

Monday, 21 October 2024

(10.00 am)

**LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.

**MR DE LA POER:** My Lady, the first witness for today is Anne Murphy, please.

**LADY JUSTICE THIRLWALL:** Very good. Ms Murphy, would you come to the table, please.

MS ANNE MURPHY (sworn)

Questions by MR DE LA POER

**LADY JUSTICE THIRLWALL:** Thank you, Ms Murphy, do sit down.

**A.** Thank you.

**MR DE LA POER:** Please could you give us your full name?

**A.** Sorry, could you just repeat that?

**Q.** Of course. Please could you give us your full name?

**A.** Mrs Anne Murphy.

**Q.** Mrs Murphy, is it right that you gave a witness statement to the Inquiry dated 7 June 2024?

**A.** Yes, that's right.

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

**A.** Yes, it is.

1

**A.** Yes.

**Q.** Did Nurse Eirian Powell report directly to you as her line manager?

**A.** Yes, she did.

**Q.** You describe yourself in your statement as having overarching responsibility for all children's services; is that correct?

**A.** Yes, yes.

**Q.** Just so that we are clear about what that means, you had management responsibility not just for the children's unit and neonatal unit, but also various community-based children's services; is that right?

**A.** Yes.

**Q.** Finally by way of introduction, did you retire from nursing in 2018?

**A.** Yes.

**Q.** So we are going to turn now to 2015 and we are going to just look at an organogram that you mention in your witness statement and identify some of the personnel on it, please.

The reference is INQ0002594. That will come up on the screen in front of you. We don't need to look at every aspect of this but this is a document that you are familiar with; is that right?

Mrs Murphy, I think you produced this in your

3

**Q.** I am going to begin by introducing your background. Did you qualify as a nurse in 1977?

**A.** Yes.

**Q.** Did you move to the Countess of Chester Hospital in 1985?

**A.** Yes.

**Q.** Since moving there, did you work in various children's based departments?

**A.** Yes.

**Q.** As part of the Agenda for Change banding in 2004, were you banded as a Nurse Consultant?

**A.** Yes.

**Q.** And having held various leadership roles with different names in 2011, was your job title Lead Nurse for Children's Services?

**A.** Yes, it was.

**Q.** At some point prior to 2015, did the neonatal unit come under your remit?

**A.** Yes. It did, it came under the child health children's services. But my main responsibility was for the ward, the manager of the children's -- of the neonatal unit.

**Q.** You say your main responsibility, just so that we understand the position correctly, did you have a supervisory role over the neonatal unit?

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witness statement?

**A.** Yes.

**Q.** So we just have a look at the top. It's dated 15 January 2015 and you are going to make a comment I think about one of the personnel involved, namely Jane Evans but before we get to Ms Evans, we can see that Karen Townsend sits at the top of the division; is that right?

**A.** Yes, but to my recollection in January 2015 it was actually Jane Evans.

**Q.** Well, I think that Jane Evans held the equivalent role to Karen Rees?

**A.** Yes, she did.

**Q.** So not Karen Townsend who is --

**A.** Sorry, Karen Townsend, yes, it was, it was --

**Q.** It is just being highlighted.

**A.** Divisional.

**Q.** Head of the division?

**A.** Yes.

**Q.** Then if we come down to the next layer of management and follow the nursing line, we can see Karen Rees who is identified there as head of nursing. Now, you are quite right looking at the evidence that we have from Karen Rees and from Jane Evans, the position appears to be that until August or September of 2015,

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1 Jane Evans was the head of nursing?

2 **A.** Yes.

3 **Q.** And Karen Rees took over from her, I will just  
4 let you know what they say in their statement because  
5 this is going to be important to a piece of your  
6 evidence in a moment.

7 Karen Rees says in her witness statement -- she is  
8 of course giving evidence this afternoon -- that she  
9 took over that role in August 2015, Jane Evans says that  
10 she gave notice in August but didn't in fact leave the  
11 role until 30 September 2015.

12 But she also says she was on annual leave for much  
13 of that period and that there was a period of handover.  
14 So it appears that by 30 September everybody agrees  
15 Karen Rees was in position.

16 So I hope that helps your recollection because we  
17 are going to have a look at the timeline as to who you  
18 were speaking to at different times.

19 **A.** Yes.

20 **Q.** So if we consider that now and focus on  
21 Jane Evans who held that role until 30 September, you  
22 say in your witness statement that you have a -- and  
23 I am quoting you here -- vague recollection of speaking  
24 to Jane Evans with Eirian Powell about the increase in  
25 mortality on the neonatal unit.

5

1 was slightly unusual for the neonatal unit to have  
2 a spate of deaths all at once.

3 **Q.** So does that fit with your thinking following  
4 the death of Child E in August of 2015 that you regarded  
5 the neonatal unit as experiencing something unusual?

6 **A.** Well, it was certainly not something that was  
7 or had been in the past that there were several more  
8 than -- than normal, certainly.

9 **Q.** Were you meeting Jane Evans regularly or did  
10 you go to see her specifically about this issue, do you  
11 know?

12 **A.** No. We had a monthly one-to-one with  
13 Jane Evans so it wasn't specific, I don't think, to --  
14 to the occurrences on the neonatal unit.

15 **Q.** And you say "we". Was Eirian Powell also  
16 attending that one-to-one that you went to?

17 **A.** It -- it was all of the, the staff who were in  
18 a management position. So it was Eirian, myself,  
19 Anne Martyn, who's manager of the Children's Unit, and  
20 Sarah Jackson who was manager of the community  
21 children's packages.

22 **Q.** So it was in the context of one of those  
23 one-on-one meetings with your immediate line manager  
24 that you think you drew attention to the fact that the  
25 neonatal unit was experiencing something unusual?

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1 So if we just have a think about that for a moment  
2 and I will just try and help you with it. We know that  
3 there were three deaths in June of 2015. There was then  
4 another death, that's Child E, at the beginning of  
5 August.

6 Do you think it was following those four deaths  
7 that you would have had a conversation with Jane Evans?

8 **A.** Yes, I would, I would have assumed that it  
9 would have been something that we would have highlighted  
10 to Jane Evans; that there had been a series of infant  
11 deaths.

12 **Q.** Obviously there is a difference between having  
13 a positive recollection of something and assuming that  
14 you would have done something because that's how you  
15 would normally act. Can we just be clear here.

16 Do you have a recollection of having spoken to  
17 Jane Evans?

18 **A.** I have a recollection that we did speak to  
19 Jane Evans but I couldn't be absolutely certain about  
20 that.

21 **Q.** And are you able to say anything beyond what  
22 you have just said about what it was that you said to  
23 Jane Evans?

24 **A.** I think that we would have said that you know  
25 there had been a -- a number of, of baby deaths which

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1 **A.** Yes.

2 **Q.** So that's all that I want to ask you about  
3 Jane Evans, unless you have any other recollection of  
4 that discussion or anything that arose from it?

5 **A.** Not as far as I am aware.

6 **Q.** Well, we will come back to the timeline in due  
7 course. Thank you very much. We can take this down.

8 **LADY JUSTICE THIRLWALL:** Mr De La Poer, just before  
9 you move on, I just wonder if I can clarify something in  
10 my own mind?

11 **MR DE LA POER:** My Lady, of course.

12 **LADY JUSTICE THIRLWALL:** Mrs Murphy, I just want to  
13 understand how many people were at the meeting because  
14 it's mentioned as a one-to-one which I assumed was one  
15 person and one manager. But you refer to "we".

16 **A.** There could have been one or there could have  
17 been four of us there, it would depend, and occasionally  
18 if there was something untoward we might have or I might  
19 have asked to stay behind or, you know.

20 So it may have been that that we informed Jane  
21 after the meeting but stayed behind and let the other  
22 two managers go. So -- but not all of us could attend  
23 every month, you know, so it could have been two or four  
24 of us that were there.

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

8

1 Thank you, Mr De La Poer.

2 **MR DE LA POER:** So we are just going to talk  
3 generally now about your impression of the neonatal unit  
4 and in particular in early 2015, so before those unusual  
5 deaths as you have described them, the first four,  
6 occurred.

7 What was your view about how well that department  
8 was functioning at early 2015?

9 **A.** Are you asking me prior to the infant deaths?

10 **Q.** Yes.

11 **A.** *(Redacted)*. But prior to that, the neonatal  
12 unit was a well run unit. They didn't appear to have  
13 a lot of problems. They often had staffing issues  
14 relating to the acuity of the patients.

15 So they -- they may well have needed additional  
16 staff at times for, to look after the babies. But  
17 generally, it was well run, the staff were always very  
18 friendly and, you know, they seemed to get along very  
19 well. They -- they managed to get the, you know,  
20 mandatory training and things all done so that from  
21 a management perspective that was fairly well completed.

22 And -- and, you know, from the perspective of the  
23 people that actually went to the unit to visit or who  
24 were working there from a medical and a nursing  
25 perspective, everyone appeared to get on very well.

9

1 lead --

2 **A.** Yes, yes.

3 **Q.** For the children's, you were lead for nursing?

4 **A.** At that time, yes, he was the Lead Clinician.

5 **Q.** What was your relationship with him?

6 **A.** I -- I believe it was very good, you know,  
7 there were -- we didn't have an issue at all.

8 **Q.** Dr Stephen Brearey who was the lead for the  
9 neonatal unit, did you have experience of working with  
10 him and seeing how he worked with others?

11 **A.** From a paediatric perspective, I worked  
12 with -- with Steve Brearey. I didn't have a lot of  
13 contact with Steve from a neonatal perspective, so  
14 I didn't -- I didn't work within neonates as, as  
15 a professional nurse.

16 So I didn't have the experience of making a comment  
17 about Steve within the neonatal unit working area. But  
18 I know from my work with him in the paediatric area, you  
19 know, that he was a very good clinician.

20 **Q.** It wasn't being reported to you that he was  
21 any different in the neonatal unit?

22 **A.** No, no.

23 **Q.** So you have mentioned the phrase "little  
24 bubble".

25 **A.** Yes.

11

1 **Q.** Presumably you had regular meetings with  
2 Eirian Powell who you managed directly?

3 **A.** Yes.

4 **Q.** Did she ever report to you any problems with  
5 relationships as between nurses or as doctors and nurses  
6 or as between doctors?

7 **A.** No, not at all.

8 **Q.** Did you have experience of working with the  
9 doctors yourself or seeing them work with the staff on  
10 the children unit?

11 **A.** On the children's unit, yes.

12 **Q.** What was your impression of the Consultant  
13 body?

14 **A.** The Consultant body were, you know, very, very  
15 good. We didn't have any real issues with any of the  
16 Consultants. Everyone did get along.

17 I think, you know, from a paediatric and neonatal  
18 perspective, we were sort of in our own little bubble  
19 I suppose a lot of the time, segregated from the rest  
20 the Trust, and because -- I think because we worked with  
21 children and families we are quite different to looking  
22 after adult patients.

23 **Q.** Your medical equivalent was Dr Ravi Jayaram so  
24 he was the equivalent to your role but in a medical  
25 perspective. Would you agree with that, he was the

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1 **Q.** There I understood you to be referring to the  
2 fact that the Children's Unit and the neonatal unit were  
3 to some degree separate from other parts of the  
4 hospital. Am I right to understand you to mean that?

5 **A.** Yes. The -- the staffing were, were different  
6 and they didn't, the neonatal unit didn't share the same  
7 coffee area as the paediatric nurses because they  
8 were -- once they got to work they were maintained  
9 within that area and, you know, for infection control  
10 reasons, really.

11 **Q.** I understand. So the two units were not --  
12 they were separate from each other to some degree?

13 **A.** Yes.

14 **Q.** But of course they had the same Consultants  
15 serving both?

16 **A.** Yes, yes.

17 **Q.** So was that separation more from a nursing  
18 perspective rather than a doctor perspective?

19 **A.** Yes. It was more from a nursing, although if,  
20 if the neonatal unit was busy then the paediatric nurses  
21 would go to help with the neonatal, with the special  
22 care element of the -- the neonatal unit.

23 So we, we did share resources if there was a need.

24 **Q.** Now, the Inquiry has heard something about the  
25 change in divisional structure at the hospital before

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1 2015, which placed the paediatric department into  
2 including neonates, into the Urgent Unplanned Care,  
3 whereas the obstetrics was in the Planned Care Division.

4 From your perspective as the nursing lead for  
5 paediatrics, what was your view about whether that  
6 divisional structure worked or didn't work?

7 **A.** I think from my perspective, it -- it was  
8 difficult because we had been Women and Children's  
9 Directorate originally. But obviously it was a Trust  
10 decision to -- to then separate. It didn't have a major  
11 effect within paediatrics, but certainly from a neonatal  
12 perspective it -- it could have led to problems really  
13 being in two different directorates.

14 **Q.** So do you want to just help us, when you say  
15 "could", we are here not just looking for a list of  
16 every theoretical one, do you know of any difficulties  
17 that that change in division or structure caused for the  
18 matters that the Inquiry is investigating?

19 **A.** I think from a clinical incident perspective,  
20 the risk levels were -- were different.

21 So there was a risk midwife, or I think it was  
22 classed as a risk midwife which -- which eventually she  
23 was also the risk lead for paediatrics as well. But  
24 from a paediatric perspective, we -- we didn't feel that  
25 that was the best for -- for paediatrics.

13

1 meeting. But we did have the opportunity obviously  
2 to -- to take paediatric policies there for sign-off.  
3 All of the clinical incidents would then be discussed at  
4 that meeting as well, any investigations that had been  
5 carried out, things like that.

6 But it was -- there was a lot of issues discussed  
7 at that meeting which were probably just, yes, yes, yes  
8 to -- you know that -- they had this incident and it was  
9 being looked at by the risk team. Things like that.

10 So it was more of a sign-off committee than -- than  
11 very much a working party.

12 **Q.** Did you feel that it scrutinised problems  
13 which were raised at it?

14 **A.** I don't think scrutiny would have been the  
15 right word, no. So -- so possibly it wasn't.  
16 Paediatric or neonatal incidents weren't necessarily  
17 scrutinised, no.

18 **Q.** Just looking back on it, do you think that  
19 that was the place for them to be scrutinised?

20 **A.** Yes, perhaps it should have been the combined  
21 group that were scrutinising, but I -- I think that  
22 after the local level incident group meetings, they went  
23 to the risk management team and a lot of it was then  
24 decided what level the incidents et cetera were.

25 So they would then come back to local level with it

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1 There was obviously a much greater link between  
2 neonates and the midwives because obviously they had  
3 a link to the central labour suite and the support was  
4 there. Should there be a delivery that needed  
5 assistance, they would get immediate help from the  
6 neonatal.

7 So the risk element were in some respects more  
8 combined from a neonatal perspective with the midwives  
9 than it would have been from a paediatric element.

10 **Q.** We will be hearing from people who undertook  
11 that role I think tomorrow.

12 As the Inquiry understands it, because of the  
13 separation of obstetrics and neonates into two separate  
14 divisions to try and keep those together in some forum,  
15 the Women's & Children's Care Governance Board was  
16 created; is that correct?

17 **A.** Yes.

18 **Q.** And you were an attendee of the  
19 Women's & Children's Care Governance Board; is that  
20 right?

21 **A.** Yes.

22 **Q.** Did you regard that as an effective forum for  
23 ensuring good governance?

24 **A.** Well, I think that there was quite a lot of  
25 issues that were very maternity-led discussed at that

14

1 being graded at whatever level.

2 **Q.** Then once -- so it's started at the local  
3 level, it's gone sideways to risk to have an assessment  
4 made, it's come back to the local level then it goes up  
5 to the governance board. What was the governance board  
6 then doing with that information?

7 **A.** From an incident perspective, I think they  
8 were just discussing it and looking at the data, how  
9 many incidents there had been, what effect there had  
10 been.

11 **Q.** If there had been concern about a particular  
12 member of staff, would it be appropriate to raise that  
13 concern, even if not naming the member of staff, at that  
14 governance board meeting?

15 **A.** I couldn't say that at some stage that that  
16 wasn't highlighted. I -- I can't really remember  
17 whether there was ever the time that that did occur.  
18 But there may well have been a time when we did take  
19 that to the governance board and say, you know, that  
20 because there had been a lot of neonatal deaths, it may  
21 well.

22 **Q.** So --

23 **A.** And, you know, I suppose by August -- December  
24 time, you know, the Consultants certainly were raising  
25 concerns.

16

1 Q. So by December of 2015?  
 2 A. Yes, sorry. Yes.  
 3 Q. Yes. So in your mind, because you think it  
 4 may have been raised, it would have been appropriate to  
 5 do so at that meeting?  
 6 A. Yes, it -- it probably should have been raised  
 7 at that meeting at some stage.  
 8 Q. So we are going to look at specific meetings  
 9 of that governance board as we work our way through the  
 10 chronology. I would just like to start by, as we turn  
 11 to look at it, working out just when it was that you  
 12 first became aware of concerns about a member of staff.  
 13 So obviously there are a number of concerns, you  
 14 have already told us that by August after the death of  
 15 Child E you had identified that it was unusual how many  
 16 deaths there had been on the neonatal unit. So  
 17 by August that was on your radar; is that fair?  
 18 A. Yes.  
 19 Q. We will start a little before that as we work  
 20 our way through and begin at 29 June 2015. So  
 21 INQ00036974 which, my Lady, is at your tab 4. I can  
 22 give that again if that helps INQ00036974.  
 23 It's Monday 29 June as you can see at the top and  
 24 it's labelled as the senior clinicians meeting and you  
 25 are identified on the list of those present at the third

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1 aware of.  
 2 Q. Well, we have got --  
 3 A. But I was obviously at that meeting, yes.  
 4 Q. We have got these -- so, I mean, are you able  
 5 to say that that record is wrong; that that wasn't  
 6 discussed in your presence and that --  
 7 A. No, no. Certainly not. I am sure that that  
 8 was actually factually correct at that time.  
 9 Q. I mean, just in terms of the approach that you  
 10 would have taken to that sort of information, this is  
 11 a concern being raised where there are Consultants  
 12 present about Registrars.  
 13 You were there as the lead nurse for children's  
 14 services. Is that something that you would have paid  
 15 attention to and been concerned about yourself or would  
 16 you have thought "that's a doctor problem, I don't need  
 17 to worry about it"?  
 18 A. I -- I think that it would have been -- the  
 19 Consultants would have been dealing with that issue, but  
 20 I would probably have gone back and asked if, you know,  
 21 there were any concerns within the staffing element of  
 22 the neonatal unit, had any of the staff voiced any  
 23 concerns from a nursing perspective.  
 24 Q. Now, the Inquiry has received some evidence  
 25 that the nurses were at the very least upset about the

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1 entry. Do you see that?  
 2 A. Yes.  
 3 Q. If we go over the page, please, to the fourth  
 4 paragraph, we can see discussed at this meeting:  
 5 "There was also an issue raised around the fact  
 6 that with the three recent neonatal deaths the  
 7 Registrars had been quite worried and felt that nothing  
 8 is being done. Behind the scenes reviews are going on  
 9 but it was felt that formal debriefs should probably  
 10 take place rather than any specific meeting to discuss  
 11 all three."  
 12 So that's being raised at that meeting following  
 13 the deaths of Child A, Child C and Child D. Those are  
 14 the three deaths that are being referred to?  
 15 A. Right.  
 16 Q. Do you have a recollection of a discussion  
 17 about those three deaths and the fact that the  
 18 Registrars were concerned?  
 19 A. No, I -- I can't remember actually hearing  
 20 that the Registrars were concerned, that any of the  
 21 Registrars had been concerned. But it would depend on  
 22 the context of -- of what their concerns were, really.  
 23 Q. Well, as recorded there --  
 24 A. To my -- to my knowledge it was the -- it was  
 25 Dr Brearey who raised the concerns that -- that I was

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1 three deaths that had occurred. Do you have any  
 2 recollection of speaking to your nursing colleagues  
 3 following this meeting and finding out whether they,  
 4 like the doctors, were worried that not enough was being  
 5 done?  
 6 A. I -- I can't recall speaking to the nurses  
 7 personally. I would have spoken to Eirian and, you  
 8 know, generally said to the nurses: are you all right?  
 9 But I can't recall sitting down with any of those  
 10 nurses. That would have been either Eirian or her  
 11 deputy or the practice development nurse if -- if they  
 12 were raising concerns themselves.  
 13 Q. So we can take that down and we can move  
 14 forward a month to 20 July. INQ0017282.  
 15 So this is marked as a paediatric specialty  
 16 meeting. The list of invitees is rather longer than the  
 17 previous meeting that we looked at which was the senior  
 18 paediatricians and if we look down the list, about  
 19 halfway down, we can see your name identified with you  
 20 marked as being in attendance. Do you see that?  
 21 A. Yes.  
 22 Q. Now, as part of your preparation for today  
 23 I hope you have had a chance to have a look at this  
 24 meeting?  
 25 A. (Nods)

20

1 Q. I am sure you will accept it from me that  
 2 there is no record within this meeting of those three  
 3 deaths being discussed or raised; is that fair?  
 4 A. Yes, that's probably true.  
 5 Q. Can we have a look at page 3, just to  
 6 understand something about the risk. "Governance Issues  
 7 Summary". Firstly, it says "No representative present".  
 8 Is that a reference meaning a representative from  
 9 the risk department?  
 10 A. Yes.  
 11 Q. Then there is a reference to risk registers,  
 12 "No risks to be added for paediatrics."  
 13 Then the NNU.  
 14 "Following QSPEC ROP will be added as currently  
 15 there is only one clinician able to access this on the  
 16 unit, there are implications to consider such as  
 17 utilising other units, other clinicians, et cetera."  
 18 Firstly can you help us with ROP?  
 19 A. It's -- it's a problem with neonates' eyes  
 20 that's caused by oxygenation. I think it is retinal --  
 21 I can't remember.  
 22 Q. Don't worry about it. The point is there is  
 23 plainly a discussion about that condition and how it  
 24 might be relevant to the risk registers.  
 25 Just helping us to understand this. We obviously

21

1 Q. So you saw that because it was a concern on  
 2 the medical side, on the doctor side, it would be for  
 3 them to raise it but from your perspective as a nurse  
 4 you didn't have anything to contribute on that point and  
 5 so not for you to raise?  
 6 A. No, other than if -- if there had been --  
 7 I mean, we may have discussed it had the clinical  
 8 incidents been highlighted at that meeting. The  
 9 specialty meeting was more of a business meeting than  
 10 a clinical meeting.  
 11 Q. But it did deal with governance issues because  
 12 we --  
 13 A. It did, yes, it did deal with governance  
 14 issues.  
 15 Q. We can see -- but is it your view that without  
 16 having the risk nurse there, that couldn't be progressed  
 17 in the way it might otherwise have been?  
 18 A. I don't think I can answer that whether it  
 19 would have been or not, really.  
 20 Q. Just one other matter to ask you about this  
 21 document.  
 22 If we go to page 5, please, this is more of  
 23 a general comment about what was being said at the time.  
 24 In the second to last bullet point, about two-thirds of  
 25 the way down the page, we can see a sentence beginning:

23

1 know that a month earlier there was a discussion about  
 2 Registrars being concerned you had had three deaths on  
 3 the neonatal unit in fairly quick succession.  
 4 Was this an appropriate meeting to discuss those  
 5 deaths or raise the fact that they had occurred?  
 6 A. I -- I think it may have been highlighted if  
 7 there had been the risk nurse there. She may well have  
 8 brought the data relating to the clinical incidents that  
 9 had been put in following each of those baby deaths and  
 10 there might have been discussion relating to those.  
 11 Q. But, I mean, I am not suggesting you were the  
 12 only one who was present at this meeting and the meeting  
 13 the previous month?  
 14 A. Yes.  
 15 Q. Obviously there were a number of doctors there  
 16 but you were present at the previous meeting, you knew  
 17 about the three deaths, you will have heard that the  
 18 registrars were concerned about it and what needed to be  
 19 done and a plan was required. Was this something that  
 20 you could have raised and said: well, I think this would  
 21 be a good forum for us to discuss this?  
 22 A. Well, because the nursing side had never  
 23 raised any concerns to me personally, then if -- if  
 24 there had been an issue then perhaps at that stage the  
 25 clinicians should have raised it, the paediatricians.

22

1 "General consensus that paediatrics is left to its  
 2 own devices and is not considered in financial matters."  
 3 The context is perhaps potentially relevant. But  
 4 it is a general remark about the attitude from those  
 5 outside paediatrics to it. Was that the view in 2015,  
 6 July, that paediatrics was effectively left to its own  
 7 devices and not taken into account in relation to the  
 8 money?  
 9 A. I think there the -- the Consultants were  
 10 obviously saying that they weren't given the opportunity  
 11 to attend the divisional board and that the business  
 12 case that had been put in, they didn't have the  
 13 opportunity to actually go and speak specifically about  
 14 the needs of -- of the paediatric service there, that  
 15 it -- it looks as if what was being discussed is that we  
 16 weren't involved in the financial side.  
 17 That ...  
 18 Q. And is that how the paediatrics department  
 19 felt generally, or is that just specific to this one  
 20 issue?  
 21 A. No, I think in general we did feel at times  
 22 that we were being let down in some way from the -- the,  
 23 you know, sort of divisional side or, you know, the  
 24 Executive side.  
 25 Q. So we can take that down, thank you very much.

24

1 So we now come to the moment in the chronology that  
2 we have already dealt with, which is your recollection  
3 although you have told us you are not sure, that  
4 following the death of Child E in August, you in  
5 a meeting that Eirian Powell may have been present spoke  
6 to your line manager Jane Evans about the increase in  
7 the deaths on the neonatal unit.

8 So that's where it fits in to what we are  
9 discussing. So clearly by that stage, you had concern  
10 that something unusual was happening; is that fair?

11 **A.** Well, it was unusual that there obviously had  
12 been a number of deaths. But there had been no high --  
13 concerns highlighted by nurses.

14 **Q.** So we will now have a look at  
15 Women's & Children's Care Governance board meeting on  
16 22 October and just so that we can absolutely understand  
17 what's been happening, we have had those four deaths  
18 that we have spoken about, all children named on the  
19 indictment, there were then two other deaths in  
20 September of non-indictment children and that's the  
21 background to the meeting that took place on 22 October.

22 We will bring up the INQ, INQ0003223.

23 Now, so that you understand where the other deaths  
24 fit into this, Child I died the day after this meeting,  
25 so that won't have been -- that death won't have been in

25

1 **A.** Yes, I think the -- it was more that these  
2 were the issues that were present at the time, what the  
3 clinical incidents had been and then in the background  
4 there would have been meetings taking place looking at  
5 the incidents themselves with the risk nurse, the  
6 neonatal unit.

7 So Eirian, Dr Brearey, at that time I think it  
8 would still have been Debbie Peacock who was the risk  
9 for -- for women and children's, so each of the  
10 incidents would have been discussed at unit level but  
11 this was just highlighting how many incidents had been  
12 in the last month or so far that year, whatever it -- it  
13 actually may have ...

14 **Q.** Did anybody attending this governance meeting  
15 have any responsibility to say "that sounds like a lot"  
16 or "I need to know more about that" or "what's being  
17 done about that?"

18 So in other words to think critically about the  
19 information that's being rehearsed and promote  
20 a discussion about it or does everybody just sit in  
21 silence, listen to the report and then move on?

22 **A.** I think that it would -- if there had been  
23 something that a particular member of -- of that board  
24 was concerned about, then there would have been the  
25 opportunity to raise it. But some of this was -- was

27

1 anybody's mind for obvious reasons although Child I had  
2 had a period of collapses prior to that. So that's the  
3 context.

4 We can see that you are identified fourth from  
5 bottom in the list as being present at the meeting and  
6 again you have had an opportunity to refresh your memory  
7 from these notes and we can just move through it one  
8 page after another so everybody can see the sort of --  
9 unfortunately every other page is blank, we can see  
10 pausing there, I am so sorry, neonatal is highlighted,  
11 47 incidents reported, 44 of which were clinical, two  
12 moderate harm incidents relate to neonates that sadly  
13 died.

14 So a reference to two deaths and the five top  
15 categories relate to seven babies with feeding problems,  
16 seven for delayed treatment, six deviation from policy,  
17 three equipment problems and three unexpected deaths.

18 So we have got those there.

19 As it's recorded there, that's just a list without  
20 any analysis or discussion or comment attached to the  
21 record of the meeting.

22 Is that how those meetings went in terms of just  
23 a rehearsal of bullet points as opposed to a discussion  
24 about what it all might mean and whether people should  
25 be worried about it?

26

1 literally the figures being put up on a screen and how  
2 many incidents there had been.

3 If there had been investigation carried out, then  
4 it -- it may well have been further discussed but the  
5 majority of the baby deaths were discussed at the  
6 morbidity and mortality group. So there were other  
7 groups that would have been concerned with literally  
8 looking at that specific incident.

9 **Q.** Absolutely and each of the baby deaths were  
10 the subject of at least one meeting considering them at  
11 a neonatal mortality meeting. But it's just trying to  
12 understand the governance role of this committee.

13 **A.** I -- I think it was more information  
14 gathering.

15 I -- I don't think there was a lot of time for  
16 discussing individual things. I -- I think that the  
17 discussions had taken place at other meetings.

18 **Q.** Well, let's move forward, please, to the day  
19 after this meeting. We know that Child I died at  
20 2.30 am on 23 October of 2015 and we are going to have  
21 a look at an email sent later that same day.

22 This is INQ0005609. We can see that at the end of  
23 the first cc line your name appears and we are going to  
24 just need to unpack this email so we will go through the  
25 different parts of it.

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1 The first sentence:  
 2 "Just to say that I have discussed the above with  
 3 Anne Murphy ..."  
 4 So a reference to you, do you agree, and  
 5 a discussion that took place before this email was sent?  
 6 **A.** I was obviously copied into this email and if  
 7 -- if she's put me in and named me, I am sure that  
 8 Eirian did actually discuss that issue. But I can't  
 9 recollect what that discussion was at this stage.  
 10 **Q.** Well, let's -- we can see when it says "I have  
 11 discussed the above", people often use that convention  
 12 to refer to the subject line of their email because that  
 13 appears above the text of the email and we can see the  
 14 subject line here is "Mortality 2015", that is the  
 15 second line down?  
 16 **A.** (Nods)  
 17 **Q.** So do you agree it appears that what  
 18 Eirian Powell is saying, she's had a conversation with  
 19 you before she sent this email about mortality in 2015.  
 20 **A.** Yes, she will have, I agree there.  
 21 **Q.** The next part is:  
 22 "... and on reflection it was decided to leave this  
 23 until Monday."  
 24 So again just trying to understand the ordinary  
 25 language that is being used here. Eirian Powell seems  
 29

1 decision-making was that it was all right to leave it  
 2 until the Monday.  
 3 **Q.** That's the natural reading of what this email  
 4 means.  
 5 **A.** But that is -- my only recollection is from  
 6 reading.  
 7 **Q.** Yes. So it appears just reading this email,  
 8 do you agree, that there was a discussion with between  
 9 Dr Brearey and Nurse Powell at which whatever it was was  
 10 going to be taken to the Director of Nursing that day,  
 11 there's then been your conversation.  
 12 You have suggested that perhaps Alison Kelly wasn't  
 13 available and we can see in the email that she wasn't in  
 14 the hospital certainly and neither was her deputy  
 15 Sian Williams and so the issue has been moved to Monday  
 16 for resolution.  
 17 **A.** Well, because I can't remember what that  
 18 discussion was, I can't really say whether it was  
 19 something that had been agreed; that we would speak to  
 20 the Executive team or not.  
 21 **Q.** Would it be normal for the unit manager,  
 22 Ms Powell, to go straight to an Executive about  
 23 an issue?  
 24 **A.** At that stage, probably not.  
 25 **Q.** Because she skipped out -- I mean, she is  
 31

1 to be suggesting that following her meeting with you, it  
 2 was decided to leave this, this topic, this issue, until  
 3 Monday. Again does that accord with your understanding  
 4 of what this email is saying?  
 5 **A.** Yes. I -- I can only assume that Eirian was  
 6 in some way responding to a conversation or an email  
 7 that she may have had with Steve Brearey. Otherwise  
 8 I -- I don't know where I would have come into this.  
 9 **Q.** Yes. So to leave this until Monday, just so  
 10 that you know, October 23 of 2015 was a Friday, so she  
 11 is referring to leave this until Monday, 26 October?  
 12 **A.** Yes.  
 13 **Q.** If we just understand what seems to have  
 14 happened here is because the email is sent to Steve, ie  
 15 Dr Brearey, she seems to be have had a conversation with  
 16 him at which it was agreed that something would be done  
 17 that day. She's then had a conversation with you and  
 18 it's been decided to leave it until Monday; do you agree  
 19 that that's what this email seems to be saying?  
 20 **A.** Well, I can't definitely say what -- what was  
 21 discussed in their conversation but it -- it obviously  
 22 whatever our discussion took place, I can only assume  
 23 that the information actually was given to me and  
 24 because we weren't able to get hold of, I don't,  
 25 Alison Kelly and Sian Williams, I assume that our  
 30

1 including you in the conversation, but she's missing out  
 2 Karen Rees, the head of nursing; she is missing out  
 3 Karen Townsend, the director of the directorate, the  
 4 Urgent Care, going straight to the very top of the  
 5 nursing chain of command?  
 6 **A.** I agree with -- from there we have missed out  
 7 Karen Rees. But it would not have been normal practice  
 8 to go to Karen Townsend.  
 9 **Q.** But at all events, you have told us that that  
 10 wouldn't be usual practice for somebody at  
 11 Eirian Powell's level to go straight to the Director of  
 12 Nursing. I am just bearing in mind the email strongly  
 13 suggests, and you are copied into it as well, that you  
 14 had a conversation about this issue, and it was unusual.  
 15 Can you give us any help at all about what Eirian Powell  
 16 was saying to you that she wanted to talk to  
 17 Alison Kelly about that day?  
 18 **A.** I'm sorry, I can't -- I can't really answer  
 19 that question. I mean, where she says "I have devised  
 20 a document", that is the Mortality 2015 --  
 21 **Q.** Yes.  
 22 **A.** -- review that she did. And she's obviously  
 23 saying that each of the baby deaths was different. So  
 24 I really don't know what the conversation had been with  
 25 Steve Brearey, unfortunately.  
 32



1 Q. I am not asking unless you were told about  
2 Dr Brearey; I am asking between you and Ms Powell?  
3 A. I'm sorry, I can't specifically recall that  
4 incident.  
5 Q. Well, we will have a look --  
6 A. The discussion.  
7 Q. We will have a look at that document in  
8 a moment. I just want to examine this idea of  
9 Alison Kelly was not in the hospital. As a director,  
10 would she have had a telephone number that you could  
11 find out from her PA to contact her when she is outside  
12 the hospital if it was sufficiently urgent?  
13 A. I would assume that if Eirian had already  
14 contacted she would have contacted the Executive office  
15 and spoken to a secretary. But it wouldn't have been  
16 normal practice for one of us to pick up the phone  
17 and -- and ring Alison Kelly or Sian when they were  
18 outside of the hospital.  
19 Q. But I think you have also told us it wouldn't  
20 be normal practice for Eirian Powell to go and see  
21 Alison Kelly about an issue directly?  
22 A. Yes, she could well have.  
23 Q. So whatever it is to be discussed with  
24 Alison Kelly is to be discussed on the Monday, do you  
25 agree that's what this email seems to be saying?

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1 Q. So two meetings to be had on Monday, on the  
2 face of it, one with the risk department, one with the  
3 Director of Nursing?  
4 A. Yes.  
5 Q. So let's have a look at that table very  
6 briefly. We have seen it many times. INQ0003189.  
7 Really, Mrs Murphy, to see if this further jogs  
8 your memory bearing in mind that this is a table that  
9 Eirian Powell appears to have created that very day, the  
10 day that Child I died, the day that she spoke to  
11 Dr Brearey, the day that she spoke to you and the day  
12 that she sent that e-mail, was that a document that she  
13 showed you before she sent the email?  
14 A. Not to my knowledge.  
15 Q. But --  
16 A. But I don't know if the conversation that  
17 Eirian and I had was face to face or whether she  
18 telephoned me. I don't know.  
19 So I don't know if I actually saw that before it  
20 was circulated.  
21 Q. But at 5.25 that day you received a copy of  
22 this table. Do you recall opening it and working your  
23 way through it and seeing Letby's name appearing in  
24 either of those two right hand columns for all but the  
25 first baby?

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1 A. That's what the email says.  
2 Q. So let's move on.  
3 "I have devised a document to reflect the  
4 information clearly and it's unfortunate that she was  
5 on. However, each cause of death was different. Some  
6 were poorly prior to their arrival on unit and others  
7 were [question mark] NEC or gastric bleeding/congenital  
8 abnormalities. I have attached the document for your  
9 perusal".  
10 Now, we know on the table that we will look at in  
11 a moment Letby's name was highlighted in red on that  
12 table, wasn't it?  
13 A. (Nods)  
14 Q. So is the "it's unfortunate that she was on"  
15 a reference to the fact that it is unfortunate that  
16 Letby was on?  
17 A. Yes.  
18 Q. Then finally before we turn and have a look at  
19 that document:  
20 "See you Monday, I will discuss with Debbie on  
21 Monday."  
22 So that's Debbie Peacock?  
23 A. Yes.  
24 Q. The risk midwife?  
25 A. Yes.

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1 A. I'm sorry, I don't. I-- I can't remember when  
2 I first saw you know this document per se. But  
3 obviously, you know, it was one of many documents that  
4 was changed a number of times. But obviously because of  
5 the conversation she had had with -- with Dr Brearey he  
6 had obviously named that particular nurse, which is why  
7 Eirian has highlighted her name to show, you know,  
8 whether she was actually on the unit, where she was  
9 caring for that infant or not.  
10 Q. Bearing in mind that conversation between  
11 Ms Powell and Dr Brearey took place before your  
12 conversation with Ms Powell --  
13 A. Yes.  
14 Q. -- and Dr Brearey and you are then -- forgive  
15 me, I will start that again. The conversation between  
16 Dr Brearey and Ms Powell took place between your  
17 conversation and Ms Powell.  
18 You are then copied into the email about the  
19 contact with Alison Kelly and the fact that this chart  
20 had been created. I mean, do you think it likely that  
21 it was in that meeting on 23 October that Ms Powell told  
22 you that Dr Brearey was worried about Letby?  
23 A. I -- I'm sorry, I can't actually answer that.  
24 I don't know if in fact concerns had been raised before  
25 or whether it was actually in October that it was first

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1 discussed that he felt that she was there for the  
2 majority of -- of the instances.  
3 **Q.** I understand. So this then -- if I have  
4 understood your answer correctly, this represents the  
5 very latest date that you would have heard about  
6 Dr Brearey's concerns but it may be that you heard about  
7 them before?

8 **A.** It may well. I -- I can't, I can't verify  
9 that, really.

10 **Q.** Whether it was this date or earlier in time,  
11 when you heard that Dr Brearey was concerned about  
12 a member of nursing staff and the fact that she was  
13 present when these various deaths occurred, did you have  
14 concerns yourself?

15 **A.** No, I -- I didn't have any concerns. You  
16 know, I -- I -- I know that I can't -- I don't know  
17 whether it was around about this time or when, but  
18 Eirian had obviously discussed the fact that the  
19 Consultant had raised concerns. But because the concern  
20 was literally that she was on the unit when all of the  
21 incidents had taken place, she wasn't looking after each  
22 of those babies.

23 So, you know, was there coincidence in -- in this  
24 situation? It was supposition that, you know, she, she  
25 unfortunately was there on those days. But there was no

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1 you know. So -- so we could never find any evidence to  
2 support any wrongdoing and -- and therefore her  
3 literally being on the unit at that particular time,  
4 I don't think we felt as nurses that we could accuse her  
5 of doing some harm without actual evidence.

6 And the fact that the babies appeared to die of,  
7 you know, varying conditions and there was nothing at  
8 post-mortem to -- to say that that was any different,  
9 and at that time I don't think we felt that it -- it was  
10 fair that a nurse should be accused, or anyone if you  
11 know I believe that if that had have been a member of  
12 the medical staff I would have felt the same thing;  
13 that, you know, what proof did we have that there was  
14 any wrongdoing?

15 **Q.** So we just need to unpack quite a lot of that  
16 answer, I will try and help you with what I am asking  
17 you.

18 You said "a number of times as nurses". Did you  
19 view this as a doctors versus nurses situation?

20 **A.** I wouldn't say that we viewed it as a doctor  
21 versus nurses at all. I mean, Dr Brearey obviously had  
22 a concern, but he also had his own route to take that  
23 further if he felt his concerns was justifiable.

24 I was being informed that to all intents purposes  
25 there, you know, there wasn't any indication to say that

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1 indication that she was causing any harm to those  
2 babies.

3 **Q.** Well, it's a serious concern that Dr Brearey  
4 had, do you agree?

5 **A.** Yes.

6 **Q.** Did you go and speak to Dr Jayaram, the Lead  
7 Clinician for paediatrics, to say: one of your  
8 Consultants, the lead for neonatal unit, has this  
9 concern, what do you think about it?

10 **A.** I can't remember having a conversation  
11 directly with Dr Brearey or Dr Jayaram at that stage and  
12 I know there were discussions that took place but  
13 I don't know, I couldn't give you the dates of those  
14 discussions.

15 **Q.** But as the lead nurse for children's services,  
16 didn't you have a responsibility to try and understand  
17 what was being suggested here, because of how serious it  
18 might be?

19 **A.** I -- I accept that it -- it was a serious  
20 matter and obviously on reflection even worse than we,  
21 we would have considered. But I was being informed by  
22 the unit manager that, you know, this -- this was  
23 literally just that she, she was actually present.

24 What could she have done to those babies,  
25 especially those babies that she wasn't caring for, I --

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1 this nurse had done anything wrong.

2 **Q.** So you had two competing points of view,  
3 Dr Brearey's concern on one side, Eirian Powell's view  
4 to you that there wasn't anything to be concerned about.  
5 Would it be fair to say that you chose to act on the  
6 basis that Eirian Powell was right, rather than that  
7 Dr Brearey may be right?

8 **A.** At that stage, yes.

9 **Q.** And that you did so without speaking to  
10 Dr Brearey yourself?

11 **A.** I cannot -- I cannot recollect speaking to  
12 Dr Jayaram.

13 **Q.** Or to the Consultant who sat above Dr Brearey,  
14 Dr Jayaram?

15 **A.** No.

16 **Q.** Again just reflecting upon this, bearing in  
17 mind how potentially serious it was, do you think that  
18 those were things you should have done at the time?

19 **A.** I -- I think the discussions that I also had  
20 with Dr Brearey and Eirian that none of us could come up  
21 with a reason why his thought process automatically went  
22 to her. So at that time, no, I really didn't believe  
23 that we should be actioning anything.

24 **Q.** Another thing that you said in your answer to  
25 my initial question was that you didn't think it was

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1 fair because you didn't have proof. I hope I have  
2 recollected that correctly?  
3 **A.** (Nods)  
4 **Q.** When it comes to keeping babies safe, do you  
5 need proof before you act?

6 **A.** I -- I think when a person is potentially  
7 going to be accused of some wrongdoing in that case,  
8 yes, I do think we should have had proof.

9 **Q.** So the fact that a senior Consultant who was  
10 in charge of the unit had a concern from your point of  
11 view didn't justify any action because you needed proof?

12 **A.** Well, I think we -- we were aware of -- that,  
13 you know, there was an -- an issue that babies obviously  
14 were dying. But not at that stage did -- did we as  
15 nurses, Eirian and myself, on discussion -- on  
16 discussion with Debbie Peacock, and then we didn't think  
17 there was an issue to address.

18 Dr Brearey could have discussed it with his  
19 colleagues himself. I don't know if he did or not at  
20 that stage. He could have taken it to other members of  
21 the Trust.

22 **Q.** When considering child safeguarding generally,  
23 if you as a nurse suspected that a parent was causing  
24 harm, but you didn't have proof, would you act?

25 **A.** That would depend on what the reason for

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1 Eirian's thought process was to go directly to  
2 Alison Kelly or to find out if Alison was in the Trust  
3 at that time or indeed what Dr Brearey had said to her,  
4 to make her feel like that.

5 **Q.** But she clearly discussed it with you and you  
6 agreed that seeing Alison Kelly on the Monday was a good  
7 idea?

8 **A.** Well, I think to leave whatever the issue was  
9 we -- we could safely leave until the Monday. I don't  
10 know if because if -- if it had been raised that they  
11 felt it was Lucy Letby causing harm to the baby that had  
12 died whether that indeed she -- she wasn't on duty again  
13 until the week after, then it -- you know, that issue  
14 could be left until the following week to be discussed.

15 **Q.** And so did you speak to Eirian Powell the  
16 following week to find out how her meeting with  
17 Alison Kelly had gone?

18 **A.** I'm sorry, I can't -- I don't know whether  
19 I did or not. I haven't had access to my own diaries  
20 for work so I -- I haven't been able to look at all of  
21 these dates and follow them up from my own information.

22 So I really don't know whether that -- that did  
23 take place whether Eirian spoke to Debbie Peacock and  
24 was happy that, you know, it didn't need to go to  
25 Alison Kelly or if indeed Eirian got in touch with

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1 that -- for that suspicion. You know, if a child came  
2 in with bruises, then obviously you are going to  
3 consider that that child has been harmed. It -- it  
4 didn't mean that it was the mother, the father or  
5 whoever it -- that would be an indication for alerting  
6 safeguarding.

7 If a child said something that made you consider  
8 they may be being sexually abused or something, but  
9 there -- to me that is evidence from that child to say  
10 that something was wrong. So I don't think we would  
11 have gone to safeguarding without elements of some  
12 evidence.

13 **Q.** The final question just about this event in  
14 October is this: it clearly was thought serious enough  
15 to involve Alison Kelly, we can see that from the email,  
16 so no accusations being made to Letby, just going right  
17 to the Director of Nursing to get her support on what is  
18 undoubtedly a very difficult situation.

19 Firstly, given that you knew about this and that  
20 you were Eirian Powell's direct line manager, was that  
21 something that you involved yourself in, so that you  
22 took this concern with Eirian Powell to Alison Kelly?

23 **A.** Well, I certainly could have. I -- I would  
24 have thought that my first port of call would have been  
25 to have gone to Karen Rees and I don't know what

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1 Alison Kelly herself, I don't -- I don't know.

2 **Q.** But you have no recollection of having been  
3 told --

4 **A.** I have no recollection.

5 **Q.** -- whether the meeting did or didn't take  
6 place?

7 **A.** No, I'm sorry, I don't have a recollection.

8 **MR DE LA POER:** My Lady, would that be a convenient  
9 moment?

10 **LADY JUSTICE THIRLWALL:** Very convenient, thank you  
11 very much indeed, Mr De La Poer.

12 Mrs Murphy, we are going to take a break now of  
13 15 minutes and we will start again at half past 11.

14 **A.** Thank you.

15 (11.14 am)

(A short break)

17 (11.30 am)

18 **MR DE LA POER:** Mrs Murphy, we are going to move  
19 forward from 23 October to 19 November. INQ0004271.

20 This is a meeting of the Women's & Children's Care  
21 Governance Board and we can see under the "Urgent Care"  
22 heading Dr Jayaram is present, that is the first entry,  
23 and you are identified as being present four entries up  
24 from the bottom?

25 **A.** Yes.

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1 Q. Dr Brearey has given his apologies that is  
2 item 1 on page 1.

3 Now, as far as this meeting is concerned, the  
4 conversation that you had had with Eirian Powell on  
5 23 October, the plan that Alison Kelly might be  
6 contacted, the discussion with Debbie Peacock, none of  
7 that appears to be recorded at this meeting.

8 That was approximately three and a half weeks  
9 before this meeting took place. Do you know why that  
10 wasn't discussed or was it, and just not recorded?

11 A. I'm sorry, I don't know why.

12 Q. Do you think that sort of concern that had  
13 developed into thinking that Alison Kelly needed to be  
14 involved was something that should be raised at the  
15 Women's & Children's Care Governance Board?

16 A. I think, if we -- if we had discussed it then  
17 it would probably have been at the senior clinicians'  
18 meeting rather than at the governance meeting. But it  
19 may have been something that Debbie Peacock would have  
20 picked up on too, but I -- I can't really recall what  
21 the process would have been.

22 Q. So we know from page 5, right at the bottom,  
23 that the minutes were to be sent to Alison Kelly in her  
24 capacity as Director of Nursing?

25 A. (Nods)

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1 Q. Of course, I will see if I can help you.

2 In her witness statement to the Inquiry,  
3 Alison Kelly says that you raised concerns about  
4 staffing levels within paediatrics --

5 A. Rights, yes.

6 Q. -- in December of 2015?

7 A. Right.

8 Q. She cites some other concerns that were raised  
9 and she says in her witness statement that she visited  
10 the department together with Sue Hodgkinson and that she  
11 also was involved in a meeting with Lorraine Burnett and  
12 as a result of those meetings what Alison Kelly says is  
13 that that led to additional nurse recruitment, the  
14 upskilling of existing staff and new Consultants.

15 So that's what she says about what happened in  
16 December 2015 which you were involved in and what the  
17 result of work that was done on the back of that. I am  
18 just wondering do you have any recollection of firstly  
19 being concerned about the staffing level on the  
20 paediatric unit generally?

21 A. Well, yes, we did have concerns about the  
22 staffing levels on both units. We certainly were not  
23 achieving the standards that -- from a paediatric  
24 perspective, that we did have standards of staffing  
25 levels.

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1 Q. But looking through the minutes, it wouldn't  
2 be possible to discern those conversations that you had  
3 been having that level of concern following Child I's  
4 death, the table with Letby's name in red, none of that  
5 would be apparent to somebody reading these minutes.

6 I am just wondering whether that was something that  
7 should have been raised at this meeting in some form or  
8 other; that that concern had been had on the nursing  
9 side, in terms of the need to contact Alison Kelly?

10 A. I think the fact that no one raised a concern  
11 at this meeting, neither medical nor nursing, I --  
12 I don't know whether it -- it should have been  
13 documented or not, really.

14 Q. We can take that -- sorry, did you want to add  
15 something? We can take that down.

16 I would just like to ask you about an issue which  
17 is more generally applicable to children's services. As  
18 part of your preparation I think you were recently sent  
19 an extract from Alison Kelly's statement in which she  
20 talked about you and some Consultants raising staffing  
21 concerns about with her in December of 2015 or  
22 thereabouts. Do you recollect reading that as part of  
23 your preparation?

24 A. I am not altogether -- could you repeat that?  
25 I don't know if I didn't quite hear.

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1 December is a particularly busy month or the winter  
2 is very busy in paediatrics itself. So if -- if there  
3 were staff off sick or if there was a recruitment  
4 problem then, yes, I would have raised that, that issue.

5 Q. Do you have a recollection of a visit to the  
6 department by Alison Kelly and Sue Hodgkinson as a result  
7 of you having raised concerns?

8 A. No, no, I can't recall. But I would not  
9 necessarily have been there if they went ad hoc to the  
10 units.

11 Q. After you had raised your concerns, did you  
12 see additional nurse recruitment by the Trust?

13 A. I can't answer that question either. At that  
14 time, without my records, I wouldn't be able to say  
15 definitely. But we certainly didn't get any additional  
16 doctors at that time, I know.

17 Q. We will move forward to 2016 and a paediatric  
18 specialty meeting that took place on 18 January.  
19 INQ0015284.

20 So we can see a number of familiar names are  
21 present including Dr Jayaram first identified,  
22 Dr Brearey towards the bottom, Dr Mittal and Dr Isaac  
23 who worked in the community and had a safeguarding role  
24 and you -- thank you very much indeed -- in between  
25 those two.

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1 A. (Nods)

2 Q. Now, we can see at this meeting if we go over  
3 the page, please, that there are a number of topics  
4 covered. We can work our way through, just to refresh  
5 your memory about it. I think we can probably turn to  
6 the next page.

7 We see here, if we pause there, we have got that  
8 same heading "Governance Issues Summaries" we have got  
9 risk registers under discussion:

10 "The Urgent Care board rejected the addition of the  
11 risks highlighted by NNU of staffing issues, transport  
12 issues, pseudomonas and gas analyser without  
13 an explanation. A representative of the NNU will attend  
14 the next session to explain the addition."

15 So these are items that had been identified as  
16 going on the risk register that the divisional board  
17 said they weren't prepared to accept without more  
18 information.

19 There doesn't seem to be in this context of  
20 governance any discussion about the increase in the  
21 mortality rate as at January 2016. Again, do you know  
22 why that topic wasn't being brought up in this context  
23 where there is a governance responsibility, and here  
24 please understand that I recognise that a number of  
25 doctors are also present, but I am asking you for your

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1 We don't need to bring up the table unless you wish  
2 to see it again, Mrs Murphy, but the table had two  
3 additional entries on it, so it had gone from 8 to 10  
4 and Letby's name was highlighted in red next to one of  
5 the two columns for both the additional deaths so that's  
6 how the table has changed since the version that was  
7 circulated in October.

8 We can briefly take that down, but we will have  
9 a look at the email of 22 January. Just while we think  
10 about that table, do you have a recollection of  
11 receiving the updated version of the table and noticing  
12 the two extra deaths?

13 A. I think at that stage, you know, it was being  
14 regularly updated and reviewed. So I can assume that  
15 I did see that table.

16 Q. When you saw that there had been two more  
17 deaths and Letby's name was associated with both of  
18 those two further deaths, what, if anything, was your  
19 thought process?

20 A. I think at that stage it was generally looked  
21 at that everything had to be reviewed, you know, not  
22 just the fact that there was a nurse who they felt was  
23 potentially involved, but all other elements; you know,  
24 the care practices, the standards that were there,  
25 infection control issues.

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1 reflections on it, please?

2 A. I am not altogether sure whether it -- it  
3 would have been highlighted. You know, the natural  
4 process would have been carried out behind the scenes,  
5 it may well then have been reported at this meeting if  
6 there had have been any discrepancies in, in the --  
7 those incidents after being investigated, it may have  
8 been discussed.

9 But it -- it obviously wasn't highlighted by Debbie  
10 herself as the risk lead for, for paediatrics.

11 Q. So we can take this down. That is the 18th.  
12 On the 19th, so the next day, Eirian Powell updated that  
13 table with the names including Letby's name in red. We  
14 will bring that up. Firstly, let's look at the email  
15 that she sent, so the email is at INQ0005643.

16 If we scroll to the bottom we can see the start of  
17 the thread, 19 January. So just the day after that  
18 meeting, and if we look at page 2, please, we will see  
19 the body of it, it is addressed to Steve:

20 "Hi, I have amended the last list to ensure that we  
21 have included all the babies that have died on the unit  
22 within this timeframe."

23 If we go back up again, we can see that you are  
24 copied into that email. Do you see that, bottom  
25 right-hand corner?

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1 I think these were also things that were being  
2 discussed behind the scenes, really, that because there  
3 still wasn't any actual evidence that she had done any  
4 wrong, no one had come forward to voice a concern, you  
5 know, from a colleague's perspective. It was still just  
6 the fact that she was present on the unit for the  
7 majority of these babies.

8 Q. You have mentioned things going on behind the  
9 scenes. What you say in your witness statement is that:

10 "I can't say if I escalated to Alison Kelly ... or  
11 if indeed I was already reporting back to Karen Rees  
12 during our usual management monthly one-to-ones at this  
13 stage."

14 So you said in terms in your witness statement you  
15 don't have any recollection of speaking to Alison Kelly  
16 about this.

17 In terms of Karen Rees, we have heard about these  
18 one-to-ones which there are sometimes more people below  
19 you coming to that meeting. Do you have a recollection  
20 of telling Karen Rees about the fact that there was  
21 an increase in deaths and the fact that a nurse had been  
22 identified as being on duty or directly caring for the  
23 baby at the time of 9 out of 10 of the deaths?

24 A. I really don't, I can't answer that question.  
25 I would have thought that we would have been informing

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1 Karen of any updates but I -- I can't say that, you  
 2 know, at what stage we did that. But because I have  
 3 a recollection of informing Jane Evans originally,  
 4 I think it would have been something that would have  
 5 been discussed, you know, how were things going, had  
 6 there been any more baby deaths, whatever, was there any  
 7 extra information to be given?

8 But I couldn't -- I mean, I cannot swear to that,  
 9 really. That is just my assumption, really.

10 **Q.** Just looking back on it now, you say you may  
 11 have raised it, you may not have, you assume that it's  
 12 something you would have raised. Do you think it is  
 13 something that should have been raised by this stage,  
 14 with Karen Rees the Director of Nursing for that  
 15 division, or the head of nursing rather?

16 **A.** Well, I certainly think that we were looking  
 17 at all of the issues that could potentially be a problem  
 18 within the unit. So, yes, I would have thought that we  
 19 would have been informing our line manager about that.

20 **Q.** So we don't need to bring it up but that email  
 21 from Dr Brearey in reply to Eirian Powell's proposes  
 22 a meeting for half a day at which Dr Subhedar was going  
 23 to attend and we now know that is the thematic review of  
 24 neonatal mortality meeting. We don't need to bring up  
 25 that email but that is his response to the table?

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1 difference that Letby's name was not highlighted in red.  
 2 Did you notice when this report was circulated that  
 3 the table no longer highlighted her name?

4 **A.** No, I can't recall that. It certainly didn't  
 5 come into the fact that it wasn't highlighted.

6 **Q.** In terms of the discussion before we look at  
 7 what's actually said, do you remember whether Letby was  
 8 discussed at this meeting, whether by name or by  
 9 reference to a nurse?

10 **A.** I think there may have been reference to the  
 11 fact that a nurse was present on the unit at all of  
 12 these or the majority of the babies that we were going  
 13 to review. Again, I couldn't really swear that that's  
 14 right.

15 **Q.** So what you say in your witness statement is:  
 16 "I believe [that] Lucy Letby's presence on the unit  
 17 at all deaths was highlighted as it was on the  
 18 Mortality 2015 report ... Letby's competence was never  
 19 questioned. It was suggested, as no one wanted to  
 20 accuse her of harm, that it may be a practice issue."

21 **A.** (Nods)

22 **Q.** So just thinking about that. Do you have  
 23 a recollection of there being a discussion about whether  
 24 Letby had a practice issue?

25 **A.** Yes, I -- I don't know whether we discussed it

55

1 **A.** (Nods)

2 **Q.** If we just bring it up, the thematic review  
 3 INQ0003217, really for the purpose of identifying that  
 4 you are one of the participants at that meeting on  
 5 8 February, aren't you?

6 **A.** Yes.

7 **Q.** We can see from the bottom of the page that  
 8 one of the objectives was any possible common themes.  
 9 We know from this first version that the timing of the  
 10 arrests was identified as one of the themes that six out  
 11 of the nine deaths that were being looked at occurred  
 12 between midnight and 4 am.

13 Can you remember that theme being discussed at the  
 14 meeting?

15 **A.** Yes, I believe I can remember that, yes, it  
 16 was one of the issues that was highlighted.

17 **Q.** I am terribly sorry, I am sure it's me but can  
 18 I ask you to keep your voice up a little bit. I just  
 19 missed what you said there?

20 **A.** Yes, I think I can recall that.

21 **Q.** Yes. And we know that attached to this report  
 22 was appendix 1 which had the columns that we have seen  
 23 before with names of nurses on who were either on duty  
 24 or who were allocated to the baby, so a version of the  
 25 table that you had seen the previous month with a key

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1 at this particular meeting or whether I had previously  
 2 discussed it with Eirian. But I do remember being told  
 3 that she was a very good nurse, neonatal nurse, that she  
 4 was up to date with all the competencies, she had done  
 5 further training into neonatal care. So as far as I was  
 6 aware there were no particular issues around that time  
 7 that could sort of defer from that.

8 **Q.** So it may be a matter of some importance  
 9 whether Letby was discussed at this particular meeting.  
 10 So I appreciate it's a very long time ago but doing the  
 11 best you can, do you think that she was discussed or do  
 12 you think that it may have been a different meeting that  
 13 you had a discussion about her competence or can you  
 14 just not say?

15 **A.** I really can't remember whether we  
 16 specifically discussed her at this meeting or not.

17 **Q.** Because one the things that is apparent from  
 18 the record of this meeting is that there is no record of  
 19 any discussion of Letby or a nurse or a potential  
 20 practice issue or anything like that in this record.

21 So is that a fact that you had appreciated before  
 22 I pointed it out now?

23 **A.** Then I think that we obviously didn't discuss  
 24 her directly.

25 **Q.** Because look at it another way. If -- if

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1 there had been a discussion about her potentially being  
2 a common theme and you had then received this record and  
3 that wasn't included in there, would that have stood out  
4 for you as well, this record isn't actually accurate?

5 **A.** Well, at that time then, yes, I probably would  
6 have queried it.

7 **Q.** So let's move forward to the paediatric  
8 specialty meeting. INQ0041363. This is on 15 February,  
9 so it's just seven days later. Again we can see that  
10 this is one of those meetings with quite a number of  
11 people who are invited, again Dr Jayaram is recorded as  
12 being present, as is Dr Brearey, and in the middle there  
13 you are recorded as being present at this meeting.

14 If we go over the page, and again the usual comment  
15 applies here. There are other people who can raise  
16 these things, I am just looking for your perspective on  
17 it.

18 We can see item 2 has just this comment under the  
19 "Performance, KPIs and Dashboards":

20 "There are no problems in school health or NNU."

21 Now, that is obviously under a specific heading  
22 which is "Performance, KPIs and Dashboards" so we have  
23 got to read it in its context. But given that the  
24 thematic review had taken place just seven days earlier  
25 was that something that should have been discussed at

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1 issues and I mean in fact Dr Subhedra at that meeting  
2 said that he was impressed on how many of the babies had  
3 had post-mortems because at the women's, he was never  
4 able to achieve that level of acceptance and agreement  
5 from -- from the families.

6 So he put that forward as a good point from --  
7 from, you know the perspective neonates. But I'm not  
8 sure sort of what, what you, you really want from that.  
9 Comment.

10 **Q.** Well, don't worry about that. It's really  
11 once you had had the thematic review, my question was:  
12 did you think that there was a clear explanation for why  
13 the number of deaths on the neonatal unit had gone up by  
14 so much?

15 **A.** No, and unfortunately I don't think we ever  
16 did get a clear review of that until obviously the  
17 police were involved. But I'm sorry, but looking at one  
18 set of minutes, I -- I can't think of what my thought  
19 process would have been at that time --

20 **Q.** Well --

21 **A.** -- or what conversations were going on behind  
22 the scenes.

23 **Q.** Let's just look at a slightly different point  
24 within these minutes the CQC. If we go to page 4. We  
25 can see the fourth bullet point under "Any Other

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1 this meeting, do you think?

2 **A.** Well, that was relating to performance. So  
3 they were really the -- the business side. So it was  
4 more like the appraisals that we had carried out, you  
5 know, so nursing competencies, mandatory training, they  
6 were the things that we would have been specifically  
7 talking about there.

8 I don't know that someone's competence, unless it  
9 had been raised as an issue, would have been brought up  
10 at that.

11 **Q.** If we have a look at page 3 we will see that  
12 heading "Governance" is also there and the "Governance  
13 Issues Summary".

14 Again what we don't see there is the fact that  
15 there was the thematic review just seven days earlier.

16 **A.** So, I mean, Debbie was saying that it would be  
17 shared, once it had been finalised and that was from  
18 a governance risk perspective for that.

19 **Q.** But we know it is not finalised until 3 March,  
20 but in terms of the content of -- sorry, 2 March, that  
21 is my mistake. But in terms of the content of the  
22 meeting, I mean, did that thematic review identify  
23 a clear explanation for the increase in deaths on the  
24 neonatal unit?

25 **A.** No, I don't think it highlighted any -- any

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1 Business":

2 "Anne Murphy asked if the junior doctors are ready  
3 for the CQC visit. Dr Jayaram said that they had all  
4 been given information relating to the visit and they  
5 had been advised that all PCs should be logged off when  
6 not in use, handover sheets should not be left in view  
7 and the notes trolley will not be taken on to the ward  
8 round."

9 So the first question is: can you remember why you  
10 wanted to know if the junior doctors were ready?

11 **A.** Well, I think we were probably ensuring from  
12 a nursing perspective that things were, you know, all  
13 ready in preparation for the CQC visit and just to ask  
14 because, you know, it may be that, at that time, I know  
15 there had been an issue that one of the handover sheets  
16 had been found, so I think we just I think probably  
17 wanted to ensure that the doctors were also aware of the  
18 visit and the fact that, you know, a lot of things would  
19 be scrutinised at that time.

20 **Q.** Obviously striving to improve standards at all  
21 times is an important aspect of work within the NHS.

22 But just help us to understand whether there was  
23 a culture here that the hospital would put its best foot  
24 forward when the CQC came just to try and satisfy the  
25 CQC, in other words for the sake of satisfying the CQC

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1 rather than because it was an intrinsically good thing  
2 to be doing, was there that culture?

3 **A.** No, I don't -- I don't think that you could  
4 say that there was a culture. I think it was more just  
5 to remind you know, the -- the nursing and medical staff  
6 at times would leave the room unlocked where -- where  
7 the notes were kept or where the computers were. They  
8 may well have left the computer on while they popped out  
9 to check on something or if, you know, they had had  
10 a call and were being asked to leave the room where all  
11 of their work was being completed.

12 So I think it was just to remind people that, you  
13 know, we were reminding all of the nurses and it may  
14 well not have just been at that particular time but  
15 obviously the CQC were coming and it was, you know, what  
16 things may we sort of let ourselves down with and -- and  
17 it may be that they were the things that had been  
18 highlighted at that time.

19 **Q.** So I just want to draw your attention to  
20 something that Nurse ZC has said, there is a cipher  
21 list -- we are not using that nurse's name but there is  
22 a cipher list if you are not sure who I am referring to.

23 She says -- and this was provided I hope in your  
24 pack:

25 "Anne Murphy, the lead nurse of paediatrics,  
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1 on 17 February 2016. You have had a chance to look at  
2 the notes prepared by the CQC recently about that  
3 meeting so hopefully that's helped to some degree.

4 It was a meeting that Dr Brearey was also present  
5 at. We can bring up the INQ0017339 and we are going to  
6 go to page 207.

7 So speaking entirely for myself, I have not found  
8 these notes the easiest to interpret. But it does  
9 appear if we look about three quarters of the way down,  
10 that the word "neonatal mortality times 2 last year",  
11 page 207?

12 **LADY JUSTICE THIRLWALL:** 207.

13 **MR DE LA POER:** That entry that I have just drawn  
14 particular attention to appears to be under a Mortality  
15 and Morbidity Meeting heading.

16 "5 from NNU last year x4 this year."

17 So in other words it does appear that there is some  
18 discussion about the number of deaths at that meeting?

19 **A.** Yes.

20 **Q.** Did the fact that there had been a thematic  
21 review feature in your discussion with the CQC? Is that  
22 something that was raised at the meeting that there had  
23 been a meeting just nine days earlier where all of these  
24 deaths had been looked at and that no clear explanation  
25 had been identified for the increase?  
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1 attended one specific safety brief where the NNU was  
2 discussed. Following the briefing we had an impending  
3 CQC visit and Anne Murphy requested we fill out our  
4 appraisal documentation and sign them so we would appear  
5 compliant for the CQC visit, despite none of us  
6 receiving appraisals, or at least I know I did not  
7 receive an appraisal during my time at the Trust, but  
8 was requested to fill out this form at the time, again  
9 evidencing the operations between senior management  
10 across the Children's Division."

11 So that's what she has said. Is that something  
12 that you did or is she wrong about that?

13 **A.** I certainly wouldn't tell someone to sign  
14 a form on an appraisal that they hadn't had. What I may  
15 have been saying is if you haven't had your appraisal  
16 then speak to your appraiser and, you know, get it  
17 sorted.

18 Obviously at that time of year, we were just  
19 finishing a busy winter so appraisals may have been put  
20 on hold until after the rush that we have between  
21 October and February. But if I was going to say  
22 something like that, it would have been to the group of  
23 appraisers, not to the staff.

24 **Q.** Thank you. We can take that document down.  
25 We are going to move forward two days to the CQC meeting  
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1 **A.** I can't remember exactly what was said at that  
2 meeting. But, you know, we have talked about the  
3 mortality/morbidity meetings and, you know, we -- we  
4 probably said the same to the CQC; that we couldn't find  
5 a reason for any of the mortality being increased.

6 But I can't remember the, you know, everything that  
7 happened. I mean, there was a lot of conversations  
8 taking place. But, I mean, we clearly told the CQC, you  
9 know, about the raised mortality but I -- I can't  
10 remember what was actually discussed.

11 **Q.** I mean, it appears that from the notes that  
12 you told them about the number of deaths which may or  
13 may not be the same thing as telling them that you had  
14 had, comparatively speaking, very many more deaths than  
15 you were used to. Do you see? Just identifying the  
16 number of deaths, which is what we have recorded here,  
17 doesn't necessarily mean that you are saying this is  
18 many more than we are used to and we haven't been able  
19 to find a clear explanation for why.

20 So it's just important, doing the best you can, we  
21 can see what the notes record as having been said. That  
22 second part namely that this was a very significant  
23 increase and that you there had been an investigation  
24 looking at all of them and that no clear explanation had  
25 been found, it's that second part. Do you have  
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1 a recollection of that being said by either you or  
2 Dr Brearey to the CQC?

3 **A.** I'm sorry, I -- I can't recall what, what  
4 exactly was discussed, whether it was highlighted in  
5 those particular themes.

6 **Q.** Given the meeting that you attended, was that  
7 the sort of thing that you should have been saying you  
8 and Dr Brearey to the CQC, to help them do their job?

9 **A.** I am not altogether sure, really. I mean  
10 I think one -- one of the participants in this was  
11 actually Lucy Letby herself. So I don't know whether we  
12 were actually withholding that information or whether it  
13 was something that just didn't come up.

14 I -- I really don't recall what the context was of,  
15 of all of the meetings that -- that we had over those  
16 couple of days.

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

18 **LADY JUSTICE THIRLWALL:** Sorry, just before you  
19 take it down.

20 **MR DE LA POER:** My Lady, of course.

21 **LADY JUSTICE THIRLWALL:** Mr De La Poer may have  
22 missed it but the line immediately below the yellow  
23 highlight, are you able to tell us, it looks as though  
24 it says "Neonatal mortality x2 last year" and then  
25 I couldn't work out the last part.

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1 **MR DE LA POER:** I think perhaps to be distinguished  
2 from the perinatal mortality and morbidity meetings,  
3 which we can see are referred to in the first part of  
4 the highlight which were regularly scheduled events,  
5 weren't they? Or it may be that you don't know that but  
6 we have certainly heard that from other witnesses.

7 Thank you, we can take that down.

8 The next event that we are going to consider -- so  
9 that was 17 February -- is the 2 March when Dr Brearey  
10 circulated the final version of the thematic review and  
11 we will just bring up the email, INQ0003114.

12 We can see that in his email Dr Brearey, which is  
13 right in the centre, thanks Nim, Dr Subhedar, Dr V,  
14 Eirian and Anne for contributions.

15 That may be a reference to contributions at the  
16 original meeting or subsequent contributions. Can you  
17 help us with whether after the meeting you had any  
18 further contribution to make to Dr Brearey finalising  
19 this report?

20 **A.** I think after the meeting the action plan was  
21 further updated, so I think that that was what he was --  
22 first it was thanking them for actually coming to the  
23 meeting, but because Nim didn't have anything to do with  
24 sort of updating the actual mortality table, I don't  
25 know if there was any further issues.

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1 **MR DE LA POER:** It may be, my Lady, we will have to  
2 ask the author.

3 **LADY JUSTICE THIRLWALL:** Yes. Are we going to hear  
4 from the author?

5 **MR DE LA POER:** I believe so but I don't want to  
6 give that answer with certainty.

7 **LADY JUSTICE THIRLWALL:** No, all right. Just in  
8 the light of the questions you were asking, I wasn't  
9 sure whether that line was the information about the  
10 previous year, although they both say "last year".

11 Anyway, we hope to hear from the author.

12 **A.** I -- I think that was the fact that there had  
13 been two neonatal mortality meetings held --

14 **LADY JUSTICE THIRLWALL:** Ah, meetings?

15 **A.** -- in the previous year but I don't really ...  
16 I can't decipher.

17 **LADY JUSTICE THIRLWALL:** Depending on cases to be  
18 discussed, that is what the last one says --

19 **A.** Depending on cases to be discussed, it  
20 depends, the mortality meetings were held if there were  
21 cases to be discussed.

22 So they weren't a regular two monthly or three  
23 monthly event. It was if there were cases to be  
24 discussed and there had obviously been two in the  
25 previous year.

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1 That was then going to be sent on to the Executive  
2 team for them to review and look at, which would  
3 obviously have included the mortality tables that had  
4 been carried out.

5 **Q.** Now, the second version the finalised version  
6 contained a new theme, it was the first theme:

7 "Sudden and unexpected deteriorations and no clear  
8 cause in some cases for death deterioration identified  
9 at post-mortem."

10 So did you, Mrs Murphy -- it is not in the email,  
11 on that later version of the thematic review, did you  
12 notice the fact that there was an additional theme that  
13 was identified? We can probably take that email down.  
14 I can show it to you, if that would be helpful?

15 **A.** I am sorry, I can't -- I can't think what had  
16 been added.

17 **Q.** Let me just --

18 **A.** Or whether it was the learning points to take  
19 forward.

20 **Q.** So make sure I get the right version for you.  
21 Forgive me for a moment. (Pause)

22 So it is INQ0003251 and we will go straight to  
23 page 7. You see number 1 there:

24 "Sudden deterioration. Some of the babies suddenly  
25 and unexpectedly deteriorated and there was no clear

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1 cause for the deterioration/death identified at [the  
2 post-mortem]."

3 **A.** (Nods) Yes.

4 **Q.** So was that a theme that you were aware of  
5 that emerged from the thematic review?

6 **A.** Well, it had been discussed, certainly at --  
7 at -- I don't know if at neonatal level or at some of  
8 the senior clinicians meeting. They obviously weren't  
9 expecting some of those babies to deteriorate.

10 But I -- I don't know at what stage we would have  
11 got the post-mortem reports back and they would normally  
12 have been discussed at the Morbidity and Mortality  
13 Meetings which I didn't attend.

14 **Q.** But --

15 **A.** But it -- I don't know if that was something  
16 that the themes -- whether that was added after the  
17 original document had been --

18 **Q.** It wasn't in the original document; it was in  
19 the document that Dr Brearey sent you --

20 **A.** Yes.

21 **Q.** -- and others on 2 March of 2016?

22 **A.** Okay.

23 **Q.** Because that's this document that we are  
24 looking at now. So my question really was: was that as  
25 at March of 2016 something that you were aware of, that

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1 be the case that you are raising with the CQC at that  
2 meeting what had been circulated two days ago.

3 Do you have a recollection of telling the CQC  
4 in March about the thematic review and the fact that  
5 there was sudden and unexpected deteriorations some of  
6 which had no explanation at post-mortem?

7 **A.** No, I don't recall telling them that, this was  
8 specifically relating to the children's ward, but -- so  
9 I don't think neonatal came into it at that stage.  
10 I think this was their review of the actual children's  
11 ward itself.

12 **Q.** Thank you, we can take that down, thank you.

13 Continuing to move forward, 15 March INQ0005697.

14 Again we see you copied into the top right-hand  
15 corner. This is an email from Eirian Powell in which  
16 she sets out how many deaths there had been on the  
17 neonatal unit from 2010 to 2016 and she also points out  
18 that Letby had commenced working on the NNU in  
19 January 2012. Did these numbers come as a surprise to  
20 you?

21 **A.** No, I don't think they did at that stage  
22 because there had been a number of discussions about  
23 these babies and -- and that that was sort of how,  
24 Eirian put it into perspective, I suppose, by  
25 highlighting previous years to -- to sort of everyone.

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1 not only had the death rate increased, but that for some  
2 of the babies there were sudden and unexpected  
3 deteriorations with no clear cause for deterioration or  
4 death identified at the post-mortem?

5 **A.** Well, yes, I suppose I did know, was aware,  
6 you know, sort of at that time that the concern was that  
7 these were unexpected deteriorations. I don't know  
8 whether I could have equated the post-mortem results  
9 to -- to you know, the reason those babies were  
10 deteriorating.

11 **Q.** But so that's what the doctor, Dr Brearey, is  
12 recording and presumably you would defer to him --

13 **A.** Yes.

14 **Q.** -- in terms of the accuracy of that?

15 **A.** Yes.

16 **Q.** So two days later -- we can take that down --  
17 you had another meeting with the CQC. INQ0017339 at  
18 page 262.

19 I believe that records the 4 March 2016 at the top.

20 We can see that the inspector is identified as  
21 Ms Cain halfway down and there is a meeting. The  
22 attendees include you.

23 Now, this was two days after the finalisation of  
24 the thematic review. You can look through the notes if  
25 you want or you can take it from me it doesn't seem to

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1 I mean, I believe that there was another bit of  
2 that email or a response or whether it was in response  
3 to an email. I think it was still at that time we were  
4 trying to pull out any issues regarding it and I believe  
5 at this stage this was when the Consultants were getting  
6 together and discussing the fact that, you know, they --  
7 they were genuinely concerned about it.

8 And I think it was from there that we or Eirian  
9 specifically but with my knowledge emailed Alison Kelly  
10 with the thematic review. She didn't know whether, you  
11 know, it had been sent to Mr Harvey for -- by  
12 Steve Brearey or not which I -- I would have assumed  
13 Steve would have sent it up to Ian Harvey anyway.

14 But I think this was in addition to that just to  
15 highlight the fact and at that stage Eirian asked for  
16 a meeting to discuss or had, you know, it may well have  
17 been just afterwards, to ask if we could have a meeting  
18 to discuss the thematic review.

19 **Q.** So we are going to come to that email which  
20 was, you are absolutely right, two days after this email  
21 but I would just like to go back to what you said about  
22 the Consultants.

23 So to your recollection it was around this time, so  
24 just after the thematic review was finalised, that  
25 Consultants in addition to Dr Brearey were expressing

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1 their concern; is that right?

2 **A.** Yes, yes.

3 **Q.** And are you able to say which of the  
4 Consultants you have a recollection of having such  
5 a concern?

6 **A.** I mean, the -- the Consultant that I know who  
7 definitely voiced that was Dr Jayaram. But I think  
8 Dr Gibbs was also -- although he speaking to Dr Gibbs he  
9 couldn't give us a reason for any of these babies having  
10 a sudden deterioration, I think because they were  
11 obviously discussing it amongst themselves, then he was  
12 also feeling that at that time, you know, there had to  
13 be something and I mean -- I don't know whether we were  
14 still looking at other elements.

15 You know, could it be something else or at this  
16 stage I think we were all just getting a bit upset about  
17 it all and discussing whether it should be put into the  
18 police hands, really. We were -- we had investigated as  
19 much as we possibly could and couldn't find a reason for  
20 it. It -- it could be coincidence that this particular  
21 nurse was there all of the time but there was nothing  
22 then to accuse her of doing.

23 So I think we were really wanting support and  
24 advice from our Executive team by this stage.

25 **Q.** So it could be coincidence but was it also

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1 needed some support from -- or, you know, different eyes  
2 to be looking at it.

3 We were, apart from the thematic review which  
4 involved one of the regional Consultants, I think it had  
5 always been an internal women and -- well, children's  
6 neonatal reviews with our risk assessor, who couldn't  
7 really -- I mean, she didn't at that time I don't think  
8 she didn't voice any concerns either about the nurse's  
9 presence. But I think at this stage I think Eirian was  
10 getting frustrated that the doctors kept saying that it  
11 had to be her, Lucy Letby, that was somehow causing  
12 this.

13 They couldn't give us a reason or, you know say how  
14 this could be happening, what exactly she could be doing  
15 to any of these babies. And we still didn't have any  
16 reports from nursing colleagues to say that they had --  
17 they were upset that these babies were dying because it  
18 was different, you know, this was different.

19 But could it just be a blip that there had been  
20 a lot of babies born with problems and, you know,  
21 subsequently deteriorated? No one could answer those  
22 questions for us. But, you know, at that stage, I think  
23 we had discussed you know that we needed support from  
24 outside.

25 **Q.** So if we just run through this email. We can

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1 within your contemplation that it could be something  
2 that she was doing, you just couldn't say what?

3 **A.** Well, I don't know that I personally felt that  
4 she was doing harm. I -- I couldn't personally consider  
5 what, what it was that she could be doing to these  
6 babies that would present in different ways.

7 I -- what -- what could she be doing? I really  
8 don't know.

9 **Q.** So in the state of mind that you had taken it  
10 as far as you could, you sought help from the Executives  
11 and in particular Ms Powell. Let's just bring that up  
12 INQ0003089, again we are very familiar with this but  
13 let's just mark that moment in the chronology. If we  
14 scroll to the bottom.

15 Forgive me, there we are. 17 March, Ms Powell --  
16 you are not in fact on copy of this first email but you  
17 become aware of this, come on to this thread later we  
18 will have a look at. We can see she sent that message  
19 but that message was sent with your knowledge and  
20 approval, was it?

21 **A.** Yes, yes, it was.

22 **Q.** And bearing in mind all of the individual  
23 reviews, the thematic review, had this situation now  
24 reached a point where it was urgent?

25 **A.** Well, I think at this stage we felt that we

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1 see that Alison Kelly replies four days later asking for  
2 the report, that is 21 March. If we then scroll up to  
3 the next page, we can see that the same day  
4 Eirian Powell sends the report to Alison Kelly and then  
5 the next email is 14 April, you are now put on copy at  
6 this stage and it's Eirian Powell chasing Alison Kelly?

7 **A.** Yes.

8 **Q.** Now, given the apparent lack of response,  
9 that's certainly what this email tends to suggest,  
10 should action have been taken before 14 April to get  
11 input from the Executives? In other words, was it  
12 acceptable to wait a period of over three weeks before  
13 following this issue up?

14 **A.** Well, perhaps not. Perhaps we should have  
15 been chasing. But I -- unfortunately we obviously  
16 didn't and, you know, I can't really say why that, why  
17 we wouldn't be doing that.

18 **Q.** Because back in --

19 **A.** Perhaps we just -- you know, we weren't always  
20 on duty at the same time, you know, there were things  
21 that were happening within the various units, I really  
22 don't know why we left it until that stage to -- to then  
23 question it again.

24 **Q.** Because back in October the plan had been to  
25 go and see Alison Kelly that day, in person. And I am

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1 just wondering if you can help us with why, that having  
2 been the thought process back in October that at this  
3 stage we see a period of over three weeks passing before  
4 an email is followed up?

5 **A.** I'm sorry, I can't answer that. I don't know  
6 why we didn't.

7 **Q.** At all events we know that by the beginning  
8 of May, there is some further action. INQ0003393. If  
9 we go right to the bottom. Thank you very much indeed.

10 We can see on 3 May there is a cancellation, and  
11 that's in the subject line of a planned meeting. So we  
12 know from other evidence that it was planned that  
13 Dr Brearey and Ms Powell would meet with Ian Harvey and  
14 Alison Kelly on that day but it was cancelled.

15 We can see Dr Brearey asking for alternative times,  
16 so that is the start of this conversation.

17 Then we have Alison Kelly saying we will advise on  
18 an alternative date and then the next day, Dr Brearey --  
19 you are not on copy to this but it's nothing that you  
20 didn't know, I don't believe.

21 "There is a nurse on the unit who's been present  
22 for quite a few deaths and other arrests. Eirian has  
23 sensibly put her on day shifts at the moment but can't  
24 do this indefinitely."

25 Can we just pause there and just ask you a couple

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1 moved to day shifts there was a sudden and unexpected  
2 collapse, Child M, during her day shift.

3 Did anybody notice that at the time or comment upon  
4 it that you were aware of?

5 **A.** I can't remember anyone commenting that to me  
6 at all. I mean, I obviously wasn't involved in some of  
7 these emails either.

8 **Q.** No, we will -- if we --

9 **A.** I was involved in the initial one, but  
10 I wasn't copied in to the others.

11 **Q.** We are going to move up and I am just going to  
12 ask for your comment on one particular thing, because  
13 Alison Kelly then in an effort to get an interim meeting  
14 it would seem, we will hear from her what she says her  
15 explanation is, asks for you -- asks for you and  
16 Ms Powell to meet Karen Rees, she is sending that to  
17 Karen Rees, do you see that at the bottom?

18 "Can you please look into this with Anne M and  
19 Eirian? If there is a staff trend here and we have  
20 already changed her shift pattern because of this then  
21 this is potentially very serious".

22 Now, absolutely I accept you are not on copy to  
23 this but this is the Director of Nursing describing  
24 what's being reported to her.

25 I mean, was she right to describe it as

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1 of questions about the day shift move. Did you know  
2 that at the beginning of April Letby had been moved on  
3 to day shifts?

4 **A.** Yes.

5 **Q.** Was that something you were told about after  
6 it had happened or something you were consulted upon?

7 **A.** I think Eirian and I had discussed that  
8 because she had been involved with so many of the deaths  
9 that it would be better for her mental health really to  
10 come on to days for a period of time.

11 But because there were also more staff around  
12 during the day she would then not necessarily have to  
13 look after the sickest babies. So it -- it was --  
14 I think it wasn't done because people were pointing the  
15 finger per se, that she was the person that was causing  
16 these babies to deteriorate, but it -- it would have  
17 been better for her and obviously if there was something  
18 happening at that stage then it could well be prevented  
19 if -- if that was the case.

20 So I don't know whether it was to appease the  
21 doctors or -- but to me it was a good suggestion to  
22 actually bring her on to days.

23 **Q.** We know the thematic review identified that  
24 six of the nine collapses took place between midnight  
25 and 4. We also know that within two days of Letby being

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1 "potentially very serious"?

2 **A.** Well, I think at that stage we all felt that  
3 it was quite serious that people were pointing the  
4 finger and, you know, I mean I -- I am not aware at that  
5 stage that there was any sort of discussions outside of  
6 sort of the senior staff on neonates and paediatrics so  
7 the clinicians and Eirian and myself.

8 I really don't know how many people were aware that  
9 the Consultants had suggested that, that there was this  
10 definite link if it was indeed a definite link. But you  
11 know, it was serious. I think at that time, the  
12 Consultants were talking about going to the police or  
13 who could we -- who could we get to support us through  
14 this?

15 **Q.** Did you agree with the suggestion that the  
16 police should be involved?

17 **A.** I think I did by this stage, not -- not that  
18 I thought that it was the nurse who was actually doing  
19 anything, but we weren't in a position to investigate  
20 this any further.

21 We -- we had looked at everything we thought we  
22 could possibly look at and -- and, you know, I think by  
23 this stage, we were all, well certainly within, I mean  
24 I can't vouch for Eirian, but I think you know because  
25 the Consultants were definitely -- there was nothing

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1 that we could say was the nurse's fault. But there  
 2 was -- you know, these babies were still dying.

3 **Q.** On 5 May you met with Karen Rees. Did you say  
 4 to her that you thought the police should be involved?

5 **A.** In actual fact I can't remember meeting with  
 6 Karen that day. But -- so I don't know you know what we  
 7 actually discussed at that meeting.

8 **Q.** Do you -- and maybe you have already answered  
 9 this -- have any recollection of telling Karen Rees that  
 10 the thematic review had identified as its first theme  
 11 that there were sudden and unexpected deteriorations and  
 12 that the post-mortem in some cases had not explained  
 13 either the collapse or the death? Was that information  
 14 that you were telling to Karen Rees?

15 **A.** I mean, I -- I don't know if -- if Karen Rees  
 16 had had a copy of the thematic review. I don't really  
 17 know sort of what had been shared with Karen other than,  
 18 you know, sort of what Alison Kelly has said in -- in  
 19 the emails. I really don't -- I can't remember what was  
 20 discussed. I am really sorry, but, you know, there was  
 21 so many meetings around that time that without minutes,  
 22 I -- I don't know what we did.

23 **Q.** We do have a record of that meeting.  
 24 INQ0003243, page 2. It's just very short. If we go to  
 25 the second page:

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1 **Q.** The next meeting I want to ask you about is  
 2 the meeting with Alison Kelly and Ian Harvey on 11 May  
 3 of 2016. What you tell us in your witness statement is  
 4 that you don't have a memory of that meeting but you  
 5 think that Alison Kelly's handwritten note is correct?

6 **A.** Yes, I mean --

7 **Q.** Or at least no reason to think that it's  
 8 incorrect?

9 **A.** I have no reason to believe that it wouldn't  
 10 be incorrect.

11 **Q.** Now, Dr Brearey has suggested that in that  
 12 meeting Eirian Powell was very defensive of Letby. Do  
 13 you have any recollection of how Letby was spoken about  
 14 and how Eirian Powell presented herself in that meeting?

15 **A.** I think Eirian was defensive about the nurse  
 16 because no one could give us any other reason and why --  
 17 why should it just be her? You know, we had highlighted  
 18 in another table that one of the Registrars had also  
 19 been present on a number of -- of occasions.

20 But for some reason it was only the nurse that was  
 21 being sort of pinned as being someone that potentially  
 22 had created all of this.

23 So, yes, Eirian probably was getting quite upset at  
 24 the fact that -- or frustrated that the only thing any  
 25 of the Consultants would look at was the fact that she

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1 "Discussion with Dr Brearey, Anne Murphy and  
 2 Eirian Powell.

3 "Karen Rees requested that we discussed exactly  
 4 what the issues, if any, were other than coincidence  
 5 that was evident. Despite highlighting the usual  
 6 factors, there was not real evidence or statement that  
 7 could confirm whether there was an issue here."

8 And then it goes on to give a list and identify the  
 9 advice sought.

10 **A.** Yes. I mean, I have obviously seen the  
 11 minutes, I was -- if I was there then I will have seen  
 12 all of this. So obviously they were all discussed and,  
 13 you know, they were the issues that had been looked at  
 14 and the advice that had been sought prior to this  
 15 meeting taking place.

16 You know, I mean, that was internal and external  
 17 because obviously there was network involvement there.  
 18 While Eirian and Dr Brearey went to the network  
 19 meetings, Nim had come to do the thematic review. So  
 20 you know, the network were aware of sort of all of those  
 21 deaths within -- presumably they knew that what our  
 22 normal death rate was. I don't know whether they ever  
 23 highlighted that they were concerned or, you know, that  
 24 that there could be issues or whether they discussed  
 25 that. I'm not sure.

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1 was present. You know, in retrospect, yes, they were  
 2 completely right but do you ever want to accuse someone?  
 3 We couldn't accuse someone of murder without any sort of  
 4 background or sorry --

5 I don't think any of us wanted there to be an "us  
 6 and them" situation.

7 **Q.** Did you agree with what Eirian Powell was  
 8 saying or did you disagree with it at that meeting?

9 **A.** No, I think I had to agree with Eirian. You  
 10 know, there was no proof that if -- if someone had come  
 11 and said, you know, that she had witnessed anything  
 12 untoward or if anything had been brought up in the  
 13 babies's postmortems then that probably would have made  
 14 a difference.

15 But, you know, to all intents and purposes this was  
 16 an excellent neonatal nurse. Why on earth would she be  
 17 doing something, what could she be doing? I couldn't  
 18 get my head around what could she be doing to harm these  
 19 babies?

20 **Q.** On that point, presumably you were aware of  
 21 past cases where nurses had and indeed doctors had  
 22 harmed patients. Did any of those come to your mind as  
 23 you thought about the situation that you were confronted  
 24 with?

25 **A.** I'm sorry, could you repeat that?

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1 Q. Yes, of course I will give you the names.  
 2 Beverley Allitt, Victorino Chua. These are nurses who  
 3 have harmed their patients, we have obviously got  
 4 Harold Shipman?  
 5 A. Yes.  
 6 Q. There are past cases?  
 7 A. Yes.  
 8 Q. My question was just really whether those  
 9 cases crossed your mind as you were trying to navigate  
 10 this particular situation?  
 11 A. I- I don't think I did think about  
 12 Beverley Allitt. I don't think I really thought that  
 13 any harm was being carried out by a particular person.  
 14 So no, I didn't consider -- and, I mean, I was very  
 15 aware of the Beverley Allitt.  
 16 Q. You were very -- I'm sorry, did you say you  
 17 were very aware of that case?  
 18 A. I mean I was aware of -- my previous manager  
 19 had been the nurse involved with the report. So -- the  
 20 investigation.  
 21 So, you know, she had actually come to back to the  
 22 Countess to get information about resuscitation trollies  
 23 from us. So I was very aware of Beverley Allitt and so.  
 24 Q. Doing the best you can, why do you think you  
 25 didn't draw that connection?

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1 the neonatal unit as anyone could really come to the  
 2 senior clinicians.  
 3 But, I mean, the only thing about that meeting that  
 4 did stand out was when Mr McCormack we had obviously  
 5 were discussing the fact that people were starting to  
 6 get upset and that there was a nurse involved and  
 7 Mr McCormack then shouted down the table, "Are you  
 8 telling us there is a murderess on the neonatal unit?"  
 9 And I think that was like a slap in the face.  
 10 Eirian retaliated and said, you know, that he  
 11 couldn't say that, there was no evidence but I think  
 12 that is the only sort of thing that has been retained in  
 13 my head about that meeting.  
 14 Q. The other meeting I wanted to ask you about  
 15 which you don't give a date for in your witness  
 16 statement is a meeting in late June of 2016 which you  
 17 say Stephen Cross attended.  
 18 A. Well, I am not -- I'm not sure about the  
 19 timeline. Certainly I only remember that at some time  
 20 there was a meeting in which there was a number of the  
 21 chief execs, and risk, safeguarding, senior management.  
 22 I don't know if Karen Rees was there or not.  
 23 I think Julie Fogarty was there as Head of  
 24 Midwifery. But -- but there was a meeting where, which  
 25 was pulled together to discuss the --

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1 A. I'm sorry, I didn't. I didn't. I didn't  
 2 think about child protection at all at that stage.  
 3 Q. Can I just ask you about a couple more  
 4 matters. We are going to move past the deaths of  
 5 Child O and Child P to two meetings on 27 June, we can  
 6 deal with fairly briefly.  
 7 The first is the lunchtime meeting involving the  
 8 paediatricians. I think you have say that you have  
 9 a recollection -- I believe it is of that meeting of  
 10 Dr McCormack saying something. Doing the best you can,  
 11 what is it that you recollect Dr McCormack as saying?  
 12 A. I don't -- I may have been wrong in what  
 13 I wrote in my statement because I'm not sure whether  
 14 that was an urgent meeting that had been called at half  
 15 past 7 that morning or whether it was the official  
 16 senior clinicians meeting which always took place at  
 17 half past 12 on a Monday, well, three Mondays of the  
 18 month.  
 19 But the only thing that did stand out in my mind  
 20 was that it was a meeting where there were obstetricians  
 21 there as well as our Consultant paediatricians and  
 22 I think there were other members, I don't know if  
 23 Julie Fogarty was there, whether there was a risk person  
 24 there. There was obviously Eirian and myself, I don't  
 25 know if there was anybody else from paediatrics or from

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1 Q. Obviously don't worry about the timings.  
 2 What is your recollection about what Mr Cross said?  
 3 A. My recollection of that was after discussion  
 4 Stephen Cross saying that that there was no, there was  
 5 no evidence to involve the police and the police would  
 6 sort of disregard what we were actually asking for. He  
 7 didn't think the police would entertain  
 8 an investigation.  
 9 So -- but as I say, I really don't know what the  
 10 timeline was for that meeting, whether it was round  
 11 about that time. I feel that it was but I may be  
 12 completely wrong.  
 13 Q. The final event to ask you about is the  
 14 meeting you had with the RCPCH on 2 September 2016. It  
 15 is just one thing that you are recorded as saying. You  
 16 describe the doctors in that meeting as being  
 17 tunnel-visioned about her presence, that is what the  
 18 note of the meeting says.  
 19 Would you like to see it?  
 20 A. I mean, I -- I can't say that I didn't say  
 21 that certainly. And in some respects we did feel that  
 22 the doctors were very sort of tunnel-visioned about the  
 23 fact that it had to be a nurse. But, I can't -- I can't  
 24 recall seeing it that late in the process because  
 25 I thought the police had already been involved by

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1 2 September.

2 **Q.** The police were not involved until April 2017?

3 **A.** Right. I think well, I can't, I can't really  
4 remember. I think we were asking for external reviews  
5 and external investigations at that point and I may well  
6 have said that I thought the Consultants were -- had  
7 tunnel vision about it. But we weren't the ones that  
8 could do anything more to prove or disprove that.

9 **Q.** The very last matter which is not about any  
10 particular meeting, it's just a comment that you make in  
11 your statement is that you describe Tony Chambers and  
12 Ian Harvey as being confrontational and threatening in  
13 your witness statement.

14 Was that behaviour that was reported to you or  
15 behaviour that you witnessed yourself?

16 **A.** I -- I couldn't say about Tony Chambers.  
17 I don't -- I can't remember whether he got  
18 confrontational at the meeting with, with the  
19 Executives.

20 I think Ian Harvey we felt was confrontational at  
21 times but I think because after we had the RCPCH review,  
22 we were asking for -- to see the report and we kept  
23 being told, no, no, no and eventually he agreed to show  
24 us the report and I think there was just Dr Brearey,  
25 Dr Jayaram and myself who went to have a look at this

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1 **MR SKELTON:** Thank you. I will try and be fairly  
2 swift, my Lady.

3 Mrs Murphy, I ask questions on behalf of some of  
4 the families.

5 I am going take you back to October 2015 and the  
6 death of Baby I, do you remember her?

7 **A.** Well, I'm sorry, you see I don't know any of  
8 these babies. I didn't work on the neonatal unit so  
9 I had nothing to do with the babies' care or their  
10 families. So, you know --

11 **Q.** I understand that, but it has been nine years  
12 since she was murdered and you are at a Public Inquiry  
13 into the death into her murder and other things?

14 **A.** Yes.

15 **Q.** Have you refreshed your memory about the care  
16 that was given to the individual babies on the units  
17 which you had responsibility for?

18 **A.** Yes.

19 **Q.** You have refreshed your memory?

20 **A.** Yes, I have looked at ...

21 **Q.** Baby I died on 23 October 2015 and we now know  
22 she was murdered by Lucy Letby, do you recognise that?

23 **A.** I have looked at all of the reports, so yes.

24 **Q.** Do you recognise that she was murdered by  
25 Lucy Letby?

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1 report which was supposed to be going out to the public.

2 But it was heavily redacted and certainly the  
3 Consultants were not happy about that. I mean, you  
4 know, it was just literally covered in black ink, we  
5 couldn't see what half of what the RCPCH had said, never  
6 mind trying to decide what lessons we could learn from  
7 it or whether, you know, they had found anything else of  
8 concern and -- and I think Ian Harvey got quite, he gave  
9 us something like 15 minutes to actually look at this  
10 document which was inappropriate really especially when  
11 it was so heavily redacted and the Consultants asked for  
12 the -- the full copy which I don't know that we ever  
13 really got, I don't know if we did get it before it was  
14 published or whether we got it the morning it was going  
15 to be published, so I think that there were heated  
16 comments certainly with the RCPCH review. But I don't  
17 know that I was present at any other meetings.

18 **MR DE LA POER:** Mrs Murphy, thank you very much for  
19 answering my questions. There will be some more  
20 questions which I hope we can accommodate before lunch,  
21 my Lady, from Mr Skelton?

22 **LADY JUSTICE THIRLWALL:** Very good. Mr Skelton.  
23 Questions by MR SKELTON

24 **LADY JUSTICE THIRLWALL:** Take the time you need,  
25 Mr Skelton.

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1 **A.** Well, she's she been found guilty by a court  
2 of law, so yes, I do.

3 **Q.** And in your opinion?

4 **A.** I mean ...

5 **Q.** Do you accept that verdict?

6 **A.** Yes, I accept that she has been found guilty.  
7 You know, there's -- and you know in some ways we were  
8 wrong for it going on so long. So yes, I would half --  
9 you know, I am so sorry for the Families who have had to  
10 deal with this for the last seven, eight years.

11 You know, it, it's awful for them. So yes, I do  
12 accept, you know, that Lucy Letby obviously has murdered  
13 or had a part in all of those babies' deaths.

14 **Q.** Just going back to what was going on in  
15 October 2015. The death of the child was unexpected,  
16 Dr Gibbs, the Consultant who was called to help the  
17 resuscitation was unsettled by her death. He hadn't  
18 expected it to occur. Do you understand, do you  
19 remember that?

20 **A.** Well, I have obviously read what has been  
21 said. I don't know that I had a discussion with  
22 Dr Gibbs about any of that, but --

23 **Q.** The --

24 **A.** I accept that --

25 **Q.** Mrs Murphy, sorry to cut across you. The

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1 reason I am asking you this is that Eirian Powell just  
 2 after the death was in contact with Dr Brearey in  
 3 respect of a mortality table which you were copied in  
 4 on.  
 5 **A.** Yes.  
 6 **Q.** So there must have been things at the time  
 7 that you must have remembered or you must have been  
 8 involved with for you to be copied in just after Baby I  
 9 died. Can you remember that, that mortality table with  
 10 Lucy Letby's name in red?  
 11 **A.** I obviously remember that a baby had died and  
 12 it will have been reported to me. But -- but that --  
 13 that was my, my only involvement in any of those babies.  
 14 **Q.** Well, just trying to put -- I am trying to  
 15 understand what you might have been thinking when you  
 16 were involved in October 2015 because you were copied in  
 17 on the email with the table and because you were  
 18 a manager, a senior manager to Ms Powell; that's right?  
 19 Yes?  
 20 **A.** Well, the manager was telling me that she  
 21 didn't think that -- that the nurse was involved in any  
 22 of those babies's deaths. But you know, I accept that  
 23 obviously you know in retrospect, yes, we were aware.  
 24 **Q.** She thought it was an unfortunate coincidence?  
 25 **A.** Yes.

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1 **Q.** I am trying to compare the seriousness of what  
 2 you needed to think about, the seriousness of the  
 3 acquisition against Lucy Letby, but the seriousness of  
 4 the death of the children, the effect on their families  
 5 and do you recognise that the latter far outweighs the  
 6 former?  
 7 **A.** Well, obviously it's devastating. It's  
 8 devastating to lose any child, any baby.  
 9 But, was that an indication that some harm was  
 10 being done? And that I think that was what we were  
 11 thinking. You know, how: what was happening? What  
 12 could have been done to those babies?  
 13 And you know I mean, I -- I can't answer that.  
 14 **Q.** Well, you accepted Ms Powell's view that it  
 15 wasn't Lucy Letby that had caused the deaths.  
 16 **A.** Well, I don't know at that stage. I accept  
 17 now but I didn't know at that stage and no one could  
 18 give me any proof that any wrongdoing had been done to  
 19 those babies.  
 20 **Q.** But you know -- and I won't take you through  
 21 all the children for obvious reasons -- but they were  
 22 stable for the most part, their deaths were unexpected  
 23 and they were unexplained for the most part; in other  
 24 words, there wasn't a clear cause of death, which is why  
 25 the Consultants were concerned, because they couldn't

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1 **Q.** She thought Lucy was a good nurse?  
 2 **A.** Yes.  
 3 **Q.** You accepted those two things?  
 4 **A.** Yes, I did.  
 5 **Q.** And you didn't investigate the matters  
 6 yourself?  
 7 **A.** No, I was involved in some of the  
 8 investigating work but I didn't investigate anything  
 9 myself. I -- you know, I was aware of the  
 10 qualifications of Lucy Letby, you know, the courses that  
 11 she had done since qualifying.  
 12 **Q.** You have mentioned repeatedly in your evidence  
 13 the seriousness of the allegation or the accusations to  
 14 be put to Lucy Letby, had it been true?  
 15 **A.** I don't think we ever made an accusation.  
 16 **Q.** No, that wasn't my question. Today you have  
 17 talked about how serious it was to accuse someone?  
 18 **A.** Yes.  
 19 **Q.** It's right though that that's nothing compared  
 20 to the seriousness of the death of the children?  
 21 **A.** Right.  
 22 **Q.** Correct?  
 23 **A.** Yes.  
 24 **Q.** And the seriousness for their Families?  
 25 **A.** (Nods)

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1 understand why the children had died.  
 2 So that in itself is concerning, isn't it, children  
 3 dying unexpectedly, obviously?  
 4 **A.** But I'm sorry, you know, I -- I -- I didn't  
 5 think any differently at that stage.  
 6 **Q.** Did you think about the consequences if you  
 7 were wrong?  
 8 **A.** Of course I think about it.  
 9 **Q.** No, at the time --  
 10 **A.** Well, no --  
 11 **Q.** So let me finish the question.  
 12 **A.** -- at the time, I -- I didn't think about the  
 13 consequences. You know, things do happen. Coincidences  
 14 do happen and the fact that she was present, you know.  
 15 And I think if she had been caring for each of those  
 16 babies and not just being on the unit then, then that  
 17 may well have, have been slightly different; you know,  
 18 the fact that only babies in her care were dying. But  
 19 that wasn't actually the case.  
 20 **Q.** But did you ever check that she had had any  
 21 contact with any of the babies that weren't in her care?  
 22 Did you actually check that?  
 23 **A.** Well, no. In fact we couldn't check that  
 24 element --  
 25 **Q.** So why --

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1 A. -- because the -- the -- there was no -- none  
2 of the staff came forward and said, you know, that there  
3 was interference with the care of their baby.

4 In the neonatal unit, they -- the nurse allocated  
5 tended to do everything for those babies and -- but  
6 I don't know whether they did sort of document if  
7 someone else took over for lunches or their breaks.

8 I really don't know, but --

9 Q. Sorry. Did you try and check that?

10 A. No, I did not personally check.

11 Q. Just going back to my original question.

12 You thought Lucy Letby was a good nurse, that is  
13 what Ms Powell had assured you, and you thought it  
14 coincidence, which is what she thought as well.

15 A. Yes.

16 Q. Did you think about the consequences if you  
17 were wrong; that she, in fact, wasn't the nurse you  
18 thought she was and that this wasn't a coincidence.

19 Unlikely as you might have thought it, but did you ever  
20 think about the consequences that you were wrong?

21 A. No, I don't think I did.

22 Q. Do you recognise that the consequences were  
23 extremely serious, in fact it couldn't be more serious?

24 A. Yes.

25 Q. In those circumstances, if you can't be

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1 structured?

2 A. It was generally a monthly meeting. It may  
3 have stretched or if there was issues it may not have  
4 occurred on a monthly basis, but it was a meeting where  
5 the four managers of the children and neonatal unit  
6 would go and speak with the head of nursing for our  
7 area.

8 Q. Did you meet her, apart from those formal  
9 meetings, the monthly sort of fixed meetings? Were you  
10 in regular contact to discuss things with her?

11 A. No, I don't think I was.

12 Q. Going back again -- and I appreciate your  
13 memory isn't perfect about these events in 2015, it was  
14 some time ago -- but after Child I died and you and  
15 Eirian Powell were thinking about what might be causing  
16 the increased mortality, did you raise that concern,  
17 either your concern on behalf of the nursing team or the  
18 Consultants' concern, with Karen Rees in 2015?

19 A. I really can't say for definite that either  
20 myself or Eirian did. I thought that it was -- at least  
21 the mortality on the unit was discussed. But I --  
22 I really couldn't swear to that.

23 Q. Doing the best you can, if you think about  
24 those monthly meetings --

25 A. Well, I -- I think that we did discuss it, but

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1 certain that children aren't being harmed, isn't the  
2 obvious step to take action urgently to protect  
3 children?

4 A. Yes. In retrospect, yes, we would -- we  
5 should have.

6 Q. Not in retrospect. Based on the information  
7 that you knew at the time, you couldn't be certain that  
8 Lucy Letby was not harming the children and therefore  
9 you needed to investigate urgently?

10 A. No.

11 Q. Do you accept that?

12 A. Yes.

13 Q. Can I just ask you about Karen Rees. I think  
14 she became the head of nursing in the Urgent Care  
15 Division in August 2015. You may not remember that  
16 date, but do you remember her becoming a manager above  
17 you?

18 A. Yes.

19 Q. Was it at that point that you would have  
20 started having regular contact with her?

21 A. Yes.

22 Q. Straight away?

23 A. With Karen Rees, yes.

24 Q. Could you just describe the frequency of the  
25 meetings and how they took place and if they were

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1 I -- I really don't know.

2 Q. In 2015, at some point, or are you taking us  
3 into 2016?

4 A. No, I -- I think -- I think that we started to  
5 inform earlier in 2015 and when Karen took over I think  
6 that we would have continued to -- to inform her if  
7 there was a baby death.

8 I don't know if we did say that the neonatal  
9 Consultant was concerned and had raised concerns  
10 about it.

11 Q. So doing the best you can, do you think that  
12 you or Eirian Powell will have told Karen Rees, some  
13 time in 2015, that there were concerns about increased  
14 mortality in the neonatal unit?

15 A. I -- I do believe that we had informed about  
16 the raised mortality. I really can't say at what stage  
17 we did do that. My recollection was that it had started  
18 earlier in 2015 with the previous head of nursing.

19 Q. And when those discussions started, were you  
20 also raising the concerns that had been raised with you  
21 or Ms Powell about Lucy Letby?

22 A. I don't -- I don't know at what stage that was  
23 raised as a concern. I think that that may have been in  
24 the June or July. I'm sorry, I really can't think --

25 I can't remember.

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1 Q. Lastly, Mrs Murphy, in your statement you  
2 don't mention The Families of the children and in your  
3 reflections you don't talk about your own responsibility  
4 for the hospital unit, for the nursing team, during the  
5 period in which the children were killed.  
6 Is there anything you would like to add in this  
7 evidence now before you go in respect of that?  
8 A. From my reflections from this is that, you  
9 know, all of those babies died and obviously some of  
10 them could have been prevented. Some of them could have  
11 been prevented from ending up with, with, you know,  
12 lifelong problems and, and, yes, from my perspective  
13 I should have done something earlier myself.  
14 But I -- I really didn't --  
15 Q. Thank you.  
16 A. I couldn't understand why, you know, it was  
17 happening. So, you know, I have to apologise to all of  
18 those Families from my perspective that, you know,  
19 I feel that I certainly failed those children by not  
20 doing something sooner. So I am sorry for that.  
21 MR SKELTON: Thank you, Ms Murphy. Thank you,  
22 my Lady.  
23 LADY JUSTICE THIRLWALL: Thank you very much,  
24 Mr Skelton.  
25 Mrs Murphy, that's the end of your evidence so you  
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1 IS true and accurate to the best of your belief?  
2 A. It is.  
3 Q. You tell us, Ms Rees, at paragraph 7 that you  
4 commenced the role of head of nursing within the Urgent  
5 Care Division later referred to as Associate Director of  
6 Nursing in August 2015 and stayed in that position until  
7 2018 at the Countess of Chester?  
8 A. That's correct.  
9 Q. What was your experience before that position?  
10 A. Before what, Sorry.  
11 Q. What was your experience before taking up that  
12 position in nursing and managing generally?  
13 A. Okay. Sort of my career path?  
14 Q. Yes.  
15 A. Prior to taking up my post as head of nursing  
16 I was theatre manager for eight years, my background is  
17 cardiology. But I wanted to gain experience within the  
18 surgical division as well as the Planned Care Division  
19 so I could get an overview, which I think that's what  
20 helped me get my head of nursing post eventually. I had  
21 responsibility for eight wards at the Countess of  
22 Chester Hospital, three wards at Ellesmere Port  
23 Hospital, I also had managerial responsibility for the  
24 emergency department, all specialist nurses within the  
25 Urgent Care Division but I was supported and of course  
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1 will be free to go in just a minute, but I just wanted  
2 to thank you for coming.  
3 A. Thank you.  
4 LADY JUSTICE THIRLWALL: I appreciate it has not  
5 been easy, but it's been helpful. Thank you.  
6 A. Thank you very much.  
7 LADY JUSTICE THIRLWALL: I know we finished  
8 a little bit late, but we are going to start again at  
9 2 o'clock.  
10 (1.10 pm)  
11 (The luncheon adjournment)  
12 (2.00 pm)  
13 LADY JUSTICE THIRLWALL: Ms Langdale.  
14 MS LANGDALE: My Lady, may I call the next witness.  
15 LADY JUSTICE THIRLWALL: Ms Rees, would you like to  
16 come forward.  
17 MS KAREN REES (sworn)  
18 Questions by MS LANGDALE  
19 LADY JUSTICE THIRLWALL: Do have a seat.  
20 A. Thank you.  
21 MS LANGDALE: Ms Rees, you have provided the  
22 Inquiry with a statement dated 14 June 2024.  
23 Do you have that with you?  
24 A. I do.  
25 Q. And can you confirm for us that the statement  
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1 neonates and paediatrics came under that umbrella too  
2 but I was supported by four matrons and one lead nurse.  
3 Q. Before you took that role, was all of your  
4 other experience related to adult patients?  
5 A. Yes.  
6 Q. So when you began this Director of Nursing  
7 role or head of nursing, did you receive any particular  
8 training or go on any course in relation to safeguarding  
9 or child protection as it used to be known?  
10 A. We all have safeguarding training to do within  
11 the environment obviously, but mine was majority adult,  
12 being in the adult. When I took over as head of  
13 nursing, I made it my business to become accommodated  
14 with the neonatal unit and paediatrics because clearly  
15 I never had any nursing experience. So I did rely  
16 heavily on the senior nurses in both those departments  
17 but I didn't have any basic training in paediatrics or  
18 neonates, no.  
19 Q. So when you say you relied heavily on the  
20 senior nurses, which ones were those?  
21 A. Okay predominately Eirian Lloyd Powell and  
22 Anne Murphy.  
23 Q. What did you at that time think should be done  
24 if you were suspicious, only suspicious or concerned  
25 that a child may have been harmed deliberately by an  
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1 adult, what did you think should happen where there is  
2 just mere suspicion?

3 **A.** It should have warranted an immediate  
4 investigation.

5 **Q.** By whom? I am not talking specifically now,  
6 just generally what was your understanding, if there's  
7 a baby in hospital and there's concerns that someone may  
8 have harmed that baby, we don't know who, a family  
9 member, a member of staff, someone might have harmed  
10 a child, a baby: what should happen next?

11 **A.** Okay. I think initially the safeguarding team  
12 should have been brought in immediately to have a look,  
13 an overview, and then make some recommendations if it  
14 needed a further deep dive into an investigation where  
15 the appropriate personnel who have got the appropriate  
16 qualifications, somebody like myself obviously couldn't  
17 investigate.

18 So we would have to make sure that we appointed  
19 somebody with those relevant -- that relevant knowledge  
20 and skills.

21 **Q.** So if somebody was concerned on the neonatal  
22 unit that an adult, a parent or a family member had  
23 harmed a child, and you were told there is some concern,  
24 at that time would you have said "go to safeguarding" or  
25 would you yourself go to safeguarding?

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1 and out of there so I could understand how that the  
2 neonatal unit run, so yes, that was my impression  
3 initially, yes.

4 **Q.** And you say at paragraph 11a when we have  
5 asked you about culture amongst different groups, you  
6 say:

7 "Clinicians and managers: initially the  
8 relationships between the clinicians and managers were  
9 good. They appeared to communicate effectively and  
10 supportive of one another."

11 What tier of management do you mean when you are  
12 saying that, that they appeared to communicate  
13 effectively?

14 **A.** Okay, well obviously myself as first line,  
15 Eirian and myself, and then the clinicians and with the  
16 Executive team.

17 **Q.** Mr Chambers, Ms Kelly?

18 **A.** Yes.

19 **Q.** Others?

20 **A.** Yes, because Sian Williams was the deputy  
21 Director of Nursing at the time, obviously Alison Kelly  
22 then you have got Ian Harvey who was the Medical  
23 Director, Tony Chambers. Yes, they were our Executive  
24 team members, and Sue Hodkinson.

25 **Q.** So at the beginning you thought that

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1 **A.** Yes, that would be -- I would have, yes,  
2 suggested that we bring safeguarding in immediately as  
3 an initial look.

4 **Q.** Right. So as an initial thought, if it was  
5 a family member, "bring in safeguarding" is what you  
6 think you would have said?

7 **A.** Yes.

8 **Q.** What would you have done if it was a member of  
9 staff, just a mere suspicion, do you think the same or  
10 should have done the same?

11 **A.** I think initially, yes, the same. And then  
12 it -- I would then rely on that safeguarding team to  
13 have a look at the situation or the allegation and then  
14 make some recommendations if a further deep dive was  
15 necessary.

16 **Q.** Paragraph 9 of your statement, you say:  
17 "In August 2015 the culture and atmosphere on the  
18 NNU was good ... a small cohesive team who appeared to  
19 work well together ... [and] the nursing team appeared  
20 happy and well-supported by Eirian Powell and her two  
21 deputies?"

22 **A.** Yes.

23 **Q.** Was that your impression?

24 **A.** That was, because like I said to you earlier  
25 I made a big effort to spend quite considerable time in

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1 communication was good?

2 **A.** Yes, nobody -- I didn't notice anything and  
3 nobody reported anything different.

4 **Q.** At 11b you say:

5 "Nurses, midwives and managers."

6 You say:

7 "The nurses on the NNU worked closely with the  
8 midwifery team supporting each other when the need  
9 arose?"

10 **A.** Yes.

11 **Q.** That was your impression. Did Eirian Powell  
12 ever say anything different to you? She's told the  
13 Inquiry that there were some issues with the midwifery  
14 team but was that ever discussed with you?

15 **A.** Not to -- not that I can recall. In fact, my  
16 recollection was the midwifery team and the neonatal  
17 team worked quite well together because they did cross  
18 boundaries with care. So no, I don't recall Eirian ever  
19 informing me of anything.

20 **Q.** And 11c, in terms of the relationship between  
21 medical professionals, doctors, nurses, midwives and  
22 others, how would you describe the working relationships  
23 between doctors and nurses on the NNU at that time?

24 **A.** Initially I thought they worked quite well  
25 together, my observation was that.

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1 I think things became a little strained as time  
2 moved on and when circumstances started to unfold. I do  
3 think there then was an element of trust, I did feel  
4 that there was a change.

5 **Q.** And when you say "element of trust", what was  
6 the issue?

7 **A.** Well, my observation was that obviously the  
8 nursing team had one view and the medical team had  
9 another. What I think it's fair for me to comment that  
10 communication could have been better.

11 **Q.** In what way -- in what way could it be better?

12 **A.** Well, meetings and reporting of incidents were  
13 going on and it wasn't cohesive. You know, it took me  
14 a while to realise that the clinicians, the  
15 paediatricians had raised concerns with the Executive  
16 team and I knew nothing about it. I wasn't involved,  
17 I wasn't told about it.

18 So these alleged meetings that I have later found  
19 out that the Consultants said they had with the  
20 Executive team, I wasn't informed of them and  
21 I certainly wasn't invited to them.

22 So it was -- it was a little bit cloak and dagger.  
23 You know, I didn't know who had been reporting to who  
24 and who had been ... so I do think that was a little bit  
25 of a breakdown in an element of trust. Nobody -- my

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1 **A.** Yes, I've seen that.

2 **Q.** You have seen the document?

3 **A.** Yes.

4 **Q.** The general point I want to ask you about is  
5 page 23 at the bottom, if we can enlarge the last two  
6 paragraphs. You are thinking about the grievance and  
7 one of the outcomes that they wanted was mediation with  
8 Dr Brearey and Dr Jayaram.

9 So if we look at the last two paragraphs, just  
10 expand or explain to us. You see here:

11 "Well, my thoughts about the way that it was or it  
12 really didn't need happening because I don't see the  
13 point, I know these are notes.

14 "I can't follow that. Can you just explain whether  
15 you thought that mediation between the doctors and Letby  
16 was a good idea or not?"

17 What are you saying at this point? Take your time  
18 to have a look at it. I know you have seen it but have  
19 a look again.

20 **A.** Yes, please. (Pause)

21 **Q.** Darren Thorne says:

22 "Did you think mediation was the right thing in the  
23 first place?

24 "Now we know what we know, probably not, but  
25 I think to be fair to the Execs, whoever, because it was

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1 observation was nobody knew who was talking to who.

2 **Q.** About what?

3 **A.** About the concerns raised.

4 **Q.** And do you think things were getting repeated  
5 by people or misstated sometimes in that practice?

6 **A.** Possibly, again I can't give you an example of  
7 that. But as time unfolded, and I got informed of  
8 meetings that had taken place between the clinicians and  
9 the Executive team, I was surprised nobody had mentioned  
10 it and I also think it's important for me to say I would  
11 have expected Ravi Jayaram and Steve Brearey to  
12 highlight their concerns initially with Eirian if you  
13 are following hospital policy and procedure.

14 If you have got concerns --

15 **Q.** I will come to that later. I am just talking  
16 about generalities at the moment.

17 **A.** Okay, sorry.

18 **Q.** If we go, please, to INQ0003057, page 23, it's  
19 the end of an interview you had with Facere Melius,  
20 Ms Rees?

21 **A.** Who, sorry?

22 **Q.** Facere Melius, it was a company that were  
23 doing a review for the hospital and you were interviewed  
24 by somebody called Kay Boyle, I think, asking you the  
25 questions?

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1 an external person ..."

2 You go on and say further down that paragraph:

3 "Come on, Executive team, you had an outcome, why  
4 aren't we driving it forward? If it had been a nurse,  
5 she'd have been told you're doing it and I did and it  
6 just saddens me. I think we are in this day and age,  
7 I just think we [if we go to the next page, page 24]  
8 perhaps have to be careful about what outcomes we put as  
9 a grievance if not going to be followed through and  
10 I suppose it reiterates maybe that perhaps things  
11 haven't changed that much, that Consultants have got the  
12 power and organisation. That's how I feel."

13 So as a generality you are clearing expressing  
14 there the relationship between nurses and Consultants,  
15 you think the Consultants have the power?

16 **A.** That's how I felt at the time because  
17 I thought a lot of effort had gone in with Lucy Letby's  
18 grievance and then to make recommendations that then  
19 weren't fulfilled and I felt that, yes, initially  
20 mediation was a good idea to try and move things forward  
21 in order for us to allow to get Lucy Letby back on the  
22 neonatal unit there had to be some mediation because  
23 obviously, like I have said to you, the amount of trust  
24 had, you know, fallen.

25 And then I think the frustration was that those

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1 mediations, or not all of them, went ahead and it didn't  
2 and that seemed to me which is why I made that comment,  
3 is that the Consultants can say no, I don't want to do  
4 it.

5 **Q.** And do you think where they had raised  
6 concerns she was deliberately harming babies it was  
7 entirely understandable that they said no?

8 **A.** Yes, I understand what you are saying. But  
9 the grievance was -- was upheld and at that time, if my  
10 memory serves me correctly, there was still no evidence  
11 tabled pointing everything at Lucy Letby.

12 **Q.** What do you mean "tabled"?

13 **A.** Well, discussed or highlighted or presented.  
14 I think that was a frustration from us all particularly  
15 as time went on.

16 **Q.** Let's have a look at paragraph 7, if we may,  
17 so paragraph 7 is when you tell us in your statement:

18 "I first became aware of the increased mortality  
19 rate on the NNU in February 2016. This was when the  
20 internal Thematic Review took place and Eirian Powell  
21 sent me an email outlining the findings of that review."

22 We can't find that email. I don't know if you  
23 remember the email now. Do you remember the table, do  
24 you remember the review table that she sent or spoke  
25 about?

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1 of babies and outcomes written down.

2 When you received that, what did you make of it?  
3 What did you think was going on?

4 **A.** I think we all had concerns when we -- when we  
5 read that. I certainly did when I read it and I did  
6 rely heavily on Eirian Lloyd Powell to discuss these  
7 things, this was her area of expertise.

8 So yes, I think I would have discussed that  
9 definitely with Eirian.

10 **Q.** Did she tell you whether there had been  
11 discussion about, for example, the time of day or night  
12 that a number of babies had died, was that raised?

13 **A.** I do recall being informed that predominantly  
14 a greater number of the mortalities happened on night  
15 shift. I'm not sure when it was -- if it was at the  
16 same time I received this.

17 **Q.** You received one in May again, didn't you?

18 **A.** Yes.

19 **Q.** With Letby's name in red, so it could have  
20 been then?

21 **A.** It might have been sorry but yes, it was  
22 definitely and the reasons why I do recall that is  
23 I think Eirian made the decision to bring Lucy Letby on  
24 days.

25 **Q.** Yes, we will get to that.

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1 **A.** The table with the -- following the thematic  
2 review?

3 **Q.** Yes, yes, did you see that?

4 **A.** Yes.

5 **Q.** Shall we put that on the screen to help you  
6 see if it -- INQ0003251, page 1 is the front sheet.  
7 This is dated February but this is the one that was sent  
8 out in March. There is one in February and one in  
9 March.

10 Does this ring a bell if we go to page 2, "Purpose  
11 of Meeting". Did she send you this?

12 **A.** I did -- I do recall seeing that, yes, I have  
13 got --

14 **Q.** Okay. So we see there:

15 "There was a higher than expected mortality rate on  
16 the NNU in 2015. An obstetric thematic review did not  
17 identify any common themes or identifiers that might be  
18 responsible for the rise in mortality. The aim of the  
19 neonatal meeting was to review the cases again as  
20 a multi-disciplinary team with an external review and  
21 tertiary level neonatologists to assess where all  
22 actions points completed, any new areas of care  
23 improvement, any possible common themes discussed if  
24 further action is required."

25 And then attached to that we know there was a list

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1 **A.** Sorry.

2 **Q.** She does, you are right, but this is March  
3 time?

4 **A.** Okay.

5 **Q.** But when you received this you realise there's  
6 increased mortality. Do you appreciate that some of  
7 these babies have suddenly and unexpectedly  
8 deteriorated? It's not simply they have died, in some  
9 cases it is that it is unexpectedly died, was that  
10 discussed between you and Eirian Powell?

11 **A.** I am sure it was because I can recall Eirian  
12 giving me assurance saying that a number of these babies  
13 had been born with congenital abnormalities, that might  
14 have explained the sudden collapse, that I think if I am  
15 right there was a sepsis issue. That's all I can recall  
16 without looking at it, sorry, but I do recall us having  
17 that conversation and she was giving me assurance  
18 saying, well, because of these things that that might  
19 explain the sudden collapses.

20 **Q.** Did you question whether she had the expertise  
21 to tell you how particular babies had collapsed or why  
22 they had died?

23 **A.** I didn't question Eirian's expertise because  
24 she had been a long time in that role and I did, like  
25 I say, rely heavily with her experience and her

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1 knowledge. So I never questioned her experience because  
2 she was a senior nurse, running the neonatal unit and  
3 had been there for quite some time. So no, I didn't  
4 question.

5 **Q.** Identifying cause of death is a very complex  
6 process --

7 **A.** Yes.

8 **Q.** -- isn't it?

9 **A.** Yes.

10 **Q.** Particularly where deaths occur in suspicious  
11 circumstances?

12 **A.** Yes.

13 **Q.** Did you understand that of itself was forensic  
14 and difficult and required scrutiny?

15 **A.** Absolutely. Yes.

16 **Q.** And you were taking responses from  
17 Eirian Powell about causes of death and being reassured  
18 about that. Do you think you should have been reassured  
19 about what she said about unexpected deaths or specific  
20 deaths?

21 **A.** I suppose in hindsight, which is a wonderful  
22 thing, but at that time and I think there were rumblings  
23 of infection -- potential infection control issues. So  
24 there were other few -- if my memory serves me  
25 correctly, if it was the right time, so perhaps not but

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1 So I think we were trying to cast the net widely to  
2 see was there anything else. Because yes, I accept  
3 Lucy Letby was on duty for a large number of those,  
4 although she wasn't allocated all of the babies under  
5 her care, but she was present on the unit at the time  
6 and I think we were just -- it was just an awful thought  
7 when I think about it to think that somebody could  
8 purposely be doing this --

9 **Q.** Pausing there, why did it matter whether she  
10 was allocated to the babies when she was on shift?

11 **A.** What tends to happen in an intensive care  
12 environment, which obviously neonatal unit was, when  
13 I used to manage coronary care, which was obviously  
14 adult, but you got allocated a patient to care for while  
15 you were on shift and the same thing happened on  
16 neonates.

17 Now, that doesn't mean to say even though you have  
18 been allocated a patient, whether adult, child, baby, if  
19 you are present on the unit and responsible for looking  
20 after another patient, that didn't mean to say that you  
21 wouldn't come in and help if for whatever reason that  
22 was required.

23 But I suppose at the time we were thinking, right,  
24 if she would have been allocated all of those babies,  
25 that might have put up a bigger red flag. It was

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1 I did rely heavily on her.

2 **Q.** When you say "rumblings of infection control"  
3 that's again something that was repeated, wasn't it, we  
4 have heard about pseudomonas in taps infection?

5 **A.** Yes.

6 **Q.** You sat on QSPEC?

7 **A.** Yes.

8 **Q.** The Quality Safety and Patient Experience  
9 body, it was never suggested that babies were dying as  
10 a consequence of infection on the ward, was it?

11 **A.** No, not at QSPEC, no.

12 **Q.** And if that was happening, whether it was any  
13 infection on that unit or across the hospital that would  
14 have been an issue attacked by a number of wards,  
15 wouldn't it, and considered?

16 **A.** Yes. But I think -- I think at that time we  
17 were all looking to see could there be -- what could be  
18 the reasons that are causing these collapses.

19 **Q.** Were you looking hard for an innocent  
20 explanation because you didn't want to look at the more  
21 difficult explanation?

22 **A.** I think all of us that were involved and  
23 certainly as it unfolded were really keen to try and  
24 find if there was a cause or causes that could account  
25 for the number of mortalities.

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1 something we -- Eirian and I discussed and, you know, we  
2 did consider.

3 **Q.** Did Eirian Powell tell you that Nurse W, who  
4 had been running a shift, complained that Letby didn't  
5 look after her allocated baby and kept gravitating to  
6 Baby C, one of the murdered infants? So she wasn't  
7 playing by the rules that you have just described about  
8 looking after her own baby. Nurse W reported this to  
9 Eirian Powell who suggested she raise a Datix in  
10 relation to the baby Nurse W was worried about at the  
11 time, the one that Letby was supposed to be looking  
12 after in a different nursery.

13 When you had this conversation about the  
14 significance or not of being a shift or allocated a baby  
15 on a shift, did Eirian Powell tell you of that complaint  
16 what that had been made to her about Letby?

17 **A.** No, I don't recall that at all. But I think  
18 the other side of that is if that particular Nurse W had  
19 put a Datix report in about that, I am sure that would  
20 come to my attention as a head of nursing at some point  
21 once it had gone through the system and I can't ever  
22 recall seeing a Datix with that issue being raised  
23 neither. But definitely I can't -- I do not recall  
24 Eirian highlighting that to me, no.

25 **Q.** Would you have been interested to know that

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1 when you are looking at everything?

2 **A.** I think -- I think Eirian would have -- well,  
3 I would have expected her to have raised that with me at  
4 some point when we were having conversations because  
5 clearly this -- as it unfolded, this got bigger and  
6 bigger and obviously --

7 **Q.** Did you ever with her talk specifically about  
8 specific babies that had died, Baby A, Baby C?

9 **A.** No.

10 **Q.** Baby D, or did you deal with these  
11 generalities?

12 **A.** It was more generalities because clearly, like  
13 I have said, neonates is not my area of expertise, so  
14 I had nothing to do with the care of those babies but  
15 clearly I liaised a lot with Eirian about obviously the  
16 whole neonatal issue.

17 But no, I wasn't aware who Baby A,B,C -- no,  
18 I wasn't, it was more general.

19 **Q.** So you never sat down with her and said,  
20 "Right, this baby, what reports have you got, what are  
21 you thinking, where are you at with this one?"

22 **A.** No.

23 **Q.** That wasn't your remit?

24 **A.** No.

25 **Q.** Who did you think was doing that?

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1 **A.** Yes, she does.

2 **Q.** "I will check the report they send through,  
3 I didn't notice there was a staff trend."

4 That is a report again with a list of babies and  
5 Letby's name very clearly in red.

6 First of all, who did you think had put her name in  
7 red and what did you think when Alison Kelly asked you  
8 to look into it, that you were supposed to be doing?

9 **A.** I can't say for certain, but I would have  
10 assumed it would be Eirian and Steve Brearey would have  
11 highlighted Lucy Letby's name in red because following  
12 the thematic review they were looking into all aspects  
13 of that, which is why when Alison had sent me that then  
14 obviously I would have had a discussion with Eirian  
15 about it, as I said there, although I have got no  
16 evidence of that discussion but clearly that put on my  
17 radar would have been something I would have discussed  
18 with Eirian.

19 **Q.** They can go down now please, thank you.

20 It is paragraph 16 of your statement. You say:

21 "I did read the schedule I had been sent by  
22 Alison Kelly ... [and] I was aware prior to receipt of  
23 these emails of an increase in the mortality rate ...  
24 I cannot recall enquiring as to what the usual mortality  
25 rate was for the NNU. I relied on Eirian Powell to

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1 **A.** I thought the team as a whole certainly  
2 following the thematic review and on the attachments  
3 that Eirian sent I would have thought that the  
4 clinicians and Eirian and the senior team would have  
5 discussed that there between themselves because they are  
6 the ones with the expertise.

7 **Q.** There's an email I would like you to go to  
8 now, I have got two INQ reference numbers. INQ0003138,  
9 page 1. So 0003138, page 1. It's an email to you,  
10 Ms Rees, the second one down. 4 May.

11 "Hi Karen, please see attached. Not sure you will  
12 have had previously sight of this. Lucy Letby  
13 highlighted in red. I have not noticed this when  
14 I first reviewed. Can you please look into this as per  
15 my previous e-mail. Thanks."

16 And you say:

17 "Dear Alison, I am meeting with Eirian tomorrow."

18 And we see below, not that she sent it to you,  
19 another email that Alison Kelly has sent.

20 "Please look into this with Anne Murphy/Eirian. If  
21 there is a staff trend here, we have already changed her  
22 shift patterns because of this. This is potentially  
23 very serious."

24 So she does send that one to you as well, doesn't  
25 she, 4 May?

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1 update me".

2 What did she update you with following receipt of  
3 this new table with her name in red?

4 **A.** I think she just went through the table with  
5 me. I can't absolutely recollect, but I know we would  
6 have sat down and discussed obviously Lucy Letby and her  
7 allocation of babies and her presence on the unit.

8 **Q.** We know you weren't copied into the email so  
9 there is no need to put it up but Dr Brearey, 4 May,  
10 emails Alison and says there is a nurse who's been  
11 present for quite a few of the deaths and other arrests,  
12 Eirian has sensibly put her on day shifts only at the  
13 moment but can't do this indefinitely.

14 So you appreciated at this time she was on day  
15 shifts as you mentioned earlier. What did you make of  
16 that?

17 **A.** My understanding when I asked Eirian about  
18 that because it was obviously a decision she made, I do  
19 remember her saying to her "Okay, what is the rationale  
20 then?" And if my memory serves me correctly, I remember  
21 her informing me that it was a neutral act to bring her  
22 on to days. It wasn't deemed as a punishment or  
23 a finger-pointing exercise.

24 It was because there are more staff on days than on  
25 nights and because of what you alluded to earlier about

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1 predominantly a lot of these mortalities were happening  
2 on the night shift, she wanted to check her competencies  
3 and bring her on to days so she could be more supervised  
4 if, I remember correctly.

5 **Q.** So she was suspicious that she may have been  
6 doing something whether it was deliberate harm or  
7 incompetence that impacted on the deaths at night and  
8 she would be better off in the day, is that the  
9 position?

10 **A.** I don't think, I think it was more checking  
11 her competencies.

12 **Q.** Right.

13 **A.** Because it goes without saying if you have got  
14 more staff on days, then you can allocate somebody to  
15 check those competencies because there's obviously more  
16 people around, whereas you have a limited number on  
17 night shift, it is harder to do that.

18 **Q.** And what did you understand checking her  
19 competencies meant?

20 **A.** Well, looking at exactly that; I am led to  
21 believe that Lucy Letby had the extra qualification in  
22 specialty and she was one of a number, there is only  
23 a small number of Eirian's team, if I remember rightly,  
24 had that qualification.

25 So it was extra training I am led to believe in ITU

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1 **Q.** At paragraph 22, you set out that you were  
2 aware that Letby had this qualification. Were you also  
3 aware there were many Band 6s on the ward and many  
4 nurses more experienced in terms of years than her?

5 **A.** Yes.

6 **Q.** She was a young nurse at the beginning of her  
7 career really, wasn't she?

8 **A.** Yes.

9 **Q.** So she may have done this course but the  
10 notion she was highly experienced or a Band 6, 7 or  
11 advanced neonatal practitioner, nothing like that, we  
12 are talking about a Band 5 who has done one course,  
13 important, but it's an important perspective isn't it,  
14 to bring to bear to this issue?

15 **A.** Yes, absolutely.

16 **Q.** And you say at paragraph 22:

17 "The sickest patients are often allocated to the  
18 most qualified nurse. This was the reason that Letby  
19 could have been allocated the sickest babies to care  
20 for."

21 Was that something you were told by anyone?

22 **A.** No, that's why I have said "could have".

23 And if I go back to when I was ward manager of  
24 coronary care, I would give my sickest patient on that  
25 unit to my most experienced nurse to care for.

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1 care of the neonate, so it will be the competencies that  
2 will be attached to the roles and responsibilities of  
3 that nurse, with that qualification and also her basic  
4 competencies as well. You know, nursing observations,  
5 all the additional roles and responsibilities that comes  
6 with that qualification, I would have thought that's  
7 what would have been checked.

8 **Q.** And when you say "been checked", who was going  
9 to be told, who should be doing the checking, you need  
10 to know you are checking on someone, don't you, if you  
11 are checking?

12 **A.** Well, I would have thought, although I can't  
13 say for sure, the neonatal unit had a practice  
14 development nurse within their team and I would have  
15 assigned it to her.

16 **Q.** You would have?

17 **A.** Yes.

18 **Q.** Do you know if it was and is that Yvonne  
19 Farmer you are talking about?

20 **A.** Yes.

21 **Q.** So you think someone like Yvonne Farmer should  
22 have been doing that or supporting her with her work at  
23 that time?

24 **A.** Yes, I would have expected her to be doing  
25 that, yes.

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1 **Q.** Well, there were a lot of Band 6s, so this is  
2 a young Band 5. So if you just stand back for  
3 a moment --

4 **A.** Okay.

5 **Q.** -- she's not a highly experienced or advanced  
6 qualified neonatal nurse or anything like that, is she,  
7 at this point?

8 **A.** She wouldn't have had the length of experience  
9 that some of those nurses on the neonatal unit would  
10 have had clearly because of their length of service.

11 But what she would have obtained, I would have  
12 thought, by doing that extra qualification is that she  
13 would have been taught additional -- what can I say? --  
14 competencies to care for a sicker baby because that  
15 surely is the whole purpose of doing a course.

16 **Q.** When you say "sicker baby", you hadn't sat  
17 down you said earlier and done a review of the  
18 unexpected deaths, you didn't know whether any of those  
19 babies were sick or not presumably, did you?

20 **A.** No, I didn't.

21 **Q.** So that is a generalisation rather than --

22 **A.** Yes.

23 **Q.** -- specific to the unexpected deaths?

24 **A.** Yes.

25 **Q.** You tell us that you had a meeting on 5 May

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1 and in fact if we go to INQ0006890, page 77, we see  
2 an email to you from Eirian following on from that  
3 meeting.

4 **A.** Sorry, it's not come up on my screen.

5 **Q.** Don't worry, it will in a moment.

6 You tell us that these are the documents that  
7 Eirian sent you after the meeting. Just to be clear,  
8 Dr Brearey doesn't recollect being at this meeting. It  
9 says it is yourself, Yvonne Griffiths, Anne Murphy and  
10 Dr Brearey. Might it be the case that he wasn't present  
11 at this meeting on 5 May?

12 Let's refresh your memory with the documents that  
13 are sent. It might help bring it back to you.

14 Lucy's shifts, you were sent documents relating to  
15 her shifts from Eirian Powell. You were sent the table  
16 again with the names of the babies. Can you remember?

17 **A.** Yes.

18 **Q.** There's a suggestion in this email:

19 "We would like to have a meeting with Alison Kelly  
20 and Ian Harvey as a matter of urgency primarily for  
21 reassurance and to ensure that we have covered all the  
22 relevant actions".

23 She also produced -- and let me ask you if you saw  
24 this -- INQ0006690, page 93. At some point this has  
25 been produced.

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1 regarding her performance."

2 Did you know about her being involved or setting  
3 a morphine rate 10 times the dose it should have been  
4 for a baby in 2013, did she mention that?

5 **A.** Never.

6 **Q.** That she had had a one-to-one and had to be  
7 checked, did you know about that?

8 **A.** No. Never.

9 **Q.** Would you like to have known about that  
10 performance issue --

11 **A.** Yes.

12 **Q.** -- at the time?

13 **A.** Yes. Honestly I -- I wasn't aware of that  
14 fact. When was that, sorry, did you say?

15 **Q.** In 2013.

16 **A.** No, no.

17 **Q.** So a couple of years previously that she had  
18 a one-to-one with Yvonne Griffiths, also with  
19 Eirian Powell and had further training with Yvonne  
20 Farmer, you weren't aware of that?

21 **A.** No, I mean appreciating that it was at least  
22 two years before I came into post, but no, I was not  
23 aware of that.

24 **Q.** Were you made aware that in fact  
25 Nurse Lightfoot -- do you know Nicola Lightfoot?

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1 I will just wait for a moment. Sorry, that's not  
2 right page. Yes, there is 6890, page 93. Did you see  
3 that?

4 **A.** Let me just read it.

5 **Q.** It is a two-page document produced by  
6 Ms Powell. And over the page, 94, next page, if  
7 possible, do we see there:

8 "Karen Rees requested we discussed exactly what the  
9 issues, if any, were other than coincidence that was  
10 evident. Despite highlighting the usual factors there  
11 is not real evidence or a statement that could confirm  
12 whether there was an issue here."

13 These are Eirian Powell's summary?

14 **A.** Yes, I do recall seeing them.

15 **Q.** Yes, you see it?

16 If we go back to the previous page, if we may,  
17 I just needed to you see that second page first. There  
18 is a whole list of factors 1 to 15 that Eirian Powell  
19 has listed. Were those discussed with you at that  
20 meeting on the 5th?

21 **A.** Yes. Yes, I do recall. I remember Eirian  
22 discussing those points with me, yes.

23 **Q.** And do you see number 2 she's recorded:

24 "There are no performance management issues and no  
25 members of staff that have complained to me or others

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1 **A.** I remember the name.

2 **Q.** Did you know that she had failed her in her  
3 final year and she had to do a retrieval placement?

4 **A.** I didn't until I got the Inquiry outline. But  
5 no, I wasn't told.

6 **Q.** Again, would you have thought that was  
7 relevant if someone was telling you there were no  
8 performance issues and she had excellent standards  
9 within the clinical area?

10 **A.** I probably wouldn't have expected to be told  
11 that because if that was at the end of her training,  
12 it's quite some years before. And people do fail  
13 placements during their nurse training so no, I wouldn't  
14 have expected to be informed of that.

15 **Q.** There is a reference at 6:

16 "Cheshire and Mersey Transport Service have been  
17 involved in a few of these mortalities."

18 What did you think that meant, what was the  
19 suggestion being made there?

20 **A.** I think there were delays, if my memory serves  
21 me correctly, between a clinician requesting the  
22 transport service. I am sure that's what Eirian meant  
23 or that number 6 meant, that because there were delays  
24 in the transport service getting to the Countess, and  
25 then transferring the baby to the appropriate tertiary

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1 centre, might have been attributable is my understanding  
2 of that.

3 **Q.** Number 7, the same about if there had been  
4 a bed sooner the infant may not have died. Did she ever  
5 link this to any child or unexpected death that you were  
6 considering?

7 **A.** No, no, I think it was just a general overview  
8 that these issues were obviously present at times, but  
9 I don't recall Eirian really laying them to a particular  
10 baby.

11 **Q.** Some of the issues related to midwifery  
12 problems, any idea what that referred to in relation to  
13 the unexpected deaths of babies?

14 **A.** I could only assume that that was perhaps  
15 a delivery issue but I -- I can't comment. Sorry,  
16 I can't recall that one.

17 **Q.** Then we have, as you described earlier,  
18 recording two of the babies diagnosed congenital  
19 pneumonia, four babies congenital abnormalities, two  
20 with necrotising enterocolitis, one overwhelming sepsis,  
21 transport team issue.

22 On its face it looks as though this is some kind of  
23 specific analysis, but it was not, as far as you are  
24 concerned; it is a generalised commentary of issues  
25 facing the unit rather than anything specific to any

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1 anything else they could look at?

2 **Q.** When you saw it, did you think there's  
3 something else you could do? Like link to specifics of  
4 the babies in the table that you had seen and give a bit  
5 more forensic scrutiny to it? Or alternatively, "Get  
6 someone else to look at this, Eirian, it's too  
7 complicated for you and it's too complicated for me"?

8 **A.** Maybe that's what Eirian -- I can't really  
9 answer for Eirian but I am looking at that. I would  
10 have thought, right, well, we have done A,B,C and D, is  
11 there anything else we need to do or should we hand it  
12 to somebody else to look at? Obviously the concerns  
13 were still there because there was no answers  
14 specifically found at that time.

15 **Q.** Let's move now to Friday, 24 June.  
16 Karen Townsend has provided a statement to the Inquiry  
17 that says she met Dr Jayaram the morning of Friday 24th  
18 at 11 am and she bleeped you immediately afterwards to  
19 speak to you.

20 **A.** (Nods)

21 **Q.** She called you and couldn't get hold of you so  
22 she bleeped you. Do you remember that now, her  
23 contacting you on the Friday?

24 **A.** Oh I do, yes, clearly.

25 **Q.** Was she right, it was Friday morning after she

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1 unexpected death?

2 **A.** Well, I am assuming from point 10 to 15 that  
3 was in relation to the mortalities because there's  
4 numbered there -- there's numbers there, isn't there,  
5 there's four babies had congenital abnormalities, one --  
6 if it had just said congenital abnormalities might have  
7 been an issue with maternal syndrome.

8 So I am assuming that is in relation to the babies  
9 that ...

10 **Q.** Nevertheless, if we can just go back to  
11 INQ0006890, page 77, this is the first email sent to you  
12 on 5 May. If we look there:

13 "We would like to have a meeting as a matter of  
14 urgency primarily for reassurance and to ensure we have  
15 covered all the relevant actions."

16 So whatever she's produced as the ward manager,  
17 she's looking for reassurance. What did you take that  
18 to mean and why did you think she was requesting it?

19 **A.** I think she was requesting that to gain  
20 reassurance from the Executive team that they hadn't  
21 missed anything, hence the request for a meeting with  
22 Alison Kelly and Ian Harvey. Because obviously they had  
23 done the thematic review, these documents showed varying  
24 bits of information and I think Eirian just wanted to  
25 make sure that she had ticked all the boxes or was there

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1 had seen him? She said she saw him at 11 so when they  
2 had finished she said she immediately contacted you; is  
3 that right?

4 **A.** My recollection was it might have been a bit  
5 later but it might have been me delaying my response to  
6 get to her because Fridays, as you can appreciate, in an  
7 acute general hospital very busy. So she might have --  
8 I recall her bleeping me, but I can't put my hand on my  
9 heart and say exactly what time, but she definitely  
10 bleeped me and said "I need to discuss something urgent  
11 with you. As soon as you are free can you come over to  
12 my office?"

13 And I was clearly busy with other things so I got  
14 there as soon as I can which might be the reason for the  
15 difference of opinion of the time.

16 **Q.** When do you think the time was?

17 **A.** It was I am sure it was after lunch by the  
18 time I spoke to Karen, in fact, I know it was. It was  
19 -- it was early, early to mid-afternoon when we had that  
20 conversation in her office, yes.

21 **Q.** And do you get urgent bleeps like that  
22 regularly?

23 **A.** All the time.

24 **Q.** Right. So you go and speak to her and you  
25 pick this up at paragraph 28/29 of your statement but

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1 you may remember it. Tell us in your words what she  
2 said to you.  
3 **A.** She Karen Townsend informed me that she had  
4 met Ravi Jayaram for a coffee over in the Comfort Zone,  
5 which was a cafe in the Women's and Children's building  
6 where she had discussions about any issues and it was at  
7 the end of that conversation that she told me that  
8 Ravi Jayaram had said to her: I just need you to be  
9 aware because we have got concerns about the clinical  
10 practice of one of the neonatal nurses.

11 My recollection is that she then asked him what  
12 were those clinical concerns of which he wasn't  
13 forthcoming with. But obviously it alerted her and  
14 concerned her enough to bleep me about it. Do you want  
15 me to go on and tell you what I --

16 **Q.** Yes, he's -- well, before we go to him, did  
17 she say to you, you say at paragraph 28:

18 "I was called to the office of Karen Townsend who  
19 informed me of allegations from Dr Jayaram that  
20 Dr Jayaram and Dr Brearey both thought Lucy was  
21 purposefully harming babies on the neonatal unit."

22 That is what you say at paragraph 28 of your  
23 statement. Do you have that in front of you? You say  
24 that in your statement to the police, sorry?

25 **A.** Yes.

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1 said to me: well, he will have been in clinic this  
2 morning, not sure where he is this afternoon. So  
3 I asked him to bleep, phone him because I said I really  
4 need to talk to him. Fortunately for me, Steve  
5 Brearey's clinic had overrun so he was still in clinic  
6 in the Women's and Children's building and so I made my  
7 way over there and sat outside his clinic until he had  
8 finished his clinic.

9 When he came out I said: I need to discuss  
10 something important with you, but clearly not in this  
11 environment, so we went back to his office.

12 Ravi Jayaram had left, he wasn't in the office. So  
13 I said to Steve Brearey, I said: look, I said you need  
14 to share with me why you have got these concerns and why  
15 and how do you think that she's purposefully harming  
16 babies and his answer to me and I remember it clearly  
17 because he says: I have got a gut feeling and I have got  
18 a drawer of doom, and he pointed to a drawer in his desk  
19 so I said to him: well, share the contents of that  
20 drawer of doom with me, of which he refused. And he  
21 just said: she needs to be moved off the neonatal unit,  
22 I am aware that she is on this weekend.

23 So I said to him: I can't remove a nurse from  
24 a clinical practice just because of gut feeling and  
25 a drawer of doom of which contents you will not share

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1 **Q.** You say that in your statement to the police?

2 **A.** Sorry, I am just trying to recollect. Yes,  
3 well, if I -- obviously it's in my police statement that  
4 is what was said to me because that's what I have  
5 reported to the police and it did cause me -- I was  
6 absolutely horrified when she told me that. So -- and  
7 particularly when there was no forthcoming rationale to  
8 support these allegations.

9 So I informed Karen Townsend that I needed to go  
10 and find both Ravi Jayaram and Steve Brearey to  
11 ascertain what exactly did they mean. So I immediately  
12 went over to the Women's and Children's building because  
13 Ravi Jayaram and Steve Brearey shared an office  
14 together. I clearly remember Ravi Jayaram being present  
15 in his office, so I knocked on his door and went in to  
16 see him. I said: you know why I am here, I said:  
17 because of what you have just said to Karen Townsend and  
18 I need more information of what on earth are you  
19 alluding to.

20 And again he just said to me: Steve Brearey and  
21 I have got concerns about the clinical practice of  
22 a nurse. I said: well, I need to understand what those  
23 clinical concerns are and if she's purposely harming  
24 babies, you need to give me more information than that.

25 I then asked him where Steve Brearey was and he

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1 with me.

2 So I wasn't getting anywhere with him. He just  
3 kept insisting I remove her, remove Lucy Letby. So  
4 I told him I was going over to the Executives' suite  
5 immediately because I was really concerned at this  
6 point.

7 **Q.** Are you sure he spoke about this that day and  
8 not in the phone call in the evening?

9 **A.** No, this was this afternoon. He did ring me  
10 later. So I went immediately over to the Executive  
11 suite by this time, it's late Friday afternoon and I was  
12 just conscious that everybody would be going home and  
13 I was getting really worried.

14 So Alison Kelly, my Director of Nursing, was the  
15 only Executive in the office at that time. So I relayed  
16 to her the events of that afternoon what Ravi had said  
17 to Karen and my subsequent actions. And she listened to  
18 me and then said: right, I need to speak to Ian Harvey  
19 about this. He wasn't in the Executive office, I don't  
20 know where he was, whether had he gone home or -- but  
21 she said she was going to make contact with him.

22 At some point, and I can't remember whether I left  
23 the Executive office then, I thought I had gone over to  
24 speak to Eirian Lloyd Powell but I think it was  
25 Yvonne Farmer, I think I made that mistake, I thought it

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1 was Eirian, to ask if she had got any concerns about  
 2 any, I didn't mention Lucy Letby's name at this point.  
 3 I just said: your nurses that you have got on unit this  
 4 weekend, have you got any concerns about their clinical  
 5 practice? Of which she gave me assurance saying:  
 6 absolutely not.

7 I then --

8 **Q.** Just pausing there.

9 **A.** Yes.

10 **Q.** So paragraph 31 you say in the Inquiry  
 11 statement:

12 "Dr Jayaram informed me that both he and Dr Brearey  
 13 had concerns about the clinical practice of one of the  
 14 NNU nurses and that she may be purposefully harming  
 15 babies."

16 So he, as you have said earlier, did say "may be  
 17 purposefully harming babies". When you asked  
 18 Yvonne Farmer if it was Yvonne Farmer; have you got  
 19 concerns about clinical practice, why didn't you say:  
 20 have you got concerns any nurse may be purposefully  
 21 harming babies, because that is the whole of what you  
 22 had been told, wasn't it, why did you just say "clinical  
 23 practice"?

24 **A.** Because I -- I suppose I didn't ask that  
 25 because if Yvonne Farmer had had concerns or anybody any

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1 reticent to give me further details, I thought at that  
 2 time it was personal.

3 Rightly or wrongly, I admit at that time I thought  
 4 there's a personal issue going on here.

5 **Q.** Because you weren't getting more information?

6 **A.** Yes, yes. Because, without me going into  
 7 details of what's happened previously with other  
 8 Consultants, yes, I did initially. But that's the  
 9 reason. I was still concerned which is why I went  
 10 immediately over to escalate to Alison Kelly, my  
 11 Director of Nursing. That's what we do, that is  
 12 hospital policy and procedure, if we think, you know: we  
 13 are not getting anywhere here or you are concerned about  
 14 an issue.

15 **Q.** So you wanted to be sure about a motive or  
 16 think about whether there could be another motive,  
 17 a personal reason.

18 You tell the police, in fact I can read it to you:

19 "As I got to know Lucy I did ask her certain  
 20 questions in these meetings. I did ask her about her  
 21 working relationships with the two Consultants. Lucy  
 22 was quite shocked, particularly with Dr Jayaram. She  
 23 thought she had quite a good working relationship with  
 24 him. I asked her either of them had ever made a pass at  
 25 her. She replied 'absolutely not'. I got the feeling

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1 senior member of that nursing team had concerns about  
 2 somebody purposely harming babies I think that would  
 3 have been brought to my attention rather than wait for  
 4 me to ask it.

5 **Q.** You had been sent tables with her name in red?

6 **A.** Yes.

7 **Q.** Was that a way of bringing it to your

8 attention these -- even if you say they weren't  
 9 expressed as clearly as you might have liked to have  
 10 done, but Eirian Powell produced that table, the nursing  
 11 manager who liked Letby, thought highly of her?

12 **A.** Yes.

13 **Q.** But she had produced that table and put the  
 14 name in red.

15 So when you say they hadn't brought concerns to  
 16 you, what did you think when you saw that?

17 **A.** I suppose I -- when I went to speak to Yvonne  
 18 Farmer, I did want to see if there was any response from  
 19 her because I think it's important, in my nursing  
 20 career, certainly latterly in my last years, on a number  
 21 of occasions I have had Consultants demand I remove  
 22 nurses either from their team or from their ward or unit  
 23 because personal and professional relationships have  
 24 broken down for varying reasons and initially, I thought  
 25 because both Ravi Jayaram and Steve Brearey were

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1 she had no idea either of them felt like this. The  
 2 distress this has caused to both Lucy and her parents  
 3 has been terrible to witness."

4 So you did explore that with Letby at the time,  
 5 didn't you, is there anything they have got against you,  
 6 and the answer was no and it was nothing?

7 **A.** It wasn't at that time.

8 **Q.** A bit later?

9 **A.** Yes, it was not on that Friday because I had  
 10 never even met Lucy Letby.

11 **Q.** Of course.

12 **A.** Yes.

13 **Q.** But looking back now, you know that there was  
 14 no personal motive having had those conversation with  
 15 her later, she couldn't give you one and didn't have  
 16 one --

17 **A.** No.

18 **Q.** -- and you didn't see one; is that right?

19 **A.** Yes.

20 **Q.** But your first thought on the Friday was: is  
 21 there something else?

22 **A.** Yes, yes.

23 **Q.** Did you ask anyone else about that before you  
 24 asked Letby further down the road about that?

25 **A.** Ask anybody about what?

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1 Q. Ask anybody on the Friday: could there have  
2 been a personal agenda here or not?

3 A. No.

4 Q. You didn't have anyone to ask?

5 A. And the reason why is because we were under  
6 pressure, it was late on Friday and I had other things  
7 to do. So no, the only person I spoke to, which  
8 I thought was Eirian at first, was Yvonne Farmer, yes,  
9 that was she was the only person.

10 Q. So you spoke you say to Alison then you went  
11 home and got a telephone call from Dr Brearey later,  
12 didn't you? Can you tell us about that call?

13 A. Yes. We have a difference of recollection of  
14 that telephone conversation. It was early evening and  
15 my mobile phone went and obviously I didn't recognise  
16 the telephone number and I answered the phone and  
17 Steve Brearey said to me "Hi Karen, it's Steve" and  
18 I remember saying "Steve who?" not imagining for one  
19 minute he would be ringing me at home.

20 So he said: I need to understand what actions you  
21 are going to take to take Lucy Letby off the neonatal  
22 unit.

23 So I reiterated to him again, I said: I can't take  
24 a nurse off a unit without just cause, appreciating the  
25 severity of your allegation and your concerns, but you

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1 a nurse that nobody else had been prepared to do until  
2 that point.

3 I also -- we have to remember that employees,  
4 because at that time employees have got rights equally  
5 and like I have said to you, because I initially thought  
6 it was personal, I had to have good reason. I couldn't  
7 just walk on the unit and say: right, I am moving you,  
8 because of a gut feeling and a drawer of doom. There  
9 has to be specific reasons to action.

10 Q. We know at this point you had received the  
11 mortality review, you had received it a second time with  
12 her name in red, there had been concerns and Eirian was  
13 asking for reassurance. Wasn't that enough at this  
14 point for you to say: actually, the babies come first,  
15 we don't know why particularly, but we must keep them  
16 safe, it's not about employer and employee rights, it's  
17 about the babies at this point?

18 A. I fully appreciate that. But then why? My  
19 question: why did Steve Brearey not give me something  
20 else?

21 Q. They have given you that they thought she may  
22 be deliberately harming babies. What more did you want?  
23 Did you need the mode of attack, what did you want? How  
24 could they give you that without the pathology,  
25 forensics that were required?

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1 are not sharing anything with me.

2 I told him -- I recall him saying, I said: I've  
3 been in to see Alison Kelly and she is discussing the  
4 whole episode of that afternoon with Ian Harvey.  
5 Steve Brearey inferred I was lying, he didn't believe  
6 that I had been into the Executive suite and the reasons  
7 why I remember this so much because I said to him: if  
8 you don't believe me, then contact Alison Kelly or  
9 Ian Harvey yourself.

10 When that phone call was terminated, I -- this is  
11 why I remember this, I called Alison Kelly back to  
12 inform her again of the conversation I had just had with  
13 Steve Brearey on the telephone and to say to her to  
14 expect a telephone call from him because he didn't  
15 believe that I had been in to speak to her.

16 Q. Looking back, the fact that they had both  
17 raised and he was repeating in that call, enough to  
18 phone you on a Friday night, he was concerned she maybe  
19 purposefully harming babies, wasn't that enough? What  
20 else did you need, really, you couldn't investigate it  
21 if he did give you anything else, could you? A serious  
22 concern had been raised.

23 A. Yes, but I thought -- the feeling I got  
24 rightly or wrongly at that time I -- I felt I was being  
25 bullied and intimidated to make a decision about moving

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1 A. I don't know. I just -- because I thought  
2 because they are not willing to give me anything else to  
3 support my decision whether to exclude or remove,  
4 I honestly thought it was personal and perhaps I was  
5 slighted by that.

6 Q. And the fact they couldn't give you something  
7 else didn't mean there wasn't something else to find?

8 A. No.

9 Q. Did it?

10 A. I appreciate that.

11 Q. Unexpected, unexplained, they couldn't give  
12 you medical causes. That was their contribution, they  
13 didn't know why these babies had died, couldn't be clear  
14 about that. So it needed proper investigation?

15 A. I fully -- I fully appreciate that. But then  
16 why tell me he's got a drawer of doom and won't share  
17 the contents of it with me?

18 Q. From the moment Karen Townsend had used those  
19 words to you, that she may have deliberately been  
20 harming a baby, do you think you should have gone  
21 straight to safeguarding as you would have done if  
22 a member of staff told you: I am worried this parent has  
23 harmed this baby that they walked in with? You wouldn't  
24 know whether that was right or wrong but you know you  
25 couldn't answer the question?

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1 A. No, I have reflected upon that and perhaps  
 2 that is what -- that's an action I should have perhaps  
 3 taken on Friday. But equally neither Consultant did  
 4 neither. I just think yes, on reflection, I perhaps  
 5 should have done and I am sorry for that. I am sorry.

6 Q. And when you refer again to the Consultants,  
 7 it does come across that you have an antipathy, as you  
 8 said in the interview with Facere Melius about  
 9 Consultants and they are in charge and they have the  
 10 power. Do you have a natural, or did you have then,  
 11 an antipathy to them as a group?

12 A. No, not, not immediately. It was just I feel  
 13 that they could have -- both Consultants, Ravi Jayaram  
 14 and Steve Brearey could have involved Eirian and I at  
 15 a much earlier stage and we could have worked together.  
 16 I -- I feel looking back that the alleged meetings  
 17 that they had with the Executive team about their  
 18 concerns I wasn't aware of them, I certainly wasn't  
 19 invited to them and that's not what I would have  
 20 expected of a senior clinician. I would have thought he  
 21 would have gone to his unit manager Eirian first, and  
 22 then she would have involved me.

23 Q. That's the point, isn't it, Eirian was invited  
 24 to a lot of the discussions with the Consultants and  
 25 eventually some of the more Senior Executives suggested

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1 been had between all of the Executives. Have a look at  
 2 that to refresh your memory of it.

3 We can see there is an action plan. So this is  
 4 following the weekend, the murder of two triplets?

5 A. (Nods)

6 Q. The Consultants are not at this meeting when  
 7 an action plan is being drawn up. Do you know who  
 8 sorted out the invitation list for this meeting to  
 9 discuss concerns and an action plan?

10 A. I honestly can't, I'm sorry. I don't know.

11 Q. When you look at it now, does it strike you as  
 12 odd that an action plan was being devised in the absence  
 13 of any input from the Consultants who had the concerns?

14 A. Yes. Yes.

15 Q. And does this already fall into the "us and  
 16 them" category?

17 A. It appears so, doesn't it? Yes.

18 Q. And we see:  
 19 "Ian Harvey to identify Royal College lead to  
 20 facilitate external review."  
 21 Did you know much about what that review was about  
 22 and what it was going to look at?

23 A. No, I wasn't involved with setting the terms  
 24 of reference or anything like that, but clearly I saw it  
 25 at some point on completion. But I wasn't familiar who

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1 there had been a rift between them and you knew that  
 2 Eirian was asked to sign something to say there wasn't  
 3 a rift, they regarded her as part of the group, didn't  
 4 they, in their discussions?

5 A. Yes, because like I say, at the beginning they  
 6 were a cohesive team and it's just as all this unfolded,  
 7 like I said previously, the element of trust had gone  
 8 and it was, it appeared like an "us and them" situation  
 9 where the nurses thought one thing and clearly the  
 10 medics thought another.

11 Q. And the nurses Eirian Powell expressed in  
 12 a document 100% thought Letby hadn't done anything. Did  
 13 you think the same at that time?

14 A. Say that again, sorry?

15 Q. Had you formed a view that Letby was innocent  
 16 at that time, innocent of any causing any harm at all?

17 A. I don't think that that was a question that  
 18 I needed to answer. Was she innocent, was she guilty?  
 19 I just thought that I -- I wasn't given enough to  
 20 act upon and honestly on reflection, you know, and we  
 21 have all done that, I am sure, I should have called  
 22 safeguarding in and I am sorry for that.

23 Q. On 27 June, you sent an email, INQ0005745,  
 24 page 1. Sorry, you didn't send it, Alison Kelly sent  
 25 it. Sorry, Ms Rees. And it follows a meeting that had

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1 had set the Terms of Reference and what they were at  
 2 that time.

3 Q. And we have here the penultimate -- in  
 4 italics -- paragraph:  
 5 "Eirian, can you also review staff competencies re  
 6 skills and knowledge to support sick babies at varying  
 7 levels of dependency. I know you will have this but it  
 8 would be good to undertake a review."  
 9 Another review, another generalised review of  
 10 everyone's competencies?

11 A. I know, I know.

12 Q. A lot of work and totally unnecessary --

13 A. I know, I know.

14 Q. -- at this point?

15 A. I am sorry, I don't know who requested that,  
 16 I assumed it was Alison. I don't know.

17 Q. You say at paragraph 56:  
 18 "I agreed with the decisions taken at the meeting  
 19 ... [Although] neither Consultant was present  
 20 Alison Kelly and Ian Harvey were to meet with them both  
 21 to discuss their concerns and the actions listed."  
 22 Again looking back I think, as you just have, and  
 23 reflecting, it was divisive, wasn't it?

24 A. It was.

25 Q. How might that have been better managed at the

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1 time just speak of your role, what would you -- if you  
2 could now, what would you input at that point?

3 **A.** I think you are right, I think both  
4 Consultants should have been at that meeting. It's like  
5 I said to you earlier, I wasn't aware of these alleged  
6 meetings that the Consultants had had with the Execs.  
7 I wasn't involved with any of them, so I -- obviously it  
8 appears there's been a breakdown in relationships at  
9 some point.

10 But, yes, I think the whole team should have been  
11 together at that meeting, including the clinicians.

12 **Q.** You say then -- Letby's removal from the unit  
13 in your statement, you say at paragraph 58:

14 "I did not play any part in the decision to remove  
15 Letby from the unit. I recall I was on annual leave  
16 ..."

17 When I was on annual leave:

18 "... a meeting took place on 14 July when she was  
19 informed of the decision that she was to be put under  
20 clinical supervision pending the completion of an  
21 external review by the Royal College of Paediatrics and  
22 Child Health."

23 Do you think there was transparency with her at  
24 that point about what was actually going on?

25 **A.** No.

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1 supervised practice because of staffing levels on the  
2 NNU. Currently a number of members of staff are absent  
3 from work including sickness which has impacted upon the  
4 availability of senior clinicians who are able to  
5 provide support."

6 And then you refer to temporary redeployment.

7 Did you think it was because there was an inability  
8 to have the staff to supervise or was it something else  
9 that led to this letter?

10 **A.** I couldn't say for sure because I wasn't  
11 involved in the meetings and the decision-making, but  
12 obviously staffing levels weren't the best on the  
13 neonatal unit -- well, across the Trust, to be honest,  
14 at times. So to put somebody under clinical supervision  
15 you do have to have an acceptable number of staff for  
16 that to continue because you can't let that fall down if  
17 somebody goes off sick the next day and then there isn't  
18 a staff member to closely supervise.

19 So I took that as, yes, that was the reason.

20 **Q.** If we go over the page, your second paragraph:

21 "You raised with me the issue of personal support  
22 and stated that your friends are work colleagues.  
23 I advised you that the purpose of the redeployment was  
24 not to stop the usual social contact but you should be  
25 mindful of discussing any matters which may be sensitive

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1 **Q.** No. And why was that?

2 **A.** I really don't know. I mean, I was tasked on  
3 return from my annual leave to remove Lucy Letby off the  
4 unit with my HR business partner. I had just come back  
5 from leave, I had come in early. I checked A&E,  
6 I checked the neonatal unit come back and my HR business  
7 partner was waiting outside for me and said: we have  
8 been given a management instruction --

9 **Q.** Would is that business partner?

10 **A.** Linda Guatella, she is like my HR wingman and  
11 so she said to me: Karen we have got to go and remove  
12 Lucy Letby off the unit now.

13 So I said: what are we saying, what's gone on?"  
14 because clearly whatever decision, meeting, whatever had  
15 taken place had clearly taken place when I was on leave.

16 **Q.** Shall we see the letter you wrote that will  
17 help you I am sure --

18 **A.** Yes.

19 **Q.** -- with your memory of this INQ0002458,  
20 page 1. It is a letter of 18 July from you.

21 **A.** Yes.

22 **Q.** If we read the third and the fourth paragraph  
23 you are telling her:

24 "Since the meeting on 14 July it has become  
25 apparent not possible to provide you with full time

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1 in nature relating to the review of the NNU."

2 So you are not telling her she can't speak to her  
3 friends or anything like that, are you?

4 **A.** No, I think it was misunderstood.

5 **Q.** Well, we note at paragraph 85 -- we don't need  
6 to turn it up -- in your statement you are criticised  
7 within the grievance process, I think, for effectively  
8 preventing Letby -- you tell us: what were you accused  
9 and what did you accept, in fact?

10 **A.** I think -- and it was my fault because  
11 I clearly didn't communicate effectively. I think Lucy  
12 took it upon herself that she thought I had stopped her  
13 going to the neonatal unit as well as having any social  
14 contact with her friends and team members and that  
15 wasn't my intention.

16 **Q.** You say that very clearly there, though, in  
17 the letter, don't you? You haven't said that, so why do  
18 you say that is your fault? You hadn't prevented it?

19 **A.** Also --

20 **Q.** She did continue to communicate with people on  
21 the unit?

22 **A.** Yes.

23 **Q.** What had you done to prevent that? What was  
24 the criticism that had come?

25 **A.** I think she misunderstood when I said that she

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1 wasn't to go back on the neonatal unit whilst she had  
2 been redeployed, even though it was temporarily until  
3 investigations had taken place.

4 I think it was Lucy misunderstanding what I had  
5 said. I probably didn't make myself clear at the time.

6 **Q.** We know if we go to INQ0002746, page 3,  
7 Tony Millea writes to you on 2 September 2016. We see  
8 at the bottom of that email --

9 **A.** Yes.

10 **Q.** -- over the page complaining about the process  
11 that the hospital is now engaging in?

12 **A.** (Nods)

13 **Q.** The RCPCH, at the top of the page:  
14 "The investigation centred around procedure,  
15 culture, staffing levels and what was it like to work on  
16 the NNU. No question of our members' involvement was  
17 discussed. In fact, it was imparted by the panel that  
18 the review will not solve the issues for Lucy  
19 personally. As a result of this I now believe our member  
20 has grounds to action a grievance."

21 What did you understand the RCN officer was saying  
22 there was need for a grievance at this point, why was  
23 there such a need?

24 **A.** I think -- I think, if I remember correctly,  
25 that somewhere along the line Tony Millea had us under  
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1 a nurse. How are the nurses on the NNU going to react?"

2 What would you like to say about that email?

3 **A.** Sorry?

4 **Q.** What would you like to say about that email?

5 **A.** I was clearly very frustrated and emotional at  
6 that time. We were planning to put Lucy Letby back on  
7 the neonatal unit, then we weren't, then we were, then  
8 we weren't. And at that time I had been given  
9 a management instruction following Lucy Letby's removal  
10 from the neonatal unit into the risk team was to meet  
11 with her on a weekly basis with two of my other senior  
12 colleagues to support her health and well-being during  
13 all of this and to give her feedback from any  
14 investigations that were going on.

15 **Q.** Just pausing there. Feedback from  
16 investigations. So you were to meet her every week it  
17 was you, Hayley Cooper and?

18 **A.** Kathryn de Berger.

19 **Q.** And you were supposed to be telling her what  
20 the hospital were doing, what investigations, whether it  
21 was the RCPCH, the Hawdon Review, she was getting the  
22 hotline with what was happening?

23 **A.** Yes, yes. And during that time, clearly I got  
24 to know Lucy Letby and that email came because we had  
25 had a meeting with Lucy and Hayley I think was present,  
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1 the impression that the Trust had decided to move  
2 Lucy Letby off the neonatal unit and redeploy her while  
3 this investigation was going on from RCPCH.

4 And then obviously somewhere along the line,  
5 he's -- he's found out what the Terms of Reference are  
6 and he was alluding to then the Trust not being open and  
7 honest with Lucy Letby and felt -- and this is hence why  
8 he advised her to have grounds for a grievance. He  
9 thought -- I recall him saying to me that he didn't  
10 think the Trust were being open, honest and being  
11 upfront and telling her the true reason why she had been  
12 redeployed.

13 **Q.** You also sent an email, 9 September, it is  
14 a bit later, a week later, to Alison Kelly INQ0002860,  
15 page 1. You say in the second paragraph:

16 "The decision to delay transfer back to the NNU.  
17 In my opinion this decision is wrong and immoral based  
18 on a senior clinician having a gut feeling with no  
19 evidence except that LL has been present at a number of  
20 these neonatal deaths."

21 The last but two paragraphs:

22 "There is also the impact not only for the NNU but  
23 for the rest of the organisation and the message that  
24 this sends out a clinician is being listened to and  
25 supported with potential devastating consequences for  
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1 Hayley Cooper, and Alison Kelly and Sue Hodkinson  
2 I think the day before and they didn't mention anything  
3 about delaying Lucy Letby's transfer back to the  
4 neonatal unit at that meeting but they called me back  
5 afterwards and said to me: I have got to tell her she  
6 can't go back on the unit yet.

7 And at that time, I was emotional and frustrated  
8 because I was witness to her -- she was absolutely  
9 devastated and I suppose I was looking at her and she  
10 kept crying and saying: why are they doing this to me,  
11 I have done nothing wrong? I -- I am not going to let  
12 them run me out of the job that I love. Why are they  
13 letting me say it and go back on the unit, then they are  
14 saying they are not? And I suppose months of that  
15 witnessing that, her being distraught, rightly or  
16 wrongly, where we are now, I understand that, but at  
17 that time and I remember looking at her thinking: oh,  
18 this is dreadful, because -- and I appreciate the  
19 enormity of the allegations and everything, but  
20 I suppose I sent that email because I was witnessing the  
21 anguish, the absolute -- she was absolutely -- it was  
22 hard to keep witnessing that week in, week out and  
23 promising her one thing and promising her another.

24 I am just trying to explain why I sent that email.

25 **Q.** You actually say in there: why have the police  
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1 not been called?

2 **A.** Yes.

3 **Q.** Paragraph 2?

4 **A.** Yes.

5 **Q.** Why weren't they? Why didn't you say they  
6 should be called? Why did you not think that they were  
7 being called?

8 **A.** I think they should have. You know, I was at  
9 fault. I didn't go to the police neither. But I --  
10 I just thought we are having this investigation, that  
11 thematic review, this, that, nothing's proven and the  
12 issues weren't going away.

13 I recall, and I can't absolutely tell you what,  
14 what the date and time was, but I do recall  
15 Sian Williams, who was the deputy Director of Nursing at  
16 the time, and myself going into to see Alison Kelly.

17 **Q.** Sian Williamson, is that?

18 **A.** Pardon?

19 **Q.** Was that Sian Williamson?

20 **A.** Yes, Sian Williams. She was the deputy and we  
21 both went in to see Alison saying: Enough is enough,  
22 you have got to be calling the police in now. This  
23 is -- we are getting nowhere.

24 So the relationships were breaking down all over  
25 the place in the neonatal unit between the clinicians,

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1 anything?

2 **A.** No, he wasn't shouting. He never shouts.

3 **Q.** But it was urgent tone. He wanted you to --

4 **A.** Insistent, I would say.

5 **Q.** If you go page 35, the next page of the  
6 grievance interview note, in the first large box there:

7 "I have heard SB is adamant LL is not going back to  
8 the unit. I feel very strongly we need to get LL back  
9 on the unit."

10 So you two are completely polarised?

11 **A.** Mm.

12 **Q.** Yes:

13 "I raised with AK and SH if we can get a deadline  
14 of date. Also questioned why haven't brought police in.  
15 KR [that is you] hasn't because of LL."

16 **A.** (Nods)

17 **Q.** "Would we like our daughter to be treated like  
18 this? I don't think so. In the meeting with Stephen  
19 Cross it was mentioned about if we call the police the  
20 unit will be shut down and people may be arrested."

21 So was that your reservation about the police not  
22 being called because of LL, because she may be arrested?  
23 How does that --

24 **A.** I think that might have been part of it. But  
25 like I say, we were all at fault, none of us went to the

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1 the Execs, we weren't getting any answers and so Sian  
2 and I pleaded with Alison to bring the police in.

3 **Q.** Do you agree that the last but one paragraph  
4 of your email is very factionalised there as well where  
5 you say "devastating consequences for a nurse". You  
6 make it about nurses and doctors rather than actually --

7 **A.** Yes, perhaps.

8 **Q.** -- somebody making a very serious complaint --

9 **A.** Yes.

10 **Q.** -- for babies actually?

11 **A.** Yes, yes, I accept that. Yes.

12 **Q.** That can come down now, please.

13 If we go to INQ0002879, page 33 is the first page.

14 This is the grievance interview that you have at the  
15 time with Dr Green in October 2016.

16 If we go to the next page, page 34, in that top  
17 box, you say:

18 "KR went straight to see Alison Kelly. Wasn't  
19 happy to exclude LL, felt no grounds to exclude. In the  
20 evening KR received a call from SB at home."

21 So this is the night you get the telephone call.

22 "Felt SB tried to bully me putting pressure on.

23 Felt he was exhibiting passive aggressive behaviour.

24 Remained professional but gently powerful."

25 "Remained professional". So he wasn't shouting or

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1 police, did we? And I think you know on, you know, when  
2 I look back on all of this, I didn't because I thought  
3 what am I going to go to them with, obviously Consultant  
4 concerns.

5 But I think also because they hadn't neither and  
6 the Executives hadn't, it was hard. But I -- I was --  
7 I was -- I have never been so relieved when they  
8 eventually did.

9 **Q.** But you do appear to be saying here you  
10 don't -- you haven't because of Letby and you refer to  
11 Stephen Cross. Did you hear Stephen Cross say: if you  
12 call the police the unit will be shut down and people  
13 may be arrested or had someone told you he had said  
14 that?

15 **A.** I honestly can't remember, I don't know  
16 whether Stephen Cross might have said that.

17 **Q.** Did you ever have a meeting with  
18 Stephen Cross, were you there at the same meetings with  
19 him or not?

20 **A.** I've been at meetings with Stephen Cross, one  
21 in particular was a Consultant meeting we had at the end  
22 of January, where I read out -- I was asked to read out  
23 Lucy Letby's statement. I think Stephen Cross was  
24 present then --

25 **Q.** Yes.

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1 A. -- and he might have inferred something to  
2 that degree. But I can't honestly say absolutely.

3 Q. Dr Tighe gave evidence to the Inquiry that the  
4 reading out of that statement was the last thing the  
5 meeting needed, it was a serious situation and he  
6 described it as a melodramatic dissertation from Letby.

7 When you look back now about reading that out and  
8 how you read that out, do you have anything to say about  
9 that?

10 A. I was asked to read that statement out.  
11 I didn't volunteer. I suppose at that time I was happy  
12 to do so because, again, we weren't getting anywhere and  
13 I think obviously Lucy Letby wanted to -- she had had  
14 a grievance upheld, if I remember, if I have got this  
15 right in chronological order.

16 Q. That can come down now. Carry on, sorry?

17 A. Sorry. And she just wanted to let the  
18 Consultants know because at that time we were still  
19 planning to put Lucy Letby back on the neonatal unit.  
20 I think as for it being melodramatic, it was emotional  
21 certainly from what I recall, what I read out. Yes, it  
22 was a hard meeting regardless.

23 MS LANGDALE: We have been going for 90 minutes, so  
24 shall we stop for a break now, Ms Rees?

25 LADY JUSTICE THIRLWALL: Very well. I will take  
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1 in case Lucy Letby was working for an agency outside the  
2 organisation.

3 Q. Yes, whether she was.

4 A. Yes.

5 Q. So what clarity was sought, what did you  
6 understand the position was?

7 A. For Lucy Letby or for?

8 Q. Yes for Letby then, what -- not working  
9 anywhere else, is that what you understood was the  
10 position or not?

11 A. Yes. I think the concerns were raised that  
12 what they didn't obviously want while this was going on  
13 couldn't remove her from the clinical placement in our  
14 Trust for then to be found out that she had been working  
15 for an agency elsewhere.

16 Q. Did you have to check with agencies or just  
17 check with her that there was no concern about that?

18 A. I didn't have to check. But I can't remember  
19 whether Dee Appleton-Cairns, somebody from HR might have  
20 checked but I certainly didn't. I wasn't tasked with  
21 that.

22 Q. INQ003529 next, please, page 3.

23 A meeting 26 January at the bottom, 2017, with  
24 Letby, Kelly Hodkinson, yourself, de Berger.

25 If we go over the page, please, to page 4, at the  
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1 a break now, Mrs Rees, until a quarter to 4.

2 15 minutes.

3 (3.31 pm)

4 (A short break)

5 (3.44 pm)

6 MS LANGDALE: Ms Rees I want to ask you about where  
7 Letby was working and what happened subsequently in  
8 terms of placements anywhere and if we go to a series of  
9 documents. If we can have first, please, INQ0003273,  
10 page 2.

11 This is an NNU action planning meeting, 30 June,  
12 and it's Alison Kelly, Dee Appleton-Cairns,  
13 Sue Hodkinson, Julie Fogarty, yourself, Sian Williams  
14 and others.

15 On page 2 we see a reference with KR, your initial  
16 next to it:

17 "LL not working anywhere else, ie at another Trust  
18 or agency. Trained at Leicester, lives alone, has  
19 elderly parents. Clarity with LL working in other units  
20 and query bank hours."

21 In June 2016 what were you tasked with, if  
22 anything, in relation to that clarity Re working on  
23 other units or bank hours, can you remember?

24 A. I don't recall being tasked with anything from  
25 there. I think it was a question that was raised just  
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1 bottom:

2 "Karen asked on you behalf if we could continue  
3 with fortnightly meetings with both Sue and Alison which  
4 we both confirmed by advising absolutely.

5 "Alison added it was a good opportunity to think  
6 about the type of messages you may want Alison to say on  
7 your behalf when having meetings with the nursing teams  
8 as we are looking to arrange a meeting with them. It is  
9 important the nursing team are there to support you and  
10 need to be clear on how they will wrap around you when  
11 you go back.

12 "Karen agreed for you, Hayley and Kathryn to  
13 discuss this further with you the following week."

14 So what was that about nurses needing to wrap  
15 around her when she went back to support her, what  
16 conversations were happening?

17 A. If my memory serves me rightly, I think there  
18 are obvious concerns because of the breakdown in working  
19 relationships between the clinicians and the nursing  
20 team and particularly with the failed mediation  
21 following the grievance. I think I was just trying to  
22 I think at that time to try and find a way to put  
23 Lucy Letby back on the neonatal unit with her full  
24 nursing team support there.

25 Q. At this point, you knew from her that she did  
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1 not think there was any personal acts from either  
 2 Dr Brearey or Dr Jayaram. We have seen you told the  
 3 police you asked her about that, there was no personal  
 4 concern. Were you still thinking that there was in some  
 5 way bad faith in the allegation that she was  
 6 deliberately or may deliberately be causing harm to  
 7 babies? Or did you think it was a reasonable and well  
 8 held belief, a genuinely held belief?

9 **A.** Yes, I suppose it was. It's hard to  
 10 absolutely recall. But yes, I think the intention was  
 11 to make sure she had enough support if we would have  
 12 been successful in returning her to the neonatal unit  
 13 and to try and help build those working relationships  
 14 again.

15 **Q.** If we go, please, to 0003529, page 5. We see  
 16 in the meeting on 31 January, the last paragraph:

17 "Finally, you advised how you had been liaising  
 18 with a colleague based at Alder Hey to view theatre  
 19 lists to have an observational contract. We agreed you  
 20 would work with Karen to come back with a plan around  
 21 this within the next week. Meeting closed at  
 22 approximately 12.30."

23 So she is speaking with you about Alder Hey and her  
 24 plan about working there. What did you understand the  
 25 position was?

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1 "Karen, Hayley and yourself spoke about how you had  
 2 gone on to the unit on your own last week and this was  
 3 a big step.

4 "Karen reiterated she would be guided by you with  
 5 shifts."

6 What had she done on her own on the unit in March?

7 **A.** Sorry, say that again? Sorry, can you repeat  
 8 that?

9 **Q.** What had she done on her own on the unit? You  
 10 see it says she tells you she's been on --

11 **A.** I think she just -- my recollection is that  
 12 she just went to visit the unit to see how she felt, so  
 13 it was -- she didn't actually work on the unit that  
 14 I can remember.

15 I think she just went because she had obviously  
 16 been removed from there for quite some time and she was  
 17 anxious about it. I think it was just a visitation.

18 **Q.** We know there was some tea party or some  
 19 welcome event organised. Did you get involved in that,  
 20 sorting that out?

21 **A.** No, I wasn't aware of that and I certainly  
 22 didn't get invited.

23 **Q.** If we go to INQ0004697, page 3, and the last  
 24 box 13:

25 "Provide continuous professional development to LL

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1 Please be careful to use the cipher if you are  
 2 going to mention any names here.

3 **A.** If I recall, Lucy Letby had a friend,  
 4 a medical colleague that worked -- she had obviously  
 5 worked with him prior and he was currently based at  
 6 Alder Hey Hospital and I recall her arranging to have  
 7 this observational contract with this particular medic,  
 8 so she could sit in his clinic and just observe.

9 There was no hands-on clinical contact as far as  
 10 I was aware, made aware. But I do recall once that had  
 11 been -- Lucy had set that up with this particular medic,  
 12 that Alison Kelly then on hindsight retracted it and  
 13 stopped it.

14 **Q.** But you didn't contact Alder Hey at any time  
 15 to either confirm or prevent that placement either way,  
 16 you didn't get involved in that or what's the position?

17 **A.** No, no.

18 **Q.** If we can go to INQ0003529, page 9, this is  
 19 a meeting on 8 March, if we go to the next page, page 9,  
 20 sorry, we concluded -- you see at the top:

21 "We concluded the meeting by discussing your plans  
 22 for transition back to the NNU. You had been working  
 23 with Karen on dates of 3 April and 10 April. You would  
 24 have support from a number of buddies and Karen had  
 25 spoken to the senior team around your competencies.

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1 to support her ongoing development and refresher re her  
 2 clinical skills. Alison Kelly delegated to Karen Rees.  
 3 Initial discussions with Alder Hey Hospital re:  
 4 observation placement."

5 So was that seen as her keeping her skills, the  
 6 observational placement? I think she was subsequently  
 7 sent on a course as well, wasn't she?

8 **A.** Was she? Definitely it was just to get her  
 9 back in renewing her knowledge and skills. I don't  
 10 recall her going on a course. I don't recall that at  
 11 all.

12 **Q.** If we go, please, to INQ0003479, page 1, we  
 13 see here by 27 April 2017 the Trust decision,  
 14 paragraph 4, was that you could not return to the unit  
 15 as this had been paused.

16 Now, you, Hayley Cooper, Kathryn de Berger and  
 17 Letby were all working towards this, weren't you, her to  
 18 be going back on to the ward?

19 **A.** Yes.

20 **Q.** So what did you make of this?

21 **A.** I'm trying to think at the time. April.

22 I think that was around Easter time, if I remember  
 23 rightly, and so her return to the unit was paused yet  
 24 again I think because the mediation with the two  
 25 Consultants, Ravi Jayaram and Steve Brearey, hadn't

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1 taken place and I think there were concerns about her  
2 going back on the neonatal unit without having that  
3 rectified.

4 **Q.** Did you support the decision that that should  
5 be paused? Did you think it was important there should  
6 be a thorough forensic investigation into the unexpected  
7 deaths or not?

8 **A.** Absolutely. It was just so difficult when  
9 there was a plan and then there wasn't a plan, and then  
10 there was a plan and then there wasn't a plan.

11 But, yes, I think -- I think it would have been  
12 really hard to put Lucy Letby back on that neonatal unit  
13 without having some sort of mediation with the two  
14 Consultants and, you know, a satisfied investigation.

15 **Q.** To complete the working INQ0002796, page 1.,  
16 the working picture, if we look at this 2796, page 1.  
17 The third paragraph:

18 "Karen Rees has just informed Lucy that both have  
19 advised Lucy does not go to Alder Hey for the time being  
20 like she has been."

21 It looks as though that was in May 2017.

22 "Would like to know why this is the case and is  
23 this a management instruction and if so on what  
24 grounds?"

25 Can you see?

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1 **Q.** And she in particular wanted apologies from  
2 four people, didn't she, not all of the Consultants?  
3 She wanted them from four people. Can you remember  
4 that?

5 **A.** I thought it was three.

6 **Q.** Who did you think she wanted apologies from?

7 **A.** Ravi Jayaram, Steve Brearey, and Jim McCormack  
8 was my recollection. I can't think...

9 **Q.** In the meeting, does Dr V ring a bell as well,  
10 Dr V? I can't give you the name.

11 **A.** Sorry, I don't recall.

12 **Q.** So Drs Brearey, Jayaram and McCormack in  
13 particular you remember that she wanted apologies from  
14 and she didn't know why all the Consultants were  
15 apologising, is that right, in one meeting?

16 **A.** I -- oh, God -- I don't think she wanted or  
17 expected an apology from other clinicians. I think it  
18 was -- just what I recall is it was those three in  
19 particular.

20 **Q.** So if we go to INQ0005810, page 1. We see at  
21 the bottom a letter from all seven Consultants. It's  
22 from Tony Chambers:

23 "An apology from the whole Consultant team will be  
24 done as a group."

25 She says:

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1 **A.** That was what I was alluding to --

2 **Q.** Yes.

3 **A.** -- just before --

4 **Q.** May 2017 when that instruction, looking at  
5 that letter --

6 **A.** Yes.

7 **Q.** "Dear Alison and Sue" from Hayley:

8 "Following the meeting we have just all attended  
9 Lucy has asked ... on behalf of the following  
10 conversation with Karen Rees."

11 You were the one to tell her, weren't you, in the  
12 conversation?

13 **A.** Yes. We had had a meeting and then I got  
14 called out of that meeting to ask to go back in to her,  
15 Lucy Letby, to tell her that we couldn't proceed and  
16 obviously Hayley Cooper wrote that email because she was  
17 clearly upset saying: Why didn't they be open and  
18 honest and tell her why we were in that meeting, and  
19 hence that, you know, I'm assuming that's why  
20 Hayley Cooper sent that email.

21 **Q.** Whatever you chose to tell her it's apparent  
22 looking at the meetings that she had worked out for  
23 herself by then that the Consultants were saying there  
24 was an issue with her, yes?

25 **A.** At some point, yes.

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1 "Why is that?"

2 Tony Chambers says:

3 "It's thought to be the most sensible. We have  
4 recognised some of their behaviour was not appropriate.  
5 This is acknowledged and we need to get into a position  
6 where we can move forwards."

7 If we go over the page, to page 2, she says:

8 "I expect four apologies. SL..."

9 Is that her mother?

10 **A.** Ah, right.

11 **Q.** "It's unacceptable if not."

12 And then they say:

13 "As a family it's easier to do a collective  
14 apology. They made it very personal again so personal  
15 allegations are redeployed. She's not been told about  
16 it."

17 And it repeats:

18 "We were expecting four apologies."

19 If we go to the next page, page 3, Mr Chambers:

20 "I am trying to advise you. The last thing we want  
21 is sensational press. This is about sick poorly babies.  
22 The story in The Sunday Times is about families saying  
23 we are keeping them in the dark."

24 What did you think the parents of the babies who  
25 had been killed and harmed were being told about the

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1 investigations?

2 **A.** I think there should have been a lot more  
3 openness and transparency with certainly the parents.  
4 Everybody.

5 **Q.** If we go to the last page of this document,  
6 page 7, we see:

7 "We want a mediation from her parents of ... or not  
8 we want her back on the unit. We can forget about  
9 individual. Mr Chambers' report will be published next  
10 week. There may be interest from media outlets. This  
11 is not about you. There was an increase in mortality,  
12 the review and recommendations. There will be a flurry  
13 of interest. Parents saying we appreciate what's been  
14 said. If her name comes up in the press we will take  
15 advice."

16 Lucy Letby says:

17 "Do all you can to avoid this."

18 You end the meeting:

19 "Important to have the mediation and to move  
20 forwards."

21 Whose needs were paramount in that meeting? That  
22 can go down now, thank you.

23 **A.** Clearly Lucy Letby's and her parents.

24 **Q.** There is no reference to the safety of babies  
25 at all in that meeting, is there?

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1 **Q.** -- about him you knew that she was -- had, as  
2 you mentioned, a placement arranged?

3 **A.** Was that the one, sorry?

4 **Q.** Yes.

5 **A.** Yes.

6 **Q.** So that person.

7 **A.** But I didn't realise they were...

8 **Q.** The extent of messaging?

9 **A.** Yes. Yes.

10 **Q.** Understood. So she had support there. She  
11 was also messaging and in contact with a couple of the  
12 nurses who she'd worked with on the unit, wasn't she?  
13 You nod, but, did you know that? She had support from  
14 some friends?

15 **A.** I don't -- I really don't know about that.

16 I know she had a close friend on the unit and one would  
17 assume she'd still. But, I can't comment. I really  
18 don't know about that.

19 **Q.** And she turned up at the Christmas party,  
20 didn't she, in December 2016 -- sorry, December 2017.  
21 She was able to go back to -- it was combined with  
22 Eirian Powell's retirement. She felt able to do that.

23 Did you go to that party?

24 **A.** No, I did not.

25 **Q.** Okay. So she wasn't short of sources of

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1 **A.** No.

2 **Q.** Do you think looking back you, in common with  
3 Eirian Powell, got too close to Lucy Letby and her  
4 position?

5 **A.** I can only answer for myself. I think the  
6 answer to that is, yes, because I was tasked to meet  
7 with her on a near-weekly basis for nearly two years and  
8 as I said previously witnessing her distress, yes,  
9 I acknowledge that.

10 **Q.** She had support from a number of sources,  
11 didn't she? She had Dr U, who was messaging her?

12 **A.** I don't know. I don't know about that.

13 **Q.** You made reference to her having a connection  
14 with a clinician who was helping her -- you mentioned it  
15 to the police -- keeping her competencies, keeping her  
16 expertise, that she spoke about stuff. You know about  
17 that at the time, didn't you, that she was messaging  
18 Dr U as we know him in the Inquiry?

19 **A.** Messaging him?

20 **Q.** Yes, messaging. Texting, Facebook messaging.  
21 She was not messaging you. Between each other, they  
22 were messaging each other. So she had support from him.

23 **A.** Okay. I don't know about that, sorry, but...

24 **Q.** You say something to the police --

25 **A.** Did I?

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1 support at that time, was she, and she had the three of  
2 you on the WhatsApp group?

3 **A.** (Nods)

4 **Q.** Hayley Cooper, Kathryn de Berger and yourself.  
5 So she had a number of people she was messaging in  
6 support, didn't she?

7 **A.** Yes.

8 **Q.** Were you aware at the time the number of  
9 people and avenues of support that she did have?

10 **A.** No, no, no.

11 **Q.** Because if we go, let's go to INQ0108337,  
12 page 1. This is a message from you that is on that  
13 group between the four of you, 24 May:

14 "See, hang on in there girl. Something I need to  
15 share with Alison and Sue. Your nursing team are fully  
16 behind you. We will get through this lol, K."

17 That's a very personal message, isn't it?

18 **A.** Yes.

19 **Q.** If we go to INQ0108337, page 2. The 1st of  
20 the 1st:

21 "Happy New Year to all. Lucy let's hope we get  
22 closure this year. I'm really proud of you and the  
23 professional way you have presented yourself throughout  
24 is admirable. We will continue to support you and  
25 I promise I will do all I can before I leave. All have

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1 a great day. See you in the week."

2 You were fully committed to her position, weren't  
3 you?

4 **A.** I was at that time, yes.

5 **Q.** And again 108337, page 3, the last message.  
6 I'm not sure if you received it. This is  
7 18 December 2018:

8 "Just to let you know we are constantly thinking of  
9 you and hope you can try and have a pleasant xmas with  
10 your family during this continuous stressful time."

11 When you say you were at the time, what did you  
12 learn since about her that questions your interaction  
13 with her at the time if anything?

14 **A.** Sorry, say that again?

15 **Q.** What have you learned, either at the criminal  
16 trial or subsequently through documents you have been  
17 sent, about Letby that you didn't know at the time when  
18 you were supporting her so fully?

19 **A.** It's certainly -- obviously when I've read all  
20 the stuff that I have been sent, you know, in regards to  
21 the public inquiry it was quite enlightening to read all  
22 of that because you do forget things and you are not  
23 aware of things. So, yes, I take it on board.

24 I think for me personally, yes, professional and  
25 personal boundaries blurred because of my -- the amount

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1 tabled at a meeting when discussing the increased  
2 mortality rates there might be a possible connection  
3 involvement with this. When Karen asked, the details of  
4 the doctor and the meeting were not provided. Is there  
5 an agenda or minutes which could be traced? I am  
6 interested to know who tabled this and who was present  
7 as they are potentially professionals that I will be  
8 working with in the future and feel that it's only fair  
9 for me to know."

10 Do you remember now which junior doctor that was  
11 who had raised the links with her?

12 **A.** No, I am sorry, I can't. I don't know whether  
13 I was aware of which junior doctor it was.

14 **Q.** Did you know she was going to write to  
15 Mr Harvey and ask for that information? She cc'd you.  
16 Did you know before?

17 **A.** Not until I had read it after she cc'd me, but  
18 she didn't tell me of her intent.

19 **Q.** But would you have supported that? I mean,  
20 you are still writing her messages of support at this  
21 time so presumably you did support her with that  
22 request.

23 **A.** Well, I think she had already done it before  
24 she had informed me she was doing it. Hence when I read  
25 it when she had cc'd me, it had already been done.

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1 of involvement I had tasked, you know, with meeting with  
2 her regularly and perhaps on hindsight that wasn't as  
3 necessary as it was made out to be.

4 **Q.** Who was the first person who asked you to meet  
5 her that regularly?

6 **A.** It was Alison Kelly and Sue Hodkinson.

7 **Q.** It was originally weekly, wasn't it, and then  
8 it went to fortnightly?

9 **A.** Yes.

10 **Q.** Is that right?

11 **A.** It was weekly for me and then I asked Alison  
12 and Sue to -- Alison Kelly and Sue Hodkinson, sorry --  
13 to join the meeting so they could give full explanations  
14 about progress or lack of it and the reasons why, which  
15 is then they agreed to do and that's when they came  
16 monthly.

17 **Q.** And another email, I don't need to put it on  
18 the screen, 21 December 2017:

19 "We will continue to fight for you and as  
20 I promised, whoever takes over from me will continue to  
21 give that support I promise."

22 If we can look though at INQ0057499, page 1. This  
23 is a message from Letby to Ian Harvey.

24 Can you see?

25 "Karen Rees informed that a junior doctor openly

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1 I don't recall supporting her or her informing me  
2 she was going to do that; send that email to Ian Harvey.  
3 I don't remember that.

4 **Q.** That can go down now, thank you.

5 Paragraph 123 of your statement. We referred you  
6 to appendix 6 of the Trust disciplinary policy which is  
7 entitled "Consideration of Referral to the Local  
8 Authority Designated Officer" and it refers to if there  
9 is a concern raised or an allegation made about a person  
10 who works with children, whether a professional staff  
11 member, foster carer or volunteer that they may have  
12 behaved in a way that has harmed a child or may have  
13 harmed a child, possibly committed a criminal offence in  
14 a way that indicates they are unsuitable to work with  
15 children then the process outlined below should be  
16 followed.

17 The disciplinary, you say you were aware of that?

18 **A.** Yes.

19 **Q.** At any point, did you think she should be  
20 being investigated for what this allegation represents  
21 in terms of what the doctors had said about her?

22 **A.** If I remember correctly, referral to the  
23 LADO -- I am trying to recall it now -- because it's in  
24 the disciplinary policy that you, your first port of  
25 call is to inform your line manager and then I think

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1 referral to the LADO has to -- well, the recommendation  
2 is it 24 hours she should -- it should have been  
3 reported to.

4 Well, this was over 12 months. So I didn't even  
5 question. I thought perhaps whoever had already  
6 reported it to the LADO because my understanding was  
7 these concerns were raised well before I was in post.  
8 So I -- I didn't even give that a thought, I am sorry,  
9 I thought it would have already been done.

10 **Q.** At paragraph 128 under reflections you say:

11 "On reflection if Eirian Powell and I had been  
12 approached by the Consultants when they first had their  
13 suspicions in relation to Letby, we could have worked  
14 together and monitored Letby's clinical practice more  
15 closely."

16 **A.** Yes.

17 **Q.** Eirian Powell was working closely with  
18 Dr Brearey right from the moment when the review into A,  
19 C and D had been conducted.

20 **A.** Right.

21 **Q.** She was communicating with you and you were  
22 aware that they were doing that work, weren't you,  
23 around the thematic reviews, increased death rates and  
24 links to a member of staff?

25 **A.** Yes, I was. But what I am referring to in my  
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1 **Q.** When you were both told that she may  
2 purposefully be harming babies, that's you and  
3 Eirian Powell, you did not believe it, and you in fact  
4 questioned their motive.

5 **A.** When did I do that, sorry?

6 **Q.** When they first mentioned that to you, that  
7 she was suspected of purposefully harming babies back on  
8 24 June, when that was said in the clearest terms --

9 **A.** Right, sorry, yes.

10 **Q.** -- you didn't believe it. So, what difference  
11 would it have made, even if it had been expressed in the  
12 loudest terms to you, three months earlier?

13 **A.** Because if they would have come to me --  
14 I went to find them on that Friday. At no time did  
15 either Consultant bleep, telephone, knock on my office  
16 door to tell me about their concerns. I wasn't one  
17 of -- the first port of call and I think that's --  
18 that's lacking is what I'm trying to explain.

19 I didn't know they were having meetings with the  
20 Executive team. I just thought I would have expected  
21 them to sit down with me and Eirian and that's just my  
22 opinion.

23 **Q.** Dr Brearey did telephone you the night of  
24 24 June?

25 **A.** He did.  
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1 comments made there was my understanding was concerns  
2 had been raised in January '15. I came into post  
3 in August 2015.

4 I would have -- on reflection I thought if, if and  
5 I wasn't aware that they were meeting with the Execs or  
6 anything like that, but I thought when I came new into  
7 post it might have been of benefit -- and hindsight's  
8 a great thing, I get that -- but if, if Ravi Jayaram and  
9 Steve Brearey had called a meeting with me and Eirian  
10 and said: Look, we have got concerns, we don't know  
11 exactly what those concerns are...

12 But that's a cohesive way of working with a team.  
13 If I put myself back in coronary care when I was ward  
14 manager there years ago if any of my Consultant  
15 cardiologists had had a concern about a nurse, I would  
16 have expected their first line of concern to be raised  
17 with me, not jump immediately into the Executive suite.

18 So yes, I was aware. I was made aware of the  
19 thematic review and all the other things that were going  
20 on later on. I just think we had a missed opportunity.

21 As the unit manager and the head of nursing we  
22 could have sat down and worked closely and perhaps that  
23 would have prevented the divide between the clinicians  
24 and the nurses and the lack of trust moving forward.  
25 That's what I meant by that.  
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1 **Q.** But it made no difference. He very clearly  
2 made his concerns aware to you?

3 **A.** Yes, but I have explained about the content of  
4 that conversation, that I felt like I was being bullied  
5 and intimidated. I didn't find it a very professional  
6 conversation and I'm not making excuse. I, you know,  
7 this is why I phoned Alison Kelly straight back and  
8 said: Look, Steve Brearey is still agitating so you  
9 need to know this.

10 **Q.** You did an interview, didn't you, with ITV  
11 on August 22 --

12 **A.** God, yes.

13 **Q.** -- 2023?

14 **A.** Yes.

15 **Q.** And you said in that interview:

16 "If I had been given a little bit more information,  
17 if it had been inferred insulin had been used but  
18 neither of them gave me anything other than they were  
19 concerned about her clinical practice. I would have  
20 acted differently."

21 And you said there they were concerned about her  
22 clinical practice. You didn't say in that interview  
23 that they had also said, certainly in June, she may  
24 purposefully be harming babies as you have told the  
25 Inquiry. There is a difference, isn't there --  
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1 A. There is.  
 2 Q. -- between people saying, "They didn't tell me  
 3 other than they were concerned about her clinical  
 4 practice" and saying, "She may purposefully be harming  
 5 babies."  
 6 Why didn't you say in that interview that that is  
 7 what you had been told?  
 8 A. I don't know. I'm sorry, I don't know.  
 9 MS LANGDALE: Those are my questions, thank you.  
 10 A. Thank you.  
 11 LADY JUSTICE THIRLWALL: Thank you very much  
 12 indeed, Ms Langdale. Mr Baker.  
 13 Questions by MR BAKER  
 14 MR BAKER: Good afternoon. I ask questions on  
 15 behalf of some of the Family groups.  
 16 A. Okay. Thank you.  
 17 Q. Part of your remit was patient safety?  
 18 A. Yes.  
 19 Q. And as part of that duty towards patient  
 20 safety, one of your jobs was to be aware of the risk  
 21 that members of staff may harm patients? That's  
 22 correct, isn't it? It wasn't an entirely novel concept  
 23 in 2015 that a member of staff may cause harm to  
 24 a patient?  
 25 A. I think in all of my career, I have never had

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1 with the Executive teams well before I was in post, and  
 2 then not to come anywhere near me but I hear what you  
 3 say yes, it was -- it was, it was an awful allegation  
 4 and for that I am sorry.  
 5 Q. Well, these were two doctors who were --  
 6 A. I know.  
 7 Q. -- sensible, they were senior, they weren't  
 8 people who would inherently denounce other members of  
 9 staff for serious crimes, were they?  
 10 A. I would hope not, no.  
 11 Q. No. And in fact they were right, as it turned  
 12 out?  
 13 A. As it turned out.  
 14 Q. Looking at when you became aware of things  
 15 going on, is it true that hearing about Ravi Jayaram  
 16 talking to Karen Townsend came completely out of the  
 17 blue, is it really true that you were unaware of any  
 18 issues of Letby before then?  
 19 A. No, because I think at the beginning I thought  
 20 that was the first time that I had heard about  
 21 Lucy Letby or her name. But clearly evidently because  
 22 it was such a long time ago, when I got all, all the  
 23 information sent to me, clearly there was a thematic  
 24 review that I was emailed after they had done that.  
 25 So you are right, no, it wasn't the first time.

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1 anybody say that a member of staff has been purposely  
 2 harming patients. You know, yes, part of my role, as is  
 3 any nurse, you know, patient safety is paramount but for  
 4 the reasons that I have explained today.  
 5 Q. We don't have to encounter it personally and  
 6 directly, do we, to be aware of the risk?  
 7 A. Sorry, say that again to me?  
 8 Q. We don't have to encounter a risk personally  
 9 to be aware of it?  
 10 A. No, true.  
 11 Q. You know from nursing practice that there are  
 12 many risks and conditions that you may only ever see  
 13 once in your career?  
 14 A. Yes, I appreciate that.  
 15 Q. And if we are thinking about the proximity of  
 16 risk in 2015 someone had been convicted of murdering  
 17 patients less than 40 miles away a nurse in a hospital.  
 18 So can I ask you this: as of 2015, what level of proof  
 19 did you think was necessary in order to act on the idea  
 20 that somebody might be harming a patient?  
 21 A. I think it's like I previously explained,  
 22 I thought it was personal at first and I appreciate what  
 23 you are saying, that what -- but I just feel that if  
 24 I had have been given something more, bearing in mind  
 25 I wasn't aware that the Consultants had raised concerns

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1 Q. No, what you say in your Facere Melius  
 2 interview is that you had been involved in discussions  
 3 regarding mortality from the end of 2015 onwards. So if  
 4 I -- it's INQ00012991 on page 3.  
 5 So if we look here on page 3, you can see there in  
 6 December 2015, there was the thematic review discussed  
 7 at the QSPEC meetings and you ask:  
 8 "Was that the internal one, the initial internal  
 9 one?"  
 10 "Yeah."  
 11 And you say:  
 12 "Yes, I think it's the one Jane Fogarty developed."  
 13 Darren Thorne says:  
 14 "... and Sian Williams were involved in."  
 15 "Yes, I do recall."  
 16 "Can you remember what was discussed at that  
 17 meeting at all?"  
 18 "All I can remember is I believe there were some  
 19 concerns raised by -- just think, some of the concerns  
 20 if I remember rightly, so apologies, that were raised by  
 21 the Consultant paediatricians with the Exec team."  
 22 You are describing there discussions taking place  
 23 in December 2015 that you are aware of?  
 24 A. Yes. Yes, and I think that's alluding to  
 25 Julie Fogarty and Sian Williams I think that was the

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1 first internal investigation and I do recall that  
 2 looking at off-duty, you know, the simple internal  
 3 things first, so I do recall that, yes I am sorry, yes.  
 4 **Q.** And as head of nursing, if there were  
 5 discussions about mortality and in particular a link  
 6 between a nurse and mortality, you would expect to be  
 7 informed about that, wouldn't you?  
 8 **A.** Yes.  
 9 **Q.** So Eirian Powell should have told you about it  
 10 and kept you up to date on anything that was going on?  
 11 **A.** Yes.  
 12 **Q.** So by the time we come on to May 2016, you  
 13 receive an email which is headed in terms "Concerns  
 14 about nurses" or "Nurse concern NNU thematic review" is  
 15 the title of the email that you receive in May,  
 16 4 May 2016.  
 17 You must have understood from what was within it  
 18 and what had gone before that there were concerns about  
 19 the connection between Lucy Letby and an increase in  
 20 neonatal mortality; that is correct, isn't it?  
 21 **A.** That is correct.  
 22 **Q.** And what you say in your witness statement at  
 23 paragraph 20 is that you went off to see Eirian Powell  
 24 about this and you say that Eirian Powell told you in  
 25 terms that Lucy Letby was -- she assured me that

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1 persistent with that view.  
 2 **Q.** Persistent?  
 3 **A.** Yes.  
 4 **Q.** You were given some reasons as to or some  
 5 background descriptions of how these babies were. But  
 6 were you told that they had all been -- the deaths had  
 7 all been unexpected and unexplained or were thought to  
 8 be unexpected and unexplained?  
 9 **A.** Sorry, can you say that again?  
 10 **Q.** So in your witness statement at paragraph 20  
 11 you describe Eirian Powell describing the background  
 12 conditions?  
 13 **A.** Yes.  
 14 **Q.** The comorbidities for these babies including  
 15 necrotising enterocolitis and sepsis.  
 16 **A.** Yes.  
 17 **Q.** Did Eirian Powell tell you that is why those  
 18 babies died or did she say to you that despite those  
 19 background conditions, the deaths were unexpected and  
 20 unexplained?  
 21 **A.** No, she didn't say to me that was the reasons  
 22 for the death. I think it was just information given to  
 23 say that they weren't deemed the stable babies that was  
 24 first alluded to at some point from Eirian.  
 25 **Q.** Would it not have been important, though, in

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1 a number of these babies were born with congenital  
 2 abnormalities, maternal syndrome, necrotising  
 3 enterocolitis and sepsis and she told me about the lack  
 4 of cot availability in Alder Hey.  
 5 She said Lucy Letby had been on shift for the  
 6 babies listed on the schedule but had only been  
 7 allocated three of them and I did not consider there was  
 8 a potential safeguarding risk to patients.  
 9 Eirian Powell was defending Lucy Letby at this  
 10 meeting you had with her, wasn't she?  
 11 **A.** Yes, and I suppose I listened to her because  
 12 as a unit manager or a ward manager you know your team  
 13 best. You know their strengths, their weaknesses, their  
 14 capabilities and so, yes, I trusted Eirian's judgment in  
 15 that regard.  
 16 **Q.** Stephen Brearey in his statement describes  
 17 attending a meeting with Anne Murphy and Eirian Powell  
 18 on 11 May 2016 and he put his concerns at that meeting  
 19 and he said with Eirian Powell countered those concerns  
 20 "forcibly and with great emotion" is how he describes  
 21 it.  
 22 Is that a fair description of how Eirian Powell was  
 23 defending Lucy Letby when you met her, forcibly,  
 24 strongly, with emotion?  
 25 **A.** I wouldn't say forcibly. But she was

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1 trying to understand neonatal mortality to understand  
 2 why those babies died?  
 3 **A.** Sure.  
 4 **Q.** So did you ask her why the babies died?  
 5 **A.** Well, we had discussions when she went through  
 6 the paperwork that identified each baby and what --  
 7 whether it was sepsis, congenital abnormality or  
 8 whatever, but I can't recall us having a conversation to  
 9 say is that definitely what they died of, no, I don't  
 10 recall that.  
 11 **Q.** And did you seek any reassurance from the  
 12 doctors, for example, as to the cause of death for these  
 13 babies or whether what had been said to you was  
 14 accurate?  
 15 **A.** No, I did not.  
 16 **Q.** Because the form that you saw with Letby's  
 17 name in red --  
 18 **A.** Yes.  
 19 **Q.** -- describes Child C's cause of death as NEC?  
 20 **A.** Yes.  
 21 **Q.** But in fact a post-mortem had been done months  
 22 before that form was completed --  
 23 **A.** Right.  
 24 **Q.** -- which did not give NEC as a cause of death?  
 25 **A.** Okay, I am sorry, I wasn't aware of that.

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1 Q. But do you think the way in which  
2 Eirian Powell defended Letby and what she said to you  
3 influenced your reaction to the allegations?  
4 A. Maybe. Maybe. Certainly at the beginning,  
5 yes.  
6 Q. Do you think in hindsight, some degree of  
7 tribal allegiance was working here and that you tended  
8 to accept her word because she was a nurse and perhaps  
9 had a bias against what the doctors might be saying?  
10 A. I think -- I think obviously I believed what  
11 Eirian was telling me for the reasons that I said just  
12 before is that a unit manager knows her team members  
13 better than anybody, better than the doctors, so yes,  
14 I did believe Eirian.  
15 Q. You assume that Eirian Powell as a serious  
16 senior nurse --  
17 A. Yes.  
18 Q. As a senior nurse, sorry, would have carried  
19 out her own serious research before saying those things  
20 to you?  
21 A. Yes.  
22 Q. Did you ask her or indeed carry out any of  
23 your own investigations as to the background to any of  
24 these collapses? Or, sorry, any of these deaths?  
25 A. No, I did not.

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1 somebody, the senior doctor, says to you in good faith:  
2 I think this nurse may be murdering babies, is that you  
3 should call the police, shouldn't you?  
4 A. On hindsight perhaps I should, but then  
5 I questioned as to why neither Consultant did that also.  
6 If they were so convinced, why did they not? But  
7 I acknowledge yes, yes.  
8 Q. Doesn't that reveal a bias because you don't  
9 apply the same level of scrutiny to what Eirian Powell  
10 tells you, you just accept her word?  
11 A. No, but I felt like I hadn't got any absolute  
12 evidence to go to the police. What was I going to say  
13 to them? Yes, two Consultants have raised massive  
14 allegation but weren't prepared to go to the police  
15 themselves.  
16 Q. Well, you are not encouraging any sort of  
17 investigation at all, are you? I mean, there is no  
18 sense of: we need to go off and scrutinise the records  
19 or ask the doctors what the basis of this and how we  
20 might scrutinise the records. All Stephen Brearey is  
21 asking you to do is to take Lucy Letby off the ward so  
22 she doesn't harm another baby, that is all he was  
23 asking, wasn't it?  
24 A. Yes, he was demanding. He wasn't asking, he  
25 was demanding, yes.

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1 Q. I mean of course you know now that if you had  
2 carried out investigations of your own you would have  
3 found out that doctors had been concerned in June 2015  
4 about a grouping of deaths and collapses?  
5 A. Yes.  
6 Q. You would have found out that Child E, one of  
7 the children who had died, had a twin who had also had  
8 an unexpected collapse?  
9 A. Yes.  
10 Q. And you would have found out if a doctor had  
11 reviewed those notes that Child F had an abnormal level  
12 of insulin in his system?  
13 A. If it was known at that time, yes.  
14 Q. Yes.  
15 So the issue, and do you accept this, is that you  
16 accepted a superficial description delivered by somebody  
17 who was shouting a defence for Lucy Letby rather than  
18 carrying out a sufficiently thorough investigation as to  
19 what was actually behind all of this?  
20 A. Well, I didn't feel that I had to personally  
21 carry out another investigation because there were  
22 a number of investigations already going on that one  
23 would hope would have looked at those things that you  
24 have highlighted.  
25 Q. I mean, what really should happen though is if

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1 Q. Did that put your back up, that he was  
2 demanding it?  
3 A. I wouldn't say put my back up but why wasn't  
4 he working with me? You know, like I have said  
5 previously just because a Consultant makes a demand, as  
6 senior nurse, you -- you don't -- when they click their  
7 fingers you don't jump how high.  
8 I mean, I accept, and looking back at all of these  
9 things, yes, and that is why we are here today so we can  
10 learn lessons and I am sorry for all of that.  
11 Q. Well, it's this serious, isn't it, because  
12 when you have a conversation with him on 24 June by  
13 telephone, he says to you: would you be happy to take  
14 responsibility for Lucy coming back on shift if she  
15 harms another baby?  
16 A. I don't recall him asking me those questions.  
17 But I can say this because apparently he said I said  
18 yes, I would take responsibility. I certainly wouldn't  
19 have answered yes and that's evident for me to phone  
20 Alison Kelly directly following that conversation to  
21 inform her that Steve Brearey had been back on the phone  
22 to me and is pushing for us to take Lucy Letby off her  
23 clinical practice.  
24 Q. Do you think though that where an otherwise  
25 senior sensible Consultant is saying to you that they

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1 have serious concerns that if Lucy Letby comes into work  
2 tomorrow that she will murder a baby, which I presume is  
3 a fairly novel conversation to be having with  
4 a Consultant, does that not immediately start alarm  
5 bells ringing from a patient safety point of view that  
6 maybe we should just take some safeguarding action?

7 **A.** Yes, and I have acknowledged that I wish I had  
8 now brought the safeguarding team in. But equally, and  
9 I will keep saying it, why did Ravi Jayaram or  
10 Steve Brearey not call the safeguarding team in if they  
11 were so insistent that she was doing? Why did they  
12 continue to work along side her? I am not making  
13 excuses, I acknowledge I should have done it too.

14 **Q.** I am sure they will be asked that question.  
15 But again, Ravi Jayaram talking to Karen Townsend in  
16 a coffee shop, that irritated you, didn't it?

17 **A.** No, it didn't irritate me. If I would have  
18 been working with any healthcare professional that  
19 I thought was purposely harming a patient I wouldn't  
20 have declared it in a hospital cafe over a cup of coffee  
21 and that was the point I was making.

22 It didn't irritate me, I was just trying to make  
23 the point that there is not a chance I would have tabled  
24 that concern over a cup of coffee in a cafe she was the  
25 divisional director. What I couldn't understand is why  
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1 Alison Kelly."

2 Can I ask on behalf of the parents of all of the  
3 children who I represent why there is no mention of  
4 a duty of candour to patients in this?

5 **A.** I don't know why I never said that. I don't  
6 know. Sorry.

7 **Q.** Because nobody told them at all about the  
8 suspicions or the investigations and they had to find  
9 out in quite horrible and upsetting circumstances?

10 **A.** Well, I wasn't aware of that, I am sorry, and  
11 of course that did not fall within my remit. But  
12 I wasn't aware of that.

13 **Q.** Who is responsible for telling the parents?

14 **A.** I would have thought the clinician that was  
15 caring for that patient in the first instance.

16 **Q.** What, Lucy Letby?

17 **A.** Sorry?

18 **Q.** Lucy Letby?

19 **A.** No, no, no I am talking about the Consultants,  
20 the Consultant team that were looking after that patient  
21 I thought, yes. They would have been first line to  
22 speak to those parents, surely. I didn't realise that  
23 they weren't informed and had to find out in a horrible  
24 way as you say. I didn't know that.

25 **MR BAKER:** Thank you, my Lady I have no more  
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1 did he not call an urgent meeting right there and then  
2 and ask for me, ask for Alison Kelly, Ian Harvey,  
3 safeguarding, on that Friday afternoon?

4 **Q.** What he did do, though, and what Ravi Jayaram  
5 did as well is to ask you not to let her come in for  
6 another shift so that this could be investigated. They  
7 were unhappy about the risk that she created for  
8 patients and your reaction to that was to effectively  
9 say: she's coming in to the unit?

10 **A.** I don't recall saying that.

11 **Q.** You refused to take her off the shift the  
12 following day. As a consequence she attacked Baby Q,  
13 didn't she?

14 **A.** Yes.

15 **Q.** Can I ask you what you understand the duty of  
16 candour to mean when it comes to patients, and I ask you  
17 this because of something you say in your police  
18 statement. So if we could go, please, to INQ0014005 at  
19 page 3.

20 So the second paragraph down beneath the "drawer of  
21 doom" paragraph begins:

22 "We have a duty of candour to both clinicians and  
23 nurses. So as Dr Brearey was pushing me to take some  
24 action even though he was not prepared to share with me  
25 the evidence of his allegations, I went to speak with  
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1 questions.

2 **LADY JUSTICE THIRLWALL:** Thank you very much,  
3 Mr Baker.

4 Mr Skelton.

5 Questions by MR SKELTON

6 **MR SKELTON:** Ms Rees, I am going to ask questions  
7 on behalf of the other family group.

8 **A.** Thank you.

9 **Q.** Can I just go back to the timings of your  
10 knowledge, please?

11 **A.** Yes.

12 **Q.** Just to be absolutely clear --

13 **A.** Okay.

14 **Q.** -- when were you first told that the mortality  
15 on the neonatal unit was higher than usual?

16 **A.** When was I?

17 **Q.** When?

18 **A.** My recollection was it was either the end of  
19 2015 or the beginning of 2016. It certainly wasn't June  
20 or July 2015 because I was not in post at that time as  
21 Head of Nursing.

22 **Q.** You came in in August?

23 **A.** Yes.

24 **Q.** It was in October -- I think you were here  
25 this morning, sat in the hearing -- when Eirian Powell  
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1 produced a mortality table --  
 2 **A.** Yes.  
 3 **Q.** -- after the death of Baby I?  
 4 **A.** Okay, yes.  
 5 **Q.** That was shared with Dr Brearey who had raised  
 6 a concern with her, so at that stage Dr Brearey is  
 7 speaking to Eirian Powell, Eirian Powell is copying in  
 8 Anne Murphy?  
 9 **A.** Yes.  
 10 **Q.** Were you involved in that knowledge circle at  
 11 that stage in October?  
 12 **A.** In what -- in October? I can't honestly  
 13 recall it being October but, like I say to you, I think  
 14 I was made aware either at the end of it, more December  
 15 or the January. It was somewhere around that time but  
 16 I do not recall being made aware of that in October.  
 17 **Q.** Who made you aware of it?  
 18 **A.** Pardon?  
 19 **Q.** Who spoke to you?  
 20 **A.** Made me aware of it?  
 21 **Q.** Yes?  
 22 **A.** Eirian Lloyd Powell at the time.  
 23 **Q.** And we have had a lot of evidence about her  
 24 views. She at that stage rejected the suggestion that  
 25 Lucy Letby had harmed children, did you accept her view?  
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1 it to me in October. I was fairly new in post. Whether  
 2 we just didn't get the opportunity, I don't know, but  
 3 I don't recall her telling me in October 2015.  
 4 **Q.** But you would have expected her to have raised  
 5 it with you?  
 6 **A.** Yes, yes.  
 7 **Q.** I won't go over the phone call in any detail  
 8 with Dr Brearey. You have been asked about it a number  
 9 of times. But what I would like to understand is in  
 10 your earlier interview with Facere Melius, and indeed in  
 11 your Inquiry statement, you don't mention being bullied  
 12 or intimidated by Dr Brearey. In fact, you have  
 13 described him as rather softly spoken.  
 14 **A.** Yes.  
 15 **Q.** So he was being more assertive than usual?  
 16 **A.** Yes.  
 17 **Q.** But you don't mention being bullied or  
 18 intimidated?  
 19 **A.** Well, perhaps that's -- but that's how I felt  
 20 on the phone. I felt he was trying to push me to remove  
 21 Lucy Letby off the neonatal unit when nobody had been  
 22 prepared to do that before. So there was a difference  
 23 this his, in his voice and his tone.  
 24 He doesn't raise his voice. Steve Brearey never  
 25 does, but because he phoned me up at home, you know, and  
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1 **A.** Well, clearly at that time I did, didn't I?  
 2 **Q.** Did you go and speak to any of the  
 3 Consultants?  
 4 **A.** No, I didn't.  
 5 **Q.** Because you have obviously said the onus was  
 6 on them to bring things to you. They had brought things  
 7 to her, she had rejected it --  
 8 **A.** Right.  
 9 **Q.** -- you yourself didn't feel the need to get  
 10 a personal grip on this.  
 11 **A.** Well, as a head of nursing I would have  
 12 expected to be told, as soon as, if there was a concern  
 13 about a nurse.  
 14 **Q.** You would have expected to have been told by  
 15 the Consultants as opposed to being told by the nursing  
 16 manager of the unit?  
 17 **A.** Well, the nurse manager, yes.  
 18 **Q.** Can I infer from that you would have expected  
 19 to have been told by Ms Powell sooner than the end of  
 20 2015 to early 2016; in fact, as soon as she was aware?  
 21 **A.** Well, she was aware, wasn't she, in June 2015.  
 22 **Q.** Yes.  
 23 **A.** And I was working in another division then, so  
 24 ... But I don't -- like I say to you, yes, she might  
 25 have been aware there, but I don't recall her mentioning  
 206

1 was pushing me to do it again that's why I phoned  
 2 Alison Kelly immediately after and said: This  
 3 Consultant is still on the phone to me agitating.  
 4 **Q.** Well, he was being assertive.  
 5 **A.** Assertive.  
 6 **Q.** He wasn't bullying you really, was he?  
 7 **A.** Okay. That's how I felt. I felt like he was  
 8 trying to push me take an action that nobody else had  
 9 been prepared to do. So you can call it assertive.  
 10 That's how I felt.  
 11 **Q.** Well, I think you said in your interview he  
 12 was assertive.  
 13 **A.** Okay.  
 14 **Q.** Were you cross about that? That's another  
 15 thing you said in the interview.  
 16 **A.** Was I cross? Maybe I was. He had phoned me  
 17 up at home, despite us having a conversation, despite me  
 18 telling him I'd escalated to the Execs. He inferred  
 19 I was lying. So, yes, probably I might have been a bit  
 20 cross. Yes, maybe.  
 21 **Q.** Did it occur to you that he might be  
 22 desperate, that this was a desperate situation  
 23 requiring -- effectively he had to get your number from  
 24 the switchboard. You were being called out of hours as  
 25 the sort of Exec responsible for responding to  
 208

1 emergencies or serious issues --

2 **A.** I wasn't the Exec.

3 **Q.** I had understood that you were, as it were,  
4 the hotline as a senior manager for that weekend?

5 **A.** No, no. There's levels. This is -- clearly  
6 people are labelling me as an Executive nurse. I never  
7 have been, never was. So that's a mistake because  
8 obviously that's Alison Kelly and we always have an Exec  
9 on-call and then a clinical manager like myself.

10 **Q.** Leaving that aside, the status issue, he  
11 clearly felt there was a desperate need to call someone  
12 to get a nurse removed. That's a highly unusual step to  
13 take.

14 **A.** Yes, I get that. But I honestly believe if  
15 I hadn't gone to find him on that Friday, he never came  
16 anywhere near me, I went to seek him out because I was  
17 concerned. As a senior nurse, I do not walk out of the  
18 organisation when you have got an allegation like that  
19 on the table. Absolutely not.

20 And the whole time I had been in post as head of  
21 nursing not one time. And I honestly feel if I hadn't  
22 had gone to find him -- and I accept all what you say --  
23 if I hadn't have gone to find Steve Brearey on that  
24 Friday afternoon, I wouldn't have had that conversation,  
25 he wouldn't have rung me at home.

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1 phone to me.

2 **Q.** Did you have the power to remove Letby from  
3 that shift?

4 **A.** Yes, I did.

5 **Q.** Without --

6 **A.** Not -- not in isolation. I would have had to  
7 have discussed it with my Director of Nursing and then  
8 involve human resources. You can't just do it in  
9 isolation.

10 **Q.** And what was your recommendation to  
11 Alison Kelly?

12 **A.** I didn't have --

13 **Q.** Presuming she was reliant on you.

14 **A.** I didn't make any recommendations to  
15 Alison Kelly. I was just informing her of the events  
16 that afternoon and the events of Steve Brearey calling  
17 me.

18 **Q.** Isn't the reality that you didn't want to  
19 remove Lucy Letby?

20 **A.** If I'd've had good reason, I would have done.

21 **Q.** And --

22 **A.** If I had been given sound reason, I would have  
23 discussed it with Alison Kelly and we would have brought  
24 in HR and we would have removed her.

25 **Q.** You said in answer to questions from

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1 **Q.** Well, leaving that aside. You had known by  
2 this stage, for at least six months or so, that there  
3 were concerns about Lucy Letby possibly harming  
4 children?

5 **A.** Okay. Yes.

6 **Q.** For a long period of time. This wasn't news  
7 to you?

8 **A.** No, it wasn't.

9 **Q.** Two babies had just died out of a family of  
10 three that had just been born?

11 **A.** I know.

12 **Q.** And you were being called by a Consultant  
13 saying: In order to protect children on the unit you  
14 need to get rid of this nurse off the shift.

15 It's an extraordinary situation to be in.

16 **A.** It is.

17 **Q.** But your response was to be cross and not to  
18 take that step. Can you actually justify that?

19 **A.** Right. I have just explained why I possibly  
20 was cross. I escalated again, the second time that day,  
21 to my Director of Nursing.

22 I was following hospital policy and procedure.

23 I was unsure what to do because he wasn't giving me  
24 anything else, so I picked up the phone immediately and  
25 told my Director of Nursing that he had been back on the

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1 Ms Langdale, and indeed in your statement, that you felt  
2 the Consultants might have had a personal issue?

3 **A.** I did. I did initially. I have admitted  
4 that. I thought it might be personal because I have had  
5 incidents before where Consultant clinicians have  
6 demanded me move nursing for varying other reasons --  
7 not this allegation clearly -- because there's been  
8 a breakdown in personal or professional relationships.

9 **Q.** Were you --

10 **A.** So you have to have more than a gut feeling  
11 and a drawer of doom to remove somebody.

12 **Q.** But there hadn't been a breakdown in the  
13 personal relationships, had there, in terms of there was  
14 no question about Lucy Letby's competence, there was no  
15 personal dislike between her and the Consultants?

16 **A.** Sorry, I'm not following that one, sorry?

17 **Q.** There was no personal reason in this case in  
18 fact. It was purely a professional decision they wanted  
19 to make --

20 **A.** Well, okay then, yes.

21 **Q.** But you didn't investigate that personal  
22 reason?

23 **A.** I didn't investigate. I escalated.

24 **Q.** And calling someone and speaking to them about  
25 a potential nurse murdering patients is of a very

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1 different order from a breakdown of personal relations,  
2 isn't it?

3 **A.** Mm-hm.

4 **Q.** Do you recognise that you may have brought  
5 a degree of bias to your decision-making in assuming  
6 that there was a personal problem?

7 **A.** Possibly. Possibly.

8 **Q.** Did you think to enquire with the other  
9 Consultants? Dr Gibbs had treated the children who had  
10 just died. Did you think to ask him: Is this safe?

11 **A.** No, I did not.

12 **Q.** Prior to -- well, at any point really, did you  
13 speak to any of the other Consultants --

14 **A.** No, I did not.

15 **Q.** -- Dr Holt, for example, who was a relatively  
16 new and female Consultant who had come to the unit, she  
17 explained that she was concerned by high mortality  
18 within weeks of arriving on the unit in 2016. Did you  
19 ever speak to her?

20 **A.** No and I wasn't aware she -- she had got  
21 concerns at that time neither.

22 **Q.** So do you think looking back that what  
23 happened was that you dug in in a certain mindset quite  
24 early on, you and Ms Powell, and never really  
25 re-examined your own conclusions as to whether Letby in

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1 somewhere in those Terms of Reference that said if you  
2 can highlight any possible causes or whatever in  
3 regards, there was something that was written, in  
4 regards to the mortality rates, I don't think it was  
5 very specific, and certainly I know Lucy Letby's name  
6 wasn't. But like I say, I -- I didn't see them.

7 I wasn't involved in setting them until well after the  
8 investigation had taken place.

9 **Q.** As far as you were concerned, throughout this  
10 period of time, how did you understand the truth was  
11 ever going to be determined about whether or not she had  
12 or had not murdered the children?

13 **A.** It needed to be -- to call the police clearly  
14 because we weren't getting anywhere, with no amount of  
15 investigations, internal/external thematic reviews,  
16 post-mortems whatever, it wasn't moving anything on.  
17 So, yes, the only way we could determine was to bring  
18 the police in.

19 **Q.** And as far as you're concerned, I think you  
20 accepted this earlier, that it was the responsibility of  
21 everyone involved --

22 **A.** Yes, and I hold my hand up to that as well.

23 **Q.** -- to call the police?

24 **A.** Yes.

25 **Q.** -- as soon as the suspicions became

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1 fact may have harmed children or not?

2 **A.** I hope not. I -- it's -- I don't know.

3 I don't know. I'm sorry.

4 **Q.** Can you give one example of you testing your  
5 own assumptions, asking questions, checking  
6 investigations?

7 **A.** Well, obviously I had numerous conversations  
8 with Eirian. I didn't commence any investigation  
9 because there were internal investigations already going  
10 on. My main conversation about all of this was  
11 definitely with Eirian Powell.

12 **Q.** Well, Ms Langdale took you to the email that  
13 you were writing in which you were greatly supporting  
14 Lucy Letby in September 2016 --

15 **A.** Mmm mm.

16 **Q.** -- just after the Royal College had come in  
17 and done their review for two days.

18 You, I think, were aware that the Royal College  
19 were not looking at increased mortality or indeed  
20 Lucy Letby, is that right?

21 **A.** I wasn't involved with setting the Terms of  
22 Reference and I hadn't seen them at that point. But  
23 I think I recall somewhere in the Terms of Reference it  
24 certainly didn't mention Lucy Letby.

25 But if my recollection is correct there is

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1 apparent --

2 **A.** Yes.

3 **Q.** -- and when it was clear that you couldn't  
4 handle them internally?

5 **A.** Yes.

6 **MR SKELTON:** Thank you.

7 **A.** Thank you.

8 **MR SKELTON:** Thank you, my Lady.

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

10 **MS LANGDALE:** No further questions, my Lady.

11 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.

12 Mrs Rees, thank you very much indeed. That  
13 concludes your evidence. Thank you for coming to help  
14 us today. You are free to go.

15 **A.** Thank you. I am sorry for everybody's loss.

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

17 Can you just remind us of the timetable?

18 **MS LANGDALE:** I would like to be able to but, I  
19 can't actually. It's 10 o'clock tomorrow, I know that  
20 much.

21 **LADY JUSTICE THIRLWALL:** Very well, that will do  
22 for now. We will resume tomorrow at 10 o'clock. Thank  
23 you all very much.

24 **(4.54 pm)**

25 **(The Inquiry adjourned until 10.00 am,**

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1 on Tuesday, 22 October 2024)

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