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.

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?

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

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,

Jane Evans was the head of nursing?
A. Yes.
Q. And Karen Rees took over from her, I will just let you know what they say in their statement because this is going to be important to a piece of your evidence in a moment.
Karen Rees says in her witness statement -- she is of course giving evidence this afternoon -- that she took over that role in August 2015, Jane Evans says that she gave notice in August but didn't in fact leave the role until 30 September 2015.
But she also says she was on annual leave for much of that period and that there was a period of handover. So it appears that by 30 September everybody agrees Karen Rees was in position.
So I hope that helps your recollection because we are going to have a look at the timeline as to who you were speaking to at different times.
A. Yes.
Q. So if we consider that now and focus on Jane Evans who held that role until 30 September, you say in your witness statement that you have a -- and I am quoting you here -- vague recollection of speaking to Jane Evans with Eirian Powell about the increase in mortality on the neonatal unit.

So if we just have a think about that for a moment and I will just try and help you with it. We know that there were three deaths in June of 2015. There was then another death, that's Child E, at the beginning of August.
Do you think it was following those four deaths that you would have had a conversation with Jane Evans?
A. Yes, I would, I would have assumed that it would have been something that we would have highlighted to Jane Evans; that there had been a series of infant deaths.
Q. Obviously there is a difference between having a positive recollection of something and assuming that you would have done something because that's how you would normally act. Can we just be clear here.
Do you have a recollection of having spoken to Jane Evans?
A. I have a recollection that we did speak to Jane Evans but I couldn't be absolutely certain about that.
Q. And are you able to say anything beyond what you have just said about what it was that you said to Jane Evans?
A. I think that we would have said that you know there had been a -- a number of, of baby deaths which

was slightly unusual for the neonatal unit to have a spate of deaths all at once.
Q. So does that fit with your thinking following the death of Child E in August of 2015 that you regarded the neonatal unit as experiencing something unusual?
A. Well, it was certainly not something that was or had been in the past that there were several more than -- than normal, certainly.
Q. Were you meeting Jane Evans regularly or did you go to see her specifically about this issue, do you know?
A. No. We had a monthly one-to-one with Jane Evans so it wasn't specific, I don't think, to -- to the occurrences on the neonatal unit.
Q. And you say "we". Was Eirian Powell also attending that one-to-one that you went to?
A. It -- it was all of the, the staff who were in a management position. So it was Eirian, myself, Anne Martyn, who's manager of the Children's Unit, and Sarah Jackson who was manager of the community children's packages.
Q. So it was in the context of one of those one-on-one meetings with your immediate line manager that you think you drew attention to the fact that the neonatal unit was experiencing something unusual?

A. Yes.
Q. So that's all that I want to ask you about Jane Evans, unless you have any other recollection of that discussion or anything that arose from it?
A. Not as far as I am aware.
Q. Well, we will come back to the timeline in due course. Thank you very much. We can take this down.
LADY JUSTICE THIRLWALL: Mr De La Poer, just before you move on, I just wonder if I can clarify something in my own mind?
MR DE LA POER: My Lady, of course.
LADY JUSTICE THIRLWALL: Mrs Murphy, I just want to understand how many people were at the meeting because it's mentioned as a one-to-one which I assumed was one person and one manager. But you refer to "we".
A. There could have been one or there could have been four of us there, it would depend, and occasionally if there was something untoward we might have or I might have asked to stay behind or, you know.
So it may have been that that we informed Jane after the meeting but stayed behind and let the other two managers go. So -- but not all of us could attend every month, you know, so it could have been two or four of us that were there.
LADY JUSTICE THIRLWALL: Thank you.

Thank you, Mr De La Poer.
MR DE LA POER: So we are just going to talk generally now about your impression of the neonatal unit and in particular in early 2015, so before those unusual deaths as you have described them, the first four, occurred.
What was your view about how well that department was functioning at early 2015?
A. Are you asking me prior to the infant deaths?
Q. Yes.
A. *(Redacted)*. But prior to that, the neonatal unit was a well run unit. They didn't appear to have a lot of problems. They often had staffing issues relating to the acuity of the patients.
So they -- they may well have needed additional staff at times for, to look after the babies. But generally, it was well run, the staff were always very friendly and, you know, they seemed to get along very well. They -- they managed to get the, you know, mandatory training and things all done so that from a management perspective that was fairly well completed.
And -- and, you know, from the perspective of the people that actually went to the unit to visit or who were working there from a medical and a nursing perspective, everyone appeared to get on very well.

Q. Presumably you had regular meetings with Eirian Powell who you managed directly?
A. Yes.
Q. Did she ever report to you any problems with relationships as between nurses or as doctors and nurses or as between doctors?
A. No, not at all.
Q. Did you have experience of working with the doctors yourself or seeing them work with the staff on the children unit?
A. On the children's unit, yes.
Q. What was your impression of the Consultant body?
A. The Consultant body were, you know, very, very good. We didn't have any real issues with any of the Consultants. Everyone did get along.
I think, you know, from a paediatric and neonatal perspective, we were sort of in our own little bubble I suppose a lot of the time, segregated from the rest the Trust, and because -- I think because we worked with children and families we are quite different to looking after adult patients.
Q. Your medical equivalent was Dr Ravi Jayaram so he was the equivalent to your role but in a medical perspective. Would you agree with that, he was the

lead --
A. Yes, yes.
Q. For the children's, you were lead for nursing?
A. At that time, yes, he was the Lead Clinician.
Q. What was your relationship with him?
A. I -- I believe it was very good, you know, there were -- we didn't have an issue at all.
Q. Dr Stephen Brearey who was the lead for the neonatal unit, did you have experience of working with him and seeing how he worked with others?
A. From a paediatric perspective, I worked with -- with Steve Brearey. I didn't have a lot of contact with Steve from a neonatal perspective, so I didn't -- I didn't work within neonates as, as a professional nurse.
So I didn't have the experience of making a comment about Steve within the neonatal unit working area. But I know from my work with him in the paediatric area, you know, that he was a very good clinician.
Q. It wasn't being reported to you that he was any different in the neonatal unit?
A. No, no.
Q. So you have mentioned the phrase "little bubble".
A. Yes.

Q. There I understood you to be referring to the fact that the Children's Unit and the neonatal unit were to some degree separate from other parts of the hospital. Am I right to understand you to mean that?
A. Yes. The -- the staffing were, were different and they didn't, the neonatal unit didn't share the same coffee area as the paediatric nurses because they were -- once they got to work they were maintained within that area and, you know, for infection control reasons, really.
Q. I understand. So the two units were not -- they were separate from each other to some degree?
A. Yes.
Q. But of course they had the same Consultants serving both?
A. Yes, yes.
Q. So was that separation more from a nursing perspective rather than a doctor perspective?
A. Yes. It was more from a nursing, although if, if the neonatal unit was busy then the paediatric nurses would go to help with the neonatal, with the special care element of the -- the neonatal unit.
So we, we did share resources if there was a need.
Q. Now, the Inquiry has heard something about the change in divisional structure at the hospital before

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

So they would then come back to local level with it

being graded at whatever level.

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

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

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

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

Q. So --

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

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

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

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

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

Q. I am sure you will accept it from me that there is no record within this meeting of those three deaths being discussed or raised; is that fair?

A. Yes, that's probably true.

Q. Can we have a look at page 3, just to understand something about the risk. "Governance Issues Summary". Firstly, it says "No representative present".

Is that a reference meaning a representative from the risk department?

A. Yes.

Q. Then there is a reference to risk registers, "No risks to be added for paediatrics."

Then the NNU.

"Following QSPEC ROP will be added as currently there is only one clinician able to access this on the unit, there are implications to consider such as utilising other units, other clinicians, et cetera."

Firstly can you help us with ROP?

A. It's -- it's a problem with neonates' eyes that's caused by oxygenation. I think it is retinal -- I can't remember.

Q. Don't worry about it. The point is there is plainly a discussion about that condition and how it might be relevant to the risk registers.

Just helping us to understand this. We obviously

know that a month earlier there was a discussion about Registrars being concerned you had had three deaths on the neonatal unit in fairly quick succession.

Was this an appropriate meeting to discuss those deaths or raise the fact that they had occurred?

A. I -- I think it may have been highlighted if there had been the risk nurse there. She may well have brought the data relating to the clinical incidents that had been put in following each of those baby deaths and there might have been discussion relating to those.

Q. But, I mean, I am not suggesting you were the only one who was present at this meeting and the meeting the previous month?

A. Yes.

Q. Obviously there were a number of doctors there but you were present at the previous meeting, you knew about the three deaths, you will have heard that the registrars were concerned about it and what needed to be done and a plan was required. Was this something that you could have raised and said: well, I think this would be a good forum for us to discuss this?

A. Well, because the nursing side had never raised any concerns to me personally, then if -- if there had been an issue then perhaps at that stage the clinicians should have raised it, the paediatricians.

Q. So you saw that because it was a concern on the medical side, on the doctor side, it would be for them to raise it but from your perspective as a nurse you didn't have anything to contribute on that point and so not for you to raise?

A. No, other than if -- if there had been -- I mean, we may have discussed it had the clinical incidents been highlighted at that meeting. The specialty meeting was more of a business meeting than a clinical meeting.

Q. But it did deal with governance issues because we --

A. It did, yes, it did deal with governance issues.

Q. We can see -- but is it your view that without having the risk nurse there, that couldn't be progressed in the way it might otherwise have been?

A. I don't think I can answer that whether it would have been or not, really.

Q. Just one other matter to ask you about this document.

If we go to page 5, please, this is more of a general comment about what was being said at the time. In the second to last bullet point, about two-thirds of the way down the page, we can see a sentence beginning:

"General consensus that paediatrics is left to its own devices and is not considered in financial matters."

The context is perhaps potentially relevant. But it is a general remark about the attitude from those outside paediatrics to it. Was that the view in 2015, July, that paediatrics was effectively left to its own devices and not taken into account in relation to the money?

A. I think there the -- the Consultants were obviously saying that they weren't given the opportunity to attend the divisional board and that the business case that had been put in, they didn't have the opportunity to actually go and speak specifically about the needs of -- of the paediatric service there, that it -- it looks as if what was being discussed is that we weren't involved in the financial side.

That ...

Q. And is that how the paediatrics department felt generally, or is that just specific to this one issue?

A. No, I think in general we did feel at times that we were being let down in some way from the -- the, you know, sort of divisional side or, you know, the Executive side.

Q. So we can take that down, thank you very much.

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

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

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

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

We will bring up the INQ, INQ0003223.

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

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

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

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

So we have got those there.

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

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

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

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

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

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

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

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

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

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

A. I -- I think it was more information gathering.

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

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

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

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

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

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

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

Q. I am not asking unless you were told about Dr Brearey; I am asking between you and Ms Powell?

A. I'm sorry, I can't specifically recall that incident.

Q. Well, we will have a look --

A. The discussion.

Q. We will have a look at that document in a moment. I just want to examine this idea of Alison Kelly was not in the hospital. As a director, would she have had a telephone number that you could find out from her PA to contact her when she is outside the hospital if it was sufficiently urgent?

A. I would assume that if Eirian had already contacted she would have contacted the Executive office and spoken to a secretary. But it wouldn't have been normal practice for one of us to pick up the phone and -- and ring Alison Kelly or Sian when they were outside of the hospital.

Q. But I think you have also told us it wouldn't be normal practice for Eirian Powell to go and see Alison Kelly about an issue directly?

A. Yes, she could well have.

Q. So whatever it is to be discussed with Alison Kelly is to be discussed on the Monday, do you agree that's what this email seems to be saying?

A. That's what the email says.

Q. So let's move on.

"I have devised a document to reflect the information clearly and it's unfortunate that she was on. However, each cause of death was different. Some were poorly prior to their arrival on unit and others were [question mark] NEC or gastric bleeding/congenital abnormalities. I have attached the document for your perusal".

Now, we know on the table that we will look at in a moment Letby's name was highlighted in red on that table, wasn't it?

A. (Nods)

Q. So is the "it's unfortunate that she was on" a reference to the fact that it is unfortunate that Letby was on?

A. Yes.

Q. Then finally before we turn and have a look at that document:

"See you Monday, I will discuss with Debbie on Monday."

So that's Debbie Peacock?

A. Yes.

Q. The risk midwife?

A. Yes.

Q. So two meetings to be had on Monday, on the face of it, one with the risk department, one with the Director of Nursing?

A. Yes.

Q. So let's have a look at that table very briefly. We have seen it many times. INQ0003189.

Really, Mrs Murphy, to see if this further jogs your memory bearing in mind that this is a table that Eirian Powell appears to have created that very day, the day that Child I died, the day that she spoke to Dr Brearey, the day that she spoke to you and the day that she sent that e-mail, was that a document that she showed you before she sent the email?

A. Not to my knowledge.

Q. But --

A. But I don't know if the conversation that Eirian and I had was face to face or whether she telephoned me. I don't know.

So I don't know if I actually saw that before it was circulated.

Q. But at 5.25 that day you received a copy of this table. Do you recall opening it and working your way through it and seeing Letby's name appearing in either of those two right hand columns for all but the first baby?

A. I'm sorry, I don't. I-- I can't remember when I first saw you know this document per se. But obviously, you know, it was one of many documents that was changed a number of times. But obviously because of the conversation she had had with -- with Dr Brearey he had obviously named that particular nurse, which is why Eirian has highlighted her name to show, you know, whether she was actually on the unit, where she was caring for that infant or not.

Q. Bearing in mind that conversation between Ms Powell and Dr Brearey took place before your conversation with Ms Powell --

A. Yes.

Q. -- and Dr Brearey and you are then -- forgive me, I will start that again. The conversation between Dr Brearey and Ms Powell took place between your conversation and Ms Powell.

You are then copied into the email about the contact with Alison Kelly and the fact that this chart had been created. I mean, do you think it likely that it was in that meeting on 23 October that Ms Powell told you that Dr Brearey was worried about Letby?

A. I -- I'm sorry, I can't actually answer that. I don't know if in fact concerns had been raised before or whether it was actually in October that it was first

discussed that he felt that she was there for the majority of -- of the instances.

Q. I understand. So this then -- if I have understood your answer correctly, this represents the very latest date that you would have heard about Dr Brearey's concerns but it may be that you heard about them before?

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

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

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

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

indication that she was causing any harm to those babies.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

this nurse had done anything wrong.

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

A. At that stage, yes.

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

A. I cannot -- I cannot recollect speaking to Dr Jayaram.

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

A. No.

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

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

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

fair because you didn't have proof. I hope I have recollected that correctly?

A. (Nods)

Q. When it comes to keeping babies safe, do you need proof before you act?

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

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

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

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

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

A. That would depend on what the reason for

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I have no recollection.

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

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

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

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

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

A. Thank you.

(11.14 am)

(A short break)

(11.30 am)

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

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

A. Yes.

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

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

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

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

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

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

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

A. (Nods)

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

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

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

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

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

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

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

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

A. Rights, yes.

Q. -- in December of 2015?

A. Right.

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

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

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

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

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

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

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

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

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

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

A. (Nods)

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

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

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

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

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

reflections on it, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. (Nods)

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

A. Yes.

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

Can you remember that theme being discussed at the meeting?

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

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

A. Yes, I think I can recall that.

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

difference that Letby's name was not highlighted in red.

Did you notice when this report was circulated that the table no longer highlighted her name?

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

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

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

Q. So what you say in your witness statement is:

"I believe [that] Lucy Letby's presence on the unit at all deaths was highlighted as it was on the Mortality 2015 report ... Letby's competence was never questioned. It was suggested, as no one wanted to accuse her of harm, that it may be a practice issue."

A. (Nods)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

this meeting, do you think?

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

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

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

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

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

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

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

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

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

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

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

Q. Well --

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

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

Business":

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

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

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

Q. Obviously striving to improve standards at all times is an important aspect of work within the NHS. But just help us to understand whether there was a culture here that the hospital would put its best foot forward when the CQC came just to try and satisfy the CQC, in other words for the sake of satisfying the CQC

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

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

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

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

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

"Anne Murphy, the lead nurse of paediatrics,

attended one specific safety brief where the NNU was discussed. Following the briefing we had an impending CQC visit and Anne Murphy requested we fill out our appraisal documentation and sign them so we would appear compliant for the CQC visit, despite none of us receiving appraisals, or at least I know I did not receive an appraisal during my time at the Trust, but was requested to fill out this form at the time, again evidencing the operations between senior management across the Children's Division."

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

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

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

Q. Thank you. We can take that document down. We are going to move forward two days to the CQC meeting

on 17 February 2016. You have had a chance to look at the notes prepared by the CQC recently about that meeting so hopefully that's helped to some degree.

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

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

LADY JUSTICE THIRLWALL: 207.

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

"5 from NNU last year x4 this year."

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

A. Yes.

Q. Did the fact that there had been a thematic review feature in your discussion with the CQC? Is that something that was raised at the meeting that there had been a meeting just nine days earlier where all of these deaths had been looked at and that no clear explanation had been identified for the increase?

A. I can't remember exactly what was said at that meeting. But, you know, we have talked about the mortality/morbidity meetings and, you know, we -- we probably said the same to the CQC; that we couldn't find a reason for any of the mortality being increased.

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

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

So it's just important, doing the best you can, we can see what the notes record as having been said. That second part namely that this was a very significant increase and that you there had been an investigation looking at all of them and that no clear explanation had been found, it's that second part. Do you have

a recollection of that being said by either you or Dr Brearey to the CQC?

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

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

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

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

Q. Thank you, we can take that down.

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

MR DE LA POER: My Lady, of course.

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

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

Thank you, we can take that down.

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

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

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

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

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

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

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

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

Anyway, we hope to hear from the author.

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

LADY JUSTICE THIRLWALL: Ah, meetings?

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

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

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

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

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

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

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

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

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

Q. Let me just --

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

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

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

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

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

A. (Nods) Yes.

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

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

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

Q. But --

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

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

A. Yes.

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

A. Okay.

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

Continuing to move forward, 15 March INQ0005697.

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

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

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

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

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

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

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

their concern; is that right?
A. Yes, yes.
Q. And are you able to say which of the Consultants you have a recollection of having such a concern?
A. I mean, the -- the Consultant that I know who definitely voiced that was Dr Jayaram. But I think Dr Gibbs was also -- although he speaking to Dr Gibbs he couldn't give us a reason for any of these babies having a sudden deterioration, I think because they were obviously discussing it amongst themselves, then he was also feeling that at that time, you know, there had to be something and I mean -- I don't know whether we were still looking at other elements.
You know, could it be something else or at this stage I think we were all just getting a bit upset about it all and discussing whether it should be put into the police hands, really. We were -- we had investigated as much as we possibly could and couldn't find a reason for it. It -- it could be coincidence that this particular nurse was there all of the time but there was nothing then to accuse her of doing.
So I think we were really wanting support and advice from our Executive team by this stage.
Q. So it could be coincidence but was it also

within your contemplation that it could be something that she was doing, you just couldn't say what?
A. Well, I don't know that I personally felt that she was doing harm. I -- I couldn't personally consider what, what it was that she could be doing to these babies that would present in different ways.
I -- what -- what could she be doing? I really don't know.
Q. So in the state of mind that you had taken it as far as you could, you sought help from the Executives and in particular Ms Powell. Let's just bring that up INQ0003089, again we are very familiar with this but let's just mark that moment in the chronology. If we scroll to the bottom.
Forgive me, there we are. 17 March, Ms Powell -- you are not in fact on copy of this first email but you become aware of this, come on to this thread later we will have a look at. We can see she sent that message but that message was sent with your knowledge and approval, was it?
A. Yes, yes, it was.
Q. And bearing in mind all of the individual reviews, the thematic review, had this situation now reached a point where it was urgent?
A. Well, I think at this stage we felt that we

needed some support from -- or, you know, different eyes to be looking at it.
We were, apart from the thematic review which involved one of the regional Consultants, I think it had always been an internal women and -- well, children's neonatal reviews with our risk assessor, who couldn't really -- I mean, she didn't at that time I don't think she didn't voice any concerns either about the nurse's presence. But I think at this stage I think Eirian was getting frustrated that the doctors kept saying that it had to be her, Lucy Letby, that was somehow causing this.
They couldn't give us a reason or, you know say how this could be happening, what exactly she could be doing to any of these babies. And we still didn't have any reports from nursing colleagues to say that they had -- they were upset that these babies were dying because it was different, you know, this was different.
But could it just be a blip that there had been a lot of babies born with problems and, you know, subsequently deteriorated? No one could answer those questions for us. But, you know, at that stage, I think we had discussed you know that we needed support from outside.
Q. So if we just run through this email. We can

see that Alison Kelly replies four days later asking for the report, that is 21 March. If we then scroll up to the next page, we can see that the same day Eirian Powell sends the report to Alison Kelly and then the next email is 14 April, you are now put on copy at this stage and it's Eirian Powell chasing Alison Kelly?
A. Yes.
Q. Now, given the apparent lack of response, that's certainly what this email tends to suggest, should action have been taken before 14 April to get input from the Executives? In other words, was it acceptable to wait a period of over three weeks before following this issue up?
A. Well, perhaps not. Perhaps we should have been chasing. But I -- unfortunately we obviously didn't and, you know, I can't really say why that, why we wouldn't be doing that.
Q. Because back in --
A. Perhaps we just -- you know, we weren't always on duty at the same time, you know, there were things that were happening within the various units, I really don't know why we left it until that stage to -- to then question it again.
Q. Because back in October the plan had been to go and see Alison Kelly that day, in person. And I am

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

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

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

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

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

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

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

Can we just pause there and just ask you a couple

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

I mean, was she right to describe it as

"potentially very serious"?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, I mean --

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes, of course I will give you the names. Beverley Allitt, Victorino Chua. These are nurses who have harmed their patients, we have obviously got Harold Shipman?

A. Yes.

Q. There are past cases?

A. Yes.

Q. My question was just really whether those cases crossed your mind as you were trying to navigate this particular situation?

A. I- I don't think I did think about Beverley Allitt. I don't think I really thought that any harm was being carried out by a particular person. So no, I didn't consider -- and, I mean, I was very aware of the Beverley Allitt.

Q. You were very -- I'm sorry, did you say you were very aware of that case?

A. I mean I was aware of -- my previous manager had been the nurse involved with the report. So -- the investigation.

So, you know, she had actually come to back to the Countess to get information about resuscitation trollies from us. So I was very aware of Beverley Allitt and so.

Q. Doing the best you can, why do you think you didn't draw that connection?

A. I'm sorry, I didn't. I didn't. I didn't think about child protection at all at that stage.

Q. Can I just ask you about a couple more matters. We are going to move past the deaths of Child O and Child P to two meetings on 27 June, we can deal with fairly briefly.

The first is the lunchtime meeting involving the paediatricians. I think you have say that you have a recollection -- I believe it is of that meeting of Dr McCormack saying something. Doing the best you can, what is it that you recollect Dr McCormack as saying?

A. I don't -- I may have been wrong in what I wrote in my statement because I'm not sure whether that was an urgent meeting that had been called at half past 7 that morning or whether it was the official senior clinicians meeting which always took place at half past 12 on a Monday, well, three Mondays of the month.

But the only thing that did stand out in my mind was that it was a meeting where there were obstetricians there as well as our Consultant paediatricians and I think there were other members, I don't know if Julie Fogarty was there, whether there was a risk person there. There was obviously Eirian and myself, I don't know if there was anybody else from paediatrics or from

the neonatal unit as anyone could really come to the senior clinicians.

But, I mean, the only thing about that meeting that did stand out was when Mr McCormack we had obviously were discussing the fact that people were starting to get upset and that there was a nurse involved and Mr McCormack then shouted down the table, "Are you telling us there is a murderess on the neonatal unit?" And I think that was like a slap in the face.

Eirian retaliated and said, you know, that he couldn't say that, there was no evidence but I think that is the only sort of thing that has been retained in my head about that meeting.

Q. The other meeting I wanted to ask you about which you don't give a date for in your witness statement is a meeting in late June of 2016 which you say Stephen Cross attended.

A. Well, I am not -- I'm not sure about the timeline. Certainly I only remember that at some time there was a meeting in which there was a number of the chief execs, and risk, safeguarding, senior management. I don't know if Karen Rees was there or not.

I think Julie Fogarty was there as Head of Midwifery. But -- but there was a meeting where, which was pulled together to discuss the --

Q. Obviously don't worry about the timings.

What is your recollection about what Mr Cross said?

A. My recollection of that was after discussion Stephen Cross saying that that there was no, there was no evidence to involve the police and the police would sort of disregard what we were actually asking for. He didn't think the police would entertain an investigation.

So -- but as I say, I really don't know what the timeline was for that meeting, whether it was round about that time. I feel that it was but I may be completely wrong.

Q. The final event to ask you about is the meeting you had with the RCPCH on 2 September 2016. It is just one thing that you are recorded as saying. You describe the doctors in that meeting as being tunnel-visioned about her presence, that is what the note of the meeting says.

Would you like to see it?

A. I mean, I -- I can't say that I didn't say that certainly. And in some respects we did feel that the doctors were very sort of tunnel-visioned about the fact that it had to be a nurse. But, I can't -- I can't recall seeing it that late in the process because I thought the police had already been involved by

2 September.
Q. The police were not involved until April 2017?
A. Right. I think well, I can't, I can't really remember. I think we were asking for external reviews and external investigations at that point and I may well have said that I thought the Consultants were -- had tunnel vision about it. But we weren't the ones that could do anything more to prove or disprove that.
Q. The very last matter which is not about any particular meeting, it's just a comment that you make in your statement is that you describe Tony Chambers and Ian Harvey as being confrontational and threatening in your witness statement.
Was that behaviour that was reported to you or behaviour that you witnessed yourself?
A. I -- I couldn't say about Tony Chambers. I don't -- I can't remember whether he got confrontational at the meeting with, with the Executives.
I think Ian Harvey we felt was confrontational at times but I think because after we had the RCPCH review, we were asking for -- to see the report and we kept being told, no, no, no and eventually he agreed to show us the report and I think there was just Dr Brearey, Dr Jayaram and myself who went to have a look at this

report which was supposed to be going out to the public.
But it was heavily redacted and certainly the Consultants were not happy about that. I mean, you know, it was just literally covered in black ink, we couldn't see what half of what the RCPCH had said, never mind trying to decide what lessons we could learn from it or whether, you know, they had found anything else of concern and -- and I think Ian Harvey got quite, he gave us something like 15 minutes to actually look at this document which was inappropriate really especially when it was so heavily redacted and the Consultants asked for the -- the full copy which I don't know that we ever really got, I don't know if we did get it before it was published or whether we got it the morning it was going to be published, so I think that there were heated comments certainly with the RCPCH review. But I don't know that I was present at any other meetings.
MR DE LA POER: Mrs Murphy, thank you very much for answering my questions. There will be some more questions which I hope we can accommodate before lunch, my Lady, from Mr Skelton?
LADY JUSTICE THIRLWALL: Very good. Mr Skelton.
Questions by MR SKELTON
LADY JUSTICE THIRLWALL: Take the time you need, Mr Skelton.

MR SKELTON: Thank you. I will try and be fairly swift, my Lady.
Mrs Murphy, I ask questions on behalf of some of the families.
I am going take you back to October 2015 and the death of Baby I, do you remember her?
A. Well, I'm sorry, you see I don't know any of these babies. I didn't work on the neonatal unit so I had nothing to do with the babies' care or their families. So, you know --
Q. I understand that, but it has been nine years since she was murdered and you are at a Public Inquiry into the death into her murder and other things?
A. Yes.
Q. Have you refreshed your memory about the care that was given to the individual babies on the units which you had responsibility for?
A. Yes.
Q. You have refreshed your memory?
A. Yes, I have looked at ...
Q. Baby I died on 23 October 2015 and we now know she was murdered by Lucy Letby, do you recognise that?
A. I have looked at all of the reports, so yes.
Q. Do you recognise that she was murdered by Lucy Letby?

A. Well, she's she been found guilty by a court of law, so yes, I do.
Q. And in your opinion?
A. I mean ...
Q. Do you accept that verdict?
A. Yes, I accept that she has been found guilty. You know, there's -- and you know in some ways we were wrong for it going on so long. So yes, I would half -- you know, I am so sorry for the Families who have had to deal with this for the last seven, eight years.
You know, it, it's awful for them. So yes, I do accept, you know, that Lucy Letby obviously has murdered or had a part in all of those babies' deaths.
Q. Just going back to what was going on in October 2015. The death of the child was unexpected, Dr Gibbs, the Consultant who was called to help the resuscitation was unsettled by her death. He hadn't expected it to occur. Do you understand, do you remember that?
A. Well, I have obviously read what has been said. I don't know that I had a discussion with Dr Gibbs about any of that, but --
Q. The --
A. I accept that --
Q. Mrs Murphy, sorry to cut across you. The

reason I am asking you this is that Eirian Powell just after the death was in contact with Dr Brearey in respect of a mortality table which you were copied in on.

A. Yes.

Q. So there must have been things at the time that you must have remembered or you must have been involved with for you to be copied in just after Baby I died. Can you remember that, that mortality table with Lucy Letby's name in red?

A. I obviously remember that a baby had died and it will have been reported to me. But -- but that -- that was my, my only involvement in any of those babies.

Q. Well, just trying to put -- I am trying to understand what you might have been thinking when you were involved in October 2015 because you were copied in on the email with the table and because you were a manager, a senior manager to Ms Powell; that's right? Yes?

A. Well, the manager was telling me that she didn't think that -- that the nurse was involved in any of those babies's deaths. But you know, I accept that obviously you know in retrospect, yes, we were aware.

Q. She thought it was an unfortunate coincidence?

A. Yes.

Q. She thought Lucy was a good nurse?

A. Yes.

Q. You accepted those two things?

A. Yes, I did.

Q. And you didn't investigate the matters yourself?

A. No, I was involved in some of the investigating work but I didn't investigate anything myself. I -- you know, I was aware of the qualifications of Lucy Letby, you know, the courses that she had done since qualifying.

Q. You have mentioned repeatedly in your evidence the seriousness of the allegation or the accusations to be put to Lucy Letby, had it been true?

A. I don't think we ever made an accusation.

Q. No, that wasn't my question. Today you have talked about how serious it was to accuse someone?

A. Yes.

Q. It's right though that that's nothing compared to the seriousness of the death of the children?

A. Right.

Q. Correct?

A. Yes.

Q. And the seriousness for their Families?

A. (Nods)

Q. I am trying to compare the seriousness of what you needed to think about, the seriousness of the acquisition against Lucy Letby, but the seriousness of the death of the children, the effect on their families and do you recognise that the latter far outweighs the former?

A. Well, obviously it's devastating. It's devastating to lose any child, any baby.

But, was that an indication that some harm was being done? And that I think that was what we were thinking. You know, how: what was happening? What could have been done to those babies?

And you know I mean, I -- I can't answer that.

Q. Well, you accepted Ms Powell's view that it wasn't Lucy Letby that had caused the deaths.

A. Well, I don't know at that stage. I accept now but I didn't know at that stage and no one could give me any proof that any wrongdoing had been done to those babies.

Q. But you know -- and I won't take you through all the children for obvious reasons -- but they were stable for the most part, their deaths were unexpected and they were unexplained for the most part; in other words, there wasn't a clear cause of death, which is why the Consultants were concerned, because they couldn't

understand why the children had died.

So that in itself is concerning, isn't it, children dying unexpectedly, obviously?

A. But I'm sorry, you know, I -- I -- I didn't think any differently at that stage.

Q. Did you think about the consequences if you were wrong?

A. Of course I think about it.

Q. No, at the time --

A. Well, no --

Q. So let me finish the question.

A. -- at the time, I -- I didn't think about the consequences. You know, things do happen. Coincidences do happen and the fact that she was present, you know. And I think if she had been caring for each of those babies and not just being on the unit then, then that may well have, have been slightly different; you know, the fact that only babies in her care were dying. But that wasn't actually the case.

Q. But did you ever check that she had had any contact with any of the babies that weren't in her care? Did you actually check that?

A. Well, no. In fact we couldn't check that element --

Q. So why --

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

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

I really don't know, but --

Q. Sorry. Did you try and check that?

A. No, I did not personally check.

Q. Just going back to my original question.

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

A. Yes.

Q. Did you think about the consequences if you were wrong; that she, in fact, wasn't the nurse you thought she was and that this wasn't a coincidence. Unlikely as you might have thought it, but did you ever think about the consequences that you were wrong?

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

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

A. Yes.

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

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

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

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

A. No.

Q. Do you accept that?

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Straight away?

A. With Karen Rees, yes.

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

structured?

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

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

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

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

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

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

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

I -- I really don't know.

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

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

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

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

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

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

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

Q. Lastly, Mrs Murphy, in your statement you don't mention The Families of the children and in your reflections you don't talk about your own responsibility for the hospital unit, for the nursing team, during the period in which the children were killed.

Is there anything you would like to add in this evidence now before you go in respect of that?

A. From my reflections from this is that, you know, all of those babies died and obviously some of them could have been prevented. Some of them could have been prevented from ending up with, with, you know, lifelong problems and, and, yes, from my perspective I should have done something earlier myself.

But I -- I really didn't --

Q. Thank you.

A. I couldn't understand why, you know, it was happening. So, you know, I have to apologise to all of those Families from my perspective that, you know, I feel that I certainly failed those children by not doing something sooner. So I am sorry for that.

MR SKELTON: Thank you, Ms Murphy. Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Skelton.

Mrs Murphy, that's the end of your evidence so you

will be free to go in just a minute, but I just wanted to thank you for coming.

A. Thank you.

LADY JUSTICE THIRLWALL: I appreciate it has not been easy, but it's been helpful. Thank you.

A. Thank you very much.

LADY JUSTICE THIRLWALL: I know we finished a little bit late, but we are going to start again at 2 o'clock.

(1.10 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call the next witness.

LADY JUSTICE THIRLWALL: Ms Rees, would you like to come forward.

MS KAREN REES (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do have a seat.

A. Thank you.

MS LANGDALE: Ms Rees, you have provided the Inquiry with a statement dated 14 June 2024.

Do you have that with you?

A. I do.

Q. And can you confirm for us that the statement

IS true and accurate to the best of your belief?

A. It is.

Q. You tell us, Ms Rees, at paragraph 7 that you commenced the role of head of nursing within the Urgent Care Division later referred to as Associate Director of Nursing in August 2015 and stayed in that position until 2018 at the Countess of Chester?

A. That's correct.

Q. What was your experience before that position?

A. Before what, Sorry.

Q. What was your experience before taking up that position in nursing and managing generally?

A. Okay. Sort of my career path?

Q. Yes.

A. Prior to taking up my post as head of nursing I was theatre manager for eight years, my background is cardiology. But I wanted to gain experience within the surgical division as well as the Planned Care Division so I could get an overview, which I think that's what helped me get my head of nursing post eventually. I had responsibility for eight wards at the Countess of Chester Hospital, three wards at Ellesmere Port Hospital, I also had managerial responsibility for the emergency department, all specialist nurses within the Urgent Care Division but I was supported and of course

neonates and paediatrics came under that umbrella too but I was supported by four matrons and one lead nurse.

Q. Before you took that role, was all of your other experience related to adult patients?

A. Yes.

Q. So when you began this Director of Nursing role or head of nursing, did you receive any particular training or go on any course in relation to safeguarding or child protection as it used to be known?

A. We all have safeguarding training to do within the environment obviously, but mine was majority adult, being in the adult. When I took over as head of nursing, I made it my business to become accommodated with the neonatal unit and paediatrics because clearly I never had any nursing experience. So I did rely heavily on the senior nurses in both those departments but I didn't have any basic training in paediatrics or neonates, no.

Q. So when you say you relied heavily on the senior nurses, which ones were those?

A. Okay predominately Eirian Lloyd Powell and Anne Murphy.

Q. What did you at that time think should be done if you were suspicious, only suspicious or concerned that a child may have been harmed deliberately by an

adult, what did you think should happen where there is just mere suspicion?

A. It should have warranted an immediate investigation.

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

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

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

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

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

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

A. Yes.

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

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

Q. Paragraph 9 of your statement, you say:

"In August 2015 the culture and atmosphere on the NNU was good ... a small cohesive team who appeared to work well together ... [and] the nursing team appeared happy and well-supported by Eirian Powell and her two deputies?

A. Yes.

Q. Was that your impression?

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

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

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

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

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

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

Q. Mr Chambers, Ms Kelly?

A. Yes.

Q. Others?

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

Q. So at the beginning you thought that

communication was good?

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

Q. At 11b you say:

"Nurses, midwives and managers."

You say:

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

observation was nobody knew who was talking to who.

Q. About what?

A. About the concerns raised.

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

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

If you have got concerns --

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

A. Okay, sorry.

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

A. Who, sorry?

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

A. Yes, I've seen that.

Q. You have seen the document?

A. Yes.

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

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

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

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

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

A. Yes, please. (Pause)

Q. Darren Thorne says:

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

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

an external person ..."

You go on and say further down that paragraph:

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

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

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

And then I think the frustration was that those

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

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

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

Q. What do you mean "tabled"?

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

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

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

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

A. The table with the -- following the thematic review?

Q. Yes, yes, did you see that?

A. Yes.

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

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

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

Q. Okay. So we see there:

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

And then attached to that we know there was a list

of babies and outcomes written down.

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

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

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

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

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

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

A. Yes.

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

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

Q. Yes, we will get to that.

A. Sorry.

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

A. Okay.

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

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

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

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

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

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

A. Yes.

Q. -- isn't it?

A. Yes.

Q. Particularly where deaths occur in suspicious circumstances?

A. Yes.

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

A. Absolutely. Yes.

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

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

I did rely heavily on her.

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

A. Yes.

Q. You sat on QSPEC?

A. Yes.

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

A. No, not at QSPEC, no.

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Would you have been interested to know that

when you are looking at everything?
A. I think -- I think Eirian would have -- well, I would have expected her to have raised that with me at some point when we were having conversations because clearly this -- as it unfolded, this got bigger and bigger and obviously --
Q. Did you ever with her talk specifically about specific babies that had died, Baby A, Baby C?
A. No.
Q. Baby D, or did you deal with these generalities?
A. It was more generalities because clearly, like I have said, neonates is not my area of expertise, so I had nothing to do with the care of those babies but clearly I liaised a lot with Eirian about obviously the whole neonatal issue.
But no, I wasn't aware who Baby A,B,C -- no, I wasn't, it was more general.
Q. So you never sat down with her and said, "Right, this baby, what reports have you got, what are you thinking, where are you at with this one?"
A. No.
Q. That wasn't your remit?
A. No.
Q. Who did you think was doing that?

A. I thought the team as a whole certainly following the thematic review and on the attachments that Eirian sent I would have thought that the clinicians and Eirian and the senior team would have discussed that there between themselves because they are the ones with the expertise.
Q. There's an email I would like you to go to now, I have got two INQ reference numbers. INQ0003138, page 1. So 0003138, page 1. It's an email to you, Ms Rees, the second one down. 4 May.
"Hi Karen, please see attached. Not sure you will have had previously sight of this. Lucy Letby highlighted in red. I have not noticed this when I first reviewed. Can you please look into this as per my previous e-mail. Thanks."
And you say:
"Dear Alison, I am meeting with Eirian tomorrow."
And we see below, not that she sent it to you, another email that Alison Kelly has sent.
"Please look into this with Anne Murphy/Eirian. If there is a staff trend here, we have already changed her shift patterns because of this. This is potentially very serious."
So she does send that one to you as well, doesn't she, 4 May?

A. Yes, she does.
Q. "I will check the report they send through, I didn't notice there was a staff trend."
That is a report again with a list of babies and Letby's name very clearly in red.
First of all, who did you think had put her name in red and what did you think when Alison Kelly asked you to look into it, that you were supposed to be doing?
A. I can't say for certain, but I would have assumed it would be Eirian and Steve Brearey would have highlighted Lucy Letby's name in red because following the thematic review they were looking into all aspects of that, which is why when Alison had sent me that then obviously I would have had a discussion with Eirian about it, as I said there, although I have got no evidence of that discussion but clearly that put on my radar would have been something I would have discussed with Eirian.
Q. They can go down now please, thank you.
It is paragraph 16 of your statement. You say:
"I did read the schedule I had been sent by Alison Kelly ... [and] I was aware prior to receipt of these emails of an increase in the mortality rate ... I cannot recall enquiring as to what the usual mortality rate was for the NNU. I relied on Eirian Powell to

update me".
What did she update you with following receipt of this new table with her name in red?
A. I think she just went through the table with me. I can't absolutely recollect, but I know we would have sat down and discussed obviously Lucy Letby and her allocation of babies and her presence on the unit.
Q. We know you weren't copied into the email so there is no need to put it up but Dr Brearey, 4 May, emails Alison and says there is a nurse who's been present for quite a few of the deaths and other arrests, Eirian has sensibly put her on day shifts only at the moment but can't do this indefinitely.
So you appreciated at this time she was on day shifts as you mentioned earlier. What did you make of that?
A. My understanding when I asked Eirian about that because it was obviously a decision she made, I do remember her saying to her "Okay, what is the rationale then?" And if my memory serves me correctly, I remember her informing me that it was a neutral act to bring her on to days. It wasn't deemed as a punishment or a finger-pointing exercise.
It was because there are more staff on days than on nights and because of what you alluded to earlier about

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

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

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

Q. Right.

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

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

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

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

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

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

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

Q. You would have?

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes, absolutely.

Q. And you say at paragraph 22:

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

Was that something you were told by anyone?

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

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

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

A. Okay.

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

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

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

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

A. No, I didn't.

Q. So that is a generalisation rather than --

A. Yes.

Q. -- specific to the unexpected deaths?

A. Yes.

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

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

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

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

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

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

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

A. Yes.

Q. There's a suggestion in this email:

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

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

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

A. Let me just read it.

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

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

These are Eirian Powell's summary?

A. Yes, I do recall seeing them.

Q. Yes, you see it?

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

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

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

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

regarding her performance."

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

A. Never.

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

A. No. Never.

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

A. Yes.

Q. -- at the time?

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

Q. In 2013.

A. No, no.

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

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

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

A. I remember the name.

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

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

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

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

Q. There is a reference at 6:

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

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

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

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

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

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

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

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

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

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

unexpected death?

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

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

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

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

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

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

anything else they could look at?

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

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

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

A. (Nods)

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

A. Oh I do, yes, clearly.

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

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

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

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

Q. When do you think the time was?

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

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

A. All the time.

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

you may remember it. Tell us in your words what she said to you.

A. She Karen Townsend informed me that she had met Ravi Jayaram for a coffee over in the Comfort Zone, which was a cafe in the Women's and Children's building where she had discussions about any issues and it was at the end of that conversation that she told me that Ravi Jayaram had said to her: I just need you to be aware because we have got concerns about the clinical practice of one of the neonatal nurses.

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

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

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

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

A. Yes.

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

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

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

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

I then asked him where Steve Brearey was and he

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

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

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

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

with me.

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

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

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

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

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

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

I then --

Q. Just pausing there.

A. Yes.

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

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

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

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

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

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

A. Yes.

Q. Was that a way of bringing it to your attention these -- even if you say they weren't expressed as clearly as you might have liked to have done, but Eirian Powell produced that table, the nursing manager who liked Letby, thought highly of her?

A. Yes.

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

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

A. I suppose I -- when I went to speak to Yvonne Farmer, I did want to see if there was any response from her because I think it's important, in my nursing career, certainly latterly in my last years, on a number of occasions I have had Consultants demand I remove nurses either from their team or from their ward or unit because personal and professional relationships have broken down for varying reasons and initially, I thought because both Ravi Jayaram and Steve Brearey were

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

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

Q. Because you weren't getting more information?

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

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

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

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

she had no idea either of them felt like this. The distress this has caused to both Lucy and her parents has been terrible to witness."

So you did explore that with Letby at the time, didn't you, is there anything they have got against you, and the answer was no and it was nothing?

A. It wasn't at that time.

Q. A bit later?

A. Yes, it was not on that Friday because I had never even met Lucy Letby.

Q. Of course.

A. Yes.

Q. But looking back now, you know that there was no personal motive having had those conversation with her later, she couldn't give you one and didn't have one --

A. No.

Q. -- and you didn't see one; is that right?

A. Yes.

Q. But your first thought on the Friday was: is there something else?

A. Yes, yes.

Q. Did you ask anyone else about that before you asked Letby further down the road about that?

A. Ask anybody about what?

Q. Ask anybody on the Friday: could there have been a personal agenda here or not?
A. No.
Q. You didn't have anyone to ask?
A. And the reason why is because we were under pressure, it was late on Friday and I had other things to do. So no, the only person I spoke to, which I thought was Eirian at first, was Yvonne Farmer, yes, that was she was the only person.
Q. So you spoke you say to Alison then you went home and got a telephone call from Dr Brearey later, didn't you? Can you tell us about that call?
A. Yes. We have a difference of recollection of that telephone conversation. It was early evening and my mobile phone went and obviously I didn't recognise the telephone number and I answered the phone and Steve Brearey said to me "Hi Karen, it's Steve" and I remember saying "Steve who?" not imagining for one minute he would be ringing me at home.
So he said: I need to understand what actions you are going to take to take Lucy Letby off the neonatal unit.
So I reiterated to him again, I said: I can't take a nurse off a unit without just cause, appreciating the severity of your allegation and your concerns, but you

are not sharing anything with me.
I told him -- I recall him saying, I said: I've been in to see Alison Kelly and she is discussing the whole episode of that afternoon with Ian Harvey. Steve Brearey inferred I was lying, he didn't believe that I had been into the Executive suite and the reasons why I remember this so much because I said to him: if you don't believe me, then contact Alison Kelly or Ian Harvey yourself.
When that phone call was terminated, I -- this is why I remember this, I called Alison Kelly back to inform her again of the conversation I had just had with Steve Brearey on the telephone and to say to her to expect a telephone call from him because he didn't believe that I had been in to speak to her.
Q. Looking back, the fact that they had both raised and he was repeating in that call, enough to phone you on a Friday night, he was concerned she maybe purposefully harming babies, wasn't that enough? What else did you need, really, you couldn't investigate it if he did give you anything else, could you? A serious concern had been raised.
A. Yes, but I thought -- the feeling I got rightly or wrongly at that time I -- I felt I was being bullied and intimidated to make a decision about moving

a nurse that nobody else had been prepared to do until that point.
I also -- we have to remember that employees, because at that time employees have got rights equally and like I have said to you, because I initially thought it was personal, I had to have good reason. I couldn't just walk on the unit and say: right, I am moving you, because of a gut feeling and a drawer of doom. There has to be specific reasons to action.
Q. We know at this point you had received the mortality review, you had received it a second time with her name in red, there had been concerns and Eirian was asking for reassurance. Wasn't that enough at this point for you to say: actually, the babies come first, we don't know why particularly, but we must keep them safe, it's not about employer and employee rights, it's about the babies at this point?
A. I fully appreciate that. But then why? My question: why did Steve Brearey not give me something else?
Q. They have given you that they thought she may be deliberately harming babies. What more did you want? Did you need the mode of attack, what did you want? How could they give you that without the pathology, forensics that were required?

A. I don't know. I just -- because I thought because they are not willing to give me anything else to support my decision whether to exclude or remove, I honestly thought it was personal and perhaps I was slighted by that.
Q. And the fact they couldn't give you something else didn't mean there wasn't something else to find?
A. No.
Q. Did it?
A. I appreciate that.
Q. Unexpected, unexplained, they couldn't give you medical causes. That was their contribution, they didn't know why these babies had died, couldn't be clear about that. So it needed proper investigation?
A. I fully -- I fully appreciate that. But then why tell me he's got a drawer of doom and won't share the contents of it with me?
Q. From the moment Karen Townsend had used those words to you, that she may have deliberately been harming a baby, do you think you should have gone straight to safeguarding as you would have done if a member of staff told you: I am worried this parent has harmed this baby that they walked in with? You wouldn't know whether that was right or wrong but you know you couldn't answer the question?

A. No, I have reflected upon that and perhaps that is what -- that's an action I should have perhaps taken on Friday. But equally neither Consultant did neither. I just think yes, on reflection, I perhaps should have done and I am sorry for that. I am sorry.

Q. And when you refer again to the Consultants, it does come across that you have an antipathy, as you said in the interview with Facere Melius about Consultants and they are in charge and they have the power. Do you have a natural, or did you have then, an antipathy to them as a group?

A. No, not, not immediately. It was just I feel that they could have -- both Consultants, Ravi Jayaram and Steve Brearey could have involved Eirian and I at a much earlier stage and we could have worked together.

I -- I feel looking back that the alleged meetings that they had with the Executive team about their concerns I wasn't aware of them, I certainly wasn't invited to them and that's not what I would have expected of a senior clinician. I would have thought he would have gone to his unit manager Eirian first, and then she would have involved me.

Q. That's the point, isn't it, Eirian was invited to a lot of the discussions with the Consultants and eventually some of the more Senior Executives suggested

there had been a rift between them and you knew that Eirian was asked to sign something to say there wasn't a rift, they regarded her as part of the group, didn't they, in their discussions?

A. Yes, because like I say, at the beginning they were a cohesive team and it's just as all this unfolded, like I said previously, the element of trust had gone and it was, it appeared like an "us and them" situation where the nurses thought one thing and clearly the medics thought another.

Q. And the nurses Eirian Powell expressed in a document 100% thought Letby hadn't done anything. Did you think the same at that time?

A. Say that again, sorry?

Q. Had you formed a view that Letby was innocent at that time, innocent of any causing any harm at all?

A. I don't think that that was a question that I needed to answer. Was she innocent, was she guilty?

I just thought that I -- I wasn't given enough to act upon and honestly on reflection, you know, and we have all done that, I am sure, I should have called safeguarding in and I am sorry for that.

Q. On 27 June, you sent an email, INQ0005745, page 1. Sorry, you didn't send it, Alison Kelly sent it. Sorry, Ms Rees. And it follows a meeting that had

been had between all of the Executives. Have a look at that to refresh your memory of it.

We can see there is an action plan. So this is following the weekend, the murder of two triplets?

A. (Nods)

Q. The Consultants are not at this meeting when an action plan is being drawn up. Do you know who sorted out the invitation list for this meeting to discuss concerns and an action plan?

A. I honestly can't, I'm sorry. I don't know.

Q. When you look at it now, does it strike you as odd that an action plan was being devised in the absence of any input from the Consultants who had the concerns?

A. Yes. Yes.

Q. And does this already fall into the "us and them" category?

A. It appears so, doesn't it? Yes.

Q. And we see:

"Ian Harvey to identify Royal College lead to facilitate external review."

Did you know much about what that review was about and what it was going to look at?

A. No, I wasn't involved with setting the terms of reference or anything like that, but clearly I saw it at some point on completion. But I wasn't familiar who

had set the Terms of Reference and what they were at that time.

Q. And we have here the penultimate -- in italics -- paragraph:

"Eirian, can you also review staff competencies re skills and knowledge to support sick babies at varying levels of dependency. I know you will have this but it would be good to undertake a review."

Another review, another generalised review of everyone's competencies?

A. I know, I know.

Q. A lot of work and totally unnecessary --

A. I know, I know.

Q. -- at this point?

A. I am sorry, I don't know who requested that, I assumed it was Alison. I don't know.

Q. You say at paragraph 56:

"I agreed with the decisions taken at the meeting ... [Although] neither Consultant was present Alison Kelly and Ian Harvey were to meet with them both to discuss their concerns and the actions listed."

Again looking back I think, as you just have, and reflecting, it was divisive, wasn't it?

A. It was.

Q. How might that have been better managed at the

time just speak of your role, what would you -- if you could now, what would you input at that point?

A. I think you are right, I think both Consultants should have been at that meeting. It's like I said to you earlier, I wasn't aware of these alleged meetings that the Consultants had had with the Execs. I wasn't involved with any of them, so I -- obviously it appears there's been a breakdown in relationships at some point.

But, yes, I think the whole team should have been together at that meeting, including the clinicians.

Q. You say then -- Letby's removal from the unit in your statement, you say at paragraph 58:

"I did not play any part in the decision to remove Letby from the unit. I recall I was on annual leave ..."

When I was on annual leave:

"... a meeting took place on 14 July when she was informed of the decision that she was to be put under clinical supervision pending the completion of an external review by the Royal College of Paediatrics and Child Health."

Do you think there was transparency with her at that point about what was actually going on?

A. No.

Q. No. And why was that?

A. I really don't know. I mean, I was tasked on return from my annual leave to remove Lucy Letby off the unit with my HR business partner. I had just come back from leave, I had come in early. I checked A&E, I checked the neonatal unit come back and my HR business partner was waiting outside for me and said: we have been given a management instruction --

Q. Would is that business partner?

A. Linda Guatella, she is like my HR wingman and so she said to me: Karen we have got to go and remove Lucy Letby off the unit now.

So I said: what are we saying, what's gone on?" because clearly whatever decision, meeting, whatever had taken place had clearly taken place when I was on leave.

Q. Shall we see the letter you wrote that will help you I am sure --

A. Yes.

Q. -- with your memory of this INQ0002458, page 1. It is a letter of 18 July from you.

A. Yes.

Q. If we read the third and the fourth paragraph you are telling her:

"Since the meeting on 14 July it has become apparent not possible to provide you with full time

supervised practice because of staffing levels on the NNU. Currently a number of members of staff are absent from work including sickness which has impacted upon the availability of senior clinicians who are able to provide support."

And then you refer to temporary redeployment.

Did you think it was because there was an inability to have the staff to supervise or was it something else that led to this letter?

A. I couldn't say for sure because I wasn't involved in the meetings and the decision-making, but obviously staffing levels weren't the best on the neonatal unit -- well, across the Trust, to be honest, at times. So to put somebody under clinical supervision you do have to have an acceptable number of staff for that to continue because you can't let that fall down if somebody goes off sick the next day and then there isn't a staff member to closely supervise.

So I took that as, yes, that was the reason.

Q. If we go over the page, your second paragraph:

"You raised with me the issue of personal support and stated that your friends are work colleagues. I advised you that the purpose of the redeployment was not to stop the usual social contact but you should be mindful of discussing any matters which may be sensitive

in nature relating to the review of the NNU."

So you are not telling her she can't speak to her friends or anything like that, are you?

A. No, I think it was misunderstood.

Q. Well, we note at paragraph 85 -- we don't need to turn it up -- in your statement you are criticised within the grievance process, I think, for effectively preventing Letby -- you tell us: what were you accused and what did you accept, in fact?

A. I think -- and it was my fault because I clearly didn't communicate effectively. I think Lucy took it upon herself that she thought I had stopped her going to the neonatal unit as well as having any social contact with her friends and team members and that wasn't my intention.

Q. You say that very clearly there, though, in the letter, don't you? You haven't said that, so why do you say that is your fault? You hadn't prevented it?

A. Also --

Q. She did continue to communicate with people on the unit?

A. Yes.

Q. What had you done to prevent that? What was the criticism that had come?

A. I think she misunderstood when I said that she

wasn't to go back on the neonatal unit whilst she had been redeployed, even though it was temporarily until investigations had taken place.

I think it was Lucy misunderstanding what I had said. I probably didn't make myself clear at the time.

Q. We know if we go to INQ0002746, page 3, Tony Millea writes to you on 2 September 2016. We see at the bottom of that email --

A. Yes.

Q. -- over the page complaining about the process that the hospital is now engaging in?

A. (Nods)

Q. The RCPCH, at the top of the page:

"The investigation centred around procedure, culture, staffing levels and what was it like to work on the NNU. No question of our members' involvement was discussed. In fact, it was imparted by the panel that the review will not solve the issues for Lucy personally. As a result of this I now believe our member has grounds to action a grievance."

What did you understand the RCN officer was saying there was need for a grievance at this point, why was there such a need?

A. I think -- I think, if I remember correctly, that somewhere along the line Tony Millea had us under

the impression that the Trust had decided to move Lucy Letby off the neonatal unit and redeploy her while this investigation was going on from RCPCH.

And then obviously somewhere along the line, he's -- he's found out what the Terms of Reference are and he was alluding to then the Trust not being open and honest with Lucy Letby and felt -- and this is hence why he advised her to have grounds for a grievance. He thought -- I recall him saying to me that he didn't think the Trust were being open, honest and being upfront and telling her the true reason why she had been redeployed.

Q. You also sent an email, 9 September, it is a bit later, a week later, to Alison Kelly INQ0002860, page 1. You say in the second paragraph:

"The decision to delay transfer back to the NNU. In my opinion this decision is wrong and immoral based on a senior clinician having a gut feeling with no evidence except that LL has been present at a number of these neonatal deaths."

The last but two paragraphs:

"There is also the impact not only for the NNU but for the rest of the organisation and the message that this sends out a clinician is being listened to and supported with potential devastating consequences for

a nurse. How are the nurses on the NNU going to react?"

What would you like to say about that email?

A. Sorry?

Q. What would you like to say about that email?

A. I was clearly very frustrated and emotional at that time. We were planning to put Lucy Letby back on the neonatal unit, then we weren't, then we were, then we weren't. And at that time I had been given a management instruction following Lucy Letby's removal from the neonatal unit into the risk team was to meet with her on a weekly basis with two of my other senior colleagues to support her health and well-being during all of this and to give her feedback from any investigations that were going on.

Q. Just pausing there. Feedback from investigations. So you were to meet her every week it was you, Hayley Cooper and?

A. Kathryn de Berger.

Q. And you were supposed to be telling her what the hospital were doing, what investigations, whether it was the RCPCH, the Hawdon Review, she was getting the hotline with what was happening?

A. Yes, yes. And during that time, clearly I got to know Lucy Letby and that email came because we had had a meeting with Lucy and Hayley I think was present,

Hayley Cooper, and Alison Kelly and Sue Hodkinson I think the day before and they didn't mention anything about delaying Lucy Letby's transfer back to the neonatal unit at that meeting but they called me back afterwards and said to me: I have got to tell her she can't go back on the unit yet.

And at that time, I was emotional and frustrated because I was witness to her -- she was absolutely devastated and I suppose I was looking at her and she kept crying and saying: why are they doing this to me, I have done nothing wrong? I -- I am not going to let them run me out of the job that I love. Why are they letting me say it and go back on the unit, then they are saying they are not? And I suppose months of that witnessing that, her being distraught, rightly or wrongly, where we are now, I understand that, but at that time and I remember looking at her thinking: oh, this is dreadful, because -- and I appreciate the enormity of the allegations and everything, but I suppose I sent that email because I was witnessing the anguish, the absolute -- she was absolutely -- it was hard to keep witnessing that week in, week out and promising her one thing and promising her another.

I am just trying to explain why I sent that email.

Q. You actually say in there: why have the police

not been called?
A. Yes.
Q. Paragraph 2?
A. Yes.
Q. Why weren't they? Why didn't you say they should be called? Why did you not think that they were being called?
A. I think they should have. You know, I was at fault. I didn't go to the police neither. But I -- I just thought we are having this investigation, that thematic review, this, that, nothing's proven and the issues weren't going away.
I recall, and I can't absolutely tell you what, what the date and time was, but I do recall Sian Williams, who was the deputy Director of Nursing at the time, and myself going into to see Alison Kelly.
Q. Sian Williamson, is that?
A. Pardon?
Q. Was that Sian Williamson?
A. Yes, Sian Williams. She was the deputy and we both went in to see Alison saying: Enough is enough, you have got to be calling the police in now. This is -- we are getting nowhere.
So the relationships were breaking down all over the place in the neonatal unit between the clinicians,

the Execs, we weren't getting any answers and so Sian and I pleaded with Alison to bring the police in.
Q. Do you agree that the last but one paragraph of your email is very factionalised there as well where you say "devastating consequences for a nurse". You make it about nurses and doctors rather than actually --
A. Yes, perhaps.
Q. -- somebody making a very serious complaint --
A. Yes.
Q. -- for babies actually?
A. Yes, yes, I accept that. Yes.
Q. That can come down now, please.
If we go to INQ0002879, page 33 is the first page. This is the grievance interview that you have at the time with Dr Green in October 2016.
If we go to the next page, page 34, in that top box, you say:
"KR went straight to see Alison Kelly. Wasn't happy to exclude LL, felt no grounds to exclude. In the evening KR received a call from SB at home."
So this is the night you get the telephone call.
"Felt SB tried to bully me putting pressure on. Felt he was exhibiting passive aggressive behaviour. Remained professional but gently powerful."
"Remained professional". So he wasn't shouting or

anything?
A. No, he wasn't shouting. He never shouts.
Q. But it was urgent tone. He wanted you to --
A. Insistent, I would say.
Q. If you go page 35, the next page of the grievance interview note, in the first large box there:
"I have heard SB is adamant LL is not going back to the unit. I feel very strongly we need to get LL back on the unit."
So you two are completely polarised?
A. Mm.
Q. Yes:
"I raised with AK and SH if we can get a deadline of date. Also questioned why haven't brought police in. KR [that is you] hasn't because of LL."
A. (Nods)
Q. "Would we like our daughter to be treated like this? I don't think so. In the meeting with Stephen Cross it was mentioned about if we call the police the unit will be shut down and people may be arrested."
So was that your reservation about the police not being called because of LL, because she may be arrested? How does that --
A. I think that might have been part of it. But like I say, we were all at fault, none of us went to the

police, did we? And I think you know on, you know, when I look back on all of this, I didn't because I thought what am I going to go to them with, obviously Consultant concerns.
But I think also because they hadn't neither and the Executives hadn't, it was hard. But I -- I was -- I was -- I have never been so relieved when they eventually did.
Q. But you do appear to be saying here you don't -- you haven't because of Letby and you refer to Stephen Cross. Did you hear Stephen Cross say: if you call the police the unit will be shut down and people may be arrested or had someone told you he had said that?
A. I honestly can't remember, I don't know whether Stephen Cross might have said that.
Q. Did you ever have a meeting with Stephen Cross, were you there at the same meetings with him or not?
A. I've been at meetings with Stephen Cross, one in particular was a Consultant meeting we had at the end of January, where I read out -- I was asked to read out Lucy Letby's statement. I think Stephen Cross was present then --
Q. Yes.

A. -- and he might have inferred something to that degree. But I can't honestly say absolutely.

Q. Dr Tighe gave evidence to the Inquiry that the reading out of that statement was the last thing the meeting needed, it was a serious situation and he described it as a melodramatic dissertation from Letby.

When you look back now about reading that out and how you read that out, do you have anything to say about that?

A. I was asked to read that statement out. I didn't volunteer. I suppose at that time I was happy to do so because, again, we weren't getting anywhere and I think obviously Lucy Letby wanted to -- she had had a grievance upheld, if I remember, if I have got this right in chronological order.

Q. That can come down now. Carry on, sorry?

A. Sorry. And she just wanted to let the Consultants know because at that time we were still planning to put Lucy Letby back on the neonatal unit. I think as for it being melodramatic, it was emotional certainly from what I recall, what I read out. Yes, it was a hard meeting regardless.

MS LANGDALE: We have been going for 90 minutes, so shall we stop for a break now, Ms Rees?

LADY JUSTICE THIRLWALL: Very well. I will take

a break now, Mrs Rees, until a quarter to 4. 15 minutes.

(3.31 pm)

(A short break)

(3.44 pm)

MS LANGDALE: Ms Rees I want to ask you about where Letby was working and what happened subsequently in terms of placements anywhere and if we go to a series of documents. If we can have first, please, INQ0003273, page 2.

This is an NNU action planning meeting, 30 June, and it's Alison Kelly, Dee Appleton-Cairns, Sue Hodkinson, Julie Fogarty, yourself, Sian Williams and others.

On page 2 we see a reference with KR, your initial next to it:

"LL not working anywhere else, ie at another Trust or agency. Trained at Leicester, lives alone, has elderly parents. Clarity with LL working in other units and query bank hours."

In June 2016 what were you tasked with, if anything, in relation to that clarity Re working on other units or bank hours, can you remember?

A. I don't recall being tasked with anything from there. I think it was a question that was raised just

in case Lucy Letby was working for an agency outside the organisation.

Q. Yes, whether she was.

A. Yes.

Q. So what clarity was sought, what did you understand the position was?

A. For Lucy Letby or for?

Q. Yes for Letby then, what -- not working anywhere else, is that what you understood was the position or not?

A. Yes. I think the concerns were raised that what they didn't obviously want while this was going on couldn't remove her from the clinical placement in our Trust for then to be found out that she had been working for an agency elsewhere.

Q. Did you have to check with agencies or just check with her that there was no concern about that?

A. I didn't have to check. But I can't remember whether Dee Appleton-Cairns, somebody from HR might have checked but I certainly didn't. I wasn't tasked with that.

Q. INQ003529 next, please, page 3.

A meeting 26 January at the bottom, 2017, with Letby, Kelly Hodkinson, yourself, de Berger.

If we go over the page, please, to page 4, at the

bottom:

"Karen asked on you behalf if we could continue with fortnightly meetings with both Sue and Alison which we both confirmed by advising absolutely.

"Alison added it was a good opportunity to think about the type of messages you may want Alison to say on your behalf when having meetings with the nursing teams as we are looking to arrange a meeting with them. It is important the nursing team are there to support you and need to be clear on how they will wrap around you when you go back.

"Karen agreed for you, Hayley and Kathryn to discuss this further with you the following week."

So what was that about nurses needing to wrap around her when she went back to support her, what conversations were happening?

A. If my memory serves me rightly, I think there are obvious concerns because of the breakdown in working relationships between the clinicians and the nursing team and particularly with the failed mediation following the grievance. I think I was just trying to I think at that time to try and find a way to put Lucy Letby back on the neonatal unit with her full nursing team support there.

Q. At this point, you knew from her that she did

not think there was any personal acts from either Dr Brearey or Dr Jayaram. We have seen you told the police you asked her about that, there was no personal concern. Were you still thinking that there was in some way bad faith in the allegation that she was deliberately or may deliberately be causing harm to babies? Or did you think it was a reasonable and well held belief, a genuinely held belief?

A. Yes, I suppose it was. It's hard to absolutely recall. But yes, I think the intention was to make sure she had enough support if we would have been successful in returning her to the neonatal unit and to try and help build those working relationships again.

Q. If we go, please, to 0003529, page 5. We see in the meeting on 31 January, the last paragraph:

"Finally, you advised how you had been liaising with a colleague based at Alder Hey to view theatre lists to have an observational contract. We agreed you would work with Karen to come back with a plan around this within the next week. Meeting closed at approximately 12.30."

So she is speaking with you about Alder Hey and her plan about working there. What did you understand the position was?

Pleases be careful to use the cipher if you are going to mention any names here.

A. If I recall, Lucy Letby had a friend, a medical colleague that worked -- she had obviously worked with him prior and he was currently based at Alder Hey Hospital and I recall her arranging to have this observational contract with this particular medic, so she could sit in his clinic and just observe.

There was no hands-on clinical contact as far as I was aware, made aware. But I do recall once that had been -- Lucy had set that up with this particular medic, that Alison Kelly then on hindsight retracted it and stopped it.

Q. But you didn't contact Alder Hey at any time to either confirm or prevent that placement either way, you didn't get involved in that or what's the position?

A. No, no.

Q. If we can go to INQ0003529, page 9, this is a meeting on 8 March, if we go to the next page, page 9, sorry, we concluded -- you see at the top:

"We concluded the meeting by discussing your plans for transition back to the NNU. You had been working with Karen on dates of 3 April and 10 April. You would have support from a number of buddies and Karen had spoken to the senior team around your competencies.

"Karen, Hayley and yourself spoke about how you had gone on to the unit on your own last week and this was a big step.

"Karen reiterated she would be guided by you with shifts."

What had she done on her own on the unit in March?

A. Sorry, say that again? Sorry, can you repeat that?

Q. What had she done on her own on the unit? You see it says she tells you she's been on --

A. I think she just -- my recollection is that she just went to visit the unit to see how she felt, so it was -- she didn't actually work on the unit that I can remember.

I think she just went because she had obviously been removed from there for quite some time and she was anxious about it. I think it was just a visitation.

Q. We know there was some tea party or some welcome event organised. Did you get involved in that, sorting that out?

A. No, I wasn't aware of that and I certainly didn't get invited.

Q. If we go to INQ0004697, page 3, and the last box 13:

"Provide continuous professional development to LL

to support her ongoing development and refresher re her clinical skills. Alison Kelly delegated to Karen Rees. Initial discussions with Alder Hey Hospital re: observation placement."

So was that seen as her keeping her skills, the observational placement? I think she was subsequently sent on a course as well, wasn't she?

A. Was she? Definitely it was just to get her back in renewing her knowledge and skills. I don't recall her going on a course. I don't recall that at all.

Q. If we go, please, to INQ0003479, page 1, we see here by 27 April 2017 the Trust decision, paragraph 4, was that you could not return to the unit as this had been paused.

Now, you, Hayley Cooper, Kathryn de Berger and Letby were all working towards this, weren't you, her to be going back on to the ward?

A. Yes.

Q. So what did you make of this?

A. I'm trying to think at the time. April.

I think that was around Easter time, if I remember rightly, and so her return to the unit was paused yet again I think because the mediation with the two Consultants, Ravi Jayaram and Steve Brearey, hadn't

taken place and I think there were concerns about her going back on the neonatal unit without having that rectified.

Q. Did you support the decision that that should be paused? Did you think it was important there should be a thorough forensic investigation into the unexpected deaths or not?

A. Absolutely. It was just so difficult when there was a plan and then there wasn't a plan, and then there was a plan and then there wasn't a plan.

But, yes, I think -- I think it would have been really hard to put Lucy Letby back on that neonatal unit without having some sort of mediation with the two Consultants and, you know, a satisfied investigation.

Q. To complete the working INQ0002796, page 1., the working picture, if we look at this 2796, page 1. The third paragraph:

"Karen Rees has just informed Lucy that both have advised Lucy does not go to Alder Hey for the time being like she has been."

It looks as though that was in May 2017.

"Would like to know why this is the case and is this a management instruction and if so on what grounds?"

Can you see?

A. That was what I was alluding to --

Q. Yes.

A. -- just before --

Q. May 2017 when that instruction, looking at that letter --

A. Yes.

Q. "Dear Alison and Sue" from Hayley:

"Following the meeting we have just all attended Lucy has asked ... on behalf of the following conversation with Karen Rees."

You were the one to tell her, weren't you, in the conversation?

A. Yes. We had had a meeting and then I got called out of that meeting to ask to go back in to her, Lucy Letby, to tell her that we couldn't proceed and obviously Hayley Cooper wrote that email because she was clearly upset saying: Why didn't they be open and honest and tell her why we were in that meeting, and hence that, you know, I'm assuming that's why Hayley Cooper sent that email.

Q. Whatever you chose to tell her it's apparent looking at the meetings that she had worked out for herself by then that the Consultants were saying there was an issue with her, yes?

A. At some point, yes.

Q. And she in particular wanted apologies from four people, didn't she, not all of the Consultants? She wanted them from four people. Can you remember that?

A. I thought it was three.

Q. Who did you think she wanted apologies from?

A. Ravi Jayaram, Steve Brearey, and Jim McCormack was my recollection. I can't think...

Q. In the meeting, does Dr V ring a bell as well, Dr V? I can't give you the name.

A. Sorry, I don't recall.

Q. So Drs Brearey, Jayaram and McCormack in particular you remember that she wanted apologies from and she didn't know why all the Consultants were apologising, is that right, in one meeting?

A. I -- oh, God -- I don't think she wanted or expected an apology from other clinicians. I think it was -- just what I recall is it was those three in particular.

Q. So if we go to INQ0005810, page 1. We see at the bottom a letter from all seven Consultants. It's from Tony Chambers:

"An apology from the whole Consultant team will be done as a group."

She says:

"Why is that?"

Tony Chambers says:

"It's thought to be the most sensible. We have recognised some of their behaviour was not appropriate. This is acknowledged and we need to get into a position where we can move forwards."

If we go over the page, to page 2, she says:

"I expect four apologies. SL..."

Is that her mother?

A. Ah, right.

Q. "It's unacceptable if not."

And then they say:

"As a family it's easier to do a collective apology. They made it very personal again so personal allegations are redeployed. She's not been told about it."

And it repeats:

"We were expecting four apologies."

If we go to the next page, page 3, Mr Chambers:

"I am trying to advise you. The last thing we want is sensational press. This is about sick poorly babies. The story in The Sunday Times is about families saying we are keeping them in the dark."

What did you think the parents of the babies who had been killed and harmed were being told about the

investigations?
A. I think there should have been a lot more openness and transparency with certainly the parents. Everybody.
Q. If we go to the last page of this document, page 7, we see:
"We want a mediation from her parents of ... or not we want her back on the unit. We can forget about individual. Mr Chambers' report will be published next week. There may be interest from media outlets. This is not about you. There was an increase in mortality, the review and recommendations. There will be a flurry of interest. Parents saying we appreciate what's been said. If her name comes up in the press we will take advice."
Lucy Letby says:
"Do all you can to avoid this."
You end the meeting:
"Important to have the mediation and to move forwards."
Whose needs were paramount in that meeting? That can go down now, thank you.
A. Clearly Lucy Letby's and her parents.
Q. There is no reference to the safety of babies at all in that meeting, is there?

A. No.
Q. Do you think looking back you, in common with Eirian Powell, got too close to Lucy Letby and her position?
A. I can only answer for myself. I think the answer to that is, yes, because I was tasked to meet with her on a near-weekly basis for nearly two years and as I said previously witnessing her distress, yes, I acknowledge that.
Q. She had support from a number of sources, didn't she? She had Dr U, who was messaging her?
A. I don't know. I don't know about that.
Q. You made reference to her having a connection with a clinician who was helping her -- you mentioned it to the police -- keeping her competencies, keeping her expertise, that she spoke about stuff. You know about that at the time, didn't you, that she was messaging Dr U as we know him in the Inquiry?
A. Messaging him?
Q. Yes, messaging. Texting, Facebook messaging. She was not messaging you. Between each other, they were messaging each other. So she had support from him.
A. Okay. I don't know about that, sorry, but...
Q. You say something to the police --
A. Did I?

Q. -- about him you knew that she was -- had, as you mentioned, a placement arranged?
A. Was that the one, sorry?
Q. Yes.
A. Yes.
Q. So that person.
A. But I didn't realise they were...
Q. The extent of messaging?
A. Yes. Yes.
Q. Understood. So she had support there. She was also messaging and in contact with a couple of the nurses who she'd worked with on the unit, wasn't she? You nod, but, did you know that? She had support from some friends?
A. I don't -- I really don't know about that. I know she had a close friend on the unit and one would assume she'd still. But, I can't comment. I really don't know about that.
Q. And she turned up at the Christmas party, didn't she, in December 2016 -- sorry, December 2017. She was able to go back to -- it was combined with Eirian Powell's retirement. She felt able to do that.
Did you go to that party?
A. No, I did not.
Q. Okay. So she wasn't short of sources of

support at that time, was she, and she had the three of you on the WhatsApp group?
A. (Nods)
Q. Hayley Cooper, Kathryn de Berger and yourself. So she had a number of people she was messaging in support, didn't she?
A. Yes.
Q. Were you aware at the time the number of people and avenues of support that she did have?
A. No, no, no.
Q. Because if we go, let's go to INQ0108337, page 1. This is a message from you that is on that group between the four of you, 24 May:
"See, hang on in there girl. Something I need to share with Alison and Sue. Your nursing team are fully behind you. We will get through this lol, K."
That's a very personal message, isn't it?
A. Yes.
Q. If we go to INQ0108337, page 2. The 1st of the 1st:
"Happy New Year to all. Lucy let's hope we get closure this year. I'm really proud of you and the professional way you have presented yourself throughout is admirable. We will continue to support you and I promise I will do all I can before I leave. All have

a great day. See you in the week."
You were fully committed to her position, weren't you?
A. I was at that time, yes.
Q. And again 108337, page 3, the last message. I'm not sure if you received it. This is 18 December 2018:
"Just to let you know we are constantly thinking of you and hope you can try and have a pleasant xmas with your family during this continuous stressful time."
When you say you were at the time, what did you learn since about her that questions your interaction with her at the time if anything?
A. Sorry, say that again?
Q. What have you learned, either at the criminal trial or subsequently through documents you have been sent, about Letby that you didn't know at the time when you were supporting her so fully?
A. It's certainly -- obviously when I've read all the stuff that I have been sent, you know, in regards to the public Inquiry it was quite enlightening to read all of that because you do forget things and you are not aware of things. So, yes, I take it on board.
I think for me personally, yes, professional and personal boundaries blurred because of my -- the amount

of involvement I had tasked, you know, with meeting with her regularly and perhaps on hindsight that wasn't as necessary as it was made out to be.
Q. Who was the first person who asked you to meet her that regularly?
A. It was Alison Kelly and Sue Hodkinson.
Q. It was originally weekly, wasn't it, and then it went to fortnightly?
A. Yes.
Q. Is that right?
A. It was weekly for me and then I asked Alison and Sue to -- Alison Kelly and Sue Hodkinson, sorry -- to join the meeting so they could give full explanations about progress or lack of it and the reasons why, which is then they agreed to do and that's when they came monthly.
Q. And another email, I don't need to put it on the screen, 21 December 2017:
"We will continue to fight for you and as I promised, whoever takes over from me will continue to give that support I promise."
If we can look though at INQ0057499, page 1. This is a message from Letby to Ian Harvey.
Can you see?
"Karen Rees informed that a junior doctor openly

tabled at a meeting when discussing the increased mortality rates there might be a possible connection involvement with this. When Karen asked, the details of the doctor and the meeting were not provided. Is there an agenda or minutes which could be traced? I am interested to know who tabled this and who was present as they are potentially professionals that I will be working with in the future and feel that it's only fair for me to know."
Do you remember now which junior doctor that was who had raised the links with her?
A. No, I am sorry, I can't. I don't know whether I was aware of which junior doctor it was.
Q. Did you know she was going to write to Mr Harvey and ask for that information? She cc'd you. Did you know before?
A. Not until I had read it after she cc'd me, but she didn't tell me of her intent.
Q. But would you have supported that? I mean, you are still writing her messages of support at this time so presumably you did support her with that request.
A. Well, I think she had already done it before she had informed me she was doing it. Hence when I read it when she had cc'd me, it had already been done.

I don't recall supporting her or her informing me she was going to do that; send that email to Ian Harvey. I don't remember that.
Q. That can go down now, thank you.
Paragraph 123 of your statement. We referred you to appendix 6 of the Trust disciplinary policy which is entitled "Consideration of Referral to the Local Authority Designated Officer" and it refers to if there is a concern raised or an allegation made about a person who works with children, whether a professional staff member, foster carer or volunteer that they may have behaved in a way that has harmed a child or may have harmed a child, possibly committed a criminal offence in a way that indicates they are unsuitable to work with children then the process outlined below should be followed.
The disciplinary, you say you were aware of that?
A. Yes.
Q. At any point, did you think she should be being investigated for what this allegation represents in terms of what the doctors had said about her?
A. If I remember correctly, referral to the LADO -- I am trying to recall it now -- because it's in the disciplinary policy that you, your first port of call is to inform your line manager and then I think

referral to the LADO has to -- well, the recommendation is it 24 hours she should -- it should have been reported to.

Well, this was over 12 months. So I didn't even question. I thought perhaps whoever had already reported it to the LADO because my understanding was these concerns were raised well before I was in post. So I -- I didn't even give that a thought, I am sorry, I thought it would have already been done.

Q. At paragraph 128 under reflections you say:

"On reflection if Eirian Powell and I had been approached by the Consultants when they first had their suspicions in relation to Letby, we could have worked together and monitored Letby's clinical practice more closely."

A. Yes.

Q. Eirian Powell was working closely with Dr Brearey right from the moment when the review into A, C and D had been conducted.

A. Right.

Q. She was communicating with you and you were aware that they were doing that work, weren't you, around the thematic reviews, increased death rates and links to a member of staff?

A. Yes, I was. But what I am referring to in my

comments made there was my understanding was concerns had been raised in January '15. I came into post in August 2015.

I would have -- on reflection I thought if, if and I wasn't aware that they were meeting with the Execs or anything like that, but I thought when I came new into post it might have been of benefit -- and hindsight's a great thing, I get that -- but if, if Ravi Jayaram and Steve Brearey had called a meeting with me and Eirian and said: Look, we have got concerns, we don't know exactly what those concerns are...

But that's a cohesive way of working with a team. If I put myself back in coronary care when I was ward manager there years ago if any of my Consultant cardiologists had had a concern about a nurse, I would have expected their first line of concern to be raised with me, not jump immediately into the Executive suite.

So yes, I was aware. I was made aware of the thematic review and all the other things that were going on later on. I just think we had a missed opportunity.

As the unit manager and the head of nursing we could have sat down and worked closely and perhaps that would have prevented the divide between the clinicians and the nurses and the lack of trust moving forward. That's what I meant by that.

Q. When you were both told that she may purposefully be harming babies, that's you and Eirian Powell, you did not believe it, and you in fact questioned their motive.

A. When did I do that, sorry?

Q. When they first mentioned that to you, that she was suspected of purposefully harming babies back on 24 June, when that was said in the clearest terms --

A. Right, sorry, yes.

Q. -- you didn't believe it. So, what difference would it have made, even if it had been expressed in the loudest terms to you, three months earlier?

A. Because if they would have come to me -- I went to find them on that Friday. At no time did either Consultant bleep, telephone, knock on my office door to tell me about their concerns. I wasn't one of -- the first port of call and I think that's -- that's lacking is what I'm trying to explain.

I didn't know they were having meetings with the Executive team. I just thought I would have expected them to sit down with me and Eirian and that's just my opinion.

Q. Dr Brearey did telephone you the night of 24 June?

A. He did.

Q. But it made no difference. He very clearly made his concerns aware to you?

A. Yes, but I have explained about the content of that conversation, that I felt like I was being bullied and intimidated. I didn't find it a very professional conversation and I'm not making excuse. I, you know, this is why I phoned Alison Kelly straight back and said: Look, Steve Brearey is still agitating so you need to know this.

Q. You did an interview, didn't you, with ITV on August 22 --

A. God, yes.

Q. -- 2023?

A. Yes.

Q. And you said in that interview:

"If I had been given a little bit more information, if it had been inferred insulin had been used but neither of them gave me anything other than they were concerned about her clinical practice. I would have acted differently."

And you said there they were concerned about her clinical practice. You didn't say in that interview that they had also said, certainly in June, she may purposefully be harming babies as you have told the Inquiry. There is a difference, isn't there --

A. There is.
Q. -- between people saying, "They didn't tell me other than they were concerned about her clinical practice" and saying, "She may purposefully be harming babies."
Why didn't you say in that interview that that is what you had been told?
A. I don't know. I'm sorry, I don't know.
MS LANGDALE: Those are my questions, thank you.
A. Thank you.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Langdale. Mr Baker.
Questions by MR BAKER
MR BAKER: Good afternoon. I ask questions on behalf of some of the Family groups.
A. Okay. Thank you.
Q. Part of your remit was patient safety?
A. Yes.
Q. And as part of that duty towards patient safety, one of your jobs was to be aware of the risk that members of staff may harm patients? That's correct, isn't it? It wasn't an entirely novel concept in 2015 that a member of staff may cause harm to a patient?
A. I think in all of my career, I have never had

anybody say that a member of staff has been purposely harming patients. You know, yes, part of my role, as is any nurse, you know, patient safety is paramount but for the reasons that I have explained today.
Q. We don't have to encounter it personally and directly, do we, to be aware of the risk?
A. Sorry, say that again to me?
Q. We don't have to encounter a risk personally to be aware of it?
A. No, true.
Q. You know from nursing practice that there are many risks and conditions that you may only ever see once in your career?
A. Yes, I appreciate that.
Q. And if we are thinking about the proximity of risk in 2015 someone had been convicted of murdering patients less than 40 miles away a nurse in a hospital. So can I ask you this: as of 2015, what level of proof did you think was necessary in order to act on the idea that somebody might be harming a patient?
A. I think it's like I previously explained, I thought it was personal at first and I appreciate what you are saying, that what -- but I just feel that if I had have been given something more, bearing in mind I wasn't aware that the Consultants had raised concerns

with the Executive teams well before I was in post, and then not to come anywhere near me but I hear what you say yes, it was -- it was, it was an awful allegation and for that I am sorry.
Q. Well, these were two doctors who were --
A. I know.
Q. -- sensible, they were senior, they weren't people who would inherently denounce other members of staff for serious crimes, were they?
A. I would hope not, no.
Q. No. And in fact they were right, as it turned out?
A. As it turned out.
Q. Looking at when you became aware of things going on, is it true that hearing about Ravi Jayaram talking to Karen Townsend came completely out of the blue, is it really true that you were unaware of any issues of Letby before then?
A. No, because I think at the beginning I thought that was the first time that I had heard about Lucy Letby or her name. But clearly evidently because it was such a long time ago, when I got all, all the information sent to me, clearly there was a thematic review that I was emailed after they had done that.
So you are right, no, it wasn't the first time.

Q. No, what you say in your Facere Melius interview is that you had been involved in discussions regarding mortality from the end of 2015 onwards. So if I -- it's INQ00012991 on page 3.
So if we look here on page 3, you can see there in December 2015, there was the thematic review discussed at the QSPEC meetings and you ask:
"Was that the internal one, the initial internal one?
"Yeah."
And you say:
"Yes, I think it's the one Jane Fogarty developed."
Darren Thorne says:
"... and Sian Williams were involved in.
"Yes, I do recall.
"Can you remember what was discussed at that meeting at all?
"All I can remember is I believe there were some concerns raised by -- just think, some of the concerns if I remember rightly, so apologies, that were raised by the Consultant paediatricians with the Exec team."
You are describing there discussions taking place in December 2015 that you are aware of?
A. Yes. Yes, and I think that's alluding to Julie Fogarty and Sian Williams I think that was the

first internal investigation and I do recall that looking at off-duty, you know, the simple internal things first, so I do recall that, yes I am sorry, yes.

Q. And as head of nursing, if there were discussions about mortality and in particular a link between a nurse and mortality, you would expect to be informed about that, wouldn't you?

A. Yes.

Q. So Eirian Powell should have told you about it and kept you up to date on anything that was going on?

A. Yes.

Q. So by the time we come on to May 2016, you receive an email which is headed in terms "Concerns about nurses" or "Nurse concern NNU thematic review" is the title of the email that you receive in May, 4 May 2016.

You must have understood from what was within it and what had gone before that there were concerns about the connection between Lucy Letby and an increase in neonatal mortality; that is correct, isn't it?

A. That is correct.

Q. And what you say in your witness statement at paragraph 20 is that you went off to see Eirian Powell about this and you say that Eirian Powell told you in terms that Lucy Letby was -- she assured me that

a number of these babies were born with congenital abnormalities, maternal syndrome, necrotising enterocolitis and sepsis and she told me about the lack of cot availability in Alder Hey.

She said Lucy Letby had been on shift for the babies listed on the schedule but had only been allocated three of them and I did not consider there was a potential safeguarding risk to patients.

Eirian Powell was defending Lucy Letby at this meeting you had with her, wasn't she?

A. Yes, and I suppose I listened to her because as a unit manager or a ward manager you know your team best. You know their strengths, their weaknesses, their capabilities and so, yes, I trusted Eirian's judgment in that regard.

Q. Stephen Brearey in his statement describes attending a meeting with Anne Murphy and Eirian Powell on 11 May 2016 and he put his concerns at that meeting and he said with Eirian Powell countered those concerns "forcibly and with great emotion" is how he describes it.

Is that a fair description of how Eirian Powell was defending Lucy Letby when you met her, forcibly, strongly, with emotion?

A. I wouldn't say forcibly. But she was

persistent with that view.

Q. Persistent?

A. Yes.

Q. You were given some reasons as to or some background descriptions of how these babies were. But were you told that they had all been -- the deaths had all been unexpected and unexplained or were thought to be unexpected and unexplained?

A. Sorry, can you say that again?

Q. So in your witness statement at paragraph 20 you describe Eirian Powell describing the background conditions?

A. Yes.

Q. The comorbidities for these babies including necrotising enterocolitis and sepsis.

A. Yes.

Q. Did Eirian Powell tell you that is why those babies died or did she say to you that despite those background conditions, the deaths were unexpected and unexplained?

A. No, she didn't say to me that was the reasons for the death. I think it was just information given to say that they weren't deemed the stable babies that was first alluded to at some point from Eirian.

Q. Would it not have been important, though, in

trying to understand neonatal mortality to understand why those babies died?

A. Sure.

Q. So did you ask her why the babies died?

A. Well, we had discussions when she went through the paperwork that identified each baby and what -- whether it was sepsis, congenital abnormality or whatever, but I can't recall us having a conversation to say is that definitely what they died of, no, I don't recall that.

Q. And did you seek any reassurance from the doctors, for example, as to the cause of death for these babies or whether what had been said to you was accurate?

A. No, I did not.

Q. Because the form that you saw with Letby's name in red --

A. Yes.

Q. -- describes Child C's cause of death as NEC?

A. Yes.

Q. But in fact a post-mortem had been done months before that form was completed --

A. Right.

Q. -- which did not give NEC as a cause of death?

A. Okay, I am sorry, I wasn't aware of that.

Q. But do you think the way in which Eirian Powell defended Letby and what she said to you influenced your reaction to the allegations?

A. Maybe. Maybe. Certainly at the beginning, yes.

Q. Do you think in hindsight, some degree of tribal allegiance was working here and that you tended to accept her word because she was a nurse and perhaps had a bias against what the doctors might be saying?

A. I think -- I think obviously I believed what Eirian was telling me for the reasons that I said just before is that a unit manager knows her team members better than anybody, better than the doctors, so yes, I did believe Eirian.

Q. You assume that Eirian Powell as a serious senior nurse --

A. Yes.

Q. As a senior nurse, sorry, would have carried out her own serious research before saying those things to you?

A. Yes.

Q. Did you ask her or indeed carry out any of your own investigations as to the background to any of these collapses? Or, sorry, any of these deaths?

A. No, I did not.

Q. I mean of course you know now that if you had carried out investigations of your own you would have found out that doctors had been concerned in June 2015 about a grouping of deaths and collapses?

A. Yes.

Q. You would have found out that Child E, one of the children who had died, had a twin who had also had an unexpected collapse?

A. Yes.

Q. And you would have found out if a doctor had reviewed those notes that Child F had an abnormal level of insulin in his system?

A. If it was known at that time, yes.

Q. Yes.

So the issue, and do you accept this, is that you accepted a superficial description delivered by somebody who was shouting a defence for Lucy Letby rather than carrying out a sufficiently thorough investigation as to what was actually behind all of this?

A. Well, I didn't feel that I had to personally carry out another investigation because there were a number of investigations already going on that one would hope would have looked at those things that you have highlighted.

Q. I mean, what really should happen though is if

somebody, the senior doctor, says to you in good faith: I think this nurse may be murdering babies, is that you should call the police, shouldn't you?

A. On hindsight perhaps I should, but then I questioned as to why neither Consultant did that also. If they were so convinced, why did they not? But I acknowledge yes, yes.

Q. Doesn't that reveal a bias because you don't apply the same level of scrutiny to what Eirian Powell tells you, you just accept her word?

A. No, but I felt like I hadn't got any absolute evidence to go to the police. What was I going to say to them? Yes, two Consultants have raised massive allegation but weren't prepared to go to the police themselves.

Q. Well, you are not encouraging any sort of investigation at all, are you? I mean, there is no sense of: we need to go off and scrutinise the records or ask the doctors what the basis of this and how we might scrutinise the records. All Stephen Brearey is asking you to do is to take Lucy Letby off the ward so she doesn't harm another baby, that is all he was asking, wasn't it?

A. Yes, he was demanding. He wasn't asking, he was demanding, yes.

Q. Did that put your back up, that he was demanding it?

A. I wouldn't say put my back up but why wasn't he working with me? You know, like I have said previously just because a Consultant makes a demand, as senior nurse, you -- you don't -- when they click their fingers you don't jump how high.

I mean, I accept, and looking back at all of these things, yes, and that is why we are here today so we can learn lessons and I am sorry for all of that.

Q. Well, it's this serious, isn't it, because when you have a conversation with him on 24 June by telephone, he says to you: would you be happy to take responsibility for Lucy coming back on shift if she harms another baby?

A. I don't recall him asking me those questions. But I can say this because apparently he said I said yes, I would take responsibility. I certainly wouldn't have answered yes and that's evident for me to phone Alison Kelly directly following that conversation to inform her that Steve Brearey had been back on the phone to me and is pushing for us to take Lucy Letby off her clinical practice.

Q. Do you think though that where an otherwise senior sensible Consultant is saying to you that they

have serious concerns that if Lucy Letby comes into work tomorrow that she will murder a baby, which I presume is a fairly novel conversation to be having with a Consultant, does that not immediately start alarm bells ringing from a patient safety point of view that maybe we should just take some safeguarding action?

A. Yes, and I have acknowledged that I wish I had now brought the safeguarding team in. But equally, and I will keep saying it, why did Ravi Jayaram or Steve Brearey not call the safeguarding team in if they were so insistent that she was doing? Why did they continue to work along side her? I am not making excuses, I acknowledge I should have done it too.

Q. I am sure they will be asked that question. But again, Ravi Jayaram talking to Karen Townsend in a coffee shop, that irritated you, didn't it?

A. No, it didn't irritate me. If I would have been working with any healthcare professional that I thought was purposely harming a patient I wouldn't have declared it in a hospital cafe over a cup of coffee and that was the point I was making.

It didn't irritate me, I was just trying to make the point that there is not a chance I would have tabled that concern over a cup of coffee in a cafe she was the divisional director. What I couldn't understand is why

did he not call an urgent meeting right there and then and ask for me, ask for Alison Kelly, Ian Harvey, safeguarding, on that Friday afternoon?

Q. What he did do, though, and what Ravi Jayaram did as well is to ask you not to let her come in for another shift so that this could be investigated. They were unhappy about the risk that she created for patients and your reaction to that was to effectively say: she's coming in to the unit?

A. I don't recall saying that.

Q. You refused to take her off the shift the following day. As a consequence she attacked Baby Q, didn't she?

A. Yes.

Q. Can I ask you what you understand the duty of candour to mean when it comes to patients, and I ask you this because of something you say in your police statement. So if we could go, please, to INQ0014005 at page 3.

So the second paragraph down beneath the "drawer of doom" paragraph begins:

"We have a duty of candour to both clinicians and nurses. So as Dr Brearey was pushing me to take some action even though he was not prepared to share with me the evidence of his allegations, I went to speak with

Alison Kelly."

Can I ask on behalf of the parents of all of the children who I represent why there is no mention of a duty of candour to patients in this?

A. I don't know why I never said that. I don't know. Sorry.

Q. Because nobody told them at all about the suspicions or the investigations and they had to find out in quite horrible and upsetting circumstances?

A. Well, I wasn't aware of that, I am sorry, and of course that did not fall within my remit. But I wasn't aware of that.

Q. Who is responsible for telling the parents?

A. I would have thought the clinician that was caring for that patient in the first instance.

Q. What, Lucy Letby?

A. Sorry?

Q. Lucy Letby?

A. No, no, no I am talking about the Consultants, the Consultant team that were looking after that patient I thought, yes. They would have been first line to speak to those parents, surely. I didn't realise that they weren't informed and had to find out in a horrible way as you say. I didn't know that.

MR BAKER: Thank you, my Lady I have no more

questions.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.

Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Ms Rees, I am going to ask questions on behalf of the other family group.

A. Thank you.

Q. Can I just go back to the timings of your knowledge, please?

A. Yes.

Q. Just to be absolutely clear --

A. Okay.

Q. -- when were you first told that the mortality on the neonatal unit was higher than usual?

A. When was I?

Q. When?

A. My recollection was it was either the end of 2015 or the beginning of 2016. It certainly wasn't June or July 2015 because I was not in post at that time as Head of Nursing.

Q. You came in in August?

A. Yes.

Q. It was in October -- I think you were here this morning, sat in the hearing -- when Eirian Powell

produced a mortality table --
A. Yes.
Q. -- after the death of Baby I?
A. Okay, yes.
Q. That was shared with Dr Brearey who had raised a concern with her, so at that stage Dr Brearey is speaking to Eirian Powell, Eirian Powell is copying in Anne Murphy?
A. Yes.
Q. Were you involved in that knowledge circle at that stage in October?
A. In what -- in October? I can't honestly recall it being October but, like I say to you, I think I was made aware either at the end of it, more December or the January. It was somewhere around that time but I do not recall being made aware of that in October.
Q. Who made you aware of it?
A. Pardon?
Q. Who spoke to you?
A. Made me aware of it?
Q. Yes?
A. Eirian Lloyd Powell at the time.
Q. And we have had a lot of evidence about her views. She at that stage rejected the suggestion that Lucy Letby had harmed children, did you accept her view?

A. Well, clearly at that time I did, didn't I?
Q. Did you go and speak to any of the Consultants?
A. No, I didn't.
Q. Because you have obviously said the onus was on them to bring things to you. They had brought things to her, she had rejected it --
A. Right.
Q. -- you yourself didn't feel the need to get a personal grip on this.
A. Well, as a head of nursing I would have expected to be told, as soon as, if there was a concern about a nurse.
Q. You would have expected to have been told by the Consultants as opposed to being told by the nursing manager of the unit?
A. Well, the nurse manager, yes.
Q. Can I infer from that you would have expected to have been told by Ms Powell sooner than the end of 2015 to early 2016; in fact, as soon as she was aware?
A. Well, she was aware, wasn't she, in June 2015.
Q. Yes.
A. And I was working in another division then, so ... But I don't -- like I say to you, yes, she might have been aware there, but I don't recall her mentioning

it to me in October. I was fairly new in post. Whether we just didn't get the opportunity, I don't know, but I don't recall her telling me in October 2015.
Q. But you would have expected her to have raised it with you?
A. Yes, yes.
Q. I won't go over the phone call in any detail with Dr Brearey. You have been asked about it a number of times. But what I would like to understand is in your earlier interview with Facere Melius, and indeed in your Inquiry statement, you don't mention being bullied or intimidated by Dr Brearey. In fact, you have described him as rather softly spoken.
A. Yes.
Q. So he was being more assertive than usual?
A. Yes.
Q. But you don't mention being bullied or intimidated?
A. Well, perhaps that's -- but that's how I felt on the phone. I felt he was trying to push me to remove Lucy Letby off the neonatal unit when nobody had been prepared to do that before. So there was a difference this his, in his voice and his tone.
He doesn't raise his voice. Steve Brearey never does, but because he phoned me up at home, you know, and

was pushing me to do it again that's why I phoned Alison Kelly immediately after and said: This Consultant is still on the phone to me agitating.
Q. Well, he was being assertive.
A. Assertive.
Q. He wasn't bullying you really, was he?
A. Okay. That's how I felt. I felt like he was trying to push me take an action that nobody else had been prepared to do. So you can call it assertive. That's how I felt.
Q. Well, I think you said in your interview he was assertive.
A. Okay.
Q. Were you cross about that? That's another thing you said in the interview.
A. Was I cross? Maybe I was. He had phoned me up at home, despite us having a conversation, despite me telling him I'd escalated to the Execs. He inferred I was lying. So, yes, probably I might have been a bit cross. Yes, maybe.
Q. Did it occur to you that he might be desperate, that this was a desperate situation requiring -- effectively he had to get your number from the switchboard. You were being called out of hours as the sort of Exec responsible for responding to

emergencies or serious issues --
A. I wasn't the Exec.
Q. I had understood that you were, as it were, the hotline as a senior manager for that weekend?
A. No, no. There's levels. This is -- clearly people are labelling me as an Executive nurse. I never have been, never was. So that's a mistake because obviously that's Alison Kelly and we always have an Exec on-call and then a clinical manager like myself.
Q. Leaving that aside, the status issue, he clearly felt there was a desperate need to call someone to get a nurse removed. That's a highly unusual step to take.
A. Yes, I get that. But I honestly believe if I hadn't gone to find him on that Friday, he never came anywhere near me, I went to seek him out because I was concerned. As a senior nurse, I do not walk out of the organisation when you have got an allegation like that on the table. Absolutely not.
And the whole time I had been in post as head of nursing not one time. And I honestly feel if I hadn't had gone to find him -- and I accept all what you say -- if I hadn't have gone to find Steve Brearey on that Friday afternoon, I wouldn't have had that conversation, he wouldn't have rung me at home.

Q. Well, leaving that aside. You had known by this stage, for at least six months or so, that there were concerns about Lucy Letby possibly harming children?
A. Okay. Yes.
Q. For a long period of time. This wasn't news to you?
A. No, it wasn't.
Q. Two babies had just died out of a family of three that had just been born?
A. I know.
Q. And you were being called by a Consultant saying: In order to protect children on the unit you need to get rid of this nurse off the shift.
It's an extraordinary situation to be in.
A. It is.
Q. But your response was to be cross and not to take that step. Can you actually justify that?
A. Right. I have just explained why I possibly was cross. I escalated again, the second time that day, to my Director of Nursing.
I was following hospital policy and procedure. I was unsure what to do because he wasn't giving me anything else, so I picked up the phone immediately and told my Director of Nursing that he had been back on the

phone to me.
Q. Did you have the power to remove Letby from that shift?
A. Yes, I did.
Q. Without --
A. Not -- not in isolation. I would have had to have discussed it with my Director of Nursing and then involve human resources. You can't just do it in isolation.
Q. And what was your recommendation to Alison Kelly?
A. I didn't have --
Q. Presuming she was reliant on you.
A. I didn't make any recommendations to Alison Kelly. I was just informing her of the events that afternoon and the events of Steve Brearey calling me.
Q. Isn't the reality that you didn't want to remove Lucy Letby?
A. If I'd've had good reason, I would have done.
Q. And --
A. If I had been given sound reason, I would have discussed it with Alison Kelly and we would have brought in HR and we would have removed her.
Q. You said in answer to questions from

Ms Langdale, and indeed in your statement, that you felt the Consultants might have had a personal issue?
A. I did. I did initially. I have admitted that. I thought it might be personal because I have had incidents before where Consultant clinicians have demanded me move nursing for varying other reasons -- not this allegation clearly -- because there's been a breakdown in personal or professional relationships.
Q. Were you --
A. So you have to have more than a gut feeling and a drawer of doom to remove somebody.
Q. But there hadn't been a breakdown in the personal relationships, had there, in terms of there was no question about Lucy Letby's competence, there was no personal dislike between her and the Consultants?
A. Sorry, I'm not following that one, sorry?
Q. There was no personal reason in this case in fact. It was purely a professional decision they wanted to make --
A. Well, okay then, yes.
Q. But you didn't investigate that personal reason?
A. I didn't investigate. I escalated.
Q. And calling someone and speaking to them about a potential nurse murdering patients is of a very

different order from a breakdown of personal relations, isn't it?
A. Mm-hm.
Q. Do you recognise that you may have brought a degree of bias to your decision-making in assuming that there was a personal problem?
A. Possibly. Possibly.
Q. Did you think to enquire with the other Consultants? Dr Gibbs had treated the children who had just died. Did you think to ask him: Is this safe?
A. No, I did not.
Q. Prior to -- well, at any point really, did you speak to any of the other Consultants --
A. No, I did not.
Q. -- Dr Holt, for example, who was a relatively new and female Consultant who had come to the unit, she explained that she was concerned by high mortality within weeks of arriving on the unit in 2016. Did you ever speak to her?
A. No and I wasn't aware she -- she had got concerns at that time neither.
Q. So do you think looking back that what happened was that you dug in in a certain mindset quite early on, you and Ms Powell, and never really re-examined your own conclusions as to whether Letby in

fact may have harmed children or not?
A. I hope not. I -- it's -- I don't know. I don't know. I'm sorry.
Q. Can you give one example of you testing your own assumptions, asking questions, checking investigations?
A. Well, obviously I had numerous conversations with Eirian. I didn't commence any investigation because there were internal investigations already going on. My main conversation about all of this was definitely with Eirian Powell.
Q. Well, Ms Langdale took you to the email that you were writing in which you were greatly supporting Lucy Letby in September 2016 --
A. Mmm mm.
Q. -- just after the Royal College had come in and done their review for two days.
You, I think, were aware that the Royal College were not looking at increased mortality or indeed Lucy Letby, is that right?
A. I wasn't involved with setting the Terms of Reference and I hadn't seen them at that point. But I think I recall somewhere in the Terms of Reference it certainly didn't mention Lucy Letby.
But if my recollection is correct there is

somewhere in those Terms of Reference that said if you can highlight any possible causes or whatever in regards, there was something that was written, in regards to the mortality rates, I don't think it was very specific, and certainly I know Lucy Letby's name wasn't. But like I say, I -- I didn't see them. I wasn't involved in setting them until well after the investigation had taken place.
Q. As far as you were concerned, throughout this period of time, how did you understand the truth was ever going to be determined about whether or not she had or had not murdered the children?
A. It needed to be -- to call the police clearly because we weren't getting anywhere, with no amount of investigations, internal/external thematic reviews, post-mortems whatever, it wasn't moving anything on. So, yes, the only way we could determine was to bring the police in.
Q. And as far as you're concerned, I think you accepted this earlier, that it was the responsibility of everyone involved --
A. Yes, and I hold my hand up to that as well.
Q. -- to call the police?
A. Yes.
Q. -- as soon as the suspicions became

apparent --
A. Yes.
Q. -- and when it was clear that you couldn't handle them internally?
A. Yes.
MR SKELTON: Thank you.
A. Thank you.
MR SKELTON: Thank you, my Lady.
LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.
MS LANGDALE: No further questions, my Lady.
LADY JUSTICE THIRLWALL: Thank you, Ms Langdale.
Mrs Rees, thank you very much indeed. That concludes your evidence. Thank you for coming to help us today. You are free to go.
A. Thank you. I am sorry for everybody's loss.
LADY JUSTICE THIRLWALL: Thank you.
Can you just remind us of the timetable?
MS LANGDALE: I would like to be able to but, I can't actually. It's 10 o'clock tomorrow, I know that much.
LADY JUSTICE THIRLWALL: Very well, that will do for now. We will resume tomorrow at 10 o'clock. Thank you all very much.
(4.54 pm)
(The Inquiry adjourned until 10.00 am,

on Tuesday, 22 October 2024)

I N D E X