

Wednesday, 16 October 2024

1
 2 (9.58 am)
 3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
 4 **MR DE LA POER:** My Lady, the first witness today is
 5 Nurse Yvonne Farmer, please.
 6 **LADY JUSTICE THIRLWALL:** Would you come to the
 7 witness box please, Ms Farmer.
 8 MS YVONNE FARMER (affirmed)
 9 Questions by MR DE LA POER
 10 **LADY JUSTICE THIRLWALL:** Do have a seat.
 11 **MR DE LA POER:** Please can we begin with your full
 12 name.
 13 **A.** Yvonne Farmer.
 14 **Q.** Ms Farmer, can you confirm, please, that you
 15 provided the Inquiry with a witness statement dated
 16 7 June of this year?
 17 **A.** Yes.
 18 **Q.** And are the contents of that witness statement
 19 true to the best of your knowledge and belief?
 20 **A.** Yes.
 21 **Q.** Turn to your background. Did you obtain
 22 a degree in nursing practice in 2001? I have taken that
 23 from your --
 24 **A.** Oh, yes, yes.
 25 **Q.** And did you complete a Neonatal Intensive Care

1

1 **A.** I did.
 2 **Q.** -- is this right, in 2015?
 3 **A.** Yes.
 4 **Q.** Your first role, as you tell us, was
 5 a non-clinical Band 7 with the title Neonatal Practice
 6 Development Nurse?
 7 **A.** Yes.
 8 **Q.** Had you held that role since 2009?
 9 **A.** Yes.
 10 **Q.** We will come back to what that involved in
 11 a moment.
 12 **A.** Okay.
 13 **Q.** But just to introduce your second role, was
 14 that a clinical Band 6 Senior Nurse?
 15 **A.** Yes, it was.
 16 **Q.** With responsibilities as a shift leader on
 17 occasions or otherwise caring directly for babies?
 18 **A.** Yes.
 19 **Q.** So as to your first role, the Neonatal
 20 Practice Development Nurse, tell us what that involved
 21 you doing.
 22 **A.** My role was as a neonatal educator based on
 23 the unit. So I worked predominantly with students, new
 24 staff and existing staff ensuring that they were
 25 inducted into the unit, that they attended the courses

3

1 Course in 2000?
 2 **A.** Yes.
 3 **Q.** And an Enhanced Neonatal Practice Course
 4 in 2002?
 5 **A.** Yes.
 6 **Q.** And at around the same time, I think it was
 7 2000, did you also complete the Nurse Teaching and
 8 Assessing Course?
 9 **A.** Yes.
 10 **Q.** And having completed that course, did you
 11 shortly thereafter move to the Countess of Chester
 12 Hospital?
 13 **A.** I did, yes.
 14 **Q.** Did you begin work on the neonatal unit?
 15 **A.** Yes.
 16 **Q.** And so you had been on the neonatal unit for
 17 something approaching 15 years --
 18 **A.** Yes.
 19 **Q.** -- at the time of the period that we are
 20 focused upon?
 21 **A.** Yes.
 22 **Q.** And finally, just to complete your background,
 23 did you retire in 2019?
 24 **A.** I did, yes.
 25 **Q.** Now, Ms Farmer, you held two roles --

2

1 that were available.
 2 Basically I constructed a programme of development
 3 so I worked with different individuals when they started
 4 and I had overall view of the training and education and
 5 the staff on the unit.
 6 **Q.** And how many hours a week were you allocated
 7 to that role?
 8 **A.** I think it was about 21 and a half but it did
 9 vary as clinical needs sometimes dictated.
 10 **Q.** Putting that another way, does that mean
 11 sometimes you were needed on the unit clinically --
 12 **A.** Yes.
 13 **Q.** -- and so you had to step back from educator
 14 role?
 15 **A.** I did, yes.
 16 **Q.** I understand. And your second role was, as
 17 you have identified, a clinical Band 6 Senior Nurse.
 18 Again, just give us an idea of what that required you
 19 to do.
 20 **A.** Yes, I was a shift leader but sometimes I was
 21 allocated as shift leader or sometimes I was given
 22 a workload. But at that time, as shift leader, we also
 23 had a small workload as well.
 24 So I might have a patient, a couple of patients
 25 that weren't intensive care. So I had overall view of

4

1 all the patients on the unit and allocated staff
 2 according to their experience and needs.
 3 **Q.** So does it follow that you got to interact
 4 with your nursing colleagues both in an educational
 5 capacity, when appropriate --
 6 **A.** Yes.
 7 **Q.** -- but also as a side-by-side colleague --
 8 **A.** Yes.
 9 **Q.** -- or in a quasi management role/shift leader?
 10 **A.** Yes, yes.
 11 **Q.** What was your view about what the NNU was like
 12 as a place to work?
 13 **A.** I really enjoyed working on the neonatal unit.
 14 It was always an area that was looking to develop,
 15 always trying to maintain safe practice. We worked well
 16 with the medical team. It was a very small unit so
 17 I felt we were a very close team and we did try and
 18 support each other when we were on shifts.
 19 **Q.** And when you say a close team are you speaking
 20 there principally about your nursing colleagues?
 21 **A.** Yes, yes.
 22 **Q.** So the nursing team was close?
 23 **A.** Yes, yes.
 24 **Q.** Well, let's just focus upon the nursing team.
 25 **A.** Okay.

5

1 to them.
 2 We had always advertised study days so we would
 3 allocate and she would make sure that it was divided
 4 equally so that not the same people went to study days.
 5 So ...
 6 **Q.** Now, how about the relationships with the
 7 doctors? Again, in summary, what was your experience of
 8 that?
 9 **A.** On a personal level I didn't have any problem
 10 with the Consultants. The Registrars rotated so -- but
 11 during that time, I think we had Registrars that were on
 12 for quite some time so we did get to know them and in my
 13 role as practice development, I did work quite closely
 14 with some of the Registrars if we were introducing a new
 15 practice.
 16 On a personal level, I didn't have a problem.
 17 **Q.** The way you have expressed if, I may just
 18 observe, is to say that there wasn't a problem?
 19 **A.** Yes.
 20 **Q.** Was it a positive relationship?
 21 **A.** Yes, yes.
 22 **Q.** Or was it --
 23 **A.** Yes, because of the nature of the unit, it had
 24 to be a positive experience.
 25 **Q.** How busy in 2015/2016 was the neonatal unit?

7

1 **Q.** On the unit, Eirian Powell was the most senior
 2 person --
 3 **A.** Yes.
 4 **Q.** -- from a nursing perspective. What was she
 5 like to work for?
 6 **A.** I always got on very well with Eirian. I had
 7 known Eirian since I started so we did develop into our
 8 roles together. So I felt she was an approachable
 9 manager.
 10 She would always come in early so that she met with
 11 the night staff going off, so she was not only -- she
 12 saw both members of staff, day staff and night staff.
 13 So in that way she was a very visible manager.
 14 **Q.** Now, the Inquiry has received some evidence
 15 from amongst your nursing colleagues about a "circle of
 16 trust" was a phrase that one nurse used. Others have
 17 used the phrase "favourites" in terms of Ms Powell.
 18 **A.** Right.
 19 **Q.** Is that something that you recognise as
 20 applying to the neonatal unit in your experience?
 21 **A.** I don't think -- no, she didn't have
 22 favourites. She ensured that all staff developed. She
 23 offered opportunities. If staff approached her about
 24 a development role or different opportunities that were
 25 within the Trust she was always very willing to listen

6

1 **A.** As I recall, we had some very busy moments and
 2 I feel certain we must have had some quieter moments but
 3 you always remember the busy times.
 4 So there were quite stressful shifts. But because
 5 of our unit, we weren't an intensive care Level 3 unit
 6 so it was peaks and troughs. But it felt busy.
 7 **Q.** It felt busy?
 8 **A.** Yes.
 9 **Q.** Did it feel busy out of all proportion to what
 10 had come before, or did it just feel like it was
 11 a busier phase?
 12 **A.** Well, in my experience I did have busy years,
 13 some years or some times seemed busier. So I just
 14 accepted the fact that we had quite a few babies that
 15 year.
 16 **Q.** One of the things that you comment upon in
 17 your statement is about the restructuring of the
 18 divisions within the hospital?
 19 **A.** Yes.
 20 **Q.** And the fact that paediatrics was placed into
 21 the Urgent Care Division.
 22 **A.** Yes.
 23 **Q.** Do you want to just tell us what your
 24 perception was about the effect of that?
 25 **A.** Yes. Well, when I first started on the

8

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

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

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

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

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

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

9

1 **A.** Not really, no.

2 **Q.** Datix.

3 **A.** Yes.

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

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

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

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

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

19 **Q.** You don't remember?

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

23 **Q.** No need to apologise. We may come back to
24 that.

25 But the third area of policy and procedure is

11

1 think?

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

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

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

10 **A.** No.

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

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

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

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

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

21 **A.** I don't think so. No.

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

10

1 debriefs?

2 **A.** Yes.

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

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

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

15 **A.** I don't know. I don't know.

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

19 **A.** Not, not always, no.

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

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

12

1 a teaching process, but I don't really remember.

2 **Q.** And would that be formally recorded if, if it
3 was used as a teaching --

4 **A.** If it was used as teaching, I would imagine
5 so, but it might have been from a medical perspective.
6 So it wasn't something as nurses we did amongst
7 ourselves.

8 **Q.** So we are going to turn now to your
9 involvement with Letby and you tell us quite a lot about
10 the period before 2015, starting with the fact that you
11 completed the list of relevant requirements with her on
12 29 January 2012.

13 **A.** Yes.

14 **Q.** And at that stage, did you have any concerns
15 about her competence, her attitude or her approach?

16 **A.** No. I had met her on the unit as a student
17 and then she was taken on as a permanent member of
18 staff. So that was the first -- we completed that
19 within the first few weeks, so no.

20 **Q.** We have heard about her last placement and the
21 fact that there were difficulties upon it. Were you
22 aware of those?

23 **A.** No, I wasn't, no.

24 **Q.** In your role of inducting Letby into the unit,
25 would you have been expected to be told about any

13

1 **Q.** And through your involvement with that period,
2 did you arrange for Letby to attend training at the
3 Liverpool Women's Hospital?

4 **A.** I did, yes.

5 **Q.** Following completion of that NMC requirement,
6 were you aware that Letby attended the Neonatal
7 North-West Induction Programme?

8 **A.** Yes.

9 **Q.** Was that a standard part of --

10 **A.** Yes.

11 **Q.** -- the training programme?

12 **A.** Yes.

13 **Q.** Did that include a further placement at the
14 Liverpool Women's Hospital?

15 **A.** It did, yes.

16 **Q.** And at the end of all of that process, was
17 there further training and observation leading up
18 to a conclusion that she was safe to practise
19 clinically?

20 **A.** Yes, yes, she had a mentor in Liverpool
21 Women's as well as a mentor on our unit during the --
22 the course of the training.

23 **Q.** And so far as you were aware, at the time that
24 she emerged from that training programme, was Letby safe
25 to practise, from your perspective?

15

1 problems during the student period or, from your point
2 of view, does somebody simply arrive qualified?

3 **A.** Because she was interviewed prior -- I wasn't,
4 I didn't interview her. If she was interviewed or if
5 another member of staff had concerns, I would imagine it
6 would be part of her references.

7 So I had no knowledge that that had occurred,
8 so ...

9 **Q.** Now you speak about a requirement of the
10 Nursing and Midwifery Council called the period of
11 preceptorship --

12 **A.** Yes.

13 **Q.** -- which is a period of approximately
14 six months.

15 **A.** Yes.

16 **Q.** And during that period, a new starter is
17 allocated a mentor, is that right?

18 **A.** Yes.

19 **Q.** And did you have some oversight role over that
20 process?

21 **A.** She had a clinical mentor.

22 **Q.** Yes.

23 **A.** And I made sure that she completed, she had
24 a file and I made sure she was completing all the
25 relevant competencies within that six-month period.

14

1 **A.** As far as I was aware, yes.

2 **Q.** I think that in your educational role you
3 facilitated Letby's attendance at a number of courses.

4 **A.** Yes.

5 **Q.** I'll just run you through them: the Cheshire
6 and Merseyside Neonatal Intensive Care Course?

7 **A.** Yes.

8 **Q.** The neonatal advance life-support course?

9 **A.** Yes.

10 **Q.** And the mentor and assessing course?

11 **A.** Yes.

12 **Q.** Now, would that be with a view, that mentor
13 and assessing course, with a view to Letby herself
14 mentoring students?

15 **A.** Yes.

16 **Q.** And throughout all of those courses, were you
17 available to receive feedback about any concerns?

18 **A.** Yes, yes.

19 **Q.** And were you informed of any concerns?

20 **A.** No.

21 **Q.** Now, in March 2012, so if we just recap, it
22 was the end of January 2012 that you completed the list
23 of relevant requirements and that six-month period
24 began --

25 **A.** Yes.

16

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

5 A. Yes, yes.

6 Q. -- that Nurse ZC has spoken about?

7 A. Yes, yes.

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

11 A. Right.

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

14 A. No, I don't, no.

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

19 A. Yes, yes.

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

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

17

1 A. Yes.

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

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

11 And further figures are given.

12 Then the action taken is shown a little below:

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

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

21 A. Yes.

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

25 A. Yes.

19

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

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

7 happen --

8 A. No, but --

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

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

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

14 A. Yes.

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

17 A. Yes.

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

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

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

24 A. Yes, yes.

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

18

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

3 A. Okay.

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

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

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

15 A. Okay, okay.

16 Q. -- which was 30 July --

17 A. Okay.

18 Q. -- so it was eight days later.

19 A. Okay, right.

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

22 A. Yes, yes.

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

20

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

21

1 Q. I would just like to consider the timing of
 2 this and we know from other documents and we will come
 3 to it in a moment --
 4 A. Yes.
 5 Q. -- that the morphine infusion was changed just
 6 before the end of the shift.
 7 A. Yes.
 8 Q. That's something that you can recollect?
 9 A. As part of the incident, yes.
 10 Q. Yes.
 11 A. Yes.
 12 Q. And following this, there was a change in
 13 policy --
 14 A. Yes.
 15 Q. -- saying that it shouldn't be changed at the
 16 end of the shift.
 17 A. Yes.
 18 Q. Just help us to understand a little bit more
 19 about those circumstances and what would be going
 20 through a nurse's mind at the end of a shift and why
 21 they would change a morphine infusion like this?
 22 A. I think if it, if it was a very busy shift
 23 it's not really ideal to start setting up infusions,
 24 especially morphine. Perhaps they wanted to just get it
 25 set up ready for the next member of staff. It's hard to

23

1 Q. So we are here talking about the two nurses
 2 who were involved in signing out --
 3 A. Yes.
 4 Q. -- the drug?
 5 A. Yes.
 6 Q. Well, we will come back to that in just
 7 a moment.
 8 A. Okay.
 9 Q. But again, it's formed part of the training
 10 you have told us?
 11 A. Yes.
 12 Q. And that includes calculation?
 13 A. Yes.
 14 Q. I mean, at this stage, Letby is not far into
 15 her career as a nurse?
 16 A. Yes.
 17 Q. But she's well outside the period of formal
 18 supervision --
 19 A. Yes.
 20 Q. -- that the NMC requires?
 21 A. Yes.
 22 Q. And what is the expectation about her being
 23 able to operate autonomously for things like this?
 24 A. Yes, yes, it would be an expectation, as
 25 a Band 5, to work autonomously.

22

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

24

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

3 **A.** Yes, yes.

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

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

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

14 **A.** No.

15 **Q.** And we can then see recorded:

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

18 Presumably that's because it was caught very
19 quickly?

20 **A.** Yes.

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

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

25 **Q.** Potentially very harmful or -- can you comment
25

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

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

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

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

14 **A.** Right.

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

20 **A.** (Nods).

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

24 **A.** Yes.

25 **Q.** -- would it be normal for somebody in that
27

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

2 **A.** Yes. Well, morphine, because it was
3 a controlled drug, it's a controlled drug for a reason.

4 So that's why I am saying it's serious.

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

7 **A.** Yes, sustain. Yes.

8 **Q.** But it may:

9 "Sustain from checking any intravenous infusions."
10 I think it may mean "refrain", meaning don't?

11 **A.** Yes.

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

14 **A.** Yes.

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

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

20 **A.** Yes, yes.

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

23 **A.** Yes, yes.

24 **Q.** The earlier entry, so the one above with my
25 word, not the word given, "Refrain from checking any
26

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

2 **A.** Maybe not. Yes.

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

6 **A.** Yes.

7 **Q.** I am sure you teach upon the subject.

8 **A.** Yes.

9 **Q.** I mean, how important is insight?

10 **A.** Gosh, you mean insight from --

11 **Q.** To recognise when you have made a mistake?

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

13 Well, I would imagine very important, yes.

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

19 **A.** No.

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

25 **A.** As regard to checking drugs or?
28

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

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

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

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

11 Q. So let's have a look at your meeting.
12 INQ0008961, page 45, it is the preceding page,
13 my Lady.

14 **LADY JUSTICE THIRLWALL:** Thank you.

15 **MR DE LA POER:** In tab 6.

16 So is this a form that you recognise?

17 A. Yes.

18 Q. And presumably that's your handwriting?

19 A. Yes.

20 Q. And so we can see:

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

24 A. Yes.

25 Q. Now, would that have emerged from a discussion

29

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

4 A. Yes, yes.

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

8 A. Yes, yes, controlled drugs. Yes.

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

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

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

16 A. No.

17 Q. -- because that doesn't come until
18 6 September?

19 A. Yes, yes. Yes.

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

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

31

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

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

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

6 A. Yes.

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

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

11 Q. I entirely understand. So it's 6th of the 9th
12 2013 entry only, is it?

13 A. Yes.

14 Q. That's your handwriting?

15 A. Yes.

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

18 A. Is Eirian's writing.

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

21 A. Yes.

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

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

30

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

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

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

10 Q. That is likely to be right.

11 So if we have got our chronology straight --

12 A. Yes.

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

16 A. Yes.

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

19 A. Yes.

20 Q. But the calculation --

21 A. Yes.

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

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

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

32

1 with the document that's being shown that it's the
 2 updated version from yesterday -- I am told it is. I am
 3 very pleased to hear that. INQ0012033.
 4 So this is on the 1st August and we don't need to
 5 worry about who's sending the message:
 6 "Hi Lucy, how are you? What happened over the drug
 7 error?"
 8 So it is talking about what had been happening over
 9 the last few days.
 10 **A.** Right.
 11 **Q.** To which we can see that Letby replies:
 12 "Thankfully Eirian felt it had been escalated more
 13 than it needed to be. Everything is back to how it was.
 14 I just have to have more training on using the pumps and
 15 it will be on my record for six months. She was very
 16 supportive, it is a case of learning to live with it now
 17 and getting my confidence back. I am on nights this
 18 week. Still feeling a bit vulnerable and thinking about
 19 what if, but I'll get there in time. Thanks for asking.
 20 Hope you are okay."
 21 So if we can take that down.
 22 Now, from your perspective as someone who was
 23 involved in part of this incident, do you think that
 24 Yvonne Griffiths escalated it further than it needed to
 25 be with her reaction?

33

1 **A.** (Nods).
 2 **Q.** Again, how would you categorise that as
 3 an error? Is it a minor error or a major error?
 4 **A.** It is not a minor error, so possibly a major
 5 error.
 6 **Q.** So if we look down into the large paragraph
 7 towards the bottom, so the largest of the paragraphs, we
 8 can see the words "on reflection", near the very centre
 9 of that text. I am sure it will be highlighted in
 10 a moment.
 11 And what Letby has written is:
 12 "On reflection I feel this situation was
 13 unavoidable."
 14 **A.** (Nods).
 15 **Q.** Now, again, from your perspective as an
 16 educator, if you give a patient a drug which was not due
 17 and had not been prescribed, is that an unavoidable
 18 error?
 19 **A.** Sorry, could you repeat that again?
 20 **Q.** Of course, yes. We can see that the drug was
 21 not due and had not been prescribed.
 22 **A.** Yes.
 23 **Q.** Is that capable of being described as an
 24 unavoidable error?
 25 **A.** No. But if it hadn't been prescribed I don't

35

1 **A.** Well, Yvonne Griffiths was the deputy manager
 2 and with the absence of the manager her next level would
 3 be the matron. So it was a joint decision and at the
 4 time, that was a good decision.
 5 **Q.** So again, just going back to what you
 6 understand about insight. Does it appear from that that
 7 Letby is demonstrating insight into the seriousness of
 8 what she did?
 9 **A.** It's difficult to say, really, I would say.
 10 **Q.** On the subject of errors, and we are going to
 11 move to a different error now, and we are going to jump
 12 right forward in our chronology to April 2016.
 13 My Lady, you have this at tab 6.
 14 I'm just going to bring up a reflection written by
 15 Letby.
 16 INQ0008961 at page 49. It is the final page behind
 17 tab 6, I hope.
 18 We might be able to crop into that a little bit.
 19 This is a reference to an antibiotic error.
 20 **A.** (Nods).
 21 **Q.** And we can see that what Letby has written
 22 was:
 23 "It wasn't due and had not been prescribed."
 24 So giving a drug to somebody who wasn't in need
 25 of it?

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1 understand -- well, I don't understand why it was given
 2 if it wasn't prescribed. So I don't know.
 3 **Q.** Is it always going to be an avoidable error?
 4 **A.** Yes, yes, if it's not prescribed then ...
 5 **Q.** You only have to look at what's prescribed to
 6 see that it isn't there and you avoid making that
 7 mistake.
 8 **A.** Yes, yes.
 9 **Q.** Again, it will be my final question about your
 10 perception of Letby's insight. Does this show good
 11 insight and reflection from somebody following an error
 12 or not?
 13 **A.** She has written that she should have been more
 14 aware and greater effort made to ensure that all the
 15 checks were made. So she has made some statement there
 16 but ...
 17 **Q.** Yes. Although she has also said it was
 18 unavoidable.
 19 **A.** Yes.
 20 **Q.** What's your view?
 21 **A.** It's hard to say really without -- I don't --
 22 I have read the incident. I don't remember the
 23 incident, so I think -- obviously it shouldn't have been
 24 given, the Gentamicin, so perhaps it is poor insight,
 25 you know, it's difficult to say really.

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1 Q. Thank you. We can take that down.
 2 We are now going to focus, please, upon the
 3 children named on the indictment who died and in
 4 particular what you thought at the time.
 5 And we will just start with an overview which is
 6 how you begin in this part of your statement. You begin
 7 at paragraph 66 -- you don't need to turn it up unless
 8 you want to, I'll just read it to you:
 9 "I was informed by my manager that Dr Brearey and
 10 later Dr Jayaram had suspicions about the conduct of
 11 Lucy. However, I do not remember when and after which
 12 neonatal death this occurred."
 13 A. (Nods).
 14 Q. Right. I just want to see if we can better
 15 understand that and the timings.
 16 Obviously, we know, and it's very well established,
 17 that there were three deaths in June of 2015.
 18 A. (Nods).
 19 Q. The death of Child E at the beginning
 20 of August of 2015 and the death of Child I on 23 October
 21 of 2015.
 22 A. (Nods).
 23 Q. So a number of deaths on the neonatal unit
 24 and, as we know from other evidence, those weren't the
 25 only deaths.

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1 staff what did that make you think?
 2 A. I was quite shocked that he thought that
 3 a member of staff was directly involved in harming
 4 babies. It wasn't something I had ever anticipated
 5 hearing or I wouldn't have expected a colleague to
 6 purposely harm babies.
 7 So I think it was quite shocking to hear that.
 8 Q. And did you take it upon yourself to speak to
 9 Dr Brearey to better understand what it was that he was
 10 worried about?
 11 A. No.
 12 Q. Again, just help us to understand what the
 13 relationships were at the time. Although you had some
 14 managerial responsibilities when you were shift
 15 leader --
 16 A. Yes.
 17 Q. -- you weren't the most senior nurse on
 18 unit --
 19 A. No.
 20 Q. -- but, nevertheless, you were extremely
 21 experienced and had been there a long time?
 22 A. Yes.
 23 Q. Do you think that it would have been
 24 appropriate for you to go and speak to Dr Brearey
 25 yourself to say, "I just want to better understand

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1 A. (Nods).
 2 Q. But focusing on the children named on the
 3 indictment. Just thinking about it now, do you think it
 4 was during 2015 that you first heard?
 5 A. Possibly. It might have been following
 6 a meeting with Eirian and the doctors. I think they
 7 were having lots of -- they reviewed quite a few notes
 8 and they were trying to find a commonality, as in
 9 a clinical one, and Eirian told me that they were also
 10 looking at staffing and there were two nurses and
 11 a doctor that seemed to be on for some or the majority
 12 of the shifts.
 13 So that's when she told me that they were looking
 14 at staff, and Lucy was one of the members of staff.
 15 Q. Was that the occasion, whenever exactly it
 16 occurred, that she told you that Dr Brearey was
 17 suspicious?
 18 A. Yes, it must have been, yes.
 19 Q. And so just doing the best you can, and we
 20 will have a look at some of the detail in moment, do you
 21 think that is likely to have been before Christmas 2015,
 22 so at some point in 2015?
 23 A. Possibly, possibly, yes.
 24 Q. And when you heard that the neonatal lead
 25 Consultant was suspicious of a particular member of

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1 this"?
 2 A. No, I didn't feel in a position at that time
 3 to go to Dr Brearey directly, no. Because there were
 4 lots of reviews and I didn't know where that allegation
 5 was going. So no, I didn't take it upon myself at that
 6 time.
 7 Q. And you had an awareness that there were lots
 8 of reviews going on.
 9 A. Mmm.
 10 Q. Did you have the thought that perhaps the
 11 senior managers, so up to the board level, should be
 12 made aware of something as potentially serious as that?
 13 Was that a thought process that you had at the time?
 14 A. I assumed at some point that they would be.
 15 Q. Was that something you ever discussed with
 16 anyone or were told about?
 17 A. No.
 18 Q. So that's, best as you can, the Dr Brearey
 19 awareness?
 20 A. Yes.
 21 Q. What you also say is "later Dr Jayaram", so
 22 now we have got the most senior --
 23 A. Yes.
 24 Q. -- Consultant in the entire children's
 25 department?

40

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

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

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

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

44

1 they were so close.

2 **Q.** And then a few weeks later, Child E at the
3 beginning of August. Again, do you have a recollection
4 of that being a trigger for you to think, "This isn't
5 a usual period for the NNU"?

6 **A.** No.

7 **Q.** Just looking back on it, why do you think that
8 that that -- I mean, you can see it laid out now.

9 **A.** Yes.

10 **Q.** But why at the time do you think that that
11 sort of thought process wasn't triggered in your mind?

12 **A.** I think because we were so -- we were busy,
13 everyone was doing their own jobs, and if you weren't
14 there at that time, or you hadn't gone to -- if there
15 was a debrief you hadn't been involved, I think you were
16 just so involved in your everyday working that it didn't
17 really stand out in your mind.

18 **Q.** And then in terms of children named on the
19 indictment deaths, towards the end of October 2015,
20 Child I. Might that have been the event that -- the
21 death that you were talking about or do you think it was
22 later than that that the concerns of Dr Brearey or
23 potentially Dr Jayaram started to emerge?

24 **A.** Can I check on who Child I is, sorry?

25 **Q.** I don't know if we have a cipher --

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1 Baby I passing away.

2 **Q.** The baby you are speaking about for
3 Dr Jayaram, was that a baby who died or a baby who
4 didn't die?

5 **A.** A baby that died, I think.

6 **Q.** Well, just try one more fact --

7 **A.** Okay.

8 **Q.** -- that we know to be true, which is that
9 following the death of Child I --

10 **A.** Yes.

11 **Q.** -- Eirian Powell created a table.

12 **A.** Ah, right, okay.

13 **Q.** Which -- on the same day, which highlighted
14 Letby's name in red.

15 **A.** Right, okay.

16 **Q.** Now, she sent that to Yvonne Griffiths and
17 other people, the emails that we have don't indicate
18 that you had received it --

19 **A.** No.

20 **Q.** -- which is why it hasn't formed part of your
21 evidence pack.

22 **A.** Yes.

23 **Q.** But were you aware of any table having been
24 created by Nurse Powell identifying each of these deaths
25 and who was on duty and in particular that Letby was

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1 **A.** Oh right, okay.

2 **Q.** -- list.

3 Oh, you do have a cipher list. No, I am corrected.

4 **A.** Because --

5 **Q.** It was quite wrong of me to --

6 **A.** Who --

7 **Q.** Yes, obviously, it's very important you don't
8 mention the name but by all means, remind yourself.

9 **A.** Yes. I do know that baby. I'm not sure, I'm
10 not sure if it was Baby I. I think it was another baby.

11 But I think that was the time that Dr Jayaram had
12 concerns after a different baby.

13 **Q.** So let's just try to understand that.

14 **A.** Yes.

15 **Q.** So do you think that Child I was the trigger
16 for you learning Dr Jayaram's concerns, so Dr Brearey's
17 concerns must have come before Child I's death or -- I'm
18 just trying to understand what you are saying there.

19 **A.** Yes, sorry.

20 **Q.** No, you don't need to apologise.

21 **A.** I can't remember the infant. There was an
22 infant that Dr Jayaram was particular -- talked about,
23 a baby that was ventilated. I think that's after that
24 point, that's when Dr Jayaram was more involved. But
25 I don't remember the date, I'm afraid. But I knew about

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1 identified?

2 **A.** I may have been, but, I can't say for
3 definite.

4 **Q.** Well, we will move forward in time, please, to
5 the CQC visit which we know took place between 16 and
6 19 February 2016, and I think you have had
7 an opportunity to refresh your memory --

8 **A.** Yes, yes.

9 **Q.** -- from some notes that have been provided.

10 **A.** Yes.

11 **Q.** By mid-February 2016, do you think you had an
12 awareness that the neonatal unit had been experiencing
13 an increase in the rate of death?

14 **A.** Well, I knew there was an increase to the
15 normal amount of infant deaths. Yes.

16 **Q.** And was that something that would have been
17 appropriate to raise in your meeting with the CQC, do
18 you think?

19 **A.** Not the involvement that I had, no.

20 **Q.** Just explain to us why that is.

21 **A.** Well, I was -- from the documents, I was shown
22 showing the group round and it just seemed to be like an
23 environmental audit. So you are obviously in an open,
24 with -- on the ward, and it wasn't something that
25 I thought about myself personally discussing with the

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1 CQC. I didn't feel it was my role to discuss that sort
 2 of thing.
 3 Q. Do you have any recollection of whether you
 4 were thinking at the time somebody else would do it or
 5 was it simply not on your mind?
 6 A. It wasn't on my mind.
 7 Q. And do you think it is something that should
 8 have been on your mind at that time?
 9 A. It's easy to look back on hindsight and say
 10 yes, it should be -- it should have been on my mind but
 11 at that time it wasn't on my mind, so ...
 12 Q. We know that on 2 March of 2016, the thematic
 13 review of neonatal mortality report in its final version
 14 was circulated to a number of people.
 15 A. (Nods).
 16 Q. Did you receive a copy of that report?
 17 A. On an email, yes.
 18 Q. And did you read it?
 19 A. Yes.
 20 Q. And what were your conclusions, having
 21 read it?
 22 A. That there were quite, that it was a thorough
 23 report and they had looked at all the different clinical
 24 reasons. It suggested lots of areas for improving
 25 practice, policies, I think I -- my -- I was named as
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1 appeared next to the babies?
 2 A. I think I noted that she had been on but
 3 hadn't been looking after the babies specifically.
 4 So I believe I was aware that she was on the shift
 5 but hadn't necessarily looked after the baby, babies
 6 themselves.
 7 Q. What was your own state of mind then about
 8 whether there was a problem that needed investigating?
 9 A. Because it was being looked after by senior
 10 people, I assumed that that would be looked at.
 11 Q. We know that Letby was moved to day shifts in
 12 early April --
 13 A. (Nods).
 14 Q. -- and we know that the thematic review had
 15 identified that six out of the nine deaths had occurred
 16 between midnight and 4 am?
 17 A. Yes.
 18 Q. Were you aware of Letby being moved to day
 19 shifts?
 20 A. Yes. Yes, I think it was discussed with me
 21 that that was the plan; that because of all the recent
 22 incidents, deaths, that they had occurred during the
 23 night, so that's why she was being moved on to days as
 24 support for her. If, if it was a training issue or if
 25 she needed emotional support, then there were lots of
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1 part of -- in some of the actions which I would have
 2 been obviously alerted to. And then there was
 3 an addendum, which looked at all the staffing that were
 4 involved and then there was an area -- a point that
 5 Dr Brearey and Eirian Powell were going to look at
 6 specifically, the staffing side of it.
 7 That's what I remember from it.
 8 Q. It is a matter you comment on in your
 9 statement but I'll ask it in an open way. Do you think
 10 that report alerted you, the reader, to staffing factors
 11 and the --
 12 A. Not specifically because there was such a lot
 13 of information in the report and I think I would have
 14 been looking at all the different actions and obviously
 15 the few that I was involved in, not specifically looking
 16 at -- because Eirian and Dr Brearey were going to
 17 review, that was something that would have followed this
 18 review. So ...
 19 Q. By this stage, the thematic review, were you
 20 aware of the concerns about Letby that the Consultants
 21 had?
 22 A. Amongst the Consultants, I must have been,
 23 yes.
 24 Q. And being aware of those concerns, did you
 25 look at the appendix to see whether Letby's name
 50

1 people around, the managers were around, so ...
 2 Q. Was any part of the explanation that you were
 3 told for her move to days, to keep babies safe?
 4 A. No.
 5 Q. Were you aware of the sudden and unexpected
 6 collapse of Child M just a couple of days after she was
 7 moved to day shifts, on the day shift?
 8 A. Can I refer to who Child M is, please?
 9 Q. Of course.
 10 A. No, I am not familiar with that baby, so, no.
 11 Q. Did you know that there was a meeting with the
 12 Executive Directors between Nurse Powell, Dr Brearey on
 13 11 May?
 14 A. No.
 15 Q. That wasn't something that was discussed with
 16 you beforehand?
 17 A. No.
 18 Q. Were you -- did you have any discussion about
 19 it afterwards?
 20 A. No, I don't remember that at all. No.
 21 Q. We know that following that meeting, an email
 22 was sent on 16 May -- you aren't on copy to that email,
 23 so let me assure you about that -- indicating that
 24 sudden and unexpected collapses should be drawn to the
 25 attention of Nurse Powell or Dr Brearey?
 52

1 A. Okay.
 2 Q. Were you aware of any such instruction having
 3 been given?
 4 A. No.
 5 Q. So we reach Child O, and Child P in the latter
 6 part of June of 2016. Prior to the deaths of those two
 7 children, did you have any suspicions or concerns that
 8 any child may have been deliberately harmed?
 9 A. No.
 10 Q. And what was your view at that time of the
 11 concerns that had been expressed by the Consultants?
 12 A. I think because there seemed to be lots of
 13 meetings going on, that it was being taken seriously and
 14 it was being investigated so -- but I wasn't directly
 15 involved, so I assumed that's what was happening.
 16 Q. You describe the death of Child O as
 17 unexpected.
 18 A. Yes.
 19 Q. And was that also your view of Child P's
 20 death?
 21 A. Yes.
 22 Q. I think you were involved in the resuscitation
 23 of Child P?
 24 A. Yes.
 25 Q. And so were you aware that Letby was present

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

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

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

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

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

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

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

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1 A. Sorry.

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

5 A. Yes, yes.

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

9 A. Yes, maybe more --

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

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

13 **LADY JUSTICE THIRLWALL:** Thank you.

14 **MR DE LA POER:** Finally, to draw attention to one
15 of the recommendations that you propose. You say:
16 "I would recommend Safeguarding training for all
17 NHS staff to include a clear process of what to do if
18 there are suspicions or they witness abuse of patients
19 by a member of staff and encourage a culture to speak
20 out."

21 A. Yes.

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

24 A. Yes, yes.

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

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1 A. Yes, yes.

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

4 A. I must have been, yes, yes.

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

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

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

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

20 A. Right, okay.

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

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

25 Q. Do you remember any discussion about any

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1 indeed. Those are my questions.

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

6 **LADY JUSTICE THIRLWALL:** Very well.
7 Mr Skelton.

8 Questions by MR SKELTON

9 **MR SKELTON:** Thank you.
10 Ms Farmer, I ask questions on behalf of one of the
11 family groups.

12 A. Okay.

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

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

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

18 A. Yes.

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

23 A. Not specifically but ...

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

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1 rashes or mottling being seen on Child A?

2 A. No.

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

5 A. No.

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

10 A. Yes.

11 Q. And the other of which is learning?

12 A. Yes.

13 Q. Is that right?

14 A. Yes.

15 Q. That's correct?

16 A. I think so, yes.

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

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

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1 But again, it was usually with the people that were
2 involved in the incident.

3 **Q.** So a debrief is the type of -- the second form
4 of debrief is the type of information sharing --

5 **A.** Yes, yes.

6 **Q.** -- meeting by the professionals to understand
7 what had happened?

8 **A.** Yes.

9 **Q.** And if there had been similar factors between
10 collapses and deaths between two children, A and B in
11 particular, would you expect those to be discussed in
12 a debrief?

13 **A.** If they followed the same pattern, do you
14 mean?

15 **Q.** Yes, if there had been similarities.

16 **A.** Possibly.

17 **Q.** Can I ask you about the treatment of Mother A
18 and B after Baby A died. Obviously she was in the very
19 difficult position of having to return to the unit
20 because her daughter was still there --

21 **A.** Yes.

22 **Q.** -- and was still being cared for?

23 **A.** Yes.

24 **Q.** Do you appreciate now that that's an
25 extraordinarily hard position for a parent to be in --

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1 so no.

2 **Q.** Did you ever speak to Dr Brearey or Dr Jayaram
3 about their concerns?

4 **A.** No.

5 **Q.** Do you accept now, looking back, that you may
6 have closed your mind to the possibility that she was
7 harming children without any curiosity as to what had
8 actually happened to the children?

9 **A.** Well, following the trial, there was a lot of
10 information that I wasn't aware of. I worked with her
11 as a colleague, we had a professional relationship and
12 that was my understanding; that she was a professional.

13 So I didn't have all the knowledge that we now know
14 about it, so I -- I can't really say more than that,
15 really.

16 **Q.** Were you aware of Beverley Allitt? She was
17 a professional nurse.

18 **A.** Yes.

19 **Q.** And you are aware of Victorino Chua, who was
20 also a nurse, and both of them had killed patients.

21 **A.** Yes.

22 **Q.** Dr Shipman, of course, famously, killed over
23 100 patients.

24 **A.** Yes, but it didn't cross my mind that that was
25 happening at that time.

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1 **A.** Oh, yes, very much so.

2 **Q.** -- one child has just died but the other is
3 still alive?

4 **A.** Of course.

5 **Q.** And she doesn't feel she was treated, at least
6 by all the staff, with the necessary sympathy and
7 consideration when she returned.

8 **A.** I am very sorry to hear that.

9 **Q.** Do you appreciate that she should have been
10 treated very sensitively given that she is coming back
11 to the scene of her other child's death?

12 **A.** I would have expected her to be treated
13 sympathetically.

14 **Q.** Mr De La Poer asked you about your
15 reflections. As I understand your evidence, throughout
16 2015 and 2016, you had no suspicions about Lucy Letby
17 harming children?

18 **A.** No.

19 **Q.** Did you ever review any of the babies' notes?

20 **A.** No.

21 **Q.** So you had no personal understanding of the
22 circumstances in which the children had died --

23 **A.** No.

24 **Q.** -- or collapsed?

25 **A.** No, they weren't available to be reviewed,

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1 **Q.** Why did you close your mind to the possibility
2 that she was harming patients without having yourself
3 conducted any form of investigation and without having
4 spoken to the two very senior clinicians that did
5 suspect her?

6 **A.** I just felt it was unconceivable that
7 a colleague would harm babies. So that was my view at
8 that time.

9 **Q.** Do you recognise that that opinion was
10 a mistake, given what you now know?

11 **A.** Well, obviously, now I know, it's very
12 devastating. So, yes. Yes.

13 **Q.** Have you got any reflections on the fact that
14 you and other nursing staff appeared to have closed your
15 minds to that possibility without taking any active
16 steps to ascertain the truth yourselves?

17 **A.** I think that's a very unfair question really
18 because we are all absolutely devastated, it's had
19 a massive effect on us all. So it's a very emotional
20 time. So it's hard to -- of course we have all
21 reflected on it, so -- but we only knew what we knew at
22 the time and could only make decisions on what we knew
23 at that time, so ...

24 **MR SKELTON:** Thank you.

25 Questions by LADY JUSTICE THIRLWALL

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1 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.

2 Just to pick up on the last question. Do you think
3 now that it's inconceivable that a nurse would harm
4 babies?

5 **A.** Well, not, not with what I have learnt from
6 all the police investigations, no.

7 **LADY JUSTICE THIRLWALL:** I'm just thinking, sort of
8 moving on, because I imagine there may have been those
9 who thought like that at the time of Beverley Allitt.

10 **A.** Yes, yes.

11 **LADY JUSTICE THIRLWALL:** I'm just wondering what it
12 is you think that would make you think the unthinkable,
13 perhaps that's an impossible question to answer but ...

14 **A.** Yes, because if a member of staff had had
15 concerns on the unit, we were a very small unit, nobody
16 raised any concerns, like, from -- none of the nurses.
17 I know I have heard evidence that they had a huddle but
18 nobody actually came and spoke to me about it.

19 **LADY JUSTICE THIRLWALL:** No one spoke to you
20 about it?

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** Yes.

23 **A.** So I think communication was quite lacking in
24 that respect. If people had suspicions perhaps they
25 should have voiced them. So perhaps we didn't have an

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1 **A.** Yes, yes.

2 **LADY JUSTICE THIRLWALL:** -- for 6 September. And
3 I just wanted to understand whether, when you wrote it
4 on 6 September, you were talking about a process with
5 Letby or whether in fact it was a single occasion --

6 **A.** Yes.

7 **LADY JUSTICE THIRLWALL:** -- when you completed
8 practice calculations with her.

9 **A.** I think it was part of a process because she
10 had a workbook to work through and then the calculations
11 were an addition and we had a competency for the use of
12 the pump, and I know we went through that --

13 **LADY JUSTICE THIRLWALL:** Yes.

14 **A.** -- and I asked her to input different doses.
15 So she actually knew -- I was confident that she knew
16 how to input the dose, whether it was a mistake, it
17 sounds like it was a mistake in the inputting rather
18 than the actual calculation.

19 **LADY JUSTICE THIRLWALL:** Yes, I think we have seen
20 from the documents, it was -- she made a mistake with
21 the pump.

22 **A.** Yes, yes.

23 **LADY JUSTICE THIRLWALL:** And I presume that all of
24 that had been tested before?

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

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1 open enough relationship, I don't know.

2 **LADY JUSTICE THIRLWALL:** Thank you.

3 Can I just ask you briefly about the incident with
4 the morphine.

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** I don't want to take a lot
7 of time on it but I really just want to understand what
8 your role was.

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** We can see from the
11 document which is INQ0008961, page 45, we have looked at
12 it already --

13 **A.** Yes.

14 **LADY JUSTICE THIRLWALL:** -- most of it, you told
15 us, in Eirian Powell's writing.

16 **A.** Yes.

17 **LADY JUSTICE THIRLWALL:** And it looks as though she
18 has a one-to-one with Lucy Letby on 30 July.

19 **A.** Yes.

20 **LADY JUSTICE THIRLWALL:** And at the bottom she then
21 writes, "Review in six months, January 30th".

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** So her contribution to the
24 document finishes at that point and then you have
25 written yours above that --

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1 **LADY JUSTICE THIRLWALL:** So was there any
2 discussion about how come she had made a mistake? Did
3 you have any discussion with her about that?

4 **A.** No, not really. She did, she was with another
5 member of staff who had checked it as well so we had two
6 people at that time who had made the mistake.

7 **LADY JUSTICE THIRLWALL:** Were you involved in
8 dealing with that nurse as well?

9 **A.** No, no. No. No, she was a very senior nurse
10 and she almost resigned over the incident, following the
11 incident and so she had more meetings with Eirian --

12 **LADY JUSTICE THIRLWALL:** I see.

13 **A.** -- rather than myself.

14 **LADY JUSTICE THIRLWALL:** Thank you, thank you very
15 much indeed. Actually, there was one other question.

16 You mentioned that you had gone along to the
17 meeting which was about the post-mortem for Child A.

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** And the reason that you
20 had gone, I think I have got this correctly, it was for
21 your own professional development.

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** Was that because you had
24 not previously gone to such an event?

25 **A.** Yes. Yes. I think in the past, we, it was

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1 always an open invite if anybody wanted to go.
 2 **LADY JUSTICE THIRLWALL:** Invitation, yes.
 3 **A.** As part of, as I have said, my development
 4 it's important to have an overview of all the different
 5 sort of meetings, areas to go to.
 6 **LADY JUSTICE THIRLWALL:** Was also a part of your
 7 decision the fact that you had been -- you knew about
 8 Child A?
 9 **A.** Yes, yes. Any, any meetings or reviews about
 10 different babies on the unit were always something of
 11 interest. You might want to go to just to see what --
 12 it was probably a more thorough review or a review that
 13 you didn't really know about. Yes.
 14 **LADY JUSTICE THIRLWALL:** Thank you very much
 15 indeed.
 16 **A.** Okay.
 17 **LADY JUSTICE THIRLWALL:** Is there anything arising
 18 out of that, Mr De La Poer?
 19 **MR DE LA POER:** No, thank you, my Lady.
 20 **LADY JUSTICE THIRLWALL:** In that case, thank you
 21 for coming to give evidence. You are free to go and we
 22 will take a break now until a quarter to 12.
 23 (11.28 am)
 24 (A short break)
 25 (11.48 am)

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1 **Q.** Did you qualify as a registered nurse in 1985?
 2 **A.** Correct, yes.
 3 **Q.** And after a period of further training
 4 including in the United States, did you join the
 5 Countess of Chester Hospital in 2004?
 6 **A.** Correct.
 7 **Q.** Did you complete an Advanced Neonatal Course
 8 in 2011?
 9 **A.** Yes.
 10 **Q.** And at around that time did you become the
 11 deputy ward manager of the neonatal unit?
 12 **A.** Yes, I did.
 13 **Q.** And for the entire period that you were deputy
 14 ward manager, was the ward manager Nurse Eirian Powell?
 15 **A.** Yes, correct.
 16 **Q.** Upon Ms Powell's retirement in December 2017,
 17 did you become ward manager for the NNU?
 18 **A.** Yes, initially acting for six months, and then
 19 took over, yes.
 20 **Q.** Now, as deputy ward manager, which was your
 21 role at the time, were you responsible for the nursing
 22 rota?
 23 **A.** I was.
 24 **Q.** What other responsibilities did you have that
 25 were particular to the role of deputy ward manager?

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1 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
 2 **MR DE LA POER:** My Lady, the person sitting in the
 3 witness box is Nurse Yvonne Griffiths, our next witness,
 4 I wonder if she may be sworn.
 5 **MS YVONNE GRIFFITHS (Sworn)**
 6 **Questions by MR DE LA POER**
 7 **MR DE LA POER:** Please could you give us your full
 8 name.
 9 **A.** Yvonne Griffiths.
 10 **Q.** Ms Griffiths, you have provided to the Inquiry
 11 two witness statements, is that correct?
 12 **A.** Correct.
 13 **Q.** The first one is dated 19 June of 2024. With
 14 the exception of paragraphs 70 to 77, is the content of
 15 that witness statement true to the best of your
 16 knowledge and belief?
 17 **A.** Yes.
 18 **Q.** And I have excepted those because you provided
 19 a second witness statement, dated 15 October of this
 20 year -- that is to say yesterday?
 21 **A.** Correct, yes.
 22 **Q.** And is the content of that second witness
 23 statement, which directly addresses paragraphs 70 to 77,
 24 true to the best of your knowledge and belief?
 25 **A.** Yes, it is.

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

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

5 **A.** No.

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

9 **A.** (Nods).

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

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

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

19 **A.** Correct.

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

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

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

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

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

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

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

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

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

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

5 **A.** Yes, I think they worked well together.

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

10 **A.** Not that I perceived, no.

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

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

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

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

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1 services.

2 **Q.** And as far as those peaks and troughs are
3 concerned, was it a peak or a trough during the period
4 2015 into 2016? Or neither, it doesn't need to be --

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

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

12 **A.** Yes.

13 **Q.** And was that aspirational or was it
14 achievable?

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

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

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

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

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1 space. The business case was for additional staff.
2 **Q.** And when approximately was that business case
3 put forward?

4 **A.** I am not aware but I have looked back and it's
5 around about 2013/14. So that was the business case
6 because I think the Kirkup Report came but this is just
7 on my knowledge I have now rather than back in the day.

8 **Q.** Well, using the knowledge you have now,
9 provided it is accurate, that's what's important. And
10 what was the response to the business case that was put
11 forward in around 2013?

12 **A.** I know Eirian and Dr Brearey and our matron,
13 they got together to compose the business case and
14 I know they would go off to the meeting and would all be
15 excited and then they would come back and it would be
16 refused because it would be on the wrong template and so
17 they would have to do it again. So they never really
18 got anywhere with it.

19 So following that we were told to Datix if we had
20 any staffing issues, so just so we could highlight that
21 to the Executive team.

22 **Q.** We are going to come to Datix in a moment, but
23 is what you are saying that in the event that you felt
24 that you were short-staffed, that should result in
25 a Datix form noting that fact?

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1 courses. We were the first to ever do the R23, which is
2 the Advanced course, because she just wanted all the
3 nurses to be highly skilled, to provide the care.

4 **Q.** In your experience of her, did she see herself
5 as an advocate for her staff?

6 **A.** Yes.

7 **Q.** And was that an appropriate approach for her
8 to take, do you think?

9 **A.** Sorry, I don't understand the question.

10 **Q.** Well, do you think that her role as manager
11 was to act as an advocate for her staff?

12 **A.** I think she was there to represent what the
13 unit needed and it was her voice to take it to the exec
14 level.

15 But I just feel because we were in Urgent Care,
16 I don't think they appreciated the world of neonatology.

17 **Q.** Now, one of the things that you say on more
18 than one occasion in your statement is that you were
19 excluded from major discussions?

20 **A.** (Nods).

21 **Q.** Or as you describe them, high profile
22 meetings, and you make a reference to your banding
23 saying it is above your banding level.

24 **A.** Yes, yes.

25 **Q.** Just to try and get underneath what you are

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1 **A.** And I think that was just to recognise -- to
2 have a record of that for the Trust to say that this is
3 why we need that business case to be approved.

4 **Q.** And so by the time we get to 2015/2016, had
5 any change been made to the staffing level by reason of
6 the business case?

7 **A.** No.

8 **Q.** Was patient care ever compromised, in your
9 view, by reason of the staffing level?

10 **A.** No, because we all had a very flexible team.
11 I think everybody, if there was a plea for extra staff,
12 the colleagues always came in as they do now. So
13 I think we were very fortunate that we had a good team.

14 We would have benefited from that additional staff
15 because that would have given us a supernumerary shift
16 leader which would have been better staffing.

17 **Q.** Finally before we turn to the topic of
18 policies and procedures, your relationship with
19 Eirian Powell. How did you find working with her?

20 **A.** I learnt a lot from Eirian Powell. I think
21 she was a very good manager. She was very passionate
22 about what she did and I think she never, if she had
23 a goal, I think she always went for it, like with
24 staffing she, you know, she persisted to try and get
25 more staff. She encouraged staff to go and do the

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1 saying by that, was it your view that you were excluded
2 when you should have been included or was it your view
3 that you were excluded and you didn't need to go?

4 **A.** I was excluded and didn't need to go because
5 obviously I was working on the shopfloor so we can't
6 just all walk off and go to meetings, you know, my
7 responsibility was to ensure that the safety of the unit
8 was staffed appropriately, and caring for the babies,
9 like any other Band 6.

10 **Q.** As somebody with management responsibility who
11 needed to be in a position to step into Nurse Powell's
12 shoes, should she not be available, how important was it
13 that you had a clear understanding of the important
14 workstreams that she was involved in as the unit
15 manager?

16 **A.** Eirian always cc'd me in any relevant emails
17 so that if she happened to not be there and I had
18 a question I could read through the thread of emails.

19 **Q.** So was it your working expectation that she
20 would always tell you about important things she was
21 doing as the unit manager?

22 **A.** Yes, I mean, with the business case and, yes.

23 **Q.** Well, we will look at individual events --

24 **A.** Okay.

25 **Q.** -- but I am talking generally here, so that's

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1 sufficient for now.

2 **A.** Yes.

3 **Q.** So I said I was going to come on to policies
4 and procedures. The first one is safeguarding. Had you
5 received any training in how to deal with a situation in
6 which a colleague was suspected of doing harm to
7 patients?

8 **A.** No, we would do adult safeguarding and
9 children safeguarding and that was specifically around
10 where I worked, it's more the scenarios around making
11 sure that the home was safe for the baby to go home and
12 we never had any scenarios regarding anybody in hospital
13 causing harm because I think it's just, for me, for
14 anyone to do any harm within a hospital setting that's
15 a Trust -- but no, we didn't have any scenarios about
16 staff.

17 **Q.** Do you think you should have?

18 **A.** In reflection now, yes. Yes.

19 **Q.** Do you think the fact that you hadn't had any
20 such training made any difference to how you acted when
21 presented with the events that we are going to look at
22 in more detail?

23 **A.** No, but obviously I have read a lot about
24 safeguarding and it is to prevent harm to, to a child,
25 so I suppose now I realise that you could connect the

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1 **A.** Not from memory, but I believe ...

2 **Q.** We will have a look at it. What was your
3 understanding about whether or not a Datix was required
4 if a child died?

5 **A.** Looking back, I feel we did Datix any child
6 that had died but I am not 100% back in 2015.

7 **Q.** And on what basis were you filling in those
8 Datix forms? Why did you think that they were required?
9 What criteria was prompting that form?

10 **A.** I think on the shopfloor at the time in
11 2015/16, we would just complete a Datix and then we
12 would expect a team to review that Datix.

13 I wasn't involved in too many reviews of Datixes.

14 **Q.** But the thought process of you have just been
15 participating as a nurse in a patient death, did you
16 understand there was an expectation that you would fill
17 in a form about that to record that?

18 **A.** Yes, but at the time I just thought it was
19 to -- so the Executive team would be aware that we have
20 had a death.

21 **Q.** What about in the event of a sudden unexpected
22 collapse that didn't lead to death? Was your
23 understanding that a Datix was required or wasn't
24 required in that situation?

25 **A.** We didn't fill one in at that time.

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1 two but we never had any scenarios regarding staff.

2 **Q.** Forgive me, it will have been my question.

3 I absolutely accept you hadn't had such training,
4 I'm just inviting you to consider that had you had such
5 training, would it have made a difference to how you
6 approached the information you were being given at the
7 time?

8 **A.** No, I don't think so.

9 **Q.** And why do you say that?

10 **A.** Because -- I suppose it was just the
11 commonalities of a certain person on shift rather than
12 witnessing any harm. If I witnessed somebody doing
13 deliberate harm, then I would escalate that.

14 **Q.** Well, we will come back to whether it was just
15 commonalities in due course but I'll move on from
16 safeguarding to Datix. What was your understanding
17 about when a Datix form was required?

18 **A.** A Datix was so that we could learn from the
19 event.

20 **Q.** Now, we know, having seen some Datix forms,
21 and we will look at one or two over the course of your
22 questioning, that there was a category of "Expected and
23 unexpected death".

24 Does that -- is that something that you recognise
25 as an option on the Datix form?

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1 **Q.** Has that changed since?

2 **A.** No, because we don't tend to have them as
3 often now.

4 **Q.** It may be that you don't have them as often
5 but when they do happen, these rare events, would you
6 expect your staff, as the current unit manager, to fill
7 in a Datix?

8 **A.** No.

9 **Q.** And why is that?

10 **A.** Because working within an ITU area, I think it
11 was quite common that that would happen and it was only
12 if it resulted in, in the baby's demise then we would
13 Datix the incident.

14 **Q.** Have you, and I readily accept that it wasn't
15 in the pack that you received, have you seen anything of
16 the concerns that were raised at the time by
17 Ruth Millward and others about the fact that the
18 neonatal unit was not filling in Datix forms when they
19 should have been?

20 **A.** I wasn't aware of that at the time.

21 **Q.** You weren't aware of that at the time?

22 **A.** No.

23 **Q.** Are you aware of that now or not? Is that
24 news to you, what I have just said?

25 **A.** I might have read it in my pack but I can't

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1 remember.

2 **Q.** Well, it's certainly not a memory test as far
3 as your pack is concerned.

4 **A.** Yes.

5 **Q.** But I'm just seeking to understand what your
6 current position is. Have you, as unit manager, had
7 meetings with the risk department about what their
8 expectation is about when Datixes are and aren't filled
9 in?

10 **A.** We normally have a Datix drop bar, so that can
11 change depending, you know, as the, as practices change,
12 so usually there is a drop bar that will indicate what
13 we need to Datix.

14 **Q.** So that's the form, but I am talking about
15 a sitdown meeting, human being to human being, you and
16 somebody from the risk department so they can say: this
17 is what our expectation is.

18 **A.** Oh, sorry, yes. I know back in the day and
19 also now we have NNIRG meetings, which is a neonatal
20 review meeting, and that's with the people from the risk
21 department and the manager and the Consultant would
22 review any Datixes and to see any learning to come from
23 that.

24 **Q.** Has any training been provided as to when they
25 are and aren't expected?

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1 case.

2 **Q.** So we have heard something about the perinatal
3 mortality and morbidity review meetings that happened
4 approximately every two months. We have also heard
5 something about the neonatal mortality meetings, which
6 were only about deaths, as the name would suggest. Is
7 that what you are referring to?

8 **A.** Yes.

9 **Q.** So I would like to turn, please, to ask you
10 about clinical incidents before the period that we will
11 focus on in due course, the first being the morphine
12 infusion incident on 22 July 2013.

13 What you tell us is that you were on a management
14 day on that occasion, but you were made aware that it
15 had occurred.

16 **A.** Yes.

17 **Q.** And what was it about this incident that would
18 need you, who wasn't on the ward at the time, to be told
19 about it?

20 **A.** I believe Eirian wasn't on duty. I think she
21 was on annual leave. I was informed of the incident and
22 because it was a very serious incident with morphine,
23 I did seek help from my matron as well on how to handle
24 the follow-on from the Datix.

25 **Q.** Very serious incident?

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1 **A.** No. No.

2 **Q.** Debriefs.

3 What was your expectation in 2015/2016 about
4 whether there would be a debrief following a death?

5 **A.** A debrief was more for pastoral care for the
6 staff to ensure that they could all come together
7 because obviously it is very traumatic for the staff.
8 We try and do that as soon as the incident was, was --
9 had happened, but depending on other demands within the
10 team. But I felt that it was -- it's important to just
11 all come together to -- to talk about the incident and
12 how people felt it went and if there was any learning or
13 anything that anybody wanted to bring up.

14 **Q.** So if not that first debrief which you have
15 described as occurring as soon as possible and for
16 pastoral purposes, was there any opportunity back in
17 2015/16 for learning that you were invited to
18 participate in relation to deaths?

19 **A.** I might have been present in a few reviews of
20 neonatal deaths. So that would be done by a Consultant
21 that wasn't part of that resus and a nurse, and
22 a manager or, if Eirian wasn't there, then I would,
23 would present. And then I think you would look at all
24 the maternal side and then the neonatal and then they
25 would come together, in my understanding, to review that

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1 **A.** Yes.

2 **Q.** Why do you say it was a very serious incident?

3 **A.** It was a morphine error on the pump that was
4 infusing. I can't remember the times fold of morphine.

5 **Q.** 10.

6 **A.** 10-fold, so if that hadn't been picked up as
7 soon as it was, it might have made the baby demise.

8 **Q.** It could have been fatal?

9 **A.** Yes.

10 **Q.** So a very serious error, one requiring you to
11 be contacted when you are not on the ward in the absence
12 of Ms Powell?

13 **A.** I was on the ward.

14 **Q.** Oh, you were on the ward?

15 **A.** It happened -- I think it was handed over at
16 8 o'clock so the incident occurred at 8 when I was
17 coming on duty.

18 **Q.** That's entirely my fault. When you said that
19 I was on a management day --

20 **A.** Yes.

21 **Q.** -- do you mean you were acting as ward manager
22 that day?

23 **A.** Correct.

24 **Q.** I'm sorry, that was my misunderstanding
25 entirely.

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1 So you were aware of the incident, and did you
 2 speak to Letby immediately after it or had she left
 3 for -- at the conclusion of her night shift before you
 4 were able to speak to her?
 5 **A.** I can't remember.
 6 **Q.** We know that there was a one-to-one --
 7 **A.** Yes.
 8 **Q.** -- the next day.
 9 **A.** That's right.
 10 **Q.** So I am not asking about that. It's just
 11 whether you have any recollection before that one-to-one
 12 of seeing Letby, what her demeanour was, what her
 13 attitude was to this error?
 14 **A.** No, sorry, I don't remember.
 15 **Q.** I'm not going to name the member of staff, but
 16 the other member of staff who was involved, you describe
 17 as being terribly upset.
 18 **A.** She was extremely upset.
 19 **Q.** And that she came to find you.
 20 **A.** Yes.
 21 **Q.** Is that right?
 22 **A.** Yes.
 23 **Q.** Are you able to say, for sure, whether Letby
 24 did or didn't come to find you on that day to talk
 25 about it?

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1 **Q.** Are you meaning by this that she should not
 2 check any intravenous infusions requiring additives and
 3 any controlled drugs until the incident review?
 4 **A.** Correct.
 5 **Q.** What were you envisaging would occur by way of
 6 incident review?
 7 **A.** I would expect the incident to be, I expected
 8 Lucy to be spoken to and, and the pump to be checked.
 9 That's what we would normally do for -- to make sure
 10 that it wasn't an input error it was a pump error. And
 11 I would just expect someone to address it higher than
 12 me.
 13 **Q.** So the incident review, were you expecting
 14 that would happen the next day or that it would require
 15 a formal meeting, put into people's calendars, what are
 16 you expecting by this incident review and when it might
 17 take place?
 18 **A.** Well, I think when I look at the date, 2013,
 19 I was pretty new at managing these situations, it was
 20 the first incident of a high calibre that I was dealing
 21 with, so I did have advice from my matron. And I just
 22 thought it was quite a safe practice to stop her from
 23 doing any competent, you know, IVs until it was --
 24 somebody more senior could take that lead.
 25 **Q.** Then we have "Complete intravenous

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1 **A.** No, she definitely didn't. No, the only
 2 meeting I had with Lucy was on the one-to-one date of
 3 the meeting.
 4 **Q.** So let's have a look at that now, please.
 5 It's INQ0008961, page 47 -- it is going to come up on
 6 the screen in front of you.
 7 Just so you know, Ms Griffiths, we did look at this
 8 with your colleague Ms Farmer earlier today.
 9 So we have read through it already but do you want
 10 to just refamiliarise yourself with the content of this
 11 document?
 12 **A.** Yes.
 13 **Q.** I am sure you have seen it many times.
 14 **A.** Yes.
 15 **Q.** What I would like to focus on are the three
 16 action points. So the first is happily, because
 17 somebody picked it up very shortly after the error was
 18 made, no detrimental effect on the infant.
 19 **A.** Correct.
 20 **Q.** And had you managed to establish that
 21 conclusively by the time of this meeting?
 22 **A.** Yes.
 23 **Q.** Now, the next word is, as I read it "sustain",
 24 I think that's your handwriting.
 25 **A.** Yes.

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1 competencies, drug calculation, with Practice
 2 Development Nurse Yvonne Farmer" as your third action
 3 point.
 4 **A.** (Nods).
 5 **Q.** Were you expecting, when you wrote this, that
 6 that competency drug calculation practice would occur
 7 before Letby was signed off to go back to administering?
 8 **A.** Yes. I think we normally have a process. So
 9 if a medication error is, is made, depending on the
 10 severity, then you would do a reflection and then you
 11 would have to do competencies before you are able to
 12 carry on.
 13 **Q.** So you were envisaging a circumstance in which
 14 Letby met with Farmer, Nurse Farmer, before she was
 15 allowed to go back to being involved with controlled
 16 drugs in this circumstance?
 17 **A.** That's what I would have thought would happen.
 18 **Q.** Now, what was Letby's demeanour? How was she
 19 presenting herself to you in this meeting?
 20 **A.** I just remember the comparison because I know
 21 the other lady was very distraught and very upset, to
 22 the point where she was going to leave nursing.
 23 Letby, I think she was upset but not to the same
 24 extent.
 25 **Q.** Now, you have told us that you consulted the

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1 matron who was Anne Murphy.
 2 **A.** Yes.
 3 **Q.** The most senior nurse on the Children's Unit,
 4 is that right?
 5 **A.** Correct.
 6 **Q.** Including neonatology. Let's just think about
 7 the order of that. Had you spoken to her before you had
 8 this meeting with Letby?
 9 **A.** Yes. I would have spoken to Anne Murphy the
 10 day that the incident occurred.
 11 **Q.** And so you, you already knew by the time you
 12 came into this meeting that what your plan was had been
 13 approved by the most senior nurse who worked at ward
 14 level?
 15 **A.** Yes.
 16 **Q.** What was Letby's reaction to you telling her
 17 that she wasn't allowed to be involved in intravenous
 18 infusions requiring additives and any controlled drugs
 19 until a review had taken place and, as you have told us
 20 the third point means, that she wasn't allowed to do any
 21 of that until she had completed competencies in drug
 22 calculation with Nurse Farmer?
 23 **A.** She seemed to accept my decision.
 24 **Q.** Did you at any point have to consult
 25 Nurse Murphy about how the situation should be handled
 97

1 showing her the 'One to One' form and discussing my
 2 plans on actions, which she agreed. The reason for my
 3 discussion with Anne Murphy was due to Letby stating
 4 that she was unhappy with my decision following our 1:1
 5 meeting. In response, I stated I would take on board
 6 her comments and speak to Anne."
 7 **A.** Yes, I think perhaps she thought I was being
 8 a bit harsh.
 9 **Q.** So just if we just roll it back a little bit.
 10 **A.** Yes, yes.
 11 **Q.** The chronology you have given us to that point
 12 was that you spoke to Nurse Murphy before.
 13 **A.** Yes.
 14 **Q.** You had an agreed plan, you saw Letby, and
 15 Letby was happy with what you decided. The account you
 16 have given in your Inquiry witness statement is that in
 17 fact your conversation with Anne Murphy happens after
 18 your one-to-one, and was only prompted by the fact that
 19 Letby was, to use your words, "unhappy" with your
 20 decision.
 21 **A.** Yes. I mean, she wasn't happy but after we
 22 discussed it, she, she agreed to sign the paper.
 23 **Q.** So this is a difficult situation for you to
 24 manage as you hadn't, you have told us, done such
 25 a review before in such a serious incident. Was it, in
 99

1 after you had had your meeting with Letby?
 2 **A.** Yes, we had a meeting after and Anne Murphy
 3 was very supportive knowing that this is the first big
 4 incident that I had had to deal with.
 5 **Q.** What degree of insight do you think Letby was
 6 showing in that meeting, about the severity of the error
 7 and the need for remedial steps to be taken?
 8 **A.** I can't really remember but I think she
 9 accepted it and she did actually sign the form, so ...
 10 **Q.** And were you involved any further with this
 11 incident?
 12 **A.** No.
 13 **Q.** I would just like to take you, please, to
 14 paragraph 39 of your witness statement just to see if
 15 I can prompt your recollection.
 16 **A.** Is it in the bundle?
 17 **Q.** It should be in your folder there. You should
 18 have your witness statement --
 19 **A.** Oh, yes.
 20 **Q.** And if you could go, please, to page 8 and
 21 paragraph 39.
 22 **A.** Yes.
 23 **Q.** I'll just read it out so you follow along:
 24 "In terms of my discussions with Anne Murphy
 25 (Matron for Paediatrics and Children's ward) I remember
 98

1 your view, appropriate for Letby to be unhappy with the
 2 decision that you had made, bearing in mind the severity
 3 of her error?
 4 **A.** No, and I think it's not that I want to use
 5 the word seniority but I think it's, you know, you have
 6 to -- she had -- she was only new into her role.
 7 I think she had only been on the unit for --
 8 **LADY JUSTICE THIRLWALL:** I think quite a lot of
 9 people in the room didn't hear that because of the
 10 noises from outside.
 11 **A.** She was relatively new on the neonatal unit
 12 and I think -- and I think any constructive criticism
 13 needs to be taken on board by, by nurses.
 14 **MR DE LA POER:** Well, I am sure that that's right,
 15 but it is just from what you have told us in your
 16 witness statement she wasn't, apparently, taking on
 17 board constructive criticism unless what you have told
 18 us in your witness statement is not correct?
 19 **A.** I just remember that she did sign the form, so
 20 I think after I spoke -- she wasn't happy that it was --
 21 she thought it was a bit severe what I was proposing but
 22 then after I explained that this is the normal process
 23 that we would do, with any medication error, she did
 24 then sign it and then I said she could meet with Eirian
 25 the following week when she returned.
 100

1 Q. Did it give you at the time any cause for
2 concern that her reaction in the face of this error was
3 to question your decision-making which was based on
4 safety grounds?
5 A. I suppose she was just protecting her
6 reputation. I think she didn't want to think that
7 she -- she was being judged so harshly and I think
8 because it had been picked up so quickly she didn't
9 think that the error had caused any harm.
10 Q. What does that response say about her insight?
11 A. Sorry?
12 Q. What does her response say about her insight
13 into that incident? Did she have good insight?
14 A. I think she knew the -- how detrimental it
15 would be if that infusion continued, if that's ...
16 Q. What -- was Anne Murphy supportive of your
17 decision in terms of what you had said should happen to
18 Letby?
19 A. Yes, and I think the other nurse as well
20 equally had the same, same instructions too.
21 Q. And did that incident lead to a change of
22 policy, that the infusions would not be made up at the
23 end of a night shift but would instead be made up at the
24 start of the day shift?
25 A. Correct.

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1 days later.
2 A. (Nods).
3 Q. Do you agree that on the face of it, it's
4 something of a countermand to what you had decided
5 should happen?
6 A. Yes.
7 Q. And we can see that it's not in fact until
8 6 September that those calculations are recorded as
9 having been done?
10 So was this something that Nurse Powell spoke to
11 you about at the time?
12 A. No. It's the first time I've seen this
13 one-to-one form.
14 Q. And I mean, did you have cause to be on the
15 ward and see whether Letby was performing infusions or
16 checking controlled drugs following the incident?
17 A. I find it difficult to answer that question.
18 I -- I suppose I acted in the best interests in her
19 absence and Eirian then has gone on and done this
20 other -- I don't know where she made these decisions or
21 what her thought process ...
22 Q. You now sit in her chair on the unit. Was it
23 appropriate that within seven days before the
24 calculations were carried out that Letby was permitted
25 to go back to being involved with controlled drugs and

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1 Q. Now, if we look, please, at the same INQ that
2 I gave a moment ago, but page 45. That's INQ0008961.
3 Just try to understand -- this is a note
4 predominantly written by Nurse Powell, I am sure you
5 recognise the handwriting.
6 A. Yes.
7 Q. We can see that the first action is, and there
8 is a symbol I'm not sure that I am able to interpret it:
9 "To continue for care for infants ..."
10 "IC", is that including "infusions"?
11 A. Yes.
12 Q. Yes.
13 A. Yes, with, yes.
14 Q. "Is able to check CDs" -- is that controlled
15 drugs?
16 A. Yes.
17 Q. And then to go over with Yvonne Farmer the
18 pump settings, calculations?
19 A. Yes.
20 Q. So if we just think about what you had
21 decided, supported by the most senior nurse. It was, as
22 you have told us, that she couldn't do either of those
23 first two things until a review had been carried out and
24 that she couldn't do either of those things until she
25 had done the practice with Yvonne Farmer. This is seven

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1 infusions?
2 A. We have adapted a new policy within the
3 network, so we have clear indications now if a drug
4 error is made. So we, we have a chart which we grade
5 the severity and depending on the severity then actions
6 follow. And with an infusion like this, that would be
7 quite a high level, so we would ensure that the
8 competencies were done before they resumed.
9 Q. Under the current protocol this simply
10 wouldn't be permitted.
11 A. No.
12 Q. But under the system that you were operating
13 at the time, was it appropriate, do you think?
14 A. We didn't really have -- not that I am aware,
15 we didn't really have any policies, that's why I sought
16 help and advice from my matron. There wasn't anything
17 I could pick up to make her -- we just tended to do
18 reflections.
19 Q. I would just like to show you one more thing.
20 INQ0012033. That's the new version of that document,
21 page 171, the one that was shown earlier.
22 So this, I hope, is something that you have seen
23 before today?
24 A. Yes.
25 Q. And we can see here she's being asked about

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

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

13 Just to give you an opportunity, Ms Griffiths, to
14 say, just given what you were told on the ward on the
15 22nd, given the steps that you took, did you escalate it
16 more than it needed to be?

17 **A.** No.

18 **Q.** Thank you, we can take that down.

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

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

22 **A.** Not that I can recall.

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

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1 **Q.** -- you have recreated the message in your
2 witness statement so we can look there. This is
3 11 June, so this is very shortly after the death of
4 Child A and the collapse of Child B:

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

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

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

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

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

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

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

25 **A.** I think sometimes young nurses that come into

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1 **A.** No.

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

5 **A.** Correct.

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

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

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

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

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

21 **A.** No.

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

25 **A.** Yes.

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

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

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

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

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

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

7 **A.** Yes. Yes.

8 **Q.** So Child C.

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

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

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

21 **A.** No.

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

24 **A.** Ms Powell.

25 **Q.** Do you recognise that if such a thing was
 109

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

7 **A.** (Nods).

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

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

12 **A.** No.

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

16 **A.** I don't recall.

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

22 **A.** I wasn't involved in the Datixes back in
 23 2015/16, but now a result of "no harm" means that they
 24 don't feel there was anything like a drug error or
 25 anything that has caused this death.
 111

1 said, it was highly insensitive and upsetting?

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

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

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

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

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

24 **Q.** I told you earlier that we would look at
 25 a Datix, INQ0000111. This is the Datix for Child C.
 110

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

5 **A.** Yes.

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

10 **A.** No.

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

13 **A.** Correct.

14 **Q.** That's the interpretation, is it?

15 **A.** Yes.

16 **Q.** Thank you. We can take that down.

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

21 **A.** Correct.

22 **Q.** So Child D.

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

25 **A.** (Nods).
 112

1 Q. Does that fit with your memory of Child D?
 2 A. Yes.
 3 Q. It is your paragraph 58 if you want to just
 4 remind yourself:
 5 "I vaguely recall some conversation in respect of
 6 Child D's skin discolouration. However, I did not get
 7 involved in any of the wider discussions. I think staff
 8 were trying to understand why we had suddenly had three
 9 episodes so close together, which was unusual. I did
 10 not see the rashes in person."
 11 A. Correct.
 12 Q. So when you say staff, are you talking about
 13 nursing staff or doctors or both?
 14 A. Nurses.
 15 Q. Nurses?
 16 A. (Nods).
 17 Q. So your belief is that this was a discussion
 18 between nurses trying to understand why there had been
 19 three episodes so close together.
 20 A. I think everyone was trying to look for, for
 21 reasons why we had so many close together and I think
 22 Nurse Oakley commented about the skin discolouration.
 23 So I never saw anything but often babies do have skin
 24 blemishes when they are born.
 25 So I didn't really see any, anything further. It
 113

1 Q. So Dr Lambie, who left in September 2015, told
 2 us about a huddle of nurses that she saw who appeared to
 3 be looking at the rota to see who was on, and her
 4 impression was this was connected to the deaths which
 5 had occurred.
 6 Is that the sort of situation that you are
 7 describing, with nurses in ones or twos talking to each
 8 other and trying to get to the bottom of this or is that
 9 something different?
 10 A. No, I was unaware of that being observed. The
 11 off-duty is the Bible of the unit because everybody
 12 wants to look at the off-duty because it changes that
 13 often, so it's not unusual for nurses to look at the
 14 off-duty to see who's coming on the next shift.
 15 Q. That's obviously a routine activity.
 16 Dr Lambie was suggesting it was not looking forward but
 17 it was looking back to see who had been on duty. Were
 18 you aware of --
 19 A. No.
 20 Q. Now, you attended on 29 July a Neonatal
 21 Mortality Meeting in relation to Child C and Child D.
 22 I'll just bring that up so that you can remind
 23 yourself, INQ0003297.
 24 So we can see Child C towards the top left and then
 25 Child D, and you are recorded as the penultimate person
 115

1 was just something that she, she noted.
 2 Q. When you say people are trying to find out,
 3 how were they trying to find out? I mean, Nurse Oakley
 4 is one example. She is saying, well, I saw a skin
 5 discolouration.
 6 A. Yes.
 7 Q. What other methods --
 8 A. I think with anything, because I think
 9 neonatal nurses are so proud and passionate with what
 10 they do, that they always feel they are missing
 11 something, why is this happening? So I think, you know,
 12 even if you had a cannula and it tissueed, you would be
 13 worried, you know.
 14 So I think it's just we, we work one-to-one, we get
 15 quite close to the families that we work with, and the
 16 babies, and we want to find out, are we missing
 17 something? Is there anything that we can do? We didn't
 18 suspect at that time any harm, but is there something
 19 that we are unaware of?
 20 Q. So is this nurses grouped together discussing
 21 this between themselves?
 22 A. I don't remember nurses getting together.
 23 I mean, we, we only work with about five nurses on
 24 a shift so one or two if, the most, but I just remember
 25 the conversation being had rather than being involved.
 114

1 in the list, do you see that?
 2 A. Yes.
 3 Q. Now, by the time of this meeting, had you
 4 heard Nurse Oakley's comment about the unusual skin
 5 discolouration?
 6 A. I can't remember.
 7 Q. Do you know whether anybody at that meeting
 8 said anything about Child A and Child B and whether
 9 there was any common features between that death and
 10 collapse and these two deaths?
 11 A. I have no recollection, I don't think so.
 12 Q. Do you have any recollection of whether
 13 Letby's name was mentioned at this meeting?
 14 A. No, she wasn't.
 15 Q. Thank you very much indeed. We can take that
 16 down.
 17 You also, in relation to Child D, attended
 18 a Level 2 root cause analysis; do you recollect that?
 19 A. Sorry?
 20 Q. A Level 2 root cause analysis in relation to
 21 Child D, 28 August. I'll bring it up. INQ0015152.
 22 No. In fact I think I suggested you attended,
 23 I would just like you to remind yourself of this
 24 document to see whether it's something that you
 25 recognise.
 116

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

4 **A.** (Nods).

5 **Q.** Do you see that?

6 **A.** Yes.

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

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

13 Do you remember any discussion about that
14 presentation?

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

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

19 **A.** I really don't remember.

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

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

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

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

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

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

16 **A.** Yes.

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

20 **A.** Yes.

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

25 **A.** Yes, correct.

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1 **A.** Yes.

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

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

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

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

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

23 **A.** I don't, no.

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

118

1 **Q.** So that's what you said first.

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

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

9 Do you see you quote that under Child I there?

10 **A.** (Nods).

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

14 "With respect to my discussion with Dr Brearey on
15 14 October 2015, I do recall having to reallocate the
16 nurse allocation as the babies' collapses were causing
17 a few concerns with the medical and nursing staff."

18 So if we just pause there for a moment.

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

21 **A.** Yes.

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

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

120

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

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

5 **A.** Yes.

6 **Q.** Then you say this:

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

10 And then:

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

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

21 **A.** Yes.

22 **Q.** And you go on to comment:

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

25 So, again, you appear to be describing Dr Brearey's
121

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

3 **A.** Yes.

4 **Q.** And you say:

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

8 **A.** Yes.

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

12 **A.** Yes.

13 **Q.** And you go on to say:

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

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

19 **A.** Yes.

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

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

123

1 reaction to what you propose to do?

2 **A.** Yes.

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

5 **A.** Yes.

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

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

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

14 **A.** Yes.

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

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

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

23 **A.** Yes.

24 **Q.** At 74, you consider Nurse T's WhatsApp
25 messages and here we can just summarise what they say:
122

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

3 **A.** Yes.

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

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

8 **A.** Yes.

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

10 **A.** Yes, that's it. Yes.

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

14 **A.** Correct.

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

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

23 **A.** (Nods).

24 **Q.** And at 7, you say you believe you were
25 mistaken when you said in your police statement that
124

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

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

9 So just so we're clear about it, we're talking
10 about therefore conversations with Dr Brearey after
11 1 July of 2016?

12 **A.** Correct.

13 **Q.** You go on to say that you didn't fully
14 understand the time frame and you draw attention to the
15 fact that Eirian Powell's table, which we know is dated
16 23 October, you hadn't appreciated that that postdates
17 14 October, which was the date you had given?

18 **A.** Correct.

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

21 "In other words, the evidence of 'commonality'
22 apparent from Eirian Powell's table was not available to
23 me at the time of the reallocation of Letby on
24 14 October 2015."

25 Then you mention the Nurse T WhatsApp messages and
125

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

4 **A.** Correct.

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

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

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

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

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

23 **A.** I do have a positive -- it was purely to
24 change the allocation because I had more experienced
25 nurses to look after the ITU baby.
127

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

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

6 And then paragraph 10 is just correcting a date
7 error.

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

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

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

16 **A.** (Nods).

17 **Q.** And does it follow that your position is that
18 the correct date must have been some time after
19 1 July 2016?

20 **A.** Correct.

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

25 **A.** Correct.
126

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

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

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

19 Are you able to offer any explanation for that?

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

25 **Q.** Just about some of the details that you gave,
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1 just to see if you can help us with your recollection.
 2 I mean, the first sentence I read to you was:
 3 "I do recall having to reallocate the nurse
 4 allocation as the babies' collapses were causing a few
 5 concerns with the medical staff."
 6 I mean, is it right that sitting there right now
 7 you simply don't have that recollection?
 8 **A.** I -- that, that is untrue because it wasn't
 9 until after the table had been produced that I realised
 10 the severity of, of their concerns.
 11 **Q.** So can you help us with how you came to write,
 12 "I do recall ..." What was in your mind when you wrote
 13 the statement?
 14 **A.** I think because I have given that many
 15 statements and I have had lots of conversations since
 16 with Dr Brearey about, about the events and I just
 17 remember reallocating the nurse assignment and I just
 18 brought that in because that's -- I had that information
 19 since.
 20 **Q.** And again if we just look at something else
 21 that you said. You said:
 22 "This was a very easy solution and one which seemed
 23 to appease Dr Brearey."
 24 Now, do you agree post-July 2016 there was no need
 25 to appease Dr Brearey about the staffing --

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1 In relation to your conversation with Nurse Powell,
 2 you say at 73:
 3 "I did mention my conversation and action, as
 4 a result, to Eirian the next time I saw her on shift
 5 which would have been the following week. Neither of us
 6 had any concerns."
 7 There you appear to be recalling a sequence of
 8 events where Dr Brearey told you something which you
 9 then relayed was the trigger for you to speak to
 10 Nurse Powell and I mean, do you agree that that is how
 11 it reads?
 12 **A.** It does.
 13 **Q.** And do you agree that in 2016, July 2016,
 14 later, that wouldn't reflect the sequence of events that
 15 occurred?
 16 **A.** Correct.
 17 **Q.** And so, again, just giving you the opportunity
 18 to, doing the best you can, how is it you think that
 19 that came to be in your Inquiry witness statement given
 20 what your recollection is now?
 21 **A.** I think I have had that many -- that much
 22 information because obviously I've been a party since,
 23 not even during the trial but after the trial and during
 24 the Inquiry, I have had a lot more information and
 25 I have had statements given to me that other people have

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1 **A.** Correct, yes.
 2 **Q.** -- because Letby was not on the ward?
 3 **A.** Yes.
 4 **Q.** So again, just doing the best you can, why do
 5 you think that you wrote in your statement that you had
 6 appeased Dr Brearey in the course of this conversation
 7 that you were recalling?
 8 **A.** I got confused and thought that the table was
 9 pre, but actually it was post Baby I's death when I gave
 10 the statement.
 11 **Q.** But whenever the table was, you appear to be
 12 recounting a recollection of an emotional reaction from
 13 Dr Brearey that he was appeased.
 14 **A.** Yes.
 15 **Q.** I mean, that isn't anything to do with the
 16 table, that's just you remembering how he was.
 17 **A.** (Nods).
 18 **Q.** But if I have understood, he wasn't appeased
 19 when, in fact, you had this conversation because Letby
 20 wasn't on the ward.
 21 **A.** Correct. Yes, I think he wasn't on the ward
 22 because I don't recall having a ...
 23 **Q.** And just finally, and I am not looking to go
 24 over it all, but I do want to give you an opportunity to
 25 deal with some of these points.

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1 written, and it's clear there that Dr Brearey had never
 2 spoken to me about any concerns over Letby and I think
 3 that is more for her -- to be confidential to work
 4 colleagues.
 5 And I think it's following that with the chart
 6 produced in October 23rd by Eirian that she emailed that
 7 to me and that's when I was in the sequence of emails
 8 and that's where I saw it, so I got confused thinking
 9 that I had -- that Dr Brearey was concerned while I was
 10 doing Baby I's statement of allocation.
 11 **Q.** So after we have undertaken that process, and
 12 I accept it's implicit in your last answer, but of the
 13 two accounts that you have given, sitting there now,
 14 which do you think is correct?
 15 **A.** The revised account.
 16 **MR DE LA POER:** My Lady, I have transgressed into
 17 the usual lunch period but I just wanted to finish that
 18 sequence. So I hope that that was appropriate.
 19 **LADY JUSTICE THIRLWALL:** Yes, thank you.
 20 So we will rise now for lunch and we will come back
 21 in at 10 past 2.
 22 (1.06 pm)
 23 (The luncheon adjournment)
 24 (2.11 pm)
 25 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

15 **A.** Yes.

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

24 So this is Friday, 23 October.

25 Were you aware on that day of any plan to escalate
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1 there was a discussion about, you know, the commonality
2 of, of staff on duty.

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

7 **A.** I would have been aware, yes.

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

10 **A.** Yes.

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

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

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

22 **A.** That's what I presume, yes.

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

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1 this to the Director or Deputy Director of Nursing

2 before you received this email?

3 **A.** No.

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

6 **A.** No.

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

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

17 What did you think when you received this document?

18 **A.** This is the first time that I had actually
19 seen all the deaths collated in a chart and I think
20 because you come to work and you are busy and you are
21 working, you hear of a baby dying but you don't have
22 that timeline. But I was reassured that the cause of
23 death was actually entered on the chart, so -- and
24 I know they were looking at the commonality and that's
25 when I was aware, after a conversation with Eirian, that
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1 **A.** I recollect that they were looking at all
2 possibilities because obviously it was a higher
3 mortality than what we would normally see, so I think
4 they were just trying to really pinpoint and look at
5 everything that they could possibly do.

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

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

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

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

15 **A.** Okay.

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

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

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

25 **A.** (Nods).

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1 Q. Would that have been your thought process at
2 the time?

3 A. Yes.

4 Q. And it would seem from the email that sent
5 this table that it was being taken extremely seriously
6 because there was discussion of going to the Director of
7 Nursing herself about it, we saw that on the email.

8 A. (Nods).

9 Q. Did that give you any reassurance or what
10 opinion did you have about the fact that this table was
11 being escalated to the very top of the organisation?

12 A. I suppose it was just to recognise that, you
13 know, we had recognised there was an increase in deaths
14 and I think they wanted the execs to see if they
15 could -- for some more guidance on how they can deal
16 with this process.

17 Q. Was the contacting of director level something
18 you discussed with Eirian Powell?

19 A. No.

20 Q. So is that an inference that you drew from the
21 information you were given in the email and the table?

22 A. Yes.

23 Q. Now, what you tell us in your witness
24 statement, we can turn it up but I am sure it will be
25 familiar to you, is you said you didn't consider

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1 clearly an ongoing conversation which involved the
2 Consultants, is that fair, in terms of how you came to
3 be aware of all of this?

4 A. Yes, but I wasn't fully aware because -- not
5 fully aware, but I wasn't involved so much in the
6 process of this chart.

7 During that time I was doing a degree, degree
8 course in university, I was also doing the -- working
9 clinically, so even though I had sight of this email
10 I wasn't really in the major discussions about the
11 processes of what to do with this information.

12 Q. Do you think at that stage you had an open
13 mind about whether the Consultants might be right, or do
14 you think you made a decision at this stage that they
15 must be wrong?

16 A. I have always stayed neutral because you never
17 really know staff and I just felt if there was that
18 niggling belief then it needed to be addressed.

19 Q. When you say "neutral" are you talking about
20 how you presented yourself to the outside world or --

21 A. Yes.

22 Q. -- what you thought internally?

23 A. Yes.

24 Q. Which was it?

25 A. How I presented myself to the outside world.

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1 referring it to Alison Kelly yourself.

2 A. No, that's right.

3 Q. And your reasoning in your statement was you
4 didn't believe there were any staffing factors?

5 A. (Nods).

6 Q. Does that accord with your recollection of
7 your thought process at the time?

8 A. Yes, and I just thought, you know, I knew that
9 this table had been escalated, so I knew that they were
10 aware of it.

11 Q. So --

12 A. -- (overspeaking) -- cc chain.

13 Q. So did you think that at this time
14 Alison Kelly was contacted?

15 A. I'm not sure. I just presumed, with
16 Sian Williams being involved that, that it would be.

17 Q. So did you have a discussion at the time with
18 anyone about whether Sian Williams had in fact been
19 spoken to?

20 A. No.

21 Q. Just in relation to your belief at the time
22 that there weren't any staffing factors. I mean, you
23 yourself hadn't carried out an investigation, had you?

24 A. No.

25 Q. And you were being brought in to what was

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1 Q. So I am just here focusing not on what you
2 were saying to people but what you were thinking?

3 A. Yes.

4 Q. At this stage do you think you had an open
5 mind about whether or not the Consultants might be
6 right?

7 A. I did, yes.

8 Q. Now, if we move forward, please, in time to
9 the Tuesday of the following week, so this is
10 27 October. INQ0003107.

11 Here we can see the recipients are Dr Brearey and
12 you and Debbie Peacock, and it is a continuation of the
13 previous email, and it reads:

14 "I have spoken at length with Debbie this morning
15 in relation to the mortality rates for this year. It
16 was decided that it was necessary to create a table that
17 includes all the doctors that was involved with the
18 deceased patients on the unit. This would then ensure
19 that all avenues have been addressed. Debbie was of the
20 same opinion that we did not think there was
21 a connection. However, we would be highlighting the
22 issue once the report has been completed."

23 And so that's what Eirian Powell is saying.

24 I mean, did you have your own opinion about how
25 this should be managed at this stage?

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1 A. No.

2 Q. Because this appears to be the day after it
3 was planned that Alison Kelly or Sian Williams would be
4 contacted. Did you know whether that had happened by
5 the --

6 A. No, I wasn't aware of these emails until
7 after, you know, I know I've been cc'd, but as I say,
8 often I was cc'd in these emails for -- email threads in
9 case Eirian wasn't there, so I knew that both Steve and
10 Eirian were dealing with this with the help of risk.

11 Q. So I mean, was it the case that you just
12 weren't really engaging with this because you thought
13 that the only reason you were being cc'd in was in case
14 Eirian was absent in the future?

15 A. Correct.

16 Q. Just looking back on it as the deputy ward
17 manager who was provided with this information, do you
18 think you had a responsibility to do more than you did
19 or do you think that you acted appropriately?

20 A. I felt as a deputy ward manager I am there to
21 support the manager and if she asked me to be involved,
22 I would. But when you, you know, just to clarify my
23 hours as deputy manager was only four to five shifts,
24 you know, seven and a half hour days a month and during
25 that time, I was more concentrating on providing

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1 Q. Do you think that the concern of the most
2 senior Consultant on the unit was in itself enough for
3 you to make more enquiries so that you could take into
4 account his concerns when doing the staffing?

5 A. No, that didn't occur to me.

6 Q. And just explain for us why do you think
7 that is?

8 A. I think staffing -- she would never be the
9 most senior nurse on duty. Unless somebody said she
10 wasn't able to work on the shopfloor I would still
11 utilise her within the nursing numbers because she is
12 a Band 5 that's skilled.

13 So I would have -- really I would wait for
14 direction as to not to allocate her any shifts, but if
15 nobody has actually said that to me then I would be
16 allocating shifts to cover the unit.

17 Q. Just to complete this and to test it.

18 If there was a competence concern that would be
19 a reason -- as yet unidentified competence concern --

20 A. Yes.

21 Q. -- that would be a reason, for example, not to
22 allocate her to the ITU --

23 A. Correct.

24 Q. -- where the sickest -- I was just wondering
25 whether that thought process went through your mind at

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1 adequate staff for the unit and constantly juggling

2 staff to accommodate the BAPM standards.

3 And I just feel, you know, as the role of the
4 manager she had a better understanding and she was
5 actually escalating these things and I was just, I just
6 hoped that there would have been governance and policies
7 in place that this would have been addressed, because
8 you've got two senior people, Eirian and you've got
9 Steve, both highlighting that there is a potential issue
10 so I just presumed that they would both be taking that
11 forward rather than myself as the deputy.

12 Q. Bearing in mind that you were responsible for
13 the rota, did you think that exactly what Letby may be
14 suspected of or what the concerns may be, was very much
15 your business when it came to the sort of children that
16 she might be caring for?

17 A. Not at this time because there was no, no
18 staff came and stated that they were concerned about
19 Lucy's practice. Parents seemed to engage and liked
20 Lucy. She was very competent. She was very highly
21 skilled. She had done all the courses. So, you know,
22 perhaps if somebody had come to me and seen something
23 then definitely I would have addressed it.

24 But actually working on the shopfloor nobody saw
25 anything to implement --

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1 the time in terms of taking on board the neonatal leads'
2 concerns, whatever they were, when doing your job?

3 A. No, not at this point in time.

4 Q. So we will move forward in the evolution of
5 this to INQ0003190.

6 My Lady, this is tab 12.

7 This is a further iteration of the table. It's
8 dated the 19th of the 1st, and it is the same first
9 eight cases as before but there are two more cases added
10 to the end, so we have now got 10 cases in total.

11 Ignoring the first one where no staffing information is
12 provided, of the now nine cases, Letby's name is
13 highlighted in red in either of those two staffing
14 columns, so that's the one change.

15 So you had seen the earlier version.

16 A. Yes.

17 Q. Did you see this version, 19 January?

18 A. No. Not, not at that time.

19 Q. Did Nurse Powell discuss with you the fact
20 that she had further developed her table to include two
21 more recent deaths?

22 A. No. (Redacted). So I wasn't aware of this
23 until I came back to duty.

24 Q. Now, what you say about these charts is:

25 "I did not feel I needed to personally take these

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

3 **A.** (Nods).

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

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

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

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

17 **Q.** (*Redacted*).

18 **A.** She did.

19 **Q.** You didn't participate in the CQC visit on
20 16 to 19 February of 2016; that's correct, isn't it?

21 **A.** Correct, I wasn't on duty.

22 **Q.** We then had the thematic review, final
23 version, and you will know now that there were two
24 versions of that document, the second of which, the
25 final version had the "sudden unexpected deterioration"
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1 I knew the unit was extremely busy and I knew I needed
2 to come in and support my team (*redacted*).

3 (*Redacted*). So she did protect me a lot from this.

4 So I mainly came back to work and concentrated on making
5 sure the unit was safely staffed and as support as
6 opposed to Eirian but -- and worked clinically, so
7 (*redacted*).

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

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

17 **A.** (Nods).

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

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

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

4 **A.** Yes.

5 **Q.** Yes. Left-hand side halfway down.

6 **A.** Yes.

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

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

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

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

19 **A.** I cannot recall.

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

25 **A.** As I say, I came back to work (*redacted*) so
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1 now, Eirian and Anne Murphy, they really didn't have the
2 support of the upper exec team, and she really had no
3 one to talk to.

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

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

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

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

17 What do you mean by the word "protecting"?

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

23 Had she had any clear evidence I am sure that would
24 have been different. She wouldn't have been protecting
25 against an act. I think she just felt more of
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1 supportive of her team rather than protecting them from
2 something they had been accused of.

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

5 **A.** Sorry?

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

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

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

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

19 **A.** Pardon?

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

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

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

25 **A.** Yes.

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1 been circulated?

2 **A.** No.

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

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

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

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

22 **Q.** INQ0003089, please.

23 My Lady, this is tab 18 at page 2.

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

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

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

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

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

21 **A.** I have, yes.

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

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1 this thread which is 17 March.

2 We have looked at this before in the Inquiry:

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

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

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

12 **A.** No.

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

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

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

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

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

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

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

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

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

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

19 So that's the account that you gave --

20 **A.** Yes.

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

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

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

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

10 **A.** I presume I would have been.

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

13 **A.** I presume maybe the commonality of
14 a Consultant.

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

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

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

22 **A.** I think it was the Thirlwall Inquiry.

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

25 **A.** Yes.

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

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

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

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

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

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

22 **A.** Yes.

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

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1 **Q.** INQ0014241, please.

2 This is an email involving Karen Rees in a meeting
3 that took place and I am sure you know which one I am
4 speaking about. You are, again, on copy and there are
5 a number of attachments including that NNU mortality
6 2015.

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

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

13 **Q.** Thank you.

14 11 May 2016, so just a few days after this, we know
15 that there was a meeting involving Ms Powell,
16 Nurse Murphy and Ian Harvey and Alison Kelly --

17 **A.** (Nods).

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

21 **A.** (Nods).

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

24 **A.** Yes.

25 **Q.** So as an advocate, effectively?

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1 A. Yes.

2 Q. Do you think she also had a role to protect
3 patients?

4 A. Yes.

5 Q. And if she is acting as a spokesperson for
6 nurses, what evidence did you see, in what she said and
7 did, that she was also acting to protect patients as she
8 undertook that view?

9 A. I think Eirian openly took these charts to the
10 Executives and was asking them for their advice and for
11 their help. This is something you don't see ordinarily
12 every day and I don't feel she was hiding the evidence,
13 that these babies were actually -- and created a chart
14 of the staff. But as I say, we had no hard evidence of
15 seeing ill/wrong.

16 And I feel if, you know, two senior people have
17 taken these concerns forward then there should be that
18 process to -- to look at these.

19 Q. I am going to move forward now to the deaths
20 of Child O, and Child P. And, again, just to help you
21 I will just read out what you say in your statement.

22 In relation to the efforts to resuscitate Child O,
23 you say:

24 "I do remember Dr Brearey looking at me with
25 concern as Letby was present but once again other than

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1 tragic death of that baby, that after that was the time
2 to go and speak to Dr Brearey and say, "What is all of
3 this about?"

4 A. At that moment in time I didn't think I needed
5 to. My main concern was supporting the family, so
6 I remember sitting in the parents' accommodation,
7 supporting the family who were grieving.

8 Q. Now, what Dr Brearey has told the Inquiry in
9 his witness statement in relation to the period between
10 the death of Child O and Child P, and I will just read
11 it out to you:

12 "I had no idea at this point that Letby was
13 returning to work the following day. I could not
14 conceive that senior nursing staff would allocate Letby
15 to care for the surviving triplets. I would have
16 expected senior nursing staff to have given Letby lower
17 acuity babies to care for after the stressful events of
18 Child O's death and I knew at least two senior nurses on
19 the unit [and he names Eirian Powell and Laura Eagles]
20 were aware of the Consultants' concerns."

21 Now, you were the person in charge of the rota. Do
22 you have any comment upon what you have just heard was
23 Dr Brearey's view about that moment in time?

24 A. And is he referring to the day after or the
25 day --

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1 being present, no one raised any other concerns.

2 Dr Brearey never approached me that day to raise any
3 verbal concerns or requests."

4 Can you just help us just to set the scene for when
5 you are saying that, "Dr Brearey looked at you with
6 concern as Letby was present"?

7 A. I think it's -- obviously some instance always
8 are ingrained in your, in your mind, and I think I can,
9 I can still visualise holding the father's hand whilst
10 witnessing his child going through this. And I just --
11 so I just remember that vivid look, but I didn't really
12 think anything at that time.

13 It isn't until hindsight that I thought, gosh,
14 that's, you know. But had he maybe voiced concerns,
15 I might have done something. But some, some scenarios
16 are just -- are ingrained in your brain forever.

17 Q. You knew by then that he did have concerns
18 about Letby?

19 A. Via Eirian yes.

20 Q. Yes. And there he is giving you this highly
21 memorable look, as you have described it, which you in
22 your mind have connected with the presence of Letby.

23 A. (Nods).

24 Q. Do you think at that point, given that what
25 you were all experiencing there was the terrible and

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1 Q. Yes, so he is talking about the day of
2 Child O's death, after Child O had died, about the
3 following day. So in other words, he had no idea that
4 Letby was returning to work and could not conceive that
5 senior nursing staff would allocate Letby to care for
6 the surviving triplets.

7 Obviously, one reading of that, although he doesn't
8 name you, I make that clear, that you might be included
9 within the category of senior nursing staff, and you
10 were responsible for the rota. I just wish to give you
11 an opportunity to comment on what Dr Brearey has said
12 about his state of mind at that time.

13 A. I know I wasn't on duty on the following day
14 when she was there and, as I say, nobody during that
15 resus, apart from the look, nobody every came to me and
16 said that they had witnessed anything or seen any
17 deliberate harm. And I -- yes. That's all I can say.

18 Q. If Dr Brearey or Ms Powell had come to speak
19 to you and said, "I don't think that Letby should be
20 caring for the triplets", the two surviving triplets at
21 that stage, "on tomorrow's shift", what would you, as
22 the person in charge of the rota, have done?

23 A. I think if somebody specifically had said
24 that, then, you know, there would have been other nurses
25 to allocate.

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

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

16 Q. You say in your witness statement:
17 "To believe that Letby had done anything to harm
18 the infants was incomprehensible."

19 A. That is following, yes.

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

23 A. No, I didn't.

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

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1 Q. Just a few more questions about events
2 following.

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

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

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

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

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

23 A. (Nods).

24 Q. Do you remember using that phrase?

25 A. Yes.

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

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

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

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

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

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

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

25 A. Yes.

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

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

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

17 A. By the grievance process.

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

20 A. Yes.

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

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

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

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

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

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

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

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

24 **LADY JUSTICE THIRLWALL:** Thank you.

Questions by MR BAKER
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1 manipulative.

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

4 **A.** It is, yes.

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

10 Could we turn up, please, INQ0012986.

11 So we can see that this is a Facere Melius
12 interview on 30 June 2020. Do you recall that
13 interview? Do you recall attending an interview on
14 30 June --

15 **A.** Yes.

16 **Q.** -- 2020?

17 **A.** Yes.

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

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

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

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1 **MR BAKER:** Thank you, my Lady.

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

5 **A.** Yes.

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

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

14 **A.** (Nods).

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

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

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

3 You respond and Kay Boyle says:

4 "So were you surprised?"

5 And you answer:

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

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

11 **A.** No.

12 **Q.** You didn't know?

13 **A.** Did I think --

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

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

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

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

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

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

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

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

8 **Q.** Well, it's recorded there --

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

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

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

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

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

18 And at the final part of that section:

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

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

25 **A.** I don't think fighting her corner because we
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1 serious allegations being made against her, that you
2 couldn't possibly know the answer to?

3 **A.** Yes.

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

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

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

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

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

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

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

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

23 **Q.** Isn't that rather the point?

24 **A.** Yes.

25 **Q.** That you must have known then that there were
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1 **Q.** Again, Mr De La Poer asked you if you perhaps
2 lost perspective here, that you adopted a polarised
3 position, nurses versus doctors, do you think with the
4 benefit of hindsight that's what had happened?

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

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

13 "I know Eirian was protecting her nursing staff."

14 **A.** I can't see that, sorry.

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

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

20 **A.** Sorry, yes. Which section?

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

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

25 "I know Eirian was protecting her nursing staff and
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1 thought it only right to include medical staff in the
2 reports".

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

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

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

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

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

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

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

5 **A.** Sorry, I have --

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

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

17 **Q.** So when did you receive those statements?

18 **A.** It was two weeks Friday.

19 **Q.** And who sent them to you?

20 **A.** Hill Dickinson.

21 **Q.** Okay. And who did you contact?

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

25 **Q.** Did anybody point out to you in sending those

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1 kicks in?

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

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

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

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

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

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1 statements particular paragraphs that you needed to
2 read?

3 **A.** Pardon?

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

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

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

14 **Q.** Sorry, why were you --

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

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

25 **A.** Not that I recall, no.

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1 Q. It was only two weeks ago.
 2 A. Yes, yes. No, no.
 3 Q. Your original statements, and indeed your
 4 commentary to the police, are very clear in suggesting
 5 that you were -- you had a conversation with
 6 Stephen Brearey in October 2015.
 7 A. (Nods).
 8 Q. Your evidence this morning, as I understand
 9 it, is that Dr Brearey didn't raise any concerns with
 10 you at all before the deaths of the triplets, is that
 11 correct, in July 2016?
 12 A. He didn't actually physically speak to me,
 13 yes.
 14 Q. So to be clear Stephen Brearey, did not say
 15 anything to you at all about suspicions or concerns
 16 prior to the death of the triplets?
 17 A. Correct.
 18 Q. Can we go then, please, to INQ0003167.
 19 Again, this is the note of the grievance interview,
 20 17 October 2016, so even closer to the events than the
 21 Facere Melius interview of 2020.
 22 If you can go on, please, to page 2. We can see
 23 here under "YG" -- so "CG" is a person asking you
 24 questions and "YG", that's your response. First of all,
 25 are these the questions that you were saying are loaded

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1 said that Steve has said the commonality is Lucy on
 2 shift so that's why I was aware that Steve was
 3 concerned.
 4 Q. So you are not there recounting what you
 5 understood to be the case, namely that Steve Brearey was
 6 the one with concerns prior to the triplets?
 7 A. (Nods).
 8 Q. That's not your recollection that's recorded
 9 there?
 10 A. Yes, Steve was the only one with concerns and
 11 about Lucy, yes.
 12 Q. So you go on to say in the next paragraph:
 13 "After the second triplet passed, Lucy was on shift
 14 the next day, then annual leave."
 15 And you talk about a meeting that you attended on
 16 4th July where Steve Brearey voiced his concerns:
 17 "I was there because Eirian Powell couldn't attend.
 18 Steve Brearey wanted to go to the chief exec and we said
 19 you can't just do that on a gut feeling. He got Ravi
 20 and Dr V on board. It's not like Steve Brearey to cause
 21 trouble."
 22 I mean, what you are describing here is that
 23 Steve Brearey had had concerns prior to the deaths of
 24 the triplets, that you were aware of, and that he then
 25 brought Ravi Jayaram and Dr V on board?

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

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1 A. (Nods).
 2 Q. Now, that's in and of itself inaccurate, isn't
 3 it, because you knew that Ravi Jayaram had concerns for
 4 a lot longer than that?
 5 A. I was just more -- more aware that Steve had,
 6 and I think it was in this meeting when they were all
 7 there that that's when they all voiced their concerns.
 8 But as I say, I was never in attendance to -- no
 9 Consultant ever came to me personally and made their
 10 concerns.
 11 Q. Well, let's be clear about the use of the word
 12 "concerns" and what that means.
 13 If you can go to INQ0000531. This is your
 14 interview with the police and if we could look on
 15 page 2, please. At the bottom, you have been taken to
 16 this section before and it's:
 17 "During the 14 October 2015 Dr Brearey may have
 18 commented to me not to give Lucy Child A (sic) again for
 19 the third night."
 20 **LADY JUSTICE THIRLWALL:** Child I.
 21 **MR BAKER:** Child I, sorry.
 22 "I cannot remember any specific conversation or
 23 decision in relation to this. I am just speculating
 24 regarding anything Dr Brearey said. I think he was
 25 suspicious of her as she had been present when several

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1 babies had collapsed."

2 It wasn't concerns, it was suspicions, wasn't it,
3 it was suggesting that she had harmed babies?

4 **A.** As I say, this is an error. And I wasn't
5 aware of Dr Brearey's concerns or suspicions until after
6 the table had been created and I think, as you can see,
7 it was more "I think I had a conversation" because since
8 I have had lots of conversations with Dr Brearey and
9 I think it's, there's lots of information. I have given
10 lots of statements. And I think that was an error.

11 **Q.** Well, you say you weren't aware of his
12 suspicions until after the table was created. The first
13 table was created in October 2015.

14 **A.** Yes.

15 **Q.** Again, what you just said now is inconsistent
16 with what you said this morning, isn't it?

17 **A.** Well, no, because I was not aware -- because
18 that grievance was in 2016.

19 **Q.** You said you weren't aware of his suspicions
20 until after the table had been created.

21 **A.** I meant from him, I was aware of the
22 commonality and Steve had raised to Eirian about his
23 concerns that she was on, so to me that was a suspicion.

24 **Q.** So when did you become aware that
25 Stephen Brearey had raised with Eirian his concerns

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1 I knew she voiced that only Dr Brearey, because he was
2 our neonatal lead, spoke to her about the concerns.

3 **Q.** Can I very finally deal with the issue that
4 you raised in relation to Child C.

5 Can I be frank and upfront about what I am about to
6 say to you.

7 The -- paragraph 53 of your witness statement in
8 which you describe reference to a ventilated basket, you
9 know that a ventilated basket is a cold cot, don't you?

10 **A.** Yes.

11 **Q.** At paragraph 54, and indeed this morning, you
12 were the only witness who has not expressed horror at
13 the words that were used to Child C's parents.

14 A cold cot is not something you put a living baby
15 in, is it?

16 **A.** No, and I think I just read and I realised
17 that the mother had said, "but she hasn't died", that
18 "the baby hasn't died yet".

19 **Q.** Yes.

20 **A.** Yes.

21 **Q.** So Letby came in with a cold cot, which is
22 designed to keep a dead baby cool so that parents can
23 spend longer with them?

24 **A.** Yes.

25 **Q.** And said, "You have said your goodbyes now, do

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1 and/or suspicions?

2 **A.** After the table was created I was cc'd in that
3 email and Eirian had spoke to me and said that, you
4 know, Steve has got concerns because Letby is on shift
5 at each incident.

6 But it wasn't until after when Baby O and P, when
7 I was in that meeting that I heard actually Dr Brearey
8 voice that he had concerns.

9 **Q.** So you were aware of Stephen Brearey's
10 concerns in or around the end of 2015 when Eirian Powell
11 told you about them?

12 **A.** Yes.

13 **Q.** So the section of your grievance interview
14 which you suggested I may have misinterpreted, where you
15 said that Stephen Brearey is the only one who had raised
16 suspicions before the deaths of the triplets, in fact
17 that was based upon your firsthand knowledge that he had
18 raised suspicions, dating back from the end of the
19 previous year?

20 **A.** Yes.

21 **Q.** In fact you also knew, didn't you, that
22 Ravi Jayaram had been copied into emails to
23 Eirian Powell about raising suspicions?

24 **A.** As I say, it was just more a conversation with
25 Eirian. Email threads are cc'd to lots of people. But

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1 you want me to put him in here?" or "Do you want to put
2 him in here?" and mum said, "He's not died yet."

3 **A.** Yes.

4 **Q.** That is horrifying, isn't it?

5 **A.** It is horrifying.

6 **Q.** You would, therefore, correct what you say at
7 paragraph 54 and sharing the horror that is expressed by
8 the other witnesses in relation to that point?

9 **A.** Yes.

10 **Q.** But can I say as well that you raise here
11 that:

12 "I do not recall anyone coming to me and
13 complaining about a nurse saying the phrase", which is
14 capitalised above.

15 I can take you to your police interview, if
16 necessary. In fact, it is INQ0007707, page 20 of that
17 document.

18 This is a transcript of a recording of an interview
19 that you gave to the police. So page 20 at the bottom.
20 You previously described how you were working on the
21 12th of --

22 **LADY JUSTICE THIRLWALL:** We haven't got the page
23 yet.

24 **MR BAKER:** We are not quite there. Yes, thank you,
25 my Lady.

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1 Towards the bottom there is a reference there to:
 2 "Okay, so that was Friday the 12th."
 3 And you have previously described, a few lines up,
 4 how mum had enjoyed holding the baby but obviously she
 5 was very anxious.
 6 Earlier, you say that when you stopped your shift
 7 on the 12th, Baby C was in a stable condition and
 8 appeared to be doing, doing well?
 9 **A.** (Nods).
 10 **Q.** And that is your recollection, isn't it?
 11 **A.** Yes.
 12 **Q.** That is the evidence you gave in the criminal
 13 trial. So that was Friday the 12th. He passed away on
 14 Sunday but you weren't back in work until the Monday and
 15 you say that's right.
 16 **A.** Yes.
 17 **Q.** So Baby C died at a little before 6 am on
 18 Sunday the 14th of June. You weren't in until the
 19 Monday so you weren't there for anybody to complain to
 20 you about what had been said?
 21 **A.** Correct.
 22 **Q.** So there is nothing unusual at all about the
 23 fact that nobody complained to you?
 24 **A.** No.
 25 **MR BAKER:** Thank you.
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1 Were you aware of that?
 2 **A.** No.
 3 **Q.** Were you aware of the rashes or the mottling
 4 that had been found on Child A when he collapsed?
 5 **A.** No.
 6 **Q.** Or Child B?
 7 **A.** No.
 8 **Q.** So you are not aware of any communications
 9 about that either between the staff or between the staff
 10 and --
 11 **A.** Not that I recall, no.
 12 **Q.** Mother A's evidence is that she arrived,
 13 effectively, to a scene where her child had collapsed
 14 and was being resuscitated with a lot of staff around
 15 him and that during that period a nurse came up to her
 16 and asked if she wanted to say a prayer.
 17 This was before she had been told what was going on
 18 and whether her child would die. Do you recognise that
 19 that is inappropriate to say to a mother who doesn't
 20 know if her child is going to die, in fact doesn't know
 21 what's going on, if she wants to say a prayer?
 22 **A.** Yes.
 23 **Q.** Another point raised by Father M in his
 24 evidence to the Inquiry is that he had the impression
 25 when he was on the unit that he felt that his child
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1 Thank you, my Lady, I have no more questions.
 2 **LADY JUSTICE THIRLWALL:** Thank you very much
 3 indeed, Mr Baker.
 4 Mr Skelton.
 5 Questions by MR SKELTON
 6 **MR SKELTON:** Ms Griffiths, a few questions first
 7 about Mother A and -- Mother A and B.
 8 First of all, information provided to her by the
 9 nursing staff. Are you aware that she was told that her
 10 children were doing well, albeit they were premature,
 11 and that particularly Child A was doing really well?
 12 **A.** Yes.
 13 **Q.** And therefore the collapse and death of
 14 Child A was a complete shock both to her and to everyone
 15 else that was caring for her?
 16 **A.** (Nods).
 17 **Q.** What was your explanation for the death of
 18 Child A?
 19 **A.** I didn't recall until I see because --
 20 I wasn't personally involved, I don't think, in the
 21 care of Child A.
 22 **Q.** The reality was, wasn't it, that there was no
 23 probable cause for his death found by the clinical staff
 24 and indeed that continued to be the case right up to and
 25 including the Inquest that took place a year later.
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1 wasn't his own and he felt that the nurses or the staff
 2 were the ones in charge and wanted to care for him
 3 rather than the parents.
 4 Do you see that as being problematic?
 5 **A.** I think when a baby is first admitted often,
 6 especially fathers, it's very stressful and distressing
 7 and I think initially if the babies do need that care
 8 then it can appear that the nurses are doing all that
 9 care.
 10 I know now that we have Family Integrated Care, so
 11 that has changed dramatically and, you know, the family
 12 are really involved in the care.
 13 I can't really say anything regarding that
 14 situation but I know the nurses, you know, try and
 15 encourage parents to be a part of that but I think if
 16 it's busy, the babies are needing attention, then the
 17 nurses are more concentrating on, on that. And I don't
 18 like to hear that they didn't feel that they were
 19 welcomed because that's not what we, you know, want
 20 families to feel.
 21 **Q.** And also that they have contact with the
 22 child, you recognise that's important? He --
 23 **A.** Especially important, and I think, you know,
 24 especially fathers, they never -- they feel too scared
 25 to hold their babies, but it's so important, so we do --
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1 that loving close relationship, we, we, you know, we do
2 realise that is most important.

3 **Q.** So the fact that he didn't feel encouraged to
4 handle his child until he went to Alder Hey, that's
5 something perhaps that shouldn't have occurred?

6 **A.** That shouldn't have occurred.

7 **Q.** Can I ask you about your reflections about
8 what has gone on at your hospital.

9 You said to counsel to the Inquiry that by early
10 2016, you had no concerns yourself and you kept an open
11 mind.

12 **A.** (Nods).

13 **Q.** But the reality is, from your statement both
14 to this Inquiry and during the grievance process, is
15 that you talk repeatedly about speculation on the part
16 of the Consultants; in other words, they didn't have any
17 particular concrete reason to be concerned about Letby,
18 to be suspicious of her, they were speculating?

19 **A.** Yes.

20 **Q.** Do you recognise that that is effectively
21 dismissing their concerns?

22 **A.** I think if I would have said that the concerns
23 were true then I would have -- and I just don't like
24 sides. You know, there isn't this side or that side.

25 We all want to get to the common goal of finding out
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1 suggested that he was anything other than a caring,
2 competent professional, correct?

3 **A.** Correct.

4 **Q.** He and other Consultants of similar similarity
5 and experience began to suspect that a member of staff
6 was harming children. That in itself, his seniority,
7 his experience, his concern, is significant, isn't it?

8 **A.** Yes.

9 **Q.** And ordinarily, if a child comes into hospital
10 and any healthcare professional has a concern that that
11 child is being harmed you have to take active steps to
12 prevent that child from being harmed any further, don't
13 you?

14 **A.** Yes.

15 **Q.** And it doesn't -- you don't need proof of the
16 harm, you don't need to have had a photograph of the
17 parent injuring the child or the school teacher abusing
18 the child. If you are suspicious you have to act,
19 correct?

20 **A.** Correct.

21 **Q.** And indeed, that accords with one of the
22 nurse's primary duties as a nurse, as a healthcare
23 professional. Your first duty is to your patients;
24 that's right, isn't it?

25 **A.** Correct.

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1 what is the problem.

2 And I just -- for my own sanity I had to keep that
3 neutral. The nurses were very upset wondering why this
4 nurse was taken away and it was like, it's okay, we are
5 supporting Lucy, the execs were coming in and saying,
6 "Don't worry, Lucy is okay, she's being supported", but
7 then I didn't dismiss, especially the latter part, going
8 to court, the beliefs of the Consultants either.

9 And I think it's -- hindsight is a wonderful thing
10 and if I would have had all the information that
11 I received following the arrest, then that would have
12 been a bit more clearer and I just feel often you are
13 always in that difficult situation where not being able
14 to disclose information, and I think that's been
15 throughout the whole process for the nurses and for,
16 especially the nurses because it's very difficult to
17 share those concerns that we have about a certain member
18 because obviously you've got to protect their, their
19 confidentiality as well and I don't even know where I am
20 going with this.

21 **Q.** Can I just take it in stages. Dr Brearey was
22 a highly experienced senior doctor. He had been
23 treating sick babies for many, many years?

24 **A.** (Nods).

25 **Q.** And there -- nobody in this Inquiry has
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1 **Q.** Not to your colleagues or your friends or
2 anyone else but to the patients, the service users in
3 the hospital?

4 **A.** Yes.

5 **Q.** So when a Consultant comes to you and says,
6 "I am concerned that there is a member of staff harming
7 children", the first duty you have is not to the person
8 who may be harming the children but to the person who
9 may be harmed; do you understand that?

10 **A.** Yes.

11 **Q.** And it's correct, isn't it?

12 **A.** Yes.

13 **Q.** It's basic.

14 **A.** (Nods).

15 **Q.** In this case, what it appears from your
16 statement and from the contemporaneous records is that
17 you thought that Dr Brearey was running a witch hunt
18 against Lucy Letby, you used that word, unprompted,
19 repeatedly, in an interview and you didn't correct it
20 when you had the chance. In other words, there was
21 something malicious about the way she was being treated
22 by this senior experienced doctor.

23 Is that right?

24 **A.** If that's been written down.

25 **Q.** Well, you said it.

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1 A. I did but, as I say, at the time I wasn't
2 suspected of anything -- I wasn't suspecting a nurse to
3 do such evil things and I think all the deaths were
4 reviewed by a lot of senior clinicians and everything
5 was gone through and there was a cause of death for the
6 babies.

7 So I wasn't suspicious that a nurse had actually
8 done deliberate harm.

9 Q. But there wasn't a cause of death, was there,
10 for all the babies? Child A, who I have just asked you
11 about at the start of my questions, there wasn't a cause
12 of death, right up until the point of the Inquest,
13 no one knew what he died from, and that was the primary
14 problem, wasn't it, these babies had unexpectedly
15 collapsed without explanation?

16 The Consultants had spent a very long time and
17 a great deal of energy looking to see if they could find
18 what the explanations were and they haven't found them
19 so they were driven to the possibility that it may have
20 been deliberate harm. And presumably they were as
21 unwilling as everyone else to contemplate that
22 possibility because it is horrifying but they needed
23 today, they had a duty to, didn't they?

24 A. Mmm.

25 Q. Now, you had that duty, too. In other words,
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1 didn't embrace change, guidelines, we were a very highly
2 skilled workforce and not one of us saw anything that we
3 would have been suspicious of and I appreciate that the
4 doctors did have -- think of that but all they had was
5 the commonality and I think on that chart there was
6 a lot of commonalities, not just one nurse.

7 Q. Would you want to send a friend or a family
8 member to a unit in a hospital where the senior
9 Consultants almost unanimously thought that a nurse was
10 killing patients?

11 A. Personally I wouldn't but, as I say, I didn't
12 think that at that time.

13 Q. But as I say, your duty was to the patients
14 and you weren't 100% certain they were wrong. So I am
15 putting to you that you should have taken action
16 personally to ensure the safety of the patients on your
17 unit. What is your response?

18 A. I accept your conversation, your critique.

19 MR SKELTON: Thank you.

20 LADY JUSTICE THIRLWALL: We haven't finished yet,
21 I just want to ask you something about the morphine --

22 A. Yes.

23 LADY JUSTICE THIRLWALL: -- pump error.

24 So the morphine was being pumped at 10 times the
25 rate that it should have been, understood. That it was
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1 you needed to confront that possibility, not to think of
2 protecting Lucy Letby from a witch hunt but to think
3 that actually it might be possible and if it is, what do
4 I need to do?

5 Do you recognise that?

6 A. Yes.

7 Q. And you weren't in a position to be 100%
8 certain at any stage that the Consultants were wrong,
9 were you?

10 A. No.

11 Q. Dr Holt gave evidence a few weeks ago and she
12 said that the touchstone that she would use is that if
13 she had to speak to her friends or her family about
14 coming into the unit, what would she want to say to them
15 and she would be concerned to allow anyone to come into
16 a unit where someone was suspected of murdering the
17 patients, and that is an obvious point, isn't it?

18 A. Yes.

19 Q. In what way did you protect these babies from
20 being murdered in that situation?

21 A. I suppose my role, as I say, as the deputy
22 manager, not the manager, taking things forward I just
23 had to ensure that the unit was staffed appropriately,
24 that the staff were confident.

25 If there was a negative culture on the unit that
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1 observed about an hour after that had been done?

2 A. (Nods).

3 LADY JUSTICE THIRLWALL: I just would like to know,
4 what are the parents told in that situation?

5 A. The parents would have been informed of the
6 error at that time.

7 LADY JUSTICE THIRLWALL: What would they have been
8 told about the reason for the error?

9 A. They would have just been told that it's been
10 programmed in wrong and it's been administrated at that
11 dose, at that rate, and it was caught within one hour
12 and that that person has been spoken to, the two people,
13 and that things have been put into place.

14 LADY JUSTICE THIRLWALL: So there would have been
15 a full explanation to the parents?

16 A. Yes.

17 LADY JUSTICE THIRLWALL: Thank you very much.
18 I have no other questions.

19 Did you have anything else, Mr De La Poer?

20 MR DE LA POER: No, thank you, my Lady.

21 LADY JUSTICE THIRLWALL: Well, thank you very much
22 indeed for coming to give evidence today.

23 I realise you have been in the witness box for
24 quite some time (*redacted*).

25 Thank you for coming to help.
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1 Now, is there a break for --

2 **MR DE LA POER:** My Lady, I am informed we need
3 a full 15 minutes to re-arrange but my expectation is
4 that that will not prevent a 4.30 finish.

5 **LADY JUSTICE THIRLWALL:** Very well. If we need
6 15 minutes, we better take that. So 4 o'clock.

7 (3.44 pm)

8 (A short break)

9 (4.02 pm)

10 **LADY JUSTICE THIRLWALL:** Yes.

11 **MR DE LA POER:** My Lady, the final witness for
12 today is Nurse Anne McGlade, please.

13 **LADY JUSTICE THIRLWALL:** Ms McGlade, will you come
14 forward.

15 MS ANNE ELIZABETH McGLADE (affirmed)

16 Questions by MR DE LA POER

17 **LADY JUSTICE THIRLWALL:** Do sit down.

18 **A.** Thank you.

19 **MR DE LA POER:** Two matters of formality before we
20 start. The first is, can you give us please your full
21 name.

22 **A.** It's Anne Elizabeth McGlade.

23 **Q.** Can you confirm that you provided to the
24 Inquiry a statement dated 3 June of this year?

25 **A.** That's correct.

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1 bravery, at the way they are dealing with what has
2 happened to their babies.

3 Thank you.

4 **Q.** Thank you. If we begin with your background,
5 please. Did you qualify as a nurse in 1996?

6 **A.** I did, yes.

7 **Q.** And did you start that same year at the
8 Countess of Chester Hospital?

9 **A.** Yes.

10 **Q.** And did you become the children's ward manager
11 in 2012?

12 **A.** That's right, yes.

13 **Q.** And within the management structure, was your
14 immediate and direct line manager Anne Murphy?

15 **A.** That's right, yes.

16 **Q.** And effectively, although I daresay your unit
17 was larger than the neonatal unit, you sat in an
18 equivalent position to Nurse Eirian Powell --

19 **A.** That's correct.

20 **Q.** -- is that right?

21 **A.** Yes.

22 **Q.** You were both head of your respective parts
23 with Anne Murphy sitting above both of you?

24 **A.** That's right, yes.

25 **Q.** In terms of which of the two of you, as unit

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1 **Q.** And there are just four matters, which I will
2 just read out to you, that you wish to correct in that
3 statement, I will just run through them, that at
4 paragraph 21 the word "student" should read "staff";
5 that at paragraph 27, "2017" should be "2016"; that at
6 paragraph 37, in relation to the typed version of the
7 notes that you took for your July 2016 exercise, they
8 were prepared by someone else and the passage in red
9 does not correspond?

10 **A.** Yes.

11 **Q.** And finally, that at paragraph 39, "2017"
12 should be "2016"; is that right?

13 **A.** I think the "2016" should be "2017" for both
14 of them, actually.

15 **Q.** Thank you.

16 Other than those corrections that you have just
17 agreed to, are the contents of that statement true to
18 the best of your knowledge and belief?

19 **A.** It is, yes.

20 **Q.** So we will start, please, as I understand you
21 want to make a statement.

22 **A.** Yes, I would like to.

23 Before I start I would just like to give my sincere
24 condolences to all The Families that have been affected
25 leading us to be here today. And I am in awe at their

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1 heads, would act up? Was it the position that you would
2 act up in the event that Anne Murphy was not available?

3 **A.** That's right, yes.

4 **Q.** And were there a number of occasions over the
5 course of 2014, '15 and '16 when it was necessary for
6 you to act up?

7 **A.** Yes, that's right.

8 **Q.** And I think we are going to see an example of
9 one of those occasions when it comes to the report that
10 you participated in?

11 **A.** Yes.

12 **Q.** So having introduced you, tell us please in
13 your own words what your perception was of the sister
14 unit to yours, the neonatal unit; what was your view of
15 the culture and atmosphere?

16 **A.** It was a professional relationship with the
17 staff. They were very, they were a busy Level 2 unit
18 and it was -- the culture was like it was on
19 paediatrics, we are very close as a medical and nursing
20 team and we would work together very well.

21 **Q.** In early 2015, so before the period that we
22 are going to focus upon, did you perceive any
23 difficulties between any of the relationships between
24 nurses and each other and between nurses and doctors?

25 **A.** In early 2015?

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1 Q. Exactly.

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

3 Q. No. Did there come a time when you perceived
4 some tensions within the relationships?

5 A. Yes. I would say that was mid-2016 when there
6 were -- when I initially found out there was some
7 suspicions that a member of staff could be hurting
8 babies on the neonatal unit and I know that my nursing
9 colleagues, Eirian and Anne, did not feel the same way
10 as the medical staff so I think that was potentially
11 causing some issues.

12 Q. Well, we will come to that in the
13 chronology --

14 A. Okay.

15 Q. -- but I would just like to focus on those
16 relationships and how people were before the tensions
17 arose.

18 A. Yes.

19 Q. What sort of manager was Eirian Powell?

20 A. I mean, bearing in mind I work on the
21 Children's Unit, so Eirian, it was a very separate
22 entity, the neonatal unit to paediatrics, but to me
23 Eirian was a good manager.

24 She was fair with the staff. She had a good
25 relationship with the staff. They had high standards on
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1 have been Anne Murphy that would have gone to that and
2 me in turn.

3 So I can't, I don't recall Eirian being at
4 safeguarding meetings that I attended.

5 Q. At any of the safeguarding meetings that you
6 attended over the period 2015, '16 and '17, was
7 a concern that a member of staff on the neonatal unit
8 might be harming babies ever raised?

9 A. No, not that I can recall.

10 Q. In your view, would it be appropriate even if
11 not naming the member of staff for such a concern to be
12 raised at those meetings?

13 A. I don't think it would have been appropriate
14 to have raised them at those meetings. But I do think
15 it would have been appropriate to have raised them out
16 of those meetings with the safeguarding team.

17 Q. Had any of the safeguarding training that you
18 had received helped you to understand what you should do
19 in the event that you suspected that a colleague was
20 deliberately causing harm to a patient?

21 A. Are we referring to 2015 or now?

22 Q. 2015.

23 A. 2015, no.

24 Q. One thing you do say, and we will need to be
25 clear about when in time you are talking about, you say:
203

1 that unit that I could see. We would both attend the
2 meeting of managers and we would give regular updates
3 regarding our services and yes, that was the general
4 feel that I had.

5 Q. We have heard it suggested that she may have
6 had favourites; was that something, a suggestion that
7 you were aware as being made at the time?

8 A. No, I wasn't aware of that.

9 Q. Now, did you have a safeguarding role as part
10 of your duties?

11 A. As ward manager for the children's unit yes, I
12 would have. Part of my role would be to ensure that we
13 adhered to our safeguarding policies and guidelines.

14 Q. And did that responsibility require you to
15 attend any meetings in that capacity?

16 A. Yes, I would attend safeguarding meetings both
17 as a manager and as acting up as Anne Murphy for lead
18 nurse, so we would have regular safeguarding meetings
19 that we would attend.

20 Q. And did Nurse Powell also attend those
21 meetings or was that particular to your role as head of
22 the Children's Unit and when acting up?

23 A. I can't recall actually. I think because
24 I was acting up for Anne on some of those meetings,
25 Eirian would not have been at those because that would
202

1 "The training instructs you to report any concerns
2 even if others may not agree or have the same concerns."
3 So that is quite a general statement about the
4 approach you should take.

5 A. Yes.

6 Q. Are you there referring to training which
7 existed in 2015 and '16?

8 A. So what I am referring to there is if, for
9 example, there was a child on the ward who, for example,
10 a nurse had safeguarding concerns for and maybe the
11 medical staff didn't agree, as a nurse we would still
12 have that responsibility to do that referral to
13 safeguarding regardless of what our medical teams, you
14 know, if they weren't in agreement.

15 Q. And was that the position in 2015?

16 A. Yes.

17 Q. So whilst there was no specific training on
18 particular circumstances involving a colleague --

19 A. Yes.

20 Q. -- there was general training that it didn't
21 matter what your colleagues were saying, if you had that
22 concern you should act upon it?

23 A. Yes. Yes.

24 Q. Unusually, but I think it will be a helpful
25 way of doing this, I would like to just bring up a part
204

1 of your statement on to the screen so everybody can see
2 what you have said about safeguarding.

3 **A.** Okay.

4 **Q.** So it is INQ0101322, and we are going to go to
5 paragraph 46, please, which is at the bottom of page 10.

6 This is in your reflections section so we can crop
7 straight into that, please.

8 I would just like you to just remind yourself of
9 what you said here in your statement and as you just
10 refresh your memory from it once, you are ready I will
11 just draw your attention to one or two elements and ask
12 you to amplify them.

13 **A.** Okay.

14 (Pause)

15 Okay, thank you.

16 **Q.** We will need to tip over the page but I think
17 we can start on this page.

18 One of the things you say in the fourth line is:

19 "I do not understand why Lucy Letby was allowed to
20 continue working in a clinical environment when medical
21 colleagues' concerns had apparently been escalated.
22 Anyone who had allegations like these shouldn't have
23 been working clinically."

24 Can you just tell us, please, why you say that?

25 **A.** Because, first and foremost, we are there to
205

1 And you then go on to set out the procedure which
2 is a strategy meeting.

3 **A.** Yes.

4 **Q.** And then you add this:

5 "As a Trust we would be expected to say how we
6 would be investigating these issues. This process has
7 been in place since 2013."

8 So, again, can I just ask you to amplify a little
9 what you have said there?

10 **A.** So, actually, when I was putting this
11 statement together, I Googled -- I don't have the policy
12 that was in place at the Trust in 2015/16, but I Googled
13 the process called LADO, so I just Googled to see how
14 long that had been around, and 2013 was the date. So
15 that's how I came to the date.

16 **Q.** And did you come across a document which is
17 commonly referred to as Working Together?

18 **A.** Yes.

19 **Q.** So is it that that you discovered the 2013
20 version which we know there was one that set out that
21 procedure?

22 **A.** I would have to look at the document to
23 absolutely confirm it. But, yes.

24 **Q.** In terms of your awareness at the time of the
25 procedure, I appreciate you are sitting here in 2024
207

1 protect patients that we are looking after. And we also
2 have a duty of care to our staff so all allegations need
3 to be investigated and that member of staff, in my
4 opinion, should be removed while those investigations
5 take place.

6 **Q.** Can I just explore with you what the threshold
7 for that is. In the event that a doctor or a nurse
8 thinks, "Having thought about it carefully and
9 investigated what I can, I think there is a chance that
10 a colleague of mine is harming babies", is that enough
11 for action?

12 **A.** For me as a manager, yes, it would be.

13 **Q.** Now, you say two-thirds of the way down the
14 paragraph:

15 "At the very least Lucy Letby should have been
16 stood down from clinical practice earlier to safeguard
17 the babies."

18 And then you say this:

19 "As a senior nurse in my role today I know that any
20 nurse that works with children and faces allegations
21 pertaining to causing harm to a baby or child would be
22 stood down immediately until a thorough investigation
23 had been carried out and any nurse that is accused of
24 harming a baby or [and over the page] child would be
25 referred to the Local Authority Designated Officer".
206

1 Googling --

2 **A.** Yes.

3 **Q.** -- to just try and reconstruct things, but do
4 you think you knew about that process in 2015/16?

5 **A.** No, I didn't. No.

6 **Q.** And who, bearing in mind that you had a role
7 that went to safeguarding meetings --

8 **A.** Yes.

9 **Q.** -- whose responsibility would it have been in
10 the hospital to ensure that you did know about that in
11 2015?

12 **A.** Well, I would have to take some responsibility
13 of that as a manager. But I also cannot remember
14 exactly what was laid out in our safeguarding training
15 at that time. So I would imagine the Trust have
16 a responsibility in terms of the training that was
17 rolled out to ensure that we have the correct
18 information.

19 Yes.

20 **Q.** Thank you. We can take that down.

21 So I would like to move off the topic of
22 safeguarding and just touch briefly upon the period of
23 Letby's training. So this is her training as a student
24 and then her very earliest period.

25 Did anybody at any stage make you aware of any
208

1 concerns about the period of Letby's training?

2 **A.** The only concerns I was aware of was when she
3 was on my ward doing her third-year last placement and
4 she was doing her management OSCE with us, and at that
5 point there were concerns that she potentially wasn't
6 ready and wouldn't pass the OSCE.

7 **Q.** And did you have any direct involvement in the
8 management of that or was that something that was taken
9 forward with the deanery?

10 **A.** It was the deputy ward manager that was
11 actually mentoring Lucy Letby at that time and I can't
12 remember exactly the conversation that we would have
13 had, but as my deputy she would have informed me there
14 were concerns. It is very unusual for a third-year
15 nurse to get to that stage where they are failing at
16 that point. So it would have been a topic of
17 conversation for us.

18 **Q.** So that is all I want to ask you about Letby's
19 training. I want to turn next to the topic of when you
20 first became aware of a number of facts that we now know
21 very well.

22 So the first fact is: when did you first become
23 aware that there was an increase in the mortality rate
24 on the neonatal unit?

25 **A.** I think that would have been when I attended
209

1 I think it was around that time.

2 **Q.** And when you first learned that a Consultant
3 or Consultants were concerned about a particular member
4 of staff, did you also learn at the same time that their
5 concern was about the possibility of deliberate harm or
6 was it not so clearly defined as that?

7 **A.** It's hard to remember due to the passage of
8 time but I think it was around -- the suspicions were
9 that it was related to a member of staff.

10 **Q.** And deliberately or incompetently or was it
11 not specified?

12 **A.** I think the inference was it was deliberate.
13 Yes.

14 **Q.** And doing the best you can, who do you think
15 you learned this from?

16 **A.** This would have either been at one of our
17 Monday lunchtime senior clinicians meeting, with the
18 Consultants, or it would have been a conversation with
19 Anne Murphy and Eirian Powell.

20 **Q.** Now, we know that on 27 June there was
21 a senior paediatrician meeting --

22 **A.** (Nods).

23 **Q.** -- the Monday meeting, at which the evidence
24 suggests that the Consultants were speaking openly about
25 their concern that deliberate harm may have been caused.

211

1 a Women & Children's Governance meeting. I think that
2 was in November or December of 2015.

3 **Q.** We are going to have a look at that document
4 in a moment.

5 **A.** Yes.

6 **Q.** So you think that is moment in time that you
7 first became aware of it?

8 **A.** Yes.

9 **Q.** So I won't ask you any more questions about
10 that for now. We will come back to it.

11 When did you first become aware that a Consultant,
12 or more than one Consultant, was concerned about
13 a particular member of staff?

14 **A.** I think, and I cannot recollect exactly, but
15 I suspect that was around June/July of 2015.

16 **Q.** If we date stamp a moment in time, you were
17 asked in early July together with Dr Gibbs --

18 **A.** Yes.

19 **Q.** -- to undertake a review. Do you think it was
20 before or after that request?

21 **A.** It was before.

22 **Q.** And do you think it was immediately before, as
23 part of your briefing for that, or do you think you had
24 known for some time?

25 **A.** No, I don't think I had known for some time.
210

1 Does that sound like the meeting that you are
2 recollecting, where there is an open conversation or was
3 it more guarded?

4 **A.** I don't think I was at that meeting so I think
5 it was afterwards I found out those concerns.

6 **Q.** So we have also heard about a meeting on
7 4th July, we just heard about that from your colleague
8 Nurse Griffiths. Might that have been the occasion --

9 **A.** Possibly.

10 **Q.** -- if not the 27th?

11 **A.** Yes.

12 **Q.** You worked in the same department but on
13 a different unit.

14 **A.** Yes.

15 **Q.** Do you think you should have been told sooner
16 than that of those concerns?

17 **A.** We were, at that time, which is very different
18 to how we work now, we were very, very separate units.
19 So whether I should have been told or not, I wasn't.

20 **Q.** Now, we will just look briefly at a couple of
21 documents. The first is the one that you have referred
22 to, the Women's & Children's Care Governance Board
23 of December 2015. This is INQ0004371.

24 We can see that Dr Brearey attended in lieu of
25 Dr Jayaram, do you see that about halfway down?

212

1 A. Sorry.
 2 Q. It is the entry immediately above your name.
 3 A. Oh, yes. I can see Dr Jayaram -- yes, sorry,
 4 Dr Brearey attended.
 5 Q. Dr Brearey has attended in his stead?
 6 A. Yes.
 7 Q. And you are identified in the row below?
 8 A. That's right, yes.
 9 Q. So we don't need to go through these minutes
 10 but just doing the best you can, what's your
 11 recollection of what was said at this meeting about the
 12 increase in the mortality rate?
 13 A. I'm afraid I have no recollection of the
 14 report that would have been presented at that meeting.
 15 Q. But you can see that you were there.
 16 A. I was, yes.
 17 Q. And you have no reason to doubt the minutes.
 18 A. No, no, not at all no.
 19 Q. If it had been the case that Dr Brearey or
 20 other Consultants were by that stage concerned about
 21 Letby, in particular, was that an appropriate forum for
 22 that to be raised?
 23 A. I -- I couldn't -- yes, I would say it would
 24 be an appropriate forum for that to have been raised.
 25 Q. Because you have said it wouldn't be
 213

1 mentioning what you were aware of in the wider
 2 department or was that for the neonatal unit to say?
 3 A. It's not that it wouldn't be appropriate for
 4 me to say it. I think the assumption that I would have
 5 had, and had, was that as they were doing a review of
 6 the neonatal unit, that the increase in mortality would
 7 have been discussed at that point.
 8 Q. So you would have expected your colleagues on
 9 the neonatal unit to say something about that to the
 10 CQC?
 11 A. Yes, and I would have expected the CQC to have
 12 asked about that. Yes.
 13 Q. Now, there came a moment in time where you
 14 were told about something you have described as gossip.
 15 A. Yes.
 16 Q. Do you think that was before or after you were
 17 informed in early July about the Consultants' concerns?
 18 A. It was after.
 19 Q. And did you take steps to make clear that such
 20 gossip, as you viewed it, was not appropriate?
 21 A. Yes. Because at that point I was aware that
 22 allegation, serious allegations had been made by the
 23 Consultants and that reviews were taking place. And
 24 obviously this was so sensitive that, yes, you know, we
 25 had to -- the message very clearly coming to us as
 215

1 appropriate to raise it in one of your safeguarding
 2 meetings but I am just really trying to look at, within
 3 the governance structure, how does something like that
 4 get reported up?
 5 A. Yes, yes.
 6 Q. And, to your mind, having been at such
 7 meetings --
 8 A. Yes.
 9 Q. -- even if the member of staff is not named,
 10 is it your view that nevertheless something should be
 11 said there?
 12 A. Yes.
 13 Q. Thank you. We can take that down.
 14 In February of 2016, did you meet with the CQC?
 15 A. Yes, I did, yes.
 16 Q. And was that effectively to show them round
 17 your ward?
 18 A. That's right, yes. Yes, it was a full
 19 inspection that was carried out over several days.
 20 Q. And by that stage, we can see from the meeting
 21 that you knew something about the increase in the
 22 neonatal mortality?
 23 A. (Nods).
 24 Q. In your view was that an appropriate forum for
 25 you, showing the CQC around the Children's Unit, to be
 214

1 managers was that we had to make sure that this wasn't
 2 being gossiped about because that would be very unfair
 3 for the investigation process.
 4 Q. Dealing with your reaction to learning about
 5 the Consultants' concerns and obviously subsequent
 6 gossip, you describe yourself as shocked and horrified
 7 that someone could do this.
 8 A. Yes.
 9 Q. And did you become aware of what your nursing
 10 colleagues, Nurse Powell's and Nurse Murphy's, views
 11 were?
 12 A. Yes.
 13 Q. And how soon after you learned of the
 14 Consultants' concerns do you think that was?
 15 A. I think it was all around the same time.
 16 Q. Did you speak to them directly and in private
 17 or is it simply conversations in public spaces or when
 18 others were present that you learned of their position?
 19 A. I am assuming you are talking about Anne and
 20 Eirian.
 21 Q. Yes.
 22 A. We would have had a private conversation and
 23 I did ask how they could be so sure as to know that it
 24 could possibly not be the case. I wasn't privy to, at
 25 that point, the information that they had been given
 216

1 from our medical colleagues, but I could only assume
 2 that maybe they didn't have the full picture because of
 3 their views that they had.
 4 **Q.** So let's just examine that just for a moment.
 5 **A.** Yes.
 6 **Q.** The starting point is: did they tell you what
 7 they thought about the Consultants' views?
 8 **A.** They told me what the Consultants' suspicions
 9 were.
 10 **Q.** And did they tell you about their own opinion
 11 about those suspicions?
 12 **A.** They said that -- I think they wanted a more
 13 generic approach to what was being investigated, to not
 14 rule anything out.
 15 **Q.** You use the phrase in your witness statement
 16 that "they didn't agree".
 17 **A.** Yes. Yes.
 18 **Q.** And when you are saying they didn't agree, are
 19 you saying they didn't agree that there were grounds to
 20 be suspicious? Is that what they weren't agreeing with?
 21 **A.** They -- they didn't agree and hence wanted
 22 a more generic look at what potentially could be
 23 going on.
 24 **Q.** That, of course, prompted you to say. How can
 25 you be so sure --

217

1 **A.** The remit of the -- what I was asked to do was
 2 to look at nursing notes of a list of babies that we
 3 were given and to look for something that looked, you
 4 know, sorry. The remit that we had was for babies that
 5 had been transferred out after collapse. And we were
 6 given a list of the babies to look at, I looked at the
 7 nursing notes, Dr Gibbs looked at the medical notes.
 8 So from a point of view of areas that could be
 9 suspicious or unusual, that was led by Dr Gibbs because
 10 yes, you are quite right, I am not a neonatal nurse and
 11 for me, you know, that isn't my area of speciality.
 12 **Q.** So you say that I am quite right. Does it
 13 come to that perhaps you weren't quite the right person
 14 to be undertaking that role of looking at the nursing
 15 notes to look for what was suspicious in a specialty
 16 that wasn't yours?
 17 **A.** I think -- undertaking the remit that we had,
 18 I think I was able to do that. But what I wouldn't have
 19 been able to do, and didn't do, was say that, you know,
 20 I thought this was wrong or this, you know, Dr Gibbs
 21 very much led that.
 22 **Q.** But Dr Gibbs was only looking at the medical
 23 notes, he wasn't looking at the nursing notes, so he
 24 wouldn't be able to do that from a nursing perspective;
 25 is that right?

219

1 **A.** Yes.
 2 **Q.** -- that there are no grounds to be suspicious
 3 presumably?
 4 **A.** Yes.
 5 **Q.** That is what you were challenging them on.
 6 **A.** Yes, yes.
 7 **Q.** And what did they say in response to that
 8 challenge?
 9 **A.** I think the initial comments were that other
 10 people were present at the times of potentially, you
 11 know, collapses, et cetera. But, again, I wasn't privy
 12 to a lot of the information that perhaps they were or
 13 they weren't privy to.
 14 **Q.** And was that all that was said between you or
 15 was there any other discussion that emanated from their
 16 response?
 17 **A.** No, no.
 18 **Q.** A final matter to ask you about, Ms McGlade,
 19 is your review with Dr Gibbs.
 20 **A.** Yes.
 21 **Q.** You were asked to undertake that review with
 22 him, is that right?
 23 **A.** That's right. Yes.
 24 **Q.** Do you think you were appropriately qualified
 25 to do the role that you undertook with him?

218

1 **A.** What was happening, he would read out the
 2 medical notes, I would read out the nursing notes, so he
 3 would know what I was looking at. Yes.
 4 **Q.** But he wouldn't have a particular nursing
 5 perspective on what --
 6 **A.** No, and obviously as a children's nurse,
 7 I can, you know, pick out some situations that looked
 8 unusual. But that would always be confirmed by
 9 Dr Gibbs.
 10 **Q.** And in summary, is this right, that of the
 11 30 or 40 cases that you looked at, six stood out as
 12 unexpected deteriorations or collapses?
 13 **A.** That's right, yes.
 14 **Q.** So even assuming 40 cases, someone will check
 15 my maths, but I think that's 15% of the cases that you
 16 were looking at?
 17 **A.** (Nods).
 18 **Q.** Did you regard that as a very small number and
 19 not a cause for concern or did you think, gosh, that's
 20 quite a lot of cases where we don't have an explanation?
 21 **A.** I think, personally, that's quite a lot, yes.
 22 **Q.** Did you ever convey that opinion about the
 23 number that you had uncovered to anybody outside of your
 24 conversation with Dr Gibbs?
 25 **A.** No, because I wasn't asked.

220

1 Q. Did you ever receive any feedback on the work
2 that you had done and how it fitted into the larger
3 picture?

4 A. No.

5 Q. And were you expecting either you or Dr Gibbs
6 to receive some feedback?

7 A. Yes.

8 Q. And so what did you think happened to the work
9 that you and Dr Gibbs did?

10 A. My understanding was that it was going to be
11 part of a larger review, that it was going to be looked
12 at from a staffing point of view because part of the
13 remit of what we were doing, we weren't looking at
14 doctors or nurses that were taking care of the babies,
15 we were purely looking at the medical and nursing
16 information.

17 So my understanding was that our report was then
18 going to be looked at, analysed and the staffing grid
19 would be, would be looked at.

20 Q. Now, you have described it as a report. In
21 fact, in terms of what you handed over, was it some
22 handwritten notes that you had made along the way?

23 A. Absolutely, yes. So it wasn't -- we hadn't
24 tidied it up, there was no conclusion written there, was
25 no introduction, it was literally just some handwritten

221

1 might have turned out differently?

2 A. Yes.

3 MR DE LA POER: Yes, Nurse McGlade, thank you very
4 much indeed for answering my questions.

5 My Lady, those are all the questions that I have.
6 There are no Rule 10 questions.

7 LADY JUSTICE THIRLWALL: Thank you, Mr De La Poer.

8 MR DE LA POER: I beg your pardon, my Lady, I am
9 just having Mr Kennedy drawing my attention and I think
10 as this is a witness who comes under his umbrella,
11 I should just speak to him if I may.

12 LADY JUSTICE THIRLWALL: Yes, of course.

13 (Pause)

14 MR DE LA POER: Mr Kennedy, and I have an
15 understanding. There is no need for any further
16 questions.

17 LADY JUSTICE THIRLWALL: Very well, thank you very
18 much.

19 Thank you very much indeed, Nurse McGlade, for
20 coming, for providing a statement and helping us this
21 afternoon, you are free to go now.

22 A. Thank you.

23 LADY JUSTICE THIRLWALL: So we will start again at
24 10 o'clock tomorrow morning.

25 MR DE LA POER: My Lady.

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1 notes.

2 Q. Was there any discussion about how you and
3 Dr Gibbs could formalise what you had found so as to
4 help the next stage of the process?

5 A. I was never asked to do that. I don't know
6 whether Dr Gibbs was.

7 Q. Do you think, looking back on how that process
8 was conducted, that that was in fact a necessary step
9 that was missed out; that you and Dr Gibbs drew your
10 conclusions together and made them absolutely clear what
11 it was that you were saying?

12 A. Yes. Yes.

13 Q. Those are all the factual matters I want to
14 ask you about.

15 I just want to return to safeguarding and
16 a recommendation that you gave.

17 You propose that the chair considers this:

18 "Any suspicions about someone working in healthcare
19 needs to be taken escalated, taken seriously, and that
20 member(s) of staff needs to be stepped down from
21 clinical work immediately whilst investigated and for
22 allegations as serious as this, police need to be
23 informed immediately."

24 A. Yes.

25 Q. And is that your reflection on how things

222

1 LADY JUSTICE THIRLWALL: Thank you, all, very much
2 indeed.

3 (4.37 pm)

4 (The Inquiry adjourned until 10.00 am,
5 on Thursday, 17 October 2024)

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