1 **Thursday, 17 October 2024**
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Ms Langdale.
4 **MS LANGDALE:** My Lady, may I call Ms Powell.
5 **LADY JUSTICE THIRLWALL:** Would you come to the
6 witness box, please, Ms Powell.
7 MS EIRIAN POWELL (affirmed)
8 Questions by MS LANGDALE
9 **LADY JUSTICE THIRLWALL:** Do sit down.
10 **A.** Thank you.
11 **MS LANGDALE:** Ms Powell, you have provided the
12 Inquiry with a statement dated 9 September 2024.
13 Can you confirm whether the contents are true and
14 accurate as far as you are concerned?
15 **A.** So far as I am aware, yes, thank you.
16 **Q.** And do you have that in front of you?
17 We are going to take you through the statement,
18 Ms Powell, and also some documents that will come on the
19 screen in front of you there when we refer to them.
20 If there's anything you can't see or hear just
21 say so.
22 **A.** Thank you.
23 **Q.** You begin your statement at paragraph 2 by
24 saying you would like to express sincere condolences to
25 all the parents and their families for the loss of their

1 children and harm suffered. Would you like to expand
2 upon that at this point or not?
3 **A.** I don't think anything I can say will
4 alleviate the pain that they continue to endure
5 throughout this process and beyond, but I can't ...
6 **Q.** And before we go into the detail of the
7 documents and the evidence, are there any reflections
8 you have, looking back now, about your role in events,
9 your trust in Letby, and how you described her at the
10 time; what do you think about that looking back now?
11 **A.** Sorry, could you repeat that, I can't quite --
12 **Q.** Yes. What do you think now, have you got any
13 reflections, looking back, about the trust you placed in
14 Letby throughout the period of time she was working at
15 the Countess, and the support you offered her? Do you
16 have any reflections about that now?
17 **A.** I think at, at the time, with the information
18 that we had at the time, all staff had that level of
19 support. I can't at that time -- on reflection today,
20 you mean, or at the time?
21 **Q.** Yes -- no, on reflections now, looking back,
22 is there anything you would have done differently or
23 think about differently now?
24 **A.** I can't, I can't see at that time or now
25 anything different, based on the evidence that we were

1 given at the time.
2 **Q.** Your nursing career and employment, you set
3 out from paragraph 4 onwards. And you say, tell us that
4 you were working at the neonatal unit between 1993 and
5 2017, is that right, so a long time?
6 **A.** Yes.
7 **Q.** And you became the neonatal unit manager, what
8 time roughly?
9 **A.** July 2011.
10 **Q.** And what were your roles and duties as the
11 neonatal unit manager. If it helps you, you set them
12 out at paragraph 8.
13 **A.** I will just take a minute.
14 It was responsibility for the day-to-day running of
15 the unit, which incorporated, it sounds oversimplified
16 in that one sentence, but that sort of ensured that the
17 skill set for the acuity on the unit at the time
18 required, recruitment. It was buying, trialling
19 equipment, buying equipment from capital resources,
20 attendance management, performances.
21 **Q.** You said you dealt with any performance
22 attendance or conduct issues involving members of staff;
23 were you ever involved in disciplinary matters, you
24 don't have to tell me who of the nurses, but for any of
25 the nurses?

1 **A.** I did, yes.
2 **Q.** So you were part of the process, were you?
3 **A.** Yes.
4 **Q.** Investigating conduct issues if they needed to
5 be investigated?
6 **A.** Any performance issues were dealt with.
7 **Q.** Performance issues?
8 **A.** Yes.
9 **Q.** Did you have HR support for that?
10 **A.** It was unnecessary at the time because when we
11 actually dealt with it, by, by encouraging extra support
12 by providing more training, where there was a deficit,
13 an obvious deficit for a new member of staff, they --
14 but they left, actually, within a very short period of
15 time because they were not happy being -- what's the
16 word? -- being directed in that manner. You know, being
17 shown that they needed to improve their performance.
18 **Q.** So you had had experience when you were
19 a manager, so from 2012 --
20 **A.** Yes, yes.
21 **Q.** -- onwards of trying to raise the performance
22 levels of somebody and them not being happy about that
23 and leaving?
24 **A.** And they have left, yes.
25 **Q.** Left nursing or just left your unit?

1 **A.** Left our unit.
2 **Q.** To work somewhere else?
3 **A.** Yes.
4 **Q.** And what kind of documentation would you keep
5 in that situation about somebody, did you record --
6 **A.** Yes, that would be on their profile.
7 **Q.** You tell us you were responsible for ensuring
8 that all data recorded via the BadgerNet system was up
9 to date. When did the BadgerNet system come in? Can
10 you remember?
11 **A.** We had different versions of it throughout.
12 We had it before I became manager. I can't, I couldn't
13 remember.
14 **Q.** Is that an electronic system for
15 record-keeping?
16 **A.** It is, it is.
17 **Q.** Do you still have handwritten notes for
18 patients, but this is an electronic system for the work
19 that you were doing, or was everything moved
20 electronically?
21 **A.** Sorry, I don't understand what you --
22 **Q.** Was everything electronically -- done
23 electronically from the moment the BadgerNet system was
24 introduced?
25 **A.** No, not everything, no.

1 **Q.** Right. So what stayed manual?
2 **A.** The patients' notes stayed manual. And the
3 staff profiles were manual and I think, at that point,
4 so was -- until electronic prescribing came in and again
5 I can't remember exactly when that came in.
6 **Q.** You tell us you also dealt with parent and
7 visitor complaints either directly or via the Patient
8 Advice and Liaison Service, PALS?
9 **A.** Yes.
10 **Q.** Roughly in your time as manager, how many
11 patients complained directly to you about service or
12 patient safety, their babies?
13 **A.** Yes, there was quite a few. I can't recall
14 their names obviously.
15 **Q.** No, I don't need names.
16 **A.** No. But yes, they would come to the office
17 and complain or they would complain to a member of staff
18 and they would ask to come and speak to me.
19 **Q.** And did you document that kind of complaint or
20 was that treated informally that they would come to see
21 you directly at the time and you could deal with it in
22 that way?
23 **A.** Gosh, I can't remember what we were doing at
24 that point. It would be, if it was at all, it would be
25 in the patients' notes.

1 **Q.** So if it was going to be anywhere, you would
2 go back to that patient's notes and put it in there?
3 **A.** Yes.
4 **Q.** Would you speak to parents about them? If it
5 was the parent making the complaint presumably you
6 would, would you tell them what you thought about the
7 complaint or what had happened?
8 **A.** Yes. Oh, yes, yes. Yes.
9 **Q.** How did you find PALS worked, was that
10 effective --
11 **A.** It was.
12 **Q.** -- for bringing complaints?
13 **A.** That was quite good because it was, it was --
14 it came via electronic system via email and then you
15 would get the information, the actual complaint, and
16 then we would then research it or involve the people
17 that were either being complained about or had more
18 information about it.
19 **Q.** We have one complaint made via PALS by one of
20 the parents named on the indictment, parents of Baby H.
21 Can I ask you to have a look, please, on the screen.
22 INQ0030106, page 2. That's page 1. If we could
23 have page 2.
24 Have a look at this, Ms Powell. This is an email
25 from you to Dr Gibbs and Yvonne Griffiths and

1 a Belinda Simcock and you are referring, if you have
2 a look there:
3 "Brenda from PALS came to speak to me this lunch
4 time to say that the family of Baby Child H have put in
5 a complaint. The complaint was the fact that there was
6 no communication from the medical or nursing staff that
7 her baby had been put on the ventilator."
8 And you set out that Dr Harkness spoke to the
9 parents at approximately 11.30 to update them.
10 "At no time did they voice any concerns."
11 Presumably you mean to Dr Harkness and you continue
12 further down and say:
13 "Midwives are preparing to discharge Mum today.
14 However, Nurse W is going to speak to them to allow her
15 to stay longer. Brenda has conveyed this information to
16 Dad they are considering the offer."
17 And you say this:
18 "My question as an addendum is why has it taken Mum
19 so long to come to the unit when she was aware how
20 poorly her baby is? Just a thought. Especially as she
21 is an inpatient or even ask the midwife to ring/use her
22 mobile for an update."
23 Had you spoken yourself to Mother H? It appears
24 that you hadn't, reading that?
25 **A.** I can't remember.

1 **Q.** You can't remember?
2 **A.** No, I cannot.
3 **Q.** She gave evidence to the Inquiry that she was
4 indeed in the unit having treatment herself and she was
5 having difficulty getting the midwives to take her down
6 to the unit and she wasn't getting mobile phone calls
7 either from the unit.
8 You didn't find that out or know that?
9 **A.** No, I didn't know.
10 **Q.** Do you think you should have tried to find
11 that out before making a comment on the complaint,
12 finding out what she had to say about it?
13 **A.** Well, yes.
14 **Q.** And instead it seems as though you are saying
15 there, "It's just a thought, why hasn't she got there?"
16 What were you meaning by that?
17 **A.** I honestly, I can't, I can't remember. But --
18 I wasn't -- when was discharge?
19 I just, I can't remember it at all. I'm sorry.
20 **Q.** But it appears reading it, doesn't it, as
21 though you are critical or potentially critical of her
22 for not asking a midwife or using her mobile phone to
23 get an update herself? You have turned it on to the
24 person who's making the complaint: why weren't they
25 doing a bit more?

1 Is that what you are trying to say there?
2 **A.** Well, no, I am just trying to ascertain the
3 information that I was getting from the complaint
4 itself.
5 **Q.** If we look at page 1. Dr Gibbs begins:
6 "I'm sorry that Child H parents were not informed
7 reasonably promptly when she was ventilated."
8 "I'm sorry". That's what that needed, didn't it?
9 **A.** Yes.
10 **Q.** "I'm sorry." You come down, your child is
11 ventilated. It is very scary to see that, isn't it?
12 **A.** It is.
13 **Q.** It is a newborn, you haven't seen it before.
14 We are not all trained nurses to see this?
15 **A.** Yes.
16 **Q.** Then "I'm sorry" would have been a nice
17 response?
18 **A.** Yes.
19 **Q.** It doesn't necessarily cover the issues but it
20 is a start, isn't it?
21 **A.** No, no, and to be fair, she should have been
22 updated by -- predominantly because it's a mechanical
23 ventilation, she should have been updated by the
24 doctors. However, if they were detained through
25 stabilising the infant then hopefully the, the nurse

1 should be able to go and speak to the parents and update
2 them or ring them if they are at home.
3 **Q.** It's a combined effort, isn't it?
4 **A.** It is.
5 **Q.** Nurses and doctors on the unit?
6 **A.** Yes.
7 **Q.** The impression -- that can go down now, thank
8 you.
9 The impression we got from parents giving evidence
10 was that on the neonatal unit they could feel they were
11 in the way, either asking about how their children were
12 or what was going on.
13 **A.** That's sad to hear. Because that's not what
14 we try to achieve.
15 **Q.** And that they were encouraged to rest, go and
16 rest, which can be important, but now the thinking is
17 much more mothers or parents and carers should stay with
18 their children on the neonatal unit.
19 **A.** Yes, as much as possible.
20 **Q.** Yes. And that wasn't happening. It is clear
21 from what the parents have told us that wasn't
22 happening?
23 **A.** No, they should have been, they should have
24 been.
25 **Q.** Should it have been even then happening?

1 **A.** Well, as you are aware the facilities there
2 were not very, very good, especially in the intensive
3 care because of the room. We only had two parents
4 accommodation on the unit. And we had Christopher Wing
5 which was over on children's ward.
6 But even so, they needed additional help from the
7 midwives, so they needed to be an in-patient if they
8 were upstairs.
9 **Q.** I think later on in your statement you say
10 there could be problems communicating with midwives,
11 couldn't there?
12 **A.** Well, yes. Yes.
13 **Q.** What were they? Why were there difficulties
14 there?
15 **A.** If, if for instance we would go to the labour
16 ward, which is mandated now that we have the safety
17 briefs, but at the time we would go there for an update
18 every morning to see what was potentially an admission
19 for the unit, and then we would we were able to plan for
20 the next 24 hours with staffing and equipment
21 preparation.
22 But we would have to wait to be spoken to. So we
23 are taking a nurse out of the unit to speak to somebody,
24 predominantly now it is a shift leader, but then it
25 would be anybody to give us an update as to what was

1 potentially coming through, and sometimes they would
2 completely ignore us.
3 **Q.** You mean you would literally be standing there
4 and someone would ignore you?
5 **A.** Oh, yes, you could be standing in the office
6 and we would be ignored. And it depended on how
7 experienced the person was going through and say,
8 "Excuse me, we need to know this."
9 But if somebody came into the unit we would
10 straight away ask, you know, what did they want to know,
11 what was the problem? But it was never, well, not that
12 it was never reciprocated, that's incorrect. It wasn't
13 always, some midwives are great, so you had this sort
14 of -- you didn't know when you went in there whether you
15 would get an update so --
16 **Q.** Did you send different nurses in for the
17 update from your unit?
18 **A.** Well, usually it is the shift leader.
19 **Q.** Right. So they are experienced nurses?
20 **A.** Well, some of them are; others have just gone
21 into the role so it takes a little bit of development
22 to --
23 **Q.** They are Band 6s?
24 **A.** Yes, yes.
25 **Q.** So your various Band 6s would go over, and did

1 they come back and say to you, "We are not getting the
2 information, I have just been standing there"?
3 **A.** Well, they would have to wait until they got
4 the information.
5 **Q.** Right, okay. Did you ever go over to get the
6 information?
7 **A.** Yes.
8 **Q.** And what was the response to you?
9 **A.** It was very dependent on who was there at the
10 time?
11 **Q.** And was it senior midwives --
12 **A.** Yes, yes.
13 **Q.** -- that were -- did you ever raise that with
14 the Executives or more widely that that was an issue?
15 **A.** Not that I can recall at the time. But I did
16 as, as time went on, did mention it because we had more
17 meetings sort of with maternity and that seemed to help
18 discussing the, the issues.
19 **Q.** Because if your nurses were experiencing it,
20 it's not surprising the parents were feeling, those who
21 were staying and needing the assistance of midwives,
22 that it was difficult or they were getting in the way to
23 ask for assistance, is it?
24 **A.** Yes.
25 **Q.** Did you think: if we are having this

1 experience, what must the patients or the parents be
2 experiencing?
3 **A.** Well, I was hoping -- because obviously
4 I wasn't privy to the parents' care that they were
5 getting, it was only on the unit from our perspective.
6 **Q.** The other issue relating to communication is
7 one parent told us that in another hospital the parents
8 could be involved in the huddles or the conversations
9 about the babies' treatment, even if they didn't follow
10 it, they could be there, ask questions.
11 That didn't happen on the neonatal unit in 2015 to
12 2016, did it?
13 **A.** No.
14 **Q.** If there was a ward round or huddles
15 discussions, parents were not invited?
16 **A.** No.
17 **Q.** Why not?
18 **A.** Well, we weren't aware of this but because
19 Bliss was actually doing -- had a toolkit, we
20 incorporated that with parents to help us develop more
21 of the parent-led care because we needed -- because the
22 new unit was being developed and what we needed in the
23 unit, this was part and parcel of what we needed to
24 improve our services of having the mother besides the
25 cot side for as long as she wanted.

1 **Q.** Mmm.
2 **A.** Because there we would have that square
3 footage around the incubator that would allow that. So
4 it was a safe, safer space and that happened in the new
5 unit and we were able to do that.
6 **Q.** So what year was the new unit again?
7 **A.** When I left.
8 **Q.** Okay.
9 **A.** Yes, that was built in 2018, I think.
10 **Q.** So that permitted parents and babies to be
11 next to each other?
12 **A.** Yes. Yes.
13 **Q.** Even without the physical space, was there
14 a reason, even if it's a bit more cramped, that they
15 couldn't be standing together with the nurses or doctors
16 when their babies were being discussed?
17 **A.** Well, ideally, we would have the parents there
18 when the ward round was there, we would encourage that,
19 that they would be there, and we did -- we were very
20 good at doing skin to skin with the mums and with the
21 dads, and they had that time and we had the -- were able
22 to make the environment more feasible to do that.
23 But we had champions on the unit that were actually
24 facilitating that, as part of the champions for parental
25 support.

1 **Q.** I haven't heard about those champions so far,
2 so tell us what you mean by -- what's their role, who
3 are they?
4 **A.** They would actually look at -- because it went
5 hand in hand with -- I have got to try and remember --
6 the breastfeeding initiatives and not all parents, not
7 all mums want to breastfeed but some would need to
8 express, some didn't want to at all. But they still had
9 the opportunity for the skin to skin for as long as they
10 wanted, or as long as the baby's stability warranted.
11 But to be fair, babies did stabilise far better
12 with the parents than they did in the incubators.
13 **Q.** And for those mothers who do choose to
14 breastfeed it's really important, isn't it, expressing
15 best milk --
16 **A.** Yes.
17 **Q.** -- it is a hugely significant thing to be able
18 to do for your infant? We have heard from a number of
19 parents that when they left breast milk in the fridge,
20 named, it wasn't there when they went back again.
21 Were you having an issue at that time with where
22 breast milk was ending up when it was in the fridge?
23 **A.** Well, yes. We, we tried, we weren't in
24 isolation here. This was network-wide. So we were
25 getting information from other units in addition to

1 postnatal ward were having the same problem.
2 So we had to put things in place in order to make
3 sure this did not happen and it became difficult. In
4 the end, we had to have the breast milk put in a locked
5 fridge in the milk room so that the nurses would
6 actually give it to the mum, they would check it
7 together, and then they would actually, as long as they
8 were happy with that, they would then use it.
9 **Q.** And one parent told us that they knew of
10 someone who was worried because they had had medication
11 that their milk wasn't there, not just that it wasn't
12 there for their baby, but if somebody else's child would
13 have that breast milk without awareness of that, that's
14 very worrying, isn't it?
15 **A.** It is. But these things were put in place and
16 it has to be treated like a blood product, and treated
17 with the same care that requires the -- to take the
18 numbers out, to check it, two nurses check the numbers
19 and then they would actually give it to the mums and
20 they would have to check it.
21 But that's how it became -- in the end, that was
22 the only way to manage it.
23 **Q.** Again, can you roughly remember when you got
24 that system in place to manage these issues?
25 **A.** I cannot -- my timelines are not accurate, I'm

1 sorry.
2 **LADY JUSTICE THIRLWALL:** You said it was "in the
3 end".
4 **A.** Sorry?
5 **LADY JUSTICE THIRLWALL:** You said it was "in the
6 end".
7 **A.** Well, I was head until 2017, so -- because we
8 had incidents, clinical incidents that actually
9 highlighted this as being a problem. And there were
10 different varieties of it, you know, we said, well, we
11 will get the mums to take the milk out because that's
12 what they were doing on postnatal but then there became
13 an incident from that.
14 So in the end we had to have two nurses to check
15 the milk out and then to check it with the, with the mum
16 before actually administering.
17 **MS LANGDALE:** You refer in your statements in
18 paragraph 16 onwards to the culture and atmosphere on
19 the NNU in 2015 and 2016.
20 You say that, in your view, the quality of the
21 management, supervision and support of the nurses was
22 excellent at that time.
23 **A.** (Nods).
24 **Q.** In what way do you say it was excellent?
25 **A.** Because there was three of us in the office

1 and three different, completely different personalities.
2 **Q.** So this is Yvonne Griffiths, Yvonne Farmer --
3 **A.** Yvonne Griffiths, Yvonne Farmer, and myself.
4 Yvonne Farmer dealt predominantly with developmental,
5 performance issues and appraisals and revalidation, and
6 Yvonne Griffiths did predominantly welfare of staff with
7 regards to the off-duty and facilitating the requests.
8 And then they were very good at coming forward
9 saying, well, do we think about this? Well, I am not
10 happy. Well, we would investigate further as to why
11 somebody wasn't happy, that we have a consensus. So
12 that was an ideal opportunity.
13 And also we had an open-door policy and staff did
14 come in as and when there was a problem. Or wasn't
15 a problem, maybe it was a welfare issue or it was
16 an issue that they wanted expanded further or developed
17 further in their careers.
18 **Q.** You tell us that Occupational Health were
19 available to provide additional support to staff where
20 needed?
21 **A.** Yes.
22 **Q.** And we know -- indeed, we have heard evidence
23 from Kathryn de Berger who provided support for Letby.
24 **A.** Yes.
25 **Q.** Were there any other -- you wouldn't have to

1 give me names, but nurses that benefited from support
2 from Occupational Health --
3 **A.** Yes.
4 **Q.** -- coming down to the unit?
5 **A.** Well, the -- they would not necessarily come
6 down to the unit at that time but -- well, they did sort
7 of, obviously, when we were going through -- during
8 a period of time. But prior to that, staff would go to
9 Occu Health for additional support.
10 **Q.** And you have referred they could also speak
11 with a vicar about any concerns.
12 There is a number of references to baptisms and
13 contacting the vicar and -- was that something that was
14 a very present theme on the unit, the --
15 **A.** Well, he came to the unit anyway on a weekly
16 basis and he's a very approachable guy. He wasn't
17 necessarily -- he was just there just generally chatting
18 to staff or to parents or anybody that would stop and
19 chat, really. It wasn't a -- he would just come and if
20 there was nobody to talk to then he would go again but
21 he would always pop in and say, you know, how is
22 everybody, how are things?
23 But it wasn't an organised, it wasn't an organised
24 visit as such.
25 **Q.** You say about relationships between doctors

1 and nurses, at paragraph 19:
2 "In my view, the Consultants felt that all staff
3 members worked cohesively but that was because the staff
4 did exactly what they were told to do by the Consultants
5 and did not challenge them. I felt that the
6 Consultants' communication with managers, nurses and
7 midwives was sometimes poor and that they did not listen
8 to the views of others."
9 The nurses that have given evidence so far to the
10 Inquiry have said they did feel supported by the
11 Consultants and could speak to them.
12 **A.** Yes.
13 **Q.** Do you think that wasn't the case for some
14 reason?
15 **A.** It is not all the Consultants. There were
16 a few Consultants that were difficult to work with.
17 **Q.** And when you say they didn't listen to the
18 views of others, what do you mean by that? Give an
19 example of that.
20 **A.** An example. Gosh. Well, I can't give
21 a specific example. I can give a difficult scenario
22 where you go in ...
23 There was an incident where there was a vent
24 setting not documented. Normally, when you change
25 ventilation settings you put it down on the chart that

1 these vent settings were changed, date and time, in
2 response to the blood taken.
3 The vent settings itself apparently were changed
4 and it wasn't documented and immediately it was the
5 nurse in charge, the nurse looking after the baby was
6 accused of changing the ventilator. We didn't change
7 the settings of the ventilator.
8 Sometimes we would ring the Consultants and say:
9 this is the blood gas results and they would say, "Just
10 up the rate" or "Change the pressure." That was fine.
11 And then we would document and say: as per Consultant.
12 But this particular incident was immediately -- it
13 would point at the nurse and accuse the nurse.
14 Fortunately, this nurse was particularly experienced and
15 therefore she challenged it and, as it happened, it was
16 the Registrar that had changed the vent settings but
17 just hadn't documented it.
18 **Q.** But the Registrar accepted that presumably
19 when --
20 **A.** Well, not initially, no.
21 **Q.** Okay. So there had to be an investigation,
22 see how it had happened?
23 **A.** Well, yes, I mean, as it happened, but it was
24 resolved. But instead of sort of looking at the avenues
25 it was straight away, well, you have done it, so you

1 must have done it, but the person said, well, no
2 actually, I didn't.
3 **Q.** But it's not unreasonable to say to anyone in
4 the room: you might have done it, you might have done
5 it, let's find out, is it?
6 **A.** True. It does sort of come down straight away
7 when that's not what our role was about. It was about
8 documentation, the Consultants or the doctors didn't
9 always document what they had actually done.
10 **Q.** Yes. You said that, the quality of case notes
11 was raised on a number of audits, that you didn't feel
12 the documents were full enough and that is, of course,
13 important to do.
14 **A.** Yes.
15 **Q.** If doctors and nurses have got time, they
16 should be doing it, shouldn't they?
17 **A.** Yes.
18 **Q.** But it is a question of does somebody have to
19 feel accused in that situation if it's a challenge to
20 say: have you done that? Have you done that?
21 **A.** It is, but it's just the accusation. Had it
22 been discussed with another doctor the accusation would
23 have been different. It's just, just the slight nuances
24 that are there that makes it difficult and if somebody
25 is less experienced that would be very traumatic.

1 **Q.** Very traumatic.
2 **A.** Yes.
3 **Q.** Why is it very traumatic if you are accused of
4 doing something?
5 **A.** Because of the insinuation of how -- that
6 your, your practice is questioned and then you have to
7 justify your practice which is fine.
8 But it's instead of sort of having a chance to
9 think, oh well, let me see, you know, give
10 an opportunity to sort of see where we are at, because
11 we are already still looking after the infant and then
12 you are having to answer the questions.
13 **Q.** Staffing issues at paragraph 28. You tell us
14 you were doing a lot of workaround staffing issues and
15 indeed I think one of the nurses we have heard from was
16 in the office with you at some time and realised how
17 much time you spent on this kind of stuff, putting
18 together data and material around staffing; was that
19 a big thing for you?
20 **A.** Yes, yes. Because it was -- it was a --
21 staffing issues were for different people at different
22 times.
23 **Q.** Yes. You say:
24 "I do not feel the staffing issues were ever fully
25 addressed and I am aware that neonatal nursing staffing

1 shortages was a national issue."
2 How were you aware it was a national issue from
3 these meetings that you went to?
4 **A.** When, when we actually go to the Neonatal
5 Network meetings this was discussed quite often, and it
6 was realised that a lot of us were not measuring the
7 same things. I think the incidents were saying we are
8 not measuring apples with apples and pears with pears,
9 we are measuring bodies on the unit, feet on the ground,
10 as opposed to who they are and the calibre of staff.
11 So we did quite a bit of work with the Network with
12 regards to that because a lot of BadgerNet doesn't
13 actually show that, what your staffing is. Our staffing
14 at the time I think was 60:40 ratio, of 60 qualified
15 against 40 unqualified, but they were untrained as in
16 trained nurses. They were qualified because they were
17 nursery nurses but they were not registered nurses.
18 **Q.** You say:
19 "I can, however, say that the NNU was always
20 covered by the appropriate skill mix of staff but this
21 was often not to the British Association for Perinatal
22 Medicine standard."
23 **A.** Well, in its entirety.
24 **Q.** Right.
25 **A.** It wasn't actually -- through people, through

1 staff changing their shifts to accommodate the acuity
2 and working overtime, this is how this was met to the
3 BAPM standards at that time.
4 But it's, it's inevitable that burnout will happen
5 because you can't keep doing that all the time.
6 **Q.** You look as though you and Dr Brearey did
7 a nurse staffing, a business case for paediatrics
8 neonatal unit nurse staffing.
9 If we can go, please, to INQ0003829, page 1.
10 So this is a draft in December 2015. If we scroll
11 through it, just to remind you of the document. We go
12 to a conclusion on page 22:
13 "The recommendation by the Urgent Care Division is
14 for the exec board to fund. Query [is that Whole Time
15 Equivalent] Band 5, 10 [Whole Time Equivalent] Band 5s
16 will be need to be recruited and the reshuffle of the
17 Band 4s to accommodate some of the changes required to
18 meet the staffing standards."
19 **A.** Yes.
20 **Q.** So this is -- I think this is December 2015
21 this one. And you have to look at the data of the years
22 previously, don't you?
23 **A.** Yes.
24 **Q.** It is difficult to understand what the
25 staffing level actually was in 2015/2016 because your

1 analysis always relies on that 2014 to 2015 --
2 **A.** Yes.
3 **Q.** -- I am going to call it the tax year, we know
4 what the months are.
5 **A.** Yes, and also the potential within -- because
6 this takes time by the time the business case goes in,
7 by the time actually it's -- we put adverts out. Also
8 what was potentially leaving through retirement --
9 **Q.** Yes.
10 **A.** -- as well. And that was quite high. So to
11 reshuffle, to accommodate that was -- there was quite --
12 and there is a time lag as well between one and the
13 other from 2014 to 2015.
14 **Q.** Exactly. We see that with your -- again, we
15 can put it on the screen just to see the work that you
16 were doing on it.
17 But if we look at INQ0042844_0001, we see that's
18 a synopsis in preparation for the business case,
19 March 2016. Sorry, if we can go further down to the
20 graph. And the data you are relying on is that
21 2013/2014 data, by the time you are in 2016.
22 **A.** (Nods).
23 **Q.** So in terms of how that data was put together,
24 about staffing across the network, was, how long did it
25 take to become available? Looking at that, you were

1 looking at it a couple of years before to do an analysis
2 for March 2016 --
3 **A.** Yes.
4 **Q.** -- but what do you remember now about that?
5 How old was the data you were looking at when you were
6 putting these things together?
7 **A.** I don't know. Well, it would probably be
8 18 months, I would imagine.
9 **Q.** And did you understand why it takes that long
10 to come through the system? Was that ever discussed at
11 the network meetings or not?
12 **A.** Well, I -- from when I took over, it takes,
13 that also took a bit of transition. But when you
14 actually look at what is required and what it is
15 potentially going to look like in a two-year forecast,
16 five-year forecast, and to also get what you want for
17 already the 2014, it then becomes apparent you probably
18 need an awful lot more to accommodate.
19 But it's, it's, I suppose everybody has the same
20 issues or similar issues. But we were already low
21 anyway at that point.
22 **Q.** That can go down now, thank you.
23 You say in your statement -- we have seen that the
24 recommendation was at that time to get more Band 5s in,
25 but you say at paragraph 30:

1 "There was a push to phase out the nursery nurses
2 but I felt they were in fact very experienced as we had
3 provided them with extra training in order to make up
4 for the shortfall in qualified nursing staff.
5 I believed that by phasing out nursery nurses it would
6 impact the integrity of the NNU."
7 What did you mean by the "integrity"?
8 **A.** It, it was almost like a knee-jerk reaction:
9 oh, right let us do this, let's -- we will do, we will
10 get -- this is what she wants, more Band 5s, we will get
11 rid of or redeploy the Band 4s. But by then, we had
12 sent them on massage courses, we had sent them -- they
13 were doing parent craft, they were doing a lot of work.
14 So to take them out and put a newly-qualified Band 5 to
15 replace them was not of equal measure at that point
16 because they were so well qualified.
17 There were also BFI, breastfeeding initiative
18 counsellors we were putting in place.
19 So it was difficult to quantify that because I had
20 already said we need more staff, well, yes, we did, but
21 we needed more staff in addition to what we currently
22 had and looking at the forecast for the next 18 months,
23 they were actually -- we were losing some of them anyway
24 to retirement.
25 **Q.** Some doctors and indeed nurses have raised the

1 suggestion that having Advanced Neonatal Practitioners
2 can really help a neonatal unit. Continuity --
3 **A.** Yes.
4 **Q.** -- better links between the doctors and
5 nurses. Would you agree with that?
6 **A.** I would.
7 **Q.** Did you have experience of that?
8 **A.** Yes. Well, we, we lost two of our advanced
9 neonatal nurse practitioners early on because they, that
10 was in, I think, pre 2011 and the opportunity for
11 development was, was great because we tried to get the,
12 I have forgotten the name of the course -- Examination
13 of the Newborn, we sent four senior members of staff on
14 that course so that would assist with the delay with the
15 babies going home or the delays in seeing what was
16 available, what -- any medical problems that may arise,
17 they could be seen sooner because they had to be seen
18 within, I think it was 72 hours. Well, that was
19 difficult to do if you haven't got the medical staff, if
20 they were busy through paediatrics and neonates.
21 So that was a great opportunity. So that helped.
22 But it was still a shortfall to help with additional
23 needs and that's why we put forward for the Advanced
24 Neonatal Practitioners course, to send two members of
25 staff for that.

1 **Q.** You say, as I have said earlier, in your view
2 the NNU because always covered by the appropriate skill
3 mix of staff. Does that remain your view that it was?
4 **A.** For that time. And that's only through --
5 I mean, normally when you have a week of staffing your
6 off-duty, most hospitals, you know what you are working
7 from Monday to Sunday. Unfortunately, that wasn't the
8 case on the unit but that was kind of the way it worked.
9 When you had the busy moments things were changing and
10 things changed anyway from people being off sick. But
11 for the acuity, to match the acuity with the staffing,
12 we would have to change staffing in order to accommodate
13 that.
14 **Q.** Were you generally satisfied with the standard
15 of care that your nurses were providing --
16 **A.** Yes.
17 **Q.** -- leaving aside what we are going to come to,
18 but when you observed them, some were doing extra shifts
19 but when you observed, you were content with the way it
20 was being run?
21 **A.** I was.
22 **Q.** Did you think it was safe the way it was being
23 run?
24 **A.** It wasn't -- I can't think of the word, it's
25 not enduring, you can't keep doing that. It's not

1 feasible to continue to request staff to come in to do
2 extra, for staff to change their shifts from nights to
3 days, days to nights. It's not in their best interests
4 or well-being.
5 **Q.** Did you have a time when no one would come in
6 and you were stuck or generally did you manage to get
7 people in?
8 **A.** They were so accommodating. They were
9 amazing.
10 **Q.** Well, from what some of them have said it felt
11 like a family to some of them.
12 **A.** Yes.
13 **Q.** Was it quite a tight ship --
14 **A.** It was.
15 **Q.** -- in terms of them getting on and being
16 prepared to come to work?
17 **A.** I mean, everybody has likes and dislikes but
18 we were all very professional and we got on with the
19 job.
20 **Q.** You say very professional. In an article in
21 a newspaper a nurse anonymously speaking to the
22 newspaper said that how: during night shifts nurses on
23 the ward would pull a name out of a hat and whoever got
24 picked would be able to leave early, despite being in
25 charge of a baby, and they would leave a handwritten

1 note by the infant leaving the baby without oversight
2 for hours at a time.
3 **A.** No. I don't know where that's coming from.
4 But if the, if the unit was quiet, as in that you
5 had six staff and you sent -- say, four had gone home,
6 there was two left or three left, the one allocated
7 would never go home.
8 **Q.** That is what Ashleigh Hudson told us.
9 **A.** Sorry?
10 **Q.** That is exactly what Nurse Ashleigh Hudson
11 told us --
12 **A.** Yes, I'd never send an allocated -- an
13 allocated nurse is somebody that stays with that child
14 throughout.
15 **Q.** But it might be that someone could go, if they
16 had done a lot of shifts or overtime, if it was quiet
17 someone could leave a bit earlier?
18 **A.** They could leave a bit earlier at the end of
19 the shift but that time would be minused from their
20 total running time owing.
21 **Q.** What was the culture like between the nurses?
22 Was it mocking? Was it unpleasant? Or was it
23 supportive?
24 **A.** Sorry, I ...
25 **Q.** Was it mocking, in any way, or unpleasant or

1 was it supportive?
2 **A.** Very supportive. Very good.
3 **Q.** The use of mobile phones on the unit, you
4 address that at paragraph 41 in your statement, and you
5 say:
6 "The use of mobile phones evolved significantly
7 over a relatively short period of time."
8 **A.** Yes.
9 **Q.** What was your understanding in 2015 to 2016,
10 about the rules about using a mobile phone at work or
11 about work?
12 **A.** Well, on the unit they were not meant to use
13 their mobile phones on the unit. However, we were
14 having difficulties with LanguageLine and there were
15 quite a few issues on the unit with regards to language
16 barriers from international parents.
17 So midwives were using the translators app on their
18 phone and this was something that we actually thought --
19 we discussed, you know, is this the way forward? We are
20 a bit antiquated, and we are not e-tech savvy, that we
21 should be perhaps looking at this in a different way.
22 **Q.** Yes, how it can help us?
23 **A.** Yes, as in a helpful format.
24 But I mean, as it happened, we got another two
25 LanguageLine facilities, so that kind of eased that

1 issue. But I guess we have moved on such an awful lot
2 these days. I don't know what they do today. But at
3 the time it was not to be used for personal use, that's
4 for sure.
5 **Q.** And you weren't on, we have seen WhatsApp
6 groups with Letby and some managers, you were not on
7 those groups; it is not -- it wasn't your thing --
8 **A.** No.
9 **Q.** -- messaging?
10 **A.** No.
11 **Q.** Did you discover at the criminal trial how
12 much messaging had taken place or did you not really
13 follow the criminal trial and the details of that?
14 **A.** There were a few messages that I did actually
15 see and that was -- that was one of my concerns, was the
16 use of mobile phones within, within the unit as to -- we
17 set -- well, Yvonne set up a WhatsApp group for the
18 off-duty and it works really well, but sometimes it
19 would come back with perhaps a statement, you know. And
20 I said: can we keep this to just staffing? Just, can
21 you do it or can you not do it? It's simple, like just
22 to do it that way.
23 **Q.** Were you on the staffing one?
24 **A.** Yes, I was on the staffing one --
25 **Q.** Yes.

1 **A.** -- whether you could work this or the other.
2 So I kind of knew when there was a problem. But that
3 was, that was always my concern. So I was -- I felt
4 justified in that, that that's what I worried about when
5 they did social groups of WhatsApp. I mean, they did it
6 when they were going to go for a Christmas venue or
7 whatever, of where does that -- to be very mindful of
8 keeping it professional always, even for an event that
9 was held outside the unit.
10 **Q.** So did you have that conversation widely with
11 the nurses or some nurses or how did you set the tone?
12 **A.** We would just -- we would -- Yvonne would
13 actually say on the WhatsApp to keep it professional.
14 And that was -- that's enough to tell them to say, oh,
15 hang on a minute, we shouldn't be discussing that, that
16 should be done independently.
17 **Q.** Paragraph 42, you say:
18 "Staff were permitted to have their phones with
19 them in their lockers but were not allowed to use them
20 on the NNU as this was both unprofessional and unsafe.
21 If a nurse on duty was seen using their mobile phone it
22 would be reported to the ward manager or deputy ward
23 manager. The member of staff would then be interviewed
24 and the interview would be documented. It would also be
25 documented during NNU meetings and via email ...

1 an email to all staff would be sent out warning them
2 about the use of mobile phones on the unit."
3 Again, I don't need names but can you remember
4 dealing with anybody yourself about that issue or having
5 a conversation with a staff member?
6 **A.** There was one, yes. Yes.
7 **Q.** And I assume it wasn't Letby; it was
8 a different one?
9 **A.** No.
10 **Q.** So you spoke to one member of staff, and did
11 that stop? Is that somebody that you had seen with
12 a phone on the unit?
13 **A.** Sorry?
14 **Q.** Was it someone that you had seen with a phone
15 on the unit?
16 **A.** Yes. Yes.
17 **Q.** So you had seen that for yourself?
18 **A.** Yes.
19 **Q.** And you had the conversation with them?
20 **A.** Yes.
21 **Q.** And did you see that again, them --
22 **A.** No, no.
23 **Q.** So you were very clear and that was the tone
24 of the unit; that messages about work, patients, things
25 that are matters within the unit, shouldn't be being

1 communicated?
2 **A.** Yes.
3 **Q.** Did you expect ever handover nurses to share
4 some information about what they were coming into or
5 leaving or not, on a phone?
6 **A.** Well, no. No, I didn't expect any of them to
7 be discussing over the mobile phone. No.
8 **Q.** Can we move now to the risk register. You
9 tell us at paragraph 44 you were responsible for the
10 risk register on the NNU which was stored on a shared
11 drive.
12 And if we can put up INQ0004657, page 1. It will
13 come up in a moment.
14 We see here various risks entered onto the register
15 and who's entered them. There is a couple that have
16 been entered by you. You have at the bottom:
17 "Nurse staffing levels for all Urgent Care wards."
18 That is not been entered by you, it's been entered
19 by Mrs Rees.
20 So was it just not the NNU that was experiencing
21 staffing level issues? Can you remember?
22 **A.** I presume so. I mean, staffing's a problem
23 for everyone --
24 **Q.** Yes.
25 **A.** -- at some point.

1 **Q.** Yes. If we go further up, you see pseudomonas
2 in taps, you enter that on the -- in May 2015.
3 What was that about, the pseudomonas in taps?
4 **A.** Oh, the pseudomonas?
5 **Q.** Yes.
6 **A.** Yes. That was around -- when was it? We had
7 two incidences of pseudomonas. And that was tested.
8 The estates came to test and they would, they would test
9 all the taps and I think, I can't remember because there
10 were two episodes, I can't remember exactly with which
11 one, but then the filters then had to be applied to the
12 taps and then they were retested and then they would
13 have to come and do some work on the pipes.
14 **Q.** And so what were the -- what kind of filters
15 were there on the taps?
16 **A.** The water filters.
17 **Q.** Yes.
18 **A.** They are like miniature water filters that are
19 actually inputted at the base of the tap.
20 **Q.** And this is where nurses are washing their
21 hands and the like?
22 **A.** Yes.
23 **Q.** If we go further up. You say:
24 "Doctor shortage and impact on medical cover on
25 NNU."

1 That is March 2016. Can you remember that?
2 **A.** Yes, I think it was --
3 **Q.** The same issue?
4 **A.** Yes, there, there was a problem.
5 **Q.** "Potential damage to reputation" has been
6 entered by Karen Townsend at the top, July 2016. Do you
7 see that?
8 **A.** Yes.
9 **Q.** What did you understand that one to mean?
10 **A.** That was with the downgrading, I believe, of
11 the unit from -- transferring out after anything less
12 than 27 weeks to, I think it was 32 weeks.
13 **Q.** So how would that damage the reputation of the
14 service?
15 **A.** Well, because of the implications that that
16 comes from, of the reasons being. So why -- that Karen
17 thought that by the potential -- by downgrading that
18 there was a knock-on effect that will have on the unit
19 and the Trust.
20 **Q.** It looks as though she's actually talking
21 about apparent increase in mortality, so the number of
22 babies dying. I know that led to the downgrading of the
23 unit in some ways, but if you look at that, was she more
24 express or clear about increase in deaths and how that
25 links to reputation?

1 **A.** I don't understand the question, sorry.
2 **Q.** Okay. So she doesn't expressly refer in this
3 to the downgrade in unit or transfers, does she?
4 **A.** But I think it comes at the same time. So
5 I am assuming that's why she's -- I haven't put that on,
6 Karen has.
7 **Q.** Okay. If we look at INQ0004625. These are
8 the same risks that you have identified but we just see
9 there you see the "not compliant with staffing", the
10 last one, that's first been added, hasn't it,
11 in June 2010?
12 **A.** Yes.
13 **Q.** Next review date, so that is just an ongoing
14 feature, non-compliance, just all the time you are there
15 really --
16 **A.** Yes.
17 **Q.** -- from when you have certainly been a manager
18 in 2011 and the year before --
19 **A.** (Nods).
20 **Q.** -- not being compliant with staffing and those
21 issues are ongoing; they are chronic?
22 **A.** Yes.
23 **Q.** You see at the top it says risk graded 16 to
24 20. How are they graded, risks?
25 **A.** They are graded, there is a matrix that you

1 have to score, it is a matrix score, that's how it comes
2 to 16 to 20 is the severity of the situation.
3 **Q.** What are they all added up together or
4 something?
5 **A.** Yes, you add, you add it up as you actually do
6 the risk assessment and then it comes up as what you --
7 well, what somebody feels it is a 16 to 20, so if you
8 think it warrants to be in the red.
9 **Q.** Do you know who -- when you say somebody
10 feels, was that you as the ward manager for the
11 neonatology unit, who was the one who came up with the
12 figures for this?
13 **A.** Sorry?
14 **Q.** Who was the one that came up with that number
15 for these concerns, then?
16 **A.** It comes from the scoring matrix.
17 **Q.** Right. Do you score those?
18 **A.** Yes.
19 **Q.** Presumably a person does the scoring?
20 **A.** Yes, a person scores that.
21 **Q.** So you applied the scoring matrix?
22 **A.** Yes.
23 **Q.** Is that all of those in combination represent
24 16 to 20, or what does it mean?
25 **A.** Well, yes. Yes.

1 **Q.** Right. Can we have a look -- that can go
2 down, please.
3 And can we have a look at INQ0004511. This is
4 a clinical risk assessment document, 18 February 2015.
5 Is this something that you have produced?
6 **A.** Yes, I think so.
7 **Q.** Do you recognise it?
8 **A.** Yes, it looks familiar.
9 **Q.** Yes? So if you look at the next page, you see
10 your grading between 5, 8 risk scores, the last page,
11 page 3. 12. And you say there:
12 "A business proposal was completed and a business
13 case is being prepared, staff shortages", et cetera,
14 in February 2016.
15 And that's graded -- is that amber? The colours
16 matter, don't they, that's not a red then, that is an
17 amber, is it?
18 **A.** Yes.
19 **LADY JUSTICE THIRLWALL:** I think the date is
20 18 February '15'?
21 **MS LANGDALE:** Sorry, that is right, my Lady, it's
22 the review date that's February 2016.
23 Yes, so February 2015, the risk is always 12, yes?
24 **A.** Yes.
25 **Q.** Who are these -- who did you produce this for,

1 do you know?
2 **A.** Oh, well, they would be discussed with my line
3 manager which would be -- yes, my line manager.
4 **Q.** Who was your line manager?
5 **A.** Anne Murphy.
6 **Q.** Anne Murphy?
7 **A.** Yes.
8 **Q.** And who was her manager? So where do you fit
9 in the hierarchy, Ms Powell? If I am using that phrase
10 correctly?
11 **A.** Nurses, then myself, and then Anne Murphy, and
12 then -- I think it's -- it kind of it goes a little
13 bit -- I think it was Jackie who was, although it was
14 changed to the business manager and then, gosh, I can't
15 remember. Then Karen Townsend, although I think it
16 might have been Lorraine at one point.
17 **Q.** Lorraine Burnett?
18 **A.** Yes.
19 **Q.** That is in the risk department.
20 What about nursing, other nurses. Who did you turn
21 to for support or if something you were worried about?
22 **A.** Anne Murphy.
23 **Q.** Anne Murphy?
24 **A.** Anne Murphy, yes.
25 **Q.** What was your interaction with Alison Kelly?

1 We will see it later on, but what ordinarily was your
2 interaction with her as Director of Nursing?
3 **A.** With ward -- yes, the ward managers meeting,
4 she would be there, in the meetings there.
5 **Q.** Which meetings, sorry?
6 **A.** The ward managers throughout the hospital,
7 Trust ward managers.
8 **Q.** So you, that is Nicola Lightfoot from
9 Children's Unit, is it? Would she be there?
10 **A.** Well, most of the ward managers for the
11 hospital.
12 **Q.** How many of you would that be at those
13 meetings?
14 **A.** There would be a lot, there would be a lot.
15 **Q.** Roughly?
16 **A.** I wouldn't necessarily go to all of them
17 because there would be competing meetings in between
18 that I would have to attend.
19 **Q.** But how many wards are you talking about,
20 roughly?
21 **A.** Within the hospital?
22 **Q.** Yes. How many managers is it? 10, 20?
23 **A.** Must be about 40.
24 **Q.** 40?
25 **A.** Yes.

1 **Q.** So about 40 of you invited to the same meeting
2 and who took those meetings, who chaired them?
3 **A.** There would be Karen Rees, it was -- and it
4 would be Alison Kelly. Yes.
5 **Q.** So they would chair the meetings with all the
6 managers?
7 **A.** Yes.
8 **Q.** And what kind of matters were discussed at
9 those meetings?
10 **A.** It was just an overall meeting of the
11 managers. So anything of interest, any points, any
12 discussion with infections control issues and suchlike.
13 **Q.** So you would discuss generic issues --
14 **A.** They were very generic, yes. It was for
15 information, really, to cascade down to staff.
16 **Q.** And is there anything striking in this period,
17 2015 to 2016, in those meetings, at the ward managers
18 meetings that you were discussing or not?
19 **A.** No.
20 **Q.** Nothing?
21 **A.** No.
22 **Q.** So nothing that was affecting the hospital at
23 large or something that you were all worried about?
24 **A.** Not that I was aware of, no.
25 **Q.** That can go down, thank you.

1 While we are on the subject of meetings, at
2 paragraph 54 you talk about Cheshire and Merseyside
3 Neonatal Network meetings. I want to understand a bit
4 more about those if I can.
5 Can I ask you, first of all, before going to the
6 meeting that discussed Babies O and P, to look at the
7 Datix that were reported in relation to O and P.
8 So the first reference is INQ0008615.
9 We see there on the first page it says
10 "Subcategory: Expected and unexpected death".
11 Is that a dropdown box?
12 **A.** Yes.
13 **Q.** So do you have to tick whether it's expected
14 or unexpected or does it just -- there we see both, so
15 what does it look like?
16 **A.** Yes. It's, it is a dropdown, you click on the
17 arrow that drops down and then it gives you the
18 categories within that category.
19 **Q.** And is that one category "expected and
20 unexpected death", they are not separated?
21 **A.** No. No.
22 **Q.** So you can't just say "unexpected death",
23 because if you read that it's not clear on the face of
24 the front of it that it was an unexpected death, is it?
25 **A.** But the important thing is that it is a death.

1 That's what it's highlighting there.
2 **Q.** What's even more significant in terms of
3 processes? If it's an unexpected death --
4 **A.** Unexpected --
5 **Q.** -- do you see there's a difference in terms of
6 the processes that would be triggered with an unexpected
7 death?
8 **A.** True. But I -- I couldn't -- it's very
9 difficult at that time with, with hindsight, sometimes
10 you say, oh well, yes, we can understand now why that
11 child collapsed at that time, that is quite obvious.
12 But if by categorising them together, I guess, it's you
13 are looking at both aspects. Because if you were
14 expecting it you wouldn't therefore look for anything
15 unexpected, whereas if it's completely unexpected it's
16 taking the death per se as an issue as opposed to
17 whether it's expected or not, so that somebody from risk
18 would have to look at that closely.
19 **Q.** There is no question that Baby O's death was
20 unexpected, is there? No question about that at the
21 time with what everybody was saying. Nobody expected
22 Baby O to die, did they?
23 **A.** Just wait a minute.
24 No.
25 **Q.** No. If we look and you do refer under

1 "Description" -- "Sudden collapse of Triplet 2"?
2 **A.** Sorry, I -- when you put your head down, I'm
3 sorry, I lose the thread.
4 **Q.** Have a look at the document in front of you
5 and it's being highlighted in yellow and that will help
6 you.
7 **A.** Yes.
8 **Q.** So "Sudden collapse of Triplet 2", so you have
9 written that or entered that, yes? And you said the
10 baby has died "cause as yet unknown" at the bottom --
11 can you see there in the last box?
12 And then if we go to the next page, page 2, we see
13 you are the person who's reported it, Eirian Powell,
14 clinical nurse manager as reporter. Employee involved,
15 Lucy Letby. Neonatal nurse. "Directly involved in the
16 incident."
17 In terms of Baby P, if we go to INQ0008624, page 1,
18 again, we see you have entered that Triplet 1 collapses
19 and dies. You put at the bottom:
20 "Parents present and updated fully throughout."
21 Pausing there, what do you think they were updated
22 about at that time?
23 **A.** Updated about the condition of their child.
24 **Q.** So that means told about the death --
25 **A.** Yes.

1 **Q.** -- or aware the death.
2 And if we go over the page again at page 2, we see
3 you are the Datix reporter and confirm that Lucy Letby
4 was the employee directly involved.
5 At that time, why did you report she was the person
6 directly involved?
7 **A.** Because she was the allocated nurse.
8 **Q.** Yes. So as the shift leader you put her down?
9 **A.** Yes.
10 **Q.** So do you think the shift -- sorry, allocated
11 nurse, not shift leader, the allocated nurse should
12 always be the person put down even if they weren't the
13 person with the baby when they died? What did you
14 think?
15 **A.** Yes, because -- the reason being is that was
16 the person you went to to actually obtain more
17 information, whereas if there was anything that
18 I couldn't ascertain as a manager, or the shift leader
19 couldn't, then at least you knew who the allocated nurse
20 was.
21 **Q.** Their deaths are discussed at a Cheshire and
22 Merseyside Neonatal Network meeting.
23 If you could go, please, to INQ0005564, page 1.
24 We see, if you look at page 1, at the front,
25 clinical leads from other hospitals, transport

1 consultants, a wide range of expertise across a number
2 of units, is that right, at these meetings?
3 **A.** Yes.
4 **Q.** And if we go to page 3, we see Countess of
5 Chester discussion about Child O and P and lessons
6 learnt. It says:
7 "Awaiting PM report but no clear cause of death
8 identified from review in relation to P."
9 And we can see there what it says in relation to O.
10 You were at that meeting. We see Dr Brearey
11 wasn't. Who was presenting and reporting to that
12 meeting about the deaths of O and P?
13 **A.** Well, I think Dr Brearey must have sent the
14 resume, the -- of the findings and lessons learnt via
15 email to the Network and then they just asked me for
16 some input, which I don't -- that's not something we
17 normally do. It's the lead that does it.
18 **Q.** But given the lead wasn't there, that is
19 Dr Brearey --
20 **A.** Yes.
21 **Q.** -- they asked you. What was your input? What
22 did you say?
23 **A.** I can't remember what I said.
24 **Q.** We know that those deaths devastated the unit
25 and people were very upset, weren't they --

1 **A.** Yes.
2 **Q.** -- at the time?
3 **A.** Yes.
4 **Q.** Dr V has told us that she also let you know
5 that Letby made the remark to her that P wasn't going to
6 get out alive. Do you remember her telling you that?
7 **A.** I remember her saying that she did an
8 inappropriate comment. She never said what it was. And
9 I asked her, "Like what?" And she said, "Well, I can't
10 think now. I can't remember what it was."
11 But, but I asked her what, what was it, because
12 I had come back. I was away at Glan Clwyd at the time
13 and I came back on the Monday and we had a senior
14 clinicians meeting and she told me after the meeting.
15 **Q.** She was upset that it happened and she said
16 she wanted to tell you that remark, and are you saying
17 she forgot in the final moment having gone to see you
18 about it, that she didn't say it?
19 **A.** No. She said that she couldn't remember
20 exactly what because I said, "Like what?" Well, it was,
21 like, "Like what?" "Well, I don't know, I can't
22 remember."
23 But she couldn't give me a definitive response.
24 **Q.** Did you go back and ask her what was it the
25 next day? She was obviously upset, you have said, or

1 couldn't remember, or --
2 **A.** No, I didn't. No.
3 **Q.** What do you think about the remark, "He's not
4 going" -- "I don't think he's going to get out here
5 alive."
6 **A.** Well, take -- yes, it's, it's totally
7 unacceptable.
8 **MS LANGDALE:** My Lady, I note the time and I am
9 moving to a different topic.
10 **LADY JUSTICE THIRLWALL:** Very well. We are going
11 to take a break now and we will come back in just after
12 half past 11.
13 **(11.16 am)**
14 **(A short break)**
15 **(11.31 am)**
16 **LADY JUSTICE THIRLWALL:** Ms Langdale.
17 **MS LANGDALE:** Ms Powell, I am going to take you to
18 "Letby and Clinical Incidents", paragraph 68 of your
19 statement, and can we have on the screen, please,
20 INQ0014469, page 1.
21 This is a Datix. Can you read that, Ms Powell?
22 **A.** Yes. Yes.
23 **Q.** This is the Datix that reports a baby was
24 receiving 10 times the rate of morphine than the baby
25 should have been administered.

1 And we know from yesterday's evidence, if we go,
2 please, to INQ0008961, page 47, that Yvonne Griffiths
3 speaks to Letby about this.
4 While we are finding the document can you help me
5 with this, the Alaris pump, when you set a rate of
6 infusion in an Alaris pump, what do you need to tap into
7 the device to do that?
8 **A.** Well, you need to tap up -- the up or down
9 keys to actually get the, the amount that's displayed.
10 **Q.** And does it ask you to confirm instructions?
11 **A.** Yes, it does.
12 **Q.** So it has safety checks, doesn't it, the
13 Alaris pump?
14 **A.** Yes.
15 **Q.** It is not just a turn up, it reminds you --
16 you have to put in patient data and you --
17 **A.** It is only confirming what you have actually
18 put in.
19 **Q.** Yes, but it asks you to confirm, it gives you
20 that check to think "What have I just done"?
21 **A.** Yes.
22 **Q.** Yes. Does it require you to put the patient
23 details at every stage? In other words, when you are
24 putting the infusion up and the rate, or do you -- do
25 you do it just once? How often do you have to put the

1 patient details in?
2 **A.** No, you just put in what you want it running
3 at and then you press "confirm".
4 **Q.** So how long does that take?
5 **A.** It doesn't take long, that in itself, no.
6 **Q.** But you have to think about it and you have
7 a chance to check it yourself as you are doing it --
8 **A.** Yes.
9 **Q.** -- before you confirm it?
10 **A.** Interestingly enough, though, they have
11 actually put guardrails on these Alaris pumps now, where
12 it doesn't allow -- you have to put in the details
13 that's on the syringe pump. That actually you have to
14 input 10 micrograms per kilogram or -- in the guardrails
15 and if, therefore, the calculation is incorrect, it will
16 not let you proceed.
17 **Q.** And that guardrail was introduced when, do you
18 know?
19 **A.** Well, it's it -- I am sure it was, it was
20 ongoing at that time in other units, and Level 3 units
21 were using them. But obviously there's a cost
22 implication in -- in putting them on but we were
23 actually on, in the process of trying to get these
24 guardrails to go on the Alaris pumps.
25 **Q.** That actually prevents the dose being

1 administered?
2 **A.** Yes.
3 **Q.** But there was still, even with the ones you
4 had, an opportunity to check the rates after you have
5 inserted the rate --
6 **A.** Yes.
7 **Q.** -- and set the rate?
8 **A.** Yes.
9 **Q.** We see on this Datix -- sorry, not Datix, the
10 one-to-one form with Yvonne Griffiths?
11 **A.** Oh, yes, right. Yes.
12 **Q.** This is the one before you are involved:
13 "Lucy had commenced a continuous infusion of
14 morphine at the end of her night shift (7 am) for
15 a re-intubated infant. At 8 am on handover infusion
16 noted to be infusing at incorrect rate."
17 So it's very clear there that with Yvonne
18 Griffiths, Lucy was accepting she had commenced that
19 continuous infusion at the wrong rate?
20 **A.** Yes.
21 **Q.** So she had set the wrong rate?
22 **A.** Yes.
23 **Q.** No doubt about that looking at this document.
24 She was the one --
25 **A.** But there's two members of staff doing that

1 together.
2 **Q.** Well, let me come on to that in a moment.
3 **A.** Yes.
4 **Q.** One person sets the rate --
5 **A.** Yes.
6 **Q.** -- and at some point someone checks the rate,
7 yes?
8 **A.** Yes.
9 **Q.** It doesn't have to be at the same time, it can
10 be subsequently; they just have to check the rate. Is
11 that right?
12 **A.** Correct.
13 **Q.** They don't have to stand there while someone
14 is checking it, they can come back moments later, as
15 long as they check it; is that the position?
16 **A.** Yes.
17 **Q.** So we know someone at some point has checked
18 the rate or seen the rate, but the person who's inputted
19 it is Lucy Letby; there is no denial about that?
20 **A.** Mm-hm.
21 **Q.** She is the one who has commenced that rate,
22 yes?
23 **A.** (Nods).
24 **Q.** Yvonne Griffiths told us she was pretty new at
25 managing these situations. She took advice from

1 a matron -- you weren't there, you were on leave,
2 I think, weren't you, at that point?
3 **A.** I know I wasn't there but ...
4 **Q.** You weren't there. She thought it was safe
5 practice to prevent Letby at this time from checking any
6 intravenous infusions or requiring additives and any
7 controlled drugs until the incident had been reviewed.
8 So she put a pause on her practice in those respects,
9 didn't she --
10 **A.** Yes.
11 **Q.** -- at that time?
12 Do you think that was a sensible thing for her to
13 do --
14 **A.** Yes.
15 **Q.** -- Yvonne Griffiths? Why?
16 **A.** Well, because she obviously needed to discuss
17 it with me once I was -- I had returned and that we
18 could actually come up with a -- an action plan.
19 **Q.** So you do return and we see INQ0008961,
20 page 45.
21 Is that your writing at the top?
22 **A.** It is.
23 **Q.** "Review with Lucy and reflect critically on
24 the clinical incident which occurred. Drug calculation
25 was correct, however the infusion pump rate was

1 incorrect."
2 So what did you or how did you discuss this with
3 her? What did you say to her?
4 **A.** Gosh, I can't, I can't remember exactly what
5 I was talking to her about. This is 2013. I would
6 have, you know, ascertained first how she felt about it
7 and gone through the process with her and stated that --
8 what the action plan moving forward was.
9 **Q.** And what did you understand the action plan
10 to be?
11 **A.** Was that she wasn't to check CDs and that she
12 wasn't to care for infants with infusions with
13 controlled drugs.
14 **Q.** How long for? What did you think the position
15 was?
16 **A.** Until we had had a discussion, a review of the
17 situation.
18 **Q.** Until you had had the review with her or
19 someone else had had the review?
20 **A.** No, since we had had the review with her, that
21 she does her competencies with Yvonne, goes through it
22 to check through it, but we also had a discussion with,
23 what's her name, the pharmacist, Gemma, she was the
24 allocated neonatal pharmacist and she actually devised
25 a failsafe system on -- where you could actually check

1 CDs -- not CDs, infusions.
2 So they would come in in syringes of 10 mics, 20
3 mics, 40 mics in the infusion.
4 So she would actually do an average so that you --
5 it was like a final check. So if you were coming up
6 with -- it should be 1.17 an hour and she -- for
7 a similar gestation and birth weight, she would actually
8 look at that and she would give what at 10 mics per
9 kilogram would that be running at, should that be
10 running at.
11 So if it was 10 times the amount you would have to
12 go back to the drawing board, you would have to think,
13 well, hang on a minute, something's not right. But that
14 was in the transition period for us waiting for
15 guardrails on the Alaris pumps.
16 **Q.** How --
17 **LADY JUSTICE THIRLWALL:** I'm sorry, Ms Langdale.
18 So when was that?
19 **A.** Well, that would be after this incident.
20 **LADY JUSTICE THIRLWALL:** Thank you.
21 **MS LANGDALE:** How serious was this incident in your
22 view?
23 **A.** It could have been catastrophic. It could
24 have been.
25 **Q.** What do you mean by that?

1 **A.** Well, it would cause a death.
2 **Q.** What was your understanding in terms of how
3 and when she went back to checking drugs and doing
4 infusions?
5 **A.** She was only checking drugs with another
6 member of staff of the controlled drugs in the CD
7 cupboard. So she was doing that with a member of staff.
8 But the -- the infusions itself was -- preparing
9 infusions was to be given to other members of staff
10 until her competencies was met.
11 **Q.** If we look at this document on screen --
12 **A.** Yes.
13 **Q.** -- your writing says:
14 "Is able to check CDs."
15 **A.** "Is able" -- yes, because it's CDs in the
16 cupboard, it is not CDs, controlled drugs are those that
17 are in the cupboard.
18 **Q.** But she is able to check them, so check them
19 being given?
20 **A.** No. Check that there was 10 in a pack, nine
21 in a pack, that it equates to what's in the book.
22 **Q.** If you look at the one above:
23 "To continue to care for infants with infusions."
24 Yes?
25 **A.** Yes.

1 **Q.** So she can do that. She can carry on caring
2 for infants with infusions and she can check the drugs?
3 **A.** Yes. But not giving that to patients. That's
4 just checking it in the cupboard.
5 **Q.** So what was your understanding about whether
6 she would give any drugs or any infusions to patients at
7 this time?
8 **A.** Sorry?
9 **Q.** What was your understanding about whether she
10 could give anything to patients at this time?
11 Just go and be around patients. Could she stand
12 and check Alaris pumps and have patients under her care
13 when they are having drugs?
14 **A.** Yes.
15 **Q.** Yes. So she could do that?
16 **A.** Yes. But not CDs. She was checking those
17 only in the cupboard.
18 But she could actually care for the infants with --
19 a lot of infants have only infusions that you don't need
20 to add to; they're just infusions, IVs, whereas in
21 fusions that you actually bring from the, the fridge,
22 that actually you add to the infusions is different.
23 **Q.** Nothing here that you write prohibits,
24 expresses anything she is prohibited from doing. Do you
25 see what I am saying? It is not clear from this --

1 **A.** No.
2 **Q.** -- or your evidence what you are saying she
3 cannot do at this point?
4 **A.** Yes.
5 **Q.** Is that because, in fact, she could do what
6 she had been doing before and treat patients and be with
7 patients --
8 **A.** But not to do the infusions. The actual --
9 I am not making myself clear -- the -- the syringes that
10 goes into, to add on additional infusions, whereas the
11 infusions that come up from pharmacy already made, you
12 don't need to add to them.
13 **Q.** So she could put infusions up that you say
14 didn't have any additives?
15 **A.** The IVs themselves, intravenous infusions that
16 come up from pharmacy, they actually go into the baby.
17 These -- the morphine one was an additional one that
18 because baby had been re-intubated, that actually had
19 been put on to help with pain relief.
20 **Q.** You don't write here what she cannot do or
21 that this could have been fatal for the baby and that
22 this was serious. That's not the impression we get
23 reading this, is it?
24 **A.** But she had already had the review with
25 Yvonne. Not the review, the actual one-to-one. This

1 was actually speaking to her subsequently, after
2 speaking to Yvonne Griffiths -- Farmer.
3 **LADY JUSTICE THIRLWALL:** I think it was Yvonne
4 Griffiths.
5 **MS LANGDALE:** It was Yvonne Griffiths she had
6 spoken to on the previous one-to-one and Yvonne had put
7 it on hold.
8 **A.** No, Lucy had yes, but this is with Yvonne
9 Farmer, I needed to make sure that she was able to go
10 over the Alaris pumps with Lucy.
11 **Q.** Yes, we see that Yvonne Farmer, 6 September,
12 records:
13 "Practice calculations completed with Lucy.
14 I observed doses required being inputted into the Alaris
15 pump by Lucy. We discussed the pump settings and safety
16 features and I am happy she is competent to use this
17 equipment."
18 She says:
19 "Review in six months."
20 And we see January 30, 2014 as a date.
21 What did you think in those six months Letby was
22 able to do?
23 **A.** In the following --
24 **Q.** Yes, the six months.
25 **A.** Well, that she was able, after her tuition

1 with Yvonne, that she could actually go back to doing
2 what she was doing subsequently, before.
3 **Q.** So is it your evidence you thought there was
4 a restriction for six months until she had done that,
5 until January 2014? I want to know --
6 **A.** No, no, the review was in case there was
7 a recurrence of the same issue.
8 **Q.** Right. So if there wasn't a recurrence you
9 wouldn't be worried about it?
10 **A.** No.
11 **Q.** And how long do you think she stayed not doing
12 the CDs? How long do you think there was any
13 restriction on what she did on the wards?
14 **A.** Once she was complete with the Alaris pump she
15 was fine.
16 **Q.** So is that, in your view, September, by
17 6 September?
18 **A.** Yes.
19 **Q.** So she was unable between July
20 and September --
21 **A.** Yes.
22 **Q.** -- for three months.
23 Was that common to have nurses on the unit that
24 were prevented from doing anything for a period of
25 months?

1 **A.** This, on -- on the unit if you did clinical
2 incidents on all the drug errors that happened, and not
3 that they were happening all the time, but they were
4 happening and to say that you didn't have a drug error
5 or that you didn't do a drug error would be more
6 worrying than those that actually come forward and
7 actually say, "I have made a mistake here" or, "This has
8 happened" or whatever.
9 **Q.** She didn't come forward. She was caught,
10 wasn't she, by the next morning -- (overspeaking) --
11 **A.** I know, but there was two of them. There was
12 a very senior Band 6 with her and she should have seen
13 that the infusion pump was actually incorrect.
14 **Q.** So let's focus on the person you were dealing
15 with first of all. We know the other Band 6, we don't
16 need to know her name, she wanted to resign and was
17 really distressed by the episode, wasn't she?
18 **A.** Yes.
19 **Q.** Really distressed.
20 Meanwhile, we see the text, the message, if we can
21 have it, please, INQ0012033, page 171.
22 We see the last text. She is responding to someone
23 asking her what happened over the drug error:
24 "Thankfully Eirian felt it had been escalated more
25 than it needed to be. Everything is back to how it was.

1 I just have to have more training on using the pumps and
2 it will be on my record for six months. She was very
3 supportive, a case of learning to live with it now and
4 getting my confidence back. I am on nights this week,
5 still feeling a bit vulnerable and thinking what if, but
6 I will get there. Thanks for asking."
7 So this is a text that's been sent on 1 August
8 saying, "Everything's back as it was."
9 So it doesn't look like she understood there were
10 any restrictions about how she was practising at that
11 point around the pumps or the drug error, was there?
12 **A.** Well, she was told. We went through it and
13 she was obviously very, very upset about it as, as was
14 the other practitioner, was the same. And, you know,
15 they appreciated, both of them did, what could have
16 been. It is -- it makes them a better nurse from
17 reviewing what it is that was a near miss.
18 **Q.** Did you tell the parents at the time or do you
19 know if someone else did about the near miss?
20 **A.** I can't remember.
21 **Q.** What would be the policy on that?
22 **A.** Well --
23 **Q.** That can go down now.
24 **A.** The Consultant, I would imagine, or the
25 Registrar would have actually informed the parents or

1 the -- I am sure Yvonne would have spoken to the
2 parents.
3 **Q.** There is another reflection on a drug error in
4 April 2016 on the -- from Letby. INQ0008961, page 49.
5 This is a reflection on a drug Gentamicin --
6 **A.** Yes.
7 **Q.** -- a drug that wasn't due and wasn't
8 prescribed for the baby.
9 **A.** Yes.
10 **Q.** So not due, not prescribed, but was given.
11 **A.** Yes.
12 **Q.** What do you make of the last paragraph of
13 that?
14 "I do not feel that anything can be added/changed
15 in order to prevent this happening again ... I do need
16 to develop my own professional role to ensure I adhere
17 to protocol and adjust my workload, escalate inadequate
18 staffing, skill mix, to ensure that a mistake like this
19 does not occur."
20 **A.** I don't think -- I mean, it says "I do not
21 feel that anything can be added", well, yes, it wasn't
22 prescribed. Period. She was incorrect.
23 However, Gentamicin, unfortunately, you've got
24 antibiotics, two antibiotics that go together, one is
25 penicillin, one is Gentamicin. Penicillin is very easy,

1 it is twice a day, morning and evening. Gentamicin,
2 however, changes. It changes throughout the doses.
3 It's given to a particular gestation, it will change
4 dose because -- the intervals will change, they have
5 a pre and post level done. So the, the intervals can,
6 can actually change according to the pre and post level
7 that's taken from the blood.
8 So in this period, I think 2016, it would have to
9 be 2016/2017, e-prescribing came into force and at one
10 point we were using prescription drugs, prescription
11 charts and electronic, which confuses and compounds
12 things in addition to -- NICE guidance came in that we
13 were giving antibiotics a lot more than we were. So we
14 were having to do a lot of antibiotics upstairs on the
15 postnatal ward in addition to downstairs.
16 There is a lot of chaos going around.
17 Still not prescribed. So she's wrong. It's, it is
18 a prescribed drug. I don't know how she gets this, but
19 yet again, there is a very senior practitioner that's
20 actually drawing this up with her. And it can't be
21 drawn up without a prescription.
22 **Q.** So does that look like that's even been
23 explored that it can't be drawn up without
24 a prescription?
25 **A.** I wasn't aware of this until the Inquiry.

1 **Q.** "I don't feel anything can be added changed in
2 order to prevent this happening again."
3 **A.** It --
4 **Q.** What about, "Sorry, my mistake".
5 **A.** Yes.
6 **Q.** "I don't know why I did this."
7 **A.** Exactly.
8 **Q.** This is a very defensive response, isn't it?
9 It is supposed to be a reflection but this is a very
10 defensive response referring to workload, inadequate
11 staffing and skill mix for what is a basic error?
12 **A.** Yes, it is.
13 **Q.** A basic error?
14 **A.** But -- and also she's actually realised --
15 the mistake was realised by herself and she has reported
16 on it.
17 **Q.** She reported it herself?
18 **A.** Yes:
19 "This mistake was realised by myself and
20 a colleague immediately after the dose had been given."
21 But I don't understand how they actually drew it up
22 without a prescription.
23 **Q.** How could you do that?
24 **A.** I don't know.
25 **Q.** So there is more questions than that

1 answers --
2 **A.** Yes.
3 **Q.** -- from your point of view? How did that even
4 happen in the first place?
5 **A.** Exactly.
6 **Q.** And if you can get that drug without
7 a prescription can you get other drugs without
8 a prescription? It doesn't make sense, does it?
9 **A.** Yes.
10 **Q.** Thank you, that can go down.
11 When you were first interviewed by the police, you
12 said that when Lucy had qualified you had no qualms
13 about employing her:
14 "Even during her interview, although I can't
15 remember much about it, I wanted her on the unit,
16 I really did. When students come through the system you
17 are almost able to hand pick the creme de la creme and
18 she was one of those."
19 We have had evidence now that she failed and had to
20 have a retrieval placement in her final year at
21 university. She had the clinical incidents that we have
22 just gone through, and there was a period of
23 three months where you understood she wasn't doing what
24 other nurses who were qualified would be doing.
25 How was it you came to describe her as "creme de la

1 creme" with that history at that point?
2 **A.** Well, when the students come through on the
3 unit, you get to know them because their, their
4 placement is quite a lengthy placement. And you --
5 those that don't want to be there are obvious. They
6 have just got no interest whatsoever, but there are
7 others that actually stand out and I think we employed
8 three from that same cohort.
9 **Q.** And she really wanted to be on intensive care
10 units, didn't she? You discussed that with other nurses
11 at some point.
12 **A.** She wanted to be?
13 **Q.** Yes. Letby, when you were there managing,
14 I think it was --
15 **A.** Oh, yes, yes.
16 **Q.** -- Kathryn Percival-Calderbank --
17 **A.** Yes.
18 **Q.** -- who spoke to you after the death of the
19 triplets about her desire to always be in intensive
20 care, and she was worried about that and you were
21 worried about that, weren't you?
22 **A.** Yes.
23 **Q.** Why were you worried about that?
24 **A.** Only because I realised from my own, this is
25 from my own experience, that being in an intensive care

1 environment isn't always healthy for your own mental
2 well-being because it's a very stressful situation to be
3 in constantly and it does need time out, take a break.
4 **Q.** So you were worried about her, not the babies,
5 about her --
6 **A.** Well, it goes hand in hand because the last
7 thing that parents need is somebody who will actually
8 burst into tears for no reason, but that is something
9 that can happen.
10 **Q.** I am going to move on now to the meetings
11 in July 2015, relating to Child A, C, and D between you
12 and Dr Brearey and it's page 86 -- sorry, paragraph 86
13 onwards of your statement.
14 If I can ask, please, to go on the screen
15 INQ0003110, page 1, which is an email from Dr Brearey to
16 Ravi Jayaram.
17 Before that is put up, can I ask you this: Baby A,
18 Baby C, Baby D, they die really closely, don't they, on
19 your unit?
20 **A.** (Nods).
21 **Q.** Did you have any conversations with nurses or
22 doctors, at the time, about their deaths, dealing with
23 Child A first of all. We know, we have heard from
24 Melanie Taylor, Caroline Bennion, Nurse T, Dr Harkness,
25 Dr Ogden, Dr Teresa MacCarrick, Dr Thomas, did you speak

1 directly with any of those nurses or doctors about
2 Baby A's death at any time?
3 **A.** Not that I can recall, no.
4 **Q.** Why not?
5 **A.** I don't recall it. I just can't remember
6 anything sort of stand out in my mind. I remember --
7 hang on. Just -- I will just refer to this.
8 **Q.** I think you are referring to a list of dates
9 you have, is that right, as a document? Death of
10 Baby A.
11 **A.** Because the staff would have spoken to me
12 about, about them.
13 **Q.** They would have done?
14 **A.** They would have done.
15 **Q.** And they probably told you what they told the
16 police and the Inquiry; that they were shocked and
17 surprised, that Baby A was stable --
18 **A.** Yes.
19 **Q.** -- stronger than his twin sister, expected him
20 to live. Did they tell you these things?
21 **A.** I honestly -- I can't remember.
22 **Q.** All of them, with one voice, have spoken about
23 the unexpected nature of it --
24 **A.** Yes.
25 **Q.** -- and the concern about a rash. Any

1 discussion with you about that?
2 **A.** I don't remember anything about a rash, no.
3 **Q.** When say you don't remember, these are -- this
4 was a significant three weeks for anyone, wasn't it?
5 **A.** Yes.
6 **Q.** A, C and D had died, B had collapsed. You
7 can't have had that in your career at any other time.
8 **A.** No.
9 **Q.** That many babies die so closely together in
10 unexpected circumstances?
11 **A.** Yes.
12 **Q.** So can you try and remember then, please, who
13 told you what about whether it was unexpected.
14 **A.** I don't know because we did a review, a deep
15 dive review on --
16 **Q.** I am not talking about a deep dive.
17 A conversation.
18 **A.** Yes.
19 **Q.** You walk into work, you run into Dr Harkness,
20 you see Melanie Taylor. You say, "How was that for
21 you?" You support your staff, don't you?
22 **A.** Yes.
23 **Q.** "How was that for you? What went on? How do
24 you feel about it?"
25 **A.** Yes.

1 **Q.** Did you ask that?
2 **A.** I can't -- honestly, I cannot remember. I --
3 I remember them coming and telling me and how upsetting
4 they were -- it was. But I, I cannot recall exactly.
5 **Q.** Did you have any interest to understand, if it
6 was unexpected, how it could have happened?
7 **A.** Well, we were just going through the process
8 and making sure that all the Datix was completed and the
9 staff themselves, how they felt, and -- because we
10 didn't -- did a lot of work on the bereavement process
11 of how we are reporting.
12 **Q.** So you did know the staff were struggling with
13 it and they were upset by it and it was unexpected?
14 **A.** Well, yes, but not -- I don't actually
15 remember the actual conversation.
16 **Q.** What was the impact of the conversation?
17 Sometimes we don't necessarily remember the words but --
18 **A.** -- (overspeaking) --
19 **Q.** -- a feeling, we remember a moment?
20 **A.** Yes, it was unexpected.
21 **Q.** Right. So it was clear, unexpected.
22 **A.** Yes.
23 **Q.** They were upset and it was unexpected.
24 Child C, you had already been approached, hadn't
25 you, by Nurse W about Child C and "Letby not looking

1 after the baby she was allocated to but keep winding her
2 way back to Child C when she shouldn't have been".
3 That was something Nurse W spoke to you about --
4 **A.** Yes.
5 **Q.** -- didn't she? And you say in your statement
6 it was really important that people stayed with their
7 allocated babies.
8 **A.** Yes.
9 **Q.** You thought that was important?
10 **A.** For an ITU and a high-dependency baby, you
11 have to -- you don't move from that space. Nobody
12 touches your baby without you knowing.
13 **Q.** So you were told by Nurse W that Letby did go
14 and be with Child C when she shouldn't have been and she
15 should have been looking after another baby that in fact
16 Nurse W, a shift leader, was worried about. She told
17 you that, didn't she?
18 **A.** Yes.
19 **Q.** You must have realised at the time that was
20 a serious breach of your ward protocol.
21 You are nodding but yes, you had said people should
22 stay with --
23 **A.** Yes, it is.
24 **Q.** So what did you say to Letby about that when
25 Nurse W told you that with Baby C that is --

1 (overspeaking) --
2 **A.** That is why I asked Nurse W to do a Datix and
3 have it documented.
4 **Q.** But the Datix was about the other baby,
5 presumably, the one she was worried about.
6 **A.** Yes, because I didn't know about the other
7 one.
8 **Q.** Yes.
9 **A.** Yes.
10 **Q.** So that didn't deal with Letby, did it? The
11 Datix doesn't deal with the complaint she was bringing
12 to you. She was saying she felt angry at the time, she
13 had been selfish, she wasn't obeying instructions, she
14 was a law unto herself, effectively; that is what she
15 was saying, wasn't she?
16 **A.** Yes.
17 **Q.** So did that worry you when she told you that?
18 **A.** Well, yes, it did. Because, again, it goes
19 back on past experiences of when you are actually -- she
20 was, Nurse W was a Band 5 that was promoted not --
21 around that time to a Band 6 and therefore it's very --
22 it takes a period of adjustment to actually get somebody
23 to respect -- that respect is very difficult to --
24 **Q.** So rather than questioning Nurse W's
25 authority, can we question what Letby did, please?

1 **A.** Yes.
2 **Q.** And what you did with what she did?
3 **A.** Yes. So it would be that she had to have --
4 she wanted to go to work more with ITU babies but this
5 was a special care baby, I think it was, that she was to
6 take time out from.
7 **Q.** So she told you she wanted to be in the ITU
8 not the special care baby unit?
9 **A.** No, that's what the understanding, this was
10 prior to this, this is why I think she was allocated to
11 take time out because she had been busy the night before
12 with an ITU baby.
13 **Q.** Right. So what did you say to Letby about the
14 complaint Nurse W made to you? Did you sit down and
15 speak to her? You have said you told her to do a Datix.
16 **A.** Yes.
17 **Q.** Did you actually speak to Letby about the
18 serious matter that Nurse W had reported to you?
19 **A.** I have no recollection of it.
20 **Q.** We don't see any reflections from her in it so
21 do we take from that you didn't speak to her about it?
22 **A.** I am saying that this is 22 -- what date was
23 it, sorry? The Datix?
24 **Q.** The Datix for the other baby we haven't looked
25 at, we are not looking at that baby. I am looking at

1 Baby C. So Nurse W tells you about Baby C, if you look
2 at your document you've got the date of the death, it is
3 actually the 14th but --
4 **A.** Of?
5 **Q.** -- it was overnight -- June.
6 **A.** Okay.
7 **Q.** So Nurse W tells you promptly that she's not
8 happy --
9 **A.** Yes.
10 **Q.** -- about that shift and the way Letby has
11 behaved on that shift.
12 **A.** I can't recall.
13 **Q.** Does that mean you didn't?
14 **A.** I can't recall. I'm sorry, I can't. I just
15 cannot -- there are some things that I have no
16 recollection.
17 **Q.** Is that selective, Ms Powell?
18 **A.** Unless somebody is screaming at me, which
19 I can remember, I cannot. When you say "selective",
20 I cannot.
21 **Q.** Dr V's comment, she did say that to you,
22 didn't she --
23 **A.** Nurse W I remember because I said to do
24 a Datix.
25 **Q.** No, I'm not talking about that. I'm going

1 back it Dr V who said this baby -- she was worried about
2 that baby. She said that to you.
3 **A.** Yes, but she was screaming to me at the time.
4 That's why I remember that.
5 **Q.** So you remember her screaming?
6 **A.** Yes.
7 **Q.** But you don't remember what she said?
8 **A.** Well, no, she was saying that it was out of --
9 she couldn't remember, and I said to her "Then I can't
10 help if I don't know what she said."
11 **Q.** Why would she come to you to say "I can't
12 remember anything"?
13 **A.** This was at a meeting, a senior clinicians
14 meeting at the end of it.
15 **Q.** Did you speak in relation to Child C, to Nurse
16 Ellis, Dr Beech, Dr Davis or Dr Gibbs about their level
17 of surprise at the death of Child C? Did you have
18 a conversation with them?
19 **A.** I did not.
20 **Q.** Did you speak to any doctors or nurses about
21 the death of Baby D at the time about their surprise?
22 **A.** I don't, I don't remember.
23 **Q.** So there's not a single person now that you
24 remember describing any of those baby deaths to you in
25 any way that strikes a chord today as you sit here?

1 **A.** Because I -- Steve -- Dr Brearey and I were
2 doing the reviews and I was arranging the debriefs
3 but ...
4 **Q.** Let's go through those then. So on the
5 screen, we have an email from Dr Brearey to Ravi Jayaram
6 and this follows a conversation that you and Dr Brearey
7 have had and you have been reviewing the case notes of
8 Child D.
9 And it says here:
10 "In regard to the three deaths all deaths occurred
11 in room 1, our intensive care room, but in different cot
12 spaces. All microbiology results have been negative to
13 date. Initial post-mortem results for Child A did not
14 identify any definite cause of death."
15 Then if we move to the bottom:
16 "Child D was not on TPN and died at less than
17 two days of age. There does not seem to be any staff,
18 medical or nursing members present at all three episodes
19 either than one nurse who was not the nurse responsible
20 for Child D on that shift."
21 So in your first conversation together it looks as
22 though you were both discussing whether one person might
23 have been there for these unexpected deaths; is that
24 fair?
25 **A.** Yes. Yes.

1 **Q.** Do you know who raised that first, you or
2 Dr Brearey?
3 **A.** I think it was Dr Brearey.
4 **Q.** So he's got three unexpected deaths on his
5 hands and he says: let's look at who's around and who
6 has been caring for the babies?
7 **A.** Yes. Because the allocated nurse is quite
8 a key issue. If -- when the allocated nurse actually
9 stands by the incubator and looks after the babies,
10 I don't know how to stress this unless, unless you are
11 there. Nobody else is allowed in that space.
12 **Q.** Well, that's not what happened to Baby C, was
13 it, because Nurse W told us about that?
14 **A.** Well, this is the role of the allocated nurse.
15 This is what they are meant to do, they are an advocate
16 for the baby. They do not allow anybody else, even the
17 doctors will say, "Is it all right for me to do my
18 examination on the baby?"
19 **Q.** You and Dr Brearey, and it is you I am
20 questioning more because in practice you knew the
21 position, say one of the babies, for Child D, that nurse
22 was not responsible on that shift. He appears to have
23 misdirected himself that because Letby wasn't
24 responsible on that shift she wouldn't have had any
25 dealings with Baby D.

1 You knew in practice that wasn't always the case,
2 was it? Nurses obviously were, and she was with Baby C
3 and Baby D, looking after or being with other babies?
4 **A.** Mmm.
5 **Q.** You knew that?
6 **A.** Sorry, I'm misunderstanding what you are
7 saying.
8 **Q.** Just because you were allocated a particular
9 baby did not prevent anybody going to look after that
10 baby. We know that, don't we?
11 **A.** That's only in the special care room but in
12 the ITU and high dependency that is different.
13 **Q.** You both have the discussion about finding
14 a person. Presumably because you are suspicious about
15 three deaths happening so rapidly and when they are
16 unexpected. Yes?
17 **A.** Yes.
18 **Q.** That is uncontroversial.
19 **A.** Yes.
20 **Q.** You are looking at it, it is such a short
21 period of time and you don't know about any of the
22 deaths and they are babies that seemed well and stable;
23 yes?
24 **A.** Yes.
25 **Q.** You have an action plan, if we go over the

1 page of that document, please. Agreed an action plan,
2 set out there.
3 If we go to INQ0003110, page 4, we see:
4 "Morning all, three babies nursed in different
5 incubators. The monitors have been checked and they are
6 all in good working order. The antibiotics that were
7 prescribed were given as per Emar."
8 So you go and do what you are required to do on the
9 action plan, don't you?
10 **A.** Yes, and that suggests that the electronic
11 prescribing was in 2015.
12 **Q.** Dr Lambie told the Inquiry that by September
13 time, in 2015, she observed a group of nurses looking at
14 information to try and correlate who may have been
15 present, she didn't know exactly what they were doing
16 but looking for data to see if someone had been present
17 or around at the time of, she took it to be the deaths
18 or events, even in 2015 trying to do that.
19 Do you know which of your nurses were looking and
20 interested to see who could have been on duty all the
21 times these were happening?
22 **A.** No.
23 **Q.** You don't know about that?
24 **A.** I don't know.
25 **Q.** She also told the Inquiry that at that time

1 there was real anxiety on the unit as further babies
2 became unexpectedly seriously ill or collapsing such
3 that they were feeling nervous at the start of shifts.
4 Did any of your nurses or did you know any of the
5 Registrars felt that way?
6 **A.** No, they didn't speak to me about that.
7 **Q.** They didn't what, sorry?
8 **A.** They didn't speak to me about that.
9 **Q.** Didn't you pick that up?
10 **A.** No, I didn't.
11 **Q.** You didn't pick up that tension or anxiety?
12 **A.** Well, the anxiety, yes, I -- I picked up that
13 there's anxiety there about the unexplained deaths, yes.
14 **Q.** In what way did you pick it up, the anxiety?
15 What did you sense or see?
16 **A.** Well, just that you just feel it, just feel
17 the aura.
18 **Q.** Tell us about that, the aura?
19 **A.** You just -- when you come on the unit
20 sometimes it's -- you can feel it's quite -- it's quite,
21 quite jovial, you know, you can feel sort of the
22 pressure in the, in the air. But when -- sometimes you
23 go there and you think, oh, what's up, you know, what's
24 happened? So you go and find out. But, yes.
25 **Q.** Were you feeling like that, were you

1 thinking --
2 **A.** Yes.
3 **Q.** -- what's going to happen next?
4 **A.** I was.
5 **Q.** So at what point were you feeling like that,
6 you know, Baby A's death? Baby C's death? Baby D's
7 death?
8 **A.** No, by Baby C it was -- that's three, but I've
9 been in a situation where we have had spikes in the
10 mid-90s. But the situation was a bit different then.
11 **Q.** Spikes of unexpected/unexplained deaths that
12 caused surprise?
13 **A.** Yes, yes.
14 **Q.** And how were they investigated? What did you
15 learn from those?
16 **A.** Well, we were having babies, all gestations,
17 we weren't transferring out at that point.
18 **Q.** Do you mean in the 90s?
19 **A.** Yes.
20 **Q.** So what were these gestation babies?
21 **A.** Well, they were 23 weekers.
22 **Q.** So under 24 weeks?
23 **A.** Yes, yes.
24 **Q.** You will be aware that didn't apply at all to
25 any of these babies, did it?

1 **A.** No, it did not.
2 **Q.** When did you take the time to look at their
3 gestation periods? It's 31 weeks for Baby A, 30 weeks
4 for C, and 37 weeks for, 37 for D?
5 **A.** Yes, I know.
6 **Q.** You know. So when did you look at that?
7 **A.** It would have been in that time frame.
8 **Q.** So you knew very distinctly from your earlier
9 experience of a spike --
10 **A.** Yes.
11 **Q.** -- with a 23 week baby, many decades ago,
12 I think you would agree with me time has moved on in
13 terms of how those babies can be cared for now,
14 hasn't it?
15 **A.** Mm-hm.
16 **Q.** Medicine has increased and it is better for
17 them. But these babies were in a different category,
18 they were nothing like that gestation, were they?
19 **A.** No.
20 **Q.** They were expected to survive, all of them?
21 **A.** A different -- different set of circumstances.
22 **Q.** Different set. So they are expected to
23 survive and it is not acceptable --
24 **A.** Yes.
25 **Q.** -- to say, is it, premature babies die and

1 therefore we weren't worried about these? That's not
2 acceptable, is it, because they were not babies where
3 you were worried on their delivery --
4 **A.** Yes.
5 **Q.** -- about their ability to survive, were you?
6 There was no concerns about that?
7 **A.** No, but we, we have been caught out before,
8 sort of, by the premise of the neonatal unit, it has --
9 the babies are there for a reason, not just the
10 gestation. They are there sometimes because there are
11 things that have occurred during their obstetric --
12 **Q.** And they need to feed and grow and they need
13 to be looked after, but that is not sick, is it? None
14 of these babies were sick?
15 **A.** Some of them are not well. They have gone
16 dusky on the postnatal ward or they have become unwell
17 since.
18 **Q.** I am talking about A, C, and D, are you saying
19 any of those babies were underlying --
20 **A.** No, no.
21 **Q.** They were not, were they?
22 **A.** No.
23 **Q.** Let's just focus on these three.
24 So you are saying by Baby C you felt something and
25 there was an aura. Did you, with your experience, think

1 this isn't right, these two?
2 **A.** Yes.
3 **Q.** This isn't right?
4 You are nodding. Is that what you thought at the
5 time?
6 **A.** I agree yes.
7 **Q.** So you felt these two are not right,
8 something's gone wrong. And then when you got Baby D,
9 did that compound that, make it worse?
10 **A.** Yes. But there didn't seem to be anything
11 coming out of the debrief of the -- the deep dive
12 review.
13 **Q.** Let's go into the documents to see what was
14 reviewed at the time.
15 So if we go INQ0026017, page 1.
16 This is a document about Baby A. On the front it's
17 you, Yvonne Griffiths, and Debbie Peacock.
18 If we go to the last page, page 3:
19 "Awaiting full report. Note also collapse of twin
20 with successful resuscitation?? Related to."
21 Do you remember now having any meaningful
22 discussion about Baby B and the link to Baby A either in
23 terms of how the baby appeared, whether it was rashes or
24 the collapse or anything like that?
25 **A.** There was nothing on the review, was there?

1 No.
2 **Q.** So you don't remember that?
3 **A.** No. Well, I don't remember anything coming
4 out of this --
5 **Q.** No.
6 **A.** -- other than any actions that were to be
7 made.
8 **Q.** This suggests that both you and Dr Brearey had
9 at least, discussing Baby E, even if it's one line, have
10 added something about Baby B, and the collapse. But in
11 terms of you reviewing the deaths, you are looking at A,
12 C and D and Baby B falls out of the picture.
13 **A.** Yes.
14 **Q.** Do you think it would have been beneficial to
15 be looking at Baby B as well then where you may have
16 made links about rashes or other signs?
17 **A.** Yes, could be, yes. We tended to do them,
18 well, one by one because normally we wouldn't have
19 a collection.
20 **Q.** So you were organising a lot of debriefs at
21 this time, weren't you, or trying to?
22 **A.** Yes.
23 **Q.** Let's go to one of the first ones, INQ0000108,
24 page 27.
25 So this is a debrief that you are present for,

1 Melanie Taylor, Sophie Ellis, Nurse, and Lucy Letby and
2 Dr Gibbs.
3 We can see here what's set out in the first
4 paragraph:
5 "Didn't seem unwell, was active."
6 We know what's set out below.
7 Did you say at this debrief or raise the point that
8 had been raised with you by Nurse W about Letby invading
9 and becoming involved in the grief of the parents of C
10 and also in looking after the baby? Was that discussed?
11 Did you raise it in the debrief?
12 **A.** Not on the debrief, no. No.
13 **Q.** Did she raise or anyone else raise those final
14 moments of the parents with C or not?
15 **A.** No.
16 **Q.** Because a debrief is to support everybody and
17 to discuss what's happened, would that not have been
18 discussed?
19 **A.** Well, this particular debrief is obviously
20 looking at the resuscitation aspect. So it was looking
21 at lessons learnt, it is seeing whether they were doing
22 things that they should have, you know what I mean, the
23 collective doing the right things at the right time.
24 **Q.** Can you learn lessons until you know how
25 a baby has died or what you might have missed? I mean,

1 don't you need vigorous investigation to see what's
2 happened?
3 **A.** You sometimes do need to know what has
4 happened especially on a post-mortem to see what had
5 happened because sometimes it's not always obvious.
6 **Q.** What is the purpose of debriefs as far as you
7 are concerned?
8 **A.** It's for the staff that were involved to be
9 able to have a safe area where they can actually discuss
10 how things, how they think they went, how things they
11 thought could have gone better, whether they felt there
12 was any issues regarding the resuscitation.
13 **Q.** If we go to INQ0005585, page 1., we see in the
14 last message you are trying to set up debriefs. As you
15 say, normally it would be one at a time but you are
16 trying to set up a number at this point, aren't you?
17 **A.** Yes.
18 **Q.** The Inquiry doesn't have a record of Child D's
19 debrief. Do you think that went ahead? You probably
20 can't remember after this passage of time.
21 Do you see at the bottom you say:
22 "Child D's debrief will be held on Monday the 6th."
23 **A.** It should have -- I thought it would have --
24 it would have done but I can't remember.
25 **Q.** Were attendance at debriefs compulsory?

1 **A.** No, they were not. Not these particular ones.
2 The one they -- how it worked is that they did a debrief
3 as soon as possible after and then with the view of
4 doing a repeat 7 to 10 days later.
5 **Q.** So it was your understanding there would be
6 a discussion on the NNU, which would be a debrief, and
7 then there would be something more formal later on, or
8 what?
9 **A.** Not necessarily no, it would be very much --
10 unless of course there was -- if they were involved with
11 other hospitals. So, for instance, if they had gone to
12 Alder Hey or -- and then come back or they had input,
13 surgical input, they then had an opportunity to be
14 invited at the 7 to 10 day slots.
15 **Q.** Who did you tell at the time, Executives or
16 risk department or anyone else, that you felt uneasy
17 about the deaths of A and C and were suspicious?
18 Looking for a name or links, you were looking actively
19 at who was on shift?
20 **A.** Yes.
21 **Q.** Do you agree with me that that's someone with
22 suspicion: it is unexpected, I need to look at what's
23 there. Yes?
24 **A.** Yes.
25 **Q.** Who did you share that with?

1 **A.** It was with Anne Murphy.
2 **Q.** Anyone else?
3 **A.** Debbie Peacock.
4 **Q.** So Debbie Peacock knew that.
5 Debbie Peacock you definitely told that -- by
6 Baby C?
7 **A.** Well, yes, because she's involved here.
8 **Q.** What was -- did anyone give you any advice or
9 thoughts about that?
10 **A.** I just said that obviously we have this, this
11 spike in, in deaths, unexplained deaths. So obviously
12 the risk team were aware.
13 **Q.** Was Ruth Millward aware?
14 **A.** Well, by the fact we do a Datix for a death,
15 whether it's unexplained or not, it goes to the risk
16 team anyway. And then Debbie Peacock's already in with
17 the meetings.
18 **Q.** Did any of them ask you more questions about
19 what you thought in your opinion about the rareness of
20 this?
21 **A.** I'm not sure if it was at this point. It
22 could be. Because I can't remember if it
23 it's July, August, when I actually did the -- the table
24 showing Lucy.
25 **Q.** Dr Brearey sends to Debbie Peacock, copying in

1 you and Dr Jayaram, doesn't he, his report on the three
2 babies.
3 If we can go, please, to INQ0003191, page 2.
4 "Learning from these cases". It sets out learning,
5 there's lots of discussion about delayed cord clamping,
6 isn't there, between the two of you?
7 And if we go to page 3, within this report, he puts
8 neonatal mortality deaths in and the figures.
9 Do you know if those figures represent unexpected
10 and unexplained deaths or if they are deaths of both
11 types?
12 **A.** I would imagine they are deaths.
13 **Q.** Deaths, full stop.
14 **A.** Yes.
15 **Q.** So not exactly a direct comparison with the
16 situation you were all in, was it? You were in a very
17 different situation with three unexpected and
18 unexplained deaths; do you agree?
19 **A.** I do. Yes. Yes.
20 **Q.** Be that as it may, he sends the figures that
21 would suggest you have more deaths, and certainly
22 unexplained deaths, and he also sets out the survival
23 percentage for gestation rates, we see there.
24 So presumably he is setting those out so we can do,
25 you both do what we did earlier, and appreciated that at

1 31 weeks, 30 weeks and 37 weeks, these babies were in
2 a strong position?
3 **A.** Yes.
4 **Q.** When you received that report, what did you
5 make of it? When he put those death rates in and the
6 gestation stats in, what did you think of it?
7 **A.** I thought it was comparative, comparable to
8 some of the others, spikes that they had.
9 **Q.** Comparable to which spikes?
10 **A.** We, we tended to have, it looks like it tends
11 to be two or three a year.
12 **Q.** Yes, and you had had that in three weeks?
13 **A.** And then we had had that three.
14 **Q.** But in a way did it alter your view about the
15 circumstances because what mattered was what had
16 happened to these babies, wasn't it?
17 **A.** Yes.
18 **Q.** Not the figures generally, they didn't help
19 with A, C and D; it mattered investigating the
20 circumstances of their deaths, didn't it?
21 **A.** Mmm but -- yes.
22 **Q.** What do you think now, looking back, could or
23 should have been done to rigorously investigate their
24 deaths at that time?
25 **A.** Well, I think perhaps we need, needed the

1 Consultant that was there at the time.
2 **Q.** Yes.
3 **A.** I don't, at the time there was nobody, there
4 was no evidence of any wrongdoing.
5 **Q.** I am not asking about that question. I am
6 asking how do you find out the cause of death in a baby?
7 What expert reports or analysis is done? Do you think
8 that is a matter for the doctors to deal with? Who does
9 further reports or investigations?
10 **A.** Dr Brearey does, yes.
11 **Q.** So you would have listened to the doctors,
12 would you, about whether a paediatric pathologist should
13 be instructed or how you should examine the deaths?
14 **A.** Yes, yes. And also I think -- well, I don't
15 know what is actually discussed with, with the Coroner
16 when they actually do the post-mortem because it is the
17 remit of the medical team, but whether they actually
18 defined the unexplained deaths at the time. I don't
19 know if they do that or they do actually say -- so,
20 perhaps, are they -- do they automatically look for
21 anything suspicious.
22 **Q.** We know that because a serious untoward
23 incident report was made in relation to Baby D there was
24 a STEIS referral, a root cause analysis investigation
25 report; do you remember seeing that report?

1 **A.** I think I do.
2 **Q.** And there was an addendum when the post-mortem
3 was added in relation to Baby D. So much more detailed
4 documentation for him; do you remember that?
5 **A.** Not offhand. I would have to refer to the --
6 **Q.** If we go to it, it is INQ0033765, if we go to
7 page 10. This is a report with -- the one with the
8 post-mortem added and what the pathologist found.
9 Pneumonia with acute lung injury.
10 Of course, what we know is Mother D didn't accept
11 that, none of it made sense, the explanations she was
12 getting, and the investigations continued. There was
13 a referral to the Coroner and we know where we are now
14 with all of the reports that have been obtained in
15 relation to Baby D.
16 But at the time -- that can go down, thank you --
17 at the time did you think there should be more medical
18 reports being obtained? I know what you were doing
19 looking for members of staff, but just medical analysis
20 as well?
21 **A.** At the time, probably not.
22 **Q.** Because you thought the doctors would deal
23 with that?
24 **A.** Yes.
25 **Q.** In terms -- I am not going to take you to it,

1 you know it and the Inquiry has seen it. The charts
2 that you were producing with Letby's name in red, you
3 were the one who was going through the shift patterns
4 first --
5 **A.** Yes.
6 **Q.** -- and linking her, weren't you?
7 **A.** Yes.
8 **Q.** And you had her name clearly in red around the
9 indictment babies?
10 **A.** (Nods).
11 **Q.** And you had other names and then later on you
12 added the doctors, didn't you? You wanted a doctors
13 column as well?
14 **A.** Yes.
15 **Q.** Why did you want the doctors column?
16 **A.** Well, only for, if, if we had -- if we had
17 everybody there that they could actually see who was
18 actually there at the time rather than homing in on my
19 own investigation.
20 I didn't want -- I'm not one that can actually
21 investigate, but I could actually see from my staff but
22 I needed to make sure that everybody was covered in the
23 columns.
24 **Q.** Did you feel that you were being pulled into
25 an investigation-style role by the time you were digging

1 out rotas and seeing who was there on that shift or the
2 previous shift?
3 **A.** Well, yes.
4 **Q.** It is a different territory, isn't it, for
5 a manager, ward manager to be doing?
6 **A.** But then it's also sort of asking, am I doing,
7 you know, am I looking at the right thing? Am I doing
8 right thing here? And it's ...
9 **Q.** Was there a time you were doing that when you
10 thought, actually, the police should be doing this, not
11 me? I don't have the tools, I don't have the
12 information, I don't have the powers to know what people
13 are saying in their messages or anything else? Did you
14 ever think that?
15 **A.** In hindsight yes, I do.
16 **Q.** So in hindsight, when did that first occur to
17 you that, actually, you had been getting involved -- an
18 unwilling investigator, because you supported her as one
19 of your staff, wasn't it?
20 **A.** Well, nothing changed as far as evidence was
21 concerned, nobody saw anything, nobody heard anything,
22 nothing changed in any of the information at the time.
23 However, you know, as time goes on, you sort of think
24 how things changed to reflect on that and it is out of
25 our remit in that respect because you need some

1 objective person to come in that's able to look at the
2 information from an objective point of view.
3 **Q.** You were adding to the information, weren't
4 you? So your table, you were adding Baby E, Baby I?
5 **A.** Yes.
6 **Q.** You were continuing with it and you kept
7 coming up with her name?
8 **A.** Yes, yes.
9 **Q.** As you continued to add and then do that --
10 **A.** I know but she did work.
11 **Q.** -- report --
12 **A.** When we got busy she did the overtime, so she
13 was there more often. There was a lot of staff that did
14 part time so they were a lot less so, but she did -- she
15 was there more often by working full time and overtime.
16 **Q.** It wasn't just about whether someone was there
17 more often, was it? It was about whether someone was
18 there when something unexpected happened?
19 **A.** Mm-hm.
20 **Q.** And she was the one that you found was there
21 when the unexpected was happening?
22 **A.** Yes.
23 **Q.** You, we know, added, as I have said, doctors
24 to the table. But when you had finished it, doing it
25 and adding to it and keep finding her name, when did you

1 start to really worry about that -- if you did start to
2 worry about that?
3 **A.** The question that was always asked of me and
4 it was the same, nothing changed, from Dr Brearey saying
5 he has some concerns but he wouldn't define them, and
6 nothing actually changed from each time. But had anyone
7 seen anything or -- there was no evidence there. So
8 when I was questioned: well, evidence have you?
9 I hadn't got any evidence.
10 **Q.** Your evidence was dead children.
11 **A.** It was the commonality.
12 **Q.** Well, dead children --
13 **A.** Yes.
14 **Q.** -- unexpectedly dying and collapsed children,
15 that was the evidence of the problem, wasn't it?
16 **A.** Yes.
17 **Q.** This was unexpected.
18 **A.** Yes.
19 **Q.** So looking around, who was in the pool? Who
20 might have had an influence on that?
21 **A.** Yes.
22 **Q.** At that point, shouldn't the police have been
23 called to investigate it?
24 **A.** Yes.
25 **Q.** And you seem to have thought they needed solid

1 evidence or direct observation of her doing something
2 wrong before she could be removed from the unit, the
3 hospital or referred to the police. Is that what you
4 thought, you needed to see something?
5 **A.** Well, that was the information that I was
6 given.
7 **Q.** Who from?
8 **A.** Well, it was Karen Rees had said that there
9 was, you know, if there is no evidence and she took it
10 further to discuss further with her respective
11 colleagues. So -- I can't remember his name.
12 Stephen Cross.
13 **Q.** Yes.
14 **A.** And discussing with them and them saying based
15 on what? On commonality.
16 **Q.** What was your relationship with Dr Brearey
17 like up until this issue?
18 **A.** Fine.
19 **Q.** And Dr Gibbs?
20 **A.** Yes.
21 **Q.** They seem -- certainly Dr Gibbs, a
22 mild-mannered pleasant man?
23 **A.** Yes.
24 **Q.** He said that he was very influenced by you
25 saying that Letby couldn't have done anything wrong, was

1 an excellent nurse, et cetera, and described if he was
2 dithering, that was influencing him about reporting the
3 matter? Can you understand that? Your position that
4 she couldn't have done anything may have impacted on the
5 doctors --
6 **A.** Well --
7 **Q.** -- who were dealing with it?
8 **A.** I find it difficult -- that difficult to take
9 that on board. Because I find that I don't normally
10 influence the Consultants.
11 **Q.** And when you say Karen Rees said there were no
12 concerns, the paediatricians had concerns that they
13 couldn't give a medical cause for these deaths, that was
14 their concern, it became suspicious --
15 **A.** Sorry, I am missing the thread.
16 **Q.** The paediatricians' concerns were that they
17 had no medical explanation for these deaths.
18 **A.** Yes.
19 **Q.** That is what was worrying them?
20 **A.** Yes.
21 **Q.** That is a concern, isn't it?
22 **A.** Yes.
23 **Q.** If the doctors can't tell you --
24 **A.** Yes.
25 **Q.** -- what they think has happened? Wasn't that

1 a concern enough -- when you say you didn't have
2 concerns, wasn't that enough for you, that the doctors
3 were telling you that?
4 **A.** Well, it, it is. But the question was given
5 to me each and every time was: what is the evidence?
6 **Q.** And that is from Karen Rees?
7 **A.** I haven't got any -- yes.
8 **Q.** Who else?
9 **A.** I haven't got evidence other than --
10 **Q.** Just --
11 **A.** Nobody's seen anything. She works overtime,
12 full time, she's a common element on a rising mortality.
13 **Q.** What about Alison Kelly? Did you have
14 a conversation further down the line with her?
15 **A.** Well, I did. I think that was, from what
16 I understand, the timeline was a bit further on. It was
17 in 2016.
18 **Q.** And what --
19 **A.** After a thematic review I believe.
20 **Q.** And what was her view about that, the concerns
21 of the paediatricians, what did she say to you about
22 them?
23 **A.** She -- well, she was of the same -- on the
24 same opinion as Karen.
25 **Q.** That you needed evidence?

1 **A.** Mm-hm.
2 **Q.** Can you remember how she expressed that to
3 you?
4 **A.** Not directly. But I can -- just she would ask
5 you know what, I -- you know, had I seen anything.
6 Well, if I'd have seen anything, we wouldn't have
7 been having that conversation. We would have moved much
8 further along. But I hadn't seen anything. Nobody else
9 had reported seeing anything.
10 **Q.** Were you aware of the case of Beverley Allitt?
11 **A.** Yes.
12 **Q.** And her crimes?
13 **A.** Yes.
14 **Q.** So she -- catching somebody in the moment is
15 quite difficult, isn't it, because nurses have access to
16 patients, don't they?
17 **A.** (Nods).
18 **Q.** They have access and having somebody, a nurse
19 over an incubator or a patient wouldn't of itself raised
20 suspicion, would it?
21 **A.** No, but in the neonatal unit it was -- it's
22 more intensive. So like I was explaining before with
23 the allocated nursing intensive care it was -- it's
24 harder to be interfering with a baby that is not your
25 patient.

1 **Q.** But you know that it can happen. People don't
2 always play by the rules if they are committing crimes,
3 do they?
4 **A.** No, they don't.
5 **Q.** So is it a mistake to think everybody plays by
6 the rules all the time when you are a manager?
7 **A.** Yes, I think so. Yes.
8 **Q.** What have you learned in terms of management
9 that might be of help to others managing wards today
10 from this experience?
11 **A.** I think we need an external reviewer or an
12 external source to come in and review any unexplained
13 deaths that is not affiliated to the NHS perhaps.
14 **Q.** Do you think having a confidential helpline to
15 report concerns about another member of staff, if you
16 think they are causing harm or you are worried about
17 their association with events, would be useful or
18 helpful?
19 **A.** Yes.
20 **Q.** A safeguarding unit of sorts where --
21 **A.** Well, I think safeguarding would have been
22 difficult given the circumstances of -- we have been
23 before to safeguarding with other things.
24 But to actually say, "Well, what have you seen?
25 What have you heard?" "Our mortality is going up."

1 Yes, but who -- all I can give them is the
2 commonality. I don't know how they would address that.
3 **Q.** Do you think of safeguarding as something
4 that's relevant to parents or families when you have got
5 concerns about them rather than members of staff in
6 a hospital, if you have got concerns about a member of
7 staff, would you think about going to safeguarding then
8 or not?
9 **A.** If they were doing harm, yes. But if it was
10 a performance issue we would deal with it then. But all
11 you are doing, I guess, is removing them from one unit
12 only for them to go somewhere else.
13 **Q.** You deal with the safeguarding issue with the
14 CQC I think and picking up from paragraph 152 in your
15 statement, if we can go please to INQ0017339, page 206.
16 While that's coming on the screen, Ms Powell, you
17 say at paragraph 152 that:
18 "In the six weeks leading up to the CQC visit,
19 I attended weekly meetings with an external CQC team to
20 ensure that the NNU was prepared for the visit."
21 Do you mean an external team or do you mean
22 internal?
23 **A.** No, they're internal. Sorry.
24 **Q.** Yes. So who was the internal team --
25 **A.** Oh, I can't remember her name. It was part of

1 a team that was put together that was actually making
2 sure that the -- everything was in place that should be
3 in place.
4 **Q.** Can you help us with that? What do you mean
5 in place, that should be in place?
6 **A.** For instance, if, if any -- we had issues with
7 some of the locked doors, the internal lock door needed
8 fixing or whether there was -- if there was anything
9 that I was putting out that needed doing and it still
10 hadn't been done that they would actually have authority
11 to push it forward to be done.
12 **Q.** Were any of the Executives part of this
13 internal team?
14 **A.** No, no. No.
15 **Q.** No. So ward managers or what --
16 **A.** Oh, Sally, Sally Good. Sally Good I think it
17 was.
18 **Q.** Was there any discussion at those kinds of
19 meetings about what you would and would not say to the
20 CQC?
21 **A.** No.
22 **Q.** Nothing like that?
23 **A.** No.
24 **Q.** So practical things that needed addressing?
25 **A.** Yes. Everything was practical and to make

1 sure that everything was as it should be.
2 **Q.** Which you should be doing anyway without --
3 **A.** Yes.
4 **Q.** -- a CQC visit, shouldn't you?
5 **A.** But they were just making sure that everything
6 was, was right; that standards hadn't slipped at all.
7 **Q.** Was that usual in preparation for CQC visit,
8 to have a run-up to it to check things were being done
9 properly?
10 **A.** Yes.
11 **Q.** Did you ever think we should be doing these
12 things anyway not just when there's a visit --
13 **A.** Well, true. But it was a way also, it was
14 a tool to actually get things done as well. So it gave
15 strength to sort of say, "We need this doing because CQC
16 is coming." So it gets done. So it's...
17 **Q.** So the same end result?
18 **A.** Yes.
19 **Q.** If we look at the document in front of us we
20 see in the last box, this is where you are interviewed
21 by Inspector Helen Cain and two others.
22 Sorry, Ben Doeka I think is the inspector. And you
23 have in that bottom box "Safeguarding Child Death
24 Review", and also a reference to morbidity and mortality
25 meetings.

1 I think you tell us fairly in your statement you
2 didn't raise with the CQC the raised mortality rate.
3 **A.** Yes.
4 **Q.** Did you raise unexpected deaths at all?
5 **A.** No. I did not.
6 **Q.** No. Where it says safeguarding Child Death
7 Reviews, is this just discussing processes then, not
8 cases?
9 **A.** Sorry?
10 **Q.** Can you see in the bottom box
11 "Safeguarding" -- it looks like "Child Death Reviews",
12 is it?
13 **A.** I don't --
14 **Q.** What were you telling them?
15 **A.** Child ... I don't know.
16 **Q.** Also on the topic of safeguarding, the same
17 INQ reference, page 213, 0213.
18 Do you see that last paragraph? Safeguarding
19 again.
20 "Phone if concerned".
21 Can you see that?
22 **A.** Yes, I can see it.
23 **Q.** So what are you telling them there about
24 safeguarding?
25 **A.** Just the process of safeguarding.

1 **Q.** And you were Level 3 trained, you say?
2 **A.** Yes.
3 **Q.** So what was the process as far as you were
4 concerned?
5 **A.** To any concerns that were highlighted to the
6 team because our team was just on the corridor.
7 **Q.** They shared offices, I think, with one of
8 the -- that is the doctors. Where was the team as far
9 as you were concerned?
10 **A.** Just down the consider door from, from the
11 unit. Between paediatrics and ourselves.
12 **Q.** So who was in it? Who were the safeguarding
13 team at that time?
14 **A.** Paula and Karen Milne.
15 **Q.** So you could pop in and out as much as you
16 wanted to --
17 **A.** Yes.
18 **Q.** -- with them, get advice, talk about babies,
19 families?
20 **A.** Yes.
21 **Q.** Did you ever talk about any member of staff or
22 concerns of patient safety with them --
23 **A.** No.
24 **Q.** -- from a member of staff? Never?
25 **A.** No.

1 **Q.** Would that not have been the route that you
2 would have thought to do that even if you had them?
3 **A.** No, I didn't.
4 **Q.** Where would you have gone with those sorts of
5 worries if it was about a member of staff harming
6 children?
7 **A.** It would have to be through the hierarchy, to
8 Anne Murphy, Karen Reece or --
9 **Q.** Executives?
10 **A.** Yes.
11 **Q.** You tell us you didn't mention -- that can go
12 down now, thank you -- the raised mortality or increased
13 mortality rate or unexpected deaths. As we know, by
14 this time you had identified in that table with Letby in
15 red that she was a commonality. You had updated it
16 19 January, 8 February, and that thematic review report
17 had been completed by Dr Brearey and shared with you.
18 Given all of that, and indeed you have added to it
19 the aura and the sense you had, do you think you should
20 have told the CQC?
21 **A.** Yes.
22 **Q.** What do you think now, looking back, you
23 should have said to them or might have said to them at
24 that time?
25 **A.** Well, I don't know. Maybe to my superiors I

1 -- it would be better that we went and got some --
2 although we -- we kind of did try and get an external
3 review, which wasn't really external because it was part
4 of the Network, but it was trying to sort of use peer --
5 **Q.** Is that Dr Subhedar's review you are thinking
6 of there?
7 **A.** The thematic review.
8 **Q.** Okay, yes.
9 **A.** Yes. Trying to get them to give an opinion on
10 what to do.
11 **Q.** They are still local, but you are right,
12 external to Countess of Chester. But as far as the
13 CQC's concerned, somebody completely independent of the
14 hospital, what about sharing where you had got to with
15 the information then?
16 **A.** Sorry?
17 **Q.** What about sharing that information, the
18 reviews that you had done then, you know, they are
19 asking about --
20 **A.** Well, I thought -- I did think maybe the
21 Consultants would have done that, maybe Dr Brearey would
22 have done that. Because they went to the feedback
23 meeting, which I came after the fact.
24 **Q.** Your meetings were quite long, weren't they?
25 **A.** Sorry?

1 **Q.** Your meetings were quite long with the CQC.
2 There is a lot of the notes in the ones you had. How
3 long was it, roughly?
4 **A.** With, with --
5 **Q.** The inspector, yes.
6 **A.** Well, I think it was an hour with, with the
7 CQC for looking at storage and drugs and suchlike and
8 then I think there was another hour with looking at the
9 risk register and I think it was the donor milk and
10 discussing about staffing and --
11 **Q.** What was the thing with the donor milk?
12 **A.** We had the donor milk bank on the unit, the
13 satellite -- well, initially, it was the major --
14 I don't -- I think they moved in 2016 but we still had
15 the satellite milk bank on the unit. So we were running
16 that as well.
17 **Q.** One of the texts that Letby sent Dr U on
18 23 June 2016 was this:
19 "I lost my handover sheet. Found it in the donor
20 milk freezer".
21 **A.** Say again, sorry.
22 **Q.** It says:
23 "I lost my handover sheet. Found it in the donor
24 milk freezer. Clearly I should still be Ibiza."
25 So a sort of jokey "I found my handover sheet in

1 the donor milk freezer"; does that make any sense to
2 you?
3 **A.** Well, I don't know. Other than went to check
4 the donor milk out for a satellite hospital to pick up
5 and gone to check the numbers and obviously must have
6 put her sheet down, I am presuming. I'm only guessing.
7 **Q.** When did you learn that she had taken 241
8 handover sheets home?
9 **A.** I -- I didn't know until after the fact.
10 **Q.** And 21 relating to the babies on the
11 indictment. So you had no idea --
12 **A.** No.
13 **Q.** -- that those sheets...
14 They should not have been leaving the ward, should
15 they, the unit?
16 **A.** No. I was, yes, surprised.
17 **MS LANGDALE:** My Lady, I think that's a convenient
18 moment.
19 **LADY JUSTICE THIRLWALL:** Very well. So we will
20 rise now for lunch and we will start again at 2 o'clock.
21 **(12.54 pm)**
22 **(The luncheon adjournment)**
23 **(1.58 pm)**
24 **LADY JUSTICE THIRLWALL:** Thank you, Ms Powell.
25 Ms Langdale.

1 **MS LANGDALE:** Ms Powell, a few more emails, if
2 I may, on the screen, they will come up.
3 The first one is one that you sent to Alison Kelly.
4 It's INQ0003558, page 2.
5 We see your email there:
6 "I was hoping we could arrange a meeting with you
7 to discuss how to move forwards."
8 You say:
9 "With regard to your findings from the thematic
10 review, high mortality, 8 as opposed to our normal 2 to
11 3 per year, commonality that particular nurse was on
12 duty either leading up to or during."
13 And you point out this particular nurse commenced
14 working in January 2012 without incident.
15 "A doctor also identified as common theme but not
16 as many as the nurse. Despite reviewing these cases
17 nothing obvious we are able to identify. Your input
18 would be valued."
19 Pausing there. You don't mention that they are
20 unexpected deaths in there, do you?
21 **A.** No.
22 **Q.** No?
23 **A.** No, but it was high for us.
24 **Q.** It was high anyway?
25 **A.** Yes.

1 **Q.** And you are asking for input, aren't you, you
2 are asking for assistance?
3 **A.** Yes.
4 **Q.** What were you hoping, when you emailed that,
5 to get?
6 **A.** Well, some way of moving forward and to have
7 some closure.
8 **Q.** If the response had come back, "I think we
9 need to go to the police now", would you have accepted
10 that?
11 **A.** Yes.
12 **Q.** So you wanted a decision about what would
13 happen?
14 **A.** Yes.
15 **Q.** It appears that you and Dr Brearey had been,
16 in your case, looking for commonalities doing those
17 tables. But you wanted someone to make a decision about
18 where you went?
19 **A.** Yes.
20 **Q.** We see at page 1, same INQ reference, 0003558,
21 page 1:
22 "Thank you."
23 You have sent the information so "thank you" from
24 Alison Kelly.
25 "Thanks for the update, Eirian ..."

1 The bottom email:
2 "... could you please send Ian and I the report.
3 Once we have reviewed, I think it would be good for me,
4 you, Ian, Steve and Ravi to meet and discuss."
5 Then if we go to INQ0003089, at page 1, you have
6 sent that email I have just read on 21 March, and on
7 14 April you are asking your follow up.
8 "What were your thoughts after going through it?
9 I noticed it didn't include the medical team, I have
10 attached the document that includes it."
11 We know Dr Brearey had sent it on without the
12 doctors, you have added that, but you are continuing the
13 discussion, aren't you, with Alison Kelly?
14 **A.** Yes.
15 **LADY JUSTICE THIRLWALL:** Just pause, Ms Langdale.
16 It's very hard for the witness and for counsel and
17 it is very hard for people in the room because there is
18 a sprung floor and so that when people move on the floor
19 it makes much more noise than you realise and the same
20 with the chairs. And I know everyone is trying very
21 hard but sometimes we just have to pause so the witness
22 can hear properly and so counsel can concentrate.
23 Yes, Ms Langdale.
24 **MS LANGDALE:** So April, you are following that up.
25 Did you feel at the time you were getting as swift a

1 response as you wanted from the Senior Executives or
2 not? Were you fine with that?
3 **A.** Probably not at the time. It just needed some
4 sort of resolution.
5 **Q.** Because we do see with that toing and froing
6 with the thematic review, when there is an action plan
7 you complete them, don't you, you do your bit?
8 **A.** Yes.
9 **Q.** We have seen the bit about the incubators, we
10 see other things where you are adding nursing notes to a
11 thematic -- you do get on and do the bits you are
12 requested to do?
13 **A.** Yes.
14 **Q.** Did you feel that was always the same pace for
15 others around you on this topic?
16 **A.** Did I feel like --
17 **Q.** That they worked on the same pace with the
18 topic? The importance of it, you know, responding
19 quickly?
20 **A.** Well, probably not. But that -- yes, probably
21 not. Not in my view.
22 **Q.** That can go down, thank you.
23 If we have instead INQ0003138, page 2.
24 This is an email from Dr Brearey to Alison Kelly,
25 again cc'ing you, saying:

1 "There is a nurse on the unit [this is 4 May now]
2 who has been present for quite a few of the deaths and
3 other arrests. Eirian has sensibly put her on day
4 shifts only at the moment but can't do this
5 indefinitely. It would be very helpful to meet before
6 she is due to go back on night shifts. There is some
7 pressure regarding staffing numbers with this at the
8 moment."
9 That can go down.
10 And can you tell us about moving her on to day
11 shifts. If it helps you, you deal with it at
12 paragraph 180 in your statement. But we know that you
13 moved Letby to day shifts in April 2016. Can you tell
14 us why?
15 **A.** Again, I -- I guess it goes back to
16 discussions with the two Yvonnes, that maybe this was an
17 opportune moment to put Lucy on to days as a well-being
18 approach because she had been involved in so many of the
19 recent deaths that that must have a profound effect on
20 her well-being.
21 And, therefore, we felt that there would be more
22 support on the days, on the day shifts, and also able to
23 see how she was in herself because we would be there
24 to -- to monitor.
25 **Q.** I think the expression you used in your

1 statements to the police "eyes watching her as well" --
2 **A.** Yes, to see whether she was missing out on any
3 other competency levels or whether she needed any
4 additional assistance with the new, the new machines
5 that were in place.
6 It gives an opportunity to check out her appraisal,
7 to make sure that if there was anything lacking that we
8 could deal with straight away or if we could see any
9 wrongdoing, that that was also an opportune moment as
10 well, because there were more people about.
11 **Q.** And the night shifts had fewer people. More
12 opportunities to be on your own with a baby?
13 **A.** They did -- well, not on your own because we
14 actually made sure that the nursing calibre was there on
15 nights. But you haven't got the same level, you haven't
16 got as many doctors on shift, you have only got those
17 that are covering the night shift, managers are
18 obviously not in, practice development is not in.
19 So on days you have got all those people around.
20 **Q.** And you said the decision to move to day
21 shifts was made collectively with Yvonne Griffiths,
22 Yvonne Farmer, and Karen Rees was also aware of it?
23 **A.** Aware of the night shift -- yes.
24 **Q.** The move to day shifts?
25 **A.** Yes.

1 **Q.** So did you have a discussion together about
2 the rationale or the reasons for that or not?
3 **A.** With, with the two Yvonnes, yes. And with
4 Anne Murphy, I think. Was it with Anne Murphy, I don't
5 know whether Ann was there or not.
6 But certainly it was the two Yvonnes.
7 **Q.** And you didn't tell Alison Kelly, it was
8 Dr Brearey's email that I have just read out that
9 informed her of that, that she had been moved to day
10 shifts?
11 **A.** I believe so, yes.
12 **Q.** Was there a reason not to discuss that with
13 Alison Kelly at the time?
14 **A.** Putting her on to days or nights -- from
15 nights to days was, I guess, a staffing issue and we
16 wouldn't necessarily have discussed that with, with
17 Alison herself. But Karen was aware.
18 **Q.** And what did you say to Letby about the
19 reasons for it?
20 **A.** The same reason. As in that we felt that she
21 had been involved in a lot of cases and therefore felt
22 that for her well-being that it would be prudent to do
23 so.
24 **Q.** Did you tell her at this point or any other
25 point that you had been doing those --

1 **A.** Yes, I did.
2 **Q.** -- charts --
3 **A.** Yes.
4 **Q.** -- finding her presence? And what did you say
5 to her about that?
6 **A.** I said that, actually, before we had the
7 thematic review. Because Nim had actually asked me that
8 question in the review and I'd said that I had said that
9 she seemed to be a commonality within, within the deaths
10 that were actually on the unit and she, she took it on
11 board.
12 But I said, you know, and obviously we need to
13 investigate further as to why that is the case.
14 **Q.** Did you ever give her the impression you were
15 investigating her?
16 **A.** Well, I said she was the commonality. But
17 there were a couple of others also at the time. But we
18 would be investigating further.
19 **Q.** So you broadened it --
20 **A.** Yes.
21 **Q.** -- so she wouldn't have felt you were
22 targeting or investigating her?
23 **A.** Well, I did say that she seemed to be the
24 common, the commonality.
25 **Q.** And when you moved her to day shifts did you

1 tell her it wasn't simply for her welfare, but that more
2 eyes would be watching her --
3 **A.** No.
4 **Q.** -- which could mean a number of things,
5 couldn't it? You didn't tell her that?
6 **A.** No.
7 **Q.** You gave the welfare reason?
8 **A.** Well, I said it was actually to ensure that
9 she had a respite from all the events that were
10 happening as appeared to be happening at night.
11 **Q.** Can we go next, please, to INQ0003115, page 1.
12 This is the meeting on 5 May, Ms Powell, which you
13 set out at paragraph 187 in your statement.
14 You tell us you attended a meeting on 5 May with
15 Karen Rees, Stephen Brearey and Anne Murphy to discuss
16 the increase in mortality and you can't remember
17 specifically what was discussed but you have done a note
18 which we can see.
19 If we go to the note that you produce after it,
20 INQ0003243, page 1.
21 If we look there at page 1, "Various remarks". If
22 we go to page 2 -- I will come back to page 1 in
23 a minute.
24 "Advice sought; Risk facilitators; External
25 Neonatologist; Network; Higher management".

1 Would you like to expand, if you can, on what
2 advice was being sought at that point?
3 **A.** The risk facilitators were for obvious reasons
4 because we were going through the neonatal clinical
5 incident meetings, so we were getting feedback.
6 But nothing how to move forward. The external
7 neonatologist was the thematic review.
8 **Q.** Dr Subhedar with Dr Brearey?
9 **A.** Yes. The network was relating back on the
10 mortality, and the higher management were the natural
11 progression, you know, the Anne Murphy, Karen Rees,
12 Alison Kelly, Ian Harvey, and suchlike.
13 **Q.** We don't see in writing, at least, in the
14 network or more widely a lot of discussion around the
15 higher mortality. Was it your impression that that was
16 being discussed at the time within networks or not?
17 **A.** Well, yes, because we had to write the numbers
18 of the mortality in each month.
19 **Q.** Right.
20 **A.** That had to be highlighted and then Dr Brearey
21 would actually send the deep dive notes or yes, the
22 notes that were found on the deep dive.
23 **Q.** If we go back to page 1 of this document, we
24 see what you say at paragraph 1 about Letby working full
25 time and having the qualification and specialty:

1 "She is therefore more likely to be looking after
2 the sickest infant on the unit."
3 Just pausing there, I think you agreed with me
4 earlier that for A, C, and D and onwards, these were not
5 sick babies, were they?
6 **A.** They weren't, sorry?
7 **Q.** Not sick babies. They weren't sick babies
8 when they collapsed, they were stable infants, weren't
9 they?
10 **A.** Yes, yes.
11 **Q.** You say there:
12 "There are no performance/management issues and no
13 members of staff that have complained to me or others
14 regarding her performance."
15 Nurse W had complained to you about her
16 performance, hadn't she?
17 **A.** Yes.
18 **Q.** Did you forget that when you wrote bullet
19 point 2?
20 **A.** Well, that was one incident.
21 **Q.** One incident relevant to one of the children
22 who had died?
23 **A.** Well, she wasn't actually looking after that
24 one, she was looking after the other one --
25 **Q.** She was, but the point was she was gravitating

1 towards the baby who died --
2 **A.** Yes.
3 **Q.** -- and intruding on the grief --
4 **A.** Okay.
5 **Q.** -- of Baby C's parents.
6 So when you say "no performance/management issues",
7 you had not thought that one was relevant or didn't want
8 to say --
9 **A.** I don't know, an oversight.
10 **Q.** Likewise, although I recognise it was
11 earlier --
12 **A.** Sorry.
13 **Q.** Although I recognise it was earlier, likewise
14 the morphine incident, you didn't --
15 **A.** Yes.
16 **Q.** -- refer to that and she had actually had to
17 have a review with you about that, hadn't she?
18 **A.** Yes.
19 **Q.** Was that an oversight?
20 **A.** Was that, sorry?
21 **Q.** An oversight not to mention that?
22 **A.** Well, we all have, I mean, if you, if you
23 looked at everybody's drug incidents on the unit,
24 somebody somewhere -- I mean, I have been involved in
25 a drug incident myself and like I say, the majority of

1 them have in one way or another.
2 **Q.** I appreciate that, Ms Powell. It's really
3 that you were asserting there were no issues. It's
4 a very positive statement: I have never had an issue to
5 deal with with this nurse, and that wasn't the position,
6 was it?
7 **A.** Yes.
8 Okay.
9 **Q.** You say at point 6:
10 "The Cheshire and Mersey Transport Service have
11 been involved in a few of these mortalities and they may
12 have survived if the service was running adequately."
13 What was your evidence base for that? Again, not
14 relating to the babies on the indictment but what was
15 making you say that?
16 **A.** Well, it was causing additional anxiety and
17 stress on the unit that when we actually needed
18 transport at that time, to come and collect, they were
19 not available. So it was an additional anxiety for the
20 staff on the unit and, and for the parents that were
21 currently on the unit.
22 **Q.** But at this point and in this meeting, having
23 focused on particular babies, it seems, once again,
24 there were generalisations being made, rather than
25 looking at each baby to see what, if any, of these could

1 apply to that baby; do you see what I mean?
2 **A.** True. But I was trying to sort of show what,
3 what else was going on in the unit at the time. Trying
4 to share the information that I had and then it's like
5 okay, that's, that's all the thinking that I have.
6 **Q.** So giving your input, it was really, you would
7 say, would you, for someone else to say, "Well, we have
8 got that general picture but now we are looking at this,
9 these are the specifics we need to focus on"?
10 **A.** Yes.
11 **Q.** That can go down, thank you, and document
12 INQ0003181, page 1. A meeting on 11 May which you deal
13 with at paragraph 198 of your statement.
14 This is a meeting you attended with Anne Murphy,
15 Dr Brearey, Alison Kelly and Ian Harvey and the notes
16 here are made by Alison Kelly, you think, and you have
17 had a chance, I hope, to have a look at these again.
18 This is a meeting where we see recorded halfway
19 down on the first page:
20 "Absolute no issues with nurse. Circumstantial".
21 Again, we have seen your document from the 5 May
22 but you are the source for saying there are no issues
23 with the nurse presumably, that's what you said before
24 and that is what you continue to say --
25 **A.** Because there was nothing, nothing had

1 changed.
2 Q. -- that she is excellent.
3 And "circumstantial"; do you know what that was
4 referring to?
5 A. Probably commonality, I am assuming.
6 Q. And if we go over the page, to page 2, we see
7 at the top:
8 "Actions. Review all babies who deteriorate. Stay
9 on days for three months, two further months to go."
10 So it looks here as though there is a decision to
11 look more closely at deteriorations, is that right?
12 A. Yes.
13 Q. Whose idea was that, can you remember, of the
14 group?
15 A. I don't know. I think, I would I not -- I
16 would be guessing, sorry.
17 Q. And then when it says "three months, two
18 further months to go", is that about Letby being on
19 days?
20 A. Yes.
21 Q. So what was the discussion about any risks she
22 might represent or otherwise staying on day shifts as
23 opposed to being offer the unit at this point?
24 A. That wasn't discussed, no.
25 Q. So no, no challenge to the notion that she

1 should stay on days for three months with two months
2 to go?
3 A. No.
4 Q. Given everything that had been put together at
5 this point?
6 A. (Nods).
7 Q. That can go down, please.
8 Just on that meeting, I think it's that meeting
9 where Alison Kelly says you were very vociferous about
10 Letby.
11 You were vociferous, vocal in your support of her,
12 that there were no issues?
13 A. I was, I was asked a question so I answered
14 it.
15 Q. Very clearly that you felt --
16 A. Yes.
17 Q. -- she was excellent, you were telling the
18 police the following year you thought she was creme de
19 la creme, so you were expressing your view.
20 A. Yes.
21 Q. Do you look back on that now and consider that
22 you might have been more reflective in that view, given
23 what you knew around the unexpected deaths of the babies
24 and the concern that you must have had looking and
25 finding the same name?

1 A. Yes. I think it would have helped. Yes.
2 Q. You say in your statement:
3 "I wasn't being defensive, I was just being honest,
4 I didn't think she was harming babies."
5 But the question for you may have been, well, is
6 this suspicious? Does someone else need to look at
7 this, not that I definitely know one of my team is doing
8 this?
9 A. Yes.
10 Q. Did you ever stand back and think, well, there
11 is a lot to look at here now?
12 A. I did. I mean, we discussed this: is there
13 anything that we are getting wrong here? Is there
14 something that we are missing? To the point I think
15 I actually even went in Case to review any Datixes
16 where -- outstanding that we didn't know about.
17 Also the fact that we considered if there was
18 anything that we could have done differently or --
19 really, all the time, because we were told at the
20 time -- I mean, Karen said that we were to discuss
21 obviously amongst ourselves, as in the two Yvonnes and
22 myself, and -- and above but not anywhere else. So it
23 was difficult.
24 Q. On the subject of Datix, we know they are
25 completed for deaths. For the collapses and serious

1 incidents it is much patchier, isn't it --
2 A. Yes.
3 Q. -- when a baby recovers? Were you aware of
4 that at the time that they were not being completed as
5 they might be for collapses and you were losing
6 intelligence through that?
7 A. Well, they were doing anybody -- it was the
8 definition of the collapses that I think was proving the
9 difficulty instead of the -- anybody that had full resus
10 that required -- was Datixed, but obviously I'm not
11 sure -- I mean, I was doing a table on the sudden and
12 unexpected collapses.
13 Q. We see at INQ0005721, page 1, Dr Brearey sends
14 an email to the Consultants cc'ing you:
15 "If you do come across a baby who deteriorates
16 suddenly or unexpectedly please could you let me and
17 Eirian know."
18 Did you send a similar email to the nurses on the
19 unit?
20 A. I don't think so, I don't know. I don't --
21 Q. I haven't seen it.
22 A. I haven't seen it.
23 Q. Do you think it would have been useful to
24 because he is clearly -- in that meeting you have
25 realised there's not as much information around those as

1 you need.
2 **A.** But any, I guess any -- yes, it would have
3 been helpful, I think, if I had or hadn't, I can't
4 remember, but bearing in mind that if it was requiring
5 full resus the doctors would be there anyway and would
6 complete a Datix.
7 **Q.** And so when you did your table, we know you
8 did it for deaths and collapses, you started it on
9 15 April 2016 and you send it -- to 5 May 2016.
10 When were you -- what data were you looking at to
11 find those collapses when you were adding them?
12 **A.** I think I start -- although I did the table on
13 a certain date, I think the first collapse was before
14 then when I was looking at the table.
15 **Q.** So you couldn't rely on Datix. Or could you,
16 how did you --
17 **A.** I would have to go through -- anybody that let
18 me know when I came in that -- the Datix would either be
19 completed or somebody had said that this one needed
20 resuscing.
21 **Q.** We spoke earlier about O and P and you deal
22 with June events from paragraph 215 in your statement.
23 Can you go, please, to this meeting, which is
24 INQ0004884, page 1. And we see this is a mortality
25 review when it comes on the screen, Ms Powell, in

1 relation to Baby P.
2 And if we go to the third page, "Lessons learnt"
3 and "Actions". We see Dr ZA, Hayley Cooper, Yvonne
4 Griffiths, Sian Williams, yourself and Dr Brearey.
5 "Dr ZA said that both herself and Dr Brearey
6 stressed the fact that we could not medically explain
7 these deaths. There was the continued escalation of
8 sudden and unexpected deaths and collapses and that the
9 association with Lucy was beyond coincidence and her
10 working pattern. We thought she must be involved in
11 some way."
12 Can you remember this meeting and that being
13 communicated that both doctors could not explain these
14 deaths and felt she must be involved in some way?
15 **A.** (Pause)
16 Sorry, what were you saying?
17 **Q.** Can you remember that at the meeting?
18 **A.** I do, yes.
19 **Q.** That is what the Consultants were saying. Do
20 you remember hearing that message that they --
21 **A.** No, I do not.
22 **Q.** We know you filled the Datix in for O and P,
23 we have seen that, and you identified Letby on the
24 Datix, you go to that meeting and they say they were
25 both clear that there couldn't be a different

1 explanation, a medical explanation, they didn't have
2 one. Do you remember them just not having one --
3 **A.** Yes.
4 **Q.** -- these two babies collapsing one day after
5 the other, no one knew why, did they?
6 **A.** Yes, they did say something similar.
7 **Q.** Yes, they did say -- you were aware in that
8 meeting they didn't know why they had died?
9 **A.** Yes, they didn't know.
10 **Q.** And you were aware yourself, having done the
11 Datix, that Letby was there for both of those deaths?
12 **A.** Yes.
13 **Q.** On day shifts when you had moved her to day
14 shifts, two occurring, when the others had happened in
15 the night.
16 Putting that all together, what did you think,
17 leaving that meeting, about referring it to the police?
18 **A.** Well, I was, as Steve Brearey had the
19 concerns, I guess as, as the neonatal lead he should
20 have forwarded it to the police being of his, he's -- he
21 is the neonatal Consultant.
22 **Q.** Did you think you had any safeguarding
23 obligation to the babies on the unit. Here you are in
24 charge of the unit, these two have died, no explanation,
25 the coincidence of Letby being on day shifts, coming

1 back in, back from her holiday, again, marrying the
2 table that you had produced?
3 **A.** Again, I -- I would find unless -- all I could
4 go with is commonality and the high mortality.
5 **Q.** Commonality and mortality?
6 **A.** Yes.
7 **Q.** But --
8 **A.** I am not -- I mean, yeah, I'm not sure what
9 they would have done with that but I guess the police
10 is, is a good way to have gone because they would do
11 their own investigation.
12 **Q.** And they had more powers, more resources?
13 **A.** Yes, yes.
14 **Q.** They could investigate the person. If you
15 look at paragraph 216 in your statement you say you
16 attended several meetings on 27 June and you and
17 Anne Murphy were called to Alison Kelly's office for an
18 update meeting regarding the mortality review meetings
19 and the outcomes.
20 The purpose of this meeting, you say, was to
21 ascertain how we felt with regard to the accusations
22 made against Letby, made regarding Letby.
23 "We were advised that the Consultants had stated
24 that as a collective all felt the same about Letby. In
25 other words, that we agreed with the concerns raised by

1 the Consultants that Letby could be directly
2 responsible."
3 What are you saying here? I am just trying to
4 understand that paragraph. Have a read of it.
5 **A.** Well, they wrote a letter, the Consultants
6 wrote a letter to say that we collectively all think
7 that Letby was responsible when in actual fact we
8 weren't consulted about that, that letter.
9 **Q.** You weren't consulted?
10 **A.** No.
11 **Q.** Did you know about that letter?
12 **A.** No. Only until they said "sign this" but we
13 hadn't -- we said we can't sign something we haven't
14 read or seen. So we didn't sign it.
15 **Q.** So you didn't want to sign it that you were
16 concerned?
17 **A.** We were concerned but we were not -- what they
18 were saying was it was -- that Lucy was responsible.
19 **Q.** And you would not have been happy to say that
20 clearly?
21 **A.** But it was an -- it wasn't, I didn't feel it
22 was our place, if they had the concerns they put it
23 forward.
24 **Q.** But you had had some concerns from Nurse W and
25 others being raised with you?

1 **A.** Yes.
2 **Q.** Did you put yours forward? You may say they
3 didn't seem significant to you but others might have
4 thought they were, mightn't they?
5 **A.** Mightn't -- yes.
6 **Q.** In terms of what Letby was being told at the
7 moment, there's a confidential email, INQ0014306,
8 page 1. This is after the deaths of O and P. You had:
9 "... spoken to Letby this afternoon to ascertain
10 her welfare in relation to recent events."
11 You say you've referred her to Occupational Health
12 for additional support.
13 "I asked her that she needs to ensure she attempts
14 to step back from the ITU area for her own well-being.
15 Informed her she will be on days for a period of time
16 and until she has attended the Occupational Health
17 sessions."
18 So what was your expectation at the moment here?
19 **A.** What was my what, sorry?
20 **Q.** Expectation that she was going to do, what did
21 you want her to do the next few days?
22 **A.** I wanted somebody to take the decision.
23 **Q.** What decision?
24 **A.** Well, it wasn't going to go away, this.
25 So we were going round in circles, really.

1 **Q.** And you wanted her to take the decision
2 because the unit -- you hadn't taken it and said you
3 can't come back at all now, that is not what you had
4 said?
5 **A.** That I was what, sorry?
6 **Q.** You hadn't said, "You can't come back now,
7 I don't want you back on the unit."
8 **A.** No, I didn't say that, no.
9 **Q.** And if we look at another email, page 2,
10 I think it is the same INQ number, page 2.
11 You are cc'd into this from Dr Brearey:
12 "Just to confirm then Ian and Alison are happy for
13 LL to work on the NNU in the same capacity as last week
14 despite the paediatric consultant body expressing our
15 concerns that this may not be safe and that we would
16 prefer her not to have further patient contact."
17 What did you think when you saw that email?
18 **A.** Well, that Steve didn't want Lucy back on the
19 unit.
20 **Q.** Was he right to think that?
21 **A.** On reflection, yes, I guess he was.
22 **Q.** What did you think at the time?
23 **A.** Well, I felt at the time that something had to
24 change, something -- a decision had to be made.
25 **Q.** Either for her to come back and ignore the

1 suspicions, carry on as normal?
2 **A.** Which was untenable.
3 **Q.** Was it?
4 **A.** Yes.
5 **Q.** For you that was untenable?
6 **A.** Well, they couldn't cope -- the working
7 environment was untenable with the Consultants and the
8 staff then because obviously the staff felt that she was
9 not responsible.
10 **Q.** Which staff felt that?
11 **A.** The majority of the staff.
12 **Q.** The nursing staff?
13 **A.** Yes.
14 **Q.** The nursing managers?
15 **A.** Yes -- no, the nursing staff.
16 **Q.** Nursing staff. People who worked with her?
17 **A.** Sorry?
18 **Q.** The people who worked with her?
19 **A.** Yes.
20 **Q.** Who were close-knit, you would say?
21 **A.** Yes.
22 **Q.** And did you think that?
23 **A.** At the time, yes. But after this incident,
24 it ...
25 **Q.** After the deaths of O and P?

1 **A.** Yes.
2 **Q.** The murders, we now know?
3 **A.** Yes, the unexpected ...
4 **Q.** So after the unexpected deaths, you wanted?
5 **A.** Yes, I wanted some resolution because it
6 wasn't, it wasn't helpful for anybody.
7 **Q.** We then see some emails that all the nurses
8 had been shown that you sent to the unit, the first one
9 INQ0002879, page 91.
10 Actually, the email looks as though it's from you
11 at the top but it's your -- sorry, Yvonne Griffiths, but
12 it is your name at the bottom "Kindest regards, Eirian",
13 I don't know why that's happened.
14 Have a look at the email.
15 **A.** I was to prepare an email.
16 **Q.** Right.
17 **A.** But it had to wait until Karen had actually,
18 or Sian had actually seen it to say that it was okay
19 to go.
20 **Q.** Have a look at the email. So this is when the
21 RCPCH review is happening, is it? Is that what -- the
22 review that you are referring to or something else?
23 **A.** Yes.
24 **Q.** So and you say:
25 "In preparation it has been decided that all

1 members of staff need to undertake a period of clinical
2 supervision."
3 That wasn't the case, was it? Or was it? That all
4 members of staff were going to have a period of clinical
5 supervision. That wasn't going to happen, was it?
6 **A.** Well, it was going to initially because this
7 was thinking that perhaps -- it's not clinical
8 supervision as such. It was an opportunity for all
9 staff to have their competencies checked and ensure that
10 they were able to ensure their appraisal and
11 revalidation was, was up to the mark.
12 **Q.** So this was suggesting everyone on the unit
13 would be supervised by another person for a period of
14 time to check they were all working as they should be.
15 **A.** Yes.
16 **Q.** And Lucy was going to be the first one, on the
17 18 July. In fact, there was difficulty finding
18 supervisors or being able to do that, was that the case?
19 Or why did that not happen?
20 **A.** There was what, sorry?
21 **Q.** Why did that not happen?
22 **A.** I think she was taken off anyway before that.
23 **Q.** Did you think that was a constructive way
24 forward?
25 **A.** I just felt, again, it was just another action

1 to -- to complete.
2 **Q.** If we go to INQ0002879, page 75.
3 This time, you are emailing about opportunities to
4 apply for secondments throughout the Trust and Lucy
5 being seconded to the Risk and Patient Safety Office.
6 Why was she seconded to the Risk and Patient Safety
7 Office?
8 **A.** That was a decision that Karen had made with,
9 I think it was with Sian.
10 **Q.** And what was the basis for that decision?
11 **A.** That was actually to take her off pending an
12 investigation.
13 **Q.** Pending the RCPCH investigation?
14 **A.** No, I think it was the Trust investigation.
15 **Q.** Do you mean the grievance procedure?
16 **A.** No, that came subsequently.
17 **Q.** So which investigation?
18 **A.** So this was an investigation within the Trust.
19 **Q.** Conducted by whom?
20 **A.** I don't know.
21 **Q.** You don't know?
22 **A.** I don't know.
23 **Q.** So it was an internal investigation?
24 **A.** Yes.
25 **Q.** So she was taken there for that reason. Did

1 you have other staff asking for secondments as
2 a consequence of this?
3 **A.** Sorry.
4 **Q.** Did you have other staff asking for
5 secondments as a consequence of this?
6 **A.** Yes. Yes, because we were downgraded, there
7 were therefore opportunities then for staffing to -- it
8 was like an opportunity to, if anybody wanted to sort of
9 look elsewhere.
10 **Q.** At this point, we know that nurses and doctors
11 were talking about what had happened and the deaths of
12 O and P?
13 **A.** Yes.
14 **Q.** You yourself say as far back as A and C there
15 was an aura, something you were worried about.
16 By the time Letby was seconded to the Risk and
17 Patient Safety Office, it must have been known that
18 there was some kind of investigation going on into her,
19 mustn't it?
20 **A.** Yes.
21 **Q.** So did that seem slightly odd sending that
22 kind of letter to all of the staff when everybody knew,
23 in effect, that she had been moved while there was this
24 investigation going on and the deaths had occurred?
25 **A.** I don't think they were aware.

1 **Q.** Don't you?
2 **A.** But I'm not sure. It's not something that
3 I could have asked them.
4 **Q.** No? Nicola Lightfoot gave evidence to the
5 Inquiry that she was involved in advising staff and in
6 meetings not to discuss the neonatal mortality rate or
7 Letby.
8 Were you doing the same, that people were advised
9 not to discuss her?
10 **A.** Not to discuss, no.
11 **Q.** Not to discuss. So what were you saying to
12 people about what they couldn't discuss?
13 **A.** What was I?
14 **Q.** Saying to people that they could not discuss?
15 **A.** I didn't say anything that they couldn't
16 discuss. It was me that wasn't allowed -- I wasn't able
17 to discuss with anybody on the shop floor, as it were.
18 **Q.** Right. Who told you that?
19 **A.** That was Karen.
20 **Q.** Karen Rees said to you, "You cannot discuss
21 this with your nurses"?
22 **A.** We are okay to do it in the office with --
23 because we were already aware because we had been
24 discussing that, and Anne Murphy. But we couldn't
25 discuss anything, that it was confidential, that we

1 couldn't do that.
2 **Q.** So Karen Rees, you and Anne Murphy could
3 discuss it, but you couldn't discuss it with --
4 **A.** With anybody on the unit.
5 **Q.** Could you discuss it with Yvonne Griffiths?
6 **A.** Yes, yes, she was in the office, Yvonne and
7 Yvonne Farmer.
8 **Q.** But everybody else working on the unit, you
9 couldn't?
10 **A.** No.
11 **Q.** What did you think the reason for that was?
12 **A.** Well, to keep, we were told to keep it
13 confidential.
14 **Q.** And why was there a need to keep it
15 confidential?
16 **A.** Because that's what I was told to do.
17 **Q.** Did you question that?
18 **A.** Well, no, because I thought it was for her
19 well-being. I -- confidentiality was a big thing, that
20 you can't -- you know, for parents, for the infants, for
21 staff. It's not something that you take lightly anyway,
22 so if somebody said this is a confidential matter, then.
23 **Q.** At this point --
24 **A.** Yes.
25 **Q.** -- did you know whether or not the parents

1 were informed -- of the babies named on the
2 indictment -- that there was an RCPCH investigation, or
3 other investigations?
4 **A.** I am not aware that they were.
5 **Q.** Do you think they should have been?
6 **A.** That's a very difficult question. Should they
7 have been? It would have caused possible harm if
8 everything was proved to be, that it wasn't the case.
9 But open and honest, if it was the case. And I guess
10 the -- it would -- it would be up to the Consultants to
11 do that.
12 **Q.** You had more information about their children
13 than they did at this point, didn't you, the association
14 of one person, the pattern of unexpected deaths. Do you
15 think it's right that as a professional healthcare
16 professional you should have more information than they
17 have about their babies at any point?
18 **A.** Yes, I guess -- it's very difficult to know
19 what is the right way.
20 **Q.** Moving on to a different topic, INQ0058624,
21 page 1.
22 We know that Letby invoked a grievance procedure
23 and we will come to that in a minute but at the end of
24 that, this letter is sent or email is sent to you and
25 others. Did you know this email was coming before you

1 got it?
2 **A.** No, I didn't.
3 **Q.** She says:
4 "As you can imagine this whole episode has been
5 extremely distressing for me and my family. I will
6 begin my return to the unit in the coming weeks. I will
7 need colleagues to be sensitive and supportive at this
8 time."
9 We know that there was as least one tea party
10 planned on the unit for her return over a weekend. Are
11 you aware what steps were taken to welcome her back to
12 the unit?
13 **A.** A tea party, it sounds more than it is. A cup
14 of tea and a cake.
15 **Q.** It sounds like a tea party, a nice thing, nice
16 thing to do normally.
17 **A.** But we did it if it was somebody's birthday,
18 we did it if, if -- it wasn't --
19 **Q.** A celebration? Something positive?
20 **A.** Sorry?
21 **Q.** A celebration? Something positive, a nice
22 thing to do?
23 **A.** Yes.
24 **Q.** So when one was held to support Letby and when
25 she was invited in, were you there at it?

1 **A.** I don't remember it, no. But I remember being
2 shocked by this, the way it was written. But then ...
3 **Q.** The way it was written by the nurse who told
4 the Inquiry about it?
5 **A.** By Lucy, yes.
6 **Q.** Oh, by Lucy. Sorry, I thought you were
7 talking about ...
8 **A.** It was a bit full on, I felt at the time.
9 **Q.** What did you think when you read it?
10 **A.** Well, I am thinking, well, it's -- she's been
11 fully exonerated but then by whom?
12 **Q.** If we can go, please, to INQ0060238, page 1.
13 You see:
14 "Off-duty is requested for new medical staff.
15 Cover from March 2017. Looking forward to seeing you
16 soon."
17 So when did you think she was coming
18 back, March 2017 or --
19 **A.** When did I think?
20 **Q.** Yes, looking at this email. When you wrote
21 that email, what did you think the position was?
22 **A.** Would it be March or was it April?
23 **Q.** If we look below she's asked you and Yvonne
24 Griffiths for a copy of the latest off-duty and
25 the March doctor rota in order to plan visits.

1 **A.** I am not -- I don't think it ever happened
2 anyway.
3 **Q.** Well, what visits was she trying to plan and
4 what information was she asking to see before she came
5 to make the visits?
6 **A.** I don't know. I can't remember what Karen
7 said. Because she went through Karen because Karen was
8 liaising a lot with, with us at the time.
9 **Q.** She's certainly cc'd Karen but it looks like
10 she's asking to know what doctors are on, isn't she?
11 **A.** Off-duty, the latest off-duty and March
12 doctors rota.
13 I think -- I don't think she wanted to visit when
14 there were certain members of the medical team there,
15 which is what makes it untenable for her coming back.
16 **Q.** So she was setting her terms to come back?
17 **A.** Mmm.
18 **Q.** None of the doctors -- what did you make of
19 that?
20 **A.** Well, only that she was going to feel extra
21 nervous if certain doctors were there, because I think
22 wasn't the -- the grievance had finished by then so
23 obviously that came out in the grievance, that she felt
24 she were got at.
25 **Q.** Dr Rackham, who the Inquiry will hear evidence

1 from, is a doctor from a neighbouring hospital?
2 **A.** Yes.
3 **Q.** And he says he was contacted by you by email
4 to ask you to put some positive comments together --
5 **A.** Yes.
6 **Q.** -- comments he had made about a resuscitation
7 for Child P, and he said it was a slightly unusual
8 request:
9 "The manner of this request at a later date was
10 slightly unusual."
11 Why had you gone to Dr Rackham for any statements?
12 **A.** Well, on the review, on the deep dive,
13 a doctor -- and I think I can't say him.
14 **LADY JUSTICE THIRLWALL:** Just check the list.
15 **A.** Okay. Dr U had said in the deep dive that
16 Dr Rackham had actually said how excellent she was and
17 that it was noted. So this was -- revalidation was now
18 in place with the NMC. So this is something that would
19 come out of that; that you get some sort of verification
20 of good practice and that was the only way -- that was
21 an email that was sent to Dr Rackham for, for that.
22 **MS LANGDALE:** Was that going above and beyond for
23 Letby at that point?
24 **A.** Well, no, because we had revalidations anyway
25 going on, that was a new thing that came out, and that

1 was something that was added to your portfolio and
2 anybody, really, that had a good word or praised you in
3 a particular way or even if it was the NLS course that
4 you were doing and you had a good response from that,
5 that also would, would go ahead for the revalidation
6 process.
7 **Q.** You were interviewed in the RCPCH review,
8 weren't you, and also spoke about Letby?
9 If we go to INQ0014603, page 1.
10 We see in the second section:
11 "EP care issue taken line on LL that it's felt to
12 be unfounded, meticulous, high standards, good
13 communication skills. Other skills: key person to go to
14 when need someone to help. Felt not been honest with LL
15 and others. Very upset by the situation."
16 Further down:
17 "LL is clever, exceptional, very professional.
18 Incident reports herself and her best friend too ...
19 "Impose the removal on her by doctors."
20 And over the page, page 2. You refer to when
21 babies die you organise a debrief within a week:
22 "Always have hot debriefs. If any member of staff
23 has had more than one incident in short space of time
24 they try to allow them to step back a little bit. Not
25 always possible."

1 That's something that you thought was a good idea
2 but it never happened, did it? She would ask
3 consciously to go back into the nurseries, intensive
4 care nurseries?
5 **A.** Sorry, I --
6 **Q.** Letby would ask to go back to intensive care
7 nurseries?
8 **A.** Yes.
9 **Q.** So although you thought the best practice was
10 to step back a little bit, you knew she was not doing
11 that and choosing not to do that. She wasn't stepping
12 back from the intensive care nursery, was she? What did
13 you make of that when you knew she wasn't doing what you
14 thought was a good thing after you had experienced --
15 **A.** Well, it was -- well, it was for her
16 well-being. But then I felt that wasn't in place when,
17 when it was happening to me and I felt it would have
18 been a good thing to happen currently.
19 **Q.** In terms of the earlier page, "Clever,
20 exceptional, very professional", did you feel able to
21 say that in September 2016 without any of the things
22 that you had been told coming into your head?
23 **A.** Hindsight's a wonderful thing. Probably not.
24 **Q.** Were you comfortable at the time saying it?
25 **A.** But I thought nothing had changed as far as --

1 nobody had seen anything.
2 **Q.** But you knew those words, you weren't
3 comfortable, you say, probably not, you weren't
4 comfortable. Did they feel hollow when you said them?
5 **A.** Was what, sorry?
6 **Q.** Did they feel hollow? Just ...
7 **A.** Well, no, because she had done what, you know,
8 reported herself on incidents, she had actually done --
9 reported on her friends as well.
10 **Q.** Is that Nurse T or someone else? I don't know
11 when you say friend, not Nurse T, sorry. It doesn't
12 matter. She had reported on somebody else?
13 **A.** Yes, she is on here, I've seen, Nurse Z.
14 **Q.** Did -- what did she report about herself?
15 **A.** About the Gent.
16 **Q.** Gentamicin?
17 **A.** Yes.
18 **Q.** So that one point enabled you to say she
19 incident reports herself, the Gentamicin?
20 **A.** Yes. I mean, I can't remember if there were
21 any more but I mean, that's -- we have many, many
22 incidents reported per day.
23 **Q.** I thought you weren't aware of that incident
24 until we sent it to you, but ...
25 **A.** No, but that's one incident that -- of Gent

1 she's reported herself it said on the top, which
2 I highlighted.
3 **Q.** Oh, the one about the morphine?
4 **A.** No, the Gent.
5 **Q.** Yes, the Gent. I thought that was one that
6 you hadn't seen before?
7 **A.** I didn't know, no, but when I was reading it
8 today.
9 **Q.** Yes.
10 **A.** Yes.
11 **Q.** But this is an interview you gave in 2016?
12 **A.** Right.
13 **Q.** So you said then that she reports herself --
14 **A.** Yes.
15 **Q.** -- incident reports herself. So I am asking
16 what in 2016 did you know she had reported herself
17 about, just to be sure that we are not missing anything?
18 **A.** No. But she did. She would -- she did a few
19 clinical incidents.
20 **Q.** Tell us what they were.
21 **A.** God. I can't -- I can't recall.
22 **Q.** Well, roughly. You have said it to them, you
23 have said clinically reports herself, so what kind of
24 errors, clinical incidents was she reporting?
25 **A.** I can't remember. I can't remember them.

1 I can't -- I can't recall them.
2 **Q.** Does that mean they can't have been
3 particularly significant or of importance?
4 **A.** Well, they weren't significant, they were just
5 reporting Datixes.
6 **Q.** Datixes reporting in relation to a child
7 rather than her own errors?
8 **A.** To her own errors? Yes.
9 **Q.** Yes. And you say here, clearly, in 2016, you
10 imposed the removal on her by the doctors -- you imposed
11 the removal on her because of the doctors imposing it?
12 **A.** Yes.
13 **Q.** Okay. That can go down, thank you.
14 The grievance procedure now. We know you were
15 interviewed by Dr Chris Green and that, if we can go to
16 it, INQ0002879, page 37. 0037.
17 You say "LL switches" -- in the box at the bottom:
18 "... switches from days/nights to suit the unit.
19 She's so amenable and flexible. One of my best nurses.
20 Was also a student in the department. Quiet but
21 diligent. Her practice is second to none."
22 **A.** (Nods).
23 **Q.** "Compared to part-timers, full-time staff
24 working overtime are going to be higher commonality.
25 "I met with Letby. She asked if anything had come

1 from the review. I told her she was a commonality. She
2 didn't seem concerned as she was full time plus
3 overtime. If you are allocated a baby, no other staff
4 should touch the baby without your permission."
5 That is exactly what Nurse W told you Letby had
6 done in relation to Baby C, wasn't it?
7 **A.** Mmm.
8 **Q.** Why didn't you tell them that?
9 **A.** Why did I, sorry?
10 **Q.** Why didn't you tell them that on the
11 grievance? But now I mention it, you bothered to
12 mention that you shouldn't touch another baby without
13 permission, but you didn't say "But I know that she did
14 that" on the grievance you didn't mention that extra --
15 **A.** But I didn't know that she had done that.
16 I had done, what -- that I hadn't -- was that she was
17 caring for the baby that she should have been caring for
18 in Nursery 3, but I was unaware of the one where she was
19 looking or interfering, as you said, for Baby C.
20 **Q.** Where was she going to be if she wasn't
21 looking after the baby she was looking after?
22 **A.** But I gathered if it's Nursery 3, it is not an
23 ITU or high-dependency baby.
24 **Q.** The question is the same. Where would she be
25 if she wasn't looking after the baby she was supposed to

1 be looking after?
2 **A.** Where wouldn't she be?
3 **Q.** Where would she be? She would have to be
4 looking after a different baby, wouldn't she? If she
5 wasn't looking after the one she was allocated to, she
6 would have to be looking after someone else's?
7 **A.** Yes.
8 **Q.** So the very thing you point out that it's
9 important not to do, you knew at the time you were
10 having the interview she had done that. So why not
11 point that out as well?
12 **A.** I don't know. I mean, in, in the greater
13 scheme of things that was hopefully an isolated
14 incident.
15 **Q.** So you assumed it was a one-off and not worthy
16 of mentioning?
17 **A.** It's not that it wasn't worth. It's just that
18 it's trying to see if there's a pattern in that respect
19 and if there was then it would be documented on her
20 profile.
21 **Q.** Moving down. At an urgent meeting -- the
22 dates, I don't think it's 16 May, but at that meeting
23 that a number of witnesses are giving evidence about,
24 regarding the downgrading of the unit you say:
25 "Stephen Brearey alluded to Letby being

1 responsible. I told him not to as it wasn't his place.
2 Jim McCormack stood up, pointed to EP, and said 'You are
3 harbouring a murderer'."
4 First of all, is that what you say happened?
5 **A.** Sorry?
6 **Q.** What do you say happened at that meeting? Did
7 Jim McCormack say that?
8 **A.** I heard him -- well, that is my interpretation
9 of the meeting.
10 **Q.** Tell us -- were you at the meeting?
11 **A.** Well, yes.
12 **Q.** So what did you hear him say and where were
13 you when he said it?
14 **A.** That's what I heard him say to me.
15 **Q.** How far away was he from you?
16 **A.** It wasn't a very big desk, it was perhaps from
17 there.
18 **Q.** And you say -- tell then that he pointed to
19 you and said, "You are harbouring a murderer"?
20 **A.** Yes, but he doesn't remember that.
21 **Q.** No. He says that in response to Dr Brearey
22 who was raising concerns about a nurse on the unit, that
23 he said, "Are you saying that a nurse on the unit is
24 murdering babies?"
25 That's what he said.

1 **A.** That is what he said, yes.
2 **Q.** Could he be right about that?
3 **A.** I heard him say what he said. Like I said,
4 I -- I remember when it's traumatic, I remember when
5 somebody is shouting at me and I remember when somebody
6 is also screaming at me.
7 **Q.** Screaming?
8 **A.** He wasn't no, but from a previous example.
9 **Q.** Dr V screaming?
10 **A.** Yes.
11 **Q.** Upset?
12 **A.** Yes. Well, yes. Steve.
13 **Q.** "Stephen Cross is ex police and he said they'd
14 have no evidence. If they put it together it would be
15 looked at."
16 What did you understand if Stephen Cross said that,
17 he meant by "if they put it together"?
18 **A.** What, what did I think he means?
19 **Q.** Yes, did he say "put it together"? He said,
20 "If they put it together it would be looked at."
21 **A.** There would be no evidence, said
22 Stephen Cross.
23 **Q.** So you understood Stephen Cross to be saying
24 even if you put it together there would be no evidence?
25 **A.** Yes.

1 **Q.** Are you sure about that?
2 **A.** No. That's the interpretation but that he had
3 been actually discussed with Stephen Cross and they said
4 that there was no evidence.
5 **Q.** Did you ever have a discussion with
6 Stephen Cross?
7 **A.** No.
8 **Q.** Right. So that is what you had heard, was it?
9 **A.** Yes.
10 **Q.** So this is hearsay?
11 **A.** Yes.
12 **Q.** Whereas Dr McCormack, you say you were present
13 and that's what was said.
14 You say also:
15 "Ravi Jayaram was heard by a nurse in outpatients,
16 when asked if anything had come from the review, to say
17 somebody is causing these deaths on this unit."
18 That nurse has said that what she heard was
19 Ravi Jayaram saying:
20 "Just because they haven't found anything doesn't
21 mean there isn't something to find", or words to that
22 effect.
23 That's that nurse's evidence. Not that he said
24 somebody is causing these deaths on this unit.
25 Did you hear this or is it, again, hearsay,

1 something that you had been told?
2 **A.** I believe that nurse actually spoke either to
3 myself or Yvonne.
4 **Q.** So did she speak to you about that?
5 **A.** I can't remember if it was me but I --
6 I recall that particular nurse telling, telling me or
7 Yvonne that. I can't remember which one.
8 But either way, it came back to the fact that she
9 had overheard them discussing it in the clinic.
10 **Q.** Who had overheard?
11 **A.** Nurse T.
12 **Q.** Well, that's not the evidence she's given
13 here.
14 **A.** Oh.
15 **Q.** And to be fair to you, Ms Powell, the nurses
16 giving evidence generally describe you as a supportive
17 manager. Nurse T describes feeling bullied and
18 intimidated by you.
19 **A.** Yes.
20 **Q.** And I think there's also a suggestion that you
21 had favourites. I don't know if that is from Nurse T or
22 another nurse.
23 But, what do you say about that? Did you ever
24 bully or intimidate people on the unit?
25 **A.** No, I didn't. I didn't bully anybody.

1 I supported everybody equally. I was one of those
2 people that -- I didn't go out on many staff dos because
3 I needed to keep objective about the staff because
4 things would get, get said outside, and you can't run
5 the unit when you are running too close.
6 **Q.** I think Dr Holt gave evidence she went to
7 a retirement party of yours or a Christmas party. She
8 thought it was 2016, but realised it may have been 2017;
9 that's when you retired?
10 **A.** Yes.
11 **Q.** There was a Christmas party then when Letby
12 came and some of the doctors; yes?
13 **A.** Yes.
14 **Q.** Was that a strange situation in 2017?
15 **A.** I couldn't have done it.
16 **Q.** If you were who?
17 **A.** If I were her.
18 **Q.** If you were Letby?
19 **A.** Yes, I couldn't have done that.
20 **Q.** So she came. And was it your retirement or
21 a combined party?
22 **A.** Well, the -- it was a Christmas do, but
23 I didn't want a retirement. So we agreed that it will
24 be fine if I went just for the retirement bit.
25 **Q.** Do you know who invited her there? When you

1 say you couldn't have done it, were you in charge of the
2 invites?
3 **A.** I didn't -- no, no. The Christmas party was
4 already --
5 **Q.** Right.
6 **A.** But Lucy had actually asked would it be all
7 right if she came and I said, "That's entirely up to
8 you."
9 **Q.** You also say going back to this grievance
10 interview:
11 "Because you are good at your job you get in the
12 position of looking after the sickest babies. LL will
13 question Registrars or Consultants and will call and say
14 if she wants them to look at the baby now if she has any
15 concerns. She will Datix herself and even close
16 colleagues."
17 Again, as far as you knew in relation to the
18 specific babies, the babies who had died, they were not
19 sick babies, were they? So --
20 **A.** Well, the potential is there.
21 **Q.** But that's not the question. The potential
22 may be there.
23 **A.** Yes, otherwise they wouldn't be on the unit.
24 **Q.** Well, they can be there because they are born
25 early, need feed support and some help along the way.

1 **A.** Yes. But also they can have underlying
2 conditions that you are not aware of.
3 **Q.** But do you see the point that, once again, you
4 are generalising as part of this grievance process and
5 saying: she looks after the sickest babies, these are
6 premature babies, it's all coincidence, there's nothing
7 in it.
8 It's not that you are just not saying there is no
9 evidence. You are actively saying why she cannot have
10 done this. Do you see the difference?
11 **A.** Yes.
12 **Q.** What do you think about that now?
13 **A.** Well, looking back at it, it looks obvious.
14 But -- with hindsight, it looks obvious.
15 **Q.** You say, finally from me, in reflections,
16 paragraph 261:
17 "I remained open minded about potential factors
18 which could have contributed to rise in deaths.
19 I participated in the various reviews undertaken and
20 there was no information arising from the review work to
21 indicate that there was an issue with Letby. As the
22 unit manager, I was used to managing staff and
23 challenging them when issues arose and had there been
24 anything more than a gut feeling ... I would have
25 immediately addressed this."

1 Do you think you were able to challenge, when there
2 were concerns raised about Letby or comments she had
3 made, that you were able to challenge her and address
4 the things --
5 **A.** Well, I have done it on numerous -- well, not
6 numerous -- on a few occasions; not with Lucy.
7 I did it with others and as I mentioned before, you
8 know, they didn't like it and, and left.
9 **Q.** When you say "gut feeling", what do you mean
10 by that?
11 **A.** Well, this is what Dr Brearey said; that he
12 had a gut feeling.
13 **Q.** And you said earlier there was an aura. It
14 had an aura. We know --
15 **A.** Well, yes, you always have that aura, you
16 know, if things had gone well or not and it's like: Oh,
17 it's very quiet, the staff are quiet. But that would be
18 through and through. That's not just for that area,
19 that time frame.
20 It could be like today I would go and it would be
21 different and then the next day you would go and you
22 think: Oh, there's that sort of subdued quietness about
23 the place.
24 **Q.** A gut feeling can amount to a suspicion, can't
25 it? A suspicion, I don't know why but something doesn't

1 feel right. It's suspicious?
2 **A.** Mmm.
3 **Q.** So you knew they had a gut feeling, or I am
4 going to say suspicion, of something was going wrong and
5 she was --
6 **A.** Yes.
7 **Q.** -- associated with it. Is that fair?
8 **A.** Yes.
9 **Q.** And don't say it if it's not. Is that fair?
10 **A.** It is.
11 **Q.** You understood "gut feeling" meant suspicion?
12 **A.** Yes. That was Dr Brearey's gut feeling.
13 **MS LANGDALE:** Thank you, I have no further
14 questions, Ms Powell.
15 My Lady, I think this is probably the best time to
16 take a break so that others asking questions afterwards
17 can go in sequence.
18 **LADY JUSTICE THIRLWALL:** Very well. So we will
19 take a break and start again at 25 past 3.
20 **(3.08 pm)**
21 **(A short break)**
22 **(3.25 pm)**
23 Questions by MR SKELTON
24 **LADY JUSTICE THIRLWALL:** Mr Skelton.
25 **MR SKELTON:** Thank you, my Lady.

1 Ms Powell, I ask questions on behalf of one of the
2 families groups?
3 **A.** Sorry?
4 **Q.** I ask questions on behalf of one of the groups
5 of families?
6 **A.** Okay, thank you.
7 **Q.** Can I just ask you briefly about Child A and
8 Child B, first of all, please.
9 **A.** Yes.
10 **Q.** You told Ms Langdale earlier that you were not
11 aware of the rashes and mottling that were found on
12 those children as they collapsed and one of them died,
13 is that correct?
14 **A.** Yes.
15 **Q.** So would it be right that you weren't aware
16 that Mother A was asked by one of the doctors to
17 photograph Child B and her rash? You weren't aware of
18 that either?
19 **A.** No.
20 **Q.** Were you aware of any communication with the
21 parents of A and B about the rashes?
22 **A.** I don't recall any, any rashes at the time.
23 Mottling, I do, more so, but rashes no. And certainly
24 not rashes and mottling.
25 **Q.** What were you aware of in relation to

1 mottling?
2 **A.** Well, only that mottling can be a precursor to
3 sepsis or hypoglycaemia or a cold -- a cold injury, but
4 not in the context of the children.
5 **Q.** So nothing in relation to A and B?
6 **A.** No.
7 **Q.** So far as Child A is concerned, the first
8 death, were you aware that his death was unascertained
9 throughout 2015 and 2016 and indeed right up to and
10 including the Inquest into his death?
11 **A.** Was, sorry?
12 **Q.** Unascertained?
13 **A.** Oh, unexplained. Yes.
14 **Q.** Mother A and B didn't get the chance to hold
15 her son in her arms before he died and that is a source
16 of enormous regret and upset to her. Do you recognise
17 how unfortunate that is?
18 **A.** That's awful.
19 **Q.** And every effort should be made to allow
20 a parent to hold their baby, even for the briefest of
21 times before they die?
22 **A.** Which is as practice should be. That's how it
23 should be.
24 **Q.** Can you explain why that might not have
25 happened in her case?

1 **A.** No, I don't. There's no excuse for that.
2 **Q.** Some of the parents, Father N for example, if
3 you want to refresh your memory about Child N, some of
4 them such as Father N has expressed the view that he
5 didn't feel like he was treated as the parent of his own
6 child in the sense of being able to hold the child and
7 involve himself with him.
8 That, again, is quite unfortunate if that is
9 a parent's view of what occurred?
10 **A.** Yes.
11 **Q.** It should be that the parents are allowed to
12 hold their children are encouraged to do so?
13 **A.** Exactly.
14 **Q.** There is also a sense on part of some parents
15 that there was a lack of communication about the
16 collapses of their children. So the mother of Child N
17 wasn't aware initially that her child had collapsed and
18 suffered a serious collapse -- as it turned out it was
19 an attempted murder, but she wasn't told about it at the
20 time?
21 **A.** No.
22 **Q.** Again, do you think parents should be told if
23 their children --
24 **A.** Well, they are supposed to. The -- it's
25 understandable that if -- while the doctors are actually

1 stabilising an infant or putting them on a ventilator or
2 that there has been a collapse in place, once that child
3 is stable, normally, normal practice is that the doctors
4 go to update.
5 Failing that, the nurse should actually undertake
6 it. So there's -- there should be no excuse why they
7 didn't. They should have been.
8 **Q.** So the only excuse might be a practical one in
9 that the staff are fully engaged in resuscitation?
10 **A.** Exactly.
11 **Q.** But beyond that period?
12 **A.** No excuse at all. Updating is part of one of
13 the BadgerNet's data set, it is updating parents, and
14 it's, it's held in high practice that that is the way
15 that you are supposed to do it.
16 **Q.** Another theme of some of the parents'
17 evidence, particularly the children that died, is that
18 they were offered the possibility of speaking to
19 a priest or saying a prayer or some other form of
20 religious --
21 **A.** Yes.
22 **Q.** -- action before they even knew that the child
23 was going to die. In other words, before a healthcare
24 professional had told them the child was in a perilous
25 condition, somebody spoke to them about that and by

1 definition that would have made them incredibly fearful
2 and distressed; do you recognise, again, that that
3 shouldn't happen?
4 **A.** It is part of admission process that if
5 a child is deemed to be unstable, or expected -- I mean,
6 as, as the case may be that isn't the issue here, but on
7 the admission page asking for permission for baptisms so
8 that we have an idea of what is important to them.
9 But it's got to be timed appropriately and
10 obviously not in this case, if it was the case.
11 **Q.** And in this case it's not just baptism, it is,
12 "Do you want to speak to a priest?"
13 **A.** Yes.
14 **Q.** "Do you want to say a prayer?" But before the
15 parent even knows that their child might die?
16 **A.** That they're that unwell.
17 **Q.** That shouldn't happen, should it?
18 **A.** No.
19 **Q.** After Mother A was discharged from hospital,
20 obviously she left hospital having lost one of her twin
21 children, her son, but with another child still in the
22 unit, they were both being cared for obviously, as you
23 know. She felt afterwards -- obviously going back to
24 the unit was particularly distressing for her because
25 for most parents they will leave the unit after their

1 child has died and probably never want to go back but
2 for her she had to go back again and again.
3 She didn't feel that the staff recognised or
4 empathised with her for that. It's admittedly an
5 unusual situation but one which was acutely difficult
6 for her. Again, that was most unfortunate, wasn't it?
7 **A.** They should -- I mean, it doesn't -- you don't
8 have to be particularly experienced to know that and
9 it's part of a bereavement package anyway, that, you
10 know, a lot of parents have lost one of their children
11 and have to come back. I mean, it constitutes PTSD,
12 it's so traumatic. It's -- I can't believe that the
13 staff didn't know that.
14 **Q.** So you agree then, she should have been
15 treated with the utmost sensitivity particularly if she
16 wanted to spend time with her other child?
17 **A.** Exactly, yes.
18 **Q.** A final specific issue is about private
19 messaging. Ms Langdale asked you a bit about private
20 messaging. In respect of the parents of Child N again,
21 they are particularly concerned that Lucy Letby and Dr U
22 engaged in private messaging on a personal form of
23 messaging, so not the professional WhatsApp that you
24 have discussed, but a private form of messaging about
25 their child. And they think that just simply should not

1 have happened.
2 **A.** No. It shouldn't.
3 **Q.** How do you think it was -- it came about that
4 one of your nurses was engaged in that kind of
5 discussion with a doctor?
6 **A.** Well, I wasn't -- I mean, it was only
7 subsequently was I aware that that was ever going on.
8 But I was always fearful of -- of mobile phones,
9 WhatsApp group. Unless you have got an invigilator or
10 somebody that actually is overseeing it, it's open to
11 abuse especially in the NHS. Anywhere else might be
12 considered okay. But certainly not in the NHS.
13 **Q.** And there are obvious issues, aren't there,
14 with privacy --
15 **A.** Yes, exactly.
16 **Q.** -- and the private nature of that information?
17 Can I turn, then, to some general matters, please.
18 I think you have accepted with Ms Langdale that it's
19 doctors who have the primary responsibility for
20 diagnosing patients and deciding what medical treatment
21 they require --
22 **A.** Yes.
23 **Q.** -- in a hospital setting and elsewhere. Of
24 course, nurses routinely assist with diagnosis and will
25 triage patients and so on who come into the hospital,

1 but they ultimately defer to doctors when it comes to
2 diagnosis and treatment?
3 **A.** Yes.
4 **Q.** It's also right, I think, that nurses can
5 confirm or verify deaths but they can't certify them or
6 determine them?
7 **A.** (Nods).
8 **Q.** In other words, it is not for a nurse to say
9 this caused the death; that is ultimately for a doctor
10 to determine or, in some cases, a Coroner.
11 **A.** Yes.
12 **Q.** Correct?
13 **A.** (Nods).
14 **Q.** Dr Brearey, who you worked with very closely,
15 was a highly respected senior doctor --
16 **A.** Yes.
17 **Q.** -- with many years of caring for extremely
18 sick children. There isn't any suggestion that he was
19 in any way incompetent, is there?
20 **A.** No.
21 **Q.** Or that he had a history of raising unfounded
22 concerns or allegations about colleagues?
23 **A.** No.
24 **Q.** There's also no evidence, certainly that this
25 Inquiry has heard, that he was generally thought of as

1 being vindictive towards members of staff, whether
2 nurses or other doctors?
3 **A.** No.
4 **Q.** And there is no suggestion that he had
5 a personal dislike of any particular members of staff
6 for any reason?
7 **A.** Oh, maybe. But that was somebody -- yes, it's
8 a clash of personalities.
9 **Q.** Well, is it something that caused any concern
10 to you?
11 **A.** No.
12 **Q.** He's repeatedly been spoken of as someone who
13 is respectful of nurses as were all the Consultants?
14 **A.** Yes.
15 **Q.** And indeed respectful of his junior doctors,
16 correct?
17 **A.** Yes.
18 **Q.** And as far as the Inquiry has heard, there is
19 no evidence that either he or any of the other doctors
20 had a personal dislike of Lucy Letby.
21 **A.** Sorry?
22 **Q.** There is no evidence that he or any of the
23 other doctors had a personal dislike of Lucy Letby prior
24 to the concerns --
25 **A.** No.

1 **Q.** -- about her harming children.
2 Neonates generally, you are obviously extremely
3 experienced at caring for neonates and have done so
4 for -- how much of your career?
5 **A.** Since 1982.
6 **Q.** Many, many years?
7 **A.** Yes.
8 **Q.** Decades. They are highly vulnerable --
9 **A.** Yes.
10 **Q.** -- patients for obvious reasons. They are
11 extremely small. Many of them will be premature. Many
12 of them will have quite serious conditions that you are
13 dealing with, and they can be suddenly caught up in
14 sudden events because of their vulnerability.
15 **A.** Yes.
16 **Q.** So that you do see neonates deteriorate
17 suddenly.
18 Ms Langdale asked you about the difference between
19 expected and unexpected events. Most of the time when
20 neonates deteriorate, there is a reason for it --
21 **A.** Yes.
22 **Q.** -- that is medically identifiable by you
23 a nurse, or by a doctor. In fact, overwhelmingly that
24 is the case?
25 **A.** (Nods).

1 **Q.** You need to say "yes" for the transcript.
2 **A.** Yes.
3 **Q.** What is different in this case is that there
4 isn't a medical explanation immediately for the
5 deteriorations, they are unexpected. In other words,
6 the doctors and the nursing staff weren't expecting
7 stable neonates to suddenly collapse and require
8 resuscitation and certainly not to die and that is
9 a common factor between these deaths, isn't it?
10 **A.** Yes.
11 **Q.** And I don't know whether you have followed the
12 earlier evidence of some of the doctors who have given
13 evidence. Did you follow the evidence of Dr McGuigan,
14 for example?
15 **A.** No.
16 **Q.** You know who Dr McGuigan is?
17 **A.** Yes.
18 **Q.** He came in relatively late.
19 **A.** He did.
20 **Q.** He is a new Consultant to the unit and he made
21 it clear that it was extremely concerning, in his words,
22 that children would unexpectedly die without
23 explanation.
24 **A.** (Nods).
25 **Q.** It is extremely concerning, isn't it?

1 **A.** Yes.
2 **Q.** Just pausing on the unexpected nature of
3 things. If a child unexpectedly collapses would you
4 expect a Datix to be completed for them?
5 **A.** Well, yes, but if it needs resuscitation it
6 would do.
7 **Q.** So any child that collapses requiring
8 resuscitation --
9 **A.** Yes, I mean, a lot of children, especially if
10 they are on a ventilator, sometimes the tube needs
11 changing and would require resuscitation, but if they
12 normally recover with bagging and masking, using the bag
13 and mask, and actually oxygenate, usually that is all
14 that is required. But these went on to full, full
15 resuscitation and then failed resuscitation.
16 **Q.** So in those cases where the children didn't
17 die but they require resuscitation the Datix should have
18 been completed?
19 **A.** Yes. Yes.
20 **Q.** As a senior nurse you are obviously well
21 placed to recognise or identify deficiencies in nursing
22 care so, for example, the wrong drugs being
23 administered?
24 **A.** Yes.
25 **Q.** Inadequate observations, failure to respond to

1 a deteriorating child, failure to escalate, all of those
2 things are squarely within your expertise, is that
3 right?
4 **A.** Yes.
5 **Q.** What isn't in your expertise, as I think you
6 have agreed, is diagnosis and identifying causes of
7 death?
8 **A.** Yes.
9 **Q.** So you needed to defer to your doctors, your
10 Consultants about that?
11 **A.** Yes, and the Coroner, yes.
12 **Q.** Sorry?
13 **A.** And the Coroner.
14 **Q.** And the Coroner?
15 **A.** Yes.
16 **Q.** We have seen on the screen a number of times
17 now a table of the children which you compiled in which
18 you list their deteriorations and deaths and, of course,
19 we know that Lucy Letby is on that column on the far
20 right. I am not going to ask about her at present but
21 just the causes of death.
22 In many cases, in fact in each case, there were
23 possibilities being discussed. So in some cases sepsis,
24 NEC, in Child A's case there was a possibility that the
25 mother's condition might have affected the child, all of

1 those are possibilities but there wasn't a direct and
2 probable cause of the deaths, was there?
3 **A.** No.
4 **Q.** So in each case what was worrying about them
5 was that you didn't know why they had died?
6 **A.** No.
7 **Q.** As I understand it, you yourself never
8 investigated the deaths and causes of deaths and indeed
9 that wasn't your job?
10 **A.** No.
11 **Q.** Had you investigated the deaths, it might have
12 been possible that you could have seen the commonality
13 between some of them. So you are very familiar with the
14 rashes that many of the children had, which we now know
15 is associated with air embolism, and you will also be
16 familiar that two of the children, Child F and Child L,
17 had unusual insulin C-peptide results, which were in the
18 notes but hadn't been spotted.
19 Had you seen that would you as a nurse have known
20 that was unusual, that children appeared to have been
21 given high doses of exogenous insulin, non-internal
22 insulin, which they shouldn't have been given?
23 **A.** I -- well, I personally wouldn't have been in
24 that position to investigate it. I guess even the -- it
25 was -- it would be a supposition if, if I -- I wouldn't

1 be in that position anyway to do that.
2 **Q.** That would be for the doctors?
3 **A.** Yes. And even on the deep dive that would be
4 something that, that would be evaluated and assessed.
5 **Q.** Were you aware, though, that the -- taking the
6 deaths across apiece, and there were many of them
7 throughout 2015, as you know, and then into 2016, that
8 there hadn't been a full investigation of all of them to
9 determine all the causes of death and any common factors
10 between them, were you aware of that?
11 **A.** Other than the commonality? I thought they
12 had -- Dr Brearey had done a deep dive.
13 **Q.** Well, he had done a deep dive but in fact he
14 didn't identify all the causes of death, as I think you
15 have accepted. So Child A, for example, never had
16 a cause of death ascertained. It was always
17 possibilities.
18 **A.** Right.
19 **Q.** Were you aware of that?
20 **A.** That there was a possibility of?
21 **Q.** That across the piece --
22 **A.** Yes.
23 **Q.** -- a full review of all the deaths to identify
24 why the children had died and whether there were common
25 causes in respect of them had not been done?

1 **A.** No.
2 **Q.** And, indeed, it might have required something
3 extra than a clinician looking at them?
4 **A.** Yes.
5 **Q.** It might have needed pathology evidence, for
6 example?
7 **A.** I think, yes, I think Dr Brearey contacted the
8 Coroner regarding pathology.
9 **Q.** He did and Child A, for example, had
10 a post-mortem or a pathology examination and again the
11 pathologist couldn't find a cause of death either. But
12 none of them, I think, had a forensic pathology check,
13 did they?
14 **A.** I think a few -- a couple did but ...
15 **Q.** I may be corrected on that, but overall --
16 **A.** Okay.
17 **Q.** -- for most of them, those extra investigative
18 steps weren't taken?
19 **A.** Yes.
20 **Q.** You then, just taking that, putting it all
21 together, you weren't clear about the causes of death
22 for these children, the doctors were concerned about
23 that there was a pattern of deaths which was highly
24 unusual in terms of each death was unusual --
25 **A.** Yes.

1 **Q.** -- and a high number of them was unusual, and
2 you weren't in a position to rule out unnatural causes,
3 personally?
4 **A.** Mmm.
5 **Q.** You couldn't, could you?
6 **A.** No.
7 **Q.** You said earlier, and I think you say in your
8 statement that you were aware of Beverley Allitt?
9 **A.** Yes.
10 **Q.** Everyone was aware of Beverley Allitt?
11 **A.** Yes.
12 **Q.** She was national news.
13 Were you also aware of Victorino Chua?
14 **A.** Of who, sorry?
15 **Q.** Mr Chua, a nurse --
16 **A.** In a local hospital?
17 **Q.** Yes, not far away, Stepping Hill.
18 **A.** Yes, yes.
19 **Q.** Were you aware of the recommendation that came
20 out of the investigation or Inquiry into
21 Beverley Allitt's murders by, it was called the
22 Clothier Report or the Allitt Report. One of the
23 recommendations, I will just read it to you.
24 **A.** Yes.
25 **Q.** Was that her actions should serve to heighten

1 awareness in all those caring for children of the
2 possibility of malevolent intervention as a cause of
3 unexplained clinical events.
4 You have been in practice a very long time, I think
5 you probably were in practice around Beverley Allitt
6 being in post?
7 **A.** Yes.
8 **Q.** You were certainly there when Victorino Chua
9 was there, and of course Harold Shipman. Had it got
10 into your consciousness, as a senior nurse, that this
11 could happen?
12 **A.** Well, yes, we discussed it.
13 **Q.** Who?
14 **A.** Myself and my colleagues, Yvonne Griffiths and
15 Yvonne Farmer and Anne Murphy.
16 **Q.** When did you first discuss it?
17 **A.** Oh gosh, we discussed it because it was --
18 Dr Brearey was suggesting it was a gut feeling and we
19 were trying to sort of establish, well, are we looking
20 everywhere and just I mean across the board, what are we
21 missing?
22 **Q.** Can you try and pinpoint when that discussion
23 took place?
24 **A.** It was, it was all the time.
25 **Q.** From June '15?

1 **A.** Maybe not, maybe just after then. But I would
2 be guessing.
3 **Q.** I think Child E is August 2015 and Child I
4 is October 2015; would it be around that time?
5 **A.** It is more likely to be when we realised this
6 wasn't just a peak.
7 **Q.** Were you aware that some of the children that
8 Beverley Allitt harmed, at least, she'd used insulin, it
9 would appear?
10 **A.** Yes, yes.
11 **Q.** And obviously Nurse Chua had used insulin as
12 well?
13 **A.** Yes.
14 **Q.** Did you think to try and exclude that
15 possibility with the children on your unit?
16 **A.** Well, we had had ours in a locked, in a locked
17 fridge.
18 **Q.** But a locked fridge to which nurses had
19 access?
20 **A.** They did but they had to have the keys from
21 the shift leader.
22 **Q.** Did you check who had had access to the
23 fridges?
24 **A.** Not without them signing their names for it,
25 no.

1 **Q.** Did you ask the doctors to think about whether
2 insulin might be a possibility and look at the notes
3 because you weren't qualified to --
4 **A.** No.
5 **Q.** No?
6 **A.** No.
7 **Q.** So you thought about it but didn't actually
8 investigate it?
9 **A.** No.
10 **Q.** You conducted what's called a neonatal or you
11 call it a neonatal review in May 2016 and we have seen
12 that document. I won't call it up on screen unless you
13 want to see it.
14 Why did you produce that document?
15 **A.** Which one was that one, sorry?
16 **Q.** We will put it on screen. INQ0003243.
17 Do you remember it?
18 **A.** Yes.
19 **Q.** Why did you produce it?
20 **A.** It was trying to internalise all the
21 information, trying to put out there everything that
22 I knew to try and, I suppose it's just trying to put out
23 there that -- the thought process really, well, it's
24 trying to put it in sections to try and see if anything
25 would come out.

1 **Q.** But you must recognise and you have recognised
2 in answers just now that you hadn't investigated the
3 deaths?
4 **A.** No.
5 **Q.** And in many cases the causes of actual death
6 were not known?
7 **A.** No.
8 **Q.** And you have also recognised that the
9 possibility that someone was harming children was a real
10 one?
11 **A.** I did, yes. But I didn't feel that there was
12 anyone that fit that bill at that time.
13 **Q.** Were you expecting a particular presentation
14 or --
15 **A.** I don't know.
16 **Q.** -- demeanour from a potential murderer?
17 **A.** I just don't expect people to behave that way.
18 **Q.** Of course not. Hardly anyone does. But
19 that's the whole point of the Allitt recommendation, is
20 to think that somebody might do and to identify that
21 person --
22 **A.** Yes.
23 **Q.** -- in circumstances where the other possible
24 factors have been excluded.
25 The key, Ms Powell, was that you had senior doctors

1 coming to you with concerns and they couldn't find
2 medical causes for these children's deaths but they had
3 found a common factor.
4 That should have been enough to make you suspicious
5 that these babies were being harmed, shouldn't it?
6 **A.** On reflection, yes.
7 **Q.** What is odd about the communications at this
8 time is that no one says the word "murder" or "killing".
9 Was there a sort of reticence about even confronting the
10 possibility that this could be happening to you and your
11 colleagues?
12 **A.** Well, yes we did. We considered it.
13 **Q.** Well, you considered it, what it looks like is
14 you dismissed it?
15 **A.** We considered it yes, and we said it can't
16 possibly be, it must be a commonality.
17 **Q.** But how could you rule that out without
18 investigating the deaths?
19 **A.** It was only that we were saying -- we put in
20 that this is what, you know, she was there often, she
21 was full time, she worked overtime. There were no
22 problems with her in respect to being at Liverpool
23 Women's or for her induction or her -- what's it
24 called? -- induction and the QIS course. So there was
25 no -- nothing to suspect. The colleagues hadn't said

1 that there was anything to suspect.
2 **Q.** But why would there be the kind of signs of
3 obvious murder that you were expecting to see?
4 **A.** I don't know.
5 **Q.** Why wouldn't the murderer, whether it is
6 Lucy Letby or anyone else, have tried to operate
7 secretly and covered their tracks?
8 **A.** It's very difficult in a neonatal unit to do
9 anything secretly.
10 **Q.** Well, it isn't, is it?
11 **A.** Obviously not.
12 **Q.** I mean, it actually isn't. These babies were
13 murdered and no one noticed. You were not in
14 a position, were you, to rule out the possibility --
15 **A.** No.
16 **Q.** -- that the children had been murdered, and
17 you were certainly not in a position to rule out
18 Lucy Letby's involvement in that murder, were you?
19 **A.** No.
20 **Q.** And the fact is that you didn't actually, as
21 a manager, need to take a position, did you? You could
22 have simply said, "This is an extremely serious
23 allegation. My babies, who I am responsible for as
24 a manager and a nurse, may have been harmed. I need to
25 ensure that they are -- they and their families get the

1 answers they need and as importantly I need to ensure
2 that all babies coming onto this unit are safe."
3 **A.** Yes.
4 **Q.** That was your responsibility and if you could
5 not exclude the possibility that they were murdered then
6 you failed in that responsibility, didn't you?
7 **A.** Yes.
8 **Q.** You were asked about the police earlier in
9 your evidence. I appreciate that you are not alone in
10 this, Ms Powell, and that matters were escalated above
11 you to your Nursing Director and further up into the
12 Medical Director and the Chief Executive, and that steps
13 were not taken immediately to intervene. But you
14 recognise now that if professionals, when the
15 professionals raise suspicions that couldn't be excluded
16 and that were not obviously malicious, that the police
17 needed to be called?
18 **A.** Yes.
19 **Q.** And that should have happened as soon as those
20 suspicions were articulated; is that right?
21 **A.** Yes.
22 **MR SKELTON:** Thank you.
23 **MR BAKER:** My Lady.
24 **LADY JUSTICE THIRLWALL:** Just a moment.
25 **MR BAKER:** Yes.

1 **LADY JUSTICE THIRLWALL:** Are you all right to
2 continue? Do you want to have five minutes?
3 **A.** Okay.
4 **LADY JUSTICE THIRLWALL:** See how we go and if you
5 want a break we will take one.
6 Mr Baker.
7 Questions by MR BAKER
8 **MR BAKER:** Thank you, my Lady.
9 My name is Richard Baker. I ask questions on
10 behalf of two of the groups of families.
11 The question you were asked by Mr Skelton, just
12 now, was that the moment suspicions began to be raised,
13 about the possibility that there was a murderer on the
14 ward, the only appropriate thing to do was to call the
15 police?
16 **A.** Yes.
17 **Q.** Your answer to that was "yes"?
18 **A.** Yes.
19 **Q.** Can I ask a few questions directed towards why
20 that didn't happen, from your point of view?
21 **A.** Yes.
22 **Q.** You were asked some questions about
23 a complaint by Nurse W following the death of Child C
24 and those questions were directed towards why you didn't
25 act or whether you did act, but what Nurse W said to you

1 in terms was that Letby had behaved in a very, very
2 unusual way following Child C's death, that she had
3 spent all her time in and out of the family room
4 focusing in on the family who were caring for their
5 dying child --
6 **A.** Yes.
7 **Q.** -- which was a job which was to be done by
8 a different nurse, was being done by a different nurse,
9 and in doing that she put the life of another baby at
10 risk. That is what was said, wasn't it?
11 **A.** Yes.
12 **Q.** And that that baby, the other baby's condition
13 deteriorated during the course the night and the care
14 needed to be escalated the following morning and that
15 Nurse W had told Letby to pay particular attention to
16 this child because she was worried about it; yes?
17 **A.** Yes.
18 **Q.** And that Letby had ignored the instructions of
19 Nurse W, a senior nurse, over and over again about this
20 and made Nurse W very angry?
21 **A.** (Nods).
22 **Q.** The thing is you did nothing at all about
23 that, did you?
24 **A.** I don't recall. I would have documented
25 something surely in her, in her.

1 **Q.** HR file?
2 **A.** Yes. And it's not -- I don't think it's there
3 anyway.
4 **Q.** No.
5 **A.** So I just don't recall it. I recall Nurse W
6 speaking to me about it and I discussed it.
7 **Q.** You remember speaking to her about it.
8 **A.** Yes.
9 **Q.** Now, this is quite a serious thing to happen,
10 isn't it?
11 **A.** Yes.
12 **Q.** It is not a trivial thing and it warranted
13 action on the level that was taken in response to the
14 morphine incident, didn't it?
15 **A.** It's different.
16 **Q.** Well, is it really that different? I mean,
17 leaving unsupervised a patient who your senior nurse has
18 told you to keep a particular eye upon --
19 **A.** Yes.
20 **Q.** -- in order to do something that is being
21 covered by other people and has no real patient safety
22 issue?
23 **A.** Business being with her, no.
24 **Q.** Can I suggest the reason you didn't do
25 anything about it and if you had done something about

1 it, it would be documented. The reason you didn't do
2 anything about is that Letby was a particular favourite
3 of yours?
4 **A.** Not at all, I don't have favourites, at all.
5 I don't, I didn't. There was nobody on the unit
6 that I favoured. That wasn't part of who I am. I don't
7 have favourites.
8 **Q.** You see, doesn't this exact same thing happen
9 in 2013 when we have the morphine --
10 **A.** Yes.
11 **Q.** -- and the pump incident, that a different
12 nurse tries to take appropriate steps in order to make
13 sure that Letby is safe and that they are countermanded
14 by you and Letby is allowed to go on back to normal
15 practice?
16 **A.** But it was with adjustments.
17 **Q.** You see, I suggest it wasn't with adjustments.
18 **A.** Yes.
19 **Q.** That Letby's text message, which you were
20 taken to, is quite clear that she was allowed to go back
21 to things being normal.
22 **A.** Well, that's -- that was her interpretation as
23 it was her interpretation with the other reflection that
24 she did. It's not quite as it was.
25 **Q.** So you are saying her text message was a lie?

1 **A.** I am saying it is her perception of what
2 it is.
3 **Q.** There is no documentation, is there, to
4 suggest that Letby was kept on reduced duties with
5 regards to medication?
6 **A.** No, but what she was meant -- I mean, maybe
7 I should have been clearer on the one-to-one; that she
8 was to continue as she was with not additional fluids,
9 fluids that come up from pharmacy that are just actually
10 put, attached, they are changed -- the bags are changed,
11 to the fluids that go into the line.
12 But the IVs, they come up from pharmacy and you
13 attach them to the three-way tap or the other line, that
14 is different. Then she would have to have somebody else
15 to do that, but the IVs are different. They are just
16 saline IVs with --
17 **Q.** But your note, with the one-to-one inquiry, is
18 quite clear that there is no reference to restrictions
19 with controlled drugs or using morphine in a syringe
20 driver?
21 **A.** No, but the controlled drugs were checking the
22 drugs in the pharmacy room, where the drugs are kept,
23 checking them with the nurse.
24 **Q.** There is no reference to her having
25 restrictions on her practice within that note. You were

1 taken to it by Ms Langdale.
2 **A.** I don't know -- sorry, I don't understand.
3 **Q.** The one-to-one supervision you provided?
4 **A.** Yes.
5 **Q.** The note that you wrote of that one-to-one
6 supervision makes no reference to restrictions on
7 Letby's practice. Now, you are saying there were
8 restrictions but the note makes no reference and Letby's
9 own text --
10 **A.** Yes.
11 **Q.** -- suggests she was allowed to go back to
12 things being as they were. You seem to have a very
13 specific memory of this --
14 **A.** Yes, well maybe --
15 **Q.** -- but a very defective memory of --
16 **A.** Yes, you could be right.
17 **Q.** Can I take you to an email that you sent
18 in June 2020. It is INQ0003527. If you could scroll to
19 the next page, please, just so you can see the email
20 that prompted this.
21 You are receiving an email here from the Countess
22 of Chester Hospital regarding an investigation that is
23 being carried out by an organisation called
24 Facere Melius, into neonatal death from 2014 onwards.
25 I can take you to the letter that's attached to it

1 if you like --
2 **A.** Yes.
3 **Q.** -- but that is what it says.
4 And you are being invited for an interview as
5 a number of members of staff were regarding incidents at
6 this time, so between 2015/16 onwards.
7 Your response to that email, if we can scroll up
8 to the previous page, is:
9 "It has been six years since the beginning of the
10 relevant time frame. I regret to say that my
11 recollection would and is problematic at the best of
12 times I would not feel confident in any relevant recall
13 for your review."
14 **A.** Yes.
15 **Q.** Now, again, is that you -- is that a response
16 that's given in good faith given that a year later you
17 give a very detailed interview for the police?
18 **A.** *(Redacted)*.
19 **Q.** You don't need to give details about that.
20 **A.** Okay, but they will actually -- I had to be --
21 *(redacted)*.
22 **Q.** Do you think it's fair though to say that you
23 had a particular bias towards Letby?
24 **A.** No.
25 **Q.** Your evidence to the counsel to the Inquiry is

1 that you didn't go out on staff do's in general --
2 **A.** No.
3 **Q.** -- because you wanted to remain impartial?
4 **A.** Yes.
5 **Q.** Could we go please to INQ0007482 and to
6 page 68, please. Thank you.
7 So this is an extract of a police interview that
8 was given by you as part of Operation Hummingbird.
9 Can you see about two-thirds of the way down, it
10 says:
11 "We went to London on an outing and Lucy was
12 there."
13 **A.** Yes.
14 **Q.** "What was that for?"
15 "I think we went to see The Bodyguard."
16 **A.** We did.
17 **Q.** So if we go down to the next page, we are
18 attempting to pinpoint the date, you say, "Before
19 2015?", you were asked. And you say, "Yeah." And then
20 you say, "I think it could be in 2013."
21 So in 2013 you went on a trip with other neonatal
22 nurses and Lucy Letby?
23 **A.** Yes, there were a few of us there.
24 **Q.** To London to see The Bodyguard?
25 **A.** Yes.

1 **Q.** Again, did you invite all neonatal nursing
2 staff to accompany you on trips to London?
3 **A.** To accompany me?
4 **Q.** Or just a select few?
5 **A.** Sorry?
6 **Q.** Did you go on outings with all neonatal staff
7 to London or just a few?
8 **A.** Well, no, they were all -- it was, it was for
9 everybody.
10 **Q.** It was for the entire department?
11 **A.** Yes.
12 **Q.** You all went to see The Bodyguard?
13 **A.** Yes, but we didn't all go, obviously, somebody
14 has to stay behind to do the shifts.
15 **Q.** Then you talk about Lucy Letby at the bottom
16 of the page:
17 "I remembered them asking me what I thought of
18 Lucy, you know, as a person and I said, 'Well, she's
19 quirky'."
20 If we go on to the next page.
21 And you were asked:
22 "I think it was in a meeting that Ravi asked me, he
23 said, 'What do you think of her personality?' 'Well,
24 she's quirky, but then, like, so am I quirky. So, well,
25 actually if you went through the off-duty, through the

1 list, we are all quirky and that is why it works'."
2 Again, did you see a particular connection to
3 Letby?
4 **A.** Did I?
5 **Q.** See a particular connection to Letby?
6 **A.** No. We are all different but we are all --
7 I think it takes a certain personality to work on the
8 unit and yes, that's been quite evident. You know, over
9 the years that I've been there, it's -- it is the quirky
10 ones that actually survive the unit.
11 **Q.** This fits with the suggestion, though, doesn't
12 it, you saw her as like yourself, that you were --
13 **A.** No.
14 **Q.** -- she was a favourite of yours?
15 **A.** Quirky is different from the norm as in
16 perhaps sees things a little bit differently.
17 **Q.** You see, the fact of the matter is that when
18 it came to Lucy Letby you favourited her, you gave her
19 favourable treatment?
20 **A.** No, not at all. Not in the slightest.
21 **Q.** If we look at how you behaved towards people
22 you took a dislike to, if we look at page 92, please.
23 So about halfway down, you say:
24 "We had one member of staff that she was not safe
25 and we had her gone within weeks. We had supervised" --

1 "Who was that?"
2 "Oh, that was years ago, that was 2011."
3 **A.** Yes.
4 **Q.** "Right? She had a first in a degree".
5 **A.** Yes.
6 **Q.** "She was -- nobody failed her, nothing,
7 everything was grand, yes. She came in and she wasn't
8 doing something that was right and I said, Right, if she
9 can't see that we will have to pull her right back and
10 start again. Oh, she didn't like that. So she left.
11 Great haha."
12 **A.** Yes.
13 **Q.** What do you mean by "Great haha"?
14 **A.** Well, she -- it was a parent that came to
15 complain, came to the office and said that she hadn't
16 given the child oxygen when they desaturated and that
17 the parent had to take over from her. So when we went
18 there to discuss with her, I got Yvonne Griffiths --
19 Yvonne Farmer to actually have a word with her about her
20 dealing with desaturation and performance and that's
21 what Yvonne did.
22 **Q.** Is that less serious or more serious than
23 almost giving a baby a 10 times morphine overdose?
24 **A.** Yes, but in the context of things of a whole
25 unit, you can, there are so many drugs that are given

1 over a period of time, I mean, there is a picture on the
2 website that shows how many lines that a baby can
3 actually have and how much medication that child
4 requires, and they have the minuscule amount over
5 a tiny -- they will have micrograms given over a period
6 of maybe 20 minutes, half an hour, over an hour, and it
7 actually is -- it is extremely difficult to actually get
8 it right all the time.
9 **Q.** No, it isn't, it is a very basic exercise in
10 making sure you put the right figures in the syringe
11 driver and if you get it wrong the baby dies.
12 **A.** Well, yes, but what I am trying to say is in
13 the context of doing medications, if you looked at other
14 units and see what their medication, that's why they do
15 guardrails, that is why they make a lot of money out of
16 you using guardrails on the Alaris pumps, is because it
17 actually helps those errors not happening. It only
18 takes a lapse of concentration and when you have got
19 things going on all the time and you are busy, it is
20 very difficult.
21 **Q.** You see, you will make every excuse for Letby
22 but this nurse was straight out the moment she made
23 a mistake, wasn't it?
24 **A.** But she didn't like being told that what she
25 did was wrong.

1 **Q.** Yes, so there was a clash of personalities
2 with you and she was gone?
3 **A.** I didn't, I didn't speak to her. It was
4 Yvonne Farmer that spoke to her.
5 **Q.** Was it -- did you find it particularly funny
6 that she had to leave?
7 **A.** No, I didn't.
8 **Q.** Why are you laughing --
9 **A.** I just thought it was a relief that it was,
10 just -- you can't have somebody who can't take the
11 criticism.
12 **Q.** So why does it say, "Great haha" at the end of
13 your quote at the top?
14 **A.** It's taken ...
15 **Q.** I'm sorry, I couldn't hear that?
16 **A.** It's taken it out of context. It's -- it's
17 not "Great haha". It's great that it's not -- it's
18 a relief that it's not a problem.
19 **Q.** You see, I suggest that when people make the
20 observation that you had favourites and if you weren't
21 a favourite, life could be made difficult for you,
22 that's borne out there, isn't it?
23 **A.** I don't think so. I think that is very
24 unfair.
25 **Q.** How did you view the doctors, the relationship

1 between doctors and nurses?
2 **A.** It was very good. On the whole.
3 **Q.** Could we look at document INQ0003166.
4 So this is a document you have already been taken
5 to. It is an interview, a grievance interview that was
6 conducted.
7 If we could go to page 2 of that document, please.
8 So the second paragraph at the bottom there, you are
9 recorded as stating that you believe that Letby is 100%
10 innocent.
11 Now, you knew at the time of making that statement
12 or your evidence today is at the time of making that
13 statement you were aware that there had been an
14 incomplete investigation and that there wasn't all the
15 evidence available to you and that you felt slightly
16 concerned about the quality of the investigation and,
17 indeed, Lucy Letby's email saying she was coming back.
18 Now, how does your evidence today fit with this
19 statement, that you believed she was 100% innocent?
20 **A.** Well, I couldn't believe that she had done it?
21 **Q.** That is a different -- an answer to
22 a different question.
23 Here you have expressed the view that Letby is 100%
24 innocent.
25 **A.** Yes.

1 **Q.** Yes.
2 Further down in this document, forgive me a moment,
3 so this is on page 4 of the document and it's the final
4 box. So:
5 "How would the Consultants respond to Letby coming
6 back?
7 "Not good. Equality doesn't run both ways.
8 Brainwashed other Consultants."
9 Who are you suggesting has brainwashed the other
10 Consultants?
11 **A.** Well, once somebody sort of suggests
12 something, then it runs a bit like wild fire.
13 **Q.** Well, you are suggesting that Stephen Brearey
14 and Ravi Jayaram have brainwashed the other Consultants;
15 it is very emotive language, isn't it?
16 **A.** No, I know, but at the time we didn't think
17 that this was going to -- that I had to watch what I was
18 saying and how I was saying it.
19 **Q.** Well, doesn't this tell us this much: that
20 there are very clear battle lines drawn here between the
21 doctors and the nurses and that you are very much in the
22 camp of the nurses criticising the doctors?
23 **A.** Well, no, not really. It was just there was
24 double standards. The doctors were treated differently
25 to nurses. We were told we couldn't do certain things,

1 doctors did them, and they actually carried on doing it.
2 **Q.** Well, do you think that, again, reveals
3 a 'them and us' attitude towards staff who weren't
4 nurses? You had that attitude and possibly still do?
5 **A.** Well, no, because we had a good relationship,
6 not all Consultants, I mean, we were lucky with our
7 Consultants in certain respects but they did have their
8 moments where they were allowed to scream and shout at
9 the staff and it was accepted as, well, that's fine,
10 he's a Consultant.
11 **Q.** Well, screaming and shouting about their
12 concerns that one of your staff is a murderer --
13 **A.** No, that wasn't just concerns, that wasn't it,
14 he was a surgeon. This, this is different.
15 The behaviour on the unit, on, with staff.
16 **Q.** Your evidence before the Inquiry is that you
17 were a mediator, that you were somebody who was being
18 objective, who was standing back, and this is the
19 complete opposite, isn't it, you are very much shouting
20 the odds on behalf of the nurses here, aren't you?
21 **A.** No, I was answering a question. When they
22 asked me what did I think, and I would say, well, there
23 is the commonality, she does supernumerary, she works
24 full time. I was being honest each time. Why would
25 I lie? If I would have lied it would have made, made it

1 a lot easier.
2 **Q.** You see, Letby was protected because she
3 occupied an intersection between two things: she was
4 a nurse who was being criticised by the doctors and she
5 was a nurse who you liked and that's why she was
6 protected, isn't it?
7 **A.** I think you are mistaking liking with actually
8 supporting your staff.
9 **Q.** Can I go to suspicions and whether they were
10 raised. You have been asked a little bit about this and
11 I just want to clarify one point about an email.
12 So it is INQ0025743. So this is an email you have
13 seen already. It begins on the next page, or the email
14 chain begins on the next page.
15 It's an email from John Gibbs:
16 "Rachel Lambie came to see me this morning, I think
17 because I was the only person in the office and she says
18 Registrars are very concerned about recent neonatal
19 deaths from collapses (Child B) where all the infants
20 showed strange purpuric looking rash."
21 Now, this is a reference to concerns regarding A,
22 B, C and D, isn't it, and if we go up to the next page,
23 we can say -- I will reorientate myself on the screen --
24 we can see that there is an email from Stephen Brearey
25 at 10.55 on 23 June, towards the bottom of the page:

1 "Hi John and Liz I have reviewed Child D's care
2 with Eirian yesterday and looked to see if there are any
3 common threads in the deaths."
4 Were you made aware that the Registrars and,
5 indeed, doctors were concerned about the deaths of A, C,
6 and D but also the collapse of B?
7 **A.** No.
8 **Q.** Are you sure about that?
9 **A.** Well, not -- not that I can recall, no.
10 **Q.** Is a collapse in this sense not something that
11 should also have been looked at in the context of the
12 neonatal review that was carried out or begun and that
13 you took part in, in October --
14 **A.** Well, we subsequently did do that afterwards.
15 But what -- yes, later than this.
16 **Q.** Yes, but when you were looking at events and
17 you began your chart in October 2015, should that chart
18 not have also included collapses?
19 **A.** Well, on reflection, yes.
20 **Q.** Because a collapse is only really
21 differentiated from a death --
22 **A.** Yes.
23 **Q.** -- by the fact that you resuscitate the baby?
24 **A.** Yes.
25 **Q.** And I think you have described in a police

1 statement a collapse as being, effectively,
2 a respiratory arrest from which a baby is resuscitated?
3 **A.** Yes.
4 **Q.** Now, if you'd looked at collapses as well, you
5 would have looked at A and B but you would also have
6 looked at E and F, wouldn't you?
7 **A.** Yes.
8 **Q.** Because E and F were twins and A and B were
9 twins -- if you want to check the references.
10 **A.** Yes.
11 **Q.** Yes. So in looking at A and B as twins, you
12 would also have looked at E and F as twins and, of
13 course, if you had investigated F then there would have
14 been a review of F's medical records and it would have
15 revealed that F had received an insulin, exogenous
16 insulin overdose, wouldn't it?
17 **A.** Yes.
18 **Q.** If you had been aware that one of the babies
19 had been given insulin, which wasn't prescribed to them,
20 that would have started alarm bells ringing, wouldn't
21 it?
22 **A.** Yes, yes.
23 **Q.** Do you think, on reflection, alongside all the
24 other points that have been put to you today, that not
25 including the collapses alongside the deaths was

1 a missed opportunity to find the answer to what was
2 happening?
3 **A.** Yes.
4 **MR BAKER:** Thank you, my Lady, I have no more
5 questions.
6 **LADY JUSTICE THIRLWALL:** Thank you very much,
7 Mr Baker.
8 Questions by LADY JUSTICE THIRLWALL
9 **LADY JUSTICE THIRLWALL:** I gather there are no
10 further questions from anyone else? No. Thank you.
11 I just have two short questions about something
12 that you mentioned very early on, the first of which you
13 mentioned very early on. You were asked about Advanced
14 Nurse Practitioners, do you remember that, quite early
15 in the evidence this morning?
16 **A.** Yes.
17 **LADY JUSTICE THIRLWALL:** And you said that you
18 thought they were a good idea and you have told us about
19 how they are currently being brought on within the unit.
20 **A.** Yes.
21 **LADY JUSTICE THIRLWALL:** And we have heard some
22 evidence about that, but you told us that earlier
23 that -- you said, "We lost two of our Advanced Nurse
24 Practitioners." Can you help me as to when that was,
25 approximately?

1 **A.** It was quite a while back.
2 **LADY JUSTICE THIRLWALL:** Was it at about the time
3 of the restructuring which was 2015, I think?
4 **A.** No, no, we lost them --
5 **LADY JUSTICE THIRLWALL:** Was it before that?
6 **A.** -- way before then.
7 **LADY JUSTICE THIRLWALL:** 2009?
8 **A.** It's more in keeping with -- possibly even
9 earlier than that.
10 **LADY JUSTICE THIRLWALL:** And what was the reason
11 why they were lost, as you put it?
12 **A.** Financial more than anything.
13 **LADY JUSTICE THIRLWALL:** So they were made
14 redundant?
15 **A.** Yes.
16 **LADY JUSTICE THIRLWALL:** I see.
17 **A.** One was brought back on. She actually went
18 elsewhere and the other one was made redundant.
19 **LADY JUSTICE THIRLWALL:** So it was for financial
20 reasons for the Trust?
21 **A.** Yes.
22 **LADY JUSTICE THIRLWALL:** And were they replaced by
23 more junior nurses?
24 **A.** No. Well, it would be a Band 6. They would
25 be replaced, but I can't recall whether they were.

1 **LADY JUSTICE THIRLWALL:** No. All right. Thank
2 you.
3 The second question I have is about phones and
4 obviously in 1982 when you started there weren't any
5 mobile phones.
6 **A.** No.
7 **LADY JUSTICE THIRLWALL:** It seems unbelievable now
8 but there weren't.
9 I understand the point you make about people not
10 gossiping on their phones or messaging on their phones
11 while they are at work. Before mobile phones were
12 everywhere, did nurses, did you as a young nurse, talk
13 to each other about patients?
14 **A.** No. Not on the phone, no.
15 **LADY JUSTICE THIRLWALL:** Not on the phone. You
16 wouldn't ring somebody up to do that?
17 **A.** But sometimes we'd ring the ward, say, if we
18 would have been on the night shift or the day shift and
19 we would have gone home and we thought, well, I
20 wonder --
21 **LADY JUSTICE THIRLWALL:** You wanted to know how
22 they were getting on.
23 **A.** Were they okay, we would ring up and just ring
24 the unit and, and ask. They wouldn't give much
25 information other than "Yes, he's doing fine."

1 **LADY JUSTICE THIRLWALL:** Yes, I understand. And so
2 when you were on the ward, presumably you would talk to
3 each other about the babies when there was time to do
4 that, if you wanted to, or did you not?
5 **A.** Well, only if it was relevant and pertinent to
6 that child or the patients.
7 **LADY JUSTICE THIRLWALL:** What do you mean?
8 **A.** You mean, when we were on the unit?
9 **LADY JUSTICE THIRLWALL:** Yes.
10 **A.** We would talk about other babies, you mean?
11 **LADY JUSTICE THIRLWALL:** Yes, whether you would
12 talk to each other about the babies you were caring for?
13 I haven't got a view one way or other I am just trying
14 to work out --
15 **A.** No, I'm just trying -- no, not necessarily
16 unless we had a problem or we wanted some help or -- no,
17 not necessarily, no.
18 **LADY JUSTICE THIRLWALL:** I'm just trying to see
19 what it is that people use their mobile phones for that
20 people didn't talk about before --
21 **A.** Yes.
22 **LADY JUSTICE THIRLWALL:** -- when they didn't have
23 mobile phones.
24 **A.** And the handover was quite clear. The
25 handover sheet and the handover that you had at the

1 board was, well, you know, when you went to have your
2 handover you got an inkling of what was --
3 **LADY JUSTICE THIRLWALL:** What was going on.
4 **A.** What was going on, yes.
5 **LADY JUSTICE THIRLWALL:** Thank you.
6 And so far as chitchat and gossip, I am not going
7 to ask you whether there was any of that on the ward,
8 I assume there would have been. But that's the thing
9 you really are very clear about that that's -- people
10 shouldn't be using their mobile phones to gossip --
11 **A.** No, they shouldn't be using their mobile
12 phones for personal use. The only exception that came
13 later on was the translation because we had a lot of
14 Polish ladies.
15 **LADY JUSTICE THIRLWALL:** Yes, you told us about
16 that. That was quite useful, I imagine.
17 **A.** Yes.
18 **LADY JUSTICE THIRLWALL:** Yes. Thank you.
19 Does anyone have any questions arising out of those
20 points?
21 Thank you very much indeed, Ms Powell, you are free
22 to go now.
23 **A.** Okay, thank you. Do I take these with me?
24 **LADY JUSTICE THIRLWALL:** If you would like to or
25 you can leave them and someone will pick them up. You

1 are free to go.
2 Now, Ms Langdale, next week I think we are sitting.
3 **MS LANGDALE:** Monday and Tuesday.
4 **LADY JUSTICE THIRLWALL:** Monday and Tuesday only.
5 And then we will rise and have the following week as
6 a break week, a break from evidence rather than a break
7 from the Inquiry.
8 All right, thank you all very much indeed. We will
9 reconvene Monday morning at 10 o'clock.
10 **(4.27 pm)**
11 **(The Inquiry adjourned until 10.00 am on Monday,**
12 **21 October 2024)**
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