Tuesday, 22 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: Yes, if we could call Mrs Peacock, please.

LADY JUSTICE THIRLWALL: Mrs Peacock, if you would like to come up to the desk, please.

MRS DEBBIE PEACOCK (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

MS BROWN: Could you please give your full name?

A. Debbie Peacock.

Q. You provided a statement to the Inquiry dated 5 June 2024 and I think there's a matter that you wish to correct at paragraph 127?

A. Yes. In reference to the risk registers, they also went through to the divisional board meetings as well as QSPEC.

Q. So that paragraph says that the risk registers will be at QSPEC and the addition is that you are now adding that they would have been also been discussed at the divisional board?

A. Yes.

Q. Taking into account that correction, is that statement true to the best of your knowledge and belief?

A. As far as I am aware, yes.

Q. I think there is something you wish to say at the start of your evidence?

A. Yes, I would just like to extend my sincere condolences and sympathies to the Families and parents involved in these events.

Q. Thank you.

Turning to your qualifications, you qualified as a Registered General Nurse and a Registered Sick Children's Nurse in 1985 and a midwife in 1987; is that correct?

A. It is, yes.

Q. You then went on to obtain a law degree in 2001. Is it correct that you then went on to qualify as a solicitor?

A. I did, yes.

Q. When did you qualify as a solicitor?

A. Oh, I think it was 2010.

Q. You also hold a National General Certificate in Occupational Health and Safety that was awarded in 2015?

A. Yes.

Q. Turning to your career, Mrs Peacock, you worked as a qualified nurse from 1985 and also as a midwife. Over what period did you work as a nurse or

midwife within the NHS?

A. I was working as a nurse and midwife either under contract or on the bank up until probably 2013.

Q. So over 30 years?

A. Yes.

Q. Was that mainly as a nurse or mainly as a midwife?

A. Mainly as a midwife and a neonatal nurse.

Q. Coming to your period as a neonatal nurse, how long did you work as a neonatal nurse on a neonatal unit?

A. There were different periods. I really couldn't quantify that at the moment off the top of my head, sorry.

Q. Just approximately, was it a number of years?

A. A number of years, yes.

Q. Roughly what period, obviously you span from 1985, quite a long period over 30 years?

A. Yes. So when I actually went to do my legal training I was working as a transitional care midwife which is a midwife on the wards looking after babies that needed a little bit of extra support. So that was still under the neonatal hat. But I probably left the neonatal unit in probably 2008 I think maybe.

Q. So a period of five years you worked on

a neonatal unit or are we talking less than that?

A. Probably a little bit more over the years.

Q. Where was the neonatal unit that you worked on?

A. So I worked at Fazakerley Hospital, which is now Aintree, as a neonatal nurse, I worked at Warrington General as a neonatal nurse and I worked at Liverpool Women's.

Q. And as a neonatal nurse that included working with babies in intensive care, did it?

A. I generally didn't do intensive care, I tended to stay in the HDUs and the nursery.

Q. So you were working with special care babies rather than those in intensive care?

A. Yes.

Q. What band nurse were you on the neonatal ward?

A. When I worked at Fazakerley I would have been a Band E and then they changed the -- the gradings. So as a midwife I was a Band 6 when I worked on the neonatal unit at Liverpool Women's.

Q. In terms of the Countess of Chester, did you work at any time as a midwife or a nurse at the Countess of Chester Hospital?

A. No, I never worked clinically.

Q. Looking at your legal career, you say that you

worked from 2008 to June 2012 as a paralegal then a trainee and then as a solicitor. How long did you work as a qualified solicitor in clinical negligence?

A. Probably just less than two years.

Q. Why did you leave your role as a solicitor?

A. There was a Clinical Risk Manager job came up that I thought suited me better.

Q. Turning to that, when you moved to work in Risk and Patient Safety in 2012, from June 2012 to December 2013 you worked as a clinical risk manager in Southport & Ormskirk Hospital, so about an 18-month period?

A. Yes.

Q. Very briefly, what did your role involve there?

A. My role there covered the whole hospital so it wasn't confined to one particular specialty. And it was just quality improvement and monitoring patient safety via Datix and investigations, obviously sharing lessons learned.

Q. Then turning to when you started employment at the Countess of Chester, you started there in December 2013 and what was the title of your role when you started at the Countess of Chester?

A. So it was Quality Improvement Facilitator when

I started and that later changed to Risk and Patient Safety Lead for Women's and Children's.

Q. That was specifically related to -- well, what was initially the Women's and Children's Department but then you went on to remain working within that area albeit then you had split?

A. It was, it was split from before I started there into different divisions. So it never changed while I was there.

Q. Did you take over from someone in that role or was it a new post?

A. I took over from somebody in that role who I don't think they were in post for a long time, I'm not sure.

Q. You have explained that your job title changed to Risk and Patient Safety Lead. But other than the change in title, was there any change to what the job involved?

A. No, it was still the same job description; that never changed.

Q. We have seen from documents that you were present at a meeting on 15 February 2016 and it appears that was your last day or near to your last day?

A. Yes, I think so.

Q. That date would fit with your recollection

that you left prior to the CQC visit which commenced on 16 February?

A. I definitely left prior to the CQC visit.

Q. So you were at the Countess of Chester as a Risk and Patient Safety Lead for just over two years?

A. Yes.

Q. When you left there, I think you took up a post in the Royal Liverpool & Broadgreen University Hospitals. Was that a promotion?

A. It was, yes.

Q. What was the role that you went to?

A. Very similar to what I had been doing, but I was -- for scheduled care so it was a larger remit.

Q. In what sense then was it a promotion, what were the additional responsibilities?

A. It was a higher band, more responsibility.

Q. And you stayed there I think for just under four years until January 2020?

A. Yes.

Q. So summarising your career and looking focusing on your Risk and Patient Safety roles, you worked in the NHS across three hospitals for approximately seven and a half years in this field?

A. Yes.

Q. How did your background in nursing and

midwifery assist you in your role in Risk and Patient Safety?

A. I think because I had such a varied nursing background, it was useful, it was applicable to all the areas that I worked within.

Q. What about your training and experience as a solicitor, how did that assist you?

A. I think it probably enabled a bit more critical thinking. Certainly it probably gave me more awareness of the things that can go wrong and do go wrong so I wasn't so tunnel-visioned and protective of the NHS. I suppose I was a little bit more cynical.

Q. In your role as Risk and Safety Lead, you covered both the neonatal unit and midwifery?

A. Yes, and gynaecology.

Q. Yes, and also general paediatrics?

A. Yes.

Q. So whilst we have heard and you confirmed that even from when you started, the maternity unit was within the Planned Care Division and the neonatal unit in the Urgent Care Division, in terms of Risk and Patient Safety you looked across both units?

A. I did, yes.

Q. And from a risk and safety perspective, why was that important?

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

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

A. Yes.

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

A. Yes.

Q. Who did you report to?

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

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

A. Yes.

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

A. As far as I am aware, yes.

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

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

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

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

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

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

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

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

A. Probably, yes.

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

the different divisions?

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

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

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

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

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

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

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

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

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

if everything is okay.

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

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

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

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

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

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

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

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

Safety Lead involved?
A. So I would manage the Datix incidents in real-time when they came through. I would --
Q. Just stopping with Datix there for a moment. Were you looking at seeing if those reports were consistent, properly filled out, was that part of your role?
A. We weren't particularly worried about the content at that stage because that was something that we would go and pick up on, we would review. So that would be the start of preliminary enquiries really to see whether there was anything that needed to be reported, escalated up for investigation.
Q. So the first thing would be to if there was anything urgent and then at a later stage you would look at those Datixes to see if they had been properly filled in, for example?
A. Yes. Yes.
Q. Yes, sorry, I have interrupted you, that was Datix, you were carrying on with your role?
A. So the majority of the Datixes were things that people had reported as a general concern and they hadn't actually caused harm so they would be managed at local level.
I took an overarching view of that and did do some

trending analysis with the individual managers and Consultants if there was anything of concern that seemed to be recurring.
Q. So just on that trending analysis. So you would be -- what does that mean, if you got a similar incident, so if you had, for example, a series of neonatal deaths, what would you do in terms of trending analysis then?
A. So the trending analysis, obviously when they were reported initially they would be classed as moderate or severe harm, so they were always picked up as soon as.
I would go along just to find out the facts, I would rely on Steve Brearey's clinical assessment to tell me whether there were any concerns. From his response I would copy and paste his assessment and put that on to an SBAR.
The SBAR would be then escalated to the Serious Incident, the SI Panel.
Q. Just stopping you there, just explain what an SBAR is, please?
A. So the SBAR is basically a communication tool to put as much information --
LADY JUSTICE THIRLWALL: What does it stand for?
A. Sorry it is an information tool that stands

for Situation Background Assessment and Recommendation.
So we would -- say a Datix has come in, that would be the situation, the background would be for instance 28 week gestation baby had been born in poor condition. The assessment would be the clinician's view of it and the recommendation would be to send it through to the Serious Incident Review Panel.
MS BROWN: And that recommendation aspect, that would be where your expertise would come in, would it, as to whether --
A. No, the SBARS were always escalated to the SI Panel. That was just -- they all said that.
Q. Yes, carry on. So was there also a recording function and collating of incidents?
A. Yes. So I would pull reports for the individual areas and also an overarching report.
So that the report -- I think I pulled the report quarterly that went to the Women's & Children's Governance Board. But I also pulled reports to -- on a monthly basis to discuss with the ward managers in the different areas to look at their trends.
Q. In terms of following up incidents, what was your role in relation to that?
A. So it depended on what the incident was and what the next steps were. So if they were at local

level then it was usually the ward manager or the lead Consultant that dealt with them. If it was escalated further, it would depend on what the recommendations of the Serious Incident Review Panel were. So if it was recommended that there was a Level 2 investigation, then the panel would appoint a chair to investigate and I would support the chair with that investigation.
Q. So drawing that all together, the purpose of your role was to improve patient safety?
A. Basically, yes.
Q. Part of the reason for having a dedicated role for risk and patient was, as you explained, to spot trends and ensure problems were carried out -- actions carried out?
A. Yes.
Q. That would be fair, would it, as a summary?
A. Yes.
Q. Just looking at the Women's & Children's Care Governance Board. If we could call up INQ0015325, which I hope is the Terms of Reference. This is tab 27, my Lady, of your bundle. We see there the Terms of Reference, this is a document we have looked at before in the Inquiry and we see there the membership and the membership here consists of people from Planned Care, so we have got the Consultant obstetrician gynaecologist

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. The third bullet point from the bottom:

"Ensuring that clinical performance quality monitoring reporting mechanisms are working effectively"?

A. Yes.

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

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

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

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

A. Yes.

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

A. Yes. On the face of it.

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

Q. How would you describe your relationship with her?

A. Excellent, I had no problem at all.

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

A. Yes.

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

A. Yes.

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

A. Not particularly because the midwives would

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

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

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

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

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

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

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

ever involved in discussing or?

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

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

A. Yes.

Q. How were those interactions with Consultants?

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

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

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

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

A. Professionally we got on fine.

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

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

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

Q. You can't give any details?

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

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

A. I was, yes.

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

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

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

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

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

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

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

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

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

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

A. So when we looked at the specific case reviews

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

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

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

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

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

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

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

A. I don't know.

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

A. Usually yes.

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

A. Yes. Yes.

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

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

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

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

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

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

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

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

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

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

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

Q. Why do you think that was?

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

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

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

Q. Did you ever ask the question?

A. I didn't, no.

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. No, I don't, sorry.

LADY JUSTICE THIRLWALL: I see, thank you.

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

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

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

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

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

Q. Because was that a drop down list?

A. It was as far as I am aware, yes.

Q. You say you didn't understand the technology of it, but if it was your role to review the Datix, wasn't it quite important to understand how these forms were filled in and what the items on the forms meant?

A. As I say, it was reporting a death and that was what was important to me. At that stage, I wouldn't expect anybody to be commenting on whether it was expected or unexpected depending who was reporting the Datix.

Q. In relation then, well, picking up on that. Surely in terms of a patient and risk safety whether it was either expected or unexpected was something that was of great significance in terms of what alarm bells it would ring to you?

A. It was greatly significant once we undertook the assessment of the medical records and any subsequent investigation.

The Datix forms were quite subjective depending who

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

Q. If we can just look down we have then got under the risk grading potential for harm and what's filled in there is high potential harm.

Why high? What was the -- who made that risk grading and why was it high potential harm chosen?

A. So the risk grading would have been entered by the person reporting the Datix.

Q. That would be something that you would review, would it?

A. We would review that, yes, with the clinicians and as I say they were quite subjective so people could -- obviously this is a child death, it wouldn't be the case. But some Datix forms --

Q. Just let's focus on child deaths because that is what we are interested in. So would high potential harm be what you would be expecting to see for what we can see further down was a sudden and unexpected deterioration, would you expect high to be what should have been filled in there?

A. As I say, that was the person submitting the form and regardless of what they put there we would do

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

Q. But did you review and see whether that had been correctly filled out, whether high potential harm was the correct -- or did you take -- did you take no view on what had been filled out in terms of potential for harm?

A. So we would obviously look at what the reporter had put on there. But as I say, we didn't take that as gospel. We would then follow up and look into it further.

Q. If we could just go over the page to page 2. We have got then -- we can see at the bottom the incident reporter here is Miss Lappalainen, who was one of the neonatal nurses.

Would it have been -- would your understanding have been it was her that would have filled in who the employees involved were?

A. No, I think that probably would have been done at a later date but I am really not sure about that.

Q. What should have been filled in under "employees involved", who should have featured in employees involved in a neonatal death?

A. So any of the team that were around at the time.

Q. So the team that were involved in the resuscitation, in this case sadly the failed resuscitation?

A. Usually, yes.

Q. Because we see there indeed doctors and the names of nurses that were working on the neonatal unit. We don't see the name of Dr Jayaram who was the doctor that was called in in this case.

Was there any reason why the Consultant wouldn't be included?

A. I really can't comment on that, sorry, I don't know.

Q. What was the purpose on a Datix of having a list of the employees involved?

A. So you would look at people who were cropping up regularly that they may have competency issues that needed to be addressed. Any other concerns, there could be somebody if there had been medication errors, they had had several medication errors that -- so we needed to look into supporting that person.

Q. So just looking at where you said you would see if someone whose name was coming up and competency issues.

So given that you were looking at trends it was quite important, was it, that the employees involved

listed were that that was completed properly?
A. Yes.
Q. If we could just go to 0000111 and this is tab 4, my Lady, in your bundle and I hope we will come up there with the Datix for Child C. We see very similar, we have got the name of the child, you as the -- Ms Kenny's name appears. Your name as the manager, the specialty we have got "Neonatology", again we have got "Expected and unexpected death".
This time under "risk grading" we have got low potential harm. Do you have any explanation as to why this would be low whereas Child A was high? We see under the description that we have got sudden deterioration of an infant following full resuscitation.
So a sudden death again. Why would this have been low whereas the other one was high?
A. Again, subjective opinion of the reporter at the time. So maybe they thought that well, I am presuming that they thought no harm had been caused.
Q. If we could go over to page 2, please. We have got there we have got the incident reporter we can see that was Yvonne Griffiths who we are aware worked on the neonatal ward. But the employees involved here named, we are not familiar with, because they are not people who worked on the neonatal ward.

We have got we can see Mr McCormack, David Semple. So we have got Consultant obstetricians there. So we have got the Consultants featuring but we have got the midwifery and the Consultants.
So we have got the -- although this is a neonatology Datix, looking at a death that happened on the neonatal ward, the employees involved, here we have got a list of people who were involved in the obstetric care. So why would that have been?
A. I really can't comment. I don't know. This again was -- I was on annual leave for this death.
Q. Well, we will look in a moment but we know you came to look at these three deaths at a meeting together. But that would be concerning wouldn't it, Mrs Peacock?
A. Sorry, what was the actual incident again?
Q. This is the -- this is the death of Child C?
A. What was the actual incident that was reported, is it the death that was reported? Sorry, can I see the first page of the Datix?
Q. Sorry. Yes, go back to the first page. So the category we have been given is "Expected and unexpected death"?
A. Mm-hm. Yes, I can't explain that at all, sorry.

Q. Because that would be quite concerning, wouldn't it, because if part of your answer before was that part of the reason for listing the employees was to see if there was any commonality, any competencies that might be raised, well, that's not going to be followed through if the employees involved there are not the employees who were involved in the resuscitation and involved in the care just prior to the baby's death?
A. As far as I am -- my opinion is that when I did any of the updating on these, well certainly when we investigated, well, when we reviewed the notes, that wasn't the investigation, but we would certainly take note of the people who had been involved in the actual incident itself. So I can't explain why the obstetric team is there instead of the neonatal team.
Q. Can we now go to 0000766 and this is tab 6, my Lady. This I hope should be the Datix of Child D. We see there again Child D, your name as manager. Again the subcategory expected and unexpected death. Again we have got low potential harm, this time. I think your evidence is you can't -- you don't know why that was filled in?
A. As I say, it would have been the reporter of the Datix.
Q. And we see there under "Action Taken", at the

bottom, the second -- the last two sentences there, a review was completed by the neonatal lead Consultant and they managed to ascertain if there are any commonalities or poor standards of care, there were none found.
That I think is a reference to the fact that Child D's case was considered alongside Child A and Child C?
A. Yes.
Q. We don't have any details but there is just a highlighter that that was done?
A. Yes.
Q. If we turn over to page 2, we have got another variant here in terms of employees involved. So we have got the incident reporter of Caroline Oakley, who we know was a neonatal nurse, senior neonatal nurse.
But the employees involved here, whereas A, we didn't have the Consultant, here we have got a paediatric Consultant but we only have the name of the Consultant, not of the names of anybody else who was involved in the resuscitation and we know that there clearly were nurses and others involved in that resuscitation.
Again, can you explain that?
A. I can't, sorry. No.

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

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

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

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

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

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

A. Yes. That's correct.

Q. You can't explain that?

A. No, no.

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

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

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

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

A. Yes.

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

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

Q. Yes, go back to page 1.

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

Q. Understood?

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

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

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

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

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

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

that wouldn't have been our priority.
Q. What did you, what was your view at the time of the Datix system of reporting of incidents and how effective it was as a means of identifying trends?
A. As a means for flagging up incidents it was obviously dependent on having a good reporting culture. So if it was used effectively, as it's meant to be, then it was -- I thought it was a good tool to use.
Obviously it wasn't perfect, there were things that could have been improved, but basically it did the job it was meant to do, just alerted us to incidents to dive a bit deeper, really.
Q. If we can turn now to when you returned from holiday. You say in your statement that you were away for the first three weeks of June 2015 and you returned to work on Monday, June 22. That was the day that Child D died. Child D had died in the early hours of the morning of 22 June.
You have explained that where a death occurred out of working hours normally you would be called first thing in the morning. Do you recall receiving a call on that first day back to work?
A. No. Sorry, no recollection at all.
Q. Over the three weeks that you had been away, two other babies had died. We have looked at the

Datixes of those already, Child A and Child C.
How would you have been informed of those deaths?
A. I am not really sure, I can't remember, to be honest, how I would have been informed. I would expect whoever had been covering for me would let me know.
I am sure when I came back to work that Eirian Powell and Steve Brearey would have let me know. But I can't remember how it actually happened.
Q. Because it would have been quite a shocking return to work, wouldn't it, Mrs Peacock? You return to work and you receive a call that a baby has died and you find that two other babies had died in a two-week period?
That would be the same total as the total number of deaths in 2014. Is that not something that would have stuck in your mind as particularly unusual, particularly concerning in fact?
A. It was unusual and concerning but no, I don't recall it, I am sorry.
Q. What -- you say you can't recall it, but what would you have done in that, in that circumstance? You say you would have gone to the -- your practice would have been to are gone to the neonatal unit in the case of a death. Can we take it that that is what it is likely you did on the 22nd?

A. Yes.
Q. What questions would you have asked then when you went to the neonatal unit?
A. Well, first I would have wanted to know how it had -- whether the SBAR had been completed and what was the result of the SBAR going to the Serious Incident Review Panel and what their determination was and what should be done next.
I would have asked if there were any particular concerns which, as far as I can recall, there were no -- obviously there were concerns that there was an increase in mortality and that there was a cluster of deaths, but there were no suspicions at that time.
Q. We have heard from Dr Lambie that at around this time she recalls seeing nurses who were looking to see whether anybody had been on duty for all of the deaths. When you visited the neonatal ward were you aware of any of that sort of discussion, who was on duty?
A. Not at all, no.
Q. The Inquiry has also heard evidence that junior doctors and Consultants were discussing these deaths. One of the issues they were discussing was the existence of a concerning rash.
Did you pick up on any of those discussions?

A. I wasn't included in any of the email trail that was going on at this time.
Q. I'm not asking about the email trail, I am just asking about when you visited on this morning, where we have got a third baby die in a very short period, were you aware of those concerns doctors speaking about those?
A. I don't recall -- I don't recall anybody mentioning concerns no, as a rash.
LADY JUSTICE THIRLWALL: Do you remember them mentioning the deaths at all?
A. Unfortunately nine years ago I really can't remember that far back. There would have been general discussions and obviously I would have spoken to Steve but what the content of those discussions was, I really don't recall.
MS BROWN: And you say that your general course would have been to report matters to Ruth Millward. Would you have reported not only the death of Child D but would you have gone to Ruth Millward about the fact that there had now been three deaths within a very short period; is that something you would have taken to Ruth Millward?
A. I would have thought so and I think Ruth actually completed one the SBARs so she was certainly

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

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

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

A. No.

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

A. No.

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

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

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

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

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

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

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

(11.06 am)

(A short break)

(11.20 am)

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

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

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

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

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

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

The number of days has been redacted.

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

Then it goes on to say:

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

Q. How did you find that out?

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

Q. Who would the discussions have been with?

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

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

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

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

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

my general understanding.

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

A. No, I don't.

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

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

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

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

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

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

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

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

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

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

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

I would have been surprised if I hadn't.
Q. If we can look then now at the meeting of 2 July. If we could go to tab INQ0008302. This is tab 15, my Lady, in your bundle.
This is an email from Stephen Brearey:
"Hi Debbie, thanks for your help today. I have attached my summary and data for tomorrow's meeting."
So this is the meeting on 2 July whereas prefaced in the email we looked at before, there is going to be consideration of Child A, Child C and Child D's death together?
A. Yes.
Q. If we could go to 0003191, these are the notes that Dr Brearey attached to that email and we see that he produces a short summary, he refers to Child A who died on 8 June and underneath Child A refers to Twin 1 and that's Child B who had a respiratory arrest 24 hours later but responded to resuscitation.
So we have got a death and a near death, a resuscitation incident.
Then we have got Child C six days later on 14 June, bottom of the page Child D, and noting and in fact as is the case for all of them "awaiting postmortem". Then there is a heading "Learning from these cases".
If we could go on to the next page, page 3, we see

Dr Brearey has also set out the mortality data and we see that in 2013 there were two neonatal deaths according to this chart in 2014 -- according to this chart, there were three.
So that rather highlights, Mrs Peacock, that this was a very unusual string of events having three deaths --
A. Yes.
Q. -- within a two-week period?
A. Mm-hm.
Q. At that meeting, we know at the meeting on 2 July, Alison Kelly, the Director of Nursing attended, Eirian Powell, Ruth Millward, so your boss, Stephen Brearey, you, and Sian Williams, how common would it be for you to be at a meeting where Alison Kelly was also present?
A. Not very common but I had been at meetings when she was present.
Q. We see the meeting, in fact the meeting is -- we don't need to go to it, it is in paragraph 88 of your statement. But the meeting is referred to in fact within a review of Child D but it's described as an Executive Serious Incident Panel on 2 July, there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there

was any commonality which linked the deaths.
Is that a meeting you recall, Mrs Peacock?
A. I don't, sorry, no.
Q. Given that it was such an unusual -- first of all an unusual string of events to have three deaths in such a short period and personally unusual for you to be at a meeting with Mrs Kelly, so with the most senior nurse in the organisation, the Director of Nursing, you have no recollection of the meeting at all, is that your evidence?
A. Sorry, no, until I saw the email sending the summary around, I didn't think I had actually been there.
Q. So in the absence of an actual recollection in terms of best practice, bearing in mind this meeting was looking at the potential commonality between three deaths, would you have had an agenda, would you have gone through the areas of commonality to see if there was anything that linked the deaths together?
A. As I say, I really don't know what we discussed at the meeting. I don't know the format of the meeting. Sorry.
Q. Would you have been concerned that the same nurse was identified as being present on those, you have heard that you were one of the people who was alert to

the fact that, whilst rare, harm inflicted by a healthcare professional was a possibility. Do you think that's something you would have raised at that meeting as something that they needed to be sure of because if that was the case, this would be an extremely serious situation?
A. I think at this stage Steve Brearey had quite clearly said that he didn't think there was a link between D and A and C and he said that the nurse wasn't actually looking after Baby D at the time. So that connection wasn't there for me.
Q. In relation to that, as you have explained, you provided an overview, is that something that you would have looked into to check whether Letby was involved in the care of Child D because in fact Letby was working in Nursery 1?
A. Right.
Q. Not as the designated nurse, but is that something you would have checked?
A. Not if Steve Brearey had told me definitively no.
Q. Well, he didn't say -- he didn't get into the detail of the nursery, he was the clinician, you were Risk and Patient Safety. Was that not something that you felt was something that was within your remit to

check, to be -- so that you could be sure in your mind?
A. It wasn't for me to personally go and check to see who was on where. I would have had those discussions to ascertain for my own peace of mind but as I say, timeline wise, I'm not sure whether at this stage I knew that there was another nurse and two doctors that had -- were in common with some of these deaths, I really don't know.
Q. You address this in paragraph 74 and 75 of your statement and you say that:
"... a particular nurse referred to was employed full time but also worked extra shifts to provide cover for the short staffing."
So it would appear from your statement that prior to this meeting you had discussed the commonality of the nurse with Eirian Powell. Would that be right, is that what you were likely to have done, is that what you say in your statement?
A. Yes, yes.
Q. So you were aware that Letby was the nurse?
A. I don't know whether I would have been aware that's who it was. I didn't know Lucy Letby at all, so it wouldn't have had any relevance them giving a name to me.
Q. It seems to be from your statement that you

are accepting what Eirian Powell said, that it was unlikely to be an issue that it was the same nurse because Letby worked a lot of shifts and Letby was not the designated nurse for Child D?
A. As I say, timeline wise, I don't know what I knew at that time. I was just aware that she did cover a lot of shifts because she was working extras, that particular nurse. So it wasn't deemed to be unusual for her to be on duty when there was an incident and I understood obviously further down the line that there were some deaths that she wasn't on duty for. So ...
Q. In terms of the number of deaths that she was there, we have seen from Dr Brearey's notes that he highlights Child B's collapse. Would you have thought it was relevant to see, well, was Letby on duty or was the nurse the common nurse on duty for Child B's collapse, that would have been relevant in order to assess the commonality?
A. At that stage I probably wouldn't, I really don't know. Sorry. As I say, I don't recall being aware of any collapses but that was obviously in the document. So it was never highlighted as an issue.
Q. Well, you were the Risk and Patient Safety Lead for neonatal care?

A. Yes.
Q. Dr Brearey had said that there was one nurse who was on duty at the three deaths and he's referred in his note there was also a collapse of Child B and it appears that you had discussed the issue of staffing with Eirian Powell.
Now surely, as the Risk and Safety Lead, the person who's drawing together the issues of risk and safety, and within your mind as you have said, the possibility that you had to always be alert to, that harm could be caused, why were you not raising that at that meeting? Was that not your role as Risk and Safety Lead at that meeting, to look into that because if there was a common factor of a nurse involved in the three deaths, but possibly in the one collapse that had been present, that is something that warranted a serious investigation, didn't it?
A. It wasn't for me to determine whether it warranted a serious investigation. I think at the time I had been led to believe that there were no suspicions, no suspicious circumstances surrounding the deaths, that they were natural causes. So concerns were raised about the increased mortality rate but --
Q. Why -- why do you say, Mrs Peacock, that these were natural causes? Where are you getting that from?

We have looked at the Datixes which talk to "unexpected deaths"?
A. So that was the impression.
Q. "Postmortems are awaited".
A. That was the impression I was given by Steve Brearey that we had a presumed natural cause for each of the deaths, we hadn't identified anything in the care that would suggest otherwise and I don't know, just overall.
So yes, it was a consideration. How much emphasis we put on that at the time, I really can't say.
Q. There were no postmortems at this stage for any of those children, so a conclusion on the cause of death had not been made, that is the case isn't it?
A. No, there had been cause of deaths suggested at that stage.
Q. And --
A. Proposed.
Q. Who -- who do you say had informed you that these were natural deaths?
A. From the proposed causes that we were given, it didn't suggest that they were unnatural.
Q. Given -- given by whom?
A. It was on one of the emails I think that Steve sent round with a presumed cause of death on them.

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

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

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

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

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

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

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

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

reference?

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

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

A. No.

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

Do you agree with Ruth Millward's view?

A. Sorry?

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

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

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

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

A. That's correct.

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

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

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

A. So this was after the third death?

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

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

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

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

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

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

A. Yes. Mmm mm.

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

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

A. I don't, sorry.

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

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

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

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

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

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

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

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

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

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

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

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

A. Sorry.

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

death of Baby E?

A. I don't no.

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

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

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

That is a reference to Letby being on duty?

A. Mm-hm.

Q. It ends:

"I will discuss further with Debbie on Monday."

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

What did you think when you received that document?

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

the time, sorry.

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

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

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

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

A. It is on the chart.

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

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

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

A. I would hope so, yes.

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

A. Yes.

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

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

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

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

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

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

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

relevant to look at other members of staff?

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

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

A. Yes.

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

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

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

A. Yes.

Q. That was to see if there was any commonality --

A. Yes.

Q. -- in terms of doctors?

It then goes, this email says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Not aware of concern at the increased mortality?

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

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

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

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

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

Can you recall being part of this review team?

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

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

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

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

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

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

A. Yes.

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

A. That's correct.

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

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

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

A. Sorry, what is the question?

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

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

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

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

A. Yes.

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

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

And it says there:

"No themes identified."

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

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

on the delivery suite and stillbirths.

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

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

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

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

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

A. Yes.

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

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

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

"I have amended the last list ..."

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

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

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

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

He says:

"I have discussed our increased mortality with Nim."

That is Dr Subhedar from Liverpool.

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

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

Q. Were you concerned about the mortality rates?

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

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

Patient Safety?
A. I was relying on Steve.
Q. He goes on to say they are going to review the cases and set up a meeting and that meeting in fact happened we know on 8 February and if we could look at INQ0003217. This is the meeting that did then take place with Dr Subhedar, we see him, Liverpool Women's Hospital Consultant, as attending. We see your name appearing there and the other attendees listed.
Is that a meeting that you recall?
A. Not in any detail, no. I certainly wouldn't have known who attended other than Steve and Nim.
Q. Most significantly this -- this has been prompted by the -- or it appears it has been prompted by the chart where Letby's name had been highlighted in red. Do you recall whether the issue of Letby harming babies was discussed at that meeting?
A. I really don't know, sorry.
Q. If it wasn't raised from a patient and safety point of view, would it not have been your responsibility to raise that and say: this is something we need to discuss?
A. I really don't know, to be honest. Yes. If those concerns hadn't been discussed already, I think, I think Steve said he did actually discuss it at this

meeting in some of the documents I have seen.
Q. Can I just take you back to your statement, Mrs Peacock, paragraph 72. You say in that statement:
"it is sadly not unusual to have an unexplained cluster of deaths on an NNU ..."
It was unusual though, wasn't it, Mrs Peacock? You had never seen a series of deaths like this before where you had a number -- a significant number of unexplained deaths, had you ever come across that before?
A. Not at the Countess of Chester. Probably at Liverpool Women's and Fazakerley I had.
Q. Sorry, where you are you saying you had seen this?
A. My first -- it wouldn't have been my first job, when I worked at Fazakerley, which is now Aintree hospital.
LADY JUSTICE THIRLWALL: When was that?
A. Oh gosh, probably in the 90s. And then at Liverpool Women's.
Q. Liverpool Women's was slightly different, wasn't it, because that was a tertiary unit, that was seen as a slightly different set of babies?
A. Yes.
Q. But the evidence that this Inquiry has received is that it was indeed very unusual to have

a series of unexplained deaths on the neonatal unit within a short period?
A. So a series of unexplained deaths yes. However, I was aware that we had postmortem results back that gave us an explanation for those deaths.
Q. If I could just then turn you to your reflections at paragraph 154, you say:
"I cannot think of any steps that could have been taken to identify earlier that Letby was harming babies on the NNU or steps that could be taken now on NNUs to prevent a similar situation."
Is that still your position?
A. Obviously with the information that we have now, and the postmortem results that gave us cause of death are now in question, aren't they, so I didn't have that at the time. So being given the same set of information at the time, then yes.
However, with the information we have now obviously things are different. So, yes, had potentially the Coroner been informed sooner, that would have, you know, stopped things in its tracks. Yes.
MS BROWN: Yes. Those are my questions but there will be some questions from Mr Baker and Mr Skelton.
LADY JUSTICE THIRLWALL: Thank you.
Questions by MR SKELTON

MR SKELTON: Mrs Peacock, I ask questions on behalf of one of the Family groups. Can I just start with some basics about the policies that were in place that governed what staff were meant to be doing in respect of reporting.
May I have on screen INQ0006466. Do you recognise this document?
A. I can't recall the document now.
Q. You can't remember it?
A. No, no.
Q. So as I understand it, if we go just to page 9 first of all, if you see -- if you could highlight right at the bottom, please, that very small print in the footer of the page, very bottom of the page on page 9, I think it's about to be put on screen, hopefully.
Can that be made legible?
There we go. Author: Sally Goode. Who's she?
A. When I first took up post at the Countess of Chester she was the head of risk and governance.
Q. When you were in post, she was -- what relation with her did you have?
A. Sorry?
Q. What relationship with her did you have when you took up your post?
A. So she would have been my line manager when

I first starred.
Q. Okay. So this is a document she has produced?
A. Yes.
Q. It's printed on 19 July 2016. Can we infer from that that it was the working document that was in post when you were there?
A. I don't know sorry I left at the beginning of 16 -- 2016.
Q. Okay. Is it really the case that you don't remember this document at all as the policy that governed reporting incidents?
A. I don't. I have had other risk in governance jobs since and I wouldn't remember which policies applied to which hospital at a given time.
Q. If we go back to page 2 and have page 2 on the screen, please. Thank you. So this is about the duties on who should report incidents and you can see that there is a section -- there are three sections there, "All staff", "Managers" and then the Risk and Patient Safety team.
So just to clarify. Was it your understanding that all staff were obliged to report incidents and near misses?
A. Yes.
Q. Likewise we can see it also says:

"All staff have a duty to raise concerns regarding care or other activities using the Speak Out Safely policy"?
A. Yes.
Q. You were familiar with that policy?
A. As I say, I don't remember the policy but if that was in place, then yes.
Q. From your perspective, would a concern about a nurse being connected with some deaths, leaving aside deliberate harm, be -- fall within that Speak Out Safely duty?
A. So somebody just being connected with deaths, no.
Q. What about concerns regarding care being substandard by that nurse?
A. Certainly if the care was substandard, yes.
Q. By definition, if the nurse was harming patients as well?
A. Yes.
Q. The duties on the managers:
"All managers are responsible for engaging all staff in the reporting and management of incidents."
If we think of the NNU, the neonatal unit, is that does that mean Eirian Powell is responsible for reporting on that unit ultimately or by "managers" does

this mean the managers of the two teams, as it were, of healthcare staff, the doctors and the nurses?
A. I think it fell to everyone, to be honest, to promote a good reporting culture.
Q. So Steve Brearey, for example, would fall into this category, would he?
A. Certainly, yes.
Q. Eirian Powell would fall into that category?
A. Yes.
Q. And are you aware of what training staff had on reporting incidents?
A. I don't think they were given any formal training on completing Datix forms and submitting them. I think that was done locally. But certainly as a Trust induction they were given a talk on risk and safety and how it's everybody's responsibility to report and not assume somebody else had.
Q. One of the duties is on managers is to ensure they have proper training, so again that would be a question perhaps to ask Dr Brearey in respect of doctors or senior nurses in respect of nurses?
A. To be honest I think it was probably Eirian would certainly oversee junior doctors if they were submitting a Datix. As I say, it was done locally, probably, you know, as new doctors or new nurses came in

and a situation arose then they would be supported through submitting a Datix.
Q. Lastly, just briefly, the Risk and Patient Safety Team in which you sat:
"Ensure managers are alerted to all significant incidents or trends in their areas in a timely manner."
So you are the collating body in the Trust when it comes to incidents?
A. Yes.
Q. You feed back out to those that need to know if you have spotted a trend from their reporting?
A. Yes.
Q. The idea being obviously it is a virtuous circle of learning?
A. I had regular meetings with all the ward managers to look at their incidents and to discuss any concerns and issues with them in their area.
Q. Thank you.
Can I go to the next page, please. Would it be possible just to highlight the second half "What should be reported as an incident" or make it a bit bigger?
I am going to ask you about this paragraph because it's quite important but it may be felt that the wording is unclear or unfortunate.
It looks a little bit like a lawyer's sentence

rather than a healthcare professional sentence.
Do you know -- would your predecessor -- sorry, your manager have drafted that, or would it have been a lawyer who attempted to draft it?
A. I would imagine it was my line manager.
Q. So can we just try and understand what it means:
"An event or circumstance which could have resulted or did result in unnecessary damage, loss or harm to patients, staff, visitors or members of the public."
So an event or circumstance which could have resulted or did result in unnecessary damage.
So "event or circumstance" is just something that happened, is it, anything?
A. It's any concern; we encouraged staff to report anything.
Q. What does the word "unnecessary" mean?
A. I really don't know.
Q. Is there an implication in this that there needs to have been something untoward, something that the staff have done or not done which they should have done?
A. Not necessarily. Staff, as I say, could report anything that was of concern to them. I think the unnecessary damage is probably looking at the -- the

buildings and equipment.
Q. Well, it's unnecessary damage, loss or harm to patients. I just want to know, what's unnecessary harm as opposed to harm?
A. Well, it's unnecessary damage, loss or harm, isn't it? So it's not unnecessary harm.
Q. I see. So you think the adjective actually just applies to damage and not just loss or harm?
A. I really don't know because this is the first time I have read it so I don't know what it means --
Q. You are responsible in this department for understanding incidents?
A. Yes.
Q. I am asking you what your understanding was of what incidents needed to be or were mandated to be reported?
A. So my understanding and certainly what I was encouraging was for any and every harm incident to be reported but also for any concerns whatsoever that they had that they felt that they needed to raise. So it didn't necessarily need to result in harm for them to report something.
Q. It seems that this consistent reporting of the deaths, so all deaths, would that apply not just to neonates and children across the hospital, would be

reported as incidents?
A. I can't comment on the rest of the hospital. I didn't see their incidents, sorry, but yes, I would imagine that all deaths.
Q. All deaths for children as far as you are concerned would be reported?
A. Yes.
Q. Eirian Powell said that all collapses requiring resuscitation were also or should also have been reported on Datix. Is that your understanding?
A. No, I don't think unless there was something untoward happened during the resuscitation, I don't think they were all reported.
Q. What's "untoward" mean?
A. So it could be an equipment failure, or a member of staff not following correct procedure. So not necessarily resulting in harm, but has caused a concern to somebody.
Q. So a child can die from nothing untoward and it would have to be reported?
A. Yes.
Q. But a child could collapse and nearly die but survive from nothing untoward, but that would not be reported insofar as you are concerned?
A. It's very difficult because if a small ET tube

blocks and some of these ET tubes that ventilated patients had a diameter of 2 mm, 2.5 mm, so could easily get blocked with secretions, if that happened, the child collapsed as in the saturations dropped and obviously the child couldn't breathe.
So that could have necessitated just suction to the tube to clear the blockage but quite often it resulted in the tube being changed so that would be classed as a collapse with intervention.
Q. But if a collapse is unexpected, then isn't it the case that you need to report it to find out what caused it?
A. I would argue a lot of collapses can't be expected because you can't anticipate that things like an ET tube is going to block. It happens.
Q. Well, the evidence almost uniformly from the Consultants who have given evidence is that the unexpected collapse of a child leading to resuscitation or death is something that needs looking at because by definition there isn't an obvious medical cause?
A. Leading to resuscitation and death?
Q. Leading to resuscitation which would otherwise have caused death, or leading to death and, I mean, the difference between life and death in those situations can often be very slight?

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

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

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

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

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

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

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

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

A. Not on Datix no.

Q. Not in Datix?

A. No.

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

A. Mmm mm I don't think the Datix forms didn't

inform the Coroner referrals.

Q. You don't think what, sorry?

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

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

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

Q. Absolutely.

A. Yes.

Q. Along the way updates are put in?

A. Yes.

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

A. Yes.

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

It's then in the next paragraph it says:

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

then receiving the usual type of support in keeping with his prematurity, ie on CPAP and receiving IV fluids and antibiotics. Initial PM findings did not give any answers, however we are awaiting the results of pathology slide examination. However, if it was due to a cardiac arrhythmia this would not show on this examination."

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

A. Mm-hm.

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

A. Yes.

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

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

So it's the initial PM findings didn't give any answers and I understand that there wasn't a cause identified in the final report.

Q. No.

A. Sorry, what was the question again?

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

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

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

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

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

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

A. Yes.

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

A. No, I was never an investigating officer. I don't know why my name has been put under that title.

Q. Well, who will have put you down?
A. I really don't know.
Q. And M&M is mortality and morbidity?
A. Morbidity, yes.
Q. So did you have no role in the type of investigation that went on as the named investigating officer?
A. So if there was a maternal concern then there was an obstetric secondary review and I was part of that.
If there was a neonatal concern there was Steve Brearey's review and Eirian, that I was generally included in somewhere along the way. But I wasn't an investigating officer.
Q. How -- how do you think it's happened that you were?
A. Sorry?
Q. Why do you think this is there?
A. I really don't know. Sometimes these titles are preset and people just put names in where they think appropriate.
Q. And when it says "level of investigation", can you explain where M&M sits in the hierarchy of seriousness?
A. I can't. I would have thought that it had

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

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

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

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

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

Q. On the 28th.

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

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

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

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

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

A. It is just called a Datix.

Q. Just called the Datix?

A. Yes.

Q. It records the Inquest results?

A. Mm-hm.

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

A. Mm-hm.

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

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

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

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

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

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

A. There was, yes.

Q. By an internal investigation potentially?

A. Yes.

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

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

Q. Precisely.

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

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

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

Q. On the question of insulin, is overdose of

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

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

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

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

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

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

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

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

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

be notified of that?
A. Yes, I would.
Q. Who by?
A. So that would usually be the clinical staff who have been dealing with the parents and explaining things as they have gone along. I think -- at the time I was due to leave I think we were looking at having a key person in the risk team to be a point of contact for parents. But I -- that's just a vague memory, I don't know whether that actually happened.
Q. The risk team?
A. Just having somebody as a point of contact if they had any questions, not to actually deliver the duty of candour that was felt it should be a clinical person doing that, so they could explain, you know, the report what we had looked at, the significance of the findings.
Q. Would you expect the person contacting the family to not simply try and deal with their questions and update them about what's going on but trying to see if they have any information that may be of value to the investigation itself?
A. Yes, and that's certainly with the introduction of the medical examiner service, they put the emphasis on the bereaved in that service and they would particularly ask the bereaved for any information

that they have that might be relevant.
Q. So in Mother A and B's case, she could have said, for example: I remember this rash on my child, have you investigated it? And that may have fed back into the investigation team?
A. I -- yes, yes. That is as it ought to be.
MR SKELTON: Thank you. Thank you.
LADY JUSTICE THIRLWALL: Thank you, Mr Skelton. I saw Mr Baker wasn't here, and I'm afraid I inferred that there were no questions.
MR JAMIESON: I'm afraid you have the understudy my Lady.
LADY JUSTICE THIRLWALL: You are very welcome.

Questions by MR JAMIESON

MR JAMIESON: What I was going to do before I started was just to remark that this witness had been giving evidence for quite a long time but it is also quite close to 1 o'clock so through you, my Lady, if I may, as to enquire whether she would like to go on a bit longer and finish?
A. I would sooner finish, if it's okay.
LADY JUSTICE THIRLWALL: I thought you might but thank you very much for raising that.
MR JAMIESON: Thank you, Mrs Peacock, I also ask you questions on behalf of the Family groups, okay? My

name is Jamieson.
Really what I would like, please, is your perspective on the importance of critical challenge in the management of risk because what you have told us about your background is that you had a unique perspective to bring through your long experience in the NHS and indeed your training as a lawyer.
My questions are going to centre on that meeting when you came back from your annual leave in the July of 2015 and the information that was available to that meeting and the actions that came out of it.
Now, I acknowledge, as you have said, that in relation to that meeting on 2 July, 2015 you, as you sit there, have no memory of that meeting?
A. No, sorry.
Q. But just to put the pieces together as best we can, this was a Serious Incident meeting?
A. My understanding was that it was a Serious Incident Review Panel meeting --
Q. Right.
A. -- to determine whether it was going to be a Serious Incident. I think they determined that they wanted the obstetric secondary review and the neonatal review brought together on a Level 2 template.
Q. That is the output of the meeting, isn't it?

A. Yes.
Q. We will look at that later.
A. So it wasn't.
Q. Really what I am interested in is that type of meeting. Was that one that you would typically go to or was this unusual for you?
A. It was unusual, yes.
Q. Yes, and the attendance at the panel, was that also unusual? For your memory, what we have are Alison Kelly and Sian Williams who were the director and deputy Director of Nursing. We had got Ruth Millward who was the head of risk and your boss, and Julie Fogarty, the Head of Midwifery Stephen Brearey and yourself, so a high powered group of individuals, is that a fair summary?
A. Yes.
Q. Yes. Now, your role at that sort of meeting I know you have no memory, but would it have been to ensure that the relevant information was there for everybody to consider, would that have been part of your role?
A. So I didn't usually attend these meetings.
Q. No.
A. So I didn't know the format of them. I think Steve Brearey supplied the information and from

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

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

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

A. I don't know, sorry.

Q. You don't know?

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

Q. Maybe just look at something that may help.

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

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

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

page.

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

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

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

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

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

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

A. Yes.

Q. -- of the attendees?

A. Yes, I accept that.

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

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

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

Q. All right.

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

Q. Sorry, say that --

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

Q. Yes.

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

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

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

A. I can, yes.

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

completed on 10 August 2015.

A. Mm-hm.

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

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

A. No, we had no conclusion.

Q. The question was still open.

A. Mm-hm.

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

A. Yes.

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

A. They mattered for pulling the Datix data

together, yes.
Q. Yes.
A. Yes.
Q. Perhaps we can just illustrate that point now before we look at another Datix. That will be the end of that document, thank you very much.
If we go to the trend report that again we have looked at briefly, so that's INQ0015141. Now I make -- we can see from the date of it it's not dealing with this cluster of deaths, it's not that time period but it would have captured at least one other death during this period --
A. Yes.
Q. -- and some collapses. But we can see that if we go on to page 3, please, we can see the overall incident table that you have pulled together, as I understand it, for presentation at one of the governance boards. They are graded by department and if we go on to page 6 we can see the particular table for the NNU and we can see just looking at that top table the way in which these risks are brought to the attention of the governance board is in order of their harm: none, low and moderate.
And if I just look under that table, I can see that the text underneath; no harm incidents do not have

a further description, but where there is some harm there will be a short explanation.
So I looked at the low harm incidents. I can see three health and safety incidents, two inoculation charts injuries and:
"A falling window blind hit a member of staff on the hand and a baby's identification band marked the skin even though it was not tight (skin remained intact)."
And then there is a description underneath that of the moderate harm of a member of staff who scalded her hand as a result of not following the standard operating procedure for a particular item.
So if I looked at that table and I am on that board, the understanding I am going to take is that there have only been a few incidents that have caused harm and they are of the nature of what I have read about in that text, aren't they? There's not going to be anything in there that tells me about sudden and unexpected baby deaths?
A. So if you look at the report that was pulled together on the SI template, I think it was regraded as severe harm.
Q. Which one, sorry?
A. The -- the combination of the obstetric

secondary review and the neonatal review on to the one document.
Q. When are you talking about? Are you talking about into 2016?
A. No. I had left by then. I am talking about the one after the July meeting that I was asked to pull together.
Q. Right, okay.
A. So it was regraded as severe harm. Because that was viewed as a Serious Incident, a Level 2, that would have been mentioned further down in my report because I would generally put --
Q. Okay.
A. -- RTAs --
Q. Okay --
A. -- or whatever. So it would be included in this report and it would go to the board as a report with an action plan for us to follow up at board. So it was very clearly it would be on that.
Q. So I believe what you are referring to is the report that was put together in relation to Child D?
A. Yes.
Q. Is that the one you mean?
A. Yes.
Q. So what you are telling me is because of those

two things were put together in that particular case, there was a special report --
A. Yes.
Q. -- which would have highlighted its import?
A. Yes.
Q. Fine. Thank you. That's important evidence and I am glad you have given it.
But just in relation to the point that I am making with you, the grading of the harm in those Datixes really matters because unless there are one of those stage 2 reports, which brings the risk to the attention of the board in another way, all they are going to get is this?
A. But if it had been deemed that there was no harm, there wouldn't be anything to report at that stage --
Q. Yes.
A. -- apart from the rise in mortality.
Q. But that's the point I am making --
A. And the rise in mortality would have come at the end of the year in my report then when we had the full year to look at and we could break it down further from there.
Q. I think with an eye on the time, I am going to really compress this right down and just look -- since

you raised Child D, may we just look at Child D. Could we look at the Datix INQ0002658.

Now, again we have looked at this one already we are going to look at it in a bit more detail now. This unusually is the Datix, as I understand it, that related to the mother, not the child?

A. Yes.

Q. But as we are going to see much of the content of it actually does relate to the child?

A. Mm-hm.

Q. But I give that clarification at the start because when we look at risk grading, which is put at actual harm, result: actual harm, actual harm, moderate, potential for harm, low potential harm; in fairness, we should probably be looking at it through the lens of the mother rather than the baby.

But in relation to the details we have them there.

If we could just go on to page 2, please. If we just crop in on the top half of that page. Do you remember that you said to me your experience of this system was that when an amendment was made to it there would be a date stamp?

A. Yes.

Q. As I look at that first paragraph, there are three date stamps. So I say first paragraph, can you

see three entries on the left-hand side?

A. Yes.

Q. At the bottom of that, as I look over to the right-hand side, there are a number of date stamps. The earliest in time is 24 June 15 at 10.45 in the morning, Debbie Peacock. Can you see that?

A. Sorry, 24 June?

Q. Yes. So of the three Mr Bennett, Mr Dean Bennett entries --

A. Yes.

Q. -- the bottom one, if you look over to the big Registrar on the right --

A. Yes.

Q. -- there are then three date stamps at the top of that paragraph.

A. Oh, yes.

Q. And it's the one that's just been highlighted for you. Thank you very much, Mrs Killingback.

24 June 15 at 10.45 "Debbie Peacock" and then what follows, as has been discussed is the email from Stephen Brearey that has been sent to you?

A. Yes.

Q. And you, it looks like, have copied and pasted this into this document at this time?

A. Yes.

Q. So can we take it that from that date and that time, this information was available to anybody who looked at this date Datix?

A. I presume so, yes, who had access to the Datix.

Q. Okay. Did you read what you copied and pasted into it?

A. Sorry, I don't remember.

Q. What was your practice? Would you have just copied and pasted it without reading it given that your job --

A. No, I would usually have read it to see whether there was any pushback that I needed, any challenge on what Steve or clarification from what Steve had found.

Q. Right. So we know that as at 24 June, a week or so before you go to that meeting on 2 July, you have received this email, you have put it into this Datix and we have got the familiar analysis of any common issues in that second paragraph underneath.

There don't seem to be any common items of infection or equipment or location. But there is a common member of staff.

The final document, please, that I would ask us to look at is the Level 2 report, as you have called it,

the which is INQ0014204.

I think this is the document that you were --

A. Yes.

Q. -- talking about in answer to my earlier question. If we go to page 2, please. Can you see under "Detection of incident", the fourth paragraph under that looks like a description, a minute of that meeting of 2 July 15. Can you see that?

A. Yes.

Q. The incident was escalated to the Medical Director. Now, did you write that paragraph?

A. I really don't know.

Q. Okay. Because what it records there is that it records the meeting, it tells us that in addition to the Director of Nursing and quality, that's Alison Kelly, this matter had also been escalated to the Medical Director at that time, but there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there was any commonality which linked the deaths.

And that section of that email that you had put into that Datix were circumstances which potentially related to commonality of the deaths, didn't it?

A. Yes.

Q. Yes. So you have no memory as to what was

discussed?
A. No, sorry.
Q. But this record, close to the time, tells us that those are the sort of features that were being discussed.
What it goes on to say is that two of the babies had medical conditions which could be clearly seen to have contributed to their deaths.
Now, just pausing there. Mr Skelton did the exercise with you with Child A. Actually when you looked at that Datix, it didn't tell you that there was something in the background that caused the death: maybe, maybe not; the question was not answered.
If we looked, if we had the time to look at the Datix for Child C, we would do a similar exercise. I am not going to do it with you now but I am just going to note it.
But what it goes on to say is this:
"The third baby appeared to be an unexplained death and at this time the baby's cause of death was unknown. It was agreed that no further investigation was warranted at this stage as there were no concerns highlighting any obstetric or neonatal views. However, the SI panel were of the opinion that the obstetric secondary review findings and the neonatal findings

should be put into this one report."
That's sort of set out even more starkly if we go, please, to page 8. Care and service delivery problems are set out. They are of the nature that they are.
Underneath there: alleged contributory factors: none. So nothing here that can have contributed to the death. Root causes: no root cause has been identified.
But yet no further analysis is going to be undertaken at this time. That's really what I would like your reflection on, your understanding on.
You have -- The Families would say to you that all of the information in relation to Child A and Child C was there to see that these were unexplained deaths at the time.
But putting that to one side, in relation to Child D, that is your conclusion. This is a sudden death, it's an unexpected death, it's an unexplained death. Why was there not more consideration?
A. So this wasn't my conclusion. I have obviously -- I don't know where I have taken this from. This report would have been circulated to the staff at the meeting before it was finalised. So I don't know whether it's been tweaked along the way. I don't know where I have got this information. I thought I had copied and pasted it looking at it. I really don't

know, I'm sorry.
Q. But this, you are telling us in clear terms, this is the outcome, this is the decision of that meeting of 2 July '15, which had the membership that I set out with you at the start.
A. So my understanding is that they were going to reconvene when we had the postmortem results --
Q. Right.
A. -- to determine then if there were further actions required.
That was my understanding reading the document.
Q. And in fairness to you that postmortem I think, or at least the Coroner's investigation, completed after you had left the Trust?
A. Right.
MR JAMIESON: There it is. My Lady, thank you very much. I apologise if I have trespassed into the lunch.
LADY JUSTICE THIRLWALL: Not at all. Thank you very much, Mr Jamieson.
MR JAMIESON: So sorry, there is another page that we are asked to put to the witness. (Pause)
I'm sure we can put that right at a different time. Thank you very much.
Questions by LADY JUSTICE THIRLWALL
LADY JUSTICE THIRLWALL: Very well. Thank you very

much, Mr Jamieson and Mr Kennedy.
Mrs Peacock, I have just got two brief matters to ask you about. I asked you a question earlier, where I had obviously not listened carefully to what you had said in the first place. It was in relation to the chart that we have looked at -- well, we have, you haven't looked at -- many times with the name of the various nurses who were on shift when babies collapsed.
And you said, quite rightly, that what you had said was that she hadn't been looking after the babies and I asked you why you were saying that, and you rightly say it's in the chart which of course we all know well.
I had a note of what you said earlier and I want to check that I have got this correct and if not, you just tell me. Much earlier in your evidence, when you were being asked about the fact that it looked as though there was a nurse who was present for number of the deaths, I have noted you as saying -- and I have not been able to check it on the transcript -- she wasn't on duty for other deaths.
Now, did you mean she wasn't on duty for other deaths or did you mean she wasn't always the allocated nurse?
A. So my understanding was that there were other deaths -- where they fell, I don't know in the timetable

of, of -- that we have here --
LADY JUSTICE THIRLWALL: So sorry --
A. -- that she wasn't actually present on the unit for.
LADY JUSTICE THIRLWALL: Thank you. So my note is correct. She wasn't on duty for other deaths. I don't suppose you are able to help us as to which ones?
A. I'm sorry, I wasn't involved in the trial at all, so I don't know the indictment babies or the others.
LADY JUSTICE THIRLWALL: No, all right. Thank you.
Then one last question, if I may. You were asked very early in your evidence about the Clothier report in relation to Beverley Allitt and one of the recommendations being that there needs to be a heightened awareness of malevolent intent and you referred us to an algorithm --
A. Yes.
LADY JUSTICE THIRLWALL: -- which you had.
But just so I understand it correctly. The algorithm doesn't anywhere direct you to consider malevolent action, does it?
A. Yes, it does.
LADY JUSTICE THIRLWALL: Oh, it does?
A. It starts off: did they do it? Was the

outcome intended? And it takes you through.
But the actions for "yes", if it was intended is consider the police.
LADY JUSTICE THIRLWALL: Thank you. But you never referred to it when considering this case because ...?
A. There was no act or omission at that stage for us to consider it in relation to any person.
LADY JUSTICE THIRLWALL: Does it mean, therefore, and I just want to understand because you mentioned that you had always at the back of your mind the possibility of malevolent intent, or whatever phrase you might use, but that never came to the front of your mind?
A. On the information that I had, no, unfortunately.
LADY JUSTICE THIRLWALL: All right. Thank you very much indeed, Mrs Peacock. You are now free to go.
A. Thank you.
LADY JUSTICE THIRLWALL: Ms Brown, are you able to help about the timetable for the afternoon? I know we have got Ms McMahon.
MS BROWN: Yes. We have two witnesses that are being called this afternoon.
LADY JUSTICE THIRLWALL: Yes. Are we going to complete their evidence this afternoon?
MS BROWN: I'm just looking behind me.

LADY JUSTICE THIRLWALL: Yes, I can see there's someone who knows better than you.
MS BROWN: Yes, yes, I am told we will.
LADY JUSTICE THIRLWALL: Good. I think Ms McMahon has probably been waiting all morning, but I'm afraid we will start again at quarter past 2.
(1.12 pm)
(The luncheon adjournment)
(2.15 pm)
LADY JUSTICE THIRLWALL: Mr De La Poer.
MR DE LA POER: My Lady, the first of our two witnesses for the afternoon is Janet McMahon and I wonder if she might come forward, please.
LADY JUSTICE THIRLWALL: Yes, do come forward, Ms McMahon.
MRS JANET MCMAHON (Sworn)
Questions by MR DE LA POER
LADY JUSTICE THIRLWALL: Do sit down.
A. Thank you.
MR DE LA POER: Please can you state your full name?
A. Mrs Janet Lesley McMahon.
Q. Mrs McMahon, is it correct that you have provided to the Inquiry two witness statements, one dated 13 June of this year and one dated 3 October of

this year?
A. That's correct.
Q. Are the contents of those two witness statements true to the best of your knowledge and belief?
A. Yes, they are.
Q. We will begin with your background. Did you qualify as a Registered Nurse in 1985?
A. Yes, I did.
Q. And then in 1987 as a midwife?
A. Yes.
Q. At that stage, did you start work at the Countess of Chester Hospital?
A. Yes.
Q. If we move forward in time to 1998, from that date forward, did you work predominantly as a midwife on the labour suite?
A. Yes, I think so, I wouldn't be sure of the dates, but I think so.
Q. Around that time at least?
A. Uh-huh.
Q. Moving forward approximately a decade. You tell us in your witness statement that you became a governance facilitator in 2007 --
A. Yes.

Q. -- is that right?
A. Yes.
Q. Which department did the governance facilitator role work from?
A. At that time I worked for therapies, pharmacy, radiology.
Q. At what stage did you join the Risk and Safety Department?
A. That was the Risk and Safety Department. It just -- we just changed names.
Q. So to all intents and purposes it was the same department, just differently branded?
A. Yes.
Q. In terms of the role of governance facilitator as it started out, in summary what were you expected to do?
A. Look at incidents daily for the areas that I covered and look into any concerns that were raised.
Q. In the early stages in terms of the areas that you covered, did that include obstetrics?
A. Not initially.
Q. Did there come a point in time where it included obstetrics?
A. Yes. So I worked for the therapies division for probably a couple of years and then moved back to

Women's and Children's.
Q. Once you moved back to Women's and Children's, did your role include looking at neonatal incidents?
A. Yes.
Q. In terms of your background, experience and training, did you have adequate knowledge as someone who had practiced as a midwife to do your role so far as neonatal medicine was concerned?
A. I believe so.
Q. What level of knowledge did you need, practically speaking, to be able to do that role when looking at an area that you hadn't practiced in?
A. To be aware of potential risks and when to escalate them for other people who had more neonatal knowledge than I did.
Q. Now, we know from Ruth Millward's statement that initially on an interim basis but that was then confirmed into a full role, she was the head of the Risk and Safety Department from about 2013. Does that accord with your recollection?
A. Probably. I wouldn't know the dates but I think so, sounds --
Q. That sounds about right?
A. That sounds about right.
Q. To put it another way, by the time we get to

2015, Ruth Millward was well-established as the head of that department; is that right?
A. Yes.
Q. And you, who had been there even longer in that department, were also well-established; is that fair?
A. No, Ruth was in the department when I joined. She was a governance facilitator at the same time that I was but I joined later.
Q. Forgive me, I should have been clearer in my question. She was well-established as the head of the department --
A. Yes.
Q. -- by the time we get to 2015?
A. Yes.
Q. But in terms of her experience of the department overall, obviously that stretched back before she took that role?
A. (Nods)
Q. Just continuing with your history. We know that Debbie Peacock who the Inquiry heard from this morning, and I think you were present in the room when she gave at least some of her evidence, left the Countess of Chester in February of 2016?
A. (Nods)

Q. At which point her role became effectively vacant. The Inquiry has information to suggest that you may have undertaken her role for a period of time on an interim basis; is that correct?
A. Yes, at the same time as doing my other role. So I was covering -- it was a dual role, but yes, for the three months before Annemarie joined, yes.
Q. Absolutely. And when by the time we get to May 2016 Annemarie Lawrence then took over the role that Debbie Peacock had previously undertaken and which you had filled in for?
A. Mm-hm.
Q. In terms of that period February 2016 to May 2016, you have described it as a dual role.
Were you given any more hours or pay or anything to reflect the fact that you were expected to do more than you had previously?
A. I don't believe so. I don't recollect.
Q. How well placed do you consider you were, at the time, to take over that role from Debbie Peacock for a period of time?
A. With my background of midwifery and previously having covered the obstetrics and gynae departments, I felt able to do that, from an experience point of view. But obviously time-wise there was a conflict.

Q. So no difficulty in terms of your qualification for the role in your mind, tell me about the time conflict as you have characterised it, what do you mean by that?

A. Because if you are doing two people's jobs, you can't do them both the same as if you are only doing your own.

Q. Were you effectively performing two full-time roles or did you have any support for the two roles that you were undertaking?

A. I don't really remember. But I imagine that you would prioritise differently given the two workloads.

Q. Just looking back on it and being as reflective as you can, do you think that you gave sufficient time in that conflict situation as you have described it, to the Risk Midwife role or do you think that you were compromised in that?

A. I think I probably did the best I could. It's quite often that situation happens, where a member of staff leaves and they are not replaced for some time afterwards so it's a recurrent happening in the NHS that roles aren't covered immediately. So that work has to be covered by somebody else in the interim.

Q. The role of Risk Midwife which you were

covering, is that an important role within the hospital, do you think?

A. Absolutely.

Q. Did you receive any additional training for undertaking that role or were you just one minute doing one role and presumably after a short period of consultation then doing both?

A. I had done the role before. And I had been in the team quite a number of years by then, so I felt qualified and experienced enough.

Q. But in terms of things move on in the NHS, computer systems change, practices change, policy changes. Did you feel you needed any additional support to undertake that role?

A. I was doing the same role but for different areas. So I was used to the -- the electronic systems, the policies.

Q. What had been your role title at the point that you took over the Risk Midwife role on an interim basis as well?

A. Project Lead.

Q. Was that the same role, Project Lead, as you had had as a governance facilitator or were there differences to it?

A. No, there were differences to it.

Q. What were those main differences, please?

A. So as Project Lead I focused on certain areas, for example I think at the time I was looking at falls in the Trust, it was a high safety incident so we looked at falls and how we could manage them and reduce harm.

Q. So we have the period of time when you are doing both the Project Lead role and the Risk Midwife role and I think it was in May of 2016 that you were seconded to the role of Patient Experience Lead; is that right?

A. That's correct.

Q. Was that also within the Risk and Safety Department or was that in a different department?

A. Initially, before I took up the post, it was a different department managed by a different manager and then three teams were merged into one at the same time as I took up that post.

Q. So was that in May 2016?

A. Yes.

Q. Who was your line manager once those departments were merged?

A. Ruth Millward.

Q. So in terms of line management it remained the same, but you were working with what was had previously been a separate part of the hospital?

A. Yes.

Q. Did you hold that role for 18 months?

A. Just over 18 months.

Q. Having undertaken that role for 18 months, did you then come back to a risk role?

A. Yes.

Q. You tell us that at that time it was described as the Risk and Safety Lead?

A. Yes.

Q. Again the Risk and Safety Lead, is that different from the Project Lead or is it the same job, just differently titled?

A. Similar job, I was just aligned to an area rather than focused on different projects. As a Project Lead I didn't have a certain area to work whereas a Risk Lead, you had certain areas.

Q. Finally to complete your history in the NHS, did you retire in 2020?

A. I did.

Q. So we are just going to move to consider in a little bit more detail the culture in the Risk and Safety Department.

Your line manager throughout the period that we are focused upon was Ruth Millward, what was your working relationship with her like?

A. I had a very good working relationship with Ruth for a long time until the merger of the three services, while I was in secondment post and the relationship deteriorated quite significantly.

Q. That was the subject matter of your second witness statement; is that right?

A. (Nods)

Q. If we just deal with that in summary. Once you were seconded to that post, did you find yourself in a position where you felt unsupported and effectively out on a limb?

A. Yes.

Q. And experiencing a very high degree of pressure upon you to deliver?

A. Yes.

Q. So before May 2016, the Inquiry can proceed on the basis that your working relationship with Ruth Millward was a good one?

A. Yes.

Q. What was she like as a manager, what was her managerial style?

A. She had an open-door policy, she was usually very supportive and welcomed challenge, escalating and she usually made very good judgments.

Q. And in terms of the pressure the department

was under, let's take it in stages, up until the point that you undertook the interim Risk Midwife role, so up to the point of February 2016, what was the working environment in the department like in terms of how busy it was, how much pressure you were under?

A. It was always very busy. Always a lot of pressure, it's quite a high pressure job looking at incidents, things that could be going wrong. So it was always very busy, quite stressful.

Q. Once you were undertaking the dual role that you were for the three-month period before your secondment, obviously you were much busier, as you have told us, but how about the department generally, was it under any greater pressure during that period or was it the same or were you simply focused upon what you were trying to achieve?

A. I think the pressure was the same for everybody, it has a knock-on effect because whilst I was covering two roles, some of the work I should have been doing would have gone to somebody else. So the pressures is sort of shared throughout the team.

Q. Now, I am given to understand that you have considerable experience of the operation of the Datix system; is that right?

A. I do.

Q. And that you can help us by starting by providing a summary with the origin of the Datix system at the Countess of Chester, we don't need precise dates or anything like that, but how it was first adopted and for what purpose and then how it developed over time?

A. So I can't remember the date it started but quite some time before I went into the risk team. It was an electronic system to monitor incident reporting initially, that is all we did on it by way of being able to pull reports, recognise trends, themes, do data analysis.

Then the system grew to include complaints and claims, the complaints side of things didn't go in there until I was actually in the patient experience post, but it was a growing system that was changing very, very frequently.

Q. In terms of who effectively had ownership of that system within the hospital, did that sit with your department?

A. Yes. I can't remember exactly when but we employed a Datix compliance manager and so she initially managed the incidents and then later on it was another person who came in and that's when the development started of the programme.

Q. But was that person in the Risk and Safety

Department?

A. Yes.

Q. So they were part of that umbrella?

A. Yes, yes.

Q. Therefore if it was effectively owned within the hospital by that department as being the place that people would turn to if they needed help, does that mean that that same department had responsibility for ensuring that everybody else in the hospital understood what their responsibilities were?

A. Yes. And we provided training on mandatory training days, we did a risk talk which included Datix, Datix reporting and the purpose of the system.

Q. In terms of the reach of that training, I mean in the beginning of 2015, to take a moment in time, would it be your expectation that everybody who had worked in the hospital over the previous 12 months would have all received Datix training in that time?

A. They should have done and also there was a statement at the top of the report to say that if you required help that you could contact us and we often assisted people reporting incidents so the support was there but it wasn't always taken but it was always there on offer.

Q. Of course that offer of support requires

a person to understand that they need the support, they need to understand their own deficiency or shortcoming or uncertainty before they can reach out; is that fair?

A. Mm-hm.

Q. That is not in any way critical of the offer that's made. The Inquiry has seen an example which we will look at with Ruth Millward about how over time definitions can sometimes change or new national policy comes out that expects a different way of working or an improved way of working, was it your experience within the NHS that there were updates to how people were expected to interact with the Datix system or Serious Incident reporting?

A. I'm not sure so much that there were updates. But we had a very, very high reporting culture nationally. So that kind of indicates that people did know when and how to report. Any updates to the system might go out to that department that's being updated or by a generic email if it affects the whole Trust.

Q. So from your point of view, just sitting at the place that people can reach out to, what was your overall impression of -- across the hospital of the understanding of what was expected of every single person in terms of Datix?

A. I believe that most staff knew that they

should report a Datix incident as soon as possible. Often you would -- when you would read an incident it wouldn't be reported as you would report it because sometimes it's subjective. For example, when things are reported as "no harm" or "severe harm" it might -- be that is their perception at the time and when we do the investigation or review the incident that is when we will change to the realistic categories.

Q. But of course the important thing is that someone has filled in a Datix so that the incident can start its paper life, it enters the process at that point and then can be reviewed to be improved, updated, corrected, that sort of thing?

A. Mm-hm.

Q. But the fundamental point is that none of that happens unless somebody completes a Datix?

A. No, because as part of the process anybody who recognises an incident should also phone, alert their manager or the risk lead. So completing the Datix is not the be-all and end-all, it is important, but the important thing is to escalate whatever concern you have picked up by either phoning the risk team or your ward manager wherever the incident happened.

Q. In just a moment we are going to look specifically at your perception of the neonatal unit but

before we get to that, can we just stay with how Datix works in principle.

Is it right to say that there were effectively three important roles at the early stage of a Datix and I will tell you which roles, I mean, you can comment on them. You have the role of the reporter, the role of the handler and the role of the manager?

A. (Nods)

Q. Each an important role. So can you just-- I mean, the first one I am sure is perfectly obvious, but let's deal with all three.

The role of the reporter?

A. So the reporter has identified an incident and they report it on the Datix system. The Datix will then be accessed within the next working day by the handler who will look through the incident and allocate it accordingly, so, for example, if it was a neonatal incident, it would have gone to Debbie Peacock, if it was a radiology incident at one time it would have gone to me as the manager.

Q. So if you just pause there. So the handler is a person within the risk department who has effectively as part of their portfolio the department that it's come from?

A. So they open up Datix in the morning to -- to

open and approve all the Datix that have been reported since the last working day.

Q. So as far as you were concerned when you took over the Risk Midwife for a period of three months, would you have been the handler for any Datix coming from the neonatal unit?

A. I would have been the manager.

Q. You would be the manager. Now you mentioned that Debbie Peacock in the context of being the handler, she was the Risk Midwife?

A. No, the handler is the person who first opens, so the handler every morning will open up the entire Datix system and access all the Datix reports that have been made since the last working day and they allocate to the manager.

Q. They allocate to the manager and so you and Debbie Peacock sit at the manager level?

A. Yes.

Q. So the handler, are they somebody junior to you or in the roles that you had within the Risk and Safety Department?

A. Junior. When I first started in the role we -- the risk leads, then governance facilitators, used to open and access the Datix. But as time went on, we had administrative staff to do that.

Q. All they are doing is really -- I hope I am not underselling it here, saying this has come from, for example, the neonatal unit, Debbie Peacock is the risk lead for the neonatal unit, I need to put it on -- across her desk?

A. (Nods)

Q. Now, we will come back to how the manager can change over time and look at some examples, but was it the manager's role to write what is termed an SBAR?

A. If it was a serious -- if it was a patient safety harm incident and required an SBAR. Not all incidents would require an SBARS, it would only be incidents of concern.

Q. SBAR of course --

A. Sorry, and yes, the manager would do that, would investigate it, get it an initial picture, write the SBAR which would go to the Execs.

Q. Situation Background Assessment Recommendation is what that acronym stands for?

A. Yes.

Q. Presumably that provides a format for the way in which such a report should be written?

A. That's right, it is a communication tool.

Q. And so the manager looks at the Datix, makes a decision about whether or not it justifies an SBAR

having made the enquiries they want to. If yes, then the SBAR is created and it's sent on to the Execs?

A. It might be discussed with Ruth Millward before an SBAR is undertaken.

Q. Once an SBAR is written is the expectation that there will be a Serious Incident Review Panel convened?

A. So the Serious Incident Review Panel happened weekly. So any SBARS would go to that panel.

Q. So not convened for that SBAR; because it is happening --

A. Unless it was something of particular concern.

Q. Is it at that review panel meeting that a decision is made about whether or not the event is going to be classified as a Serious Incident so far as the NHS England criteria is concerned?

A. Yes.

Q. Are there two levels of investigation at that stage?

A. There is MPSA Level 1, MPSA Level 2 and MPSA Level 3.

Q. Three. So tell us please what the difference so far as you can recall between the different levels are and who's deciding that?

A. So it was the National Patient Safety Agency

that decided on the levels of investigation. Level 1 is a lower level, less concerns, Level 2 would be more serious where there may have been serious harm, for example, and every event where something shouldn't have happened. And Level 3 is more about deaths but I think it's homicide it's actually classed as in the -- in the literature.

Q. In terms of?

A. Sorry, external investigations they are normally, so like the police.

Q. External investigations therefore for police.

So within the system, had somebody been saying in the clearest possible terms all the way up the chain "We think that Letby has killed this baby", quite aside from whether anyone is immediately going to pick up the phone and call the police and whether that should happen, the system allows for that position to be arrived at in any event?

A. Yes.

Q. What is the level of certainty required in terms of how one classifies Level 1, Level 2 or Level 3 and by that I mean do you simply have to suspect that it is a homicide to reach Level 3 or do you need to have some form of evidence or more likely than not standards.

What's -- at that stage what's the test?

A. You would have to have some sort of evidence to warrant that, the same as you would have to have some sort of severity to warrant a Level 2 investigation.

Q. Now, Datix was a live system; is that right?

A. Yes.

Q. By that, so I define what I mean, is that it was constantly running and constantly capable of being accessed and constantly capable of being updated?

A. Mm-hm.

Q. From an audit perspective, just for the ordinary user screen, was it sometimes difficult to tell when an update was applied?

A. No. We usually knew if there had been an update because the system would go down for a period of time, so we would have been informed that that was going to happen.

Q. I don't mean software update.

A. Sorry.

Q. I mean updated information. So if you were going to change a field within the Datix system, to change a name or something like that -- well, let's have a look at an example, I will make myself clearer I am sure in this way.

INQ0040506. This is the Datix form for Child I. We will just pick out one or two details on it. We can

see the reported date is 23 October and the submitted time is 9.05?

A. (Nods)

Q. Although presumably the time this incident is created on Datix, we don't need to worry about who the handler is, you have told us they have an administrative function and we can see that at the time that this form was -- this moment in time whenever that was from this form, you are identified as the manager?

A. (Nods) Yes.

Q. We don't need to worry too much about the moment of time because we are going to just lay this alongside another form. But if we just go over the page, just so that we can satisfy ourselves because obviously multiple people can create Datix entries for the same event.

We can see that the reporter at the bottom is Caroline Oakley?

A. Yes.

Q. So we know that this is an event in respect of Child I reported by Caroline Oakley at 9.05 on 23 October. Let's bring it down and let's please bring up INQ0000457.

Again we see this is Child I, we see the time is 9.05 but here we can see that the manager who had

previously been you is now identified as Mrs Anne-Marie Lawrence.

A. (Nods)

Q. If we go over the page just to satisfy ourselves it is the same event, in fact I think we might need to go one more to get to our incident reporter. Just towards the top we can see Caroline Oakley, so this is the same event by the same person, but a field has been updated --

A. (Nods)

Q. -- to reflect that at the moment in time that we are looking at, it's Lawrence who is the manager, not you; is that right?

A. Yes.

Q. My point really about updates and audits was that just on the face of this document it isn't immediately apparent when that change was made?

A. No and both the documents are quite different and the only way to see when the change has been made is to get the audit trail so you can print out a copy that shows every date and time a change has been made.

Q. Absolutely, I am sure that sits in the background of it but just looking at the form, you wouldn't actually be able to tell from that. Obviously you can see that if you lay them side by side some will

have later dates in time, but that was really the point I was making.

So can we go back to page 2 just to have a look at the succession management of this event, because we can see under the incident investigation, this is obviously Child I who was murdered on 23 October 2015, Debbie Peacock is the first entry there on 17 December. We can see the 25 January, Debbie Peacock is still identified, unsurprising given that her role was Risk Midwife until February 2016.

Then on 1 March, you have sent an email according to the entry for an update on the incident review. The following day, you got a response from the Consultant paediatrician:

"Case has been reviewed internally in a tabletop meeting in AHCH ..."

AHCH?

A. Alder Hey Children's Hospital.

Q. "... and awaiting PM results, will forward draft minutes of thematic review when complete."

You have sent a chaser on 15 April:

"Further email sent requesting update on review."

Is that a request for the thematic review that you are asking for?

A. I'm not sure.

Q. I mean, the word "review" appears twice in the preceding entry, one that it's been reviewed internally and secondly, the thematic review when complete.

A. I don't know this is the review that had been done at Alder Hey Children's Hospital.

Q. The tabletop meeting?

A. Yes.

Q. Then we can see again an entry 27 April still with you because Ms Lawrence hasn't taken over by this point:

"Still awaiting feedback from review."

Presumably those entries you have managed to take from the medical records just to pick out some details because Child I as we know was transferred between a number of hospitals over a period of time, so you have done a little digging to try and get to the bottom of that and put that in and then we can see because we know that Ms Lawrence takes over in May, that she's now the manager and she's got the postmortem report and she is recorded as sending an email to the Consultant paediatrician requesting update on 1 June and a further entry 22nd of the 6th, Ms Lawrence entering some data in -- we can ask her about that.

But in terms of just an example, is this the sort of thing that we can see across all the Datix forms that

at various points people have the opportunity to add data, and that managers can change as people move roles?

A. Yes.

Q. Thank you very much indeed. We can take that down.

That's all that I am going to ask you about the theory of Datix. We are going to have a look shortly potentially at another one, but let's see how we get on.

I would like to just ask you some questions about the Women's & Children's Care Governance Board. Was that a committee that you attended?

A. I believe I attended between Debbie Peacock leaving and Annemarie starting.

Q. So do we infer from that that you would have attended in your capacity as Risk Midwife?

A. Yes.

Q. Well, helpfully we have some Terms of Reference which are dated the period that you began attending that, so we can see what it says about itself. Ms Peacock looked at these earlier in the day but just a couple of things to pick out, INQ0015325.

I'm not going to duplicate what Ms Brown asked about this morning, so we can go over to page 2 because we have the membership well in mind.

I just wanted to ask you about number 3 on the list

or the third on the list. We have:

"Review and monitor the risk registers, escalate risks to the divisional and organisational risk registers."

Now, we heard from Mrs Murphy about how the risk interacted at the local level and she described for us a situation in which once there is -- an incident is identified at a local level, there will be input from the risk department about that and that by the time the incident is escalated to the Women's & Children's Care Governance Board, a decision has already been made effectively about the level of risk around this incident and how it should be treated.

Is that your experience of it or was the risk input at this board level?

A. It depended on the level of risk which risk register it sat on, you would have a local risk register, a divisional risk register and a board assurance framework so it would depend on the level of risk, where it was reviewed and how it was scored. And then the scoring would then dictate which level of risk register it sat on.

Q. Would that all be decided before you get to the Women's & Children's Care Governance Board?

A. Yes. Usually, unless it needed discussion by

some areas rather than just a single area.

Q. Did this governance board, as far as you understood it, have a function to consider that particular case if somebody wanted to raise something about it and reflect upon whether it was being managed correctly?

A. Yes.

Q. That is rather what governance means, would you agree?

A. (Nods)

Q. Similarly, if there was a report that looked at a number of events, again would that be something for this board to consider?

A. (Nods)

Q. So as to reflect upon whether the conclusions are right, ask questions, challenge and really just establish whether or not it was being managed properly?

A. Yes, usually, yes.

Q. The only other question to ask you about is the next one down says:

"Review and monitor staffing levels for obstetrics and anaesthetists and midwifery staff."

My question really was this: this is February 2016, which we can see from the next page, but I am sure you have seen it before, you can take that from me, there

doesn't appear to be a similar function in relation to paediatrics or neonatology in terms of their staffing levels?

A. (Nods)

Q. Now, obviously you only joined this committee in February on an interim basis but I was just wondering whether you can help us with that, because -- I'll explain why. We know that in December of 2015, there were repeated complaints to the senior management about the staffing levels within the paediatric department generally and yet when we get to February and the Terms of Reference appear to be settled once again, we see only a focus upon the obstetrics side.

So can you shed any light on to that?

A. Well, first of all it is a draft document, so it may have been updated to include neonatal staff.

Q. Can I just pause you there?

A. Yes.

Q. Obviously that is a theoretical possibility. Do you know whether or not that happened or?

A. No.

Q. You are just allowing for the possibility because it's got "draft" written on it?

A. No, I don't know.

Q. Thank you. Please continue.

A. The other thing is it could be that staffing in obstetrics and anaesthetists and midwifery staff might have been highlighted as an issue and if that were the case, it would indicate that the neonatal staffing wasn't an issue but I don't know the answer.

Q. Well, certainly --

A. I don't know why the omission.

Q. Well, you can take it from me, although you probably can't comment, that certainly there is very clear evidence that by the end of 2015, from both the nursing and a medical side, the managers were being told there is a problem on the paediatric unit?

A. (Nods)

Q. There we are, that is all that you can tell us about that. Thank you very much indeed for your help on that.

I would just like to ask you about the neonatal unit and your experience of the neonatal unit's attitude towards the Risk Department, and that is something you mention in your witness statement.

I would just like you to just tell us what your perception was?

A. At that time, I didn't actually have -- so from 2015 to 2016 I didn't have any time spent with the unit, the staff. Obviously the short time where I was

covering that role I will have had some interaction with them. I didn't pick up anything that concerned me in any behaviours.

Q. You didn't pick up anything. What you suggest in your statement is that -- it's paragraph 5 if you want to look at it:

"Governance has historically not always been welcomed and/or understood by some clinicians, which at times could lead to difficulty with some professional relationships and maintenance of robust governance policies. I would not be able to pinpoint anything in particular between the years 2015 and 2016 or that specifically affected the neonatal department at that time."

So are we to take it that that comment is across the hospital, rather than intended to be -- because the preceding paragraph is talking about the NNU I was just trying to understand whether or not the clinicians you are referring to were paediatric clinicians who worked on the neonatal department or whether it wasn't specific?

A. It wasn't specific. I think that was a more general observation.

Q. The second question about the neonatal unit is to the best that you are able to help us it's important

for an understanding about when people became aware of particular things.

It's now very well-established that there was an increase in the mortality rate on the neonatal unit. When do you think you first became aware of the increase in the mortality rate?

A. I can't recall becoming aware of the increase in the mortality rate. The first time I knew of a link a potential link with Lucy Letby was --

Q. Can I just, I have --

A. I have gone too far.

Q. You have moved to my second question --

A. Sorry.

Q. -- which will be when a member of staff might be resolved in it. I am just talking about the fact that there were more deaths on the neonatal unit than people were expecting. When do you think your first awareness of that was?

A. I really couldn't pinpoint when I was -- when I first became aware and I think now my memory is very muddled by things that I have read and heard since, so it's hard to pinpoint any particular time.

I -- I don't believe I was aware before May 16 that there was.

Q. Before May 16. If I can give you some moments

in time, we have got the period before February 2016 when you took over the Risk Midwife role, we have got the period that that ended May 2016 and we have got the end of June 2016 when Letby was taken off the department, although that wasn't confirmed until her return and there was a period where that was in doubt and then she started in the risk department in July.

So thinking about those dates, are you able to help us with when you might become aware of the increase in mortality?

A. I really don't remember any specific dates. I don't know whether it was something I just knew or I don't even know if I was aware of it at the time.

Q. Bearing in mind your role as risk midwife during the period February to May 2016, was that something that you should have known during that period?

A. Yes.

Q. Sitting there now, do you think that is something that you did know at the time or that you didn't know, or can you not say?

A. I -- I don't think I did know because of what happened next, otherwise I think I would have been a lot more concerned.

Q. There are you referring to the discussion you had once Annemarie Lawrence came?

A. (Nods)
Q. So we will come to that. How about the second part of my question, which is: when you first became aware that there was a concern that a particular member of staff may be somehow connected to the increase in mortality?
A. When did I become aware?
Q. Yes.
A. In I think late May/early June soon after Annemarie had started in post.
Q. Well, we will come to that in a moment.
Let's just deal with the thematic review that we know took place on 8 February. Debbie Peacock was in the role that you took over at that time, it was right towards the end of her time and she attended that meeting, we know that from records and you may have heard that this morning?
A. (Nods)
Q. When she handed over to you, did she tell you anything about a meeting that she had been to on the neonatal unit, was there any such handover?
A. Not that I remember, no.
Q. Again looking back on things, is that something that should have been the subject of a handover?

A. Yes.
Q. Now, I would just like to look a little bit further at what information you had.
Please -- you were asked to have a look at an email today, something that I asked to have drawn to your attention. It's INQ0014226. This is an email dated 2 March 2016 and it's an email that Dr Brearey sends to a number of people and he attaches the final version of the neonatal thematic review. And if we look on the cc list, both you and Ruth Millward are recorded as recipients of that email. There's some text about it in the body of the email but it's the report that's attached that's important.
Now, you have told us that you don't have any recollection of having seen that report before speaking to Ms Lawrence in late May and looking at this email, can you see that it appears to have been sent to you?
A. Yes, I can.
Q. And you have told us you were doing two roles at that time. But the reason you would be on copy for this would be as your as the Risk Midwife role, not as your Project Lead role; is that right?
A. Yes.
Q. So this is your second job having taken over from Debbie Peacock.

If we just remember that date, 2 March 2016 and go back to INQ0000457. We go to page 2 and we just slot that into the chronology that we looked at earlier. We can see that the day before, so 1 March, you emailed for an update. On the day that that email was sent and it was sent at 14:57, so at 10.09 you made an entry that you received a response from the Consultant paediatrician, the case had been reviewed internally. We know that because it was reviewed on 8 February and at tabletop meeting in AHCC, 25th of the 3rd 16.
Just pausing there. In terms of that 25th of the 3rd 16, that appears to be a date in the future. Might that be a typo?
A. Yes, I would imagine so.
Q. Because as you have written it, it appears to be talking about the past, doesn't it?
A. Yes.
Q. And:
"Awaiting PM results. Will forward draft minutes of thematic review when complete."
And:
"Consultant paediatrician likely to be Dr Brearey",
are you able to recall now who that was?
A. (Shakes head)
Q. Let's assume for a moment it was -- Dr Brearey

was the person running the thematic review and later that day, about four hours later, it appears that he sent you the thematic review, you were on copy together with your boss?
A. Mm-hm.
Q. We can then see that on 15 April, you have sent an email requesting an update on review. Now, you have told us you are not sure whether that's the Alder Hey review or whether that's the thematic review. But if it was the thematic review you were referring to, it would tend to suggest that you hadn't realised that you had received it by this date, do you agree?
A. Yes. And maybe -- I don't know but maybe the Alder Hey Children's meeting was -- was to be held in the future, the case has been reviewed internally?
Q. And at a tabletop meeting in Alder Hey?
A. Mm-hm. I mean I have absolutely no recollection. I am sorry.
Q. And again you appear to have chased it again whatever it is the feedback from review on 27 April and then we get to the end of your tenure and Ms Lawrence takes over?
A. Within Datix all the emails sent and received should be saved, so without looking, if I was able to look at them, I might be able to piece that story

together but without that, I just can't recall. I'm sorry.

Q. Absolutely, and I am sure that's something that we can look into. If we just take that down and just look at this from another perspective. The thematic review, which I know that you have recently had a chance to see, and which reaches the conclusion that no theme has been identified and that there are sudden and unexpected deteriorations, some of which have no explanation, was that the sort of report that should have been considered by the Women's & Children's Care Governance Board?

A. It should have been received there.

Q. You as part of your preparation I think have had a chance to consider the board meetings for both April and May and we can bring them up if you want, but I am sure you will be able to agree with me that in fact although you are recorded as present at both of those meetings, the thematic review was not tabled at either of them?

A. I don't recollect, sorry.

Q. Is that something that would help you to have a look at if you don't have it in mind?

A. Yes, please. Each month looks at the month before, so I would have expected if it had been

completed, but looking at that the email and the Datix, if I was chasing the incident review in April, then I wouldn't -- I hadn't -- I wouldn't have had it for the May report, if that makes sense.

Q. But if you were sent the thematic review on 2 March, then as we have seen from the email, then it would be available to you and others to table it from that date?

A. I just wonder why I have written that I have chased it again in April.

Q. One explanation is that you haven't realised it being an email you are copied into that you have it?

A. Have I then written that I have received it later on? No.

Q. No, because in fact as we will get to, it seemed like a fresh document to you when your colleague Annemarie Lawrence showed it to you in May and so I am just -- if we triangulate these pieces of information, we have got the fact you appear on one interpretation to be chasing it, we have got the fact that on the records it hasn't been tabled by you in April or May?

A. (Nods)

Q. And we have got the fact that it appeared to you to be a brand new document when your colleague was showing it to you in May.

So if you take three pieces of information, an interpretation for your comment is that you just didn't notice that you had been put on copy or didn't realise that you had it on 2 May -- 2 March, when of course you were performing those two roles?

A. I really don't remember either. I -- I would be guessing.

Q. Well, let's just come then to deal with the events involving your colleague Ms Lawrence. We know that she started at some point in May of 2016, in fact she's recorded as attending the 19 May Women's & Children's Care Governance Board.

Shortly after she joined your department, I think she came and had a conversation with you?

A. (Nods)

Q. And I would just like you, please, to help us with exactly what happened.

A. Annemarie approached me I think one morning quite early and asked me to have a look at this, and it was a table of the children -- the babies with Lucy Letby identified as present in some capacity for each of the deaths or collapses.

Q. If we just bring up what you were looking at so there can be no misunderstanding about this INQ0003251, page 9. You can have a look at this and see

whether I have identified the document that you were talking about. Forgive me, I don't think that is the document that I was intending to come up. By all means consider that but I don't think that that meets the description that you have previously given.

Just bear with me a moment. INQ0003217. I'm sorry if I read that out incorrectly. This is the appendix 1 Neonatal Mortality 2015 January to 2016.

Obviously we have applied some ciphers but we can see the "Staff allocated", "Staff on duty" columns. Is that the document that to the best you can recollect that Ms Lawrence brought to you or was it a different one?

A. I can't be 100% certain. I just know that what I looked at had a column where Lucy Letby was identified as being present on duty.

Q. Well, this is not the best page to start on because the first entry doesn't appear like that, but if we look at Child A we can see in the "staff allocated" column, if we go over the page because that first entry is the exception, we can see that for Child C, she is in the right-hand column, we can see for Child D, she is in the right-hand column, if we go over the page just to satisfy you, Child E, she is staff allocated, for the next child, she's right-hand column.

Does that help you with the sort of pattern that you were looking at?
A. Yes.
Q. So Ms Lawrence came to see you, brought a document and what did she say to you?
A. She just asked me to look at it and what did I think the fact that Lucy Letby was on duty when each baby either died or collapsed?
Q. Did you do that?
A. Yes.
Q. And what did you say once you had had a chance to consider the document?
A. I said that Annemarie needed to go and speak to Ruth about it.
Q. Why did you say that?
A. Because it is quite a significant trend to have the same member of duty on staff for all those occurrences.
Q. Now, other witnesses have drawn a distinction between the staff allocated and the staff on duty and have used the fact that Letby is not always staff allocated as being somehow significant in the interpretation of this chart.
That doesn't seem to have been the approach that you were taking; is that fair?

A. Sorry, can you say that again?
Q. Absolutely. Was it sufficient for you that she was either on duty or allocated to the baby?
A. Yes, because just because she wasn't allocated to a baby doesn't mean she wouldn't have been involved in some care, if she was covering a meal break. It's still a trend that she's on duty all of those times but it could be for any other number of reasons and it needed more investigation.
Q. So you told Ms Lawrence to go and see Ruth Millward?
A. Mmm mm.
Q. At the time did either of you describe your thoughts about this trend in terms of its potential significance or otherwise?
A. I don't think so, not that I recollect.
Q. What was your view about the potential significance of the trend that had been shown to you and that you had seen for yourself?
A. I didn't really have a view, it was just one piece of information that was quite a significant trend. It could be for a number of reasons so I didn't know any other background information.
Q. And you tell us in your witness statement that you thought that the theme identified could be

a significant finding and should be discussed with Ruth Millward?
A. (Nods)
Q. So did Annemarie Lawrence tell you that is what she was going to do?
A. I know that she went and did it virtually straight away.
Q. Yes, and did she speak to you immediately afterwards or after some time?
A. Fairly soon afterwards, I don't know exactly. But she did say.
Q. What did Ms Lawrence tell you had been said between her and Ruth Millward?
A. That Ruth had dismissed her and told her that she shouldn't be saying or implying things like that and it needed more investigation.
Q. What did you understand her to mean by "implying things like that"?
A. That with -- that it was a deliberate harm or that it could be a deliberate harm.
Q. I mean, is that something that crossed your mind when you looked at the trend as a possibility?
A. Not at all.
Q. So when you looked at it that hadn't crossed your mind?

A. It would be more of a competency issue would be your first thoughts if something recurrent is happening with a member of staff.
Q. But then Anne-Marie Lawrence comes back to you, says that her concern has been dismissed and then is talking in terms that you understood might imply that deliberate harm had been caused or was being alleged?
A. Sorry, say that again?
Q. Not at all. When Annemarie Lawrence came back to you and said that she shouldn't be implying things like that, correct me if I am wrong, but it sounds like the idea or the implication that deliberate harm might be being caused was suddenly in the room, so to speak?
A. Yes, yes.
Q. When that was said to you, what were your thoughts about whether that was at least a possibility based upon what you had seen?
A. I agreed with what Ruth alleged to have said in that it needed more investigation.
Q. But Ruth--
A. Ruth had said to Annemarie.
Q. That it needed more investigation?
A. Yes.
Q. I thought you had said that her concern had been dismissed and that she shouldn't be implying things

like that?
A. But also that it needed more investigation.
Q. Who did you understand from Ms Lawrence was going to carry out that investigation?
A. Well, Annemarie and Ruth, that side of the team.
Q. So did you think that it was staying with Ms Lawrence to investigate?
A. Yes. But also it could have been if -- if there were any concerns about a certain member of staff it would often be a HR investigation rather than a clinical incident investigation and I think this probably crossed borders.
Q. What about it being a safeguarding issue?
A. Yes. But that would come as part of an incident investigation that would be included in that.
Q. Obviously investigations take time. If there is a safeguarding issue, do you agree that it needs to be acted upon immediately?
A. Mm-hm.
Q. So did you have any discussion with Ms Lawrence about whether or not immediate action needed to be taken to safeguard babies?
A. No.
Q. Looking back on it, why do you think that you

be harming patients?
A. Not deliberately, no.
Q. So this is the one and only time in your experience that that has been, as I have previously termed it and you have agreed in the room, so inherent in the conversation that you are having?
A. (Nods)
Q. Looking back on it, do you think you should have done more to make sure that the matter was being progressed or do you think your response was reasonable?
A. If I had had any more concerns, I would have escalated them but I didn't have any concerns and I didn't -- with the knowledge I had it wasn't enough to escalate any further with that one piece of information I had and so I am sure in that situation again, without the benefit of hindsight, I would probably do the same again.
It wasn't my role to undertake any investigation and I knew that there were people who did have that responsibility and trusted them to be doing that and I had no reason to think that they weren't.
Q. The last thing I would like to ask you about is a reflection that you added at the end of your witness statement. I will just read out to you what you said:

didn't raise that or discuss that in those terms?
A. Because I didn't think of any -- any thing that deliberate.
Q. Well, you have told us that the idea that it might be deliberate harm was inherent in what was being fed back to you.
A. It's a bit difficult really to remember exactly with the length of time. I just knew it needed more investigation to -- to find out exactly what was happening.
Q. Did you ever follow up with Ms Lawrence or Ms Millward about whether or not that investigation was progressing?
A. No. I had my own role to do and I trusted both Ruth and Annemarie to undertake those further investigations and nothing ever came to me afterwards to suggest that that wasn't happening.
Q. But if nothing was happening, then nothing would necessarily come back to you?
A. But I didn't become aware of any other concerns from anyone.
Q. In your role over the years in the Risk and Patient Safety Department, I am not asking you to name the incident, but had you ever come across a situation where it was even suggested that a member of staff might

"I think that the concerns raised by the paediatricians were not acknowledged or taken seriously enough or soon enough by the Executive team."
I just wanted you to help us with whether that was as a result of things that you saw happening or whether that is an impression that you formed having read newspapers and so on. So if you just help us with what that reflection is based upon?
A. So it is the latter, it's what -- what I now know following the investigations and the criminal trial. Because I wasn't aware at the time what was happening.
MR DE LA POER: Mrs McMahon, thank you very much indeed.
A. Thank you.
MR DE LA POER: I don't have any more questions for you.
There are no Rule 10s.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms McMahon I have got no questions for you.
A. Thank you.
LADY JUSTICE THIRLWALL: Thank you for waiting all morning and you are free to go now.
MR DE LA POER: My Lady if I just check, no thank you very much indeed, it occurred to me I needed to make

a check -- I have now made that check, I'm sorry to interrupt.

LADY JUSTICE THIRLWALL: That is all right. Are we ready for the next witness?

MR DE LA POER: Yes, we are.

Annemarie Lawrence, please.

MRS ANNEMARIE LAWRENCE (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

Mr De La Poer.

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

A. Mrs Annemarie Lawrence.

Q. Mrs Lawrence, is it correct that on 8 July of this year you provided to the Inquiry a witness statement?

A. I did, yes.

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

A. They are.

Q. Did you qualify as a midwife in 2006?

A. I did.

Q. And did you start in the role of midwife at the Countess of Chester in 2014?

A. I did, yes.

Q. And in May of 2016, as we have just heard from Ms McMahon, did you take up the role of Risk Midwife?

A. I did.

Q. And just to summarise how you came by that role, did you see the job advertised within the hospital buildings?

A. Yes, it was on one of the staff forums within the central labour suite as expressions of interest to apply via the NHS Jobs Trac system.

Q. I am terribly sorry and I don't mean this in any way critically, can I just ask you to keep your voice up a little or move slightly closer to the microphones. That would be really kind. Thank you very much?

A. Yes, of course.

Q. So you saw the job advertised and did you consider that you meat the criteria that they were identifying?

A. I did, I went to speak to my current manager, after she had asked me to have a look at it on the board, she felt I had the necessary knowledge and skills and she thought I would be a good fit for the role. So I did apply.

Q. The application involved you making a presentation to Ruth Millward and Julie Fogarty; is

that right?

A. That's correct.

Q. You were then appointed to the role effectively taking over from Debbie Peacock as the full-time occupant but in practice taking over from Janet McMahon who had been doing the job for about three months?

A. That's correct.

Q. What you tell us that the role that you undertook required -- well, let's put it a different way: tell us what you thought the role of Risk Midwife involved?

A. I thought the role would be regarding the day-to-day incident management, the governance facilitation guidelines, governance board, et cetera.

It was very multi-faceted but it would be involving midwifery and the neonates as well.

Q. So on the subject of neonates, you were, before this role, a midwife by background and training?

A. That's right.

Q. Did you consider that you were able to provide a risk role for a department that you weren't trained to work in?

A. Yes, because we don't undertake this role as sole practitioners. We work as part of

a multi-disciplinary team, so I would always be within the capacity of neonatal nurses, neonatologists or paediatricians.

So if there was anything that needed any expert guidance per se, I would go to the expert for that relevant area.

Q. And bearing in mind your role involved looking after the neonatal department, or unit, as much as it did the midwifery obstetric side of things, did you ever ask why you were the Risk Midwife as opposed to a broader term that included neonates?

A. I think certainly over the last few years leading up to maybe 2018, when there was some national guidance published, neonates was very much added on to maternity as an addition.

Maternity is very much nationally driven by various drivers, et cetera, and the workload and incidences is significant compared to other areas and therefore it takes up a large proportion of time that isn't the same within neonates, gynaecology or children's and that has changed over the last few years with the publication of MBRRACE and PMRT, et cetera.

But certainly at that time, it wouldn't have warranted a full time officer for that area.

Q. In terms of where your focus lay, and the

hours that you were spending, do we infer from your previous answer that most of your work was involved looking at the midwifery obstetrics side?

A. It was, yes.

Q. Just to complete the picture as far as you are concerned, in 2019 did you take up the role of governance matron for the Women and Children's Hospital at the Wirral University Teaching Hospital?

A. I did, yes.

Q. And in 2020, were you promoted to clinical service lead for obstetrics and gynaecology?

A. I was.

Q. When you were training as a midwife, and then practising, did you receive any safeguarding training specifically in relation to what you should do in the event that you were concerned that a member of staff was harming patients?

A. Not specifically for a member of staff, no. I think that is a gap within our national safeguarding training because certainly, when I have looked back retrospectively at the various trusts I have worked in across the north-west and when I did my training, it wasn't covered in any shape or form within safeguarding training specifically for harm by a staff member or service user.

Q. Now, you have described it as a gap. Obviously we are going to get to a moment in time where you were presented with some particular information and you reached some particular conclusions about it. Would it have helped you navigate that situation if you had had such training?

A. I think so and that is an area of reflection for myself over several years now. If I'd have had the knowledge I have now back in 2016, then I do believe I would have escalated further. It may be that I would have continued not to be listened to, but at least I would have tried harder than I did at the time.

Q. Now, you went from practical on-the-ward midwifery into a non-patient-facing role in the Risk Department as Risk Midwife?

A. Yes.

Q. Did that involve you having a greater degree of interaction with the Datix system?

A. Yes. I worked significantly with the Datix system.

Q. So presumably you had some prior knowledge of it from the point of view of a clinician on the ward putting -- making entries?

A. Yes.

Q. Did you receive any additional training when

you joined the Risk Department in terms of how its other functions worked and what your role was with that?

A. Yes. We had a Datix compliance manager, or administrator he was at the time, who talked me through the back office functions, and then we also had the office PA, Joanna Donnelly, who filled in for the Datix administrator who knew the system inside and out. So if there was anything you needed and you were unsure of, she would always be on hand to help navigate or help a workaround if you were unsure.

Q. Now, we are just going to spend a short period of time looking at when a Datix is required. Was it an important part of your role as Risk Midwife to have a clear understanding of when a Datix was required?

A. Absolutely. Because a large part of my role was as educator as well, with some of the visits to the clinical areas, sometimes you hear things, sometimes you see things, and sometimes you know when -- once something should be submitted. So it's really important to have a very clear understanding of both the obstetric and the neonatal pick list, as we called it, which is a selection of incidents that would automatically normally generate a Datix being submitted.

It's important to have that knowledge on the tip of your tongue so that you can use it in action when you

are in those clinical areas.

Q. And of course you have this unique perspective, as far as Inquiry witnesses are concerned, is that you practised on the labour suite, no doubt --

A. Yes.

Q. -- filling in Datixes yourself up until May of 2016, at which point you effectively went behind the curtain and were able to see what happened to them after that.

Did your knowledge and understanding about the importance of ward level Datix completion change once you joined the Risk Department?

A. It really did, yes. It was very much an eye-opener because I got to see -- if you don't fill in a certain box, I got to see the ramifications of that in the background. So how difficult it is if you don't include the staff involved in an incident at the time you submit the Datix. It can be really difficult to go back at a moment in time, especially if the incident reporter is on annual leave for a period of two weeks. Sometimes you are coming back several weeks later and people's memories are not what they were, and you may miss an opportunity to identify somebody or something that was important at the time.

Q. Now, we are going to look at some policies in

a moment, and this isn't by any means a test or vie of you but we have heard the term "Serious Incident" and we have heard the term "Incident" and you use both in your witness statement.

A. Yes.

Q. Can you just help us to understand what you understand to be the difference between an Incident and a Serious Incident?

A. Yes, absolutely. So an Incident is -- certainly in midwifery and more so in neonatology over the last few years, we submit an incident report for things where there is a deviation from normal. And, as I say, in midwifery certainly we use an incident Datix submission for a data collection as well. So we will collect data on the number of third degree tears whether or not they have been caused or have occurred, and I will give an example of that, if I may.

So a lady could deliver at home without a midwife present and could experience a third degree tear. We wouldn't have caused that harm by an individual but it is still a harm that has occurred to the woman and should be reported. So that would be an incident. And then a Serious Incident is where there has been an act or omission of care that has contributed, or may have contributed, and, as we move into PSIRF, which is the

Patient Safety Incident Response Framework, which it wasn't in place in 2016 so I don't want it blur lines or things, but it's really important that we look at harm suffered versus harm caused as well because the experience of a neonatal death, for example, in an expected death -- so a baby that is incompatible with life -- we used to grade those incidents as "no harm" because there is no act or omission that would have prevented that baby's demise.

However, when you look at it from the point of view of the patient and the family, for them to see that incident graded as "no harm" was quite detrimental to them because it's not no harm to them, which is why we have moved over into the Patient Safety Incident Response Framework so we are a bit more empathetic as to the impact on our women and families.

Q. Now, we are going to look at this in more detail with Ruth Millward but it may have been on your radar at the time, it may not. But we know that in June of 2015, so whilst you were still working as a midwife, she sent an email which was to this effect: that child death, so outside your area of work, is no longer included as a Serious Incident by definition in the SI framework or on STEIS. However, it may be reported as a Serious Incident under another category.

So, in other words, it would appear that a policy change has resulted in how events should be categorised.

You don't need to comment upon that, particularly if you don't know about it, but was it your experience that there were evolutions in what was expected and how things were defined over time?

A. Yes, I think -- and in some ways it shows a good link to the latest available evidence. It's really important as clinicians we stay as current as we can and we maintain our clinical credibility.

So being aware of the latest guidance and updates I think is really important. I won't share my personal view on that if you don't mind but ...

Q. Now, you comment in your witness statement about the approach, as you perceived it to be, to Datix on the neonatal unit. I will just read out what you have said:

"The neonatal unit staff did not approach the Datix reporting system in an open and transparent way. They would often only report an incident if they felt it was avoidable or there had been an obvious omission in care."

A. Okay.

Q. So a number of things to ask about that.

A. Yes.

Q. The first thing is when you say "neonatal unit staff", are you talking all staff or are you talking doctors or nurses or Consultants, or managers? Who do you mean by "staff" when you say that?

A. I mean every person who works within the neonatal unit umbrella.

Q. Obviously you frame that in the past tense "did not". So we just need to understand what our date parameters are. Presumably, that wasn't an opinion you held before May 2016 because you didn't have access?

A. Absolutely.

Q. So this is from May 2016?

A. Yes.

Q. And over what period from May 2016 did that apply?

A. I am not certain of the dates with any certainty. But there was a change in leadership from the Neonatal Risk Department and there was a Dr Dangerfield who was appointed into that risk role.

And after her appointment, the department seemed to be much more amenable because she -- she got risk. That is the only way I can describe it really. She understood the impact of acts or omissions and that risk isn't just about managing the incident that's happened, it's about learning from acts or omissions and

preventing the next incident from happening.
There was certainly an improvement after the Royal College review as well. So kind of after the Royal College, maybe September, October time, and then up until the point where Jo Dangerfield, Dr Dangerfield, took over things definitely improved after then.
Q. Can you give us a year when Dr Dangerfield took over?
A. '18. Definitely she was there by '18.
Q. Now, you have chosen to use the words "Did not approach Datix reporting system in an open and transparent way". And what you go on to say might be thought to imply that you thought that this was deliberate or in some way calculated as opposed to born of confusion or ignorance.
Can you help us with whether that is what you are implying, that you thought that they knew they had to fill out Datixes for certain situations and they made a cynical decision not to fill them in, or whether it might be a misunderstanding, a cultural misunderstanding, about the importance? So can you help us with what you are meaning to imply?
A. I think there is an element of both situations that you have described. I think there were definitely some staff who, certainly new to department, may not

have understood the need to report certain things.
But there was also a number of other staff who I would say purposely didn't report things until they had discussed it with managers or Consultants to agree that something should be reported. They certainly didn't do it freely in the same way that the maternity service did.
Q. Well, I'm afraid can you help us please with who?
A. Band 5 nurses, Band 6 nurses, some shift leaders, although I wasn't sure of their grading at the time, and certainly some managers as well.
Q. And is that all on the nursing side or are there any doctors involved in this?
A. I suppose there would be some Registrars involved in that, although I definitely couldn't give you names of that. But what they would do is they would come along to the Incident Review Group or they would come along to an MDT forum, they would discuss it and they would be in agreement in that meeting that, yes, it should be reported and then an incident form would be submitted.
Q. And from the point of view of your impression of the Consultants in this issue -- and we will get to your relationship with Dr Brearey -- but speaking about

the Consultant body, was this a concern that you had about the Consultants, that they were cynically and deliberately not filling in Datix until effectively they had no choice?
A. Yes.
Q. And which Consultants are you referring to?
A. I think I would say the body of Consultants. What you -- what I found certainly in neonatology was they all stuck together. If -- they wouldn't go against one another. So even if they thought somebody had made a clinical omission, rather than report it, they would have a conversation first Consultant to Consultant.
So I would say, yes.
Q. Just to understand that. I am not here as an apologist for the Consultants but, based on what you have just described, a reason for doing that may be to check that in fact an error has been made by getting a second opinion by someone who's perhaps a bit more objective about it, a little less introspective about it. I mean, is that a legitimate way to approach the Datix system or the moment you think you may have created -- done something in error, are you obligated to immediately declare it without further reflection?
A. Well, it has to be safe to undertake that submission. So if you are involved in a clinical

incident and you are still working clinically, it wouldn't be appropriate to step away to submit an incident form. But any individual can submit an incident form. Even if you don't have time on your clinical shift, you can hand it over to the next person. But generally we say as close to the time of the event as possible, that is when you should submit the form because your memory is as fresh as it can be.
Q. And it's not appropriate to take a colleague aside before you do that and say, "Look, this has just happened. I just want to check whether you think anything has gone wrong here"?
A. I wouldn't say that it's not appropriate because there may be situations where the situation, for example, that conversation has just manifested itself, there was an opportunity and the clinician has taken it. So I wouldn't say there were times when it was never appropriate to do that.
But Datix should be used to learn lessons. It is an open and transparent way of improving the safety and culture of a hospital. So my view to it is that it should be done regardless.
Q. One of the matters of interest to the Inquiry, and which is commented upon in relation to the immediate internal investigation of July 2016, was whether or not

there was adequate completion of Datix and, from the Inquiry's point of view, children who suddenly and unexpectedly collapsed but who did not die is an area of interest.

So I just want to gauge your opinion as someone who worked in the Risk Department. If a baby suddenly and unexpectedly deteriorated but was successfully resuscitated and no error in care was identified at that time, was a Datix form required in 2015/2016?

A. So are you asking me whether I think it was required?

Q. Yes, as in mandated by the hospital policy at the time.

A. I don't think it was mandated per se because I don't think it was in the pick list at the time and that was some of the challenges that I faced as a newcomer to the organisation, that the Risk Department was that, trying to amend the pick list to have the appropriate things in there.

There were some things that were out of date and some things that, on the information that I had been researching, I felt should be included but wasn't and when put that to the clinicians the view wasn't reciprocated.

So if you wanted to add something like that,

there'd have to be a consensus and an agreement among the clinicians to have the pick list changed. It was quite difficult to do.

Q. Well, let's just have a look at the policy and it was put on screen earlier today. INQ0010022. Were you sitting in when your former colleague Ms Peacock was being asked questions about this?

A. I was, yes.

Q. Well, that is extremely helpful to know. If we go over the page, we can see there the duties applied to all staff and there is a sort of reflection expected of the Risk and Patient Safety team which is once it comes to them, they should be making sure it goes back to the local level so that managers are aware. So we have seen all of that. We don't need to go over that again. Let's look at that definition that was considered this morning, page 3:

"What should be reported? An event or circumstance which could have resulted or did result in unnecessary damage, loss or harm to patients, staff, visitors or members of the public."

And then some examples are given:

"Clinical affecting a patient eg, investigation, diagnosis, treatment, medical equipment malfunction, misuse, decontamination issues, medicine management,

confidentiality, consent."

So a list of examples.

Now, Ms Peacock read the word "unnecessary" as only applying to damage as opposed to applying to loss or harm. What was your understanding at the time as to whether or not unnecessary applied or was this not a close reading that you gave it at the time?

A. I think I had a different view to earlier.

Q. So you think that "unnecessary" applies to loss and to harm as well? So it needs to be unnecessary harm to focus on what we are concerned with?

A. I think it's unnecessary damage, unnecessary loss or unnecessary harm, yes.

Q. So for harm, which is what we are focused upon --

A. Yes.

Q. -- that is the most important thing because that is talking about patients as opposed to property?

A. Absolutely.

Q. Unnecessary harm. And, of course, if we think about how harm was being interpreted at that time, you have told us about how there's been a change in understanding and a more empathetic approach to harm --

A. Yes.

Q. -- in fact, "harm" was meaning harm that the

NHS has or may have caused; is that right?

A. That is how I understand it.

Q. When we talk about harm, perhaps the most striking example of that, if we look at INQ0000111 -- this is the Datix for Child C's death -- we can see that this is right in the middle "subcategory expected/unexpected death." So the report is not about some aspect of care but about the death itself. That is the pick list item?

A. Yes.

Q. And then result: "no harm."

A. (Nods).

Q. And that's perhaps the most striking illustration --

A. It is.

Q. -- because the notion that death isn't a harm to the patient is plainly ludicrous in an ordinary understanding, but in the way that the word "harm" was being used for Datix it means harm that we, the NHS staff, have or may have caused?

A. That's the way they were interpreting it back in 2015, yes.

Q. Absolutely. And when you combine it with the word "unnecessary" -- and we must be careful not to be too lawyerly about this -- but "unnecessary" means

something that could have been prevented?
A. Absolutely. Avoidable.
Q. And so that really adds to the understanding about harm and the approach you should take. Now, obviously we have got an exception to that because an unexpected death, or an expected death for that matter, is in fact required to be reported by Datix. But that doesn't actually fit within the hospital policy at the time, does it?
A. No.
Q. I mean, it's plainly an exception. It may not be if the death, whether expected or unexpected, has been caused by some NHS staff action, but whether or not that happens -- and Child C and the Datix is a clear example of how that was being thought about at the time -- the mere fact of death is reportable?
A. Absolutely.
Q. So when we think about the position of the staff on the neonatal unit and how they should be approaching a sudden, unexpected collapse that they have no explanation for at the time, so no malpractice is suspected, no deficiency in care has been identified as being potentially causative of that, we know why those collapses were caused now, under the policy, would the staff have been expected to fill in a Datix?

A. It's a difficult one, isn't it, because the communication that went out said these didn't need to be reported and yet they sit there on the pick list as you should report it.
Certainly --
Q. Forgive me, I'm sorry to interrupt you, but the pick list for death, yes. I am talking about a collapse that is successfully resuscitated.
A. Oh, sorry, of course.
Q. So no death; so we can't use this category. We have got a sudden unexpected collapse, resuscitation, a very high level of intervention is required, everybody is standing around immediately afterwards saying, "I have no idea why that happened but I can't see that we did anything wrong", no Datix would be required under the policy. Do you agree with that?
A. No, I don't agree with it. I think that is what happened, but I don't agree with it because how do we learn from these events if we don't report them?
Q. My question was framed by reference to the policy.
A. Okay, sorry.
Q. Did the policy, bearing in mind what we have looked at in terms of unnecessary harm, did that require a Datix to be completed?

A. I think it is unnecessary harm though, isn't it? If you can't understand it and you can't explain it, then it should be reported because it fits into that category of "unnecessary".
Q. But then what would you fill in about what the potential cause of it was under the policy?
A. Under the pick list or under the policy?
Q. Well, both. This is the --
A. Because the policy -- we really look at the policy when it comes to applying here and I don't think there would be anybody in the risk team who would hold you against the policy for reporting a collapse. They wouldn't report you for a deviation of the policy for reporting a collapse on Datix.
Q. Absolutely. But I suppose what I'm really trying to get under the skin of is whether you can criticise somebody for not reporting something which the policy doesn't appear to mandate and it's just --
A. I suppose --
Q. -- you've described the best practice?
A. Yes.
Q. But what we are trying to do is -- and there is a different question about whether the policy should have been different.
A. Yes.

Q. But judging people by the policy at the time, can you criticise those clinicians, as opposed to the policy and other aspects of the hospital practice, for not having filled in the form for those collapses?
A. I suppose it would be difficult. It would be difficult to criticise when the policy doesn't support it.
However, me being me, I would find it really difficult not to report it because it's the right thing to do and how do we learn from things we don't understand if we don't investigate? And I think that's some of the challenges that I experienced.
MR DE LA POER: Well, I am sure we can come to that. My Lady, I wonder if that is a convenient moment to break.
LADY JUSTICE THIRLWALL: Certainly. For how long, Mr De La Poer?
MR DE LA POER: If we could take a slightly shorter than normal break, I am sure everybody would appreciate that, but I look to the shorthand writer who is very happy to continue. So I am very grateful for that.
So if we could reconvene perhaps just after or on 4 o'clock just so everybody can stretch their legs.
LADY JUSTICE THIRLWALL: Shall we say five past.
MR DE LA POER: Five past, thank you.

(3.54 pm)

(A short break)

(4.05 pm)

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: I am going to look briefly now at an NHS England document relevant to this issue and in particular Serious Incident and what that means.

INQ0009236. We see this is the Serious Incident Framework document I hope you have some familiarity with?

A. I do.

Q. Page 12, please. Forgive me, it will be page 12 internally so that will be 13, thank you, my mistake.

Ms Lawrence, here we are not talking about incidents, which is what one needs for a Datix, here we are talking about serious incidents which is what one needs to have in order to report upwards to NHS England; Is that right?

A. Yes.

Q. We have got a broad definition there:

"Serious Incidents are events in healthcare where the potential for learning is so great."

That is very much your point, isn't it?

A. Yes.

Q. That when it comes to a Serious Incident, there might be a substantial opportunity for learning:

"... or the consequences to patients, families and careers, staff or organisations are so significant they warrant using additional resources to mount a prehensive response."

A. (Nods)

Q. And:

"... they can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare."

Then we have this: there is no definitive list of events, this is the next but one paragraph:

"Incidents that constitute a Serious Incident."

And:

"Lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents."

Now, we need to hold two things in our heads here. We have got what an incident is and that is Datix, and then what a Serious Incident is. The advice here is that for a Serious Incident you shouldn't have a preprepared list that you are working against?

A. (Nods)

Q. I just want you to just help us with how that interacts with the fact that in order to create a Datix, you are looking at a pick list?

A. I suppose that the Datix system and the incident trigger lists are for specific everyday incidents from low to no to moderate to severe or death associated with the incident or not.

When it comes to a Serious Incident, you can send even no harm incidents, no harm incidents -- so an incident graded as no harm by the reporter could still be -- undergo an SBAR if felt significant enough by either the local manager, so the manager at ward level or the Risk and Patient Safety Lead.

Sometimes there was occasions where there would be a cluster of no harms but, for example, there may be complaints and so you might undertake an SBAR and send that to the Serious Incident Panel for the Executives to consider a cluster of low harm incidents which may as it talks about here, impact an organisation's ability to deliver ongoing healthcare, ie it may affect the reputation of the organisation.

So in terms of Serious Incidents like this, if it was serious enough to warrant attention or it developed the Risk and Patient Safety Lead's interest enough, it would go to the Serious Incident Panel but it would be

those Executives who decided in that panel as to whether it was reported or not.

Q. The only way it would in those cluster of individual incidents that in themselves are not sufficiently serious the only way that they will get to the Executives is if a Datix has been filled out for each of them?

A. Absolutely.

Q. So Datix is the gatekeeper?

A. It is.

Q. For whether or not something could be considered to be a Serious Incident, whether a cumulative cluster or an individual event and bearing in mind that Datix operates on a pick list, so you can't get near a decision about a Serious Incident whether it is a Serious Incident or not. I am just wondering how that fits with the NHS England guidance which says you shouldn't operate pick lists?

A. That is for Serious Incidents, though, so the Datix trigger list, there is an option of "other". So somebody could report things under "other" and quite often we found that.

So when you made reference to the handler earlier, the handler would go into what we call a pool where all of the Datixes that come in for the organisation are

located in a virtual pool and in a holding bay and it's for them to work through the incidents but sometimes they couldn't allocate it to a certain area because somebody had selected "other" and that's where the risk in patient safety leads or the Datix administrator would need to navigate that system to try and think of the best appropriate place for that to go.

So I wouldn't want you to think you couldn't report something if you really wanted to because there wasn't a pick list for it because there would be a way to navigate that somewhere.

Q. So in other words the pick list wasn't a closed list, there was an option for more of a free text incident specific description?

A. Yes, it was closed in the sense that I wanted to add things to it and you had to go through various different hoops to get the pick list altered, so that you could pull data from it because you will have to appreciate when you are pulling data from another field, it's meaningless because you pool that much there. So in order to be able to inform future healthcare provision or quality improvement initiatives you have to have that narrowed down in that pick list. So getting that changed was very, very difficult to do but you could get things added through "other".

Q. So a person could have if they had wanted to, thought: this is a unexpected very serious collapse, we can't identify any failing in care that's responsible, but it's the third one that I've seen in recent weeks?

A. Correct.

Q. Go on to Datix, access "other" if you can't find that adequately described?

A. Yes.

Q. And then put in a commentary?

A. And often we would see: I have not found this pick list here so but this is the third case I've seen this week and so I am reporting it, file it under whichever various field you feel necessary. And sometimes they would record things under a relevant Planned Care or Urgent Care, so you wouldn't see it straight away but the beauty about that pool I mentioned earlier, so that where all the Datixes come into is the experienced person working through that Datix trigger list would realise actually that's not paediatrics, that is obstetrics and they would allocate it then to the relevant person and it reduced that risk of error that incidents would be reported but go unseen.

Q. Thank you, we can take that down and we are going to move away from Serious Incidents because obviously that, as you have told us, is for the

Executives to decide and I think it was Ruth Millward who decided ultimately within your department whether something went to a Serious Incident Review Panel; is that right?

A. Yes, at the SBAR we completed -- the "Recommendation" section of that SBAR would be to forward on to the review panel to determine whether any further investigation was required and I believe that was an instruction from the Executives because they wanted to be the people to make that decision as to whether something was STEIS reported or not.

Q. Let's leave Serious Incidents and look at the culture and atmosphere on the NNU and again we need to remember that over our relevant period you wore different hats?

A. Yes.

Q. You were a midwife, interacting with the neonatal unit in that capacity and then latterly you were in the Risk Midwife role where you had oversight from a risk perspective of the neonatal unit.

Now, you say this in your witness statement of the neonatal unit:

"I would describe the relationship between clinicians and managers as far from equal. Nurse managers rarely challenged the medical team even when

they knew they were deviating from process or guidance. They would just go along with what they were told to do."

Which of the two job roles that you held have you derived that impression from?

A. So that is from the Risk and Patient Safety aspect.

Q. So post May 2016?

A. Yes.

Q. How would you know if you are based in the Risk Department that nurse managers are just going along and not challenging the clinicians?

A. Because my role was very much an active role in that when there was Neonatal Incident Review Meeting or a Term Admission Review Meeting, which is every baby who was born over the gestation of 37 completed weeks, we would -- if they were admitted to the neonatal unit, we would review their care completely to determine whether there was any ways of avoiding that mother and baby separation. It was something that we were looking at quite closely in 2016 nationally not just in the Countess of Chester.

And I had lots of meetings with both the managers and the Consultants, sometimes with senior nurses and junior nurses present, but there would be some

discussions and I would prompt the discussion or lead the discussion and I would be hoping for support from the ward managers for that area or the senior nurses.

And I don't feel they had the autonomy or the confidence to -- to challenge the Consultants and certainly it frustrated me at times because -- because I wanted them to -- to feel autonomous to say: actually from a nursing perspective, that's not appropriate or: we are not going to do that. Or: if we could just pause there and find out some more information. They were very much led by the doctors.

Q. Did you witness for yourself any overbearing authoritative dictatorial behaviour from the doctors that might have created that or was the extent of your observation the fact that the nurses weren't speaking up when you had hoped that they might?

A. I think a bit of both. Sometimes we would be in meetings where discussions were a bit fractious and you could see tensions rise in that meeting and you could -- I don't quite know how to describe it really other than the Consultants would become just that little bit louder and the nurse voice would become that little bit lower and they would contribute less into that meeting and then I would always follow up the meeting with a discussion to see if everybody was okay, to see

if they felt their voices were heard, because sometimes it would be they would say: I don't feel -- I feel we need to reconvene and I feel I can challenge it more now I have taken a pause, et cetera. And it would just be decisions around clinical practice or next steps in terms of managing nurses who may or may not have made a -- an error or judgment. For example, in a term admission review or somebody might have contributed something, the clinicians would often influence -- we need to have a conversation with this nurse or we need to do this or we need to do that and it wasn't the same when it came to the doctors either.

Q. In these catch-ups that you had afterwards to check that everybody felt their voice had been heard did anybody ever say to you: look, we just can't speak up at those meetings because what the doctors want, they get, or was it never voiced as a concern like that to you?

A. Only from Eirian Powell who was the ward manager. But at the same time, when she had said things like that she would say they have always been the same and: he will calm down, you know, in a few hours and he will come and see me and he will come and apologise and it will be okay. So she would ask for it not to be escalated further and she would say she would deal with it and it was as though it was a long-standing

relationship that she was used to.

Q. You say there was definitely a hierarchy and some Consultants were more respectful than others -- I will read that to you again:

"There was a definite hierarchy and some Consultants were more respectful than others"?

A. Yes.

Q. That is what you put your witness statement. So which were the respectful Consultants and which were the non-respectful or less respectful Consultants?

A. Do you really want me to answer that?

Q. I wouldn't have asked it if I didn't.

A. Okay so some of our more respectful Consultants were our female Consultants, Mr John Gibbs.

Q. Sorry -- just so you are aware there is a cipher list if you are going to mention female Consultants?

A. Sorry, okay.

Q. So do consult it. It is on the desk in front of you. You said Dr Gibbs, does he fall in the respectful category?

A. Respectful, absolutely and all of the female Consultants.

Q. So Dr Newby initially, although I don't think she overlapped with you, Dr Holt who joined in March of

2016, Dr ZA and Dr V?

A. That's correct, yes.

Q. Yes.

A. Some of our less respectful Consultants were definitely Mr Brearey and Mr Jayaram, although less often with Mr Jayaram.

Q. We are going to come and look at an email that Dr Brearey sent in a moment. What was your relationship Dr Brearey?

A. It was a difficult relationship. I will be honest. Every communication I had with him felt it was more difficult than it needed to be and I didn't understand why at the time. I have a little bit more detail, having been prepared for the Inquiry, I've seen some emails one I think that you are going to show me today which references him not being included in the decision to appoint a midwife to the role, I think that may have been why he was very offhand with me when I started in the role.

It certainly -- I understand now as to why he felt the way he did at the time and I think that was how our relationship started off on the wrong foot. I very much have an appreciative enquiry, I will press and press and press. It's just in my nature and I don't think it was welcomed or appreciated by Mr Brearey.

Q. We will come to that email in due course. Just concluding your reflections upon how you perceived that department, you say this in your witness statement. "The neonatal team considered incident reporting to be punitive"?

A. (Nods)

Q. Was that something that you inferred from their behaviour or was that something that they said out loud?

A. That was something that was said out loud, certainly on several occasions by Mr Brearey to begin with especially in the very first few weeks of me starting because I was trying to get them to understand the importance of incident reporting and things that did not impact on the outcome and that was a real culture shift around that time in incident reporting and risk and governance because prior to that and around that time certainly in the neonatal units they were reporting things that were related to the outcome, so something that may or may not have played a direct part or process in what happened to the individual whereas within obstetrics we had moved away from that and started to pre-empt improvements in care so we were looking at incidents whereby something had happened related to something totally different but you found it as an

incidental finding.

So in reviewing the care of a woman who may have experienced a stillbirth you look at the care from the moment she booked and you look at the care right the way through until she is discharged from your care and the incident you are looking at might be a post partum haemorrhage at delivery. But if you found something in the antenatal period which didn't impact on the outcome but was an opportunity for learning, we would report that as an incident because otherwise we don't learn those lessons from it.

And it's that that I am talking about we were trying to apply to neonates and they perceived that culture change as our clinicians will see that as punitive, they won't understand that it's around the next lessons learned. So ensuring the next individual does not experience that same incident. And it was really, really difficult.

Q. So we are going to move to the --

LADY JUSTICE THIRLWALL: You said you had started that in the first few weeks when you arrived, you wanted to introduce that shift?

A. Yes.

LADY JUSTICE THIRLWALL: Thank you. Can I just ask something else. Everyone else has referred to

Dr Brearey and Dr Jayaram and you are describing them as "Mr" which is the first time I have heard them described as "Mr". Which is correct?

A. We normally call junior doctors "Dr" and the Consultants are normally referred to as "Mr" in my experience in the NHS.

LADY JUSTICE THIRLWALL: I think "Mr" is usually a surgeon, isn't that it?

I am just thinking of all the other doctors, all the female doctors are "Dr" and they are all Consultants.

A. The women would be.

LADY JUSTICE THIRLWALL: Yes.

A. You wouldn't call a female Consultant "Mrs"; you would always call her "Dr". That is just the way I have been raised within the NHS.

LADY JUSTICE THIRLWALL: I see just that everyone else has referred to them as "Dr" that we have heard it may be entirely irrelevant.

A. Thank you.

LADY JUSTICE THIRLWALL: Sorry to take time about that, Mr De La Poer.

MR DE LA POER: Sure.

We have seen the minutes of a meeting on 19 May of the Women's & Children's Care Governance Board which

record you as being present in the role of Risk Midwife. I give you that date to try and help you understand when you started the role.

A. Yes.

Q. Does that sound about right?

A. Yes, that was my first governance board.

Q. That was your first governance board.

Had you had any handover from Mrs McMahon?

A. Yes -- yes, and no. I think to be fair to Mrs McMahon, she was doing two roles at the time and there was a -- I suppose an overview given of certain things that needed to be completed at that time but some things that she was close to completion with she kept hold of and we kind of drew a line in the sand, if you like, for any incidents, new incidents or things happening after I had been in post I think for two weeks I would deal with and she would keep everything up until that point.

Just for consistency and certainly from a patient experience perspective because we link in with our women and families very closely, it made sense for her to conclude those elements of it before.

Q. Now, we know the thematic review of neonatal mortality meeting took place an 8 February, we know that the finalised report was completed and dated 2 March?

A. Yes.
Q. You were in the hearing room this afternoon when I showed Mrs McMahon an email which she and Ruth Millward were copied into receiving that report on the 2 March. Did Mrs McMahon speak to you about that report as part of the handover or when you took over that role?
A. No.
Q. Did Ruth Millward speak to you about that report?
A. No.
Q. You have since learned the content of the report?
A. (Nods)
Q. Bearing in mind that we know that it arrived in both of their inboxes on 2 March, should they have spoken to you or either of them spoken to you about that report when you took up your role?
A. I think there is two things there, yes absolutely, they should have spoken to me. I think in hindsight, today is the first time I've seen that and I think looking back into 2016, I doubt very much that either of them opened the attachment to that email and as you pointed out in your questioning of Mrs McMahon, that is likely -- it's likely due to the volume of work

that both had at the time.
It's not -- it's not an excuse for them. But they should have opened it and it should have been known when I took over in post and I was incredibly disappointed seeing that email come up because what happened and the challenges I had upon trying to get hold of that report and subsequently escalating that report should never have happened and I can see that now by seeing that email dated 2 March.
Q. We will come to the conversation which you found out about it but let's just talk about how you have characterised it.
A. Yes.
Q. Without any knowledge of that email, and the fact that Dr Brearey had sent to two members of the Risk Department that report, you characterise the conversation that you overheard and the reaction to your request as being a bit secretive?
A. Yes.
Q. Exchanging looks, reticence on their part that you perceived to providing you with that report. I just want to give you an opportunity to reflect upon that in light of what you now know and whether you think that is a reliable impression or not.
I am not for a moment suggesting you are right or

wrong about it but you now know that in fact it was shared with the Risk Department --
A. It was shared previously.
Q. -- on the day that it was published and not just with one person but with the head of risk as well.
So just to give you an opportunity to reflect upon your characterisation and impression of those two as they spoke, and whether you think that that is a reliable impression that you formed?
A. I would possibly say on reflection it can't have been the right impression because there would have been an opportunity to take that report to governance both in the March given that it was shared on 2 March, the March, the April and the May.
So the fact that I got it and then took it in the June is irrelevant because it was shared openly and transparently with the governance team at the time.
Q. Reading between the lines, tell me if I am wrong about this, but you seem to be suggesting that you got the impression that they did not want it to go to the Women's & Children's Care Governance Board?
A. I did.
Q. That was your take-away from looking at their body language and the looks they exchanged and the words that they used but I think you would be bound to accept

now that they can't have intended that, certainly not on 2 March 2016?
A. Well, I don't think in that email I saw there was any mention of it going to be the governance board.
Q. No.
A. So that conversation might have come up if they would have known or seen it was tabled as an agenda item, so we may have come to that conclusion further down the line, or we may not of. But certainly, my impression was they didn't want me to see it, hence me now reflecting and thinking although I must be not mistaken because I am very vivid of the body language I saw, I saw from their body language there was something in that report that they did not want me to see and that's why, when I went to it, I was looking for something specifically which is what I found, I didn't look at the content of the mortality reviews in any detail per se because there was nothing jumping out at me which is why I continued to look through the whole of the report because I was looking for something that would tell me why they were -- why their body language showed the body language in the way that it did and eventually I found it.
Q. Let's just deal with that conversation in terms of what was said, you have given us a clear

impression of the unsaid things. But you tell us you overheard the two of them speaking?

A. Mm-hm.

Q. Did they mention expressly in that conversation the thematic review or what was it that caught your ear?

A. It was mortality review that -- that I meant that I heard and like I say, the appreciative enquiry of me is: can I have a look at it? And they advised that -- sorry, Mr Brearey advised that it wasn't for sharing and obviously I continued to press and I had asked: when has it been to governance board because I knew I could go back and access the agenda and papers, I felt it was important if there was a mortality review for an area that I was holding risk responsibility for that I needed to see it and I needed to be aware of the content. And so I was a little bit like a dog with a bone at that point, because I thought there was information there which was important to my role and I needed to see it.

Q. If we go to the end, how did you end up receiving that?

A. Mr Brearey I think emailed it to me.

Q. So whatever had taken place in the conversation there came a point when he said he would

give it to you and then he did?

A. He did, yes.

Q. Had it occurred to you in that conversation to go back to the Risk Department and ask whether there was already a copy on file or did the conversation just evolve organically and there wasn't that opportunity?

A. No, I did go back and I checked the -- we had what was called an S drive at the time, I checked the folders and looked myself to see whether there was anything that would fit that description and obviously there wasn't.

Q. So again, knowing how the Risk Department works and drawing an inference it would appear that neither Ruth Millward nor Janet McMahon had taken it from the attachment --

A. Yes.

Q. -- and put it in the S drive folder?

A. Yes, they definitely hadn't otherwise it would have been in there.

Q. So you read the report when you received it and can you give us an approximate date, was it before the end of May?

A. It was before the end of May, yes, I think it was very close to the end of May because I am just thinking how I managed to get it on the agenda for

governance board for the June. So it would have had to have been at least the 30th, 31st or 1 or 2 June to have made that agenda. But yes, close towards the end of May.

Q. You read it as you have told us very carefully looking for something that might have caused you to form the impression that you had?

A. Yes.

Q. What was it that you identified?

A. It was in the appendix section, there was a grid which you have shown during today's proceedings which identified a number of babies who had been subjected to a unexplained or unexpected death and there was a staff present and staff on duty grid and apart from the first column on the page, every other column had a nurse's name identified in each of them and I got a highlighter out and I went through it with a highlighter and I think once I had highlighted through it, it kind of jumped off the page a little bit more obvious to me.

Q. Now, you heard me asks Mrs McMahon this question. Other witnesses have placed particular store by the fact that Letby's name wasn't in the nurse allocated to the child column. What was your view of the relevance of that to the significance of what you

were looking at?

A. I -- I did think about that at the time but I look at it to my clinical practice and often we are not caring for individual women but we are involved in their care, so we might respond to a normal buzzer, a care buzzer, an emergency buzzer and that would apply in the role of neonates as well.

You know, nurses have breaks usually, when we have got staffing levels we relieve our -- our colleagues for breaks and just because she wasn't allocated that baby does not mean she wouldn't have had access and for me it was something so obvious it just jumped off the page to me.

Q. When you read the balance of the report, did you see any indication that what you were seeing had been identified or discussed?

A. No, so I read it in more detail afterwards, after I went into Ruth and Ruth said what she had around, you know --

Q. We will come to that in a moment but tell us when you read it in more detail?

A. I went back to it and read it and I thought I must have been wrong because when I had looked through each of the case reviews there was nothing that anybody -- they just hadn't highlighted it as a common

denominator, there wasn't -- there wasn't the recognition, I think, it wasn't obvious. So when I took it to governance board there wasn't that same discussion and I certainly didn't mention it again after the conversation with Ruth.

Q. We will come to that governance board. So having read it, we will go back in time a little bit?

A. Yes.

Q. Having read it, having applied your highlighter, having decided that you need to do something, did you go and speak to Janet McMahon?

A. I did, yes.

Q. Just tell us briefly what did you say to her and what did she say to you?

A. I went to Jan and I said: Jan, can you have a look at something for me? Obviously I am brand new to role, I am clinically very experienced as a senior midwife but this governance role was -- I was only maybe two, three weeks in post at that point and I didn't know whether I was seeing something that was really obvious or whether I was barking up the wrong tree. And Jan's response was, she looked at it, she looked at what I had highlighted and she said: we need to go and see Ruth.

Q. Up until that moment, whether said out loud between the two of you or simply in your head at some

point, had you considered the possibility of deliberate harm?

A. I think that's what was jumping out the -- was jumping out the page to me because having a cluster of deaths, it can be unusual it cannot be unusual. It's not unusual in maternity to have a cluster of stillbirths if we have, for example, a community acquired infection, parvovirus, for example, sometimes we can have clusters which wouldn't be unusual, but over the year they would balance out. We don't normally have real spikes in stillbirths.

But because I was new to the neonatology world and new to risk it looked really, really obvious that there was a real anomaly here that needed further investigation. But then I -- when I escalated it and I felt that I went to somebody more experienced to say: is this something I have found when I got the response I got, I thought maybe I had misunderstood and I didn't challenge that because I didn't have the experience.

Q. There I think you are talking about the conversation you had with Mrs Millward?

A. Yes.

Q. So you have spoken to Janet McMahon?

A. Yes.

Q. She has told you that her view is you are not

barking up the wrong tree?

A. Yes.

Q. Did you go immediately to see Ruth Millward?

A. I did. I went straight to see Ruth, she did have a really open-door policy, she was very amenable, I had only been there a couple of weeks at that point but that open-door policy continued even after that, that incident.

So I went to see Ruth and I explained to her first of all the challenges I had getting hold of the report because I felt like that was -- that was important. Without that background information, I don't think it gave the -- I don't think it gave the same narrative.

You know, I watched the non-verbals between two people who it felt at the time did not want me have to have that report and I have since reflected this afternoon. It may be because there is a link then to the information being shared within the maternity department, I don't know whether they trusted me professionally at that point because they had only just started to work with, me whether confidentiality would be maintained and maybe that's what the non-verbal conversation was. I don't know.

But I explained to her the challenges I had in putting my fingers on the report and the non-verbals and

the reluctance to share it with me.

I had shared that with Julie Fogarty as the Head of Midwifery before that in our one-to-one, I had some very regular one-to-ones to begin with and she had said: Mr Brearey is really amenable, go back to him, ask him for it again, et cetera. So I shared with Ruth the challenges that had led up to me getting hold of it and that I had gone there specifically looking for something to leap off the page and it did.

And I showed her -- I had the report out to show her but she didn't want to look at it.

Q. Can I just pause you there for a moment. Did she at any point in your conversation say: I don't know why you had such difficulty getting it, you could have asked me, I had a copy --

A. No.

Q. -- emailed to me?

A. No.

Q. Did she give you any indication at all that she had seen that before?

A. No, never. She didn't say she hadn't and she didn't say she had. She didn't look like she didn't need to see it because she had already seen it before. She just didn't -- she didn't look.

Q. I should have asked this at the time, but in

terms of Mrs McMahon, again did she appear to you to have seen that document before or did it appear to be new to her?

A. It appeared to be new to her. When I showed it to her she actually looked, she went through because I don't know whether you could tell on the digital display but you had to turn over several pages to look at all of the names because there were that many and she paid attention to the document, she looked at it, looked at the highlighted and then there was again an unspoken verbals between us and she said; you need to go to Ruth.

Q. I have gone back in time. Let's go back to Ruth Millward. Just tell us as close as you can remember it what did Ruth Millward say to you after you talked her through the difficulty you had, what you had found and the highlights you had applied?

A. As I have said in my statement the exact words I -- I couldn't tell you with 100% certainty. But it was something along the lines of, you know, you need to be really careful, Annemarie, you can't come in here and just start throwing accusations around about an individual nurse being present for all of these deaths, you need to have -- you need to have evidence, you need to -- just because she's present and on duty doesn't mean that there is a link and I know you are new to Risk

and Patient Safety, you know, but you need to be really, really careful and mindful and you need to have something proper to be able to go and like raise alarms.

Q. Did you form any impression about whether what you were suggesting namely that a particular nurse was associated with an increase in mortality was something that Ruth Millward already knew or whether she was talking in general terms about what you should and shouldn't do?

A. I thought she was talking in general terms. I don't -- I didn't get the impression at all she was aware of anything and I didn't know that until I got the information from the pack that that was I believe the only -- the first time she did know anything according to -- to her information.

Q. So she's warned you effectively not to make allegations like that, was there any more discussion between you or was that the end of the conversation?

A. No, she just said you need to be really careful and really mindful that, you know, you have got evidence to support what you are saying, you can't just go round saying these things. And I left her office and I will be honest, I am under oath, I felt embarrassed.

I felt extremely embarrassed, I was new in post and I felt like I had embarrassed myself in front of my

boss. So I came away and I looked at the mortality review in detail and I went through all of the information in the pack and -- and I thought: okay, I must be barking up the wrong tree because there is no mention of this commonality in any of the -- the information within the pack and I will just chalk that up to experience and I am new to role, so that was that.

Q. Did you think that the idea that you had had, namely that it required investigation, effectively ended at that point or did you think that anything more would be done?

A. I thought it had ended at that point. I suppose in hindsight I kind of hoped something might have happened afterwards. But obviously the next thing that happened was we had two further deaths and ...

Q. There is one event that we need to look at between the conversation and that is we will just briefly bring it up on screen INQ0003212, this is the Women's & Children's Care Governance Board meeting.

We can see it is on 16 June, we can see that you attended, you are listed under the Planned Care department as Risk Midwife although in fact your role was across both divisions, wasn't it?

A. Yes.

Q. If we go to page 5, we can see that it was

tabled at that meeting and who was responsible for that.

A. So the agenda is prepared under -- with discussion of the chair, whether that is Mr McCormack or Mrs Fogarty in his -- if he is on annual leave. So if -- if it was Mr McCormack or Mrs Fogarty I would need to see the front page again but generally the agenda is prepared for under the instruction of the chair.

Q. But was this a spontaneous decision by the chair or did you have anything to do with?

A. Oh no, I had asked for it -- I had asked for it to be put on the agenda having got hold of it at the end of the month.

Q. We can see wording which is largely taken from the report --

A. Yes.

Q. -- concludes with:

"There was no common theme identified in all cases."

A. Mm-hm.

Q. That's what the minutes show to anybody reading them. In fact, you had identified a common theme, hadn't you?

A. I had, yes.

Q. So just talk us through your reasoning as to why, unless these minutes are wrong, why that theme

wasn't articulated and why instead the official record is no common theme?

A. I think at the time the report was tabled as an agenda item, we were looking at the content of the report and what the report had found, that's generally how reports are received and noted and minuted in governance.

My theme that I had identified was outside of that report process so this is -- is a snapshot of what the report had found rather than what me as an individual had had seen outside of that fact.

Q. This being a governance meeting, attendees are entitled to scrutinise what is put in front of them, it is not a rubber-stamping exercise.

A. They are yes.

Q. So the person you are now, attending a meeting like that, would that meeting have been an appropriate forum to say: well, I have had a look at this report but I've seen a theme?

A. The person I am now would absolutely have had that discussion in that -- in that forum at that time and -- and looking back I think because nobody else had raised the issues that I raised, I think it kind of confirmed to me that when Ruth had said; you need to be really careful about this, nobody else had picked up on

it and I think it kind of cemented that I had obviously got the wrong impression and that wasn't what I should have done, you know, I -- I didn't escalate beyond Ruth. That was my route of escalation and if that was to happen now and I was still in a junior role, I would -- I would absolutely have learned from what happened in 2016 and I would have continued to escalate.

Me being in the role I am in currently today I would be the person who was raising that in that forum and then if it wasn't being escalated up through the Planned Care governance board I would have been going directly to the Executives myself to say you need to do something about this and if I wasn't satisfied I would continue to escalate.

Q. Did you think of the issue that you had identified as a safeguarding issue? Did you think of it in those terms?

A. It would have been a safeguarding issue absolutely. You know, a member of staff doing what happened, in this example is -- is a safeguarding concern. Absolutely.

And your next question will be why did I not escalate it to safeguarding?

Q. Exactly so.

A. Because I -- I was embarrassed about finding

something that I thought wasn't -- wasn't it was just something that was in my mind and nobody else's.

Q. So we will just move forward to the deaths of Child O and Child P here really just to illustrate a point. You didn't find out about those deaths until Monday, 27 June; is that right?

A. That's correct.

Q. They having occurred on 23rd and 24th?

A. Yes.

Q. If we just run through your experience. You were on the central labour suite when you overheard discussion about it and that led you to go into the neonatal unit; is that right?

A. The Practice Development Midwife Lorraine Millward, when I came on to the central labour suite, seeing me and said: oh my goodness, Annemarie, have you heard that one of the triplets have died? And I was shocked. I said: I haven't heard anything, nothing has been reported and she said: none of us can believe it but one of the triplets have died.

So I said: I am going to go there now, the delivery suite was connected to the neonatal unit and so I made my way straight there and there was a lot of people on the neonatal unit, several more bodies than I would ever normally see, and they prevented me from entering

further into the neonates. Obviously they knew who I was, some people might not have done because I was only in post a short time by that point.

But those who didn't, I said I am the Risk Lead, I have come here, I have heard one of the triplets have died and it's not been reported and one of the staff nurses -- one of them got tearful and upset and the other -- another staff nurse said: two of the triplets have died, not one.

Q. Who wouldn't let you on to the unit?

A. So there was a number of staff there, they had said that there was a meeting taking place in the office and they were not to be disturbed. I asked them to disturb them and said: I am the Risk Lead and I need to be involved, I need to know what's going on. But they wouldn't let me in.

Q. Just again, who?

A. The -- the staff members present I didn't, I didn't --

Q. Were they doctors or nurses?

A. They were -- there were no doctors outside, they were nurses.

Q. So you asked to join the meeting that you were told was going on and you were told by them that you couldn't?

A. Yes.
Q. Did they go and make an enquiry?
A. They did, I asked them to go, knock on the door and tell them who I was and what my role was and they would let me in, and she did that and came back and said: they said they are not to be disturbed.
Q. We don't need to bring these up but did you go back to the Risk Department to check on the Datix system to see if you had overlooked --
A. I did.
Q. -- the filing of Datix?
A. I checked to make sure I had overlooked it but my normal practice is every morning when I used to come in, we all did this as risk leads. Some of us like me actually did it the night before we came in just to see what -- plan our workload and if things had happened the night before sometimes I might go to -- you know, straight to -- to the labour suite because the building we were in is not was not connected to the hospital.
So sometimes I would look the night before to see but I did go back to the office and I checked the -- the pool that I talked about, the holding bay, and I also checked under the relevant searches. So, for example, somebody might have put it in and put it under "paediatrics" for example. But I double-checked

everywhere with I think Joanna Donnelly and nothing had been reported.
Q. That was because we now know there was nothing to be found because the Datix --
A. Yes.
Q. -- for Child A and P are both dated the 29th, aren't they?
A. Yes.
Q. Now, we just need to deal briefly with a number of events and I will try to be as efficient as I can about this, but you shouldn't feel inhibited by that.
A. Okay.
Q. You participated in a mortality review on 5 July of 2016, is that right, in relation to Child O and Child P? Were you aware of that taking place?
A. I would need to --
Q. Well, I think in the circumstances I don't have any particular questions about the detail of that so we will leave that one for now.
Can we turn to the extraordinary meeting, as you describe it, in July of 2016?
A. Yes.
Q. This was a meeting which was attended by Sian Williams and Julie Fogarty; is that right?

A. Yes.
Q. Alison Kelly you tell us was also present?
A. Yes.
Q. So far as you can recall, was anybody else present?
A. There was lots of people there. Some I know to be Executives because I was -- around that time I was trying to be staff governor so I was getting to be a bit more familiar with -- with who people were so I knew there was a couple of Execs there but I couldn't have told you the names of them in that respect.
Q. Were you looking at staff rotas, is that what you were doing in that meeting?
A. No.
Q. What were you doing?
A. No, it was -- they had asked us to look through the Meditech and look and try and identify any collapses or deteriorations and look for a name -- look for Lucy's name associated in the notes.
Q. At that stage did you make the connection with what you had seen at the end of May?
A. I did, yes. I think I made it a little bit before that if I am honest before that meeting, after the babies had died.
Q. So far as any unspoken agenda for what you

were doing was concerned, did you perceive one or was it just as far as you were concerned a good faith search for -- through the records?
A. No, I knew they were, when I say I know, I didn't know, nobody came right out and said specifically. But I -- I knew based on what they were asking me to do that they were looking for other cases that may or may not be connected to Lucy.
Q. You tell us that your notes of that work were taken off you at the conclusion?
A. (Nods)
Q. You also tell us that you undertook a Datix search subsequently for cases --
A. Yes.
Q. -- involving Letby and you found that there were missing records?
A. Not missing records in relation to the search per se, but there was a number of IT systems that we searched and a number of reports that were run and they were put into a folder in -- in our risk and governance S drive. I think if I remember it was Dean Bennett at the time -- and Jo Donnelly at the time who were also searching their systems. We all contributed into the folder and then one day that folder had just disappeared and I don't think it was very long after, a couple of --

couple of days, maybe a week or so and the folder just no longer existed.

Q. Did you ever speak to anybody about or get to the bottom of why that was?

A. I did ask Ruth where the folder had gone and she told me not to concern myself with it. So I just thought it -- access has been restricted from me or that it had been moved to for example one of the other department S drives or Y drives that clinicians such as me wouldn't have had access to.

Q. I do need to ask you about an email that you have since seen sent by Dr Brearey. I will just ask for it to come up on screen, please, INQ0006769. You have seen this email before. It is dated 15 July?

A. I have, I saw it on Friday.

Q. On Friday. So if we just scroll down to get the context so everybody can follow, your boss Ruth Millward had made a request of Dr Brearey in terms of some information to support the RCPCH review, we can see that down there?

A. Yes.

Q. We don't need to go to the detail of that. What we are going to be look at is what Dr Brearey says about you so that you have an opportunity to comment upon it.

So if we just go back to the preceding page, we can see that Dr Brearey begins by making some observations about the timing of providing the material. He then goes on to say that he's completely underwhelmed by the support:

"... your department [that is the same as your department] has provided this year. Concerns are shared by colleagues, nursing staff on paediatrics, neonatology and obstetrics."

Then we can see:

"To think the role of Risk Midwife was created without any discussion with paediatricians or consideration that she would have to cover neonatology is quite concerning. I also have concerns about Annemarie's competence. Both Eirian and myself sat down with her at the beginning of her job to explain her role and our expectations, the most significant [we will need to go over the page] of which was to arrange a monthly incident review meeting. Seemingly forgotten. We are now at a point where I will be meeting to go through three months' worth of incidents. I value her contribution to the weekly term admissions audit. There have been times when busy on-call Consultants have come to review cases at agreed times and she's not been present and not given her apologies. I have also

offered to meet to discuss with you term admissions reporting and yet I am yet to receive a reply. I've not seen Annemarie for over a month. In addition ..."

And he goes on to talk about the fact that he's heard that there is criticism of the Datix reporting and he makes the point about the fact that it's consistent with other neonatal units on the network.

So really this is just to give you an opportunity, Ms Lawrence, to comment upon this and whether it is right to your recollection that Dr Brearey hadn't seen you, that you hadn't turned up for meetings without giving your apologies, and that you were not supporting him and his colleagues adequately.

A. Like I say, I saw this on Friday. I was disappointed when I read it. It felt an unfair representation. I had been in post at that point -- I had started in May. This was the 14 July, I think. There was an awful lot that had happened between starting in post. Some mandatory training -- obviously I had done some training in relation to risk and incident management and the NHS England framework, so I have to have time to undertake mandatory training -- and I was also working clinically at the time as well.

So clinical credibility was extremely important to me when I started in the role. And there was some

staffing challenges, so I also worked as a Band 7 labour ward co-ordinator, as well as my role, at the time for probably the first six months but only maybe one long day every week or every fortnight.

I think the first sentence where he says he's been underwhelmed by the support from the Risk Department for the most part of that year, I think he's got a fair point because when Debbie left in February to ask another Risk Leader with a whole other service to cover two -- what would be two whole time equivalent jobs is no small task.

So I think you can't continue to run a really good service with less people, otherwise we wouldn't employ these people to do the jobs and certainly in Risk and Patient Safety at the Countess, it's got to be one of the most under-resourced Risk and Patient Safety teams I have ever known in my experience in maternity, maternity departments per se, and I have worked in a few units in my career across the north-west and including the Midlands. So it would be fair to say he's got a point because there were some absolute gaps in the service.

I am disappointed that he says he's not seen me for a month and he has issues around my competence because if he hasn't seen me for a month at that point, and

I have only been in post about nine weeks at that point, then he's made a summative assessment in a very short space of time and I would have liked an opportunity to have commented at the time he sent that, rather than left it unchallenged and unsaid.

Q. I have got two more topics to ask you about.

A. Okay.

Q. Both of them, I hope, brief. Take that email down, thank you.

We know that Letby was moved to your department. In summary, what was your view about whether it was appropriate for her to work in your department?

A. I don't think it was appropriate and I certainly voiced that in the beginning and the response was that she was working in the Complaints Team and wouldn't be working in the Risk and Patient Safety Team.

But what I think my Lady is not aware of is the Risk and Patient Safety team and the Complaints Team are on the same floor. So we have only got a door that separates the two of us with a very, very small corridor, not as long as where you are away from me. So although she was working in the Complaints Team initially, she was working -- she was making tea and coffee in our office because that is where the tea

machine was and I didn't think it was appropriate.

Q. Who did you say that to?

A. Ruth and I had a conversation initially and Ruth's response was that -- I think she said she had asked for her in the beginning. She was concerned about how she would how it would be handled with her and she felt like she wanted to give her a constant whilst the review process was going on.

Q. So far as you were aware, did Letby have access to patient notes or reports such as the thematic review had she wished to look at them?

A. I think if she wanted to look at them, she absolutely could have because she had access to the Risk and Patient Safety team S drive. Now, I don't know whether her access was limited in terms of what folder she could or couldn't access. But you will notice from my statement I talk about her having information that I didn't have at that point and so I think it's fair to say that if you were to ask me would she be able to access these things, I would say that would be a possibility, yes.

Q. Did you think it was appropriate for her to have access to things that you didn't have access to?

A. Absolutely not, and I did report that to -- that incident to Karen Rees at the time. Just for the

benefit of my Lady, if she's not sure of the incident I am referring to, on coming to work one morning, as I came up the stairs, Lucy came out of the office, out of her office on that corridor, to greet me and she was very distressed.

She almost jumped down my throat really with a "there's been a collapse and a baby's been transferred out and does that mean somebody else is going to be under investigation and I can go back to work". And she bombarded me with a lot of questions and I didn't know what she was talking about because I wasn't aware of a collapse because, as you know, at the time there was some challenges around whether we were reporting them or not. But she knew this information and it hadn't reached me. It wasn't in the Datix system. It wasn't emailed to me. And so I emailed Karen Rees to say, "I am concerned that Lucy has had access to information that she shouldn't have. I wonder whether there is something in the neonatal unit who was feeding her information". But it concerns me that she knows something clinically that I don't know as the Risk Lead.

Q. Was that an email that you sent?

A. It was, yes.

Q. Can you give us an approximate date so that we can see if we can find that?

A. Oh, gosh. I would say it would definitely be the autumn of 2016.

Q. Thank you very much indeed.

Finally on this topic before we just deal briefly with root cause analysis, what you say in your statement is:

"We were made to believe that she was being made a scapegoat for poor medical care and a lack of team working which then conflicted me further."

So there are two parts.

A. Yes.

Q. We will get to the conflict in a moment.

A. Yes.

Q. But who was making you believe, or seeking to make you believe, that she had been their scapegoat?

A. So that was conversations, lots of conversations were had, not directly with me because I was a Band 7 Risk Midwife at that point, but conversations were had without I think any thought to confidentiality. Lucy would have conversations with her Union rep and also some of the managers and things would be overheard, they would walk along the corridors and there would be conversations that would be happening and if you were walking behind them closely enough or if you happened to be walking the other way, there was

information that you were able to, able to glean from their discussions or if you entered into a room it would take a minute or so before those discussions quietened down.

Q. Who was saying that she was being made a scapegoat, was she saying that or were the people she was speaking to telling her that?

A. Both, really. She had I think -- I think from the information I had available to me at the time, and like I say it wasn't a conversation I was included in but it was something I was listening to on a regular basis, they were conversations between Hayley Cooper who was her Union representative, Lucy, Karen Rees, some discussions with Ruth but then Ruth left and then those discussions took place with Julie Fogarty -- sorry Julie Fogarty after, after Ruth left so there was often things that you could hear.

Q. And were the people you have identified Hayley Cooper, Karen Rees, Ruth Millward, Julie Fogarty, were they simply offering a listening ear or were they contributing, making comment themselves about whether it was true that she was being made a scapegoat?

A. I think at the time that's what they truly believed. I don't think they were intentionally being unprofessional in terms of knowingly having

a conversation that would be overheard. But where they had those conversations and often with doors that weren't closed it was -- it was obvious to anybody who was working nearby and many times we have -- I say "we" me and other members of the team, who haven't been as close to the door have got up and closed the door because you can hear things coming into the office and when you are trying to concentrate and trying to write things and there is a group of people having a conversation outside it can be very districting.

Q. The second part of what you said "then conflicted me further", I just want to give you a brief opportunity to just comment upon how you were feeling about this whole situation bearing in mind what had happened in May?

A. I was hoping you wouldn't ask me that question, if I am honest. It's something I have reflected on for many, many years. It was a very, very difficult time. I was working alongside somebody who initially I had thought had done some terrible, terrible crimes and then I -- I can't say I was made to feel because nobody can make me feel anything but I felt ashamed for raising them.

And then I spent some time thinking if I had have just raised them a little bit louder potentially I could

have prevented the deaths of two of those babies and I didn't. And then I had to work with her alongside her listen to conversations that perhaps she might have been innocent and it was really difficult. And having heard some of the things I have heard today and seen some of the evidence, a lot of that was avoidable, certainly a lot of the deaths were avoidable and a lot of the difficulties we faced as clinicians working in that department was avoidable.

Q. The final topic is the root cause analysis. You tell us that in April of 2017 you were asked to conduct a root cause analysis in relation to Child O and Child P and that you looked at Dr Hawdon's report and the RCPCH and generated those reports based upon that content.

A. Yes.

Q. You reached three conclusions, three identical conclusions in each case and we will just have a look at it. INQ0018008 and we will look at the conclusions that you reached in the root cause analysis. We will go, please, straight to pages 9 and 10. So this is for Child O but the text is exactly the same, I am sure you can confirm for Child P?

A. It is, yes, just very different timelines but the text is --

Q. The Coroner's cause of death instance was given as complications associated with prematurity and in addition this investigation has identified no one singular root cause but several that may well haven --

A. Contributed to the outcome.

Q. Which include, if we go over the page: we can see that at the top there is that hanging paragraph in italics in the centre: significant sub optimal care that is possibly relevant to the outcome, failures in care to recognise problems and a failure to act appropriately?

A. Yes.

Q. So the conclusions that you are reaching in this root cause analysis are pointing towards NHS staff failings in care quality.

I mean, firstly is that a fair summary of the conclusions that you are raising as possible?

A. I think that is a fair representation of the conclusions but I must say I --when I -- when I was asked to put the findings of the various reviews into a report, I must say this is what I have taken out of those and I have put together in a way that it can be read by the CCG.

So the majority of it is not my words or my thoughts. It's me concluding the documents that are available to me.

Q. Did you know that in late March of 2017, the Executives were discussing putting together a bundle of documentation for the Cheshire Police?

A. No.

Q. We know it wasn't until the end of April that the Cheshire Police were contacted through the CDOP. But was it appropriate taking into account that fact that you were writing a root cause analysis in relation to the deaths of Child O and Child P where you were specifically drawing attention to failures in care as being a potential explanation for those two deaths, whilst it was in active contemplation that those deaths may have been murders because the police were required?

A. It was not appropriate, no and that information wasn't shared with me. Through Ruth Millward, Ruth asked me to -- that she said that Alison Kelly had asked her to ask me to put this information which was a number of documents could I culminate it into a template that could be submitted to the CCG. And so when I sat there and it took me a significant amount of time to put these documents together because I had to go from one piece to the next piece to the next piece and so forth, it was on the understanding that the CCG were looking for an MPSA Level 2 report that they could receive in the

Alison Kelly wanted these reports created in April of 2017 because of course we know the deaths occurred back in June, we know that the reports came in from the RCPCH and Dr Hawdon. But why April? Were you given any information at all about that?

A. No. The only thing that Ruth had said was that they had been requested, they needed to be -- they needed to be received at the CCG Serious Incident Review Group and I know from previous where they have -- they perhaps have sent separate documents, the CCG have asked for them to be collated into a thematic review or something that they can receive in their entirety.

So I suppose at the time, given my junior position I didn't really question it or question the integrity of the ask, because it wouldn't have been unusual for the CCG to ask for a few things to be brought together under one document if indeed that was the ask from the CCG based on what you have just said.

MR DE LA POER: Mrs Lawrence, thank you very much indeed for answering my questions and can I particularly acknowledge the time, and I take full responsibility for that, there is no reflection on you. My Lady, I am told that although permission has been granted for Rule 10 it would appear that I have covered the issues that needed to be covered and so there are no further questions from

Serious Incident Review Group.

Q. From the point of view of official paperwork a root cause analysis is a very well identified way of capturing potential learning within the NHS, isn't it?

A. It is, yes.

Q. And it is the sort of document that might be shown to board members in the case that they have an enquiry or to, as we know, the commissioning group and I just would like to just tease out, if I may, your reflections, given particularly you hold a senior role now, about the risk of creating a root cause analysis such as you did, in circumstances where other people might read it and get the wrong idea that everything had been adequately investigated and ascribed to a particular cause, can you just from your experience help us understand that, please?

A. Absolutely. So at the time, I was given an instruction and I acted on it. But in a senior role now I can see that the submission of this Level 2 was an attempt to move from reassurance to assurance. So we are telling you we are looking into it but here is of proof of such in a Level 2 document. I can see how that could mislead many people in the organisation and also outside agencies as well.

Q. Were you given any reason as to why

the advocates for Mrs Lawrence.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you. Mrs Lawrence, I have just got a couple of questions myself.

When you went to see Ruth Millward, you say you gave her the or showed her the report and she didn't want to look at it. But what did you say to her?

A. I -- I went in the room and I said: I wonder if you have got a minute which is how I normally would start those conversations and then I had the report in my hands and it was open and I said: I need to tell you about this report I have got here and the challenges I have faced in getting it, because I need you to understand what it is I have found. And I proceeded to tell her about the discussion that I witnessed between Stephen Brearey and Eirian Powell and the non-verbals which I felt were particularly important and that I sat with that document purposely looking for something based on the non-verbals and the reluctance that I had felt when I had asked for a copy.

And she did -- when I say she didn't look at the report, what she did was she said she didn't want to see it but she did acknowledge that yes, okay, so you have got somebody present for all of these deaths but, you know, what does that mean?

LADY JUSTICE THIRLWALL: Had you pointed out that that was what the report showed that there was someone present for all, did you say that to her?

A. Yes, absolutely, I had highlighted -- each section on that table I had highlighted with a yellow highlighter so it kind of made it a bit more real and it came off the page a bit more.

LADY JUSTICE THIRLWALL: Then that was when she said: you have got to be very careful, or whatever it is she said, we have a note of that?

A. Yes.

LADY JUSTICE THIRLWALL: You don't need to repeat that. I just wanted to know what you had said from your perspective after setting the scene.

Then just one last thing. You sent an email to Karen Rees about Lucy Letby's conversation with you which you have described?

A. Yes.

LADY JUSTICE THIRLWALL: Did you get a reply from Karen Rees?

A. I did. So I do believe there is access to my email, so it should be in my "Sent" if not in Karen's "Received" and Karen then went on and sent a -- she sent a circulatory email through herself and Eirian to say something around being mindful of professional

conversations, don't be discussing things outside of work. So I think they address addressed it generically rather than specifically is my understanding but that information will be in the NHS mailbox.

LADY JUSTICE THIRLWALL: All right. Thank you very much.

A. Thank you.

LADY JUSTICE THIRLWALL: Yes, those are all my questions, thank you very much for staying so late --

A. Thank you.

LADY JUSTICE THIRLWALL: -- and being so comprehensive and helpful in all your replies. Thank you for coming. You are free to go now, please don't wait for me to leave.

A. Thank you.

LADY JUSTICE THIRLWALL: Now, Mr De La Poer we start again on?

MR DE LA POER: Monday, 4 November, we will begin with Karen Townsend and then Ruth Millward will be heard later that day.

LADY JUSTICE THIRLWALL: Thank you very much. So we will rise now until 4 November but I hope that -- I won't say anyone will have a rest because I know you won't, but thanks for all the hard work to date.

May I especially mention the shorthand writer whose

efforts are Herculean and, as far as I know, uncomplaining. I am very grateful to her.

We will rise now.

(5.20 pm)

(The Inquiry adjourned until 10.00 am on Monday, 4 November 2024)

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