
Q. Now, we will just look briefly at a couple of documents. The first is the one that you have referred to, the Women's & Children's Care Governance Board of December 2015. This is INQ0004371.
We can see that Dr Brearey attended in lieu of Dr Jayaram, do you see that about halfway down?

A. Sorry.
Q. It is the entry immediately above your name.
A. Oh, yes. I can see Dr Jayaram -- yes, sorry, Dr Brearey attended.
Q. Dr Brearey has attended in his stead?
A. Yes.
Q. And you are identified in the row below?
A. That's right, yes.
Q. So we don't need to go through these minutes but just doing the best you can, what's your recollection of what was said at this meeting about the increase in the mortality rate?
A. I'm afraid I have no recollection of the report that would have been presented at that meeting.
Q. But you can see that you were there.
A. I was, yes.
Q. And you have no reason to doubt the minutes.
A. No, no, not at all no.
Q. If it had been the case that Dr Brearey or other Consultants were by that stage concerned about Letby, in particular, was that an appropriate forum for that to be raised?
A. I -- I couldn't -- yes, I would say it would be an appropriate forum for that to have been raised.
Q. Because you have said it wouldn't be

appropriate to raise it in one of your safeguarding meetings but I am just really trying to look at, within the governance structure, how does something like that get reported up?
A. Yes, yes.
Q. And, to your mind, having been at such meetings --
A. Yes.
Q. -- even if the member of staff is not named, is it your view that nevertheless something should be said there?
A. Yes.
Q. Thank you. We can take that down.
In February of 2016, did you meet with the CQC?
A. Yes, I did, yes.
Q. And was that effectively to show them round your ward?
A. That's right, yes. Yes, it was a full inspection that was carried out over several days.
Q. And by that stage, we can see from the meeting that you knew something about the increase in the neonatal mortality?
A. (Nods).
Q. In your view was that an appropriate forum for you, showing the CQC around the Children's Unit, to be

mentioning what you were aware of in the wider department or was that for the neonatal unit to say?
A. It's not that it wouldn't be appropriate for me to say it. I think the assumption that I would have had, and had, was that as they were doing a review of the neonatal unit, that the increase in mortality would have been discussed at that point.
Q. So you would have expected your colleagues on the neonatal unit to say something about that to the CQC?
A. Yes, and I would have expected the CQC to have asked about that. Yes.
Q. Now, there came a moment in time where you were told about something you have described as gossip.
A. Yes.
Q. Do you think that was before or after you were informed in early July about the Consultants' concerns?
A. It was after.
Q. And did you take steps to make clear that such gossip, as you viewed it, was not appropriate?
A. Yes. Because at that point I was aware that allegation, serious allegations had been made by the Consultants and that reviews were taking place. And obviously this was so sensitive that, yes, you know, we had to -- the message very clearly coming to us as

managers was that we had to make sure that this wasn't being gossiped about because that would be very unfair for the investigation process.
Q. Dealing with your reaction to learning about the Consultants' concerns and obviously subsequent gossip, you describe yourself as shocked and horrified that someone could do this.
A. Yes.
Q. And did you become aware of what your nursing colleagues, Nurse Powell's and Nurse Murphy's, views were?
A. Yes.
Q. And how soon after you learned of the Consultants' concerns do you think that was?
A. I think it was all around the same time.
Q. Did you speak to them directly and in private or is it simply conversations in public spaces or when others were present that you learned of their position?
A. I am assuming you are talking about Anne and Eirian.
Q. Yes.
A. We would have had a private conversation and I did ask how they could be so sure as to know that it could possibly not be the case. I wasn't privy to, at that point, the information that they had been given

from our medical colleagues, but I could only assume that maybe they didn't have the full picture because of their views that they had.

Q. So let's just examine that just for a moment.

A. Yes.

Q. The starting point is: did they tell you what they thought about the Consultants' views?

A. They told me what the Consultants' suspicions were.

Q. And did they tell you about their own opinion about those suspicions?

A. They said that -- I think they wanted a more generic approach to what was being investigated, to not rule anything out.

Q. You use the phrase in your witness statement that "they didn't agree".

A. Yes. Yes.

Q. And when you are saying they didn't agree, are you saying they didn't agree that there were grounds to be suspicious? Is that what they weren't agreeing with?

A. They -- they didn't agree and hence wanted a more generic look at what potentially could be going on.

Q. That, of course, prompted you to say. How can you be so sure --

A. Yes.

Q. -- that there are no grounds to be suspicious presumably?

A. Yes.

Q. That is what you were challenging them on.

A. Yes, yes.

Q. And what did they say in response to that challenge?

A. I think the initial comments were that other people were present at the times of potentially, you know, collapses, et cetera. But, again, I wasn't privy to a lot of the information that perhaps they were or they weren't privy to.

Q. And was that all that was said between you or was there any other discussion that emanated from their response?

A. No, no.

Q. A final matter to ask you about, Ms McGlade, is your review with Dr Gibbs.

A. Yes.

Q. You were asked to undertake that review with him, is that right?

A. That's right. Yes.

Q. Do you think you were appropriately qualified to do the role that you undertook with him?

A. The remit of the -- what I was asked to do was to look at nursing notes of a list of babies that we were given and to look for something that looked, you know, sorry. The remit that we had was for babies that had been transferred out after collapse. And we were given a list of the babies to look at, I looked at the nursing notes, Dr Gibbs looked at the medical notes.

So from a point of view of areas that could be suspicious or unusual, that was led by Dr Gibbs because yes, you are quite right, I am not a neonatal nurse and for me, you know, that isn't my area of speciality.

Q. So you say that I am quite right. Does it come to that perhaps you weren't quite the right person to be undertaking that role of looking at the nursing notes to look for what was suspicious in a specialty that wasn't yours?

A. I think -- undertaking the remit that we had, I think I was able to do that. But what I wouldn't have been able to do, and didn't do, was say that, you know, I thought this was wrong or this, you know, Dr Gibbs very much led that.

Q. But Dr Gibbs was only looking at the medical notes, he wasn't looking at the nursing notes, so he wouldn't be able to do that from a nursing perspective; is that right?

A. What was happening, he would read out the medical notes, I would read out the nursing notes, so he would know what I was looking at. Yes.

Q. But he wouldn't have a particular nursing perspective on what --

A. No, and obviously as a children's nurse, I can, you know, pick out some situations that looked unusual. But that would always be confirmed by Dr Gibbs.

Q. And in summary, is this right, that of the 30 or 40 cases that you looked at, six stood out as unexpected deteriorations or collapses?

A. That's right, yes.

Q. So even assuming 40 cases, someone will check my maths, but I think that's 15% of the cases that you were looking at?

A. (Nods).

Q. Did you regard that as a very small number and not a cause for concern or did you think, gosh, that's quite a lot of cases where we don't have an explanation?

A. I think, personally, that's quite a lot, yes.

Q. Did you ever convey that opinion about the number that you had uncovered to anybody outside of your conversation with Dr Gibbs?

A. No, because I wasn't asked.

Q. Did you ever receive any feedback on the work that you had done and how it fitted into the larger picture?

A. No.

Q. And were you expecting either you or Dr Gibbs to receive some feedback?

A. Yes.

Q. And so what did you think happened to the work that you and Dr Gibbs did?

A. My understanding was that it was going to be part of a larger review, that it was going to be looked at from a staffing point of view because part of the remit of what we were doing, we weren't looking at doctors or nurses that were taking care of the babies, we were purely looking at the medical and nursing information.

So my understanding was that our report was then going to be looked at, analysed and the staffing grid would be, would be looked at.

Q. Now, you have described it as a report. In fact, in terms of what you handed over, was it some handwritten notes that you had made along the way?

A. Absolutely, yes. So it wasn't -- we hadn't tidied it up, there was no conclusion written there, was no introduction, it was literally just some handwritten

notes.

Q. Was there any discussion about how you and Dr Gibbs could formalise what you had found so as to help the next stage of the process?

A. I was never asked to do that. I don't know whether Dr Gibbs was.

Q. Do you think, looking back on how that process was conducted, that that was in fact a necessary step that was missed out; that you and Dr Gibbs drew your conclusions together and made them absolutely clear what it was that you were saying?

A. Yes. Yes.

Q. Those are all the factual matters I want to ask you about.

I just want to return to safeguarding and a recommendation that you gave.

You propose that the chair considers this:

"Any suspicions about someone working in healthcare needs to be taken escalated, taken seriously, and that member(s) of staff needs to be stepped down from clinical work immediately whilst investigated and for allegations as serious as this, police need to be informed immediately."

A. Yes.

Q. And is that your reflection on how things

might have turned out differently?

A. Yes.

MR DE LA POER: Yes, Nurse McGlade, thank you very much indeed for answering my questions.

My Lady, those are all the questions that I have. There are no Rule 10 questions.

LADY JUSTICE THIRLWALL: Thank you, Mr De La Poer.

MR DE LA POER: I beg your pardon, my Lady, I am just having Mr Kennedy drawing my attention and I think as this is a witness who comes under his umbrella, I should just speak to him if I may.

LADY JUSTICE THIRLWALL: Yes, of course.

(Pause)

MR DE LA POER: Mr Kennedy, and I have an understanding. There is no need for any further questions.

LADY JUSTICE THIRLWALL: Very well, thank you very much.

Thank you very much indeed, Nurse McGlade, for coming, for providing a statement and helping us this afternoon, you are free to go now.

A. Thank you.

LADY JUSTICE THIRLWALL: So we will start again at 10 o'clock tomorrow morning.

MR DE LA POER: My Lady.

LADY JUSTICE THIRLWALL: Thank you, all, very much indeed.

(4.37 pm)

(The Inquiry adjourned until 10.00 am, on Thursday, 17 October 2024)

I N D E X