

Tuesday, 22 October 2024

1
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Ms Brown.
4 **MS BROWN:** Yes, if we could call Mrs Peacock,
5 please.
6 **LADY JUSTICE THIRLWALL:** Mrs Peacock, if you would
7 like to come up to the desk, please.
8 MRS DEBBIE PEACOCK (affirmed)
9 Questions by MS BROWN
10 **LADY JUSTICE THIRLWALL:** Do sit down.
11 **MS BROWN:** Could you please give your full name?
12 **A.** Debbie Peacock.
13 **Q.** You provided a statement to the Inquiry dated
14 5 June 2024 and I think there's a matter that you wish
15 to correct at paragraph 127?
16 **A.** Yes. In reference to the risk registers, they
17 also went through to the divisional board meetings as
18 well as QSPEC.
19 **Q.** So that paragraph says that the risk registers
20 will be at QSPEC and the addition is that you are now
21 adding that they would have been also been discussed at
22 the divisional board?
23 **A.** Yes.
24 **Q.** Taking into account that correction, is that
25 statement true to the best of your knowledge and belief?
1

1 midwife within the NHS?
2 **A.** I was working as a nurse and midwife either
3 under contract or on the bank up until probably 2013.
4 **Q.** So over 30 years?
5 **A.** Yes.
6 **Q.** Was that mainly as a nurse or mainly as
7 a midwife?
8 **A.** Mainly as a midwife and a neonatal nurse.
9 **Q.** Coming to your period as a neonatal nurse, how
10 long did you work as a neonatal nurse on a neonatal
11 unit?
12 **A.** There were different periods. I really
13 couldn't quantify that at the moment off the top of my
14 head, sorry.
15 **Q.** Just approximately, was it a number of years?
16 **A.** A number of years, yes.
17 **Q.** Roughly what period, obviously you span from
18 1985, quite a long period over 30 years?
19 **A.** Yes. So when I actually went to do my legal
20 training I was working as a transitional care midwife
21 which is a midwife on the wards looking after babies
22 that needed a little bit of extra support. So that was
23 still under the neonatal hat. But I probably left the
24 neonatal unit in probably 2008 I think maybe.
25 **Q.** So a period of five years you worked on
3

1 **A.** As far as I am aware, yes.
2 **Q.** I think there is something you wish to say at
3 the start of your evidence?
4 **A.** Yes, I would just like to extend my sincere
5 condolences and sympathies to the Families and parents
6 involved in these events.
7 **Q.** Thank you.
8 Turning to your qualifications, you qualified as
9 a Registered General Nurse and a Registered Sick
10 Children's Nurse in 1985 and a midwife in 1987; is that
11 correct?
12 **A.** It is, yes.
13 **Q.** You then went on to obtain a law degree in
14 2001. Is it correct that you then went on to qualify as
15 a solicitor?
16 **A.** I did, yes.
17 **Q.** When did you qualify as a solicitor?
18 **A.** Oh, I think it was 2010.
19 **Q.** You also hold a National General Certificate
20 in Occupational Health and Safety that was awarded in
21 2015?
22 **A.** Yes.
23 **Q.** Turning to your career, Mrs Peacock, you
24 worked as a qualified nurse from 1985 and also as
25 a midwife. Over what period did you work as a nurse or
2

1 a neonatal unit or are we talking less than that?
2 **A.** Probably a little bit more over the years.
3 **Q.** Where was the neonatal unit that you worked
4 on?
5 **A.** So I worked at Fazakerley Hospital, which is
6 now Aintree, as a neonatal nurse, I worked at
7 Warrington General as a neonatal nurse and I worked at
8 Liverpool Women's.
9 **Q.** And as a neonatal nurse that included working
10 with babies in intensive care, did it?
11 **A.** I generally didn't do intensive care, I tended
12 to stay in the HDUs and the nursery.
13 **Q.** So you were working with special care babies
14 rather than those in intensive care?
15 **A.** Yes.
16 **Q.** What band nurse were you on the neonatal ward?
17 **A.** When I worked at Fazakerley I would have been
18 a Band E and then they changed the -- the gradings. So
19 as a midwife I was a Band 6 when I worked on the
20 neonatal unit at Liverpool Women's.
21 **Q.** In terms of the Countess of Chester, did you
22 work at any time as a midwife or a nurse at the Countess
23 of Chester Hospital?
24 **A.** No, I never worked clinically.
25 **Q.** Looking at your legal career, you say that you
4

1 worked from 2008 to June 2012 as a paralegal then
 2 a trainee and then as a solicitor. How long did you
 3 work as a qualified solicitor in clinical negligence?
 4 **A.** Probably just less than two years.
 5 **Q.** Why did you leave your role as a solicitor?
 6 **A.** There was a Clinical Risk Manager job came up
 7 that I thought suited me better.
 8 **Q.** Turning to that, when you moved to work in
 9 Risk and Patient Safety in 2012, from June 2012 to
 10 December 2013 you worked as a clinical risk manager in
 11 Southport & Ormskirk Hospital, so about an 18-month
 12 period?
 13 **A.** Yes.
 14 **Q.** Very briefly, what did your role involve
 15 there?
 16 **A.** My role there covered the whole hospital so it
 17 wasn't confined to one particular specialty. And it was
 18 just quality improvement and monitoring patient safety
 19 via Datix and investigations, obviously sharing lessons
 20 learned.
 21 **Q.** Then turning to when you started employment at
 22 the Countess of Chester, you started there in
 23 December 2013 and what was the title of your role when
 24 you started at the Countess of Chester?
 25 **A.** So it was Quality Improvement Facilitator when

5

1 that you left prior to the CQC visit which commenced on
 2 16 February?
 3 **A.** I definitely left prior to the CQC visit.
 4 **Q.** So you were at the Countess of Chester as
 5 a Risk and Patient Safety Lead for just over two years?
 6 **A.** Yes.
 7 **Q.** When you left there, I think you took up
 8 a post in the Royal Liverpool & Broadgreen University
 9 Hospitals. Was that a promotion?
 10 **A.** It was, yes.
 11 **Q.** What was the role that you went to?
 12 **A.** Very similar to what I had been doing, but
 13 I was -- for scheduled care so it was a larger remit.
 14 **Q.** In what sense then was it a promotion, what
 15 were the additional responsibilities?
 16 **A.** It was a higher band, more responsibility.
 17 **Q.** And you stayed there I think for just under
 18 four years until January 2020?
 19 **A.** Yes.
 20 **Q.** So summarising your career and looking
 21 focusing on your Risk and Patient Safety roles, you
 22 worked in the NHS across three hospitals for
 23 approximately seven and a half years in this field?
 24 **A.** Yes.
 25 **Q.** How did your background in nursing and

7

1 I started and that later changed to Risk and Patient
 2 Safety Lead for Women's and Children's.
 3 **Q.** That was specifically related to -- well, what
 4 was initially the Women's and Children's Department but
 5 then you went on to remain working within that area
 6 albeit then you had split?
 7 **A.** It was, it was split from before I started
 8 there into different divisions. So it never changed
 9 while I was there.
 10 **Q.** Did you take over from someone in that role or
 11 was it a new post?
 12 **A.** I took over from somebody in that role who
 13 I don't think they were in post for a long time, I'm not
 14 sure.
 15 **Q.** You have explained that your job title changed
 16 to Risk and Patient Safety Lead. But other than the
 17 change in title, was there any change to what the job
 18 involved?
 19 **A.** No, it was still the same job description;
 20 that never changed.
 21 **Q.** We have seen from documents that you were
 22 present at a meeting on 15 February 2016 and it appears
 23 that was your last day or near to your last day?
 24 **A.** Yes, I think so.
 25 **Q.** That date would fit with your recollection

6

1 midwifery assist you in your role in Risk and Patient
 2 Safety?
 3 **A.** I think because I had such a varied nursing
 4 background, it was useful, it was applicable to all the
 5 areas that I worked within.
 6 **Q.** What about your training and experience as
 7 a solicitor, how did that assist you?
 8 **A.** I think it probably enabled a bit more
 9 critical thinking. Certainly it probably gave me more
 10 awareness of the things that can go wrong and do go
 11 wrong so I wasn't so tunnel-visioned and protective of
 12 the NHS. I suppose I was a little bit more cynical.
 13 **Q.** In your role as Risk and Safety Lead, you
 14 covered both the neonatal unit and midwifery?
 15 **A.** Yes, and gynaecology.
 16 **Q.** Yes, and also general paediatrics?
 17 **A.** Yes.
 18 **Q.** So whilst we have heard and you confirmed that
 19 even from when you started, the maternity unit was
 20 within the Planned Care Division and the neonatal unit
 21 in the Urgent Care Division, in terms of Risk and
 22 Patient Safety you looked across both units?
 23 **A.** I did, yes.
 24 **Q.** And from a risk and safety perspective, why
 25 was that important?

8

1 A. It gave me a better overarching view of what
2 was going on across the units, I think. So obviously
3 any issues in obstetrics could feed into problems with
4 babies who then subsequently went to the neonatal unit.

5 Q. So you were able to follow through from
6 antenatal the birth and then if the child was treated on
7 the neonatal unit?

8 A. Yes.

9 Q. So you could see the picture and you would
10 look at the patient safety across that?

11 A. Yes.

12 Q. Who did you report to?

13 A. I reported to the head of risk and governance
14 which was Ruth Millward for most the time. Sally Goode
15 was originally in post but she left soon after
16 I started.

17 Q. So for most of this period, certainly from
18 June 2015, you were reporting to Ruth Millward?

19 A. Yes.

20 Q. She in turn I think reported to Sian Williams,
21 the Deputy Director of Nursing?

22 A. As far as I am aware, yes.

23 Q. Were there other Risk and Patient Safety Leads
24 for the other departments? You were covering, as you
25 explained, the neonatal unit, midwifery, paediatrics

9

1 the different divisions?

2 A. No, we were in a separate building away from
3 our divisions.

4 Q. And you say "in a separate building". To what
5 extent would you have any day-to-day contact with those
6 working in the neonatal unit?

7 A. I had a lot of contact, I made sure I was
8 quite visible on all the units.

9 Q. What does that mean in practical terms, you
10 made sure you were visible?

11 A. So I would probably be there at least once
12 a day depending what meetings I had and the reason I had
13 for going on to the different units.

14 Q. So obviously we are focusing on the neonatal
15 unit. Would you go to the neonatal unit once a day?

16 A. Possibly. There might have been some days
17 when I didn't go but if I had gone through to delivery
18 suite or the ward for any reason or paediatrics
19 sometimes I would pop in and say: any concerns, anything
20 you want to discuss?

21 Q. So when you went there, what was your purpose
22 of going to the neonatal unit?

23 A. Quite often there had been an incident or we
24 were having one of our regular Neonatal Incident Review
25 Groups and sometimes it would just be in passing to see

11

1 obstetrics and gynaecology. What about other Risk and
2 Patient Safety Leads?

3 A. So there was a Risk and Patient Safety Lead
4 for each division as well and I can't remember how, what
5 specialties fell into which division, I am sorry.

6 Q. So can you just give an indication
7 approximately of how many Risk and Patient Safety Leads
8 there were other than you?

9 A. I think there were probably four of five
10 others.

11 Q. Can you give an indication of how many people
12 worked within the Risk and Patient Safety Team, so
13 obviously yourself the other Risk and Patient Leads,
14 Ruth Millward, supervising. Were there other
15 individuals that worked within the Risk and Patient
16 Safety?

17 A. We had somebody who was part of clinical
18 audit, we had somebody who managed the Datix system for
19 us and there was a PA, a personal assistant, secretary,
20 that worked for Ruth Millward and Sian Williams.

21 Q. So we are looking at a team of about 12,
22 something like that?

23 A. Probably, yes.

24 Q. Physically in the hospital, did you work as
25 one unit together or were you embedded, so to speak, in

10

1 if everything is okay.

2 Q. When you say "everything okay", who would you
3 be asking that of who would you be speaking to when you
4 got there?

5 A. Usually it was either Dr Steve Brearey or
6 Eirian or Yvonne Griffiths or Yvonne Farmer.

7 Q. Would you talk to the doctors working there or
8 the nurses working or would you just speak to the
9 Consultants and the managers?

10 A. It would usually be just the Consultants and
11 the managers.

12 Q. Did you think it was important to, in terms of
13 patient safety, also speak to the doctors and nurses or
14 was that not something that would have been a useful
15 conversation?

16 A. I certainly passed the time of day with them.
17 But generally speaking they were busy doing their work
18 and from an infection control point of view, I wouldn't
19 go into rooms unnecessarily with the babies in there.

20 Q. At paragraph 7 of your statement, you say in
21 terms of your role that it was to ensure that identified
22 risk was managed via appropriate investigation reporting
23 and action planning.

24 Can you just break that down and explain in very
25 practical terms what your role as Risk and Patient

12

1 Safety Lead involved?

2 **A.** So I would manage the Datix incidents in
3 real-time when they came through. I would --

4 **Q.** Just stopping with Datix there for a moment.
5 Were you looking at seeing if those reports were
6 consistent, properly filled out, was that part of your
7 role?

8 **A.** We weren't particularly worried about the
9 content at that stage because that was something that we
10 would go and pick up on, we would review. So that would
11 be the start of preliminary enquiries really to see
12 whether there was anything that needed to be reported,
13 escalated up for investigation.

14 **Q.** So the first thing would be to if there was
15 anything urgent and then at a later stage you would look
16 at those Datixes to see if they had been properly filled
17 in, for example?

18 **A.** Yes. Yes.

19 **Q.** Yes, sorry, I have interrupted you, that was
20 Datix, you were carrying on with your role?

21 **A.** So the majority of the Datixes were things
22 that people had reported as a general concern and they
23 hadn't actually caused harm so they would be managed at
24 local level.

25 I took an overarching view of that and did do some
13

1 for Situation Background Assessment and Recommendation.

2 So we would -- say a Datix has come in, that would
3 be the situation, the background would be for instance
4 28 week gestation baby had been born in poor condition.
5 The assessment would be the clinician's view of it and
6 the recommendation would be to send it through to the
7 Serious Incident Review Panel.

8 **MS BROWN:** And that recommendation aspect, that
9 would be where your expertise would come in, would it,
10 as to whether --

11 **A.** No, the SBARS were always escalated to the SI
12 Panel. That was just -- they all said that.

13 **Q.** Yes, carry on. So was there also a recording
14 function and collating of incidents?

15 **A.** Yes. So I would pull reports for the
16 individual areas and also an overarching report.

17 So that the report -- I think I pulled the report
18 quarterly that went to the Women's & Children's
19 Governance Board. But I also pulled reports to -- on
20 a monthly basis to discuss with the ward managers in the
21 different areas to look at their trends.

22 **Q.** In terms of following up incidents, what was
23 your role in relation to that?

24 **A.** So it depended on what the incident was and
25 what the next steps were. So if they were at local
15

1 trending analysis with the individual managers and
2 Consultants if there was anything of concern that seemed
3 to be recurring.

4 **Q.** So just on that trending analysis. So you
5 would be -- what does that mean, if you got a similar
6 incident, so if you had, for example, a series of
7 neonatal deaths, what would you do in terms of trending
8 analysis then?

9 **A.** So the trending analysis, obviously when they
10 were reported initially they would be classed as
11 moderate or severe harm, so they were always picked up
12 as soon as.

13 I would go along just to find out the facts,
14 I would rely on Steve Brearey's clinical assessment to
15 tell me whether there were any concerns. From his
16 response I would copy and paste his assessment and put
17 that on to an SBAR.

18 The SBAR would be then escalated to the Serious
19 Incident, the SI Panel.

20 **Q.** Just stopping you there, just explain what an
21 SBAR is, please?

22 **A.** So the SBAR is basically a communication tool
23 to put as much information --

24 **LADY JUSTICE THIRLWALL:** What does it stand for?

25 **A.** Sorry it is an information tool that stands
14

1 level then it was usually the ward manager or the lead
2 Consultant that dealt with them. If it was escalated
3 further, it would depend on what the recommendations of
4 the Serious Incident Review Panel were. So if it was
5 recommended that there was a Level 2 investigation, then
6 the panel would appoint a chair to investigate and
7 I would support the chair with that investigation.

8 **Q.** So drawing that all together, the purpose of
9 your role was to improve patient safety?

10 **A.** Basically, yes.

11 **Q.** Part of the reason for having a dedicated role
12 for risk and patient was, as you explained, to spot
13 trends and ensure problems were carried out -- actions
14 carried out?

15 **A.** Yes.

16 **Q.** That would be fair, would it, as a summary?

17 **A.** Yes.

18 **Q.** Just looking at the Women's & Children's Care
19 Governance Board. If we could call up INQ0015325, which
20 I hope is the Terms of Reference. This is tab 27,
21 my Lady, of your bundle. We see there the Terms of
22 Reference, this is a document we have looked at before
23 in the Inquiry and we see there the membership and the
24 membership here consists of people from Planned Care, so
25 we have got the Consultant obstetrician gynaecologist
16

1 Mr McCormack, who is the chair, the Head of Midwifery
2 Ms Fogarty then under Urgent Care we have got Dr Brearey
3 and Dr Jayaram and we see there at the bottom that you
4 were there as part of the membership as the Risk and
5 Patient Safety Lead?

6 **A.** Yes.

7 **Q.** If we just could turn over to page 2. In
8 addition to the membership, there were a few individuals
9 who we can see there who would attend when requested,
10 the people with asterisks?

11 **A.** Yes.

12 **Q.** Just looking down in terms of the duties and
13 responsibilities, just picking out two of those, the
14 second bullet point down, one of the Terms of Reference
15 was to provide assurance to the board lead Executive of
16 effective risk management?

17 **A.** Yes.

18 **Q.** So the minutes from this I think you
19 understood certainly went to Alison Kelly, so what was
20 reported here went up to the Executive?

21 **A.** Yes.

22 **Q.** The third bullet point from the bottom:
23 "Ensuring that clinical performance quality
24 monitoring reporting mechanisms are working
25 effectively"?

17

1 But that would have been picked up at the end of year
2 report that I would have pulled together for the -- the
3 meeting, yes.

4 **Q.** But an unexpected or an unexplained death or
5 concerns about a trend in that respect this would have
6 been the forum to raise that?

7 **A.** This one and the perinatal mortality meetings,
8 the M&M meetings that the paediatricians held. So
9 I would expect them to be discussed there and then
10 escalated to this meeting.

11 **Q.** You in your role, any death would have been
12 reported to you as the Risk and Patient Safety Lead, any
13 neonatal death?

14 **A.** Yes.

15 **Q.** You say in your statement that you worked
16 closely with Mr McCormack who was the Consultant
17 obstetrician and gynaecologist and the chair of the
18 Women's & Children's Care Governance Board to produce
19 the agenda. Did you have a good working relationship
20 with Mr McCormack?

21 **A.** Yes.

22 **Q.** So if you suggested an item for the agenda, he
23 would be amenable to that?

24 **A.** That never actually occurred but yes, I am
25 sure he would. Yes.

19

1 **A.** Yes.

2 **Q.** So whilst you as Risk and Patient Safety Lead
3 yourself brought together, gave that overview, looked at
4 trends, this was the committee where you would bring
5 concerns to and then they in turn would take concerns up
6 to the Executive?

7 **A.** Yes. I think given that we were only allowed
8 an hour and a half for this meeting, and it covers
9 a large breadth -- obviously it covered all the
10 departments, I think a lot of the documents would be
11 sent out prior to the meeting for people to read and
12 comment on and they would bring any queries to this
13 meeting.

14 But generally, I think things were just noted at
15 this meeting and then escalated from that point of view.

16 **Q.** So it was a meeting where you would focus on
17 the most important matters?

18 **A.** Yes.

19 **Q.** Baby deaths amongst those would be one of the
20 most important matters, if that was a trend that would
21 be something that you would see as important for this
22 meeting in principle?

23 **A.** Yes. On the face of it.

24 If the baby deaths had been due to natural causes
25 then that wouldn't cause any concern enough to escalate.

18

1 **Q.** That clearly was one way of raising concerns
2 through the medium of governance boards. If you had
3 a concern that you felt needed more senior consideration
4 another route would have been referring matters to
5 Ruth Millward?

6 **A.** Yes.

7 **Q.** How would you describe your relationship with
8 her?

9 **A.** Excellent, I had no problem at all.

10 **Q.** I think you say in your statement she had an
11 open-door policy, so I take that to mean that you felt
12 very able to walk in and raise any concerns you had with
13 her?

14 **A.** Yes.

15 **Q.** You say in your statement this is
16 paragraph 18, that you worked with senior nurses and
17 midwives. You of course were yourself a qualified nurse
18 and a midwife and you have told us that you made
19 frequent daily or thereabouts visits to the neonatal
20 ward. Would you also be visiting the obstetric -- the
21 delivery ward as well?

22 **A.** Yes.

23 **Q.** So were you able to or did you observe
24 relationships between nurses and midwives?

25 **A.** Not particularly because the midwives would

20

1 have been in the delivery rooms. So I didn't see any
2 interaction between the neonatal staff when they were
3 coming to the delivery suite for babies that were
4 problematic.

5 **Q.** Because the Inquiry has heard some accounts of
6 there being tensions between midwives and nurses, was
7 that something that you observed of or were aware of?

8 **A.** I was aware of some comments here and there,
9 nothing specific and I think it boiled down to
10 personalities rather than anything else.

11 **Q.** Would that tension be something that would be
12 of some concern to you in your Patient and Safety Risk,
13 because lack of communication can lead to concerns?

14 **A.** If there was a lack of communication, then
15 yes. But if there were problems with a baby not being
16 transferred appropriately, then, yes, I would pick up on
17 that.

18 But generally speaking, they were professionals and
19 whilst they might not like each other personally,
20 I think they dealt with each other professionally very
21 well.

22 **Q.** Did you -- you said what you would have done.
23 Did you in fact ever get involved in speaking about
24 difficulties between nurses and midwives in your Risk
25 and Patient Safety role, was that something you were

21

1 relationships between Consultants and nurses. Was that
2 something that you observed?

3 **A.** Sometimes I picked up on a bit of tension
4 between Steve Brearey and Eirian Powell. But I didn't
5 delve into that, that was -- it didn't affect the
6 working relationship.

7 **Q.** You can't give any details?

8 **A.** No, it's just a -- sorry.

9 **Q.** Mrs Peacock, when you were working within Risk
10 and Patient Safety at the Countess of Chester Hospital,
11 were you aware of the case of Beverley Allitt?

12 **A.** I was, yes.

13 **Q.** And Recommendation 13 of the Clothier Inquiry
14 into Beverley Allitt was that Beverley Allitt's actions
15 should serve to heighten awareness in all those caring
16 for children of the possibility of malevolent
17 intervention as a cause of unexplained clinical events.

18 Now, you may not have been aware of the exact
19 wording or indeed the number of the Recommendation, but
20 were you aware of the principle that as Risk and Patient
21 Safety Lead you should be aware of the possibility of
22 deliberate harm as a cause of unexplained clinical
23 events?

24 **A.** I was and it was something that we considered
25 with every review that we did, whether there was a harm

23

1 ever involved in discussing or?

2 **A.** No, it would usually be the result of an
3 incident if there had been a delay in a baby being
4 reviewed for whatever reason.

5 **Q.** You worked, you explain in your statement,
6 across obstetrics, gynaecology, paediatrics, neonates,
7 so you had interactions with quite a number of
8 Consultants?

9 **A.** Yes.

10 **Q.** How were those interactions with Consultants?

11 **A.** Again, as with everyday life, you don't make
12 friends with everybody but everybody worked very well
13 together as far as I could see at the time I was there.

14 **Q.** Specifically, did you feel your views were
15 listened to, that you were treated appropriately with
16 appropriate respect for your role?

17 **A.** I think so. I can't think of any particular
18 time when I had a problem.

19 **Q.** In particular, we are focusing on the neonatal
20 ward, the neonatal unit, so in particular Dr Brearey,
21 how would you describe your relationship with him?

22 **A.** Professionally we got on fine.

23 **Q.** Again because you are in a position of giving
24 an overview visiting these wards, on a regular basis, we
25 have heard some references to difficulties in

22

1 event, whether there was an action or omission during
2 the care that would have caused or contributed to harm.

3 So that was at the back of our -- our mind
4 whichever review we did.

5 **Q.** So you were -- I think you are saying very
6 explicitly that you were open to deliberate harm as
7 a possible cause?

8 **A.** Yes, and we also -- as a tool in risk and
9 governance we had something called the Decision Incident
10 Tree. So if a member of staff was thought to have
11 caused harm we would use the Incident Decision Tree
12 which was an algorithm for us to follow to determine
13 what the best course of action was.

14 **Q.** I don't think we have heard about that at all
15 before. Was that something that was ever used in the
16 period that you worked at the Countess of Chester?

17 **A.** So it was something that I don't think I ever
18 took along to any of the review meetings but it was
19 certainly at the back of my mind and I had a copy in my
20 desk to refer back to if ever I needed it.

21 **Q.** You never considered using it once you became
22 aware -- we will move to that, but you never considered
23 using that once you became aware of the correlation
24 between Letby's presence and the deaths of babies?

25 **A.** So when we looked at the specific case reviews

24

1 that we did, there was no suspicion there, there was no
2 thought there that there was an act or omission from the
3 evidence that we had that had caused harm.

4 So no, it wouldn't have been used then.

5 **Q.** But presumably the tool you had was there not
6 when there was certainty that someone had been harming,
7 but the very purpose of the tool was to assist in
8 identifying if that might be the case?

9 **A.** You needed probably something to prompt that
10 thought. So the -- there would have been whether it
11 was, you know, not following procedure, whether there
12 was an action that had caused harm. But as far as I can
13 remember, there was nothing that actually along those
14 lines was picked up from the reviews.

15 **Q.** And this, you say you had it on your desk.
16 Can you just explain a bit more what it was you had on
17 your desk, was it a flowchart?

18 **A.** Yes, it is an algorithm flowchart, yes.

19 **Q.** Would that have been on the desk of everybody
20 working within Risk and Patient Safety?

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

22 **Q.** Would this be something that Ruth Millward
23 would be aware of?

24 **A.** I would have thought so, if she -- the
25 National Patient Safety Agency training on root cause

25

1 **A.** It would come to me and other relevant people.
2 But they -- the neonatal unit and delivery suite were
3 very good at picking the phone up as soon as something
4 like that happened.

5 **Q.** Yes, you refer to this in your statement and
6 I was going to ask who was it who would actually pick up
7 the phone to you, who would you speak to?

8 **A.** I think generally speaking it would have been
9 Eirian Powell, the unit manager but it could have been
10 anyone. I don't know whether other people did, my
11 recollection isn't that good I'm afraid, sorry.

12 **Q.** What information would be given to you over
13 the phone?

14 **A.** That there had been a baby death. So
15 obviously then I would usually go over to the unit, we
16 would have a look through the medical records and sit
17 down with Steve Brearey, who was obviously the
18 clinician, to review the notes and see whether there
19 was -- we thought there was any concern. Even if it was
20 a natural death, natural cause of death, we would still
21 go through the notes anyway just to make sure that all
22 policies and procedures had been followed correctly.

23 **Q.** So just breaking that down. You would get
24 a call and if the death had occurred during the night
25 that call would be first thing in the morning?

27

1 analysis introduced the decision tree. So anybody that
2 had done that training would know about it.

3 **Q.** How did you come to have that on your desk,
4 why did you have that on your desk?

5 **A.** Because I had done the three-day NPSA
6 training.

7 **Q.** So, Mrs Peacock, we have heard clinicians
8 saying that to them, from a clinician's point of view,
9 someone harming -- a healthcare professional harming
10 a child was unthinkable that wasn't your perspective
11 from your risk and patient -- that was something that
12 very much you did think and was a possibility that you
13 were open to?

14 **A.** Given my clinical negligence background, yes,
15 very open to it.

16 **Q.** In relation to Datix you say at paragraph 27
17 that baby deaths were reported on Datix and that would
18 have been the case for all baby deaths on the maternity
19 ward or the neonatal ward?

20 **A.** Yes.

21 **Q.** When a Datix form was completed as
22 I understand it that would trigger an automatic email
23 notification to you so it wasn't reliant on someone
24 remembering to forward it to you, you would be through
25 the system notified?

26

1 **A.** Usually yes.

2 **Q.** Then your procedure would be to visit the unit
3 to look at the clinical -- look at the notes, speak to
4 Dr Brearey if he was there and speak to Eirian Powell,
5 is that a fair summary of what you would do?

6 **A.** Yes. Yes.

7 **Q.** What was your understanding of the Datix
8 reporting position where a baby collapsed unexpectedly
9 requiring resuscitation, but survived. Would you have
10 expected that to have been reported on Datix?

11 **A.** They generally weren't unless there was
12 an actual issue with a piece of equipment or somebody
13 had competency issues. So something -- it's dreadful to
14 term a collapse as normal but something out of the
15 ordinary had happened, then they would Datix it but
16 generally speaking collapses weren't Datixed.

17 **Q.** So obviously an unexpected -- particularly if
18 it was an unexpected collapse requiring resuscitation
19 would be a concerning clinical event. From what
20 I understand it, there would be no way under the Datix
21 system that that would be brought to your attention in
22 Risk and Patient Safety, so whereas if the baby died you
23 would be aware, you would go through these processes you
24 have explained. If the baby survived you wouldn't even
25 be aware of that; is that correct?

28

1 A. That's correct. But I think small babies do
2 collapse, it's not unusual.

3 Q. Well, just leaving aside that for a moment.
4 Was that not a flaw in the system, that it was only
5 those babies that died that were reported and therefore
6 you didn't have a complete picture because babies who
7 collapsed but survived, that was never raised as
8 an issue?

9 A. I think it was certainly a flaw in the system.
10 However, if they reported every collapse on Datix, it
11 would be its own industry, I think. However, in this
12 situation, I would have thought it was relevant for us
13 to be notified of the collapses, which we weren't.

14 Q. So taking that answer that in this situation,
15 once you became aware and we are going to go through
16 that, once you became aware that there were a number,
17 a trend, a cluster of neonatal deaths, it would at that
18 point have been relevant to know whether there were
19 collapses where the baby survived?

20 A. It certainly would have been relevant to know,
21 yes, at that time. I think the difficulty was from my
22 perspective that they were seen as natural causes, the
23 deaths. Obviously we had the postmortems that gave
24 natural causes. So at that stage we weren't thinking
25 that they were particularly -- there was a cluster, an

29

1 Q. Can we just go through some of the Datixes
2 now. If I could have INQ000016 and this is tab 2,
3 my Lady, in the bundle. This I hope will be a Datix
4 relating to Child A.

5 You will see there, Mrs Peacock if we just work
6 through it we see that it relates to Child A and then we
7 have got "reported date" and "opened date". Can you
8 just explain why we have got a difference of date,
9 what's the difference between reported and open and why
10 do we have two different dates?

11 A. So the reported date is as it suggests, it is
12 the date that the incident was reported. And the opened
13 day was when the Datix was actually accessed by somebody
14 either in the risk -- risk department or on the wards.

15 Q. So that would be opened by you, would it, if
16 it came straight to you as this was a neonatal?

17 A. I would have thought so but I was actually on
18 annual leave when Child A died.

19 Q. Yes, so it would be the person, if not you,
20 when you were there or the person covering for you when
21 you were away?

22 A. Yes.

23 Q. We see "handler", a Ms Kenny, what was the
24 handler?

25 A. I don't know, I don't know who Ms Kenny is.

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1 unexplained cluster, which we needed to review but we
2 hadn't thought anything further than that at the time.

3 Q. Well, we will come back in a moment to the
4 individual deaths. But in terms of you say that, with
5 your legal career, analysis was one of the things that
6 brought to your role, you had identified that it would
7 have been helpful to know if there were collapses where
8 the babies survived, what action did you take in
9 response to that? Did you raise that with Mrs Millward
10 and say: this is something we need to be following, this
11 is a trend we need to look at?

12 A. No, I didn't at the time.

13 Q. Why do you think that was?

14 A. Because I thought if there were any collapses
15 that I needed to know about that they would have been
16 escalated.

17 Q. Well, you have explained they wouldn't have
18 been on Datix, how would they have been escalated to
19 you?

20 A. So we had numerous meetings about the
21 unexpected rise in mortality, so I would have expected
22 either Steve Brearey or Eirian to let me know about
23 those collapses.

24 Q. Did you ever ask the question?

25 A. I didn't, no.

30

1 Q. And did you not ask that when you looked at
2 these when you came to review these Datix, who is the
3 handler?

4 A. I don't know whether that was on there, it
5 must have been on there at the time, I wasn't aware of
6 it, to be honest.

7 **LADY JUSTICE THIRLWALL:** I am sorry, Ms Brown.
8 I appreciate you don't know who Ms Kenny is but do you
9 not know what the handler was meant to be?

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

11 **LADY JUSTICE THIRLWALL:** I see, thank you.

12 **MS BROWN:** You are then listed as the manager.
13 What does that mean "manager"? I think you said in your
14 statement you certainly weren't a manager of anyone.
15 But what does "manager" mean in that context?

16 A. I managed the actual Datix from opening it and
17 then following up on any information that we needed to
18 gather for the SBAR if that was necessary, obviously in
19 this case it was.

20 Q. Then if we come down, we see subcategory and
21 "Expected and Unexpected Death". Now, we know that
22 Child A was an unexpected death. Why does it say
23 "Expected and Unexpected Death"?

24 A. We didn't have anything to do with the -- the
25 titles. I don't know why, whether they were titles that

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1 came with the Datix, I don't understand the
 2 technological side of it, but to me it didn't matter
 3 whether it was expected or unexpected at this stage
 4 because we would be looking into it anyway. We just
 5 needed to be notified that there had been a death.

6 **Q.** Because was that a drop down list?
 7 **A.** It was as far as I am aware, yes.

8 **Q.** You say you didn't understand the technology
 9 of it, but if it was your role to review the Datix,
 10 wasn't it quite important to understand how these forms
 11 were filled in and what the items on the forms meant?
 12 **A.** As I say, it was reporting a death and that
 13 was what was important to me. At that stage, I wouldn't
 14 expect anybody to be commenting on whether it was
 15 expected or unexpected depending who was reporting the
 16 Datix.

17 **Q.** In relation then, well, picking up on that.
 18 Surely in terms of a patient and risk safety whether it
 19 was either expected or unexpected was something that was
 20 of great significance in terms of what alarm bells it
 21 would ring to you?
 22 **A.** It was greatly significant once we undertook
 23 the assessment of the medical records and any subsequent
 24 investigation.
 25 The Datix forms were quite subjective depending who

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1 our own assessment with the clinician to determine
 2 whether that was indeed correct or not.

3 **Q.** But did you review and see whether that had
 4 been correctly filled out, whether high potential harm
 5 was the correct -- or did you take -- did you take no
 6 view on what had been filled out in terms of potential
 7 for harm?
 8 **A.** So we would obviously look at what the
 9 reporter had put on there. But as I say, we didn't take
 10 that as gospel. We would then follow up and look into
 11 it further.

12 **Q.** If we could just go over the page to page 2.
 13 We have got then -- we can see at the bottom the
 14 incident reporter here is Miss Lappalainen, who was one
 15 of the neonatal nurses.
 16 Would it have been -- would your understanding have
 17 been it was her that would have filled in who the
 18 employees involved were?
 19 **A.** No, I think that probably would have been done
 20 at a later date but I am really not sure about that.

21 **Q.** What should have been filled in under
 22 "employees involved", who should have featured in
 23 employees involved in a neonatal death?
 24 **A.** So any of the team that were around at the
 25 time.

35

1 completed them and really the -- the information that
 2 was on there was only guidance for us to look further
 3 into it or -- or not depending on the incident that had
 4 been reported.

5 **Q.** If we can just look down we have then got
 6 under the risk grading potential for harm and what's
 7 filled in there is high potential harm.
 8 Why high? What was the -- who made that risk
 9 grading and why was it high potential harm chosen?
 10 **A.** So the risk grading would have been entered by
 11 the person reporting the Datix.
 12 **Q.** That would be something that you would review,
 13 would it?
 14 **A.** We would review that, yes, with the clinicians
 15 and as I say they were quite subjective so people
 16 could -- obviously this is a child death, it wouldn't be
 17 the case. But some Datix forms --

18 **Q.** Just let's focus on child deaths because that
 19 is what we are interested in. So would high potential
 20 harm be what you would be expecting to see for what we
 21 can see further down was a sudden and unexpected
 22 deterioration, would you expect high to be what should
 23 have been filled in there?
 24 **A.** As I say, that was the person submitting the
 25 form and regardless of what they put there we would do

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1 **Q.** So the team that were involved in the
 2 resuscitation, in this case sadly the failed
 3 resuscitation?
 4 **A.** Usually, yes.

5 **Q.** Because we see there indeed doctors and the
 6 names of nurses that were working on the neonatal unit.
 7 We don't see the name of Dr Jayaram who was the doctor
 8 that was called in in this case.
 9 Was there any reason why the Consultant wouldn't be
 10 included?
 11 **A.** I really can't comment on that, sorry, I don't
 12 know.

13 **Q.** What was the purpose on a Datix of having
 14 a list of the employees involved?
 15 **A.** So you would look at people who were cropping
 16 up regularly that they may have competency issues that
 17 needed to be addressed. Any other concerns, there could
 18 be somebody if there had been medication errors, they
 19 had had several medication errors that -- so we needed
 20 to look into supporting that person.

21 **Q.** So just looking at where you said you would
 22 see if someone whose name was coming up and competency
 23 issues.
 24 So given that you were looking at trends it was
 25 quite important, was it, that the employees involved

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1 listed were that that was completed properly?

2 **A.** Yes.

3 **Q.** If we could just go to 0000111 and this is
4 tab 4, my Lady, in your bundle and I hope we will come
5 up there with the Datix for Child C. We see very
6 similar, we have got the name of the child, you as
7 the -- Ms Kenny's name appears. Your name as the
8 manager, the specialty we have got "Neonatology", again
9 we have got "Expected and unexpected death".

10 This time under "risk grading" we have got low
11 potential harm. Do you have any explanation as to why
12 this would be low whereas Child A was high? We see
13 under the description that we have got sudden
14 deterioration of an infant following full resuscitation.

15 So a sudden death again. Why would this have been
16 low whereas the other one was high?

17 **A.** Again, subjective opinion of the reporter at
18 the time. So maybe they thought that well, I am
19 presuming that they thought no harm had been caused.

20 **Q.** If we could go over to page 2, please. We
21 have got there we have got the incident reporter we can
22 see that was Yvonne Griffiths who we are aware worked on
23 the neonatal ward. But the employees involved here
24 named, we are not familiar with, because they are not
25 people who worked on the neonatal ward.

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1 **Q.** Because that would be quite concerning,
2 wouldn't it, because if part of your answer before was
3 that part of the reason for listing the employees was to
4 see if there was any commonality, any competencies that
5 might be raised, well, that's not going to be followed
6 through if the employees involved there are not the
7 employees who were involved in the resuscitation and
8 involved in the care just prior to the baby's death?

9 **A.** As far as I am -- my opinion is that when
10 I did any of the updating on these, well certainly when
11 we investigated, well, when we reviewed the notes, that
12 wasn't the investigation, but we would certainly take
13 note of the people who had been involved in the actual
14 incident itself. So I can't explain why the obstetric
15 team is there instead of the neonatal team.

16 **Q.** Can we now go to 0000766 and this is tab 6,
17 my Lady. This I hope should be the Datix of Child D.
18 We see there again Child D, your name as manager. Again
19 the subcategory expected and unexpected death. Again we
20 have got low potential harm, this time. I think your
21 evidence is you can't -- you don't know why that was
22 filled in?

23 **A.** As I say, it would have been the reporter of
24 the Datix.

25 **Q.** And we see there under "Action Taken", at the

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1 We have got we can see Mr McCormack, David Semple.

2 So we have got Consultant obstetricians there. So we
3 have got the Consultants featuring but we have got the
4 midwifery and the Consultants.

5 So we have got the -- although this is
6 a neonatology Datix, looking at a death that happened on
7 the neonatal ward, the employees involved, here we have
8 got a list of people who were involved in the obstetric
9 care. So why would that have been?

10 **A.** I really can't comment. I don't know. This
11 again was -- I was on annual leave for this death.

12 **Q.** Well, we will look in a moment but we know you
13 came to look at these three deaths at a meeting
14 together. But that would be concerning wouldn't it,
15 Mrs Peacock?

16 **A.** Sorry, what was the actual incident again?

17 **Q.** This is the -- this is the death of Child C?

18 **A.** What was the actual incident that was
19 reported, is it the death that was reported? Sorry, can
20 I see the first page of the Datix?

21 **Q.** Sorry. Yes, go back to the first page. So
22 the category we have been given is "Expected and
23 unexpected death"?

24 **A.** Mm-hm. Yes, I can't explain that at all,
25 sorry.

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1 bottom, the second -- the last two sentences there,
2 a review was completed by the neonatal lead Consultant
3 and they managed to ascertain if there are any
4 commonalities or poor standards of care, there were none
5 found.

6 That I think is a reference to the fact that
7 Child D's case was considered alongside Child A and
8 Child C?

9 **A.** Yes.

10 **Q.** We don't have any details but there is just
11 a highlighter that that was done?

12 **A.** Yes.

13 **Q.** If we turn over to page 2, we have got another
14 variant here in terms of employees involved. So we have
15 got the incident reporter of Caroline Oakley, who we
16 know was a neonatal nurse, senior neonatal nurse.

17 But the employees involved here, whereas A, we
18 didn't have the Consultant, here we have got
19 a paediatric Consultant but we only have the name of the
20 Consultant, not of the names of anybody else who was
21 involved in the resuscitation and we know that there
22 clearly were nurses and others involved in that
23 resuscitation.

24 Again, can you explain that?

25 **A.** I can't, sorry. No.

40

1 Q. Then if we can go to 0002658, and this is
2 tab 5, going back one tab. Now, this is a slightly
3 different Datix because this is the Datix for Mother D
4 so the mother of Child D who died, and we can see there
5 as you would expect the specialty is obstetrics because
6 this is looking at her care.

7 But if we could go over to page 2 in this Datix, we
8 have got a long entry and I think this is -- we will see
9 this later, but this is in fact copy pasted from
10 an email from Dr Brearey and that's setting out if you
11 look at the beginning, just confirm that I have met and
12 that is referring to Dr Brearey has met with Eirian
13 reviewed the case notes of Child D and then if you scan
14 down, you can see it's referring to Child A and Child C.

15 So that's a discussion about the care or discussion
16 of the consideration of the cases of Child A, Child C
17 and Child D and yet that's appearing in the Datix for
18 the mother of Child D. It wasn't -- I am not going to
19 go back to it but it wasn't in the Datix of Child D and
20 it's not in the Datixes of Child A or Child C.

21 So someone coming to that Datix wouldn't have the
22 advantage of seeing that, they would find it only after
23 the mother's Datix, doesn't that suggest that this is
24 a system that wasn't working, that wasn't creating an
25 accurate record?

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1 reporter was Letby and under the employees involved it
2 simply hasn't been filled in. There are no employees
3 involved. Would that -- ought that to have been
4 a highlighter? I think we are going to look at your
5 holiday period but E was a period where you were
6 working?

7 A. Yes.

8 Q. When you received a Datix where it said "no
9 employees" under employees involved, would that not have
10 been something that you would have wanted to
11 investigate?

12 A. Sorry, can you just go to the first page
13 again?

14 Q. Yes, go back to page 1.

15 A. So the risk grading here, the result the
16 actual harm was no harm caused.

17 Q. Understood?

18 A. The actual harm, which is what we looked at,
19 so obviously we considered the potential for harm as
20 well for if we needed to put processes in place to stop
21 it reoccurring, whatever had happened.

22 But the -- it was the actual harm that we looked at
23 and staff were generally not very good at determining
24 actual harm when they completed the Datix. So as
25 I started saying earlier, they could be used as if

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1 A. No. We actually merged -- if there were
2 several incidents about one particular patient, or that
3 they were connected, we would merge the incidents so
4 that could see it on all the incident forms. It
5 wouldn't have been on A and C Datixes at this stage
6 until we decided what we were doing, investigation-wise,
7 and I think Steve Brearey had said that he didn't think
8 there was a connection between Baby D and the other two.

9 Q. Yes, I think the point, Mrs Peacock, is that
10 that information about the review of Child A, Child C
11 and Child D is not appearing on the Datixes of Child C
12 or Child D or indeed Child A?

13 A. Yes. That's correct.

14 Q. You can't explain that?

15 A. No, no.

16 Q. Just finally, if we could look at 000194,
17 I might have said one two few zeros there, 0000194 and
18 this is the Datix concerning the death of Child E. And
19 it's tab 7 for my Lady.

20 Again, we can go very briefly. It is Child E again
21 you are the manager, "Expected and unexpected death".
22 Here we have gone back to high potential harm and we see
23 under the details "Unexpected death, full resuscitation
24 unsuccessful".

25 If we could go over to page 2, here the incident
42

1 somebody had their own agenda, if they wanted -- for
2 instance, if there was poor staffing on one shift the
3 person reporting the poor staffing could put that there
4 was high actual harm but when we looked into it there
5 was no incident had been caused as a result of that
6 staffing.

7 So, as I say, it could be very subjective, that
8 grading. So if this was taken as a no harm when we
9 assessed with Steve Brearey, then we probably wouldn't
10 have looked at the staff at that stage that were
11 involved in the incident.

12 Q. But Mrs Peacock, surely where a baby has died,
13 and you have got what's described as an unexpected
14 death, and you have got a form that allows for the
15 employees involved as you have said that would be
16 important to see if there were any issues of
17 competencies, was it not a concern that this report
18 filled in by Letby where it says "employees involved"
19 there are none, was that not something that as a matter
20 of course, as a matter of your overarching role as Risk
21 and Patient Lead, you should have picked up on, asked
22 the questions, there must have been employees involved,
23 who were they?

24 A. I think if we had reviewed the case and
25 Steve Brearey said there were no concerns then possibly

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1 that wouldn't have been our priority.

2 **Q.** What did you, what was your view at the time
3 of the Datix system of reporting of incidents and how
4 effective it was as a means of identifying trends?

5 **A.** As a means for flagging up incidents it was
6 obviously dependent on having a good reporting culture.
7 So if it was used effectively, as it's meant to be, then
8 it was -- I thought it was a good tool to use.

9 Obviously it wasn't perfect, there were things that
10 could have been improved, but basically it did the job
11 it was meant to do, just alerted us to incidents to dive
12 a bit deeper, really.

13 **Q.** If we can turn now to when you returned from
14 holiday. You say in your statement that you were away
15 for the first three weeks of June 2015 and you returned
16 to work on Monday, June 22. That was the day that
17 Child D died. Child D had died in the early hours of
18 the morning of 22 June.

19 You have explained that where a death occurred out
20 of working hours normally you would be called first
21 thing in the morning. Do you recall receiving a call on
22 that first day back to work?

23 **A.** No. Sorry, no recollection at all.

24 **Q.** Over the three weeks that you had been away,
25 two other babies had died. We have looked at the

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1 **A.** Yes.

2 **Q.** What questions would you have asked then when
3 you went to the neonatal unit?

4 **A.** Well, first I would have wanted to know how it
5 had -- whether the SBAR had been completed and what was
6 the result of the SBAR going to the Serious Incident
7 Review Panel and what their determination was and what
8 should be done next.

9 I would have asked if there were any particular
10 concerns which, as far as I can recall, there were no --
11 obviously there were concerns that there was an increase
12 in mortality and that there was a cluster of deaths, but
13 there were no suspicions at that time.

14 **Q.** We have heard from Dr Lambie that at around
15 this time she recalls seeing nurses who were looking to
16 see whether anybody had been on duty for all of the
17 deaths. When you visited the neonatal ward were you
18 aware of any of that sort of discussion, who was on
19 duty?

20 **A.** Not at all, no.

21 **Q.** The Inquiry has also heard evidence that
22 junior doctors and Consultants were discussing these
23 deaths. One of the issues they were discussing was the
24 existence of a concerning rash.

25 Did you pick up on any of those discussions?

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1 Datixes of those already, Child A and Child C.

2 How would you have been informed of those deaths?

3 **A.** I am not really sure, I can't remember, to be
4 honest, how I would have been informed. I would expect
5 whoever had been covering for me would let me know.

6 I am sure when I came back to work that
7 Eirian Powell and Steve Brearey would have let me know.
8 But I can't remember how it actually happened.

9 **Q.** Because it would have been quite a shocking
10 return to work, wouldn't it, Mrs Peacock? You return to
11 work and you receive a call that a baby has died and you
12 find that two other babies had died in a two-week
13 period?

14 That would be the same total as the total number of
15 deaths in 2014. Is that not something that would have
16 stuck in your mind as particularly unusual, particularly
17 concerning in fact?

18 **A.** It was unusual and concerning but no, I don't
19 recall it, I am sorry.

20 **Q.** What -- you say you can't recall it, but what
21 would you have done in that, in that circumstance? You
22 say you would have gone to the -- your practice would
23 have been to are gone to the neonatal unit in the case
24 of a death. Can we take it that that is what it is
25 likely you did on the 22nd?

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1 **A.** I wasn't included in any of the email trail
2 that was going on at this time.

3 **Q.** I'm not asking about the email trail, I am
4 just asking about when you visited on this morning,
5 where we have got a third baby die in a very short
6 period, were you aware of those concerns doctors
7 speaking about those?

8 **A.** I don't recall -- I don't recall anybody
9 mentioning concerns no, as a rash.

10 **LADY JUSTICE THIRLWALL:** Do you remember them
11 mentioning the deaths at all?

12 **A.** Unfortunately nine years ago I really can't
13 remember that far back. There would have been general
14 discussions and obviously I would have spoken to Steve
15 but what the content of those discussions was, I really
16 don't recall.

17 **MS BROWN:** And you say that your general course
18 would have been to report matters to Ruth Millward.
19 Would you have reported not only the death of Child D
20 but would you have gone to Ruth Millward about the fact
21 that there had now been three deaths within a very short
22 period; is that something you would have taken to
23 Ruth Millward?

24 **A.** I would have thought so and I think Ruth
25 actually completed one the SBARs so she was certainly

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1 aware of at least one of the deaths. Whether she would
2 have been aware what the normal acceptable death rate
3 was for the unit, I don't know. But she -- yes,
4 I certainly would have escalated that there had been
5 a cluster.

6 **Q.** We are going to come on to a meeting in due
7 course but just on a few other matters. In relation to
8 Child Death Overview Panels and Sudden Death in Infancy
9 Panels you say in your statement that was not a matter
10 that you were involved in and not trained in.

11 Is that the case? Did the Risk and Safety
12 Department have any involvement in when deaths should be
13 reported to an external?

14 **A.** No.

15 **Q.** That was not -- neither you nor Ruth Millward,
16 that was something that the Risk and Safety Patient
17 Department didn't deal with?

18 **A.** No.

19 **Q.** In relation to Coroners, is that the same
20 situation?

21 **A.** Yes, it was the legal department and
22 bereavement that dealt with Coroner referrals.

23 **Q.** You say in terms of the management and your
24 unit that Ruth Millward introduced daily huddles within
25 the risk team.

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1 with you copied in. We can see your name on the copy
2 list there:

3 "Just to confirm that I have met with Eirian and
4 reviewed the case notes of Child D who died in the early
5 hours of this morning. We have discussed whether there
6 are any other issues in view of the two other recent
7 sudden deaths on the NNU."

8 So at that point, you were clearly being copied in
9 and made aware of the fact that there had been these
10 three deaths and then Dr Brearey says:

11 "All deaths occurred in Room 1 in different cot
12 spaces. All microbiology results have been negative.
13 The initial postmortem did not identify a definite cause
14 of death in relation to Child A. The other two
15 postmortems are in progress. Child D was not on TPN
16 [Total Parental Nutrition] ... died ..."

17 The number of days has been redacted.

18 Nosocomial infection, so no hospital acquired
19 infection, or that's unlikely. They say that is very
20 unlikely.

21 Then it goes on to say:

22 "There does not seem to be any staff, medical or
23 nursing members present at all three episodes other than
24 one nurse who was not the nurse responsible for Child D
25 on that shift".

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1 Do you think the fact of three deaths occurring in
2 such short succession would be something that you would
3 have raised at that huddle? You are the risk team as
4 I take it to be an informal meeting, is that the sort of
5 thing you would have shared then?

6 **A.** I am not really sure to be honest. I think
7 I would have shared that with Ruth outside of the
8 huddle. The huddle was mainly to catch up on what your
9 plans were for the day, who would be in the office,
10 cascading any information that we needed.

11 **MS BROWN:** My Lady, I don't know if that would be
12 a convenient moment. I am going to turn now to going
13 through some documents in quite some detail so that
14 might be an appropriate moment?

15 **LADY JUSTICE THIRLWALL:** Very well. So we will
16 take a break now and we will come back at 20 past 11.

17 (11.06 am)

(A short break)

18 (11.20 am)

19 **MS BROWN:** If we could go to INQ0003110, please, at
20 page 6. So, Mrs Peacock, this is the email that was
21 sent on the evening of 22 June so on the Monday evening
22 after you had returned to work so presumably you would
23 have received it on the Tuesday when you came into work.

24 It's from Dr Brearey and it's sent to Dr Jayaram

50

1 Then if we go on, if we could go to page 7, it says
2 there at the bottom of the paragraph just before the
3 numbers:

4 "I would be very surprised if Child D's death is
5 linked in any way to the previous recent deaths of
6 Child A and Child C. We have agreed an action plan
7 however ..."

8 And then the action plan is set out, to review
9 Child A and Child C in detail, review Child A's
10 postmortem, discuss microbiology. Eirian to check the
11 thermometers, the incubator the antibiotics prescribed
12 and Dr Brearey is going to speak to Jo Davies, so the
13 obstetrician involved, in relation to Child D.

14 So it seems there what Dr Brearey is saying is that
15 they are going to look at or he is initiating looking at
16 these deaths together and presumably that would have
17 been something that you would have wanted from a patient
18 risk and patient safety perspective too?

19 **A.** Yes.

20 **Q.** In terms of the action plan, considering
21 whether there are points in, you know, potential themes,
22 potential things that might link the deaths?

23 **A.** Yes.

24 **Q.** We see if we go then to page 4, that
25 Eirian Powell on the 25th responds at the top that all

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1 three babies were nursed in different incubators, the
2 thermometers have been checked, antibiotics prescribed
3 were given as prescribed.

4 So we are -- in terms of the common -- possible
5 common themes, they have been checked out and proved to
6 be negative?

7 **A.** Yes.

8 **Q.** If we just go to page 1 of that document, that
9 email trail, we see that you responded you had actually
10 responded prior to Eirian Powell, you had responded on
11 23 June:

12 "Hi Steve, who spoke with the Coroner regarding
13 recent deaths? Do you know if the Coroner has raised
14 any specific concerns".

15 You have said that you weren't involved in the
16 Coroner's proceedings, what was the reason for that
17 email?

18 **A.** Obviously I would have liked to have known in
19 response to the Coroner referrals whether the Coroner
20 had any confirmed --any concerns, if things had been
21 discussed with him, whether there were there was
22 anything suggested by the Coroner.

23 **Q.** One of the things of course that
24 Stephen Brearey -- Eirian Powell has checked on the
25 thermometers and the incubators. One of the other

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1 my general understanding.

2 **LADY JUSTICE THIRLWALL:** So you don't know whether
3 it was at this stage --

4 **A.** No, I don't.

5 **LADY JUSTICE THIRLWALL:** -- or not. Thank you.

6 **MS BROWN:** Can we just look briefly at what else
7 was going on at this point. If we could just go now to
8 INQ0025767 and this is tab 13.

9 So one of the other things that was going on is
10 that there were meetings -- sorry, meetings being held
11 of the Neonatal Incident Review Group and we see there
12 that is an email from you sent on the 24th to a number
13 of recipients attaching the incidents for review. We
14 don't need to go to that document now but the document
15 was a list of the various incidents and we see on that
16 that certainly Child A and Child D, it doesn't appear
17 that Child C, but certainly Child A and Child D's deaths
18 are referred to in that.

19 Do you recall that discussion that was held on
20 24 June?

21 **A.** So these were regular meetings that we held.
22 We tried to have them fortnightly depending on
23 availability of Eirian and Steve Brearey. So we pulled
24 up all the incidents to review them all and this is
25 where we were doing the trending.

55

1 things Stephen Brearey had raised was the commonality of
2 one nurse.

3 Was that something that you felt as Risk and
4 Patient Safety Lead you should look into at that point?

5 **A.** No. My understanding at that point was that
6 there were a couple of nurses and a couple of doctors
7 that were -- had a commonality with the babies.

8 **Q.** How did you find that out?

9 **A.** I really don't know. I think it was
10 discussions rather than something that was written down.

11 **Q.** Who would the discussions have been with?

12 **A.** It would have been with Stephen Brearey and
13 Eirian, I would presume, because they would have been
14 the only two people I was talking to in relation to
15 this.

16 **Q.** So what was the context, you were discussing
17 which nurses were in common, because it seems that
18 Stephen Brearey had already identified that, he had
19 identified that there was just one nurse in common?

20 **A.** As I say, I don't know where I got the
21 understanding from but I understood that there were two
22 nurses and two doctors, that there was a commonality.

23 **LADY JUSTICE THIRLWALL:** Are you sure that was at
24 this stage and not later?

25 **A.** I really don't know, I am sorry. It was just

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1 But certainly if the baby deaths had have come up
2 at these, I think they would have been reviewed and
3 discussed at a separate meeting.

4 **Q.** At that meeting, what would your role be, who
5 first of all would be have been at that meeting?

6 **A.** So there was -- you can see the recipients of
7 the email. So generally there was Stephen Brearey,
8 Eirian Powell, quite often Eirian's deputy, depending on
9 her workload, we had the pharmacist for the neonatal
10 unit and it was also used as a teaching experience as
11 well for members of staff could come in if they were
12 available just to see how the process worked.

13 We would sit down and have the notes for the
14 babies. I think Steve would get the prescription charts
15 and suchlike up on the computer and we would go through
16 them and it would be Steve that would determine the
17 level of harm, if any, was caused and what the follow-up
18 was from that.

19 **Q.** Would you in terms of Risk and Patient Safety
20 Lead and knowing at this point that there had been three
21 deaths in a short period, would you have raised this as
22 a concern at that meeting would that have been a topic
23 of discussion?

24 **A.** I really don't know, I am sorry, I can't
25 remember. I would have hoped that I would have done.

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1 I would have been surprised if I hadn't.

2 **Q.** If we can look then now at the meeting of
3 2 July. If we could go to tab INQ0008302. This is
4 tab 15, my Lady, in your bundle.

5 This is an email from Stephen Brearey:

6 "Hi Debbie, thanks for your help today. I have
7 attached my summary and data for tomorrow's meeting."

8 So this is the meeting on 2 July whereas prefaced
9 in the email we looked at before, there is going to be
10 consideration of Child A, Child C and Child D's death
11 together?

12 **A.** Yes.

13 **Q.** If we could go to 0003191, these are the notes
14 that Dr Brearey attached to that email and we see that
15 he produces a short summary, he refers to Child A who
16 died on 8 June and underneath Child A refers to Twin 1
17 and that's Child B who had a respiratory arrest 24 hours
18 later but responded to resuscitation.

19 So we have got a death and a near death,
20 a resuscitation incident.

21 Then we have got Child C six days later on 14 June,
22 bottom of the page Child D, and noting and in fact as is
23 the case for all of them "awaiting postmortem". Then
24 there is a heading "Learning from these cases".

25 If we could go on to the next page, page 3, we see
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1 was any commonality which linked the deaths.

2 Is that a meeting you recall, Mrs Peacock?

3 **A.** I don't, sorry, no.

4 **Q.** Given that it was such an unusual -- first of
5 all an unusual string of events to have three deaths in
6 such a short period and personally unusual for you to be
7 at a meeting with Mrs Kelly, so with the most senior
8 nurse in the organisation, the Director of Nursing, you
9 have no recollection of the meeting at all, is that your
10 evidence?

11 **A.** Sorry, no, until I saw the email sending the
12 summary around, I didn't think I had actually been
13 there.

14 **Q.** So in the absence of an actual recollection in
15 terms of best practice, bearing in mind this meeting was
16 looking at the potential commonality between three
17 deaths, would you have had an agenda, would you have
18 gone through the areas of commonality to see if there
19 was anything that linked the deaths together?

20 **A.** As I say, I really don't know what we
21 discussed at the meeting. I don't know the format of
22 the meeting. Sorry.

23 **Q.** Would you have been concerned that the same
24 nurse was identified as being present on those, you have
25 heard that you were one of the people who was alert to
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1 Dr Brearey has also set out the mortality data and we
2 see that in 2013 there were two neonatal deaths
3 according to this chart in 2014 -- according to this
4 chart, there were three.

5 So that rather highlights, Mrs Peacock, that this
6 was a very unusual string of events having three
7 deaths --

8 **A.** Yes.

9 **Q.** -- within a two-week period?

10 **A.** Mm-hm.

11 **Q.** At that meeting, we know at the meeting on
12 2 July, Alison Kelly, the Director of Nursing attended,
13 Eirian Powell, Ruth Millward, so your boss,
14 Stephen Brearey, you, and Sian Williams, how common
15 would it be for you to be at a meeting where
16 Alison Kelly was also present?

17 **A.** Not very common but I had been at meetings
18 when she was present.

19 **Q.** We see the meeting, in fact the meeting is --
20 we don't need to go to it, it is in paragraph 88 of your
21 statement. But the meeting is referred to in fact
22 within a review of Child D but it's described as an
23 Executive Serious Incident Panel on 2 July, there had
24 been three neonatal deaths in a short period of time and
25 the circumstances were discussed to identify if there
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1 the fact that, whilst rare, harm inflicted by
2 a healthcare professional was a possibility. Do you
3 think that's something you would have raised at that
4 meeting as something that they needed to be sure of
5 because if that was the case, this would be an extremely
6 serious situation?

7 **A.** I think at this stage Steve Brearey had quite
8 clearly said that he didn't think there was a link
9 between D and A and C and he said that the nurse wasn't
10 actually looking after Baby D at the time. So that
11 connection wasn't there for me.

12 **Q.** In relation to that, as you have explained,
13 you provided an overview, is that something that you
14 would have looked into to check whether Letby was
15 involved in the care of Child D because in fact Letby
16 was working in Nursery 1?

17 **A.** Right.

18 **Q.** Not as the designated nurse, but is that
19 something you would have checked?

20 **A.** Not if Steve Brearey had told me definitively
21 no.

22 **Q.** Well, he didn't say -- he didn't get into the
23 detail of the nursery, he was the clinician, you were
24 Risk and Patient Safety. Was that not something that
25 you felt was something that was within your remit to
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1 check, to be -- so that you could be sure in your mind?

2 **A.** It wasn't for me to personally go and check to
3 see who was on where. I would have had those
4 discussions to ascertain for my own peace of mind but as
5 I say, timeline wise, I'm not sure whether at this stage
6 I knew that there was another nurse and two doctors that
7 had -- were in common with some of these deaths,
8 I really don't know.

9 **Q.** You address this in paragraph 74 and 75 of
10 your statement and you say that:

11 "... a particular nurse referred to was employed
12 full time but also worked extra shifts to provide cover
13 for the short staffing."

14 So it would appear from your statement that prior
15 to this meeting you had discussed the commonality of the
16 nurse with Eirian Powell. Would that be right, is that
17 what you were likely to have done, is that what you say
18 in your statement?

19 **A.** Yes, yes.

20 **Q.** So you were aware that Letby was the nurse?

21 **A.** I don't know whether I would have been aware
22 that's who it was. I didn't know Lucy Letby at all, so
23 it wouldn't have had any relevance them giving a name to
24 me.

25 **Q.** It seems to be from your statement that you

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1 **A.** Yes.

2 **Q.** Dr Brearey had said that there was one nurse
3 who was on duty at the three deaths and he's referred in
4 his note there was also a collapse of Child B and it
5 appears that you had discussed the issue of staffing
6 with Eirian Powell.

7 Now surely, as the Risk and Safety Lead, the person
8 who's drawing together the issues of risk and safety,
9 and within your mind as you have said, the possibility
10 that you had to always be alert to, that harm could be
11 caused, why were you not raising that at that meeting?
12 Was that not your role as Risk and Safety Lead at that
13 meeting, to look into that because if there was a common
14 factor of a nurse involved in the three deaths, but
15 possibly in the one collapse that had been present, that
16 is something that warranted a serious investigation,
17 didn't it?

18 **A.** It wasn't for me to determine whether it
19 warranted a serious investigation. I think at the time
20 I had been led to believe that there were no suspicions,
21 no suspicious circumstances surrounding the deaths, that
22 they were natural causes. So concerns were raised about
23 the increased mortality rate but --

24 **Q.** Why -- why do you say, Mrs Peacock, that these
25 were natural causes? Where are you getting that from?

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1 are accepting what Eirian Powell said, that it was
2 unlikely to be an issue that it was the same nurse
3 because Letby worked a lot of shifts and Letby was not
4 the designated nurse for Child D?

5 **A.** As I say, timeline wise, I don't know what
6 I knew at that time. I was just aware that she did
7 cover a lot of shifts because she was working extras,
8 that particular nurse. So it wasn't deemed to be
9 unusual for her to be on duty when there was an incident
10 and I understood obviously further down the line that
11 there were some deaths that she wasn't on duty for.
12 So ...

13 **Q.** In terms of the number of deaths that she was
14 there, we have seen from Dr Brearey's notes that he
15 highlights Child B's collapse. Would you have thought
16 it was relevant to see, well, was Letby on duty or was
17 the nurse the common nurse on duty for Child B's
18 collapse, that would have been relevant in order to
19 assess the commonality?

20 **A.** At that stage I probably wouldn't, I really
21 don't know. Sorry. As I say, I don't recall being
22 aware of any collapses but that was obviously in the
23 document. So it was never highlighted as an issue.

24 **Q.** Well, you were the Risk and Patient Safety
25 Lead for neonatal care?

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1 We have looked at the Datixes which talk to "unexpected
2 deaths"?

3 **A.** So that was the impression.

4 **Q.** "Postmortems are awaited".

5 **A.** That was the impression I was given by
6 Steve Brearey that we had a presumed natural cause for
7 each of the deaths, we hadn't identified anything in the
8 care that would suggest otherwise and I don't know, just
9 overall.

10 So yes, it was a consideration. How much emphasis
11 we put on that at the time, I really can't say.

12 **Q.** There were no postmortems at this stage for
13 any of those children, so a conclusion on the cause of
14 death had not been made, that is the case isn't it?

15 **A.** No, there had been cause of deaths suggested
16 at that stage.

17 **Q.** And --

18 **A.** Proposed.

19 **Q.** Who -- who do you say had informed you that
20 these were natural deaths?

21 **A.** From the proposed causes that we were given,
22 it didn't suggest that they were unnatural.

23 **Q.** Given -- given by whom?

24 **A.** It was on one of the emails I think that Steve
25 sent round with a presumed cause of death on them.

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1 Q. Well, maybe we can return to that if we need
2 to. But looking at the conclusion of that meeting, the
3 meeting concluded that no further investigation was
4 warranted at this stage. Was that a conclusion that you
5 agreed with?

6 A. On the information that we had that Steve had
7 presented, then yes.

8 Q. What did you take it to mean at this stage?

9 A. We were waiting for the postmortem to come
10 back on Baby D, I think.

11 Q. Would another aspect of at this stage be that
12 if there were further deaths and the same nurse was
13 found to be on duty, that that would also be a reason
14 for reconsidering further investigation?

15 A. I don't think we had considered that at that
16 stage that there would be more deaths.

17 Q. But that's something that should have been
18 considered, wasn't it, Mrs Peacock, because you have
19 already alerted the fact that in terms of three deaths
20 it was the same nurse.

21 You were aware that in unexpected circumstances,
22 and these -- we have looked at the Datixes -- were all
23 unexpected deaths, that harm by a health professional
24 has to at least be considered. Was that not something
25 that you were noting, if not at this stage, for future

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1 nurse and the baby deaths, that's correct, is it, you at
2 that point didn't see a connection between the nurse and
3 the baby deaths?

4 A. That's correct.

5 Q. On the possibility that you were wrong, did
6 you consider that there was a safeguarding risk here,
7 did you ever see this in terms of safeguarding, that if
8 there was a risk that harm was being caused to a baby
9 that was something that you should be reporting?

10 A. I am not aware of having that conscious
11 thought, but yes.

12 Q. Looking back now, can you think why you didn't
13 see this as a safeguarding, where there was harm caused
14 to a baby and a possibility that someone was involved
15 and that should be raised through safeguarding channels,
16 can you explain why that didn't occur to you?

17 A. So this was after the third death?

18 Q. Yes. Or indeed at any point, did you consider
19 safeguarding at any point we are going to go on and look
20 at subsequently?

21 A. I don't know whether safeguarding actually
22 crystallised as a thought. I certainly would have
23 reported if I -- I had any suspicions. But at that
24 stage, although there were concerns, there were no
25 suspicions that somebody had actually caused harm and

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1 reference?

2 A. I think I was noting it. But Steve had also
3 said that that nurse wasn't looking after Baby D at the
4 time.

5 Q. Do you accept that you didn't look to see to
6 find out any further details about that, whether Letby
7 was in fact on Nursery 1, did you undertake any
8 investigations?

9 A. No.

10 Q. Ruth Millward in her statement to the Inquiry
11 says it would have been appropriate for the hospital to
12 have reported the overall increase in neonatal deaths
13 that occurred in June as a Serious Incident and this
14 would have then triggered a comprehensive investigation
15 into the increased mortality at an earlier stage.

16 Do you agree with Ruth Millward's view?

17 A. Sorry?

18 Q. Should there have been at that stage in June,
19 after the deaths in June, a comprehensive investigation
20 of the increased mortality?

21 A. I really can't say. That wasn't my decision
22 to make.

23 Q. In terms of safeguarding, you say -- and
24 I think you are relying on the fact that you say that
25 you didn't consider there was a connection between the

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1 I was aware that there were conversations with the
2 Coroner at the time and I would have thought the doctors
3 would have raised any concerns, certainly with the
4 Coroner referrals and then obviously the postmortems
5 when we had got them back, they gave natural causes as
6 well.

7 So I suppose my thought processes never moved
8 forward to that stage.

9 Q. Moving forward a little in terms of what
10 happened then after that meeting, so the meeting
11 concluded that there was no further investigation at
12 that stage.

13 We then see that in fact what was decided at that
14 meeting was that there should be a full review of
15 Baby D's death and if we can see INQ0004520, this is
16 tab 10. This is -- I will get it on screen in
17 a moment -- this shows there was a report, a fuller
18 report into death of Child D and we can see there in the
19 investigation team of obstetrics, you feature in the
20 investigation team for the secondary review obstetric
21 and indeed in the Neonatal Review Team and that reflects
22 your role, doesn't it, that you were looking both from
23 an obstetric and from a neonatal perspective?

24 A. Yes. Mmm mm.

25 Q. Why is it that this was done for Baby D

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1 a fuller report, but not for A and C? Do you recall why
2 that decision was made?

3 **A.** I don't, sorry.

4 **Q.** How was this report produced was there
5 actually a meeting or was this a paper exercise?

6 **A.** So this was a paper exercise. The obstetric
7 secondary report had already been done as had the
8 neonatal review. So this paper was just combining the
9 two, the narrative from the two reports.

10 **Q.** That was something you did, you physically
11 brought these together, did you, was this a document
12 that you produced?

13 **A.** It's a document that I produced which was copy
14 and pasting so it -- it's -- the authors would be the
15 obstetric team and the neonatal, or Steve Brearey, it
16 would have been.

17 **Q.** There was then subsequently a round table
18 meeting after the postmortem was obtained in the case of
19 Child D and at that time, I think there was an actual
20 meeting. Do you recall that meeting when Dr Davies,
21 Dr Newby, Ms Fogarty, Eirian Powell and yourself met to
22 consider the postmortem results of Baby D?

23 **A.** I am sorry, I don't recall it, no.

24 **Q.** Because by that stage that was held on
25 12 October -- considering Baby D -- by that stage Baby E

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1 death of Baby E?

2 **A.** I don't no.

3 **Q.** So moving forward now to 23 October. That was
4 the day that Child I died and if we could go to
5 INQ0005609 and this is tab 21, my Lady.

6 So we have got an email here from Eirian Powell
7 that you are copied into and it says:

8 "Hi Steve, just to say that I have discussed the
9 above with Anne Murphy and on reflection it was decided
10 to leave this until Monday. Alison Kelly was not in the
11 hospital and Sian had just left. I have devised
12 a document to reflect the information clearly ... it is
13 unfortunate that she was on."

14 That is a reference to Letby being on duty?

15 **A.** Mm-hm.

16 **Q.** It ends:

17 "I will discuss further with Debbie on Monday."

18 Attached to that was a chart that listed eight
19 deaths, the first of which was back in March. But all
20 the deaths from June onwards, and that included Child A,
21 Child C, Child D, Child E and Child I, on each of those
22 occasions Eirian Powell has noted that Lucy Letby was on
23 duty and she had highlighted her name in red.

24 What did you think when you received that document?

25 **A.** I really don't know what my thoughts were at

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1 had died as well in August. Did you consider that now
2 we have got an additional baby death that you needed to
3 review the position and consider whether to look first
4 of all to see whether this same nurse was present at
5 that death?

6 **A.** I really don't recall, I am sorry.

7 **Q.** Is that something that you should have been
8 doing as patient and safety where you have got
9 an additional death, it's been identified the same nurse
10 is present at A, C and D, you have then got a very short
11 period afterwards another unexpected death? As Risk and
12 Patient Safety Lead, you have said that your role was
13 patient safety. What were you proactively doing to --
14 to investigate at this point, to take steps for patient
15 safety?

16 **A.** So I would like to think that I did have that
17 thought. I can't say whether I did or not. I would be
18 surprised if I didn't but that would have been
19 a discussion with Steve Brearey and Eirian. Other than
20 that, I can't say any more, sorry, because I have no
21 recollection of it.

22 **Q.** If we can move forward again now. So Baby E
23 has died, you say you don't recall that death?

24 **A.** Sorry.

25 **Q.** Is that your evidence, you don't recall the

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1 the time, sorry.

2 **Q.** Well, you were Risk and Patient Safety Lead.
3 That must have caused concern, mustn't it, that we have
4 now got the initial three but two additional deaths that
5 we are concerned at, but indeed other deaths as well,
6 all of which Lucy Letby was present at and her name's
7 being highlighted in red and that's been prompted, it
8 appears, by the clinical -- the neonatal lead
9 Dr Brearey, contacting the ward manager.

10 That has to be a very serious patient safety
11 concern, doesn't it?

12 **A.** It would be looking at it, but I also
13 understood that she wasn't looking after all the babies
14 that she died that had died.

15 **LADY JUSTICE THIRLWALL:** So where do you understand
16 that from?

17 **A.** It is on the chart.

18 **LADY JUSTICE THIRLWALL:** I see, so you do remember
19 that?

20 **A.** I -- I remember -- I don't remember the chart
21 I've seen it on the chart in the documents that were
22 provided to me.

23 **LADY JUSTICE THIRLWALL:** I see, and that is
24 something you would have taken account of, is it?

25 **A.** I would hope so, yes.

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1 **MS BROWN:** So by that you mean that whilst Letby
2 was staff on duty, she wasn't necessarily allocated to
3 the baby, is that the point you are making?

4 **A.** Yes.

5 **Q.** Why did you think that Eirian Powell had
6 highlighted Lucy Letby's name in red and what did you
7 understand to be Dr Brearey's concern?

8 **A.** Dr Brearey never discussed any concerns with
9 me. He certainly never discussed any suspicions about
10 any member of staff. Obviously this -- we looked at all
11 the staff that were on.

12 **Q.** But what did you understand to be --
13 Eirian Powell had drawn up this statement. What did you
14 understand to be Dr Brearey's concern that had led to
15 the creation of this chart?

16 **A.** Other than noting that she had been on for
17 a lot of the deaths he never voiced a concern and
18 I didn't know what his concern was.

19 **Q.** Well, why did you think that Stephen Brearey
20 had asked Eirian Powell to draw up a chart stating who
21 was on duty and why Eirian Powell had highlighted Letby
22 in red?

23 **A.** He obviously had some concern about her being
24 on duty.

25 **Q.** So that was obvious, wasn't it, that was

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1 relevant to look at other members of staff?

2 **A.** To see whether there were any competency
3 issues, if it was a recurrent theme with one member of
4 staff.

5 **Q.** So you were clear that what this chart was
6 doing was looking to see a connection between someone
7 being on duty and the death of the baby whether there
8 was a connection to be made?

9 **A.** Yes.

10 **Q.** And the connection what had been made was with
11 Letby, that is why she was in red.

12 **A.** As I say, on that table, yes, I had been led
13 to understand that there was another nurse that was
14 a commonality and two doctors.

15 **Q.** Well, you were then saying that doctors should
16 be highlighted as well?

17 **A.** Yes.

18 **Q.** That was to see if there was any
19 commonality --

20 **A.** Yes.

21 **Q.** -- in terms of doctors?
22 It then goes, this email says:

23 "Debbie was of the same opinion that we did not
24 think there was a connection."

25 So you are referring there, are you, Mrs Peacock,

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1 obvious from the fact he asked for this and a chart was
2 produced with her name in red that he had concerns?

3 **A.** I -- I suppose at the time I believed that he
4 had any concerns, any suspicions, they would have been
5 reported to the Coroner or the police.

6 **Q.** Well, let's just look at what was being
7 reported to you. At the stage of that email being sent
8 on 23rd, it appears that the view of Eirian Powell was
9 that it was going to be raised with Alison Kelly.

10 What discussion did you then have with
11 Eirian Powell about this, about the chart and your views
12 on this?

13 **A.** As I say, I don't recall the discussion.

14 **Q.** Can we just turn to INQ0003107. So that's
15 an email from Eirian Powell to Steve:

16 "I have spoken at length with Debbie this morning
17 in relation to the mortality rate."

18 So do you have any recollection of that
19 conversation that was at length about the mortality
20 rate?

21 **A.** I have a vague recollection of discussing with
22 Eirian that we should look at all the staff that were
23 present, not just highlighting one particular member of
24 staff.

25 **Q.** Why was that? Why did you think it was

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1 to a connection between Letby and the deaths, that is
2 the connection you are talking about, is it? If you
3 just look at the email?

4 **A.** No, I was talking about a connection with all
5 the deaths, with all the variables, not just Letby, I --
6 I would imagine.

7 **Q.** Well, let's just look at the sequence because
8 you have, at this point, the chart you are -- you have
9 in front of you was a chart that lists a number of baby
10 deaths against each of those, barring the death that was
11 much earlier in the year, but all of the deaths from
12 Baby A onwards until October 23, which was Child I's
13 death, against each of those Letby was shown to be on
14 duty and her name was highlighted in red and then you
15 are responding after a lengthy meeting saying that you
16 were of the "opinion we did not think there was
17 a connection".

18 Now the obvious meaning of that is, isn't it,
19 Mrs Peacock, is that there wasn't a connection between
20 Letby and the deaths; that's what you were saying, was
21 it?

22 **A.** As I say I can't comment because I don't
23 remember the conversation.

24 **Q.** Because what could have been your basis for
25 concluding that there wasn't a connection between Letby

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1 and the deaths, what would you have seen that could have
2 led you to that conclusion?

3 **A.** I am presuming because she wasn't the nurse
4 caring for the -- some of the babies that died at the
5 time of their death.

6 **Q.** Can you recall what information you had in
7 front of you to inform you of who was of that
8 information?

9 **A.** Only this chart that's been produced and the
10 documents.

11 **Q.** So that wouldn't have told you whether she had
12 attended that baby through looking at the medical
13 records, for example?

14 **A.** It wouldn't have told me whether she had
15 attended the baby but it was the nurse assigned to that
16 baby and these were ill babies so the nurses stay with
17 the babies a lot of -- most of the time.

18 **Q.** So whereas Stephen Brearey was raising that as
19 a concern, hence the production of the chart, you were
20 saying there wasn't a connection. Did you feel in
21 a position to say that?

22 **A.** No, I wasn't in a position to say that at all.

23 **Q.** The consequences it appears of that discussion
24 was that this wasn't then raised with the Executive team
25 and Alison Kelly at that point so this was a very --

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1 **A.** I was aware of his concerns at the rise in the
2 mortality rate but I wasn't aware of any suspicions that
3 he had or concerns in relation to a particular member of
4 staff.

5 **Q.** If we could go now to INQ0003222, that is
6 tab 25.

7 So this is a review of neonatal deaths. We see
8 "Review of neonatal deaths and stillbirths at the
9 Countess of Chester" and you were part, you can see, of
10 the review team.

11 Can you recall being part of this review team?

12 **A.** I actually wasn't part of the review team,
13 I sat in to observe this meeting which is why I didn't
14 organise it, I didn't take minutes from the meeting.

15 **Q.** What was your purpose as an observer there,
16 presumably it was you observing from the point of view
17 of Risk and Patient Safety?

18 **A.** As I say my -- my recollection of this meeting
19 is quite sketchy. I did think that there were
20 paediatricians present at this meeting but patently
21 there weren't.

22 **Q.** We will see that the heading of that report is
23 review of neonatal deaths and stillbirths at the
24 Countess of Chester. In fact, this was just looking at
25 the obstetric care, wasn't it?

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1 there were very serious consequences to this discussion
2 because at that point this matter it would appear then
3 did not go to Alison Kelly?

4 **A.** From what I know now after seeing the
5 documents I think Steve was escalating this outside of
6 meetings with risk and governance to Alison Kelly.

7 **Q.** And at this stage, so we have moved on now,
8 you have said that you visited the neonatal ward I think
9 on an almost daily basis.

10 Were you aware of rumours by this stage that now we
11 have got more deaths and we have also got the death of
12 Child E, the death of Child I, were you aware of rumours
13 or concerns on the neonatal ward when you visited, that
14 there was an undue number of deaths, that they were
15 unexpected and that there may be a staff member
16 involved?

17 **A.** No, I wasn't aware of any of the rumblings
18 behind the scenes.

19 **Q.** Not aware of concern at the increased
20 mortality?

21 **A.** No, I didn't really speak to the nurses, as
22 I say, they were in the rooms with their babies and
23 I tended not to go in the rooms unless it was necessary.

24 **Q.** But you were -- you said you spoke to
25 Dr Brearey and you were aware of his concerns?

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1 **A.** It was looking at the early neonatal deaths as
2 well, the babies that had been born in poor condition
3 and died on delivery suite.

4 **Q.** But it was just looking at it from the
5 obstetric point of view?

6 **A.** Yes.

7 **Q.** It wasn't looking at it from the neonatal
8 aspect?

9 **A.** That's correct.

10 **Q.** So that heading was actually misleading,
11 wasn't it?

12 **A.** As I say, the obstetricians would have
13 referred to early neonatal deaths for babies that died
14 on delivery suite from their way of thinking, yes, it is
15 misleading. But probably not intentional.

16 **Q.** If we just look then at tab 27 -- sorry,
17 tab 28, if we could look at INQ0004371. So this is
18 then -- so we have that review in November, and that
19 review, the obstetric review, didn't identify any themes
20 or concerns; that is the case, isn't it?

21 **A.** Sorry, what is the question?

22 **Q.** The obstetric review didn't reveal any themes
23 or concerns about the maternity care?

24 **A.** I don't think so looking at the documents, no.

25 **Q.** Then the Women's and Children's Care and

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1 Governance Board meeting on 18 December, and that was
2 one that you sat on, this was the committee, the board,
3 that you sat on?

4 **A.** Yes.

5 **Q.** We will see if we could go to page 2 of that,
6 we see there at point 9:

7 "Stillbirth and early neonatal death review and
8 action plan."

9 And it says there:

10 "No themes identified."

11 Did you think at that point from a risk and safety
12 point of view, you should have been alerting the meeting
13 knowing that these minutes went on to Alison Kelly
14 alerting the meeting that this was only the obstetric
15 clean bill of health and that there were concerns in
16 terms of neonatal, the neonatal care and in fact you
17 were aware certainly of Stephen Brearey's concerns about
18 the commonality of the nurse because that appears to
19 suggest that there were no themes identified but that is
20 purely from an obstetric point of view?

21 **A.** It is, yes. But it does say "Stillbirth and
22 early neonatal death" and it comes to assuming people
23 have similar knowledge to yourself. So I would have
24 thought seeing who the authors were and what the report
25 was that people would have realised that it was deaths

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1 **Q.** If we could just go to page 6 where you deal
2 with neonatology. We don't have to work through that in
3 detail but there's nothing in that report that draws
4 attention to the increased mortality or concerns about
5 the number of unexpected deaths. Was that not something
6 that was headed "Trend Analysis Report" should have been
7 referred to?

8 **A.** So this was just the pure data from Datix that
9 I pulled looking at the highest category of reported
10 incidents and explaining what they were. If there had
11 been investigations and they were raised as a separate
12 agenda item at the Women's and Children's, I think the
13 end of year report when we had the yearly figures in,
14 that would have been something that I would raise then.

15 **Q.** Can we just turn now to INQ0005643. So this
16 is in January. So we have had the -- you have looked at
17 the obstetric review, that has happened in November, we
18 have seen back in October you saw and discussed the
19 chart identifying Letby's name next to child deaths and
20 then we come to January and we see at the bottom of that
21 page there is an email from Eirian Powell to
22 Stephen Brearey and if one goes over the page, you can
23 see what she is saying is:

24 "I have amended the last list ..."

25 That is the list where Letby's name was in red:

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1 on the delivery suite and stillbirths.

2 **Q.** But you didn't highlight at any point,
3 Mrs Peacock, in the Women's and Children's Care
4 Governance Board or indeed the other meetings that went
5 ahead the various reviews you had, that there was
6 a concern about the deaths on the neonatal unit?

7 **A.** No. I would have escalated it had one of the
8 paediatricians raised it, then that would have been
9 something that I would have escalated.

10 **Q.** But you were employed to give risk and to look
11 specifically at Risk and Patient Safety. Given that
12 Stephen Brearey had raised the commonality of a nurse
13 you had seen that document with the deaths and her name
14 highlighted in red, did you not think that at that point
15 this is something that needs to be highlighted, this
16 needs the Executives need to be aware, this needs to be
17 discussed at this meeting? Why -- from a risk and
18 safety point of view, why weren't you bringing that to
19 these meetings? That is what we need to understand.

20 **A.** I think I was aware at this stage that Steve
21 was escalating to Ian Harvey and Alison Kelly.

22 **Q.** If we could just look at 0015141. So this is
23 an Incident Trend Analysis Report that I think you
24 authored, do you recall that?

25 **A.** Yes.

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1 "... to ensure that we have included all the babies
2 that have died on the unit within the timeframe."

3 Because in fact two further babies had died where
4 Letby had been on duty.

5 If we just go back then to page 1 because the
6 emails are in the wrong order, so to speak. So we have
7 got the reply from Stephen Brearey on 22 January and you
8 are copied in to this reply.

9 He says:

10 "I have discussed our increased mortality with
11 Nim."

12 That is Dr Subhedar from Liverpool.

13 Why did you understand that Dr Brearey was wanting
14 to bring in an outsider, a specialist from outside the
15 Trust?

16 **A.** I would presume because he was concerned about
17 the raise in mortality rates and he wanted
18 an independent person to come and review the notes to
19 see whether anything had been missed.

20 **Q.** Were you concerned about the mortality rates?

21 **A.** Yes, sorry, I thought I had already said that
22 earlier. Yes, I did have a concern.

23 **Q.** You were concerned and -- and this is
24 Stephen Brearey's initiative, were you taking any
25 initiative from a patient safety -- from your Risk and

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1 Patient Safety?

2 **A.** I was relying on Steve.

3 **Q.** He goes on to say they are going to review the
4 cases and set up a meeting and that meeting in fact
5 happened we know on 8 February and if we could look at
6 INQ0003217. This is the meeting that did then take
7 place with Dr Subhedar, we see him, Liverpool Women's
8 Hospital Consultant, as attending. We see your name
9 appearing there and the other attendees listed.

10 Is that a meeting that you recall?

11 **A.** Not in any detail, no. I certainly wouldn't
12 have known who attended other than Steve and Nim.

13 **Q.** Most significantly this -- this has been
14 prompted by the -- or it appears it has been prompted by
15 the chart where Letby's name had been highlighted in
16 red. Do you recall whether the issue of Letby harming
17 babies was discussed at that meeting?

18 **A.** I really don't know, sorry.

19 **Q.** If it wasn't raised from a patient and safety
20 point of view, would it not have been your
21 responsibility to raise that and say: this is something
22 we need to discuss?

23 **A.** I really don't know, to be honest. Yes. If
24 those concerns hadn't been discussed already, I think,
25 I think Steve said he did actually discuss it at this

85

1 a series of unexplained deaths on the neonatal unit
2 within a short period?

3 **A.** So a series of unexplained deaths yes.
4 However, I was aware that we had postmortem results back
5 that gave us an explanation for those deaths.

6 **Q.** If I could just then turn you to your
7 reflections at paragraph 154, you say:

8 "I cannot think of any steps that could have been
9 taken to identify earlier that Letby was harming babies
10 on the NNU or steps that could be taken now on NNUs to
11 prevent a similar situation."

12 Is that still your position?

13 **A.** Obviously with the information that we have
14 now, and the postmortem results that gave us cause of
15 death are now in question, aren't they, so I didn't have
16 that at the time. So being given the same set of
17 information at the time, then yes.

18 However, with the information we have now obviously
19 things are different. So, yes, had potentially the
20 Coroner been informed sooner, that would have, you know,
21 stopped things in its tracks. Yes.

22 **MS BROWN:** Yes. Those are my questions but there
23 will be some questions from Mr Baker and Mr Skelton.

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

25 Questions by MR SKELTON

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1 meeting in some of the documents I have seen.

2 **Q.** Can I just take you back to your statement,
3 Mrs Peacock, paragraph 72. You say in that statement:
4 "it is sadly not unusual to have an unexplained
5 cluster of deaths on an NNU ..."

6 It was unusual though, wasn't it, Mrs Peacock? You
7 had never seen a series of deaths like this before where
8 you had a number -- a significant number of unexplained
9 deaths, had you ever come across that before?

10 **A.** Not at the Countess of Chester. Probably at
11 Liverpool Women's and Fazakerley I had.

12 **Q.** Sorry, where you are you saying you had seen
13 this?

14 **A.** My first -- it wouldn't have been my first
15 job, when I worked at Fazakerley, which is now Aintree
16 hospital.

17 **LADY JUSTICE THIRLWALL:** When was that?

18 **A.** Oh gosh, probably in the 90s. And then at
19 Liverpool Women's.

20 **Q.** Liverpool Women's was slightly different,
21 wasn't it, because that was a tertiary unit, that was
22 seen as a slightly different set of babies?

23 **A.** Yes.

24 **Q.** But the evidence that this Inquiry has
25 received is that it was indeed very unusual to have

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1 **MR SKELTON:** Mrs Peacock, I ask questions on behalf
2 of one of the Family groups. Can I just start with some
3 basics about the policies that were in place that
4 governed what staff were meant to be doing in respect of
5 reporting.

6 May I have on screen INQ0006466. Do you recognise
7 this document?

8 **A.** I can't recall the document now.

9 **Q.** You can't remember it?

10 **A.** No, no.

11 **Q.** So as I understand it, if we go just to page 9
12 first of all, if you see -- if you could highlight right
13 at the bottom, please, that very small print in the
14 footer of the page, very bottom of the page on page 9,
15 I think it's about to be put on screen, hopefully.

16 Can that be made legible?

17 There we go. Author: Sally Goode. Who's she?

18 **A.** When I first took up post at the Countess of
19 Chester she was the head of risk and governance.

20 **Q.** When you were in post, she was -- what
21 relation with her did you have?

22 **A.** Sorry?

23 **Q.** What relationship with her did you have when
24 you took up your post?

25 **A.** So she would have been my line manager when

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1 I first started.

2 **Q.** Okay. So this is a document she has produced?

3 **A.** Yes.

4 **Q.** It's printed on 19 July 2016. Can we infer

5 from that that it was the working document that was in

6 post when you were there?

7 **A.** I don't know sorry I left at the beginning of

8 16 -- 2016.

9 **Q.** Okay. Is it really the case that you don't

10 remember this document at all as the policy that

11 governed reporting incidents?

12 **A.** I don't. I have had other risk in governance

13 jobs since and I wouldn't remember which policies

14 applied to which hospital at a given time.

15 **Q.** If we go back to page 2 and have page 2 on the

16 screen, please. Thank you. So this is about the duties

17 on who should report incidents and you can see that

18 there is a section -- there are three sections there,

19 "All staff", "Managers" and then the Risk and Patient

20 Safety team.

21 So just to clarify. Was it your understanding that

22 all staff were obliged to report incidents and near

23 misses?

24 **A.** Yes.

25 **Q.** Likewise we can see it also says:

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1 this mean the managers of the two teams, as it were, of

2 healthcare staff, the doctors and the nurses?

3 **A.** I think it fell to everyone, to be honest, to

4 promote a good reporting culture.

5 **Q.** So Steve Brearey, for example, would fall into

6 this category, would he?

7 **A.** Certainly, yes.

8 **Q.** Eirian Powell would fall into that category?

9 **A.** Yes.

10 **Q.** And are you aware of what training staff had

11 on reporting incidents?

12 **A.** I don't think they were given any formal

13 training on completing Datix forms and submitting them.

14 I think that was done locally. But certainly as a Trust

15 induction they were given a talk on risk and safety and

16 how it's everybody's responsibility to report and not

17 assume somebody else had.

18 **Q.** One of the duties is on managers is to ensure

19 they have proper training, so again that would be

20 a question perhaps to ask Dr Brearey in respect of

21 doctors or senior nurses in respect of nurses?

22 **A.** To be honest I think it was probably Eirian

23 would certainly oversee junior doctors if they were

24 submitting a Datix. As I say, it was done locally,

25 probably, you know, as new doctors or new nurses came in

91

1 "All staff have a duty to raise concerns regarding

2 care or other activities using the Speak Out Safely

3 policy"?

4 **A.** Yes.

5 **Q.** You were familiar with that policy?

6 **A.** As I say, I don't remember the policy but if

7 that was in place, then yes.

8 **Q.** From your perspective, would a concern about

9 a nurse being connected with some deaths, leaving aside

10 deliberate harm, be -- fall within that Speak Out Safely

11 duty?

12 **A.** So somebody just being connected with deaths,

13 no.

14 **Q.** What about concerns regarding care being

15 substandard by that nurse?

16 **A.** Certainly if the care was substandard, yes.

17 **Q.** By definition, if the nurse was harming

18 patients as well?

19 **A.** Yes.

20 **Q.** The duties on the managers:

21 "All managers are responsible for engaging all

22 staff in the reporting and management of incidents."

23 If we think of the NNU, the neonatal unit, is that

24 does that mean Eirian Powell is responsible for

25 reporting on that unit ultimately or by "managers" does

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1 and a situation arose then they would be supported

2 through submitting a Datix.

3 **Q.** Lastly, just briefly, the Risk and Patient

4 Safety Team in which you sat:

5 "Ensure managers are alerted to all significant

6 incidents or trends in their areas in a timely manner."

7 So you are the collating body in the Trust when it

8 comes to incidents?

9 **A.** Yes.

10 **Q.** You feed back out to those that need to know

11 if you have spotted a trend from their reporting?

12 **A.** Yes.

13 **Q.** The idea being obviously it is a virtuous

14 circle of learning?

15 **A.** I had regular meetings with all the ward

16 managers to look at their incidents and to discuss any

17 concerns and issues with them in their area.

18 **Q.** Thank you.

19 Can I go to the next page, please. Would it be

20 possible just to highlight the second half "What should

21 be reported as an incident" or make it a bit bigger?

22 I am going to ask you about this paragraph because

23 it's quite important but it may be felt that the wording

24 is unclear or unfortunate.

25 It looks a little bit like a lawyer's sentence

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1 rather than a healthcare professional sentence.

2 Do you know -- would your predecessor -- sorry,
3 your manager have drafted that, or would it have been
4 a lawyer who attempted to draft it?

5 A. I would imagine it was my line manager.

6 Q. So can we just try and understand what it
7 means:

8 "An event or circumstance which could have resulted
9 or did result in unnecessary damage, loss or harm to
10 patients, staff, visitors or members of the public."

11 So an event or circumstance which could have
12 resulted or did result in unnecessary damage.

13 So "event or circumstance" is just something that
14 happened, is it, anything?

15 A. It's any concern; we encouraged staff to
16 report anything.

17 Q. What does the word "unnecessary" mean?

18 A. I really don't know.

19 Q. Is there an implication in this that there
20 needs to have been something untoward, something that
21 the staff have done or not done which they should have
22 done?

23 A. Not necessarily. Staff, as I say, could
24 report anything that was of concern to them. I think
25 the unnecessary damage is probably looking at the -- the

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1 reported as incidents?

2 A. I can't comment on the rest of the hospital.
3 I didn't see their incidents, sorry, but yes, I would
4 imagine that all deaths.

5 Q. All deaths for children as far as you are
6 concerned would be reported?

7 A. Yes.

8 Q. Eirian Powell said that all collapses
9 requiring resuscitation were also or should also have
10 been reported on Datix. Is that your understanding?

11 A. No, I don't think unless there was something
12 untoward happened during the resuscitation, I don't
13 think they were all reported.

14 Q. What's "untoward" mean?

15 A. So it could be an equipment failure, or
16 a member of staff not following correct procedure. So
17 not necessarily resulting in harm, but has caused
18 a concern to somebody.

19 Q. So a child can die from nothing untoward and
20 it would have to be reported?

21 A. Yes.

22 Q. But a child could collapse and nearly die but
23 survive from nothing untoward, but that would not be
24 reported insofar as you are concerned?

25 A. It's very difficult because if a small ET tube

95

1 buildings and equipment.

2 Q. Well, it's unnecessary damage, loss or harm to
3 patients. I just want to know, what's unnecessary harm
4 as opposed to harm?

5 A. Well, it's unnecessary damage, loss or harm,
6 isn't it? So it's not unnecessary harm.

7 Q. I see. So you think the adjective actually
8 just applies to damage and not just loss or harm?

9 A. I really don't know because this is the first
10 time I have read it so I don't know what it means --

11 Q. You are responsible in this department for
12 understanding incidents?

13 A. Yes.

14 Q. I am asking you what your understanding was of
15 what incidents needed to be or were mandated to be
16 reported?

17 A. So my understanding and certainly what I was
18 encouraging was for any and every harm incident to be
19 reported but also for any concerns whatsoever that they
20 had that they felt that they needed to raise. So it
21 didn't necessarily need to result in harm for them to
22 report something.

23 Q. It seems that this consistent reporting of the
24 deaths, so all deaths, would that apply not just to
25 neonates and children across the hospital, would be

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1 blocks and some of these ET tubes that ventilated
2 patients had a diameter of 2 mm, 2.5 mm, so could easily
3 get blocked with secretions, if that happened, the child
4 collapsed as in the saturations dropped and obviously
5 the child couldn't breathe.

6 So that could have necessitated just suction to the
7 tube to clear the blockage but quite often it resulted
8 in the tube being changed so that would be classed as
9 a collapse with intervention.

10 Q. But if a collapse is unexpected, then isn't it
11 the case that you need to report it to find out what
12 caused it?

13 A. I would argue a lot of collapses can't be
14 expected because you can't anticipate that things like
15 an ET tube is going to block. It happens.

16 Q. Well, the evidence almost uniformly from the
17 Consultants who have given evidence is that the
18 unexpected collapse of a child leading to resuscitation
19 or death is something that needs looking at because by
20 definition there isn't an obvious medical cause?

21 A. Leading to resuscitation and death?

22 Q. Leading to resuscitation which would otherwise
23 have caused death, or leading to death and, I mean, the
24 difference between life and death in those situations
25 can often be very slight?

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1 A. Yes, yes.
 2 Q. For obvious reasons I am trying to understand
 3 why you make a -- in terms of learning, why there is
 4 a differentiation from your perspective?
 5 A. As I say, the -- the -- I think if there were
 6 lessons to be learned then they would be reported. They
 7 would be discussed at some level. That's the only
 8 answer I can give, I am sorry.
 9 Q. Briefly before I move on, and it might be said
 10 one of the reasons to report the unexpected collapse
 11 where a child has nearly died and required full
 12 resuscitation is to set in motion an investigative
 13 process which might not otherwise occur and to make sure
 14 that patterns -- a series of children were collapsing
 15 requiring full resuscitation is by definition worrying?
 16 A. Yes.
 17 Q. The whole purpose of your job was to identify
 18 such trends so that they could be addressed --
 19 A. Mm-hm.
 20 Q. -- and remedied; do you accept that as
 21 logical?
 22 A. Yes, yes.
 23 Q. In this document I don't think it's fully
 24 defined what a Serious Incident is. What's the
 25 difference between an incident and a Serious Incident as

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1 from Ms Brown, that the degree of ambiguity about what
 2 should or shouldn't be reported is a problem that needs
 3 to be thought about?
 4 A. It certainly needs thinking about, yes. Yes.
 5 Q. Because if Eirian Powell thinks you should
 6 report resuscitations that nearly cause death, you don't
 7 think you should report them, the wording --
 8 A. I am not saying we shouldn't report them, no.
 9 I am telling you what actually happened. I think --
 10 I think there should be some sort of local review of
 11 collapses to pick up on trends and I'm not sure that
 12 that wasn't happening. But they -- at the time, they
 13 weren't reported on Datix unless there was something
 14 unusual.
 15 Q. Without going into all the details, there does
 16 appear to be quite -- there is an inconsistent pattern
 17 between the children, all of whom suffered collapses and
 18 many of whom died, in terms of exactly what incidents or
 19 what investigations were prompted by the incident
 20 reporting?
 21 A. (Nods)
 22 Q. One of the causes for that may be that there
 23 was a lack of understanding about what should or
 24 shouldn't be done in response each time. So should
 25 a Datix be completed, should a Serious Incident

99

1 far as you are concerned?
 2 A. So a Serious Incident would usually be
 3 resulting in some level of harm. However, it could also
 4 be -- a Serious Incident could be a thematic review
 5 picking up on trends that could cause potential harm.
 6 Q. There is a framework, I won't take you to it
 7 because it is a national framework?
 8 A. There is, yes.
 9 Q. Were you aware of that the NHS framework for
 10 serious harm --
 11 A. Yes.
 12 Q. -- that was in place at the time as a
 13 document, publicly available from March 2015?
 14 A. Yes.
 15 Q. Which I think is still in use? Is that the
 16 document which you would use as the sort of source for
 17 what defines a Serious Incident as far as the NHS is
 18 concerned nationally?
 19 A. Yes, it is. However, that wasn't my decision.
 20 So, as I said earlier, we would complete an SBAR,
 21 escalate that to the Serious Incident Review Panel and
 22 it would be their determination whether something was
 23 classed as a Serious Incident.
 24 Q. Do you think, stepping back now, and having
 25 listened to your own answers, both to my questions and

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1 investigation be initiated?
 2 That clearly needs to be thought about, doesn't it,
 3 to make sure that --
 4 A. I think so, yes yes.
 5 Q. It's important for those on the ground
 6 involved in the incident they know exactly, or as close
 7 as possible to exactly, what they need to do when
 8 a child collapses or dies: I need to do a Datix?
 9 A. Yes.
 10 Q. Dr Brearey or his or her equivalent needs to
 11 initiate a certain type of investigation?
 12 A. Yes.
 13 Q. That is clearly important?
 14 A. Mm-hm.
 15 Q. Can I ask you about Child A. Child A as you
 16 know died, he was the first death, as you know he was
 17 murdered by Lucy Letby. There was a Datix in respect of
 18 his death. It is at INQ0000016.
 19 Ms Brown has already asked you a bit about this
 20 I just want to ask you a little bit more. I will try
 21 not to cover the same ground.
 22 So this is the Datix admin form for Child A.
 23 Would you expect extra details about a child's
 24 collapse and death from the medical notes to find their
 25 way into the Datix?

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1 A. Not in detail, no. So this was just an alert
2 to us that there had been a death. And then we would
3 make preliminary enquiries whereas I say Steve Brearey
4 would review the death, the care. And that would be
5 escalated. So no, at this stage, probably not.

6 Q. So it's the responsibility of the clinician
7 who's following up on the initial report to garner the
8 information about the child's death, Steve Brearey in
9 that case?

10 A. Steve Brearey would do the review of the
11 child's death, yes.

12 Q. Okay. So information -- you may have heard
13 about Child A had a rash as did his sister that was
14 unusual that was spotted at the time. Would you expect
15 during the Datix investigation process or associated
16 processes that that kind of information would be
17 captured?

18 A. Not on Datix no.

19 Q. Not in Datix?

20 A. No.

21 Q. Well, we will come on to the other things that
22 are mentioned within the Datix because Datix, this form
23 at least reports other investigations or considerations,
24 doesn't it, like the Coroners' process, for example?

25 A. Mmm mm I don't think the Datix forms didn't
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1 then receiving the usual type of support in keeping with
2 his prematurity, ie on CPAP and receiving IV fluids and
3 antibiotics. Initial PM findings did not give any
4 answers, however we are awaiting the results of
5 pathology slide examination. However, if it was due to
6 a cardiac arrhythmia this would not show on this
7 examination."

8 There is a query about the mother's background
9 there which we see elsewhere on the form. But the
10 reality is here that there is no explanation for the
11 child's death been found on the PM or identified by
12 whoever has filled this assessment in?

13 A. Mm-hm.

14 Q. You have said repeatedly in your evidence
15 today that you understood that the children had died
16 from natural causes?

17 A. Yes.

18 Q. In respect of Child A that was wrong, wasn't
19 it, there wasn't an identified natural cause for his
20 death?

21 A. This wasn't my SBAR and I -- I don't know,
22 well, it's worded the way it is, obviously.

23 So it's the initial PM findings didn't give any
24 answers and I understand that there wasn't a cause
25 identified in the final report.
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1 inform the Coroner referrals.

2 Q. You don't think what, sorry?

3 A. The Datix forms didn't inform the Coroner
4 referrals as far as I am aware.

5 Q. No, but it is the other way round, I think
6 isn't it. This document includes material from the
7 Inquest process?

8 A. Not in the initial stages, no. That's only
9 added to later on.

10 Q. Absolutely.

11 A. Yes.

12 Q. Along the way updates are put in?

13 A. Yes.

14 Q. Perhaps we will come on to it and you can
15 explain what's happening. Can we go to 5, please. You
16 were asked about this previously. So there is the SBAR.
17 This is the SBAR section.

18 A. Yes.

19 Q. You can see that there is an assessment bit
20 there where the mother's background, ie her medical
21 background, is considered, that has been removed for
22 privacy reasons.

23 It's then in the next paragraph it says:

24 "At present there is no explanation for the sudden
25 cardiorespiratory collapse. Twin 1 was stable until
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1 Q. No.

2 A. Sorry, what was the question again?

3 Q. I am trying to understand how you came to the
4 view that this child died of natural causes?

5 A. I think I am going from what cause of death
6 the doctors proposed and the fact that Steve Brearey
7 didn't find anything to suggest otherwise on his review.

8 Q. But he -- there was some speculation that the
9 mother's condition may have related to the child's but
10 that was never turned into anything positive?

11 A. I don't remember, I am sorry.

12 Q. Can I ask you about just a little bit further
13 on, as we go down on to the SI Panel meeting, this is
14 another section. You can see Alison Kelly there, if we
15 go overleaf, please.

16 Again, we do see as I mentioned before midway
17 through that first section may be related to maternal
18 disease but again there's nothing in there that actually
19 identifies the cause of the child's death. Can you see
20 that?

21 A. Yes.

22 Q. You are listed there I think as investigating
23 officer. So at some point you were aware?

24 A. No, I was never an investigating officer.

25 I don't know why my name has been put under that title.
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1 Q. Well, who will have put you down?
 2 A. I really don't know.
 3 Q. And M&M is mortality and morbidity?
 4 A. Morbidity, yes.
 5 Q. So did you have no role in the type of
 6 investigation that went on as the named investigating
 7 officer?
 8 A. So if there was a maternal concern then there
 9 was an obstetric secondary review and I was part of
 10 that.
 11 If there was a neonatal concern there was
 12 Steve Brearey's review and Eirian, that I was generally
 13 included in somewhere along the way. But I wasn't an
 14 investigating officer.
 15 Q. How -- how do you think it's happened that you
 16 were?
 17 A. Sorry?
 18 Q. Why do you think this is there?
 19 A. I really don't know. Sometimes these titles
 20 are preset and people just put names in where they think
 21 appropriate.
 22 Q. And when it says "level of investigation", can
 23 you explain where M&M sits in the hierarchy of
 24 seriousness?
 25 A. I can't. I would have thought that it had

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1 A. I would have thought it was a Coroner referral
 2 in the first instance.
 3 Q. It was a Coroner referral --
 4 A. So --
 5 Q. But does that call off a Serious Incident
 6 investigation if that happens?
 7 A. No, but the Coroner could direct us to
 8 undertake a Serious Incident Review. And I think on one
 9 of the cases I know when we had the neonatal review on
 10 8 February, there had been a request come through from
 11 the Coroner for us to undertake a Serious Incident
 12 Review for long lines and catheter insertion.
 13 Q. So there is a request in fact for this child
 14 repeatedly?
 15 A. Right, so I had seen that, yes. So ...
 16 Q. So just to understand. If -- if a Coroner
 17 referral is made by someone like in Dr Brearey's
 18 position, the Serious Investigation will cease unless
 19 the Coroner asks for it to be done?
 20 A. I really don't know, to be honest.
 21 Quite often the -- they are done in tandem I think
 22 because quite often the Coroner will ask if there has
 23 been a Serious Incident Review. But obviously the
 24 Coroner referral timeline-wise is almost immediately
 25 after the death. So it could be that we have started

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1 been discussed at the Morbidity and Mortality Meeting
 2 and any concerns would have been escalated, which
 3 I would have sent forward to the SI Panel on an SBAR.
 4 Q. Okay. The NHS Framework for Serious Incidents
 5 requires a root cause analysis to be done.
 6 A. Yes.
 7 Q. Does Child A's death qualify as a Serious
 8 Incident in the sense that he died unexpectedly without
 9 explanation within an NHS setting?
 10 A. So as I say the review that Steve Brearey did
 11 and I wasn't, I was in America at the time of this
 12 death, Steve Brearey's assessment, and obviously we have
 13 had an obstetric secondary review here, I would have
 14 expected them to go to the Serious Incident Review
 15 Panel.
 16 So I didn't set the level of investigation. It was
 17 set at the Serious Incident Review Panel that I was not
 18 part of.
 19 Q. Well, I understand that. What I am trying to
 20 ask you is looking at the facts of Child A's death, he
 21 is a premature baby, but he's in stable condition, he
 22 unexpectedly collapses and he dies and there is no
 23 medical explanation identified on investigation.
 24 On the face of it that looks like a Serious
 25 Incident?

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1 a Serious Incident in the meantime but I don't know
 2 whether it would actually put the brakes on a Serious
 3 Incident Review.
 4 Q. Difficult to say, certainly in my own
 5 experience it can run in parallel and the Coroner asks
 6 for the report and it becomes part of the Inquest but
 7 that's maybe local practice.
 8 A. Yes. As I say, I don't know what happened in
 9 this situation.
 10 Q. You I think left in February; is that right?
 11 A. Yes.
 12 Q. So the communications that went on with the
 13 Coroner are completely outside of your knowledge when it
 14 comes to February onwards?
 15 A. Yes.
 16 Q. The Coroner does appear through their officer
 17 to have requested repeatedly for an SI --
 18 A. Sorry, I can't hear you.
 19 Q. The Coroner's officer repeatedly requested for
 20 an SI or chased up if one had been done but it was never
 21 done?
 22 A. Oh, right.
 23 Q. Are you able to explain why that decision
 24 might have come about at least in principle?
 25 A. I noticed in my document bundle that there was

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1 an email from the legal department titled "Urgent"
2 from -- well, it had obviously come from the Coroners's
3 officer to the legal department asking for that SI to be
4 undertaken.

5 I unfortunately didn't get the email until the day
6 after we had done the neonatal review because it was
7 only sent to me on 8 February, although the initial
8 email was at the end of January, so I don't know.

9 **Q.** On the 28th.

10 **A.** I don't know what that delay was caused by.

11 Obviously I was on the point of leaving, so
12 I escalated that to my line manager, Ruth, and in my
13 response to the legal department in the hospital,
14 I think I had put that Ruth had determined that it
15 wasn't -- I think she -- I can't remember the wording.
16 It was to wait and see the outcome of some meeting or
17 review. But obviously that was -- I presume I had left
18 by that stage.

19 **Q.** Well, I appreciate you are doing the best you
20 can. This may be a question for Ms Millward; is that
21 right?

22 **A.** Why there was no follow-up, yes, definitely.

23 **Q.** Okay. When it comes to this Datix document,
24 if I am calling it, is this called a Datix document?

25 **A.** It is just called a Datix.

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1 probably know, the rashes that the children had become
2 a thing of significance because it led Dr Jayaram to
3 think these children may have been injected with air, so
4 there was information within the hospital that could
5 have been captured?

6 **A.** There was, yes.

7 **Q.** By an internal investigation potentially?

8 **A.** Yes.

9 **Q.** I can't say it would have been.

10 **A.** And I am surprised it wasn't picked up on
11 Dr Brearey's review, to be -- to be honest, the same
12 with the insulin results that we had.

13 **Q.** Precisely.

14 **A.** They seem to have all been overlooked and
15 I think having a Serious Incident Review -- well, we
16 will never know now whether it would have identified
17 those at the time.

18 **Q.** But do you accept in principle the hospital
19 were in possession of some information in respect of
20 this child and indeed in other children that could have
21 led internally to the recognition earlier on of an
22 untoward event?

23 **A.** Potentially. But as I say on those initial
24 results, those things weren't picked up then.

25 **Q.** On the question of insulin, is overdose of

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1 **Q.** Just called the Datix?

2 **A.** Yes.

3 **Q.** It records the Inquest results?

4 **A.** Mm-hm.

5 **Q.** The Inquest result is that the death is
6 unascertained and there the story ends when it comes to
7 investigation of the child's death within the hospital?

8 **A.** Mm-hm.

9 **Q.** Is that an appropriate response, the Coroner's
10 investigation has proceeded, the Coroner's investigation
11 has not found an answer. But the other routes that
12 could find answers, the SI route, et cetera, the
13 root cause analysis, have not been undertaken and never
14 do get undertaken?

15 **A.** I think if we had postmortem results and the
16 Coroner had been involved I'm not sure what else we
17 would find out at a Serious Incident Review.

18 **Q.** Well, in this case of course you know what you
19 might have found out: the child was murdered.

20 **A.** Yes, in retrospect we have that knowledge now
21 but we didn't at the time. There were no suspicions at
22 the time and with this being the first baby death.

23 **Q.** Again I have to take issue with that to some
24 extent and it may be outside your knowledge but you
25 mentioned the rash that the child had had. As you

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1 insulin or giving children a child insulin that isn't
2 medically required, is that a Never Event, or do
3 Never Events -- gross errors of administration?

4 **A.** I'm not sure whether it falls within a Never
5 Event. Insulin is mentioned somewhere, but I would have
6 to have the document in front of me, sorry. The list of
7 Never Events.

8 **Q.** It is mentioned but I think it's probably too
9 much of a digression to take you to the wording of it.

10 Can I just put it this way perhaps: giving a child
11 a large dose of insulin that they don't require lead to
12 go their collapse must be a Serious Incident requiring
13 investigation?

14 **A.** I don't think anybody would dispute that.

15 **Q.** Just involvement of the parents. The parents
16 are mentioned a number of times in here being spoken to
17 and the Datix documents and there's mention of a duty of
18 candour.

19 To what extent did you feel that there is
20 an obligation to keep the parents updated about the
21 investigation process?

22 **A.** I think there is an obligation there to keep
23 them updated, yes.

24 **Q.** So if, for example, a Serious Incident
25 Investigation proceeds, would you expect the parents to

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1 be notified of that?

2 **A.** Yes, I would.

3 **Q.** Who by?

4 **A.** So that would usually be the clinical staff
5 who have been dealing with the parents and explaining
6 things as they have gone along. I think -- at the time
7 I was due to leave I think we were looking at having
8 a key person in the risk team to be a point of contact
9 for parents. But I -- that's just a vague memory,
10 I don't know whether that actually happened.

11 **Q.** The risk team?

12 **A.** Just having somebody as a point of contact if
13 they had any questions, not to actually deliver the duty
14 of candour that was felt it should be a clinical person
15 doing that, so they could explain, you know, the report
16 what we had looked at, the significance of the findings.

17 **Q.** Would you expect the person contacting the
18 family to not simply try and deal with their questions
19 and update them about what's going on but trying to see
20 if they have any information that may be of value to the
21 investigation itself?

22 **A.** Yes, and that's certainly with the
23 introduction of the medical examiner service, they put
24 the emphasis on the bereaved in that service and they
25 would particularly ask the bereaved for any information

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1 name is Jamieson.

2 Really what I would like, please, is your
3 perspective on the importance of critical challenge in
4 the management of risk because what you have told us
5 about your background is that you had a unique
6 perspective to bring through your long experience in the
7 NHS and indeed your training as a lawyer.

8 My questions are going to centre on that meeting
9 when you came back from your annual leave in the July of
10 2015 and the information that was available to that
11 meeting and the actions that came out of it.

12 Now, I acknowledge, as you have said, that in
13 relation to that meeting on 2 July, 2015 you, as you sit
14 there, have no memory of that meeting?

15 **A.** No, sorry.

16 **Q.** But just to put the pieces together as best we
17 can, this was a Serious Incident meeting?

18 **A.** My understanding was that it was a Serious
19 Incident Review Panel meeting --

20 **Q.** Right.

21 **A.** -- to determine whether it was going to be
22 a Serious Incident. I think they determined that they
23 wanted the obstetric secondary review and the neonatal
24 review brought together on a Level 2 template.

25 **Q.** That is the output of the meeting, isn't it?

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1 that they have that might be relevant.

2 **Q.** So in Mother A and B's case, she could have
3 said, for example: I remember this rash on my child,
4 have you investigated it? And that may have fed back
5 into the investigation team?

6 **A.** I -- yes, yes. That is as it ought to be.

7 **MR SKELTON:** Thank you. Thank you.

8 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
9 I saw Mr Baker wasn't here, and I'm afraid I inferred
10 that there were no questions.

11 **MR JAMIESON:** I'm afraid you have the understudy
12 my Lady.

13 **LADY JUSTICE THIRLWALL:** You are very welcome.

14 Questions by MR JAMIESON

15 **MR JAMIESON:** What I was going to do before
16 I started was just to remark that this witness had been
17 giving evidence for quite a long time but it is also
18 quite close to 1 o'clock so through you, my Lady, if
19 I may, as to enquire whether she would like to go on
20 a bit longer and finish?

21 **A.** I would sooner finish, if it's okay.

22 **LADY JUSTICE THIRLWALL:** I thought you might but
23 thank you very much for raising that.

24 **MR JAMIESON:** Thank you, Mrs Peacock, I also ask
25 you questions on behalf of the Family groups, okay? My

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1 **A.** Yes.

2 **Q.** We will look at that later.

3 **A.** So it wasn't.

4 **Q.** Really what I am interested in is that type of
5 meeting. Was that one that you would typically go to or
6 was this unusual for you?

7 **A.** It was unusual, yes.

8 **Q.** Yes, and the attendance at the panel, was that
9 also unusual? For your memory, what we have are
10 Alison Kelly and Sian Williams who were the director and
11 deputy Director of Nursing. We had got Ruth Millward
12 who was the head of risk and your boss, and
13 Julie Fogarty, the Head of Midwifery Stephen Brearey and
14 yourself, so a high powered group of individuals, is
15 that a fair summary?

16 **A.** Yes.

17 **Q.** Yes. Now, your role at that sort of meeting
18 I know you have no memory, but would it have been to
19 ensure that the relevant information was there for
20 everybody to consider, would that have been part of your
21 role?

22 **A.** So I didn't usually attend these meetings.

23 **Q.** No.

24 **A.** So I didn't know the format of them. I think
25 Steve Brearey supplied the information and from

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1 a neonatal perspective and Julie Fogarty was the head of
2 midwifery provided the obstetric overview.

3 So no, I didn't contribute at that meeting.

4 **Q.** Really what I am particularly interested in
5 respect the Datixes if that is the plural for each of
6 these children that we have had a bit of a look at, we
7 will look at again in a moment, were those available at
8 the meeting, had the attendees read them ahead of time,
9 what was your expectation?

10 **A.** I don't know, sorry.

11 **Q.** You don't know?

12 **A.** I would presume that they -- they were not
13 available, but I can't be certain about that.

14 **Q.** Maybe just look at something that may help.

15 It's a document, I am sorry, we have looked at
16 a couple of times, but we will do it quickly. It is
17 Datix for Child A, it is INQ0000016.

18 Now, we have looked at this lots of times. I'm not
19 going to take you through what you have been through
20 already but what we have on this first page are the
21 initial details of what is reported.

22 If we go on to page 5, please, we have the SBAR
23 which you have told us is the then subsequent
24 investigation that takes place upon the reporting of
25 a Datix, but then it's really just at the bottom of this

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1 Is this or if I were to suggest to you that this
2 looks like a minute of that meeting, can you help me?

3 **A.** As I say, I really don't remember. I don't
4 recall at all.

5 **Q.** All right.

6 **A.** I was used to the Datix forms having the
7 person's name and time if they made an amendment to the
8 form.

9 **Q.** Sorry, say that --

10 **A.** I was used to the Datix forms actually logging
11 who had made any amendments.

12 **Q.** Yes.

13 **A.** The date and time that those amendments had
14 been made. So without seeing that on here, I wouldn't
15 know whether it was my work or not.

16 **Q.** I think we are going to see an example of that
17 in a moment and you're right that there isn't one here.

18 But what I can see, just looking at this page, is
19 that under "SI tracker", somebody called Janet McMahon
20 has stated as at 10 August '15 that this report is
21 complete. Can you see that?

22 **A.** I can, yes.

23 **Q.** And if we went on to page 8 of this document,
24 thank you very much, we would see right at the bottom
25 the closed date, this document is being marked as

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1 page.

2 Can you see that this is a section that's headed
3 "SI Panel meeting", it has the date of that meeting that
4 took place, 2 July, and then thank you very much, if we
5 could just go on to the next page, so page 6, it is the
6 follow-on. That appears to be a minute or a note of
7 what was discussed on that meeting, 2 July.

8 My question is, would that have been one of your
9 tasks, the inputting of this information into this
10 document to take away from that meeting?

11 **A.** I didn't normally update Datix with -- as
12 I say, I didn't go to the SI Panel meetings.

13 **Q.** I understand that. But in relation to this
14 meeting --

15 **A.** I really don't know, I'm sorry.

16 **Q.** In relation to this meeting you are there, you
17 are, and I say this respectfully, but I think you are
18 the most junior --

19 **A.** Yes.

20 **Q.** -- of the attendees?

21 **A.** Yes, I accept that.

22 **Q.** So we can see although you are clear that you
23 would not have been the investigating officer, the name
24 that has been attached to the bottom of this segment is
25 yours, Debbie Peacock.

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1 completed on 10 August 2015.

2 **A.** Mm-hm.

3 **Q.** So it doesn't look like any entries or any
4 substantive entries after that point in time.

5 Now, Mr Skelton has just asked you questions about
6 what you had said about thinking natural causes for the
7 death and in fact when you looked at the contents of
8 what was here, there was nothing that proved natural
9 causes?

10 **A.** No, we had no conclusion.

11 **Q.** The question was still open.

12 **A.** Mm-hm.

13 **Q.** Right. So with that in mind, can we go all
14 the way back to page 1, please. The risk grading of
15 this form at the point that it is closed looks very much
16 like it is graded as: no harm. Can we see that?

17 **A.** Yes.

18 **Q.** The potential for harm is there and it has
19 been properly noted, but the decision at the point of
20 closure of this form when the postmortem and the
21 Coroner's investigation is not going to be completed for
22 another year, I believe, is that there is no harm and no
23 actual harm. And those gradings really mattered for
24 your system, didn't they?

25 **A.** They mattered for pulling the Datix data

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1 together, yes.

2 **Q.** Yes.

3 **A.** Yes.

4 **Q.** Perhaps we can just illustrate that point now
5 before we look at another Datix. That will be the end
6 of that document, thank you very much.

7 If we go to the trend report that again we have
8 looked at briefly, so that's INQ0015141. Now I make --
9 we can see from the date of it it's not dealing with
10 this cluster of deaths, it's not that time period but it
11 would have captured at least one other death during this
12 period --

13 **A.** Yes.

14 **Q.** -- and some collapses. But we can see that if
15 we go on to page 3, please, we can see the overall
16 incident table that you have pulled together, as
17 I understand it, for presentation at one of the
18 governance boards. They are graded by department and if
19 we go on to page 6 we can see the particular table for
20 the NNU and we can see just looking at that top table
21 the way in which these risks are brought to the
22 attention of the governance board is in order of their
23 harm: none, low and moderate.

24 And if I just look under that table, I can see that
25 the text underneath; no harm incidents do not have

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1 secondary review and the neonatal review on to the one
2 document.

3 **Q.** When are you talking about? Are you talking
4 about into 2016?

5 **A.** No. I had left by then. I am talking about
6 the one after the July meeting that I was asked to pull
7 together.

8 **Q.** Right, okay.

9 **A.** So it was regraded as severe harm. Because
10 that was viewed as a Serious Incident, a Level 2, that
11 would have been mentioned further down in my report
12 because I would generally put --

13 **Q.** Okay.

14 **A.** -- RTAs --

15 **Q.** Okay --

16 **A.** -- or whatever. So it would be included in
17 this report and it would go to the board as a report
18 with an action plan for us to follow up at board. So it
19 was very clearly it would be on that.

20 **Q.** So I believe what you are referring to is the
21 report that was put together in relation to Child D?

22 **A.** Yes.

23 **Q.** Is that the one you mean?

24 **A.** Yes.

25 **Q.** So what you are telling me is because of those

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1 a further description, but where there is some harm

2 there will be a short explanation.

3 So I looked at the low harm incidents. I can see
4 three health and safety incidents, two inoculation
5 charts injuries and:

6 "A falling window blind hit a member of staff on
7 the hand and a baby's identification band marked the
8 skin even though it was not tight (skin remained
9 intact)."

10 And then there is a description underneath that of
11 the moderate harm of a member of staff who scalded her
12 hand as a result of not following the standard operating
13 procedure for a particular item.

14 So if I looked at that table and I am on that
15 board, the understanding I am going to take is that
16 there have only been a few incidents that have caused
17 harm and they are of the nature of what I have read
18 about in that text, aren't they? There's not going to
19 be anything in there that tells me about sudden and
20 unexpected baby deaths?

21 **A.** So if you look at the report that was pulled
22 together on the SI template, I think it was regraded as
23 severe harm.

24 **Q.** Which one, sorry?

25 **A.** The -- the combination of the obstetric

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1 two things were put together in that particular case,
2 there was a special report --

3 **A.** Yes.

4 **Q.** -- which would have highlighted its import?

5 **A.** Yes.

6 **Q.** Fine. Thank you. That's important evidence
7 and I am glad you have given it.

8 But just in relation to the point that I am making
9 with you, the grading of the harm in those Datixes
10 really matters because unless there are one of those
11 stage 2 reports, which brings the risk to the attention
12 of the board in another way, all they are going to get
13 is this?

14 **A.** But if it had been deemed that there was no
15 harm, there wouldn't be anything to report at that
16 stage --

17 **Q.** Yes.

18 **A.** -- apart from the rise in mortality.

19 **Q.** But that's the point I am making --

20 **A.** And the rise in mortality would have come at
21 the end of the year in my report then when we had the
22 full year to look at and we could break it down further
23 from there.

24 **Q.** I think with an eye on the time, I am going to
25 really compress this right down and just look -- since

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1 you raised Child D, may we just look at Child D. Could
2 we look at the Datix INQ0002658.

3 Now, again we have looked at this one already we
4 are going to look at it in a bit more detail now. This
5 unusually is the Datix, as I understand it, that related
6 to the mother, not the child?

7 **A.** Yes.

8 **Q.** But as we are going to see much of the content
9 of it actually does relate to the child?

10 **A.** Mm-hm.

11 **Q.** But I give that clarification at the start
12 because when we look at risk grading, which is put at
13 actual harm, result: actual harm, actual harm, moderate,
14 potential for harm, low potential harm; in fairness, we
15 should probably be looking at it through the lens of the
16 mother rather than the baby.

17 But in relation to the details we have them there.

18 If we could just go on to page 2, please. If we
19 just crop in on the top half of that page. Do you
20 remember that you said to me your experience of this
21 system was that when an amendment was made to it there
22 would be a date stamp?

23 **A.** Yes.

24 **Q.** As I look at that first paragraph, there are
25 three date stamps. So I say first paragraph, can you

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1 **Q.** So can we take it that from that date and that
2 time, this information was available to anybody who
3 looked at this date Datix?

4 **A.** I presume so, yes, who had access to the
5 Datix.

6 **Q.** Okay. Did you read what you copied and pasted
7 into it?

8 **A.** Sorry, I don't remember.

9 **Q.** What was your practice? Would you have just
10 copied and pasted it without reading it given that your
11 job --

12 **A.** No, I would usually have read it to see
13 whether there was any pushback that I needed, any
14 challenge on what Steve or clarification from what Steve
15 had found.

16 **Q.** Right. So we know that as at 24 June, a week
17 or so before you go to that meeting on 2 July, you have
18 received this email, you have put it into this Datix and
19 we have got the familiar analysis of any common issues
20 in that second paragraph underneath.

21 There don't seem to be any common items of
22 infection or equipment or location. But there is
23 a common member of staff.

24 The final document, please, that I would ask us to
25 look at is the Level 2 report, as you have called it,

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1 see three entries on the left-hand side?

2 **A.** Yes.

3 **Q.** At the bottom of that, as I look over to the
4 right-hand side, there are a number of date stamps. The
5 earliest in time is 24 June 15 at 10.45 in the morning,
6 Debbie Peacock. Can you see that?

7 **A.** Sorry, 24 June?

8 **Q.** Yes. So of the three Mr Bennett,

9 Mr Dean Bennett entries --

10 **A.** Yes.

11 **Q.** -- the bottom one, if you look over to the big
12 Registrar on the right --

13 **A.** Yes.

14 **Q.** -- there are then three date stamps at the top
15 of that paragraph.

16 **A.** Oh, yes.

17 **Q.** And it's the one that's just been highlighted
18 for you. Thank you very much, Mrs Killingback.

19 24 June 15 at 10.45 "Debbie Peacock" and then what
20 follows, as has been discussed is the email from
21 Stephen Brearey that has been sent to you?

22 **A.** Yes.

23 **Q.** And you, it looks like, have copied and pasted
24 this into this document at this time?

25 **A.** Yes.

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1 the which is INQ0014204.

2 I think this is the document that you were --

3 **A.** Yes.

4 **Q.** -- talking about in answer to my earlier
5 question. If we go to page 2, please. Can you see
6 under "Detection of incident", the fourth paragraph
7 under that looks like a description, a minute of that
8 meeting of 2 July 15. Can you see that?

9 **A.** Yes.

10 **Q.** The incident was escalated to the Medical
11 Director. Now, did you write that paragraph?

12 **A.** I really don't know.

13 **Q.** Okay. Because what it records there is that
14 it records the meeting, it tells us that in addition to
15 the Director of Nursing and quality, that's
16 Alison Kelly, this matter had also been escalated to the
17 Medical Director at that time, but there had been three
18 neonatal deaths in a short period of time and the
19 circumstances were discussed to identify if there was
20 any commonality which linked the deaths.

21 And that section of that email that you had put
22 into that Datix were circumstances which potentially
23 related to commonality of the deaths, didn't it?

24 **A.** Yes.

25 **Q.** Yes. So you have no memory as to what was

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1 discussed?

2 **A.** No, sorry.

3 **Q.** But this record, close to the time, tells us
4 that those are the sort of features that were being
5 discussed.

6 What it goes on to say is that two of the babies
7 had medical conditions which could be clearly seen to
8 have contributed to their deaths.

9 Now, just pausing there. Mr Skelton did the
10 exercise with you with Child A. Actually when you
11 looked at that Datix, it didn't tell you that there was
12 something in the background that caused the death:
13 maybe, maybe not; the question was not answered.

14 If we looked, if we had the time to look at the
15 Datix for Child C, we would do a similar exercise. I am
16 not going to do it with you now but I am just going to
17 note it.

18 But what it goes on to say is this:

19 "The third baby appeared to be an unexplained death
20 and at this time the baby's cause of death was unknown.
21 It was agreed that no further investigation was
22 warranted at this stage as there were no concerns
23 highlighting any obstetric or neonatal views. However,
24 the SI panel were of the opinion that the obstetric
25 secondary review findings and the neonatal findings

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1 know, I'm sorry.

2 **Q.** But this, you are telling us in clear terms,
3 this is the outcome, this is the decision of that
4 meeting of 2 July '15, which had the membership that
5 I set out with you at the start.

6 **A.** So my understanding is that they were going to
7 reconvene when we had the postmortem results --

8 **Q.** Right.

9 **A.** -- to determine then if there were further
10 actions required.

11 That was my understanding reading the document.

12 **Q.** And in fairness to you that postmortem
13 I think, or at least the Coroner's investigation,
14 completed after you had left the Trust?

15 **A.** Right.

16 **MR JAMIESON:** There it is. My Lady, thank you very
17 much. I apologise if I have trespassed into the lunch.

18 **LADY JUSTICE THIRLWALL:** Not at all. Thank you
19 very much, Mr Jamieson.

20 **MR JAMIESON:** So sorry, there is another page that
21 we are asked to put to the witness. (Pause)

22 I'm sure we can put that right at a different time.

23 Thank you very much.

24 Questions by LADY JUSTICE THIRLWALL

25 **LADY JUSTICE THIRLWALL:** Very well. Thank you very

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1 should be put into this one report."

2 That's sort of set out even more starkly if we go,
3 please, to page 8. Care and service delivery problems
4 are set out. They are of the nature that they are.

5 Underneath there: alleged contributory factors:
6 none. So nothing here that can have contributed to the
7 death. Root causes: no root cause has been identified.

8 But yet no further analysis is going to be
9 undertaken at this time. That's really what I would
10 like your reflection on, your understanding on.

11 You have -- The Families would say to you that all
12 of the information in relation to Child A and Child C
13 was there to see that these were unexplained deaths at
14 the time.

15 But putting that to one side, in relation to
16 Child D, that is your conclusion. This is a sudden
17 death, it's an unexpected death, it's an unexplained
18 death. Why was there not more consideration?

19 **A.** So this wasn't my conclusion. I have
20 obviously -- I don't know where I have taken this from.
21 This report would have been circulated to the staff at
22 the meeting before it was finalised. So I don't know
23 whether it's been tweaked along the way. I don't know
24 where I have got this information. I thought I had
25 copied and pasted it looking at it. I really don't

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1 much, Mr Jamieson and Mr Kennedy.

2 Mrs Peacock, I have just got two brief matters to
3 ask you about. I asked you a question earlier, where
4 I had obviously not listened carefully to what you had
5 said in the first place. It was in relation to the
6 chart that we have looked at -- well, we have, you
7 haven't looked at -- many times with the name of the
8 various nurses who were on shift when babies collapsed.

9 And you said, quite rightly, that what you had said
10 was that she hadn't been looking after the babies and I
11 asked you why you were saying that, and you rightly say
12 it's in the chart which of course we all know well.

13 I had a note of what you said earlier and I want to
14 check that I have got this correct and if not, you just
15 tell me. Much earlier in your evidence, when you were
16 being asked about the fact that it looked as though
17 there was a nurse who was present for number of the
18 deaths, I have noted you as saying -- and I have not
19 been able to check it on the transcript -- she wasn't on
20 duty for other deaths.

21 Now, did you mean she wasn't on duty for other
22 deaths or did you mean she wasn't always the allocated
23 nurse?

24 **A.** So my understanding was that there were other
25 deaths -- where they fell, I don't know in the timetable

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1 of, of -- that we have here --
 2 **LADY JUSTICE THIRLWALL:** So sorry --
 3 **A.** -- that she wasn't actually present on the
 4 unit for.
 5 **LADY JUSTICE THIRLWALL:** Thank you. So my note is
 6 correct. She wasn't on duty for other deaths. I don't
 7 suppose you are able to help us as to which ones?
 8 **A.** I'm sorry, I wasn't involved in the trial at
 9 all, so I don't know the indictment babies or the
 10 others.
 11 **LADY JUSTICE THIRLWALL:** No, all right. Thank you.
 12 Then one last question, if I may. You were asked
 13 very early in your evidence about the Clothier report in
 14 relation to Beverley Allitt and one of the
 15 recommendations being that there needs to be
 16 a heightened awareness of malevolent intent and you
 17 referred us to an algorithm --
 18 **A.** Yes.
 19 **LADY JUSTICE THIRLWALL:** -- which you had.
 20 But just so I understand it correctly. The
 21 algorithm doesn't anywhere direct you to consider
 22 malevolent action, does it?
 23 **A.** Yes, it does.
 24 **LADY JUSTICE THIRLWALL:** Oh, it does?
 25 **A.** It starts off: did they do it? Was the
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1 **LADY JUSTICE THIRLWALL:** Yes, I can see there's
 2 someone who knows better than you.
 3 **MS BROWN:** Yes, yes, I am told we will.
 4 **LADY JUSTICE THIRLWALL:** Good. I think Ms McMahon
 5 has probably been waiting all morning, but I'm afraid we
 6 will start again at quarter past 2.
 7 (1.12 pm)
 8 (The luncheon adjournment)
 9 (2.15 pm)
 10 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
 11 **MR DE LA POER:** My Lady, the first of our two
 12 witnesses for the afternoon is Janet McMahon and
 13 I wonder if she might come forward, please.
 14 **LADY JUSTICE THIRLWALL:** Yes, do come forward,
 15 Ms McMahon.
 16 MRS JANET MCMAHON (Sworn)
 17 Questions by MR DE LA POER
 18 **LADY JUSTICE THIRLWALL:** Do sit down.
 19 **A.** Thank you.
 20 **MR DE LA POER:** Please can you state your full
 21 name?
 22 **A.** Mrs Janet Lesley McMahon.
 23 **Q.** Mrs McMahon, is it correct that you have
 24 provided to the Inquiry two witness statements, one
 25 dated 13 June of this year and one dated 3 October of
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1 outcome intended? And it takes you through.
 2 But the actions for "yes", if it was intended is
 3 consider the police.
 4 **LADY JUSTICE THIRLWALL:** Thank you. But you never
 5 referred to it when considering this case because ...?
 6 **A.** There was no act or omission at that stage for
 7 us to consider it in relation to any person.
 8 **LADY JUSTICE THIRLWALL:** Does it mean, therefore,
 9 and I just want to understand because you mentioned that
 10 you had always at the back of your mind the possibility
 11 of malevolent intent, or whatever phrase you might use,
 12 but that never came to the front of your mind?
 13 **A.** On the information that I had, no,
 14 unfortunately.
 15 **LADY JUSTICE THIRLWALL:** All right. Thank you very
 16 much indeed, Mrs Peacock. You are now free to go.
 17 **A.** Thank you.
 18 **LADY JUSTICE THIRLWALL:** Ms Brown, are you able to
 19 help about the timetable for the afternoon? I know we
 20 have got Ms McMahon.
 21 **MS BROWN:** Yes. We have two witnesses that are
 22 being called this afternoon.
 23 **LADY JUSTICE THIRLWALL:** Yes. Are we going to
 24 complete their evidence this afternoon?
 25 **MS BROWN:** I'm just looking behind me.
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1 this year?
 2 **A.** That's correct.
 3 **Q.** Are the contents of those two witness
 4 statements true to the best of your knowledge and
 5 belief?
 6 **A.** Yes, they are.
 7 **Q.** We will begin with your background. Did you
 8 qualify as a Registered Nurse in 1985?
 9 **A.** Yes, I did.
 10 **Q.** And then in 1987 as a midwife?
 11 **A.** Yes.
 12 **Q.** At that stage, did you start work at the
 13 Countess of Chester Hospital?
 14 **A.** Yes.
 15 **Q.** If we move forward in time to 1998, from that
 16 date forward, did you work predominantly as a midwife on
 17 the labour suite?
 18 **A.** Yes, I think so, I wouldn't be sure of the
 19 dates, but I think so.
 20 **Q.** Around that time at least?
 21 **A.** Uh-huh.
 22 **Q.** Moving forward approximately a decade. You
 23 tell us in your witness statement that you became
 24 a governance facilitator in 2007 --
 25 **A.** Yes.
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1 Q. -- is that right?
 2 A. Yes.
 3 Q. Which department did the governance
 4 facilitator role work from?
 5 A. At that time I worked for therapies, pharmacy,
 6 radiology.
 7 Q. At what stage did you join the Risk and Safety
 8 Department?
 9 A. That was the Risk and Safety Department. It
 10 just -- we just changed names.
 11 Q. So to all intents and purposes it was the same
 12 department, just differently branded?
 13 A. Yes.
 14 Q. In terms of the role of governance facilitator
 15 as it started out, in summary what were you expected to
 16 do?
 17 A. Look at incidents daily for the areas that
 18 I covered and look into any concerns that were raised.
 19 Q. In the early stages in terms of the areas that
 20 you covered, did that include obstetrics?
 21 A. Not initially.
 22 Q. Did there come a point in time where it
 23 included obstetrics?
 24 A. Yes. So I worked for the therapies division
 25 for probably a couple of years and then moved back to

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1 2015, Ruth Millward was well-established as the head of
 2 that department; is that right?
 3 A. Yes.
 4 Q. And you, who had been there even longer in
 5 that department, were also well-established; is that
 6 fair?
 7 A. No, Ruth was in the department when I joined.
 8 She was a governance facilitator at the same time that
 9 I was but I joined later.
 10 Q. Forgive me, I should have been clearer in my
 11 question. She was well-established as the head of the
 12 department --
 13 A. Yes.
 14 Q. -- by the time we get to 2015?
 15 A. Yes.
 16 Q. But in terms of her experience of the
 17 department overall, obviously that stretched back before
 18 she took that role?
 19 A. (Nods)
 20 Q. Just continuing with your history. We know
 21 that Debbie Peacock who the Inquiry heard from this
 22 morning, and I think you were present in the room when
 23 she gave at least some of her evidence, left the
 24 Countess of Chester in February of 2016?
 25 A. (Nods)

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1 Women's and Children's.
 2 Q. Once you moved back to Women's and Children's,
 3 did your role include looking at neonatal incidents?
 4 A. Yes.
 5 Q. In terms of your background, experience and
 6 training, did you have adequate knowledge as someone who
 7 had practiced as a midwife to do your role so far as
 8 neonatal medicine was concerned?
 9 A. I believe so.
 10 Q. What level of knowledge did you need,
 11 practically speaking, to be able to do that role when
 12 looking at an area that you hadn't practiced in?
 13 A. To be aware of potential risks and when to
 14 escalate them for other people who had more neonatal
 15 knowledge than I did.
 16 Q. Now, we know from Ruth Millward's statement
 17 that initially on an interim basis but that was then
 18 confirmed into a full role, she was the head of the Risk
 19 and Safety Department from about 2013. Does that accord
 20 with your recollection?
 21 A. Probably. I wouldn't know the dates but
 22 I think so, sounds --
 23 Q. That sounds about right?
 24 A. That sounds about right.
 25 Q. To put it another way, by the time we get to

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1 Q. At which point her role became effectively
 2 vacant. The Inquiry has information to suggest that you
 3 may have undertaken her role for a period of time on an
 4 interim basis; is that correct?
 5 A. Yes, at the same time as doing my other role.
 6 So I was covering -- it was a dual role, but yes, for
 7 the three months before Annemarie joined, yes.
 8 Q. Absolutely. And when by the time we get to
 9 May 2016 Annemarie Lawrence then took over the role that
 10 Debbie Peacock had previously undertaken and which you
 11 had filled in for?
 12 A. Mm-hm.
 13 Q. In terms of that period February 2016 to
 14 May 2016, you have described it as a dual role.
 15 Were you given any more hours or pay or anything to
 16 reflect the fact that you were expected to do more than
 17 you had previously?
 18 A. I don't believe so. I don't recollect.
 19 Q. How well placed do you consider you were, at
 20 the time, to take over that role from Debbie Peacock for
 21 a period of time?
 22 A. With my background of midwifery and previously
 23 having covered the obstetrics and gynae departments,
 24 I felt able to do that, from an experience point of
 25 view. But obviously time-wise there was a conflict.

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1 Q. So no difficulty in terms of your
2 qualification for the role in your mind, tell me about
3 the time conflict as you have characterised it, what do
4 you mean by that?

5 A. Because if you are doing two people's jobs,
6 you can't do them both the same as if you are only doing
7 your own.

8 Q. Were you effectively performing two full-time
9 roles or did you have any support for the two roles that
10 you were undertaking?

11 A. I don't really remember. But I imagine that
12 you would prioritise differently given the two
13 workloads.

14 Q. Just looking back on it and being as
15 reflective as you can, do you think that you gave
16 sufficient time in that conflict situation as you have
17 described it, to the Risk Midwife role or do you think
18 that you were compromised in that?

19 A. I think I probably did the best I could. It's
20 quite often that situation happens, where a member of
21 staff leaves and they are not replaced for some time
22 afterwards so it's a recurrent happening in the NHS that
23 roles aren't covered immediately. So that work has to
24 be covered by somebody else in the interim.

25 Q. The role of Risk Midwife which you were
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1 Q. What were those main differences, please?

2 A. So as Project Lead I focused on certain areas,
3 for example I think at the time I was looking at falls
4 in the Trust, it was a high safety incident so we looked
5 at falls and how we could manage them and reduce harm.

6 Q. So we have the period of time when you are
7 doing both the Project Lead role and the Risk Midwife
8 role and I think it was in May of 2016 that you were
9 seconded to the role of Patient Experience Lead; is that
10 right?

11 A. That's correct.

12 Q. Was that also within the Risk and Safety
13 Department or was that in a different department?

14 A. Initially, before I took up the post, it was
15 a different department managed by a different manager
16 and then three teams were merged into one at the same
17 time as I took up that post.

18 Q. So was that in May 2016?

19 A. Yes.

20 Q. Who was your line manager once those
21 departments were merged?

22 A. Ruth Millward.

23 Q. So in terms of line management it remained the
24 same, but you were working with what was had previously
25 been a separate part of the hospital?

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1 covering, is that an important role within the hospital,
2 do you think?

3 A. Absolutely.

4 Q. Did you receive any additional training for
5 undertaking that role or were you just one minute doing
6 one role and presumably after a short period of
7 consultation then doing both?

8 A. I had done the role before. And I had been in
9 the team quite a number of years by then, so I felt
10 qualified and experienced enough.

11 Q. But in terms of things move on in the NHS,
12 computer systems change, practices change, policy
13 changes. Did you feel you needed any additional support
14 to undertake that role?

15 A. I was doing the same role but for different
16 areas. So I was used to the -- the electronic systems,
17 the policies.

18 Q. What had been your role title at the point
19 that you took over the Risk Midwife role on an interim
20 basis as well?

21 A. Project Lead.

22 Q. Was that the same role, Project Lead, as you
23 had had as a governance facilitator or were there
24 differences to it?

25 A. No, there were differences to it.
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1 A. Yes.

2 Q. Did you hold that role for 18 months?

3 A. Just over 18 months.

4 Q. Having undertaken that role for 18 months, did
5 you then come back to a risk role?

6 A. Yes.

7 Q. You tell us that at that time it was described
8 as the Risk and Safety Lead?

9 A. Yes.

10 Q. Again the Risk and Safety Lead, is that
11 different from the Project Lead or is it the same job,
12 just differently titled?

13 A. Similar job, I was just aligned to an area
14 rather than focused on different projects. As a Project
15 Lead I didn't have a certain area to work whereas a Risk
16 Lead, you had certain areas.

17 Q. Finally to complete your history in the NHS,
18 did you retire in 2020?

19 A. I did.

20 Q. So we are just going to move to consider in
21 a little bit more detail the culture in the Risk and
22 Safety Department.

23 Your line manager throughout the period that we are
24 focused upon was Ruth Millward, what was your working
25 relationship with her like?

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1 **A.** I had a very good working relationship with
 2 Ruth for a long time until the merger of the three
 3 services, while I was in secondment post and the
 4 relationship deteriorated quite significantly.
 5 **Q.** That was the subject matter of your second
 6 witness statement; is that right?
 7 **A.** (Nods)
 8 **Q.** If we just deal with that in summary. Once
 9 you were seconded to that post, did you find yourself in
 10 a position where you felt unsupported and effectively
 11 out on a limb?
 12 **A.** Yes.
 13 **Q.** And experiencing a very high degree of
 14 pressure upon you to deliver?
 15 **A.** Yes.
 16 **Q.** So before May 2016, the Inquiry can proceed on
 17 the basis that your working relationship with
 18 Ruth Millward was a good one?
 19 **A.** Yes.
 20 **Q.** What was she like as a manager, what was her
 21 managerial style?
 22 **A.** She had an open-door policy, she was usually
 23 very supportive and welcomed challenge, escalating and
 24 she usually made very good judgments.
 25 **Q.** And in terms of the pressure the department

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1 **Q.** And that you can help us by starting by
 2 providing a summary with the origin of the Datix system
 3 at the Countess of Chester, we don't need precise dates
 4 or anything like that, but how it was first adopted and
 5 for what purpose and then how it developed over time?
 6 **A.** So I can't remember the date it started but
 7 quite some time before I went into the risk team. It
 8 was an electronic system to monitor incident reporting
 9 initially, that is all we did on it by way of being able
 10 to pull reports, recognise trends, themes, do data
 11 analysis.
 12 Then the system grew to include complaints and
 13 claims, the complaints side of things didn't go in there
 14 until I was actually in the patient experience post, but
 15 it was a growing system that was changing very, very
 16 frequently.
 17 **Q.** In terms of who effectively had ownership of
 18 that system within the hospital, did that sit with your
 19 department?
 20 **A.** Yes. I can't remember exactly when but we
 21 employed a Datix compliance manager and so she initially
 22 managed the incidents and then later on it was another
 23 person who came in and that's when the development
 24 started of the programme.
 25 **Q.** But was that person in the Risk and Safety

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1 was under, let's take it in stages, up until the point
 2 that you undertook the interim Risk Midwife role, so up
 3 to the point of February 2016, what was the working
 4 environment in the department like in terms of how busy
 5 it was, how much pressure you were under?
 6 **A.** It was always very busy. Always a lot of
 7 pressure, it's quite a high pressure job looking at
 8 incidents, things that could be going wrong. So it was
 9 always very busy, quite stressful.
 10 **Q.** Once you were undertaking the dual role that
 11 you were for the three-month period before your
 12 secondment, obviously you were much busier, as you have
 13 told us, but how about the department generally, was it
 14 under any greater pressure during that period or was it
 15 the same or were you simply focused upon what you were
 16 trying to achieve?
 17 **A.** I think the pressure was the same for
 18 everybody, it has a knock-on effect because whilst I was
 19 covering two roles, some of the work I should have been
 20 doing would have gone to somebody else. So the
 21 pressures is sort of shared throughout the team.
 22 **Q.** Now, I am given to understand that you have
 23 considerable experience of the operation of the Datix
 24 system; is that right?
 25 **A.** I do.

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1 Department?
 2 **A.** Yes.
 3 **Q.** So they were part of that umbrella?
 4 **A.** Yes, yes.
 5 **Q.** Therefore if it was effectively owned within
 6 the hospital by that department as being the place that
 7 people would turn to if they needed help, does that mean
 8 that that same department had responsibility for
 9 ensuring that everybody else in the hospital understood
 10 what their responsibilities were?
 11 **A.** Yes. And we provided training on mandatory
 12 training days, we did a risk talk which included Datix,
 13 Datix reporting and the purpose of the system.
 14 **Q.** In terms of the reach of that training, I mean
 15 in the beginning of 2015, to take a moment in time,
 16 would it be your expectation that everybody who had
 17 worked in the hospital over the previous 12 months would
 18 have all received Datix training in that time?
 19 **A.** They should have done and also there was
 20 a statement at the top of the report to say that if you
 21 required help that you could contact us and we often
 22 assisted people reporting incidents so the support was
 23 there but it wasn't always taken but it was always there
 24 on offer.
 25 **Q.** Of course that offer of support requires

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1 a person to understand that they need the support, they
2 need to understand their own deficiency or shortcoming
3 or uncertainty before they can reach out; is that fair?

4 **A.** Mm-hm.

5 **Q.** That is not in any way critical of the offer
6 that's made. The Inquiry has seen an example which we
7 will look at with Ruth Millward about how over time
8 definitions can sometimes change or new national policy
9 comes out that expects a different way of working or an
10 improved way of working, was it your experience within
11 the NHS that there were updates to how people were
12 expected to interact with the Datix system or Serious
13 Incident reporting?

14 **A.** I'm not sure so much that there were updates.
15 But we had a very, very high reporting culture
16 nationally. So that kind of indicates that people did
17 know when and how to report. Any updates to the system
18 might go out to that department that's being updated or
19 by a generic email if it affects the whole Trust.

20 **Q.** So from your point of view, just sitting at
21 the place that people can reach out to, what was your
22 overall impression of -- across the hospital of the
23 understanding of what was expected of every single
24 person in terms of Datix?

25 **A.** I believe that most staff knew that they
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1 before we get to that, can we just stay with how Datix
2 works in principle.

3 Is it right to say that there were effectively
4 three important roles at the early stage of a Datix and
5 I will tell you which roles, I mean, you can comment on
6 them. You have the role of the reporter, the role of
7 the handler and the role of the manager?

8 **A.** (Nods)

9 **Q.** Each an important role. So can you just--
10 I mean, the first one I am sure is perfectly obvious,
11 but let's deal with all three.

12 The role of the reporter?

13 **A.** So the reporter has identified an incident and
14 they report it on the Datix system. The Datix will then
15 be accessed within the next working day by the handler
16 who will look through the incident and allocate it
17 accordingly, so, for example, if it was a neonatal
18 incident, it would have gone to Debbie Peacock, if it
19 was a radiology incident at one time it would have gone
20 to me as the manager.

21 **Q.** So if you just pause there. So the handler is
22 a person within the risk department who has effectively
23 as part of their portfolio the department that it's come
24 from?

25 **A.** So they open up Datix in the morning to -- to
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1 should report a Datix incident as soon as possible.

2 Often you would -- when you would read an incident it
3 wouldn't be reported as you would report it because
4 sometimes it's subjective. For example, when things are
5 reported as "no harm" or "severe harm" it might -- be
6 that is their perception at the time and when we do the
7 investigation or review the incident that is when we
8 will change to the realistic categories.

9 **Q.** But of course the important thing is that
10 someone has filled in a Datix so that the incident can
11 start its paper life, it enters the process at that
12 point and then can be reviewed to be improved, updated,
13 corrected, that sort of thing?

14 **A.** Mm-hm.

15 **Q.** But the fundamental point is that none of that
16 happens unless somebody completes a Datix?

17 **A.** No, because as part of the process anybody who
18 recognises an incident should also phone, alert their
19 manager or the risk lead. So completing the Datix is
20 not the be-all and end-all, it is important, but the
21 important thing is to escalate whatever concern you have
22 picked up by either phoning the risk team or your ward
23 manager wherever the incident happened.

24 **Q.** In just a moment we are going to look
25 specifically at your perception of the neonatal unit but
150

1 open and approve all the Datix that have been reported
2 since the last working day.

3 **Q.** So as far as you were concerned when you took
4 over the Risk Midwife for a period of three months,
5 would you have been the handler for any Datix coming
6 from the neonatal unit?

7 **A.** I would have been the manager.

8 **Q.** You would be the manager. Now you mentioned
9 that Debbie Peacock in the context of being the handler,
10 she was the Risk Midwife?

11 **A.** No, the handler is the person who first opens,
12 so the handler every morning will open up the entire
13 Datix system and access all the Datix reports that have
14 been made since the last working day and they allocate
15 to the manager.

16 **Q.** They allocate to the manager and so you and
17 Debbie Peacock sit at the manager level?

18 **A.** Yes.

19 **Q.** So the handler, are they somebody junior to
20 you or in the roles that you had within the Risk and
21 Safety Department?

22 **A.** Junior. When I first started in the role
23 we -- the risk leads, then governance facilitators, used
24 to open and access the Datix. But as time went on, we
25 had administrative staff to do that.
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1 Q. All they are doing is really -- I hope I am
 2 not underselling it here, saying this has come from, for
 3 example, the neonatal unit, Debbie Peacock is the risk
 4 lead for the neonatal unit, I need to put it on --
 5 across her desk?
 6 A. (Nods)
 7 Q. Now, we will come back to how the manager can
 8 change over time and look at some examples, but was it
 9 the manager's role to write what is termed an SBAR?
 10 A. If it was a serious -- if it was a patient
 11 safety harm incident and required an SBAR. Not all
 12 incidents would require an SBARS, it would only be
 13 incidents of concern.
 14 Q. SBAR of course --
 15 A. Sorry, and yes, the manager would do that,
 16 would investigate it, get it an initial picture, write
 17 the SBAR which would go to the Execs.
 18 Q. Situation Background Assessment Recommendation
 19 is what that acronym stands for?
 20 A. Yes.
 21 Q. Presumably that provides a format for the way
 22 in which such a report should be written?
 23 A. That's right, it is a communication tool.
 24 Q. And so the manager looks at the Datix, makes
 25 a decision about whether or not it justifies an SBAR

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1 that decided on the levels of investigation. Level 1 is
 2 a lower level, less concerns, Level 2 would be more
 3 serious where there may have been serious harm, for
 4 example, and every event where something shouldn't have
 5 happened. And Level 3 is more about deaths but I think
 6 it's homicide it's actually classed as in the -- in the
 7 literature.
 8 Q. In terms of?
 9 A. Sorry, external investigations they are
 10 normally, so like the police.
 11 Q. External investigations therefore for police.
 12 So within the system, had somebody been saying in
 13 the clearest possible terms all the way up the chain "We
 14 think that Letby has killed this baby", quite aside from
 15 whether anyone is immediately going to pick up the phone
 16 and call the police and whether that should happen, the
 17 system allows for that position to be arrived at in any
 18 event?
 19 A. Yes.
 20 Q. What is the level of certainty required in
 21 terms of how one classifies Level 1, Level 2 or Level 3
 22 and by that I mean do you simply have to suspect that it
 23 is a homicide to reach Level 3 or do you need to have
 24 some form of evidence or more likely than not standards.
 25 What's -- at that stage what's the test?

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1 having made the enquiries they want to. If yes, then
 2 the SBAR is created and it's sent on to the Execs?
 3 A. It might be discussed with Ruth Millward
 4 before an SBAR is undertaken.
 5 Q. Once an SBAR is written is the expectation
 6 that there will be a Serious Incident Review Panel
 7 convened?
 8 A. So the Serious Incident Review Panel happened
 9 weekly. So any SBARS would go to that panel.
 10 Q. So not convened for that SBAR; because it is
 11 happening --
 12 A. Unless it was something of particular concern.
 13 Q. Is it at that review panel meeting that
 14 a decision is made about whether or not the event is
 15 going to be classified as a Serious Incident so far as
 16 the NHS England criteria is concerned?
 17 A. Yes.
 18 Q. Are there two levels of investigation at that
 19 stage?
 20 A. There is MPSA Level 1, MPSA Level 2 and MPSA
 21 Level 3.
 22 Q. Three. So tell us please what the difference
 23 so far as you can recall between the different levels
 24 are and who's deciding that?
 25 A. So it was the National Patient Safety Agency

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1 A. You would have to have some sort of evidence
 2 to warrant that, the same as you would have to have some
 3 sort of severity to warrant a Level 2 investigation.
 4 Q. Now, Datix was a live system; is that right?
 5 A. Yes.
 6 Q. By that, so I define what I mean, is that it
 7 was constantly running and constantly capable of being
 8 accessed and constantly capable of being updated?
 9 A. Mm-hm.
 10 Q. From an audit perspective, just for the
 11 ordinary user screen, was it sometimes difficult to tell
 12 when an update was applied?
 13 A. No. We usually knew if there had been an
 14 update because the system would go down for a period of
 15 time, so we would have been informed that that was going
 16 to happen.
 17 Q. I don't mean software update.
 18 A. Sorry.
 19 Q. I mean updated information. So if you were
 20 going to change a field within the Datix system, to
 21 change a name or something like that -- well, let's have
 22 a look at an example, I will make myself clearer I am
 23 sure in this way.
 24 INQ0040506. This is the Datix form for Child I.
 25 We will just pick out one or two details on it. We can

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1 see the reported date is 23 October and the submitted
2 time is 9.05?

3 **A.** (Nods)

4 **Q.** Although presumably the time this incident is
5 created on Datix, we don't need to worry about who the
6 handler is, you have told us they have an administrative
7 function and we can see that at the time that this form
8 was -- this moment in time whenever that was from this
9 form, you are identified as the manager?

10 **A.** (Nods) Yes.

11 **Q.** We don't need to worry too much about the
12 moment of time because we are going to just lay this
13 alongside another form. But if we just go over the
14 page, just so that we can satisfy ourselves because
15 obviously multiple people can create Datix entries for
16 the same event.

17 We can see that the reporter at the bottom is
18 Caroline Oakley?

19 **A.** Yes.

20 **Q.** So we know that this is an event in respect of
21 Child I reported by Caroline Oakley at 9.05 on
22 23 October. Let's bring it down and let's please bring
23 up INQ0000457.

24 Again we see this is Child I, we see the time is
25 9.05 but here we can see that the manager who had

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1 have later dates in time, but that was really the point
2 I was making.

3 So can we go back to page 2 just to have a look at
4 the succession management of this event, because we can
5 see under the incident investigation, this is obviously
6 Child I who was murdered on 23 October 2015,
7 Debbie Peacock is the first entry there on 17 December.
8 We can see the 25 January, Debbie Peacock is still
9 identified, unsurprising given that her role was Risk
10 Midwife until February 2016.

11 Then on 1 March, you have sent an email according
12 to the entry for an update on the incident review. The
13 following day, you got a response from the Consultant
14 paediatrician:

15 "Case has been reviewed internally in a tabletop
16 meeting in AHCH ..."

17 AHCH?

18 **A.** Alder Hey Children's Hospital.

19 **Q.** "... and awaiting PM results, will forward
20 draft minutes of thematic review when complete."

21 You have sent a chaser on 15 April:

22 "Further email sent requesting update on review."

23 Is that a request for the thematic review that you
24 are asking for?

25 **A.** I'm not sure.

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1 previously been you is now identified as Mrs Anne-Marie
2 Lawrence.

3 **A.** (Nods)

4 **Q.** If we go over the page just to satisfy
5 ourselves it is the same event, in fact I think we might
6 need to go one more to get to our incident reporter.
7 Just towards the top we can see Caroline Oakley, so this
8 is the same event by the same person, but a field has
9 been updated --

10 **A.** (Nods)

11 **Q.** -- to reflect that at the moment in time that
12 we are looking at, it's Lawrence who is the manager, not
13 you; is that right?

14 **A.** Yes.

15 **Q.** My point really about updates and audits was
16 that just on the face of this document it isn't
17 immediately apparent when that change was made?

18 **A.** No and both the documents are quite different
19 and the only way to see when the change has been made is
20 to get the audit trail so you can print out a copy that
21 shows every date and time a change has been made.

22 **Q.** Absolutely, I am sure that sits in the
23 background of it but just looking at the form, you
24 wouldn't actually be able to tell from that. Obviously
25 you can see that if you lay them side by side some will

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1 **Q.** I mean, the word "review" appears twice in the
2 preceding entry, one that it's been reviewed internally
3 and secondly, the thematic review when complete.

4 **A.** I don't know this is the review that had been
5 done at Alder Hey Children's Hospital.

6 **Q.** The tabletop meeting?

7 **A.** Yes.

8 **Q.** Then we can see again an entry 27 April still
9 with you because Ms Lawrence hasn't taken over by this
10 point:

11 "Still awaiting feedback from review."

12 Presumably those entries you have managed to take
13 from the medical records just to pick out some details
14 because Child I as we know was transferred between
15 a number of hospitals over a period of time, so you have
16 done a little digging to try and get to the bottom of
17 that and put that in and then we can see because we know
18 that Ms Lawrence takes over in May, that she's now the
19 manager and she's got the postmortem report and she is
20 recorded as sending an email to the Consultant
21 paediatrician requesting update on 1 June and a further
22 entry 22nd of the 6th, Ms Lawrence entering some data in
23 -- we can ask her about that.

24 But in terms of just an example, is this the sort
25 of thing that we can see across all the Datix forms that

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1 at various points people have the opportunity to add
2 data, and that managers can change as people move roles?

3 **A.** Yes.

4 **Q.** Thank you very much indeed. We can take that
5 down.

6 That's all that I am going to ask you about the
7 theory of Datix. We are going to have a look shortly
8 potentially at another one, but let's see how we get on.

9 I would like to just ask you some questions about
10 the Women's & Children's Care Governance Board. Was
11 that a committee that you attended?

12 **A.** I believe I attended between Debbie Peacock
13 leaving and Annemarie starting.

14 **Q.** So do we infer from that that you would have
15 attended in your capacity as Risk Midwife?

16 **A.** Yes.

17 **Q.** Well, helpfully we have some Terms of
18 Reference which are dated the period that you began
19 attending that, so we can see what it says about itself.
20 Ms Peacock looked at these earlier in the day but just
21 a couple of things to pick out, INQ0015325.

22 I'm not going to duplicate what Ms Brown asked
23 about this morning, so we can go over to page 2 because
24 we have the membership well in mind.

25 I just wanted to ask you about number 3 on the list
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1 some areas rather than just a single area.

2 **Q.** Did this governance board, as far as you
3 understood it, have a function to consider that
4 particular case if somebody wanted to raise something
5 about it and reflect upon whether it was being managed
6 correctly?

7 **A.** Yes.

8 **Q.** That is rather what governance means, would
9 you agree?

10 **A.** (Nods)

11 **Q.** Similarly, if there was a report that looked
12 at a number of events, again would that be something for
13 this board to consider?

14 **A.** (Nods)

15 **Q.** So as to reflect upon whether the conclusions
16 are right, ask questions, challenge and really just
17 establish whether or not it was being managed properly?

18 **A.** Yes, usually, yes.

19 **Q.** The only other question to ask you about is
20 the next one down says:

21 "Review and monitor staffing levels for obstetrics
22 and anaesthetists and midwifery staff."

23 My question really was this: this is February 2016,
24 which we can see from the next page, but I am sure you
25 have seen it before, you can take that from me, there
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1 or the third on the list. We have:

2 "Review and monitor the risk registers, escalate
3 risks to the divisional and organisational risk
4 registers."

5 Now, we heard from Mrs Murphy about how the risk
6 interacted at the local level and she described for us
7 a situation in which once there is -- an incident is
8 identified at a local level, there will be input from
9 the risk department about that and that by the time the
10 incident is escalated to the Women's & Children's Care
11 Governance Board, a decision has already been made
12 effectively about the level of risk around this incident
13 and how it should be treated.

14 Is that your experience of it or was the risk input
15 at this board level?

16 **A.** It depended on the level of risk which risk
17 register it sat on, you would have a local risk
18 register, a divisional risk register and a board
19 assurance framework so it would depend on the level of
20 risk, where it was reviewed and how it was scored. And
21 then the scoring would then dictate which level of risk
22 register it sat on.

23 **Q.** Would that all be decided before you get to
24 the Women's & Children's Care Governance Board?

25 **A.** Yes. Usually, unless it needed discussion by
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1 doesn't appear to be a similar function in relation to
2 paediatrics or neonatology in terms of their staffing
3 levels?

4 **A.** (Nods)

5 **Q.** Now, obviously you only joined this committee
6 in February on an interim basis but I was just wondering
7 whether you can help us with that, because -- I'll
8 explain why. We know that in December of 2015, there
9 were repeated complaints to the senior management about
10 the staffing levels within the paediatric department
11 generally and yet when we get to February and the Terms
12 of Reference appear to be settled once again, we see
13 only a focus upon the obstetrics side.

14 So can you shed any light on to that?

15 **A.** Well, first of all it is a draft document, so
16 it may have been updated to include neonatal staff.

17 **Q.** Can I just pause you there?

18 **A.** Yes.

19 **Q.** Obviously that is a theoretical possibility.
20 Do you know whether or not that happened or?

21 **A.** No.

22 **Q.** You are just allowing for the possibility
23 because it's got "draft" written on it?

24 **A.** No, I don't know.

25 **Q.** Thank you. Please continue.
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1 A. The other thing is it could be that staffing
2 in obstetrics and anaesthetists and midwifery staff
3 might have been highlighted as an issue and if that were
4 the case, it would indicate that the neonatal staffing
5 wasn't an issue but I don't know the answer.

6 Q. Well, certainly --

7 A. I don't know why the omission.

8 Q. Well, you can take it from me, although you
9 probably can't comment, that certainly there is very
10 clear evidence that by the end of 2015, from both the
11 nursing and a medical side, the managers were being told
12 there is a problem on the paediatric unit?

13 A. (Nods)

14 Q. There we are, that is all that you can tell us
15 about that. Thank you very much indeed for your help on
16 that.

17 I would just like to ask you about the neonatal
18 unit and your experience of the neonatal unit's attitude
19 towards the Risk Department, and that is something you
20 mention in your witness statement.

21 I would just like you to just tell us what your
22 perception was?

23 A. At that time, I didn't actually have -- so
24 from 2015 to 2016 I didn't have any time spent with the
25 unit, the staff. Obviously the short time where I was

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1 for an understanding about when people became aware of
2 particular things.

3 It's now very well-established that there was
4 an increase in the mortality rate on the neonatal unit.
5 When do you think you first became aware of the increase
6 in the mortality rate?

7 A. I can't recall becoming aware of the increase
8 in the mortality rate. The first time I knew of a link
9 a potential link with Lucy Letby was --

10 Q. Can I just, I have --

11 A. I have gone too far.

12 Q. You have moved to my second question --

13 A. Sorry.

14 Q. -- which will be when a member of staff might
15 be resolved in it. I am just talking about the fact
16 that there were more deaths on the neonatal unit than
17 people were expecting. When do you think your first
18 awareness of that was?

19 A. I really couldn't pinpoint when I was -- when
20 I first became aware and I think now my memory is very
21 muddled by things that I have read and heard since, so
22 it's hard to pinpoint any particular time.

23 I -- I don't believe I was aware before May 16 that
24 there was.

25 Q. Before May 16. If I can give you some moments

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1 covering that role I will have had some interaction with
2 them. I didn't pick up anything that concerned me in
3 any behaviours.

4 Q. You didn't pick up anything. What you suggest
5 in your statement is that -- it's paragraph 5 if you
6 want to look at it:

7 "Governance has historically not always been
8 welcomed and/or understood by some clinicians, which at
9 times could lead to difficulty with some professional
10 relationships and maintenance of robust governance
11 policies. I would not be able to pinpoint anything in
12 particular between the years 2015 and 2016 or that
13 specifically affected the neonatal department at that
14 time."

15 So are we to take it that that comment is across
16 the hospital, rather than intended to be -- because the
17 preceding paragraph is talking about the NNU I was just
18 trying to understand whether or not the clinicians you
19 are referring to were paediatric clinicians who worked
20 on the neonatal department or whether it wasn't
21 specific?

22 A. It wasn't specific. I think that was a more
23 general observation.

24 Q. The second question about the neonatal unit is
25 to the best that you are able to help us it's important

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1 in time, we have got the period before February 2016
2 when you took over the Risk Midwife role, we have got
3 the period that that ended May 2016 and we have got the
4 end of June 2016 when Letby was taken off the
5 department, although that wasn't confirmed until her
6 return and there was a period where that was in doubt
7 and then she started in the risk department in July.

8 So thinking about those dates, are you able to help
9 us with when you might become aware of the increase in
10 mortality?

11 A. I really don't remember any specific dates.
12 I don't know whether it was something I just knew or
13 I don't even know if I was aware of it at the time.

14 Q. Bearing in mind your role as risk midwife
15 during the period February to May 2016, was that
16 something that you should have known during that period?

17 A. Yes.

18 Q. Sitting there now, do you think that is
19 something that you did know at the time or that you
20 didn't know, or can you not say?

21 A. I -- I don't think I did know because of what
22 happened next, otherwise I think I would have been a lot
23 more concerned.

24 Q. There are you referring to the discussion you
25 had once Annemarie Lawrence came?

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1 A. (Nods)
 2 Q. So we will come to that. How about the second
 3 part of my question, which is: when you first became
 4 aware that there was a concern that a particular member
 5 of staff may be somehow connected to the increase in
 6 mortality?
 7 A. When did I become aware?
 8 Q. Yes.
 9 A. In I think late May/early June soon after
 10 Annemarie had started in post.
 11 Q. Well, we will come to that in a moment.
 12 Let's just deal with the thematic review that we
 13 know took place on 8 February. Debbie Peacock was in
 14 the role that you took over at that time, it was right
 15 towards the end of her time and she attended that
 16 meeting, we know that from records and you may have
 17 heard that this morning?
 18 A. (Nods)
 19 Q. When she handed over to you, did she tell you
 20 anything about a meeting that she had been to on the
 21 neonatal unit, was there any such handover?
 22 A. Not that I remember, no.
 23 Q. Again looking back on things, is that
 24 something that should have been the subject of
 25 a handover?

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1 If we just remember that date, 2 March 2016 and go
 2 back to INQ0000457. We go to page 2 and we just slot
 3 that into the chronology that we looked at earlier. We
 4 can see that the day before, so 1 March, you emailed for
 5 an update. On the day that that email was sent and it
 6 was sent at 14:57, so at 10.09 you made an entry that
 7 you received a response from the Consultant
 8 paediatrician, the case had been reviewed internally.
 9 We know that because it was reviewed on 8 February and
 10 at tabletop meeting in AHCC, 25th of the 3rd 16.
 11 Just pausing there. In terms of that 25th of the
 12 3rd 16, that appears to be a date in the future. Might
 13 that be a typo?
 14 A. Yes, I would imagine so.
 15 Q. Because as you have written it, it appears to
 16 be talking about the past, doesn't it?
 17 A. Yes.
 18 Q. And:
 19 "Awaiting PM results. Will forward draft minutes
 20 of thematic review when complete."
 21 And:
 22 "Consultant paediatrician likely to be Dr Brearey",
 23 are you able to recall now who that was?
 24 A. (Shakes head)
 25 Q. Let's assume for a moment it was -- Dr Brearey

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1 A. Yes.
 2 Q. Now, I would just like to look a little bit
 3 further at what information you had.
 4 Please -- you were asked to have a look at an email
 5 today, something that I asked to have drawn to your
 6 attention. It's INQ0014226. This is an email dated
 7 2 March 2016 and it's an email that Dr Brearey sends to
 8 a number of people and he attaches the final version of
 9 the neonatal thematic review. And if we look on the cc
 10 list, both you and Ruth Millward are recorded as
 11 recipients of that email. There's some text about it in
 12 the body of the email but it's the report that's
 13 attached that's important.
 14 Now, you have told us that you don't have any
 15 recollection of having seen that report before speaking
 16 to Ms Lawrence in late May and looking at this email,
 17 can you see that it appears to have been sent to you?
 18 A. Yes, I can.
 19 Q. And you have told us you were doing two roles
 20 at that time. But the reason you would be on copy for
 21 this would be as your as the Risk Midwife role, not as
 22 your Project Lead role; is that right?
 23 A. Yes.
 24 Q. So this is your second job having taken over
 25 from Debbie Peacock.

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1 was the person running the thematic review and later
 2 that day, about four hours later, it appears that he
 3 sent you the thematic review, you were on copy together
 4 with your boss?
 5 A. Mm-hm.
 6 Q. We can then see that on 15 April, you have
 7 sent an email requesting an update on review. Now, you
 8 have told us you are not sure whether that's the
 9 Alder Hey review or whether that's the thematic review.
 10 But if it was the thematic review you were referring to,
 11 it would tend to suggest that you hadn't realised that
 12 you had received it by this date, do you agree?
 13 A. Yes. And maybe -- I don't know but maybe the
 14 Alder Hey Children's meeting was -- was to be held in
 15 the future, the case has been reviewed internally?
 16 Q. And at a tabletop meeting in Alder Hey?
 17 A. Mm-hm. I mean I have absolutely no
 18 recollection. I am sorry.
 19 Q. And again you appear to have chased it again
 20 whatever it is the feedback from review on 27 April and
 21 then we get to the end of your tenure and Ms Lawrence
 22 takes over?
 23 A. Within Datix all the emails sent and received
 24 should be saved, so without looking, if I was able to
 25 look at them, I might be able to piece that story

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1 together but without that, I just can't recall. I'm
 2 sorry.
 3 **Q.** Absolutely, and I am sure that's something
 4 that we can look into. If we just take that down and
 5 just look at this from another perspective. The
 6 thematic review, which I know that you have recently had
 7 a chance to see, and which reaches the conclusion that
 8 no theme has been identified and that there are sudden
 9 and unexpected deteriorations, some of which have no
 10 explanation, was that the sort of report that should
 11 have been considered by the Women's & Children's Care
 12 Governance Board?

13 **A.** It should have been received there.

14 **Q.** You as part of your preparation I think have
 15 had a chance to consider the board meetings for both
 16 April and May and we can bring them up if you want, but
 17 I am sure you will be able to agree with me that in fact
 18 although you are recorded as present at both of those
 19 meetings, the thematic review was not tabled at either
 20 of them?

21 **A.** I don't recollect, sorry.

22 **Q.** Is that something that would help you to have
 23 a look at if you don't have it in mind?

24 **A.** Yes, please. Each month looks at the month
 25 before, so I would have expected if it had been

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1 So if you take three pieces of information, an
 2 interpretation for your comment is that you just didn't
 3 notice that you had been put on copy or didn't realise
 4 that you had it on 2 May -- 2 March, when of course you
 5 were performing those two roles?

6 **A.** I really don't remember either. I -- I would
 7 be guessing.

8 **Q.** Well, let's just come then to deal with the
 9 events involving your colleague Ms Lawrence. We know
 10 that she started at some point in May of 2016, in fact
 11 she's recorded as attending the 19 May
 12 Women's & Children's Care Governance Board.

13 Shortly after she joined your department, I think
 14 she came and had a conversation with you?

15 **A.** (Nods)

16 **Q.** And I would just like you, please, to help us
 17 with exactly what happened.

18 **A.** Annemarie approached me I think one morning
 19 quite early and asked me to have a look at this, and it
 20 was a table of the children -- the babies with
 21 Lucy Letby identified as present in some capacity for
 22 each of the deaths or collapses.

23 **Q.** If we just bring up what you were looking at
 24 so there can be no misunderstanding about this
 25 INQ0003251, page 9. You can have a look at this and see

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1 completed, but looking at that the email and the Datix,
 2 if I was chasing the incident review in April, then
 3 I wouldn't -- I hadn't -- I wouldn't have had it for
 4 the May report, if that makes sense.

5 **Q.** But if you were sent the thematic review on
 6 2 March, then as we have seen from the email, then it
 7 would be available to you and others to table it from
 8 that date?

9 **A.** I just wonder why I have written that I have
 10 chased it again in April.

11 **Q.** One explanation is that you haven't realised
 12 it being an email you are copied into that you have it?

13 **A.** Have I then written that I have received it
 14 later on? No.

15 **Q.** No, because in fact as we will get to, it
 16 seemed like a fresh document to you when your colleague
 17 Annemarie Lawrence showed it to you in May and so I am
 18 just -- if we triangulate these pieces of information,
 19 we have got the fact you appear on one interpretation to
 20 be chasing it, we have got the fact that on the records
 21 it hasn't been tabled by you in April or May?

22 **A.** (Nods)

23 **Q.** And we have got the fact that it appeared to
 24 you to be a brand new document when your colleague was
 25 showing it to you in May.

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1 whether I have identified the document that you were
 2 talking about. Forgive me, I don't think that is the
 3 document that I was intending to come up. By all means
 4 consider that but I don't think that that meets the
 5 description that you have previously given.

6 Just bear with me a moment. INQ0003217. I'm sorry
 7 if I read that out incorrectly. This is the appendix 1
 8 Neonatal Mortality 2015 January to 2016.

9 Obviously we have applied some ciphers but we can
 10 see the "Staff allocated", "Staff on duty" columns. Is
 11 that the document that to the best you can recollect
 12 that Ms Lawrence brought to you or was it a different
 13 one?

14 **A.** I can't be 100% certain. I just know that
 15 what I looked at had a column where Lucy Letby was
 16 identified as being present on duty.

17 **Q.** Well, this is not the best page to start on
 18 because the first entry doesn't appear like that, but if
 19 we look at Child A we can see in the "staff allocated"
 20 column, if we go over the page because that first entry
 21 is the exception, we can see that for Child C, she is in
 22 the right-hand column, we can see for Child D, she is in
 23 the right-hand column, if we go over the page just to
 24 satisfy you, Child E, she is staff allocated, for the
 25 next child, she's right-hand column.

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1 Does that help you with the sort of pattern that
 2 you were looking at?
 3 **A.** Yes.
 4 **Q.** So Ms Lawrence came to see you, brought
 5 a document and what did she say to you?
 6 **A.** She just asked me to look at it and what did
 7 I think the fact that Lucy Letby was on duty when each
 8 baby either died or collapsed?
 9 **Q.** Did you do that?
 10 **A.** Yes.
 11 **Q.** And what did you say once you had had a chance
 12 to consider the document?
 13 **A.** I said that Annemarie needed to go and speak
 14 to Ruth about it.
 15 **Q.** Why did you say that?
 16 **A.** Because it is quite a significant trend to
 17 have the same member of duty on staff for all those
 18 occurrences.
 19 **Q.** Now, other witnesses have drawn a distinction
 20 between the staff allocated and the staff on duty and
 21 have used the fact that Letby is not always staff
 22 allocated as being somehow significant in the
 23 interpretation of this chart.
 24 That doesn't seem to have been the approach that
 25 you were taking; is that fair?

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1 a significant finding and should be discussed with
 2 Ruth Millward?
 3 **A.** (Nods)
 4 **Q.** So did Annemarie Lawrence tell you that is
 5 what she was going to do?
 6 **A.** I know that she went and did it virtually
 7 straight away.
 8 **Q.** Yes, and did she speak to you immediately
 9 afterwards or after some time?
 10 **A.** Fairly soon afterwards, I don't know exactly.
 11 But she did say.
 12 **Q.** What did Ms Lawrence tell you had been said
 13 between her and Ruth Millward?
 14 **A.** That Ruth had dismissed her and told her that
 15 she shouldn't be saying or implying things like that and
 16 it needed more investigation.
 17 **Q.** What did you understand her to mean by
 18 "implying things like that"?
 19 **A.** That with -- that it was a deliberate harm or
 20 that it could be a deliberate harm.
 21 **Q.** I mean, is that something that crossed your
 22 mind when you looked at the trend as a possibility?
 23 **A.** Not at all.
 24 **Q.** So when you looked at it that hadn't crossed
 25 your mind?

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1 **A.** Sorry, can you say that again?
 2 **Q.** Absolutely. Was it sufficient for you that
 3 she was either on duty or allocated to the baby?
 4 **A.** Yes, because just because she wasn't allocated
 5 to a baby doesn't mean she wouldn't have been involved
 6 in some care, if she was covering a meal break. It's
 7 still a trend that she's on duty all of those times but
 8 it could be for any other number of reasons and it
 9 needed more investigation.
 10 **Q.** So you told Ms Lawrence to go and see
 11 Ruth Millward?
 12 **A.** Mmm mm.
 13 **Q.** At the time did either of you describe your
 14 thoughts about this trend in terms of its potential
 15 significance or otherwise?
 16 **A.** I don't think so, not that I recollect.
 17 **Q.** What was your view about the potential
 18 significance of the trend that had been shown to you and
 19 that you had seen for yourself?
 20 **A.** I didn't really have a view, it was just one
 21 piece of information that was quite a significant trend.
 22 It could be for a number of reasons so I didn't know any
 23 other background information.
 24 **Q.** And you tell us in your witness statement that
 25 you thought that the theme identified could be

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1 **A.** It would be more of a competency issue would
 2 be your first thoughts if something recurrent is
 3 happening with a member of staff.
 4 **Q.** But then Anne-Marie Lawrence comes back to
 5 you, says that her concern has been dismissed and then
 6 is talking in terms that you understood might imply that
 7 deliberate harm had been caused or was being alleged?
 8 **A.** Sorry, say that again?
 9 **Q.** Not at all. When Annemarie Lawrence came back
 10 to you and said that she shouldn't be implying things
 11 like that, correct me if I am wrong, but it sounds like
 12 the idea or the implication that deliberate harm might
 13 be being caused was suddenly in the room, so to speak?
 14 **A.** Yes, yes.
 15 **Q.** When that was said to you, what were your
 16 thoughts about whether that was at least a possibility
 17 based upon what you had seen?
 18 **A.** I agreed with what Ruth alleged to have said
 19 in that it needed more investigation.
 20 **Q.** But Ruth--
 21 **A.** Ruth had said to Annemarie.
 22 **Q.** That it needed more investigation?
 23 **A.** Yes.
 24 **Q.** I thought you had said that her concern had
 25 been dismissed and that she shouldn't be implying things

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1 like that?
 2 **A.** But also that it needed more investigation.
 3 **Q.** Who did you understand from Ms Lawrence was
 4 going to carry out that investigation?
 5 **A.** Well, Annemarie and Ruth, that side of the
 6 team.
 7 **Q.** So did you think that it was staying with
 8 Ms Lawrence to investigate?
 9 **A.** Yes. But also it could have been if -- if
 10 there were any concerns about a certain member of staff
 11 it would often be a HR investigation rather than
 12 a clinical incident investigation and I think this
 13 probably crossed borders.
 14 **Q.** What about it being a safeguarding issue?
 15 **A.** Yes. But that would come as part of an
 16 incident investigation that would be included in that.
 17 **Q.** Obviously investigations take time. If there
 18 is a safeguarding issue, do you agree that it needs to
 19 be acted upon immediately?
 20 **A.** Mm-hm.
 21 **Q.** So did you have any discussion with
 22 Ms Lawrence about whether or not immediate action needed
 23 to be taken to safeguard babies?
 24 **A.** No.
 25 **Q.** Looking back on it, why do you think that you

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1 be harming patients?
 2 **A.** Not deliberately, no.
 3 **Q.** So this is the one and only time in your
 4 experience that that has been, as I have previously
 5 termed it and you have agreed in the room, so inherent
 6 in the conversation that you are having?
 7 **A.** (Nods)
 8 **Q.** Looking back on it, do you think you should
 9 have done more to make sure that the matter was being
 10 progressed or do you think your response was reasonable?
 11 **A.** If I had had any more concerns, I would have
 12 escalated them but I didn't have any concerns and
 13 I didn't -- with the knowledge I had it wasn't enough to
 14 escalate any further with that one piece of information
 15 I had and so I am sure in that situation again, without
 16 the benefit of hindsight, I would probably do the same
 17 again.
 18 It wasn't my role to undertake any investigation
 19 and I knew that there were people who did have that
 20 responsibility and trusted them to be doing that and
 21 I had no reason to think that they weren't.
 22 **Q.** The last thing I would like to ask you about
 23 is a reflection that you added at the end of your
 24 witness statement. I will just read out to you what you
 25 said:

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1 didn't raise that or discuss that in those terms?
 2 **A.** Because I didn't think of any -- any thing
 3 that deliberate.
 4 **Q.** Well, you have told us that the idea that it
 5 might be deliberate harm was inherent in what was being
 6 fed back to you.
 7 **A.** It's a bit difficult really to remember
 8 exactly with the length of time. I just knew it needed
 9 more investigation to -- to find out exactly what was
 10 happening.
 11 **Q.** Did you ever follow up with Ms Lawrence or
 12 Ms Millward about whether or not that investigation was
 13 progressing?
 14 **A.** No. I had my own role to do and I trusted
 15 both Ruth and Annemarie to undertake those further
 16 investigations and nothing ever came to me afterwards to
 17 suggest that that wasn't happening.
 18 **Q.** But if nothing was happening, then nothing
 19 would necessarily come back to you?
 20 **A.** But I didn't become aware of any other
 21 concerns from anyone.
 22 **Q.** In your role over the years in the Risk and
 23 Patient Safety Department, I am not asking you to name
 24 the incident, but had you ever come across a situation
 25 where it was even suggested that a member of staff might

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1 "I think that the concerns raised by the
 2 paediatricians were not acknowledged or taken seriously
 3 enough or soon enough by the Executive team."
 4 I just wanted you to help us with whether that was
 5 as a result of things that you saw happening or whether
 6 that is an impression that you formed having read
 7 newspapers and so on. So if you just help us with what
 8 that reflection is based upon?
 9 **A.** So it is the latter, it's what -- what I now
 10 know following the investigations and the criminal
 11 trial. Because I wasn't aware at the time what was
 12 happening.
 13 **MR DE LA POER:** Mrs McMahon, thank you very much
 14 indeed.
 15 **A.** Thank you.
 16 **MR DE LA POER:** I don't have any more questions for
 17 you.
 18 There are no Rule 10s.
 19 **LADY JUSTICE THIRLWALL:** Thank you very much
 20 indeed, Ms McMahon I have got no questions for you.
 21 **A.** Thank you.
 22 **LADY JUSTICE THIRLWALL:** Thank you for waiting all
 23 morning and you are free to go now.
 24 **MR DE LA POER:** My Lady if I just check, no thank
 25 you very much indeed, it occurred to me I needed to make

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1 a check -- I have now made that check, I'm sorry to
 2 interrupt.
 3 **LADY JUSTICE THIRLWALL:** That is all right. Are we
 4 ready for the next witness?
 5 **MR DE LA POER:** Yes, we are.
 6 Annemarie Lawrence, please.
 7 **MRS ANNEMARIE LAWRENCE (sworn)**
 8 Questions by MR DE LA POER
 9 **LADY JUSTICE THIRLWALL:** Do sit down.
 10 Mr De La Poer.
 11 **MR DE LA POER:** Please can you give us your full
 12 name?
 13 **A.** Mrs Annemarie Lawrence.
 14 **Q.** Mrs Lawrence, is it correct that on 8 July of
 15 this year you provided to the Inquiry a witness
 16 statement?
 17 **A.** I did, yes.
 18 **Q.** And are the contents of that witness statement
 19 true to the best of your knowledge and belief?
 20 **A.** They are.
 21 **Q.** Did you qualify as a midwife in 2006?
 22 **A.** I did.
 23 **Q.** And did you start in the role of midwife at
 24 the Countess of Chester in 2014?
 25 **A.** I did, yes.

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1 that right?
 2 **A.** That's correct.
 3 **Q.** You were then appointed to the role
 4 effectively taking over from Debbie Peacock as the
 5 full-time occupant but in practice taking over from
 6 Janet McMahon who had been doing the job for about three
 7 months?
 8 **A.** That's correct.
 9 **Q.** What you tell us that the role that you
 10 undertook required -- well, let's put it a different
 11 way: tell us what you thought the role of Risk Midwife
 12 involved?
 13 **A.** I thought the role would be regarding the
 14 day-to-day incident management, the governance
 15 facilitation guidelines, governance board, et cetera.
 16 It was very multi-faceted but it would be involving
 17 midwifery and the neonates as well.
 18 **Q.** So on the subject of neonates, you were,
 19 before this role, a midwife by background and training?
 20 **A.** That's right.
 21 **Q.** Did you consider that you were able to provide
 22 a risk role for a department that you weren't trained to
 23 work in?
 24 **A.** Yes, because we don't undertake this role as
 25 sole practitioners. We work as part of

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1 **Q.** And in May of 2016, as we have just heard from
 2 Ms McMahon, did you take up the role of Risk Midwife?
 3 **A.** I did.
 4 **Q.** And just to summarise how you came by that
 5 role, did you see the job advertised within the hospital
 6 buildings?
 7 **A.** Yes, it was on one of the staff forums within
 8 the central labour suite as expressions of interest to
 9 apply via the NHS Jobs Trac system.
 10 **Q.** I am terribly sorry and I don't mean this in
 11 any way critically, can I just ask you to keep your
 12 voice up a little or move slightly closer to the
 13 microphones. That would be really kind. Thank you very
 14 much?
 15 **A.** Yes, of course.
 16 **Q.** So you saw the job advertised and did you
 17 consider that you meet the criteria that they were
 18 identifying?
 19 **A.** I did, I went to speak to my current manager,
 20 after she had asked me to have a look at it on the
 21 board, she felt I had the necessary knowledge and skills
 22 and she thought I would be a good fit for the role. So
 23 I did apply.
 24 **Q.** The application involved you making
 25 a presentation to Ruth Millward and Julie Fogarty; is

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1 a multi-disciplinary team, so I would always be within
 2 the capacity of neonatal nurses, neonatologists or
 3 paediatricians.
 4 So if there was anything that needed any expert
 5 guidance per se, I would go to the expert for that
 6 relevant area.
 7 **Q.** And bearing in mind your role involved looking
 8 after the neonatal department, or unit, as much as it
 9 did the midwifery obstetric side of things, did you ever
 10 ask why you were the Risk Midwife as opposed to
 11 a broader term that included neonates?
 12 **A.** I think certainly over the last few years
 13 leading up to maybe 2018, when there was some national
 14 guidance published, neonates was very much added on to
 15 maternity as an addition.
 16 Maternity is very much nationally driven by various
 17 drivers, et cetera, and the workload and incidences is
 18 significant compared to other areas and therefore it
 19 takes up a large proportion of time that isn't the same
 20 within neonates, gynaecology or children's and that has
 21 changed over the last few years with the publication of
 22 MBRRACE and PMRT, et cetera.
 23 But certainly at that time, it wouldn't have
 24 warranted a full time officer for that area.
 25 **Q.** In terms of where your focus lay, and the

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1 hours that you were spending, do we infer from your
 2 previous answer that most of your work was involved
 3 looking at the midwifery obstetrics side?
 4 **A.** It was, yes.
 5 **Q.** Just to complete the picture as far as you are
 6 concerned, in 2019 did you take up the role of
 7 governance matron for the Women and Children's Hospital
 8 at the Wirral University Teaching Hospital?
 9 **A.** I did, yes.
 10 **Q.** And in 2020, were you promoted to clinical
 11 service lead for obstetrics and gynaecology?
 12 **A.** I was.
 13 **Q.** When you were training as a midwife, and then
 14 practising, did you receive any safeguarding training
 15 specifically in relation to what you should do in the
 16 event that you were concerned that a member of staff was
 17 harming patients?
 18 **A.** Not specifically for a member of staff, no.
 19 I think that is a gap within our national safeguarding
 20 training because certainly, when I have looked back
 21 retrospectively at the various trusts I have worked in
 22 across the north-west and when I did my training, it
 23 wasn't covered in any shape or form within safeguarding
 24 training specifically for harm by a staff member or
 25 service user.

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1 you joined the Risk Department in terms of how its other
 2 functions worked and what your role was with that?
 3 **A.** Yes. We had a Datix compliance manager, or
 4 administrator he was at the time, who talked me through
 5 the back office functions, and then we also had the
 6 office PA, Joanna Donnelly, who filled in for the Datix
 7 administrator who knew the system inside and out. So if
 8 there was anything you needed and you were unsure of,
 9 she would always be on hand to help navigate or help
 10 a workaround if you were unsure.
 11 **Q.** Now, we are just going to spend a short period
 12 of time looking at when a Datix is required. Was it
 13 an important part of your role as Risk Midwife to have
 14 a clear understanding of when a Datix was required?
 15 **A.** Absolutely. Because a large part of my role
 16 was as educator as well, with some of the visits to the
 17 clinical areas, sometimes you hear things, sometimes you
 18 see things, and sometimes you know when -- once
 19 something should be submitted. So it's really important
 20 to have a very clear understanding of both the obstetric
 21 and the neonatal pick list, as we called it, which is
 22 a selection of incidents that would automatically
 23 normally generate a Datix being submitted.
 24 It's important to have that knowledge on the tip of
 25 your tongue so that you can use it in action when you

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1 **Q.** Now, you have described it as a gap.
 2 Obviously we are going to get to a moment in time where
 3 you were presented with some particular information and
 4 you reached some particular conclusions about it. Would
 5 it have helped you navigate that situation if you had
 6 had such training?
 7 **A.** I think so and that is an area of reflection
 8 for myself over several years now. If I'd have had the
 9 knowledge I have now back in 2016, then I do believe
 10 I would have escalated further. It may be that I would
 11 have continued not to be listened to, but at least
 12 I would have tried harder than I did at the time.
 13 **Q.** Now, you went from practical on-the-ward
 14 midwifery into a non-patient-facing role in the Risk
 15 Department as Risk Midwife?
 16 **A.** Yes.
 17 **Q.** Did that involve you having a greater degree
 18 of interaction with the Datix system?
 19 **A.** Yes. I worked significantly with the Datix
 20 system.
 21 **Q.** So presumably you had some prior knowledge of
 22 it from the point of view of a clinician on the ward
 23 putting -- making entries?
 24 **A.** Yes.
 25 **Q.** Did you receive any additional training when

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1 are in those clinical areas.
 2 **Q.** And of course you have this unique
 3 perspective, as far as Inquiry witnesses are concerned,
 4 is that you practised on the labour suite, no doubt --
 5 **A.** Yes.
 6 **Q.** -- filling in Datixes yourself up until May of
 7 2016, at which point you effectively went behind the
 8 curtain and were able to see what happened to them after
 9 that.
 10 Did your knowledge and understanding about the
 11 importance of ward level Datix completion change once
 12 you joined the Risk Department?
 13 **A.** It really did, yes. It was very much an
 14 eye-opener because I got to see -- if you don't fill in
 15 a certain box, I got to see the ramifications of that in
 16 the background. So how difficult it is if you don't
 17 include the staff involved in an incident at the time
 18 you submit the Datix. It can be really difficult to go
 19 back at a moment in time, especially if the incident
 20 reporter is on annual leave for a period of two weeks.
 21 Sometimes you are coming back several weeks later and
 22 people's memories are not what they were, and you may
 23 miss an opportunity to identify somebody or something
 24 that was important at the time.
 25 **Q.** Now, we are going to look at some policies in

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1 a moment, and this isn't by any means a test or vie of
2 you but we have heard the term "Serious Incident" and we
3 have heard the term "Incident" and you use both in your
4 witness statement.

5 **A.** Yes.

6 **Q.** Can you just help us to understand what you
7 understand to be the difference between an Incident and
8 a Serious Incident?

9 **A.** Yes, absolutely. So an Incident is --
10 certainly in midwifery and more so in neonatology over
11 the last few years, we submit an incident report for
12 things where there is a deviation from normal. And, as
13 I say, in midwifery certainly we use an incident Datix
14 submission for a data collection as well. So we will
15 collect data on the number of third degree tears whether
16 or not they have been caused or have occurred, and
17 I will give an example of that, if I may.

18 So a lady could deliver at home without a midwife
19 present and could experience a third degree tear. We
20 wouldn't have caused that harm by an individual but it
21 is still a harm that has occurred to the woman and
22 should be reported. So that would be an incident. And
23 then a Serious Incident is where there has been an act
24 or omission of care that has contributed, or may have
25 contributed, and, as we move into PSIRF, which is the

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1 So, in other words, it would appear that a policy
2 change has resulted in how events should be categorised.

3 You don't need to comment upon that, particularly
4 if you don't know about it, but was it your experience
5 that there were evolutions in what was expected and how
6 things were defined over time?

7 **A.** Yes, I think -- and in some ways it shows
8 a good link to the latest available evidence. It's
9 really important as clinicians we stay as current as we
10 can and we maintain our clinical credibility.

11 So being aware of the latest guidance and updates
12 I think is really important. I won't share my personal
13 view on that if you don't mind but ...

14 **Q.** Now, you comment in your witness statement
15 about the approach, as you perceived it to be, to Datix
16 on the neonatal unit. I will just read out what you
17 have said:

18 "The neonatal unit staff did not approach the Datix
19 reporting system in an open and transparent way. They
20 would often only report an incident if they felt it was
21 avoidable or there had been an obvious omission in
22 care."

23 **A.** Okay.

24 **Q.** So a number of things to ask about that.

25 **A.** Yes.

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1 Patient Safety Incident Response Framework, which it
2 wasn't in place in 2016 so I don't want it blur lines or
3 things, but it's really important that we look at harm
4 suffered versus harm caused as well because the
5 experience of a neonatal death, for example, in an
6 expected death -- so a baby that is incompatible with
7 life -- we used to grade those incidents as "no harm"
8 because there is no act or omission that would have
9 prevented that baby's demise.

10 However, when you look at it from the point of view
11 of the patient and the family, for them to see that
12 incident graded as "no harm" was quite detrimental to
13 them because it's not no harm to them, which is why we
14 have moved over into the Patient Safety Incident
15 Response Framework so we are a bit more empathetic as to
16 the impact on our women and families.

17 **Q.** Now, we are going to look at this in more
18 detail with Ruth Millward but it may have been on your
19 radar at the time, it may not. But we know that in June
20 of 2015, so whilst you were still working as a midwife,
21 she sent an email which was to this effect: that child
22 death, so outside your area of work, is no longer
23 included as a Serious Incident by definition in the SI
24 framework or on STEIS. However, it may be reported as
25 a Serious Incident under another category.

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1 **Q.** The first thing is when you say "neonatal unit
2 staff", are you talking all staff or are you talking
3 doctors or nurses or Consultants, or managers? Who do
4 you mean by "staff" when you say that?

5 **A.** I mean every person who works within the
6 neonatal unit umbrella.

7 **Q.** Obviously you frame that in the past tense
8 "did not". So we just need to understand what our date
9 parameters are. Presumably, that wasn't an opinion you
10 held before May 2016 because you didn't have access?

11 **A.** Absolutely.

12 **Q.** So this is from May 2016?

13 **A.** Yes.

14 **Q.** And over what period from May 2016 did that
15 apply?

16 **A.** I am not certain of the dates with any
17 certainty. But there was a change in leadership from
18 the Neonatal Risk Department and there was
19 a Dr Dangerfield who was appointed into that risk role.

20 And after her appointment, the department seemed to
21 be much more amenable because she -- she got risk. That
22 is the only way I can describe it really. She
23 understood the impact of acts or omissions and that risk
24 isn't just about managing the incident that's happened,
25 it's about learning from acts or omissions and

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1 preventing the next incident from happening.

2 There was certainly an improvement after the Royal
3 College review as well. So kind of after the Royal
4 College, maybe September, October time, and then up
5 until the point where Jo Dangerfield, Dr Dangerfield,
6 took over things definitely improved after then.

7 **Q.** Can you give us a year when Dr Dangerfield
8 took over?

9 **A.** '18. Definitely she was there by '18.

10 **Q.** Now, you have chosen to use the words "Did not
11 approach Datix reporting system in an open and
12 transparent way". And what you go on to say might be
13 thought to imply that you thought that this was
14 deliberate or in some way calculated as opposed to born
15 of confusion or ignorance.

16 Can you help us with whether that is what you are
17 implying, that you thought that they knew they had to
18 fill out Datixes for certain situations and they made
19 a cynical decision not to fill them in, or whether it
20 might be a misunderstanding, a cultural
21 misunderstanding, about the importance? So can you help
22 us with what you are meaning to imply?

23 **A.** I think there is an element of both situations
24 that you have described. I think there were definitely
25 some staff who, certainly new to department, may not
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1 the Consultant body, was this a concern that you had
2 about the Consultants, that they were cynically and
3 deliberately not filling in Datix until effectively they
4 had no choice?

5 **A.** Yes.

6 **Q.** And which Consultants are you referring to?

7 **A.** I think I would say the body of Consultants.
8 What you -- what I found certainly in neonatology was
9 they all stuck together. If -- they wouldn't go against
10 one another. So even if they thought somebody had made
11 a clinical omission, rather than report it, they would
12 have a conversation first Consultant to Consultant.

13 So I would say, yes.

14 **Q.** Just to understand that. I am not here as an
15 apologist for the Consultants but, based on what you
16 have just described, a reason for doing that may be to
17 check that in fact an error has been made by getting
18 a second opinion by someone who's perhaps a bit more
19 objective about it, a little less introspective about
20 it. I mean, is that a legitimate way to approach the
21 Datix system or the moment you think you may have
22 created -- done something in error, are you obligated to
23 immediately declare it without further reflection?

24 **A.** Well, it has to be safe to undertake that
25 submission. So if you are involved in a clinical
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1 have understood the need to report certain things.

2 But there was also a number of other staff who
3 I would say purposely didn't report things until they
4 had discussed it with managers or Consultants to agree
5 that something should be reported. They certainly
6 didn't do it freely in the same way that the maternity
7 service did.

8 **Q.** Well, I'm afraid can you help us please with
9 who?

10 **A.** Band 5 nurses, Band 6 nurses, some shift
11 leaders, although I wasn't sure of their grading at the
12 time, and certainly some managers as well.

13 **Q.** And is that all on the nursing side or are
14 there any doctors involved in this?

15 **A.** I suppose there would be some Registrars
16 involved in that, although I definitely couldn't give
17 you names of that. But what they would do is they would
18 come along to the Incident Review Group or they would
19 come along to an MDT forum, they would discuss it and
20 they would be in agreement in that meeting that, yes, it
21 should be reported and then an incident form would be
22 submitted.

23 **Q.** And from the point of view of your impression
24 of the Consultants in this issue -- and we will get to
25 your relationship with Dr Brearey -- but speaking about
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1 incident and you are still working clinically, it
2 wouldn't be appropriate to step away to submit an
3 incident form. But any individual can submit an
4 incident form. Even if you don't have time on your
5 clinical shift, you can hand it over to the next person.
6 But generally we say as close to the time of the event
7 as possible, that is when you should submit the form
8 because your memory is as fresh as it can be.

9 **Q.** And it's not appropriate to take a colleague
10 aside before you do that and say, "Look, this has just
11 happened. I just want to check whether you think
12 anything has gone wrong here"?

13 **A.** I wouldn't say that it's not appropriate
14 because there may be situations where the situation, for
15 example, that conversation has just manifested itself,
16 there was an opportunity and the clinician has taken it.
17 So I wouldn't say there were times when it was never
18 appropriate to do that.

19 But Datix should be used to learn lessons. It is
20 an open and transparent way of improving the safety and
21 culture of a hospital. So my view to it is that it
22 should be done regardless.

23 **Q.** One of the matters of interest to the Inquiry,
24 and which is commented upon in relation to the immediate
25 internal investigation of July 2016, was whether or not
200

1 there was adequate completion of Datix and, from the
2 Inquiry's point of view, children who suddenly and
3 unexpectedly collapsed but who did not die is an area of
4 interest.

5 So I just want to gauge your opinion as someone who
6 worked in the Risk Department. If a baby suddenly and
7 unexpectedly deteriorated but was successfully
8 resuscitated and no error in care was identified at that
9 time, was a Datix form required in 2015/2016?

10 **A.** So are you asking me whether I think it was
11 required?

12 **Q.** Yes, as in mandated by the hospital policy at
13 the time.

14 **A.** I don't think it was mandated per se because
15 I don't think it was in the pick list at the time and
16 that was some of the challenges that I faced as
17 a newcomer to the organisation, that the Risk Department
18 was that, trying to amend the pick list to have the
19 appropriate things in there.

20 There were some things that were out of date and
21 some things that, on the information that I had been
22 researching, I felt should be included but wasn't and
23 when put that to the clinicians the view wasn't
24 reciprocated.

25 So if you wanted to add something like that,
201

1 confidentiality, consent."

2 So a list of examples.

3 Now, Ms Peacock read the word "unnecessary" as only
4 applying to damage as opposed to applying to loss or
5 harm. What was your understanding at the time as to
6 whether or not unnecessary applied or was this not
7 a close reading that you gave it at the time?

8 **A.** I think I had a different view to earlier.

9 **Q.** So you think that "unnecessary" applies to
10 loss and to harm as well? So it needs to be unnecessary
11 harm to focus on what we are concerned with?

12 **A.** I think it's unnecessary damage, unnecessary
13 loss or unnecessary harm, yes.

14 **Q.** So for harm, which is what we are focused
15 upon --

16 **A.** Yes.

17 **Q.** -- that is the most important thing because
18 that is talking about patients as opposed to property?

19 **A.** Absolutely.

20 **Q.** Unnecessary harm. And, of course, if we think
21 about how harm was being interpreted at that time, you
22 have told us about how there's been a change in
23 understanding and a more empathetic approach to harm --

24 **A.** Yes.

25 **Q.** -- in fact, "harm" was meaning harm that the
203

1 there'd have to be a consensus and an agreement among
2 the clinicians to have the pick list changed. It was
3 quite difficult to do.

4 **Q.** Well, let's just have a look at the policy and
5 it was put on screen earlier today. INQ0010022. Were
6 you sitting in when your former colleague Ms Peacock was
7 being asked questions about this?

8 **A.** I was, yes.

9 **Q.** Well, that is extremely helpful to know. If
10 we go over the page, we can see there the duties applied
11 to all staff and there is a sort of reflection expected
12 of the Risk and Patient Safety team which is once it
13 comes to them, they should be making sure it goes back
14 to the local level so that managers are aware. So we
15 have seen all of that. We don't need to go over that
16 again. Let's look at that definition that was
17 considered this morning, page 3:

18 "What should be reported? An event or circumstance
19 which could have resulted or did result in unnecessary
20 damage, loss or harm to patients, staff, visitors or
21 members of the public."

22 And then some examples are given:

23 "Clinical affecting a patient eg, investigation,
24 diagnosis, treatment, medical equipment malfunction,
25 misuse, decontamination issues, medicine management,
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1 NHS has or may have caused; is that right?

2 **A.** That is how I understand it.

3 **Q.** When we talk about harm, perhaps the most
4 striking example of that, if we look at INQ0000111 --
5 this is the Datix for Child C's death -- we can see that
6 this is right in the middle "subcategory
7 expected/unexpected death." So the report is not about
8 some aspect of care but about the death itself. That is
9 the pick list item?

10 **A.** Yes.

11 **Q.** And then result: "no harm."

12 **A.** (Nods).

13 **Q.** And that's perhaps the most striking
14 illustration --

15 **A.** It is.

16 **Q.** -- because the notion that death isn't a harm
17 to the patient is plainly ludicrous in an ordinary
18 understanding, but in the way that the word "harm" was
19 being used for Datix it means harm that we, the NHS
20 staff, have or may have caused?

21 **A.** That's the way they were interpreting it back
22 in 2015, yes.

23 **Q.** Absolutely. And when you combine it with the
24 word "unnecessary" -- and we must be careful not to be
25 too lawyerly about this -- but "unnecessary" means
204

1 something that could have been prevented?

2 **A.** Absolutely. Avoidable.

3 **Q.** And so that really adds to the understanding
4 about harm and the approach you should take. Now,
5 obviously we have got an exception to that because an
6 unexpected death, or an expected death for that matter,
7 is in fact required to be reported by Datix. But that
8 doesn't actually fit within the hospital policy at the
9 time, does it?

10 **A.** No.

11 **Q.** I mean, it's plainly an exception. It may not
12 be if the death, whether expected or unexpected, has
13 been caused by some NHS staff action, but whether or not
14 that happens -- and Child C and the Datix is a clear
15 example of how that was being thought about at the
16 time -- the mere fact of death is reportable?

17 **A.** Absolutely.

18 **Q.** So when we think about the position of the
19 staff on the neonatal unit and how they should be
20 approaching a sudden, unexpected collapse that they have
21 no explanation for at the time, so no malpractice is
22 suspected, no deficiency in care has been identified as
23 being potentially causative of that, we know why those
24 collapses were caused now, under the policy, would the
25 staff have been expected to fill in a Datix?

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1 **A.** I think it is unnecessary harm though, isn't
2 it? If you can't understand it and you can't explain
3 it, then it should be reported because it fits into that
4 category of "unnecessary".

5 **Q.** But then what would you fill in about what the
6 potential cause of it was under the policy?

7 **A.** Under the pick list or under the policy?

8 **Q.** Well, both. This is the --

9 **A.** Because the policy -- we really look at the
10 policy when it comes to applying here and I don't think
11 there would be anybody in the risk team who would hold
12 you against the policy for reporting a collapse. They
13 wouldn't report you for a deviation of the policy for
14 reporting a collapse on Datix.

15 **Q.** Absolutely. But I suppose what I'm really
16 trying to get under the skin of is whether you can
17 criticise somebody for not reporting something which the
18 policy doesn't appear to mandate and it's just --

19 **A.** I suppose --

20 **Q.** -- you've described the best practice?

21 **A.** Yes.

22 **Q.** But what we are trying to do is -- and there
23 is a different question about whether the policy should
24 have been different.

25 **A.** Yes.

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1 **A.** It's a difficult one, isn't it, because the
2 communication that went out said these didn't need to be
3 reported and yet they sit there on the pick list as you
4 should report it.

5 **Certainly --**

6 **Q.** Forgive me, I'm sorry to interrupt you, but
7 the pick list for death, yes. I am talking about
8 a collapse that is successfully resuscitated.

9 **A.** Oh, sorry, of course.

10 **Q.** So no death; so we can't use this category.
11 We have got a sudden unexpected collapse, resuscitation,
12 a very high level of intervention is required, everybody
13 is standing around immediately afterwards saying,
14 "I have no idea why that happened but I can't see that
15 we did anything wrong", no Datix would be required under
16 the policy. Do you agree with that?

17 **A.** No, I don't agree with it. I think that is
18 what happened, but I don't agree with it because how do
19 we learn from these events if we don't report them?

20 **Q.** My question was framed by reference to the
21 policy.

22 **A.** Okay, sorry.

23 **Q.** Did the policy, bearing in mind what we have
24 looked at in terms of unnecessary harm, did that require
25 a Datix to be completed?

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1 **Q.** But judging people by the policy at the time,
2 can you criticise those clinicians, as opposed to the
3 policy and other aspects of the hospital practice, for
4 not having filled in the form for those collapses?

5 **A.** I suppose it would be difficult. It would be
6 difficult to criticise when the policy doesn't support
7 it.

8 **However, me being me, I would find it really**
9 **difficult not to report it because it's the right thing**
10 **to do and how do we learn from things we don't**
11 **understand if we don't investigate? And I think that's**
12 **some of the challenges that I experienced.**

13 **MR DE LA POER:** Well, I am sure we can come to
14 that. My Lady, I wonder if that is a convenient moment
15 to break.

16 **LADY JUSTICE THIRLWALL:** Certainly. For how long,
17 Mr De La Poer?

18 **MR DE LA POER:** If we could take a slightly shorter
19 than normal break, I am sure everybody would appreciate
20 that, but I look to the shorthand writer who is very
21 happy to continue. So I am very grateful for that.

22 **So if we could reconvene perhaps just after or on**
23 **4 o'clock just so everybody can stretch their legs.**

24 **LADY JUSTICE THIRLWALL:** Shall we say five past.

25 **MR DE LA POER:** Five past, thank you.

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1 (3.54 pm)

2 (A short break)

3 (4.05 pm)

4 LADY JUSTICE THIRLWALL: Yes.

5 MR DE LA POER: I am going to look briefly now at
6 an NHS England document relevant to this issue and in
7 particular Serious Incident and what that means.

8 INQ0009236. We see this is the Serious Incident
9 Framework document I hope you have some familiarity
10 with?

11 A. I do.

12 Q. Page 12, please. Forgive me, it will be
13 page 12 internally so that will be 13, thank you, my
14 mistake.

15 Ms Lawrence, here we are not talking about
16 incidents, which is what one needs for a Datix, here we
17 are talking about serious incidents which is what one
18 needs to have in order to report upwards to NHS England;
19 Is that right?

20 A. Yes.

21 Q. We have got a broad definition there:
22 "Serious Incidents are events in healthcare where
23 the potential for learning is so great."

24 That is very much your point, isn't it?

25 A. Yes.

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1 Q. I just want you to just help us with how that
2 interacts with the fact that in order to create a Datix,
3 you are looking at a pick list?

4 A. I suppose that the Datix system and the
5 incident trigger lists are for specific everyday
6 incidents from low to no to moderate to severe or death
7 associated with the incident or not.

8 When it comes to a Serious Incident, you can send
9 even no harm incidents, no harm incidents -- so an
10 incident graded as no harm by the reporter could still
11 be -- undergo an SBAR if felt significant enough by
12 either the local manager, so the manager at ward level
13 or the Risk and Patient Safety Lead.

14 Sometimes there was occasions where there would be
15 a cluster of no harms but, for example, there may be
16 complaints and so you might undertake an SBAR and send
17 that to the Serious Incident Panel for the Executives to
18 consider a cluster of low harm incidents which may as it
19 talks about here, impact an organisation's ability to
20 deliver ongoing healthcare, ie it may affect the
21 reputation of the organisation.

22 So in terms of Serious Incidents like this, if it
23 was serious enough to warrant attention or it developed
24 the Risk and Patient Safety Lead's interest enough, it
25 would go to the Serious Incident Panel but it would be

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1 Q. That when it comes to a Serious Incident,
2 there might be a substantial opportunity for learning:
3 "... or the consequences to patients, families and
4 careers, staff or organisations are so significant they
5 warrant using additional resources to mount a prehensive
6 response."

7 A. (Nods)

8 Q. And:

9 "... they can extend beyond incidents which affect
10 patients directly and include incidents which may
11 indirectly impact patient safety or an organisation's
12 ability to deliver ongoing healthcare."

13 Then we have this: there is no definitive list of
14 events, this is the next but one paragraph:

15 "Incidents that constitute a Serious Incident."

16 And:

17 "Lists should not be created locally as this can
18 lead to inconsistent or inappropriate management of
19 incidents."

20 Now, we need to hold two things in our heads here.

21 We have got what an incident is and that is Datix, and
22 then what a Serious Incident is. The advice here is
23 that for a Serious Incident you shouldn't have
24 a preprepared list that you are working against?

25 A. (Nods)

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1 those Executives who decided in that panel as to whether
2 it was reported or not.

3 Q. The only way it would in those cluster of
4 individual incidents that in themselves are not
5 sufficiently serious the only way that they will get to
6 the Executives is if a Datix has been filled out for
7 each of them?

8 A. Absolutely.

9 Q. So Datix is the gatekeeper?

10 A. It is.

11 Q. For whether or not something could be
12 considered to be a Serious Incident, whether
13 a cumulative cluster or an individual event and bearing
14 in mind that Datix operates on a pick list, so you can't
15 get near a decision about a Serious Incident whether it
16 is a Serious Incident or not. I am just wondering how
17 that fits with the NHS England guidance which says you
18 shouldn't operate pick lists?

19 A. That is for Serious Incidents, though, so the
20 Datix trigger list, there is an option of "other". So
21 somebody could report things under "other" and quite
22 often we found that.

23 So when you made reference to the handler earlier,
24 the handler would go into what we call a pool where all
25 of the Datixes that come in for the organisation are

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1 located in a virtual pool and in a holding bay and it's
 2 for them to work through the incidents but sometimes
 3 they couldn't allocate it to a certain area because
 4 somebody had selected "other" and that's where the risk
 5 in patient safety leads or the Datix administrator would
 6 need to navigate that system to try and think of the
 7 best appropriate place for that to go.

8 So I wouldn't want you to think you couldn't report
 9 something if you really wanted to because there wasn't
 10 a pick list for it because there would be a way to
 11 navigate that somewhere.

12 **Q.** So in other words the pick list wasn't
 13 a closed list, there was an option for more of a free
 14 text incident specific description?

15 **A.** Yes, it was closed in the sense that I wanted
 16 to add things to it and you had to go through various
 17 different hoops to get the pick list altered, so that
 18 you could pull data from it because you will have to
 19 appreciate when you are pulling data from another field,
 20 it's meaningless because you pool that much there. So
 21 in order to be able to inform future healthcare
 22 provision or quality improvement initiatives you have to
 23 have that narrowed down in that pick list. So getting
 24 that changed was very, very difficult to do but you
 25 could get things added through "other".

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1 Executives to decide and I think it was Ruth Millward
 2 who decided ultimately within your department whether
 3 something went to a Serious Incident Review Panel; is
 4 that right?

5 **A.** Yes, at the SBAR we completed -- the
 6 "Recommendation" section of that SBAR would be to
 7 forward on to the review panel to determine whether any
 8 further investigation was required and I believe that
 9 was an instruction from the Executives because they
 10 wanted to be the people to make that decision as to
 11 whether something was STEIS reported or not.

12 **Q.** Let's leave Serious Incidents and look at the
 13 culture and atmosphere on the NNU and again we need to
 14 remember that over our relevant period you wore
 15 different hats?

16 **A.** Yes.

17 **Q.** You were a midwife, interacting with the
 18 neonatal unit in that capacity and then latterly you
 19 were in the Risk Midwife role where you had oversight
 20 from a risk perspective of the neonatal unit.

21 Now, you say this in your witness statement of the
 22 neonatal unit:

23 "I would describe the relationship between
 24 clinicians and managers as far from equal. Nurse
 25 managers rarely challenged the medical team even when

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1 **Q.** So a person could have if they had wanted to,
 2 thought: this is a unexpected very serious collapse, we
 3 can't identify any failing in care that's responsible,
 4 but it's the third one that I've seen in recent weeks?

5 **A.** Correct.

6 **Q.** Go on to Datix, access "other" if you can't
 7 find that adequately described?

8 **A.** Yes.

9 **Q.** And then put in a commentary?

10 **A.** And often we would see: I have not found this
 11 pick list here so but this is the third case I've seen
 12 this week and so I am reporting it, file it under
 13 whichever various field you feel necessary. And
 14 sometimes they would record things under a relevant
 15 Planned Care or Urgent Care, so you wouldn't see it
 16 straight away but the beauty about that pool I mentioned
 17 earlier, so that where all the Datixes come into is the
 18 experienced person working through that Datix trigger
 19 list would realise actually that's not paediatrics, that
 20 is obstetrics and they would allocate it then to the
 21 relevant person and it reduced that risk of error that
 22 incidents would be reported but go unseen.

23 **Q.** Thank you, we can take that down and we are
 24 going to move away from Serious Incidents because
 25 obviously that, as you have told us, is for the

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1 they knew they were deviating from process or guidance.
 2 They would just go along with what they were told to
 3 do."

4 Which of the two job roles that you held have you
 5 derived that impression from?

6 **A.** So that is from the Risk and Patient Safety
 7 aspect.

8 **Q.** So post May 2016?

9 **A.** Yes.

10 **Q.** How would you know if you are based in the
 11 Risk Department that nurse managers are just going along
 12 and not challenging the clinicians?

13 **A.** Because my role was very much an active role
 14 in that when there was Neonatal Incident Review Meeting
 15 or a Term Admission Review Meeting, which is every baby
 16 who was born over the gestation of 37 completed weeks,
 17 we would -- if they were admitted to the neonatal unit,
 18 we would review their care completely to determine
 19 whether there was any ways of avoiding that mother and
 20 baby separation. It was something that we were looking
 21 at quite closely in 2016 nationally not just in the
 22 Countess of Chester.

23 And I had lots of meetings with both the managers
 24 and the Consultants, sometimes with senior nurses and
 25 junior nurses present, but there would be some

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1 discussions and I would prompt the discussion or lead
2 the discussion and I would be hoping for support from
3 the ward managers for that area or the senior nurses.

4 And I don't feel they had the autonomy or the
5 confidence to -- to challenge the Consultants and
6 certainly it frustrated me at times because -- because
7 I wanted them to -- to feel autonomous to say: actually
8 from a nursing perspective, that's not appropriate or:
9 we are not going to do that. Or: if we could just pause
10 there and find out some more information. They were
11 very much led by the doctors.

12 **Q.** Did you witness for yourself any overbearing
13 authoritative dictatorial behaviour from the doctors
14 that might have created that or was the extent of your
15 observation the fact that the nurses weren't speaking up
16 when you had hoped that they might?

17 **A.** I think a bit of both. Sometimes we would be
18 in meetings where discussions were a bit fractious and
19 you could see tensions rise in that meeting and you
20 could -- I don't quite know how to describe it really
21 other than the Consultants would become just that little
22 bit louder and the nurse voice would become that little
23 bit lower and they would contribute less into that
24 meeting and then I would always follow up the meeting
25 with a discussion to see if everybody was okay, to see

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1 relationship that she was used to.

2 **Q.** You say there was definitely a hierarchy and
3 some Consultants were more respectful than others --
4 I will read that to you again:

5 "There was a definite hierarchy and some
6 Consultants were more respectful than others"?

7 **A.** Yes.

8 **Q.** That is what you put your witness statement.
9 So which were the respectful Consultants and which were
10 the non-respectful or less respectful Consultants?

11 **A.** Do you really want me to answer that?

12 **Q.** I wouldn't have asked it if I didn't.

13 **A.** Okay so some of our more respectful
14 Consultants were our female Consultants, Mr John Gibbs.

15 **Q.** Sorry -- just so you are aware there is
16 a cipher list if you are going to mention female
17 Consultants?

18 **A.** Sorry, okay.

19 **Q.** So do consult it. It is on the desk in front
20 of you. You said Dr Gibbs, does he fall in the
21 respectful category?

22 **A.** Respectful, absolutely and all of the female
23 Consultants.

24 **Q.** So Dr Newby initially, although I don't think
25 she overlapped with you, Dr Holt who joined in March of

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1 if they felt their voices were heard, because sometimes
2 it would be they would say: I don't feel -- I feel we
3 need to reconvene and I feel I can challenge it more now
4 I have taken a pause, et cetera. And it would just be
5 decisions around clinical practice or next steps in
6 terms of managing nurses who may or may not have made
7 a -- an error or judgment. For example, in a term
8 admission review or somebody might have contributed
9 something, the clinicians would often influence -- we
10 need to have a conversation with this nurse or we need
11 to do this or we need to do that and it wasn't the same
12 when it came to the doctors either.

13 **Q.** In these catch-ups that you had afterwards to
14 check that everybody felt their voice had been heard did
15 anybody ever say to you: look, we just can't speak up at
16 those meetings because what the doctors want, they get,
17 or was it never voiced as a concern like that to you?

18 **A.** Only from Eirian Powell who was the ward
19 manager. But at the same time, when she had said things
20 like that she would say they have always been the same
21 and: he will calm down, you know, in a few hours and he
22 will come and see me and he will come and apologise and
23 it will be okay. So she would ask for it not to be
24 escalated further and she would say she would deal with
25 it and it was as though it was a long-standing

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1 2016, Dr ZA and Dr V?

2 **A.** That's correct, yes.

3 **Q.** Yes.

4 **A.** Some of our less respectful Consultants were
5 definitely Mr Brearey and Mr Jayaram, although less
6 often with Mr Jayaram.

7 **Q.** We are going to come and look at an email that
8 Dr Brearey sent in a moment. What was your relationship
9 Dr Brearey?

10 **A.** It was a difficult relationship. I will be
11 honest. Every communication I had with him felt it was
12 more difficult than it needed to be and I didn't
13 understand why at the time. I have a little bit more
14 detail, having been prepared for the Inquiry, I've seen
15 some emails one I think that you are going to show me
16 today which references him not being included in the
17 decision to appoint a midwife to the role, I think that
18 may have been why he was very offhand with me when
19 I started in the role.

20 It certainly -- I understand now as to why he felt
21 the way he did at the time and I think that was how our
22 relationship started off on the wrong foot. I very much
23 have an appreciative enquiry, I will press and press and
24 press. It's just in my nature and I don't think it was
25 welcomed or appreciated by Mr Brearey.

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1 Q. We will come to that email in due course.
2 Just concluding your reflections upon how you perceived
3 that department, you say this in your witness statement.
4 "The neonatal team considered incident reporting to be
5 punitive"?

6 A. (Nods)

7 Q. Was that something that you inferred from
8 their behaviour or was that something that they said out
9 loud?

10 A. That was something that was said out loud,
11 certainly on several occasions by Mr Brearey to begin
12 with especially in the very first few weeks of me
13 starting because I was trying to get them to understand
14 the importance of incident reporting and things that did
15 not impact on the outcome and that was a real culture
16 shift around that time in incident reporting and risk
17 and governance because prior to that and around that
18 time certainly in the neonatal units they were reporting
19 things that were related to the outcome, so something
20 that may or may not have played a direct part or process
21 in what happened to the individual whereas within
22 obstetrics we had moved away from that and started to
23 pre-empt improvements in care so we were looking at
24 incidents whereby something had happened related to
25 something totally different but you found it as an

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1 Dr Brearey and Dr Jayaram and you are describing them as
2 "Mr" which is the first time I have heard them described
3 as "Mr". Which is correct?

4 A. We normally call junior doctors "Dr" and the
5 Consultants are normally referred to as "Mr" in my
6 experience in the NHS.

7 LADY JUSTICE THIRLWALL: I think "Mr" is usually
8 a surgeon, isn't that it?

9 I am just thinking of all the other doctors, all
10 the female doctors are "Dr" and they are all
11 Consultants.

12 A. The women would be.

13 LADY JUSTICE THIRLWALL: Yes.

14 A. You wouldn't call a female Consultant "Mrs";
15 you would always call her "Dr". That is just the way
16 I have been raised within the NHS.

17 LADY JUSTICE THIRLWALL: I see just that everyone
18 else has referred to them as "Dr" that we have heard it
19 may be entirely irrelevant.

20 A. Thank you.

21 LADY JUSTICE THIRLWALL: Sorry to take time about
22 that, Mr De La Poer.

23 MR DE LA POER: Sure.

24 We have seen the minutes of a meeting on 19 May of
25 the Women's & Children's Care Governance Board which

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1 incidental finding.

2 So in reviewing the care of a woman who may have
3 experienced a stillbirth you look at the care from the
4 moment she booked and you look at the care right the way
5 through until she is discharged from your care and the
6 incident you are looking at might be a post partum
7 haemorrhage at delivery. But if you found something in
8 the antenatal period which didn't impact on the outcome
9 but was an opportunity for learning, we would report
10 that as an incident because otherwise we don't learn
11 those lessons from it.

12 And it's that that I am talking about we were
13 trying to apply to neonates and they perceived that
14 culture change as our clinicians will see that as
15 punitive, they won't understand that it's around the
16 next lessons learned. So ensuring the next individual
17 does not experience that same incident. And it was
18 really, really difficult.

19 Q. So we are going to move to the --

20 LADY JUSTICE THIRLWALL: You said you had started
21 that in the first few weeks when you arrived, you wanted
22 to introduce that shift?

23 A. Yes.

24 LADY JUSTICE THIRLWALL: Thank you. Can I just ask
25 something else. Everyone else has referred to

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1 record you as being present in the role of Risk Midwife.
2 I give you that date to try and help you understand when
3 you started the role.

4 A. Yes.

5 Q. Does that sound about right?

6 A. Yes, that was my first governance board.

7 Q. That was your first governance board.

8 Had you had any handover from Mrs McMahon?

9 A. Yes -- yes, and no. I think to be fair to

10 Mrs McMahon, she was doing two roles at the time and
11 there was a -- I suppose an overview given of certain
12 things that needed to be completed at that time but some
13 things that she was close to completion with she kept
14 hold of and we kind of drew a line in the sand, if you
15 like, for any incidents, new incidents or things
16 happening after I had been in post I think for two weeks
17 I would deal with and she would keep everything up until
18 that point.

19 Just for consistency and certainly from a patient
20 experience perspective because we link in with our women
21 and families very closely, it made sense for her to
22 conclude those elements of it before.

23 Q. Now, we know the thematic review of neonatal
24 mortality meeting took place on 8 February, we know that
25 the finalised report was completed and dated 2 March?

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1 A. Yes.

2 Q. You were in the hearing room this afternoon
3 when I showed Mrs McMahon an email which she and
4 Ruth Millward were copied into receiving that report on
5 the 2 March. Did Mrs McMahon speak to you about that
6 report as part of the handover or when you took over
7 that role?

8 A. No.

9 Q. Did Ruth Millward speak to you about that
10 report?

11 A. No.

12 Q. You have since learned the content of the
13 report?

14 A. (Nods)

15 Q. Bearing in mind that we know that it arrived
16 in both of their inboxes on 2 March, should they have
17 spoken to you or either of them spoken to you about that
18 report when you took up your role?

19 A. I think there is two things there, yes
20 absolutely, they should have spoken to me. I think in
21 hindsight, today is the first time I've seen that and
22 I think looking back into 2016, I doubt very much that
23 either of them opened the attachment to that email and
24 as you pointed out in your questioning of Mrs McMahon,
25 that is likely -- it's likely due to the volume of work

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1 wrong about it but you now know that in fact it was
2 shared with the Risk Department --

3 A. It was shared previously.

4 Q. -- on the day that it was published and not
5 just with one person but with the head of risk as well.

6 So just to give you an opportunity to reflect upon
7 your characterisation and impression of those two as
8 they spoke, and whether you think that that is
9 a reliable impression that you formed?

10 A. I would possibly say on reflection it can't
11 have been the right impression because there would have
12 been an opportunity to take that report to governance
13 both in the March given that it was shared on 2 March,
14 the March, the April and the May.

15 So the fact that I got it and then took it in the
16 June is irrelevant because it was shared openly and
17 transparently with the governance team at the time.

18 Q. Reading between the lines, tell me if I am
19 wrong about this, but you seem to be suggesting that you
20 got the impression that they did not want it to go to
21 the Women's & Children's Care Governance Board?

22 A. I did.

23 Q. That was your take-away from looking at their
24 body language and the looks they exchanged and the words
25 that they used but I think you would be bound to accept

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1 that both had at the time.

2 It's not -- it's not an excuse for them. But they
3 should have opened it and it should have been known when
4 I took over in post and I was incredibly disappointed
5 seeing that email come up because what happened and the
6 challenges I had upon trying to get hold of that report
7 and subsequently escalating that report should never
8 have happened and I can see that now by seeing that
9 email dated 2 March.

10 Q. We will come to the conversation which you
11 found out about it but let's just talk about how you
12 have characterised it.

13 A. Yes.

14 Q. Without any knowledge of that email, and the
15 fact that Dr Brearey had sent to two members of the Risk
16 Department that report, you characterise the
17 conversation that you overheard and the reaction to your
18 request as being a bit secretive?

19 A. Yes.

20 Q. Exchanging looks, reticence on their part that
21 you perceived to providing you with that report. I just
22 want to give you an opportunity to reflect upon that in
23 light of what you now know and whether you think that is
24 a reliable impression or not.

25 I am not for a moment suggesting you are right or
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1 now that they can't have intended that, certainly not on
2 2 March 2016?

3 A. Well, I don't think in that email I saw there
4 was any mention of it going to be the governance board.

5 Q. No.

6 A. So that conversation might have come up if
7 they would have known or seen it was tabled as an agenda
8 item, so we may have come to that conclusion further
9 down the line, or we may not of. But certainly, my
10 impression was they didn't want me to see it, hence me
11 now reflecting and thinking although I must be not
12 mistaken because I am very vivid of the body language
13 I saw, I saw from their body language there was
14 something in that report that they did not want me to
15 see and that's why, when I went to it, I was looking for
16 something specifically which is what I found, I didn't
17 look at the content of the mortality reviews in any
18 detail per se because there was nothing jumping out at
19 me which is why I continued to look through the whole of
20 the report because I was looking for something that
21 would tell me why they were -- why their body language
22 showed the body language in the way that it did and
23 eventually I found it.

24 Q. Let's just deal with that conversation in
25 terms of what was said, you have given us a clear

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1 impression of the unsaid things. But you tell us you
 2 overheard the two of them speaking?
 3 **A.** Mm-hm.
 4 **Q.** Did they mention expressly in that
 5 conversation the thematic review or what was it that
 6 caught your ear?
 7 **A.** It was mortality review that -- that I meant
 8 that I heard and like I say, the appreciative enquiry of
 9 me is: can I have a look at it? And they advised
 10 that -- sorry, Mr Brearey advised that it wasn't for
 11 sharing and obviously I continued to press and I had
 12 asked: when has it been to governance board because
 13 I knew I could go back and access the agenda and papers,
 14 I felt it was important if there was a mortality review
 15 for an area that I was holding risk responsibility for
 16 that I needed to see it and I needed to be aware of the
 17 content. And so I was a little bit like a dog with
 18 a bone at that point, because I thought there was
 19 information there which was important to my role and
 20 I needed to see it.
 21 **Q.** If we go to the end, how did you end up
 22 receiving that?
 23 **A.** Mr Brearey I think emailed it to me.
 24 **Q.** So whatever had taken place in the
 25 conversation there came a point when he said he would
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1 governance board for the June. So it would have had to
 2 have been at least the 30th, 31st or 1 or 2 June to have
 3 made that agenda. But yes, close towards the end
 4 of May.
 5 **Q.** You read it as you have told us very carefully
 6 looking for something that might have caused you to form
 7 the impression that you had?
 8 **A.** Yes.
 9 **Q.** What was it that you identified?
 10 **A.** It was in the appendix section, there was
 11 a grid which you have shown during today's proceedings
 12 which identified a number of babies who had been
 13 subjected to a unexplained or unexpected death and there
 14 was a staff present and staff on duty grid and apart
 15 from the first column on the page, every other column
 16 had a nurse's name identified in each of them and I got
 17 a highlighter out and I went through it with
 18 a highlighter and I think once I had highlighted through
 19 it, it kind of jumped off the page a little bit more
 20 obvious to me.
 21 **Q.** Now, you heard me asks Mrs McMahon this
 22 question. Other witnesses have placed particular store
 23 by the fact that Letby's name wasn't in the nurse
 24 allocated to the child column. What was your view of
 25 the relevance of that to the significance of what you
 231

1 give it to you and then he did?
 2 **A.** He did, yes.
 3 **Q.** Had it occurred to you in that conversation to
 4 go back to the Risk Department and ask whether there was
 5 already a copy on file or did the conversation just
 6 evolve organically and there wasn't that opportunity?
 7 **A.** No, I did go back and I checked the -- we had
 8 what was called an S drive at the time, I checked the
 9 folders and looked myself to see whether there was
 10 anything that would fit that description and obviously
 11 there wasn't.
 12 **Q.** So again, knowing how the Risk Department
 13 works and drawing an inference it would appear that
 14 neither Ruth Millward nor Janet McMahon had taken it
 15 from the attachment --
 16 **A.** Yes.
 17 **Q.** -- and put it in the S drive folder?
 18 **A.** Yes, they definitely hadn't otherwise it would
 19 have been in there.
 20 **Q.** So you read the report when you received it
 21 and can you give us an approximate date, was it before
 22 the end of May?
 23 **A.** It was before the end of May, yes, I think it
 24 was very close to the end of May because I am just
 25 thinking how I managed to get it on the agenda for
 230

1 were looking at?
 2 **A.** I -- I did think about that at the time but
 3 I look at it to my clinical practice and often we are
 4 not caring for individual women but we are involved in
 5 their care, so we might respond to a normal buzzer,
 6 a care buzzer, an emergency buzzer and that would apply
 7 in the role of neonates as well.
 8 You know, nurses have breaks usually, when we have
 9 got staffing levels we relieve our -- our colleagues for
 10 breaks and just because she wasn't allocated that baby
 11 does not mean she wouldn't have had access and for me it
 12 was something so obvious it just jumped off the page to
 13 me.
 14 **Q.** When you read the balance of the report, did
 15 you see any indication that what you were seeing had
 16 been identified or discussed?
 17 **A.** No, so I read it in more detail afterwards,
 18 after I went into Ruth and Ruth said what she had
 19 around, you know --
 20 **Q.** We will come to that in a moment but tell us
 21 when you read it in more detail?
 22 **A.** I went back to it and read it and I thought
 23 I must have been wrong because when I had looked through
 24 each of the case reviews there was nothing that
 25 anybody -- they just hadn't highlighted it as a common
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1 denominator, there wasn't -- there wasn't the
2 recognition, I think, it wasn't obvious. So when I took
3 it to governance board there wasn't that same discussion
4 and I certainly didn't mention it again after the
5 conversation with Ruth.

6 **Q.** We will come to that governance board. So
7 having read it, we will go back in time a little bit?

8 **A.** Yes.

9 **Q.** Having read it, having applied your
10 highlighter, having decided that you need to do
11 something, did you go and speak to Janet McMahon?

12 **A.** I did, yes.

13 **Q.** Just tell us briefly what did you say to her
14 and what did she say to you?

15 **A.** I went to Jan and I said: Jan, can you have
16 a look at something for me? Obviously I am brand new to
17 role, I am clinically very experienced as a senior
18 midwife but this governance role was -- I was only maybe
19 two, three weeks in post at that point and I didn't know
20 whether I was seeing something that was really obvious
21 or whether I was barking up the wrong tree. And Jan's
22 response was, she looked at it, she looked at what I had
23 highlighted and she said: we need to go and see Ruth.

24 **Q.** Up until that moment, whether said out loud
25 between the two of you or simply in your head at some

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1 barking up the wrong tree?

2 **A.** Yes.

3 **Q.** Did you go immediately to see Ruth Millward?

4 **A.** I did. I went straight to see Ruth, she did
5 have a really open-door policy, she was very amenable,
6 I had only been there a couple of weeks at that point
7 but that open-door policy continued even after that,
8 that incident.

9 So I went to see Ruth and I explained to her first
10 of all the challenges I had getting hold of the report
11 because I felt like that was -- that was important.
12 Without that background information, I don't think it
13 gave the -- I don't think it gave the same narrative.

14 You know, I watched the non-verbals between two
15 people who it felt at the time did not want me have to
16 have that report and I have since reflected this
17 afternoon. It may be because there is a link then to
18 the information being shared within the maternity
19 department, I don't know whether they trusted me
20 professionally at that point because they had only just
21 started to work with, me whether confidentiality would
22 be maintained and maybe that's what the non-verbal
23 conversation was. I don't know.

24 But I explained to her the challenges I had in
25 putting my fingers on the report and the non-verbals and

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1 point, had you considered the possibility of deliberate
2 harm?

3 **A.** I think that's what was jumping out the -- was
4 jumping out the page to me because having a cluster of
5 deaths, it can be unusual it cannot be unusual. It's
6 not unusual in maternity to have a cluster of
7 stillbirths if we have, for example, a community
8 acquired infection, parvovirus, for example, sometimes
9 we can have clusters which wouldn't be unusual, but over
10 the year they would balance out. We don't normally have
11 real spikes in stillbirths.

12 But because I was new to the neonatology world and
13 new to risk it looked really, really obvious that there
14 was a real anomaly here that needed further
15 investigation. But then I -- when I escalated it and
16 I felt that I went to somebody more experienced to say:
17 is this something I have found when I got the response
18 I got, I thought maybe I had misunderstood and I didn't
19 challenge that because I didn't have the experience.

20 **Q.** There I think you are talking about the
21 conversation you had with Mrs Millward?

22 **A.** Yes.

23 **Q.** So you have spoken to Janet McMahon?

24 **A.** Yes.

25 **Q.** She has told you that her view is you are not

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1 the reluctance to share it with me.

2 I had shared that with Julie Fogarty as the Head of
3 Midwifery before that in our one-to-one, I had some very
4 regular one-to-ones to begin with and she had said:
5 Mr Brearey is really amenable, go back to him, ask him
6 for it again, et cetera. So I shared with Ruth the
7 challenges that had led up to me getting hold of it and
8 that I had gone there specifically looking for something
9 to leap off the page and it did.

10 And I showed her -- I had the report out to show
11 her but she didn't want to look at it.

12 **Q.** Can I just pause you there for a moment. Did
13 she at any point in your conversation say: I don't know
14 why you had such difficulty getting it, you could have
15 asked me, I had a copy --

16 **A.** No.

17 **Q.** -- emailed to me?

18 **A.** No.

19 **Q.** Did she give you any indication at all that
20 she had seen that before?

21 **A.** No, never. She didn't say she hadn't and she
22 didn't say she had. She didn't look like she didn't
23 need to see it because she had already seen it before.
24 She just didn't -- she didn't look.

25 **Q.** I should have asked this at the time, but in

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1 terms of Mrs McMahon, again did she appear to you to
2 have seen that document before or did it appear to be
3 new to her?

4 **A.** It appeared to be new to her. When I showed
5 it to her she actually looked, she went through because
6 I don't know whether you could tell on the digital
7 display but you had to turn over several pages to look
8 at all of the names because there were that many and she
9 paid attention to the document, she looked at it, looked
10 at the highlighted and then there was again an unspoken
11 verbals between us and she said; you need to go to Ruth.

12 **Q.** I have gone back in time. Let's go back to
13 Ruth Millward. Just tell us as close as you can
14 remember it what did Ruth Millward say to you after you
15 talked her through the difficulty you had, what you had
16 found and the highlights you had applied?

17 **A.** As I have said in my statement the exact words
18 I -- I couldn't tell you with 100% certainty. But it
19 was something along the lines of, you know, you need to
20 be really careful, Annemarie, you can't come in here and
21 just start throwing accusations around about an
22 individual nurse being present for all of these deaths,
23 you need to have -- you need to have evidence, you need
24 to -- just because she's present and on duty doesn't
25 mean that there is a link and I know you are new to Risk

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1 boss. So I came away and I looked at the mortality
2 review in detail and I went through all of the
3 information in the pack and -- and I thought: okay,
4 I must be barking up the wrong tree because there is no
5 mention of this commonality in any of the -- the
6 information within the pack and I will just chalk that
7 up to experience and I am new to role, so that was that.

8 **Q.** Did you think that the idea that you had had,
9 namely that it required investigation, effectively ended
10 at that point or did you think that anything more would
11 be done?

12 **A.** I thought it had ended at that point.
13 I suppose in hindsight I kind of hoped something might
14 have happened afterwards. But obviously the next thing
15 that happened was we had two further deaths and ...

16 **Q.** There is one event that we need to look at
17 between the conversation and that is we will just
18 briefly bring it up on screen INQ0003212, this is the
19 Women's & Children's Care Governance Board meeting.

20 We can see it is on 16 June, we can see that you
21 attended, you are listed under the Planned Care
22 department as Risk Midwife although in fact your role
23 was across both divisions, wasn't it?

24 **A.** Yes.

25 **Q.** If we go to page 5, we can see that it was

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1 and Patient Safety, you know, but you need to be really,
2 really careful and mindful and you need to have
3 something proper to be able to go and like raise alarms.

4 **Q.** Did you form any impression about whether what
5 you were suggesting namely that a particular nurse was
6 associated with an increase in mortality was something
7 that Ruth Millward already knew or whether she was
8 talking in general terms about what you should and
9 shouldn't do?

10 **A.** I thought she was talking in general terms.
11 I don't -- I didn't get the impression at all she was
12 aware of anything and I didn't know that until I got the
13 information from the pack that that was I believe the
14 only -- the first time she did know anything according
15 to -- to her information.

16 **Q.** So she's warned you effectively not to make
17 allegations like that, was there any more discussion
18 between you or was that the end of the conversation?

19 **A.** No, she just said you need to be really
20 careful and really mindful that, you know, you have got
21 evidence to support what you are saying, you can't just
22 go round saying these things. And I left her office and
23 I will be honest, I am under oath, I felt embarrassed.

24 I felt extremely embarrassed, I was new in post and
25 I felt like I had embarrassed myself in front of my

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1 tabled at that meeting and who was responsible for that.

2 **A.** So the agenda is prepared under -- with
3 discussion of the chair, whether that is Mr McCormack or
4 Mrs Fogarty in his -- if he is on annual leave. So
5 if -- if it was Mr McCormack or Mrs Fogarty I would need
6 to see the front page again but generally the agenda is
7 prepared for under the instruction of the chair.

8 **Q.** But was this a spontaneous decision by the
9 chair or did you have anything to do with?

10 **A.** Oh no, I had asked for it -- I had asked for
11 it to be put on the agenda having got hold of it at the
12 end of the month.

13 **Q.** We can see wording which is largely taken from
14 the report --

15 **A.** Yes.

16 **Q.** -- concludes with:

17 "There was no common theme identified in all
18 cases."

19 **A.** Mm-hm.

20 **Q.** That's what the minutes show to anybody
21 reading them. In fact, you had identified a common
22 theme, hadn't you?

23 **A.** I had, yes.

24 **Q.** So just talk us through your reasoning as to
25 why, unless these minutes are wrong, why that theme

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1 wasn't articulated and why instead the official record
2 is no common theme?

3 **A.** I think at the time the report was tabled as
4 an agenda item, we were looking at the content of the
5 report and what the report had found, that's generally
6 how reports are received and noted and minuted in
7 governance.

8 My theme that I had identified was outside of that
9 report process so this is -- is a snapshot of what the
10 report had found rather than what me as an individual
11 had had seen outside of that fact.

12 **Q.** This being a governance meeting, attendees are
13 entitled to scrutinise what is put in front of them, it
14 is not a rubber-stamping exercise.

15 **A.** They are yes.

16 **Q.** So the person you are now, attending a meeting
17 like that, would that meeting have been an appropriate
18 forum to say: well, I have had a look at this report but
19 I've seen a theme?

20 **A.** The person I am now would absolutely have had
21 that discussion in that -- in that forum at that time
22 and -- and looking back I think because nobody else had
23 raised the issues that I raised, I think it kind of
24 confirmed to me that when Ruth had said; you need to be
25 really careful about this, nobody else had picked up on

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1 something that I thought wasn't -- wasn't it was just
2 something that was in my mind and nobody else's.

3 **Q.** So we will just move forward to the deaths of
4 Child O and Child P here really just to illustrate
5 a point. You didn't find out about those deaths until
6 Monday, 27 June; is that right?

7 **A.** That's correct.

8 **Q.** They having occurred on 23rd and 24th?

9 **A.** Yes.

10 **Q.** If we just run through your experience. You
11 were on the central labour suite when you overheard
12 discussion about it and that led you to go into the
13 neonatal unit; is that right?

14 **A.** The Practice Development Midwife
15 Lorraine Millward, when I came on to the central labour
16 suite, seeing me and said: oh my goodness, Annemarie,
17 have you heard that one of the triplets have died? And
18 I was shocked. I said: I haven't heard anything,
19 nothing has been reported and she said: none of us can
20 believe it but one of the triplets have died.

21 So I said: I am going to go there now, the delivery
22 suite was connected to the neonatal unit and so I made
23 my way straight there and there was a lot of people on
24 the neonatal unit, several more bodies than I would ever
25 normally see, and they prevented me from entering

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1 it and I think it kind of cemented that I had obviously
2 got the wrong impression and that wasn't what I should
3 have done, you know, I -- I didn't escalate beyond Ruth.
4 That was my route of escalation and if that was to
5 happen now and I was still in a junior role, I would --
6 I would absolutely have learned from what happened in
7 2016 and I would have continued to escalate.

8 Me being in the role I am in currently today
9 I would be the person who was raising that in that forum
10 and then if it wasn't being escalated up through the
11 Planned Care governance board I would have been going
12 directly to the Executives myself to say you need to do
13 something about this and if I wasn't satisfied I would
14 continue to escalate.

15 **Q.** Did you think of the issue that you had
16 identified as a safeguarding issue? Did you think of it
17 in those terms?

18 **A.** It would have been a safeguarding issue
19 absolutely. You know, a member of staff doing what
20 happened, in this example is -- is a safeguarding
21 concern. Absolutely.

22 And your next question will be why did I not
23 escalate it to safeguarding?

24 **Q.** Exactly so.

25 **A.** Because I -- I was embarrassed about finding

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1 further into the neonates. Obviously they knew who
2 I was, some people might not have done because I was
3 only in post a short time by that point.

4 But those who didn't, I said I am the Risk Lead,
5 I have come here, I have heard one of the triplets have
6 died and it's not been reported and one of the staff
7 nurses -- one of them got tearful and upset and the
8 other -- another staff nurse said: two of the triplets
9 have died, not one.

10 **Q.** Who wouldn't let you on to the unit?

11 **A.** So there was a number of staff there, they had
12 said that there was a meeting taking place in the office
13 and they were not to be disturbed. I asked them to
14 disturb them and said: I am the Risk Lead and I need to
15 be involved, I need to know what's going on. But they
16 wouldn't let me in.

17 **Q.** Just again, who?

18 **A.** The -- the staff members present I didn't,
19 I didn't --

20 **Q.** Were they doctors or nurses?

21 **A.** They were -- there were no doctors outside,
22 they were nurses.

23 **Q.** So you asked to join the meeting that you were
24 told was going on and you were told by them that you
25 couldn't?

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1 A. Yes.
 2 Q. Did they go and make an enquiry?
 3 A. They did, I asked them to go, knock on the
 4 door and tell them who I was and what my role was and
 5 they would let me in, and she did that and came back and
 6 said: they said they are not to be disturbed.
 7 Q. We don't need to bring these up but did you go
 8 back to the Risk Department to check on the Datix system
 9 to see if you had overlooked --
 10 A. I did.
 11 Q. -- the filing of Datix?
 12 A. I checked to make sure I had overlooked it but
 13 my normal practice is every morning when I used to come
 14 in, we all did this as risk leads. Some of us like me
 15 actually did it the night before we came in just to see
 16 what -- plan our workload and if things had happened the
 17 night before sometimes I might go to -- you know,
 18 straight to -- to the labour suite because the building
 19 we were in is not was not connected to the hospital.
 20 So sometimes I would look the night before to see
 21 but I did go back to the office and I checked the -- the
 22 pool that I talked about, the holding bay, and I also
 23 checked under the relevant searches. So, for example,
 24 somebody might have put it in and put it under
 25 "paediatrics" for example. But I double-checked
 245

1 A. Yes.
 2 Q. Alison Kelly you tell us was also present?
 3 A. Yes.
 4 Q. So far as you can recall, was anybody else
 5 present?
 6 A. There was lots of people there. Some I know
 7 to be Executives because I was -- around that time I was
 8 trying to be staff governor so I was getting to be a bit
 9 more familiar with -- with who people were so I knew
 10 there was a couple of Execs there but I couldn't have
 11 told you the names of them in that respect.
 12 Q. Were you looking at staff rotas, is that what
 13 you were doing in that meeting?
 14 A. No.
 15 Q. What were you doing?
 16 A. No, it was -- they had asked us to look
 17 through the Meditech and look and try and identify any
 18 collapses or deteriorations and look for a name -- look
 19 for Lucy's name associated in the notes.
 20 Q. At that stage did you make the connection with
 21 what you had seen at the end of May?
 22 A. I did, yes. I think I made it a little bit
 23 before that if I am honest before that meeting, after
 24 the babies had died.
 25 Q. So far as any unspoken agenda for what you
 247

1 everywhere with I think Joanna Donnelly and nothing had
 2 been reported.
 3 Q. That was because we now know there was nothing
 4 to be found because the Datix --
 5 A. Yes.
 6 Q. -- for Child A and P are both dated the 29th,
 7 aren't they?
 8 A. Yes.
 9 Q. Now, we just need to deal briefly with
 10 a number of events and I will try to be as efficient as
 11 I can about this, but you shouldn't feel inhibited by
 12 that.
 13 A. Okay.
 14 Q. You participated in a mortality review on
 15 5 July of 2016, is that right, in relation to Child O
 16 and Child P? Were you aware of that taking place?
 17 A. I would need to --
 18 Q. Well, I think in the circumstances I don't
 19 have any particular questions about the detail of that
 20 so we will leave that one for now.
 21 Can we turn to the extraordinary meeting, as you
 22 describe it, in July of 2016?
 23 A. Yes.
 24 Q. This was a meeting which was attended by
 25 Sian Williams and Julie Fogarty; is that right?
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1 were doing was concerned, did you perceive one or was it
 2 just as far as you were concerned a good faith search
 3 for -- through the records?
 4 A. No, I knew they were, when I say I know,
 5 I didn't know, nobody came right out and said
 6 specifically. But I -- I knew based on what they were
 7 asking me to do that they were looking for other cases
 8 that may or may not be connected to Lucy.
 9 Q. You tell us that your notes of that work were
 10 taken off you at the conclusion?
 11 A. (Nods)
 12 Q. You also tell us that you undertook a Datix
 13 search subsequently for cases --
 14 A. Yes.
 15 Q. -- involving Letby and you found that there
 16 were missing records?
 17 A. Not missing records in relation to the search
 18 per se, but there was a number of IT systems that we
 19 searched and a number of reports that were run and they
 20 were put into a folder in -- in our risk and governance
 21 S drive. I think if I remember it was Dean Bennett at
 22 the time -- and Jo Donnelly at the time who were also
 23 searching their systems. We all contributed into the
 24 folder and then one day that folder had just disappeared
 25 and I don't think it was very long after, a couple of --
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1 couple of days, maybe a week or so and the folder just
2 no longer existed.

3 **Q.** Did you ever speak to anybody about or get to
4 the bottom of why that was?

5 **A.** I did ask Ruth where the folder had gone and
6 she told me not to concern myself with it. So I just
7 thought it -- access has been restricted from me or that
8 it had been moved to for example one of the other
9 department S drives or Y drives that clinicians such as
10 me wouldn't have had access to.

11 **Q.** I do need to ask you about an email that you
12 have since seen sent by Dr Brearey. I will just ask for
13 it to come up on screen, please, INQ0006769. You have
14 seen this email before. It is dated 15 July?

15 **A.** I have, I saw it on Friday.

16 **Q.** On Friday. So if we just scroll down to get
17 the context so everybody can follow, your boss
18 Ruth Millward had made a request of Dr Brearey in terms
19 of some information to support the RCPCH review, we can
20 see that down there?

21 **A.** Yes.

22 **Q.** We don't need to go to the detail of that.
23 What we are going to be look at is what Dr Brearey says
24 about you so that you have an opportunity to comment
25 upon it.

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1 offered to meet to discuss with you term admissions
2 reporting and yet I am yet to receive a reply. I've not
3 seen Annemarie for over a month. In addition ..."

4 And he goes on to talk about the fact that he's
5 heard that there is criticism of the Datix reporting and
6 he makes the point about the fact that it's consistent
7 with other neonatal units on the network.

8 So really this is just to give you an opportunity,
9 Ms Lawrence, to comment upon this and whether it is
10 right to your recollection that Dr Brearey hadn't seen
11 you, that you hadn't turned up for meetings without
12 giving your apologies, and that you were not supporting
13 him and his colleagues adequately.

14 **A.** Like I say, I saw this on Friday. I was
15 disappointed when I read it. It felt an unfair
16 representation. I had been in post at that point --
17 I had started in May. This was the 14 July, I think.
18 There was an awful lot that had happened between
19 starting in post. Some mandatory training -- obviously
20 I had done some training in relation to risk and
21 incident management and the NHS England framework, so
22 I have to have time to undertake mandatory training --
23 and I was also working clinically at the time as well.

24 So clinical credibility was extremely important to
25 me when I started in the role. And there was some

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1 So if we just go back to the preceding page, we can
2 see that Dr Brearey begins by making some observations
3 about the timing of providing the material. He then
4 goes on to say that he's completely underwhelmed by the
5 support:

6 "... your department [that is the same as your
7 department] has provided this year. Concerns are shared
8 by colleagues, nursing staff on paediatrics, neonatology
9 and obstetrics."

10 Then we can see:

11 "To think the role of Risk Midwife was created
12 without any discussion with paediatricians or
13 consideration that she would have to cover neonatology
14 is quite concerning. I also have concerns about
15 Annemarie's competence. Both Eirian and myself sat down
16 with her at the beginning of her job to explain her role
17 and our expectations, the most significant [we will need
18 to go over the page] of which was to arrange a monthly
19 incident review meeting. Seemingly forgotten. We are
20 now at a point where I will be meeting to go through
21 three months' worth of incidents. I value her
22 contribution to the weekly term admissions audit. There
23 have been times when busy on-call Consultants have come
24 to review cases at agreed times and she's not been
25 present and not given her apologies. I have also

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1 staffing challenges, so I also worked as a Band 7 labour
2 ward co-ordinator, as well as my role, at the time for
3 probably the first six months but only maybe one long
4 day every week or every fortnight.

5 I think the first sentence where he says he's been
6 underwhelmed by the support from the Risk Department for
7 the most part of that year, I think he's got a fair
8 point because when Debbie left in February to ask
9 another Risk Leader with a whole other service to cover
10 two -- what would be two whole time equivalent jobs is
11 no small task.

12 So I think you can't continue to run a really good
13 service with less people, otherwise we wouldn't employ
14 these people to do the jobs and certainly in Risk and
15 Patient Safety at the Countess, it's got to be one of
16 the most under-resourced Risk and Patient Safety teams
17 I have ever known in my experience in maternity,
18 maternity departments per se, and I have worked in a few
19 units in my career across the north-west and including
20 the Midlands. So it would be fair to say he's got
21 a point because there were some absolute gaps in the
22 service.

23 I am disappointed that he says he's not seen me for
24 a month and he has issues around my competence because
25 if he hasn't seen me for a month at that point, and

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1 I have only been in post about nine weeks at that point,
2 then he's made a summative assessment in a very short
3 space of time and I would have liked an opportunity to
4 have commented at the time he sent that, rather than
5 left it unchallenged and unsaid.

6 **Q.** I have got two more topics to ask you about.

7 **A.** Okay.

8 **Q.** Both of them, I hope, brief. Take that email
9 down, thank you.

10 We know that Letby was moved to your department.
11 In summary, what was your view about whether it was
12 appropriate for her to work in your department?

13 **A.** I don't think it was appropriate and
14 I certainly voiced that in the beginning and the
15 response was that she was working in the Complaints Team
16 and wouldn't be working in the Risk and Patient Safety
17 Team.

18 But what I think my Lady is not aware of is the
19 Risk and Patient Safety team and the Complaints Team are
20 on the same floor. So we have only got a door that
21 separates the two of us with a very, very small
22 corridor, not as long as where you are away from me. So
23 although she was working in the Complaints Team
24 initially, she was working -- she was making tea and
25 coffee in our office because that is where the tea

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1 benefit of my Lady, if she's not sure of the incident
2 I am referring to, on coming to work one morning, as
3 I came up the stairs, Lucy came out of the office, out
4 of her office on that corridor, to greet me and she was
5 very distressed.

6 She almost jumped down my throat really with a
7 "there's been a collapse and a baby's been transferred
8 out and does that mean somebody else is going to be
9 under investigation and I can go back to work". And she
10 bombarded me with a lot of questions and I didn't know
11 what she was talking about because I wasn't aware of
12 a collapse because, as you know, at the time there was
13 some challenges around whether we were reporting them or
14 not. But she knew this information and it hadn't
15 reached me. It wasn't in the Datix system. It wasn't
16 emailed to me. And so I emailed Karen Rees to say,
17 "I am concerned that Lucy has had access to information
18 that she shouldn't have. I wonder whether there is
19 something in the neonatal unit who was feeding her
20 information". But it concerns me that she knows
21 something clinically that I don't know as the Risk Lead.

22 **Q.** Was that an email that you sent?

23 **A.** It was, yes.

24 **Q.** Can you give us an approximate date so that we
25 can see if we can find that?

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1 machine was and I didn't think it was appropriate.

2 **Q.** Who did you say that to?

3 **A.** Ruth and I had a conversation initially and
4 Ruth's response was that -- I think she said she had
5 asked for her in the beginning. She was concerned about
6 how she would how it would be handled with her and she
7 felt like she wanted to give her a constant whilst the
8 review process was going on.

9 **Q.** So far as you were aware, did Letby have
10 access to patient notes or reports such as the thematic
11 review had she wished to look at them?

12 **A.** I think if she wanted to look at them, she
13 absolutely could have because she had access to the Risk
14 and Patient Safety team S drive. Now, I don't know
15 whether her access was limited in terms of what folder
16 she could or couldn't access. But you will notice from
17 my statement I talk about her having information that
18 I didn't have at that point and so I think it's fair to
19 say that if you were to ask me would she be able to
20 access these things, I would say that would be
21 a possibility, yes.

22 **Q.** Did you think it was appropriate for her to
23 have access to things that you didn't have access to?

24 **A.** Absolutely not, and I did report that to --
25 that incident to Karen Rees at the time. Just for the

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1 **A.** Oh, gosh. I would say it would definitely be
2 the autumn of 2016.

3 **Q.** Thank you very much indeed.

4 Finally on this topic before we just deal briefly
5 with root cause analysis, what you say in your statement
6 is:

7 "We were made to believe that she was being made
8 a scapegoat for poor medical care and a lack of team
9 working which then conflicted me further."

10 So there are two parts.

11 **A.** Yes.

12 **Q.** We will get to the conflict in a moment.

13 **A.** Yes.

14 **Q.** But who was making you believe, or seeking to
15 make you believe, that she had been their scapegoat?

16 **A.** So that was conversations, lots of
17 conversations were had, not directly with me because
18 I was a Band 7 Risk Midwife at that point, but
19 conversations were had without I think any thought to
20 confidentiality. Lucy would have conversations with her
21 Union rep and also some of the managers and things would
22 be overheard, they would walk along the corridors and
23 there would be conversations that would be happening and
24 if you were walking behind them closely enough or if you
25 happened to be walking the other way, there was

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1 information that you were able to, able to glean from
2 their discussions or if you entered into a room it would
3 take a minute or so before those discussions quietened
4 down.

5 **Q.** Who was saying that she was being made
6 a scapegoat, was she saying that or were the people she
7 was speaking to telling her that?

8 **A.** Both, really. She had I think -- I think from
9 the information I had available to me at the time, and
10 like I say it wasn't a conversation I was included in
11 but it was something I was listening to on a regular
12 basis, they were conversations between Hayley Cooper who
13 was her Union representative, Lucy, Karen Rees, some
14 discussions with Ruth but then Ruth left and then those
15 discussions took place with Julie Fogarty -- sorry
16 Julie Fogarty after, after Ruth left so there was often
17 things that you could hear.

18 **Q.** And were the people you have identified
19 Hayley Cooper, Karen Rees, Ruth Millward, Julie Fogarty,
20 were they simply offering a listening ear or were they
21 contributing, making comment themselves about whether it
22 was true that she was being made a scapegoat?

23 **A.** I think at the time that's what they truly
24 believed. I don't think they were intentionally being
25 unprofessional in terms of knowingly having

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1 have prevented the deaths of two of those babies and
2 I didn't. And then I had to work with her alongside her
3 listen to conversations that perhaps she might have been
4 innocent and it was really difficult. And having heard
5 some of the things I have heard today and seen some of
6 the evidence, a lot of that was avoidable, certainly
7 a lot of the deaths were avoidable and a lot of the
8 difficulties we faced as clinicians working in that
9 department was avoidable.

10 **Q.** The final topic is the root cause analysis.
11 You tell us that in April of 2017 you were asked to
12 conduct a root cause analysis in relation to Child O and
13 Child P and that you looked at Dr Hawdon's report and
14 the RCPCH and generated those reports based upon that
15 content.

16 **A.** Yes.

17 **Q.** You reached three conclusions, three identical
18 conclusions in each case and we will just have a look at
19 it. INQ0018008 and we will look at the conclusions that
20 you reached in the root cause analysis. We will go,
21 please, straight to pages 9 and 10. So this is for
22 Child O but the text is exactly the same, I am sure you
23 can confirm for Child P?

24 **A.** It is, yes, just very different timelines but
25 the text is --

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1 a conversation that would be overheard. But where they
2 had those conversations and often with doors that
3 weren't closed it was -- it was obvious to anybody who
4 was working nearby and many times we have -- I say "we"
5 me and other members of the team, who haven't been as
6 close to the door have got up and closed the door
7 because you can hear things coming into the office and
8 when you are trying to concentrate and trying to write
9 things and there is a group of people having
10 a conversation outside it can be very distracting.

11 **Q.** The second part of what you said "then
12 conflicted me further", I just want to give you a brief
13 opportunity to just comment upon how you were feeling
14 about this whole situation bearing in mind what had
15 happened in May?

16 **A.** I was hoping you wouldn't ask me that
17 question, if I am honest. It's something I have
18 reflected on for many, many years. It was a very, very
19 difficult time. I was working alongside somebody who
20 initially I had thought had done some terrible, terrible
21 crimes and then I -- I can't say I was made to feel
22 because nobody can make me feel anything but I felt
23 ashamed for raising them.

24 And then I spent some time thinking if I had have
25 just raised them a little bit louder potentially I could

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1 **Q.** The Coroner's cause of death instance was
2 given as complications associated with prematurity and
3 in addition this investigation has identified no one
4 singular root cause but several that may well have --

5 **A.** Contributed to the outcome.

6 **Q.** Which include, if we go over the page: we can
7 see that at the top there is that hanging paragraph in
8 italics in the centre: significant sub optimal care that
9 is possibly relevant to the outcome, failures in care to
10 recognise problems and a failure to act appropriately?

11 **A.** Yes.

12 **Q.** So the conclusions that you are reaching in
13 this root cause analysis are pointing towards NHS staff
14 failings in care quality.

15 I mean, firstly is that a fair summary of the
16 conclusions that you are raising as possible?

17 **A.** I think that is a fair representation of the
18 conclusions but I must say I -- when I -- when I was
19 asked to put the findings of the various reviews into
20 a report, I must say this is what I have taken out of
21 those and I have put together in a way that it can be
22 read by the CCG.

23 So the majority of it is not my words or my
24 thoughts. It's me concluding the documents that are
25 available to me.

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1 Q. Did you know that in late March of 2017, the
2 Executives were discussing putting together a bundle of
3 documentation for the Cheshire Police?

4 A. No.

5 Q. We know it wasn't until the end of April that
6 the Cheshire Police were contacted through the CDOP.
7 But was it appropriate taking into account that fact
8 that you were writing a root cause analysis in relation
9 to the deaths of Child O and Child P where you were
10 specifically drawing attention to failures in care as
11 being a potential explanation for those two deaths,
12 whilst it was in active contemplation that those deaths
13 may have been murders because the police were required?

14 A. It was not appropriate, no and that
15 information wasn't shared with me. Through
16 Ruth Millward, Ruth asked me to -- that she said that
17 Alison Kelly had asked her to ask me to put this
18 information which was a number of documents could
19 I culminate it into a template that could be submitted
20 to the CCG. And so when I sat there and it took me
21 a significant amount of time to put these documents
22 together because I had to go from one piece to the next
23 piece to the next piece and so forth, it was on the
24 understanding that the CCG were looking for an
25 MPSA Level 2 report that they could receive in the

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1 Alison Kelly wanted these reports created in April of
2 2017 because of course we know the deaths occurred back
3 in June, we know that the reports came in from the RCPCH
4 and Dr Hawdon. But why April? Were you given any
5 information at all about that?

6 A. No. The only thing that Ruth had said was
7 that they had been requested, they needed to be -- they
8 needed to be received at the CCG Serious Incident Review
9 Group and I know from previous where they have -- they
10 perhaps have sent separate documents, the CCG have asked
11 for them to be collated into a thematic review or
12 something that they can receive in their entirety.

13 So I suppose at the time, given my junior position
14 I didn't really question it or question the integrity of
15 the ask, because it wouldn't have been unusual for the
16 CCG to ask for a few things to be brought together under
17 one document if indeed that was the ask from the CCG
18 based on what you have just said.

19 MR DE LA POER: Mrs Lawrence, thank you very much
20 indeed for answering my questions and can I particularly
21 acknowledge the time, and I take full responsibility for
22 that, there is no reflection on you. My Lady, I am told
23 that although permission has been granted for Rule 10 it
24 would appear that I have covered the issues that needed
25 to be covered and so there are no further questions from

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1 Serious Incident Review Group.

2 Q. From the point of view of official paperwork
3 a root cause analysis is a very well identified way of
4 capturing potential learning within the NHS, isn't it?

5 A. It is, yes.

6 Q. And it is the sort of document that might be
7 shown to board members in the case that they have an
8 enquiry or to, as we know, the commissioning group and
9 I just would like to just tease out, if I may, your
10 reflections, given particularly you hold a senior role
11 now, about the risk of creating a root cause analysis
12 such as you did, in circumstances where other people
13 might read it and get the wrong idea that everything had
14 been adequately investigated and ascribed to
15 a particular cause, can you just from your experience
16 help us understand that, please?

17 A. Absolutely. So at the time, I was given
18 an instruction and I acted on it. But in a senior role
19 now I can see that the submission of this Level 2 was an
20 attempt to move from reassurance to assurance. So we
21 are telling you we are looking into it but here is of
22 proof of such in a Level 2 document. I can see how that
23 could mislead many people in the organisation and also
24 outside agencies as well.

25 Q. Were you given any reason as to why

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1 the advocates for Mrs Lawrence.

2 Questions by LADY JUSTICE THIRLWALL

3 LADY JUSTICE THIRLWALL: Thank you. Mrs Lawrence,
4 I have just got a couple of questions myself.

5 When you went to see Ruth Millward, you say you
6 gave her the or showed her the report and she didn't
7 want to look at it. But what did you say to her?

8 A. I -- I went in the room and I said: I wonder
9 if you have got a minute which is how I normally would
10 start those conversations and then I had the report in
11 my hands and it was open and I said: I need to tell you
12 about this report I have got here and the challenges
13 I have faced in getting it, because I need you to
14 understand what it is I have found. And I proceeded to
15 tell her about the discussion that I witnessed between
16 Stephen Brearey and Eirian Powell and the non-verbals
17 which I felt were particularly important and that I sat
18 with that document purposely looking for something based
19 on the non-verbals and the reluctance that I had felt
20 when I had asked for a copy.

21 And she did -- when I say she didn't look at the
22 report, what she did was she said she didn't want to see
23 it but she did acknowledge that yes, okay, so you have
24 got somebody present for all of these deaths but, you
25 know, what does that mean?

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1 **LADY JUSTICE THIRLWALL:** Had you pointed out that
2 that was what the report showed that there was someone
3 present for all, did you say that to her?

4 **A.** Yes, absolutely, I had highlighted -- each
5 section on that table I had highlighted with a yellow
6 highlighter so it kind of made it a bit more real and it
7 came off the page a bit more.

8 **LADY JUSTICE THIRLWALL:** Then that was when she
9 said: you have got to be very careful, or whatever it is
10 she said, we have a note of that?

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** You don't need to repeat
13 that. I just wanted to know what you had said from your
14 perspective after setting the scene.

15 Then just one last thing. You sent an email to
16 Karen Rees about Lucy Letby's conversation with you
17 which you have described?

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** Did you get a reply from
20 Karen Rees?

21 **A.** I did. So I do believe there is access to my
22 email, so it should be in my "Sent" if not in Karen's
23 "Received" and Karen then went on and sent a -- she sent
24 a circulatory email through herself and Eirian to say
25 something around being mindful of professional

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1 efforts are Herculean and, as far as I know,
2 uncomplaining. I am very grateful to her.

3 We will rise now.

4 **(5.20 pm)**

(The Inquiry adjourned until 10.00 am
on Monday, 4 November 2024)

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1 conversations, don't be discussing things outside of
2 work. So I think they address addressed it generically
3 rather than specifically is my understanding but that
4 information will be in the NHS mailbox.

5 **LADY JUSTICE THIRLWALL:** All right. Thank you very
6 much.

7 **A.** Thank you.

8 **LADY JUSTICE THIRLWALL:** Yes, those are all my
9 questions, thank you very much for staying so late --

10 **A.** Thank you.

11 **LADY JUSTICE THIRLWALL:** -- and being so
12 comprehensive and helpful in all your replies. Thank
13 you for coming. You are free to go now, please don't
14 wait for me to leave.

15 **A.** Thank you.

16 **LADY JUSTICE THIRLWALL:** Now, Mr De La Poer we
17 start again on?

18 **MR DE LA POER:** Monday, 4 November, we will begin
19 with Karen Townsend and then Ruth Millward will be heard
20 later that day.

21 **LADY JUSTICE THIRLWALL:** Thank you very much. So
22 we will rise now until 4 November but I hope that --
23 I won't say anyone will have a rest because I know you
24 won't, but thanks for all the hard work to date.

25 May I especially mention the shorthand writer whose
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